MINISTRY OF HEALTH

County Government Of
KAJIADO

DEPARTMENT OF MEDICAL SERVICES AND PUBLIC HEALTH

KAJIADO COUNTY

COUNTY NUTRITION ACTION PLAN 2024-2029

A County Free From Malnutrition In All Its Forms

Kajiado County Nutrition Action Plan

2024 - 2029

Vision statement

A county free from malnutrition in all its forms

Mission statement

To provide effective and efficient preventive, promotive and curative nutrition services through nutrition specific and sensitive intervention within the county.

Core Values

Integrity
Quality
Accountability
Ethics And Equity
Collaboration And Partnership
Technology And Innovation
Efficiency And Effectiveness
Sustainable

FOREWORD

Proper nutrition is one of the critical foundations for the development of a healthy and productive workforce, with the first 1000 days of an individuals' life being the most critical period.

Investing in proper nutrition for all population groups across different ages and diversities and especially for women and children, will be essential in achieving the overall developmental goals for Kajiado County.

Kajiado County Government recognizes that the high rate of malnutrition is a threat to achieving Sustainable Development Goals(SDGs) and Vision 2030 and goes against our constitution, which emphasizes the right to the highest standard of health. Reducing the rates of malnutrition in Kajiado is not just a health issue but calls for a multi-sec- toral approach where different sectors join hands with a common goal. Men and women across all ages and diversities must be empowered to claim their right to proper nutrition and provided with equal opportunities and enabling the environment to meaningfully contribute to an equal benefit from the development agenda towards realizing this right.

Kajiado County Nutrition Action Plan (KCNAP) has been aligned to Key County strategic documents such as the County Integrated Development Plan(CIDP), County Health Strategy and Investment Plan(CHSIP), and County Medium Term Expenditure Plans (CMTEP). The solutions to solving nutrition issues are practical and basic; the CNAP has outlined a road map for reaching the goal. It provides practical guidance to implementation and a framework for coordinated implementation of proven and cost-effective High Impact Nutrition Interventions (HINI).

This CNAP will facilitate mainstreaming of the nutrition budgeting process into County development plans, and subsequent allocation of resources to nutrition programs.

The County Health Management Team (CHMT) shall be directly in charge of coordination and the implementation of the plan at the county level. On the other hand, the Sub-County Health Management teams (SCHMTs) shall oversee the devolved coordination system at the sub-county level, which will feed into the county level coordination unit.

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

Alex Kilowua
CECM Medical Services and Public Health Kajiado County

PREFACE

Eddy Kimani

Good health has been identified as a crucial driver to improved development in the country. Kenya set up the development blueprint in Vision 2030 under the economic, social, and political pillars, aiming to provide an effcient and high quality health care system with the best standards. Nutrition is fundamental to the achievement of good health among the population.

Stephen Pelo

Proper nutrition lays a strong foundation for future productive lives, as evidenced by research. The first 1000 days offer a window of opportunity for healthy brain development and adequate growth and development.

It has far-reaching effects on the cognitive development of children, academic performance, and work performance in adult hood. Investing in proper nutrition for women, adolescents, and children host benefits that are carried on to the next generation.

Existing challenges and constraints are beyond an individual, a unit, or a department. Beyond early exposure to adverse conditions such as illness or inappropriate diets and feeding practices, poor diets as the immediate causes of malnutrition underlie the socio-cultural, political, and economic factors contributing to malnutrition.

With this realization, the Kajiado Department of Health brought together other government line ministries, agencies, and development partners to enrich the county nutrition action plan to ensure a shared multisectoral approach to ending malnutrition.

The process involved revising the 2nd CNAP (2019-2023) and considered the lessons learned, best practices and challenges in the implementation towards achieving proper nutrition for all and has come up with the 3rd generation CNAP 2024/25-2028/29. KCNAP, therefore, focuses on three main areas of intervention; nutrition-sensitive, nutrition-specific, and an enabling environment.

A lot has been done by the County Government to implement existing nutrition policies and guidelines through integration into the county government policy documents and to set up necessary structures. Despite all this, the county still faces immense challenges to the achievement of the laid targets like perennial droughts affecting the community's livelihood.

In an effort to ensure effective and sustainable nutrition outcomes and health-related outcomes, the action plan has integrated gender-responsive interventions to address the underlying and deep-rooted gender inequalities, socio-cultural and economic differences.

This in turn closely affects the improved food and nutrition security and wellbeing of men and women across different ages and diversities in the county. This is in line with the several conventions targeted to achieve gender equality, women empowerment and sustainable elimination of hunger and malnutrition.

These include but not limited to sustainable development goal 2, on the elimination of Hunger, SDG 5 on promoting gender equality including SDGs 1,3,4,6 and 10. The Convention of the Rights of the Child, Convention on Elimination of all forms of Discrimination Against Women and the Declaration of Human Rights, are vital in creating an enabling environment for improved and sustainable food and nutrition security. Inaction is costly, and as a county, we are convinced that this county nutrition action plan will propel our county towards achieving nutrition for all.

Eddy Kimani
Chief Officer, Public Health

Stephen Pelo
Chief Officer, Medical Services

ACKNOWLEDGEMENT

Dr. Lydia Munteyian

Samson Saigilu

The Kajiado Department of Health takes this opportunity to appreciate everyone who participated in the development of the County Nutrition Action Plan (CNAP) 2024-2028. The CNAP could not have been finalized without the valuable contributions and full commitment of the technical committee members of different working groups drawn from both the government and partner organizations. The support from the Ministry of Health, Division of Nutrition & Dietetics is highly appreciated.

This CNAP was developed with financial support from Nutrition International (NI) under the Institutional Support Grant (ISG) from Global Affairs Canada (GAC). Special thanks go to Nutrition International staff led by Geoffrey Kinyua, Mary Kihara and Simon Gacheru, and United Nations Children's Fund (UNICEF) Kenya staff Harriet Namale, for the immense technical leadership support in the entire process of developing the CNAP 2022/23 to 2024/29. Further, we express our sincere gratitude and indebtedness to Feed the Children (FEED), Welthungerhilfe (WHH), Kenya Red Cross Society (KRCS) and Trust for Indigenous Culture and Health (TICAH) for technical and support in developing this County Nutrition Action Plan.

The contributions of the following ministries in providing overall leadership and technical inputs to the CNAP are also highly appreciated: This mainly goes to Ministries of but not limited to Health; Education; Water and Sanitation; Gender, Youth, Culture, Sports, Social and Children Services, Finance and planning, County Emergency Unit, Agriculture and Livestock. The contribution of the County Executive Committee Member (CECM), Chief Officers Medical Services and Public Health, the County Health Management Teams (CHMTs), other Health program officers and Sub-County Nutrition Coordinators (SCNCs) and Nutrition Officers during the development and validation of the CNAP is gratefully acknowledged.

Special appreciation goes to Ruth Nasi koi County Nutrition Coordinator, for the overall leadership during the entire process.

Lastly, the County Department of Health greatly appreciates the technical support of Leila Odhiambo -Deputy Head of Nutrition and Dietetics at the Ministry of Health and Lilian Kaindi -Technical Support Nutrition Information Technical Working Group (NITWG) for providing technical support throughout the whole development process.

Dr. Lydia Munteyian
Director, Medical Services

Samson Saigilu
Director, Public Health

LIST OF ABBREVIATIONS AND ACRONYNMS

AAK	Agro-chemical Association of Kenya	**IYCF**	Infant and Young Child Feeding
AIDS	Acquired Immunodeficiency Syndrome	**KAP**	Knowledge Attitude And Practice
ANC	Antenatal Care	**KCNAP**	Kajiado County Nutrition Action Plan
ASDSP	Agricultural Sector Development Support Programme	**KDB**	Kenya Dairy Board
BETA	Bottom-up Economic Transformation Agenda	**KDHS**	Kenya Demographic Health Survey
BFCI	Baby Friendly Community Initiative	**KEBS**	Kenya Bureau of Statistics
BFHI	Baby Friendly Hospital Initiative	**KHIS**	Kenya Health Information System
BMS	Breast Milk Substitutes	**KNAP**	Kenya National Action Plan
CDALP	County Department for Agriculture and Livestock Production	**KNBS**	Kenya National Bureau Of Statistics
CDF	Constituency Development Fund	**KRA**	Key Result Area
CDH	County Department of Health	**KRCS**	Kenya Red Cross Society
CDSP	County Department of Social Protection	**LBW**	Low Birth Weight
CDT	County Department of Trade	**MAD**	Minimum Acceptable Diets
CDVS	County Department of Veterinary Services	**MAM**	Moderate Acute Malnutrition
CDW	County Department of Water	**MDGs**	Millennium Development Goals
CECM	County Executive Committee Member	**MEAL**	Monitoring Evaluation Accountability And Learning
CHMT	County Health Management Team	**MIYCN**	Maternal Infant And Young Child Nutrition
CHPs	Community Health Promoters	**MOE**	Ministry of Education
CHSIP	County Health Strategy And Investment Plan	**NAVCDP**	National Agricultural Value Chain Development Project
CIDP	County Integrated Development Plan	**N4G**	Nutrition for Growth
CMTEP	County Medium Term And Expenditure Plan	**NASCOP**	National Aids And STI Control Programme
CNAP	County Nutrition Action Plan	**NCDs**	Non-Communicable Diseases
CNC	County Nutrition Coordinator	**NI**	Nutrition International
CNTF	County Nutrition Technical Forum	**NITWG**	Nutrition Information Technical Working Group
CPIMS	Child Protection Information Management System	**OVC**	Orphaned And Vulnerable Children
DHIS	District Health Information System	**PCPB**	Pest Control Products Board
DRNCD	Diet Related Non-Communicable Diseases	**PFMA**	Public Finance Management Act
ECDE	Early Childhood Development Education	**SAM**	Severe Acute Malnutrition
eCHIS	Electronic Community Health Information System	**SCHMT**	Sub County Health Management Teams
EIBF	Early Initiation to Breastfeeding	**SCNC**	Sub County Nutrition Coordinator
FEED	Feed The Children	**SDGs**	Sustainable Development Goals
FIF Act	Facilities Improvement Financing Act	**SMART**	Standardized Methodology And Assessment Of Relief And Transitions
FLLOCA	Financing Locally-Led Climate Action Program	**SQUEAC**	Semi-Quantitative Evaluation of Access and Coverage
FMTP	Fourth Medium Term Plans	**STIs**	Sexually Transmitted Inflections
FSS	Food Systems Summit	**TAN**	Technical Assistance For Nutrition
GDP	Gross Domestic Point	**TBA**	Traditional Birth Attendant
GOK	Government Of Kenya	**TICAH**	Trust For Indigenous Culture And Health
HAZ	Height-for-Age Z-score	**TWG**	Technical Working Group
HINI	High Impact Nutrition Interventions	**UN**	United Nations
HH	Household	**UNICEF**	United Nations Children's Fund
HIV	Human Immunodeficiency Virus	**VAD**	Vitamin A Deficiency Disease
ICN2	Institut Català de Nanociència i Nanotecnologia	**WHA**	World Health Assembly
IFAS	Iron Folic Acid Supplementation	**WHH**	Welthungerhilfe
IFMIS	Integrated Financial Management Information System	**WHZ**	Weight-for-Height Z-score
IMAM	Integrated Management Of Acute Malnutrition	**WHO**	World Health Organization

DEFINITION OF CONCEPTS AND TERMINOLOGIES

Concept/Terminology	Operational Definition
Common Results and Accountability Framework	A summary of select results and indicators that mutually tracked and reported on by all sectors responsible for the implementation of CNAP.
MEAL Framework	The Monitoring Evaluation Accountability and Learning Framework facilitates tracking and evaluation of performance of set targets, as well as serving as an accountability and learning framework for the various nutrition stakeholders.
Key Result Areas	The Key Result Areas (KRAs) are a set of activities or interventions modelled around the KNAP theory of change, which, if realized, at scale, would contribute to improved nutritional status for all Kenyans. The KRAs are categorized into three focus areas: (a) Nutrition-specific (b) Nutrition- sensitive and (c) Enabling environment.
Nutrition-Sensitive:	Pertaining to interventions or strategies that indirectly impact nutrition outcomes by addressing underlying determinants such as food security, education, and healthcare.
Nutrition-Specific:	Referring to interventions specifically designed to address direct nutrition outcomes, such as supplementation, fortification, and treatment of malnutrition.
Enabling Environments:	Conditions that facilitate and support the implementation of effective nutrition programs, including policy frameworks, community engagement, and resource allocation.
Life-cycle Approach:	A comprehensive strategy that addresses the nutritional needs and challenges of individuals at different stages of life, from infancy to old age.
Life-course Approach:	An extended perspective considering the various influences, experiences, and exposures throughout an individual's life that contribute to their nutritional status.
Equity:	The promotion of fairness and justice in the distribution of resources, opportunities, and outcomes, with a focus on eliminating disparities among different population groups.
Human Rights:	An approach recognizing and emphasizing that all individuals have inherent rights and dignity, and nutrition is considered a fundamental human right.
Sustainability:	Ensuring that nutrition interventions and programs are viable in the long term, considering economic, social, and environmental factors.
Thematic Working Groups:	Collaborative units focused on specific thematic areas within the nutrition sector to enhance coordination, planning, and implementation of nutrition- related activities.
Gender:	Acknowledging and addressing the roles, expectations, and opportunities of both men and women concerning nutrition, ensuring equality and empowerment.
Inclusion:	Ensuring the active participation and representation of diverse groups, including vulnerable populations, in nutrition-related activities and decision-making processes.
Cross-Sectional Mixed-Methods Design:	A research approach combining both qualitative and quantitative methods applied simultaneously during the end term review to provide a comprehensive evaluation.
Desk Review:	A systematic examination of relevant documents and reports, serving as a foundation for the end term review to understand the historical context and previous evaluations.
Abstraction/Data Mining:	The process of extracting valuable information from raw and analyzed data sources, including KDHS 2022, KHIS/ DHIS2, department of Health analyzed data, and partners' / stakeholders' data, for the purpose of the end term review.
In-Depth Interviews:	In-depth interviews refer to qualitative research methods involving detailed, one-on-one conversations between an interviewer and a participant. These interviews aim to gather comprehensive insights and understanding by exploring individual perspectives, experiences, and opinions in depth.
Focus Group Discussions:	Focus Group Discussions (FGDs) involve structured group interactions facilitated by a moderator. Participants discuss specific topics, share their views, and respond to each other's perspectives. FGDs are commonly used in qualitative research to explore diverse opinions and generate insights.
End-Term Review:	The End-Term Review (ETR) is a comprehensive evaluation conducted at the conclusion of a program or project. It assesses the overall achievements, impact, challenges, and lessons learned over the implementation period. The ETR aims to inform future planning and decision-making.

Mid-Term Review (MTR):	The Mid-Term Review (MTR) is an assessment conducted midway through the implementation of a program or project. It evaluates progress, identifies challenges, and provides recommendations for adjustments. The MTR contributes to adaptive management and improved project outcomes.
County Nutrition Action Plan (CNAP):	The County Nutrition Action Plan (CNAP) is a strategic document that outlines a county-level approach to addressing nutrition challenges. It typically includes targeted interventions, goals, and strategies to improve the nutritional status of the population within a specific geographical area.
Kenya Nutrition Action Plan (KNAP):	The Kenya Nutrition Action Plan (KNAP) is a national-level strategic framework outlining the country's approach to addressing nutrition-related challenges. It provides a roadmap for coordinated efforts across sectors to improve the nutritional well-being of the population.
Water, Sanitation and Hygiene (WASH):	Water, Sanitation, and Hygiene (WASH) represent a collective term for initiatives and interventions aimed at ensuring access to clean water, improved sanitation facilities, and promotion of hygienic practices. WASH programs contribute to better health outcomes.
Integrated Management of Acute Malnutrition (IMAM):	Integrated Management of Acute Malnutrition (IMAM) is a comprehensive approach that combines preventive and curative strategies to address
	acute malnutrition. It includes activities such as therapeutic feeding, nutritional counselling, and community-based interventions.
Micronutrient Deficiencies:	Micronutrient deficiencies occur when the body lacks essential vitamins and minerals needed for optimal health. Common micronutrient deficiencies include those of vitamin A, iron, iodine, and zinc, leading to various health problems.
Maternal, Newborn, Infant and Young Child Nutrition (MIYCN):	Maternal, Newborn, Infant, and Young Child Nutrition (MIYCN) encompasses nutritional interventions and care practices targeted at pregnant women, newborns, infants, and young children. It aims to ensure optimal nutrition during critical life stages.
Scaling Up Nutrition Movement:	The Scaling Up Nutrition (SUN) Movement is a global initiative that brings together governments, civil society, businesses, and other stakeholders to prioritize and scale up efforts to address malnutrition in all its forms.
Monitoring	The routine monitoring of project resources, activities, and results, and analysis of the information to guide project implementation.
Evaluation	The periodic (midterm, final) assessment and analysis of an existing strategy/action plan.
Accountability	Transparency of processes: planning, execution, and reporting.
Learning	The process through which information generated from M&E is reflected upon and intentionally used to continuously improve the ability of an action plan/strategy to achieve results.

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1.1 Background information

1.1.1 Location and size

Kajiado County is one is the 47 counties in the republic of Kenyan Rift Valley region and borders Narok county to the West, Nakuru County, Kiambu County and Nairobi County to the North, Machakos County, Makueni County and Taita- Taveta County to the East and Tanzania to the South constituting one of the five counties that share the country's border with Tanzania. It covers an area of 21,871.1Kms sq. According to the 2019 Kenya Population and Housing Census the population was 1,117,840 with male constituting of 49.8 percent and female constituting 50.2 percent of the total population. It has an annual growth rate of 5.5% and a population density of 51 people per Km. (Source: KNBS 2019 projections). The county lies within Arid and semi-Arid Lands (ASALs). It has three (3) main livelihood zones; Pastoral all species (52%), Agro-pastoral (31%) and mixed farming (12%) livelihood zones.

1.1.2 Administrative

Kajiado County lies within ASALs regions of Kenya. Kenya covering 21,871km2 with an estimated population of 1,117,840 (Source: KNBS 2019 projections). Administratively, the county is divided into five sub counties namely Kajiado Central, Kajiado North, Kajiado South, Kajiado East and Kajiado West, which act as constituencies. The County has 25 wards as distributed in the figure 1 below:

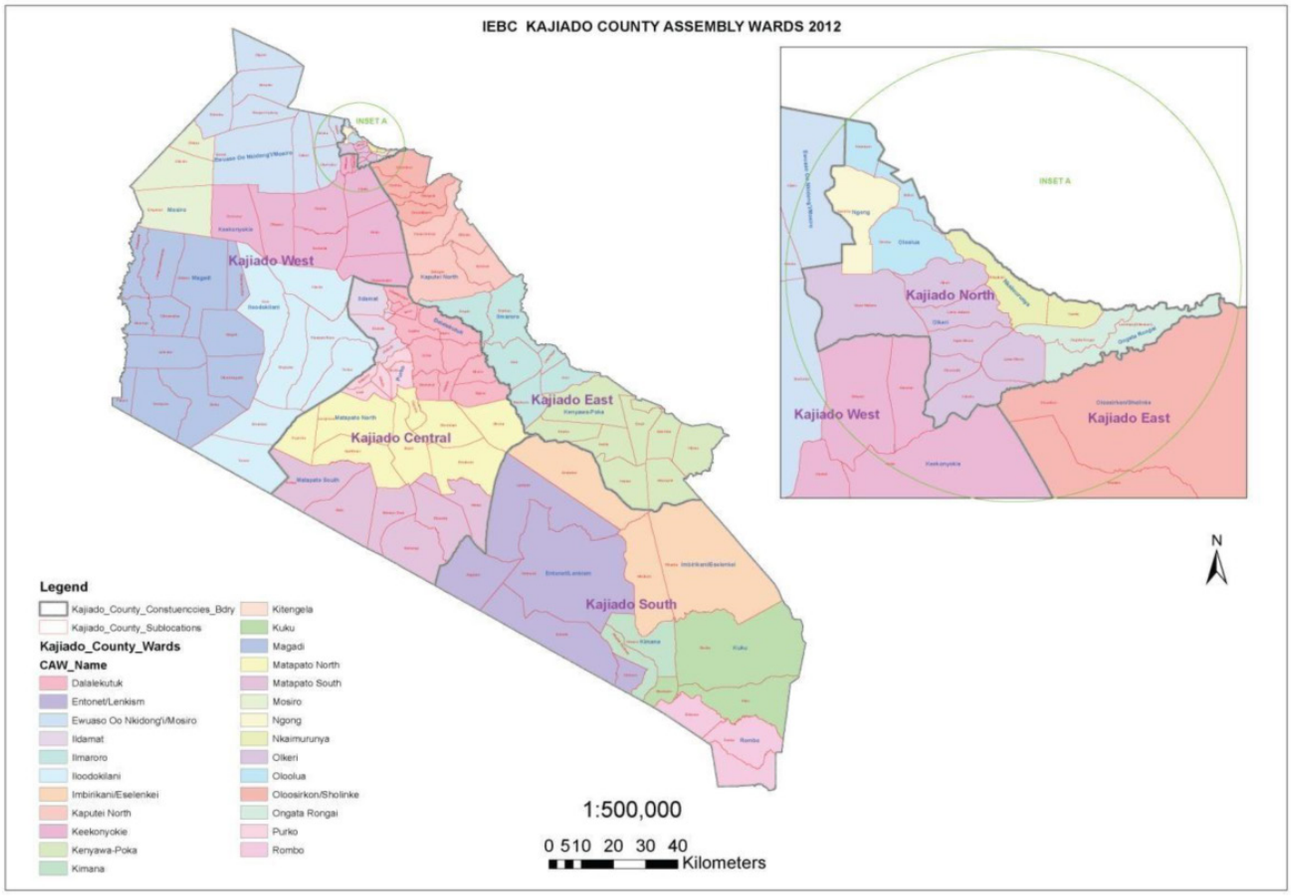

Figure 1: Map of Kajiado County showing the administrative wards

1.1.3 Population size and composition

According to the 2019 Kenya Population and Housing Census, the total population in Kajiado county stood at 1,117,840 persons of which 557,098 are males, 560,705 females and 38 intersex persons. Tables 1 and 2 show population distribution per sub county and disaggregation by gender respectively.

Table 1: Kajiado Population distribution per Sub County

Sub county	Male	Female	Intersex	Total
Isinya	105,607	104,860	6	210,473
Kajiado Central	81,514	80,343	5	161,862
Kajiado North	150,675	155,908	13	306,596
Kajiado West	91,607	91,237	5	182,849
Loitokitok	94,613	97,225	8	191,846
Mashuuru	33,082	31,131	1	64,214
Total	**557,098**	**560,704**	**38**	**1,117,840**

Source: (KNBS, 2019)

Table 2: Population Distribution Disaggregated by gender

Age Cohort	Census (2019)															
	M	F	I/s	T	M	F	I/s	T	M	F	I/s	T	M	F	I/s	T
0-4	78,943	77,385		156,328	77,268	77,446		154,715	80,500	78,485		158,985	80,685	78,658		159,343
5-9	73,245	72,350		145,595	73,093	75,222		148,315	74,524	77,477		152,001	76,670	78,175		154,845
10-14	63,973	65,659		129,632	70,624	71,489		142,114	71,937	73,613		145,549	72,898	75,128		148,026
15-19	49,647	51,721		101,368	65,179	66,047		131,226	69,788	70,422		140,210	70,671	71,849		142,520
20-24	54,143	64,676		118,819	64,193	65,021		129,214	63,460	64,572		128,032	66,597	67,557		134,154
25-29	55,664	59,489		115,153	63,906	61,896		125,802	66,328	66,610		132,938	65,877	66,364		132,242
30-34	49,549	50,284		99,833	54,236	52,889		107,125	63,475	58,872		122,346	65,140	62,033		127,173
35-39	37,290	33,284		70,574	42,675	42,865		85,540	48,637	48,650		97,288	54,892	52,635		107,527
40-44	28,158	25,175		53,333	33,777	34,200		67,978	38,602	38,438		77,040	42,612	42,277		84,889
45-49	22,305	18,734		41,039	25,738	26,810		52,548	29,776	30,099		59,875	32,934	32,827		65,761
50-54	15,555	13,269		28,824	16,356	17,531		33,887	22,067	23,296		45,363	24,646	25,376		50,022
55-59	10,289	9,333		19,622	9,541	10,509		20,050	11,491	12,665		24,156	15,015	16,245		31,260
60-64	7,031	6,896		13,927	6,532	7,024		13,556	7,182	8,235		15,417	8,324	9,549		17,873
65-69	4,441	4,280		8,721	4,281	4,580		8,861	5,022	5,558		10,581	5,398	6,277		11,676
70-74	3,302	3,490		6,792	3,350	3,656		7,006	2,884	3,422		6,306	3,284	3,994		7,278
75-79	1,596	1,802		3,398	2,124	2,468		4,593	2,585	3,192		5,777	2,382	3,064		5,445
80+	1,954	2,869		4,823	2,777	3,124		5,901	2,785	3,281		6,065	2,990	3,768		6,758

Source: (KNBS, 2019)

1.2 Review of Kajiado County Nutrition Action Plan (KCNAP) 2018-2023

1.2.1 Overview

The KCNAP was aligned to key county strategic documents such as the Kenya national Nutrition Action Plan (KNAP), County Health Strategic plan, County Integrated Development Plan (CIDP), Health and Nutrition Policies and the County Medium Term Expenditure Plans and acted as a road map for reaching nutrition goals to date. KCNAP 2018-2023 provided a practical guide to a coordinated implementation of proven and cost effective High Impact Nutrition Interventions (HINI) which focused on nutrition specific, and sensitive

interventions targeted to women of reproductive age, children aged less than five years, school going children, population groups challenged with overweight & obesity and activities that addressed non-communicable diseases. It also aimed at mainstreaming the nutrition budgeting process into County development plans, and subsequently, allocation of resources to nutrition programs. The Multisector team led by the County Health Management team was directly in charge of coordinating the implementation of the plan at the county level, while the Sub-County Health Management teams (SCHMTs) oversaw coordination at the sub-county level. The KCNAP was rolled out at all levels of service delivery through a collaborative effort by all stakeholders and coordinated by the County Nutrition Technical Forum (CNTF) and multisector team.

1.2.2 Achievements of KCNAP 2018-2023 (During the Implementation period)

There was Implementation of above 50% of some of the proposed Interventions which led to improvement of indicators i.e.;

- Reduction of low-birth-weight rate (LBW) from 10% to 5.5%, stunting from 25.2% to 21.9%, underweight 25.5% to 13.3%, wasting 10% to 5.3%, additionally there was an improvement in EBF rates from 40% to 82% and IFAS consumption for more 90 days for pregnant women from 37.9% to 65%
- Routine monitoring and reporting of nutrition programs strengthened, both at the county and sub-county, support supervision was conducted quarterly
- Increased prioritization of Nutrition both at the health department and line ministries
- Improved collaborations and coordination including Multisector platform for Nutrition. Nutrition TWGs were conducted on a quarterly basis
- Increased Human resources for Nutrition from 24 to 68 in the county.
- Procurement of Nutrition commodities e.g. enteral and parenteral feeds
- Household level monitoring of salt Iodization
- Weekly supplementation of iron and folic (WIFs) to schoolgirls in Kajiado West and North Sub Counties,
- Development of Childcare policy and Facility Bill and County Nutrition Policy and Bill.
- Co-funding for the implementation of CNAP 2018-23 by County Government and Nutrition International was successful.
- The county carried out nutrition surveys; KAP, SMART and Community Coverage assessment.
- Successful implementation of the nutrition drought response program.
- Good collaboration with the media team for information sharing
- Male involvement in maternal, infant and young child nutrition and health through father-to-father support groups in Kajiado West Sub County.
- Conversion of TBAs to birth companions which improved skilled
- Improvement of proxy coverage in the IMAM program

1.2.3 Challenges during the implementation period of KCNAP 2018-2023

- Food insecurity because of recurrent drought
- Death of livestock and migration of domestic animals for pasture and water, led to reduction of milk availability at household level

- The drought response program interfered with the implementation of other programs due to competing priorities, more attention was given to response activities.
- The achievement of activities for all KRAs is still low due to inadequate resources and the vastness of the County.
- Poor infrastructure leading to low access to services.
- There is a gap in documentation of successes and best practices
- Insufficient monitoring of the Process Indicators.
- Low utilization of mass media/local stations for wider coverage of key nutrition messages

1.2.4 Proposed Recommendations during the implementation period of KCNAP 2018-2023

- **Guidelines and policies**: Relevant guidelines and policies to be disseminated and implemented.
- **Advocacy**: There is need for continuous advocacy for prioritization of nutrition activities in sector and multisector, increased nutrition budget as well as Recruitment of more nutritionists,
- **Capacity building:** Capacity building of nutritionists and other health workers on key nutrition packages as part of system strengthening. Training of CHPs on key nutrition packages and equipping the community with nutrition knowledge.
- **Commodities:** Include outputs on nutrition commodities in the relevant KRAs.
- Scale up the programs in place e.g., Increase BFCI sites, strengthen targeted supportive supervision by the county and sub county teams, include growth monitoring and nutrition assessment for over five, adults and elderly for continued surveillance.
- **Information management:** Leverage on existing opportunities to document and share best practices/ lessons learnt at the county level i.e., county media, local media stations etc. Strengthen data quality through data quality audits (DQAs) and data review meetings. There should be timely CNAP midterm and end term review, this gives allowance for proper evaluation of activities and planning for the next CNAP.
- **Coordination:** Strengthen sectoral and multisectoral coordination in County and Sub- County, including celebration of International and National days in the respective departments, improve service delivery through integration with existing structures in the other departments e.g. integrate nutrition education in the social protection programs for OVCs and the elderly to ensure proper coordination of activities between sector and multisector there is a need for a common result framework.

1.2.5 Best practices during the implementation period of KCNAP 2018-2023

- Joint financing of Nutrition Intervention and opening of a special purpose account
- Mapping and coordination of the respective line ministries
- Development of Childcare policy and Facility bill, Nutrition policy and bill
- Conversion of TBA s to birth companions
- Formation of father-to-father support groups for MIYCN
- Involvement of the County's legal department to lead in the development of Policies and Bill.

1.2.6 Lessons learnt during the implementation period of KCNAP 2018-2023

- Multisector collaboration in the planning and implementation of Nutrition programs enhances the impact of services.
- Nutrition advocacy to the key decision makers enhances ownership and accountability.
- There should be a timely CNAP end-term review, this gives allowance for proper evaluation of activities and planning for the next CNAP.
- To ensure proper coordination of activities between sector and multisector there is a need to have a common result framework.
- There is need for midterm review to aid in decision-making and taking stock of initial lessons and readjustments of the program

1.3 Health Access (Health Facilities, Human resource for health)

There is (1) County Referral hospital six (6) sub-county hospitals, twenty-six (26) health centers and a hundred (100) dispensaries under the county government. There are also nine (9 hospitals, thirteen (13) nursing homes, and one hundred and thirteen (113) clinics which are either run by private, faith-based, Community-Based and other Non-Government Organizations. Together with these, the county has a total of ninety-two (163) Community Health Units established, out of which only seventy-three (132) are active and functional. The health facilities in the county are vastly distributed. The average distance to a health facility is 14.3 km, with a health facility density of 3 health facilities per 10,000 people. Majority of population cannot access primary health care which affects their productivity.

The inability to access health care can be firmly attributed to high levels of poverty in the county, with more than 60 percent of the population living below the poverty line, Others include high levels of illiteracy, frequent droughts, poor infrastructure, inadequate water resources, and socio-economic vulnerabilities. Based on deprivation score thresholds, people are classified as multi-dimensionally poor, that is severe multidimensional poverty or vulnerable to multidimensional poverty. National MPI is 0.171. This disproportionately affects women and girls, resulting from their unequal access, control, and benefit from productive resources like land and live- stock, which is a preserve for men. Most people in rural areas also rely on traditional methods of treatment as they are cheap and readily available. There are also high occurrences of nutrition-related ailments in children due to lack of food variety and inadequate quantity because of frequent droughts.

Human Resource for health allocation accounts for the highest proportion of budgets assigned to the health sector. In Kenya, the doctor to patient ratio is 2 to 10,000 against the World Health Organization's recommended ratio of 1 to 1,000. The nurse-patient ratio is 1:10,000, way below the 25: 10,000 ratios recommended by the World Health Organization.

In Kajiado County, there are 72 doctors serving a population of over a million giving a doctor-patient ratio of 1 to 17,575, almost at par with the national ratio. Nurses are 644 in the county giving a ratio of 1:1800 against a ratio of 1:400. The distribution of health care workers is dependent upon a number of health facilities and levels of service delivery. Kajiado County has over 1,741 Human Resource for Health, with only 68 being nutrition staff. Table 3 below depicts the human resource for nutrition within the county as well as the gaps.

Table 3: Kajiado County Human Resource for Nutrition

Sub Category	Available number	Needed Gap
Nutrition and Dietetics Officers	29	116 87
Nutrition and Dietetics Technologists	22	476 454
Nutrition and Dietetics Technicians	17	304 287
TOTAL	**68**	**896 828**

1.4 Nutrition Situation: National and County

1.4.1 National Nutrition Situation

In Kenya, over a quarter of children under five suffer from stunted growth, affecting approximately two million children. Stunting, the most common form of under-nutrition, has severe and lasting effects on mental and physical development. Additionally, 11% of children are underweight, with 4% experiencing wasting. Malnutrition's annual cost, covering health, education, and labor productivity, ranges from 1.9% to 16.5% of the GDP. According to a recent Kenya Demographic Health Survey report of 2022, 18% of children under the age of five years are stunted, 5% are wasted, 3% are overweight while 10% are underweight (KNBS and ICF, 2023). However, comparison of KDHS data over time indicates an overall improvement in children's nutritional status in Kenya. Since 1998, stunting has declined from 38 percent to 26 percent, wasting has declined from 7 percent to 4 percent, and the proportion of underweight children has declined from 18 percent to 11 percent. Kenya met the 2015 Millennium Development Goal (MDG) target of reducing the prevalence of underweight children under age 5 to 11 percent (Ministry of Devolution and Planning, 2013).

Despite national efforts, according to KDHS 2022, exclusive breastfeeding rates remain stagnant at 60%. Only 31% of children aged 6–23 months receive a minimum acceptable diet. The under-5 mortality rate, infant mortality rate, and neonatal mortality rate emphasize the gravity of the situation.

Programming for the nutrition sector in Kenya is shaped by evidence gathered from National Surveys, as well as local and global knowledge on highly impactful nutrition interventions and incorporates findings from evaluations of past National Nutrition Action plans. Furthermore, Kenya aligns its strategies with the long-term development goals outlined in Vision 2030, which aims to elevate Kenya to a newly industrializing, middle-income country by 2030, ensuring a high quality of life for all its citizens. Additionally, these efforts are in accordance with the global health and nutrition agenda and uphold the rights enshrined in the 2010 Kenyan constitution.

The Kenya Nutrition Action Plan 2023-2027 which the Kajiado Nutrition Action Plan is customized from is developed in the context of the Kenya Kwanza government agenda which will be implemented in the period of the KNAP. The Bottom-up Economic Transformation Agenda (BETA) is designed to address the current challenges facing the country's economy, stimulate economic recovery and bolster resilience. It places special emphasis on priorities that target reduction in the cost of living, creation of jobs, achievement of more equitable distribution of income, enhancement of social security, expansion of the tax base and increase of foreign exchange earnings. The BETA is operationalized through the Fourth Medium Term Plan themed "BETA for Inclusive Growth" with nutrition strongly addressed through two pillars - the Social and Economic pillars.

Kenya is committed to various global agreements and mechanisms addressing nutrition issues. These include the Scaling Up Nutrition (SUN) Movement, the World Health Assembly (WHA) 2025 nutrition targets, the Sustainable Development Goals (SDGs), the United Nations (UN) International Decade on Food and Nutrition (2016-2025), the ICN2 Declaration and Plan of Action, the Nutrition for Growth (N4G) Summit commitments, Food Systems Summit (FSS) commitments, Global Action Plan for Prevention and Control of Non-Communicable Diseases. These frameworks provide a robust foundation for tackling the multifaceted causes of malnutrition. The commitments and frameworks aim to address the complex challenges of malnutrition globally and promote sustainable, equitable, and resilient food systems that support healthy

diets and nutrition for all. They underscore the importance of multi-sectoral collaboration and coordinated efforts to achieve significant improvements in nutrition outcomes worldwide.

Kenya, as part of the global community, recognizes and is committed to the global goals and aspirations of eliminating malnutrition. Accordingly, the KNAP 2023-2027 is aligned with nutrition-relevant United Nations 2030 Agenda for Sustainable Development goals. By focusing on these key Sustainable Development Goals (SDGs)—including SDG 1 (No Poverty), SDG 2 (Zero Hunger), SDG 3 (Good Health and Well-being), SDG 4 (Quality Education), SDG 5 (Gender Equality), SDG 8 (Decent Work and Economic Growth), SDG 10 (Reduced Inequalities), SDG 12 (Responsible Consumption and Production), SDG 13 (Climate Action), SDG 14 (Life Below Water), and SDG 15 (Life on Land) – the plan aims to contribute significantly to the global objectives of eradicating malnutrition by addressing its determinants through integrated approaches.

In relation to the SDG Recovery and Acceleration Strategy (2022-2030), KNAP 2023-2027 aligns its initiatives with the overarching goal of accelerating progress towards achieving the SDGs, particularly in the wake of setbacks caused by the COVID-19 pandemic. By integrating the goals of the SDG Recovery and Acceleration Strategy within the KNAP framework, Kenya aims to strengthen its commitment to sustainable development, fostering recovery processes that promote inclusive growth, enhance food security, and reinforce health systems.

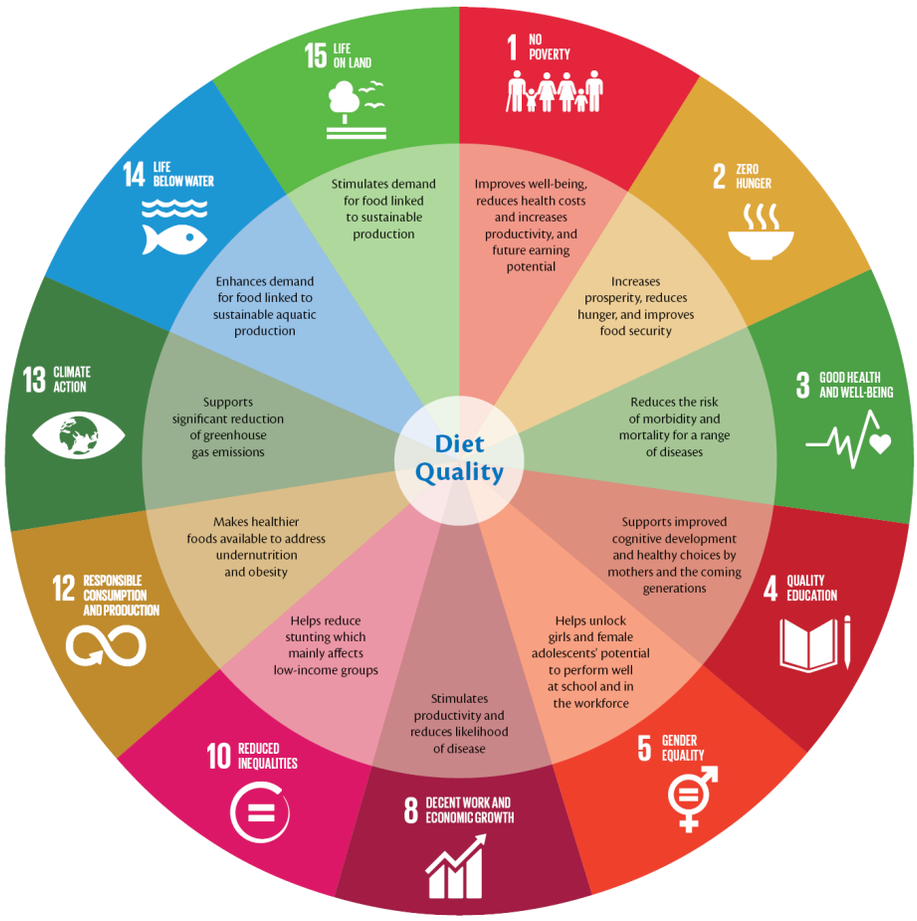

Figure 2: Nutrition – SDG linkage – Situation Analysis of Nutrition in Kenya 2024 from Scaling Up Nutrition

1.4.2 Kajiado County Nutrition Situation

1.4.2.1 Undernutrition

Kajiado County grapples with hunger and inadequate food supply, particularly affecting children. Due to insufficient food, malnutrition poses significant threats to physical and mental development. Ongoing county efforts aim to align with Sustainable Development Goals, striving to end hunger, achieve food security, and promote sustainable agriculture (SDG 2).

According to Kajiado SMART survey (2023), stunting prevalence among children under 5 stands at 21.9%, with rural areas experiencing higher rates (25.2%). Wasting and underweight also show disparities between rural and urban areas. Notably, the 2023 SMART survey reveals a stagnant malnutrition level compared to previous surveys, demanding targeted interventions.

The prevalence of undernutrition in Kajiado County, impacts vulnerable groups including children and pregnant women. Undernutrition manifests in various forms, including stunting, wasting, and underweight. The root causes of undernutrition are multifaceted, often intertwined with socio- economic factors, limited healthcare access, insufficient food and dietary diversity. Children experiencing undernutrition face long-term consequences, including impaired physical and cognitive development. Pregnant women face increased risks, as undernutrition during pregnancy leads to adverse outcomes for both the mother and the developing fetus.

Addressing the high prevalence of undernutrition demands a holistic approach encompassing increased food production and productivity, improved healthcare, education, improved water and sanitation and community engagement. By identifying and targeting the specific determinants contributing to undernutrition, the Nutrition Policy aims to break the cycle of inadequate nutrition, ensuring a healthier and more resilient population in Kajiado County

Proper maternal nutrition is critical for positive pregnancy outcomes, but limited access to maternal and child health services leads to missed preventive care opportunities. Inadequate immunization coverage exposes children to preventable diseases, further compromising their nutritional status. Improving the delivery and accessibility of maternal and child health services is a fundamental component of this policy to ensure the well-being of mothers and children.

Poverty is a major contributing factor to the poor nutrition situation in Kajiado county. Poor access to clean and safe drinking water, inadequate health services, hygiene practices, and gender inequalities contribute to malnutrition. Addressing these issues is vital for effective and sustainable intervention. Figure 3 below highlight the trend in malnutrition from the national demographic health surveys and county specific SMART surveys

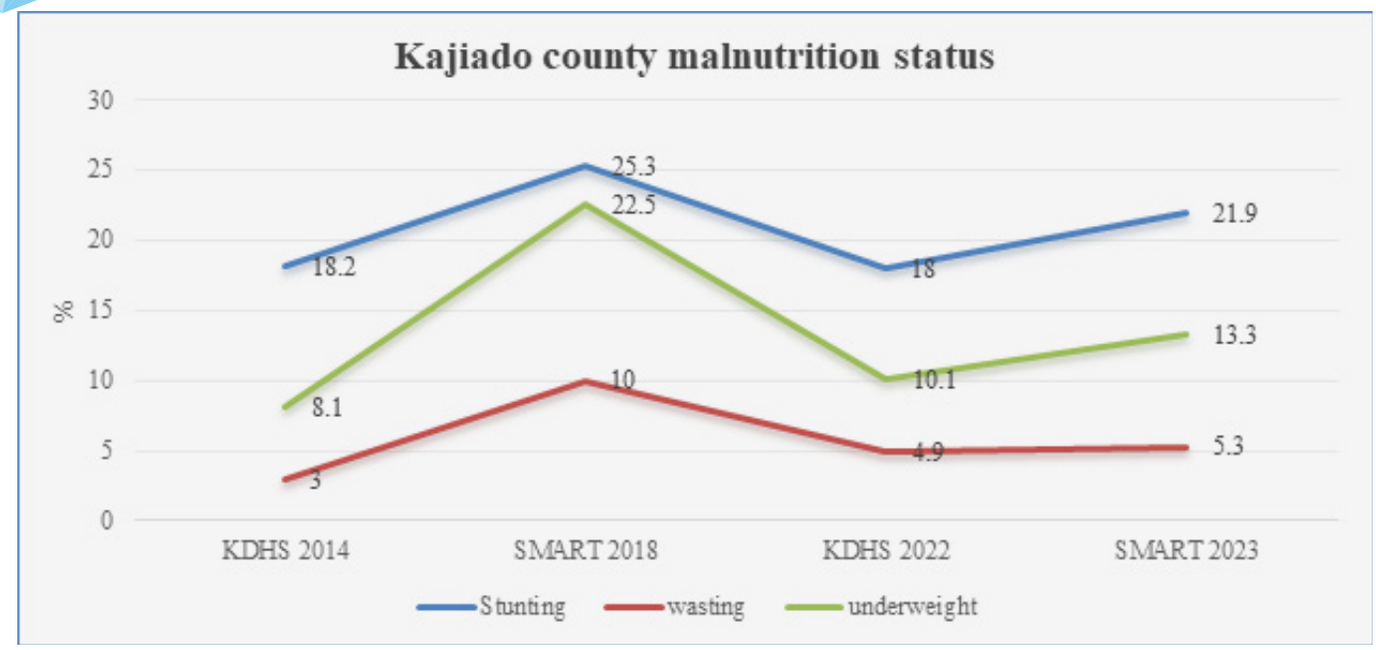

Figure 3: Stunting, Wasting and Underweight in Kajiado County

Source: (KDHS, 2014), (SMART SURVEY, February 2018) and (SMART SURVEY July 2023)

1.4.2.2 Overweight, Obesity and Diet Related Non-Communicable Diseases

Non-communicable diseases (NCDs), mainly cardiovascular diseases, cancers, chronic respiratory diseases, and diabetes, are the world's biggest killers. Most of these premature deaths from NCDs are largely preventable by enabling health systems to respond more effectively and equitably to the healthcare needs of people with NCDs and influencing public policies in sectors outside health that tackle shared risk factors—namely tobacco use, unhealthy diet, physical inactivity, and the harmful use of alcohol. Diet and physical exercise are powerful tools for the prevention of NCDs. There is a gap in NCD population-based data for Kajiado. Given its proximity to the city, it's likely that the prevalence of NCD is on the rise. The patients seeking services for NCD related diseases like hypertension, diabetes, and cancer are on the rise. Hospital data shows an increase in hypertension and diabetes from 31,331 (2022) to 38,078, an increase of 21.5%

1.4.2.2 Micronutrient deficiency situation

In Kenya, micronutrient deficiencies remain a major public health threat, with high prevalence rates especially amongst women and children. The most common deficiencies are those of iron, folate, zinc, iodine and vitamin A1. About one third of children aged 6-59 months and 42% of pregnant women are anemic2. The prevalence of zinc deficiency is very high at 81.6% among children 6-59 months old and 67.9% for pregnant women. The prevalence of other types of nutritional anemia, such as folic acid and vitamin B12 deficiency, is 31.5% and 47.7% respectively among non-pregnant women aged 15–19 years. Vitamin A Deficiency (VAD) and marginal VAD among preschool children are at 9.2% and 52.6%, respectively3.

Kajiado County faces challenges in addressing vitamin A, iron, zinc, and iodine deficiencies. Despite efforts, coverage for supplementation remains low, highlighting the need for enhanced strategies. Micronutrient deficiencies in Kajiado involve essential micronutrients such as iron, vitamin A, and iodine Lack of essential

1 Global Nutrition Report. (2019). Kenya Nutrition Profile

2 Kenya National Bureau of Statistics et al. (2022). Kenya Demographic Health Survey (KDHS)

3 Kenya Ministry of Health. (2011). Kenya National Micronutrient Survey 2011

micronutrients in diets contributes to conditions like anemia, compromised immune systems, and impaired cognitive development. Addressing micronutrient deficiencies requires strategies that enhance diet, dietary diversity and ensure the availability and accessibility of fortified foods and supplementation. In mitigating the impact of micronutrient deficiencies, the government of Kajiado focus is on increased food production, food fortification of staple foods, micronutrient supplementation for vulnerable groups, deworming with support from education sector, nutrition education at community level and dietary diversification. This CNAP integrates strategies involving county departments that contribute towards improved nutrition to ensure reduction of micronutrients deficiency.

1.4.2.3 Infant and Young Child Feeding status

Optimal infant and young child feeding practices (IYCF) during the first 2 years of life are critical for child development (Perez-Escamilla et al., 2023; WHO & UNICEF, 2021). Exclusive breastfeeding (EBF) has been associated with better cognition and motor development in childhood and primary school-aged children (Kramer et al., 2008; Oddy et al., 2003). Longer duration of breastfeeding is also associated with better cognitive development from early childhood through adulthood (Horwood et al., 2001; Huang et al., 2014; Kim & Choi, 2020; Nyaradi et al., 2015; Victora et al., 2005, 2015; Walker et al., 2011). Early initiation of breastfeeding (EIBF) within 1 h of birth is not only critical for establishing and maintaining breastfeeding practices (Nguyen et al., 2020; Perez-Escamilla et al., 2023), but has also been shown to protect newborns against infections and neonatal mortality (Hajeebhoy et al., 2014; WHO & UNICEF, 2021). Dietary diversity in the first 2 years of life has also been positively associated with child development (Larson et al., 2017; Miller et al., 2020; Nyaradi et al., 2015; Prado et al., 2017).

Over the time, Kajiado county has made significant strides particularly in the area on infant and young child nutrition. Exclusive breastfeeding levels have improved from 34.6% in 2014 to 82.5% in 2022 based on KAP survey conducted in the same period. However, complementary feeding levels remain sub-optimal minimum adequate diet report at 22.6% as summarized figure 4 below.

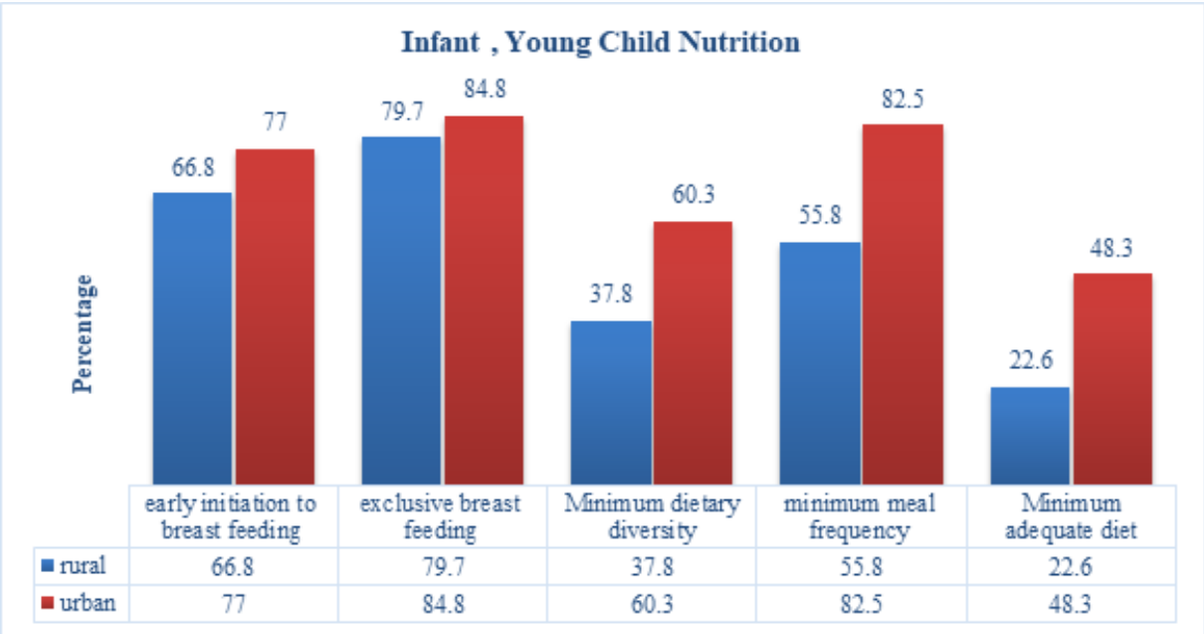

Figure 4: Infant and Young Child Nutrition in Kajiado County
Source: (MIYCN KAP, 2022), (SMART SURVEY, 2023)

1.4.2.5 Mortality and Morbidity Status

Childhood mortality continues to decline in Kenya. Infant mortality in Kenya is at 32 deaths per 1,000 live births (KDHS 2022) compared to 39 deaths per 1000 live births reported in KDHS 2014. In Kenya, under-five mortality stands at 41 deaths per 1,000 live births (KDHS, 2022). In Kajiado county the under-five mortality stands at 30 deaths per 1,000 live births. The burden of communicable diseases in the County, especially HIV/AIDS, STIs, and tuberculosis is high. According to the National Aids and STI Control Program (NASCOP), According to Kajiado County HIV/AIDS strategic Plan 2024, the HIV prevalence in Kajiado County, Kenya is around 4.4–4.7%. This is lower than the national prevalence. According to Kenya health information system (KHIS), in the year 2022, the top three most common causes of morbidity in under five are: Disease of Respiratory System (42.8%), Diarrhea (13%), Skin Disease (5%). The major risk factors include houses that are congested and poorly ventilated, as well as poor environmental sanitation.

1.4.2.6 Water, Sanitation and Hygiene and Nutrition

Kajiado County faces challenges to access to clean, safe drinking water and sanitation, a critical determinant of nutritional well-being. Poor access to water and sanitation infrastructure contribute to waterborne diseases such as diarrhea, negatively impacting health and nutritional status of the population. This action plan recognizes the symbiotic relationship between water, sanitation and nutrition. Efforts to enhance access to clean, safe drinking water is a must if nutrition improvement is to be achieved in Kajiado County, average distance covered by households to the nearest water point has been reduced from 4.8km in 2018 to 4.5km as at 2022 (CIDP 2023). This has been attributed to accumulative sinking of 1,313 boreholes against the county target of 3,000 boreholes by 2030. SMART survey conducted in 2023 revealed that 48% of the water supply is from boreholes. The survey further revealed that the proportion of households walking for more than 2km (>2km) was high in the Rural areas at 8.9% which is coupled by queuing for water for more than 30 minutes.

The proportion of households accessing clean and safe drinking water stands at 69.5% (CIDP 2023) with the main water source for most households in the rural zone being borehole or protected springs or protected shallow well (47.9%) and piped water system (19.8%). In urban areas, the main water source for most households was water vendors at 45.0%. Overall, the proportion of households fetching water from safe water sources in Kajiado County is 55.4% (SMART, 2023). The average cost of a 20 litres jerrican of clean drinking water was Ksh 14.07 in rural areas and Ksh 11.33 in urban Kajiado. This high cost of safe clean water has attributed to low access to safe clean water (SPHERE standards average person water consumption 15 and more litres per day). Water treatment is sub-optimal with only 26.4% and 36.0% of households in Rural and Urban Zones respectively treat their drinking water. According to KDHS 2022, 14% of children had diarrhea which is corroborated with a SMART survey conducted in 2023 which reported diarrhea levels at 15% and 13% diarrhea in rural and urban Kajiado respectively.

Handwashing practice at critical times is an attributing factor to high diarrhea cases in the county, worse performance observed mostly in the Rural Kajiado. Only 19% and 31% of the caregivers in Rural and Urban Zones with or without awareness of handwashing practices, washed their hands during all the four critical points. Strategies that involve increased water for irrigation, and for domestic uses are included in the policy. Education, promoting hygiene and behavior change is also emphasized.

1.4.2.7 Agriculture and Food Access

Agricultural productivity is central in securing food and nutrition for all. Kajiado County over- reliance on rain-fed agriculture, makes food production vulnerable to climate variability, impacting crop yields and food availability. In addition, in adequate training in climate SMART agriculture and modern farming practices, and post-harvest losses contribute to limited food production. Boosting agricultural and livestock productivity is integral to providing a sustainable source of diverse and nutritious foods for the population.

The production of maize grew from 71,983 tons per annum in 2018 to 30,375 tons per annum in 2022 against set target of 86,380 tons (CIDP 2023-2027). This was a downward growth that was attributed to drought that was experienced in the county for the last two years. A similar trend was observed in production of beans which recorded a decline in production from 18,357 tons per annum in 2018 to 4,612 tons per annum in 2022. However, there was a positive trend in production of Irish potatoes, bulb onions and tomatoes. Irish potatoes recorded an increase in production from 1,768 tons per annum in 2018 to 3,700 tons per annum in 2022. Tomatoes recorded an increase in production from 36,460 tons per annum in 2018 to 53,112 tons per annum in 2022, whereas bulb onions production grew from 1,630 tons per year in 2018 to 25,233 tons per year in 2022. There was mixed performance on productivity of the above crops with bulb onions and Irish potatoes recording a positive growth. Productivity of bulb onions was recorded at 38 tons per hectare in 2022 from 8.9 tons per hectare in 2018, whereas Irish potatoes productivity grew from 3 tons per hectare in 20218 to 10 tons per hectare in 2022. Maize recorded are productivity of 1 ton per hectare in 2022 which was a decline from 2.2 tons/ha in 2018. Beans productivity declined from 0.4 tons per hectare in 2018 to 0.2 tons per hectare in 2022. Tomato productivity declined from 23 tons per hectare to 10 tons per hectare in 2022. These declines in crop productivity were caused by the prolonged drought among other causes like inadequate farming technologies and limited farm inputs.

Similarly, the county experienced a decline in livestock production across the key livestock kept in the county. Goat products showed a positive change recording a production of 2,674,113 Kgs of meat in 2022 from 858,045 Kgs that was recorded in 2018. Beef production declined to 3,764,389 Kgs in 2022 from 9,777,820 Kgs in 2018. Production of milk declined from 21,529,998 litres in 2018 to 10,356,823 litres in 2022. Decrease in annual livestock production was attributed to severe drought that affected the county

Strategies that involve transforming agricultural sand livestock systems, promoting climate-SMART practices, and empowering farmers with the knowledge and resources to diversify their crops and livestock husbandry will be key to unlocking Kajiado county potential in food production and productivity, making the county food secure, a step towards addressing malnutrition.

1.4.2.8 Limited Education on Food and Nutrition

Education is a powerful tool for fostering positive nutrition practices, yet Kajiado County's limited education on food and nutrition perpetuates misconceptions about dietary needs and diversity, resulting in poor food choices and inadequate feeding practices especially among vulnerable populations. Limited knowledge on the importance of nutrition, leads to lack of awareness about the importance of adequate diets, dietary diversity, and optimal feeding practices contributing to sub-optimal nutritional outcomes. Strengthening nutrition education is key to empowering communities with the knowledge to make informed choices about their diets. Thus, integrating food and nutrition in education by incorporating and mainstreaming nutrition into educational curriculum for institutions, community programs, agricultural practices and healthcare services is essential for addressing this challenge.

According to County childcare assessment conducted in 2018 in Kajiado urban areas, the level of education for care givers for young children at formal and informal day care centers was found to be 13.8%, primary schools at 29.3%, secondary schools and tertiary institutions at 37.9% respectively. The assessment reported that registration and record keeping in the day care facilities was at 10.3%. Additionally, the findings of survey reported that the food given to children at day care centers did not meet the recommended dietary diversity. Out of the 8 food groups recommended by WHO guidelines, the most consumed food group was grain and starchy foods at 33% which is just one group. There was minimal linkage between Health care facilities and the Childcare facilities therefore nutrition assessment was not adequately conducted.

The County has 638 Public ECDE Centers with a population of 36,349 (County Education Desk). Despite provision of school feeding program at ECDEs, the coverage is still low and lacking adequate supply consistency. The department of health has constantly had malezi bora programs conducted in schools and childcare facilities by supplementing children with dewormers and vitamin A twice a year. There is minimal linkage between schools and health facilities (capacity building and health education) and the county has had no training on the same except for schools with Weekly Iron and Folic Acid Adolescent Health program in Kajiado West and North. The teenage pregnancy in the county stands at 22%, above the national level at 15%. Poor nutrition in particularly among adolescent girls leads to poor birth outcomes. There is need to scale up the adolescent health and nutrition program in schools to avert such deleterious effects.

1.4.2.9 Emerging Health Issues and Threats

The evolving health landscape, including the rise of non- communicable diseases, changing dietary patterns, disease outbreaks necessitate an adaptive and forward-looking policy. By addressing emerging health issues, this plan seeks to create a resilient and responsive nutritional framework. Kajiado county shares a porous border with the republic of Tanzania putting it at risk of infectious diseases such as measles. The immunization coverage across the border is a major concern with the recent epidemiological data indicating that this is major health concern. Over the last one year, Kajiado has experienced measles and m-pox outbreak triggering activation of the county disease outbreak response plan.

- **Shocks and Hazards:** Climate change is emerging as a major threat to food and nutrition security exacerbating an already dire situation in ASAL regions such as Kajiado. Over the last five years for instance, Kajiado county experienced one the worst drought nearly wiping all the livestock which is the main source of livelihood for rural populations.
- **Economic turbulence**: Increase in the cost of living is likely to limit the ability to acquire varieties of food thus affecting nutrition status.
- **Changes in political landscape in** Kenya such as the unrest due to new legislations e.g. finance bill 2024, legislation of SHIF, impeachments and emerging government partnership projects. Such political volatility can lead to disruptions in food supplies and production thus impacting on nutrition.
- **Gender disparity:** Despite the emerging focus on the masculinity and gender identities, traditional gender stereotypes and discriminatory attitudes towards women is continuing to pose challenges in Kajiado. The county is largely patriarchal community and therefore intra-household decision including food choices are by and large influenced by men. Such disparities remain to be one of the basic causes of malnutrition.

1.4.3 Constraints in Nutrition Programming

The challenges facing the county in terms elimination and reduction of malnutrition are as follows:

Table 4: Constrains

Specific Nutrition programming	• Inadequate nutrient intake, poor nutritional and lifestyle practices, low physical activity • Increased incidences of opportunistic infections due to malnutrition • Lack of knowledge on NCD • Lack of nutrition programmes for the elderly persons • Lack of prioritization of nutrition reports due to inadequate nutrition staff. Most the of the work is done by nurses • Low of latrine coverage • Long distances to health facilities • Low coverage on IMAM services • Low demand for nutrition services • Low health and nutrition education amongst vulnerable group • Low levels of awareness on nutrition needs for older children • Low linkages of facility and community linkages. • Low male and other key influencers engagement and support on MIYCN. • Poor health seeking behavior • Poor knowledge of nutrition among health workers and community • Poor linkage of the elderly persons into nutrition programs • Poor maternal nutrition • Poor referral health systems • Stigma and misconceptions regarding the use of nutrition commodities • Increased defaulter rate due to lack of food
Sensitive Nutrition programming	• Inaccessibility to safe and quality water • Lack of awareness on food diversification • Lack of sewer system • No linkage between nutrition and social protection • Over dependence on livestock keeping • Poor dietary diversification • Poor post-harvest practices leading to losses. • inconsistent multi sectoral coordination • high prevalence adolescents' pregnancies • inadequate school feeding programs and screening for malnutrition in schools • poor knowledge on nutrition in nutrition sensitive sectors • High food prices, inflation and market inaccessibility • Inadequate social protection programs • Mushrooming unregulated day-care/ childcare facilities centers
Enabling environment	• Inadequate operation research to inform evidence-based actions • Inadequate resources to respond to nutrition emergencies • Inadequate staffing for nutrition • Inadequate support supervision and mentorship • Insufficient funds and resources to conduct community dialogues • Lack of awareness on some of the existing regulatory acts • Lack of capacity to enforce the regulations • Inadequate financial support for the sectoral coordination at sub county level • Poor data quality from community to the DHIS • Low community engagement, participation and feedback mechanism • poor dissemination of guidelines • There is no joint, integrated planning and monitoring activities (common result framework) • Low knowledge levels on nutrition among non-nutrition staff • Negative cultural practices including food uptake related stereotypes e.g. avoidance of iron rich foods

Table 5: Strengths, Weaknesses, Threats and Opportunities (SWOT) Analysis

Strengths	Governor vision - (Livable towns, modulated pastoralism Climate proofed environment) Availability of the CIDP Political goodwill from Governor and MCAs	Nutrition Int'l - County co-funding Joint work plan with NI Kajiado County Facility Improvement Fund ACT Existence of implementing and supporting partners Budget allocations	Strong structures – CNTF, CHMT, CUs Support of the social services programs by the county Multisectoral Platform approaches Existing organized groups e.g. MTMSGs FTFSGs Existing of Departmental Annual work plans Advocacy and awareness to HCWs on matters management of Non communicable diseases through Online forums Empowerment programs or trainings for women on business startup.	Use of CPIMS and KHIS in data reporting Use of KHIS for data reporting Use of LMIS for commodity data reporting County surveys KAP, SMART, SQUEAC ECHIS Platform Existence of Local media i.e. Radio platforms Radio Mayian, Nosim fm, Social media platforms – WhatsApp, Facebook	Arable land for agricultural activities Available land for Demo farms	Adherence of PFMA Act Adherence of BMS Act 2012 Adherence of Food drugs and chemical substances Act Community Health services bill 2022 Constitution of Kenya 2010 article Health Act article 71 and 72. Women Economic Empowerment policy.
Opportunities	Autonomy of the county governments following devolution Leverage on governor's manifestos Existing intergovernmental coordination mechanisms allow for strong county-level action towards nutrition priorities. Existing good will from the IPs and donors in the nutrition sector Leveraging on the CNAP as a resource mobilization tool across sectors by lobbying for specific KRA aligned to the nutrition sensitive sectors	Leverage on Kajiado County Association of Millers to advocate for food fortification. Climate change financing	Leverage on social protection programs to create a linkage for malnutrition referrals. Availability of Multisectoral forum The increased interest on multi-sectoral approach in nutrition programming can create a good platform for more sustainable and impactful interventions. Availability of health facilities Roll out of CHPs in the county. Strengthen linkage between health and education dept.	Leverage on existing data collection platforms Electronic data entry reporting Availability of alternative online cost-effective platforms for trainings and capacity enhancement	Take advantage of the increasing innovativeness on climate SMART Agriculture Position for the increasing call on climate change interventions	Leverage on the accountability framework at the country e.g. PFMA ACT, IFMIS etc. Draft childcare Bill and Policy Draft Nutrition Bill and Policy
Weakness /Threats	Change of leadership every 5 years Departmental head reshuffling affecting delivery of services affecting consistency. Persistent high turnover of trained staff despite the heavy investment made in training facility-based health workers. The actions by each ministry/sector are guided by what they do best, but the mechanisms for coordination on CNAP implementation are mostly based on partner goodwill, but they are both unstructured and non-institutionalized.	High Inflation rates affecting the cost of implementation. Fluctuation of food prices in the market Household food insecurity Poverty indices Funding limitations to meet the demand for nutrition commodities	Retrogressive Cultural practices Migration of communities due to nomadism Inadequate childcare practice Cultural beliefs against some foods Myths and misconceptions Knowledge gap on NCDs management	Data Confidentiality Poor documentation Poor network coverage	Prolonged drought in the county Flooding Wildlife human conflict Disease outbreaks Harsh Environmental Conditions Poor infrastructure Climate change	Lack of policies and regulatory frameworks Poor enforcement of policies and laws

CHAPTER TWO: COUNTY NUTRITION ACTION PLAN

2.1 Introduction

Malnutrition is caused by factors that are broadly categorized as immediate, underlying, and basic. Immediate causes of malnutrition include disease and inadequate food intake; this means that disease can affect nutrient intake and absorption, leading to malnutrition, while not taking sufficient quantities and the right quality of food can also lead to malnutrition.

The underlying causes are food insecurity-including availability, economic access and use of food; feeding and care practices-at maternal, household and community level; and environment and access to and use of health services (World Health Organization and The World Bank, 2012). Household food insecurity implies that there is a lack of access to sufficient, safe, nutritious food to support a healthy and active life.

The level of nutrition awareness among mothers or caregivers and other influencers affects the child feeding and care practices, consequently impacting on their nutrition. Similarly, poor access to and utilization of health services as well as environmental contaminants brought about by inadequate water, poor sanitation, and hygiene practices, influence the nutrition of households.

Lastly, the underlying causes of malnutrition which act at the enabling environment on macro-level include issues such as knowledge and evidence, politics and governance, leadership, infrastructure and financial resources in general nutrition-specific interventions address the manifestation and immediate causes; nutrition-sensitive interventions the underlying causes and enabling environment interventions the primary or root causes of malnutrition.

Nutrition is neither a sector nor a domain of one ministry or discipline but a Multisectoral and multi-disciplinary issue that has many ramifications from the individual, household, community national to global levels. Addressing all forms of malnutrition at all three levels of causation (immediate, underlying, and essential) requires Triple-duty actions that have the potential to improve nutrition outcomes across the spectrum of malnutrition through integrated initiatives, policies, and programs.

The potential for triple-duty actions emerges from the shared drivers behind different forms of malnutrition, and from shared platforms that can be used to address these various forms. Examples of shared platforms for delivering triple-duty actions include health systems, agriculture and food security systems, education systems, social protection systems, WASH systems, and nutrition-sensitive policies, strategies, and programs. Strategies for integration of nutrition-specific interventions and sensitive interventions have been tested and proven to work.

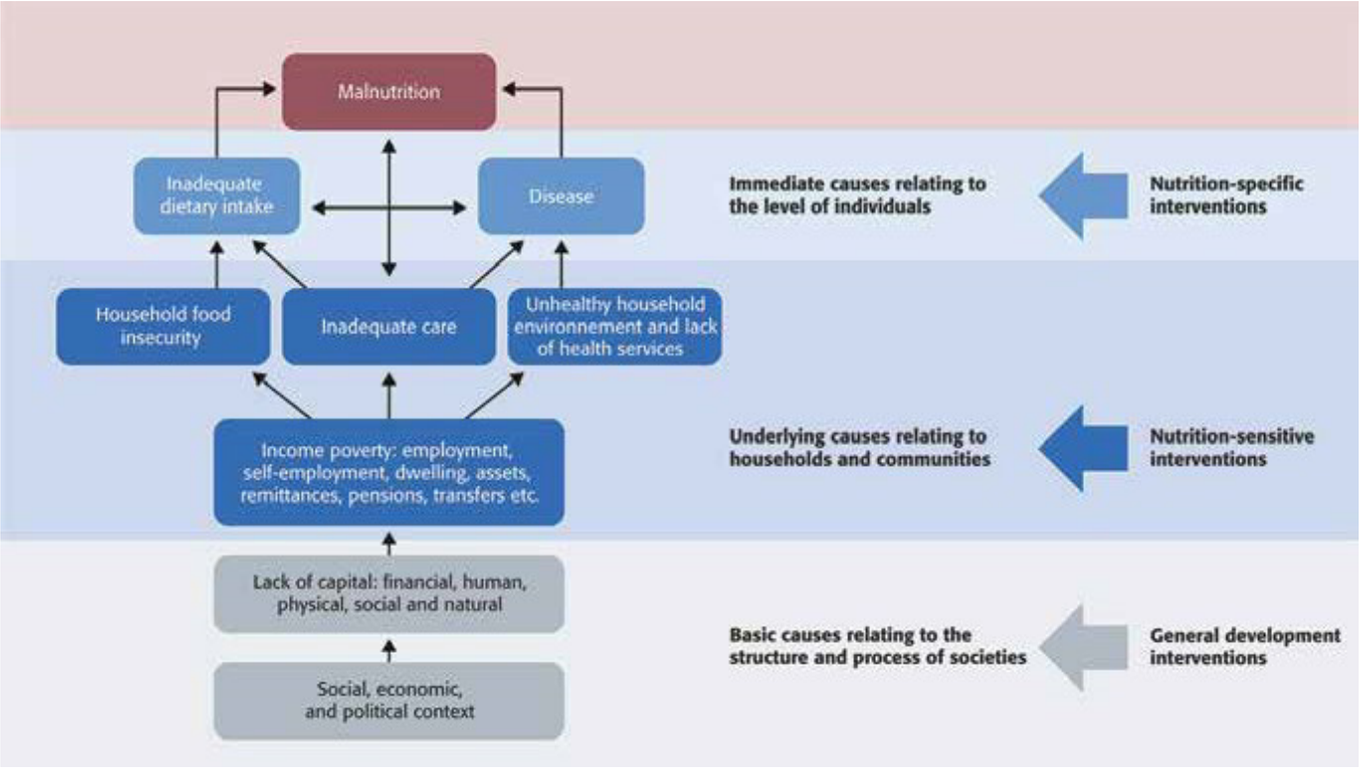

Figure 5: Conceptual framework for malnutrition
Source: (UNICEF, June 2015)

2.2 Vision

A county free from malnutrition in all its forms.

2.3 Mission

To provide effective and efficient preventive, promotive and curative nutrition services through nutrition specific and sensitive intervention within the county.

2.4 Core Values

Integrity
Quality
Accountability
Ethics and Equity
Collaboration and Partnership
Technology and Innovation
Efficiency and Effectiveness
Sustainability

2.5 National Policy and Legal Framework for CNAP

The constitution of Kenya gives every child the right to basic nutrition (Article 43 c) and all individuals the right to free from hunger and food of acceptable quality (art 53c). The country has a huge responsibility of ensuring the communities have access to good quality health care and live a healthy life. To achieve the

aspirations of the Constitution and Vision 2030, Kenya has given legislative force to some key aspects of nutrition interventions.

These include legislation on the following:

1. Prevention and control of iodine deficiency disorders through mandatory salt iodization,
2. Mandatory food fortification of cooking fats and oils and cereal flours, through the Food, Drugs and Chemical Substances Act.
3. The benefits of breastfeeding are protected through the Breast Milk Substitutes (Regulation and Control Act) 2012.
4. Mandatory establishment of lactation stations at workplaces (Health act art 71 & 72)
5. The Food, Drugs and Chemical Substances Act (food labeling, additives, and standard (amendment) regulation 2015 on trans fats) is also key legislation central to the control of Diet Related Non-Communicable Diseases (DRNCDs).
6. The Nutritionists and Dieticians Act 2007 (Cap 253b) which determine and set up a frame- work for the professional practice of nutritionists and dietician

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. The counties will have a key role in implementing, monitoring and enforcement.

2.6 Rationale

County Nutrition Action Plan has been developed to accelerate and scale up efforts towards the elimination of malnutrition as a problem of public health significance. The three basic rationales for the action plan are: (a) The health consequences – improved nutrition status leads to a healthier population and enhanced quality of life; (b) Economic consequences – improved nutrition and health is the foundation for rapid economic growth; and (c) The ethical argument – optimal nutrition is a human right.

2.7 Nutrition through the life course approach

Nutritional needs and concerns vary during different stages of life from childhood to elderly years. Nutritional requirements in the different segments of the population can be classified into the following groups which correspond to different parts of the lifespan, namely, pregnancy and lactation, infancy, childhood, adolescence, adulthood, and old age

The development of this CNAP had been through intensive consultation to capture the nutritional requirements of individuals or groups across different ages and diversities living in the county. The KCNAP has considered the following factors: Physical activity — whether a person is engaged in heavy physical activity; age and sex of the individual or group; body size and composition, Geography; and Physiological states, such as pregnancy and lactation.

From infancy to late life, nutritional needs change. Children must grow and develop, while older adults must counter the effects of aging. The importance of gender, age, and diversity-appropriate nutrition during

all stages of the life cycle cannot be overlooked. It is for this background that this action plan has been developed, taking into consideration nutrition needs as per specific appropriate stages of life as well as to capture and optimize the heterogeneity of nutrition needs regardless of gender, age, and other socio-economic, cultural and physiological determinants and dimensions. Nutritional needs and concerns change significantly throughout the stages of life, from childhood to old age. These requirements can be categorized into key life stages: pregnancy and lactation, infancy, childhood, adolescence, adulthood, and old age.

The development of this County Nutrition Action Plan (CNAP) involved extensive consultations to address the nutritional needs of individuals and groups across different ages and diversities in the county. The plan takes into account various factors, including physical activity levels (e.g., heavy physical labor), age, sex, body size and composition, geographical location, and physiological conditions such as pregnancy and lactation.

Nutritional demands evolve from infancy through late life. Children require adequate nutrition for growth and development, while older adults need support to counter the effects of aging. Addressing the importance of nutrition tailored to gender, age, and diversity across all life stages is essential. This action plan has been designed with this understanding in mind, ensuring that nutrition interventions are aligned with specific life stages while considering the diverse socio-economic, cultural, and physiological factors that influence nutritional needs.

2.8 Gender integration

Gender and nutrition are inextricable parts of the vicious cycle of poverty, and it's an important cross-cutting issue. Gender inequalities are a cause as well as an effect of malnutrition and hunger. Higher levels of gender inequality are associated with higher levels of under nutrition, both acute and chronic undernutrition. Gender equality is firmly linked to enhanced productivity, better development outcomes for future generations, and improvements in the functioning of institutions.

Across Kenyan communities, which are patriarchal, women continue to face discrimination and often have less access to power and resources, including those related to nutrition. It is, therefore, imperative to provide equal opportunity for all genders to participate in economic development for optimal resource generation. The adoption of a gender-responsive approach to the identification, planning, and implementation of development activities is eminent for improved, transformative, and sustainable food and nutrition security. Household food insecurity aggravated biased social systems, cultural norms, beliefs, and practices that greatly influence the socio-economic vulnerability and human development form part of the major factors leading to malnutrition in Kajiado County.

Deep-rooted gender inequalities within the county including unequal access to, use and control over benefits from productive resources especially by women and girls and their limited autonomy in decision making which is culturally a preserve for men deny women and girls equal opportunities to exploit their potential as strong agents for increased food and nutrition security (CIDP, 2023). The youth who form the majority of the productive population have equally been left out, thus the possibility of missing out on the existing potentials and their essential role towards contributing socio-economic development in the county. On the other hand, the above 64 years' category is mainly composed of the aged, with a large proportion being dependent on the working population. This places a heavy burden on the economically active population that contributes to economic development and, at the same time, provides basic needs to the households.

This calls for the need to direct more resources to provide adequate youth polytechnics and invest special programmers in creating employment opportunities. Poverty alleviation programmes should aim at providing subsidies and healthcare programmes for the aged population and their dependents.

Despite their social status as custodians of household and community based productive resources and decision making, men are inadequately involved in issues related to nutrition largely perceived as women's role. This is likely to result in an inadequate lack of support by men, which can have a major negative impact on the efforts being made towards achieving improved nutrition and health-related outcomes.

Other factors such as overburdening maternal roles, socio-cultural beliefs and practices around food sharing and uptake, negative cultural practices such as child and forced marriages, unequal or limited access to information, and literacy levels disproportionately women and girls further represent part of the factors negatively impacting on food and nutrition security. This underscores the need to apply a rights-based approach to gender programming, with opportunities to leverage complementary rights-based and gender-responsive nutrition principles which have been factored in the county CNAP.

Notwithstanding, the roles, priorities, norms, needs, and use of resources may differ between men and women. The way women and men are affected by nutrition actions may also vary, as demonstrated within the CNAP. Weak inter-sectoral linkages, inadequate gender integration in nutrition assessments, surveys/ research lead to lack of evidence-based decision making and the design of tailor-made nutrition and health interventions responsive to the specific nutrition needs, priorities, challenges while building on the existing capacities, experience, and knowledge among men and women of different age and diversities.

Additionally, disaggregation of data by sex, age groups and diversities at all levels is import- ant to inform the necessary response interventions to address different population group's specific nutrition and health-related needs in the county.

In order to achieve effective and sustainable nutrition and health outcomes, the CNAP seeks to integrate a gender transformative approach through effective gender mainstreaming at all levels of nutrition and health interventions. Specifically, this nutrition action plan has used mix approaches to a larger extent; integrate gender in the development process and the final action plan. These include:

- The use of the life cycle approach "all residents of Kajiado County, throughout their life-cycle enjoy safe food in sufficient quantity and quality to satisfy their nutritional needs for optimal health at all times." By using the life-course approach, the action identifies key nutrition inter- venations for each age cohort and provides the linkages of nutrition to food production and other relevant sectors that impact on nutrition.
- Ensuring nutrition programming at all levels in Kajiado County is consistently informed by context-based gender analysis defining the gender issues and relations relating to the specific nutrition needs and priorities of men and women of different ages and diversities across the county
- Specific strategies, interventions, and activities are prioritized within the CNAPs addressing nutrition needs specific to women, men, adolescents (boys and girls) giving weight in identification and addressing the socio-cultural, economic, technology and political barriers to achieving gender equality in areas of human rights, equal participation of men and women in key decision processes about their nutrition and wellbeing, equal access, use and control over and benefit from resource development resources adequately respond to the specific nutrition and health-related needs of women and men across all ages and diversities.
- Development and implementation of an SBCC strategy to address underlying socio-economic barriers,

cultural norms, beliefs, knowledge and practices are affecting improved and sustain-able food, nutrition, and health-related outcomes in Kajiado County.

- Development and implementation of an SBCC strategy to address underlying socio-economic and cultural barriers and practices affecting improved and sustainable food security, nutrition, and health-related outcomes in Kajiado County.
- Support interventions promoting increased male and community engagement on their role in supporting improved uptake of optimal nutrition and health practices at the household level, community, and across the county at large.
- Strengthening health systems to improve delivery of gender-responsive health services by health care workers as well as increased demand and equitable uptake of optimal nutrition and health services and practices, by men and women of all ages and diversities in Kajiado County.
- The CNAP development process has mainstreamed gender in its development process by making sure both females and males are invited and make meaningful participation all the stages of CNAP development, this includes active participation in the inception meeting, writ- in and interventions prioritization meetings including validation, making the process inclusive and participatory with women and men having equal opportunity to in setting Nutrition agenda for Kajiado County.
- The common result and accountability framework for Kajiado CNAP has intentionally included an indicator that is meant to monitor and evaluate gender-transformative nutrition interventions for improved and sustainable nutrition and health-related outcomes.
- Accountability for results is enhanced to improve transparency, leadership, and the quality of statistics and information made available to the various stakeholders and the public by collecting sex age disaggregated data at all levels.
- Gender and nutrition are deeply intertwined, forming part of the cycle of poverty. Gender inequality is both a driver and a consequence of malnutrition and hunger. Evidence shows that higher levels of gender inequality are linked to increased rates of acute and chronic undernutrition. Addressing these inequalities is essential, as gender equality promotes productivity, improves development outcomes for future generations, and strengthens institutions.
- In Kajiado County, deep-rooted gender disparities significantly impact food and nutrition security. Women and girls face unequal access to and control over productive resources, as well as limited autonomy in decision-making, which is often reserved for men due to cultural norms. These inequalities hinder their potential to contribute effectively as agents of change in food and nutrition security. Furthermore, socio-cultural barriers, such as overburdened maternal roles, food-sharing norms, and negative practices like child and forced marriages, disproportionately affect women and girls, exacerbating their vulnerability to malnutrition.
- Youth in Kajiado County, despite forming the majority of the productive population, are often excluded from decision-making and development processes. This exclusion limits their opportunities to contribute to socio-economic growth and food security. On the other hand, the elderly population, particularly those above 64 years, places significant pressure on the working population, as many older adults are dependent on the economically active for basic needs.
- Men's roles in nutrition are often undervalued, as nutrition-related responsibilities are culturally perceived as the domain of women. This lack of male involvement reduces the support available for improving nutrition and health outcomes. Weak inter-sectoral linkages and insufficient gender integration in nutrition assessments and decision-making further exacerbate the issue. Inadequate data disaggregation by sex, age, and diversity limits the ability to design tailored, evidence-based interventions that address the unique needs of different groups.
- To address these challenges, the County Nutrition Action Plan (CNAP) adopts a gender-responsive and transformative approach. It integrates strategies that focus on improving equality, participation, and decision-

making among all genders while addressing the socio-economic and cultural barriers that undermine progress. These strategies include:

- **Life Cycle Approach:** Nutrition interventions are tailored to specific age groups, ensuring that residents across all stages of life have access to safe, sufficient, and nutritious food. These interventions link nutrition to food production and other relevant sectors for a comprehensive approach.
- **Gender Analysis and Targeted Programming:** Nutrition programming is informed by context-based gender analysis to identify and address the unique nutrition needs of men and women of different ages and diversities. Specific strategies focus on overcoming socio-cultural, economic, and political barriers to gender equality, particularly in decision-making and resource access and utilization.
- **Social and Behavior Change Communication (SBCC) Strategies:** The CNAP prioritizes SBCC strategies to challenge socio-economic barriers, cultural norms, and practices that hinder food security and nutrition outcomes.
- **Increased Male and Community Engagement:** The plan emphasizes engaging men and communities to support improved nutrition and health practices at the household and community levels.
- **Strengthened Health Systems:** Efforts are directed at improving the delivery of gender-responsive health services and increasing equitable access to nutrition and health practices for men and women of all ages and diversities.
- **Inclusive Development Process:** The CNAP development process ensured equal participation of men and women in setting the county's nutrition agenda, making the process inclusive and participatory.
- **Accountability and Monitoring:** The plan incorporates a result-oriented framework with gender-transformative indicators to monitor progress and ensure transparency. The collection and use of disaggregated data by sex, age, and diversity at all levels will enhance decision-making and accountability.

2.8 Target audience for CNAP

The target audience for the Kajiado County Nutrition Action Plan (KCNAP) cuts across policy makers and decision makers both at national and county governments, donors and implementing partners of both nutrition specific and sensitive interventions, county health management team, sub county health management teams, nutrition workforce in health and other departments that influence and provide enabling environment for nutrition to be achieved and the communities at the grassroots level.

The target audience for the Kajiado County Nutrition Action Plan (KCNAP) includes policymakers and decision-makers at both national and county government levels, donors, and implementing partners involved in nutrition-specific and nutrition-sensitive interventions. It also targets the county and sub-county health management teams, the nutrition workforce within health and other related departments that contribute to creating an enabling environment for achieving nutrition goals at the county and grassroots level.

CHAPTER THREE: KEY RESULT AREAS, STRATEGIES AND INTERVENTIONS

3.1 Introduction

The overall expected result or desired change for the CNAP is to contribute to the goal of KNAP 2024-2029 in achieving optimal nutrition for a healthier and better-quality life and improved productivity for the country's accelerated social and economic growth. To achieve the expected result, a total of 12 key result areas (KRAs) have been defined for Kajiado County. The KRAs are categorized into three focus areas: (a) Nutrition-specific (b) Nutrition-sensitive and (c) Enabling environment, See, Table 6. The KRAs have been matched with corresponding set of expected outcomes and outputs, as well priorities activities per each of the KRA presented in see, section 3.3).

Table 6: Prioritized KRAs per Focus Area

CATEGORY OF KRAs BY FOCUS AREAS	KEY RESULT AREAS (KRAs)	OUTCOMES
a. Nutrition specific	1. Maternal, Newborn, Infant, and Young Child (MNIYC) nutritional well-being enhanced	Outcome 1: Improved care practices and services for enhanced maternal, infant, and young child nutrition
	2. Improved nutritional well-being[4] of older children, adolescents, adults, and older persons	Outcome 2: Increased awareness and adoption of healthy dietary practices and uptake of nutrition services by older children, adolescents, adults and older persons.
	3. Enhanced Industrial Fortification for Prevention and control of micronutrient deficiencies	Outcome 3: Increased awareness, availability and adoption of industrially fortified foods in Kenya.
	4. Sustained nutritional well-being of individuals and communities during emergencies and climate-related shocks.	Outcome 4: Improved community and individual resilience to climate-related shocks and emergencies
	5. Enhanced clinical nutrition and dietetic services across all levels of health care.	Outcome 5: Enhanced and expanded clinical nutrition and dietetic services for the prevention, control, and management of nutrition-related diseases.
b. Nutrition sensitive	6. Enhanced integration of nutrition into agriculture, livestock, and fisheries sectors.	Outcome 6: Increased production, access, and utilization of diverse, safe, nutrient-dense foods at the household level.
	7. Enhanced integration of nutrition in the education sector	Outcome 7: Enhanced nutrition interventions within the education sector
	8. Enhanced integration of nutrition within the Water, Sanitation, and Hygiene (WASH) sector	Outcome 8: Increased access to improved nutrition sensitive[5] WASH services.
	9. Nutrition integrated across Social Protection programs	Outcome 9: Nutrition mainstreamed within social protection policies, strategies and interventions.
c. Enabling Environment	10. Strengthened multisectoral Nutrition Information, M&E systems, research and Knowledge management.	Outcome 10: Improved multi-sectoral Nutrition information systems, robust M&E frameworks and effective knowledge management.
	11. Enhanced [6]multisectoral nutrition governance, coordination, partnerships, advocacy, and community engagement.	Outcome 11: Improved governance, financing, coordination, partnerships and community participation in Multisectoral nutrition programs
	12. Strengthened Supply chain management for nutrition commodities and equipment	Outcome 12: Improved supply chain management system for nutrition commodities and allied tools.

4 Nutritional wellbeing refers to the overall health and balance of an individual's diet and nutritional intake. It encompasses not only the adequacy of nutrient intake but also factors such as dietary diversity, food quality, and the body's ability to utilize nutrients effectively. Achieving nutritional wellbeing involves consuming a balanced diet that meets individual needs for growth, development, and maintenance of health throughout various life stages. It also includes considerations of food security, access to nutritious foods, and the cultural and environmental factors that influence dietary choices and habits. Overall, nutritional wellbeing is essential for promoting good health, preventing disease, and supporting optimal physical and mental function.

5 Nutrition-sensitive approaches aim to create environments and conditions that support healthy diets and nutritional well-being across populations

6 Enhanced" means improved, strengthened, or increased in quality, effectiveness, or capability. It suggests that something has been made better or more robust than before. In the context of programs or initiatives, it implies that efforts have been taken to elevate or optimize their impact, efficiency, or outcomes

3.2 Theory of Change and CNAP Logic Framework

The "Theory of Change" (Toc) is a specific type of methodology for planning, participation, and evaluation that is used to promote social change – in this case nutrition improvement. Toc defines long-term goals and then maps backward to identify necessary preconditions. It describes and illustrates how and why a desired change is expected to happen in a particular context.

The pathway of change for the CNAP is therefore best defined through the theory of change. The Toc was used to develop a set of result areas that if certain strategies are deployed to implement prioritized activities using the appropriate then a set of results would be realized and if at scale, contribute to improved nutritional status of Kajiado residents. The logic frame- work outlining the key elements in the change process is captured in the Figure 6. The expected outcome expected output and priorities activities in line with the process logic have been discussed in section 3.3.

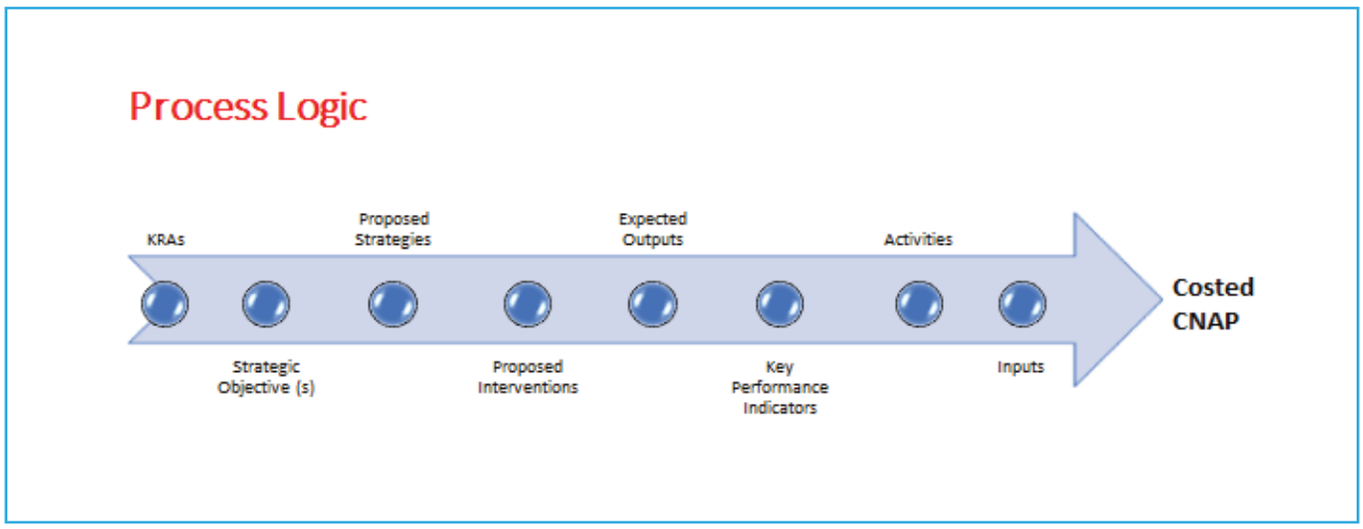

Figure 6: The CNAP Logic Process

3.3 Key Result Area, corresponding Strategic Objective, Outputs and Activities

KRA 01. Maternal, Newborn, Infant, and Young Child (MNIYC) nutritional well-being enhanced

Context

Proper maternal nutrition is very critical for pregnancy outcomes. Women of reproductive age consuming more than five food groups out of 10 are 69% (SMART survey 2023). The percentage of children under 6 months exclusively breastfed is at 82% (KAP survey 2022). This is below the national level of 61% (KDHS 2022). Breast milk continues to be an important meal in a child's diet up to two years of age. The percentage of children under two years who continue breastfeeding is at 63.3% (KAP survey 2022). The minimum acceptable diet for 6-23 months is at 36.8%. This means that a higher proportion of children 6-23 months do not have an adequate diet. Poor dietary intake for children 6-23 months is related to increased morbidity up to 45%. Biased gender roles and responsibilities between men and women resulting in overburdening maternal workload for women and girls, with the limited community and male support, lead to insufficient time for women and girls of reproductive age, especially PLWs to practice optimal care and feeding practices for

themselves and their young children. Water scarcity leads to long-distance trekking in search of water, food insecurity. This is normally aggravated by unequal social systems and deep-rooted gender inequalities that have a wide range influence to unequal access to, ownership of and control over benefits from productive resources and decision making disproportionately affecting women and girls in the county. This has a great impact on maternal and infant and young children care and feeding practices. Further cultural norms, beliefs and practices around breastfeeding, food sharing, and uptake related stereotypes, perceptions, and practices. This in turn affects maternal, infant and young children optimal dietary diversity through locally available and affordable nutritious foods.

Micronutrient deficiencies are of public health concern due to their devastating effect on the physical and mental well-being of the population. The most common deficiencies are of iron, folate, zinc, iodine and vitamin A. They are risk factors for increased morbidity and mortality among children under five years, pregnant and lactating women. Folic acid deficiency in pregnancy is a risk factor for Neural Tube Defects (NTD) in newborns and iodine deficiency during pregnancy is the commonest risk factor for preventable brain damage in the newborn. Kajiado County employs the national strategies in prevention, control and management of micronutrient deficiencies which include; periodic, high dose Vitamin A Supplementation (VAS) (a proven, low-cost intervention which has been shown to reduce all-cause mortality by 12 to 24 percent, hence an important program in support of efforts to reduce child mortality), dietary diversification, food fortification, supplementation and public health measures such as parasitic control through deworming, WASH, malaria control, health education and counselling. The county is also faced with some of the main challenges in prevention, control and management of micronutrient deficiencies among pregnant women and children below five years. These include low uptake of VAS and deworming services, especially for children aged 12–59 months and low coverage of iron and folic acid supplementation (IFAS) during pregnancy coupled with poor compliance and inconsistencies in uptake. The capacity to offer VAS and deworming services remains low as only a small proportion of male and female HCWs are sensitized on relevant micronutrient guidelines and policies. Consequently, levels of knowledge on nutrition among men and women across different ages and diversities further greatly determines the level of support, especially by men and other key influencers within communities. This is crucial in promoting increased uptake of optimal nutrition and health care and practices by women and children in the county. In addition to improved health and nutrition service provision, renewed focus to integrate interventions in nutrition programming to identify and address the underlying gender inequalities, socio-economic, and cultural issues across communities in Kajiado county is a prerequisite towards realizing improved MIYCN outcomes.

Strategic Objective

Improved nutrition status of women of reproductive age (15-49 years, and children (0-59 months).

Output 1.1

MIYCN services provided at all health service delivery points

Activities

1. Training of Health Care workers on Baby Friendly Hospital Initiative
2. Training Health Care workers on Baby Friendly Community Initiative
3. Sensitization to health care workers on growth monitoring for children and under five.
4. Sensitization to health care workers for screening for malnutrition among pregnant and lactating mothers at ANC and PNC

5. Targeted Continuous Medical Education to HCW on BFHI and BFCI
6. Scale up Baby Friendly Hospital Initiative certification
7. Screening for malnutrition among pregnant and lactating mothers at ANC.
8. Conduct Growth monitoring for children under five years at all service delivery points
9. Conduct Nutrition education/counselling during ANC and PNC clinics on early initiation of breastfeeding
10. Nutrition education/counselling on exclusive breastfeeding
11. Nutrition education/counselling on complementary feeding for children 6-23 months
12. Nutrition education/counselling on maternal nutrition to Women of Reproductive Age
13. Conduct cooking demonstration sessions for complementary feeding at the health facility.
14. Conduct Quarterly BFHI and BFCI support supervision
15. Conduct OJT/Mentorship to HCWs on BFHI and BFCI

Output 1.2

Knowledge of caregivers and influencers on MIYCN improved

Activities

1. Conduct community sensitization on key messaging on appropriate MIYCN practices
2. Training of TOTs on BFCI
3. Implement BFCI 10 steps in targeted CHUS-(unit cost per CHU for all the 10 steps)
4. Conduct semi-annual BFCI self-assessment – Baseline, Internal, and External
5. Training of CHPs on BFCI
6. Hold community dialogue meetings on MIYCN
7. Conduct childcare facility monitoring.

Output 1.3

Enabling environment for adoption of recommended MIYCN practices reinforced

Activities

1. Sensitize CHMT/SCHMT on relevant policies and bills
2. Sensitize employers/managers and business community on BMS Act and Child Care Policy
3. Sensitize BMS enforcers (PHOs)
4. Conduct quarterly monitoring of BMS in the local markets.
5. Establish breastfeeding space in social and workplaces.

Output 1.4

Optimal MIYCN practices sustained during emergencies

Activities

1. Train health workers on MIYCN-*e*
2. Sensitize CHPs on MIYCN-*e*
3. Sensitize community members on MIYCN-*e*
4. Conduct Rapid Assessment during emergencies.

Output 1.5

Kangaroo Mother Care services scaled up

Activities

1. Train TOTs on KMC
2. Train HCW on KMC
3. Sensitize CHPs on KMC
4. Scale up KMC.
5. Sensitize birth companions on KMC.
6. Conduct supervision monitoring to the health facilities offering KMC services

Output 1.6

Behavior change on diverse micronutrient intake to prevent micronutrient deficiency prevention promoted in the community level

Activities

1. Train HCWs on relevant guidelines and policies on micronutrient deficiencies
2. Sensitize community health promoters on prevention and control of micronutrient deficiencies.
3. Conduct health education to the community members on prevention and control of micronutrient deficiencies
4. Conduct health education to the community (equally targeting men and women across different ages and diversities) on dietary diversity, bio-fortified foods
5. Educate the community on production, preservation and consumption of micronutrient rich foods at household level

Output 1.7

Women of reproductive age and children 6-59months in the county optimally supplemented

Activities

1. Supplement pregnant women with IFAS
2. Supplement children 6 -59months years of age with vitamin A and dewormers (*Malezi bora*)
3. Procurement of Vitamin A and dewormers Tablets
4. Educate the community member on production, preservation and consumption of micronutrient rich foods at household level
5. Sensitize HCWs on documentation and micronutrient reporting of Vitamin A, Zinc IFAS and Deformers from the community level up to the DHIS

KRA 02. Improved Nutritional Well-Being of Older Children, Adolescents, Adults, And Older Persons

Context

This KRA will focus on older children (those aged 5-9 years), adolescents (those aged 10-19 years), adults (men and women aged 20 – 59 years) and the elderly population aged 60 years and above. These age cohorts are uniquely faced with social and nutritional challenges. Children aged 5–9 years, characterized by a slow, steady rate of physical growth, experience a high rate of cognitive, social and emotional development. They are usually very active. From seven, a child's weight and height increase more quickly in preparation for adolescence. Adolescents have increased nutrient needs for their accelerated growth spurt, and for the emotional and social transition from childhood to adulthood. Kajiado County's limited education on food and nutrition perpetuates misconceptions about dietary needs and diversity, resulting in poor food choices and inadequate feeding practices especially among vulnerable populations. Limited knowledge of the importance of nutrition means lack of awareness about the importance of adequate diets, dietary diversity, and optimal feeding practices contributing to sub-optimal nutritional outcomes. Strengthening nutrition education is key to empowering communities with the knowledge to make informed choices about their diets.

Rapid growth for this cohort increases nutritional requirements for all nutrients. Hence, older children and adolescents should be encouraged to eat on a diversified diet and avoid junk food. The population aged 20–59 years constitute the economically productive workforce upon which the other groups depend to meet their requirements for livelihood and subsistence. Promoting healthy eating behaviors in these specific cohorts promotes growth, development and improved nutritional status among children aged 5 to 9 years, promotes growth, development, prevents micronutrient deficiencies and eating disorders among adolescents, and prevents non-communicable diseases among adults and elderly.

The Kajiado CNAP 2023/2024 – 2028/2029, will work to improve micronutrient intake for adolescent girls in schools through training of schoolteachers to support the Weekly Iron Folic Acid Supplementation (WIFAs) in all sub counties. In addition, nutrition awareness and education sessions for caregivers with all school going children will be conducted. However, identification and referral of malnourished children disaggregated by age and sex to link facilities will be achieved due to improved appropriate equipment supply. In addition, the county will initiate programs that will deal with older children including feeding programs and growth monitoring for those beyond 5 years of age.

Strategic Objective

Improved nutrition well-being of Older children, Adolescents, Adults and Older Persons in Kajiado County

Output 2.1

Enhanced Capacity of health care workers and Community Health Promoters on nutrition for older children.

Activities

1. Sensitize C/SCHMT members on relevant Nutrition policies and guidelines
2. Sensitize health worker, Education and Agriculture officers on adolescent Nutrition policies and guidelines
3. Sensitize community health promoters on healthy diets and lifestyle policies and guidelines from the National Government.
4. Disseminate formulated National policy on healthy diets and lifestyle for older children, adolescents, adults and older persons to Health care workers.

Output 2.2

Increased reporting and surveillance of malnourished cases for older children, adolescents and adults

Activities

1. Scale up screening and referral of malnourished adolescents, older children and adults.
2. Capacity build teachers to identify and linking malnourished older children
3. Promote continuous Nutrition education in schools.
4. Capacity building of CHPs on identifying and referring malnourished older children, adolescent, adults and older persons

Output 2.3

Increased proportion of Adolescent girls supplemented with micronutrients.

Activities

1. Increase the number of schools participating in the adolescent Health Nutrition (AHN) program.
2. Procure and Dispatch of AHN commodities to schools.
3. Sensitize teachers on AHN and management of T1DM.
4. Sensitize guardians / caregivers on AHN
5. Sensitize key stakeholders on AHN.
6. Conduct community Education on AHN.
7. Conduct health education to adolescents (Boys & Girls) in schools on WIFS.
8. Training of health care workers on AHN.

Output 2.4

Malnourished Older people at community level detected early for treatment and referral

Activities

1. Sensitize CHPs on mapping, identification and support for older persons.
2. Integrate nutrition information in the support groups for older persons.
3. Sensitize CHPs on healthy diets and lifestyle for the older persons.
4. Conduct targeted dialogues on healthy diets for older persons in the community.
5. Draft Key messages for healthy diets for the older persons

Output 2.5

Increased Community awareness on healthy diets and lifestyle for Older Children, Adolescents, Adults and Older Persons within urban and rural areas

Activities

1. Mapping and conducting relevant stakeholder engagements
2. Disseminate to key stakeholders the national policy and guidelines on healthy diets and lifestyle
3. Conduct mass community education on healthy diets and lifestyle for Older Children, Adolescents, Adults and Older Persons during thematic and cultural days (e.g. Moran's' initiation ceremony)
4. Collaborate with key stakeholders to Promote healthy diets and physical activity for older children and adolescents through youth gatherings in urban and rural areas (football, drama, church)

KRA 03. Enhanced Industrial Fortification for Prevention and Control of Micronutrient Deficiencies

Context

Micronutrient deficiencies are of public health concern due to their devastating effect on the physical and mental well-being of the population. The most common deficiencies are of iron, folate, zinc, iodine and vitamin A. They are risk factors for increased morbidity and mortality among children under five years, pregnant and lactating women. Folic acid deficiency in pregnancy is a risk factor for Neural Tube Defects (NTD) in newborns and iodine deficiency during pregnancy is the commonest risk factor for preventable brain damage in the newborn. Fortification, just like the other strategies for preventing micronutrients covered in KRA 1 (including high dose Vitamin A Supplementation (VAS), dietary diversification and parasitic control through deworming), is an evidence-informed intervention that contributes to the prevention, reduction and control of micronutrient deficiencies. It can be used to correct a demonstrated micronutrient deficiency in the general population through mass or large-scale fortification or in specific population groups (targeted fortification including point of use home fortification) such as children, pregnant women and the beneficiaries of social protection programmes.

The 2022 KDHS findings show that anaemia prevalence among pregnant women in Kajiado County improved from 36% to 28%, though still below the target of 25%. Tracking change on the prevalence of iodine

deficiency among under-fives and consumption of iodized salts remains a challenge as there is still no data. Overall, only 4 out of 10 (36%) children under two years in the county are consuming an adequate diet. The county has put an effort to ensure consumption of nutrient dense foods by training over 100% of the targeted community health workers on bio diversification. In addition, there is more effort being put on legislation of the fortification strategy hence an observed improved proportion of factories surveyed and monitored on production of fortified food, though still below the target. There is a slight improvement on the proportion of factories that are doing food fortification at processing level. However, fortification in Kajiado, like most counties of Kenya is way below scale due challenges affecting implementation of this micronutrient deficiency prevention strategy. The challenges in mass food fortification in the county include slow adoption of fortification by small and medium-scale millers, poor compliance with standards, inadequate human capital and infrastructure and limited enforcement of the regulatory framework. To achieve the desired outcome a series of strategies and interventions with related outputs will be prioritized for implementation over the plan period.

Strategic objective

Access to fortified foods to improve micronutrient status of the population in Kajiado County scaled up

Output 3.1

Advocacy, Leadership and coordination mechanism for food safety and fortification strengthened

Activities

1. Formation of County Food Safety and Fortification Alliance (CFSFA)
2. Conduct quarterly CFSFA meetings for review and planning of food safety and fortification activities in the county
3. Conduct sensitization of managers and directors in relevant sectors (CHMT, Ministry of Trade) on food safety and fortification
4. Conduct advocacy meetings with MOH, Ministry of Trade leadership, and Members of County Assembly (MCAs) to lobby for budgetary allocation to food safety and fortification programming in the county
5. Conduct Advocacy forums to increase awareness on food safety and fortification - World Food Safety Day, County FF Summit

Output 3.2

Capacity of food industries /millers to produce safe and fortified foods strengthened

Activities

1. Conduct sensitization meetings for industries (maize, wheat flour, edible oil, salt) on relevant government legislation on food safety and fortification
2. Conduct on-site training and mentorship of food business operators and industries to institute Quality Assurance and Quality Control (QA/QC) in their businesses

Output 3.3

Capacity of surveillance and enforcement officers on regulatory monitoring, surveillance and enforcement of food safety and fortification enhanced

Activities

1. Train PHOs on food safety and fortification surveillance and enforcement
2. Conduct quarterly surveillance and monitoring on food fortification at the market level in the county
3. Establish a food safety and food fortification Mini laboratory

Output 3.4

Demand for consumption of fortified foods by households created

Activities

1. Mass sensitization on Food fortification through *barazas,* community action days, community dialogues
2. Mass sensitization on Food fortification through Radio spots
3. Sensitize CHPs on consumption of food fortification
4. Sensitize community gatekeepers on consumption of food fortification
5. Conduct household surveys to monitor consumption pattern of fortified foods

KRA 04. Sustained Nutritional Well-being of Individuals and Communities During Emergencies and Climate-related Shocks

Context

Kenya experiences various climate and weather extremes including prolonged droughts; frost in some of the productive agricultural areas; hailstorms; extreme flooding leading to fluctuating lake levels; and drying of rivers and wetlands. These extremes can lead to large economic losses and adversely impact food security. Notably, Kenya experiences major droughts every decade and minor ones every three to four years, which have led to significant crop failures and higher food prices. At the other extreme, Kenya also experiences severe riverine and flash flooding, particularly during the rainy seasons. Both lead to devastating impacts on lives, livelihoods and infrastructure (Opere 2013). The risk certain populations face to climate impacts is mediated by a combination of social, economic and political factors. Populations, and the people within them, may face heightened exposure to natural hazards and weather events, or barriers that limit their individual coping capacities. In general, people living in poverty, people who have been displaced, and often women, children and the elderly are disproportionately at risk of climate change impacts due to their limited access to knowledge, technology and financial resources.

Floods along with dry spells leading to droughts can cause an increase in diarrheal diseases, including Typhoid Fever and Cholera, which influence the prevalence of malnutrition, especially in children under five years old in poor neighborhoods. Increase in waterborne diseases, especially in children under five years old has always been observed in cases of increased number of days of prolonged rainfall; Cholera is linked to more extreme El Niño years; displacement of populations into camps sometimes could lead to a

rise in communicable diseases. The disease patterns are linked to changes in rainfall patterns – reduced rain has an impact on agricultural production which has a knock-on effect on food security and undernutrition; if water sources are drying up, then people more likely to drink dirty water or reduce their daily hygienic practices; conversely, flooding causes problems for sanitation systems, often resulting in toilets becoming flooded and contaminating water. Changing patterns of rainfall and temperature impact food availability which affects mothers' diets, and, consequently, birth weights (Bakhtsiyarava, Grace, and Nawrotzki 2018). Floods and other extreme events may limit women's access to healthcare facilities or interrupt supplies of contraceptives or medication. Extreme weather events have direct and indirect impacts on mental health. Studies engaging Kenyan farmers on their perceptions of the impacts of climate change (in 2009–2015) showed that they perceive these impacts as having a direct risk to their livelihoods and reported feelings of despair and irritation, which can sometimes lead to suicide by male household heads (Mwaniki and Ngibuini 2020). These communities were very inclined to participate in adaptation strategies, which may present an opportunity to incorporate mental health awareness and interventions as an adaptation measure in national programming.

Community resilience towards climate related shocks and emergencies is key factor towards nutritional well-being of individuals particularly children under five and pregnant and lactating women in the society, through scaling up of maternal, infant and young child nutrition, managing malnutrition in emergencies and resilience building, promoting nutrition in social protection and strengthening sectoral and multisectoral nutrition information system. This is made possible by the county government of Kajiado in collaboration with key supporting partners, MoH, UNICEF, WFP, Global Fund, NHP, USAID, AMREF, Nutrition International (NI), KEMSA.

Strategic objective

Enhanced community resilience to climate-related shocks and emergencies.

Output 4.1

Community supported to withstand climate shocks and emergency

Activities

1. Disseminate Early Warning Climate Information to communities
2. Integrate local knowledge with expert information in Participatory Scenario Planning forums
3. Conduct civic education to communities on emergencies
4. Conduct psychosocial support session on SGBV and nutrition counselling
5. Intensify case screening on malnutrition by the health care workers at the community
6. Mapping and identifying malnutrition hotspots.
7. Building preparedness into the communities using climate information by identifying areas at risk of flash floods and mapping the essential assets that could be affected (e.g. health facilities cropland or key roads);
8. Conduct mass screening activities in hotspot areas.
9. Linking vulnerable households for food assistance in emergency setting

Output 4.2

Capacity of Healthcare workers on nutrition surveillance for emergency response enhanced

Activities

1. Training health workers on conducting nutritional assessments for emergency response
2. Training health workers on IMAM surge
3. Scale up IMAM surge in targeted health facilities
4. Monitor IMAM surge activities
5. Train health workers on IYCN-e

Output 4.3

Enhanced multi-sectoral coordination in emergency

Activities

1. Linkage of households with malnutrition cases to cash transfer programs during emergency
2. Conduct multi-sectoral climate – health risk assessment (early warning early actions).
3. Develop sectoral emergency plans
4. Packaging and dissemination of early warning information messaging to the population
5. Develop county sectoral contingency plans
6. Conduct bi-weekly multi-sectoral platform (MSP) meetings on nutrition and food security during emergencies

KRA 5. Enhanced Clinical Nutrition and Dietetic Services Across all Levels of Health Care

Context

Clinical nutrition involves the nutrition care in disease and illness cutting across communicable and non-communicable diseases as well as life conditions and disabilities like cerebral palsy and autism in children, osteoporosis and arthritis in older people. A comprehensive approach to the management of disease that includes nutrition as a strong component contributes to the reduction of the burden of disease to a country. The increase in lifestyle diseases and the registered non communicable diseases have further increased demand for nutrition services. Undernutrition presenting as wasting also belongs in this KRA. In Kajiado County, programmes for the management of acute, severe and moderate malnutrition are implemented despite significant challenges which affect coverage of IMAM services, including; distance from health facilities, program me challenges like erratic supplies, inadequate staff who can offer the services, poor health-seeking behaviors by the community, prioritization of other competing activities over health seeking, migration of families leading to early defaulting from IMAM programme, and little or no IMAM programme awareness. Despite low wasting prevalence in the county, recurrent drought emergencies have recorded very high caseloads of malnourished children requiring emergency response to reach distant communities through approaches such as mass screening for case identification, door-to-door defaulter tracing and integrated mobile health and nutrition outreaches to overcome some of the above barriers.

Irrespective of the cause of morbidity, all inpatient and outpatient clients require nutrition care services ranging from counseling and education to nutrition support therapies. Further, with more specialized care in the medical field, there is a need for specialized nutrition services e.g. in renal, diabetes, critical care, geriatric and pediatric care. Feeding in the hospitals is also another area of concern, with increased use of therapeutic foods (commercial and hospital based) and therapeutic nutrition supplements playing a significant role. The overall planning of infrastructure, personnel, commodities and coordination affect the amount and quality of food served in hospitals.

The implementation of Kajiado CNAP 2018 – 2023, targeted to reduce the proportion of hospital-based malnutrition by 30%, but this target was surpassed, hence hospital-based malnutrition was reduced by 60%. The proportion of the population screened and assessed for malnutrition while accessing healthcare services was 10%, lower than the target (30%). Similarly, the proportion of healthcare workers trained on parenteral and enteral feeding in Kajiado is low (17%) against the targeted (100%) healthcare workers, with no training being conducted in the nutrition care process. In addition, knowledge, skills and competencies of health care workers in disease management and dietetics services remain low as indicated by the proportion of nutritionists (20%) trained on specialized short courses in clinical nutrition (pediatric oncology, renal, diabetes etc.) and low number of hospitals (1 out of 5 targeted health facilities) utilizing enteral feeds. Besides, no quality service assessment on clinical nutrition was conducted during the CNAP lifetime.

Considering the high number of in-patient admissions in level four Government hospitals and private hospitals in Kajiado, clinical nutrition and dietetics requires strengthening through improving capacity of the health facilities and healthcare workers in nutrition service delivery, improving access to quality curative nutrition services and specialized nutrition services, and increasing resources to support clinical nutrition activities. Health care workers play a major role in the prevention and care of non-communicable diseases by educating their clients on the need to adopt healthy lifestyles. The Department of Health made some progress towards prevention, management and control of DRNCD non-communicable diseases by training 500 health care workers through continuous medical education (CMEs). Data gaps on screening and management of cases owing to poor documentation, and lack of resources for the stepwise surveys on DRNCDs are required to be strengthened if the county is on the journey to reduce overweight or obesity in adults (18 to 69 years) and mortality attributable to dietary risk factors. In the IMAM program, death rates of under-fives being managed in the SAM and MAM program remained as per the recommended SPHERE thresholds, below 3% and 10% respectively. However, the recovery rate in both SAM and MAM programs, though slightly improved, remained below the recommended SPHERE thresholds of 75% for all IMAM exits, at 69.2% and 58.8% respectively. There is need to strengthen access to IMAM services through scaling up of integrated medical outreach activities, mass screening and case-finding to identify and treat malnourished cases, retention of clients from admission to cure through organized defaulter tracing mechanisms and building capacity of the health care workers and Community Health Promoters to manage acute malnutrition.

Strategic objective

Clinical nutrition and dietetics services Enhanced

Outputs 5.1

Increased access and coverage of Integrated Management of Acute Malnutrition(IMAM) Services

Activities

1. Conduct training of HCW on IMAM and disseminate the IMAM guidelines
2. Distribute/disseminate nutrition services SOPs and treatment protocols in all sub counties
3. Integrate management of acutely malnourished children in other programs within the health system
4. Carryout facility visits for On the Job Training on IMAM service delivery in primary care facilities and the community
5. Train HCWs on nutrition commodity quantification, forecasting and management
6. Conduct IMAM program performance reviews;

Output 5.2

Enhanced early case identification of all forms of malnutrition through community mobilization and referral

Activities

1. Train CHPs on CMAM
2. Train CHPs on family MUAC
3. Sensitization of caregivers on use of family MUAC
4. Sensitization of Opinion leaders on Malnutrition conditions and nutrition services
5. Conduct quarterly outreaches for Acute Malnutrition in hot spots areas at community
6. Conduct routine Nutrition assessment by CHP at household level
7. Support CHPs to follow up beneficiaries and trace IMAM defaulters

Output 5.3

Accelerated nutrition response for prevention and control of diet related NCDs

Activities

1. Training of HCWs on control and prevention of diet-related NCDs at all levels of service delivery
2. Scale -up integration of nutrition services in NCD programs and Clinics at sub county and facility level
3. Training of health workers on critical nutrition and dietetics care package
4. Disseminate SOPs and treatment protocols on critical nutrition and dietetics and inpatient feeding
5. Strengthened Nutrition screening, assessment and triage of all patients and clients seeking healthcare services

Output 5.4

Strengthened Nutrition Assessment, Counselling and Support services in HIV and TB clinics

Activities

1. Train healthcare workers on Nutrition and TB
2. Set-up nutrition assessment and screening stations in all outpatient and Inpatient departments
3. Implement bi-directional screening for TB disease and Nutrition conditions in TB and Nutrition clinics
4. Training of healthcare workers on Nutrition and HIV

KRA 06. Enhanced Integration of Nutrition into Agriculture, Livestock, and Fisheries Sectors.

Context

Agricultural productivity is central in securing food and nutrition for all. Kajiado County over- reliance on rain-fed agriculture, makes food production vulnerable to climate variability, impacting crop yields, livestock production and food availability. In addition, inadequate training in climate SMART and modern farming practices, and post-harvest losses contribute to limited food production. Boosting agricultural and livestock productivity is integral to providing a sustainable source of diverse and nutritious foods for the population. The country produces different kinds of food types, both of crops and livestock sources. Food crop sources include cereals (maize, sorghum) legumes (beans, cow peas, green grams, Dolichos), root crops (cassava, sweet potatoes, Irish potato), vegetables (kales, cabbages, spinach, onions, tomatoes, capsicum), fruits (mangoes, bananas, melons, pawpaw, avocadoes, citrus). Livestock food sources include milk, red meat, poultry, fish, eggs, rabbits, honey. The major food markets in the county include Ngong, Ongata Rongai, Kitengela, Kiserian, Kajiado, Isinya, Namanga, Sultan, Emali, Kimana, Loitoktok, Ilasit where other agricultural products not produced in the county can be accessed

During the lifetime of the second generation CNAP (2018 - 2023), knowledge and capacity on quality safe farm produce in Kajiado has been enhanced through training of farmer groups on safe use of chemicals, sensitizing community members on minimum residue levels of chemicals in food and aflatoxins in cereals and supporting peer groups to implement income generating activities. The success was realized through collaboration of the County Department of Agriculture in partnership with Kenya Climate SMART Agriculture Project, FAO, Agriculture Sector Development Support Programme, Africa in Store, Aquaculture Business Development Programme (ABDP), SIVAP, FAO, ALIN, WVK, Aquaculture Business Development Programme(ABDP), NIA, WHH, Dupoto and E Maa, among others.

There is a need to continue creating an enabling environment for linkages between nutrition, agriculture and food security by ensuring that the entire food system from production to consumption, which has influence on the nutritional status of a population, is strengthened. Linkages can be realized through strengthening sustainable and inclusive food systems that are diverse, productive and profitable for improved nutrition, improving access to nutritious and safe foods along the food value chain, promoting increased access to nutritious and safe food along the food value chain pathways, promoting consumption of safe, diverse, and nutritious foods and as well as strengthening Agri-Nutrition capacities and coordination at all levels. The 2024 – 2029 CNAP strategies for this KRA involve transforming agricultural and livestock systems, promoting climate-SMART practices, and empowering farmers with the knowledge and resources to diversify their

crops and animal husbandry. These strategies will be key to unlocking Kajiado county's potential in food production and products

Strategic Objective

Increased production and consumption of nutrient dense foods

Output 6.1

Farmers supported to increase availability and access of nutritious foods (crops/ livestock /fish)

Activities

1. Enhance and scale up community awareness on sustainable environment friendly production of diversified and nutritious foods
2. Enhance community awareness on post-harvest losses with both food and nutrition content
3. Facilitate training of community groups on establishment and maintenance of kitchen gardens
4. Staff trainings and demonstrations on post-harvest handling of produce to reduce food loss

Output 6.2

Innovative approaches for increased knowledge on Food consumption, utilization and processing supported

Activities

1. Conduct nutrition demonstrations to farmer groups on food preservation, preparation and utilization for various food categories (Animal, crops, fish)
2. Conduct demonstrations to farmers on household food preservation and processing

Output 6.3

Farmers supported to increase capacity on quality safe farm produce (crops, livestock, fish)

Activities

1. Enhance and scale up community awareness on food safety
2. Contact collaboration meetings with food safety regulatory bodies
3. Conduct staff trainings on food safety standards and regulations

KRA 07. Enhanced Integration of Nutrition in the Education Sector

Good nutrition is essential to realize the learning potential of children and maximize returns on educational investments. Poor nutrition (substandard diet quantity and/or quality resulting in under- or over nutrition) and lack of early learning opportunities contribute to the loss of developmental and academic potential and lead to lifelong health and economic disparities in the county. According to the SMART survey 2022 the malnutrition rate in Kajiado County stands at 21.9% are stanted,5.3% wasting and 13.3% underweight. Moreover, the early provision of optimal nutrition and opportunities for learning (supported by responsive

caregiving behaviors that are prompt, contingent on children's actions, and developmentally appropriate and stimulating) have been linked to positive early childhood development (ECD) outcomes. Single-sector interventions representing either early childhood development (ECD) or nutrition have been linked to positive child development and/or nutritional status. It's therefore important to currently advocate for the development and testing of integrated interventions. Nutrition education in schools is known to foster healthy eating habits in children and later in their families in the short and longer term.

In the third generation CNAP, Kajiado County expects to make some progress towards strengthening nutrition and education linkages by training its ECDE teachers and childcare facility care givers on nutrition assessment and having 100% of the targeted ECDEs on effective school feeding programs. Currently only 32.8.6% of ECDEs get a diversified diet in the feeding program. Currently, lack of data on other ECDE Nutrition related interventions like health education sessions for childcare facility caregivers and ECDE Teachers, Vitamin A Supplementation, deworming and growth monitoring indicate that there is inadequate integration of nutritional interventions in the school curriculum in Kajiado County. The county will endeavor to improve its adherence to the provision of healthy diets and a safe food environment in the ECDEs and childcare facilities. The county will increase its efforts of referral, treatment and management of malnourished children in ECDEs and childcare centers promptly to save them from the adverse effects of malnutrition. There is a great need for an Increased nutrition sensitivity program in childcare centers in Kajiado county to avert the repeated treatments of the same children in our medical facilities.

Strategic Objective

Improved nutrition status for childcare centers, ECDE and school going children

7.1 Output

Healthy and safe food environments promoted in learning and childcare centers

Activities

1. Scale up school gardens for public schools in the county
2. Create and strengthen nutrition sensitive health and 4 K clubs in schools
3. Conduct Nutrition education to parents of school going children in schools within the County
4. Sensitize the childcare facility management on healthy diet and safe food environment

7.2 Output

Nutrition assessment conducted in learning centers and childcare centers.

Activities

1. Conduct nutrition sensitization to ECD teachers in schools within the county.
2. Conduct nutrition sensitization to childcare centers owners in the county.
3. Growth monitoring among ECD children promoted

7.3 Output

Child care centers real time data established in the county

Activities

1. Conduct mapping and profiling of childcare centers in the county.
2. Linkage of the ECDE centers to catchment health facilities
3. Renovation and operationalization of a model public childcare center in Majengo, Isinya.
4. Sensitize all relevant stakeholders on childcare facilities and policy.
5. Conduct support supervision and M & E in nutrition sensitive programs in Childcare centers, ECD and schools

KRA 08: Enhanced Integration of Nutrition Within the Water, Sanitation, and Hygiene (WASH) Sector

Context

Water shortages undercut food security and the incomes of rural farmers while improving water management makes national economies, the agriculture and food sectors more resilient to rainfall variability and able to fulfil the needs of growing population. Protecting and restoring water-related ecosystems and their biodiversity can ensure water purification and water quality standards. A growing body of evidence indicates that access to safe drinking-water, sanitation, and hygiene has an important positive impact on nutrition. People who suffer from food and nutrition insecurity are often the same people who lack access to water, sanitation and hygiene, leaving them in extremely vulnerable situations and reducing their chances of living healthy and productive lives. One example is the link between open defecation and stunting. Diarrhea accounts for 9 percent of the deaths of children under 5 years old each year and is essentially a fecal-oral disease, where germs are ingested due to contact with infected feces. Where rates of toilet or latrine use are low, rates of diarrhea tend to be high. Multiple episodes of diarrhea permanently alter the gut and prevent the absorption of essential nutrients, increasing the risk of not only stunting or death, but of long-term consequences on cognitive and social abilities, school performance and work productivity in adulthood.

The Kajiado County multisector team adopted this KRA in the second generation CNAP which aligns with the sixth (6^{th}) goal of sustainable development goals (SDGs) which is to ensure availability and sustainable management of water and sanitation for all. Some of the strategies associated with this SDG are; Achieve universal and equitable access to safe and affordable drinking water for all; Achieve access to adequate and equitable sanitation and hygiene for all and end open defecation, paying special attention to the needs of women and girls and those in vulnerable situations; Support and strengthen the participation of local communities in improving water and sanitation management. The slight reduction in stunting prevalence in Kajiado can be attributed to improved WASH practices, treatment of drinking water slightly increased from 31.0% to 32%, handwashing at all critical times increased from 15.0% to 26.0% and open defecation reduced from 59.2% to 15.0%, during the implementation period of the second generation CNAP. In promotion of school health and hygiene, 46% of school going girls had access to sufficient menstrual products and education. The improvement was a concerted effort by various stakeholders in the nutrition and WASH sector through conducting sensitization sessions at household, and community levels and in institutions.

With the high levels of stunting and open defecation in the rural zones of Kajiado is at 33.1%, the review

recommends triggering the schools and communities to integrate nutrition in WASH activities through Community Led Total Sanitation (CLTS) and sanitation marketing, formation and capacity building of community nutrition groups, and capacity building of the law makers (members of county assembly) on linkages between WASH and nutrition to advocate an increase in budgetary allocation. In addition, conduct training of teachers and patrons on Personal Hygiene and Sanitation Education (PHASE) and Menstrual Hygiene Management (MHM), sensitize food handlers and Parent–Teacher Associations (PTA) on healthy and safe food environment, and support commemoration and documentation of Global and National days on WASH and nutrition.

Strategic Objective

Improved uptake of optimal WASH practices resulting from integration of nutrition in WASH

Output 8.1

Increased access to Clean portable water to households and institutions

Activities

1. Protection and restoration of water catchment areas
2. Promote water access by installations of rain water harvesting infrastructure in schools and homestead
3. Pipeline extension from existing water systems (last mile connectivity)
4. Sensitization on household water treatment techniques
5. Scale-up water quality surveillance

Output 8.2

Appropriate WASH practices at the community level promoted

Activities

1. Sensitize community on appropriate WASH practices during community action or dialogue days
2. Conduct targeted community led total sanitation (CLTS) in areas affected most by poor sanitation
3. Support CHPs to conduct household visitation with key messaging on appropriate WASH practices

Output 8.3

Appropriate WASH practices in Learning institutions promoted

Activities

1. Sensitize the learning institutions on the importance of point of use (POA) water treatment
2. Train school children and teachers on opportunities WASH and nutrition linkages (water treatment, hand water, human waste disposal, food handling hygiene etc.)
3. Conduct sensitization forums to BOMs on WASH and nutrition in learning institutions

Output 8.4

Water users' associations (WUA) and communities' capacity build on Nutrition and WASH linkage

Activities

1. Sensitize the water user associations (WUA) and Community Water Committees on avenues for WASH and Nutrition Linkage
2. Support WUA and CWCs to promote point of use water treatment to community members
3. Train WUA and CWCs opportunities for linkage between nutrition and WASH (water treatment, hand water, human waste disposal, food handling hygiene etc.)

Output 8.5

Actors in food preparation value chain capacity build on Nutrition and WASH linkage

Activities

1. Conduct sensitization on safe and hygienic practices during food preparation and storage to school administrators, food handlers
2. sensitize schools and communities on integration of nutrition in WASH activities through ULTS, CLTS and sanitation marketing
3. Sensitize teachers and patrons on PHASE (personal hygiene and sanitation education) and promotion of handwashing with soap during critical times

KRA 09. Nutrition Integrated Across Social Protection Programs

Context

Nutritional well-being is a fundamental aspect for the health, autonomy and, therefore, the quality of life of all people, but especially the vulnerable groups. It is estimated that at least half of non-institutionalized vulnerable people need nutritional intervention to improve their health and that 85% have one or more chronic diseases (MOH Kajiado 2022) This could improve with correct nutrition. Although prevalence estimates are highly variable, depending on the population considered and the tool used for its assessment, malnutrition in the vulnerable people has been reported up to 50%. Vulnerable people are particularly at risk of malnutrition, due to multiple etiopathogenetic factors which can lead to a reduction or utilization in the intake of nutrients, a progressive loss of functional autonomy with dependence on food, and psychological problems related to economic or social isolation, e.g., linked to poverty or loneliness.

Social protection in its broadest sense aims to alleviate income poverty, for example, through the promotion of income-generating activities, to reduce vulnerability, such as through insurance against crop failure, and to foster greater social justice and inclusion, for instance, through the empowerment of marginalized groups. Social protection interventions are commonly categorized as protective (when the focus is on recovering from shocks), **preventative** (when people's resilience to cope with shocks is strengthened), **promotive** (when the aim is mainly to enhance income or capabilities which allow people to escape from poverty), or **transformative** (when structural inequalities are addressed to improve social justice and inclusion). Source: Devereux, 2012 (11). Social protection policies and programs hold huge potential for improving the nutritional situation of vulnerable populations. To ensure that these policies holistically combat malnutrition, a nutrition-

sensitive approach was incorporated in the design and implementation of the second generation CNAP for Kajiado County. Over the implementation period, 100% of the targeted officers should be sensitized on the relevant guidelines and policies, the proportion of the vulnerable people enrolled to cash transfer funds [INUA JAMII program] However, 52 older children were assessed in February 2023 by the county's social services unit for cerebral palsy, autism related disorders and 300 assorted devices were issued to PWDs.

Mapping of the vulnerable groups for easy registration in the safety net programs will be key in addition to providing information desks for easy access to the safety net programs. The mapping can be eased through timely sensitization of community members on the importance of identification documents for registration of safety net programs. Disaggregation of data by disability status, age and sex will be key. There need to link and integrate nutrition education in routine social protection programing including during community engagement and disbursement of funds.

Strategic objective

Nutrition Integrated in Social Protection Programs

9.1 Output

Improved Dietary diversity promoted in Social Protection programs

Activities

1. Conduct a baseline survey/situation analysis on status of nutrition and health for the vulnerable groups.
2. Conduct assessment to establish gaps in linkages between nutrition and social protection programs in the county
3. In collaboration with social protection department conduct mapping and ranking of vulnerable households based on their vulnerability with nutrition status as part of criteria
4. Promote and integrate nutrition in Social Protection programmes e.g. cash transfers, hunger safety nets, others.
5. Mobilize financial resources for nutrition interventions in social protection programmes
6. Link vulnerable households (affected by disaster or crisis) to food transfer programs (relief foods)
7. Conduct nutrition screening for social protection families and linking the malnourished cases to the health facilities for support (IMAM and NCDs)
8. Support CHPs to conduct nutrition education to households targeted by social protection programs
9. Link vulnerable households with the department of agriculture to be supported to improve food production (provision of farm tools, farming skills, kitchen gardens)

9.2 Output

Care practices improved through linkage of Nutrition in Social Protection Programs

Activities

1. Support women to initiate Income Generating Activities to promote household income
2. Promote male involvement in key messaging on childcare practices
3. Targeted employer education on empowering women to promote optimal childcare practices while ensuring

productivity at work (educating employers on labor laws, MIYCN policy)

4. Promote Village Savings and Loans Activities (VSLAs) to empower women to improve care practices
5. Advocate for nutrition safety and security of families by addressing threats affecting PWD, infant and young children nutrition.
6. Empower women and make them the recipients of social protection benefits, focusing on increasing women's access to education on nutrition, assets and resources, while at the same time considering women's work burden and time constraints.
7. Engage men when addressing gender issues to strengthen the positive impact of social protection on nutrition.

9.3 Output

Healthy household environment and health services advocated for in Social Protection Programs

Activities

1. Link vulnerable households with Water Department for support to accessible safe drinking water (last mile connectivity, targeted for improved water sources)
2. Link vulnerable households with the available Social Health Authority(SHA)
3. Support CHPs to conduct household visitation promoting appropriate WASH practices to households targeted by social protection programs
4. Targeting support groups (HIV/AIDS, OVCs, Elderly, Youths) with key messaging on appropriate WASH and Nutrition practices during their meetings

9.4 Output

Coordination activities for Nutrition mainstreaming in Social Protection Program promoted

Activities

1. Conduct Key stakeholder mapping
2. Sensitize stakeholders on nutrition and social protection programs linkage opportunities.
3. Advocate for the linkage of nutrition services and Social Protection for all vulnerable groups to SHA.
4. Conduct monitoring and evaluation of nutrition and social protection programs linkage progress
5. Conduct research to inform implementation of social assistance interventions in health and nutrition, and a transfer and graduation practice of beneficiaries of nutrition inclusion in social protection programs
6. Advocate for social protection schemes that promote adoption of positive behaviors (for instance, cash transfer programs that promote Growth monitoring, pre and post-natal care services)
7. Advocate for harmonization of nutrition and social protection services for vulnerable groups.

KRA 10: Strengthened Multisectoral Nutrition Information, M&E Systems, Research and Knowledge Management

Context

Nutrition plans and Strategies are complex policies that require solid monitoring systems to accurately and timely assess implementation progress. To monitor progress of Kajiado CNAP FY 2024/25-2028/29 and to guide decision makers towards their political nutrition commitments, a robust nutrition information system is needed to enable the continuous collection, analysis and interpretation of nutrition-related data across all sectors involved. When the second generation CNAP was developed, a CNAP MEAL Plan that aimed to provide strategic information needed for evidence-based decisions at county level through Common Results and Accountability Framework (CRAF) was validated with a list of over 130 multispectral indicators to monitor the overall progress of the CNAP. The MEAL Plan outlined what indicators to track when, how and by whom data will be collected, and suggests the frequency and the timeline for collective, program performance reviews with stakeholders.

During implementation of the third generation CNAP FY 2024/25 - 2028/29, monitoring of the CNAP will be done through review and development of Annual Work Plans, weekly surveillance reports from the IDSR, monthly surveillance and early warning bulletin by NDMA, quarterly health facility data review meetings, monthly program reports and, annual departmental performance reports and reviews. In addition, at least two integrated SMART, a coverage and a KAP_survey will be implemented to estimate the prevalence of acute and chronic malnutrition and the contributing factors for malnutrition (child morbidity, immunization, micronutrient supplementation, food consumption, child nutrition, maternal nutrition, and WASH). The coverage assessment will also review the performance of the IMAM program. Quarterly data quality audits on nutrition indicators will be done with the aim to improve data for accuracy, completeness and consistency of formatting.

Over the CNAP implementation period, there is a need to strengthen joint nutrition performance review meetings with other sectors to evaluate program performance, discuss strengths and weaknesses, as well as provide feedback, and collaboratively set goals for the quarter and year ahead. Besides conducting seasonal assessment review meetings, there is a need to ensure improved utilization of Integrated Phase Classification data, there is need to sensitize multisectoral members on the short rains and long rain assessment reports. In addition, there is a need for periodic review of the CNAP by MSP and the County Government in order to track progress and institute corrective measures.

Strategic objective

Improved nutrition data quality for decision making

Output 10.1

Nutrition Information and reporting system strengthened

Activities

1. Conduct quarterly Data Quality Audits at the facility level
2. Conduct quarterly county support supervision
3. Conduct quarterly sub county support supervision

4. Conduct quarterly performance review meetings nutrition indicators
5. Conduct monthly in-charges meetings at sub county level
6. Train health workers on health information and reporting systems
7. Procure sets of nutrition tools and registers
8. Sensitize members of the multisectoral platform on NDMA monthly bulletins, Integrated Phase Classification
9. Conduct quarterly field visit at NDMA sentinel sites
10. Participate in annual Short Rains Assessment and Long Rains assessment review meetings
11. Conduct KAP survey
12. Conduct SMART survey
13. Conduct a midterm review of the CNAP
14. Hold forums to disseminate research nutrition findings and information
15. Develop joint Annual Work Plans with Multi Sector players
16. Validation workshop for TOR for the multi sector players
17. Train data analyst on conducting and analyzing integrated phase classification in the County
18. Conduct a workshop to develop a Common Results Framework for the Multi Sector Stakeholders
19. Nutrition monthly situational analysis bulletin

Output 10.2

Learning and Research in Kajiado County Strengthened

Activities

1. Development of Nutrition policy briefs
2. Documentation of innovations and best practices
3. Conduct knowledge sharing forums (conferences, seminars, summits)
4. Conduct Nutrition Operational Research.
5. Establish a repository for nutrition data

KRA 11: Enhanced Multi Sectoral Nutrition Governance, Coordination, Partnerships, Advocacy and Community Engagement

Context

Government commitment to improve nutrition is essential for improved health outcomes for everyone. Nutrition governance starts with political will and includes coordination across multiple sectors, from health and agriculture to education and finance. It requires sustainable and transparent financing, and mechanisms to monitor and influence decision-making and policy implementation. Strong nutrition governance improves the effectiveness, scale-up, and sustainability of nutrition programming and propels countries toward achieving nutrition goals.

Kajiado CNAP 2024/25 – 2028/29 targets partners from across health, agriculture, social protection,

Environment & Water and education sectors among others. Following the design and launch of this plan, the Department of Health and County Health Management Team led by the County Nutrition Coordinator coordinated multi sector meetings to guide terms of reference. County and Sub- County Nutrition Technical Forums, Annual Work Plan, review meetings and multisector forums will create platforms for coordination of advocacy, governance, resource mobilization, linkages and implementation of the CNAP strategies.

Important to note is that the prolonged drought emergency after at least five consecutive seasons of rainfall failure that dated back in 2021 disrupted the usual coordination mechanisms where the county adopted enhanced more frequent multi sectoral coordination mechanisms at county level to coordinate drought response activities; more resources were also availed. Resource mobilization for drought response was prioritized over resource mobilization for the usual strategies as laid out in the nutrition plan.

Despite the success and progress realized during the past implementation period, a lot more needs to be done to sustain the gains and strengthen coordination and collaboration with other sectors at county and sub-county levels. There is a need for a clear-cut resource mobilization strategy and Planning and budgeting guidelines for nutrition-sensitive sectors to ensure a successful implementation of the third generation CNAP.

Strategic objective

Strengthened sectoral and multisectoral Nutrition Governance, Coordination, Legal/regulatory frameworks, Leadership and Advocacy

Output 11.1

Enhanced Governance through implementation of regulatory frameworks, policies and acts

Activities

1. Create awareness on legal documents e.g. BMS act, workplace support to decision- makers
2. Conduct sensitization meetings to health care workers on legal documents
3. Domesticate nutrition guidelines/policies
4. Development of nutrition Acts

Output 11.2

Nutrition Advocacy, Communication, Social and Mobilization enhanced

Activities

1. Conduct advocacy meetings with MCAs, county budgetary allocation committee and executive committee members in the county to advocate for increased resource allocation for nutrition human resource, nutrition medical camps, nutrition equipment and commodities.
2. Participate in the budgetary planning meetings
3. Commemoration of health and nutrition days
4. Proposal development for resource mobilization
5. Identify opportunities for private sector engaged in nutrition activities
6. Identify and engage nutrition champions

Output 11.3

Sectoral and Multisectoral nutrition coordination strengthened

Activities

1. Map and build capacity of private sectors engaged in nutrition activities
2. Conduct nutrition multi-sectoral engagement
3. Hold Nutrition Multi Sectoral task force meetings
4. Conduct Quarterly County Nutrition Technical Forums
5. Conduct monthly Sub County Nutrition Technical Forums

Output 11.4

Increased human resource for nutrition, equipment and commodities ensured

Activities

1. Support attendance of budget hearing meetings and advocate for funding of nutrition actions
2. Develop advocacy fact sheets on nutrition financing and nutrition briefs for use
3. Conduct nutrition awareness sessions for teachers and BOM on optimal nutrition
4. Conduct nutrition awareness sessions for caregivers

Output 11.5

Awareness creation on healthy diet and physical, general optimal nutrition activities intensified

Activities

1. Incorporate awareness session creation on physical activity and lifestyle habits with the local media
2. Disseminate relevant policies and guidelines on health diets and NCDs to HCW
3. Hold awareness sessions on healthy feeding habits to adolescent boys and girls across all diversities
4. Hold education awareness forums on lifestyle and dietary diversification and good nutrition
5. Design, develop, print and disseminate IEC materials for nutrition
6. Train CHPs on community nutrition module

KRA 12: Strengthened Supply Chain Management for Nutrition Commodities and Equipment

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 the UHC agenda. An increased scope of commodities is also necessary to support the reviewed Kenya Expanded Programme for Health (KEPH) that focuses on responsiveness to the population needs especially expanding to coverage for more non-communicable diseases. Advocacy for expansion of Essential Medicines & Medical Supplies (EMMS) lists to incorporate new commodities e.g. Nutrition commodities for chronic diseases such as cancer etc. is critical. An important aspect that determines the scale of procurement is the cyclical emergencies and disasters that increases the caseloads of children affected by malnutrition consequently increasing the requirements for key products necessary in treatment and management of malnutrition.

Procurement of nutrition commodities is predominantly done by the Kenya Medical Supplies Authority (KEMSA) which is a state corporation under the Ministry of Health established under the KEMSA Act 2013. There are however limitations in the full range of commodities and quality of the same, that KEMSA is currently able to stockpile. Similarly, the ability of counties to forecast, quantify and procure commodities from KEMSA is of great importance in maintaining the integrity of the supply chain. The mandate of the authority is to procure, warehouse and distribute nutrition commodities to facilities. The Nutrition commodities steering committee was formed under the leadership of the director of medical services and hosted under Nutrition and Dietetics Unit to Coordinate Nutrition Commodity Supply Chain Integration and Management in collaboration with key supporting partners, MoH, UNICEF, World Bank, WFP, DFID, Global Fund, NHP, USAID, AMREF, GAIN, Nutrition International (NI), KEMSA.

The key issues and challenges with regard to nutrition commodities are: -

1. Inadequate County funding and prioritization of nutrition commodities and equipment for routine programme implementation across the various programs leading to erratic supply and overreliance on partners for support
2. Inadequate capacity on commodity management, target setting, seasonal forecasting and quantification, quality and timely reporting affecting facility reporting rates and consistent availability of supplies.
3. Inadequate / poor storage facilities and space for nutrition commodities and equipment.
4. Insecurity with regards commodities and quality.
5. Poor road network to some health facilities affecting effective nutrition commodity distribution.
6. Theft of the nutrition commodities
7. Inadequate data collection and reporting tools
8. Difficulties with downstream warehousing and distribution chain.
9. Inadequate utilization of the Logistic Management Information System (LMIS)

Strategic objective

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

Output 12.1

Uninterrupted supply and use of nutrition commodities and anthropometric equipment at the facility level sustained

Activities:

1. Procurement of nutrition commodities
2. Delivering nutrition commodities to health facilities
3. Purchase anthropometric equipment

Output 12.2

Capacity of healthcare workers in nutrition supply chain management enhanced

Activities:

1. Conduct quarterly joint supportive supervision on nutrition commodities and warehousing
2. Conduct targeted On Job Training on nutrition commodities and warehousing
3. Train healthcare workers on Logistics Management and Information System (LMIS)
4. Scale up the use of LMIS in all health facilities
5. Conduct monthly data review meetings on nutrition commodities
6. Conduct quarterly routine Data Quality Assessments nutrition commodities

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

4.1. Introduction

This chapter provides guidance on the monitoring, evaluation, accountability and learning process, and how the monitoring process will inform the county nutrition action plan. The CNAP will evolve as the county assesses data gathered through monitoring.

Monitoring and evaluation systematically track the progress of suggested interventions, and assesses the effectiveness, effciency, relevance and sustainability of these interventions. Monitoring is the ongoing, routine collection of information about a program's activity in order to measure progress toward results. That information tells us if a change occurred (the situation got better or worse) which, in turn, helps in making more informed decisions about what to do next. Regular monitoring helps in detection of obstacles resulting in data-driven decisions, on how to address them. A program may remain on course or change significantly based on the data obtained through monitoring. Monitoring and evaluation therefore form the basis for modification of interventions and assessment of the quality of activities being conducted.

It is critical to have a transparent system of joint periodic data and performance reviews that involves key health stakeholders who use the information generated from it. In order to ensure ownership and accountability, the nutrition program will maintain an implementation tracking plan which will keep track of review and evaluation recommendations and feedback.

Stakeholders may include donors, departments, staff, national government and the community. Involvement of stakeholders contributes to better data quality because it reinforces their understanding of indicators, the data they expect to collect, and how that data will be collected. In addition, it helps to ensure that their user needs will be satisfied.

An assessment of the technical M&E capacity of the program within the county is crucial. This includes the data collection systems that may already exist and the level of skill of the staff in M&E. It is recommended that approximately 10% of a program's total resource should be slated for M&E, which may include the creation of data collection systems, data analysis software, information dissemination, and M&E coordination.

4.2. Background and Context:

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

4.3. Purpose of the MEAL Plan:

The CNAP MEAL Plan aims to provide strategic information needed for evidence-based decisions at county level through development of a Common Results and Accountability Frame- work (CRAF). The CRAF will form the basis of one common results framework that integrates the information from the various sectors related to nutrition, and other non-state actors e.g. Private sector, CSOs, NGOs; and external actors e.g. Development partners, technical partners resulting in overall improved efficiency, transparency and accountability.

While the CNAP describes the current situation (situation analysis), and strategic interventions, the MEAL Plan outlines what indicators to track when, how and by whom data will be collected, and suggests the frequency and the timeline for collective, program performance reviews with stakeholders.

Elements to be monitored include:

- Service statistics
- Service coverage/Outcomes
- Client/Patient outcomes (behavior change, morbidity)
- Clients' equitable access to and uptake of quality and gender responsive quality of health services responsive to the specific needs of men and women across different ages and diversity.
- Impact of interventionism response to the specific nutrition and health needs of men and women across different ages and diversities.

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

In effort to ensure gender integration at all levels of the CNAP, all data collected, analyzed, and reported on will be broken down (disaggregated) by sex and age to provide information and address the impact of any gender issues and relations including benefits from the nutrition programming between men and women. Sex disaggregated data and monitoring can help detect any negative impact of nutrition programming or issues with targeting in relation to gender, age and diversity. Similarly, positive influences and outcomes from the interventions supporting gender equality for improved nutrition and health outcomes shall be documented and learned from to improve and optimize interventions. Other measures that will be in place to ensure a gender responsive MEAL plan will include:

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

4.4. MEAL Team

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

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

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

4.5. Logic Model

The logic model looks at what it takes to achieve intended results, thus linking result expected, with the strategies, outputs an input, for shared understanding of the relationships between the results expected, activities conducted, and resources required.

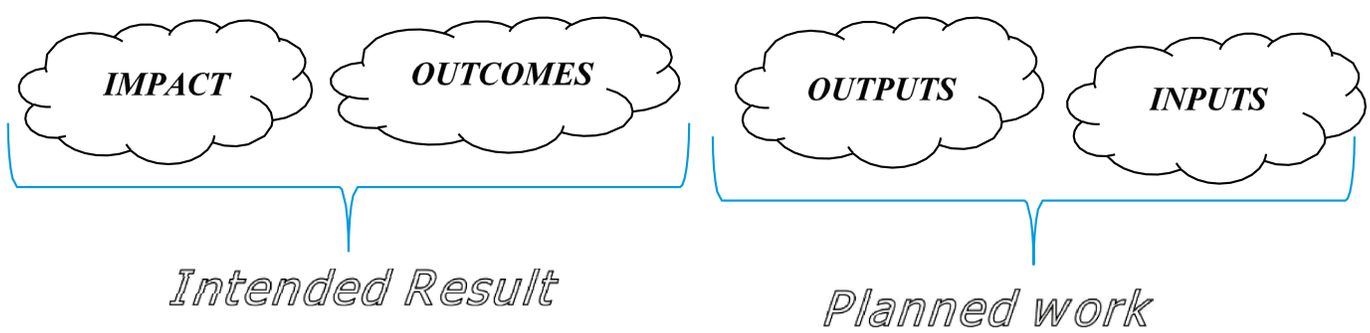

Figure 7: The Logic Model

Table 7: Results Framework

IMPACT	1. Improved nutrition status of women of reproductive age (15-49 years, and children (0-59 months). 2. Reduce the number of children under five who are stunted by 40% (WHA Target 2012) by 2025 3. Improve child survival for children below 5 years 4. Improved nutrition status of women of reproductive age (15-49 years) 5. Increase proportion of children who are optimally breastfed by 25% 6. Improved food consumption for women of reproductive age (15-49 years, and children (0-59 months). 7. Improved micronutrient consumption 8. Improved nutrition well-being of older children adolescents, adults and older persons 9. Clinical Nutrition and dietetics services Enhanced 10. Increased production and consumption of nutrient dense foods 11. Improved nutrition status for childcare centers, ECDE and school going children 12. Improved uptake of optimal WASH practices			
STRATEGIC OBJECTIVES	**Reduction in undernutrition**	**Reduction micronutrient deficiencies:**	**Reduction of dietary related NCDs**	**Improved multisectoral coordination**
	– Reduce prevalence of stunting among – children under five years by 40%; – Reduce and maintain childhood – wasting to less than 5%; – Reduce and maintain childhood – underweight to less than 10%; – Increase dietary diversity by 90%. – Maintain mortality rates at below 3% – for MAM and 10% for SAM – Improved cure rate for IMAM Program of ≥75	– Improved uptake of Iron Folic Acid among women of reproductive age (15-49 years) – Access to fortified foods to improve micronutrient status of the population in Kajiado County scaled up – Improve the proportion of children consuming Minimum Acceptable diet to 47% – Improve the proportion of VAS coverage among under-fives to above 80% national target	– Reduce the prevalence of overweight/ obesity in adults (18-69 years) – Reduce the mortality attributable to dietary risk factors – Healthy lifestyle diseases promoted	– Number of joint planning and progress review meetings held. – Number of coordination forums held at the county level – Number of multisectoral coordination forums held at the county level – Number of joint nutrition performance review meetings with other sectors
OUTPUTS	1. Maternal, Newborn, Infant, and Young Child (MNIYC) nutritional well-being enhanced 2. Improved nutritional well-being7 of older children, adolescents, adults, and older persons 3. Enhanced Industrial Fortification for Prevention and control of micronutrient deficiencies 4. Sustained nutritional well-being of individuals and communities during emergencies and climate-related shocks. 5. Enhanced clinical nutrition and dietetic services across all levels of health care. 6. Enhanced integration of nutrition into agriculture, livestock, and fisheries sectors. 7. Enhanced integration of nutrition in the education sector 8. Enhanced integration of nutrition within the Water, Sanitation, and Hygiene (WASH) sector 9. Nutrition integrated across Social Protection programs 10. Strengthened multisectoral Nutrition Information, M&E systems, research and Knowledge management. 11. Enhanced 8multisectoral nutrition governance, coordination, partnerships, advocacy, and community engagement. 12. Strengthened Supply chain management for nutrition commodities and equipment			
INPUTS	1. Organization of service delivery for nutrition;	Nutrition research;		
	2. Human Resource for Nutrition;	8. Nutrition leadership;		
	3. Nutrition infrastructure;	9. Household access to better quality and quantity of resources;		
	4. Nutrition products and Technology;	10. Financial, human, physical and social capital;		
	5. Nutrition Information;	11. Socio cultural, economic and political context		
	6. Nutrition Financing;			

7 Nutritional wellbeing refers to the overall health and balance of an individual's diet and nutritional intake. It encompasses not only the adequacy of nutrient intake but also factors such as dietary diversity, food quality, and the body's ability to utilize nutrients effectively. Achieving nutritional wellbeing involves consuming a balanced diet that meets individual needs for growth, development, and maintenance of health throughout various life stages. It also includes considerations of food security, access to nutritious foods, and the cultural and environmental factors that influence dietary choices and habits. Overall, nutritional wellbeing is essential for promoting good health, preventing disease, and supporting optimal physical and mental function.

8 Enhanced" means improved, strengthened, or increased in quality, effectiveness, or capability. It suggests that something has been made better or more robust than before. In the context of programs or initiatives, it implies that efforts have been taken to elevate or optimize their impact, efficiency, or outcomes

4.6. Implementation Plan

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

- Develop standard operating procedures for management of data, monitoring, evaluation and learning among all stakeholders.
- Improve performance monitoring and review process
- Enhance sharing of data and use of information for evidence-based decision making

4.7. Monitoring process

In order to achieve a robust monitoring system, effective policies, tools, processes and systems should be in place and adequately disseminated. The collection, tracking and analyzing of data makes implementation effective to guide decision making. The critical elements to be monitored are: Resources (inputs); Service statistics; Service coverage/Outcomes; Client/Patient outcomes (behavior change, morbidity); Investment outputs; Access to services; and impact assessment.

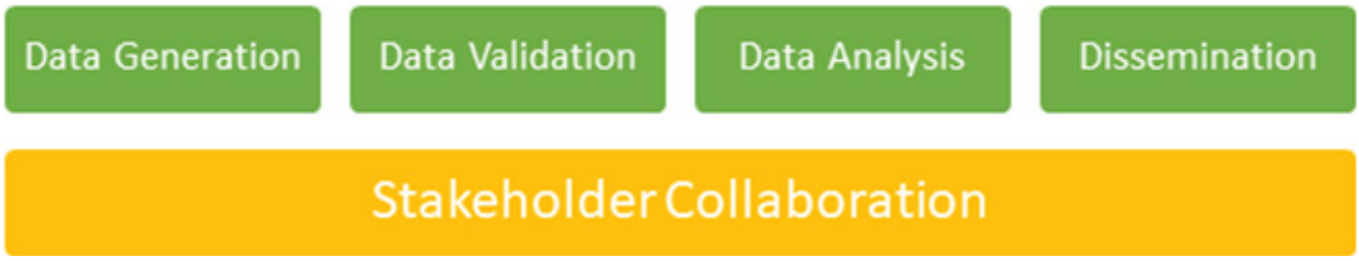

Figure 8: Monitoring Process

Data Generation

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

Data Validation

Data validation through checking or verifying whether or not the reported progress is of the highest quality and ensures that data elements are clear and captured in various tools and management information systems, through regular data quality assessment. Annual and Quarterly verification process should be carried out, to review the data across all the indicators.

Data analysis

This step ensures transformation of data into information which can be used for decision making at all levels.

Information dissemination

Information products developed will be routinely disseminated to key sector stakeholders and the public as part of the quarterly and annual reviews 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.

4.8. Monitoring Reports

The following are the monitoring reports and their periodicity:

Table 8: Monitoring Reports

Process/Report	Frequency	Responsible	Timeline
Annual Work Plans	Yearly	All departments	End of June
Surveillance Reports	Weekly	DSSC and health facility in charges	COB Friday
Health Data Reviews	Quarterly	All departments	End of each quarter
Monthly reports submissions	Monthly	Facilities, CUs	5th of every month
Quarterly reports	Quarterly	All departments	After 21st of the preceding Month
Bi-annual Performance Reviews	Every six Months	All departments	End of January and end of July
Annual performance Reports and reviews	Yearly	All departments	Begins July and ends November
Expenditure returns	Monthly	All levels	5th of every month
Surveys and assessments	As per need	Nutrition program	Periodic surveys

4.9. Calendar of key M&E Activities

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

Updating of the Framework

Regular update of the M&E framework will be done based on learning experienced along the implementation way. It will be adjusted to accommodate new interventions to achieve any of the program-specific objectives. A mid-term review of the framework will be conducted in 2026/27 to measure progress of its implementation and hence facilitate necessary amendments.

Indicators and Information Sources

The indicators that will guide monitoring of the implementation of CNAP a will be captured and outlined in the Common Results and Accountability Framework as shown in Table 4.3.

4.10. Evaluation of the CNAP

Evaluation is intended to assess if the results achieved can be attributed to the implementation of CNAP by all stakeholders. Evaluation ensures both the accountability of various stakeholders and facilitates learning with a view to improving the relevance and performance of the health sector over time. A midterm review and an end evaluation will be undertaken to determine the extent to which the objectives of this CNAP are met.

Evaluation Criteria

To carry out an effective evaluation of the CNAP, there will be need for clear evaluation questions. Evaluators will analyze relevance, efficiency, effectiveness and sustainability for the CNAP. The proposed evaluation criterion is elaborated on below;

- **Relevance:** The extent to which the objectives of the CNAP correspond to population needs including the vulnerable groups. It also includes an assessment of the responsiveness in light of changes and shifts caused by external factors.
- **Efficiency:** The extent to which the CNAP objectives have been achieved with the appropriate amount of resources
- **Effectiveness:** The extent to which CNAP objectives have been achieved, and the extent to which these objectives have contributed to the achievement of the intended results. Assessing the effectiveness will require a comparison of the intended goals, outcomes and outputs with the actual achievements in terms of results.
- **Sustainability:** The continuation of benefits from an outlined intervention after its termination and the commitment of the beneficiaries leverage on those benefits.
- The CNAP will be evaluated through a set of indicators outlined in the Common Results and Accountability Framework in Tables 9, 10 and 11.

Common Results and Accountability Framework

Table 9: Common Results and Accountability Framework

Impact or Outcome	Key performance Indicator	Baseline	Mid Term	End term	Means of verification	Frequency	Lead	Associated
Improved nutrition status of women of reproductive age (15-49 years, and children (0-59 months).	Proportion of Children with Low Birth Weight (<2.5kg)	5.50%	5.00%	<4.5%	SMART	Bi-annually	CDH	Other Sectors & Partners
	Prevalence of underweight (W/A) in children 6 to 59 months	13.3% (SMART survey 2023)	11%	<10.0%	SMART survey	Bi-annually	CDH	Other Sectors & Partners
	Prevalence of Wasting (H/W) in children 6 to 59 months	5.5% (SMART, 2023)	4%	2%	SMART survey	Bi-annually	CDH	Other Sectors & Partners
Reduce the number of children under five who are stunted by 40% (WHA Target 2012) by 2025	Prevalence of Stunting (H/A) in children 6 to 59 months	21.9% (SMART, 2023)	17.4%	13.1%	SMART survey	Bi-annually	CDH	Other Sectors & Partners
Improve child survival for children below 5 years	Child mortality rate (0-4 years)	0.30(0.09-0.92) (SMART, 2023)	0.20	<0.20	SMART survey	Every 5 years	CDH	Other Sectors & Partners
Improved nutrition status of women of reproductive age (15-49 years)	Prevalence of anemia in pregnant women (%)	28%	26%	<25%	KHIS	Annually	CDH	Partners
Increase proportion of children who are optimally breastfed by 25%	Proportion of children on Exclusive breastfeeding	82.40%	88%	92%	KAP survey	3-5 years	CDH	Other Sectors & Partners
Improved food consumption for women of reproductive age (15-49 years, and children (0-59 months).	Proportion of children consuming Minimum Acceptable diet	36.80%	43%	47%	KAP survey / SMART survey	3-5 years	CDH	Other Sectors & Partners
	Proportion of children 6–23 months of age who receive MDD	50% (KAP survey)	52%	55%	KAP survey / SMART survey	3-5 years	CDH	Partners KNBS
	Proportion of children 6–23 months of age who received MMF	60.5% (KAP survey)	64%	68%	KAP survey / SMART survey	3-5 years	CDH	Partners KNBS
Improved micronutrient consumption	VAS coverage for children 6 to 59 months above national target 80%	39.1% (SMART, 2023)	60%	80%	SMART survey	Bi-annually	CDH	Partners KNBS
	% of Households consuming fortified foods	0% (Program Report)	30%	>50%	SMART Surveys	Bi-annually	CDH	CDT
Improved nutrition well-being of older children adolescents, adults and older persons in Kajiado County	Proportion of adolescents, Older children and Adults with a normal BMI	No Baseline Data	>50%	>50%	Screening data	Annually	CDH	MOE, CDSP, Partners
Clinical Nutrition and dietetics services Enhanced	% Improved coverage for IMAM Program ≥50%	No data	50%	≥50%	Coverage Survey, KHIS (direct & indirect coverage)	Annually	CDH	Other line ministries & Partners
	% Reduced malnutrition in NCDs	No baseline data	Reduce by 10%	Reduce by 20%	Program, Survey Report	Every 2-3 years	CDH	Other line ministries & Partners
Increased production and consumption of nutrient dense foods	% of Households with Improved Household Dietary Diversity Score	40.6% (SMART2023)	50%	>60.0%	SMART Survey	3 – 5 years	CDALP, CDH	Partners
Improved nutrition status for childcare centers, ECDE and school going children	Reduction in malnutrition among child care, ECDE and school going children	No Baseline data	Reduce by 5%	Reduce by 5%	Survey reports	Annually	MOE, CDH	Partners
Improved uptake of optimal WASH practices	Reduced Open defecation	33.1% (SMART)	25.00%	<20%	SMART Surveys	Bi-annually	CDW/CDH	Partners
	Proportion of household with safe water consumption	55.4% (SMART, 2023)	60.0%	70.0%	SMART Surveys	Bi-annually	CDW/CDH	Partners

Table 10: Annual Indicators as per Nutrition Objectives

Outcome	Key performance Indicator	Baseline	Mid Term	End term	Means of verification	Frequency	Lead	Associated
Outcome: Reduction in undernutrition								
Improved rates of breastfeeding	Proportion of children on Early Initiation of breastfeeding	71.90%	78	82	KAP survey	Annually	CDH	Other Sectors & Partners
	Proportion of children on Exclusive breastfeeding	82.40%	88	92	KAP survey	Annually	CDH	Other Sectors & Partners
Improved food consumption for women of reproductive age (15-49 years, and children (0-59 months).	Proportion of children consuming Minimum Acceptable diet	36.80%	43	47	KAP survey / SMART survey	Annually	CDH	Other Sectors & Partners
	Proportion of children 6–23 months of age who receive MDD	50% (KAP survey)	52%	55%	KAP survey / SMART survey	Annually	CDH	Partners KNBS
	Proportion of children 6–23 months of age who received MMF	60.5% (KAP survey)	64%	68%	KAP survey / SMART survey	Annually	CDH	Partners KNBS
	Proportion of children 6-23 months of age who received MAD	20.7% (KAP survey)	24%	28%	KAP survey / SMART survey	Annually	CDH	Partners KNBS
Clinical Nutrition and dietetics services Enhanced	% Improved cure rate for IMAM Program ≥75%	OTP - 53% SFP - 47% (Coverage Survey, 2023)	OTP - 75% SFP - 75%	OTP - ≥75% SFP - ≥75%	KHIS Data	Annually	CDH	Other line ministries & Partners
	% Reduced defaulter rate for IMAM Program <15%	OTP - 42% SFP - 46% (Coverage Survey, 2023)	OTP - 25% SFP - 25%	OTP - <15% SFP - <15%	KHIS Data	Annually	CDH	Other line ministries & Partners
Improved nutrition status for childcare centers, ECDE and school going children	Reduction in malnutrition among child care, ECDE and school going children	No Baseline data	Reduce by 5%	Reduce by 5%	Survey reports	Annually	MOE, CDH	Partners
Outcome: Reduction of micronutrient deficiencies								
Improved uptake of Iron Folic Acid among children under-five and women of reproductive age (15-49 years)	VAS coverage for children 6 to 59 months above national target 80%	39.1% (SMART, 2023)	60%	80%	SMART survey	Annually	CDH	Partners KNBS
	Proportion of pregnant women consuming IFAS within the recommended time (%)	28%	50%	>50%	KHIS, SMART	Annually	CDH	Partners
	Iron Folic Acid supplementation among pregnant women (>180 days)	8.0% (SMART, 2023)	15.0%	20%	SMART survey	Annually	CDH	Other Sectors & Partners
Access to fortified foods to improve micronutrient status of the population in Kajiado County scaled up	% of food industry and millers' compliance to food fortification regulations and standards	0% (Program Report)	30%	>50%	Food Fortification Surveillance, Program Report	Annually	CDH	CDT
	% of Households consuming fortified foods	0% (Program Report)	30%	>50%	SMART Surveys	Annually	CDH	CDT
	% of Households with improved Knowledge, Attitude and perception on fortified foods	0% (Program Report)	30%	>50%	KAP Surveys	Annually	CDH	CDT
Enhanced community resilience to climate-related shocks and emergencies.	% Increase in the proportion of affected households who feel empowered to recover from emergency	No data	25%	75%	KIIs, Preparedness & Response Report	Annually	CDH, NDMA	UNICEF, NI, KRCS & Other partners
Improved Dietary diversity promoted in Social Protection programs	No. of social protection programs that are including nutrition in their programing	0 (2024	50%	50%	NIMES and CPIMS reports	Annually	MOH/ ML&SP	Other line ministries, development partners
Increased production and consumption of nutrient dense foods	% of Households with Improved Household Dietary Diversity Score	40.6% (SMART2023)	50%	>60.0%	SMART Survey	Annually	CDALP, CDH	Partners
Outcome: Improved WASH uptake								

Improved uptake of optimal WASH practices resulting from integration of nutrition in WASH	Reduced time taken at the water points (More than 30 Minutes)	53.20%	45%	35%	SMART Surveys	Annually	CDW	Partners
	Reduced Open defecation	33.1% (SMART)	25.00%	<20%	SMART Surveys	Annually	CDW/CDH	Partners
	Improved per capita water consumption	60.9% (SMART, 2023)	70.00%	>75.0%	SMART Surveys	Annually	CDW/CDH	Partners
	Improved handwashing practices at all 4 critical times	25.7% (SMART, 2023)	35.00%	60.00%	SMART Surveys	Annually	CDW/CDH	Partners
Outcome: Cross-cutting Areas								
Improved nutrition data quality for decision making	Number of policies/ programmes informed by research	0	At least 1	At least 1	Program Report	Annually	CDH	Line Ministries & Partners
Nutrition strategy in Kajiado County funded	% increase of budgetary allocation for nutrition program	ND	20%	40%	Signed grants, Policy documents	Annually	CDH/County AG	Line ministries & Partners
Uninterrupted supply and use of nutrition commodities and Anthropometric equipment at the health facilities sustained	Facilities submitting timely reports 733	20% (LMIS/ KHIS)	60.00%	>80%	LMIS/ KHIS	Annually	MOH/COG	MOH/Partners
	Reduced proportion of Health facilities reporting nutrition commodity stock outs	21.2% (28 out of 132 OTP Centers, Coverage survey)	15.00%	<5%	Coverage survey, Program Report	Annually	CDH,	UNICEF Partners

Table 11: Output Indicators per Key Result Areas

KEY RESULT AREA 1: MATERNAL, INFANT AND YOUNG CHILD NUTRITION (MIYCN) SCALED UP **Outcome 1: Improved nutrition status of women of reproductive age (15-49 years, and children (0-59 months).**									
Output	**Expected Results**	**Indicator**	**Baseline**	**Mid Term**	**End term**	**Means of verification**	**Frequency**	**Lead**	**Associated**
1.1	MIYCN services provided at all health service delivery points	Proportion of targeted health facilities offering maternity services certified as Baby friendly	0%	25%	>25%	Program reports	3-5 years	CDH	Other Sectors & Partners
		Proportion of health providers in health facilities offering maternity services, trained on BFHI, by level of HCW	0.00%	30.0%	>50%	Program reports	3-5 years	CDH	Other Sectors & Partners
1.2	Improved knowledge of mothers and influencers on MIYCN	Proportion of mothers of children 0-23 months who have received counselling, support or messages on optimal breastfeeding at least	42.7%	60%	>75%	KAP survey / SMART survey	3-5 years	CDH	Other Sectors & Partners

		once in the last year							
		Proportion of mothers of children 0-23 months who have received counselling, support or messages on optimal complimentary feeding at least once in the last year	42.7%	60%	>75%	KAP survey / SMART survey	3-5 years	CDH	Other Sectors & Partners
		Number of MTMSG/ Father to Father support group formed	10	20	40	Program reports	Quarterly	CDH	Other Sectors & Partners
1.3	Improved MIYCN policy environment at County level	Proportion of the targeted breastfeeding spaces established	No data	25%	>75%	Program reports	Annually	CDH	Other Sectors & Partners
		Number of HCWs sensitized on BMS Act violation cases	0	50	100	Program reports	Annually	CDH	Other Sectors & Partners
1.4	Optimal MIYCN practices sustained during emergencies	% of Health Workers equipped with capacity to support caregivers during emergency	0	30%	>50%	Program reports	Quarterly	CDH	Other Sectors & Partners
		% of mothers out of all Breastfeeding in the emergency affected area supported to maintain lactation during the emergency period	No data	50%	>75%	Program reports	Quarterly	CDH	Other Sectors & Partners
1.5	Kangaroo Mother Care services for Premature / LBW infants scaled up	Proportion of targeted facilities with in-patient capacity where KMC is operational, by level of facility and type of KMC service	No data	50%	>75%	>75%	Annually	CDH	Partners
		% Increase in the health facilities offering KMC services to premature / low birth weight babies	No data	50%	>75%	>75%	Annually	CDH	Partners
		Proportion of premature / LBW babies who received KMC in catchment area of the KMC facilities)	No data	50%	>75%	>75%	Annually	CDH	Partners
		% Increase of caregivers of premature / LBW newborns receiving support with improved quality of care from HCWs	No data	50%	>75%	>75%	Annually	CDH	Partners
1.6	Women of reproductive age and children 6-59 months in the county optimally supplemented	% Increase in IFAS consumption for >180 days among Women of Reproductive Age	35.2% (SMART, 2023)	45%	60%	SMART	Every 3-5 years	CDH	Partners and Nutrition stakeholders
		% Increase in VAS coverage among children aged 6 to 59 months	39.0% (SMART, 2023)	45%	80%	SMART/KHIS	Annually	CDH	Partners and Nutrition stakeholders
		% Increase in Deworming coverage among children aged 12 to 59 months	22.0% (SMART, 2023)	50%	80%	SMART/KHIS	Annually	CDH	partners and Nutrition stakeholders
1.7	Behavior change on diverse micronutrient intake to prevent micronutrient deficiency and prevention promoted in the community level	%Increase in the population with adequate Household Dietary Diversity score	22.1% (HDDS, SMART2023)	28%	35%	SMART	Annually	CDH	partners and Nutrition stakeholders
		% increase in the Minimum Dietary Diversity for Women	31% (MDD-W, SMART2023)	36%	40%	SMART	Annually	CDH	partners and Nutrition stakeholders
KRA 2: NUTRITION WELL-BEING FOR OLDER CHILDREN, ADOLESCENTS, ADULTS & OLDER PERSONS PROMOTED **Outcome 2: Improved nutrition Well-being for Children, adolescents, women of reproductive age, men and older persons**									
Output	**Expected Results**	**Indicator**	**Baseline**	**Mid Term**	**End term**	**Means of verification**	**Frequency**	**Lead**	**Associated**
2.1	Enhanced capacity of health care workers on nutrition for older	No. of health facilities reporting improved service delivery on feeding older children and AHN	No Baseline Data	7	10	Program Report	Annually	CDH	MOE, CDSP, Partners

	children, adolescents, adults and older persons	% increase of health care workers with improved capacity of nutrition for older children, adolescents, adults and older persons.	No Baseline Data	40%	60%	Program reports,	Annually	CDH	MOE, CDSP, Partners
2.2	Malnourished children in schools and community detected early for treatment and referral	Proportion of malnourished older children in schools and community detected and referred	No Baseline Data	40%	60%	Program Report	Annually	CDH	MOE, CDSP, Partners
		% Increase of reported and documented cases of malnourished school going children.	No Baseline Data	Increase by 10%	Increase by 20%	Program Report	Annually	CDH	MOE, CDSP, Partners
2.3	Adolescent girls in schools supplemented with micronutrients	Increased proportion of Adolescent girls supplemented with weekly Iron Folic Acid supplements (WIFAs).	No baseline data	Increase by 10%	Increase by 20%	Program Report	Annually	CDH	MOE, CDSP, Partners
2.4	Malnourished Older people at community level detected early for treatment and referral	Proportion of mapped and identified older persons receiving any nutrition related support	0	15%	25%	Program Report	Annually	CDH, CDSP	Partners
		Proportion of Older persons reached with Key messages on nutrition	0	30%	50%	Program Report	Annually	CDH, CDSP	Partners
2.5	Increased Community awareness on healthy diets and lifestyle for Older Children, Adolescents, Adults and Older Persons within urban and rural areas	No of healthy diets and physical health promotion targeted activities conducted	No Baseline Data	10	18	Program reports	Annually	CDH, CDSP	Partners

KRA 3: ENHANCED INDUSTRIAL FOOD FORTIFICATION FOR PREVENTION AND CONTROL OF MICRONUTRIENT DEFICIENCIES

OUTCOME: Access to fortified foods to improve micronutrient status of the population in Kajiado County scaled up

Output	Expected Results	Indicator	Baseline	Mid term	End term	Means of verification	Frequency	Lead	Associated
3.1	Advocacy, Leadership and co-ordination mechanism for food safety and fortification strengthened	% Increase in budgetary allocation to fortification program in the county	0% (Program Report)	10.0%	20.0%	Program Reports	after every 2 years	CDH	CDT
3.2	Capacity of food industries /millers to produce safe and fortified foods strengthened	% Increase in food industries / millers with increased capacity to produce safe and fortified foods	0% (Program Report)	50.0%	100.0%	Program Reports	after every 2 years	CDH	CDT
		% millers fortifying at production level	0% (Program Report)	50.0%	100.0%	Program Reports	after every 2 years	CDH	CDT
3.3	Capacity of surveillance and enforcement officers on regulatory monitoring, surveillance and enforcement of food safety and fortification enhanced	% Increase in monitoring activities	0% (Program Report)	50.0%	100.0%	Program Reports	Annually	CDH	CDT
		Notice of violations reported	No data (Program Report)	Yes	Yes	Program Reports	Annually	CDH	CDT
		% increase in the Number of samples collected and tested	0% (Program Report)	30.0%	60.0%	MOH 708	Annually	CDH	CDT
3.4	Demand for consumption of fortified foods by households created	Proportion of the survey respondents who ever heard of Food Fortification	17.7% (SMART Survey)	40%	>60%	SMART Surveys	Annually	CDH	CDT
		Proportion of the survey respondents who can identify the Food Fortification Logo	57.0% (SMART Survey)	70%	>80%	SMART Surveys	Annually	CDH	CDT

KRA 4: SUSTAINED NUTRITIONAL WELL-BEING OF INDIVIDUALS AND COMMUNITIES DURING EMERGENCIES AND CLIMATE-RELATED SHOCKS

Outcome 4: Enhanced community resilience to climate-related shocks and emergencies.

Output	Expected Results	Indicator	Baseline	Mid term	End term	Means of verification	Frequency	Lead	Associated

4.1	Community Supported to withstand climate shocks and emergency	% of Affected HHs support Increased	No data	5%	10%	NDMA, CSG Reports	Bi-annually / annually	CDH	UNICEF, NI, KRCS & Other partners
4.1	Capacity of Healthcare workers on nutrition surveillance for emergency response enhanced	% Increase in the proportion of HCWs with capacity for Nutrition Surveillance	10%	30%	>50%	DHIS Report, Program Report	Quarterly / Annually	CDH	UNICEF, NI, KRCS & Other partners
4.2	Enhanced Multisectoral coordination in emergencies	Functional (regular fortnight meetings) multi-sector emergency coordination system established	1 (2024)	4	4	Coordination meeting minutes	Annually	CDH	UNICEF, NI, KRCS & Other partners
KEY RESULT AREA: 5 CLINICAL NUTRITION AND DIETETICS SERVICES STRENGTHENED **Outcome 5: Clinical Nutrition and dietetics services Enhanced**									
Output	**Expected Results**	**Indicator**	**Baseline**	**Mid term**	**End term**	**Means of verification**	**Frequency**	**Lead**	**Associated**
5.1	Increased access and coverage of Integrated Management of Acute Malnutrition (IMAM) Services	Proportion of health facilities offering Integrated Management of Acute Malnutrition (IMAM) Services	90%	95%	100%	Program Reports	Monthly	CDH	Other line ministries & Partners
		Proportion of health care workers trained on clinical nutrition package	45%	60%	≥75%	Program Reports	Annually	CDH	Other line ministries & Partners
		Proportion of patients diagnosed with Severe Acute Malnutrition	No baseline data	Increase by 10%	Increase by 20%	Program Reports	Annually	CDH	Other line ministries & Partners
		Proportion of patients diagnosed with Moderate Acute Malnutrition	No baseline data	Increase by 10%	Increase by 20%	Program Reports	Annually	CDH	Other line ministries & Partners
5.2	Enhanced early case identification of all forms of malnutrition through community mobilization and referral	Proportion of CHPs sensitized on continuum of nutrition care in the community	No baseline data	Increase by 10%	Increase by 20%	Program Reports	Annually	CDH	Other line ministries & Partners
		Proportion of children diagnosed with Acute malnutrition through community health promotion support	No baseline data	Increase by 10%	Increase by 20%	Program Reports	Quarterly	CDH	Other line ministries & Partners
5.3	Accelerated nutrition response for prevention and control of diet related NCDs	Proportion of patients diagnosed with diet related NCDs.	No baseline data	Increase by 5%	Increase by 10%	County reports Facility assessment reports	Quarterly	CDH	Other line ministries & Partners
		Proportion of facilities with Nutrition and NCDs screening SOPs and Protocols	75%	90%	100%	Program Reports	Annually	CDH	Other line ministries & Partners
		Proportion of Health facilities implementing Nutrition screening and triage at OPD	40%	80%	100%	Program Reports	Quarterly	CDH	Other line ministries & Partners
		Proportion of population screened and assessed for nutrition status while accessing healthcare services	No baseline data	50%	≥80%	Program Reports	Quarterly	CDH	Other line ministries & Partners
5.4	Strengthened Nutrition Assessment, Counselling and Support services in HIV and TB clinics	Proportion of health facilities implementing Nutrition Assessment, Counselling and Support services in HIV and TB clinics	No baseline data	75%	100%	Program Reports	Monthly	CDH	Other line ministries & Partners
KEY RESULT AREA 6: NUTRITION AND FOOD SECURITY IN AGRICULTURE SCALED-UP **OUTCOME: Increased production and consumption of nutrient dense foods**									
Output	**Expected Results**	**Indicator**	**Baseline (2024)**	**Mid-term (2026)**	**End term (2029)**	**Means of verification**	**Frequency**	**Lead**	**Associated**
6.1	Farmers supported to increase availability, access of nutritious foods (crops, livestock, fish)	**% Increase in proportion of farmers supported**	**No data**	**Increase by 5%**	**Increase by 5%**	Sector Report	Annually	CDA, CDLP, CDF, CDVS	NAVCDP, FLOCCA, other partners
		#No. of nutrient dense value chains promoted	5	7	10	Sector Report	Annually	CDA, CDLP, CDF, CDVS	NAVCDP, FLOCCA, other partners

		No. of farmer groups trained by gender on agricultural production	25	40	50	Sector reports	Quarterly	CDA, CDLP, CDF, CDVS	NAVCDP, FLOCCA, other partners
6.2	Innovative approaches for increased knowledge on Food consumption, utilization and processing supported	#No. of Innovative approaches adopted by farmers	0	1	5	Sector reports	Quarterly	CDA, CDLP, CDF, CDVS	NAVCDP, FLOCCA, other partners
		% increase in farmers reporting adoption of innovative approaches	xx%	5%	25%	Sector reports	Quarterly	CDA, CDLP, CDF, CDVS	NAVCDP, FLOCCA, other partners
6.3	Reduced levels of mycotoxins, drug and chemical residues in farm produce as Farmers supported to increase capacity on quality safe farm produce (crops, livestock, fish)	% Increase in proportion of farmers with capacity on quality safe farm produce	No data	Increase by 5%	Increase by 25%	Sector reports	Quarterly	CDA, CDLP, CDF, CDVS	NAVCDP, FLOCCA, other partners
		No. of rapid testing centers for agricultural products operationalized	10	15	15	Sector reports	Annually	CDA, CDLP, CDF, CDVS	NAVCDP, FLOCCA, other partners
		No. of technical staff trained on food safety, standards and regulations	15	45	75	Sector reports	Quarterly	CDA, CDLP, CDF, CDVS	KEBS, KDB, KEPHIS, PCPB, AAK, State Departments
		No. of collaboration meetings with food safety regulatory bodies held	2	2	2	Sector, meeting reports	Biannual	CDA, CDLP, CDF, CDVS	KEBS, KDB, KEPHIS, PCPB, AAK, State Departments

KRA 7: NUTRITION IN EDUCATION AND EARLY CHILDHOOD DEVELOPMENT (ECDE) PROMOTED

Outcome 7: Improved nutrition status for childcare centers, ECDE and school going children

Output	Expected Results	Indicator	Baseline	Mid term	End term	Means of verification	Frequency	Lead	Associated
7.1	Healthy diets and safe food environments promoted in learning and child care centers	% Increase in the proportion of schools, ECDE and Child Care centers meeting healthy diets and safe food environment standards	No Baseline data	Increase by 5%	Increase by 10%	Assessment Reports	Annually	MOE, CDH	Partners
7.2	Increased referral, treatment and management of malnourished children in schools, ECDE and child care centers	% Increase in no of malnourished school cases identified and managed appropriately.	No data	30%	50%	Assessment Reports	Quarterly	MOE, CDH	Partners
7.3	Nutrition Integrated and scaled up in Child Care Centers in the county	% Increase in Proportion of learning centers reporting Integrated Nutrition and Education activities	No Baseline data	20%	35%	Assessment Reports	Quarterly	MOE, CDH	Partners

KRA 8: NUTRITION IN WATER, SANITATION AND HYGIENE (WASH) PROMOTED

Outcome 1: Improved uptake of optimal WASH practices resulting from integration of nutrition in WASH

Output	Expected Results	Indicator	Baseline	Mid term	End term	Means of verification	Frequency	Lead	Associated
8.1	Increased access to Clean portable water to households and institutions	% of HHs accessing water from safe water sources	55.4% (Program Report)	60%	70%	SMART Surveys	After every 2 years	CDW/Partners	NDMA
		% of HHs reporting reduced time taken at the water points (More than 30 Minutes)	46.5% (SMART, 2023)	35%	<35%	SMART Surveys	After every 2 years	CDW/CDH	Partners
		% of HHs treating water at the point of use	31%	40%	50%	SMART Surveys	After every 2 years	CDW/CDH	Partners
8.2	Appropriate WASH practices at the community	% Increase in HHs with Hand washing facilities	25%	35%	>40%	SMART Surveys, Program Report	After every 2 years	CDH-WASH Hub	DND

	level promoted	% decrease in HH practicing O/D	63%	40%	<20	WASH Hub	Annually	CDH-WASH Hub	DND
		% Increase in HH using improved sanitation facilities	37%	40%	>42%	SMART Surveys	After every 2 years	CDH	DND
8.3	The learning institution community is sensitized on linkage between nutrition and WASH	% Increase in institutions supported to improve capacity on Nutrition in WASH	0%	30%	>50%	Project Report	Annually	CDW/CDH	Partners
8.4	Water users' associations (WUA) and communities' capacity build on Nutrition and WASH linkage	% increase functional mapped water sources	45%	60%	70%	Program Report	Annually	CDW	Partners
		% of water catchment protection done	30%	40	60	Program Report	Annually	MOH-WASH Hub	DND
8.5	Actors in the food preparation value chain capacity build on Nutrition and WASH linkage	% increase in institutions practicing safe food preparation and handling	No data	30%	40%	Program Report	After every 2 years	MOH-WASH Hub	DND

KRA 9: NUTRITION MAINSTREAMED IN SOCIAL PROTECTION PROGRAMS

Outcome 9.0: Integration of Nutrition in Social Protection Programmes strengthened

Output	Expected Results	Indicator	Baseline	Mid term	End term	Means of verification	Frequency	Lead	Associated
9.1	Improved Dietary Diversity promoted in Social Protection programmes	% Increase in proportion of HHs with improved household dietary diversity	0 (2024)	Increase by 5%	Increase by 10%	Assessment Reports	Annually	CDSP, CDH	Other line ministries, partners
9.2	Care practices improved through linkage of Nutrition in Social Protection Programs	No. of households empowered and adopting care practice for improved nutrition.	no baseline data	Increase by 15%	Increase by 25%	Program Reports	Annually	CDSP, CDH	Other line ministries, partners
9.3	Healthy household environment and health services advocated for in Social Protection Programs	No. of HHs in social protection reached with WASH and nutrition interventions	0 (SMART 2023)	Increase by 10%	Increase by 10%	Assessment Reports	Every 2-3 years	CDSP, CDH	Other line ministries, partners
		No. of HHs reporting Improved WASH and nutrition practices	0 (SMART 2023)	Increase by 10%	Increase by 10%	Assessment Reports	Every 2-3 years	CDSP, CDH	Other line ministries, partners
9.4	Coordination activities for Nutrition mainstreaming in Social Protection Program promoted	Proportion of social protection programs integrating nutrition-sensitive interventions	0	5%	10%	Program Reports	Annually	CDSP, CDH	Other line ministries, partners

KRA 10: SECTORAL AND MULTISECTORAL NUTRITION INFORMATION SYSTEMS, LEARNING AND RESEARCH STRENGTHENED

Outcome 10: Improved nutrition data quality for decision making

Output	Expected Results	Indicators	Baseline	Mid term	End term	Means of verification	Frequency	Lead	Associated
10.1	Strengthened Nutrition information and reporting system	County Nutrition Repository developed and in use	0	1	1	Program Report	Annually	CDH	Line Ministries & Partners
		Proportion of health facility with monthly reporting rate of 100%	3%	40%	60%	KHIS	Annually	CDH	Line Ministries & Partners

		Common Results Framework for the multisector stakeholders developed	0	1	1	Program Report	Annually	CDH	Line Ministries & Partners
10.2	Strengthened nutrition Research in Kajiado County	Number of policy briefs developed	2	2	4	Policy Documents, line attendance	Annually	CDH	Line Ministries & Partners
		Number of documentaries for best practices and innovations	0	1	2	Documentaries	Bi-annually	CDH	Line Ministries & Partners

KRA 11: SECTORAL AND MULTISECTORAL NUTRITION GOVERNANCE, COORDINATION, LEGAL/REGULATORY FRAMEWORKS, LEADERSHIP AND ADVOCACY STRENGTHENED

Outcome 11.0: Enhanced commitment and continued prioritization of nutrition in county agenda

Output	Expected Results	Indicator	Baseline	Mid term	End term	Means of verification	Frequency	Lead	Associated
11.1	Enhanced implementation of regulatory frameworks, policies and acts	# of legal frameworks developed and disseminated.	No data	3	5	development reports, minutes, attendance list, MEMOs	Bi-annually	CDH/County AG	Line ministries & Partners
11.2	Enhanced Nutrition Advocacy, Communication, Social & Mobilization	No. of advocacy sessions conducted	No data	5	10	signed grants, program report	Annually	CDH/County AG	Line ministries & Partners
11.3	Strengthen partnerships for nutrition	# of MSP meetings held	4	4	4	Reports, minutes, attendance list	Bi-annually	CDH	Line ministries & Partners
11.4	Increased human resource for nutrition, equipment and commodities ensured	# of budget cycles with Nutrition program budget allocation	No data	2	5	Signed grants, Reports, minutes	Annually	CDH/line ministries/	Line ministries & Partners
11.5	Awareness creation on healthy diet and physical, general optimal nutrition activities intensified	% increase in awareness creation sessions on healthy lifestyle diets conducted	No data	20%	40%	Program Report	Annually	CDH/line ministries/	Line ministries & Partners

KRA 12: SUPPLY CHAIN MANAGEMENT FOR NUTRITION COMMODITIES AND EQUIPMENT STRENGTHENED

Outcome 12.0: Enhanced uninterrupted nutrition commodities supply and use at the facility level

Output	Expected Results	Indicator	Baseline	Mid term	End term	Means of verification	Frequency	Lead	Associated
12.1	Enhanced uninterrupted supply of nutrition commodities and equipment	Proportion of facilities supplied with nutrition commodities in the county	87.7% (LMIS/ KHIS)	93.8%	100%	LMIS/ KHIS	Annually	CDH	PARTNERS
12.2	Capacity of Healthcare workers in nutrition supply chain management enhanced	Proportion of Healthcare workers in public facilities with capacity on nutrition supply chain management	60%	90%	100%	LMIS/ KHIS	Annually	CDH	PARTNERS
		Proportion of health facilities reporting on LMIS	20%	60%	100%	LMIS/ KHIS	Annually	CDH	PARTNERS

CHAPTER FIVE: CNAP RESOURCE MOBILIZATION AND COSTING FRAMEWORK

5.1 Introduction

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

Costing is a process of determining in monetary terms, the value of inputs that are required to generate a particular output. It involves estimating the quantity of inputs required by an activity/projected market rates. 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 afford- able. This is a process that allocates costs of inputs based on each intervention and activity with an aim of achieving set goals /results. It attempts to identify what causes the cost to change (cost drivers). All costs of activities are traced and attached to the intervention or service for which the activities are performed.

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

5.2 Costing Approach

5.2.1 Overview of the Costing Approach

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

The ABC uses a bottom-up, input-based approach, indicating the cost of all inputs required to achieve Strategic plan targets. ABC is a process that allocates costs of inputs based on each activity, it attempts to identify what causes the cost to change (cost drivers); All costs of activities are traced to the product or service for which the activities are performed. The premise of the methodology under the ABC approach will be as follow; (I) The activities require inputs, such as labor, conference hall etc.; (ii) These inputs are required in certain quantities, and with certain frequencies; (iii) It is the product of the unit cost, the quantity, and the frequency of the input that gave the total input cost; (iv) The sum of all the input costs gave the Activity Cost. These were added up to arrive at the Output Cost, the Objective Cost, and eventually the budget. The cost over time for all the thematic areas provides important details that will initiate debate and allow CDH and development partners to discuss priorities and decide on effective resource allocation for Nutrition.

5.2.2 Total Resource Requirements (2024/25 – 2028/29)

The Strategic plan was brought to cost 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 2024/25 – 2028/29. 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. The total cost of implementing Kajiado CNAP for the five years is estimated at Ksh. 2.4 billion, See, and table 12. Further annual breakdown of cost requirement (s) is also presented by each of the output and activities is presented in annex 2.

Table 12: Summary Cost per KRA

KEY RESULT AREAS	2023/24	2024/25	2025/26	2026/27	2027/28	Total Cost (Ksh)
KRA 1	88,552,861	87,537,861	87,537,861	87,537,861	87,537,861	**438,704,305**
KRA 2	16,247,040	16,411,740	16,411,740	16,466,640	16,247,040	**81,804,200**
KRA 3	25,203,500	23,011,500	25,328,500	23,011,500	24,328,500	**120,883,500**
KRA 4	19,687,360	19,687,360	25,015,360	19,687,360	25,015,360	**109,092,800**
KRA 5	19,480,000	19,480,000	19,480,000	19,480,000	19,480,000	**97,400,000**
KRA 6	17,494,100	17,494,100	17,494,100	17,494,100	17,494,100	**87,470,500**
KRA 7	6,598,100	5,867,600	6,232,600	5,867,600	6,233,100	**30,799,000**
KRA 8	142,510,200	81,921,900	78,125,700	74,289,000	70,522,200	**447,369,000**
KRA 9	5,154,800	12,774,800	5,534,800	7,454,800	8,074,800	**38,994,000**
KRA 10	33,185,200	39,745,200	41,449,200	35,245,200	28,685,200	**178,310,000**
KRA 11	20,668,800	21,716,800	20,668,800	21,716,800	20,668,800	**105,440,000**
KRA 12	137,218,088	137,218,088	137,218,088	137,218,088	137,218,088	**686,090,440**
GRAND TOTAL	**532,000,049**	**482,866,949**	**480,496,749**	**465,468,949**	**461,505,049**	**2,422,357,745**

The annual breakdown of cost key result areas is presented in Table 12. KRA 12: supply chain management for nutrition commodities and equipment Strengthened accounts for the highest pro- portion of total resources need accounting for 28.3%, while KRA 7, Nutrition in Education and Early Childhood Centers promoted, accounts for the least at 1.3% of the total resource requirement (See, figure 9).

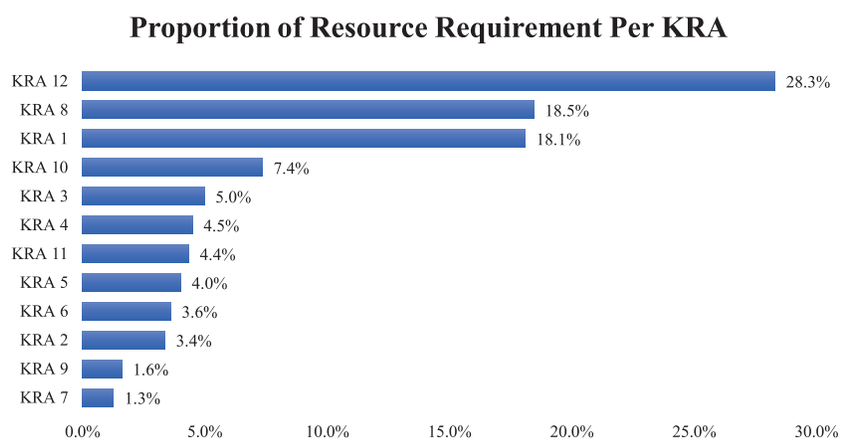

Figure 9: Proportion of resource requirements by KRA

5.3 Strategies to ensure available resources are sustained

5.3.1 Strategies to mobilize resources from new sources

- Lobbying for a legislative framework in the county assembly for resource mobilization and allocation
- Identification of potential donors both bilateral and multi-lateral
- Conducting stakeholder mapping
- Call the partners to a resource mobilization meeting
- Identification, appointment and accreditation of eminent persons in the community as
- resource mobilization good will ambassadors
- Strategies to ensure efficiency in resource utilization
- Through planning for utilization of the allocated resources (SWOT analysis) Implementation plans with timelines
- Continuous monitoring of impact process indicators
- Periodic evaluation objectives if they have been achieved as planned

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APPENDICES

Annex 1: Kajiado 2024 – 2029 CNAP implementation Plan

Level	Code	KRA, Outcome, Output, Activity statement	Geographical coverage	Outcome/Output indicator Description	Baseline year 2023/ 2024	2024/ 25	2025/ 26	2026/ 27	2027/ 28	2028/ 29	End line target	Frequency of data collection	Data source	Lead Department	Other sectors & Partners
KRA	**1.0**	**KEY RESULT AREA 1: Maternal, Infant and Young Child Nutrition (MIYCN) Scaled Up**													
Outcome		**Improved Nutrition Status of Women of Reproductive Age (15 - 49 years) and Children (0 - 59 months)**	**County wide**	**Prevalence of underweight (W/A) in children 6 to 59 months**	**13.3% (SMART survey 2023)**			**11%**			**<10.0%**	**2 years**	**SMART**	**CDH**	**Line ministries & partners**
			County wide	**Prevalence of Stunting (H/A) in children 6 to 59 months**	**21.9% (SMART, 2023)**			**19%**			**14%**	**2 years**	**SMART**	**CDH**	**Line ministries & partners**
			County wide	**Prevalence of Wasting (H/W) in children 6 to 59 months**	**5.5% (SMART, 2023)**			**4%**			**2%**	**2 years**	**SMART**	**CDH**	**Line ministries & partners**
			County wide	**Proportion of Children with Low Birth Weight (<2.5kg)**	**5.5%**	**5.0%**	**5.0%**	**5.0%**	**4.5%**	**4.5%**	**<4.5%**	**2 years**	**SMART**	**CDH**	**Line ministries & partners**
			County wide	**Proportion of children on Early Initiation of breastfeeding**	**71.90%**		**76**	**78**	**80**	**82**	**82**	**3-5 years**	**KAP survey**	**CDH**	**Line ministries & partners**
			County wide	**Proportion of children on Exclusive breastfeeding**	**82.40%**	**84**	**86**	**88**	**90**	**92**	**92**	**3-5 years**	**KAP survey**	**CDH**	**Line ministries & partners**
			County wide	**Proportion of children consuming Minimum Acceptable diet**	**36.80%**	**39**	**41**	**43**	**45**	**47**	**47**	**3-5 years**	**KAP survey / SMART survey**	**CDH**	**Line ministries & partners**
Output	***1.1***	*MIYCN services provided at all health service delivery points*	*County wide*	*Proportion of targeted health facilities offering maternity services certified as Baby friendly*	*0%*	*20%*	*40%*	*50%*	*60%*	*70%*	*>70%*	*3-5 years*	*Program reports*	*CDH*	*Line ministries & partners*
				Proportion of health providers in health facilities offering maternity services, trained on BFHI, by level of HCW	*0%*	*10%*	*20%*	*30%*	*40%*	*50%*	*>50%*	*3-5 years*	*Program reports*	*CDH*	*Line ministries & partners*
Activity	***1.1.1***	Training of Health Care workers on Baby Friendly Hospital Initiative.	County wide	no of health care workers trained on BFHI	4	30	30	30	30	30	154	quarterly	Program reports	CDH	Line ministries & partners
Activity	***1.1.2***	Training of Health Care workers on Baby Friendly Community Initiative.	County wide	No of health care workers trained on BFCI	91	30	30	30	30	30	241	quarterly	Program reports	CDH	Line ministries & partners
Activity	***1.1.3***	Sensitization to health care workers on growth monitoring for children under five years	County wide	No of health care workers sensitized on GMP	0	50	50	50	50	50	250	quarterly	Program reports	CDH	Line ministries & partners
Activity	***1.1.4***	Sensitization of HCW for Screening for malnutrition among pregnant and lactating mothers at ANC and PNC clinic.	County wide	No of health care workers sensitized screening screening of malnutrition among PLW	0	50	50	50	50	50	250	quarterly	Program reports	CDH	Line ministries & partners
Activity	***1.1.5***	Targeted Continuous Medical Education to HCW on BFHI and BFCI.	County wide	No of CMEs conducted on BFHI and BFCI	150	150	150	150	150	150	900	monthly	Program reports	CDH	Line ministries & partners
Activity	***1.1.6***	Baby Friendly Hospital Initiative assessment and certification	County wide	No of health facilities certified as baby friendly	0	1	1	1	1	1	5	biannually	Program reports	CDH	Line ministries & partners

Activity	***1.1.7***	Screening for malnutrition among pregnant and lactating mothers at ANC.	County wide	Proportion of WRA screened for malnutrition	No data	10	10	10	10	10	50	monthly	Program reports	CDH	Line ministries & partners
Activity	***1.1.8***	Conduct Growth monitoring for children under five years at all service delivery points	County wide	proportion of underweight children attending CWC	13.30%	12.30 %	11.30 %	10.30 %	9.30 %	8.30 %	7%	monthly	KHIS	CDH	Line ministries & partners
Activity	***1.1.9***	Conduct Nutrition education /counselling on Early Initiation to breastfeeding to mothers attending ANC and PNC clinics	County wide	no of sessions conducted on early initiation of breastfeeding	0	92	92	92	92	92	460	quarterly	Program reports	CDH	Line ministries & partners
Activity	***1.1.10***	Conduct Nutrition education /counselling on exclusive breastfeeding to mothers attending ANC and PNC clinics	County wide	no of sessions conducted on EBF	0	92	92	92	92	92	460	quarterly	Program reports	CDH	Line ministries & partners
Activity	***1.1.11***	Conduct Nutrition education/counselling on complementary feeding for children 6-23 months.	County wide	no of sessions conducted on complementary feeding	0	92	92	92	92	92	460	quarterly	Program reports	CDH	Line ministries & partners
Activity	***1.1.12***	Nutrition education/counselling on maternal nutrition to Women of Reproductive Age.	County wide	no of sessions conducted on maternal nutrition	0	92	92	92	92	92	460	quarterly	Program reports	CDH	Line ministries & partners
Activity	***1.1.13***	Conduct cooking demonstration sessions for complementary feeding at the health facility.	County wide	No of demonstration sessions conducted	0	5	15	20	20	20	80	quarterly	Program reports	CDH	Line ministries & partners
Activity	***1.1.14***	Conduct Quarterly BFHI and BFCI support supervision	County wide	no of supervisions conducted	0	20	20	20	20	20	100	quarterly	Program reports	CDH	Line ministries & partners
Activity	***1.1.15***	Conduct OJT/Mentorship to HCWs on BFHI and BFCI	County wide	No. of mentorship/OJT sessions done.	0	30	30	30	30	30	150	quarterly	Program reports	CDH	Line ministries & partners
output	***1.2***	***Improved knowledge of mothers and influencers on MIYCN***	***County wide***	***Proportion of mothers of children 0-23 months who have received counselling, support or messages on optimal breastfeeding at least once in the last year***	***42.70%***	***42.70 %***	***50%***	***60%***	***70%***	***75%***	***>75%***	***3-5 years***	***MIYCN KAP***	***CDH***	***Line ministries & partners***
			County wide	***Proportion of mothers of children 0-23 months who have received counselling, support or messages on optimal complimentary feeding at least once in the last year***	***42.70%***	***42.70 %***	***50%***	***60%***	***70%***	***75%***	***>75%***	***3-5 years***	***MIYCN KAP***	***CDH***	***Line ministries & partners***
Activity	*1.2.1*	Conduct community Sensitization on key messaging on appropriate MIYCN practices	County wide	No of community sensitization sessions conducted.	0	20	20	20	20	20	100	quarterly	program report	CDH	Line ministries & partners
Activity	*1.2.2*	Training of TOTs on BFCI	County wide	No of BFCI TOTs trained.	9	-	20	-	-	-	29	Annually	program report	CDH	Line ministries & partners
Activity	*1.2.3*	Implement BFCI 10 steps in targeted CHUS-(unit cost per CHU for all the 10 steps)	County Wide	No of new CUs scaled up for BFCI activities	23	2	2	2	2	2	33	Annually	program report	CDH	Line ministries & partners
				No. of strengthened existing CU implementing 10 steps of BFCI	23	25	27	29	31	33	168	monthly	program	CDH	Line ministries & partners
Activity	*1.2.4*	Conduct semiannual BFCI self-assessment - Baseline, Internal and External	County Wide	No of self-assessments conducted	5	5	5	5	5	5	30	quarterly	program	CDH	Line ministries & partners
				No of external assessment conducted	0	3	3	3	3	3	15	quarterly	program	CDH	Line ministries & partners

Activity	*1.2.5*	Training of CHPs on BFCI	County Wide	No of CHPs trained on BFCI	230	100	100	50	50	50	580	quarterly	program	CDH	Line ministries & partners
Activity	*1.2.6*	Hold community dialogue meetings on MIYCN		No of community dialogues held	0	25	30	35	40	45	175	quarterly	program	CDH	Line ministries & partners
Activity	*1.2.7*	Conduct childcare facility monitoring	Kajiado East & North	No. of monitoring sessions conducted	0	8	8	8	8	8	40	monthly	program	CDH	Line ministries & partners
Output	***1.3***	***Improved MIYCN policy environment at County level***	***County Wide***	***Proportion of the targeted breastfeeding spaces established***	***No data***	***5%***	***10%***	***25%***	***50%***	***75%***	***>75%***	***Annually***	***Program Report***	***CDH***	***Line ministries & partners***
				Proportion increase in BMS Act violation cases reported by the enforcers	***No data***	***5%***	***5%***	***5%***	***5%***	***5%***	***25%***	***Annually***			
Activity	***1.3.1***	sensitize CHMT / SCHMT on relevant policies and bills	County Wide	number of sessions conducted on relevant bills and policies	0	1		1		1	3	Annually	Program reports	CDH	Line ministries & partners
Activity	***1.3.2***	Sensitize Employers/managers and business community on BMS Act and Child Care Policy.	County Wide	No of sessions conducted on relevant bills and policies targeting employers/managers	0	5	5	5	5	5	25	Annually	program reports	CDH	Line ministries & partners
Activity	***1.3.3***	sensitize BMS enforcers (PHOs)	County Wide	No of PHO sensitized	0	30	30	30	30	30	150	Annually	program reports	CDH	Line ministries & partners
Activity	***1.3.4***	Conduct quarterly monitoring of BMS in the local markets	County Wide	No of supervisions conducted	0	4	4	4	4	4	20	Annually	program reports	CDH	Line ministries & partners
Activity	***1.3.5***	Establish breastfeeding space in social and workplaces	County Wide	No of breastfeeding stations	3	3	1	1	1	1	10	Annually	program reports	CDH	Line ministries & partners
Output	***1.4***	***Optimal MIYCN practices sustained during emergencies***	***County /Sub County /Ward***	***% of Health Workers equipped with capacity to support caregivers during emergency***	***0%***	***10%***	***20%***	***30%***	***40%***	***50%***	***>50%***	***Annually***	***Program reports***	***CDH***	***Line ministries & partners***
				% of mothers out of all Breastfeeding in the emergency affected area supported to maintain lactation during the emergency period	***No data***	***10%***	***25%***	***50%***	***60%***	***75%***	***>75%***	***Annually***	***Program reports***	***CDH***	***Line ministries & partners***
Activity	***1.4.1***	Train health workers on MIYCN e	County Wide	No of HCW trained	30	30		30		30	120	quarterly	program reports	CDH	Line ministries & partners
Activity	***1.4.2***	Sensitize of CHPs on MIYCN e	County Wide	No of CHP sensitized	0	260		260		260	780	quarterly	program reports	CDH	Line ministries & partners
Activity	***1.4.3***	Sensitize community members on MIYCN e	County Wide	No of sessions conducted.	0	5	5	5	5	5	25	quarterly	program reports	CDH	Line ministries & partners
Activity	**1.4.4**	Conduct Rapid Assessment during emergencies	County Wide	No. of Assessments conducted	1	1	1	1	1	1	6	quarterly	program reports	CDH	Line ministries & partners
Output	***1.5***	***Kangaroo Mother Care services for Premature / LBW infants scaled up***	***County Wide***	***Proportion of targeted facilities with in-patient capacity where KMC is operational, by level of facility and type of KMC service***	***0%***	***20%***	***30%***	***50%***	***60%***	***75%***	***>75%***	***Annually***	***Program reports***	***CDH***	***Line ministries & partners***
				% Increase in the health facilities offering KMC services to premature / low birth weight babies	***0%***	***20%***	***30%***	***50%***	***60%***	***75%***	***>75%***	***Annually***	***Program reports***	***CDH***	***Line ministries & partners***
				Proportion of premature / LBW babies who received KMC in catchment area of the KMC facility(ies)	***0%***	***20%***	***30%***	***50%***	***60%***	***75%***	***>75%***	***Annually***	***Program reports***	***CDH***	***Line ministries & partners***

				% Increase of caregivers of premature / LBW newborns receiving support with improved quality of care from HCWs	***0%***	***20%***	***30%***	***50%***	***60%***	***75%***	***>75%***	***Annually***	***Program reports***	***CDH***	***Line ministries & partners***
Activity	1.5.1	Train TOTs on KMC	County Wide	No of TOTs trained on KMC	2	20	-	-	-	-	22	quarterly	program reports	CDH	Line ministries & partners
Activity	1.5.2	Train HCW on KMC	County Wide	No of HCW trained	2	30		30		30	92	quarterly	program reports	CDH	Line ministries & partners
Activity	1.5.3	sensitize CHPs on KMC	County Wide	No of CHPs sensitized on KMC	0	60	60	60	60	60	300	quarterly	program reports	CDH	Line ministries & partners
Activity	1.5.4	Scaling up KMC	County Wide	No of KMC sites scaled up	5	2	2	2	2	2	15	annual	program reports	CDH	Line ministries & partners
Activity	1.5.5	sensitize birth companions on KMC	**County wide**	No. birth companions trained on KMC	0	30	30	30	30	30	150	quarterly	program reports	CDH	Line ministries & partners
Activity	1.5.6	Conduct supervision monitoring to H/facilities offering KMC for improved quality of care	County Wide	No. of Supervision visits conducted annually	0	4	4	4	4	4	20	quarterly	program reports	CDH	Line ministries & partners
Output	***1.6***	***Behavior change on diverse micronutrient intake to prevent micronutrient deficiency and prevention promoted in the community level***	***County wide***	***%Increase in the population with adequate micronutrient intake***	***22.1% (HDDS, SMART 2023)***	***22.1%***	***25.0%***	***28.0%***	***30.0%***	***32.0%***	***35.0%***	***Annually***	***SMART***	***CDH***	***Line ministries & partners***
				% increase in the Minimum Dietary Diversity for Women	***31% (MDD-W, SMART 2023)***	***32.0%***	***34.0%***	***36.0%***	***38.0%***	***40.0%***	***40.0%***	***Annually***	***SMART***	***CDH***	***Line ministries & partners***
Activity	1.6.1	Train HCWs on relevant guidelines and policies on micronutrient deficiencies	County wide	Number of Health care workers Trained on micronutrients deficiencies guidelines and policies	2	50	50	50	50	50	250	Annually	Program report	CDH	Line ministries & partners
Activity	1.6.2	Sensitize community health promoters on prevention and control of micronutrient deficiencies.	County wide	Number of Community health promoters sensitized	220	184	184	184	184	184	924 chps	Anually	Program report	CDH	Line ministries & partners
Activity	1.6.3	Conduct health education to the community members (equally targeting men and women across different ages and diversities)on prevention and control of micronutrient deficiencies	County wide	No. of sessions conducted on prevention and control of micronutrient deficiencies	5	50	50	50	50	50	250	Anually	Program report	CDH	Line ministries & partners
Activity	1.6.4	Educate the community member on production, preservation and consumption of micronutrient rich foods at household level	County wide	# of community sensitization sessions conducted on production preservation and consumption of micronutrient rich foods	5	50	50	50	50	50	250	Quarterly	Program report	CDH	Line ministries & partners
Activity	1.6.5	Conduct health education to the community on dietary diversity and bio diversification	County wide	# of health education sessions on dietary diversity and bio diversity conducted	5	50	50	50	50	50	250	Annually	Program report	CDH	Line ministries & partners
Output	***1.7***	***Women of reproductive age and children 6-59months in the county optimally supplemented***	***County wide***	***% Increase in IFAS consumption for >180 days among Women of Reproductive Age***	***35.2% (SMART, 2023)***	***40%***	***45%***	***50%***	***55%***	***60%***	***60%***	***Every 3-5 years***	***SMART***	***CDH***	***Line ministries & partners***
			County wide	***% Increase in VAS coverage among children aged 6 to 59 months***	***39.0% (SMART, 2023)***	***39%***	***45%***	***50%***	***60%***	***70%***	***80%***	***Every 3-5 years***	***SMART***	***CDH***	***Line ministries & partners***
			County wide	***% Increase in Deworming coverage among children aged 12 to 59 months***	***22.0% (SMART, 2023)***	***35%***	***50%***	***60%***	***70%***	***80%***	***80%***	***Every 3-5 years***	***SMART***	***CDH***	***Line ministries & partners***
Activity	1.7.1	Supplement pregnant women with	County	Percentage of pregnant women supplemented	84%	100	100	100	100	100	100%	Monthly	KHIS,	CDH	Line

		IFA	wide	with IFA		%	%	%	%	%			SMART		ministries & partners
				Percentage of pregnant consuming IFA for 90 days	35%	40%	50%	60%	70%	75%	80%				
Activity	1.7.2	Supplement children 6-59 months of age with vitamin A	County wide	Proportion of children 6-11 months supplemented with Vitamin A	75%	75%	80%	80%	80%	80%	80%	Bi-annually	SMART	CDH	Line ministries & partners
			County wide	Proportion of children 12-59 months supplemented with Vitamin A	39%	45%	50%	60%	70%	80%	80%	Bi-annually	SMART	CDH	Line ministries & partners
Activity	1.7.3	Supplement 6-59months with Dewormers	County wide	Proportion of children 12-59 months supplemented with Dewormers	22%	35%	50%	60%	70%	80%	80%	Bi-annually	SMART	CDH	Line ministries & partners
Activity	1.7.4	Sensitize HCWs on documentation and micronutrient reporting of Vitamin A, Zinc IFAS and Dewormers, from the community level up to the DHIS	County wide	# of HCWs sensitized on documentation and micronutrient reporting conducted	35	40	40	40	40	40	200	Annually	Program report	CDH	Line ministries & partners
Level	**Code**	**KRA, Outcome, Output, Activity statement**	**Geographical coverage**	**Outcome/Output indicator Description**	**Baseline year 2022 / 2023**	**2023/ 24**	**2024/ 25**	**2025/ 26**	**2026/ 27**	**2027/ 28**	**End line target**	**Frequency of data collection**	**Data source**	**Lead Department**	Other sectors & Partners
KRA	**2**	**KEY RESULT AREA 2; Nutrition well-being for older children, adolescents , adults and older persons promoted**													
Outcome	**2.0**	**Improved nutrition well-being of older children, adolescents, adults and older persons in Kajiado County**	**county wide**	**Proportion of adolescents, Older children and Adults with a normal BMI**	**No data**			**50%**			**>50%**	**Annually**	**Screening data, Program Report**	**CDH, CDSP**	**Other sectors & Partners**
Output	***2.1***	***Enhanced Capacity of health care workers and Community Health Promoters on nutrition for older children.***	***county wide***	***No. of health facilities reporting improved service delivery on feeding older children and AHN***	***No Baseline Data***	***7***		***7***			***10***	***Annually***	***Training/ Program Report***	***CDH, CDSP***	***Other sectors & Partners***
			county wide	***% increase of health care workers with improved capacity of nutrition for older children, adolescents and adults.***	***No Baseline Data***	***40%***		***40%***			***60%***	***Annually***	***Training/ Program Report***	***CDH, CDSP***	***Other sectors & Partners***
Activity	*2.1.1*	Sensitize C/SCHMT members on relevant Nutrition policies and guidelines	county wide	No of C/SCHMT trained on relevant Nutrition policies and guidelines	0	-	30	34	34	-	98	Quarterly	Training reports	CDH	Other sectors & Partners
Activity	*2.1.2*	Sensitize health worker, Education and Agriculture officers on adolescent Nutrition policies and guidelines	county wide	No of HCWs and non-health care workers sensitized on policies and guidelines	0	35	35	35	35	35	175	Quarterly	Training reports	CDH	Other sectors & Partners
Activity	*2.1.3*	Sensitize community health volunteers on healthy diets and lifestyle policies and guidelines	county wide	No of CHPs sensitized on relevant nutrition policies and guidelines.	0	2056	2056	2056	2056	2056	2056	Quarterly	Training reports	CDH	Other sectors & Partners
Activity	2.1.4	Disseminate formulated policy on healthy diets and lifestyle for older children, adolescents, adults and older persons to Health care workers	County wide	No of dissemination meeting conducted in all the sub counties	0	1	1	1	1	5	9	Quarterly	Training reports	CDH	Other sectors & Partners
				No of HCWs reached	0	25	25	25	25	25	125	Annually	Meeting Report	CDH	Other sectors & Partners
Output	***2.2***	***Malnourished children in schools and community detected early for treatment and referral***	***County wide***	***Proportion of malnourished older children in schools and community detected and referred***	***No Baseline Data***	***40%***		***40%***			***60%***	***Annually***	***Program Report***	***CDH, CDSP***	***Other sectors & Partners***
			County wide	***% Increase of reported and documented cases of malnourished school going children***	***No Baseline Data***	***Increase by 10%***		***Increase by 10%***			***Increase by 20%***	***Annually***	***Program Report***	***CDH, CDSP***	***Other sectors & Partners***
Activity	2.2.1	Scale up screening and referral of malnourished adolescents, older children and adults	County wide	No of older Children screened and referred	0	30	30	30	30	30	150	Quarterly	Program Report	CDH	Other sectors & Partners
				No of adolescent screened and referred	0	67500	67500	67500	67500	67500	337500				
				No. of older adults screened and referred	0	350			350		700				

Activity	2.2.2	Capacity build teachers to identify and linking malnourished older children	County wide	No. of teachers trained.	0	70	70	70	70	70	350	Annually	Program Report	CDH	Other sectors & Partners
Activity	2.2.3	Promote continuous Nutrition health education in schools	County wide	No. of children reached with Nutrition health education.	0	70	70	70	70	70	350	Annually	Program Report	CDH	Other sectors & Partners
Activity	2.2.4	Capacity building of CHPs on identifying and referring malnourished older children , adolescent and adults	County wide	No. of CHPs staff trained	0	0	523	511	511	511	2056	Annually	Program Report	CDH	Other sectors & Partners
Output	***2.3***	***Increased proportion of Adolescent girls supplemented with micronutrients.***	***County wide***	***Increased proportion of Adolescent girls supplemented with weekly Iron Folic Acid supplements (WIFAs).***	***No Baseline Data***	***Increase by 10%***		***Increase by 10%***			***Increase by 20%***	***Annually***	***Program Report***	***CDH. CDSP***	***Other sectors & Partners***
Activity	2.3.1	Increase number of schools participating in the adolescent Health Nutrition (AHN) program	County wide	No of schools participating in the WIFS program	50	25	25	25	25	25	125	Continuous	reports	CDH	Other sectors & Partners
Activity	2.3.2	Procure and Dispatch of AHN commodities to schools.	County wide	Quantity of WIFs procured	852000	952000	952000	952000	952000	952000	4760000	Quarterly	delivery note	CDH	Other sectors & Partners
Activity	2.3.3	Sensitize teachers on Older children and AHN and management of T1DB.	county wide	No of male and female officers sensitized on WIFs	50	50	50	50	50	50	250	Quarterly	Training reports	CDH	Other sectors & Partners
Activity	2.3.4	Sensitize guardians / caregivers on AHN	county wide	No of sessions conducted to caregivers on WIFS	50	25	25	25	25	25	125	Quarterly	Training reports	CDH	Other sectors & Partners
			county wide	No of guardians / caregivers sensitized	0							Quarterly	Training reports	CDH	Other sectors & Partners
Activity	2.3.5	Sensitize key stakeholders on AHN	county wide	No of sessions conducted to stakeholders on WIFS	50	5	5	5	5	5	25	Quarterly	Training reports	CDH	Other sectors & Partners
			county wide	No of key stakeholders sensitized	0							Quarterly	Training reports	CDH	Other sectors & Partners
Activity	2.3.6	Sensitize community on AHN	county wide	No of sessions conducted to the community on WIFS	0	5	5	5	5	5	25	Quarterly	Training reports	CDH	Other sectors & Partners
Activity	2.3.7	Conduct health Education to adolescents (Boys & Girls) in schools on WIFS & AHN	county wide	No of sessions conducted	50	20	20	20	20	20	100	Quarterly	Training reports	CDH	Other sectors & Partners
			county wide	No of Adolescent (boys & girls) sensitized on AHN	0	200	200	200	200	200	1000	Quarterly	Training reports	CDH	Other sectors & Partners
Activity	2.3.8	Training of health care workers on AHN	county wide	No of health care workers trained on AHN	0	20	20	20	20	20	100	Quarterly	Training reports	CDH	Other sectors & Partners
Output	***2.4***	***Malnourished Older people at community level detected early for treatment and referral***	***county wide***	***Proportion of mapped and identified older persons receiving any nutrition related support***	***No Baseline Data***	***15%***		***15%***			***25%***	***Annually***	***Program Report***	***CDH, CDSP***	***Other sectors & Partners***
			county wide	***Proportion of Older persons reached with Key messages on nutrition***	***0***	***10%***	***20%***	***30%***	***40%***	***50%***	***50%***	***Annually***	***Program Report***	***CDH, CDSP***	***Other sectors & Partners***
Activity	2.4.1	Sensitize CHPs on mapping, identification and support for Older persons	county wide	No of CHPS sensitized on elderly persons identification and mapping	0	60	60	60	60	60	300	Quarterly	Training reports	CDH	Other sectors & Partners
Activity	2.4.2	Integrate nutrition information in the elderly support groups	county wide	Proportion of health care workers and community members with knowledge on healthy diets and lifestyle	0	30	30	30	30	30	150	Quarterly	Training reports	CDH	Other sectors & Partners

Activity	2.4.3	Sensitize CHPs on healthy diets and lifestyle for the elderly	county wide	no of CHPs sensitized on healthy diets and lifestyle	0	60	60	60	60	60	300	Quarterly	Training reports	CDH	Other sectors & Partners
Activity	2.4.4	Conduct targeted dialogues on healthy diets for elderly in the community	county wide	No of dialogue sessions conducted on healthy diets for elderly in the community	0	200	200	200	200	200	1000	Quarterly	Training reports	CDH	Other sectors & Partners
Activity	2.4.5	Draft Key messages for healthy diets for Older Persons	county wide	Copy of drafted key messages	0	0	0	1	0	0	1	Quarterly	Training reports	CDH	Other sectors & Partners
			county wide	Number of Older persons reached with Key messages	0	0	0	0	0	0	0	Quarterly	Training reports	CDH	Other sectors & Partners
Output	***2.5***	***Increased Community awareness on healthy diets and lifestyle for Older Children, Adolescents, Adults and Older Persons within urban and rural areas***	***County Wide***	***No. of healthy diets and physical health promotion targeted activities conducted***	***No Baseline Data***	***2***	***4***	***4***	***4***	***4***	***18***	***Annually***	***Program Report***	***CDH, CDSP***	***Other sectors & Partners***
Activity	2.5.1	Mapping and conducting relevant stakeholder engagements	county wide	No of Stakeholders mapped	0	5	5	5	5	5	>25	Annually	Program Report	CDH, Social	Line Ministries & partners
			county wide	No of Stakeholders engagements conducted	0	1	1	1	1	1	5	Annually	Program Report	CDH, Social	Line Ministries & partners
Activity	2.5.2	Disseminate to stakeholders the relevant policies and guidelines that promote healthy diets and lifestyle	county wide	No of dissemination meetings conducted	1	1	1	1	1	1	5	Annually	Program Report	CDH, Social	Line Ministries & partners
			county wide	Proportion of mapped Stakeholders reached								Annually	Program Report	CDH, Social	Line Ministries & partners
Activity	2.5.3	Conduct mass community education on healthy diets and lifestyle for Older Children, Adolescents, Adults and Older Persons during thematic and cultural days (e.g. Morans' initiation ceremony)	county wide	No of mass education sessions conducted	0	1	1	1	1	1	5	Annually	Program Report	CDH, Social	Line Ministries & partners
Activity	2.5.4	Collaborate with stakeholders to Promote healthy diets and physical activity for older children and adolescents through youth gatherings in urban zones (football, drama, church)	county wide	No of healthy diets and physical health promotion targeted activities conducted	0	2	4	4	4	4	18	Quarterly	Program Report	CDH, Social	Line Ministries & partners
Level	**Code**	**KRA, Outcome, Output, Activity statement**	**Geographical coverage**	**Outcome/Output indicator Description**	**Baseline year 2022/2023**	**2024/25**	**2025/26**	**2026/27**	**2027/28**	**2028/29**	**End line target**	**Frequency of data collection**	**Data source**	**Lead Department**	**Associated department/ organization**
KRA	**3**	**KEY RESULT AREA 3: Enhanced industrial food fortification for prevention and control of micronutrient deficiencies**													
Outcome	**3.0**	**Access to fortified foods to improve micronutrient status of the population in Kajiado County scaled up**	**County Wide**	**% of food industry and millers compliance to food fortification regulations and standards**	**0% (Program Report)**	**10%**	**20%**	**30%**	**40%**	**50%**	**>50%**	**Every 3-5 years**	**Program Report**	**CDH**	**CDT & Partners**
			County Wide	**% of Households consuming fortified foods**	**0% (Program Report)**	**10%**	**20%**	**30%**	**40%**	**50%**	**>50%**	**Bi-annually**	**SMART Surveys**	**CDH**	**CDT & Partners**
			County Wide	**% of Households with improved Knowledge, Attitude and perception on fortified foods**	**0% (Program Report)**	**10%**	**20%**	**30%**	**40%**	**50%**	**>50%**	**Bi-annually**	**KAP Surveys**	**CDH**	**CDT & Partners**

Output	***3.1***	***Advocacy, Leadership and co-ordination mechanism for food safety and fortification strengthened***	***County wide***	***% Increase in budgetary allocation of resources for food safety and fortification programming***	***0% (Program Report)***	***0%***	***5%***	***10%***	***15%***	***20%***	***20%***	***Annually***	***Program reports***	***CDH***	***CDT & Partners***
Activity	3.1.1	Formation of County Food Safety and Fortification Alliance (CFSFA)	County wide	CFSFAs formed	0	1	0	0	0	0	1	Annually	Program reports	CDH	CDT & Partners
Activity	3.1.2	Conduct quarterly CFSFA meetings for review and planning of food safety and fortification activities in the county	County wide	Number of CFSFAs review meetings held	0	4	4	4	4	4	20	Annually	Program reports	CDH	CDT & Partners
Activity	3.1.3	Conduct sensitization of managers and directors in relevant sectors (CHMT, Min of Trade) on food safety and fortification	County wide	Number of managers sensitization meetings held	0	30	0	0	0	0	30	Annually	Program reports	CDH	CDT & Partners
Activity	3.1.4	Conduct advocacy meetings with MOH, Min of Trade leadership, and Members of County Assembly (MCAs) to lobby for budgetary allocation to food safety and fortification programming in the county	County wide	Number of advocacy meetings held	0	0	0	1	0	0	1	Bi-annually	Program report	CDH	CDT & Partners
			County wide	Number of leaders reached with Advocacy messaging	0	0	0	35	0	0	35	Bi-annually	Program report	CDH	CDT & Partners
Activity	3.1.5	Conduct Advocacy forums to increase awareness on food safety and fortification - World Food Safety Day, County FF Summit	County wide	Number of world food safety day commemorations held	0	1	1	1	1	1	5	Annually	Program report	CDH	CDT & Partners
Output	***3.2***	***Capacity of food industries /millers to produce safe and fortified foods strengthened***	***County***	***% Increase in food industries / millers with increased capacity to produce safe and fortified foods***	***0% (Program Report)***	***0.0%***	***25.0%***	***50.0%***	***75.0%***	***100.0 %***	***100.0%***	***Annually***	***Program report***	***CDH***	***CDT & Partners***
			County wide	***% millers fortifying at production level***	***0% (Program Report)***	***0.0%***	***25.0%***	***50.0%***	***75.0%***	***100.0 %***	***100.0%***	***Annually***	***Program report***	***CDH***	***CDT & Partners***
Activity	3.2.1	Conduct sensitization meetings for industries (maize, wheat flour, edible oil, salt) on relevant government legislation on food safety and fortification	County wide	Number of sensitization meetings held	2	0	1	0	0	1	4	Bi-annually	Program report	CDH	CDT & Partners
			County wide	No of industries reached	9	0	12	0	0	12	12	Bi-annually	Program report	CDH	CDT & Partners
Activity	3.2.2	Conduct on-site training and mentorship of food business operators and industries to institute Quality Assurance and Quality Control (QA/QC) in their businesses	County wide	No trainings and mentorship meetings held	0	0	1	0	0	0	1	Bi-annually	Program report	CDH	CDT & Partners
Output	***3.3***	***Capacity of surveillance and enforcement officers on regulatory monitoring, surveillance and enforcement of food safety and fortification enhanced***	***County wide***	***% Increase in monitoring activities***	***0% (Program Report)***	***10%***	***10%***	***50%***	***75%***	***100%***	***5***	***Annually***	***Program reports***	***CDH***	***CDT & Partners***
			County wide	***Notice of violations reported***	***No data (Program Report)***	***Yes***	***Yes***	***Yes***	***Yes***	***Yes***	***Yes***	***Annually***	***Program reports***	***CDH***	***CDT & Partners***
			County wide	***% increase in the Number of sample collected and tested***	***0% (Program Report)***	***0.0%***	***15.0%***	***30.0%***	***45.0%***	***60.0%***	***60.0%***	***Annually***	***Program reports***	***CDH***	***CDT & Partners***
Activity	3.3.1	Train PHOs on food safety and fortification surveillance and enforcement	County wide	Number of PHOs trained	35	0	50	0	0	50	135	Annually	Program reports	CDH	CDA & Partners
Activity	3.3.2	Conduct quarterly surveillance and monitoring on food fortification at the market level in the county	County wide	Number of food samples collected for food fortification testing	55	20	20	20	20	20	155	Quarterly	Program reports	CDH	CDA & Partners
Activity	3.3.3	Establish a food safety and food fortification Mini-laboratory	County wide	Number of food fortification mini lab established	0	0	1	0	0	0	1	Once	Program reports	CDH	CDA & Partners

Output	***3.4***	***Demand for consumption of fortified foods by households created***	***County wide***	***Proportion of the survey respondents who ever heard of Food Fortification***	***17.7% (SMART Survey)***	***20%***	***30%***	***40%***	***50%***	***60%***	***>60%***	***Annually***	***SMART Surveys***	***CDH***	***CDT & Partners***
			County wide	***Proportion of the survey respondents who can identify the Food Fortification Logo***	***57.0% (SMART Survey)***	***60%***	***65%***	***70%***	***75%***	***80%***	***>80%***	***Annually***	***SMART Surveys***	***CDH***	***CDT & Partners***
Activity	3.4.1	Mass sensitization on Food fortification through barazas, community action days, community dialogues	County wide	Number of community sensitization sessions conducted	0 (Program Report)	4	4	4	4	4	20	Annually	Program reports	CDH	CDA & Partners
	3.4.2	Mass sensitization on Food fortification through Radio spots	County wide	Number of Radio spots covered	0 (Program Report)	4	4	4	4	4	20	Annually	Program reports	CDH	CDA & Partners
Activity	3.4.3	Sensitize CHPs on consumption of food fortification	County wide	Number of CHPs sensitized	0 (Program Report)	100	100	100	100	100	500	Annually	Program reports	CDH	CDA & Partners
Activity	3.4.4	Sensitize community gate keepers on consumption of food fortification	County wide	Number of community gatekeepers sensitized	0 (Program Report)	50	50	50	50	50	250	Annually	Program reports	CDH	CDA & Partners
Activity	3.4.5	Conduct household surveys to monitor consumption pattern of fortified foods	County wide	Number of household surveys conducted	0 (Program Report)	1	0	1	0	1	3	Bi-annually	Program reports	CDH	CDA & Partners
Level	**Code**	**KRA, Outcome, Output, Activity statement**	**Geographical coverage**	**Outcome/Output indicator Description**	**Baseline / year 2022 / 2023**	**2024/25**	**2025/26**	**2026/27**	**2027/28**	**2028/29**	**End line target**	**Frequency of data collection**	**Data source**	**Lead Department**	**Line Ministries & partners**
KRA	**4**	**KEY RESULT AREA 4:Sustained nutritional wellbeing of individuals and communities during emergencies and climate related shocks**													
Outcome	**4.0**	**Enhanced community resilience to climate-related shocks and emergencies.**	**County wide**	**% Increase in the proportion of affected households who feel empowered to recover from emergency**	**0%**	**10%**	**25%**	**45%**	**50%**	**75%**	**>75%**	**Annually**	**Response Report**	**CDH/ NDMA**	**Line Ministries & partners**
Output	***4.1***	***Community supported to withstand climate shocks and emergency***	***County wide***	***% of Affected HHs support Increased***	***No data***	***10%***	***20%***	***30%***	***40%***	***50%***	***>50%***	***Annually***	***Preparedness & Response Report***	***CDH/ NDMA***	***Line Ministries & partners***
Activity	4.1.1	Disseminate Early Warning Climate Information to communities	County wide	No. of EWIS dissemination forums conducted	2	2	2	2	2	2	10	Quarterly	Preparedness & Response Report	CDH/ NDMA	Line Ministries & partners
Activity	4.1.2	Integrate local knowledge with expert information in Participatory Scenario Planning forums	County wide	No. of joint PSP forums conducted	1	2	2	2	2	2	10	Quarterly	CSG, Departmental Reports	CDH/ NDMA	Line Ministries & partners
Activity	4.1.3	Community civic education on emergencies	County wide	No of awareness forums on emergencies conducted	1	2	2	2	2	2	10	Biannually	CSG, Emergency Reports	CDH/ NDMA	Line Ministries & partners
Activity	4.1.4	Conduct psychosocial support sessions on GBV, nutrition counselling	County wide	No of psychosocial Sessions conducted		50	50	50	50	50	250	Monthly	CDH	CDH/ NDMA	Line Ministries & partners
Activity	4.1.5	Intensify case screening of malnutrition by the Health Care workers at the community	County wide	No.of children screened for malnutrition	6000	8400	8400	8400	8400	8400	42000	Quarterly	Facility Reports	CDH/ NDMA	Line Ministries & partners
Activity	4.1.6	Mapping and identifying malnutrition hotspots	County wide	No. of hotspots mapped	15	15	30	30	30	30	30	Annually	Preparedness & Response Report	CDH/ NDMA	Line Ministries & partners
Activity	4.1.7	Identifying areas at risk of flash floods and mapping the essential assets that could be affected (e.g. health facilities cropland or key roads);	County wide	Mapping of High risk areas conducted	2	2	2	2	2	2	10	Bi-annually	Preparedness & Response Report	CDH/ NDMA	Line Ministries & partners
			County wide	No. of HHs sensitized	0	5000	5000	5000	5000	5000	25000	Quarterly	Preparedness & Response Report	CDH/ NDMA	Line Ministries & partners
Activity	4.1.8	Conduct mass screening outreaches in Hotspot areas	County wide	No. of mass screening conducted	0	4	4	4	4	4	20	Quarterly	Facility Reports	CDH/ NDM	Line Ministries

														A	& partners
Activity	4.1.9	Linking vulnerable households to food assistance in emergency settings	County wide	No. of Households who received Food assistance	8000	20000	20000	20000	20000	20000	20000	Quarterly	CSG, Emergency Reports	CDH/ NDM A	Line Ministries & partners
Output	***4.2***	***Capacity of Healthcare workers on nutrition surveillance for emergency response enhanced***	***County wide***	***% Increase in the proportion of HCWs with Enhanced capacity for Nutrition Surveillance***	***10%***	***10%***	***20%***	***30%***	***40%***	***50%***	***>50%***	***Annually***	***Program Report***	***Coverage Survey***	***Line Ministries & partners***
Activity	4.2.1	Train health workers on conducting nutritional assessments for emergency response	**county wide**	No. of Health workers trained	0	120	120	120	120	120	600	Annually	**Program Report**	CDH	Line Ministries & partners
Activity	4.2.2	Training of health workers on IMAM Surge	County wide	No. of healthcare workers trained on IMAM surge	75	120	120	120	120	120	600	Annually	**Program Report**	CDH	Line Ministries & partners
Activity	4.2.3	scale up IMAM surge in targeted health facilities	County wide	No. of health facilities conducting IMAM Surge	15	20	20	20	20	20	100	Annually	**Program Report**	CDH/PARTNERS	Line Ministries & partners
Activity	4.2.4	Monitor IMAM surge activities	County wide	No. of IMAM surge activities monitored	0	50	50	50	50	50	250	Annually	**Program Report**	CDH/PARTNERS	Line Ministries & partners
Activity	4.2.5	Train Health Workers on IYCNE	County wide	No. of health workers trained on IYCNE	130	50	50	50	50	50	250	Annually	**Program Report**	CDH/PARTNERS	Line Ministries & partners
Output	***4.3***	***Enhanced multi sectoral coordination in emergencies***	***County wide***	***Functional (regular fortnight meetings) multi-sector emergency coordination system established***	***0***			***4***			***4***	***Annually***	***Coordination minutes***	***CDH/ NDM A***	***Line ministries & Partners***
Activity	4.3.1	Linkage of households with malnutrition cases to Cash transfer programs during emergencies	County wide	No of cash transfers' beneficiaries linked during emergencies	130	50	50	50	50	50	250	Annually	Preparedness & Response Report	CDH	Line ministries & Partners
Activity	4.3.2	Conduct multi-sectoral climate – health risk assessment (early warning early actions)	County wide	No of Joint multi-sectoral climate – health risk assessment (early warning early actions) conducted	1	1	1	1	1	1	5	Annually	Preparedness & Response Report	CDH	Line ministries & Partners
Activity	4.3.3	Develop sectoral emergency plans	County wide	No. of sectoral emergency plans developed	8500	8925	9350	9775	10200	10625	5%	Annually	Preparedness & Response Report	CDH	Line ministries & Partners
Activity	4.3.4	Packaging of Early Warning Information messaging to the public	County wide	No. of messages developed for EWI	0	2	2	2	2	2	10	Annually	Preparedness & Response Report	CDH	Line ministries & Partners
Activity	4.3.5	Develop County sectoral contingency plans	County wide	No. of sectoral contingency plans operationalized	10	3	3	3	3	3	15	Annually	Preparedness & Response Report	CDH	Line ministries & Partners
Activity	4.3.6	Conduct weekly CSG meetings on Nutrition and Food Security during emergencies	County wide	No. of CSG meetings held during emergencies	2	4	4	4	4	4	20	Annually	Preparedness & Response Report	CDH	Line ministries & Partners
Level	**Code**	**KRA, Outcome, Output, Activity statement**	**Geographical coverage**	**Outcome/Output indicator Description**	**Baseline year 2022/2024**	**2024/25**	**2025/26**	**2026/27**	**2026728**	**2028/29**	**End line target**	**Frequency of data collection**	**Data source**	**Lead Department**	**Line ministries & Partners**
KRA	**5**	**KEY RESULT AREA 5 Clinical Nutrition and dietetics services strengthened**													
Outcome		**Clinical Nutrition and dietetics services Enhanced**	**County wide**	**% Improved coverage for IMAM Program ≥50%**	**<50%**			**50%**			**≥50%**	**2-3 years**	**Coverage Survey**	**CDH**	**Line ministries & Partners**
			County wide	**% Improved cure rate for IMAM Program ≥75%**	**OTP - 53% SFP - 47% (Coverage Survey, 2023)**			**OTP - 75% SFP - 75%**			**OTP - ≥75% SFP - ≥75%**	**Annually**	**KHIS Data**	**CDH**	**Line ministries & Partners**

			County wide	**% Reduced defaulter rate for IMAM Program <15%**	**OTP - 42% SFP - 46% (Coverage Survey, 2023)**			**OTP - 25% SFP - 25%**			**OTP - <15% SFP - <15%**	**Annually**	**KHIS Data**	**CDH**	**Line ministries & Partners**
			County wide	**% Reduced malnutrition in NCDs**	**No baseline data**			**Reduce by 10%**			**Reduce by 20%**	**Every 2-3 years**	**Program, Survey Report**	**CDH**	**Line ministries & Partners**
Output	***5.1***	***Increased access and coverage of Integrated Management of Acute Malnutrition (IMAM) Services***	***County wide***	***Proportion of public health facilities offering Integrated Management of Acute Malnutrition (IMAM) Services***	*90%*			*95%*			*100%*	*Monthly*	*Program Reports*	***CDH***	***Line ministries & Partners***
			County wide	***Proportion of health care workers trained on clinical nutrition package***	*45%*			*60%*			*≥75%*	*Annually*	*Program Reports*	***CDH***	***Line ministries & Partners***
			County wide	***Proportion of patients diagnosed with Severe Acute Malnutrition***	*No baseline data*			*Increase by 10%*			*Increase by 20%*	*Annually*	*Program Reports*	***CDH***	***Line ministries & Partners***
			County wide	***Proportion of patients diagnosed with Moderate Acute Malnutrition***	*No baseline data*			*Increase by 10%*			*Increase by 20%*	*Annually*	*Program Reports*	***CDH***	***Line ministries & Partners***
Activity	5.1.1	Conduct training of HCW on IMAM and disseminate the IMAM guidelines	County wide	No. of H/W trained on IMAM	99	60	60	60	60	60	399	Quarterly	Activity report	CDH	Line ministries & Partners
Activity	5.1.2	Distribute/ disseminate nutrition services SOPs and treatment protocols in all sub counties	County wide	No. of Health facilities with Nutrition services SOPs and protocols	63	20	20	20	20	20	163	biannually	Activity report	CDH	Line ministries & Partners
Activity	5.1.3	Integrate management of acutely malnourished children in other programs within the health system	County wide	No. of HF implementing integrated services for acute Malnutrition	135	5	5	5	5	5	160	Quarterly	Activity report	CDH	Line ministries & Partners
Activity	5.1.4	Carryout facility visits for On the Job Training on IMAM service delivery in primary care facilities and the community	County wide	Number of primary care facilities assessed	82	43	43	43	43	43	297	Quarterly	Activity report	CDH	Line ministries & Partners
Activity	5.1.5	train HCWs on nutrition commodity quantification, forecasting and management	County wide	No. of H/W trained on quantification and forecasting	130	30	30	30	30	30	280	biannually	Activity report	CDH	Line ministries & Partners
Activity	5.1.6	Conduct IMAM program performance reviews;	County wide	No. of performance review meetings on IMAM conducted	0	10	10	10	10	10	50	Quarterly	Activity report	CDH	Line ministries & Partners
Output	***5.2***	***Enhanced early case identification of all forms of malnutrition through community mobilization and referral***	***County wide***	***Proportion of CHPs sensitized on continuum of nutrition care in the community***	*No baseline data*	*Increase by 10%*		*Increase by 10%*			*Increase by 20%*	***Annually***	***Program Reports***	***CDH***	***Line ministries & Partners***
				Proportion of children diagnosed with Acute malnutrition through community health promotion support	*No baseline data*	*Increase by 10%*		*Increase by 10%*			*Increase by 20%*	***Quarterly***	***Program Reports***	***CDH***	***Line ministries & Partners***
Activity	5.2.1	Train CHPs on CMAM	County wide	No. of CHPS trained on CMAM	0	150	150	150	150	150	750	Quarterly	Activity report	CDH	Line ministries & Partners
Activity	5.2.3	Train CHPs on family MUAC	County wide	No. of CHPS trained on family MUAC	300	150	150	150	150	150	1050	Quarterly	Activity report	CDH	Line ministries & Partners
Activity	5.2.3	Sensitization of care givers on use of family MUAC	County wide	No of caregivers sensitized	2000	600	600	600	600	600	5000	Quarterly	Activity report	CDH	Line ministries & Partners
Activity	5.2.4	Sensitization of Opinion leaders on Malnutrition conditions and nutrition services	County wide	No. leaders sensitized	0	500	500	500	500	500	2500	Quarterly	Activity report	CDH	Line ministries & Partners
Activity	5.2.5	conduct quarterly outreaches for Acute Malnutrition in hot spots	County wide	No. of Outreaches conducted	0	15	20	25	30	35	125	Quarterly	Activity report	CDH	Line ministries

		areas at community													& Partners
Activity	5.2.6	Conduct routine Nutrition assessment and defaulter tracing by CHP at house hold level	County wide	Proportion of households visited	5%	9%	9%	9%	9%	9%	50%	Routinely	monthly Report	CDH	Line ministries & Partners
Output	***5.3***	***Accelerated nutrition response for prevention and control of diet related NCDs***	***County wide***	***Proportion of patients diagnosed with diet related NCDs.***	***No baseline data***			***Increase by 5%***			***Increase by 10%***	***Quarterly***	***Program Reports***	***CDH***	***Line ministries & Partners***
			County wide	***Proportion of facilities with Nutrition and NCDs screening SOPs and Protocols***	***75%***			***90%***			***100%***	***Annually***	***Program Reports***	***CDH***	***Line ministries & Partners***
			County wide	***Proportion of Health facilities implementing Nutrition screening and triage at OPD***	***40%***			***80%***			***100%***	***Quarterly***	***Program Reports***	***CDH***	***Line ministries & Partners***
			County wide	***Proportion of population screened and assessed for nutrition status while accessing healthcare services***	***No baseline data***			***50%***			***≥80%***	***Quarterly***	***Program Reports***	***CDH***	***Line ministries & Partners***
Activity	5.3.1	Training of HCWs on control and prevention of diet-related NCDs at All levels of service delivery	County wide	No. of HCWs sensitized diet related NCDs	0	100	100	100	100	100	500	Annual	Activity report	CDH	Line ministries & Partners
Activity	*5.3.2*	Scale -up integration of nutrition services in NCD programs and Clinics at sub county and facility level No of facilities implementing integrated services	County wide	No of Facilities implementing integrated NCD and Nutrition services	7	50	50	50	50	50	257	Routinely	monthly Report	CDH	Line ministries & Partners
Activity	5.3.3	Training of health workers on critical nutrition and dietetics care package	County wide	No. of HCWs trained	0	20	20	20	20	20	100	Annual	Activity report	CDH	Line ministries & Partners
Activity	5.3.4	Disseminate SOPs and treatment protocols on critical nutrition and dietetics and inpatient feeding	County wide	Proportion of facilities with SOPs and protocols	0	30	30	30	30	30	30	Annual	Activity report	CDH	Line ministries & Partners
Activity	5.3.5	Strengthened Nutrition screening , assessment and triage of all patients and clients seeking healthcare services	County wide	No of health facilities with triage	15	10	10	10	10	10	65	Monthly		CDH	Line ministries & Partners
Output	***5.4***	***Strengthened Nutrition Assessment , Counselling and Support services in HIV and TB clinics***	***County wide***	***Proportion of health facilities implementing Nutrition Assessment, Counselling and Support services in HIV and TB clinics***	***No baseline data***			***75%***			***100%***	***Monthly***	***Program Reports***	***CDH***	***Line ministries & Partners***
Activity	5.4.1	Training of healthcare workers on Nutrition and TB	County wide	No of HCWs trained on Nutrition and TB	0	30	30	30	30	30	100%	Quarterly	Activity report	CDH	Line ministries & Partners
Activity	5.5.2	Implement bi-directional screening for TB disease and Nutrition conditions in TB and Nutrition clinics	County wide	Proportion of facilities conducting bi-directional screening	25	30	30	30	30	30	175	Quarterly	Activity report	CDH	Line ministries & Partners
Activity	5.5.3	Training of healthcare workers on Nutrition and HIV	County wide	No of HCWs trained on Nutrition and HIV	0	30	30	30	30	30	100%	Quarterly	Activity report	CDH	Line ministries & Partners
Level	**Code**	**KRA, Outcome, Output, Activity statement**	**Geographical coverage**	**Outcome/Output indicator Description**	**Baseline year 2022/2023**	**2024/25**	**2025/26**	**2026/27**	**2027/28**	**2028/29**	**End line target**	**Frequency of data collection**	**Data source**	**Lead Department**	**Associated department/ organization**
KRA	**6**	**KEY RESULT AREA 6: Nutrition and Food Security in Agriculture scaled-up**													
Outcome	**6**	**Increased production and consumption of nutrient dense foods**	**County wide**	**% of Households with Improved Household Dietary Diversity Score**	**40.6% (SMART 2023)**	**40.6 %**	**45.0 %**	**50.0 %**	**55.0 %**	**60.0 %**	**>60%**	**Every 3-5 years**	**SMART**	**CDLP**	**CDH, Partners**

Output	***6.1***	***Farmers supported to increase availability, access of nutritious foods (crops, livestock, fish)***	***County wide***	***% Increase in proportion of farmers supported***	***No data***	***Increase by 5%***	***Increase by 5%***	***Increase by 5%***	***Increase by 5%***	***Increase by 5%***	***Increase by 25%***	***Annually***	***Sectional reports***	***CDLP***	***CDH, Partners***
			County wide	***#No. of nutrient dense value chains promoted***	***5***	***1***	***1***	***1***	***1***	***1***	***10***	***Annually***	***Sectional reports***	***CDLP***	***CDH, Partners***
Activity	6.1.1	Enhance and scale up community awareness on sustainable ,environment friendly production of diversified and nutritious foods	County wide	No. of awareness sessions held	20	10	10	10	10	10	50	quarterly	Sectional reports	CDA	CDH, Partners
Activity	6.1.2	Promotion of indigenous crops, fruits and Livestock to increase availability and access of nutrient dense and safe foods	County wide	No. of promotional campaigns conducted	10	15	15	15	15	15	85	Quarterly	Sectional Reports	CDA, CDLP, CDVS	CDH, Partners
Activity	6.1.3	Enhance community awareness on harvest and post-harvest interventions to reduce food losses	County wide	No. of awareness sessions conducted	25	50	50	50	50	10	235	Quarterly	Sectional reports	CDA, CDLP, CDVS	CDH, Partners
Activity	6.1.4	Staff trainings and demonstrations on post-harvest handling of produce to reduce food loss	County wide	No. of staff trainings held	1	2	2	2	2	2	11	Quarterly	Sectional reports	CDA, CDLP, CDF	CDH, Partners
Activity	6.1.5	Promote kitchen gardens which incorporate innovative gardening and small stock rearing	County wide	No of kitchen gardens established	50	25	25	25	25	25	175				CDH, Partners
Output	***6.2***	***Innovative approaches for increased knowledge on Food consumption, utilization and processing supported***	***County wide***	***#No. of Innovative approaches adopted by farmers***	***2***	***1***	***1***	***1***	***1***	***1***	***7***	***Annually***	***Sectional reports***	***CDLP***	***CDH, Partners***
			County wide	***% increase in farmers reporting adoption of innovative approaches***	***xx%***	***5%***	***5%***	***5%***	***5%***	***5%***	***25%***	***Annually***	***Sectional reports***	***CDLP***	***CDH, Partners***
Activity	6.2.1	Conduct nutrition demonstrations to farmer groups on food preservation , preparation and utilization for various food categories(Animal, crops, fish)	County wide	No of farmer groups trained	60	60	60	60	60	60	360	Quarterly	Sectional reports	CDA, CDLP, CDF	CDH, Partners
Activity	6.2.2	Conduct Farmer demonstrations on household food preservation and processing	County wide	No. of trainings held on yoghurt making	40	40	40	40	40	40	240	Quarterly	Sectional reports	CDLP, CDA, CDF	CDH, Partners
Output	***6.3***	***Farmers supported to increase capacity on quality safe farm produce (crops, livestock, fish)***	***County wide***	***% Increase in proportion of farmers with capacity on quality safe farm produce***	***No data***	***5%***	***5%***	***5%***	***5%***	***5%***	***Increase by 25%***	***Annually***	***Sectional reports***	***CDLP, CDH***	***Line ministries & Partners***
			County wide	***No. of rapid testing centers for agricultural products operationalized***	***10***			***15***			***15***	***Annually***	***Sectional reports***	***CDLP, CDH***	***Line ministries & Partners***
			County wide	***No. of technical staff trained on food safety, standards and regulations***	***15***			***45***			***75***	***Quarterly***	***Sector reports***	***CDLP, CDH***	***Line ministries & Partners***
			County wide	***No. of collaboration meetings with food safety regulatory bodies held***	***2***			***2***			***2***	***Biannual***	***Sector reports***	***CDLP, CDH***	***Line ministries & Partners***
Activity	6.3.1	Enhance and scale up community awareness on food safety	County wide	No. of awareness sessions held	4	4	4	4	4	4	24	Quarterly	Sectional reports	CDLP, CDH	Line ministries & Partners
Activity	6.3.2	Conduct Collaboration meetings with food safety regulatory bodies	County wide	No. of collaborative meetings held	4	5	5	5	5	5	29	Quarterly	Sectional reports	CDLP, CDH	Line ministries & Partners
Activity	6.3.3	conduct staff trainings on food safety standards and regulations	County wide	No. of staff trained on various standards and regulations	7	75	75	75	75	75	382	Annually	Sectional reports	CDLP, CDH	Line ministries & Partners

KRA	7	KEY RESULT AREA 7: Nutrition in Education and Early Childhood Development (ECDE) promoted													
Outcome	**7.0**	**Improved nutrition status for childcare centers, ECDE centers and school going children**		**Reduction in malnutrition among child care, ECDE and school going children**	**no data**				**Reduce by 5%**		**Reduce by 10%**	**Annually**	**Survey Reports**	**CDH, MOE**	**Line ministries & Partners**
Output	***7.1***	***Healthy and safe food environments promoted in learning and child care centers***	***County***	***% Increase in the proportion of schools, ECDE and Child Care centers meeting healthy diets and safe food environment standards***	***no data***	***Increase by 2%***	***Increase by 2%***	***Increase by 2%***	***Increase by 2%***	***Increase by 2%***	***Increase by 10%***	***Annually***	***Program Report***	***MOE, CDH***	***Line ministries & Partners***
Activity	7.1.1	Scale up school gardens for public schools in the county	County	No of School Garden initiated	26	50	57	60	65	68	300	Once in 5 years	Agriculture records	MOE, CDH	Line ministries & Partners
Activity	7.1.2	Create and strengthen nutrition sensitive health and 4 K clubs in schools	Schools	No of schools with active Health and 4K clubs	50	70	70	70	70	70	350	Annually	Agriculture records	MOE, CDH	Line ministries & Partners
Activity	7.1.3	Conduct advocacy for school feeding program - sourcing for finances and sustainability	County	No. of Advocacy sessions conducted	no data	4	4	4	4	4	20	Annually	Program Report	MOE, CDH	Line ministries & Partners
Activity	7.1.4	Conduct Nutrition education to parents of school going children in schools within the County	County	No of parents sensitized	0	400	400	400	400	400	2000	Annually	Public Health Section	MOE, CDH	Line ministries & Partners
Activity	7.1.5	Sensitize childcare facility management on healthy diet and safe food environment	County	No of facilities targeted	0	10	10	10	5	5	40	Annually	Public Health Section	MOE, CDH	Line ministries & Partners
			County	No of personnel / staff sensitized	0	10	10	10	10	10	50	Annually	Public Health Section	MOE, CDH	Line ministries & Partners
Output	***7.2***	***Increased referral, treatment and management of malnourished children in schools, ECDE and child care centers***	***County***	***% Increase in malnourished school cases identified and managed appropriately.***	***no data***			***30%***			***50%***	***Monthly***	***Program Report***	***MOE, CDH***	***Line ministries & Partners***
Activity	7.2.1	Conduct nutrition sensitization to ECD teachers in schools within the county	County	No of teachers sensitized on Nutrition	60	90	120	140	180	220	750	Annually	Education Records	MOE, CDH	Line ministries & Partners
Activity	7.2.2	Conduct nutrition sensitization to child care centers owners in the county	County	No of child care centers owners sensitized	0	5	8	12	18	24	67	Annually	Education Records	MOE, CDH	Line ministries & Partners
Activity	7.2.3	Conduct Growth monitoring among ECDE children	county wide	Proportion of children U5 attending growth monitoring				80%			100%	Monthly	CWC, MCH Records	MOE, CDH	Line ministries & Partners
Output	***7.3***	***Nutrition Integrated and scaled up in Child Care Centers in the county***	***County***	***% Increase in Proportion of learning centers reporting Integrated Nutrition and Education activities***	***no data***			***20%***			***35%***	***Quarterly basis***	***Program Report***	***MOE, CDH***	***Line ministries & Partners***
Activity	7.3.1	Conduct mapping and profiling of child care center in the county	County	No of child care centers mapped	0	3	5	7	10	12	37	Twice in 5 years	Education Records	MOE, CDH	Line ministries & Partners
Activity	7.3.2	Linkage of the mapped ECDE centers to catchment health facilities	County	Proportion of ECDE centers linked	0	20%	20%	20%	20%	20%	100%	Annually	Education Records	MOE, CDH	Line ministries & Partners
Activity	7.3.3	Renovation and operationalization of a model public child care center In Majengo, Isinya	Isinya	No of model Public Child Care Centers operational	1	1	1	1	1	1	5	Annually	Education Records	MOE, CDH	Line ministries & Partners
Activity	7.3.4	Sensitization to all relevant stakeholders on child care facilities and policy	County	No of sessions conducted	0	0	1	0	0	0	1	Once in 5 years	Health reports	MOE, CDH	Line ministries & Partners
Activity	7.3.5	Improve support supervision and M & E in nutrition sensitive programs in Child care centers,	County	No of school monitoring visit done	0	1 per school	1 per school	1 per school	1 per school	1 per school	1 per school	Annually	Education Records	MOE, CDH	Line ministries & Partners

		ECD and schools	County	Consolidated data on nutrition status of all child care centers, ECD and school across the county.	0	1 per school	1 per school	1 per school	1 per school	1 per school	1 per school	Annually	Education Records	MOE, CDH	Line ministries & Partners
Level	**Code**	**KRA, Outcome, Output, Activity statement**	**Geographical coverage**	**Outcome/Output indicator Description**	**Baseline year 2022/2023**	**2024/25**	**2025/26**	**2026/27**	**2027/28**	**2028/29**	**End line target**	**Frequency of data collection**	**Data source**	**Lead Department**	**Associated department/ organization**
KRA	**8**	**KEY RESULT AREA 8:Nutrition in Water, Sanitation and Hygiene (WASH) promoted**													
Outcome	**8.0**	**Improved uptake of optimal WASH practices resulting from integration of nutrition in WASH**	**County wide**	**Reduced time taken at the water points (More than 30 Minutes)**	**53.20%**			**45%**		**35%**	**135%**	**After every 2 years**	**SMART Surveys**	**CDW**	**Partners**
			County wide	**Improved per capita water consumption**	**60.9% (SMART, 2023)**			**70.0 %**		**>75.0 %**	**>75.0%**	**After every 2 years**	**SMART Surveys**	**CDW/ CDH**	**Partners**
			County wide	**Improved handwashing practices at all 4 critical times**	**25.7% (SMART, 2023)**			**35.0 %**		**60.0 %**	**60.0%**	**After every 2 years**	**SMART Surveys**	**CDW/ CDH**	**Partners**
Output	***8.1***	***Increased access to Clean portable water to households and institutions***	***County wide***	***% of HHs accessing water from safe water sources***	***55.4% (SMART, 2023)***	***55.40 %***	***60.00 %***	***62.00 %***	***64.00 %***	***66.00 %***	***70.00%***	***Annually***	***Program Report***	***CDW/ CDH***	***Partners***
			County wide	***% of HHs reporting reduced time taken at the water points (More than 30 Minutes)***	***46.5% (SMART, 2023)***			***35.00 %***			***<35%***	***Annually***	***Program Report***	***CDW/ CDH***	***Partners***
			County wide	***% of HHs treating water at the point of use***	***31%***			***40.00 %***			***50.00%***	***Annually***	***Program Report***	***CDW/ CDH***	***Partners***
Activity	8.1.1	Training of WRUA's and communities on Protection and restoration of water catchment areas	County wide	Number of training sessions done	0	20	20	20	20	20	100	quarterly	Project reports	CDW/ Partners	CDH
Activity	8.1.2	Promote installation of rain water harvesting infrastructure in schools and homestead	County wide	Number of rain water harvesting systems installed	0	20	20	20	20	20	100	quarterly	Project reports	CDW/ Partners	CDH
Activity	8.1.3	Pipeline extension from existing water systems (last mile connectivity)	County wide	Number of connections done	0	20	20	20	20	20	100	quarterly	surveys	CDW/ Partners	CDH
Activity	8.1.4	Sensitization on household water treatment techniques	County wide	Number of sensitization sessions done	0	25	25	25	25	25	125	quarterly	Project reports	CDW/ Partners	CDH
Activity	8.1.5	Scale-up water quality surveillance	County wide	Number of water samples collected and tested	0	50	50	50	50	50	250	quarterly	KHIS	CDW/Partners	CDH
Output	***8.2***	***Appropriate WASH practices at the community level promoted***	***County wide***	***% Increase in HHs with Hand washing facilities***	***25%***	***25%***	***30%***	***35%***	***35%***	***35%***	***>40%***	***Annually***	***Program reports***	***CDH/ CDW***	***Partners***
			County wide	***% decrease in HH practicing O/D***	***63.0%***	***63.0 %***	***55.0 %***	***40%***	***40%***	***40%***	***<20***	***Annually***	***Program reports***	***CDH/ CDW***	***Partners***
			County wide	***% Increase in HH using improved sanitation facilities***	***37%***	***37%***	***39%***	***40%***	***41%***	***42%***	***>42%***	***Annually***	***Program reports***	***CDH/ CDW***	***Partners***
Activity	8.2.1	Sensitize community on appropriate WASH practices during community action or dialogue days	County wide	Number of sensitization sessions done	0	100	100	100	100	100	500	quarterly	Project reports	CDW/ CDH	Partners
Activity	8.2.2	Conduct targeted community led totals sanitation (CLTS) in areas affected most by poor sanitation	County wide	Number of rain water harvesting systems installed	0	20	20	20	20	20	100	quarterly	Project reports	CDW/ CDH	Partners
Activity	8.2.3	Support CHPs to conduct household visitation with key messaging on appropriate WASH practices	County wide	Number of connections done	0	20	20	20	20	20	100	quarterly	surveys	CDW/ CDH	Partners
Output	***8.3***	***The learning institution community is sensitized on linkage between nutrition and***	***County wide***	***% Increase in institutions supported to improve capacity on Nutrition in WASH***	***0%***	***10%***	***20%***	***30%***	***40%***	***50%***	***>50%***	***Annually***	***Project reports***	***CDW/ Partners***	***CDH***

		WASH													
Activity	8.3.1	Sensitize the learning institutions on the importance of point of use (POU) water treatment	County wide	Number of institutions sensitized	0	10	10	10	10	10	50	quarterly	Project reports	CDE/ CDH	Partners
Activity	8.3.2	Train school children and teachers on WASH and nutrition linkages	County wide	Number of sessions on linkage between sanitation and nutrition conducted in schools	0	60	60	60	60	60	300	quarterly	Project reports	CDE/ CDH	Partners
Activity	8.3.3	Conduct sensitization forums to BOMs on WASH and nutrition in learning institutions	County wide	Number of sensitization forums to BOMs on WASH and Nutrition	0	60	60	60	60	60	300	quarterly	Project reports	CDE/ CDH	Partners
				Number of BOMs sensitized	0	60	60	60	60	60	300	quarterly	Project reports	CDE/ CDH	Partners
Output	***8.4***	***Water users associations (WUA) and communities capacity build on Nutrition and WASH linkage***	***County wide***	***% Increase in functional mapped water sources***	***55%***	***55%***	***60%***	***60%***	***65%***	***70%***	***70%***	***Annually***	***Project reports***	***CDE/ CDH***	***Partners***
Activity	8.4.1	Sensitize the water user associations (WUA) and Community Water Committees on essential hygiene and household water treatment	County Wide	Number of WUAs/ Community Water Committees trained on essential hygiene and household water treatment	0	10	10	10	10	10	50	Annually	Project reports	CDE/CDH	Partners
Activity	8.4.2	Support WUA and CWCs to promote point of use water treatment to community members	County Wide	Number of CHPs trained on WASH and Nutrition linkages	0	150	150	150	150	150	750	Annually	Project reports	CDE/CDH	Partners
Activity	8.4.3	Train WUA and CWCs opportunities for linkage between nutrition and WASH (water treatment, hand water, human waste disposal, food handling hygiene etc.)	County Wide	Number of training sessions on WASH and Nutrition linkages	0	12	12	12	12	12	60	Annually	Project reports	CDE/CDH	Partners
Output	***8.5***	***Actors in the food preparation value chain capacity build on Nutrition and WASH linkage***	***County Wide***	***% increase in institutions practicing safe food preparation and handling***	***No data***	***25%***	***30%***	***35%***	***38%***	***40%***	***40%***	***Annually***	***Project reports***	***CDW/ CDH***	***Partners***
Activity	8.5.1	Conduct sensitization on safe and hygienic practices during food preparation and storage to school administrators, food handlers	county wide	No. of sensitization forums on safe and hygienic practices during food preparation and storage to school administrators and food handlers	0	10	10	10	10	10	50			CDH/Partners	2 Per Ward
Activity	8.5.2	sensitize schools and communities on integration of nutrition in WASH activities through ULTS, CLTS and sanitation marketing	county wide	Number of integrated sessions on ULTS and CLTS and sanitation marketing	14	15	15	15	15	15	75		CLTS Hub	CDH/Partners	1 per ward per year
Activity	8.5.3	Sensitize teachers and patrons on PHASE (personal hygiene and sanitation education) and promotion of handwashing with soap during critical times	county wide	Number of sensitization sessions on PHASE and Handwashing	0	24	24	24	24	24	24			CDH/Partners	
Level	***Code***	***KRA, Outcome, Output, Activity statement***	***Geographical coverage***	***Outcome/Output indicator Description***	***Baseline year 2022 / 2023***	***2023/ 24***	***2024/ 25***	***2025/ 26***	***2026/ 27***	***2027/ 28***	***End line target***	***Frequency of data collection***	***Data source***	***Lead Department***	***Associated department/ organization***
KRA	***9***	***KEY RESULT AREA 9: Nutrition Integrated across social protection programs***													
Outcome	***9***	***Nutrition Integrated across social protection programs***	***county wide***	***No. of social protection programs that are including nutrition in their programing***											
Output	***9.1***	***Improved Dietary diversity promoted in Social Protection programs***	***county wide***	***% Increase in proportion of HHs with improved household dietary diversity***	***0***			***Increase by 5%***		***Increase by 5%***	***Increase by 10%***	***Annually***	***Survey Report***	***CDSP, CDH***	***Line Ministries, Partners***
Activity	9.1.1	Conduct a baseline survey/situation analysis on status of nutrition and health for the vulnerable groups.	country wide	Baseline survey / situation analysis conducted	0	1	0	0	0	0	1	Once	Survey Report	CDH, CDSP	Line Ministries, Partners

Activity	9.1.2	Conduct assessment to establish gaps in linkages between nutrition and social protection programs in the county	country wide	assessment conducted	0	0	1	0	0	1	2	Bi-annually	Program reports	CDH, CDSP	Line Ministries, Partners
			county wide	No. of linkages established between nutrition and social protection	0	1	1	1	1	1	5	Annually	Training reports	CDH, CDSP	Line Ministries, Partners
Activity	9.1.3	In collaboration with social protection department conduct mapping and ranking of vulnerable households based on their vulnerability with nutrition status as part of criteria	county wide	Mapping conducted	0	Yes	Yes	Yes	Yes	Yes	Yes	Annually	Program reports	CDH, CDSP	Line Ministries, Partners
			county wide	Proportion of HHs ranked per priority	no data	5%	5%	5%	5%	5%	At least 25%	Annually	Program Reports	CDH, CDSP	Line Ministries, Partners
Activity	9.1.4	Promote and integrate nutrition in Social Protection programmes e.g. cash transfers, hunger safety nets, others.	county wide	No. of reported interventions on nutrition in social protection.	0	2	2	2	2	2	10	Quarterly	Training reports	CDH, CDSP	Line Ministries, Partners
Activity	9.1.5	mobilize financial resources for nutrition interventions in social protection programmes	county wide	No. of partners supporting nutrition interventions in social protection programmes.	0	0	1	1	1	1	4	Annually	Training reports	CDH, CDSP	Line Ministries, Partners
Activity	9.1.6	Link vulnerable households (affected by disaster or crisis) to food transfer programs (relief foods)	county wide	No of disaster affected HHs linked	no data	At least 20	At least 20	At least 20	At least 20	At least 20	At least 100	Annually	Program Report	CDH, CDSP	Line Ministries, Partners
Activity	9.1.7	Conduct nutrition screening for social protection families and linking the malnourished cases to the health facilities for support (IMAM and NCDs)	County wide	No of malnourished cases identified and referred appropriately	no data	20	20	20	20	20	100	Annually	Program Report	CDH, CDSP	Line Ministries, Partners
Activity	9.1.8	Support CHPs to conduct nutrition education to households targeted by social protection programs	county wide	Community Education sessions conducted	no data	4	4	4	4	4	20	Annually	Program Report	CDH, CDSP	Line Ministries, Partners
			county wide	No of HHs reached by Education sessions	no data	100	100	100	100	100	At least 5OO	Annually	Program Report	CDH, CDSP	Line Ministries, Partners
Activity	9.1.9	Link vulnerable households with the department of agriculture to be supported to improve food production (provision of farm tools, farming skills, kitchen gardens)	county wide	No. of vulnerable HHs linked with the Department of Agriculture	no data	At least 20	At least 20	At least 20	At least 20	At least 20	At least 100	Annually	Program Report	CDH, CDSP	Line Ministries, Partners
Output	***9.2***	***Care practices improved through linkage of Nutrition in Social Protection Programs***	***County wide***	***No. of households empowered and adopting care practice for improved nutrition.***	***no data***			***Increase by 5%***			***Increase by 10%***	***Annually***	***Program Report***	***CDH, National and CDSP***	***Line Ministries, Partners***
Activity	9.2.1	Support women to initiate Income Generating Activities to promote household income	County wide	No. of women Groups supported	0	10	10	10	10	10	50	Bi-annually	Program Report	CDH, CDSP	Line Ministries, Partners
			County wide	Proportion of HHs empowered	0%	10%	20%	30%	40%	50%	50%	Annually	Program Report	CDH, CDSP	Line Ministries, Partners
Activity	9.2.2	Promote male involvement in key messaging on childcare practices	County wide	No of Male involvement sensitization meetings	0	4	4	4	4	4	20	Annually	Program Report	CDH, CDSP	Line Ministries, Partners
			County wide	No of Male involved	0	250	250	250	250	250	250	Annually	Program Report	CDH, CDSP	Line Ministries, Partners
Activity	9.2.3	Targeted employer education on empowering women to promote optimal childcare practices while	county wide	No. of Employer Sensitization sessions	0	1	1	1	1	1	5	Annually	Program Report	CDH, CDSP	Line Ministries, Partners

		ensuring productivity at work (educating employers on labour laws, breastfeeding policies)	County wide	No of women empowered	0	250	250	250	250	250	1250	Annually	Program Report	CDH, CDSP	Line Ministries, Partners
Activity	9.2.4	Promote Village Savings and Loans Activities (VSLAs) to empower women to improve care practices	County wide	No of men engaged	0	250	250	250	250	250	1250	Annually	Program Report	CDH, CDSP	Line Ministries, Partners
			County wide	No. of joint activities between health sector and social protection	0	1	1	1	1	1	5	Annually	Program Report	CDH, CDSP	Line Ministries, Partners
			County wide	No of stakeholders mapped	0	3	3	3	3	3	15	Annually	Program Report	CDH, CDSP	Line Ministries, Partners
Activity	9.2.5	Advocate for nutrition safety and security of families by addressing threats affecting PWD, infant and young children nutrition.	County wide	No of stakeholders trained on good nutrition practices	0	50	50	50	50	50	250	Annually	Program Report	CDH, CDSP	Line Ministries, Partners
			County wide	No of baseline surveys conducted on nutrition status for the vulnerable groups	0	0	0	1	0	0	1	Annually			
Activity	9.2.6	Empower women and make them the recipients of social protection benefits, focusing on increasing women's access to education on nutrition, assets and resources, while at the same time considering women's work burden and time constraints.	County wide	No of people/Institutions sensitized on health and nutrition.	0	0	50	50	50	50	200	Annually	Program Report	CDH, CDSP	Line Ministries, Partners
			County wide	No of meetings/campaigns on harmonization of nutrition and SPS	0	0	2	2	1	1	6	Annually			
			County wide	No. of vulnerable groups linked to nutritional services through S/NHIF	0	250	250	250	250	250	1250	Annually			
Activity	9.2.7	Engage men when addressing gender issues to strengthen the positive impact of social protection on nutrition.	County wide	No of male engagement sessions conducted	no data	4	4	4	4	4	4	Annually	Program Report	CDH, CDSP	Line Ministries, Partners
Output	***9.3***	***Healthy household environment and health services advocated for in Social Protection Programs***	***county wide***	***No. of HHs in social protection reached with WASH and nutrition interventions***	***0 (SMART 2023)***			***Increase by 10%***			***Increase by 10%***	***Every 2 - 3 years***	***Assessment Reports***	***CDH, National and CDSP***	***Line Ministries, Partners***
			county wide	***No. of HHs reporting Improved WASH and nutrition practices***	***0 (SMART 2023)***			***Increase by 10%***			***Increase by 10%***	***Every 2 - 3 years***			
Activity	**9.3.1**	Link vulnerable households with Water Department for support to accessible safe drinking water (last mile connectivity, targeted for improved water sources)	county wide	No of HHs linked Water Department for support to access safe drinking water	No data	50	50	50	50	50	250	Annually	Program Report	CDH, National and CDSP	Line Ministries, Partners
Activity	9.3.2	Link vulnerable households with the available Social Health Authority(SHA)	county wide	No of HHs linked with the available social departments	No data	50	50	50	50	50	250	Annually	Program Report	CDH, National and CDSP	Line Ministries, Partners
Activity	9.3.3	Support CHPs to conduct household visitation promoting appropriate WASH practices to households targeted by social protection programs	county wide	No of CHPs supported to conduct	0	50	50	50	50	50	250	Annually	Program Report	CDH, National and CDSP	Line Ministries, Partners
			county wide	No of HH visitations conducted	0	50	50	50	50	50	250	Semi-annually			
Activity	9.3.4	Targeting support groups (HIV/AIDS, OVCs, Elderly, Youths) with key messaging on appropriate WASH and Nutrition practices during their meetings	county wide	No of key messaging education sessions conducted	0	4	4	4	4	4	20	Semi-annually	Program Report	CDH, National and CDSP	Line Ministries, Partners
Output	***9.4***	***Coordination activities for Nutrition mainstreaming in Social Protection Program promoted***	***county wide***	***Proportion of social protection programs integrating nutrition-sensitive interventions***	***0***			***5%***			***10%***	***Annually***	***Program Report***	***CDH, National and CDSP***	***Line Ministries, Partners***
Activity	9.4.1	Conduct Key stakeholder mapping	county wide	No of stakeholder sensitization sessions	0	Yes		Yes		Yes	Yes	Bi-annually	Program Report	CDH, National and	Line Ministries, Partners

														CDSP	
Activity	9.4.2	Sensitize stakeholders on nutrition and social protection programs linkage opportunities.	county wide		0	2	2	2	2	2	10	Annually	Program Report	CDH, National and CDSP	Line Ministries, Partners
	9.4.3	Advocate for the linkage of nutrition services and Social Protection for all vulnerable groups to S/NHIF.	county wide	No of advocacy meetings conducted	0	1	1	1	1	1	5	Annually	Program Report	CDH, National and CDSP	Line Ministries, Partners
Activity	9.4.4	Conduct monitoring and evaluation of nutrition and social protection programs linkage progress	county wide	No of monitoring sessions conducted	0	1	1	1	1	1	5	Annually	Program Report	CDH, National and CDSP	Line Ministries, Partners
Activity	9.4.5	Conduct research to inform implementation of social assistance interventions in health and nutrition, and a transfer and graduation practice of beneficiaries of nutrition inclusion in social protection programs.	county wide	Research conducted	0	1					1	Once every 5 years	Program Report	CDH, National and CDSP	Line Ministries, Partners
Activity	9.4.6	Advocate for social protection schemes that promote adoption of positive behaviors (for instance, cash transfer programs that promote Growth monitoring, pre and post-natal care services)	county wide	No of advocacy meetings conducted	0	1	1	1	1	1	5	Annually	Program Report	CDH, National and CDSP	Line Ministries, Partners
Activity	9.4.7	Advocate for harmonization of nutrition and social protection services for vulnerable groups	county wide	No of advocacy meetings conducted	0	1	1	1	1	1	5	Annually	Program Report	CDH, National and CDSP	Line Ministries, Partners
Level	**Code**	**KRA, Outcome, Output, Activity statement**	**Geographical coverage**	**Outcome/ Output indicator Description**	**Baseline year 2022/2023**	**2024/25**	**2025/26**	**2026/27**	**2027/28**	**2028/29**	**End line target**	**Frequency of data collection**	**Data source**	**Lead Department**	**Associated department/ organization**
KRA	**10**	**KEY RESULT AREA 10: Sectoral and multisectoral Nutrition Information Systems, Learning and Research strengthened**													
Outcome		**Improved nutrition data quality for decision making**	**County wide**	**Number of policies/ programmes informed by research**	**0**			**1**			**1**	**Annually**	**Program Report**	**CDH**	**Line Ministries & partners**
Output	***10.1***	***Nutrition information and reporting system strengthened in the county***	***County wide***	***County Nutrition Repository developed***	***0***				***1***		***1***	***Annually***	***Program reports, KHIS***	***CDH***	***Line Ministries & partners***
				Proportion of health facility with monthly reporting rate of 100%	***3%***				***40%***		***60%***	***Annually***			
				Common Results Framework for the multisector stakeholders developed	***0***	***1***					***1***	***Every 5 years***			
Activity	10.1.1	Conduct quarterly Data Quality Audits at the Sub County level	County wide	# of Data Quality Audits conducted(per Sub County)	4	20	20	20	20	20	100	Quarterly	Supervision Reports	CDH	Line Ministries & partners
Activity	10.1.2	Conduct quarterly county support supervision	County wide	#of support supervision conducted at county level(Per Sub County)	2	20	20	20	20	20	100	Quarterly	Supervision Reports	CDH	Line Ministries & partners
Activity	10.1.3	Conduct monthly sub county support supervision	County wide	#of support supervision conducted at sub county level(per Sub County)	3	60	60	60	60	60	300	Monthly	Program reports	CDH	Line Ministries & partners
Activity	10.1.4	Conduct quarterly performance review meetings	County wide	Number of performance review meetings conducted at county level	1	4	4	4	4	4	20	Quarterly	Program reports	CDH	Line Ministries & partners
Activity	10.1.5	conduct monthly in charges meeting at sub county level	County wide	Number of performance review meetings conducted at sub county level	No data	20	20	20	20	20	100	Quarterly	Program reports	CDH	Line Ministries

															& partners
Activity	10.1.6	Train health workers on health information and reporting systems (LMIS, KHIS,	County wide	Number of health workers trained on health information and reporting systems	35	25	25	25	25	25	125	Annually	Program reports	CDH	Line Ministries & partners
Activity	10.1.7	Quantify, forecasting and procure nutrition reporting tools (BFCI, IMAM, WIFS and MCH tools)	County wide	Number of nutrition set of tools and registers printed (set is equivalent to 5 registers)	50	100	100	100	100	100	500	Annually	Program reports	CDH	Line Ministries & partners
Activity	10.1.8	Sensitize members of the multisectoral platform on NDMA monthly bulletins, Integrated Phase Classification interpretation	County wide	number of multisector members sensitized on NDMA bulletin and IPC	0	30	30	30	30	30	150	Annually	NDMA Monthly Bulletin	CDH, NDMA	Line Ministries & partners
Activity	10.1.9	Conduct Quarterly review meetings NDMA sentinel sites reports	County wide	Number of review meetings conducted on NDMA sentinel sites reports	0	4	4	4	4	4	20	Monthly	NDMA Monthly Bulletin	CDH, NDMA	Line Ministries & partners
Activity	10.1.10	Participate in annual Short Rains Assessment and Long Rains assessment review meetings	County wide	Number of Rain assessment review meetings participated	2	2	2	2	2	2	10	Annually	Minutes	CDH, NDMA	Line Ministries & partners
Activity	10.1.11	Conduct KAP survey	County wide	Number of KAP surveys conducted	0	1	0	0	1	0	2	Biannually	Work Plans	CDH	Line Ministries & partners
Activity	10.1.12	Conduct SMART Survey	County wide	Number of SMART surveys conducted	1	0	1	0	1	0	2	Biannually	Work Plans	CDH	Line Ministries & partners
Activity	10.1.13	Conduct a midterm and end reviews of the CNAP	County wide	No. of reviews of the CNAP conducted	0	0	0	1	0	1	2	Annually	Work plans	CDH	Line Ministries & partners
Activity	10.1.14	Hold forums to disseminate nutrition research findings and information	County wide	Number of research dissemination forums conducted	2	2	2	2	2	2	8	Annually	Work plans	CDH	Line Ministries & partners
Activity	10.1.15	Develop joint Annual Work Plans with Multisector stakeholders	County wide	Number of joint work plans developed for the multisector platform	0	1	1	1	1	1	5	Annually	Work Plan Document	CDH	Line Ministries & partners
Activity	10.1.16	Conduct workshop to validate TOR for the multisector stakeholders	County wide	TOR for the multisector platform validated	0	1	1	1	1	1	5	Annually	TOR Document	CDH	Line Ministries & partners
Activity	10.1.17	Train County data analysts on conducting and analyzing Integrated Phase Classification	County wide	Number of data analyst trained in the county	1	5	5	5	5	5	25	annually	Multisector Platform Report	CDH	Line Ministries & partners
Activity	10.1.18	Conduct a workshop to develop a Common Results Framework for the Multisector Stakeholders	County wide	Common Results Framework for the multisector stakeholders developed	0	1	0	0	0	0	1	Annually	Multisector Platform Report	CDH	Line Ministries & partners
Activity	10.1.19	Nutrition monthly situational analysis bulletin	County wide	Developed and disseminated	0	12	12	12	12	12	60	Monthly	Program reports	CDH	Line Ministries & partners
Activity	10.1.20	Conduct IMAM coverage assessment (SQUEAC survey)	County wide	Coverage survey conducted	0		1			1	2	Every 2-3 years	Program reports	CDH	Line Ministries & partners
Output	***10.2***	***Nutrition Research in Kajiado County Strengthened***	***County wide***	***Number of policies/programmes informed by research***	***0***				***1***		***1***	***Every 5 years***	***Program reports***	***CDH***	***Line Ministries & partners***
Activity	10.2.1	Development of Nutrition policy briefs	County wide	Number of policy briefs developed	0	1	1	1	1	1	5	Annually	Multisector Platform Report	CDH	Line Ministries & partners
Activity	10.2.2	Documentation of innovations and best practices	County wide	Number of documentaries for best practices and innovations done	No data	1	1	1	1	1	5	Annually	Multisector Platform Report	CDH	Line Ministries & partners

Activity	10.2.3	Conduct knowledge sharing forums (conferences, seminars, summits)	County wide	Number of knowledge sharing forums held	No data	0	0	1	0	1	2	Annually	Multisector Platform Report	CDH	Line Ministries & partners
Activity	10.2.4	Conduct nutrition Operational Research.	County wide	Number of Operational Research conducted.	No data	0	1		1	0	2	Annually	Multisector Platform Report	CDH	Line Ministries & partners
Activity	10.2.5	Establish a repository for nutrition data	County wide	Number of repositories for nutrition data established and maintained		1	1	1	1	1	5	Annually	Multisector Platform Report	CDH	Line Ministries & partners
Level	**Code**	**KRA, Outcome, Output, Activity statement**	**Geographical coverage**	**Outcome/Output indicator Description**	**Baseline year 2023/ 2024**	**2024/ 25**	**2025/ 26**	**2026/ 27**	**2027/ 28**	**2028/ 29**	**End line target**	**Frequency of data collection**	**Data source**	**Lead Department**	**Line Ministries & partners**
KRA	**11**	**Sectoral and multisectoral nutrition governance, coordination, legal/frameworks, leadership and advocacy**													
Outcome	**11.0**	**Enhanced commitment and continued prioritization of nutrition in county agenda**	**County wide**	**% increase of budgetary allocation for nutrition program**	**no data**			**20.00 %**			**40%**	**Annually**	**Signed grants, Policy documents**	**CDH/ County AG**	**Line ministries & Partners**
Output	***11.1***	***Enhanced implementation of regulatory frameworks, policies and acts***	***County wide***	***No. of legal frameworks developed and disseminated***	***no data***			***1***			***1***	***Annually***	***Reports, minutes, MEMOs***	***CDH/ County AG***	***Line ministries & Partners***
Activity	11.1.1	Create awareness on legal documents e.g. BMS act, workplace support to decision-makers	County wide	No of awareness creation sessions on regulatory acts and policies conducted	0	1	1	1	1	1	5	Annually	Program Reports	CDH	Line Ministries & partners
Activity	11.1.2	Conduct sensitization meetings to health care workers on legal documents	County wide	No of sensitization meetings conducted	0	1	1	1	1	1	5	Annually	Program Reports	CDH	Line Ministries & partners
Activity	11.1.3	Domesticate nutrition guidelines/policies	County wide	# of guidelines nutrition developed/ domesticated	1	0	1	0	1	0	2	Annually	Program Reports	CDH	Line Ministries & partners
Activity	11.1.4	Development of nutrition Acts	County wide	# of Nutrition Acts developed	0	0	1	0	0	1	2	Annually	Program Reports	CDH	Line Ministries & partners
Output	***11.2***	***Enhanced Nutrition Advocacy, Communication, Social & Mobilization***	***County wide***	***No. of advocacy sessions conducted***	***no data***			***5***			***10***	***Annually***	***signed grant, program report***	***CDH/ County AG***	***Line ministries & Partners***
Activity	11.2.1	Conduct advocacy meetings with MCA, county budgetary allocation committee and executive committee members in the county to advocate for increased resource allocation for nutrition human resource, nutrition medical camps, nutrition equipment and commodities.	County wide	No of advocacy meetings held	1	1	1	1	1	1	5	Annually	Program Reports	CDH	Line ministries & Partners
Activity	11.2.2	Participate in the budgetary planning meetings	County wide	No of budgetary planning meetings carried out	1	1	1	1	1	1	5	Annually	Program Reports	CDH	Line ministries & Partners
Activity	11.2.3	Proposal development for resource mobilization	County wide	% of the budget proposal funded	0	50%	50%	50%	50%	75%	50%	Annually	Program Reports	CDH	Line ministries & Partners
			County wide	# of resource mobilization proposals developed	0	0	1	1	1	1	4	Annually	Program Reports	CDH	Line ministries & Partners
Activity	11.2.4	Commemoration of health and nutrition days	County wide	No of health and nutrition days celebrated inclusive of days of line ministries	8	11	11	11	11	11	55	Annually	Program Reports	CDH	Line ministries & Partners
Activity	11.2.5	Identify opportunities for private sector engaged in nutrition	County wide	No. of activities that private sector has been engaged in	0	1	1	1	1	1	5	Annually	Program Reports	CDH	Line ministries

		activities													& Partners
Activity	11.2.6	Identify and engage nutrition champions	County wide	Nutrition champion identified and engaged	0	1	1	1	1	1	1	Annually	Program Reports	CDH	Line ministries & Partners
Output	***11.3***	***strengthen multisectoral nutrition coordination***	***County wide***	***# of MSP meetings held***	***4***			***4***			***4***	***Bi-annually***	***Reports, minutes***	***CDH***	***Line ministries & Partners***
Activity	11.3.1	Map stakeholders for engagement	County wide	# of relevant nutrition stakeholders mapped	**No data**						**Yes**	Annually	Program Report	**CDH**	Line ministries & Partners
Activity	11.3.2	Conduct nutrition multisectoral engagement	County wide	# of multisectoral engagement	4	4	4	4	4	4	20	Quarterly	Program Reports	CDH	Line ministries & Partners
Activity	11.3.3	Hold Nutrition Multisectoral taskforce meetings	County wide	# of taskforce engagement		1	1	1	1	1	5	Annually	Program Reports	CDH	Line ministries & Partners
Activity	11.3.4	Conduct Quarterly County Nutrition Technical Forums	County wide	# of CNTF meetings held	4	4	4	4	4	4	20	Quarterly	Program Reports	CDH	Line ministries & Partners
Activity	11.3.5	Conduct monthly Sub County Nutrition Technical Forums	County wide	# of SCNTF meetings held	0	60	60	60	60	60	300	Quarterly	Program Reports	CDH	Line ministries & Partners
Output	***11.4***	***Increased human resource for nutrition, equipment and commodities ensured***	***County wide***	***# of budget cycles with Nutrition program budget allocation***	***no data***			***2***			***5***	***Annually***	***Signed grants, Program Reports***	***CDH***	***Line ministries & Partners***
Activity	11.4.1	Support attendance of budget hearing meetings and advocate for funding of nutrition actions	County wide	No. of persons and sessions supported	0	5	5	5	5	5	25	Annually	Program Reports	CDH	Line ministries & Partners
Activity	11.4.2	Develop advocacy fact sheets on nutrition financing and nutrition briefs for use	County wide	No of advocacy fact sheets developed	0	1	1	1	1	1	5	Annually	Program Reports	CDH	Line ministries & Partners
Activity	11.4.3	Conduct nutrition awareness sessions for teachers and BOM on optimal nutrition	County wide	No of awareness creation sessions conducted	0	3	3	3	3	3	15	Annually	Program Reports	CDH	Line ministries & Partners
Activity	11.4.4	Conduct nutrition awareness sessions for caregivers	County wide	No of awareness creation sessions conducted	0	20	20	20	20	20	100	quarterly	Program Reports	CDH	Line ministries & Partners
Output	***11.5***	***Awareness creation on healthy diet and physical, general optimal nutrition activities intensified***	***County wide***	***% increase in awareness creation sessions on healthy lifestyle diets conducted***	***no data***			***20%***			***40%***	***Annually***	***Program Reports***	***CDH***	***Line ministries & Partners***
Activity	11.5.1	Incorporate awareness session creation on physical activity and lifestyle habits with the local media	County wide	No of awareness creation sessions conducted	0	5	5	5	5	5	25	Annually	Program Reports	CDH	Line ministries & Partners
Activity	11.5.2	disseminate relevant policies and guidelines on health diets and NCDs to HCW	County wide	No of policies and guidelines customized and disseminated	0	1	1	1	1	1	5	Annually	Program Reports	CDH	Line ministries & Partners
Activity	11.5.3	Hold awareness sessions on healthy feeding habits to adolescent boys and girls across all diversities	County wide	No of awareness creation sessions conducted	0	2	2	2	2	2	10	Annually	Program Reports	CDH	Line ministries & Partners
Activity	11.5.4	Hold education awareness forums on lifestyle and dietary diversification and good nutrition	County wide	No of education awareness forums held	0	15	15	15	15	15	75	Annually	Program Reports	CDH	Line ministries & Partners
Activity	11.5.5	Design, develop, print and disseminate IEC materials for nutrition	County wide	No of IEC Materials designed, developed, printed and disseminated	0	1	-	-	1	-	2	Annually	Program Reports	CDH	Line ministries & Partners

Activity	11.5.6	Train CHPs on community nutrition module 8	County wide	No of CHPs trained on Nutrition module 8	0	264	264	264	264	264	1320	Annually	Program Reports	CDH	Line ministries & Partners
Level	**Code**	**KRA, Outcome, Output, Activity statement**	**Geographical coverage**	**Outcome/Output indicator Description**	**Baseline / year 2022 / 2023**	**2024/25**	**2025/26**	**2026/27**	**2027/28**	**2028/29**	**End line target**	**Frequency of data collection**	**Data source**	**Lead Department**	**Line ministries & Partners**
KRA	**12**	**KEY RESULT AREA 12; Strengthen supply chain management for nutrition commodities and equipment**													
Outcome	**12.0**	**Uninterrupted supply and use of nutrition commodities and Anthropometric equipment at the health facilities sustained**	**County wide**	**Facilities submitting timely reports 733**	**20% (LMIS/ KHIS)**	**40.0%**	**50.0%**	**60.0%**	**70.0%**	**80.0%**	**>80%**	**Annually**	**LMIS/ KHIS**	**CDH**	**Line ministries & Partners**
			County wide	**Proportion of facilities supplied with nutrition commodities in the county**	**87.7% (LMIS/ KHIS)**			**93.8%**			**100%**	**Annually**	**LMIS/ KHIS**	**CDH**	**Line ministries & Partners**
			County wide	**Reduced proportion of Health facilities reporting nutrition commodity stock outs**	**21.2% (28 out of 132 OTP Centers, Coverage survey)**	**21.0%**	**18.0%**	**15.0%**	**10.0%**	**5.0%**	**<5%**	**2 - 3 years**	**Coverage survey**	**CDH**	**Line ministries & Partners**
Output	***12.1***	***Enhanced uninterrupted supply of nutrition commodities and equipment***	***County wide***	***Proportion of facilities supplied with nutrition commodities in the county***	***87.7% (LMIS/ KHIS)***			***93.8 %***			***100%***	***Annually***	***LMIS/ KHIS***	***CDH***	***Line ministries & Partners***
Activity	12.1.1	Procurement of nutrition commodities	County wide	Proportion of nutrition commodities procured	40%	60%	80%	100 %	100 %	100 %	100%	monthly	LMIS/KHIS	CDH	Line ministries & Partners
Activity	12.1.2	Delivering of nutrition commodities to health facilities	County wide	Proportion of nutrition commodities delivered	60%	80%	100 %	100 %	100 %	100 %	100%	Monthly	LMIS/KHIS	CDH	Line ministries & Partners
Activity	12.1.3	Purchase of anthropometric equipment	County wide	Proportion of anthropometric equipment purchased	30%	50%	80%	100 %	100 %	100 %	100%	Quarterly	RECORDS	CDH	Line ministries & Partners
Output	***12.2***	***Capacity of healthcare workers in nutrition supply chain management enhanced***	***County wide***	***Proportion of Healthcare workers with improved capacity on nutrition supply chain management***	***<10%***	***10%***	***20%***	***30%***	***40%***	***50%***	***>50%***	***Annually***	***Program Report***	***CDH***	***Line ministries & Partners***
			County wide	***Proportion of health facilities reporting on LMIS***	***20%***	***30%***	***40%***	***60%***	***80%***	***100 %***	***100%***	***Annually***	***Program Report***	***CDH***	***Line ministries & Partners***
Activity	12.2.1	Conduct Quarterly Joint supportive supervision on nutrition commodities and warehousing	County wide	No. of support supervision conducted	1	8	8	8	8	8	41	Quarterly	Program Report	CDH	Line ministries & Partners
Activity	12.2.2	Conduct targeted OJT on nutrition commodities and warehousing	County wide	No. of OJTs conducted	7	8	8	8	8	8	47	Quarterly	Program Report	CDH	Line ministries & Partners
Activity	12.2.3	Train health care workers on the use of KHIS	County wide	No. of healthcare workers trained	10	25	25	25	25	25	135	Quarterly	Program Report	CDH	Line ministries & Partners
Activity	12.2.4	Scale up the use of LMIS in all health facilities	County wide	No. of facilities using LMIS	8500	8925	9350	9775	10200	10625	5%	Quarterly	Program Report	CDH	Line ministries & Partners
Activity	12.2.5	Conduct monthly data review meetings on nutrition commodities	County wide	No. of data review meetings conducted	0	2	2	2	2	2	10	Quarterly	Program Report	CDH	Line ministries & Partners
Activity	12.2.6	Conduct quarterly Routine DQAs on nutrition commodities	County wide	No. of Routine DQAs conducted	7	8	8	8	8	8	8%	Quarterly	Program Report	CDH	Line ministries & Partners

Annex 2: Summary Table Resources Needs by KRA, Outputs and Activities

Level	Code	KRA, Outcome, Output, Activity statement	2023/24	2024/25	2025/26	2026/27	2027/28	Total Cost (Ksh)
		TOTAL CNAP COST	**749,400,749**	**700,431,149**	**698,262,949**	**683,033,149**	**678,703,749**	**3,509,851,745**
KRA	**1**	**KEY RESULT AREA 1: Maternal, Infant and Young Child Nutrition (MIYCN) Scaled Up**	**88,552,861**	**87,537,861**	**87,537,861**	**87,537,861**	**87,537,861**	**438,704,305**
Outcome	**1.0**	**Increased proportion of care givers who practice optimal behaviors for improved nutrition of young children under five years**	**-**	**-**	**-**	**-**	**-**	**-**
output	**1.1**	**MIYCN services provided at all health service delivery points**	**17,313,000**	**17,313,000**	**17,313,000**	**17,313,000**	**17,313,000**	**86,565,000**
Activity	1.1.1	Training of Health Care workers on Baby Friendly Hospital Initiative.	2,823,500	2,823,500	2,823,500	2,823,500	2,823,500	**14,117,500**
Activity	1.1.2	Training of Health Care workers on Baby Friendly Community Initiative.	3,099,500	3,099,500	3,099,500	3,099,500	3,099,500	**15,497,500**
Activity	1.1.3	Sensitization of health care workers on growth monitoring for children <5	4,760,000	4,760,000	4,760,000	4,760,000	4,760,000	**23,800,000**
Activity	1.1.4	Sensitization of health care workers on screening for malnutrition among pregnant and lactating mothers at ANC and PNC	860,000	860,000	860,000	860,000	860,000	**4,300,000**
Activity	1.1.5	Targeted Continuous Medical Education to HCW on BFHI and BFCI.	45,000	45,000	45,000	45,000	45,000	**225,000**
Activity	1.1.6	Baby Friendly Hospital Initiative assessment and certification	161,000	161,000	161,000	161,000	161,000	**805,000**
Activity	1.1.7	Screening for malnutrition among pregnant and lactating mothers at ANC.	-	-	-	-	-	**-**
Activity	1.1.8	conduct Growth monitoring for children under five years conducted at all service delivery points.	-	-	-	-	-	**-**
Activity	1.1.9	conduct Nutrition education / counselling during ANC and PNC clinics on early initiation of breastfeeding	-	-	-	-	-	**-**
Activity	1.1.10	conduct Nutrition education /counselling on exclusive breastfeeding.	-	-	-	-	-	**-**
Activity	1.1.11	conduct Nutrition education/counselling on complementary feeding for children 6-24 months.	-	-	-	-	-	**-**

Activity	1.1.12	conduct Nutrition education/counselling on maternal nutrition to women of productive age	-	-	-	-	-	-
Activity	1.1.13	Conduct cooking demos using locally available foods on complementary feeding at the health facility	20,000	20,000	20,000	20,000	20,000	**100,000**
Activity	1.1.14	Conduct quarterly BFHI and BFCI support supervision	3,168,000	3,168,000	3,168,000	3,168,000	3,168,000	**15,840,000**
Activity	1.1.15	Conduct Mentorship/OJT sessions	2,376,000	2,376,000	2,376,000	2,376,000	2,376,000	**11,880,000**
output	**1.2**	**MIYCN activities integrated at community level**	**16,634,800**	**16,634,800**	**16,634,800**	**16,634,800**	**16,634,800**	**83,174,000**
Activity	1.2.1	Conduct community sensitization on key messaging on appropriate MIYCN practices	-	-	-	-	-	-
Activity	1.2.2	Training of TOTs on BFCI	425,600	425,600	425,600	425,600	425,600	**2,128,000**
Activity	1.2.3	Implement BFCI 10 steps in all CHUS- (unit cost per CHU for all the 10 steps)	11,880,000	11,880,000	11,880,000	11,880,000	11,880,000	**59,400,000**
Activity	1.2.4	Conduct semiannual BFCI self-assessment - Baseline, Internal and External	942,400	942,400	942,400	942,400	942,400	**4,712,000**
Activity	1.2.5	Training of CHPs on BFCI	2,054,800	2,054,800	2,054,800	2,054,800	2,054,800	**10,274,000**
Activity	1.2.6	Hold community dialogue meetings on MIYCN	900,000	900,000	900,000	900,000	900,000	**4,500,000**
Activity	1.2.7	conduct childcare facility monitoring	432,000	432,000	432,000	432,000	432,000	**2,160,000**
output	**1.3**	**Enabling environment for adoption of recommended MIYCN practices reinforced**	**3,861,600**	**2,846,600**	**2,846,600**	**2,846,600**	**2,846,600**	**15,248,000**
	1.3.1	sensitize CHMT / SCHMT on relevant policies and bills	285,600	285,600	285,600	285,600	285,600	**1,428,000**
	1.3.2	Sensitize Employers/managers on BMS Act and Child Care Policy.	1,012,000	1,012,000	1,012,000	1,012,000	1,012,000	**5,060,000**
Activity	1.3.3	sensitize BMS enforcers (PHO)	1,052,000	1,052,000	1,052,000	1,052,000	1,052,000	**5,260,000**
Activity	1.3.4	Establish breastfeeding space in social and workplaces	1,512,000	497,000	497,000	497,000	497,000	**3,500,000**
output	**1.4**	**Optimal MIYCN practices sustained during emergencies**	**2,624,880**	**2,624,880**	**2,624,880**	**2,624,880**	**2,624,880**	**13,124,400**
Activity	1.4.1	Train health workers on MIYCN e	1,440,000	1,440,000	1,440,000	1,440,000	1,440,000	**7,200,000**
Activity	1.4.2	Sensitize of CHPs on MIYCN e	569,880	569,880	569,880	569,880	569,880	**2,849,400**
Activity	1.4.3	Sensitize community members on MIYCN e	315,000	315,000	315,000	315,000	315,000	**1,575,000**
Activity	1.4.4	Conduct Rapid Assessment during emergencies	300,000	300,000	300,000	300,000	300,000	**1,500,000**
output	**1.5**	**Strengthened Kangaroo Mother Care**	**3,683,800**	**3,683,800**	**3,683,800**	**3,683,800**	**3,683,800**	**18,419,000**
Activity	1.5.1	Train TOTs on KMC	480,000	480,000	480,000	480,000	480,000	**2,400,000**
Activity	1.5.2	Train HCW on KMC	1,800,000	1,800,000	1,800,000	1,800,000	1,800,000	**9,000,000**

Activity	1.5.3	sensitize CHPs on KMC	111,800	111,800	111,800	111,800	111,800	**559,000**
Activity	1.5.4	Scaling up KMC - KMC Kits (equipping KMC sites)	500,000	500,000	500,000	500,000	500,000	**2,500,000**
Activity	1.5.5	Sensitizing Birth Companions on KMC	-	-	-	-	-	-
Activity	**1.5.6**	Conduct supervision monitoring for improved quality of care	792,000	792,000	792,000	792,000	792,000	**3,960,000**
output	**1.6**	**Behavior change on diverse micronutrient intake to prevent micronutrient deficiency prevention promoted in the community level**	**34,975,600**	**34,975,600**	**34,975,600**	**34,975,600**	**34,975,600**	**174,878,000**
Activity	1.6.1	Train HCWs on relevant guidelines and policies on macronutrients deficiencies	23,600,000	23,600,000	23,600,000	23,600,000	23,600,000	**118,000,000**
Activity	1.6.2	Sensitize community health promoters on prevention and control of micronutrient deficiencies.	2,860,800	2,860,800	2,860,800	2,860,800	2,860,800	**14,304,000**
Activity	1.6.3	Conduct health education to the community members(equally targeting men and women across different ages and diversities) on prevention and control of micronutrient deficiencies	3,819,600	3,819,600	3,819,600	3,819,600	3,819,600	**19,098,000**
Activity	1.6.4	Educate the community on production, preservation and consumption of micronutrient rich foods at household level	2,347,600	2,347,600	2,347,600	2,347,600	2,347,600	**11,738,000**
Activity	1.6.5	Conduct health education to the community on dietary diversity, bio-fortified foods	2,347,600	2,347,600	2,347,600	2,347,600	2,347,600	**11,738,000**
output	**1.7**	**Women of reproductive age and children 6-59months in the county optimally supplemented**	**9,459,181**	**9,459,181**	**9,459,181**	**9,459,181**	**9,459,181**	**47,295,905**
Activity	1.7.1	Supplement pregnant women with IFA	420,000	420,000	420,000	420,000	420,000	**2,100,000**
Activity	1.7.2	Supplement children 6 -59months years of age with vitamin A (procure vitamin A Capsule)	2,485,321	2,485,321	2,485,321	2,485,321	2,485,321	**12,426,605**
Activity	1.7.3	Supplement children 12 -59months years of age with dewormers	742,500	742,500	742,500	742,500	742,500	**3,712,500**
Activity	1.7.4	Educate the community member on production, preservation and consumption of micronutrient rich foods at household level	2,347,600	2,347,600	2,347,600	2,347,600	2,347,600	**11,738,000**
Activity	1.7.5	Conduct health education to the community members on dietary diversity and bio diversification	2,347,600	2,347,600	2,347,600	2,347,600	2,347,600	**11,738,000**
Activity	1.7.6	Sensitize HCWs on documentation and micronutrient reporting of Vitamin A, IFAS from the community level up to the DHIS	1,116,160	1,116,160	1,116,160	1,116,160	1,116,160	**5,580,800**
Level	**Code**	**Statement (KRA, Outcome, output, activity)**	**2023/24**	**2024/25**	**2025/26**	**2026/27**	**2027/28**	**Total (Ksh)**
KRA	**2**	**KEY RESULT AREA 2: Nutrition for Older children, Adolescents, Adults & Older persons**	**16,247,040**	**16,411,740**	**16,411,740**	**16,466,640**	**16,247,040**	**81,804,200**

		promoted						
Outcome	**2.0**	**Improved nutrition well-being of Older children, Adolescents, Adults and Older persons in Kajiado County**	-	-	-	-	-	-
output	**2.1**	**Enhanced skills of health care workers and community health volunteers on nutrition for older children and adolescent**	**5,073,240**	**5,073,240**	**5,073,240**	**5,073,240**	**5,073,240**	**25,366,200**
Activity	2.1.1	Sensitize C/SCHMT members on relevant Nutrition policies and guidelines	674,240	674,240	674,240	674,240	674,240	**3,371,200**
Activity	2.1.2	Sensitize health workers, Education and Agriculture officers on adolescent Nutrition policies and guidelines	602,000	602,000	602,000	602,000	602,000	**3,010,000**
Activity	2.1.3	sensitize community health volunteers on nutrition policies and guidelines	3,109,000	3,109,000	3,109,000	3,109,000	3,109,000	**15,545,000**
Activity	2.1.4	Dissemination of formulated policy on feeding older children to Health care workers (68 Nutritionists and 132 facility in-charges)	688,000	688,000	688,000	688,000	688,000	**3,440,000**
output	**2.2**	**Malnourished children in schools and community detected early for treatment and referral**	**5,692,400**	**5,692,400**	**5,692,400**	**5,692,400**	**5,692,400**	**28,462,000**
Activity	2.2.1	Scale up screening and referral of older children and adolescent	900,000	900,000	900,000	900,000	900,000	**4,500,000**
Activity	2.2.2	Capacity build teachers to identify and linking malnourished older children	2,968,000	2,968,000	2,968,000	2,968,000	2,968,000	**14,840,000**
Activity	2.2.3	Promote continuous Nutrition health education in schools	1,400,000	1,400,000	1,400,000	1,400,000	1,400,000	**7,000,000**
Activity	2.2.4	Capacity building of CHPs on identifying and referring malnourished older children , adolescent and adults	424,400	424,400	424,400	424,400	424,400	**2,122,000**
output	**2.3**	**Adolescent girls in schools supplemented with micronutrients**	**4,099,000**	**4,099,000**	**4,099,000**	**4,099,000**	**4,099,000**	**20,515,000**
Activity	2.3.1	Increase number of schools participating in the WIFS program	516,000	516,000	516,000	516,000	516,000	**2,580,000**
Activity	2.3.2	Procure and Dispatch of WIFS commodities to schools.	-	-	-	-	-	-
Activity	2.3.3	Sensitize teachers on WIFS	300,000	300,000	300,000	300,000	300,000	**1,500,000**
Activity	2.3.4	Sensitize guardians / caregivers on WIFS	102,000	102,000	102,000	102,000	102,000	**510,000**
Activity	2.3.5	Sensitize key stakeholders on WIFS	900,000	900,000	900,000	900,000	900,000	**4,500,000**
Activity	2.3.6	Sensitize community groups on WIFS	490,000	490,000	490,000	490,000	490,000	**2,450,000**

Activity	2.3.7	Conduct health Education in schools on WIFS	175,000	175,000	175,000	175,000	175,000	**875,000**
Activity	2.3.8	Train HCWs on AHN	1,620,000	1,620,000	1,620,000	1,620,000	1,620,000	**8,100,000**
output	**2.4**	**Malnourished Older people at community level detected early for treatment and referral**	**1,296,400**	**1,296,400**	**1,296,400**	**1,296,400**	**1,296,400**	**6,482,000**
Activity	2.4.1	Sensitize CHPs on mapping, identification and referral for elderly persons	205,000	205,000	205,000	205,000	205,000	**1,025,000**
Activity	2.4.2	Integrate nutrition information in the support groups for Older persons	100,000	100,000	100,000	100,000	100,000	**500,000**
Activity	2.4.3	Sensitize CHPs on healthy diets and lifestyle for Older persons	385,000	385,000	385,000	385,000	385,000	**1,925,000**
Activity	2.4.4	Conduct targeted dialogues on healthy diets for Older Persons in the community	400,000	400,000	400,000	400,000	400,000	**2,000,000**
Activity	2.4.5	Draft Key messages for healthy diets for Older Persons	206,400	206,400	206,400	206,400	206,400	**1,032,000**
output	**2.5**	**Increased Community awareness on healthy diets and lifestyle for Older Children, Adolescents, Adults and Older Persons within urban and rural areas**	**86,000**	**250,700**	**250,700**	**305,600**	**86,000**	**979,000**
Activity	2.5.1	Mapping and conducting relevant stakeholder.	-	13,500	13,500	18,000	-	**45,000**
Activity	2.5.2	Disseminate to stakeholders the relevant policies and guidelines that promote healthy diets and lifestyle	-	151,200	151,200	201,600	-	**504,000**
Activity	2.5.3	Conduct mass community education on healthy diets and lifestyle for Older Children, Adolescents, Adults and Older Persons during thematic and cultural days (e.g. Morans' initiation ceremony)	6,000	6,000	6,000	6,000	6,000	**30,000**
Activity	2.5.4	Collaborate with stakeholders to Promote healthy diets and physical activity for older children and adolescents through youth gatherings in urban zones (football, drama, church)	80,000	80,000	80,000	80,000	80,000	**400,000**
Level	**Code**	**Statement (KRA, Outcome, output, activity)**	**2023/24**	**2024/25**	**2025/26**	**2026/27**	**2027/28**	**Total (Ksh)**
KRA	**3**	**KEY RESULT AREA 3: Enhanced industrial food fortification for prevention and control of micronutrient deficiencies**	**25,203,500**	**23,011,500**	**25,328,500**	**23,011,500**	**24,328,500**	**120,883,500**
Outcome	**3.0**	**Access to fortified foods to improve micronutrient status of the population scaled up**	**-**	**-**	**-**	**-**	**-**	**-**
output	**3.1**	**Leadership and co-ordination mechanism for food safety and fortification strengthened**	**20,983,500**	**20,003,500**	**20,703,500**	**20,003,500**	**20,003,500**	**101,697,500**
Activity	3.1.1	Formation of County Food Safety and Fortification Alliance (CFSFA)	380,000	-	-	-	-	**380,000**

Activity	3.1.2	Conduct quarterly CFSFA meetings for review and planning of food safety and fortification activities in the county	19,456,000	19,456,000	19,456,000	19,456,000	19,456,000	**97,280,000**
Activity	3.1.3	Conduct sensitization of managers and directors in relevant sectors (CHMT, Min of Trade) on food safety and fortification	600,000	-	-	-	-	**600,000**
Activity	3.1.4	Conduct advocacy meetings with MOH, Min of Trade leadership, and Members of County Assembly (MCAs) to lobby for budgetary allocation to food safety and fortification programming in the county	-	-	700,000	-	-	**700,000**
Activity	3.1.5	Conduct Advocacy forums to increase awareness on food safety and fortification - World Food Safety Day, County FF Summit	547,500	547,500	547,500	547,500	547,500	**2,737,500**
output	**3.2**	**Capacity of food industries /millers to produce safe and fortified foods strengthened**	**58,000**	**58,000**	**463,000**	**58,000**	**463,000**	**1,100,000**
Activity	3.2.1	Conduct sensitization meetings for industries (maize, wheat flour, edible oil, salt) on relevant government legislation on food safety and fortification	58,000	58,000	58,000	58,000	58,000	**290,000**
Activity	3.2.2	Conduct on-site training and mentorship of food business operators and industries to institute Quality Assurance and Quality Control (QA/QC) in their businesses	-	-	405,000	-	405,000	**810,000**
output	**3.3**	**Capacity of surveillance and enforcement officers on regulatory monitoring, surveillance and enforcement of food safety and fortification enhanced**	**830,000**	**1,718,000**	**830,000**	**1,718,000**	**830,000**	**5,926,000**
Activity	3.3.1	Train PHOs on food safety and fortification surveillance and enforcement	-	888,000	-	888,000	-	**1,776,000**
Activity	3.3.2	Conduct quarterly surveillance and monitoring on food fortification at the market level in the county	330,000	330,000	330,000	330,000	330,000	**1,650,000**
Activity	3.3.3	Establish a food safety and food fortification Mini-laboratory	500,000	500,000	500,000	500,000	500,000	**2,500,000**
output	**3.4**	**Demand for consumption of fortified foods by households created**	**3,332,000**	**1,232,000**	**3,332,000**	**1,232,000**	**3,032,000**	**12,160,000**
Activity	3.4.1	Mass sensitization on Food fortification through barazas, community action days, community dialogues	440,000	440,000	440,000	440,000	440,000	**2,200,000**
Activity	3.4.2	Mass sensitization on Food fortification through Radio spots	480,000	480,000	480,000	480,000	480,000	**2,400,000**
Activity	3.4.3	Sensitize CHPs on consumption of food fortification	236,000	236,000	236,000	236,000	236,000	**1,180,000**
Activity	3.4.4	Sensitize community gate keepers on consumption	76,000	76,000	76,000	76,000	76,000	**380,000**

		of food fortification						
Activity	3.4.5	Conduct household surveys to monitor consumption pattern of fortified foods	2,100,000	-	2,100,000	-	1,800,000	**6,000,000**
Level	**Code**	**Statement (KRA, Outcome, output, activity)**	**2023/24**	**2024/25**	**2025/26**	**2026/27**	**2027/28**	**Total (Ksh)**
KRA	**4**	**KEY RESULT AREA 4: Sustained nutritional wellbeing of individuals and communities during emergencies and climate related shocks**	**19,687,360**	**19,687,360**	**25,015,360**	**19,687,360**	**25,015,360**	**109,092,800**
Outcome	**4.0**	**Enhanced community resilience to climate-related shocks and emergencies.**	-	-	-	-	-	**-**
output	**4.1**	**Community supported to withstand climate shocks and emergencies**	**8,995,520**	**8,995,520**	**8,995,520**	**8,995,520**	**8,995,520**	**44,977,600**
Activity	4.1.1	Disseminate Early Warning Climate Information to communities	1,280,000	1,280,000	1,280,000	1,280,000	1,280,000	**6,400,000**
Activity	4.1.2	Integrate local knowledge with expert information in Participatory Scenario Planning forums	1,500,000	1,500,000	1,500,000	1,500,000	1,500,000	**7,500,000**
Activity	4.1.3	Community civic education on emergencies	750,000	750,000	750,000	750,000	750,000	**3,750,000**
Activity	4.1.4	Conduct psychosocial support sessions on GBV, nutrition counselling	300,000	300,000	300,000	300,000	300,000	**1,500,000**
Activity	4.1.5	Intensify case screening of malnutrition by the Health Care workers at the community	1,200,000	1,200,000	1,200,000	1,200,000	1,200,000	**6,000,000**
Activity	4.1.6	Mapping and identifying malnutrition hotspots	224,000	224,000	224,000	224,000	224,000	**1,120,000**
Activity	4.1.7	Identifying areas at risk of flash floods and mapping the essential assets that could be affected (e.g. health facilities cropland or key roads);	224,000	224,000	224,000	224,000	224,000	**1,120,000**
Activity	4.1.8	Conduct mass screening	3,210,800	3,210,800	3,210,800	3,210,800	3,210,800	**16,054,000**
Activity	4.1.9	Linking vulnerable households to food assistance in emergency settings	306,720	306,720	306,720	306,720	306,720	**1,533,600**
output	**4.2**	**Capacity of Healthcare workers on nutrition surveillance for emergency response enhanced**	**4,679,840**	**4,679,840**	**4,679,840**	**4,679,840**	**4,679,840**	**23,399,200**
Activity	4.2.1	Training health workers on conducting nutritional assessments for emergency response	263,040	263,040	263,040	263,040	263,040	**1,315,200**
Activity	4.2.2	Training of health workers on IMAM Surge	2,130,400	2,130,400	2,130,400	2,130,400	2,130,400	**10,652,000**
Activity	4.2.3	Scale up IMAM surge in targeted health facilities	78,000	78,000	78,000	78,000	78,000	**390,000**
Activity	4.2.4	Monitor IMAM surge activities	78,000	78,000	78,000	78,000	78,000	**390,000**
Activity	4.2.5	Train Health Workers on MIYCN-E	2,130,400	2,130,400	2,130,400	2,130,400	2,130,400	**10,652,000**
output	**4.3**	**Enhanced multi sectoral coordination in emergencies**	**6,012,000**	**6,012,000**	**11,340,000**	**6,012,000**	**11,340,000**	**40,716,000**
Activity	4.3.1	Linkage of households with malnutrition cases to Cash transfer programs during emergencies	400,000	400,000	400,000	400,000	400,000	**2,000,000**
Activity	4.3.2	Conduct multi-sectoral climate – health risk assessment (early warning early actions)	-	-	5,328,000	-	5,328,000	**10,656,000**

Activity	4.3.3	Develop sectoral emergency plans	300,000	300,000	300,000	300,000	300,000	**1,500,000**
Activity	4.3.4	Packaging and dissemination of early warning information messaging to the population	2,064,000	2,064,000	2,064,000	2,064,000	2,064,000	**10,320,000**
Activity	4.3.5	Develop County sectoral response plans	2,408,000	2,408,000	2,408,000	2,408,000	2,408,000	**12,040,000**
Activity	4.3.6	Conduct weekly County Steering Group meetings on nutrition and food security during emergencies	840,000	840,000	840,000	840,000	840,000	**4,200,000**
Level	**Code**	**Statement (KRA, Outcome, output, activity)**	**2023/24**	**2024/25**	**2025/26**	**2026/27**	**2027/28**	**Total (Ksh)**
KRA	**5**	**KEY RESULT AREA 5: Clinical Nutrition and dietetics services strengthened**	**19,480,000**	**19,480,000**	**19,480,000**	**19,480,000**	**19,480,000**	**97,400,000**
Outcome	**5.0**	**Clinical Nutrition and dietetics services enhanced**						
output	**5.1**	**Increased access and coverage of Integrated Management of Acute Malnutrition (IMAM) Services in Health facilities**	**9,028,000**	**9,028,000**	**9,028,000**	**9,028,000**	**9,028,000**	**45,140,000**
Activity	5.1.1	Conduct training of HCW on IMAM and disseminate the IMAM guidelines	5,352,000	5,352,000	5,352,000	5,352,000	5,352,000	**26,760,000**
Activity	5.1.2	Distribute/disseminate nutrition services SOPs and treatment protocols in all sub counties	60,000	60,000	60,000	60,000	60,000	**300,000**
Activity	5.1.3	Integrate management of acutely malnourished children in other programs within the health system	150,000	150,000	150,000	150,000	150,000	**750,000**
Activity	5.1.4	Carryout facility visits for On the Job Training on IMAM service delivery in primary care facilities and the community	90,000	90,000	90,000	90,000	90,000	**450,000**
Activity	5.1.5	Train HCWs on nutrition commodity quantification, forecasting and management	2,856,000	2,856,000	2,856,000	2,856,000	2,856,000	**14,280,000**
Activity	5.1.6	Conduct IMAM program performance reviews;	520,000	520,000	520,000	520,000	520,000	**2,600,000**
output	**5.2**	**Enhanced early case identification of all forms of malnutrition through community mobilization and referral**	**1,484,000**	**1,484,000**	**1,484,000**	**1,484,000**	**1,484,000**	**7,420,000**
Activity	5.2.1	Train CHPs on CMAM	206,000	206,000	206,000	206,000	206,000	**1,030,000**
Activity	5.2.2	Train CHPs on family MUAC	206,000	206,000	206,000	206,000	206,000	**1,030,000**
Activity	5.2.3	Sensitization of care givers on use of family MUAC	480,000	480,000	480,000	480,000	480,000	**2,400,000**
Activity	5.2.4	Sensitization of Opinion leaders on Malnutrition conditions and nutrition services	500,000	500,000	500,000	500,000	500,000	**2,500,000**
Activity	5.2.5	conduct quarterly outreaches for Acute Malnutrition in hot spots areas at community	92,000	92,000	92,000	92,000	92,000	**460,000**
Activity	5.2.6	Conduct routine Nutrition assessment by CHP at household level	-	-	-	-	-	**-**

Activity	5.2.7	Conduct routine Nutrition assessment and defaulter tracing by CHP at house hold level	-	-	-	-	-	-
output	***5.3***	**Accelerated nutrition response for prevention and control of diet related NCDs**	**6,070,000**	**6,070,000**	**6,070,000**	**6,070,000**	**6,070,000**	**30,350,000**
Activity	5.3.1	Training of HCWs on control and prevention of diet-related NCDs at All levels of service delivery	4,300,000	4,300,000	4,300,000	4,300,000	4,300,000	**21,500,000**
Activity	*5.3.2*	Scale -up integration of nutrition services in NCD programs and Clinics at sub county and facility level	150,000	150,000	150,000	150,000	150,000	**750,000**
Activity	5.3.3	Training of health workers on critical nutrition and dietetics care package	1,560,000	1,560,000	1,560,000	1,560,000	1,560,000	**7,800,000**
Activity	5.3.4	Disseminate SOPs and treatment protocols on critical nutrition and dietetics and inpatient feeding	60,000	60,000	60,000	60,000	60,000	**300,000**
Activity	**5.3.5**	Strengthened Nutrition screening, assessment and triage of all patients and clients seeking healthcare services	-	-	-	-	-	-
output	**5.4**	**Strengthened Nutrition Assessment, Counselling and Support services in HIV and TB clinics**	**2,898,000**	**2,898,000**	**2,898,000**	**2,898,000**	**2,898,000**	**14,490,000**
Activity	5.4.1	Training of healthcare workers on Nutrition and TB	1,404,000	1,404,000	1,404,000	1,404,000	1,404,000	**7,020,000**
Activity	5.4.2	Set-up nutrition assessment and screening stations in all outpatient and Inpatient departments	-	-	-	-	-	-
Activity	5.4.3	Implement bi-directional screening for TB disease and Nutrition conditions in TB and Nutrition clinics	90,000	90,000	90,000	90,000	90,000	**450,000**
Activity	5.4.4	Training of healthcare workers on Nutrition and HIV	1,404,000	1,404,000	1,404,000	1,404,000	1,404,000	**7,020,000**
Level	**Code**	**Statement (KRA, Outcome, output, activity)**	**2023/24**	**2024/25**	**2025/26**	**2026/27**	**2027/28**	**Total (Ksh)**
KRA	6	**KEY RESULT AREA 6: Nutrition and Food Security in Agriculture scaled-up**	**17,494,100**	**17,494,100**	**17,494,100**	**17,494,100**	**17,494,100**	**87,470,500**
Outcome	**6.0**	**Strengthened linkages with nutrition and Agriculture**	-	-	-	-	-	-
output	**6.1**	**Farmers supported to increase availability, access of nutritious foods (crops, livestock, fish)**	**10,338,100**	**10,338,100**	**10,338,100**	**10,338,100**	**10,338,100**	**51,690,500**
Activity	6.1.1	Enhance and scale up community awareness on sustainable ,environment friendly production of diversified and nutritious foods	1,143,000	1,143,000	1,143,000	1,143,000	1,143,000	**5,715,000**
Activity	6.1.2	Promotion of indigenous crops, fruits and Livestock to increase availability and access of nutrient dense and safe foods	193,500	193,500	193,500	193,500	193,500	**967,500**
Activity	6.1.3	Enhance community awareness on harvest and	5,148,000	5,148,000	5,148,000	5,148,000	5,148,000	**25,740,000**

		post-harvest interventions to reduce food losses						
Activity	6.1.4	Staff trainings and demonstrations on post-harvest handling of produce to reduce food loss	2,761,600	2,761,600	2,761,600	2,761,600	2,761,600	**13,808,000**
Activity	6.1.5	Promote kitchen gardens which in cooperate innovative gardening and small stock rearing	1,092,000	1,092,000	1,092,000	1,092,000	1,092,000	**5,460,000**
output	6.2	**Innovative approaches for increased knowledge on Food consumption, utilization and processing supported**	**5,522,000**	**5,522,000**	**5,522,000**	**5,522,000**	**5,522,000**	**27,610,000**
Activity	6.2.1	Conduct Nutrition demonstrations to farmer groups on food preservation , preparation and utilization for various food categories (Animal, crops, fish)	5,298,000	5,298,000	5,298,000	5,298,000	5,298,000	**26,490,000**
Activity	6.2.2	Conduct demonstrations on food preparation and utilization for various food categories(Animal, crops, fish)	224,000	224,000	224,000	224,000	224,000	**1,120,000**
output	**6.3.0**	**Farmers supported to increase capacity on quality safe farm produce (crops, livestock, fish)**	**1,634,000**	**1,634,000**	**1,634,000**	**1,634,000**	**1,634,000**	**8,170,000**
Activity	6.3.1	Enhance and scale up community awareness on food safety	344,000	344,000	344,000	344,000	344,000	**1,720,000**
	6.3.2	Conduct Collaboration meetings with food safety regulatory bodies	488,000	488,000	488,000	488,000	488,000	**2,440,000**
Activity	6.3.3	Conduct staff trainings on food safety standards and regulations	802,000	802,000	802,000	802,000	802,000	**4,010,000**
Level	**Code**	**Statement (KRA, Outcome, output, activity)**	**2023/24**	**2024/25**	**2025/26**	**2026/27**	**2027/28**	**Total (Ksh)**
KRA	**7**	**KEY RESULT AREA 7: Nutrition in Education and Early Childhood Development (ECDE) promoted**	**6,598,100**	**5,867,600**	**6,232,600**	**5,867,600**	**6,233,100**	**30,799,000**
Outcome	**7.0**	**Improved nutrition status for childcare centers, ECDE and school going children**						
Output	**7.1**	**Healthy and safe food environments promoted in learning and child care centers**	**4,656,400**	**4,656,400**	**4,656,400**	**4,656,400**	**4,656,400**	**23,282,000**
Activity	7.1.1	Scale up school gardens for public schools in the county	2,400,000	2,400,000	2,400,000	2,400,000	2,400,000	**12,000,000**
Activity	7.1.2	Create and strengthen nutrition sensitive health and 4 K clubs in schools	536,000	536,000	536,000	536,000	536,000	**2,680,000**
Activity	7.1.3	Conduct advocacy for school feeding program - sourcing for finances and sustainability	960,000	960,000	960,000	960,000	960,000	**4,800,000**
Activity	7.1.4	Conduct Nutrition education to parents of school going children in schools within the County	680,000	680,000	680,000	680,000	680,000	**3,400,000**
Activity	7.1.5	Sensitize the childcare facility management on healthy diet and safe food environment	80,400	80,400	80,400	80,400	80,400	**402,000**

Output	**7.2**	**Nutrition assessment conducted in learning centers and child care centers**	**487,400**	**487,400**	**487,400**	**487,400**	**487,400**	**2,437,000**
Activity	7.2.1	Conduct nutrition sensitization to ECD teachers in schools within the county	392,000	392,000	392,000	392,000	392,000	**1,960,000**
Activity	7.2.2	Conduct nutrition sensitization to private child care centers (day cares) owners in the county	95,400	95,400	95,400	95,400	95,400	**477,000**
Activity	7.2.3	Growth monitoring among ECDE children	-	-	-	-	-	**-**
Output	**7.3.**	**Child care centers real time data established in the county**	**1,454,300**	**723,800**	**1,088,800**	**723,800**	**835,800**	**5,080,000**
Activity	7.3.1	Conduct mapping and profiling of child care center in the county	123,800	123,800	123,800	123,800	123,800	**619,000**
Activity	7.3.2	Linkage of the ECDE centers to catchment health facilities	-	-	-	-	-	**-**
Activity	7.3.3	Renovation and operationalization of a model public child care center In Majengo, Isinya	600,000	600,000	600,000	600,000	600,000	**3,000,000**
Activity	7.3.4	Sensitization to all relevant stakeholders on child care facilities and policy	477,000	-	365,000	-	112,000	**954,000**
Activity	7.3.5	Conduct support supervision and M & E in nutrition sensitive programs in Childcare centers, ECD and schools	253,500	-	-	-	253,500	**507,000**
Level	**Code**	**Statement (KRA, Outcome, output, activity)**	**2023/24**	**2024/25**	**2025/26**	**2026/27**	**2027/28**	**Total (Ksh)**
KRA	**8**	**KEY RESULT AREA 8:Nutrition in Water, Sanitation and Hygiene (WASH) promoted**	**142,510,200**	**81,921,900**	**78,125,700**	**74,289,000**	**70,522,200**	**447,369,000**
Outcome	**8.0**	**Improved uptake of optimal WASH practices resulting from Integration of nutrition in WASH**						
output	**8.1**	**Clean portable water is accessible to households and institutions**	**136,388,400**	**75,800,100**	**72,003,900**	**68,167,200**	**64,400,400**	**416,760,000**
Activity	8.1.1	Protection and restoration of water catchment areas	6,030,000	6,030,000	6,030,000	6,030,000	6,030,000	**30,150,000**
Activity	8.1.2	Promote water access installation of rain water harvesting infrastructure in schools and homestead	528,000	460,500	451,500	402,000	348,000	**2,190,000**
Activity	8.1.3	Pipeline extension from existing water systems (last mile connectivity)	127,956,000	67,956,000	64,206,000	60,456,000	56,706,000	**377,280,000**
Activity	8.1.4	Sensitization on household water treatment techniques	1,356,000	936,000	906,000	876,000	906,000	**4,980,000**
Activity	8.1.5	Scale-up water quality surveillance	518,400	417,600	410,400	403,200	410,400	**2,160,000**
output	**8.2.0**	**Appropriate WASH practices at the community level promoted**	**2,800,000**	**2,800,000**	**2,800,000**	**2,800,000**	**2,800,000**	**14,000,000**
Activity	8.2.1	Sensitize community on appropriate WASH practices during community action or dialogue days	800,000	800,000	800,000	800,000	800,000	**4,000,000**

Activity	8.2.2	Conduct targeted community led totals sanitation (CLTS) in areas affected most by poor sanitation	1,200,000	1,200,000	1,200,000	1,200,000	1,200,000	**6,000,000**
Activity	8.2.3	Support CHPs to conduct household visitation with key messaging on appropriate WASH practices	800,000	800,000	800,000	800,000	800,000	**4,000,000**
output	**8.3.0**	**The learning institution community is sensitized on linkage between nutrition and WASH**	**1,224,800**	**1,224,800**	**1,224,800**	**1,224,800**	**1,224,800**	**6,124,000**
Activity	8.3.1	Sensitize the learning institutions on the importance of point of use (POA) water treatment	256,000	256,000	256,000	256,000	256,000	**1,280,000**
Activity	8.3.2	Train school children on WASH and nutrition linkages	176,800	176,800	176,800	176,800	176,800	**884,000**
Activity	8.3.3	Conduct sensitization forums to BOMs on WASH and nutrition in learning institutions	792,000	792,000	792,000	792,000	792,000	**3,960,000**
output	**8.4.0**	**Water users associations (WUA) and communities capacity build on Nutrition and WASH linkage**	**1,102,000**	**1,102,000**	**1,102,000**	**1,102,000**	**1,102,000**	**5,510,000**
Activity	8.4.1	Sensitize the water user associations (WUA) and Community Water Committees on essential hygiene and household water treatment	166,000	166,000	166,000	166,000	166,000	**830,000**
Activity	8.4.2	Support WUA and CWCs to promote point of use water treatment to community members	360,000	360,000	360,000	360,000	360,000	**1,800,000**
Activity	8.4.3	Train WUA and CWCs opportunities for linkage between nutrition and WASH (water treatment, hand water, human waste disposal, food handling hygiene etc.)	576,000	576,000	576,000	576,000	576,000	**2,880,000**
output	**8.5.0**	**Actors in the food preparation value chain capacity build on Nutrition and WASH linkage**	**995,000**	**995,000**	**995,000**	**995,000**	**995,000**	**4,975,000**
Activity	8.5.1	Conduct sensitization on safe and hygienic practices during food preparation and storage to school administrators	672,000	672,000	672,000	672,000	672,000	**3,360,000**
Activity	8.5.2	Integrate nutrition in WASH activities through UCLTS, CLTS and sanitation marketing at schools and communities	128,000	128,000	128,000	128,000	128,000	**640,000**
Activity	8.5.3	Sensitize teachers and patrons on PHASE (personal hygiene and sanitation education) and promotion of handwashing with soap during critical times	195,000	195,000	195,000	195,000	195,000	**975,000**
Level	**Code**	**Statement (KRA, Outcome, output, activity)**	**2023/24**	**2024/25**	**2025/26**	**2026/27**	**2027/28**	**Total (Ksh)**
KRA	**9**	**KEY RESULT AREA 9: Nutrition in social protection programs promoted**	**5,154,800**	**12,774,800**	**5,534,800**	**7,454,800**	**8,074,800**	**38,994,000**
Outcome	**9.0**	**Inclusion of Nutrition activities in Social Protection Programs**	-	-	-	-	-	**-**
output	**9.1**	**Nutrition promoted in Social Protection programmes**	**634,000**	**3,734,000**	**1,014,000**	**1,194,000**	**3,554,000**	**10,130,000**

Activity	9.1.1	Conduct a baseline survey/situation analysis on status of nutrition and health for the vulnerable groups.	-	2,000,000	-	-	2,000,000	**4,000,000**
Activity	9.1.2	Conduct assessment to establish gaps in linkages between nutrition and social protection programs in the county	-	540,000	-	-	540,000	**1,080,000**
Activity	9.1.3	In collaboration with social protection department conduct mapping and ranking of vulnerable households based on their vulnerability with nutrition status as part of criteria	-	380,000	380,000	380,000	380,000	**1,520,000**
Activity	9.1.4	Promote and integrate nutrition in Social Protection programmes e.g. cash transfers, hunger safety nets, others.	344,000	344,000	344,000	344,000	344,000	**1,720,000**
Activity	9.1.5	Mobilize financial resources for nutrition interventions in social protection programmes	30,000	30,000	30,000	30,000	30,000	**150,000**
Activity	9.1.6	Link vulnerable households (affected by disaster or crisis) to food transfer programs (relief foods)	30,000	30,000	30,000	30,000	30,000	**150,000**
Activity	9.1.7	Conduct nutrition screening for social protection families and linking the malnourished cases to the health facilities for support (IMAM and NCDs)	30,000	30,000	30,000	30,000	30,000	**150,000**
Activity	9.1.8	Support CHPs & children's officers to conduct nutrition education to households targeted by social protection programs	200,000	200,000	200,000	200,000	200,000	**1,000,000**
Activity	9.1.9	Link vulnerable households with the department of agriculture to be supported to improve food production (provision of farm tools, farming skills, kitchen gardens)	-	180,000	-	180,000	-	**360,000**
output	**9.2**	**Care practices improved through linkage of Nutrition in Social Protection Programs**	**3,487,200**	**3,487,200**	**3,487,200**	**3,487,200**	**3,487,200**	**17,436,000**
Activity	9.2.1	Support women to initiate Income Generating Activities to promote household income	500,000	500,000	500,000	500,000	500,000	**2,500,000**
Activity	9.2.2	Promote male involvement in key messaging on childcare practices	996,000	996,000	996,000	996,000	996,000	**4,980,000**
Activity	9.2.3	Targeted employer education on empowering women to promote optimal childcare practices while ensuring productivity at work (educating employers on labour laws, breastfeeding policies)	247,200	247,200	247,200	247,200	247,200	**1,236,000**
Activity	9.2.4	Promote Village Savings and Loans Activities (VSLAs) to empower women to improve care practices	360,000	360,000	360,000	360,000	360,000	**1,800,000**
Activity	9.2.5	Advocate for nutrition safety and security of families by addressing threats affecting PWD, infant and young children nutrition.	160,000	160,000	160,000	160,000	160,000	**800,000**

Activity	9.2.6	Empower women and make them the recipients of social protection benefits, focusing on increasing women's access to education on nutrition, assets and resources, while at the same time considering women's work burden and time constraints.	462,000	462,000	462,000	462,000	462,000	**2,310,000**
Activity	9.2.7	Engage men when addressing gender issues to strengthen the positive impact of social protection on nutrition.	762,000	762,000	762,000	762,000	762,000	**3,810,000**
Output	**9.3**	**Healthy household environment and health services advocated for in Social Protection Programs**	**360,000**	**550,000**	**360,000**	**550,000**	**360,000**	**2,180,000**
Activity	9.3.1	Link vulnerable households with Water Department for support to accessible safe drinking water (last mile connectivity, targeted for improved water sources)	-	95,000	-	95,000	-	**190,000**
Activity	9.3.2	Link vulnerable households with the available social health services (SHIF, NHIF)	-	95,000	-	95,000	-	**190,000**
Activity	9.3.3	Support CHPs to conduct household visitation promoting appropriate WASH practices to households targeted by social protection programs	180,000	180,000	180,000	180,000	180,000	**900,000**
Activity	9.3.4	Targeting support groups (HIV/AIDS, OVCs, Elderly, Youths) with key messaging on appropriate WASH practices during their meetings	180,000	180,000	180,000	180,000	180,000	**900,000**
Output	**9.4**	**Coordination activities for Nutrition mainstreaming in Social Protection Program promoted**	**673,600**	**5,003,600**	**673,600**	**2,223,600**	**673,600**	**9,248,000**
Activity	9.4.1	Conduct stakeholder mapping of various players	-	90,000	-	90,000	-	**180,000**
Activity	9.4.2	Sensitize stakeholders on nutrition and social protection programs linkage opportunities.	-	1,370,000	-	1,370,000	-	**2,740,000**
Activity	9.4.3	Advocate for the linkage of nutrition services and Social Protection for all vulnerable groups to S/NHIF.	-	90,000	-	90,000	-	**180,000**
Activity	9.4.4	Conduct monitoring and evaluation of nutrition and social protection programs linkage progress	63,600	63,600	63,600	63,600	63,600	**318,000**
Activity	9.4.5	Conduct research to inform implementation of social assistance interventions in health and nutrition, and a transfer and graduation practice of beneficiaries of nutrition inclusion in social protection programs.	-	2,780,000	-	-	-	**2,780,000**

Activity	9.4.6	Advocate for social protection schemes that promote adoption of positive behaviors (for instance, cash transfer programs that promote Growth monitoring, pre and post-natal care services)	180,000	180,000	180,000	180,000	180,000	**900,000**
Activity	9.4.7	Advocate for harmonization of nutrition and social protection services for vulnerable groups	430,000	430,000	430,000	430,000	430,000	**2,150,000**
Level	**Code**	**Statement (KRA, Outcome, output, activity)**	**2023/24**	**2024/25**	**2025/26**	**2026/27**	**2027/28**	**Total (Ksh)**
KRA	**10**	**KEY RESULT AREA 10: Sectoral and multisectoral Nutrition Information Systems, Learning and Research strengthened**	**33,185,200**	**39,745,200**	**41,449,200**	**35,245,200**	**28,685,200**	**178,310,000**
Outcome	**10.0**	**Improved nutrition data quality for decision making**	-	-	-	-	-	**-**
Output	**10.1**	**Nutrition information and reporting system strengthened in the county**	**29,666,000**	**32,166,000**	**37,258,000**	**27,666,000**	**25,166,000**	**151,922,000**
Activity	10.1.1	Conduct quarterly Data Quality Audits at the facility level	2,502,000	2,502,000	2,502,000	2,502,000	2,502,000	**12,510,000**
Activity	10.1.2	Conduct quarterly county support supervision	1,426,000	1,426,000	1,426,000	1,426,000	1,426,000	**7,130,000**
Activity	10.1.3	Conduct quarterly sub county support supervision	5,290,000	5,290,000	5,290,000	5,290,000	5,290,000	**26,450,000**
Activity	10.1.4	Conduct quarterly performance review meetings nutrition indicators	2,064,000	2,064,000	2,064,000	2,064,000	2,064,000	**10,320,000**
Activity	10.1.5	Conduct monthly in charges meetings at sub county level	6,192,000	6,192,000	6,192,000	6,192,000	6,192,000	**30,960,000**
Activity	10.1.6	Train health workers on health information and reporting systems	1,554,000	1,554,000	1,554,000	1,554,000	1,554,000	**7,770,000**
Activity	10.1.7	Procure sets of nutrition tools and registers	6,500,000	-	6,500,000	-	-	**13,000,000**
Activity	10.1.8	Sensitize members of the multisectoral platform on NDMA monthly bulletins, Integrated Phase Classification	150,000	150,000	150,000	150,000	150,000	**750,000**
Activity	10.1.9	Conduct quarterly field visit at NDMA sentinel sites	168,000	168,000	168,000	168,000	168,000	**840,000**
Activity	10.1.10	Participate in annual Short Rains Assessment and Long Rains assessment review meetings	100,000	100,000	100,000	100,000	100,000	**500,000**
Activity	10.1.11	Conduct KAP survey	-	4,500,000	-	4,500,000	-	**9,000,000**
Activity	10.1.12	Conduct SMART survey	-	4,500,000	4,500,000	-	-	**9,000,000**
Activity	10.1.13	Conduct a midterm review of the CNAP	-	-	2,000,000	-	2,000,000	**4,000,000**
Activity	10.1.14	Hold forums to disseminate research nutrition findings and information	360,000	360,000	360,000	360,000	360,000	**1,800,000**

Activity	10.1.15	Develop joint Annual Work Plans with Multisector players	2,160,000	2,160,000	2,160,000	2,160,000	2,160,000	**10,800,000**
Activity	10.1.16	Validation workshop for TOR for the multisector players	180,000	180,000	180,000	180,000	180,000	**900,000**
Activity	10.1.17	Train data analyst on conducting and analyzing integrated phase classification in the County	-	-	60,000	-	-	**60,000**
Activity	10.1.18	Conduct a workshop to develop a Common Results Framework for the Multisector Stakeholders	-	-	1,032,000	-	-	**1,032,000**
Activity	10.1.19	Nutrition monthly situational analysis bulletin	1,020,000	1,020,000	1,020,000	1,020,000	1,020,000	**5,100,000**
Output	**10.2**	**Nutrition Research in Kajiado County Strengthened**	**3,519,200**	**7,579,200**	**4,191,200**	**7,579,200**	**3,519,200**	**26,388,000**
Activity	10.2.1	Development of Nutrition policy briefs	564,000	564,000	564,000	564,000	564,000	**2,820,000**
	10.2.2	Documentation of innovations and best practices	207,700	207,700	207,700	207,700	207,700	**1,038,500**
	10.2.3	Conduct knowledge sharing forums (conferences, seminars, summits)	2,700,000	2,700,000	2,700,000	2,700,000	2,700,000	**13,500,000**
	10.2.4	Conduct nutrition Operational Research.	-	4,060,000	672,000	4,060,000	-	**8,792,000**
	10.2.5	Establish a repository for nutrition data	47,500	47,500	47,500	47,500	47,500	**237,500**
Level	**Code**	**Statement (KRA, Outcome, output, activity)**	**2023/24**	**2024/25**	**2025/26**	**2026/27**	**2027/28**	**Total (Ksh)**
KRA	**11.0**	**KEY RESULTAREA 11: Sectoral and multisectoral nutrition governance, coordination, legal/frameworks, leadership and advocacy**	**20,668,800**	**21,716,800**	**20,668,800**	**21,716,800**	**20,668,800**	**105,444,000**
Outcome		**Enhanced commitment and continued prioritization of nutrition in county agenda**	-	-	-	-	-	**-**
output	**1.1**	**Enhanced implementation of regulatory acts**	**10,565,600**	**11,613,600**	**10,565,600**	**11,613,600**	**10,565,600**	**54,924,000**
Activity	11.1.1	Create awareness on legal documents e.g. BMS act, workplace support to decision- makers	-	1,048,000	-	1,048,000	-	**2,096,000**
Activity	11.1.2	Conduct sensitization meetings to health care workers on legal documents	616,000	616,000	616,000	616,000	616,000	**3,080,000**
Activity	11.1.3	Domesticate nutrition guidelines/policies	3,972,400	3,972,400	3,972,400	3,972,400	3,972,400	**19,862,000**
Activity	11.1.4	Development of nutrition Acts	5,977,200	5,977,200	5,977,200	5,977,200	5,977,200	**29,886,000**
output	**11.2**	**Enhanced Nutrition Advocacy, Communication, Social & Mobilization**	**1,514,200**	**1,514,200**	**1,514,200**	**1,514,200**	**1,514,200**	**7,571,000**
Activity	11.2.1	Conduct advocacy meetings with MCA, county budgetary allocation committee and executive committee members in the county to advocate for increased resource allocation for nutrition program	280,000	280,000	280,000	280,000	280,000	**1,400,000**
Activity	11.2.2	Participate in the budgetary planning meetings	600,000	600,000	600,000	600,000	600,000	**3,000,000**

Activity	11.2.3	Proposal development for resource mobilization	559,200	559,200	559,200	559,200	559,200	**2,796,000**
Activity	11.2.4	Commemoration of health and nutrition days	395,000	395,000	395,000	395,000	395,000	**1,975,000**
Activity	11.2.5	Identify opportunities for private sector engaged nutrition activities	150,000	150,000	150,000	150,000	150,000	**750,000**
Activity	11.2.6	Identify and engage nutrition champions	130,000	130,000	130,000	130,000	130,000	**650,000**
output	**11.3**	**strengthen multisectoral nutrition coordination**	**6,840,000**	**6,840,000**	**6,840,000**	**6,840,000**	**6,840,000**	**34,200,000**
Activity	11.3.1	Map stakeholders for engagement	-	-	-	-	-	**-**
Activity	11.3.2	Conduct nutrition multisectoral engagement	720,000	720,000	720,000	720,000	720,000	**3,600,000**
Activity	11.3.3	Hold Nutrition Multisectoral taskforce meetings	2,400,000	2,400,000	2,400,000	2,400,000	2,400,000	**12,000,000**
Activity	11.3.4	Conduct Quarterly County Nutrition Technical Forums	2,000,000	2,000,000	2,000,000	2,000,000	2,000,000	**10,000,000**
Activity	11.3.5	Conduct monthly Sub County Nutrition Technical Forums	1,720,000	1,720,000	1,720,000	1,720,000	1,720,000	**8,600,000**
output	**11.4**	**Increased human resource for nutrition, equipment and commodities ensured**	**604,000**	**604,000**	**604,000**	**604,000**	**604,000**	**3,020,000**
Activity	11.4.1	Support attendance of budget hearing meetings and advocate for funding of nutrition actions	40,000	40,000	40,000	40,000	40,000	**200,000.00**
Activity	11.4.2	Develop advocacy fact sheets on nutrition financing and nutrition briefs for use	384,000	384,000	384,000	384,000	384,000	**1,920,000**
Activity	11.4.3	Conduct nutrition awareness sessions for teachers and BOM on optimal nutrition	180,000	180,000	180,000	180,000	180,000	**900,000**
Activity	11.4.4	Conduct nutrition awareness sessions for caregivers	-	-	-	-	-	**-**
output	**11.5**	**Awareness creation on healthy diet and physical, general optimal nutrition activities intensified**	**1,145,000**	**1,145,000**	**1,145,000**	**1,145,000**	**1,145,000**	**5,725,000**
Activity	11.5.1	Incorporate awareness session creation on physical activity and lifestyle habits with the local media	600,000	600,000	600,000	600,000	600,000	**3,000,000**
Activity	11.5.2	disseminate relevant policies and guidelines on health diets and NCDs to HCW	-	-	-	-	-	**-**
Activity	11.5.3	Hold awareness sessions on healthy feeding habits to adolescent boys and girls across all diversities	-	-	-	-	-	**-**
Activity	11.5.4	Hold education awareness forums on lifestyle and dietary diversification and good nutrition	160,000	160,000	160,000	160,000	160,000	**800,000**
Activity	11.5.5	Design, develop, print and disseminate IEC materials for nutrition	200,000	200,000	200,000	200,000	200,000	**1,000,000**
Activity	11.5.6	Train CHPs on community nutrition module 8	185,000	185,000	185,000	185,000	185,000	**925,000**
Level	**Code**	**Statement (KRA, Outcome, output, activity)**	**2023/24**	**2024/25**	**2025/26**	**2026/27**	**2027/28**	**Total (Ksh)**
KRA	**12**	**KEY RESULT AREA 12; Strengthen supply chain management for nutrition commodities and equipment**	**137,218,088**	**137,218,088**	**137,218,088**	**137,218,088**	**137,218,088**	**686,090,440**
Outcome	**12.0**	**To ensure uninterrupted supply of nutrition**						

		commodities and equipment to health facilities						
Output	**12.1**	**Enhanced uninterrupted nutrition commodities supply and use at the facility level**	**123,540,088**	**123,540,088**	**123,540,088**	**123,540,088**	**123,540,088**	**617,700,440**
Activity	12.1.1	Procurement of nutrition commodities	108,084,888	108,084,888	108,084,888	108,084,888	108,084,888	**540,424,440**
Activity	12.1.2	Delivering nutrition commodities to health facilities	-	-	-	-	-	**-**
Activity	12.1.3	Purchase anthropometric equipment	8,110,000	8,110,000	8,110,000	8,110,000	8,110,000	**40,550,000**
Activity	12.1.4	Conduct data quality audits for commodity reporting	1,681,200	1,681,200	1,681,200	1,681,200	1,681,200	**8,406,000**
Activity	12.1.5	Conduct monthly review meetings on nutrition commodity at Sub County and County level	5,664,000	5,664,000	5,664,000	5,664,000	5,664,000	**28,320,000**
Output	**12.2**	**Capacity of healthcare workers in nutrition supply chain management enhanced**	**13,678,000**	**13,678,000**	**13,678,000**	**13,678,000**	**13,678,000**	**68,390,000**
Activity	12.2.1	Conduct quarterly Joint Supportive Supervision nutrition commodities & warehousing	1,681,200	1,681,200	1,681,200	1,681,200	1,681,200	**8,406,000**
Activity	12.2.2	Conduct targeted On Job Training on nutrition commodities and warehousing	1,681,200	1,681,200	1,681,200	1,681,200	1,681,200	**8,406,000**
Activity	12.2.3	Train health care workers on the use of LMIS	652,800	652,800	652,800	652,800	652,800	**3,264,000**
Activity	12.2.4	Scale up the use of LMIS in all health facilities	1,908,000	1,908,000	1,908,000	1,908,000	1,908,000	**9,540,000**
Activity	12.2.5	Conduct monthly review meetings on nutrition commodity at Sub County and County level	5,664,000	5,664,000	5,664,000	5,664,000	5,664,000	**28,320,000**
Activity	12.2.6	Conduct Quarterly DQAs on nutrition commodity at Sub County and County level	2,090,800	2,090,800	2,090,800	2,090,800	2,090,800	**10,454,000**

Annex 3: List of Key Contributors

	NAME	DESIGNATION	ORGANIZATION
1.	Alex Kilowua	CECM - Medical services & Public Health	County Government of Kajiado
2.	Stephen Pelo	Chief Officer Medical Services	County Government of Kajiado
3.	Eddy Kimani	Chief Officer - Public Health	County Government of Kajiado
4.	Samson Saigilu	Director Public Health	County Government of Kajiado
5.	Dr. Lydia Munteyian	Director - Medical Services & Public Health	County Government of Kajiado
6.	R Betty Musyoka	Agriculture Officer	County Government of Kajiado
7.	Evalyne Soila	Sub County Nutrition Coordinator	County Government of Kajiado
8.	Evans Solitei	County Water Hygiene and Sanitation	County Government of Kajiado
9.	Simon Gacheru	County Program Coordinator	Nutrition International
10.	Faith Mbuguah	Sub County Nutrition Coordinator	County Government of Kajiado
11.	George Olibor	Deputy Director	County Government of Kajiado
12.	Yuniah Nyatichi	Sub County Health Records and Information Officer	County Government of Kajiado
13.	Irene Katete	Director Social Services	County Government of Kajiado
14.	Collins Likam	Deputy County Nutrition Coordinator	County Government of Kajiado
15.	Ruth Mbuthia	Project Officer	Save The Children
16.	Monica Obiny	Nursing Officer	County Government of Kajiado
17.	Eva Mopel	County Quality Assurance	County Government of Kajiado
18.	Lilian Kaindi	Technical Support	National Nutrition Information Working Group
19.	Harriet Namaie	Nutritionist	United Nations Children's Fund
20.	Ann Kangethe	Children Officer	County Government of Kajiado
21.	Ruth Nasinkoi	County Nutrition Coordinator	County Government of Kajiado
22.	Godfrey Ogembo	Sub County Nutrition Coordinator	County Government of Kajiado
23.	Angela Njenga	Sub County Nutrition Coordinator	County Government of Kajiado
24.	Peter Kasaine	Director-Water	County Government of Kajiado
25.	Geoffrey Kinyua	Senior Programme Officer	Nutrition International
26.	Mary Kihara	Senior Programme Officer	Nutrition International
27.	Pashile Siaka	Asst Director-Food Safety	County Government of Kajiado
28.	Fred Ntore	County Nursing Officer	County Government of Kajiado
29.	Mary Taiko	Director Gender	County Government of Kajiado
30.	Simon Seita	Water Department	County Government of Kajiado
31.	Leila Akinyi	Deputy Head Of Nutrition-Div Of Nutrition	National Ministry Of Health
32.	Mwai John	Division Of Nutrition	National Ministry Of Health-Division Of Nutrition
33.	Ezekiel Rauta	Planning Officer	County Government of Kajiado
34.	Erick Oduor	Director-Livestock	County Government of Kajiado
35.	Faith Selian	Commodity Nurse	County Government of Kajiado
36.	Lydia Nzoka	Veterinary Officer	County Government of Kajiado
37.	Daphine Mwendwa	Nutritionist	County Government of Kajiado
38.	Victoria Nthenya	Director Agriculture	County Government of Kajiado
39.	Christopher Parsimei	Primary Health Care Coordinator	County Government of Kajiado
40.	Joy Seleton	Human Resource for Health Coordinator	County Government of Kajiado
41.	Daniel Matipe	Economic And Planning	County Government of Kajiado

42.	Esther Lemarkoko	County Laboratory Coordinator	County Government of Kajiado
43.	Timothy Ntinina	Mental Health Coordinator	County Government of Kajiado
44.	Nuria Mohammed	Nutritionist	County Government of Kajiado
45.	Simon Nkatet	Emergency Unit	County Government of Kajiado
46.	Nick Odero	Procurement Department	County Government of Kajiado
47.	Susan Kirobi	Accountant	County Government of Kajiado
48.	Kores Sammy	Human Resource Officer	County Government of Kajiado
49.	Joseph Sankok	County Clinical Officer And Tuberculosis Coordinator	County Government of Kajiado
50.	Samwel Silale	County Physiotherapy Coordinator	County Government of Kajiado
51.	Rose Muganya Leina	Emergency Operation	County Government of Kajiado
52.	Caroline Ngala	Program Manager	Ticah
53.	Mary Elias	Program Manager	Ticah
54.	Josphine Keloi	Sub County Nutrition Coordinator	County Government of Kajiado
55	Kelvin Lenjir	Nutrition Field Officer	Welt Hunger Hilfe

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