SAMBURU
COUNTY GOVERNMENT
DEPARTMENT OF HEALTH

County Nutrition Action Plan 2019-2023

Adopting harmonized Multisectoral approaches to address malnutrition.

The financial contribuon of DFID-UK through UNICEF's Maternal & Child Nutrition Programme II and USAID in the development of this County Nutrition Action Plan is greatly acknowledged.

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List of Abbreviations and Acronyms

BFCI	baby friendly community Initiative
CHMT	County Health Management Team
CNAP	County Nutrition Action Plan
MSP	Multi sector platform
MIYCN	Maternal Infant and Young Child Nutrition
CHW	Community Health Workers
EBF	Exclusive Breast feeding
ECDE	Early Childhood Development Education
BMI	Body Mass Index
BMS	Breast Milk Substitute
IFAS	Iron Folate Acid Supplement
MUAC	Mid Upper Arm Circumference
SCHMT	Sub County Health Management Team
KEPH	Kenya Essential Package for Health
KNBS	Kenya National Bureau of Statistics
BFHI	Baby Friendly Hospital Initiative
GAM	Global Acute Malnutrition
SAM	Severe Acute Malnutrition
DRNCD	Diet Related Non-Communicable Disease
CHIS	Community Health Information System
ANC	Anti Natal Care
CHV	Community Health Volunteers
KRA	Key Result Areas
HINI	High Impact Nutrition Intervention
CHSSIP	County Health Sector Strategic Investment Plan
CIDP	County Integrated Development Plan
KNAP	Kenya Nutrition Action Plan
FNSP	Food and Nutrition Security Policy
UNICEF	United Nation
WVK	World Vision Kenya
KRCs	Kenya Red Cross
NHP plus	Nutrition and Health program plus
HIV	Human Immuno Deficiency Virus
AIDS	Acquired Immune Deficiency Syndrome
CHEWS	Community Health Extension Workers
CHUs	Community House hold Units
CMSG	Community Mother Support Groups
CMEs	Continuos Medical Education
ACSM	Advocacy Communication AND Social Mobilization
WBW	World Breastfeeding Week
SLTS	School Led Total Sanitation
CLTS	Community Led Total Sanitation
MNP	Micro Nutrient Powder
WRA	Women of Reproductive Health
OJT	On Job Training
LMIS	Logistic Management Information System
KHIS	Kenya Health Information System
EMR	Electronic Medical Records
IMAM	Integrated Management of Acute Malnutrition
HNSRP	Health and Nutrition Sector Contingency and Response Plan
NACs	Nutrition Assessment and Counseling
TB	Tuberculosis
ASDSP	Agriculture Sector Development and Sustainable Livelihood Program
MOALF	Ministry of Agriculture Livestock Fisheries and Irrigation
GMP	Growth Monitoring Promotion
IDD	Iodine Deficiency Disorder
NSMS	National School Meals Strategy
NSHP	National School Health Program
QASO	Quality Assurance and Standard Officer
WASH	Water, Sanitation and Hygiene
IQ	Intelligence quotient
KABP	Knowledge Attitude Beliefs and Practices
SQUEAC	Semi Quantitative Evaluation of Access and Coverage
IYCN	Infant and Young Child Nutrition
IYCFe	Infant and Young Child Feeding in Emergency
KEBS	Kenya Bureau of Standards
CRAF	Commodity Result and Accountability Framework
MEAL	Monitoring, Evaluation, Accountability and Learning
KDHS	Kenya Demographic and Health Survey
KFSSG	Kenya Food Security Steering Group
CSG	County Steering Group
DQA	Data Quality Assurance
IDSR	Integrated Disease Surveillance
KFSM	Kenya Food Security Meeting
KIRA	Kenya Integrated Rapid Assessment
MCA	Member of County Assembly
CECM	County Executive Committee Member
NCD	Non-Communicable Diseases
NDMA	National Drought Management Authority
IGAs	Income Generating Activities
CNTF	County Nutrition Technical Forum
SCNTF	Sub County Nutrition Technical Forum
NDU	Nutrition and Dietetic Unit
NIPN	Nutrition Information Platform
OTP	Outpatient Therapeutic Program
PHC	Primary Health Care
SFP	Supplementary Feeding Program
PLWH	People Living with Hiv
ORS	Oral Rehydration Salts
SAM	Severe Acute Malnutrition

Preface

It's my pleasure to present the Samburu County Nutrition Action Plan 2018– 2023. The multi sector plan presents a road map for the implementation of nutrition activities in the county over a 5 years period. The goal of this 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. This will go a long way in improving the Health and Nutrition status of the residents of Samburu County. The process of formulating this Action Plan has given us the opportunity to learn and build on our past successes. We have identified strategic interventions across various sectors to respond to emerging health and nutrition issues and meet the nutritional needs of our growing population. It is our duty to robustly coordinate and engage all key stakeholders and the community to enhance nutrition and food security as is presently articulated as part of the key pillars under the President's Big Four Agenda. This document has been well articulated since all key stakeholders were brought on board from the development to the validation process. I acknowledge the contributions from our stakeholders and the leadership and coordination provided by the department of Health in the development of this vital document. The County Government will provide the necessary platform for monitoring its implementation. To implement and achieve the health policy objectives, we need to develop an enabling environment in which our human, financial and physical resources are appropriately allocated and deployed.

Stephen Lekupe

CECM- Health

Foreword

As guided by the robust health sector strategic plan, Samburu County is committed to providing quality healthcare to its residents. In envisioning a County that is free from malnutrition, non-communicable diseases and ill health, a multi-sector lens is proposed for the implementation of proposed programs that are aligned to in the universal health care goals. A situational analysis was conducted in a comprehensive and participatory manner to review the 2013-2018 County Nutrition Action Plan (CNAP) and guide the development of a contextualized 2018-2022. The department of health has made strides in strengthening nutrition services in the County by prioritizing scaling up the delivery of low-cost, high impact nutrition interventions (HINI) to about 75% of the current health facilities and recruiting additional 9 Nutrition officers.

Most importantly, the recognition of nutrition as a sub program in the program-based budgeting is aimed at improving and sustaining funding for nutrition activities. I also recognize the technical support and commitment by all individuals and partners who contributed in making this exercise a success. I look forward to a continuation of this great partnership beyond the implementation, monitoring and periodic review of this plan.

Sam Nakope

Chief Officer - Health

Acknowledgement

The development of the Samburu CNAP 2018-2022 involved a 6 month long participatory and consultative process involving many stakeholders from both nutrition sensitive and specific state non-state actors. I wish to thank those who worked tirelessly to provide technical and financial input, and institutions and individuals who collectively participated and contributed in the development of this plan. These include sector representative from County departments of Agriculture, Water, Education and Non-Governmental Organizations. I acknowledge the Director of Health Services for his coordination, leadership, and stewardship. Special gratitude to all department heads, program managers, County and Sub-County Health Management Teams with leadership from their respective SCMOHs for their technical input and commitment during the process of developing the Action Plan. In addition, I recognize the efforts of the Action Plan Technical Working Groups (TWGs) – that drew membership from the health sector and beyond to steer the review of previous CNAP, drafting and continuous review of the zero draft plan to align with the County Integrated Development Plan (CIDP).

The Department of Health would like to appreciate the technical role and acknowledge the financial support provided by UNICEF, NHP plus, World Vision, Feed the Children and Afya Timiza. Without your support, it would have been impossible to achieve this milestone. I now appeal to our partners and all stakeholders to support the county government in the implementation of this Nutrition Action Plan as envisioned there in.

The department of health wish to convey special thanks and recognize Hon. Stephen Lekupe, County Health Executive Member for Health, Hon Sam Nakope, the Chief Officer-Health, and Dr. Martin Thuranira, the County Health Director for their effort to consolidate the CNAP team throughout the development process as well as providing an enabling environment and mobilizing the necessary resources and expertise to develop the plan.

The department also wish to appreciate all the officers from the various sectors who participated in drafting the Action plan. In particular, the contribution of Delphina Kaaman - County Nutrition Coordinator for providing strategic leadership, Geoffrey Mukuria (County M&E Officer - Department of Health), Tarcisio Nakuo (Public health Officer - Department of Health), Mary Bett (Agricultural Officer), Sicily Matu - UNICEF, Janet Ntwiga - UNICEF, Edward Kutondo - UNICEF, Francis Kidake - UNICEF, James Muita (NSO-UNICEF), Simon Eris (NHP Plus), Lamech Okello (world Vision Kenya), Anthony Muburi (Feed the Children), Sub County MoHs, ScNCs and Partners for their effort during drafting and final editing of the final document;

Dr. Martin Thuranira

County Director of Health.

Executive summary

The Samburu County Nutrition Action Plan (SCNAP) 2018–2022 is an evidence-based five-year strategic action plan that seeks to address malnutrition in Samburu in all its forms and for all ages. It is the second-generation County Nutrition Action Plan that is anchored in the Kenya Food and Nutrition Security Policy (FNSP), the cunty Integrated Development Plan 2018-2022. It builds on the success, limitations and opportunities from first County Nutrition Action Plan 2013–2018. The Kenya Vision 2030, implemented in five-year midterm plans and the Big Four Agenda, together with the overall global health and nutrition agenda, the Kenyan constitution and legal framework, form the over-arching guidance for the development of CNAP. The plan applies a life-cycle approach and promotes cross-sectoral collaboration to address the social determinants of malnutrition in a sustainable way.

The overall expected result of the CNAP is Samburu achieving optimal nutrition for a healthier and better-quality of life and, improved productivity for the county's accelerated social and economic growth. 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 a set of results would be realized at scale and, contribute to improved nutritional status of the population. The CNAP development process was driven by the county government department of health and aligned to the Kenya Nutrition Action Plan blueprint that was spearheaded by the Nutrition and Dietetics Unit, Ministry of Health. The process involved wide consultation with all key stakeholders including line ministries, county governments, development partners and donor agencies, civil society organizations, research and academic institutions and the private sector. The process was evidence informed. A review of the implementation of the 2013–2018 CNAP identified glaring gaps such as poor linkage with other sectors, limited funds allocation from the County Government due to lack of prioritization of nutrition activities, inadequate monitoring and evaluation of the Nutrition Action Plan all of which have now been addressed in the current CNAP. The document will be used by policy makers, donors, health management teams and other nutrition sensitive departments and Institutions in planning and decision making. The document will also help the public at large to understand what the government is doing to ensure optimal nutrition for all citizens, and what they can do individually to contribute to improved nutrition.

This CNAP has been organized into Five chapters as follows: Chapter 1 covers the introduction, discusses the background information, and legal framework for CNAP, trends in nutrition and health situation both in the County, human resource for nutrition and constraints to service delivery. Chapter 2 discusses the vision, mission and goals of nutrition in Samburu County and the guiding principles. It also presents the rationale, CNAP overall objectives/purpose, CNAP development process and target audience. Chapter 3 captures the key result areas, strategies and interventions. Chapter 4 captures the Monitoring, Evaluation, Accountability and Learning (MEAL) Framework. Chapter 5 outlines the CNAP resource mobilization and costing. Further, the chapter is organized into three categories of result areas with corresponding interventions.

CHAPTER 1

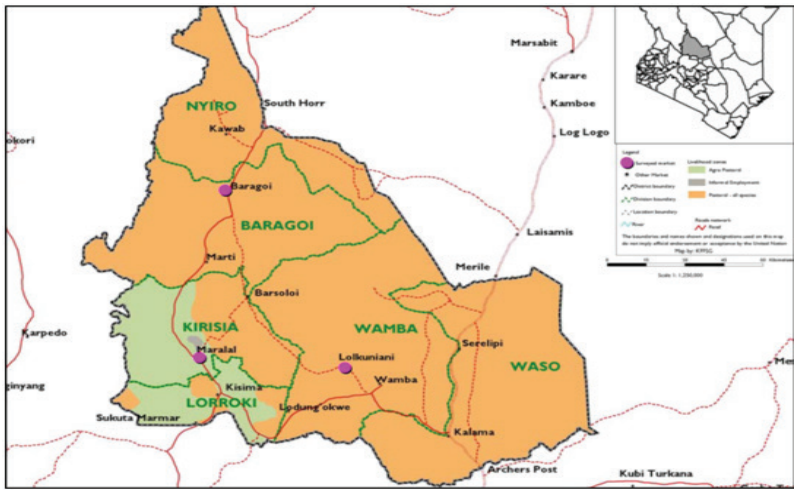
INTRODUCTION

1.0 Background information

1.1.1 Location and size

Samburu County is among the 47 counties in the Republic of Kenya. The County borders Marsabit County to the east and north east, Isiolo County to the south east, Laikipia to the south, Baringo County to the south west and Turkana County to the west and north west. The County has a land area of approximately (21,022) Km^2 and is administratively divided into three Sub Counties namely Samburu Central, Samburu North, and Samburu East. The county has three constituencies, 15 wards, 7 divisions, 39 locations, and 108 sub-locations. Geographically, the county is divided into lowland and the plateau. Vegetation is mainly grassland with scattered shrubs, while deciduous forests dominate the mountainous ranges.

Figure 1. Samburu County Map.



The Lorroki and Kirisia plateaus do also have mountains and indigenous forests. The zone serves as a water catchment area and grazing area for livestock during dry seasons. The area is fairly served by earth dams, water pans, and boreholes. The county is generally a water deficit area as there are no permanent rivers except Uaso Ng'iro, which marks the southern boundary with Laikipia and Isiolo counties. The lowland range is composed of dwarf shrub grassland with deciduous bushes. Water sources are main streams, shallow wells, and a few boreholes and rock catchments.

The rainfall pattern of the county falls into two distinct seasons, whose occurrence is determined by geographical location. The highlands receive their long rains between March and May and the short rains between July and August. The lowlands receive long rains between March-May and short rains in October and November. Rainfall is erratic and therefore drought is a common phenomenon. However, average rainfall in the county is about 500mm annually. Temperatures in the County vary with altitude and ranges between 21°C to 35°C. In terms of economic activities, the largest part of the County's population are pastoralists (57%) while others are agro-pastoralists (37%) and a small population of the business community (6%). The pastoralists mainly keep cattle, sheep, goats, camels, and donkeys, while the agro-pastoralists produce maize, beans, potatoes and vegetables. Wheat is grown by large scale commercial farmers in the Lorroki Plateau in Samburu Central Sub County.

Table 1: Samburu county; Area by Sub-county and administrative divisions

National Government Administrative Structure				
Sub-county	Division	Area (km^2)	No. of Locations	No. of Sub-locations
Samburu Central	Lorroki	1,399.30	6	17
	Kirisia	1,237.70	5	18
	Malasso	1,300.30	3	11
Total		3,937.3	14	46
Samburu East	Wamba	4,670.80	8	19
	Waso	5,378.90	4	10
Total		10,049.7	12	29
Samburu North	Baragoi	4,024.40	7	17
	Nyiro	3,010.70	6	16
Total		7,035.1	13	33
Grand total		21, 022, 10	39	108

Source: Administration Dept 2018.

1.1.2 Demographic profile

1.1.2.1 Population description County and sub-counties.

Table 2: Samburu County Catchment Population Trends and Projection.

Description	Population estimates	Samburu County	2018	2019	2020	2021	2022
Total population	4.45%	223,947	331,376	346,122	361,525	377,613	394,416
Total Number of Households	5per HH	44,789	66,275	69,224	72,305	75,523	78,883
Population Female	51.00%	114,213	169,002	176,522	184,378	192,582	201,152
Population Male	49.00%	109,734	162,374	169,600	177,147	185,030	193,264
Children under 1 year (12 months)	3.60%	8,062	11,930	12,460	13,015	13,594	14,199
Children under 5 years (60 months)	18.93%	42,393	62,730	65,521	68,437	71,482	74,663
Under15-year Population	50.72%	113,586	168,074	175,553	183,365	191,525	200,048
Women of child bearing age (15 – 49 Years)	21.19%	47,454	70,219	73,343	76,607	80,016	83,577
Estimated Number of Pregnant Women	4.48%	10,033	14,846	15,506	16,196	16,917	17,670
Estimated Number of Deliveries	3.93%	8,801	13,023	13,603	14,208	14,840	15,501
Estimated Live Births	3.93%	8,801	13,023	13,603	14,208	14,840	15,501
Total number of Adolescent (15-24)	20.23%	45,304	67,037	70,021	73,136	76,391	79,790
Adults (25-59)	28.06%	9,898	14,647	15,299	15,979	16,690	17,433
Elderly (60+)	4.42%	9,898	14,647	15,299	15,979	16,690	17,433
Estimated Emergency obstetric complications	0.75%	1,680	2,485	2,596	2,711	2,832	2,958
Estimated of post abortion cases	0.75%	1,680	2,485	2,596	2,711	2,832	2,958
0 -6 Months	50% < 1yr	4,031	5,965	6,230	6,507	6,797	7,099
6 - 11 Months	10% < 5yrs	4,239	6,273	6,552	6,844	7,148	7,466
12 - 59 Months	80% < 5yrs	33,915	50,184	52,417	54,749	57,186	59,730
6 - 59 Months	90% < 5yrs	38,154	56,457	58,969	61,593	64,334	67,197
0 - 11 Months	20% < 5yrs	8,479	12,546	13,104	13,687	14,296	14,933
0 - 28 Days.	10% of <1yr	806	1,193	1,246	1,301	1,359	1,420

Source: KNBS Population Projections 2017.

According to the 2009 census, Samburu County had a population of 223,947 persons of which 109,734 and 114,213 were male and female respectively. Using County population growth rate of 4.45% per annum, the population of Samburu County was projected to be 331,376 persons by 2018. The population cohorts have been adopted nationally for purposes of estimating requirements for health services delivery in line with the Kenya Essential Package for Health (KEPH). For example, the population under 15 years of age (children) constitutes the largest population proportion at 50.72% while pregnant women constitute 4.48% of the population. Each population cohort has its unique health services needs and requirements that this action plan has taken into consideration. Throughout this document, 2018 is adopted as the baseline year for planning and projection. This section shows Samburu county population trends and projections by County and Sub-county from 2018 up to the year 2022 based on the 2009 population census. Table 1 shows the county's population by cohort and key population indicators.

Table 3: Sub-Counties Population Projection

Sub-County	2018	2019	2020	2021	2022
Samburu Central	153,668	160,506	167,648	175,109	182,901
Samburu East	90,267	94,283	98,479	102,861	107,439
Samburu North	87,442	91,333	95,397	99,643	104,077

Source: KNBS Population Projections 2017.

1.1.3 Facility distribution in the County

Samburu County has 96 Health facilities distributed amongst GOK, FBO, NGO and private referral hospitals, health centers', dispensaries, medical clinics and CUs within the County and three sub-counties. The County has 67 Government facilities, 12 Faith-Based Organization, 14 private clinics and 43 Community units.

Figure 2: Facilities distribution by Ownership.

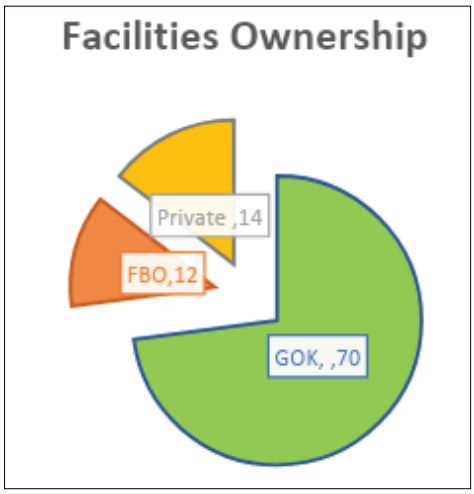


Figure 3: Facility mapping in Samburu County

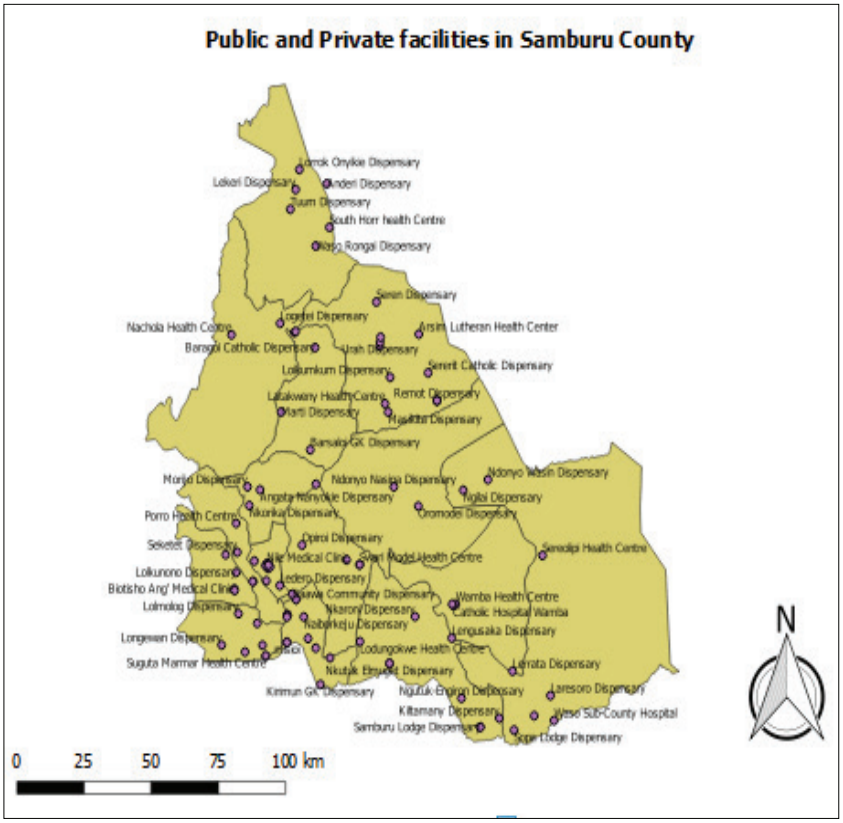


Table 4: Status of Health Infrastructure comparable to facility norms.

Tier of care	Infrastructure	Number functional, by type of provider				Total	Required	Gap
		Public	Faith Based	NGO	Private			
County Referrals	Total facilities	2	1	0	0	3	6	3
	Total beds	230	200	0	0	430	530	100
	Total functional Community Units	5	0	0	0	5	08	3
	Total with functional boards	2	1	0	0	03	6	3
Primary Care facilities	Total facilities	65	9	0	14	88	104	16
	Total beds	193	51	13	10	267	509	242
	Total functional Community Units	38	0		0	38	79	41
	Total with functional management committee's	65	9		0	88	104	16
Overall total for County	Total facilities	67	12		14	98	120	22
	Total beds	423	251	13	10	697	1039	342
	Total functional Community Units	43	0	0	0	43	87	44
	Total with functional Governance structure	67	12		14	98	126	53

Source CHISP 2018- 2022

1.2 National Context Policy Framework

1.2.1 Nutrition Policy and strategies

Kenya has well developed policies on nutrition and food security. The most recent ones are National Food and Nutrition Security Policy 2011 and National Nutrition Action plan 2012-2017. Food and nutrition security refer to a situation where all people, at all times, have physical and economic access to sufficient, safe and nutritious food to meet their dietary needs and food preferences for an active and healthy life. It is a Kenyan government's commitment to reduce hunger and malnutrition; this includes efforts to build resilience to reduce chronic food insecurity and malnutrition with the intention to achieve long term development. This policy is built on several pillars which include; food availability and access, food safety, standards and quality control, nutrition improvement, school nutrition and nutrition awareness, food security and nutrition information, early warning and emergency management, institutional and legal frame work and financing and strategic approaches for policy implementation monitoring and evaluation. As a result, the national nutrition action plan (NNAP) was developed to provide a frame work for coordinated implementation of nutrition intervention activities by the government and nutrition stakeholder. This national framework has been cascaded to the county through the devolution process.

1.2.2 The County Government Act 2012

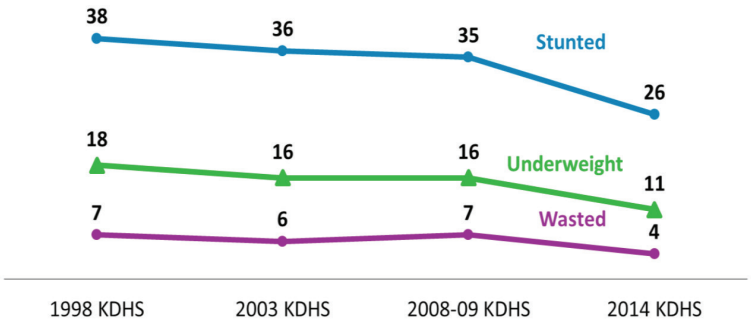
According to the county government act 2012 part XI on county planning, it elaborates that county departments (which include the Ministry of Health) shall develop sectoral plans as a component part of the county integrated development plan (CIDP). According to this act: The County sectoral plans shall be programme based; provide the basis for budgeting and performance management; and reviewed every five years by the county executive and approved by the county assembly but updated annually.

1.3 Nutrition and health situation in Kenya

Kenya is experiencing high burden of malnutrition as per the Global Nutrition 2018 report. The main burden is undernutrition (underweight, stunting and wasting), Micronutrients deficiencies, overweight and obesity with increasing burden of diet related non-communicable diseases. Acute Malnutrition tends to be high in ASALs counties, though it exists at lower levels in all other counties.

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

Figure 3: Trends of Underweight, Stunting and Wasting in Kenya.



1.4 Nutrition and health situation in Samburu County

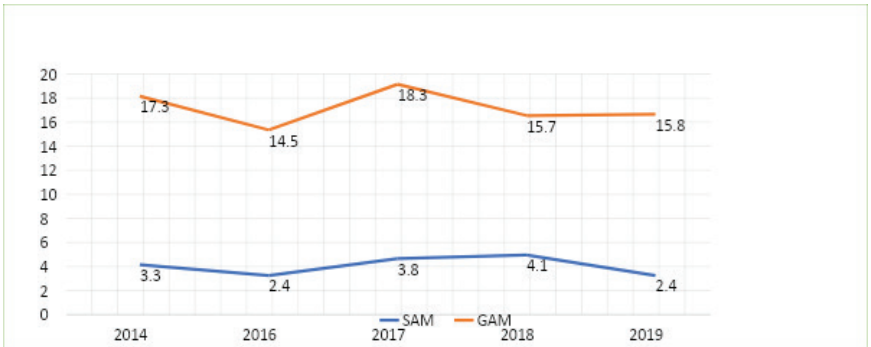
The June 2019 integrated health and nutrition SMART survey conducted in Samburu County indicated a Global Acute Malnutrition (GAM) of 15.8% and a Severe Acute Malnutrition (SAM) of 2.4%. This means that there are approximately 16 severely and moderately malnourished children for every 100 and of these 2 are up to five times likely to die under similar circumstances than their well-nourished counterparts. These children are likely to experience increased and repeated chances of illnesses. Whereas the county has move in the positive direction in management of severe wasting and stunting since 2017, the nutrition outcomes however remain poor and largely above the national thresholds of malnutrition. The high rates of malnutrition is further exacerbated by poor nutrition knowledge and practices among the communities, recurrent emergencies, emerging lifestyle and behavior such as alcoholism, Food and Nutrition insecurity, Disease and disease outbreaks .

Unpredictable rainfall patterns in most parts of the County has led to low pasture coverage and minimal farming activities resulting to frequent migrations. Population migrations related to insecurity has also contributed to the poor nutritional status due to the interruption in the coping mechanisms and increased vulnerabilities.

1.5 Trends of Undernutrition-stunting, wasting, underweight

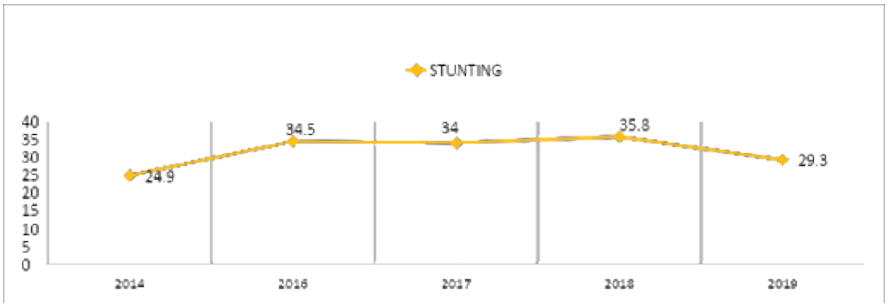
The rate of acute malnutrition has remained constant for the last 5 years and largely above the emergency threshold of 15%. This shows a lack of improvement despite significant investment made to reduce vulnerability among target population. Further, the level of stunting is also one of the highest in the region. The reduction of stunting by 6.5% shows a promising trend in the fight against malnutrition

Figure 4: Trends of Acute Malnutrition in Samburu County



Source: 2019 SMART Survey

Figure 5: Trends of Stunting in Samburu County.



Source: 2014 - 2019 SMART Surveys

1.6 Over nutrition and DRNCD

Over nutrition is not a challenge currently in the county of Samburu but with the current increase in urbanization there is likelihood of increase. At National Level, the Kenya 2015 STEPwise Survey confirmed an increasing rate of overweight/obesity and diet-related non-communicable diseases (DRNCDs) in adults. A total of 28% of adults aged 18–69 years were either overweight or obese, with a prevalence rate of 38.5% in women and 17.5% in men. Similar trends are seen when comparing the 2008–2014 KDHS. The proportion of women who were overweight increased from 25% to 33% and those who were obese increased from 7% to 10%. The prevalence of overweight or obesity is higher in urban areas (43%) than in rural areas (26%). There is a notable increase in Non-Communicable conditions as depicted in the

Table 5 : Non-Communicable conditions

Type of NCD.	2017	2018
Hypertension	949	1231
Diabetes	356	414

Source: KHIS 2, 2018

1.7 Micronutrient including coverage

There is no county specific data detailing the extent and gravity of micronutrient deficiency in Samburu County. However, falling under the realm of the national micronutrient surveys, then one can postulate that the deficiencies must exist within. It is inherent that the deficiencies may be higher than the national averages due to the prevailing levels of macronutrient deficiencies. The 2019 SMART Survey places coverage for Vitamin A supplementation for children 6-11 months at 66.7% and 6- 59months at 72.6%. The coverage of VAS in Samburu county for children 6-11 months of age improved from 70.5% in 2018 to 193% and reduced from 84.2% to 65.6% for children 12-59 months for the same period respectively (DHIS 2019).

1.8 Maternal Infant MIYCN

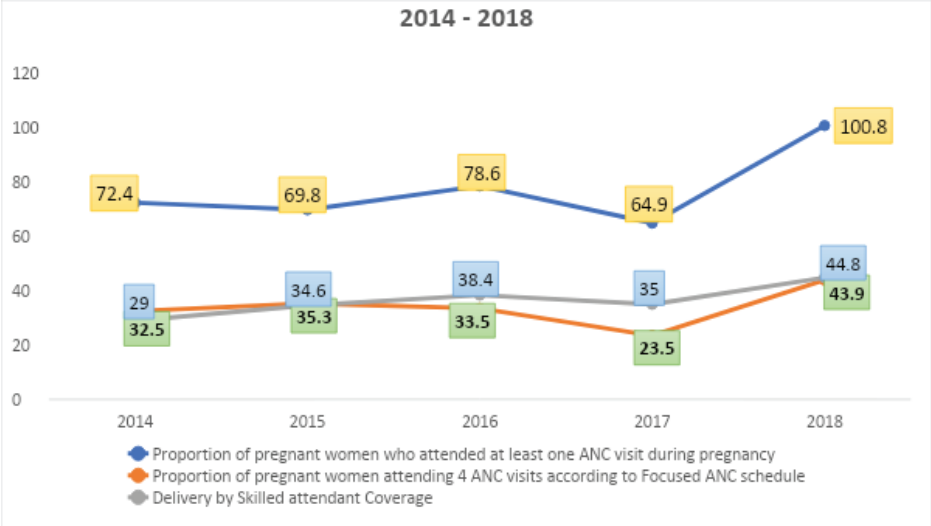
The county made a positive progress in Maternal infant and Young Child Nutrition indicators under CNAP 1. The county exclusive breastfeeding has significantly improved from 69.4% in 2014 to 77.6% in 2018. However, the EBF rates remain below the national target of 80%. Proportion of women consuming foods from more than the recommended 5 food groups remain at significantly low rate of 31% while only a quarter of children in the county consume minimum acceptable diet at a low of 25.7%.

IFAS consumption for over 90 days among pregnant women in Samburu county remain below the national targets at 11.1% while only 50.2% of pregnant women attend ANC services for at least 4 times.

1.8.1 Health coverage - skilled birth, ANC

The County has shown great improvement in skilled birth deliveries and 4th ANC visits despite immense challenges. Figure 5 shows the trends of Skilled birth and 1st and 4th ANC visits.

Figure 6: Trends of Skilled birth delivery and 1st and 4th ANC visits.



Source: 2019 Smart Survey

W-MDD of less than 5 food groups increased from 66% to 69% and more than 5 food groups dropped from 34% to 31% in 2019 possible cause of increase in women malnutrition from 10.4% in 2018 to 12.3% in 2019.

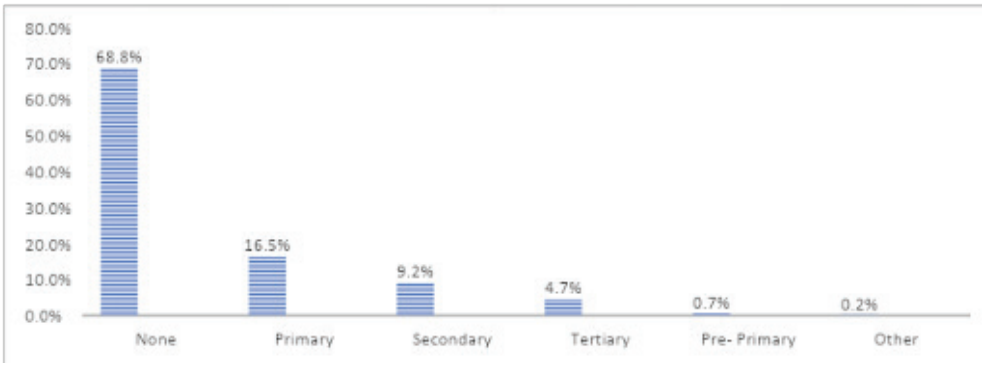
1.8.2 Food access

The main food crops grown are maize and beans with maize production contributing to 80% of food and beans to 10%. All markets are operational and well stationed with staple foods but lack food diversity. Household lack diversity in their crop and livestock production.

1.8.3 Education

Approximately 31.2 % of the population can read and write. The chart below shows the highest level of education attained by household members over 18 years old (SMART 2019) which is an improvement by 2% from 2018 (adult education literacy survey 2018).

Figure 7: Education



Source: Adult education literacy survey 2018

Enrollment of adult education classes has been fluctuating over the years. The level of literacy is expected to continue increasing across all education sectors of the County because of the introduction of free primary education, free day secondary and subsidized boarding secondary schools from the beginning of planning period.

1.8.4 Human resource for nutrition

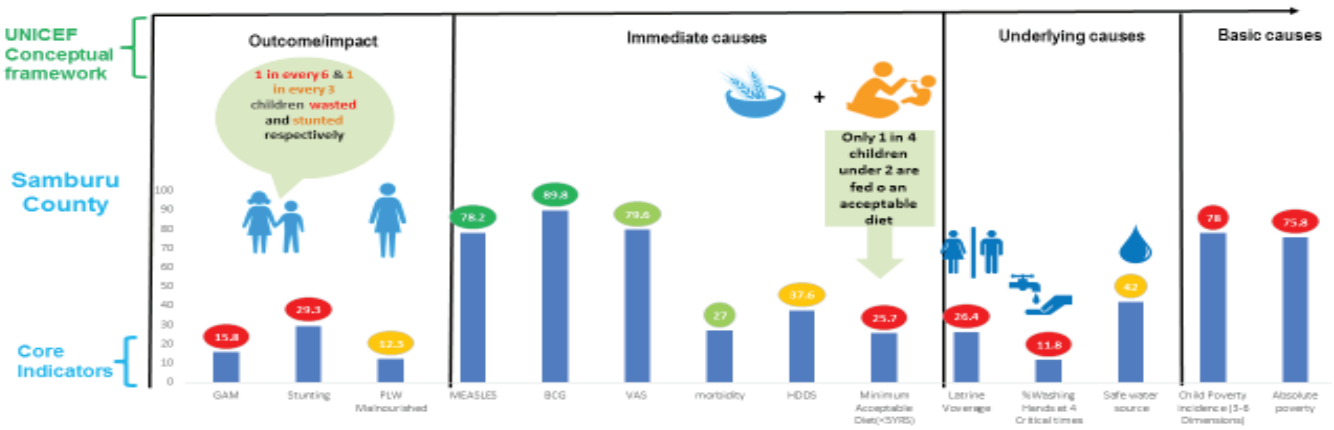
The department has been understaffed for many years, however after continuous advocacy for recruitment of more nutritionists, the number was increased from 4 to 16. Although it is a notable increase, it is still below the standards of human resource for health. The requirement for the county as per the number of facilities is 259 nutritionists hence need for more advocacy to increase the number to the required standard.

1.9 Constraints

- Understaffing - only 16 nutritionists against the required 259 in the entire County
- Underfunding from county government/ the county doesn't give nutrition department priority in allocation of funds
- Transitioning of partners which will ultimately lead to diminished support for nutrition programs and supply
- Insecurity that leads to migration and hence high defaulter and low cure rates for the integrated management of malnutrition program
- Poor documentation
- Household food insecurity leading to shared nutrition commodities contributing to poor cure rates
- Limited capacity among health care workers fundamental nutrition programs & policies

Acute and chronic malnutrition in Samburu County is critical. Almost half of children endure common childhood illnesses in very unhygienic conditions. Figure xx below shows that the key drivers of malnutrition in Samburu County are poor access to water& sanitation, poor hygiene practices, household food insecurity and absolute poverty. This requires a multisector and system wide approach in addressing them.

Figure: Interrelatedness of selected key drivers of malnutrition in Samburu County



Source: Samburu SMART 2019; KABP 2018; DHIS 2019

CHAPTER 2

COUNTY NUTRITION ACTION PLAN (CNAP) FRAMEWORK (2018 - 2022)

2.0 Introduction

The 2012-2017 CNAP contributed to substantial improvements in the nutrition sector through implementation of various intervention as outlined in the document.

However, some achievements made from CNAP 1 (2012-2017) because of high-level advocacy and lobbying for nutrition with the leadership of the County government of Samburu for increased investments in the sector. Through the public service board, the department recruited and deployment of 9 nutritionists thereby contributing to improved management of nutrition services in the health facilities. Additionally, more health facilities were constructed and are offer a wide range of nutrition services, increasing to 66 health facilities in the last 5 years, an addition of 5 health facilities per sub-county. The capacity building of health care workers on HiNi packages, provision of anthropometric equipment and related nutrition supplies and commodities enabled the operationalization of these new sites.

During the lifespan of CNAP 1 (2012 -2017) the county successfully adopted the IMAM Surge approach in 21 health facilities in the county, an innovative risk-informed strategy for emergency preparedness and response. Further, the roll out of Community Baby Friendly Community Initiative (c - BFCI) at the community/household level in 22 CUs (8, 8 and 6 in Samburu Central, East and North respectively) has reduced on demand side barriers to access and utilization of RMNHCN services in the county. To crown it the vison of CNAP 1 (2012 - 2017) was achieved through the establishment of standalone nutrition sub program with a funding allocation of Ksh. 14,600,000/- for the financial year 2019 -2020.

This second generation CNAP (2018 -2022) is a blue print and reference document for nutrition programming in the next 5 years. The plan has outlined the vision for nutrition in Samburu county for the next 4 years, its guiding principles, the aim and objectives for this plan. This section also enumerates a roadmap adopted right from review of previous CNAP to developing, launching and implementing this new CNAP 2(2018 – 2022) using extensive stakeholder consultations both from nutrition specific and sensitive programs.

2.0.1: Vision

This CNAP 2 envisions a county free from malnutrition.

2.0.2: Mission

Its mission is to reduce all forms of malnutrition within the County through a coordinated multi-sectoral and community centered approach for optimal health of the population and contribute to progressive to economic growth.

2.1: Guiding Principles

1. **Synergy and inclusivity** – The plan seek all the key stakeholders/partners to be involved and be included in the CNAP making and implementation process. This will include those with programs that are nutrition specific and nutrition sensitive. The multi-sectors that provide enabling environment for CNAP objectives to be met will be brought on board to build a sense of ownership and sustainability through a shared resource envelope.
2. **Prioritization and adoption of low-cost High Impact Nutrition Interventions (HiNi)** – it is a known fact that resources are limited and the little that is available at our disposal should be utilized prudently. The rational use of resources to maximize on the desirable outcomes through selection of interventions that have been proven to bear results with minimal investments will be given priority when implementing activities.
3. **Evidence-based decision making** – data should always be relied upon and used to make sound decision. evidence gathered from different platforms such as SMART surveys, SQUAEC, KPC, Coverage assessment including routine M&E will be used to guide stakeholders on critical decision making and implementation.
4. **Conformity and alignment** – This document conforms and align with the national policies and mirrors the Kenya Nutrition Action Plan (KNAP) based on county nutrition needs assessment and context.

5. **Stringent and effective Monitoring and Evaluation (M & E) mechanism** – to guide and ensure strategic objectives for CNAP 2 (2018 -2022) are achieved ultimately, the PLAN adopts a results-based approach to programming vision.
6. **Reference document** - CNAP 2 (2018 - 2022) forms the blue print for all stakeholders/partners and for implementation of activities in the next 5 years.
7. **Stewardship and coordination** – The plan recognize the importance of partnership, leadership and governance by tasking the MoH through the County Nutrition Coordinator (CNC) to lead and guide the development process to its logical conclusion and seamless operationalization of the final document.
8. **Continuity** – noting the unfinished business form the CNAP 1 (2012 -2017) vision, the development and seamless transition to CNAP 2 (2018 - 2022) will carry ahead strategies that worked, borrowing and adopt lessons learnt and best practices from CNAP 1.

2.2: Rationale for CNAP 2

1. CNAP 2 (2018 - 2022) shall be a tool for effective resource mobilization to bridge the funding gaps in nutrition sub program in the County department of health budget.
2. CNAP 2 (2018 - 2022) shall provide a platform for rational resource utilization. Resources are never adequate for implementation of all planned nutrition activities. The option then is to use cost effective and efficient interventions to address pressing nutrition needs based on agreed priority areas.
3. CNAP 2 (2018 - 2022) shall be the binding document for all stakeholders/partners to draw their nutrition activities from therein.
4. CNAP 2 (2018 - 2022) shall mirror other county development plans like County Integrated Development Plan (CIDP) and County Health Sector Strategic & Investment Plan (CHSSIP). So, CNAP 2 (2018 - 2022) interventions shall constitute integral part of Samburu County development agenda.
5. CNAP 2 (2018 - 2022)) vision and 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.
6. CNAP 2 (2018 - 2022) implementation is boldly to high level policy directions that are geared towards increasing budgetary allocation and states that the Big 4 agenda which is the focus of the Kenyan Government wherein Universal Health Coverage (UHC), Food and Nutrition security form part of the 4 pillars to accelerate National development.
7. CNAP 2 (2018 - 2022) shall form the basis upon which the prioritized county nutrition needs shall be addressed as planned interventions and activities.

2.3: CNAP 2 Objective and Purpose

2.3.1: 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).

2.3.2 CNAP 2 Objectives

The objectives of CNAP 2 (2018 - 2022) are derived from agreed KRAs that are specific to Samburu County depending on the nutrition needs. However, the selected KRAs are aligned with the Kenya Nutrition Action Plan (KNAP).

These strategic objectives are:

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.

2.4 CNAP 2 development process

The development of CNAP 2 (2018 - 2022) has undergone several stages before the final document is adopted and made official to guide the nutrition sub program.

Stage 1: Review of CNAP 1 (2012 - 2017) borrowing on lessons learnt and best practices.

Stage 2: Stakeholders/partners, sector and multi – sector consensus on Key Result Areas (KRAs) depending on nutrition needs and context of the county.

Stage 3: Populating CNAP template (strategic objectives, strategies, interventions, outputs, period for implementation, indicators, targets and costing)

Stage 4: Review of CNAP 2 (2018 - 2022) zero draft.

Stage 5: Finalizing zero draft to make it final draft.

Stage 6: Validation of the final draft by the national team.

Stage 7: Launch and adoption for implementation.

Stage 8: Implementation, monitoring, periodic review/evaluation and lesson learning and documentation.

2.5 Target audience for CNAP 2

The target audience for CNAP 2 (2018 - 2022) document cuts across from policy makers and decision makers both at national and county governments, the implementers of both nutrition specific and sensitive stakeholders/partners, high and mid-level managers in health and other departments that influence and provide enabling environment for nutrition to be achieved and the communities at the grassroots level. They include the following categories:

	Category	Players/Actors
1.	Policy makers at National government	Ministry of Health – Afya House, KNAP secretariat, Division of Nutrition, NITWG, NDMA
2.	Policy makers county government	Governor, Members of County Assembly, Speaker, CECs, PSB
3.	Executive at county government	COs, Directors, CSG, MSP
4.	High level managers	CHMT members
5.	Mid-level managers	SCHMT members
6.	Implementing partners	UNICEF, WVK, KRCS, Feed the Children, World Concern, Afya Timiza, NHP plus, Child Fund, Acted, Caritas, WFP, KEMSA
8.	Line ministries	MOALFI, MOE, MOW, Gender and social services, Special Program.
9.	Health facilities	GOK, FBOs, Private facilities
10.	Community/households	CHUs, M2MSG, Care groups, F2FSG, CMSG

CHAPTER 3

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, Adolescent, Adults and Older persons promoted KRA 3. Prevention, control and management of Micronutrient Deficiencies Scaled up KRA 4. Clinical Nutrition and dietetics strengthened including Prevention, control and management of Diet Related Non-Communicable Diseases (DRNCDs) KRA 5. Integrated Management of Acute Malnutrition Strengthened KRA 6. Nutrition in Emergencies Strengthened KRA 7. Nutrition in Tuberculosis (TB) and HIV strengthened
B. Nutrition Sensitive Result Area	KRA 8. Strengthened nutrition in Agriculture & Food security, Education, WASH and social protection sectors
C. Enabling Environment Result Areas.	KRA 9. Sectoral and multisector Nutrition Governance, Coordination, Legal/regulatory frameworks, Nutrition Information Systems, Learning and Research strengthened KRA 10. Advocacy, Communication and Social Mobilization (ACSM) strengthened KRA 11. Supply chain management for nutrition commodities and equipment strengthened

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

Context

Optimal maternal nutrition is crucial for the health and development of both the fetus and the mother. It has further been shown to have positive impact on obstetric outcomes, with better nourished mothers having greater chances of delivering healthy infants. Maternal malnutrition increases the risk of poor obstetric outcomes including obstructed labor, premature or low-birthweight babies and post-partum hemorrhage. Severe anemia during pregnancy is linked to increased mortality at labor. Samburu county is experiencing poor child care practices, early marriages, maternal workload and teenage pregnancy that affect maternal nutrition. The current situation includes; EBF at 77.6% (KABP 2019), minimum diet diversity at 59.6% (SMART June 2019) and stunting at 29.3% (SMART June 2019).

The county exclusive breastfeeding has significantly improved from 69.4% in 2014 to 77.6% in 2018. However, the EBF rates remain below the national target of 80%. Proportion of women consuming foods from more than the recommended 5 food groups remain at significantly low rate of 31% while only a quarter of children in the county consume minimum acceptable diet at a low of 25.7%. IFAS consumption for over 90 days among pregnant women in Samburu county remain below the national targets at 11.1% while only 50.2% of pregnant women attend ANC services for at least 4 times.

1. **Expected Outcome**

Strengthened maternal, Infant and young child care practices, behavior and nutrition outcomes.

Output 1: Health workers and CHVs have the capacity to implement MIYCN programmes

Strategy: Strengthen Capacity of County and Sub county Health Management Teams, health care workers and Community Health Volunteers on Maternal Infant and Young Child Nutrition

Interventions/Activities

1. Train S/CHMT, HCW, CHVs, CMSGs on Maternal Infant and Young Child Nutrition
2. Roll out BFHI, Care Groups and BFCI in the county
3. Create awareness on reporting for MIYCN programme
4. Procure and distribute of Maternal Infant and Young Child Nutrition commodities and reporting tools.

Output 2: Community have improved knowledge and skills on MIYCN

Strategy: Increase awareness campaigns and information passing of MIYCN through SBCC strategies

Interventions/Activities

1. Support awareness campaigns and health action days on key MIYCN messages
2. Conduct advocacy and sensitization forums with different stakeholders on MIYCN

Output 3: Improve M&E for Maternal Infant and Young Child Nutrition program

Strategy: Strengthen M&E for Maternal Infant and Young Child Nutrition program

Interventions/Activities

1. Conduct assessment of Baby Friendly Community Initiative and Baby Friendly Hospital Initiatives.
2. Strengthen routine reporting on Maternal Infant and Young Child Nutrition.

3.0.2 KRA2: Nutrition of older children, Adolescent, Adults and Older persons promoted.

Context

This KRA focuses on older children (those aged 5-9 years) and adolescents (those aged 10-19 years), adults (those aged 20-59 years) and older persons (60 years and above). The main issues that affect these cohorts are; iron deficiency in adolescent girls, poor nutrition status for adolescent boys than girls, poor nutrition status for adult women which currently stands at 34% (KABP 2019), poor dietary diversity in schools and inadequate nutrition assessment for adults. Early marriages and teenage pregnancy are some of the cultural contributors to poor nutrition status for adolescent girls. Knowledge gap on dietary diversity among adolescents, adults and elderly is very high and these affect their nutrition status.

It is important to note that adults also face several nutritional challenges including inadequate energy and micronutrient intake due to poverty, inadequate dietary diversity, poor access to nutrition information, and poor lifestyles often adopted during adolescence. Poor nutritional and lifestyle practices range from overconsumption of fats, sugars and salt to smoking, excessive consumption of alcohol, and low physical activity – all of which increase the risk of diet-related NCDs; for example, diabetes, cardiovascular diseases, hypertension and cancers.

Expected Outcome

Improved nutrition status of older children, Adolescent, Adults and Older persons

Output 1: Older children, Adolescent, Adults and Older persons access and utilize nutrition services at Health facility and community level.

Strategy: Improve access and utilization of nutrition services by older children, Adolescent, Adults and Older persons

Interventions/Activities

1. Screening, referral & treatment of malnourished of older children (5-9yrs), Adolescent, Adults and Older persons.
2. Weekly supplementation of adolescents with IFAS & menstrual hygiene education
3. Increasing service delivery points for nutrition services of older children (5-9yrs), Adolescent, Adults and Older persons.
4. Advocate and strengthen physical activity programmes for adolescence, adults and older persons

Output 2: increased awareness of healthy diet and physical activities in schools

Strategy: capacity building of stakeholders (school administration, Parents and pupils) on healthy diets and physical activity

Interventions/Activities

- sensitization of school administration on provision of quality and safe nutritious meals
- Sensitization of teachers and pupils on nutrition in school health clubs
- Output 3: Improve school feeding programs

Strategy: Strengthen food quality, safety and security in schools

Interventions/Activities

- Collaborate in promotion of food quality, safety and security in schools and community.
- Improve quality diet among older children (6-9yrs), Adolescent, Adults and Older persons.

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

Context

Micronutrient deficiencies are of public health concern due to their devastating effect on the physical and mental well-being of the population. The most common deficiencies are 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 (NTD) in newborns and iodine deficiency during pregnancy is the commonest risk factor for preventable brain damage in the newborn. The status of the micronutrients supplementation coverage in the county is; IFAS 81.12% (SMART Survey 2019), Vitamin A, 6-11 (66.7%), 12-59 months (72.6%) (SMART 2019). Zinc Supplementation stands at 56.3% (KDHIS 2016). Malezi bora is the one of the strategies which has helped to increase the coverage for micronutrients uptake.

Expected Outcome

- improved micronutrient status among vulnerable children and women

Output 1: Children and women of reproductive age are supplemented and dewormed according to the approved protocols.

Strategy: Enhance access to micronutrient supplementation and deworming services among children, WRA and the general population in the community.

Interventions/Activities

- Capacity build the health care workers, Stakeholders, CHVs and community on micronutrient supplementation.
- Conduct supplementation through static health facilities, integrated outreaches, ECDs, schools-especially for adolescence etc

Output 2: Communities consume fortified foods

Strategy: Advocate and monitor the consumption of fortified foods in the community

Interventions/Activities

- Advocate for policy adoption on food fortification law.
- iodine monitoring/promotion of consumption of iodized salt
- Conduct community awareness and promote the consumption of fortified foods available in the market and bio-fortified foods produced at household level.
- In collaborator with the public health department, enforce the law on sell of products in category of mandatory fortification e.g. iodized salt.
- Conduct home fortification using micronutrient powders.

3.0.4 KRA 4. Clinical Nutrition and dietetics strengthened including Prevention, control and management of Diet Related Non-Communicable Diseases (DRNCDs)

Context

Non-communicable diseases (NCDs), mainly cardiovascular diseases, cancers, chronic respiratory diseases and diabetes are the world's leading killer diseases and Samburu County is not an exception. In 2018, the number of DRNCDs cases reported in DHIS were as follows; Arthritis and joint pains-5420 cases, Hypertension -1231, Diabetes -414 cases (KHIS, 2018), cancers cases and chronic respiratory diseases are on an increasing trend despite the poor documentation within the health care system. Health care workers play a key role in the prevention and management of non-communicable diseases through educating their clients on the adoption of healthy lifestyles. Nutrition education coupled with clinical nutrition counselling is provided at facility and community level to all diagnosed patients. However, the capacity of health workers to manage these diseases remains limited.

Expected Outcome

- Prevalence of diet and nutrition related diseases and conditions reduced.

Output 1: Health care workers' skills and knowledge on DRNCDs management improved

Strategies:

a) Strengthen the capacity of health care workers and health facilities to screen and assess diet related non-communicable diseases

Interventions/Activities

- Train HCWs, CHV's on nutrition screening, assessment and triage for Diet Related Non-Communicable Diseases
- Train nutritionist and dieticians to provide specialized clinical nutrition services for patients
- Train HCWs on logistics management and reporting for clinical nutrition commodities and equipment.

Output 2: Clients or patients affected by DRNCDs access and utilize quality clinical nutrition treatment and management services

Strategy: Improve access and utilization to clinical nutrition and management services.

Interventions/Activities

- Conduct nutrition screening, assessment and triage for Diet Related Non-Communicable Diseases
- Provide clinical nutrition and management services to clients affected by DRNCDs.
- Scale- up and sustain special clinics for management of NCDs including modern/diet kitchen to provide therapeutic foods
- Procure and install facilities for the provision of quality DRNCDs services.

3.0.5 KRA 5. Integrated Management of Acute Malnutrition Strengthened

Context

Acute malnutrition among children and women in Samburu County has remained unchanged and unacceptably high for the last five years. This has contributed to a high burden of malnutrition exacerbated by inadequate dietary intake and/or high disease incidence as the two immediate causes in a deadly symbiotic relationship between acute malnutrition and infection. The June 2019 integrated health and nutrition SMART survey conducted in Samburu County indicated a Global Acute Malnutrition (GAM) of 15.8% and a Severe Acute Malnutrition (SAM) of 2.4%. This means that there are approximately 16 severely and moderately malnourished children for every 100 and of these 2 are up to five times likely to die under similar circumstances than their well-nourished counterparts. Access and completion of treatment among children and women has been good but with isolated periods of underwhelming performance due to challenges in access and utilization of IMAM services at community level

Expected Outcome:

- Improved treatment outcomes among malnourished children and women

Output 1: Malnourished children and women access timely and quality IMAM services.

Strategy: Capacity building of Health Care workers and community Health Volunteers on Integrated Management of Acute Malnutrition (IMAM)

Interventions/Activities

- Improve on surveillance on referral of malnutrition at community level - Mother MUAC, CHVs screening & Referrals, Drought monitors referrals
- Offer quality IMAM Services at HFs and community level e.g. in outreaches

Output 2: Health care workers' knowledge and skills to manage acute malnutrition improved

Strategy: Build capacity of health workers on integrated management of acute malnutrition

Interventions/Activities

- Train more HCWs at facility and community level on IMAM
- Conduct OJT and mentorship of health workers on IMAM
- Distribute job Aids and IMAM guidelines to HFs and other service delivery points.

3.0.6 KRA 6. Nutrition in Emergencies Strengthened

Context

Samburu County experiences cycles of drought every year which the main emergency in the county is. The drought worsens household food security leading to inadequate food intake which results to malnutrition. Water scarcity and inaccessibility due to long distances to water points during these periods exacerbate malnutrition and poor hygiene practices at the households' level.

Human and livestock disease outbreaks are rampant during these drought periods and leads to further deterioration of nutrition status. During the drought the livestock prices fall while that of farm products increase and thereby reducing the household purchasing power and hence poor dietary diversity.

Expected Outcome

Improved nutrition risk-responsiveness preparedness and response to emergencies.

Output 1: County capacity for nutrition emergency preparedness strengthened.

Strategy: Capacity building of technical county stakeholders including Community on emergency preparedness and response.

Intervention/ Activities

- Train county stakeholder teams on health and nutrition preparedness planning and response.
- Train communities on community level emergency preparedness planning
- Develop or updated Contingency plans and emergency response plans
- Build capacity of county teams on resource mobilization and leveraging for emergency preparedness and response.
- Build capacities of health workers on conducting rapid assessments, monitoring and reporting on emergencies
- Scale-up the IMAM surge approach to all IMAM implementing Health facilities
- preposition/stock-pile in anticipation of emergencies based on early-warning information
- Establish and continuously strengthen technical and community level coordination committees for emergency response

Output 2: Households affected by emergencies receive quality health and nutrition services.

Strategy: Scale-up service delivery to affected populations during emergencies.

Intervention/ Activities

- Sensitize health care workers on nutrition surveillance, active Case Finding and response.
- Conduct Mass screening and referral of affected populations during emergencies
- Mobilize rapid response teams for emergency response
- Conduct emergency integrated outreaches
- Monitor the CODE violations
- Strengthen the emergency supply chain to ensure access to lifesaving commodities, supplies and equipment

Output 3: Strengthened coordination and partnerships for integrated preparedness and response initiatives

Strategy: strengthen mechanisms for coordination and partnership

Intervention/ Activities

- Map out and update the 4Ws matrix for partners dealing with emergency risk reduction preparedness and response
- Conduct coordination meeting during and before the emergency response
- Conduct resource mobilization and leveraging for emergency response
- Periodically report as per guidelines and timeliness on the progress of response for an impending or ongoing emergency.
- Document lessons learnt and conduct operational research to improve on response moving forward

3.0.7 KRA 7. Nutrition in Tuberculosis (TB) and HIV strengthened

Context:

The overall goals of medical management of HIV and TB are to reduce HIV and TB-related morbidity and mortality, improve the quality of life, restore and preserve immunological function, and maximize suppression of viral replication. Optimizing and extending the usefulness of currently available therapies and minimizing drug toxicity and managing side effects are important goals in both medical and nutritional management. The prevalence of HIV in Samburu County is 1.5% across the population. Nutrient deficiencies play important roles in the pathogenesis of HIV and TB disease. Nutrition therapy with individualized counselling is critical in overall treatment. In Samburu County, 1480 persons with HIV and TB are supplemented with nutrition commodities on monthly basis. However, due to a changing donor landscape, nutrition support for HIV-AIDS and TB has been dwindling posing a risk for effective management of these conditions.

Expected Outcome: Nutrition status of TB and HIV clients improved.

Output: Health care worker skills and knowledge on nutrition management of TB and HIV improved

Strategy: Capacity build health care workers and CHVs on TB and HIV management in nutrition.

Intervention/activities:

- Train health care workers on nutrition in TB and HIV management in nutrition
- Sensitize CHVs on lost follow up for TB and HIV cases at the community level.
- Build capacity of HCWs on routine reporting in DHIS and LMIS.

Output: TB and HIV-AIDS clients receive quality nutrition services.

Strategy: Access to and utilization of nutrition services enhanced for TB and HIV clients.

Intervention/activities:

- Conduct nutrition screening and management for malnutrition among HIV-AIDS and TB clients
- Strengthen supply chain on nutrition commodities for TB and HIV.
- Strengthen M&E/reporting on Nutrition in TB and HIV management

3.0.8 KRA 8. Strengthened nutrition in Agriculture & Food security, Education, WASH and social protection sectors.

Context

The entire food system from production to consumption has an influence on the nutritional status of a population. Challenges in food production, storage, processing, marketing, consumer demand and preparation, consequently result in dietary inadequacy that leads to nutritional inadequacy at household level. The nutrition sector in Samburu County works closely with the agriculture department to enhance food production and security. The county endeavors to build and operationalize markets to improve food accessibility and availability. NDMA and Partners carry out interventions aimed at improving livelihoods through income generating activities and household purchasing power for food.

Good nutrition is essential to realize the learning potential of school children and maximize returns on educational investments. Good nutrition combined with child stimulation through play and physical activity promotes optimal brain development. Undernourished children in early childhood centers (ECDs) have lower performance in Intelligence Quotient (IQ) and other cognitive tests. The nutrition department also works closely with MOE to strengthen growth monitoring and micro nutrient supplementation by sensitizing ECD teachers on growth monitoring on Vitamin A & deworming. On the other hand, poor WASH status such as limited access to clean water combined with poor sanitation and hygiene practices have been strongly correlated with high incidence of stunting, a major deprivation in Samburu County. Further, social protection programme have been designed to pull poor households up the social ladder and enhance their capacity to access and utilize basic services. integration with nutrition especially through SBCC strategies can have a positive impact on nutrition outcomes. Noting this critical linkage, there is a grow need to strengthen multisector planning and coordination in the County through Nutrition Technical forum, Multisector Platform and County Steering Group committee for maximum benefits.

Expected outcome: Nutrition integration in Agriculture & Food security, Education, WASH and social protection sectors strengthened.

Output 1: County multi-sector coordination platforms strengthened

Strategy. Strengthen the existing multi-sector coordination mechanisms

Interventions/activities

- Strengthen Multi-sector coordination forums (MSP)
- Update the MSP- 4Ws matrix
- Finalize and operationalize a MSP-CRF

Output 2: Nutrition in Agriculture sector strengthened

Strategy. Strengthen the existing Agri-nutrition linkages for improved nutrition outcomes

Interventions/activities

- Advocate for Sensitization of farmers on diversified food production and household diets including bio-fortification
- Collaborate with the department of agriculture to enhance enterprises and cooperatives to enable farmers to have ready markets for their produce through Agricultural Sector Development and Sustainable Livelihood Program (ASDSP)
- Advocate for sustainability handling and storage technologies that improve access to and intake of nutritious foods
- Build capacity of Agricultural extension workers on Agri-nutrition strategies.

Output 3: Health and nutrition programming in schools Promoted

Interventions/activities

- Sensitize Quality Assurance and Standards Officers (QASO), food handlers, parents and school management committee on environment, food safety and appropriate recipes for maximum nutrition impact.
- Sensitization of ECD teachers on growth monitoring and micronutrient supplementation
- Conduct health and nutrition outreaches in schools to offer comprehensive Child health, adolescence health, school WASH services
- Use school children as change agents for nutrition programme areas/priority messaging.

Output 4: Communities benefit from nutrition counselling and education alongside water, sanitation and hygiene (WASH) interventions.

Strategy: SBCC on WASH in Nutrition

Intervention/activities

- Advocate and promote adequate WASH at household level and institutions through Community Led Total Sanitation (SLTS/CLTS) approach and integration with Nutrition Messaging (SANNUT).
- Advocate for Improvement of safe water coverage and accessibility.

Output 5: Households enrolled in social protection programmes receive nutrition services.

Intervention/activities:

- Advocate for integration of nutrition in social services programme design
- Sensitize and train SP programme managers and staff on nutrition integration in Social protection.
- Enroll SP beneficiaries to nutrition programmes.

3.0.9 KRA 9. Sectoral and multi-sectoral Nutrition Governance, Coordination, Legal/ regulatory frameworks, Nutrition Information Systems, Learning and Research strengthened.

Context

Samburu County has an active and vibrant county and sub county nutrition technical forums (CNTF and SCNTF). Through this forums policy, technical guidelines and planning of interventions on nutrition are discussed. This in turn ensures that nutrition activities in the sub counties run seamlessly. There is good coordination of emergencies interventions in the county spearheaded by NDMA through County Steering Group (CSG). The county nutrition coordinator is a member of the CSG and is fully involved and participates in long and short rain assessments and mapping of nutrition hotspots. However, there is need to strengthen the county multi sectoral platform (MSP) to coordinate both nutrition specific and sensitive high impact nutrition interventions (HINI).

Nutrition data from facilities are promptly uploaded to Kenya Health Information System (KHIS) and the data is available for use in decision making by all stakeholders. The findings from SMART survey, KAP survey, KPC assessment and End user monitoring are analyzed, validated and disseminated for use by stakeholders. However, there is need to initiate operation research in nutrition field.

Expected Outcome

Improved coordination mechanism for programs implementation at County, Sub County and Community.

Output 1: Nutrition coordination mechanism at County, Sub County and Community level Strengthened.

Strategy: Strengthen existing nutrition coordination platforms/ structures including monitoring and evaluation across all sectors at County and Sub-county level.

Intervention/ Activities

- Develop and update Terms of Reference for nutrition coordination forums.
- Hold consistent nutrition coordination meeting.

Output 2: County nutrition information system strengthened

Strategy: Strengthen evidence generation and utilization for decision making.

Intervention/ Activities

- Create awareness of the existing nutrition information management policies to all stakeholders.
- Procure and distribute reporting tools and strengthen LMIS/DHIS reporting.
- Sensitize and train health care workers on nutrition management information systems and research methodologies.
- Develop information management platform for nutrition i.e GIS, county dashboard and nutrition website for the County.
- Conduct data reviews and DQAs
- Roll out innovations in data collection and management at facility and community levels

Output 3: Operation research and learning systems in the County strengthened.

Strategy: Strengthen operation research and learning systems in the County (Smart surveys, SQUEAC etc, KABP, KPC, Barrier Analysis)

Intervention/ Activities

- Conduct nutrition surveys and assessments eg. SMART, capacity assessments, coverage surveys, KABP, SRA/ LRA etc and dissemination of findings to stakeholders
- Conduct nutrition operational research and documentation
- Develop action plans based on findings and follow them up
- Document best practices and lessons learnt using a variety of tools, both in print and visual.
- Participate in forums to share and gain new knowledge.

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

Context

Advocacy is an important key result area if a good nutrition outcome is to be achieved in the county. The result area aims to ensure improved and strengthened governance, capacity to deliver, increased awareness, increased demand and adoption of nutrition services and practices at all levels within the county. The County Nutrition Coordinator (CNC) supported by the County Director of health (CDH) and other members of the county Health Management Team (CHMT) have held several high-level advocacy meetings with the members of the County Assembly and Health committee. This has resulted into increased allocation for nutrition department that stands at 14.1 million for financial year 2019-2020. Through the same lobbying more nutritionists were also recruited to fill the staffing gap.

Samburu County government health department uses the local FM radio station namely Serian FM, Watchman FM and Mchungaji FM to reach out to the community to create awareness on nutrition and other health concerns. The coverage of these radio stations is limited to Samburu Central and parts of Samburu North, which implies that it is mainly the population in these locations which receive the health education messages. Another strategy which is utilized to disseminate nutrition information and messages is use of DIGISOMO recorded messages for CHVs and households. The creation of awareness on nutrition concerns have gradually shaped the communities on desirable nutrition practices like breastfeeding and maternal nutrition.

Expected Outcome

The nutrition sector is allocated adequate resources and utilizes them effectively

Output 1: Strengthened Advocacy, Communication and Social Mobilization (ACSM)

Strategy: Strengthen nutrition advocacy for improved resource allocation, leveraging and utilization.

Intervention/Activities

- Conduct high level advocacy targeting key county decision makers and stakeholders on county nutrition priorities.
- Enhance policy and guidelines dissemination.
- Conduct nutrition financial tracking.

Output 2: Nutrition communication Strengthened

Strategy: Strengthen Social behavior change and communication for nutrition

Intervention/Activities

- Develop and disseminate county specific nutrition ACSM strategy.
- Strengthen social mobilization for nutrition
- Documentation and sharing of best practices.
- Radio shows

3.0.11 KRA 11. Supply chain management for nutrition commodities and equipment strengthened.

Context

Nutrition commodities and equipment are a key component for prevention and management of malnutrition and diseases specific conditions along the life course. The key objective is to ensure uninterrupted supply by facilitating integration into a single more effective and efficient Government led supply chain system with KEMSA as the key warehousing and distribution agency of nutrition commodities directly to the health facilities. LMIS reporting from facilities is currently at 100% and this is a clear indication of capacity building and investments done with the support of partners. The health care workers have also been capacity build on commodity management and practices like use of bin cards, stacking guidelines and pallet use has been embraced. Occasional stock outs do occur due to transporters not able to reach the facility door step due to impassable roads and difficult terrains. The county also needs to do more by building permanent stores/ warehouses at the sub county level for storage of nutrition commodities. This will ensure that the nutrition commodities are stored under optimal ideal conditions to prevent spoilages and contamination. The county also needs to put in place a mechanism for prompt repairs and maintenance of anthropometric equipment. This will include facilitation for maintenance personal to go around all the facilities and repair faulty equipment. This if done on a quarterly basis will ensure all equipment function properly and give accurate measurements for management of all nutrition conditions.

Expected Outcome

County nutrition supply chain management improved

Output 1: Health facilities have adequate nutrition supplies and equipment.

Strategy: Strengthen Nutrition supply chain

Intervention/Activities

- Procurement of nutrition commodities supplies and equipment
- Provision of quality storage facilities for the supplies
- Capacity building of staff on warehouse management.

Output 2: Health facilities submit quality and timely Supplies/commodity utilization reports to county and national level

Strategy: Strengthen Nutrition Logistics management information systems

Intervention/Activities

- Capacity build Health Care Workers on Logistics Management Information Systems.
- Timely and accurate reporting on LMIS/KHIS 2 aggregate
- Conduct Supportive Supervision on LMIS
- Conduct OJT/CMEs on LMIS
- Conduct end-user monitoring.

CHAPTER 4

MONITORING, EVALUATION, ACCOUNTABILITY AND LEARNING (MEAL) FRAMEWORK

4.0.1 Introduction

This chapter provides guidance on the monitoring, evaluation, accountability and learning process, and how the monitoring process will inform the county nutrition action plan. The CNAP will evolve as the county assesses data gathered through monitoring. Monitoring and evaluation systematically track the progress of suggested interventions, and assesses the effectiveness, efficiency, relevance and sustainability of these interventions. Monitoring is the ongoing, routine collection of information about a programs activity 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. 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.

4.0.2 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). Samburu has identified and selected 29 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.

4.0.3 County Nutrition Adopted Targets by 2023

Table 6: County Nutrition Adopted Targets by 2023

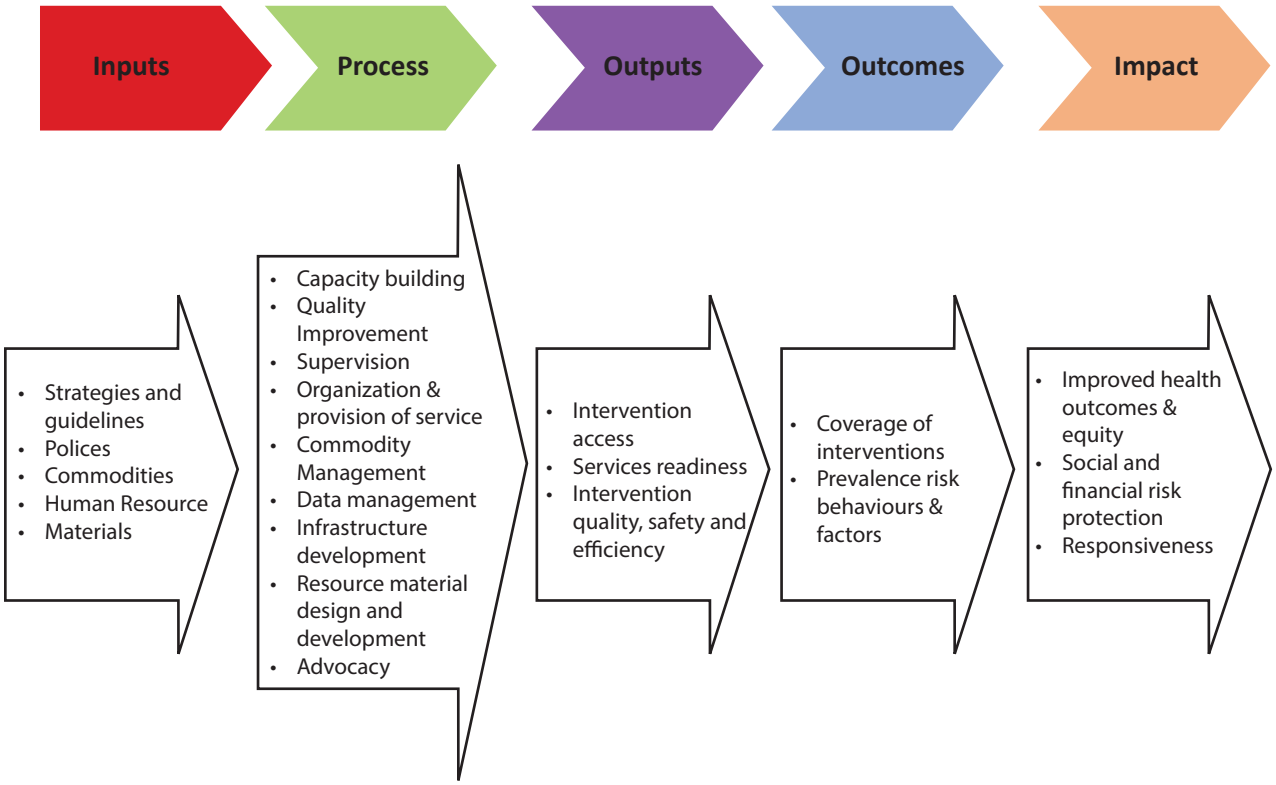
SN	CNAP expected results (National targets used where applicable)	Indicator	Baseline 2018	Data Source	Target 2023	Framework for targets.
1	Reduce the prevalence of stunting among children under five years by 40%	Prevalence of stunting in children 6-59 months (%)	29.3	SMART 2019.	18	WHA targets
2	Reduce the prevalence of anaemia in women of reproductive age by 30%	Prevalence of anaemia in women 15-49 years (%)	27	KDHS 2014	19	WHA targets
3	Reduce the prevalence of low birthweight by 50%	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 20% and above	Prevalence of exclusive breastfeeding in children 0-6 months (%)	77.6	KABP 2018	93	WHA targets
6	Maintain childhood wasting at less than 15.8%	Prevalence of wasting (W/H <2SD) in children 0-59 months (%).	15.8	SMART Survey 2019.	<15.8	WHA targets
7	Reduce childhood underweight by 30%	Prevalence of underweight (W/A<2SD) in children 0-59 months	28.2	SMART Survey 2019.	15.4	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 0.11 SAM 0.52	KHIS 2018	MAM <0.11 SAM <0.52	NFNSP
9	Reduce anaemia in children 6-59 months by 30%	Prevalence of anaemia in children 0-59 months (%)	26%	KDHS 2014	25%	CNAP
10	Reduce anaemia in pregnant women by 40% or more.	Prevalence of anaemia in pregnant women (%)	36	KDHS 2014	35	NFNSP
11	Reduce anaemia in adolescent girls by 30%	Prevalence of anaemia in girls 15-19 years (%)	21	KMNS	19	CNAP
12	Reduce folic acid deficiency among non- pregnant women by 50%	Proportion of non-pregnant women with folic acid deficiency (%)	39	KMNS	35	NFNSP
13	Reduce vitamin A deficiency in children by 50%	Prevalence of VAD in children 0-59 months (%)	9	KMNS	6	NFNSP
14	Reduce iodine deficiency among children <5 years by over 50%	Prevalence of iodine deficiency in children <5 years (%)	22	KMNS	<10	NFNSP
15	Reduce iodine deficiency among non-pregnant women by over 50%	Prevalence of iodine deficiency in non-pregnant women (%)	26	KMNS	<20	NFNSP
16	Reduce prevalence of zinc deficiency in pre-school children by 40%	Prevalence of zinc deficiency in children <5 years (%)	83	KMNS	60	NFNSP
17	Reduce prevalence of zinc deficiency among pregnant women by 40%	Prevalence of zinc deficiency among pregnant women (%)	60	KMNS	45	NFNSP

SN	CNAP expected results (National targets used where applicable)	Indicator	Baseline 2018	Data Source	Target 2023	Framework for targets.
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 25%	Proportion of population with raised blood pressure or currently on medication (%)	24	STEPwise survey report.	<2	NCD 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.	3	NFNSP
21	Increased proportion of men with normal waist: hip ratio	Proportion of men with normal waist: hip ratio (%).	73	STEPwise survey report.	<50	NFNSP
22	Increased proportion of women with normal waist: hip ratio	Proportion of women with normal waist: hip ratio (%)	64	STEPwise survey report.	<50	NFNSP
23	A 30% relative reduction in mean population intake of salt/sodium	Mean intake of sodium salt (g/ day)	3	STEPwise survey report.	<2	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.	14	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	-	50	Clinical Nutrition targets.
27	Increased budgetary allocation towards nutrition	Percentage of nutrition budget in county health budget	0.0015	County Government 2019/2020 Budget.	1	Samburu County Health Budget
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.	NASCOP Quantification 2018.	95	HIV Nutrition targets as indicated in Quantification plan.
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.	NASCOP Quantification 2018.	95	HIV Nutrition targets as indicated in Quantification plan.

4.0.4 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



4.0.5 CNAP Evaluation process

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)	County 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)	County Nutrition Coordinator, M&E Coordinator
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)	County 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)	County 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)	County Nutrition Coordinator, M&E Coordinator

CNAP accountability process

Accountability of the CNAP is part of the basics of good-quality programming practice and results-based management. What we want to ensure is that accountability is systematically embedded in our ways of working. It will entail the following;

- Timely and relevant Information sharing.
- Participation - discussing together, deciding together and working together with other HWs, communities and partners.
- Seeking and giving feedback from other HWs, communities and partners
- Monitoring, evaluating and learning
- Building competencies for accountable programming by all health care workers

4.0.6 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. Learning will involve assessing what works well or does not work well in a context, which aspects have more influence on the achievement of results, which strategies can be replicated, etc. The following initiatives will guide learning in this CNAP:

1. Compare results across time to determine which ones contribute to achieving the mission and expected results.
2. Facilitation of both formal and informal learning and reflection meetings of all stakeholders, by sharing learning experiences (positive and negative) with partners, communities and other stakeholders, in response to their needs. This will strengthen social accountability and transparency.
3. Documentation of processes and reports (paper based, photos, videos, etc.); and appropriate storage (filing – electronic, paper based) of MEAL outputs to keep learning within the organization.
4. Mentoring of staff /on job training with a focus on specific issues or identified needs and helping individuals reflect and question existing practice.
5. Training courses in response to feedback.
6. Development of innovative tools for MEAL.

4.0.7 Financial tracking and budget analysis

An important aspect in measuring the performance of the CNAP is to be able to track the nutrition investments made through the CNAP regularly and transparently. This will help in better use of finance data (allocations vs expenditures) to mobilize increased internal and external resources for improved nutrition outcomes and for purposes of advocacy and better planning. County Governments invest in nutrition through budgetary allocation to various sectors, e.g., health, agriculture, education, WASH and social protection, and the CNAP has incorporated nutrition targets in these sectors to ensure these budgets work harder for nutrition impact.

4.0.8 Institutional arrangement for M&E

Samburu County is implementing the M&E framework 2018-2022. At the County level, there is a focal person for M&E within the MoH whose functions are to: 1) provide strategic direction for M&E in the health sector; 2) coordinate M&E activities as well as supporting programmes in their M&E needs; and 3) work with other line ministries, collect health information and vital statistics required for County development. Development of an overall research agenda to support the CNAP is important. Some key implementation research questions that the CNAP may want to be answered as part of implementation monitoring could include:

1. How functional and effective are the coordinating structures at the County and sub-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 concerns created by the CNAP?
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) attributed to CNAP?

4.0.9 Role of national and county government in implementation of CNAP

National

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

4.0.10 Data management for nutrition M&E

What data are to be collected, how and when, are key to the success of 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, the County department of health must developed various policy documents and guidelines.

4.0.11 Research

The objective of implementation research is to promote the systematic uptake of research findings and other evidence-based practices into routine practice, and, hence, to improve the quality and effectiveness of chosen interventions. In the context of the CNAP, the structure of implementation (for example, the roles played by the County, non- governmental organizations, development partners, the private sector and citizens in general) can also be subjected to implementation research.

4.0.12 Limitation of the data source

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

4.0.13 Cost of MEAL.

MEAL should be allocated between 5 and 10 per cent of the 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 costs for 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, KSh. 1.7 billion is required as shown in the figure below. Further annual breakdown of cost requirement (s) is also presented.

Appendices

Appendix I: County Result Accountability Framework.

	Output	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										
Output 1.1	**Output 1**: Health workers and CHVs have the capacity to implement MIYCN programmes	1. Number of health workers trained on MIYCN	124	0	60	60	30	Training reports	CDH	Health Partners and MOA
		2. Number of CHVs trained on MIYCN	624	60	60	60	30	Training Reports	CDH	Health Partners and MOA
Output 1.2	**Output 2**: Communities have improved knowledge and skills on MIYCN	1. Number of households adapting good MIYCN practices	3740	3655	3500	3400	3200	KABP Survey	CDH, CDA	Health and Agriculture partners
Output 1.3	**Output 3**: Improved M&E for Maternal Infant and Young Child Nutrition program	1. Number of DQA and Assessment conducted	12	12	12	12	12	DQA report	CDH	Health and Partners
KRA2: Nutrition of older children, Adolescent, Adults and Older persons promoted										
Output 2.1	**Output1**: Older children, adolescents, adults and older persons access and utilize nutrition services at Health facility and community Level	Number of health facilities screening older children, Adolescent, Adults and Older persons for malnutrition.	No Data	18	18	18	18	KHIS	CDH	Health and Partners
Output 2.2	**Output 2**: increased awareness of healthy diet and physical activities in schools	Number of school Board of Management sensitized.	0	5	5	5	5	Training report.	CNC	Health and Agriculture partners
Output 2.3	**Output 3:** Improve school feeding programs	Number of schools sensitized on menu guide	0	5	5	5	5	Training report.	CNC	Health and Agriculture partners
		Number of schools adopting menu guide	0	5	5	5	5	Training report.	CNC	Health and Agriculture partners

	Output	Indicator	Baseline 2018/2019	2019/20	2020/21	2021/22	2022/23	Means of verification	Lead	Associated
KRA 3. Prevention, control and management of Micronutrient Deficiencies Scaled up.										
Output 3.1	**Output 1:** children and women of reproductive age are supplemented and dewormed according to the approved protocal	Proportion of WRA taking IFAS.	89.3	95	95	100	100	KHIS	CDH	Health and partners.
		Proportion of children 6-59 supplemented with Vitamin A.	72.6	80	80	80	80	KHIS	CDH	Health and partners
Output 3.2	**Output 2:** community consumes fortified foods	No of households consuming fortified foods.	60193	60193	60193	60193	60193	KHIS	CDH	Health and Agriculture partners
KRA 4. Clinical Nutrition and dietetics strengthened including Prevention, control and management of Diet Related Non-Communicable Diseases (DRNCDs)										
Output 4.1	**Output 1:** Clinical nutrition and dietetic services strengthened including prevention, control and management of diet related and communicable diseases	Number of health facilities offering management of diet related non-communicable diseases	3	3	3	3	3	KHIS	CDH	Health
Output 4.2	**Output 2:** clients/patients affected by DRNCDs access and utilize quality clinical nutrition treatment and management services	Proportion of Diet Related Non-Communicable Diseases clients referred.	No data	2.4	3.4	4.4	5.4	KHIS	CDH	Health
KRA 5. Integrated Management of Acute Malnutrition Strengthened										
Output 5.1	**Output 1:** malnourished children and women access timely and quality IMAM services	Number of children and women treated for malnutrition	66	71	76	81	85	KHIS	CDH	Health
Output 5.2	**Output 2:** HCWs knowledge and skills to manage Acute malnutrition improved	No. of HCWs with capacity to manage acute malnutrition								

	Output	Indicator	Baseline 2018/2019	2019/20	2020/21	2021/22	2022/23	Means of verification	Lead	Associated
KRA 6. Nutrition in Emergencies Strengthened										
Output 6.1	**Output 1** County capacity on Nutrition emergency preparedness strengthened	No. of Contingency plans updated	1	1	1	1	1	Activity report	CDH and NDMA	Partners in Health and Resilience and response
		No. of HFs implementing IMAM surge	19	15	15	15	15	Activity Report	CNC	
		No of HWs trained on emergency preparedness	0	15	15	15	15	Activity report	NDMA	CDH, MOA and partners.
Output 6.2	**Output 2** Households affected by emergencies received quality health and nutrition services	No. of bimonthly integrated Outreaches done	100	100	100	100	100	Activity report	NDMA and CDH	Partners in Health and Resilience and response
		Estimated No. of children malnourished	19,326	18,326	17,326	16,326	15,326			
Output 6.3	**Output 3:** Strengthened Coordination and partnership for integrated preparedness and response initiative	No. of emergency response coordination forums	12	12	12	12	12			
KRA 7. Nutrition in Tuberculosis (TB) and HIV strengthened										
Output 7.1	**Output 1:** Improved nutrition management of HIV and TB	No. of HIV and TB clients put on nutrition supplements	1892	1900	2000	2100	2350	KHIS	CDH	NASCOP and health partners.
Output 7.2	**Output 2:** Improved capacity of HCWs on nutrition management of HIV & TB	No. of Health care workers trained on Nutrition in HIV	52	60	30	60	60	IHRIS	CDH	NASCOP and health partners
		No. of Health care workers trained on Nutrition in TB.	52	60	30	60	60	IHRIS	CDH	CNC & TB Coordinator and health partners
KRA 8. Strengthen and promote nutrition in Agriculture & Food security, Education, WASH and social protection sectors										
Output 8.1	**Output 1:** County MSP coordination strengthened	Number of MSP coordination forums held	4	4	4	4	4	Activity Report	CDH	CDH, CDA and Partners
Output 8.2	**Output 2:** Nutrition in agriculture sector strengthened	No. of agriculture extension workers trained on agri-nutrition strategies	0	10	10	10	10	Activity Report	CDH	CDH, CDA and Partners
		No. of farmers sensitized on Agri-nutrition	0	50	50	50	50	Activity Report	CDH	CDH, CDA and Partners

	Output	Indicator	Baseline 2018/2019	2019/20	2020/21	2021/22	2022/23	Means of verification	Lead	Associated
Output 8.3	**Output 3**: Health and nutrition programing in schools promoted	Number of QASO, food handlers, parents and school management committees sensitized on food safety and recipes	0	180	185	190	200	Activity report	MOE	CDH, CDA and Partners
		Number of comprehensive health and nutrition outreaches conducted in schools	0	10	10	10	10	Activity report	MOE	CDH, CDA and Partners
		No. school going children reached with messages on nutrition	0	100	100	100	100	Activity report	MOE	CDH, CDA and Partners
Output 8.4	**Output 4:** communities benefit from nutrition counselling and education alongside WASH.	Number of Households reached with combined health messages on WASH and Nutrition	57623	62000	62000	62000	62000	KPC surveys	CDH	CDH, CDW and Partners.
		No. of HHs with access to potable water								
Output 8.5	**Output 5:** HHs enrolled in social protection programs receive nutrition services	Proportion of vulnerable persons (OVC, Disabled and elderly) receiving nutrition support.	ND	30	40	50	60	Activity Report	Social services	CDH,CDA and Partners
		Number of technical officers in social protection sensitized on Nutrition	0	5	5	5	5	Activity Report	Social services	CDH,CDA and Partners
KRA 9. Sectoral and multi-sectoral Nutrition Governance, Coordination, Legal/regulatory frameworks, Nutrition Information Systems, Learning and Research strengthened.										
Output 9.1	**Output 1** Nutrition coordination mechanism at county, sub-county and community level strengthened	Number of monthly nutrition technical forums.	12	12	12	12	12	Activity report	CDH	GOK departments and partners
Output 9.2	**Output 2** County Nutrition information system strengthened	No. of data reviews/DQAs done	4	4	4	4	4	Activity report	CDH	GOK departments and partners
		Proportion of HFs reporting on KHIS (MoH 713)	95%	100%	100%	100%	100%	KHIS	CDH	GOK
		Number of HCWs trained on FCDRR	0	20	20	20	20			
Output 9.3	**Output 3:** Operation research and learning systems in the County strengthened.	Number of nutrition Operation research conducted in the county	ND	1	1	1	1	Activity report	CDH and Health partners	CNC other supporting partners
		Number of nutrition documentations done	1	1	1	1	1	Activity report	CDH and Health partners	CNC other supporting partners
KRA10. Advocacy, Communication and Social Mobilization (ACSM) strengthened										

	Output	Indicator	Baseline 2018/2019	2019/20	2020/21	2021/22	2022/23	Means of verification	Lead	Associated
Output 10.1	**Output 1:** Strengthened Advocacy, Communication and Social Mobilization (ACSM)	Number of High level Nutrition advocacy meeting conducted.	4	4	4	4	4	Meeting Minutes.	CDH and Health partners	CNC other supporting partners
		Number of nutrition financial tracking done	0	4	4	4	4	Activity Report	CDH and Health partners	CNC other supporting partners
		No. of nutrition SBCC strategy review session done	0	1	0	1	0	Activity Report	CDH and Health partners	CNC other supporting partners
Output 10.2	**Output 2:** Nutrition communication Strengthened	ACSM nutrition strategies done	0	1	0	1	0	Meeting Minutes.	CDH and Health partners	CNC other supporting partners
		No. of nutrition documentations done	1	1	1	1	1		CDH and Health partners	CNC other supporting partners
KRA 11. Supply chain management for nutrition commodities and equipment strengthened.										
Output 11.1	Output 1: Health facilities submit quality and timely supplies utilization reports	Number of healthcare workers trained on LMIS.	62	60	60	60	60	iHRIS	CDH and Health partners	CNC other supporting partners
		Proportion of facilities supported to conduct end user monitoring	12	25	40	55	70	Activity Report	CDH and Health partners	CNC other supporting partners
	Output 2: Health facilities have adequate nutrition supplies and equipment	Proportion of HFs implementing IMAM reporting zero stock outs	9%	0%	0%	0%	0%	iHRIS	CDH and Health partners	CNC other supporting partners
		Proportion of HFc with adequate storage of nutrition commodities	15	25	40	55	70	LMIS, KHIS	CDH and Health partners	CNC other supporting partners

5.4 Implementation resources

Table 7: Summary of Resource Need By KRA

Category of intervention	KRA	2019/2020	2020/21	2021/2022	2022/2023	Total KSH	Total USD
Nutrition Specific	KRA 1. Maternal, Infant and Young Child Nutrition (MIYCN) Scaled Up	27309960	47703420	46349420	31478540	152841340	
	KRA 2. Nutrition of older children, Adolescent, Adults and Older persons promoted	19876500	19876500	19876500	19876500	79506000	
	KRA 3. Prevention, control and management of Micronutrient Deficiencies Scaled up	8175775	9902600	9902600	9902600	37883575	
	KRA 4. Clinical Nutrition and dietetics strengthened including Prevention, control and management of Diet Related Non-Communicable Diseases (DRNCDs)	18909500	18909500	18909500	18909500	75638000	
	KRA 5. Integrated Management of Acute Malnutrition Strengthened	16106860	15633860	16106860	15633860	63481440	
	KRA 6. Nutrition in Emergencies Strengthened	25983600	25983600	25983600	25983600	155014000	
	KRA 7. Nutrition in Tuberculosis (TB) and HIV strengthened	48497949	58827129	66597801	73063881	246986760	
Nutrition Sensitive	KRA 8. Strengthen and promote nutrition in Agriculture & Food security, Education, WASH and social protection sectors	30487000	30487000	30487000	30487000	121948000	
Enabling environment/ Crossing Cutting	KRA 9. Sectoral and multi-sectoral Nutrition Governance, Coordination, Legal/regulatory frameworks, Nutrition Information Systems, Learning and Research strengthened.	37808000	37808000	37808000	37808000	151232000	
	KRA 10. Advocacy, Communication and Social Mobilization (ACSM) strengthened KRA 10. Advocacy, Communication and Social Mobilization (ACSM) strengthened	15939216	18362288	17632752	17492752	69427008	
	KRA 11. Supply chain management for nutrition commodities and equipment strengthened	143001560	143066560	143001560	143066560	572136240	

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 14,144,518.

Appendix II: County Nutrition 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:** Health workers and CHVs have the capacity to implement MIYCN programmes	Build capacity of S/CHMT, HCW, CHVs, CMSGs on Maternal Infant and Young Child Nutrition	3516000	23876400	22522400	13019200	62934000	
		Roll out BFHI, Care Groups and BFCI in the county	9695860	9728920	9728920	4361240	33514940	
		Create awareness on reporting for MIYCN Programme	316000	316000	316000	316000	1264000	
		Procure and distribute of Maternal Infant and Young Child Nutrition commodities and reporting tools.	2200000	2200000	2200000	2200000	8800000	
	Output 2: Community have improved Behaviors and practices on MIYCN	Support awareness campaigns and health action days geared at passing information	6286900	6286900	6286900	6286900	25147600	
		Conduct BFHI and BFCI assessments	405,000	405,000	405,000	405,000	1620000	
	Output3: Improve M&E for Maternal Infant and Young Child Nutrition program	Conduct assessment of BFCI and BFHI.	2290200	2290200	2290200	2290200	9160800	
		Strengthen reporting on MIYCN program	2600000	2600000	2600000	2600000	10400000	
KRA2: Nutrition of older children, Adolescent, Adults and Older persons promoted	**Output1**: Improved nutrition of older children, Adolescent, Adults and Older persons	Collaborate in CLTS activities.	5817500	5817500	5817500	5817500	23,270,000	
		Support Early detection of malnutrition of older children (6-9yrs), Adolescent, Adults and Older persons.	1680000	1680000	1680000	1680000	6720000	
	Output 2: Improved handwashing practices in schools and in the community	Advocate for establishment and use of handwashing facilities in schools and community.	3090000	3090000	3090000	3090000	12360000	
	Output 3: Food quality, safety and security in schools	Collaborate in promotion of food quality, safety and security in schools and community.	321000	321000	321000	321000	1284000	
		Improve quality diet among older children (6-9yrs), Adolescent, Adults and Older persons.	8968000	8968000	8968000	8968000	35872000	
	Total		19876500	19876500	19876500	19876500	79506000	

KRA	Output	Intervention	2019/2020	2020/2021	2021/2022	2022/2023	Total Ksh	Total USD
KRA 3. Prevention, control and management of Micronutrient Deficiencies Scaled up	**Output 1:** Food-based approaches/dietary diversity in the community promoted	Sensitize the community on dietary diversity through promotion of home gardening, growing of bio fortified foods and promote consumption of bio-fortified foods	5633000	5633000	5633000	5633000	22532000	
		Conduct integrated outreaches and in cooperate Prevention, control and management of Micronutrient Deficiencies	-	-	-	-	-	
	Output2: Improved micronutrient supplementation among children, WRA and the general population	Capacity build the health care workers, Stakeholders CHVs and community on micronutrient supplementation	8175	1735000	1735000	1735000	5213175	
	Output3: Consumption of fortified foods in the community Promoted	Advocate for policy environment on food fortification law.	100000	100000	100000	100000	400000	
		Strengthen reporting and surveillance for micronutrient	2434600	2434600	2434600	2434600	9738400	
	Total		**8175775**	**990260**	**990260**	**990260**	**37883575**	
KRA 4. Clinical Nutrition and dietetics strengthened including Prevention, control and management of Diet Related Non-Communicable Diseases (DRNCDs)	**Output 1:** Clinical nutrition and dietetic services strengthened	Capacity build HCWs, CHV's on nutrition screening, assessment and triage for Diet Related Non-Communicable Diseases	4494000	4494000	4494000	4494000	17976000	Capacity build HCWs, CHV's on nutrition screening, assessment and triage for Diet Related Non-Communicable Diseases
		Capacity build nutritionist and dieticians to provide specialized services for patients	2271000	2271000	2271000	2271000	9084000	Capacity build nutritionist and dieticians to provide specialized services for patients
		Capacity build HCWs on LMIS, KHIS and EMR for nutrition commodity procurement	4308000	4308000	4308000	4308000	17232000	Capacity build HCWs on LMIS, KHIS and EMR for nutrition commodity procurement
	Output 2: Improved effective management and referral services of diet related non-communicable diseases	Capacity build HCW's, CHV'S and community on Diet Related Non-Communicable Diseases (DRNCDs)	1914000	1914000	1914000	1914000	7656000	Capacity build HCW's, CHV'S and community on Diet Related Non-Communicable Diseases (DRNCDs)
		Awareness creation on DRNCDs	5922500	5922500	5922500	5922500	23690000	Awareness creation on DRNCDs
		Enhance standards for provision of clinical nutrition	-	-	-	-	-	Enhance standards for provision of clinical nutrition
	Total		**18909500**	**18909500**	**18909500**	**18909500**	**75638000**	

KRA	Output	Intervention	2019/2020	2020/2021	2021/2022	2022/2023	Total Ksh	Total USD
KRA5. Integrated Management of Acute Malnutrition Strengthened	**Output1:** Improved IMAM Services	Build capacity of S/CHMT, HCWs, CHVs and community on IMAM	11000000	10527000	11000000	10527000	Build capacity of S/CHMT, HCWs, CHVs and community on IMAM	11000000
		Enhance Integrated Management of Acute Malnutrition (IMAM) supply chain strengthen	-	-	-	-	Enhance Integrated Management of Acute Malnutrition (IMAM) supply chain strengthen	-
		Strengthen Monitoring and Evaluation (M&E) of Integrated Management of Acute Malnutrition (IMAM) services	4636900	4636900	4636900	4636900	Strengthen Monitoring and Evaluation (M&E) of Integrated Management of Acute Malnutrition (IMAM) services	
		Expand IMAM services to the community	469960	469960	469960	469960	1879840	
	Total		**16106860**	**15633860**	**16106860**	**15633860**	**63481440**	
KRA 6. Nutrition in Emergencies Strengthened	**Output 1** •Nutrition in emergency preparedness, response and assessment Strengthened	Participate in Community Managed Disaster Risk Reduction (CMDRR) in identified nutrition hotspots.	8224100	8224100	8224100	8224100	33976000	
		Sensitize health care workers on nutrition surveillance and response	9658000	9658000	9658000	9658000	88632000	
		Advocate for resource Mobilization on emergency and response.	50000	50000	50000	50000	200000	
		Advocate for inclusion of nutritionist in county steering group.	394000	394000	394000	394000	1576000	
	Output 2 Strengthened coordination and partnerships for integrated preparedness and response initiatives	Map partners in preparedness and emergency risk reduction	0	0	0	0	0	
		Establish functional emergency preparedness and risk reduction committees	7391000	7391000	7391000	7391000	29564000	
		Procure nutrition commodities for prepositioning.	266500	266500	266500	266500	1066000	
		Distribution of commodities to peripheral stores as buffer stocks.	0	0	0	0	0	
	Total		**25983600**	**25983600**	**25983600**	**25983600**	**155014000**	

KRA	Output	Intervention	2019/2020	2020/2021	2021/2022	2022/2023	Total Ksh	Total USD
KRA 7. Nutrition in Tuberculosis (TB) and HIV strengthened	**Output 1:** Improved Nutrition in TB and HIV management Program	Train health care workers on nutrition in TB and HIV management in nutrition	3598805	7423985	7423985	7423985	25870760	
		Sensitize CHVs on lost follow up for TB and HIV cases at the community level.	21855744	28283904	35997696	42425856	128563200	
		Strengthen supply chain of TB and HIV commodities.	379200	455040	511920	549840	1896000	
		Strengthen M$E on Nutrition in TB and HIV management	22664200	22664200	22664200	22664200	90656800	
	Total		**48497949**	**58827129**	**66597801**	**73063881**	**246986760**	
KRA 8. Strengthen and promote nutrition in Agriculture & Food security, Education, WASH and social protection sectors	**Output 1:** Existing coordination platforms strengthened	Advocate for Sensitization of farmers on diversified food production and household diet	2850800	2850800	2850800	2850800	11403200	
		Collaborate with the department of agriculture to enhance enterprises and cooperatives to enable farmers to have ready markets for their produce through Agricultural Sector Development and Sustainable Livelihood Program (ASDSP)	2586300	2586300	2586300	2586300	1045200	
		Advocate for sustainability to food access, availability and utilization	7282400	7282400	7282400	7282400	29129600	
	Output 2: Capacity for nutrition programming in schools Promoted	Sensitize Quality Assurance and Standards Officers (QASO), food handlers, parents and school management committee on environment and food safety.	3304700	3304700	3304700	3304700	13218800	
	Output 3: Nutrition integration in water, sanitation and hygiene (WASH) strengthened.	Advocate and promote adequate WASH at household level and institutions through Community Led Total Sanitation (SLTS/CLTS) approach	2032500	2032500	2032500	2032500	8130000	
		Advocate for Improvement of safe water coverage and accessibility.	3132200	3132200	3132200	3132200	12528800	
	Output 4: Nutrition integration in social protection sectors strengthen.	Advocate for integration of social services in nutrition programming	2722000	2722000	2722000	2722000	10888000	
		sensitize the public and management of institutions of vulnerable persons, and correction facilities on health and nutrition.	6576100	6576100	6576100	6576100	26304400	
	Total		**30487000**	**30487000**	**30487000**	**30487000**	**121948000**	

KRA	Output	Intervention	2019/2020	2020/2021	2021/2022	2022/2023	Total Ksh	Total USD
KRA 9. Sectoral and multi-sectoral Nutrition Governance, Coordination, Legal/regulatory frameworks, Nutrition Information Systems, Learning and Research strengthened.	**Output 1** Strengthened coordination mechanism for programs implementation at County, Sub County and Community.	Develop common Result Framework (CRF) and Terms of Reference for coordination forums.	8032000	8032000	8032000	8032000	32128000	
		Advocate for consistent quarterly multi sectoral platform meeting.	5344000	5344000	5344000	5344000	21376000	
	Output 2 Nutrition information system strengthened	Create awareness of the existing policies to all stakeholders.	920000	920000	920000	920000	7680000	
		Sensitize health care workers on nutrition management information systems.	1800000	1800000	1800000	1800000	7200000	
		Develop information management platform for nutrition i.e GIS and nutrition website for the County.	48000	48000	48000	48000	192000	
		Conduct nutrition capacity assessment in mid -term review of 2nd generation CNAP in 2020.	4600000	4600000	4600000	4600000	18400000	
	Output 3 Operation research and learning systems in the County strengthened.	Conduct nutrition assessments.	16064000	16064000	16064000	16064000	64256000	
	Total		**37808000**	**37808000**	**37808000**	**37808000**	**151232000**	
KRA 10. Advocacy, Communication and Social Mobilization (ACSM) strengthened	**Output 1:** Strengthened Advocacy, Communication and Social Mobilization (ACSM)	Conduct high level advocacy targeting key county decision makers and stakeholders on county nutrition priorities.	1397568	2174736	2202240	2202240	7976784	
		Enhance policy and guidelines dissemination.	996000	1285440	1285440	1285440	4878240	
	Output 2: Nutrition communication Strengthened	Develop and distribute County specific nutrition IEC materials.	11122048	11708512	11708512	11708512	46247584	
		Strengthen social mobilization	1847600	1707600	1847600	1707600	7110400	
		Documentation and sharing of best practices.	576000	1486000	576000	576000	321400	
	Total		**15939216**	**18362288**	**17632752**	**17492752**	**69427008**	

KRA	Output	Intervention	2019/2020	2020/2021	2021/2022	2022/2023	Total Ksh	Total USD
KRA 11. Supply chain management for nutrition commodities and equipment strengthened.	**Output:** Nutrition supply chain management Strengthened	Capacity build Health Care Workers on Logistics Management Information Systems.	106700	106700	106700	106700	4268000	
		Procure and distribute nutrition commodities and reporting tools.	140577060	140642060	140577060	140642060	562438240	
		Improve storage facilities for nutrition commodities	157500	157500	157500	157500	630000	
		Conduct Supportive Supervision on LMIS	0	0	0	0	0	
		Conduct OJT/CMEs on LMIS	1200000	1200000	1200000	1200000	480000	
	Total		**143001560**	**143066560**	**143001560**	**143066560**	**572136240**	

References

- Kenya Nutrition Action Plan (KNAP) 2018-2023.
- County Integrated Development Plan (CIDP) 2018-2023
- Samburu County Health Strategic Plan (SCHSP) 2018-2023
- Samburu County SMART Survey (June 2018)
- Knowledge, attitudes, Beliefs and practices survey
- Kenya Health Information System (KHIS 2)
- Kenya Demographics Health Survey

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SAMBURU
COUNTY GOVERNMENT
DEPARTMENT OF HEALTH

County Nutrition Action Plan
2019-2023

Adopting harmonized Multisectoral approaches to address malnutrition.

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