BARINGO COUNTY GOVERNMENT

County Nutrition Action Plan
2019-2023

Working Together Towards Reduction of Malnutrition

The financial contribution of DFiD-UK in the development of this County Nutrition Action Plan through UNICEF's Maternal & Child Nutrition Programme II is gratefully acknowledged.

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List of Abbreviations and Acronyms

ACSM	*Advocacy Communication and Social Mobilization*
AWP	*Annual Work Plan*
BCC	*Behavior Change Communication*
BFCI	*Baby Friendly Community Initiative*
BFHI	*Baby Friendly Hospital Initiative*
BMI	*Body Mass Index*
CBO	*Community Based Organization*
CHANIS	*Child Health and Nutrition Information System*
CHEWs	*Community Health Extension Workers*
CHMT	*County Health Management Committee*
CHSSIP	*County Health Sector Strategic and Investment Plan*
CHV	*Community Health Volunteer*
CIDP	*County Integrated Development Plan*
CNAP	*County Nutrition Action Plan*
COTU	*Central Organization of Trade Unions*
CSO	*Civil Society Organization*
CNTF	*County Nutrition Action Plan*
EBF	*Exclusive Breastfeeding*
ECD	*Early Childhood Development*
ERS	*Economic Recovery Strategy*
FKE	*Federation of Kenya Employers*
FNSS	*Food and Nutrition Security Strategy*
GAM	*Global Acute Malnutrition*
GoK	*Government of Kenya*
HiNi	*High Impact Nutrition Interventions*
HIS	*Health Information Supplementation*
HIV	*Human Immunodeficiency Virus*
HMIS	*Health Management Information Systems*
ICN	*International Conference on Nutrition*
IDA	*Iron Deficiency Anemia*
IEC	*Information, Education and Communication*
IFAS	*Iron and Folic Acid*
IMC	*International Medical Corps*
IYCF	*Infant and Young Children Feeding*
KDHS	*Kenya Demographic and Health Survey*
KABP	*Knowledge attitudes Behaviour and Practice*
MAM	*Moderate Acute Malnutrition*

MDGs	*Millennium Development Goals*
MIYCN	*Maternal Infant and Young Children Nutrition*
MoH	*Ministry of Health*
MTMSG	*Mother to Mother Support Groups*
MEAL	*Monitoring evaluation Accountability and Learning*
MAD	*Minimum Acceptable Diets*
NNAP	*National Nutrition Action Plan*
NCD	*Non-Communicable Diseases*
NGO	*Non-Governmental Organizations*
NSO	*Nutrition Support Officer*
OJT	*On Job Training*
PLW	*Pregnant and Lactating Women*
SAM	*Severe Acute Malnutrition*
SDG	*Sustainable Development Goal*
SMART	*Standardized monitoring and assessment of relief and transition*
SOP	*Standard Operating Procedures*
TOC	*Theory of change*
SUN	*Scaling Up Nutrition*
UNICEF	*United Nations Children Fund*
UHC	*Universal Health Coverage*
VAS	*Vitamin A Supplementation*

Foreword

The Constitution of Kenya, 2010 not only guarantees the right to health for the people, but also assigns specific responsibilities towards achievements of these rights to county governments. This presents an opportunity for county governments to make significant contribution in improving the livelihood of citizens at the local level. The health sector is therefore at the centre of economically empowering citizens by ensuring that they remain healthy and productive. Baringo County Government holds this responsibility with nobility. The county government recognises that the delivery of this responsibility is an onerous assignment that requires intense planning, execution and close monitoring while at the same time engaging the citizenry. The county envisions a health system that is responsive to the needs of the population. The development of this Baringo County Nutrition Action Plan 2019-2023 is therefore a step towards ensuring that the expectations of the citizens are clarified into implementable interventions and mechanisms.

The main objective of the Baringo CNAP is to accelerate and scale up efforts towards the elimination of malnutrition as a problem of public health significance, focusing on specific achievements by 2022/23. The CNAP focuses on three areas of intervention, namely nutrition-specific; nutrition-sensitive; and enabling environment, putting emphasis on the need for strengthening multisectoral collaboration in addressing malnutrition. This plan will assist the county in meeting its vision on developmental agenda while contributing to the national goal of a healthy nation. The government is committed to creating an enabling environment for citizens to realize these rights as evidenced in the Vision 2030, Kenya Health Policy (2014–2030) and the National Food and Nutrition Security Policy, 2012.

It has taken into consideration the lessons learnt from the county government's implementation 2013-2017 County Nutrition Action Plan. It also takes into consideration inputs and feedback obtained from various county health stakeholders. The strategy takes into consideration the priorities of the national health sector. Achievement of the ambitious targets in this plan requires close collaboration between the county government and all stakeholders, both public and non – public. The county government will provide the necessary platform for enabling this collaboration.

I wish to call upon all stakeholders to provide the much-esteemed support in planning, during implementation and in monitoring this Baringo County Nutrition Action Plan.

Hon. Mary Panga

County Executive Member,

Health Services

Preface

Nutrition is a vital building block in the foundation of human health and development. It has a direct relationship with child survival, physical and mental growth, learning capacity, adult productivity and overall social and economic development. Unacceptably high levels of malnutrition remain a public health concern and a hindrance to achieving the county's developmental agenda, with an emerging triple burden of malnutrition, where undernutrition (underweight, stunting and wasting), overweight and obesity and micronutrient deficiencies are on the increase in addition to the burden of Non-Communicable Diseases (NCDs) (Kenya Demographic and Health Survey (KDHS), 2014).

The development of the Baringo County Nutrition Action Plan for the period 2019-2023 is the second-generation action plan that builds on the success, limitations and opportunities of the previous nutrition action plan. The development undertook a multi sector approach, A series of dedicated meetings were held at the county level with spearheaded by the department of health leadership during the entire development process whereby several stakeholders were involved. Some of these included County department of health services, representatives of the County Treasury and Economic Planning, Agriculture, Livestock and Fisheries Development, Water and Irrigation, Education and Vocational Training Departments, representatives from the Ministry of Health and various partner representatives. This is because several approaches are needed in order to improve the nutrition situation in Baringo County.

The CNAP will provide a critical catalyst for enhancing accountability, multisectoral collaboration and coordination, linking national and county actions, and tracking progress of the CNAPs' results. Key priorities to be implemented during the five years from 2018/19 to 2022/23 have been identified. It is my expectation that in working together, the overall objectives of the CNAP will be achieved

I am optimistic that the document will go a long way in achieving our objectives as far as nutrition is concerned.

David R. Cherop

Chief Officer

Public Health

Acknowledgement

The Baringo County Nutrition Action Plan for the period 2019-2023 has been developed with the support of numerous Stakeholders. First, we wish to appreciate the role of the Baringo County Government Executive under the leadership and support of His Excellency Stanley Kiptis, the Governor, Baringo County. The County Government also recognises and appreciates the leadership offered by County Executive Committee Member for Health Services Hon. Mary Panga and the departments' chief officers David R Cherop and Dr Gideon Toromo throughout the entire process.

The County government further recognizes over all coordination offered by the County Directors for Health that was fundamental in ensuring that the plan was developed through participation of key stakeholders. The department is grateful to the members of County and Sub county Health Management Teams for their valuable technical support during the CNAP development process that was crucial in enriching the content.

We are especially grateful to members of the core CNAP team pooled from key county health stakeholders including representatives of the County Treasury and Economic Planning, Agriculture, Livestock and Fisheries Development, Water and Irrigation, Education and Vocational Training Departments, and partner representatives for strategic planning who participated in data collection, analysis and planning workshops undertaken to generate this plan. Their inputs were indeed invaluable.

The county is grateful to all its health partners including World Vision Kenya, Kenya Red Cross Society, Afya UZAZI and WFP for their Technical support. We are specifically grateful for financial support from DFID as well as UNICEF for their immense Financial and Technical support in the entire CNAP development process.

It is our hope that this document will be implemented in full through multisectoral collaborations to achieve all intended objectives for better nutrition in Baringo County.

Dr. Gideon Toromo

Chief Officer

Medical Services

Executive Summary

The Baringo County Nutrition Action Plan (2019-2023) is an evidence-based five-year strategic action plan that seeks to address malnutrition in all its forms and for all ages. It is the second Nutrition Action Plan and follows implementation of the first Nutrition Action Plan 2013–2018, building on the success, limitations and opportunities of the previous five years. The overall expected result of the CNAP is achieving optimal nutrition for a healthier and more productive population in Baringo County. The pathway of change for the CNAP is defined using the theory of change. The theory of change was used to develop a set of key result areas so that if certain inputs were in place, and certain activities implemented, then certain results would be realized which would contribute to improved nutritional status in Baringo.

The CNAP development process was driven by the department of Health Services. The process involved wide consultations with all key stakeholders including: several County departments, development partners and donor agencies. The process was evidence-informed and recognized successes, challenges and lessons learnt from the implementation of the 2013–2018 CNAP.

A review of the implementation of the 2013–2018 CNAP indicated substantial achievements during the period of implementation, such as improved maternal and childcare practices through implementation of baby friendly community initiatives. There was also an improved nutrition supply chain through Logistics Management Information System (LMIS) and improved coordination between health and other sectors. However, the review also noted key challenges encountered during implementation of the CNAP, including limited funds allocation from the County government for implementation.

The main audience for the CNAP will be County planning entities, nutrition sensitive sectors, health and nutrition managers and officers at all levels, development partners, donors, Non-Government Organizations (NGOs), civil society organizations (CSOs), faith-based organizations (FBOs) and the private sector. The document will also help the public at large to understand what the department of Health services is doing to ensure optimal nutrition in Baringo. This CNAP has been organized into five chapters as follows: Chapter 1, the introduction, discusses the Country and County nutrition situation. The chapter further highlights key drivers of malnutrition; both drawn from nutrition-specific and nutrition sensitive sectors. Chapter 2 describes the CNAP Framework including the Vision, Mission and objectives while Chapter 3 presents the key result areas, strategies and interventions. Chapter 4 presents the Monitoring, Evaluation, Accountability and Learning (MEAL) Framework. Chapter 5 contains the resource mobilization and costing framework.

Chapter 1: Introduction

1.1 Background information

1.1.1 Location and size

Baringo County borders Turkana and Samburu Counties to the North, Laikipia to the East, Nakuru and Kericho to the South, Uasin Gishu to the South West, and Elgeyo - Marakwet and West Pokot to the West. The County covers an approximate area of 11,015 square kilometres (Km^2) with an estimated population of 703,697 persons (Kenya National Bureau of Statistics, 2016 Projected Population). The County has four main livelihoods namely, Mixed Farming, Pastoral, Agro Pastoral and Irrigated Cropping.

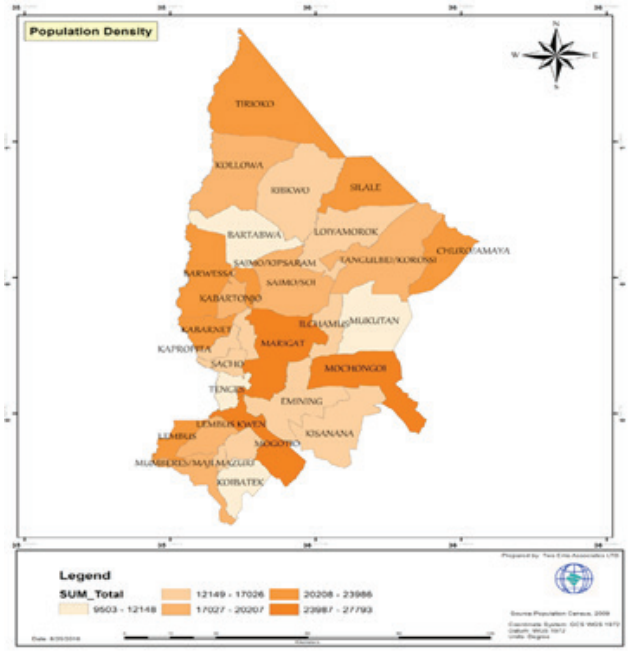

*Figure SEQ Figure * ARABIC 1: Baringo County map.*

1.1.2 Sub counties, wards and locations

The county is administratively divided into 6 sub-counties, 30 wards and 116 locations. Notably, the 7th sub-county – Tiaty East has been gazette but awaits delimitation by the IEBC. It has a geographical area of 11,015 square kilometers. The table below outlines the wards and locations per each sub county

Table 1: Sub county demographics

Sub county	Area per KM Sq	Ward	Location
Baringo Central	1,678	4	17
Mogotio	1,315	3	24
Eldama Ravine	1,003	6	16
Baringo central	800	5	21
Baringo North	1,704	5	14
Tiaty	4,517	7	24
TOTALS	**11,015**	**30**	**116**

1.1.3 Demographic profile

Baringo County has a population of 666,763 with 336,322 male and 330,428 female (KNBS 2019). The county is majorly rural with 89 per cent of its citizens inhabiting rural areas and only 11 per cent living in the key urban centres of Kabarnet, Eldama Ravine, Marigat, Kabartonjo, Chemoligot and Mogotio. The main ethnic communities inhabiting Baringo County are the Tugen, Pokot and Ilchamus communities. The minority groups include Endorois, Nubians, Ogiek, Kikuyu and Turkana communities. The table below shows the population distribution per sub counties segregated for both male and female

Table 2: Population Distribution per County (Source: KNBS, 2019)

Sub County Population	2019		
	Male	Female	Totals
Baringo Central	48,120	48,829	96,951
Baringo North	52,369	52,500	104,871
Marigat	45,706	45,246	90,955
Koibatek	65,295	64,238	129,535
Mogotio	46,014.	45,088	91,104
East Pokot	40,462	39,459	79,923
Tiaty East	38,356	35,068	73,424
Total	**336,322**	**330,428**	**666,763**

In terms of demographics, the county is estimated to have 150,803 households. The population of those under 15 years accounts for 42.30% while adolescents account for 25.50% of the population, women of reproductive age account for 24% and the under 5 children for 16.40%. The table below presents the estimates for the population projection based on the demographic groupings.

1.1.3.1 Population Demographics

Table 3: Population Demographics (District Health Information System (DHIS), 2018)

Description	% Population Estimates	Targets				
		2018	2019	2020	2021	2022
Total population		754013	768466	783211	798236	813550
Total Number of Households		150803	153694	156643	159648	162710
Children under 1 year (12 Months)	3.80%	28652	29202	29762	30333	30915
Children under 5 years (60 Months)	16.40%	123658	126028	128447	130911	133422
Under 15-year population	42.30%	318947	325061	331298	337654	344132
Women of childbearing age (15-49 Years)	24%	180963	184432	187971	191577	195252
Estimated Number of Pregnant Women	3.80%	28652	29202	29762	30333	30915
Estimated Number of Deliveries	3.80%	28652	29202	29762	30333	30915
Estimated Live Births	3.60%	27144	27665	28196	798236	29288
Total number of Adolescent (15-24 years)	25.50%	192273	195959	199719	203550	207455
Adults (25-59)	34.10%	257118	262047	267075	272198	277421
Elderly (60+)	5.40%	40717	41497	42293	43105	43932

The population pyramid highlights most of the population is youthful with most of the population below 49 years accounting for over 60%. The youthful population size has implications on the interventions for Nutrition, sexual and reproductive health. The female reproductive age population (circa 24%) has implications on the investments made towards maternal and child healthcare, reproductive health as well as nutrition programs.

The children under five (16.40%) account for the pre-school going age and the ones targeted for immunization coverage, nutrition program and monitoring of growth outcomes. The primary school going children estimated at over 190,000 (approximately 26%) is targeted with school-based health interventions and interventions for integrated management of childhood illnesses (ICMI) and nutrition.

The 50-65 years population that accounts for about 16% of the total County population has implications on the interventions for screening, diagnosis, and treatment of non-communicable diseases such as diabetes mellitus, cancer and hypertension. The aged population of 65 years and above though accounting for about 5.4% has significant implications on interventions for social protection and geriatric and palliative care programs.

1.1.4 Health Facility distribution per Sub County

Table 4: Health Facility distribution per sub County

Sub County	Hospitals		Health Centres		Dispensaries		Private Clinics	Community Units	Nursing Homes
	GOK	FBO	GOK	FBO	GOK	FBO			
Baringo North	1	0	4	0	40	1	1	6	0
Baringo Central	1	0	6	0	29	1	10	4	1
Marigat	1	0	3	0	25	2	2	5	0
Koibatek	1	1	4	1	24	0	9	11	1
East Pokot	1	0	2	1	14	3	0	12	0
Tiaty East	0	0	3	0	13	2	0	11	0
Mogotio	1	0	4	0	25	1	4	9	0

1.1.5 National policy and legal framework for CNAP

To achieve the aspirations of the Constitution and Vision 2030, Kenya has given legislative force to some key aspects of nutrition interventions. These include prevention and control of iodine deficiency disorders through mandatory salt iodization, and control of other micronutrient deficiencies by mandatory food fortification of cooking fats and oils and cereal flours, through the Food Drugs and Chemical Substances Act. The benefits of breastfeeding are protected through the Breast Milk Substitutes (Regulation and Control Act) 2012. The Food, Drugs and Chemical Substances Act (food labelling, additives, and standard (amendment) regulation 2015 on trans fats) is also key legislation central to the control of DRNCDs. Additionally, the Nutritionists and Dieticians Act 2007 (Cap 253b) has been set up to determine and set up a framework for the professional practice of nutritionists and dieticians; set and enforce standards of professional practice and ethics on nutrition and dietetics; enforce a programme of quality assurance for the nutrition and dietetic profession; research into and provide public education on nutrition and dietetics; and design programmes and methods for sensitization on suitable dietary and nutritional habits through capacity-building, competency oriented trainings and specialization in nutrition service delivery.

Kenya government has developed a national multiyear plan; Kenya Nutrition Action Plan (KNAP) 2018–2022 that seeks to address malnutrition in Kenya in all its forms and for all ages. It is anticipated that when fully implemented it will contribute to an improvement in nutritional status for the population of Kenya. Plan applies a multi sectoral approach and promotes cross-sectoral collaboration to address the social determinants of malnutrition sustainably.

1.2 Nutrition and health situation in Kenya

1.2.1 Under Nutrition

In Kenya, the situation of undernutrition is very similar to the global one. Out of 7.22 million children under five years, nearly 1.8 million are stunted (26 per cent); 290,000 are wasted (4 per cent); 794,200 (11 per cent) are underweight. However, there are geographical and social demographic variations in the severity of malnutrition across the counties. Out of the 47 counties, 9 (19 per cent) have a prevalence of stunting above 30 per cent, a level categorized as 'very high' in public health significance. Consistent with other low-income countries, stunting is highest in the 19–23-month age group (36 per cent); with boys having a slightly higher stunting prevalence (30 per cent) as compared to girls (22 per cent) and rural areas having higher rates (29 per cent) than urban areas with 20 per cent. Generally stunting decreases with the level of education of the mother, with women who have not completed primary school having children who are twice as likely to suffer from stunting (34 per cent) as mothers with secondary or higher education (17 per cent).

Various forms of malnutrition can coexist in an individual. A child can be stunted as well as wasted, underweight, and suffer from one or more micronutrient deficiencies. On the other hand, a person may be overweight or obese and at the same time suffer from multiple micronutrient deficiencies.

1.2.1.1 Trends of under nutrition in Kenya

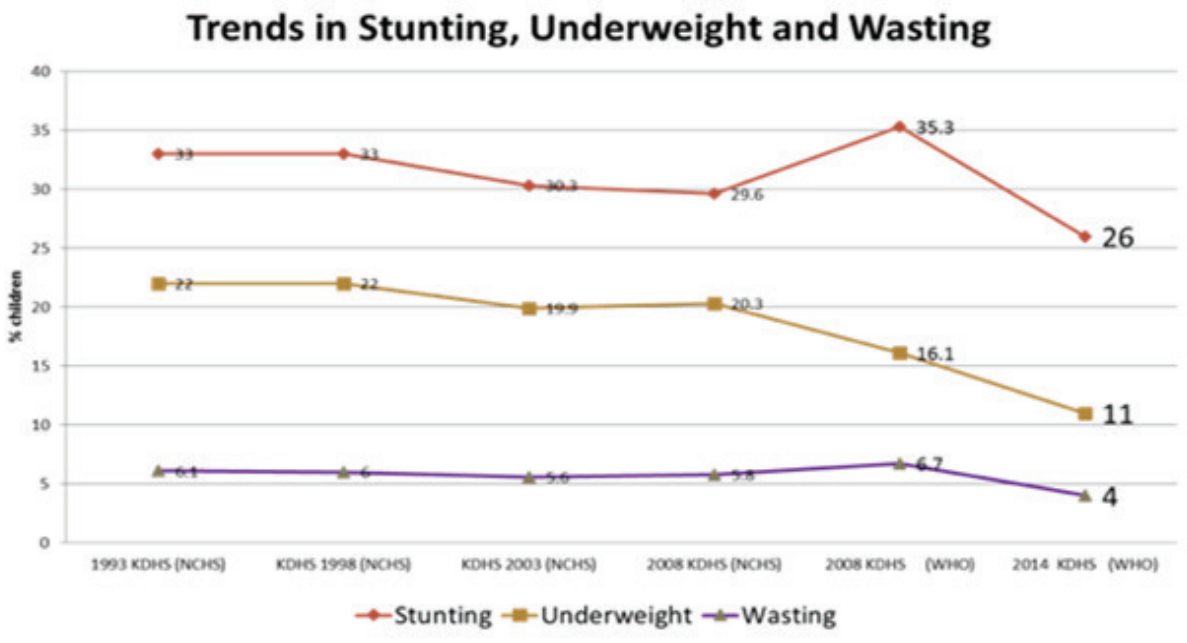

Figure 2: Trends in stunting and wasting in Kenya (source: KDHS 2014)

1.2.2 Over Nutrition

The Kenya 2015 STEP wise Survey22 indicated an increasing rate of overweight/obesity and diet-related non-communicable diseases (DRNCDs) in adults. A total of 28 per cent of adults aged 18–69 years were either overweight or obese, with the prevalence in women being 38.5 per cent and men 17.5 per cent. Similar trends are seen when comparing the 2008– 2014 KDHS. The proportion of women who were overweight or obese increased from 25 per cent to 33 per cent and those who were obese increased from 7 per cent to 10 per cent. The prevalence of overweight or obesity is higher in urban areas (43 per cent) than in rural areas (26 per cent); in women with higher education (38 per cent) than with low education (18 per cent); and higher in women in the highest wealth quintile (50 per cent) compared with those in the lowest wealth quintile (12 per cent).

1.2.3 Micronutrient deficiencies

According to the Kenya National Micronutrient Survey of 2013, significant progress is being made in reducing the prevalence of micronutrient deficiencies, except for zinc deficiency. The prevalence of anaemia was highest in pregnant women (41.6 per cent), followed by children 6–59 months (26.3 per cent), school–age children (5–14 years) at 16.5 per cent. The prevalence of iron deficiency was 21.8 per cent, 9.4 per cent and 36.1 per cent in the same groups respectively. The prevalence of other types of nutritional anaemia, such as folic acid and vitamin B12 deficiency, was at 31.5 per cent and 47.7 per cent respectively among non-pregnant women aged 15–19 years. The prevalence of vitamin A deficiency among children 6–59 months was 9.2 per cent. Iodine deficiency disorders (IDD) are the most common cause of brain damage, which can easily be prevented by Universal Salt Iodization (USI) programmes. The prevalence of iodine deficiency in pre-school and non-pregnant women was 22.1 per cent and 25.6 per cent respectively.

However, the prevalence of zinc deficiency was high across the population, averaging at about 70 per cent, with pre-school children being 81.6 per cent, school-age children 79.0 per cent, pregnant women 67.9 per cent and non-pregnant women 79.9 per cent. Zinc is a vital trace element with many health benefits.24 Deficiency in children can lead to growth impediments and an increased risk of infection. There are other micronutrients of public health concern demonstrated by disease conditions that have been observed; these include calcium, vitamin D, vitamin B12 and omega 3, especially for older persons and the general population. About 12 per cent of adolescent girls (15–19 years) are overweight or obese (BMI >25) and close to 17 per cent are underweight (BMI).

1.3 Health and nutrition situation in Baringo County

Malnutrition situation in Baringo County takes a similar pattern as that of the Country where both over and under nutrition are manifested in various population in the County owing to diversity in livelihoods and social economic status of the across the County. However, undernutrition has remained a persistent challenge to the greater population and especially to children 6-59 months and women of reproductive age (15-49 years). July 2019 integrated health and nutrition SMART survey conducted in Baringo County indicated a Global Acute Malnutrition (GAM) of 9.3% in Baringo North and South (medium) and a Severe Acute Malnutrition (SAM) of 2.3% in children aged 6-59 months. The same survey indicated a Global Acute Malnutrition (GAM) in Tiaty of 20.9% (very high) and Severe Acute malnutrition (SAM) of 3.5% in children aged 6-59 months. Baringo county has a high proportion of stunted children aged 6-59 months. The July 2019 SMART survey classified the county between medium and very high phase of stunting with Baringo South and marigat at 28.1% and Tiaty being highest with 40.1%.

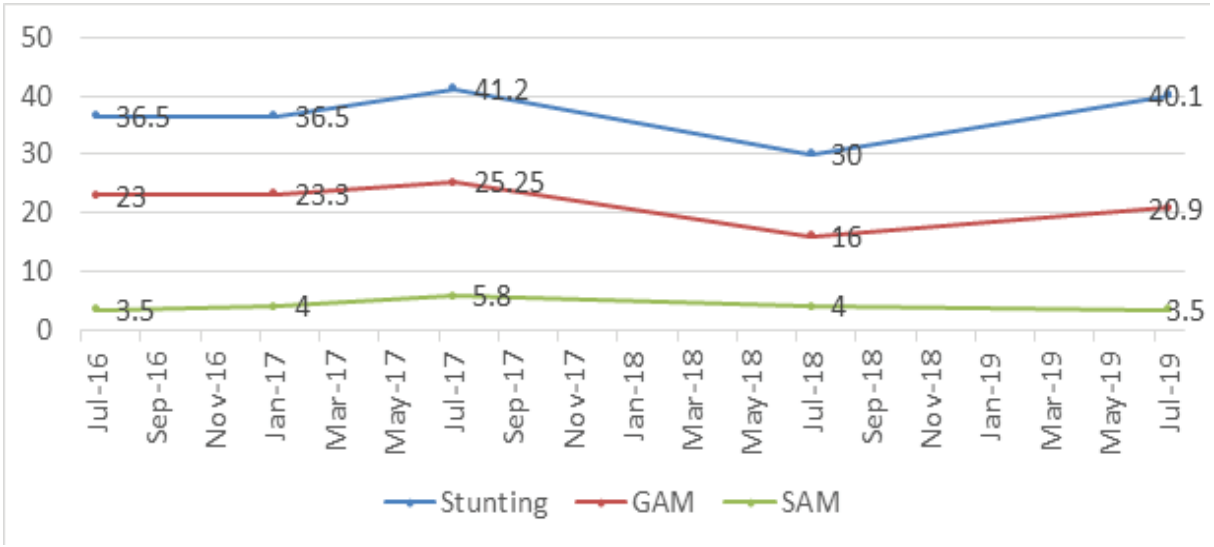

Figure 3: Malnutrition trends in Baringo County (Tiaty)

The causes of this persistently high levels of malnutrition in Baringo County is multi-faceted. These include poor maternal, infant and young child nutrition practices with Exclusive breastfeeding rate in the county is at 32% (KDHS 2014) Food accessibility and consumption is poor across the county with only 33.7% and 66.1% of women consuming foods from the 5 recommended food groups. This translates to poor nutrition status among women of reproductive age which manifest in poor birth outcomes, complications during delivery and generally low economical productivity. The high rate of malnutrition in Baringo County is further complicated by other social/cultural economic challenges including high nutrition knowledge gap in the community, rampant disease outbreaks, insecurity and cyclic draught seasons which altogether complicate nutrition and food insecurity in the county. Below is a summary of the causal pathway for poor nutrition outcomes in the county

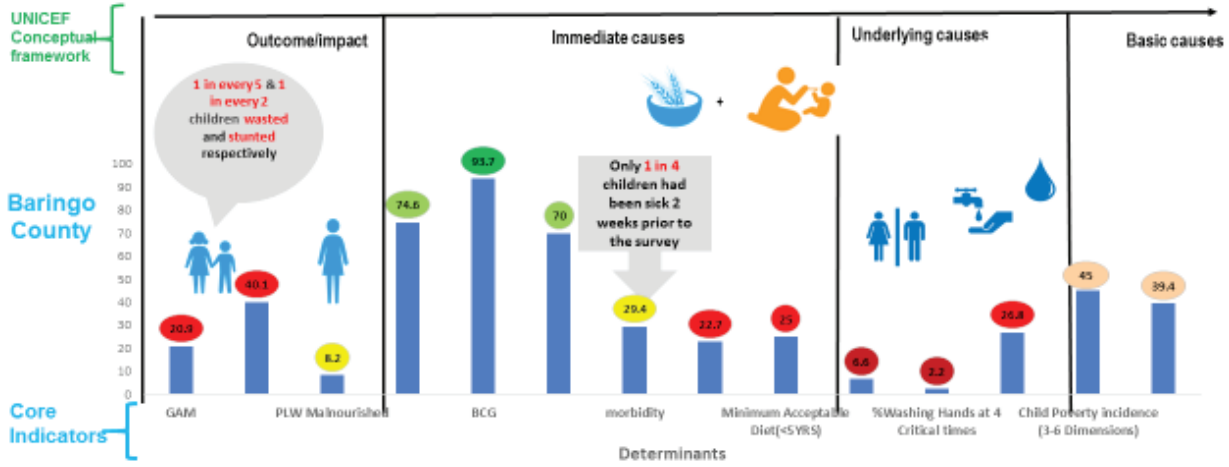

Figure 4. Causality analysis of malnutrition in Baringo County

1.3.1 Feeding practices for children aged under 5 years and women of reproductive age

One of the vital contributors to good child health and survival is the promotion and adoption of appropriate maternal, infant and young child nutrition practices. However, there has been a low uptake of these practices often caused by deeply ingrained cultural beliefs as evidenced by poor/low exclusive breastfeeding rates at and inappropriate introduction to complementary feeds. Majority of households in Baringo (Tiaty Sub county) consume foods form less than the recommended five food groups where majority 43% consume foods from 3-5 food groups with Tiaty Sub county worst where a significant households 34.1% consuming food from less than 3 food groups. Women of reproductive are worst affected where 66.3% and 34.9% of women in Tiaty and Baringo North/South sub counties respectively consuming foods from less than 5 recommended food groups.

These poor feeding patters have a negative impact on birth outcomes including low birthweight. Complementary feeding is poor with negatives outcomes on child wellbeing like stunting attributed partly to the poor feeding practices or prolonged dietary inadequacy (chronic malnutrition) at 29.3% and 40.1% in Baringo North/South and Tiaty sub counties respectively. Such high levels paint a bleak future for the generations to come due to the accompanying negative effect, increased cost of health care, increased expenditure on education and decreased productivity

1.3.2 Morbidity and mortality trends

Table 5: Top ten causes of morbidity among children and the entire population of Baringo county (DHIS 2-2018).

Top Ten Morbidity causes for All ages		Top Ten Morbidity Causes for children Under 5 years	
1	Upper Respiratory Tract Infections	1	Other Disease of Respiratory System
2	Malaria	2	Confirmed Malaria
3	Skin Diseases	3	Disease of the skin
4	Diarrheal diseases	4	Diarrhea
5	Rheumatism	5	Pneumonia
6	Pneumonia	6	Accidents
7	Accidents/Injuries	7	Eye Infections
8	Eye infections	8	Rheumatism
9	Ear Infections	9	Ear infection
10	Typhoid	10	Urinary Tract infection

In terms of inpatient morbidity cases, the main contributors to the burden are both communicable and non-communicable diseases such as diarrhoea diseases, malaria, pneumonia, peptic ulcers, hypertension, psychosis, poisoning, diabetes, anaemia and road injuries. Notably, abortion is also a contributor to admissions indicating that there is gap in provision of family planning and other reproductive health services. The associated risk factors for other conditions include inadequate water, inadequate ventilation, lifestyle habits, poor health seeking behaviours, drugs and alcohol abuse as well as inadequacies in diagnosis and treatment.

1.3.3 Education

The majority community members older than 18 years in Baringo county have no education at 68.8% indicating a high illiteracy level in the county. 16.5% have completed primary level of education with 9.2% having schooled up to secondary education. Only 4.7% of the adults had tertiary education.

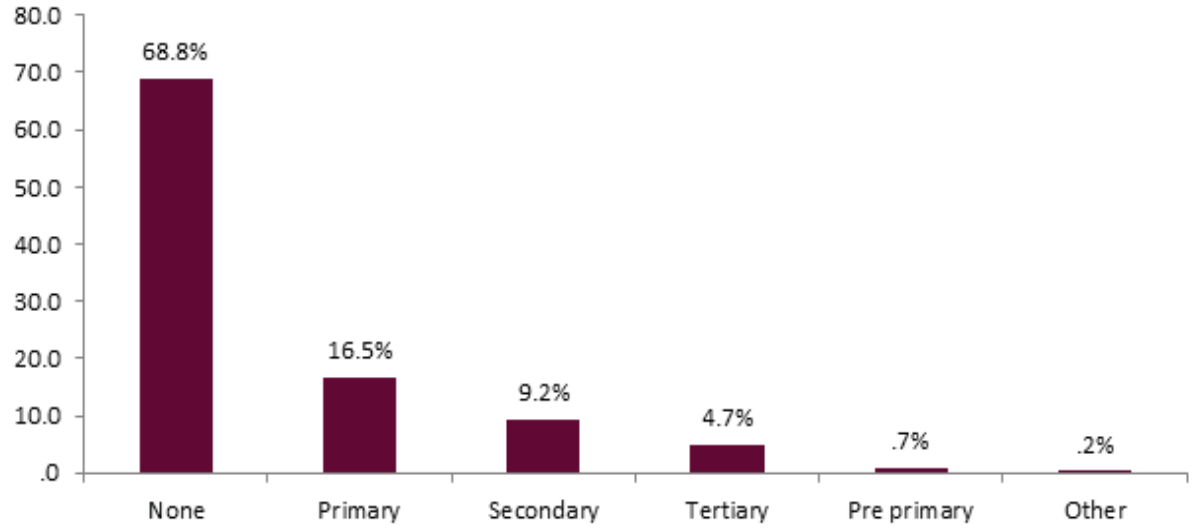

Figure 5: Adult literacy level (SAMRT Survey 2019)

About 77.5% of the school going children are enrolled in school while 22.5% are not enrolled in any school. Major reasons for non-enrolment to school being family labour responsibilities at 68.5%.

1.3.4 Human resource for nutrition

The county has a total of 1,210 staff in the health services department distributed across the levels of the healthcare system. Of these about 200 staff were recruited over the last five years by the county government in a bid to address the capacity gaps in staffing. The distribution of staff across cadres indicate that there are 9 specialists, 19 doctors, 535 nurses and 113 clinical officers. Distribution of staff across the sub-counties also reveals significant inequity.

Table 6: Human Resources for health establishment in Baringo Coutny-2019

Cadre	Baringo Central	Baringo North	Koibatek	Marigat	Mogotio	Tiaty	Total
Nurse	151	65	121	57	59	70	523
Clinical Officer	46	5	39	5	3	2	100
Medical Doctor	31	2	15	5	2	2	57
Dentist	7	0	3	2	1	0	13
Nutritionist	6	3	8	1	4	2	24
Pharmacist	9	3	11	2	2	2	29
HRIO	14	3	4	3	3	3	30
Public Health staff	58	22	46	8	19	13	166

1.4 Nutrition response

Effective and sustainable efforts to improve nutrition must be country led and the government of Kenya has shown strong commitment in tackling malnutrition, particularly by developing the Kenya Nutrition Action Plan (KNAP) 2018-2022 and through its role as the 30th country worldwide to join the Scaling up Nutrition (SUN) movement. The SUN movement lays emphasis on the 11 High Impact Nutrition Interventions (HINI) which if implemented at scale, are effective in preventing malnutrition and mortality in children. They include: promotion of exclusive breastfeeding for the first six months, timely complementary feeding for infants after the age of six months, improved hygiene practices including hand washing, vitamin A supplementation, multiple micronutrient supplementation, zinc supplementation for diarrhea management, de-worming, iron-folic acid supplementation for pregnant women, salt iodization, iron fortification of staple foods, prevention and treatment acute malnutrition.

In realization of this noble goal and with focus on the new government structure, Baringo County department of health services has undertaken to develop a 5year strategic County Nutrition Action Plan in line with the Kenya Nutrition Action Plan 2018-2022 to county level. The county is currently implementing the HINI package of interventions of 2010. This being one of the arid and semi-arid counties in Kenya, it is inherent that undernutrition and other types of malnutrition are manifest and pose the greatest threat to child growth and survival. A raft of measures including the scaling up of the full package of HINI is necessary to mitigate/negate the negative effects of undernutrition.

Over the years, nutrition services have received low attention as evidenced by funding gaps and human resource allocations from the county government. This scenario effectively relegated nutrition services to the realm of being partner-driven whereas it is supposed to be at the epicenter of promotive and preventive health services.

Chapter 2: County Nutrition Action Plan Framework (2019 - 2023)

2.1 Introduction

This is the second generation CNAP building on the gains and lessons learnt from the previous CNAP. It is anchored in the KNAP, The County Health Sector Strategic Plan (2019-2022) and the County Integrated Development Plan (CIDP) 2018-2022. The document has adopted a multisectoral system-wide approach noting that key drivers of malnutrition in Baringo County have multiple causes.

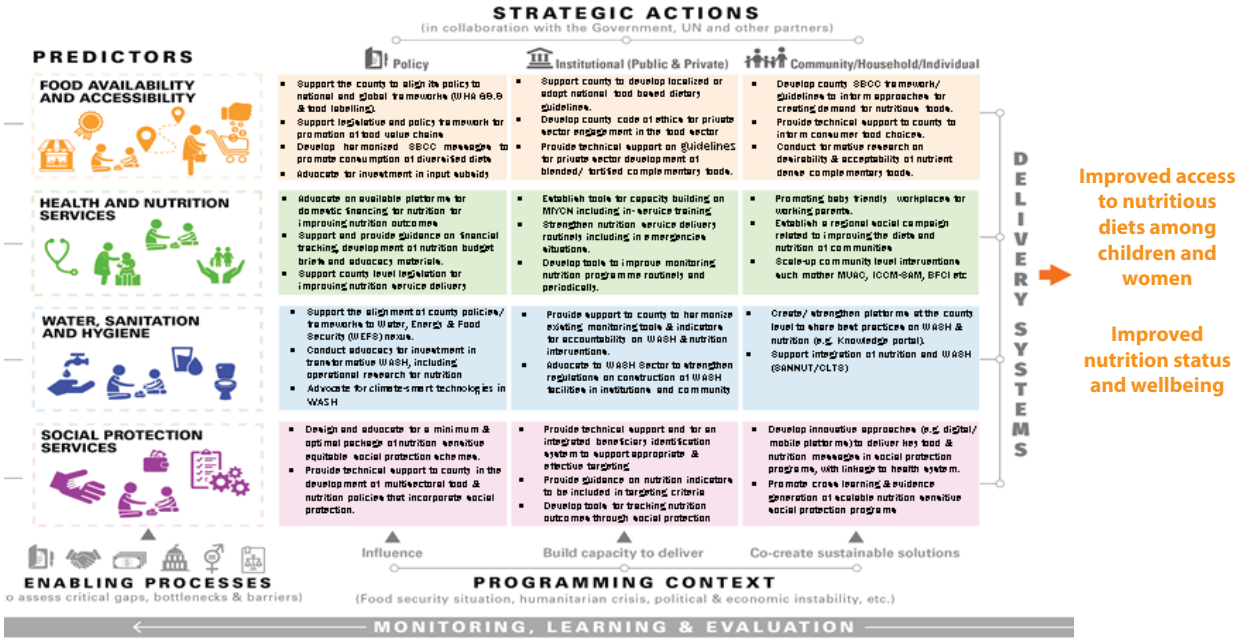

Figure 6: Framework for improving nutrition outcomes in Turkana County: Adapted from the UNICEF Action Frameworks to improve the diets of young children (6-23 months of age) in the East and southern Africa Region (UNICEF, 2019)

The goal of this CNAP is to accelerate scale up of multisectoral nutrition interventions geared towards elimination of malnutrition in Baringo County. Based on the County nutrition analysis, key result areas and strategies have been identified to improve the nutrition situation in the County across all the livelihoods. CNAP 2 has identified 14 key result areas further classified into 3 categories as follows:

1. Nutrition specific
2. Nutrition sensitive
3. An enabling environment

2.0.1 Vision

A county free from malnutrition.

2.1.1 Mission

To reduce all forms of malnutrition within the County through a coordinated multi-sectoral and community centered approaches for optimal health of the population and maximum contribution to economic growth.

2.1.2 Guiding Principles

1. Synergy and inclusivity –The CNAP have adopted a multisectoral implementation approach to build a sense of ownership and sustainability through a shared resource envelope.
2. Prioritization and adoption of High Impact Nutrition Interventions (HiNi) –HiNi has been proven to bear results.
3. Evidence Based decision making – the CNAP promotes use of data for policy formulation, planning and implementation of nutrition interventions
4. Conformity and alignment – This document conform to the National and County strategies and mirrors the Kenya Nutrition Action Plan (KNAP).
5. Stringent and effective Monitoring and Evaluation (M & E) mechanism – M&E matrix in place to measure progress and performance
6. Stewardship and coordination – the document leverages on the existing coordination mechanisms
7. Continuity – the document is based on lessons learnt from the previous CNAP and will provide a basis for future reference

2.2 Rationale for CNAP 2

CNAP 2 shall be a tool for effective resource mobilization to bridge the funding gaps in the nutrition sub program. It will serve as a reference document for all stakeholders/partners. It is integrated into other county strategic documents like County Integrated Development Plan (CIDP) and County Health Sector Strategic & Investment Plan (CHSSIP).

CNAP 2 objectives are anchored in the Constitution of Kenya (2010) and the National Vision 2030. Article 43 1 (c) of the Constitution guarantees right to be free from hunger and have adequate food of acceptable quality, Article 53(1)(c) of the Constitution guarantees the right of every child to basic nutrition, shelter and health, Article 21 of the Constitution establishes progressive realization of social and economic rights and obligate the state to observe, respect, protect, promote and fulfill the rights and fundamental freedoms in the bill of rights. It is boldly supported in High level policy directives such as the Big 4 agenda wherein Universal Health Coverage (UHC), Food and Nutrition security form part of the 4 pillars to accelerate National development.

2.3 CNAP 2 Objective and Purpose

2.3.1 CNAP 2 Objectives

The specific objectives are as follows:

1. To improve nutrition status for women of reproductive age (15 to 49 years) and children (0 to 59 months).
2. To improve the nutrition status for older children, adolescents, adults and older persons.
3. To scale up prevention, control and management of micro-nutrient deficiencies.
4. To strengthen clinical nutrition and dietetics including prevention, control and management of diet related non communicable diseases (DRNCDs).
5. To strengthen the management of acute malnutrition.
6. To strengthen nutrition in emergencies.
7. To strengthen nutrition in TB and HIV management.
8. To strengthen integration of nutrition in Agriculture and Food security, Education, WASH and Social Protection sectors.
9. To strengthen multi-sectoral nutrition governance, coordination and regulation including nutrition information system, learning and research.

10. To strengthen advocacy, communication and social mobilization for nutrition.
11. To strengthen the supply chain management for nutrition and anthropometric equipment.

2.3.2 CNAP 2 Purpose

The purpose of CNAP 2 (2018 - 2022) is to improve the nutritional status and wellbeing of the population with special consideration to targeted cohorts. The focus is to enhance optimal nutrition among women of reproductive age (15 to 49 years), children (0 to 59 months), older children, adolescent, adults and elderly persons. The overall improvement of nutrition status in the population will be determined by concerted efforts of all the stakeholders/partners, multi-sectoral and community centered interventions. The ultimate purpose of CNAP 2 (2018 - 2022) is to bring all the actors together for ownership and joint implementation on Key Result Areas (KRAs).

2.4 CNAP 2 development process

The development of CNAP 2 adopted a consultative multi sectoral approach. Several meetings were held to review CNAP 1, plan for CNAP 2 to the eventual completion of the final document. The document underwent County validation process before eventual launch and adoption

2.5 Target audience for CNAP 2

The target audience for CNAP 2 includes policy makers and decision makers both at national and county levels, county level implementers of both nutrition specific and sensitive interventions, Baringo community as illustrated in the table below.

Table 7: Target Audience

	Category	Players/Actors
1.	Policy makers at National government	Ministry of Health, Ministry of Water and Irrigation, Ministry of Education, Ministry of Agriculture, Ministry of Devolution, Ministry of Labor, NDMA
2.	Policy makers county government	Governor, Members of County Assembly, County Executive, County Departments of Health, Water, Education , Agriculture, Livestock and Fisheries, CPSB
3.	Other stakeholders	Government Agencies and Parastatals, UN Agencies, International and Local non-governmental organizations, religious organizations
4.	Community/households	Caregivers, religious leaders, local administrators, opinion leaders, community at large

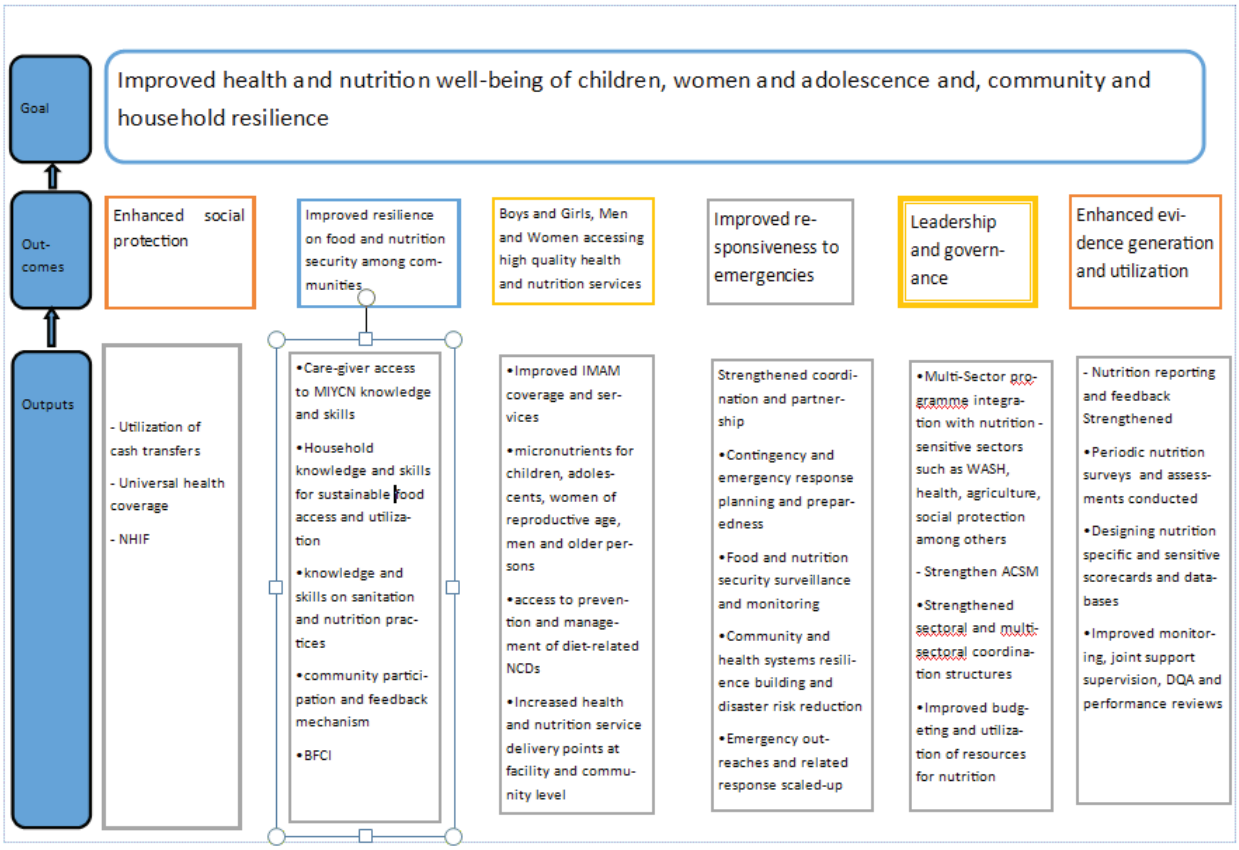

Figure 7: Theory of Change

Chapter 3: Results Framework

3.1 Key result areas (KRAS), strategies and interventions

Table 8: Key Result Areas (KRAs), Strategies and Interventions

CATEGORY OF KRAs by Focus Area	KEY RESULT AREAS (KRAs)
A. Nutrition Specific Result Areas.	KRA 1. Maternal, Infant and Young Child Nutrition (MIYCN) Scaled Up
	KRA 2. Nutrition of older children and Adolescent Promoted
	KRA 3. Prevention, control and management of Micronutrient Deficiencies Scaled up
	KRA 4. Prevention, control and management of Diet Related Non-Communicable Diseases (DRNCDs) scaled up
	KRA 5. Integrated Management of Acute Malnutrition Strengthened
	KRA 6. Nutrition in Emergencies Strengthened
	KRA 7. Clinical Nutrition and Dietetics Strengthened
	KRA 8. Nutrition in Agriculture and Food Security scaled-up
B. Nutrition Sensitive Result Area	KRA 9. Nutrition in Education and Early Childhood Development (EECD) promoted
	KRA 10. Nutrition in Water, Sanitation and Hygiene (WASH) promoted
	KRA 11 Nutrition in Social Protection promoted
C. Enabling Environment Result Areas.	KRA 12. Sectoral and multisectoral Nutrition Governance, Coordination, Legal/regulatory frameworks, Leadership and Management strengthened
	KRA 13. Sectoral and multi sectoral Nutrition Information Systems, Learning and Research strengthened.
	KRA 14. Advocacy, Communication and Social Mobilization (ACSM) strengthened.

KRA 1. Maternal, Infant and Young Child Nutrition (MIYCN) Scaled Up

Optimal maternal nutrition is crucial for the health and development of both the foetus and the mother. Better nourished mothers have increased chances of delivering healthier infants while maternal malnutrition increases the risk of poor pregnancy outcomes. Optimal infant and young child feeding practices including early initiation of breastfeeding, exclusive breastfeeding for the first six months of life and continued breastfeeding up to two years or beyond in addition to timely introduction of adequate, appropriate and safe complementary foods is crucial to ensure good physical and mental development and also contribute to long-term health benefits.

In Baringo County, optimal maternal and child feeding practices are largely influenced by availability, access, affordability and sustainability of food resulting to poor feeding behavior and practices. Only 31.6% of children are exclusively breastfed for six months with only 16% continuing with breastfeeding after 6 months. Only 26.2% of children aged 6-8 months are introduced to complementary feeds appropriately. Child feeding practices further deteriorate with only 31.9% of children aged 6-23 Months consuming Minimum Acceptable diet[1].

1 Baringo County KABP Survey 2015

Output 1.1

Capacity and skills of health workers and Community health volunteers to offer MIYCN services at community and health facilities improved.

Proposed Strategy

Strengthen the capacity of health workers to adequately offer maternal nutrition

Interventions/Activities

1. Train health workers on MIYCN
2. Conduct OJT and Mentorship session on health workers
3. Conduct quarterly joint support supervision
4. Printing and dissemination of MIYCN policies and counselling cards
5. Conduct health education, CMEs on MIYCN at health facilities
6. Train Community health Volunteers on MIYCN
7. Train health workers on BMS Act monitoring

Output 1.2

Uptake of maternal nutrition services at community and health facilities improved

Proposed Strategies

Strengthen Social and behavior change communication (SBCC) at community and health facilities.

Interventions/Activities

1. Facilitate implementation of baby friendly community initiatives in community units
2. Initiate baby friendly hospital initiatives in county and sub county hospitals
3. Initiate social accountability and feedback mechanisms in health facilities
4. Conduct Nutrition focused community dialogue days and action days to CHVs and community leaders and caregivers
5. Initiate care groups in targeted community units.
6. Review and update county SBCC strategy.
7. Conduct BMS act monitoring
8. Support set up of breastfeeding station at workplace

Output 1.3

Evidence generation on maternal nutrition improved

Proposed Strategies

Strengthen collection, documentation, and dissemination of maternal nutrition information at community level

Interventions/activities

1. Conduct maternal nutrition studies and surveys
2. Document and disseminate maternal nutrition information
3. Strengthen reporting on Maternal nutrition activities

KRA 2. Nutrition of older children and Adolescent Promoted

Older Children aged 5-9 years and adolescents aged 10-19 years are faced with social and nutrition challenges. This stage is characterized by a slow, steady rate of physical growth, but a high rate of cognitive, social and emotional development. Adolescents are faced with profound external changes beginning with the body growth spurt and followed by the development of the sex organs and secondary sexual characteristics. Rapid growth increases nutritional requirements.

Output 2.1

knowledge and skills of health workers and school administrators/teachers to offer adolescents health nutrition services improved.

Proposed Strategies

Strengthen capacity of school administration and health workers to offer quality nutrition services

Interventions/Activities

1. Train health workers on adolescent's health and nutrition packages
2. Sensitize school administrators/teachers on school meals policies
3. Train teachers on growth monitoring and health and hygiene promotion packages.
4. Sensitize the school administration and teachers on the importance of nutrition assessment, school meal guidelines and healthy diets &lifestyle among older children and adolescents
5. Sensitive teachers to facilitate formation and activation of school health and nutrition clubs

Output 2.2

Uptake of nutrition services in schools improved

Proposed strategies

Strengthen capacity of schools to offer quality nutrition services

Interventions/activities

1. Conduct biannual deworming in schools
2. Facilitate formation of school health clubs

Output 2.3

Evidence generation on adolescent's health and nutrition improved

Proposed strategies

Strengthen generation and documentation of adolescent's health and nutrition information

Interventions/activities

1. Conduct adolescent's health and Nutrition survey
2. Production of adolescent health and Nutrition documentaries in schools

KRA 3. Prevention, control and management of Micronutrient Deficiencies Scaled up

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 to neural tube defects in newborns and iodine deficiency during pregnancy is the commonest risk factor for preventable brain damage in the newborn.

Baringo County has significantly low rates of combined Iron Folate Acid supplementation with only 58.8% of pregnant women supplemented. Compliance is further compromised by low rates of consumption with 86.7% of the supplemented consuming less than 90 days[2].

Vitamin A supplementation among children aged 6-59 months in Baringo County remain a key gap with 70% of children supplemented at least once in a year[3]. Proportion of children receiving 2 recommended doses of vitamin A in a year is significantly lower at 31.9% in Baringo North/Marigat sub counties and 50.2% in Tiaty[4]. Zinc supplementation remained a key challenge in some parts of Baringo county where only 68.6% of children with diarrhea supplemented with Zinc.

Output 3.1

Knowledge and skills of health workers to offer quality micronutrient supplementation improved

Proposed Strategies

Strengthen capacity of health workers and Community health volunteers to offer micronutrient supplementation among children 6-59 months and pregnant women

Interventions/Activities

1. Train health workers on micronutrient supplementation
2. Sensitization of Community health volunteers and lead mothers on Micronutrients (IFAS, Vitamin A, Micronutrients powders) Supplementation
3. Train health workers on Vitamin a supplementation package
4. Disseminate Micronutrient (IFAS, Vitamin A, Micronutrients powders) policies

Output 3.2

Uptake of Micronutrients by children 6-59 months and pregnant women improved

Proposed Strategies

To promote production and consumption of fortified foods.

Strengthen uptake/consumption of micronutrient by communities

Interventions/Activities

1. Conduct community sensitization/education activities on micronutrient
2. Conduct malezi bora activities
3. Conduct household salt sampling for iodization assessment.
4. Conduct sensitization to local manufacturers and retailers on food fortification
5. Procure and distribute of micronutrients

KRA 4. Prevention, control and management of Diet Related Non-Communicable Diseases (DRNCDs) scaled up

Non-communicable diseases (NCDs)—mainly cardiovascular diseases, cancers, chronic respiratory diseases and diabetes—are the world's biggest killers. Low- and middle-income countries already bear 86% of the burden of these premature deaths, resulting in cumulative economic losses of USD $7 trillion over the next 15 years and millions of people trapped in poverty.

2 Baringo County KABP Survey 2015

3 KHIS 2019

4 SMART Survey 2019

Most of these premature deaths from NCDs are largely preventable by enabling health systems to respond more effectively and equitably to the health-care 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 is a powerful tool for prevention of NCDs. To reduce the preventable and avoidable burden of morbidity, mortality and disability due to non-communicable diseases multi sectoral collaboration is key.

Output 4.1

Prevention and control of DRNCDs at communities improved

Proposed Strategies

Strengthen communication on prevention and control of DRNCDs to communities.

Interventions/Activities

1. Conduct community sensitization and education on prevention of DRNCDs
2. Conduct nutrition counseling to DRNCDs at risk groups in the community on DRNCDs
3. Conduct DRNCDs screening campaigns/activities in the communities
4. Sensitize media, journalists, and editors on NCDs
5. Review County SBCC strategy to include nutrition in management of NCDs
6. Sensitize communities and institutions on adoption of physical activity and healthy diet at workplace.

Output 4.2

Capacity of health workers to manage DRNCDs improved

Proposed Strategies

Strengthen knowledge and skills of health workers to monitor and manage DRNCDs

Interventions/Activities

1. Train health workers on screening of DRNCDs
2. Train health workers on specialized nutrition therapy modules
3. Dissemination of DRNCDs policies to health workers
4. Conduct CMEs on DRNCDs
5. Conduct OJT/mentorship on DRNCDs

Output 4.3

Management of DRNCDs at health facilities improved

Proposed Strategies

Strengthen capacity of health facilities to screen and manage DRNCDs

Interventions/Activities

1. Procure and distribute DRNCDs screening equipment to health facilities
2. Procure nutrition feeds and nutrients for DRNCDs management.
3. Establish specialized clinics for DRNCDs

Output 4.4

Evidence generation on DRNCDs improved

Proposed strategy

Strengthen Information generation and documentation on DRNCDs

Interventions/Activities

1. Conduct operational research on DRNCDs
2. Procure and distribute DRNCDs reporting tools
3. Conduct data quality audits on DRNCDs reports

KRA 5. Integrated Management of Acute Malnutrition Strengthened

Acute malnutrition results from inadequate dietary intake and/or disease as the two immediate causes. A deadly vicious cycle is often created between acute malnutrition and infection, whereby acutely malnourished children are predisposed to infection, and vice versa. Children with acute malnutrition are at a five to nine time's higher risk of death when compared to well-nourished children. In Baringo, there are large disparities in terms of areas affected by acute malnutrition with Tiaty, pockets of Baringo South, Baringo North and Mogotio Sub counties recording high prevalence of Acute malnutrition. 20.9% and 9.3% of children aged 6-59 months in Tiaty Sub County and Baringo North and south sub counties respectively were acutely malnourished with 3.5% and 2.3% suffering from severe acute malnutrition[5].

Output 5.1

Capacity of health workers and community health volunteers on management of acute malnutrition improved

Proposed Strategies

Health workers and Community health volunteers have knowledge and skills on management of acute malnutrition

Interventions/Activities

1. Train health workers on Integrated management of acute malnutrition package
2. Train community health volunteers on Integrated management of acute malnutrition
3. Conduct targeted on job trainings and mentorship activities on IMAM in health facilities
4. Conduct CMEs on IMAM

Output 5.2

Nutrition supply chain improved

Proposed Strategies

Strengthen County acute malnutrition supply chain

Interventions/Activities

1. Procure and distribute nutrition IMAM commodities
2. Conduct Quarterly nutrition commodity supply end user monitoring
3. Train health workers on Logistics management and information systems (LMIS)
4. Procure and distribute nutrition reporting tools

5 Baringo SMART Survey 2019

Output 5.3

Surveillance for acute malnutrition at community level improved

Proposed Strategies

Strengthen nutrition surveillance activities at community level and health facilities

Interventions/Activities

1. Procure and distribute nutrition anthropometric tools and equipment's
2. Conduct nutrition screening and referral at community level through Community units
3. Conduct mass screening exercises in identified hotspots

Output 5.4

Evidence generation on Acute malnutrition improved

Proposed Strategies

Strengthen IMAM monitoring and Evaluation

Interventions/Activities

1. Conduct operational research on IMAM
2. Conduct quarterly nutrition support supervision
3. Support quarterly nutrition data quality audits
4. Procure and distribute nutrition reporting tools

KRA 6. Nutrition in Emergencies Strengthened

Baringo county experiences frequent emergencies such as drought, floods, disease outbreaks (Human, Livestock and Crop) and ethnic violence, among others, These emergencies often cause disruption in normal way of life affecting the health and nutrition of the most vulnerable groups who include pregnant and lactating women, infants and young children, older persons as well as persons with disabilities. National frameworks such as the Ending Drought Emergencies Framework 2018–2022 are in place and are guiding drought management efforts through the National Drought Management Authority.

Output 6.1

Nutrition emergency preparedness and response improved

Proposed Strategies

Scale up Nutrition emergency preparedness activities

Interventions/Activities

1. Participate in Contingency planning review exercise
2. Map Emergency hots spots in Baringo County.
3. Pre-positioning of nutrition supplies in selected sub county stores.

Output 6.2

Capacity of health workers on nutrition in emergencies improved

Proposed Strategies

Nutrition response teams/health workers have knowledge and skills to respond to nutrition emergencies

Interventions/Activities

1. Train NDMA field monitors on Nutrition surveillance in collaboration with NDMA,
2. Train health workers on monitoring and enforcement of breast milk substitute act
3. Train health workers on Nutrition in Emergencies package module
4. Train Community health volunteers on Nutrition in emergencies package module

Output 6.3

Surveillance of Nutrition emergencies improved

Proposed Strategies

Scale up IMAM surge in all health facilities offering IMAM services

Interventions/Activities

1. Train health workers on IMAM surge
2. Set up IMAM surge in all health facilities offering IMAM services
3. Conduct annual County IMAM surge review meetings
4. Conduct OJT and Mentorship on IMAM surge

Output 6.4

Response to nutrition emergencies improved

Proposed Strategies

Strengthen Nutrition emergency response interventions

Interventions/Activities

1. Conduct mass screening in all hot spot areas
2. conduct bimonthly Integrated mobile outreaches in selected hot spots
3. Conduct nutrition and health response monitoring meetings
4. Conduct bimonthly nutrition emergency review meetings
5. Participate in emergency county steering groups meetings

KRA 7. Clinical Nutrition and Dietetics Strengthened

Clinical nutrition practice has emerged as an important discipline in modern medicine. It entails the use of diets and nutrients in prevention of diseases and as an essential component of the medical treatment. An increase in the prevalence of diseases, co-morbidities and related conditions has increased the demand for clinical nutrition and dietetics services at all levels of health care including community-level services. Some of these conditions require specialized nutrition services and specific therapeutic nutrition interventions. Malnutrition as a result of disease is an area of concern worldwide, with global prevalence of hospital-based malnutrition nearly 50 per cent.

Output 7.1

Capacity of health workers on clinical nutrition in disease management improved

Proposed Strategies

Enhance knowledge, skills and competence on clinical nutrition care for health workers

Interventions/Activities

1. Sensitize health workers in nutrition specialized clinics and inpatient on clinical nutrition SOPs
2. Conduct on job trainings/CMEs and Mentorships on health workers on Clinical and dietetics care package
3. Disseminate clinical nutrition guidelines/manual to health workers
4. Sponsor Nutritionists for specialized clinical nutrition courses.

Output 7.2

Management of diseases through nutrition and dietetics therapy improved

Proposed Strategies

Strengthen management of diseases and conditions through clinical nutrition and dietetics

Interventions/Activities

1. Conduct nutrition screening, assessment and diagnosis in all the facilities and communities
2. Procure specialized nutrition commodities for nutrition management
3. Procure and distribute diagnostic tools and other critical care equipment
4. Conduct Nutrition therapy clinics (Diabetes, Hypertension)
5. Nutrition Assessment and care for all inpatient and outpatient clients

Proposed Strategies

Strengthen standards for provision of clinical nutrition services in disease management and referral services

Interventions/Activities

1. Develop SOPs for inpatient care
2. Conduct clinical nutrition data review meetings

KRA 8. Nutrition in Agriculture and Food Security scaled-up

The entire food system from production to consumption has an influence on the nutritional status of a population. Challenges in food production, storage, processing, marketing, consumer demand and preparation, consequently, result in dietary inadequacy that leads to nutritional problems at household level. Markets plays a critical role in increasing access to safe and nutritious foods. Challenges, however, exist in weak market structures and there are opportunities to improve the marketing channels to provide well-defined outlets and markets. Food quality and safety along the value chain is critical to good health and nutrition outcomes.

In Baringo, safe and adequate nutritious diets are not easily accessible and adequately utilized by most households as 33.7 % of households consumed less than 5 or more food groups, This is as a result of high post-harvest losses (farm level PHL of maize is estimated to be more than 30% and half of this occur in storage) ,Low production diversification across all the agriculture sector, Weak market structures and Poor infrastructure.

Output 8.1

Household access to nutritious and safe food along different food value chains improved

Proposed Strategies

Promote adoption of appropriate technologies for improved production and utilization of nutritious foods.

Interventions/Activities

1. Conduct sensitization forums for community groups (i.e. MTMSG & CMSG) on establishment and management of kitchen gardens.
2. Advocate on use of low-cost energy technologies to MTMSGs
3. Conduct cooking demonstrations/ food processing, preservation and storage on job extension trainings at the community level.

Proposed Strategies

Support community institutions Nutrition education programmes through Agri-nutrition.

Interventions/Activities

1. Conduct practical/ demonstrations teaching sessions on health diet at specific community meetings (i.e chief barazas,)
2. Sensitize community group leaders (churches, and youth groups) on diversified health diet per cohorts.

Output 8.2

Nutrition Knowledge, attitudes, and practices at Household level improved

Proposed Strategies

Support the development of key nutrition messages and dissemination.

Interventions/Activities

1. Conduct formative study on maternal infant and young child nutrition feeding practices at the community level.
2. Form and train a taskforce to review the SBCC strategy and develop simplified nutrition Key messages.

Proposed Strategies

Dissemination of Nutrition messages through vernacular FM stations.

Interventions/Activities

1. Conduct monthly nutrition messages in FM stations.

Activation of radio listener groups through wind up radios.

Proposed Strategies

Information sharing and dissemination of nutrition best practices among the community groups.

Interventions/Activities

1. Conduct learning and exposure/visits among different community groups on nutrition best practices.

Output 8.3

Sustainable and inclusive food systems that are diverse and profitable for enhanced nutrition at household level improved

Proposed Strategies

Advocate for joint planning and implementation of nutrition-sensitive programmes by all stakeholders.

Interventions/Activities

1. Hold meetings with technical leads from the relevant sectors (county and Sub County) to disseminate the Agri Nutrition Framework.
2. Conduct Sensitization meeting for the department of agriculture on food composition tables to inform design and implementation of nutrition sensitive value chains in the county
3. Joint planning meeting with relevant sectors to design a calendar and programme of joint events (World Food Day, Breastfeeding week, World Water Day and County Annual Shows)
4. Joint design with Department of Agriculture of cooking demonstrations during the WFD and breastfeeding week

Proposed Strategies

Encourage the production and preservation of safe and nutritious sensitive value chains

Interventions/Activities

1. In collaboration with Agriculture sector, organize six value chain specific community forums on production techniques of nutritious value chains (poultry, indigenous vegetables, doper and Gala goat) and of bio fortified foods (orange flesh sweet potato, vitamin A rich cassava).
2. In collaboration with Agriculture sector, six value chain specific sensitization meetings for County and sub county officials on production techniques of nutritious value chains (poultry, indigenous vegetables, doper and Gala goat) and of bio fortified foods (orange flesh sweet potato, vitamin A rich cassava).
3. In collaboration with Agriculture sector, support the identification and development of targeting criteria of vulnerable households who will benefit from food preservation projects.
4. Advocating with relevant sectors for equipping the communities with food preservation technologies
5. In Collaboration with Agriculture department, organize a training for the CHVs, MTMSG, and others on food preservation technologies (Solar driers)
6. Support the integration of food safety and quality training in the civic education forums, especially targeting MTMSG, community units and women of reproductive age.

Output 8.4

Access to nutritious and safe foods by all households improved.

Proposed Strategies

Promote accessibility of nutritious and safe foods by all households

Interventions/Activities

1. Conduct sensitization meetings targeting the community through organized groups (MTMSG, VSLs, chief Barraza's, churches, farmers groups etc.) on meal planning, meal preparation, preservation and storage
2. Sensitize traders on stocking of diversified foods to deficient areas

3. Organize and Participate in exhibitions on information sharing learning and linkages on consumption of nutritious foods
4. Sensitize the community through organized groups on household budgeting towards improved access to diversified nutritious foods
5. Advocate through the department of gender and social services, donors and implementation partners for social safety nets on the link of cash transfers with the market days
6. Sensitize the cash transfer beneficiaries on importance of purchasing and consuming diversified foods
7. Develop recipes/menus and adopt them in local languages
8. Conduct Nutrition education and demonstration sessions on locally diversified available foods at the community level

Proposed Strategies

Strengthen kitchen gardening technique

Interventions/Activities

1. Sensitize the CHEWS and CHVs on kitchen gardening
2. Establish demo kitchen garden sites at identified health facilities within the 7 sub counties
3. Sensitize the community through community organized groups (MTMSG, VSLs, chief barazas, churches, farmers groups etc.) on how to establish and manage kitchen gardens/home gardens
4. Conduct quarterly cooking demonstrations for complementary feeding at the community through organized community groups
5. Collaborate with the agriculture to disseminate national framework for Agri-nutrition to county leadership for department of agriculture and health
6. Collaborate with department of agriculture to Sensitize agriculture extension officers, nutritionist and CHEWs on Agri-nutrition framework
7. Participate and support in the development of county specific Agri-nutrition action plan

Proposed Strategies

Advocate for joint planning and implementation of nutrition-sensitive programmes by all stakeholders

Interventions/Activities

1. Carry out joint strategic planning meetings by stakeholders for nutrition-sensitive food systems.
2. Hold meeting to identify and profile target groups from the community to be trained for one day
3. Conduct one day Training of target groups on nutrition sensitive food production technologies
4. Sensitizing Mother to mother support group, Farmers/ pastoral fields Schools members on alternative livelihood including startups of Kitchen gardens, multi storey gardens, Indigenous poultry, small animal breeding including poultry and fish
5. Conduct Training of target groups on food storage technologies
6. Sensitization of groups on food composition tables, food recipes and preparation
7. Training of Mother to mother Support groups on adoption of mother MUAC tapes for screening for early detection and referral

Proposed Strategies

Facilitate extension officers and stakeholders on extension service delivery

Interventions/Activities

1. Conduct a capacity needs assessment for Agricultural officers, and nutrition officers in Agri Nutrition (including knowledge on social protection programmes , food composition tables, UHC and NHIF)
2. Training/ Sensitization of Extension officers (home economics) on food composition tables, formulation of local food recipes and preparation
3. Support training of extension officers (refresher course) on Agri-Nutrition as ToTs/Agri-Nutrition Champions
4. Adopt appropriate extension methodologies for Agri Nutrition to the community (Farmer/pastoral field schools)

KRA 9. Nutrition in Education and Early Childhood Development (EECD) promoted

Good nutrition is essential to realize the learning potential of children and maximize returns on educational investments and child stimulation through play and physical activity promotes optimal brain development. Undernourished children in early childhood have lower performance in Intelligence Quotient (IQ) and other tests. In addition, poor child nutrition is associated with poor school enrolment, low attendance and high school dropout. 40% of ECDE learners are not adequately reached in health and nutrition services, Nutrition education in schools is known to foster healthy eating habits in the children themselves and in their families in the short and longer terms. School meals ensure children are well nourished and healthy and can learn.

Output 9.1

Uptake of nutrition services in ECDEs Improved

Proposed Strategies

strengthen capacity of ECDEs to offer quality nutrition services

Interventions/Activities

1. Conduct growth monitoring in ECDE schools in collaboration with education
2. Conduct administration of de-wormers
3. Administration of VIT A supplementation in collaboration with Nutrition personnel to all ECDE children
4. Procure and distribute anthropometric tools
5. Procure and distribute reporting tools

Output 9.2

Capacity of ECDE centers administrators to offer quality nutrition services improved

Proposed Strategies

To promote safe food environment in ECDE Centers and Schools

Interventions/Activities

1. Sensitize school stakeholders in collaboration with Agriculture on production of dietary diversified foods through promotion of School gardens in schools to complement the school meals program
2. Sensitization of stakeholders including curriculum support officers, food service providers and handlers, PTA on healthy and safe food environment
3. sensitize school food handlers on safe and hygiene during food preparation and storage in collaboration with department of public health and school administration.
4. Sensitize school administration (BOMs and head teachers) on school meals guidelines, healthy diets & lifestyle and comprehensive school health policy

KRA 10 Nutrition in Water, Sanitation and Hygiene (WASH) promoted

Context

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

In Baringo County, fundamental challenges to water access, safety and utilization pause a major challenge to communities thereby predisposing communities to greater risk of malnutrition. 76.2% in Tiaty and 52.3% in Baringo north and south sub counties accessing water from surface water while about 35% in Baringo North and South and trek for more than 500 meters to acquire household water. With only 10% of households treating their drinking water, a greater risk stems from the significantly high population; 71.4% in Baringo south and 95.6% in Tiaty sub counties that does not treat by any method their drinking water.

Despite majority of the population having knowledge on latrine use and hand washing practices, open defecation and hand washing practices remain among key challenges in Baringo County. 27.4% of communities in Baringo South and North sub counties and 93.4% in larger Tiaty have no toilets for use. Poor hand washing practices are attributed to high malnutrition and morbidity in the county. Only 2.2% and 10.1% of the communities in Baringo South/North and larger Tiaty wash hands in the 4 critical times defined by WHO.

Output 10.1

Community awareness in nutrition and sanitation improved

Proposed Strategies.

Strengthen community awareness on nutrition and sanitation

Interventions/Activities

1. Roll out SANNUT in community units
2. Conduct triggering activities at community units
3. Conduct community awareness session on utilization and storage of safe drinking water at the community level and institutions.
4. Conduct community/household demonstration on water treatment and hand washing practices

Output 10.2

Capacity of health and WASH professionals on WASH improved

Proposed strategies

Strengthen knowledge and skills of health and key WASH workers on WASH improved

Interventions/Activities

1. Train health workers on basic WASH packages
2. Sensitize community health Volunteers on basic WASH packages
3. Train Water sector staffs on basic hygiene packages
4. Train Health workers and WASH professional on SANNUT

KRA 11. Nutrition in Social Protection promoted

The goal of social protection is that "All Kenyans live in dignity and are cushioned from poverty and vulnerability through social protection to enable them exploit their human capabilities for their own social, economic and political development".

One of the pillars of social protection is to have an increased proportion of poor and vulnerable individuals and households having access to social assistance interventions such as cash transfers. These can be used to buy nutritious food and therefore improve the nutritional status of indigents. The nutrition sector can work closely with social protection to advice on nutritious low cost, locally available foods.

Currently, there are more than 14, 950 beneficiaries under cash Transfer programs supported by National Government, County Government and other Implementing partners. Targeting is largely based on hazard map, poverty Index, food insecurity and other vulnerabilities.

Output 11.1

Integration of nutrition in social protection programing improved

Proposed Strategies

Strengthen linkage and coordination of nutrition priorities in social protection

Interventions/Activities

1. Participate in social protection technical working groups and other relevant meeting
2. collaborate with the social protection department to carry out landmark assessment on the extend on of nutrition integration in the current social protection interventions
3. participate in the design of social protection programmes to include nutrition priorities in all aspect of programme design
4. collaborate with the social protection departments to map out the children and the elderly homes

Output 11.2

Awareness on nutrition and social protection at community level improved

Proposed Strategies

Create awareness on nutrition and social protection at community level

Interventions/Activities

1. Sensitize the social protection officers on good nutrition priorities
2. Sensitize the health workers on social protection interventions
3. sensitize CHVs on social protection programmes /interventions to link and refer the OVC/PWDS and the elderly
4. sensitize beneficiaries and care of social protection on good nutrition practices

KRA 12. Sectoral and multisector Nutrition Governance, Coordination, Legal/regulatory frameworks, Leadership and Management strengthened

The capacity to coordinate and provide leadership in nutrition remains critical in this strategic document. Similarly, the ability to monitor coordination efforts and processes is fundamental, as the number of stakeholders and forums increase/ diversify given the renewed focus on multi sectoral action and collaboration which is a key deliverable of this result area. Achieving nutrition outcomes requires a whole-system approach, with sectors implementing their actions and programmes through mechanisms that promote mutual accountability and ownership for results. Currently, the CSG, CNTF and sector working groups have been the key avenues in the county. This CNAP envisions a robust cross sector coordination which will be sustained through common interests.

At the county level the CNAP envisions private sector collaboration in providing support across focusing on areas of comparative advantage through market forces, product innovations, value addition and engagement in coordination and partnership mechanisms. There is a focus on reduction of fats, sugars and salt in food products; fortification, including of flour, edible oil and iodation of salt in value addition and creation of consumer awareness. The county has also undertaken efforts to enforce of nutrition-relevant regulations including sensitizing health workers on monitoring breast milk substitutes.

Output 12.1

Nutrition governance and coordination improved.

Proposed Strategy

Strengthen multi sectoral nutrition, coordination mechanism at County, Sub County and Community level

Interventions/Activities

1. Hold quarterly county nutrition technical forums
2. Hold Monthly sub county Nutrition technical forums
3. Hold quarterly Nutrition multi sectoral platform meetings
4. Participate in County Steering Group Meetings
5. Participate in the County Public participation forums

Output 12.2

Nutrition legal and regulatory frameworks improved

Proposed Strategy

Strengthen Nutrition legal/ Regulatory frameworks

Interventions/Activities

1. Printing and distribution of IEC materials
2. Dissemination of Nutrition sensitive and specific policies
3. Participate in County health and nutrition policies/bill formulation
4. Participate in the development of SOPs
5. In collaboration with Public health participate in monitoring and enforcement of nutrition sensitive policies.

Output 12.3

Multisectoral health and Nutritional governance improved

Proposed Strategies

Strengthen Health and Nutrition Governance

Interventions/Activities

1. Established Nutrition Multi sector common results framework
2. Participate in quarterly monitoring of the common nutrition framework
3. Facilitate establishment and institutionalization of nutrition social accountability mechanism/ group

KRA 13. Sectoral and multi sectoral Nutrition Information Systems, Learning and Research strengthened

Enhancing nutrition information systems, learning and research is a key objective for this CNAP. This results area thus forms an integral aspect of implementing nutrition interventions and tracking the progress and outcome of implementation, which plays a key role in informing nutrition program improvement, redesigns and decisions making for both the county government and other nutrition stakeholders.

At the county there exist an infrastructure that collects, collates and analyses surveillance and service delivery data through the platforms such as District Health Information software (DHIS2), NDMA early warning system and continuous assessments. Periodic surveys i.e. Kenya Demographic Health Surveys (KDHS) are a repository of information on the county.

Routine data is collected monthly and reported in DHIS, while other nutrition outcome and impact indicators are monitored through periodically collected through small scale surveys such as integrated nutrition SMART surveys and MIYCN KAP assessments, sentinel surveillance by NDMA, the Long Rains Assessment (LRA), Short Rains Assessment (SRA and Coverage assessments (SQUEAC). The information is analyzed, shared and used for decision making in planning appropriate interventions.

Though there has been significant improvement in the nutrition information systems, learning and reflection, challenges still exist including: (1) Limited allocation of financial resources to nutrition information (2) Stock outs of nutrition MoH tools in health facilities (3) Poor documentation of nutrition data and reporting (4) Limited capacity to analyzed and utilize nutrition information. This therefore necessitates a rigorous cross sector engagement and capacity building to ensure that the county improved capacity.

Output 13.1

Multisector Nutrition information systems improved

Proposed Strategies

Strengthen county nutrition information system

Interventions/Activities

1. Routine update of Nutrition Quality improvement tools (IMAM surge Dashboard, LMIS, etc)
2. Conduct Quarterly Nutrition Routine Data Audits
3. Carry out timely update of nutritional score card

4. Carry out midterm evaluation of CNAP
5. Carry out final evaluation of the CNAP to inform the preparation of 3rd generation CNAP
6. Conduct quarterly nutrition data review meeting

Output 13.2

Capacity of health workers on data management and utilization improved

Proposed Strategies

Improve capacity of health workers on collection of quality nutrition data, analysis and dissemination

Interventions/Activities

1. Training of health care workers on data collection, documentation and reporting.
2. Train nutritional officers and other health workers on nutrition survey methodologies (SMART, SQUEAC)
3. Sensitize records officers and nutritionist on timely processing of data (submission, collating and uploading)

Output 13.3

Nutrition research and evidence generation for decision making improved

Proposed Strategies

Strengthen nutrition evidence generation through research and dissemination.

Interventions/Activities

1. Conduct Nutrition SMART survey
2. Conduct Nutrition SQUEAC Survey
3. Conduct Nutrition KABP Survey
4. Conduct Nutrition Capacity Assessment
5. Participate in county, National, and international conferences and workshops on nutrition related research
6. Carry out timely update of nutritional score card
7. Carry out departmental updates on nutrition sensitive programmes during CNTF

KRA 14. Advocacy, Communication and Social Mobilization (ACSM) strengthened

This result area aims to improve and strength governance, capacity to deliver, increase awareness, increase demand and adoption of nutrition services and practices at all levels within the country. The priority for Baringo County is to ensure nutrition-specific and nutrition-sensitive actors are engaged to achieve good nutrition outcomes.

In Baringo Scaling up nutrition movement has been activated resulting in identification of nutrition champions. There have been notable efforts in engagement of members of the county assembly in nutrition financial tracking tool and understanding the impacts of chronic and acute malnutrition. The financial tracking tool created awareness among policy makers on county expenditure and where funding for nutrition. These efforts will be amplified to ensure positive impact on nutrition outcomes are sustained.

The marginal gains on advocacy notwithstanding, gaps still exist. Human resource for nutrition and capacity for advocacy remains low as identified during capacity assessments for Baringo county.

At the community level, minimal community engagement, participation and poor feedback mechanisms has resulted in poor social accountability. Actions in this result area will ensure communities are mobilized to identify and support actions in nutrition which will ensure their well-being. Empirical evidence from SMART surveys and other assessment shows that nutrition-sensitive actions have a big role to play if we are to improve the nutrition indicators. The advocacy actions therefore will ensure line sectors mainstream nutrition in their policies and actions. The objectives and strategies of these key result area aim to address these gaps.

Output 14.1

Nutrition priorities awareness at community improved

Proposed Strategies

Strengthen nutrition Social, Behavior change Communication

Interventions/Activities

1. Review County nutrition SBCC Strategy
2. Train SBCC task force and nutrition champions on designing and disseminating the nutrition strategy
3. Develop and locally contextualize content for mass education programme
4. Document and Share best practices and other nutrition information
5. Mark National days/Campaigns (Malezi bora, World Breast feeding week)

Output 14.2

Advocacy and nutrition resource mobilization improved

Proposed Strategies

Enhance advocacy for increased funding for Nutrition.

Interventions/Activities

1. Conduct advocacy meetings with County Assembly health Committee, Finance and Economic Planning departments for increased allocation to health department.
2. Produce and disseminate nutrition advocacy materials (fact sheets/ briefs, etc)
3. Identify and mentor Nutrition champions
4. Participation in all stages of budget making process

Chapter 4: 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. Evaluation assesses the effectiveness, efficiency, relevance and sustainability of these interventions. Monitoring is the ongoing, routine collection of information about a programs activity in order to measure progress toward results.

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 those 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 key. 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 programs total resources 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 Common results and accountability framework

CNAP has identified results expected upon full implementation of the action plan, together with indicators that will measure the progress of achievement of the strategies outlined. Important to note is a set of key indicators and targets that are referred to as the CRAF that have been three levels (impacts, outcome and output results). Baringo County has identified and selected 26 nutrition targets that constitute the CRAF and if achieved will contribute significantly to the desired change. Table details the baseline data, and mid- and end-term target as well as the sources for these indicators. The largely impact targets are derived from three sources: The World Health Assembly (WHA) six targets for 2025.

Table 9: Results framework

SN	CNAP expected results used where applicable)	Indicator	Baseline 2018 (%)	Data Source	Target 2023 (%)	Framework for targets.
1	Reduce the prevalence of stunting among children under five years by 5%	Prevalence of stunting in children 6-59 months (%)	29.5	KDHS 2014.	25	WHA targets
2	Reduce the prevalence of anaemia in women of reproductive age by 7%	Prevalence of anaemia in women 15-49 years (%)	27	KDHS 2014	20	WHA targets
3	Reduce the prevalence of low birthweight by 4%	Prevalence of low birth weight of 2.5 kg and below (%)	8	KDHS 2014	4	WHA targets
4	No increase in childhood overweight/obese	Prevalence of overweight/ obese in children.	4	KDHS 2014	2	WHA targets
5	Increase the rate of exclusive breastfeeding in the first six months by 28% and above	Prevalence of exclusive breastfeeding in children 0-6 months (%)	31.6	KAPB 2015	60	WHA targets
6	Maintain childhood wasting to less than 15.7%	Prevalence of wasting (W/H <2SD) in children 0-59 months (%).	20.9 (East Pokot). 9.3 (Baringo North/ south)	SMART Survey 2019.	<15.7	WHA targets
7	Reduce childhood underweight by 13%	Prevalence of underweight (W/A<2SD) in children 0-59 months	40.4 (East Pokot). 20.2 (Baringo North/ south)	SMART Survey 2019.	27	NFNSP
8	Maintain proportion of deaths at below 3% for MAM and 10% for SAM	Proportion (%) of discharges from treatment program who have died (among acutely malnourished children for MAM and SAM)	MAM 0.3 SAM 0.1	KHIS 2019	MAM <0.11 SAM <0.52	NFNSP

SN	CNAP expected results used where applicable)	Indicator	Baseline 2018 (%)	Data Source	Target 2023 (%)	Framework for targets.
9	Reduce anaemia in children 6-59 months by 6%	Prevalence of anaemia in children 6-59 months (%)	26%	KDHS 2014	20	CNAP
10	Reduce anaemia in pregnant women by 6% or more.	Prevalence of anaemia in pregnant women (%)	36	KDHS 2014	30	NFNSP
11	Reduce anaemia in adolescent girls by 6%	Prevalence of anaemia in girls 15-19 years (%)	21	KMNS 2011	15	CNAP
12	Reduce folic acid deficiency among non- pregnant women by 9%	Proportion of non-pregnant women with folic acid deficiency (%)	39	KMNS 2011	30	NFNSP
13	Reduce vitamin A deficiency in children by 4%	Prevalence of VAD in children 0-59 months (%)	9	KMNS 2011	5	NFNSP
14	Reduce iodine deficiency among children <5 years by over 7%	Prevalence of iodine deficiency in children <5 years (%)	22	KMNS 2011	15	NFNSP
15	Reduce iodine deficiency among non-pregnant women by over 9%	Prevalence of iodine deficiency in non-pregnant women (%)	26	KMNS 2011	15	NFNSP
16	Reduce prevalence of zinc deficiency in pre-school children by 33%	Prevalence of zinc deficiency in children <5 years (%)	83	KMNS 2011	50	NFNSP
17	Reduce prevalence of zinc deficiency among pregnant women by 20%	Prevalence of zinc deficiency among pregnant women (%)	60	KMNS 2011	40	NFNSP
18	A 10% relative reduction in prevalence of insufficient physical activity	Prevalence of insufficient physical activity in adults 18–64 years of age (%).	6.5	STEPwise survey report.	5	NCD Targets
19	Reduce proportion of population with raised blood pressure or currently on medication by 4%	Proportion of population with raised blood pressure or currently on medication (%)	24	STEPwise survey report.	20	NCD Targets

SN	CNAP expected results used where applicable)	Indicator	Baseline 2018 (%)	Data Source	Target 2023 (%)	Framework for targets.
20	Reduce proportion of population with raised fasting blood sugar	Proportion of adults 18-69 years with raised fasting blood sugar. (%)	1.9	STEPwise survey report.	<1.9	NFNSP
21	Increased proportion of men with normal waist: hip ratio	Proportion of men with normal waist: hip ratio (%).	73	STEPwise survey report.	>73	NFNSP
22	Increased proportion of women with normal waist: hip ratio	Proportion of women with normal waist: hip ratio (%)	64	STEPwise survey report.	>64	NFNSP
23	A 30% relative reduction in mean population intake of salt/sodium	Mean intake of sodium salt (g/ day)	3	STEPwise survey report.	<3	NCDs targets
24	Halt and reverse the rise in obesity by 30%	Prevalence of overweight/ obesity in adults (18-69 years)	28	STEPwise survey report.	25	NCDs targets
25	10% of Population accessing health care services screened and assessed for nutrition status	Proportion of population screened and assessed for nutrition status while accessing healthcare services.	No data		70	Clinical Nutrition targets.
26	Increase access by the population to clinical nutrition and dietetics services	Proportion of population with access to clinical nutrition and dietetics services	No data		10%	Clinical Nutrition targets.
27	Increased budgetary allocation towards nutrition	Percentage of nutrition budget in county health budget	0.1%	County Government 2019/2020 Budget.	2%	Financing of Nutrition.
28	Increase coverage of nutrition assessment counselling and support for people living with HIV	Percentage of People Living with HIV (PLHIV) in care and treatment who were nutritionally assessed.	<50%	NASCOP Quantification 2018.	95%	HIV Nutrition targets as indicated in Quantification plan.

SN	CNAP expected results used where applicable)	Indicator	Baseline 2018 (%)	Data Source	Target 2023 (%)	Framework for targets.
29	Increase access to therapeutic and/ or supplemental food for clinically undernourished people living with HIV	Proportion of clinically undernourished PLHIV who received therapeutic or supplementary food.	<50%	NASCOP Quantification 2018.	70%	HIV Nutrition targets as indicated in Quantification plan.

4.3 CNAP monitoring process

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

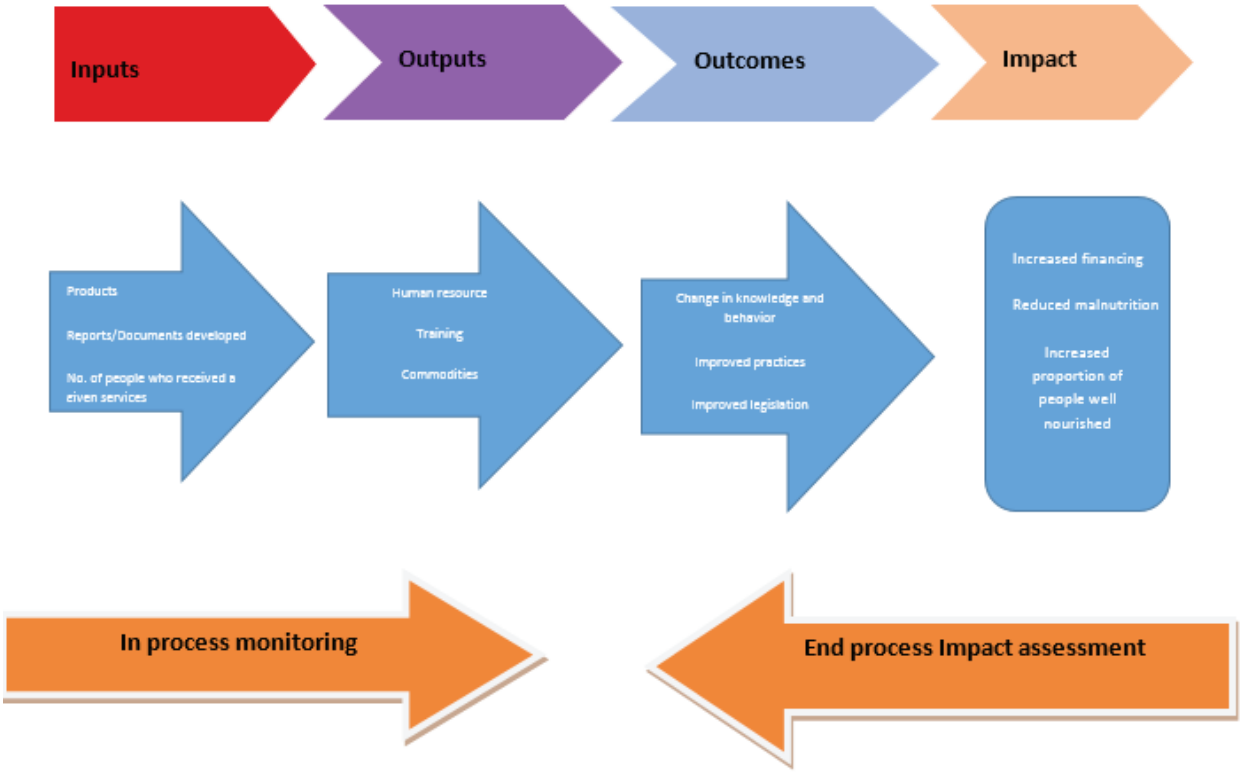

Figure 8: Basic Monitoring and Evaluation Logic Framework

4.4 CNAP Evaluation process

Table 10: CNAP evaluation criteria

What to Measure	Evaluation Questions	Method to answer the Questions	Frequency	Responsible Person
Relevance	• How well was the nutrition programme planned out, and how well was that plan put into practice? • To what extent are the objectives of the nutrition programme still valid? • Are the activities and outputs of the nutrition programme consistent with the overall goal and the attainment of its objectives? • Are the activities and outputs of the programme consistent with the intended impacts and effects?	• Monitoring system that tracks actions and accomplishments related to bringing about the mission of the initiative (activity) • Survey on satisfaction with goals (Client satisfaction survey) • Survey on satisfaction with outcomes (Provider satisfaction survey)	• Baseline (2018) • Annual • Midterm (2021) • End term (2023)	Nutrition Coordinator, M&E Coordinator
Effectiveness	• To what extent were the objectives achieved / are likely to be achieved? • What were the major factors influencing the achievement or non-achievement of the objectives?	• Monitoring system that tracks actions and accomplishments related to bringing about the mission of the interventions (activities) • Behavioural surveys (primary and secondary data sources) • Interviews with key informants	• Baseline (2018) • Annual • Midterm (2021) • End term (2023)	Nutrition Coordinator, M&E Coordinator

What to Measure	Evaluation Questions	Method to answer the Questions	Frequency	Responsible Person
Efficiency	• Were activities cost-efficient? • Were objectives achieved on time? • Was the nutrition programme implemented in the most efficient way compared to alternatives?	• Cost-effectiveness analysis	• Baseline (2018) • Annual • Midterm (2021) • End term (2023)	Nutrition Coordinator, M&E Coordinator
Impact	• What resulted from the nutrition programme? • How has behavior changed as a result of participation in the program? • Are participants satisfied with the experience? • Were there any negative results from participation in the program? • Were there any negative results from the program? • How many people have been affected? • Do the benefits of the program outweigh the costs?	• Behavioural surveys (primary and secondary data sources) • Interviews with key informants	• Baseline (2018) • End term (2023)	Nutrition Coordinator, M&E Coordinator
Sustainability	• To what extent did the benefits of the programme or project continue after donor funding ceased? • What were the major factors which influenced the achievement or non-achievement of sustainability of the programme or project?	• Monitoring system that tracks actions and accomplishments related to bringing about the mission of the initiative (activity) • Behavioural surveys (primary and secondary data sources) • Interviews with key informants	• Baseline (2018) • Midterm (2021) • End term (2023)	Nutrition Coordinator, M&E Coordinator

4.5 CNAP learning process

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

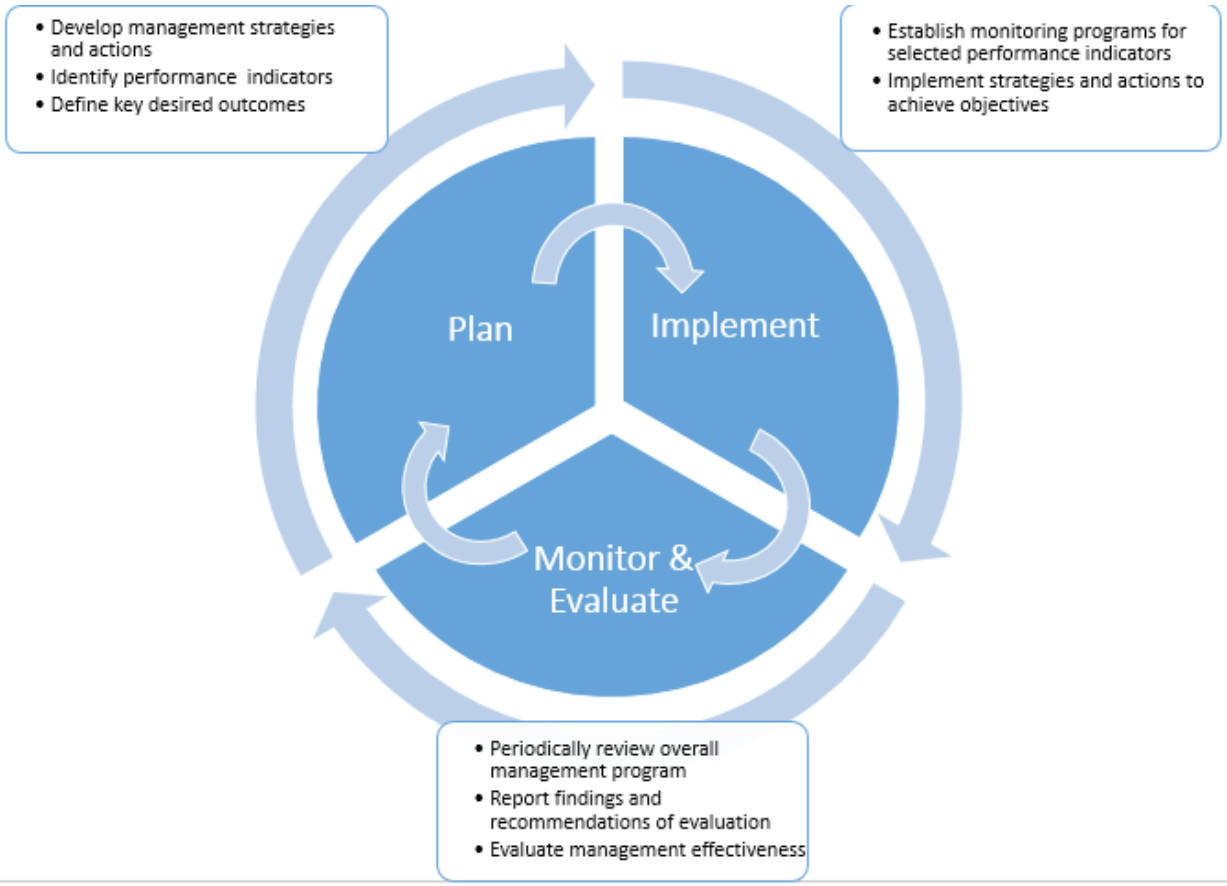

Figure 9: CNAP learning process

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

The CNAP learning process will be guided by the following initiatives:

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

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

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

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

V. Training courses in response to feedback.

VI. Development of innovative tools for MEAL.

4.6 Financial tracking and budget analysis

Tracking the nutrition investments made through the CNAP regularly and transparently is an important aspect in measuring the performance. This will allow the use of finance data (allocations vs expenditures) to mobilize increased domestic and external resources for improved nutrition and for purposes of advocacy and better planning. The county investment in nutrition through budgetary allocation to various sectors, e.g., health, agriculture, education, WASH and social protection, and the KNAP has incorporated nutrition targets in these sectors to ensure these budgets work harder for nutrition impact.

Nutrition financial tracking tool will be adopted. The tool follows a three-step approach namely;

1. Identify relevant budget-line items through a strategically created key word search.
2. Assess whether or not the identified items are specific to nutrition and whether they fall into the category's nutrition-specific, nutrition-sensitive, or enabling environment. Items not related to nutrition are excluded from the analysis after further consultations;
3. Weight or apply an attributable percentage of the allocated budget-line item to nutrition, based on the three categories in step two: nutrition-specific, nutrition sensitive and enabling environment.

4.7 Institutional arrangement for M&E

Baringo County Integrated Monitoring Evaluation System (CIMES), track all government programs. The systems County Integrated Development Plans (CIDPs), which and will provide the county government with reliable policy implementation feedback to help it efficiently allocate resources over time. The County department of health will: 1) provide strategic direction for M&E in the health sector; 2) coordinate M&E activities as well as supporting nutrition programs in their M&E needs; and 3) Work with the HIS team to collect health information and vital statistics required for county health planning. The designated M&E focal persons will also aid in management of data and using it.

4.8 Role of national and county government in implementation of CNAP

National

1. Provision of technical services and coordination in CNAP implementation
2. Financial and technical support to micronutrient survey.
3. Coordinating and supervising the implementation of all CNAP activities at the county level
4. Develop and disseminate the national annual nutrition sector report
5. Develop and disseminate necessary policies and legal acts to support implementation of the CNAP

County Government

1. Provision of technical services and coordination in CNAP implementation
2. Establishment and equipping of robust M&E units aligned to their respective departmental organograms
3. Provide dedicated staff team in implementation of CNAP
4. Coordinating and supervising the implementation of all CNAP activities at the county, sub county, facility levels and community units.
5. Develop and disseminate the County annual nutrition sector report

4.9 Data management for nutrition M&E

The data to be collected, how and when, are key to the success of this CNAP. The role of the health and nutrition information system is collection of health and nutrition data, collation, conveyance and management of the data to information for decision making. This information is only useful when it is reliable and timely. To support health and nutrition information systems strengthening various existing policy documents and guidelines will be used.

4.10 Research

Development of an overall research agenda to support the CNAP is important. The county will link with academic sector on need basis to support nutrition research. Some key implementation research questions that the CNAP may want to be answered as part of implementation monitoring will include:

1. How functional and effective are the coordinating structures at county levels?
2. Have the different sectors and development partners aligned their strategies and programmes with the CNAP?
3. What is the extent of public awareness on nutrition created by the KCAP?
4. Is the leadership and accountability mechanism of the CNAP working as envisaged?
5. Is the change in the nutrition situation (at midterm & end time) a result of the CNAP?

4.10.1 Limitation of the data source

- Poor data quality
- Outdated/ Inadequate data collection tools
- Knowledge gap of healthcare workers in M&E

4.11 Cost of MEAL

MEAL has been allocated between 7 per cent of the total CNAP budget. However, it is recommended that specific activities involved in MEAL should be costed, including assessments, baselines, routine monitoring, ongoing reflection and learning, and periodic evaluations.

Chapter 5: 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 involves estimating the quantity of inputs by an activity/ program, it may also be described as a quantitative process, which involves estimating both operational (recurrent) costs and capital costs of a program. The process ensures that the value of resources required to deliver services are cost effective and affordable.

5.2 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 resource need to implement the action plan for the next five years. The action plans were costed using the Activity-Based Costing (ABC) approach. The ABC uses a bottom-up, input-based approach, indicating the cost of all inputs required to achieve Strategic plan targets. ABC is a process that allocates costs of inputs based on each activity, it attempts to identify what causes the cost to change (cost drivers); 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 labour, 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.

5.3 Total Resource Requirements (2018/19 – 2022/23)

The Strategic plan was costed using the Activity Based Costing (ABC) approach. The ABC uses a bottom-up, input-based approach, indicating the cost of all inputs required to achieve planned targets for the financial years of 2018/19 – 2022/23. The cost over time for all the Key Result Areas provides important details that will initiate debate and allow County health management and development partners to discuss priorities and decide on effective resource allocation.

The KRAs provided targets to be achieved within the plan period and the corresponding inputs to support attainment of the targets. Based on the targets and unit costs for the inputs, the ABC costing provides a clear picture of activity requirement at a glance. The strategic plan was computed. According to the Activity Based Costing, to fully actualize the strategic plan, KShs. 4,303,813,157 billion is required as shown in the figure below.

5.4 Implementation resources

Table 11: Summary of Resource Need By KRA

Category of intervention	KRA	2019/ 2020	2020/ 21	2021/ 2022	2022/ 24	Total KSH
Nutrition Specific	KRA 1. Maternal, Infant and Young Child Nutrition (MIYCN) Scaled Up	23,799,000	23,799,000	23,799,000	23,799,000	95,196,000
	KRA 2. Nutrition of older children and Adolescent Promoted	8,049,450	8,049,450	8,049,450	8,049,450	32,197,450
	KRA 3. Prevention, control and management of Micronutrient Deficiencies Scaled up	33,123,000	33123000	33123000	33123000	132,492,000
	KRA 4. Prevention, control and management of Diet Related Non-Communicable Diseases (DRNCDs) scaled up	2,732,000	2,732,000	2,732,000	2,732,000	10,928,000
	KRA 5. Integrated Management of Acute Malnutrition Strengthened	81,419,800	81,779,440	81,419,800	81,779,440	325,648,480
	KRA 6. Nutrition in Emergencies Strengthened	27,590,650	33,145,400	27,590,650	33,145,400	121,472,100
	KRA 7. Clinical Nutrition and Dietetics Strengthened	11,738,900	12,738,900	11,138,900	11,138,900	46,755,600
Nutrition Sensitive	KRA 8. Nutrition in Agriculture and Food Security scaled-up	3,089,350	3,089,350	3,089,350	3,089,350	12,357,400

Category of intervention	KRA	2019/ 2020	2020/ 21	2021/ 2022	2022/ 24	Total KSH
	KRA 9. Nutrition in Education and Early Childhood Development (EECD) promoted	4,847,000	4,847,000	4,847,000	4,847,000	19,388,000
	KRA 10. Nutrition in Water, Sanitation and Hygiene (WASH) promoted	5,244,400	5,244,400	5,244,400	5,244,400	29,177,600
	KRA 11 Nutrition in Social Protection promoted	553,000	1,281,500	1,805,501	553,000	4,193,001
Enabling environment/ Crossing Cutting	KRA 12. Sectoral and multisectoral Nutrition Governance, Coordination, Legal/regulatory frameworks, Leadership and Management strengthened	16,657,800	24,619,400	24,619,400	24,619,400	90,516,000
	KRA 13. Sectoral and multi sectoral Nutrition Information Systems, Learning and Research strengthened.	22,383,800	32307800	24395800	39377800	118,465,200
	KRA 14. Advocacy, Communication and Social Mobilization (ACSM) strengthened.	8,176,400	9,713,850	9,964,450	8,567,550	36,422,250
Total		246,116,350	273,182,290	258,530,501	276,777,490	1,075,209,431

5.5 Funding opportunities and sustainability of CNAP

While it is critical to mobilize domestic resources to fund full implementation of the CNAP, the role of donors and NGOs is very important. For the past several years, expenditure on nutrition has been relatively low. There has been no allocation for nutrition except for financial 2019/2020 whereby the allocation was 2,000,000.

Appendices

Appendix i

References

1. County Integrated Development Pan
2. County health strategic plan
3. County SMART survey 2019
4. County SQUEAC Survey
5. Kenya demographic health survey 2014
6. Kenya Nutrition Action Plan
7. Short rains assessment report 2019

Appendix ii

Detailed MEAL Matrix

No	Expected Results	Indicator	Baseline 2018/ 2019	2019/ 20	2020/ 21	2021/ 22	2022/ 23	Means of verification	Lead	Associated
KRA 1. Maternal, Infant and Young Child Nutrition (MIYCN) Scaled Up										
1	Capacity and skills of health workers and Community health volunteers to offer MIYCN services at community and health facilities improved.	Proportion of health workers trained on MIYCN	30%	40%	60%	75%	90%	Training reports	CNC/ CDH	CGB/ IPs
		Proportion of health workers trained on BMS Act	10%	20%	35%	50%	65%	SMART survey	CNC/ CDH	CGB/ IPs
		Proportion of CHVs sensitized on MIYCN	33%	45%	60%	65%	70%	SMART Survey reports	CNC/ CDH	CGB/ IPs
	Uptake of maternal nutrition services at community and health facilities improved	Proportion of community units implementing BFCI	40%	45%	55%	70%	80%	BFCI Reports	CNC/ CDH	CGB/ IPs
		Number of health facilities implementing BFHI	1	1	3	5	7	Facility Report	CNC/ CDH	CGB/ IPs
		Proportion of Children 0-5 Months Exclusively breastfed	31.6%	35%	40%	45%	50%	KABP Report	CNC/ CDH	CGB/ IPs
		Proportion of children 6-23 months consuming Minimum acceptable Diet	31.9%	35%	40%	45%	50%	KABP Survey	CNC/ CDH	CGB/ IPs
		Proportion of health facilities with Social accountability and feedback mechanism	5	10	25	40	50	Facility Report	CNC/ CDH	CGB/ IPs
		Updated SBCC strategy	1	1	1	1	1	SBCC Strategy	CNC/ CDH	CGB/ IPs
		Number of organizations/ institutions with breast feeding places	0	1	4	7	10	Facility Reports	CNC/ CDH	CGB/ IPs
	Evidence generation on maternal nutrition improved	Number of MIYCN studies/ surveys conducted	0	0	1	0	1	Research report	CNC/ CDH	CGB/ IPs
		Number of MIYCN documentaries conducted	1	1	1	1	1	Documentary report	CNC/ CDH	CGB/ IPs
KRA 2. Nutrition of older children and Adolescent Promoted										
	knowledge and skills of health workers and school administrators/ teachers to offer adolescents health nutrition services improved.	Proportion of schools with administration sensitized on school meal guidelines	0	2%	4%	6%	8%	Nutrition program reports	CNC/ CDH	CGB/ IPs
		Proportion of health workers trained on adolescent's health and nutrition	0	10%	25%	50%	70%	Nutrition program reports	CNC/ CDH	CGB/ IPs

No	Expected Results	Indicator	Baseline 2018/ 2019	2019/ 20	2020/ 21	2021/ 22	2022/ 23	Means of verification	Lead	Associated
	Uptake of nutrition services in schools improved	Proportion of schools with health and nutrition clubs	0	2%	4%	6%	8%	Nutrition program reports	CNC/ CDH	CGB/ IPs
		Proportion of schools with children dewormed annually	0%	5%	10%	20%	40%	Nutrition program reports	CNC/ CDH	CGB/ IPs
	Evidence generation on adolescent's health and nutrition improved	Number of adolescent's health and nutrition studies conducted	0	0	1	0	1	Study report	CNC/ CDH	CGB/ IPs
		Number of health and Nutrition documentaries on adolescents done	0	0	1	0	1	Documentary report	CNC/ CDH	CGB/ IPs
KRA 3. Prevention, control and management of Micronutrient Deficiencies Scaled up										
1	Knowledge and skills of health workers to offer quality micronutrient supplementation improved	Proportion of health workers trained on micronutrient supplementation	0%	20%	50%	75%	100%	Training reports	CNC/ CDH	CGB/ IPs
		Proportion of health workers trained on VAS	0%	20%	50%	75%	100%	Training reports	CNC/ CDH	CGB/ IPs
		Proportion of CHVs sensitized on Micronutrients	0%	20%	50%	75%	100%	Training reports	CNC/ CDH	CGB/ IPs
		Number of Micronutrient policies disseminated	1	1	1	1	1	Meeting reports	CNC/ CDH	CGB/ IPs
2	Uptake of Micronutrients by children 6-59 months and pregnant women improved	Proportion of children aged 6-59 months supplemented with Vitamin A	70%	80%	85%	90%	100%	Nutrition program Report/ SMART Survey	CNC/ CDH	CGB/ IPs
		Proportion of pregnant women consuming IFAS for more than 90 days	15%	20%	30%	40%	50%	KABP Survey	CNC/ CDH	CGB/ IPs
KRA 4. Prevention, Control and management of Diet Related Non-Communicable Diseases (DRNCDs) scaled up										
1	Prevention and control of DRNCDs at communities improved	Number of sensitization meetings held with county leadership and stakeholders on prevention, management and control of DRNCDs	0	1	1	1	1	Training reports	CNC/ CDH	CGB/ IPs
		Number of media messages/talks held on Diet related DRNCDs	1	2	4	4	4	Media brief	CNC/ CDH	CGB/ IPs
2	Capacity of health workers to manage DRNCDs improved	Proportion of health facilities screening for DRNCDs and reporting	28%	45%	65%	85%	100%	Nutrition reports	CNC/ CDH	CGB/ IPs
		Number of health workers trained on DRNCDs	24	30	30	30	30	Training report	CNC/ CDH	CGB/ IPs
3	Management of DRNCDs at health facilities improved	Proportion of health facilities with DRNCDs clinics	1	2	4	4	4	Media brief	CNC/ CDH	CGB/ IPs
4	Evidence generation on DRNCDs improved	Number of DRNCDs research/Studies conducted	0	0	1	0	1	Research Report	CNC/ CDH	CGB/ IPs
KRA 5. Integrated Management of Acute Malnutrition Strengthened										
1	Capacity of health workers and community health volunteers on management of acute malnutrition improved	proportion of health workers trained on Integrated management of acute malnutrition	60%	70%	80%	90%	100%	IRIS	CNC/ CDH	CGB/ IPs
		Proportion of CHVs sensitized on IMAM	25%	40%	60%	80%	100%	Training reports	CNC/ CDH	CGB/ IPs
		Number of Joint Support supervisions conducted	4	4	4	4	4	Monitoring reports	CNC/ CDH	CGB/ IPs

No	Expected Results	Indicator	Baseline 2018/ 2019	2019/ 20	2020/ 21	2021/ 22	2022/ 23	Means of verification	Lead	Associated
2	Nutrition supply chain improved	Proportion of health facilities reporting 0 stock outs for OTP/SFP commodities	9%	7%	5%	3%	0%	LMIS Reports	CNC/ CDH	CGB/ IPs
		Number of health workers trained on Logistics management and information systems (LMIS)	0	50	50	50	50	IRIS	CNC/ CDH	CGB/ IPs
3	Surveillance for acute malnutrition at community level improved	Proportion of community units conducting active case finding	20%	30%	50%	75%	90%	Nutrition program Reports	CNC/ CDH	CGB/ IPs
		Proportion of CHVs with MoH 100 referral tools	20%	30%	50%	75%	100%	Nutrition program Reports	CNC/ CDH	CGB/ IPs
4	Evidence generation on Acute malnutrition improved	Proportion of health facilities supported to conduct IMAM data quality audits	25%	35%	50%	60%	70%	Nutrition program Reports	CNC/ CDH	CGB/ IPs
		Number of operational studies conducted	2	1	2	1	2	Study report	CNC/ CDH	CGB/ IPs
KRA 6. Nutrition in Emergencies Strengthened										
1	Nutrition emergency preparedness and response improved	Number of contingencies reviewed and updated	1	1	1	1	1	Updated Contingency plan	CNC/ CDH	CGB/ IPs
		Number of sub counties with pre-positioned nutrition commodities	1	3	6	7	7	Nutrition program Reports	CNC/ CDH	CGB/ IPs
2	Capacity of health workers on nutrition in emergencies improved	Number of health workers trained on monitoring and enforcement of breast milk substitute act	33	30	30	30	30	IRIS/ Nutrition program Reports	CNC/ CDH	CGB/ IPs
		Number of health workers trained on Nutrition in Emergencies package module (MIYCN-e)	32	35	35	35	35	IRIS/ Nutrition program Reports	CNC/ CDH	CGB/ IPs
3	Surveillance of Nutrition emergencies improved	Number of health workers trained on IMAM surge	20	30	50	75	100	IRIS/ Nutrition program Reports	CNC/ CDH	CGB/ IPs
		Number of health facilities reporting in facility IMAM surge dashboard	15	30	50	75	100	IMAM Surge dashboard	CNC/ CDH	CGB/ IPs
4	Response to nutrition emergencies improved	Proportion of mapped hotspots supported to conduct mass screening	50%	60%	70%	80%	90%	Updated hotspots Mapping Matrix	CNC/ CDH	CGB/ IPs
		Proportion of mapped hotspots supported to conduct integrated outreaches	50%	60%	70%	80%	90%	Updated outreach Mapping Matrix	CNC/ CDH	CGB/ IPs
		Number sub counties conducting Emergency review/coordination meetings	2	4	5	7	7	Meeting reports/ minutes	CNC/ CDH	CGB/ IPs
KRA 7: Clinical Nutrition and Dietetics Strengthened										
1	Capacity of health workers on clinical nutrition in disease management improved	Number of health workers trained on Clinical Nutrition manual	20	30	30	30	30	IRIS/ Training Reports	CNC/ CDH	CGB/ IPs
		Number of clinical Nutrition guidelines disseminated	0	2	2	2	2	Nutrition program report	CNC/ CDH	CGB/ IPs
2	Management of diseases through nutrition and dietetics therapy improved	Number of health facilities Screening for diet related NCDs (Diabetes, Hypertension) in the county	2	5	15	23	31	KHIS	CNC/ CDH	CGB/ IPs
		Proportion of health facilities with equipment to screen for diet related NCDs	5	10	15	23	31	Nutrition program report	CNC/ CDH	CGB/ IPs

No	Expected Results	Indicator	Baseline 2018/ 2019	2019/ 20	2020/ 21	2021/ 22	2022/ 23	Means of verification	Lead	Associated
3	Standards for provision of clinical nutrition services in disease management strengthened	No of health facilities with SOPs on management of diet related NCDs	2	5	15	23	31	Nutrition program report	CNC/ CDH	CGB/ IPs
		No of health workers trained on specialized Clinical (Enteral/ Parenteral) Nutrition	0	5	10	15	20	Training Report	CNC/ CDH	CGB/ IPs
KRA 8. Nutrition in Agriculture and Food Security scaled-up										
1	Household access to nutritious and safe food along different food value chains improved	Proportion of households accessing nutritious, diversified safe food along different food value chains	20%	40%	60%	80%	90%	Nutrition reports	MOAL/MOPH	CGB/ IPs
		Number of MTMSGs sensitized on appropriate technologies (food processing, food preservation and storage)	100	300	500	600	700	Nutrition reports	MOAL/MOPH	CGB/ IPs
		Number of target groups trained on nutrition sensitive food production technologies	7	14	21	28	35	Nutrition reports	MOAL/MOPH	CGB/ IPs
2	Nutrition Knowledge, attitudes, and practices at Household level improved	Number of Health workers/ nutrition sensitive sector representatives trained on SBCC strategy and develop simplified nutrition Key messages.	0	15	20	30	60	Nutrition reports	MOAL/MOPH	CGB/ IPs
		Number of people reached with nutrition key messages	1500	100,000	200,000	300,000	435,000	Nutrition reports	MOAL/MOPH	CGB/ IPs
		Number of wind- up radios procured	5	5	5	10	10	Nutrition reports	MOAL/MOPH	CGB/ IPs
		Number of formative studies conducted	0		1			Study report	MOAL/MOPH	CGB/ IPs
		Number of health facilities with Established demo kitchen garden sites At the 7 sub counties	1	2	4	5	6	Nutrition reports	MOAL/MOPH	CGB/ IPs
3	Sustainable and inclusive food systems that are diverse and profitable for enhanced nutrition at household level improved	Number of organized value chain community forums held on food composition tables, food recipes and preparation	0	10	25	40	50	Nutrition reports	MOAL/MOPH	CGB/ IPs
		Number of coordination meetings held with Agriculture department and social protection in identification of vulnerable households to benefit from nutrition sensitive programs and food storage technologies	0	1	1	1	1	Nutrition reports	MOAL/MOPH	CGB/ IPs
		Number of Extension officers (home economics) trained on food composition tables, formulation of local food recipes and preparation	0	7	15	20	30	Nutrition reports	MOAL/MOPH	CGB/ IPs
KRA 9. Nutrition in Education and Early Childhood Development (ECDE) promoted										
1	Improved nutritional status of all children in ECDE centers and schools	proportion of ECDE and schools administering VIT A supplementation	70%	80%	90%	100%	100%	MOE& MOH reports	MoH	CGB/ IPs
		Proportion of ECDE centers conducting growth monitoring	10%	20%	30%	45%	60%	School Reports	MoH/MoE	CGB/ IPs
		Number of schools with kitchen gardens producing and utilizing dietary diversified foods.	15	30	50	60	70	MOE reports	MOE, MOA	CGB/ IPs

No	Expected Results	Indicator	Baseline 2018/ 2019	2019/ 20	2020/ 21	2021/ 22	2022/ 23	Means of verification	Lead	Associated
		Proportion of BOMs and head teachers sensitized on school meals guidelines, healthy diets &lifestyle and comprehensive school health policy	0%	10%	25%	40%	60%	MOE reports	MoH	CGB/ IPs
		Proportion of ECDE teachers trained on Hygiene promotion and growth monitoring package	60%	70%	80%	90%	100%	MOE reports	MoH	CGB/ IPs
		Number of support staff and education stakeholders trained on safe food handling	0	30	50	60	70	MoH and MOE reports	MoH	CGB/ IPs
KRA 10 Nutrition in Water, Sanitation and Hygiene (WASH) promoted										
1	Community awareness in nutrition and sanitation improved	Number of households treating their drinking water	10%	15%	20%	25%	30%	SMART Survey	MoPH/MoW	CGB/ IPs
		Number of Joint planning meetings held	0	1	1	1	1	Meeting Reports	MoPH	CGB/ IPs
		Number of community units implementing SUNNUT	0	0	15	30	50	Program Reports	MoPH/MoW	CGB/ IPs
		Proportion of population washing hands in all 4 critical points	10.1% B. north/ South)	14%	19%	25%	30%	SMART Survey	MoPH/MoW	CGB/ IPs
		Proportion of Households with toilets	43.6%	48%	53%	58%	65%	SAMRT Survey	MoPH/ Ministry of interior coordination	CGB/ IPs
2	Capacity of health and WASH professionals on WASH improved	Proportion of health workers trained on basic WASH Packages	0%	10%	20%	35%	50%	Training reports	MoPH/MoW	CGB/ IPs
		Proportion of CHVs trained on SUNNUT	0%	10%	20%	35%	50%	Training reports	MoPH/MoW	CGB/ IPs
		Proportion of WASH professionals trained on hygiene promotion Packages	0%	10%	20%	35%	50%	Training reports	MoPH/MoW	CGB/ IPs
KRA 11. Nutrition in Social Protection promoted										
1	Integration of nutrition in social protection programing improved	Proportion of social protection programs with a nutrition component	0	30%	45%	60%	75%	NIMES and CPIMS reports	MoH, ML&SP	CGB/ IPs
		Number of nutrition indicators integrated on the information system for social protection programs	0	10%	15%	30%	40%	NIMES and CPIMS reports	MoH, ML&SP	CGB/ IPs
		Number of social protections working group meeting attended	2	2	4	4	4	Meeting minutes	MoH, ML&SP	CGB/ IPs
2	Awareness on nutrition and social protection at community level improved	Number of social protection officers sensitized on Nutrition priorities	0	10	10	10	10	Sensitization reports	MoH, ML&SP	CGB/ IPs
		Number of joint community awareness sessions done	0	0	2	2	2	Sensitization reports	MoH, ML&SP	CGB/ IPs
KRA 12. Sectoral and multi sector Nutrition Governance, Coordination, Legal/regulatory frameworks, Leadership and Management strengthened										
1	Nutrition governance and coordination improved.	Number of functional nutrition coordination committees' meetings held	4	12	12	12	12	MoH and CSG minutes	MoH, NDMA, DRM	CGB/ IPs
		Multi sector common result framework for nutrition developed	0	1	1	1	1	MoH and MSP minutes	MoH, NDMA	CGB/ IPs

No	Expected Results	Indicator	Baseline 2018/ 2019	2019/ 20	2020/ 21	2021/ 22	2022/ 23	Means of verification	Lead	Associated
2	Nutrition legal and regulatory frameworks improved	Number of Nutrition sensitive bills passed	12	30	60	60	70	Community units reports	MoH	CGB/ IPs
		Number of nutrition sensitive policies disseminated	0	1	2	2	2	Meeting reports	MSP	CGB/IPs
3	Multisectoral health and Nutritional governance improved	Number of social accountability groups	4	20	30	30	45	Community units reports	MoH	CGB/ IPs
		Common Results framework formed	0	0	1	1	1	CRF framework	MSP	CGB/IPs
KRA 13. Sectoral and multi sectoral Nutrition Information Systems, Learning and Research strengthened										
1	Multisector Nutrition information systems improved Capacity of health workers on data management and utilization improved	Number of nutrition quality improvement tools updated	2	4	4	4	4	MoH reports	CDH/CNC	CGB/ IPs
		County RMNCH score card updated	1	1	1	1	1	Updated scorecard	CDH/CNC	CGB/ IPs
		Number of staff trained survey methodologies, data collection, documentation, and reporting	10	15	10	10	10	IRIS/MoH reports	CDH/CNC	CGB/ IPs
		Number of health workers trained on Nutrition data management	10	10	20	20	20	IRIS/MoH Reportd	CDH/CNC	CGB/ IPs
3	Nutrition research and evidence generation for decision making improved	Number of capacity assessments conducted	1	0	1	0	1	Capacity assessment report	CDH/CNC	CGB/ IPs
		Number of nutrition assessments/Surveys conducted (SMART Survey, KABP, SQEAC and CNAP evaluations done)	2	2	2	2	2	Survey and Evaluation database	CDH/CNC	CGB/ IPs
		Number of data quality review and dissemination forums	4	7	7	7	7	MoH reports	CDH/CNC	CGB/ IPs
KRA 14. Advocacy, Communication and Social Mobilization (ACSM) strengthened										
1	Nutrition priorities awareness at community improved	Number of media spots, publications, programs highlighting key nutrition issues in the county	0	6	6	12	12	Reports	CDH/CNC	CGB/ IPs
		Review and update county health and Nutrition SBCC strategy	0	0	1	0	1	Updated SBCC strategy	CDH/CNC	CGB/ IPs
2	Advocacy and nutrition resource mobilization improved	Percentage increase in funding for the nutrition program in the county budget	0	2%	2.8%	3%	4%	Approved County program based budget	CDH/CNC	CGB/ IPs
		Number high level advocacy forums conducted with County executive and member of county assembly	2	4	4	4	4	Advocacy reports	CDH/CNC	CGB/ IPs
		Number of nutrition facts sheets developed and disseminated	0	2	2	2	2	Policy briefs papers	CDH/CNC	CGB/ IPs

Appendix iii

Detailed CNAP Budget

Table 12: Detailed CNAP Budget

KRA	Output	Intervention	2019/ 2020	2020/ 2021	2021/ 2022	2022/ 2023	Total Ksh	Total USD
KRA 1. Maternal, Infant and Young Child Nutrition (MIYCN) Scaled Up	Output 1: Capacity and skills of health workers and Community health volunteers to offer MIYCN services at community and health facilities improved.	Building the capacity of health workers on IFAS	1,313,500	1,313,500	1,313,500	1,313,500	5,254,000	52,540
		Roll out of MIYCN information	1,910,000	1,910,000	1,910,000	1,910,000	7,640,000	76,400
		Building the capacity of health workers and CHVs on MIYCN	7,802,500	7,802,500	7,802,500	7,802,500	31,210,000	312,100
	Output 2: Uptake of maternal nutrition services at community and health facilities improved	Scale up BFCI in the county through building capacity of health workers, CHVs and MTMSGs	9,295,800	9,295,800	9,295,800	9,295,800	37,183,200	371,832
		Conduct support supervision, mentorship and assessment of BFCI activities	3,339,000	3,339,000	3,339,000	3,339,000	13,356,000	133,560
		Print and distribute BFCI IEC materials	138,200	138,200	138,200	138,200	552,800	5,528
	Total		**23,799,000**	**23,799,000**	**23,799,000**	**23,799,000**	**95,196,000**	**951,960**
KRA2: Nutrition of older children, Adolescent, Adults and Older persons promoted	Output 2.1 knowledge and skills of health workers and school administrators/ teachers to offer adolescents health nutrition services improved.	Sensitize school administration on school meal guidelines	4,896,250	4,896,250	4,896,250	4,896,250	19,585,000	195,850
		Training of health workers on adolescent's health and nutrition packages						
	Output 2.2 Uptake of nutrition services in schools improved	Formation of school health and nutrition clubs	3,153,200	3,153,200	3,153,200	3,153,200	12,612,800	126,128
		Deworming of school children annually						
	Total		**8,049,450**	**8,049,450**	**8,049,450**	**8,049,450**	**32,197,800**	**321,978**
KRA 3. Prevention, control and management of Micronutrient Deficiencies Scaled up	Uptake of Micronutrients by children 6-59 months and pregnant women improved	Build capacity of health workers, CHVs, stakeholders and community of micronutrient supplementation	2,000,000	2,000,000	2,000,000	2,000,000	8,000,000	80,000
		Support health workers and CHVs to conduct micronutrient supplementation	3,785,000	3,785,000	3,785,000	3,785,000	15,140,000	151,400
		Strengthen reporting and surveillance for micronutrients	300,000	300,000	300,000	300,000	1,200,000	12,000
	Knowledge and skills of health workers to offer quality micronutrient supplementation improved	Sensitization of traders, CHVs, health workers and community leaders on food consumption	675,000	675,000	675,000	675,000	2,700,000	27,000
		Support health workers and CHVs to routinely monitor iodized salt	363,000	363,000	363,000	363,000	1,452,000	14,520
		Procure and distribute Vitamin A and micronutrient supplementation	26,000,000	26,000,000	26,000,000	26,000,000	104,000,000	1,040,000
	Total		**33,123,000**	**33,123,000**	**33,123,000**	**33,123,000**	**132,492,000**	**1,324,920**

KRA	Output	Intervention	2019/ 2020	2020/ 2021	2021/ 2022	2022/ 2023	Total Ksh	Total USD
KRA 4: Prevention, control and management of diet related NCDs	Prevention and control of DRNCDs at communities improved	County leaders sensitization/Advocacy meeting	150,000	150,000	150,000	150,000	600,000	6,000
		Capacity building of health workers on screening and reporting of NCDs	927,000	927,000	927,000	927,000	3,708,000	37,080
		Periodic surveys and operational research on nutrition related risk factors for NCDs	677,500	677,500	677,500	677,500	2,710,000	27,100
	Capacity of health workers to manage DRNCDs improved	Taskforce developing SBCC on NCDs	247,500	247,500	247,500	247,500	990,000	9,900
		Develop key messages and engage media	730,000	730,000	730,000	730,000	2,920,000	29,200
	Total		**2,732,000**	**2,732,000**	**2,732,000**	**2,732,000**	**10,928,000**	**109,280**
KRA5. Integrated Management of Acute Malnutrition Strengthened	Capacity of health workers and community health volunteers on management of acute malnutrition improved Nutrition supply chain improved Surveillance for acute malnutrition at community level improved Evidence generation on Acute malnutrition improved	Strengthen capacity of health workers on IMAM	2,158,200	2,158,200	2,158,200	2,158,200	8,632,800	86,328
		Train community health volunteers on Integrated management of acute malnutrition	288,000	288,000	288,000	288,000	1,152,000	11,520
		Conduct targeted on job trainings and mentorship activities on IMAM in health facilities	1,350,000	1,350,000	1,350,000	1,350,000	5,400,000	54,000
		Train health workers on Logistics management and information systems (LMIS)	940,000	940,000	940,000	940,000	3,760,000	37,600
		Procure RUTF (Plumpy Nut)	21,000,000	21,000,000	21,000,000	21,000,000	84,000,000	840,000
		Procure RUSF (Plumpy Sup)	27,000,000	27,000,000	27,000,000	27,000,000	108,000,000	1,080,000
		Procure F75/F100	130,000	130,000	130,000	130,000	520,000	5,200
		Mother child Electronic scale	187,500	187,500	187,500	187,500	750,000	7,500
		Procure CSB	24,600,000	24,600,000	24,600,000	24,600,000	98,400,000	984,000
		Conduct Quarterly nutrition commodity supply end user monitoring	760,000	760,000	760,000	760,000	3,040,000	30,400
		Strengthen Nutrition surveillance at community and health facility levels	600,000	600,000	600,000	600,000	2,400,000	24,000
		Scale up non-IMAM health facilities to offer IMAM services	-	359,640	-	359,640	719,280	7,193
		Strengthen IMAM monitoring and Evaluation	2,046,100	2,046,100	2,046,100	2,046,100	8,184,400	81,844
		Procure IMAM Reporting Tools	360,000	360,000	360,000	360,000	1,440,000	14,400
	Total		**81,419,800**	**81,779,440**	**81,419,800**	**81,779,440**	**326,398,480**	**3,263,985**

KRA	Output	Intervention	2019/ 2020	2020/ 2021	2021/ 2022	2022/ 2023	Total Ksh	Total USD
KRA 6. Nutrition in Emergencies Strengthened	Nutrition emergency preparedness and response improved	Participate in Contingency planning review exercise	193,500	193,500	193,500	193,500	774,000	7,740
	Capacity of health workers on nutrition in emergencies improved	Map Emergency hots spots in Baringo County.	162,450	162,450	162,450	162,450	649,800	6,498
		Pre-positioning of nutrition supplies in selected sub county stores.	907,200	907,200	907,200	907,200	3,628,800	36,288
	Surveillance of Nutrition emergencies improved	Training of Nutrition response team on Nutrition surveillance	-	1,450,000	-	1,450,000	2,900,000	29,000
		Sensitization of health workers on breast milk Substitute Act	-	1,870,000	-	1,870,000	3,740,000	37,400
		Train health workers on Nutrition in Emergencies package module	-	835,000	-	835,000	1,670,000	16,700
		Train Community health volunteers on Nutrition in emergencies package module	-	1,015,000	-	1,015,000	2,030,000	20,300
		Scale up IMAM surge in all health facilities offering IMAM services	953,500	1,338,250	953,500	1,338,250	4,583,500	45,835
		Conduct Mass screening in Hot spots	1,814,000	1,814,000	1,814,000	1,814,000	7,256,000	72,560
	Response to nutrition emergencies improved	Conduct Bi monthly Integrated Outreaches	22,120,000	22,120,000	22,120,000	22,120,000	88,480,000	884,800
		Strengthen Nutrition emergency response coordination	1,440,000	1,440,000	1,440,000	1,440,000	5,760,000	57,600
	Total		**27,590,650**	**33,145,400**	**27,590,650**	**33,145,400**	**121,472,100**	**1,214,721**
KRA 7: Clinical Nutrition and Dietetics Strengthened	Capacity of health workers on clinical nutrition in disease management improved	Training on clinical management	503,000	503,000	503,000	503,000	2,012,000	20,120
		CME, OJTs	61,200	61,200	61,200	61,200	244,800	2,448
		Developing and disseminating SOPs	402,100	402,100	402,100	402,100	1,608,400	16,084
	Management of diseases through nutrition and dietetics therapy improved	Disseminate clinical dietetics manual and train hospital dietetics on clinical dietetics SOP	9,400,000	9,400,000	9,400,000	9,400,000	37,600,000	376,000
		Procure specialized commodities for inpatient care						
	Standards for provision of clinical nutrition services in disease management strengthened	Procurement equipment i.e. anthropometric, specialized equipment for critical care					-	-
	Total		**10,366,300**	**10,366,300**	**10,366,300**	**10,366,300**	**41,465,200**	**414,652**

KRA	Output	Intervention	2019/ 2020	2020/ 2021	2021/ 2022	2022/ 2023	Total Ksh	Total USD
KRA 8. Nutrition in Agriculture & Food security scaled up	Household access to nutritious and safe food along different food value chains improved	Build the capacity of existing groups and community leaders on diversified health diets and appropriate technologies	881,200	881,200	881,200	881,200	3,524,800	35,248
	Nutrition Knowledge, attitudes, and practices at Household level improved	Conduct formative study on maternal infant and young child nutrition feeding practices at the community level	518,400	518,400	518,400	518,400	2,073,600	20,736
		Multi sector Taskforce developing SBCC nutrition key messages	165,000	165,000	165,000	165,000	660,000	6,600
		Dissemination of nutrition messsages through local FM radio and activation of radio listeners groups	795,000	795,000	795,000	795,000	3,180,000	31,800
		Conduct learning and exposure/visits among different community groups on nutrition best practices	426,750	426,750	426,750	426,750	1,707,000	17,070
	Sustainable and inclusive food systems that are diverse and profitable for enhanced nutrition at household level improved	Strengthen coordination with other nutrition sensitive sectors	303,000	303,000	303,000	303,000	1,212,000	12,120
	Total		**3,089,350**	**3,089,350**	**3,089,350**	**3,089,350**	**12,357,400**	**123,574**
KRA 9. Nutrition in Education and Early Childhood Development (ECDE) promoted	Improved nutritional status of all children in ECDE centers and schools	Strengthen nutrition Assessment and Vitamin A supplementation on in ECDE centers	1,312,000	1,312,000	1,312,000	1,312,000	5,248,000	52,480
		Sensitizing school administration (BOMs and head teachers) meals guidelines, healthy diets &lifestyle &comprehensive school health policy	2,747,500	2,747,500	2,747,500	2,747,500	10,990,000	109,900
		Sensitization on production of dietary diversified foods, promotion of School gardens, Food safety and storage, food handling, food hygiene and food production	787,500	787,500	787,500	787,500	3,150,000	31,500
	Total		**4,847,000**	**4,847,000**	**4,847,000**	**4,847,000**	**19,388,000**	**193,880**

KRA	Output	Intervention	2019/ 2020	2020/ 2021	2021/ 2022	2022/ 2023	Total Ksh	Total USD
KRA 10 Nutrition in Water, Sanitation and Hygiene (WASH) promoted		Promote hand washing practices in collaboration with public health officers at learning and community institutions.	1,416,800	1,416,800	1,416,800	1,416,800	5,667,200	56,672
	Community awareness in nutrition and sanitation improved	Promote use of water treatment technologies at household and community levels	933,600	933,600	933,600	933,600	3,734,400	37,344
		Roll out SUNNUT in community units	2,050,000	2,050,000	2,050,000	2,050,000	8,200,000	82,000
	Capacity of health and WASH professionals on WASH improved	Build capacity of CHVs and community leaders on sanitation (latrine utilization and waste disposals).	1,454,000	1,454,000	1,454,000	1,454,000	5,816,000	58,160
		Strengthen coordination mechanisms, linking nutrition to WASH	1,440,000	1,440,000	1,440,000	1,440,000	5,760,000	57,600
	Total		**7,294,400**	**7,294,400**	**7,294,400**	**7,294,400**	**29,177,600**	**291,776**
KRA 11. Nutrition in Social Protection promoted	Integration of nutrition in social protection programing improved	Strengthen coordination, assessments and mapping	-	272,500	-	-	272,500	2,725
		Advocate for inclusion of nutrition activities	140,000	140,000	140,000	140,000	560,000	5,600
		Sensitize the social protection officers, nutrition officers, CHV and member of elderly and children's home management nutrition and social protection	329,000	785,000	1,581,501	329,000	3,024,501	30,245
	Awareness on nutrition and social protection at community level improved	Sensitize beneficiaries and care of social protection on good nutrition practices	84,000	84,000	84,000	84,000	336,000	3,360
	Total		**553,000**	**1,281,500**	**1,805,501**	**553,000**	**4,193,001**	**41,930**
KRA 12. Sectoral and multisector Nutrition Governance, Coordination, Legal/regulatory frameworks, Leadership and Management strengthened	Nutrition governance and coordination improved.	Strengthen multi sectoral nutrition, coordination mechanism at County, Sub County and Community level	7,740,000	7,740,000	7,740,000	7,740,000	30,960,000	309,600
	Nutrition legal and regulatory frameworks improved	Strengthen Nutrition, legal/ Regulatory frameworks	3,512,000	3,512,000	3,512,000	3,512,000	14,048,000	140,480
	Multisectoral health and Nutritional governance improved	Strengthen Health and Nutrition Governance	5,405,800	13,367,400	13,367,400	13,367,400	45,508,000	455,080
	Total		**16,657,800**	**24,619,400**	**24,619,400**	**24,619,400**	**90,516,000**	**905,160**

KRA	Output	Intervention	2019/ 2020	2020/ 2021	2021/ 2022	2022/ 2023	Total Ksh	Total USD
KRA 13. Sectoral and multi sectoral Nutrition Information Systems, Learning and Research strengthened	Multisector Nutrition information systems improved	Monitor the implementation of nutrition program	10,827,400	2,907,400	3,917,400	9,977,400	27,629,600	276,296
	Capacity of health workers on data management and utilization improved	Improve capacity of health workers on quality nutrition data collection, analysis and dissemination	2,634,400	2,634,400	2,634,400	2,634,400	10,537,600	105,376
	Nutrition research and evidence generation for decision making improved	Strengthen nutrition evidence generation through research.	8,922,000	26,766,000	17,844,000	26,766,000	80,298,000	802,980
	Total		**22,383,800**	**32,307,800**	**24,395,800**	**39,377,800**	**118,465,200**	**1,184,652**
KRA 14. Advocacy, Communication and Social Mobilization (ACSM) strengthened.	Nutrition priorities awareness at community improved	SBCC review,training and dissemination to relevant stakeholders	1,822,000	1,822,000	1,822,000	1,822,000	7,288,000	72,880
		Local media content creation, Mass education programme,	49,000	399,350	649,950	153,450	1,251,750	12,518
		Training of nutritionist and stakeholders on communication, and media engagement					-	-
		Participation in nutrition symposium and conferences		900,000	900,000		1,800,000	18,000
		Document and Share best practices and other nutrition information		287,100	287,100	287,100	861,300	8,613
		Mark National days/ Campaigns	5,324,000	5,324,000	5,324,000	5,324,000	21,296,000	212,960
	Advocacy and nutrition resource mobilization improved	Conduct advocacy meetings with County Assembly and executive for increased allocation to health department.	744,400	744,400	744,400	744,000	2,977,200	29,772
		Produce and disseminate nutrition advocacy materials	237,000	237,000	237,000	237,000	948,000	9,480
	Total		**8,176,400**	**9,713,850**	**9,964,450**	**8,567,550**	**36,422,250**	**364,223**
TOTAL						**1,070,669,031**	**10,706,690**	

Appendix iv

List of CNAP Contributors

	NAME	DESIGNATION
1.	HON. MARY PANGA	CEC – HEALTH SERVICES
2.	DR. GIDEON TOROMO	CHIEF OFFICER – MED. SERVICES
3.	DR. WINNIE BORE	CHIEF OFFICER PREV. HEALTH
4.	DR. PATRICK BORUETT	CDH-PUBLIC HEALTH
5.	SALOME CHELIMO	CDH – ADMIN / PLANNING
6.	THOMAS CHEPCHIENG	CDH – MEDICAL
7.	DR. MARY SANG	PHARMACIST
8.	ANNAH KIMWA	COUNTY NUTRITION OFFICER
9.	MS. JANE SARICH	SCSHC – TIATY
10.	MR ZAKAYO KIMUGE	SCNC
11.	MR. KIPRONO KOSGEI	SENIOR COUNTY ECONOMIST
12.	ABDI LENTAPANA	COUNTY RESEARCH OFFICER
13.	LAWRENCE MAKAU	AGRICULTURE
14.	HENRY NYAMWEYA	WATER SECTOR
15.	ERIC MUIA	WVK
16.	WINNIE MEGIRI	EDUCATION
17.	LINNET OCHIENG	KRC
18.	EDWARD KUTONDO	NUTRITION OFFICER - UNICEF
19.	FRANCIS KIDAKE	NUTRITION SPECIALIST - UNICEF
20.	JANET NTWIGA	NUTRITION OFFICER - UNICEF
21.	JAMES MUITA	UNICEF
22.	SICILY MATU	NUTRITION SPECIALIST - UNICEF
23.	KEN WAMBUGU	WVK
24.	SALINAH KANGWONY	MARIGAT
25.	MIRIAM CHESIRE	KOIBATEK
26.	BRIGID MAIKONG	SCNC – MOGOTIO
27.	DAN NYAMBAJA	SCNC – TIATY
28.	JANE CHESEREK	HOSPITAL NUTRITIONIST
29.	JOSPHINE MWEMA	WFP
30.	FAITH NYAMAI	WFP
31.	MICHAEL BAMEITT	RESELIENCE OFFICER – DRM
32.	ESTHER ACHAR	AFYA UZAZI
33.	GEORGE OBANYI	AFYA UZAZI

BARINGO COUNTY GOVERNMENT

County Nutrition Action Plan
2019-2023
Working Together Towards Reduction of Malnutrition

Our Partners

unicef
for every child

Kenya Red Cross

USAID FROM THE AMERICAN PEOPLE
Afya Uzazi Program

WFP World Food Programme

World Vision