MINISTRY OF HEALTH

BARINGO COUNTY
NUTRITION ACTION PLAN (CNAP) 2023-2027

Working Together Towards Reduction of Malnutrition in our County

©County Government of Baringo

Our Partners

Our Vision

A healthy and productive populace with sustainable and adequate nutrition throughout their life cycle.

Our Mission

To improve the nutritional well-being of all residents through a coordinated, integrated, evidence-based, multisectoral approach

Guiding Principles

- Equity
- Evidence- based
- Primary care focus
- Life course approach
- Integrity and accountability
- People-centered
- Gender responsive
- Universal coverage
- Right-based approach
- Multisectoral approach throughout adult life

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List of Acronyms and Abbreviations

ABC	Activity-Based Costing
ACF	Action Against Hunger
ACSM	Communication and Social Mobilization
ARIs	Acute Respiratory Infections
ASALs	Arid and Semi-Arid Lands
AWP	Annual Work Plan
BCC	Behavior Change Communication
BCNAP	Baringo County Nutrition Action Plan
BFCI	Baby-Friendly Community Initiatives
BFHI	Baby-Friendly Hospital Initiative
BMI / BMIs	Body Mass Index / Body Mass Indices
BMS	Breast Milk Substitutes
BMZ	German Federal Ministry for Economic Cooperation and Development (Bundesministerium für wirtschaftliche Zusammenarbeit und Entwicklung)
CADP	County Annual Development Plan
CBFCI	Community-Based Baby Friendly Community Initiative
CBO	Community Based Organization
CCC	Comprehensive Care Centre
CDA	County Development Agenda
CHANIS	Child Health and Nutrition Information System
CHAs	Community Health Assistants
CHEWs	Community Health Extension Workers
CHMT	County Health Management Team
CHP /s	Community Health Promoters
CHPS	Community Health Planning and Services
CHSSIP	County Health Sector Strategic and Investment Plan
CHUs	Community Health Units
CHVs	Community Health Volunteers
CIDP	County Integrated Development Plan
CLTS	Community-Led Total Sanitation
CME	Continuous Medical Education
CNAP	County Nutrition Action Plan
CNTF	County Nutrition Technical Forum
CNTWG	County Nutrition Technical Working Group
CO / Cos	County Officer / County Officers
COVID-19	Coronavirus Disease 2019
CRAF	Common Results and Accountability Framework
CSB	Corn-Soy Blend (usually in nutrition context)
CSG	County Steering Group
CSR	Social Responsibility
CU	Care Unit
CWC	Child Welfare Clinic
CWTC	Community Water Treatment Committee
DFID	Department for International Development (UK)
DRNCDs	Diet-Related Non-Communicable Diseases

EBF	Exclusive Breastfeeding
ECD	Early Childhood Development
ECDE	Early Childhood Development Education
ECHIS	Electronic Community Health Information System
ETR	End-Term Review
FBOs	Faith-Based Organizations
FGM	Female Genital Mutilation
FS	Food Systems
FSQ	Food Safety and Quality
GAM	Global Acute Malnutrition
GAP	Good Agricultural Practices
GMP	Growth Monitoring and Promotion
GOK	Government of Kenya
HCW /s	Health Care Worker(s)
HINI	High Impact Nutrition Interventions
HIV	Human Immunodeficiency Virus
HKI	Helen Keller International
HMIS	Health Management Information System
HMT /s	Health Management Team(s)
HPTU	Health Products and Technologies Unit
HR	Human Resources
HRH	Human Resources for Health
HSNP	Hunger Safety Net Programme
HSSIP	Health Sector Strategic and Implementation Plan
IDD	Iodine Deficiency Disorders
IEC	Information, Education and Communication
IFA	Iron and Folic Acid
IFAS	Iron and Folic Acid Supplementation
IMAM	Integrated Management of Acute Malnutrition
IMNCI	Integrated Management of Newborn and Childhood Illnesses
IPC	Infection Prevention and Control
IPM	Integrated Pest Management
ITN	Insecticide-Treated Net
IU	International Unit
IV	Intravenous
IYCF	Infant and Young Child Feeding
KABP	Knowledge, Attitudes, Beliefs, and Practices
KAP	Knowledge, Attitudes and Practices
KDHS	Kenya Demographic and Health Survey
KHIS	Kenya Health Information System
KHP	Kenya Health Policy
KHSSP	Kenya Health Sector Strategic and Investment Plan
KMC	Kangaroo Mother Care
KNAP	Kenya Nutrition Action Plan
KRAs	Key Result Areas
LMIS	Logistics Management Information System

MAD	Minimum Acceptable Diet
MAM	Moderate Acute Malnutrition
MDD	Minimum Dietary Diversity
MDT	Multidisciplinary Teams
MEAL	Monitoring, Evaluation, Accountability and Learning
MIYCN	Maternal, Infant, and Young Child Nutrition
MMR	Maternal Mortality Ratio
MMS	Multiple Micronutrient Supplementation
MNP	Micronutrient Powder
MoH	Ministry of Health
MSMEs	Micro, Small and Medium Enterprises
MSP	Multi-Sectoral Nutrition Platform
MTCs	Medicines and Therapeutic Committees
MTEF	Medium-Term Expenditure Framework
MTP	Medium-Term Plan
MTR	Medium-Term Review
MUAC	Mid-Upper Arm Circumference
NCD	Non-Communicable Disease
NDMA	National Drought Management Authority
NFNSP	National Food and Nutrition Security Policy
NGO	Non-Governmental Organization
NSA	Nutrition Sensitive Agriculture
OD	Open Defecation
ODF	Open Defecation Free
ORS	Oral Rehydration Salts
OTP	Outpatient Therapeutic Program
PCNs	Primary Care Networks
PD	Participatory Development
PD-Hearth	Positive Deviance Hearth
PECs	Primary Education Committees
PER	Public Expenditure Review
PHOs	Public Health Officers
PLHIV	People Living with HIV
PMTCT	Prevention of Mother-To-Child Transmission
PPP	Public-Private Partnership
PTA	Parent-Teacher Association
RDQA	Routine Data Quality Assessment
RUSF	Ready-to-Use Supplementary Food
RUTF	Ready-to-Use Therapeutic Food
SAM	Severe Acute Malnutrition
SBCC	Social and Behavior Change Communication
SCHMT	Sub-County Health Management Team
SDG	Sustainable Development Goals
SHIF	Social Health Insurance Fund
SMART	Standardized Monitoring and Assessment of Relief and Transitions
SOPs	Standard Operating Procedures

SP	Strategic Plan
SUN	Scaling Up Nutrition
SWG	Sector Working Group
SWOT	Strengths, Weaknesses, Opportunities, and Threats
TB	Tuberculosis
ToC	Theory of Change
ToT	Training of Trainers
TPN	Total Parenteral Nutrition
TVET	Technical and Vocational Education and Training
TWG	Technical Working Group
U5MR	Under-Five Mortality Rate
UHC	Universal Health Coverage
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
UTJ	USAID Tujenge Jamii
VAD	Vitamin A Deficiency
VAS	Vitamin A Supplementation
WASH	Water, Sanitation and Hygiene
WFP	World Food Programme
WHA	World Health Assembly
WHO	World Health Organization

Foreword

Kenya, through the Ministry of Health, recently developed third generation Kenya Nutrition Action Plan (KNAP) 2023–2027 to provide national guidance for nutrition programming. This strategic document aims to strengthen efforts to address malnutrition and promote optimal health and well-being across the country. In alignment with national priorities and policy frameworks including Kenya Vision 2030, the Fourth Medium-Term Plan (MTP IV), and the County Integrated Development Plan (CIDP), Baringo County has developed its own third generation County Nutrition Action Plan (CNAP). This CNAP also draws on global and regional commitments such as the

Sustainable Development Goals (SDGs) and the African Union Agenda 2063, ensuring that local interventions are integrated within broader health and development agendas.

The CNAP was developed through a collaborative and participatory process, coordinated by the Division of Nutrition and involving a broad spectrum of stakeholders. These include government agencies, development partners, healthcare providers, community representatives, and other key actors in the nutrition sector. Consultative meetings and data-driven situational analyses helped identify progress made, persistent gaps, and the challenges encountered in both resource mobilization and the implementation of nutrition interventions.

As we enter this new implementation period, the CNAP is grounded in the principles of inclusivity, stakeholder engagement, and a rights-based approach. We are confident that, through coordinated action, sufficient resource allocation, and innovative strategies, we can significantly reduce the burden of malnutrition and improve the overall health and well-being of the people of Baringo County.

We call upon all stakeholders public and private, local and international to support and actively engage in the implementation of this plan. The CNAP is not just a roadmap; it is a shared commitment to ensuring a healthier, more resilient future for all residents of Baringo County.

Dr Solomon Sirma
County Executive Committee Member Health Services
Baringo County

Preface

A healthy population is a cornerstone for enhanced productivity and sustained economic growth. Recognizing this, the Government—through the health sector—has demonstrated its strong commitment to achieving Universal Health Coverage (UHC) as a national priority.

The Baringo County Nutrition Action Plan (CNAP) 2023– 2027 serves as a comprehensive and strategic framework to guide the coordination, implementation, and resource mobilization for nutrition interventions across the health sector and other key county departments. This plan is aligned with the Baringo County Integrated Development Plan

(CIDP) 2023–2027 and the County Health Sector Strategic Plan, providing a basis for the development of annual nutrition work plans. The formulation of this CNAP was informed by the end-term evaluation of the previous plan, building on its successes, lessons learned, and emerging opportunities. The development process included a thorough analysis of existing data and involved a wide range of stakeholders through a participatory, multisectoral approach. The CNAP 2023–2027 promotes cross-sector collaboration, recognizing the critical role of addressing the underlying social determinants of malnutrition for sustainable impact.

The plan outlines both high-impact, nutrition-specific interventions as well as nutrition- sensitive strategies to be implemented across the health sector and other county departments. Its goal is to achieve sustainable food and nutrition security, ultimately leading to improved health and nutrition outcomes for the people of Baringo County. This document will remain a living strategy—periodically reviewed and updated to incorporate new ideas, innovations, programs, and policies. We call upon all stakeholders, partners, and county departments to actively engage with the CNAP and align their efforts with its objectives. Familiarity with and commitment to the plan's content are vital for its successful implementation.

The Department of Public Health and Medical Services will provide strong leadership and oversight throughout the implementation period. Both departments are dedicated to optimizing resource utilization while advocating for additional support from both County and National Governments. We also urge our development partners and stakeholders to complement these efforts through active participation and resource mobilization to ensure the full realization of this plan.

Evans Rutto Kangogo
Chief Officer Preventive and Promotive Health Services
Baringo County

Statement By Chief Officer Medical Services

The leadership of Baringo County reaffirms its unwavering commitment to transforming the Department of Health to deliver high-quality nutrition services that meet the evolving needs and expectations of our communities. The development of this five- year County Nutrition Action Plan (CNAP) is a clear demonstration of that commitment.

In crafting this plan, we reflected on our rich history and critically assessed our existing and projected capacities to ensure our goals are aligned with the dynamic changes in our environment. This process enabled us to identify our strengths and weaknesses, giving us a strong foundation to strategically respond to both opportunities and challenges within our context.

The CNAP outlines thirteen Key Result Areas that will guide our efforts toward realizing our vision: A healthy and productive population with sustainable and adequate nutrition throughout the life cycle. Our mission is to improve the nutritional well-being of all residents through a coordinated, integrated, evidence-based, and multisectoral approach. This mission is grounded in a core set of values: equity, people-centered service delivery, evidence-based decision-making, gender responsiveness, a focus on primary care, universal health coverage, a life-course perspective, a rights-based approach, integrity and accountability, and strong multisectoral collaboration.

We are committed to supporting the Department of Nutrition in building a capable and dedicated team that will drive and monitor the effective implementation of this plan. We are proud to lead this initiative and pledge our continued support through strengthened oversight and resource mobilization.

I extend my sincere gratitude to all those who provided technical and financial support during the development of this strategic plan. As we move into the implementation phase, I call upon our partners, stakeholders, and the broader community to continue their support and collaboration to ensure the successful realization of this vision.

Dr Nancy Chesire
Chief Officer Medical Services
Baringo County

Acknowledgement

The County Department of Health extends its sincere gratitude to all individuals and organizations whose contributions were vital to the successful development of the Baringo County Nutrition Action Plan (CNAP) 2023/24–2027/28.

We are especially grateful to our development partners and stakeholders for their generous support and collaboration throughout this process. In particular, we recognize the invaluable contributions of Helen Keller International (HKI), UNICEF, Action Against Hunger (ACF), World Vision, Kenya Red Cross Society, Farming Systems (BMZ Project), and USAID Tujenge Jamii (UTJ). Their advocacy, financial assistance, and technical expertise were instrumental in mobilizing the resources required to advance our nutrition agenda.

We also acknowledge, with deep appreciation, the communities and individuals we serve. Their resilience, participation, and unwavering commitment have been a constant source of inspiration and motivation as we strive to implement impactful and inclusive nutrition interventions.

Our heartfelt thanks go to the Division of Nutrition and Dietetics, represented by Florence Mugo, for the critical support and guidance in aligning the Baringo CNAP with the Kenya Nutrition Action Plan (KNAP). We are equally grateful to Clementina Ngina, Nutrition Consultant, for her exemplary leadership and dedication in steering the development of this plan.

We further recognize the dedication of the Baringo CNAP Technical Working Group, comprising members from the Departments of Health, Agriculture, and Education. Their hard work and collaborative spirit, supported technically by the Division of Nutrition and the Department of Research and Public Policy, played a central role in shaping this strategic document.

As we transition into the implementation phase, we remain committed to working in close partnership with all stakeholders. Together, we are confident that we can make significant strides in reducing the burden of malnutrition and improving the health and well-being of the people of Baringo County

Dr Patrick Boruett
Director Preventive and Promotive Health Services

Dr. Joseph K. Kangor
Director Medical Services

Executive Summary

Baringo County, situated in Kenya's Rift Valley, spans 11,075 square kilometers characterized predominantly by arid and semi-arid conditions, with only 20% of the land being arable. Chapter One sets the context, highlighting persistent food insecurity driven by climate variability, resource conflicts, and socio-cultural practices such as early marriage and female genital mutilation. These challenges significantly impact health outcomes, especially among children under five and women of reproductive age. The county's population is expected to grow from 666,773 in 2019 to about 795,000 by 2027, increasing the demand for nutrition and health services. However, service delivery is hindered by inadequate infrastructure, workforce shortages, and geographic isolation. Community Health Units remain essential for promoting nutrition at the grassroots level but face constraints due to limited resources and capacity.

The CNAP 2024–2027 aligns with national and regional frameworks, including the Kenya Nutrition Action Plan (KNAP), Sustainable Development Goals (SDGs), Agenda 2063, and East African Community (EAC) Vision 2050. Developed through a multi-sectoral, participatory process, the plan addresses key gaps identified in the previous CNAP by recommending stronger coordination, increased investments, enhanced monitoring and evaluation, workforce development, sustainable financing, and community engagement. This chapter establishes the foundation for an inclusive and coordinated strategy to improve nutrition outcomes amid ongoing environmental and developmental challenges.

Chapter Two delivers an in-depth analysis of Baringo's nutrition situation, emphasizing the triple burden of malnutrition: undernutrition, micronutrient deficiencies, and rising overweight and obesity. Undernutrition remains a major concern, with high stunting rates in children under five, especially in drought-affected sub-counties, which impairs cognitive development and economic potential. Wasting exhibits seasonal fluctuations, while underweight prevalence remains persistent. Micronutrient deficiencies—particularly iron, vitamin A, and zinc—are widespread due to limited dietary diversity and restricted access to fortified foods, increasing vulnerability among children and women. Meanwhile, overweight and obesity rates are climbing, predominantly among women, raising the risk of non-communicable diseases such as hypertension and diabetes. National data from the Kenya Demographic and Health Survey (KDHS) 2022 shows progress overall but also highlights ongoing challenges in arid and semi- arid lands (ASALs) like Baringo, where drought, poverty, and fragile ecosystems exacerbate malnutrition. This chapter stresses the need for multi-sectoral, evidence-based interventions in line with KNAP 2023–2027, World Health Assembly (WHA) Nutrition Targets, and SDG 2 (Zero Hunger), framing malnutrition as a critical public health, developmental, and economic priority.

Chapter Three outlines the CNAP's 13 Key Result Areas (KRAs) designed to improve nutrition across all population groups. These KRAs include maternal, infant, and young child nutrition (MIYCN); school and adolescent nutrition; emergency nutrition response; and integration with sectors such as agriculture, water, sanitation and hygiene (WASH), education, social protection, governance, data systems, and supply chain management. The strategy aims to foster coordinated, measurable, and scalable interventions that strengthen nutrition resilience amid climate and socioeconomic challenges. Guided by a Theory of Change, the CNAP posits that achieving these strategic priorities—supported by adequate resources, coordination, andaccountability—will lead to substantial improvements in nutrition outcomes. This chapter sets the stage for systematic planning and implementation of nutrition programs in Baringo.

Chapter Four presents the Monitoring, Evaluation, Accountability, and Learning (MEAL) framework, which is essential for ensuring transparency, tracking progress, adaptive learning, and evidence-based decision-making. The MEAL system integrates data from health, agriculture, education, WASH, and social protection sectors, promoting a unified and inclusive approach. It emphasizes gender-responsive data collection, routine performance reviews, data validation, and stakeholder engagement to maintain program relevance and accountability. Aligned with national nutrition strategies, the MEAL framework supports continuous monitoring of inputs, service delivery, equity, outcomes, and impact. Midterm and end-term evaluations will assess the efficiency, effectiveness, sustainability, and overall impact of CNAP interventions, fostering a culture of learning and adaptive management.

Chapter Five details the CNAP's financial plan, employing an Activity-Based Costing (ABC) approach to estimate a total implementation cost of KES 1.3 billion over five years (2023/24– 2027/28). The budget covers both nutrition-specific and nutrition-sensitive interventions and aligns with the County Integrated Development Plan (CIDP) and Medium-Term Expenditure Framework (MTEF). The costing process was inclusive, engaging stakeholders across multiple sectors. While the county government has committed funding and institutional support, successful implementation will require additional investments from development partners and donors to bridge financing gaps and scale up impactful interventions. The implementation framework clearly defines roles, responsibilities, timelines, and coordination mechanisms to promote accountability, foster partnerships, and enable real-time learning. The success of CNAP hinges on sustained political commitment, effective multi-sectoral collaboration, adequate resources, sectoral ownership, reliable data systems, and a functioning results chain.

CHAPTER ONE

Introduction

1.1 Background

Baringo County, situated in Kenya's Rift Valley region, spans an expansive 11,075 square kilometers. It is bordered by Turkana and Samburu Counties to the north, Laikipia County to the east, Nakuru and Kericho Counties to the south, Uasin Gishu County to the southwest, and Elgeyo Marakwet and West Pokot Counties to the west. Despite its strategic location, Baringo faces significant geographical and climatic challenges. Approximately 80% of the county's land is arid or semi-arid, leaving only 20% arable. This stark limitation on fertile land constrains agricultural productivity and heightens food insecurity within the region. The county's under-five population as per the 2019 census was 95031, with this projected to be 105,541 in 2022, with further projections to 108, 840 in 2025 and 109366 in 2027. This age group is highly susceptible to stunting, wasting, and underweight, which are indicative of the region's poor nutritional status. The preschool population (ages 3-5) emphasizes the critical need for targeted interventions in nutrition, such as promoting proper feeding practices, exclusive breastfeeding, and ensuring access to essential micronutrients that support growth and development. The population of Women of reproductive age per the 2019 census was 151637, with this projected to be 181,588 in 2022, with further projections to 198,653 in 2025 and 209,607 in 2027. This underscores the importance of maternal nutrition programs to improve child health outcomes.

The county has five main livelihood zones: Mixed farming (39.2%, Pastoral (29%), Agro- pastoral (13.9%), Marginal mixed (13%) Irrigated cropping (5%). According to the 2024 Long Rains Assessment (LRA), the county's overall Integrated Phase Classification (IPC) is phase two (alert). However, the pastoral livelihood zone is in phase three (serious), and the agro- pastoral and irrigated livelihood zones are in phase two (alert). Major hazards include drought, water shortages, and conflicts, with additional threats of livestock pests and diseases in pastoral and agro-pastoral zones. Tiaty faces significant food security challenges due to market disruptions caused by insecurity, placing it in phase three. Livestock, particularly in the lowlands, remains a primary source of livelihood, while crop farming is more prevalent in the highland areas. Despite these efforts, food availability is often limited, and households face challenges in maintaining diversified healthy diets, which contributes to the county's high rates of malnutrition.

Baringo also contends with resource-based conflicts, particularly over water scarcity and grazing land among others which are common in both arid and semi-arid zones where pastoralism is dominant. These conflicts intensify food insecurity and malnutrition, especially in regions like Tiaty, where malnutrition rates are particularly high. Additionally, retrogressive cultural practices such as early marriage and female genital mutilation (FGM) hinder women's health, leading to complications during pregnancy, poor birth outcomes, and an increased risk of malnutrition for both mothers and children.

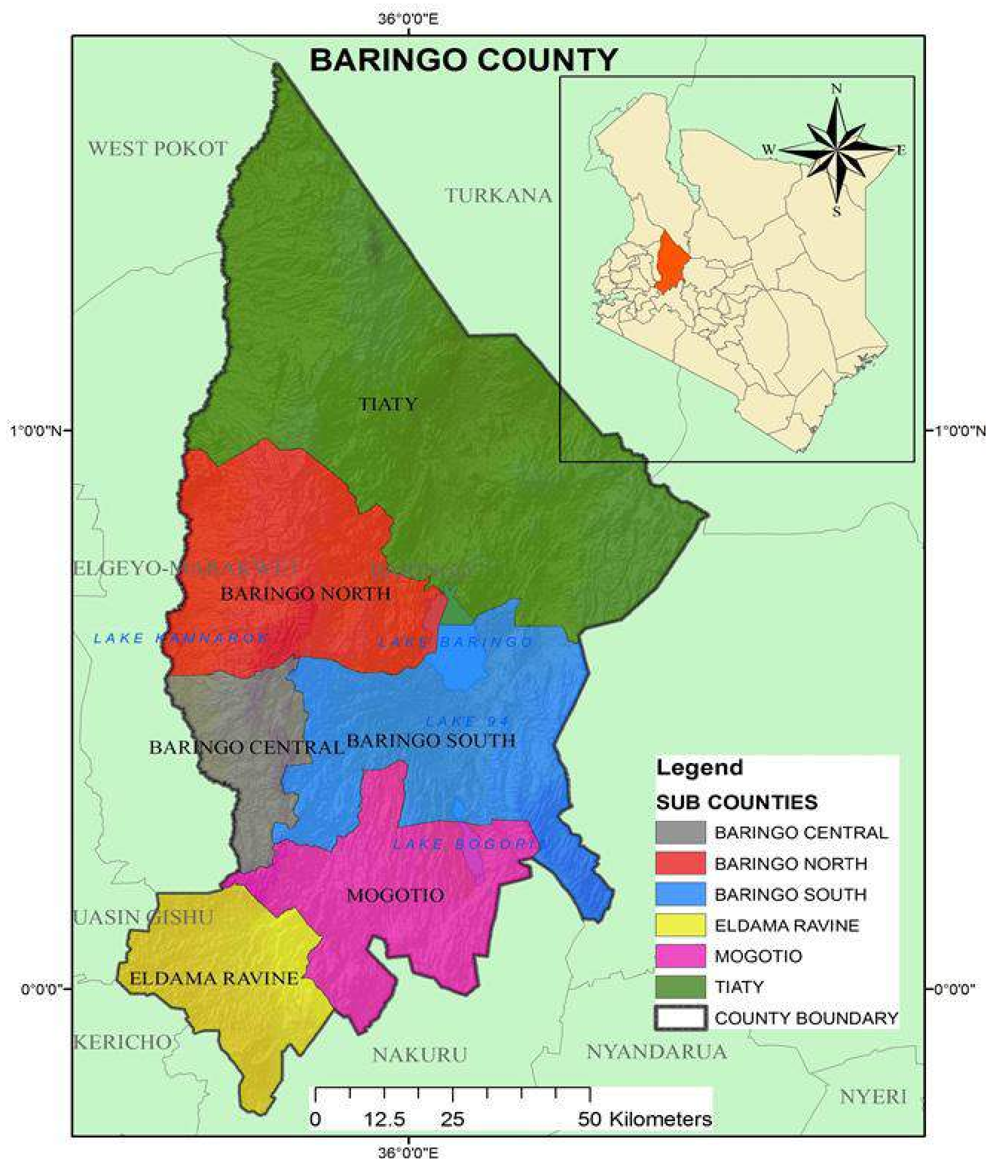


Figure 1: Map of Baringo County

1.2 Demographic Profile

According to the 2019 Kenya Population and Housing Census, Baringo County had a population of 666,773, comprising 336,322 males and 330,428 females. Among the sub- counties, Eldama Ravine has the highest population, with 129,535 people, while Tiaty East had the lowest, at 73,434. By 2022, the population is projected to increase to 717,794, with further projections indicating growth to 764,411 by 2025, and 794,793 by 2027, based on the county's intercensal growth rate.

Baringo is predominantly rural, with 89% of its population living in rural areas. The remaining 11% reside in key urban centers, with the largest concentrations in Baringo Central (32%), Eldama Ravine (25%), and smaller urban areas like Marigat (9%) and Mogotio (6%). As of the 2019 census, Tiaty and Baringo North had no recorded urban populations, but over time, several urban centers within these sub-counties have grown significantly. It is expected that migration to six major urban centers—Kabarnet, Marigat, Mogotio, Eldama Ravine, Kabartonjo, and Chemolingot—will continue to rise in the coming years.

The county's population is diverse, with different age categories, including infants, school-age children, youth, women of reproductive age, the economically active, and the elderly. These demographic groups present various needs and opportunities for development, particularly in the areas of education, healthcare, and employment.

Table 1: Population Projections by Broad Age Groups

Age Group	2019 (Census)			2022 (Projection)			2025 (Projection)			2027 (Projection)		
	M	F	T	M	F	T	M	F	T	M	F	T
Infant Population (<1 Year)	8303	7982	16285	9028	9058	18086	9488	9165	18653	9534	9207	18741
Under 5 Population	48508	46523	95031	52,746	52,795	105,541	55,430	53,410	108,840	55,702	53,664	109,366
Pre-School (35 Years)	32011	30409	62420	30779	31192	61971	31929	31689	63618	32499	31878	64377
Primary School (6-13 Years)	82640	78668	161308	76822	78633	155455	78188	80610	158798	79901	81548	161449
Secondary School (13-19 Years)	61991	56942	118933	58362	59509	119018	60359	61115	121474	61024	62194	123218
Youth (15-29 Years)	95805	94246	190051	114,436	118,052	232,488	120,902	124,131	245,033	123,554	127,105	250,659
Women of Reproductive Age (15-49 Years)	0	151637	151637	0	181,559	181,559	0	198,653	198,653	0	209,607	209,607
Economically Active Population (15-64 Years)	172710	172114	344824	192,581	199,960	392,541	212,143	218,407	430,550	225,089	230,901	455,989
Aged (65+)	11843	13905	25748	12,081	13,195	25,275	12,184	14,347	26,531	12,413	15,151	27,564

Source KNBS,2019

1.3 Baringo Administrative Units

The county is divided into seven sub-counties: Baringo South, Mogotio, Eldama Ravine, Baringo Central, Baringo North, Tiaty West, and Tiaty East. It encompasses 30 electoral wards and 124 locations. Kabarnet, located approximately 140 kilometers from Nakuru City and 295 kilometers from Nairobi, serves as the county's administrative headquarters. The County Government is yet to establish the village administration units as per the County Government Act.

Table 2: Baringo sub-counties and the electoral wards

Sub-County	Area in Km2	Electoral Wards	Area in Km2
Baringo North	1703	Barwessa	475.5
		Saimo Kipsaraman	85.6
		Saimo Soi	542
		Kabartonjo	126.7
		Bartabwa	473.5
Tiaty West	2500	Tirioko	1102.68
		Kolowa	752.55
		Ribkwo	871.49
Tiaty East	2039.5	Silale	335.36
		Tangulbei	591.25
		Loiyamorok	597.8
		Churo/Amaya	289.35
Mogotio	1304	Mogotio	287.53
		Emining	529.21
		Kisanana	487.13
Baringo South	1985.11	Mukutani	534.9
		Marigat	682.71
		Mochongoi	586.8
		Ilchamus	180.7
Eldama Ravine	954	Lembus	142.89
		Ravine	33.55

Source: Baringo CIDP 2023-27

1.4 Health facility distribution

Health facilities in Baringo County play a critical role in addressing nutrition issues, particularly among vulnerable populations such as children and pregnant and lactating women. Key services include growth monitoring and promotion for children, integrated management of severe and moderate acute malnutrition (SAM and MAM), maternal and infant young child nutrition maternal nutrition counselling, micronutrient supplementation, Nutrition education, nutrition management in specialized clinics, outpatient and in-patient nutrition management among others. However, the delivery of these services faces challenges, including staffing shortages, inadequate infrastructure, cultural barriers, and limited access to essential nutrition supplies (nutrition commodities, reporting tools, anthropometric equipment). Geographic isolation and long distances to health facilities further complicate access. To improve nutrition services, there is a need for strengthened workforce capacity, improved supply chain management, integration of nutrition services within other health related services and enhanced infrastructure. Engaging communities in social behaviour change nutrition education and addressing cultural practices will also help increase the effectiveness of nutrition interventions, ultimately improving the nutritional health of Baringo's residents

Table 3: Health facilities distribution per sub-county

	Level 5	Level 4	Level 4	Level 4	Level 3	Level 3	Level 3	Level 2	Level 2	Level 2	Level 2	Level 2	TOTAL
	GOK	GOK	Private	FBO	GOK	Private	FBO	GOK	Private	FBO	NGO	Public Facility	
Baringo North	0	1	0	0	3	0	0	49	3	1	0	0	57
Baringo Central	1	0	3	0	6	3	0	27	9	1	1	1	52
Marigat	0	1	0	1	3	3	0	36	11	1	0	0	56
Koibatek	0	1	1	1	4	2	1	25	8	0	0	0	43
TiatyWest	0	1	0	0	1	0	1	16	2	3	0	0	24
Mogotio	0	1	1	0	4	1	0	29	7	1	1	0	45
Tiaty East	0	1	0	0	4	0	0	18	2	4	0	0	29
Total	1	6	5	2	25	9	2	200	42	11	2	1	306

Source: County Department of Healt

1.5 Community health Units distribution

Community Health Units (CHUs) serve as a vital vehicle for improving nutrition at the grassroots level. Within these units, Community Health Assistants (CHAs) and Community Health Promoters (CHPs) play a central role in delivering essential nutrition services. They are key in creating awareness about various nutrition issues, such as Maternal, Infant, and Young Child Nutrition (MIYCN), Integrated Management of Acute Malnutrition (IMAM), and the prevention and management of Diet-Related Non-Communicable Diseases (DRNCDs). By engaging directly with communities, CHUs foster healthier nutrition practices, promote early detection and management of malnutrition, and contribute to better health outcomes for vulnerable populations. Despite their significant role, challenges remain in maximizing the effectiveness of CHUs. However, when supported with adequate training, resources, and community engagement, CHUs can significantly reduce malnutrition and improve overall nutrition outcomes. The table below illustrates the distribution of CHUs across the county.

Table 4 : Community health units per sub-county

Sub county	No of community Units
Baringo central	18
Baringo North	21
Baringo South (Marigat)	18
Mogotio	18
Koibatek	21
Tiaty East	16
Tiaty West	17
Total	129

Source: County Department of Health

1.6 Human resource for health and Nutrition

Human resources for health (HRH) are crucial for delivering effective health and nutrition services in Baringo County. These professionals, including nutritionists, community health workers, nurses, doctors, and public health officers, all play key roles in addressing nutrition and health challenges, particularly for vulnerable populations such as children, pregnant and lactating women, and the elderly. However, the county faces significant challenges, notably the shortage of skilled nutritionists, which forces other healthcare workers to take on nutrition- related tasks outside their primary roles. This strain hampers the quality and consistency of nutrition services. To address these issues, Baringo needs to increase the number of trained nutritionists and provide specialized training in nutrition for clinical areas like oncology, critical care, and parenteral and enteral feeding. By filling these gaps, Baringo can improve its ability to combat malnutrition and enhance the overall health of its population. The table below highlights the current HR establishment for health in Baringo County.

Table 5: Human resource for health and Nutrition

Cadre	Approved Establishment	In post	Variance
County Health Leadership	9	5	4
County Doctors	176	55	121
County Nurses	1043	580	463
County Clinical officers	608	149	459
Pharmacists	211	36	175
Nutritionist	112	29	83
Public Health Officers	317	155	162
Medical Laboratory officer	314	79	235
Dental Officers	22	8	14
Community Health Assistant	284	0	284
Community Oral Health Officers	29	8	21
Occupational Therapist	49	9	40
Medical Engineers	75	13	62
Orthapeadic officers	53	21	32
Physiotherapist officers	49	7	42
Radiologist Officers	37	9	28
Health Promotion officers	48	0	48
Health Records officers	160	24	136
Sterile Service Assistance	22	0	22
Medical Social workers	43	12	31
Plaster technologist	32	16	16
Health Administrative	24	2	22
Clerical Officers	52	9	43
Human Resource	14	1	13
Supply chain	17	2	15
Drivers	120	40	80
Office Assistant	33	3	30
Farewell Assistant	20	2	18
Support staff	380	70	310
Total	4353	1344	3009

Source: County health HR,2025

1.7 Policy Context in line with KNAP 2023-2027

United Nations 2030 Agenda for Sustainable Development

Baringo County CNAP is designed to address malnutrition and improve the overall nutritional status of the population in line with KNAP. It aligns with the United Nations 2030 Agenda for Sustainable Development Goals (SDGs), recognizing their critical role in achieving long-term health and prosperity for the county. The plan integrates approaches across health, economic, social, and environmental sectors, targeting the root causes of malnutrition and promoting food security. It focuses on key SDGs, including No Poverty (SDG 1), Zero Hunger (SDG 2), Good Health and Well-being (SDG 3), and Quality Education (SDG 4), among others. Key strategies include promoting sustainable agriculture, improving maternal and child nutrition, increasing access to nutrition education, and addressing gender disparities. The plan also emphasizes the importance of climate resilience, water and sanitation, and responsible food production. It aligns with the SDG Recovery and Acceleration Strategy (2022-2030), addressing setbacks from the COVID-19 pandemic by rebuilding food systems, strengthening health services, and fostering inclusive economic growth. By focusing on these areas, the KNAP aims to reduce malnutrition, enhance food security, and promote sustainable development across Baringo County.

African Union-Agenda 2063

The CNAP allied to KNAP 2023-2027 which is aligned with the African Union's Agenda 2063, provides a comprehensive roadmap for transforming Africa into a global powerhouse, emphasizing health and nutrition as crucial elements of this vision. Agenda 2063 has influenced regional initiatives like the African Union Nutrition Policy and the African Regional Nutrition Strategy (ARNS 2015-2025), which stresses the importance of the first 1,000 days concept, focusing on the nutrition of women and children through an integrated approach. The ARNS highlights nutrition as essential for national growth and calls for new policies and reinforced government commitments. The four strategic outcome areas of the ARNS, based on the World Health Assembly's 2025 nutrition targets, are incorporated into KNAP 2023-2027, offering a strategic approach to addressing malnutrition in Kenya.

East African Community Vision 2050

Baringo County's Nutrition Action Plan 2023-2027 is strategically aligned with the East African Community Vision 2050. By focusing on economic prosperity, social inclusion, nutritional security, multi-sectoral collaboration, and consumer awareness, BCNAP contributes to regional goals while addressing local nutrition challenges. Through these efforts, Baringo County will play a key role in advancing the shared vision of a prosperous, healthy, and united East Africa.

Constitution of Kenya

The Constitution of Kenya (2010) establishes a robust legal framework for the right to health, enshrining it as a fundamental human right. Article 43 guarantees every Kenyan the right to the highest attainable standard of health, which includes access to reproductive healthcare. Furthermore, Article 21 outlines the state's obligations to observe, respect, promote, and fulfil the rights within the Bill of Rights, emphasizing the government's duty to ensure the realization of health rights for all citizens. Article 53c guarantees the right to basic nutrition, shelter and health care.

These constitutional provisions empower the Kenyan government to address health issues through a rights-based approach, ensuring that healthcare services are accessible, equitable, and aligned with broader health objectives. This framework not only underscores the importance of health as a basic human right but also reinforces the state's responsibility in fulfilling the health needs of its population.

Kenya Vision 2030, Bottom-Up Economic Transformation Agenda and Fourth Medium Term Plan

Kenya Vision 2030 is the country's comprehensive development blueprint designed to transform Kenya into a newly industrialized, middle-income nation that ensures a high quality of life for all its citizens. A key component of this Vision is a strong health pillar, which aims to enhance healthcare infrastructure, expand human resources for health, and improve service delivery, including the establishment of specialized cancer care centers. The Medium-Term Plan (MTP) IV, under the Bottom-up Economic Transformation Agenda (BETA), seeks to promote inclusive growth and sustainable development, with a particular focus on strengthening the health sector. BETA prioritizes improving healthcare delivery, upgrading infrastructure, and securing necessary funding for critical initiatives such as cancer prevention and control. It also emphasizes the efficient allocation of resources to vital sectors, including agriculture, MSMEs, housing, healthcare, and the digital economy. Key health priorities within BETA include fortifying the primary healthcare system by recruiting and training community health workers, establishing community health units, and enhancing health commodity supply through a national procurement scheme. Further, BETA aims to expand the health workforce by employing 20,000 healthcare workers, initiating payment for community health workers,and improving the management of human resources for health. Another crucial aspect is the digitization of health facilities to enhance health information technology, alongside the provision of universal social health insurance and the consolidation of health schemes under the Social Health Insurance Fund (SHIF). Additionally, the modernization of the regulatory framework and governance of unregulated healthcare professions will be prioritized. These collective efforts are geared toward building an efficient, inclusive, and sustainable healthcare system that will serve the needs of all Kenyans.

1.8 Other global frameworks

World Health Assembly Targets

The CNAP aligns with the KNAP 2023-2027, which aligns with the World Health Assembly's (WHA) 2025 nutrition targets. These targets aim to address the pervasive burden of malnutrition among mothers, infants, and young children. The WHA nutrition targets focus on the following key outcomes:

- Reducing stunting in children under 5 by 40%
- Decreasing anaemia in women of reproductive age by 50%
- Reducing low birth weight by 30%
- Ensuring no increase in childhood overweight
- Increasing exclusive breastfeeding rates in the first six months to at least 50%
- Reducing and maintaining childhood wasting to less than 5

The Scaling Up Nutrition (SUN) Movement.

The SUN movement was established in 2012 with an aim to support countries in ending malnutrition by 2030. The Baringo CNAP supports the objectives of the SUN Movement's vision and its Roadmap (2016-2020), which championed a multi-sectoral approach to eradicating malnutrition. Building on this foundation, it adopts the third phase of the SUN Movement Strategy (3.0) for 2021-2025, which places a strong emphasis on a country-led and country-driven approach. This strategy aims to accelerate progress towards achieving critical nutrition outcomes, in line with the World Health Assembly (WHA) and Sustainable Development Goals (SDG) nutrition targets. Through this enhanced, integrated approach, the Baringo CNAP contributes to strengthening national efforts to reduce malnutrition and promote sustainable nutrition improvements.

Non-Communicable Disease Targets

The Baringo CNAP is fully aligned with the KNAP 2023-2027, which integrates three critical Voluntary Global Non-Communicable Disease (NCD) Targets. These targets aim to enhance public health nutrition and address the rising burden of non-communicable diseases (NCDs) in the county. The key NCD targets include

a. **Target 3:** Promotion of Physical Activity - KNAP aims to integrate physical fitness into daily life and community initiatives to reduce NCD risk and promote overall well-being.

b. **Target 4:** Reduction of Salt/Sodium Intake - The plan will address high salt and sodium consumption through public education, healthier food options, and collaboration with the food industry to lower sodium levels.

c. **Target 7:** Combating Diabetes and Obesity - KNAP will focus on nutritional education, promoting healthy & diverse diets is, and access to healthy foods.

1.9 National Policy and Health System Framework for Nutrition

Kenya has developed and implemented several national nutrition policies designed to tackle nutrition-related challenges and improve overall health outcomes. Key policies include: Kenya Health Policy (2014–2030): This policy upholds the constitutional right of every Kenyan to access quality health services, integrating nutrition as a fundamental component of primary healthcare. It emphasizes the importance of nutrition services in improving health outcomes across the population and need to strengthen multi-stakeholder collaboration.

- **National Food and Nutrition Security Policy (NFNSP):** This comprehensive policy framework addresses food and nutrition security in Kenya, focusing on boosting food production, promoting optimal nutrition across the life course, and ensuring equitable access to food and nutrition services. It seeks to create a sustainable food system that supports the nutritional needs of all citizens.

- **Kenya School Health Policy, 2018:** Aimed at promoting the health and well-being of school-aged children, this policy includes initiatives such as school feeding programs, health education, and the promotion of healthy lifestyles. It recognizes the critical role that schools play in fostering lifelong healthy habits and addressing malnutrition among children.

- **The Kenya National Non-Communicable Diseases (NCD) Strategic Plan (2020/21-2025/26)** serves as a strategic framework for the prevention and control of non-communicable diseases at both the national and county levels over the next five years. The plan aims to address the rising burden of NCDs in Kenya through targeted interventions, health promotion, and strengthening healthcare systems to reduce risk factors and improve outcomes for those affected.

- **The Kenya Health Sector Strategic and Investment Plan (KHSSP)** outlines the key priorities for the country's health sector, with a strong emphasis on integrating nutrition into primary healthcare. This plan highlights the importance of embedding nutrition services within the broader health system, ensuring that nutrition interventions are delivered alongside other health services to improve overall health outcomes and tackle nutrition-related issues across the population.

1.9.0 CNAP Development Process

The Baringo CNAP 2023 - 2027 is the third generation of the county's nutrition plan aimed at addressing malnutrition challenges Its development was rooted in a comprehensive and consultative process to ensure it effectively targets the county's nutritional needs. The drafting process involved key sectors, including Health, Agriculture, Education, WASH, NDMA, Disaster & Climate Change, Economic Planning & Finance, along with Development Partners such as Helen Keller, ACF, World Vision, and KRCS, each contributing their expertise and insights. A structured and inclusive approach was adopted throughout the drafting meetings and consultations, which took place at various levels to guarantee wide-ranging stakeholder participation. After the draft CNAP was completed, it went through a stakeholder validation process, during which feedback was collected and integrated into the final version. This ensured that the plan was both comprehensive and aligned with the county government's priorities. The final document was then endorsed by county management for dissemination and implementation.

1.9.1 Review of the CNAP 2018-2022

Challenges in implementation of CNAP 2018-2022

The End-Term Review (ETR) of the County Nutrition Action Plan (CNAP) highlighted several systemic challenges that have hindered the effective implementation of nutrition interventions in Baringo County. These challenges span across monitoring and evaluation, coordination, resource allocation, and human resource capacity. Below is a summary of the key issues observe:

General challenges observed from the ETR

1. Weak monitoring and evaluation framework in the following areas:
    - Indicators not matching or corresponding to the activity description
    - Indicators poorly framed
    - Targets not very well thought about and distributed against the years
    - Lack of documentation of activities carried out which led to lack of reports
    - under the evidence folder
    - Supportive supervision not conducted frequently/quarterly due to limited resources
    - Lack of joint supportive supervision
    - No nutrition survey was conducted to understand the indicator performance for various nutrition programs-MIYCN, IMAM

2. Weak Multi sectoral collaboration
    - This has been attributed to departments working on silos

3. Weak sectoral and multi sectoral coordination
    - County nutrition technical forum not established
    - Multi sectoral nutrition platform not established
    - SUN movement chapter for Baringo not in formed

4. Inadequate funding for nutritional interventions
    - Inadequate county funding for nutrition activities
    - Reliance of development partners to support nutrition activities

5. Inadequate nutrition staffing
    - Very few nutritionists as per MOH standards and norms requirements to meet the demands for the population in regard to nutrition interventions.

6. Inadequate capacity building amongst nutrition cadres and nutrition workforce
   - Limited capacity building opportunities both at national and county level for the nutrition staff and workforce which has effects on the current guidance on the implementation of nutrition interventions
   - Inadequate nutrition specialists such as oncology, critical care among others by the nutrition technical staff

County Summary of Key Lessons Learnt, Good Practices & utilization of Innovations

- The resource allocation is key to the implementation of the CNAP
- Multi sector approach in both nutrition sensitive and specific programs improved nutrition interventions and implementations.
- Strengthened health systems building blocks are key to the implementation of CNAP
- Demand creation activities can improve nutritional outcomes

1.9.2 Recommendations of review report for CNAP 2018-2022

The following recommendations were proposed during the End-Term Review (ETR):

1. Enhance Multi-Sectoral Coordination and Collaboration: Establish and operationalize county-level nutrition coordination mechanisms such as the County Nutrition Technical Working Group (CNTWG), the Multi-Sectoral Nutrition Platform (MSP), and the SUN Movement Baringo Chapter. These platforms will facilitate joint planning, implementation, and monitoring of nutrition actions across sectors.

2. Advocate for Increased Human Resources for Nutrition: The county should prioritize recruitment and deployment of skilled nutritionists to support the implementation of the County Nutrition Action Plan (CNAP). These professionals will also spearhead community-based education programs, address rising non- communicable diseases (NCDs), and provide essential support in prevention and treatment efforts. Engaging local leaders, community health promoters, and grassroots organizations will further enhance outreach and adoption of sustainable nutrition practices.

3. Increase Investment in Nutrition-Specific and Nutrition-Sensitive Programs: Scale up funding for nutrition-sensitive initiatives across agriculture, water, sanitation, hygiene (WASH), education, and social protection. Prioritize programs that promote crop diversity, climate-resilient agriculture, and improved hygiene practices, particularly in schools and underserved areas. Ensure interdepartmental collaboration to avoid duplication, strengthen partnerships, and optimize resource use.

4. Strengthen Supply Chain Management for Nutrition Commodities: Improve the procurement and distribution systems for essential nutrition commodities—including therapeutic and supplementary foods and micronutrients—ensuring their availability across all health facilities. Invest in digital inventory tracking tools and capacity building for logistics personnel to minimize stock-outs, especially in hard-to-reach areas.

5. Strengthen Monitoring, Evaluation, Accountability, and Learning (MEAL): Invest in digital data collection tools and train nutrition staff in data management to enhance data quality and availability. Adopt the multisectoral nutrition scorecard provided by the Division of Nutrition and Dietetics to monitor key indicators across sectors. Strengthen inter-departmental data sharing to inform timely decisions and foster accountability. Promote peer learning by sharing best practices locally and beyond, and document activities for integration into the CNAP evaluation before the close of FY 2023/24.

6. Enhance Resource Mobilization for Sustainable Nutrition Financing: Advocate for the establishment of a dedicated county nutrition fund, supported by public, private, and community contributions.

Engage with county decision-makers to secure long-term domestic financing for nutrition interventions. Leverage public-private partnerships and corporate social responsibility (CSR) programs to supplement county resources and reduce dependency on external donors.

7. Promote Culturally Sensitive and Inclusive Nutrition Communication: Develop and disseminate nutrition messages tailored to the cultural and linguistic diversity of Baringo County. Work with local leaders and influencers to deliver culturally relevant messages that promote positive nutrition behaviors. Materials should be available in local languages and reflect community values to enhance uptake and sustainability.

8. Prioritize Capacity Building for Frontline and Community-Based Nutrition Workers: Expand training opportunities for nutritionists, health workers, and community health promoters. Equip them with the latest knowledge and skills in both nutrition-specific and sensitive areas. Include specialized training in fields such as oncology nutrition and critical care nutrition to improve service delivery in specialized contexts.

9. Disseminate the End-Term Review (ETR) Report: The County Nutrition Coordinator should request funds from Hellen International to facilitate the dissemination of the CNAP ETR report to a wider group of multi-sectoral stakeholders to foster ownership, accountability, and cross-sectoral learning.

10. Establish a County Directorate of Nutrition: Advocate for the creation of a standalone Directorate of Nutrition within the County Department of Health. This will institutionalize the nutrition agenda, ensure dedicated budgetary allocation, and strengthen the deployment of nutrition personnel across service delivery points.

11. Strengthen MEAL Systems for Transparency and Accountability: Institutionalize MEAL frameworks at county level to improve transparency and accountability in the planning, implementation, and evaluation of nutrition programs by both government and partners.

12. Advocate for a Dedicated Nutrition Vote Head and Budget Allocation: Push for the inclusion of a dedicated budget line for nutrition within the county budget to ensure consistent and targeted funding for priority interventions.

13. Strengthen Stakeholder Implementation Matrix: Enhance coordination among implementing partners to promote equity and improve access to nutrition services, especially in marginalized and hard-to-reach areas.

14. Promote Community Accountability and Social Responsibility: Foster platforms that allow community members to provide feedback, monitor services, and co-own nutrition outcomes. This includes village health committees and community scorecards.

15. Reinforce Nutrition Technical Working Groups: Strengthen the capacity and mandate of existing technical working groups to lead coordination, advocacy, and oversight of the county's nutrition agenda.

16. Develop County Nutrition Policies and Strategies: Formulate key policy documents such as the Baringo County Nutrition Policy, Advocacy, Communication and Social Mobilization (ACSM) Strategy, and County Agri-Nutrition Strategy. These will harmonize multi-sectoral actions and provide a clear roadmap toward eliminating malnutrition in Baringo.

17. Mobilize Resources to Support Development of the 3rd Generation CNAP: Secure financial and technical support to draft and launch the third generation County Nutrition Action Plan, ensuring continuity and sustainability of the county's nutrition programming.

1.9.3 Target audience for the CNAP

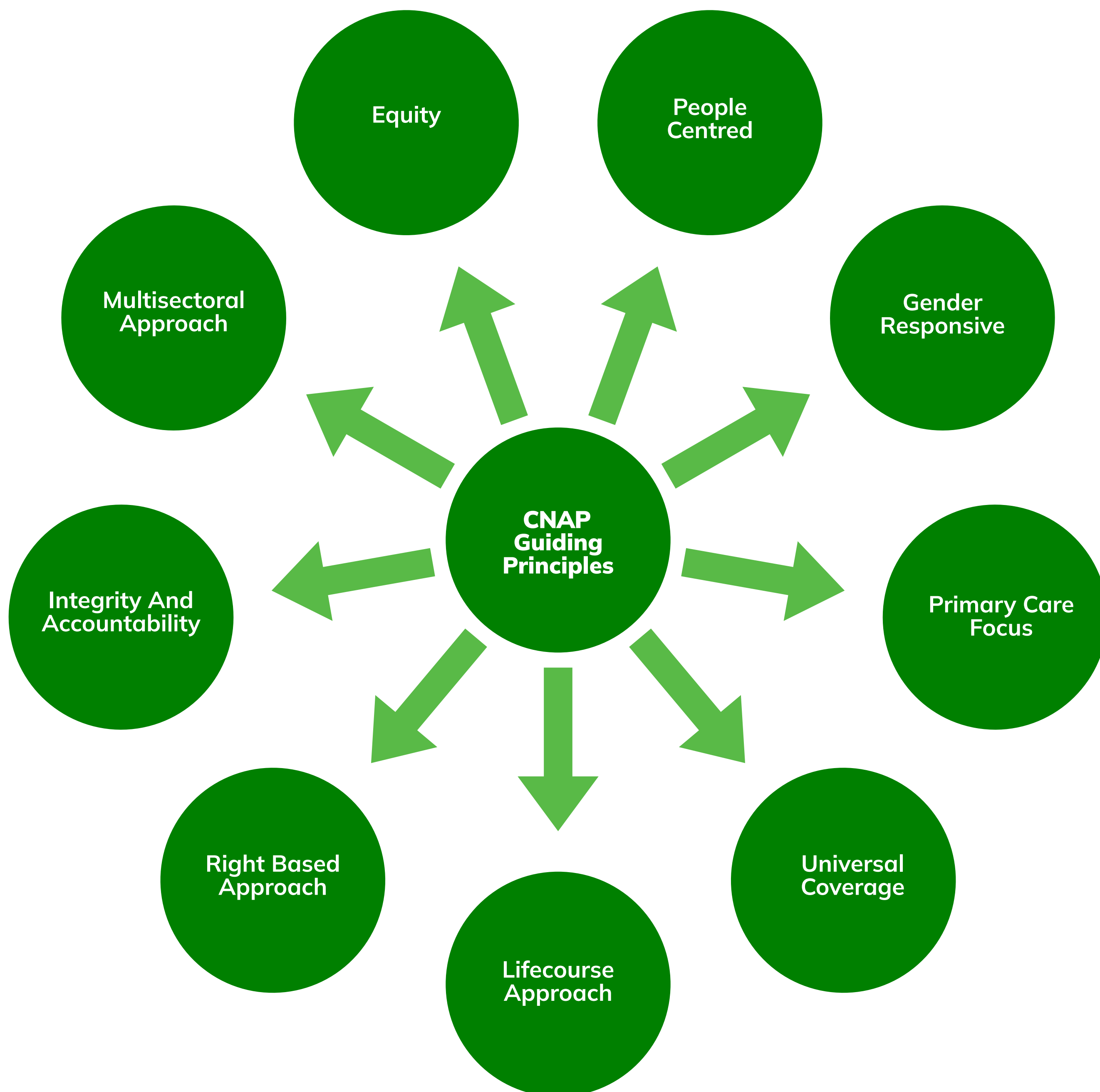
The Baringo CNAP is designed to engage a broad and diverse group of stakeholders who are essential to advancing nutrition and improving health outcomes across the county. By targeting this wide-ranging audience, the Baringo CNAP will foster coordinated, inclusive, and sustained action to achieve the county's goal of optimal nutrition for all. This stakeholder includes:

- Global and national decision-makers: They play a vital role by aligning strategic support and funding toward impactful nutrition initiatives.
- Health care decision makers and policymakers at both the county and national levels, whose leadership is critical in formulating, resourcing, and implementing effective nutrition policies.
- Nutrition-sensitive sectors—including agriculture, education, water, and social protection—are key partners, as their interventions directly influence food security and nutritional well-being.
- Nutrition coordinators and officers across all levels of government, equipping them with the tools to design and deliver targeted, high-impact nutrition programs.
- Development partners, donors, NGOs, civil society organizations, and faith-based groups are indispensable in mobilizing resources, providing technical expertise, and strengthening community-based nutrition interventions. Meanwhile, the private sector, especially food producers, processors, and distributors, has a significant role in promoting food fortification, enhancing food safety, and adopting innovative, nutrition- friendly practices.
- Academic and research institutions contribute critical data, evaluations, and evidence-based insights that shape smarter policies and more effective implementation. The media serves as a powerful platform to raise awareness, educate the public, and advocate for behavior change.
- Community involvement remains at the heart of the CNAP. Engaging local leaders, families, and community-based groups is essential to ensure ownership, sustainability, and cultural relevance of nutrition programs.

1.9.4 Guiding principles of the CNAP

The implementation of the Baringo County Nutrition Action Plan (CNAP) is anchored on a set of guiding principles that ensure the delivery of equitable, effective, and sustainable nutrition interventions.

Figure 2: Guiding principles of the CNAP



These principles reflect the county's commitment to achieving optimal health and nutrition outcomes for all residents through a collaborative, inclusive, and evidence-driven approach

CHAPTER TWO

County Nutrition Situation

2.0 Introduction

Nutrition remains a pressing public health concern in Baringo. The county continues to grapple with a triple burden of malnutrition—undernutrition, micronutrient deficiencies, and emerging over-nutrition, mirroring national trends. Chronic undernutrition, particularly stunting among children under five, remains unacceptably high in several sub-counties, significantly impairing cognitive development, school performance, and future economic productivity. Acute malnutrition (wasting) persists as a cyclical challenge, especially during droughts and lean seasons. At the same time, micronutrient deficiencies, such as iron, vitamin A, iodine, and zinc, remain widespread due to poor dietary diversity and limited access to fortified foods. Furthermore, overweight and obesity are on the rise, particularly among women of reproductive age, increasing the risk of diet-related non-communicable diseases (NCDs) like hypertension and diabetes. The consequences of malnutrition are far-reaching: malnourished children are more susceptible to disease, less likely to thrive in school, and more likely to experience reduced economic productivity later in life. For Baringo, this translates into a slowed development trajectory and a significant burden on the health system and economy

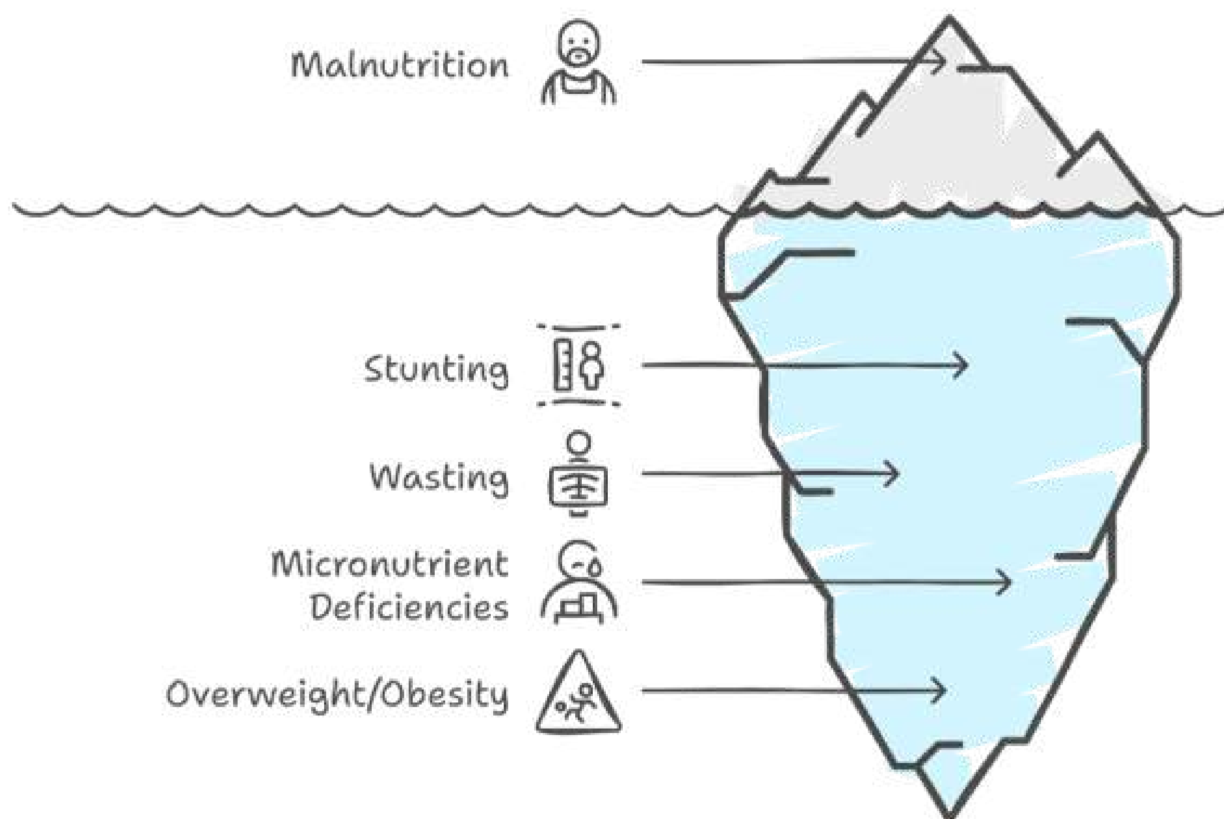


Figure 3: Burden of Malnutrition

2.1 Nutrition Situation Analysis

This Nutrition Situational Analysis provides a comprehensive, evidence-based overview of the county's nutrition landscape. It identifies trends, disparities, and underlying drivers of malnutrition and serves as a foundation for the development of the County Nutrition Action Plan (CNAP). The analysis is aligned with the Kenya Nutrition Action Plan (KNAP 2023– 2027) and forthcoming national priorities and supports Kenya's commitments to Sustainable Development Goal 2 (Zero Hunger) and the World Health Assembly (WHA) Nutrition Targets. The analysis advocates for a multi-sectoral, locally led response to galvanize action across county leadership, development partners, civil society, and communities. Addressing all forms of malnutrition is a health priority and a strategic investment in Baringo's human capital and socioeconomic development.

Nutrition Situational Analysis and Action Plan Development

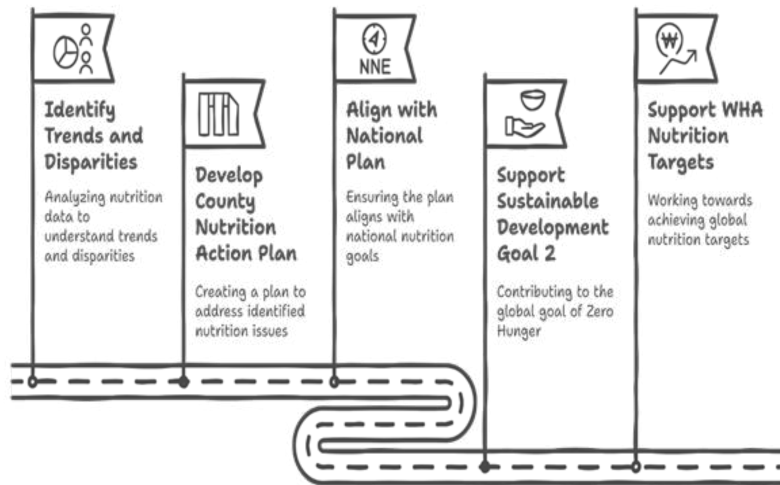


Figure 4: Nutrition Situation Analysis

2.2 The National Nutrition Context

Over the past decade, Kenya has made notable strides in improving the nutritional status of its population, particularly among children and women. According to the Kenya Demographic and Health Survey (KDHS) 2022, the prevalence of stunting among children under five has declined from 26% in 2014 to 18%, reflecting sustained efforts to improve child health and nutrition across the country. Similarly, wasting—a measure of acute malnutrition—has remained relatively low at 5%, and overweight prevalence in under-fives stands at 3%, though concerns about its gradual rise remain. These gains demonstrate Kenya's progress in reducing undernutrition, but they also highlight the emerging challenge of the triple burden of malnutrition: persistent undernutrition, widespread micronutrient deficiencies, and increasing rates of overweight and diet-related non-communicable diseases (NCDs), especially among adults.

Percent of children under 5, based on 2006 WHO Child Growth Standards:

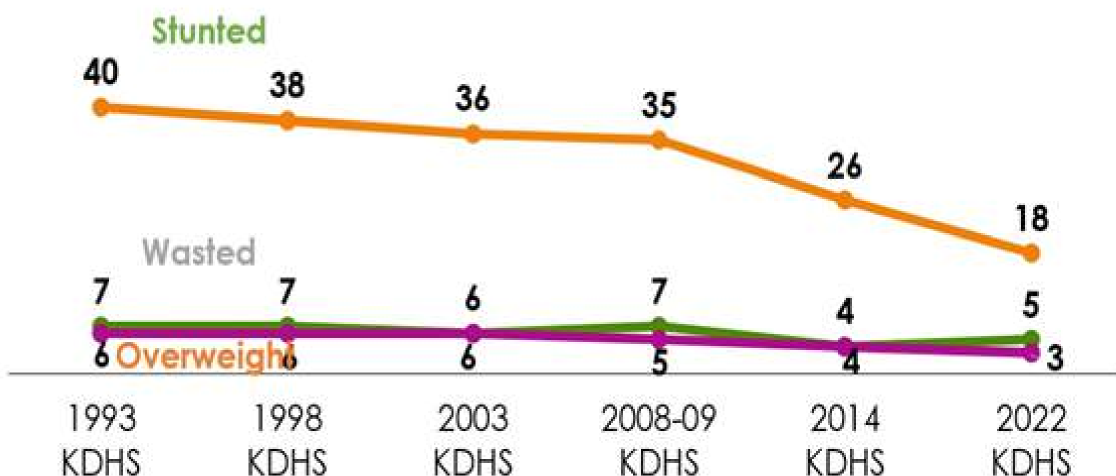


Figure 5: Malnutrition trends in Kenya

This complex nutrition landscape is particularly pronounced in the Arid and Semi-Arid Lands (ASALs), where recurrent droughts, food insecurity, limited access to health services, and high poverty levels continue to drive high rates of malnutrition. Counties such as Baringo, characterized by fragile ecosystems and a mix of pastoral and farming communities remain disproportionately affected, with periodic spikes in acute malnutrition during dry spells and lean seasons.

To address these multifaceted challenges, the Government of Kenya has put in place a strong policy and programmatic framework. The Kenya Nutrition Action Plan (KNAP) 2018–2022 outlined a comprehensive strategy for eliminating malnutrition in all its forms, anchored in multi-sectoral collaboration and implementation of high-impact nutrition interventions. A current iteration of the KNAP 2023-2028 has been developed and reinforces Kenya's commitment to achieving the World Health Assembly (WHA) nutrition targets and the Sustainable Development Goals (SDGs), particularly SDG 2: Zero Hunger. National initiatives such as vitamin A supplementation, Deworming, routine growth monitoring, iron and folic acid supplementation for pregnant women, and food fortification (including salt iodization, and mandatory fortification of wheat and maize flour) are being implemented countrywide and form the backbone of the national nutrition strategy.

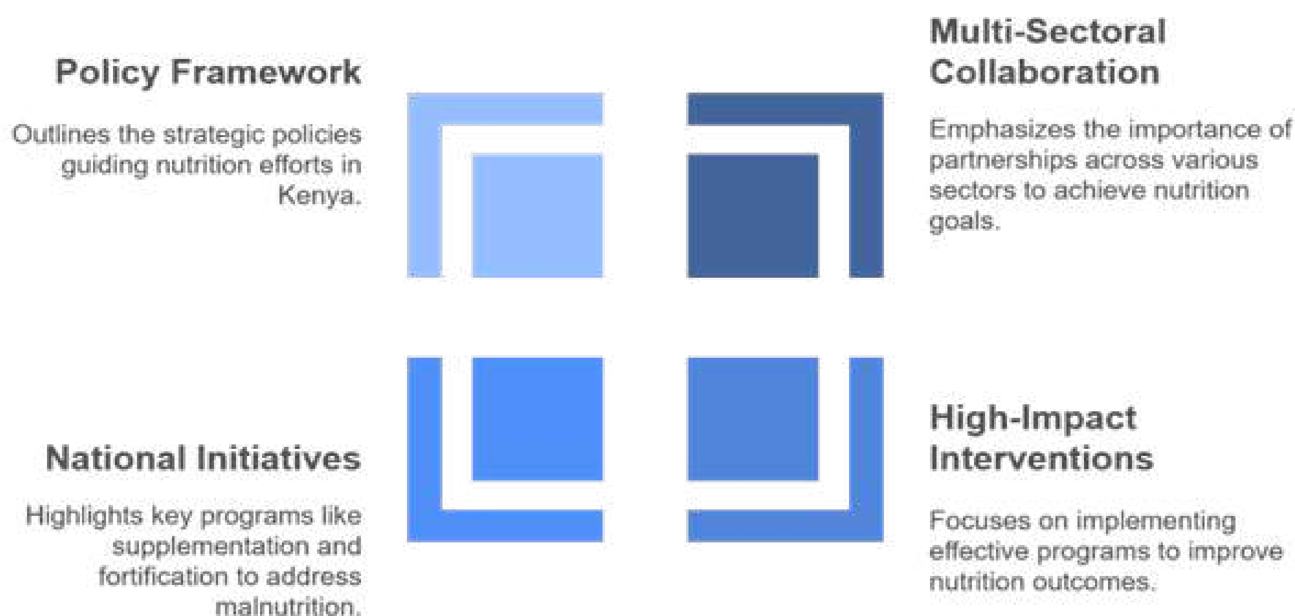


Figure 6: Strengthening Kenya's Nutrition Strategy.

2.3 Trends of Malnutrition in Baringo County

2.3.1 Trends in Undernutrition (Stunting, Wasting, Underweight)

Baringo County continues to face a complex and evolving nutrition challenge, reflective of the triple burden of malnutrition—undernutrition, micronutrient deficiencies, and the emergence of overweight and diet-related non-communicable diseases (NCDs). While the county has seen some progress in improving nutritional outcomes over the past decade, the pace of change remains slow, and disparities persist, particularly in hard-to-reach and drought-prone sub- counties.

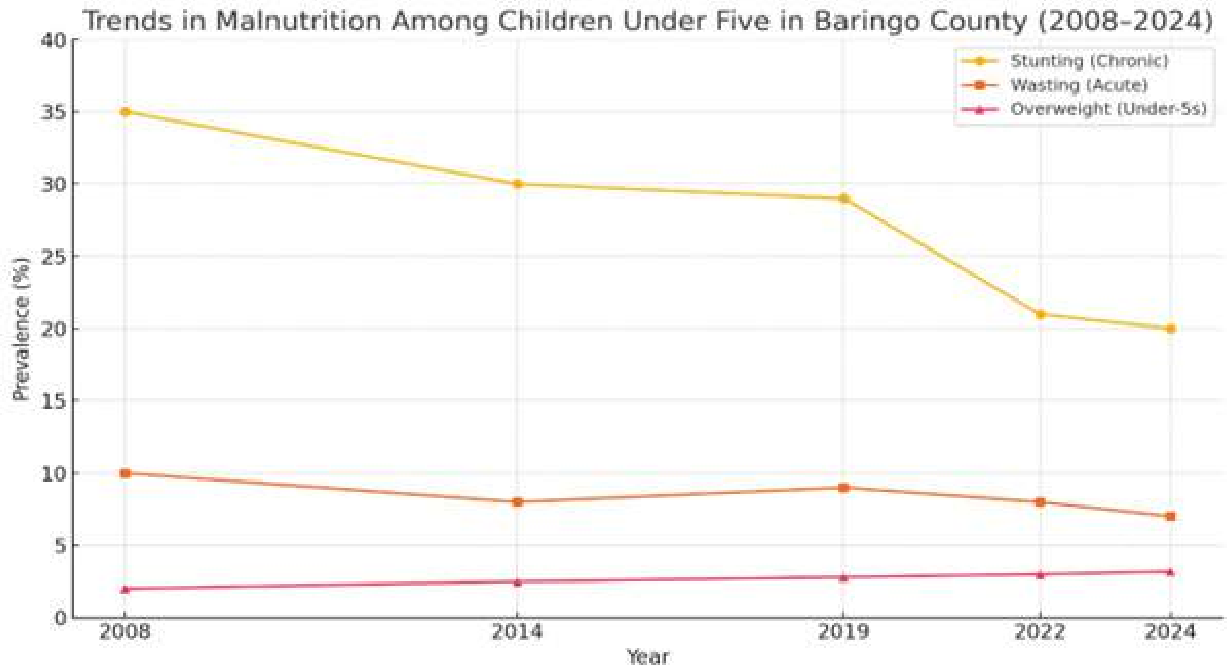


Figure 6: Trends in Undernutrition (Stunting, Wasting, Underweight)

Over the period 2008 to 2024, Baringo County has recorded a gradual but notable decline in stunting, with prevalence dropping from approximately 35% to 20%. This improvement reflects the cumulative impact of expanded health and nutrition services, better maternal care, and increased community awareness of optimal infant and young child feeding practices. The sharp decline to 21% in 2022 marks a significant turning point, aligning with national progress. In contrast, wasting levels have fluctuated over the years, peaking during drought episodes and food insecurity periods, but showing recent improvements as emergency nutrition interventions, community outreach, and health service coverage have scaled up. While the current prevalence remains above desired thresholds, the downward trend is encouraging. Meanwhile, overweight among children under five has shown a slow yet consistent increase, indicating a growing shift in dietary patterns and signaling the onset of the double burden of malnutrition—where undernutrition coexists with rising over-nutrition. This calls for an integrated approach that balances efforts to combat undernutrition with early prevention of diet-related non-communicable diseases. Together, these trends highlight the evolving nutrition landscape in Baringo and necessitate the need for life-course, equity-focused, and multi-sectoral interventions in the County Nutrition Action Plan.

2.3.2 Stunting (Chronic Undernutrition)

Stunting remains a prominent and persistent concern in Baringo. According to the 2022 Kenya Demographic and Health Survey (KDHS), approximately 21% of children under five years in the county are stunted, significantly higher than the current national average of 18% (KDHS 2022). This means nearly one in every five children in Baringo is too short for their age, reflecting long-term nutritional deprivation and repeated infections during early childhood. While there may have been marginal improvements since 2014, available data suggests stunting levels have remained in the high range, particularly in sub-counties such as Tiaty, which are characterized by limited access to health services, low dietary diversity, and recurrent food insecurity.

2.3.3 Wasting (Acute Malnutrition)

Wasting, an indicator of acute undernutrition, also remains a concern, particularly during lean seasons and drought periods. Recent seasonal assessments and SMART surveys indicate that Global Acute Malnutrition (GAM) in East Pokot (Tiaty East and Tiaty West) is above 15% (critical phase). Which places the county in the "Serious" to "Emergency" classification according to WHO thresholds. During severe drought episodes such as the 2022–2023 period, some communities experienced spikes above emergency thresholds, signaling heightened vulnerability among children under five. Though GAM levels have stabilized slightly with improved rainfall in 2024, acute malnutrition remains a cyclical threat tied to food availability, water access, care giving practices and disease outbreaks.

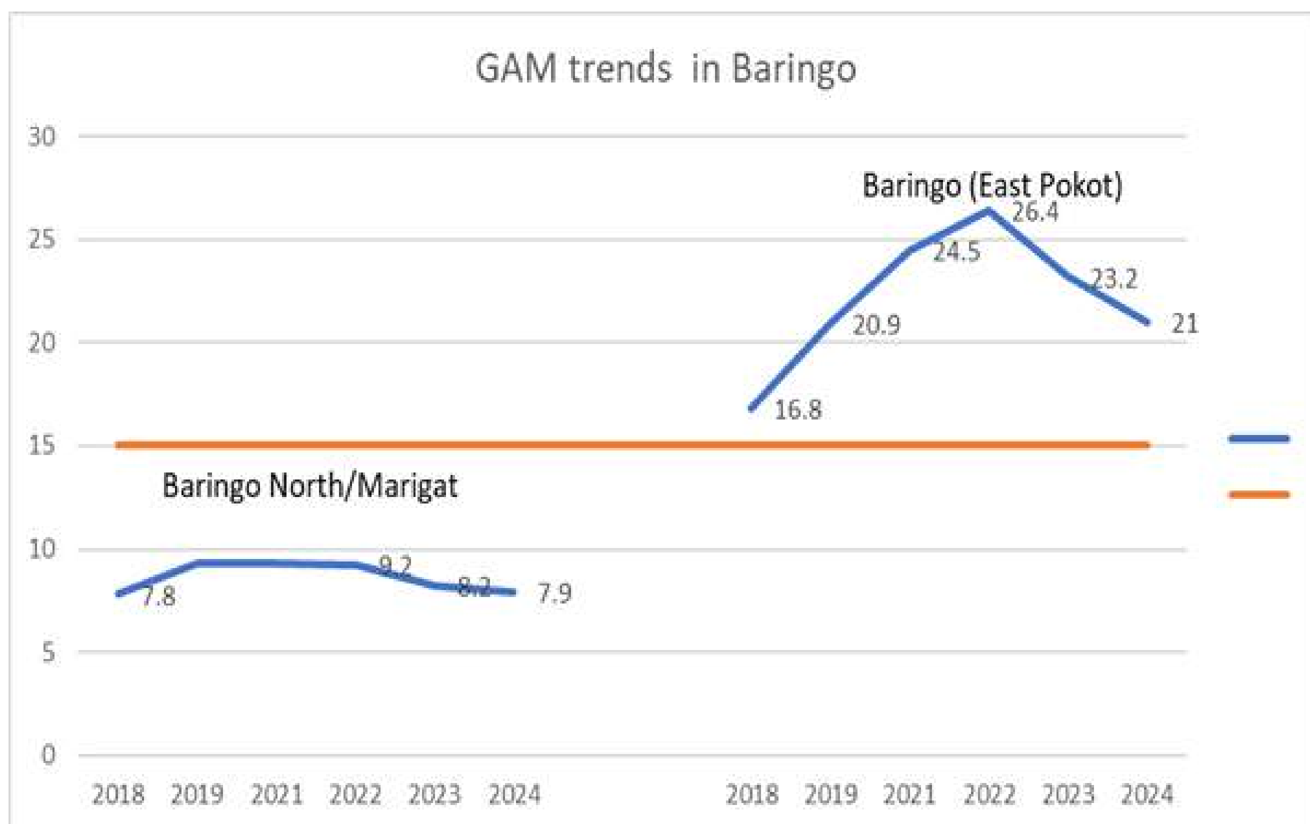


Figure 7: Trend of Global Acute Malnutrition (wasting) in Baringo County (2018–2024.

The prevalence of acute malnutrition in children under five has fluctuated around the "Serious" threshold in recent years, peaking around 9–10% during drought periods and improving to about 8% in 2023–2024. (Data source: SMART surveys) The red line indicates the emergency threshold (15% GAM).

2.3.4 Overweight and Obesity

While undernutrition remains the most visible challenge, overweight and obesity are emerging concerns, particularly among adults. Nationally, the KDHS 2022 reports that about one-third of women aged 15–49 years are overweight or obese, and while county-specific data is limited, urbanizing sub-counties in Baringo are likely experiencing similar trends. Among children under five, approximately 3% are overweight, signaling a shift toward poor-quality, energy dense diets even in rural areas. The growing burden of non-communicable diseases (NCDs) such as hypertension and diabetes further illustrate the nutrition transition underway and highlights the need for integrated approaches that address both ends of the malnutrition spectrum.

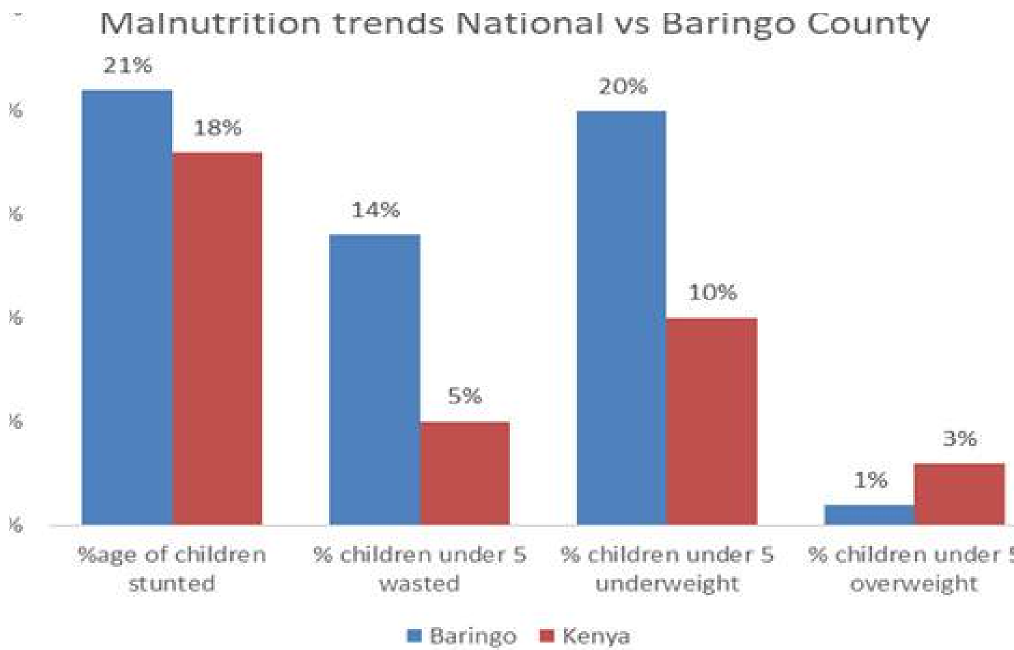


Figure 8: Trends in nutrition outcomes National compared to Baringo County

2.3.4 Maternal Nutrition.

Maternal nutrition in Baringo County reveals a landscape that undernutrition, overweight and associated communicable diseases co-exist. In 2024 the proportion of underweight women is 10.3%, 22.4% are overweight and 6.2% are obese. This situation is driven by sedentary lifestyles and increased consumption of processed foods posing growing risks for maternal complications, gestational diabetes and future child health.

Micronutrient deficiencies remain a silent but critical public health concern. Anemia in pregnant women, a common indicator of iron deficiency and overall dietary quality, has improved gradually—from 12% in 2018 to 19% in 2024—but remains above the acceptable threshold for public health. Persistent anemia contributes to maternal morbidity, poor birth outcomes, and low birth weight, especially in food-insecure households.

The trends call for a multi-pronged strategy: sustaining undernutrition reduction, promoting healthy diets and physical activity among women, addressing hidden hunger through supplementation and food fortification, and ensuring continuity of care across the reproductive lifecycle. During the drought an estimated over 4,000 pregnant and lactating women required nutrition support for acute malnutrition. This shows that undernutrition affects mothers with risks for newborns.

2.4 Overnutrition and the Rising Burden of Non-Communicable Diseases in Baringo County

While undernutrition remains the most pressing nutrition challenge in Baringo County, emerging trends indicate a rising incidence of overweight, obesity, and associated non- communicable diseases (NCDs). This evolving profile reflects a nationwide nutrition transition, driven by shifting dietary patterns, urbanization, and increasingly sedentary lifestyles.

2.4.0 Overweight and Obesity in Children

Though still relatively low, the prevalence of childhood overweight in Baringo is slowly increasing and warrants attention. The Kenya Demographic and Health Survey (KDHS) 2022 reports that approximately 3% of children under five nationally are overweight. Baringo mirrors this trend, with anecdotal reports from school health programs and nutrition assessments suggesting a gradual rise in overweight among children, particularly in peri-urban and trading center communities.

This subtle shift is concerning as it reflects early exposure to poor-quality diets—high in sugar, fats, and refined foods—and limited physical activity. Overweight children are at increased risk of obesity in adolescence and adulthood, along with chronic health conditions such as type 2 diabetes and cardiovascular disease. The co-existence of childhood overweight with stunting in the same populations illustrates the early onset of the double burden of malnutrition, even in rural settings.

2.4.1 Overweight, Obesity and Diet related NCDs in Adults

The most pronounced increase in over-nutrition is observed among adults, particularly women of reproductive age. Nationally, KDHS 2014 reported that 33% of women and 17% of men (ages 15–49) were overweight or obese, with subsequent trends suggesting continued growth. Kenya's overall adult overweight prevalence is now estimated at nearly 28%, according to recent analyses. In Baringo, while overweight prevalence may still be below urban county levels, the trend is unmistakably upward. Women in market centers, health workers, and public servants—populations with increased access to processed foods and sedentary work environments—are reporting higher body mass indices (BMIs). Nutrition assessments and facility data point to a growing number of adults presenting with weight-related health complications, particularly in Eldama Ravine, Kabarnet, and other rapidly urbanizing areas.

Parallel to these trends in overweight and obesity is the increasing burden of NCDs in Baringo. Health facilities across the county are witnessing a rising number of clients diagnosed with hypertension, type 2 diabetes, and cardiovascular conditions—diseases strongly linked to poor diet and physical inactivity. Although comprehensive county-level data are limited, anecdotal evidence from sub-county hospitals suggests that NCD cases have increased significantly over the last decade, particularly among middle-aged and elderly populations. Nationally, NCDs now account for approximately 27% of all deaths, according to the World Health Organization (WHO), and their contribution to the overall disease burden in Kenya is expected to rise.

In Baringo's context, it is not uncommon to find households where a stunted child and an overweight adult coexist, reflecting the socioeconomic and environmental complexity of malnutrition.

In line with national trends, Baringo's health facilities are reporting an increase in adult patients with NCDs, particularly hypertension and type 2 diabetes. This epidemiological shift—from communicable to non-communicable diseases—is driven by changes in diet, physical inactivity, and urbanization. Though comprehensive data is lacking, healthcare workers in Kabarnet, Eldama Ravine, and Marigat have observed rising outpatient visits for NCD complications. This has significant implications for nutrition programming, as overweight and obesity are now contributing to a new face of malnutrition in the county. Diets rich in refined grains, sugar, and fats—especially in peri-urban settings—are displacing traditional, high-fiber diets, contributing to poor adult health outcomes.

2.5 Responding to the Triple Burden of Malnutrition

The emerging picture in Baringo points to a triple burden of malnutrition—the persistence of undernutrition, particularly in children, alongside rising over-nutrition and NCDs in adults. Addressing this dual challenge requires a comprehensive, life-course approach within the County Nutrition Action Plan (CNAP), integrating both nutrition-specific and nutrition- sensitive strategies

Table 6: Indicative Adult Nutrition Profile (Kenya & Baringo Context)

Indicator	National Estimate (KDHS/Steps)	Estimated Baringo Trend
Women overweight/obese (15–		
49 yrs)	33%	40%
Men overweight/obese (15–49 yrs)	17%	25%
Maternal underweight (BMI < 18.5)	12%	Data not available

Micronutrient deficiencies, often referred to as "hidden hunger," represent a significant yet less visible dimension of malnutrition in Baringo County. These deficiencies—particularly of vitamin A, iron, iodine, and zinc—can impair growth, immunity, cognitive development, and productivity, especially in children and women of reproductive age. Although county-specific data are limited, national surveys and proxy indicators suggest that micronutrient malnutrition remains a critical public health concern in Baringo, exacerbated by low dietary diversity and recurrent food insecurity. Nationally, anemia affects about 26% of young children and 42% of pregnant women, with similar or higher prevalence likely in rural and pastoral areas of the county.

Vitamin A Deficiency and Supplementation.

Vitamin A deficiency (VAD) compromises immune function and increases vulnerability to infections, particularly among children under five. According to the Kenya Micronutrient Survey 2011, VAD was a moderate public health issue nationally. While there is no recent data specific to Baringo, the high rates of undernutrition, poor dietary diversity, and low fruit and vegetable intake imply a substantial risk of VAD in the county. On a positive note, Vitamin A supplementation coverage for children 6–59 months in Baringo has shown steady progress over the past decade, primarily through Malezi Bora campaigns and expanded outreach services. The county currently maintains an estimated coverage rate of 75–80%, consistent with national averages. This regular supplementation is likely contributing to a decline in severe VAD cases, though gaps remain, especially in remote and pastoralist communities where outreach coverage is limited. Sustaining and expanding this trend is essential for reducing child morbidity and mortality.

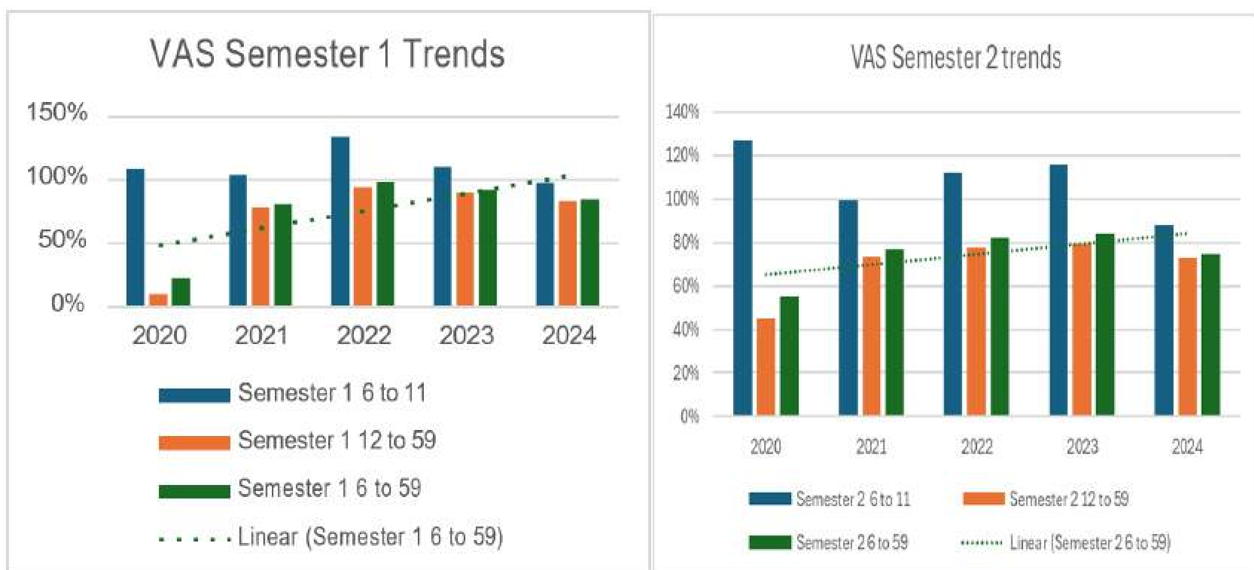


Figure 9:VAS Semester Trends

Iron Deficiency and Anemia

Anemia, primarily caused by iron deficiency, remains widespread in Kenya, affecting 26% of children under five and 42% of pregnant women nationally. In Baringo, anemia prevalence is likely comparable or even higher, especially among pregnant and lactating women, given persistent food insecurity, low intake of iron-rich foods, and limited access to health services in some sub-counties.

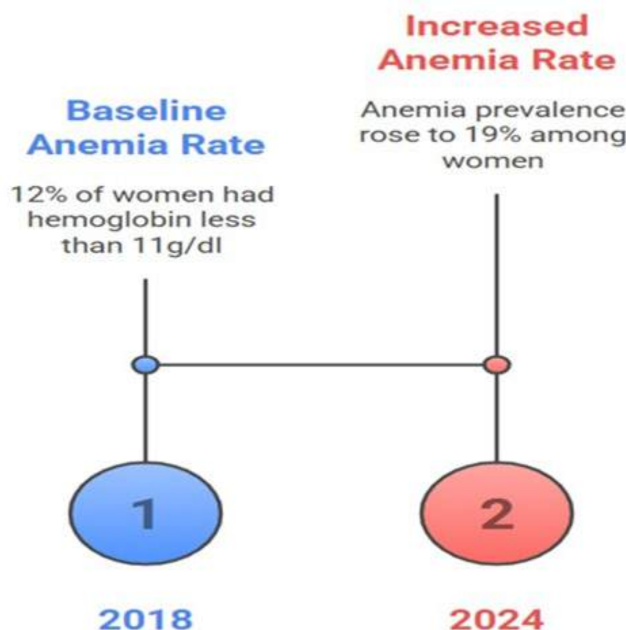


Figure 10: Anemia Trends in Women

Health facility data and anecdotal reports from antenatal clinics suggest that anemia in pregnancy is a routine clinical concern, with many women presenting hemoglobin levels below the WHO threshold of 11g/dL for pregnant women. Iron and folic acid (IFA) supplementation is part of routine antenatal care, and coverage has improved in recent years through strengthened health systems. However, adherence remains a challenge, particularly due to side effects, late ANC initiation, and inconsistent supply of supplements. Deworming programs and malaria prevention efforts may have contributed to slight reductions in anemia, but comprehensive data is needed to confirm trends. In 2018, 12% of women had a HB less than 11g/dl rising to 19% in 2024.

Zinc, Folate, and Other Micronutrients

Zinc deficiency is highly prevalent in Kenya, affecting over 80% of children nationally, as per the 2011 micronutrient survey and is likely widespread in Baringo due to high consumption of cereal- based diets with low animal protein. Zinc is crucial for immune function and growth, and its deficiency contributes to stunting and increased susceptibility to infections. Zinc is supplemented to children who present to health facilities as a routine of care in Baringo County. 250 health facilities have a dedicated ORS corner for addressing diarrheal disease and these are fully equipped with zinc.

Kenya's food fortification program

A legal notice requiring the fortification of wheat and maize flour with iron, zinc, and B vitamins, and vegetable oils with vitamin A, offers a promising avenue to reduce micronutrient gaps. However, the impact of fortification in Baringo depends on market access and household consumption patterns. In remote communities where informal milling is the norm. The micro small and medium millers lack the necessary to adhere to the fortification legal notice.

Figure 11: Micronutrient deficiencies.

Feeding Practices in the Early Years and Household Dietary Patterns in Baringo County

Feeding practices in the early years of life, are immediate determinants of a child's nutritional status and long-term development. In Baringo County, trends in infant and young child feeding (IYCF) remain below national recommendations, while broader household dietary patterns reflect persistent gaps in food diversity, frequency, and nutritional quality. These issues contribute significantly to the high rates of undernutrition and emerging overnutrition in the county.

Infant and Young Child Feeding (IYCF) Practices

Despite ongoing efforts, IYCF indicators in Baringo show suboptimal trends, signaling missed opportunities during the critical window of the first 1,000 days of life.

- **Exclusive Breastfeeding (0–6 months):** Only 31.2 % of infants in Baringo are exclusively breastfed for the first six months of life, well below the national average of 61% (KDHS 2022). This indicates that nearly 7 in 10 infants are introduced to water, animal milk, or other foods too early, exposing them to infections and undermining their nutrition.

Figure 12: Exclusive Breastfeeding rates

While this represents a modest improvement from earlier estimates (~20% in 2008), it remains a critical gap that requires sustained community-level behavior change communication (BCC).

- **Continued Breastfeeding and Complementary Feeding:** The continuation of breastfeeding beyond six months is also low, with only 16% of children still breastfed after six months. This trend may be influenced by early return to work, subsequent pregnancies, or cultural practices. Complementary feeding practices are equally concerning—only 26.2% of infants aged 6–8 months receive complementary foods at the recommended six-month mark, indicating poor timeliness in food introduction.
- **Dietary Diversity and Meal Frequency (6–23 months):** Only 31.9% of children aged 6–23 months consume a Minimum Acceptable Diet (MAD), a composite indicator reflecting both dietary diversity and meal frequency. Furthermore, just 33% of these children achieve Minimum Dietary Diversity (MDD), meaning most are missing essential nutrients from key food groups like animal-source foods, fruits, and vegetables. These figures have shown limited improvement over the past decade and point to systemic barriers in access, knowledge, and affordability of nutritious foods.
- **Feeding During Illness:** While no recent statistics are available, anecdotal reports indicate that caregivers in some communities still reduce or withhold food and fluids during episodes of illness such as diarrhea. This traditional practice worsens malnutrition and points to the need for enhanced caregiver education on child nutrition during illness and recovery.

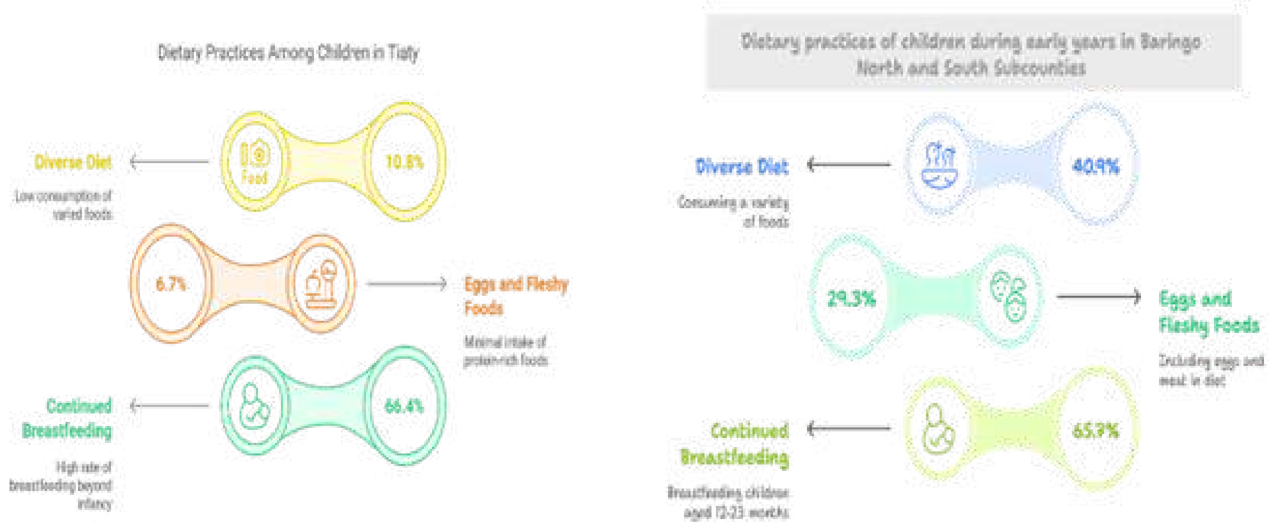


Figure 13: Dietary feeding practices among children in Baringo.

These findings illustrate that IYCF practices in Baringo fall significantly short of global and national standards. Strengthening maternal counseling through community health promoters (CHPs), scaling up Baby-Friendly Community Initiatives (BFCI), counselling at the health facilities and addressing cultural myths around breastfeeding and child feeding are essential interventions to improve these outcomes.

- **Household Dietary Practices:** At the household level, dietary patterns in Baringo County are marked by low diversity, seasonal fluctuations in food availability, and an increasing shift toward processed foods—each contributing to the county's complex nutrition burden.
- **Household Dietary Diversity:** As of the latest assessments, 33.7% of households in Baringo consume fewer than five food groups per day, indicating highly monotonous diets. Meals are typically centered on staples such as maize flour (ugali or porridge), with limited inclusion of protein-rich or micronutrient-dense foods, especially during drought or lean seasons.
- **Meal Frequency and Food Access:** Household meal frequency varies with food availability. During the 2022 drought, many families reduced their meals to one or two per day, particularly in pastoral communities like Tiaty. While conditions improved following favorable rains in 2023, the fluctuation highlights the county's vulnerability to climate-driven food insecurity and the need for resilient food systems.
- **Shift in Diet Patterns:** There is a growing trend of increased consumption of processed, energy-dense foods, even in rural markets. Items such as sweetened beverages, deep-fried snacks, and refined grains are now more readily available and often cheaper than healthier alternatives. This nutrition transition is slowly displacing traditional, fiber-rich diets and contributing to the rise in overweight and diet-related NCDs.
- **Cultural Practices:** Dietary norms in some communities restrict the consumption of certain nutritious foods by women and children. For example, eggs, meat, or milk may be preferentially reserved for male household heads or withheld from young children due to misconceptions (e.g., fear of delayed speech or over-dependence). While some cultural barriers are easing with education and generational shifts, others persist and continue to influence intra-household food distribution and child nutrition.
- **Adult Feeding Patterns and NCD Risk:** Adult diets—particularly in urbanizing centers— are increasingly shaped by convenience, affordability, and social habits. Many adults now consume more calorie-dense, nutrient-poor foods (e.g., white bread, sweetened tea, fried snacks), contributing to the rising burden of overweight, obesity, and non-communicable diseases such as hypertension and diabetes. The CNAP must integrate dietary guidance for adults alongside child nutrition efforts to promote healthy eating across the life course.

Feeding practices in Baringo County, from the early years through adulthood require a strategic focus. Poor infant feeding, low household dietary diversity, and rising consumption of unhealthy processed foods are directly fueling the county's burden of malnutrition.

2.6 Mortality Trends

Understanding mortality trends in Baringo County provides critical insight into the ultimate consequence of malnutrition—preventable deaths, particularly among young children and mothers. While Kenya has made significant strides in reducing mortality rates over the past decade, malnutrition remains an underlying factor in a large proportion of these deaths, especially in arid and semi-arid counties like Baringo.

Figure 14: Reducing malnutrition-related mortality in Baringo

Under-Five Mortality (U5MR)

Nationally, the under-five mortality rate (U5MR) has declined markedly from 74 deaths per 1,000 live births in 2008 to approximately 41 per 1,000 live births in 2022 (KDHS 2022). Baringo's under- five mortality is estimated at 55 per 1,000 live births exceeding the national average, particularly in remote sub-counties like Tiaty, where access to health services remains a challenge. This translates to at least 1 in 24 children not surviving to their fifth birthday—a stark reminder of the health and nutrition inequities still faced by many families. Globally, undernutrition contributes to nearly 45% of all under-five deaths, and in Baringo, recurrent child malnutrition, coupled with common childhood illnesses such as diarrhea, pneumonia, and malaria, has historically contributed to elevated mortality levels.

The scale-up of community-based nutrition programs, immunization coverage, and health outreach services over the last decade has likely contributed to gradual improvements in child survival.

However, the 2022 prolonged drought likely exacerbated child vulnerabilities, increasing risks of severe acute malnutrition and related mortality, particularly in food-insecure households.

Infant and Neonatal Mortality

Kenya's infant mortality rate (deaths before age 1) now stands at approximately 32 per 1,000 live births, while the neonatal mortality rate (deaths within the first month of life) is 21 per 1,000 live births (KDHS 2022). These figures represent a national improvement, though neonatal deaths now account for more than half of all under-five deaths, reflecting increased survival beyond infancy but continued vulnerability in the critical newborn period.

In Baringo, neonatal mortality 33 deaths per 1,000 live births and infant mortality 50 deaths per 1,000 live births is influenced by maternal health, nutrition, and access to skilled delivery. Maternal malnutrition especially anemia and teenage pregnancies contributes to low birth weight and increases the risk of early neonatal death. In remote sub-counties, limited access to health facilities and skilled birth attendants has historically heightened neonatal risks. Nevertheless, the trend toward safer deliveries is improving facility-based births have increased nationally from 66% in 2014 to 89% in 2022, and Baringo has seen similar gains, at 83% of women delivering at home due to targeted investments in maternity shelters and community referral systems. Continued progress in neonatal survival will depend on further improving antenatal nutrition, timely access to emergency obstetric care, and quality newborn services.

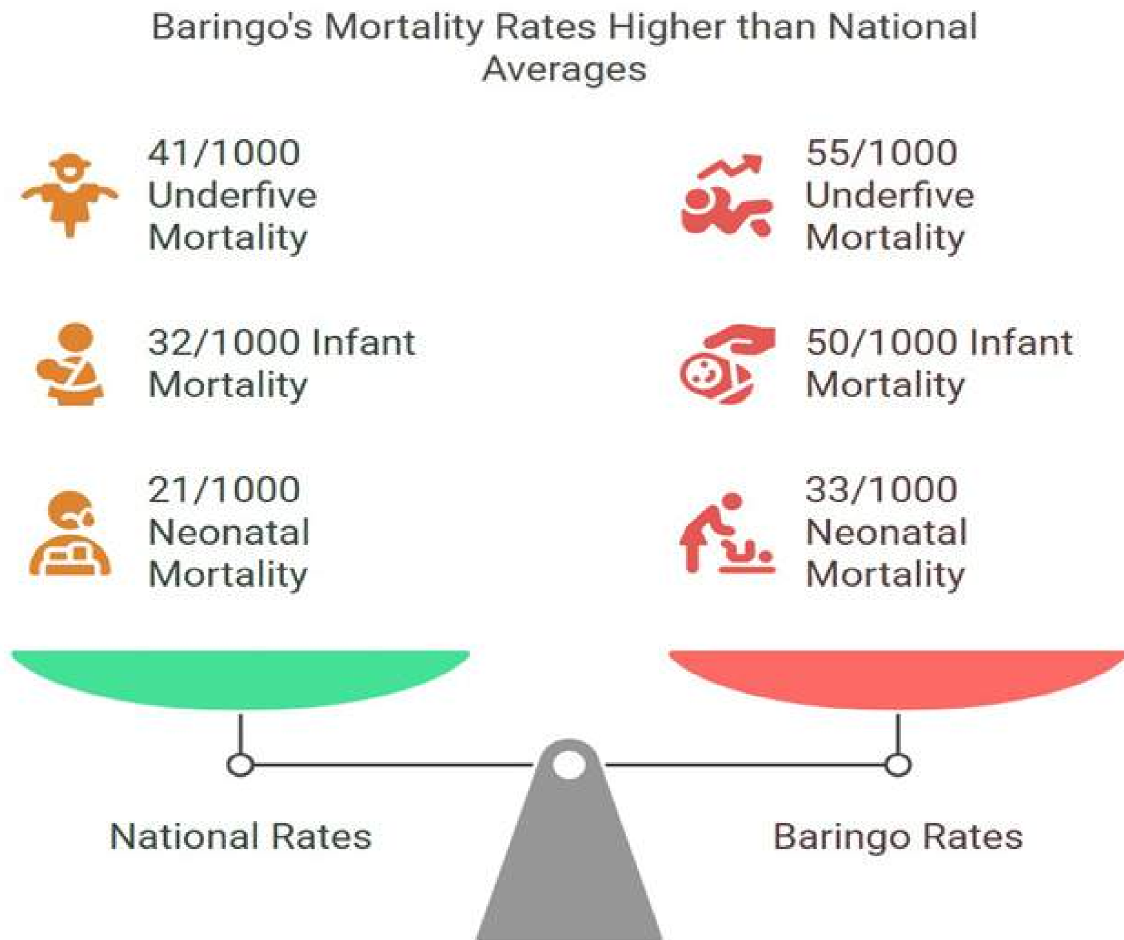


Figure 15:Mortality rates in Kenya. Source: KDHS 2022

Maternal Mortality

Kenya's maternal mortality ratio (MMR) remains high at approximately 342 deaths per 100,000 live births (KDHS 2014), with modest improvements expected in forthcoming surveys. Although there are no recent county-specific maternal mortality figures for Baringo, challenges such as geographic barriers, inadequate transport systems, and low uptake of antenatal services in rural areas have historically led to higher maternal mortality, especially in the event of hemorrhage, sepsis, or hypertensive disorders. Malnutrition compounds this risk. Maternal anemia weakens the mother's capacity to withstand complications during delivery and increases the likelihood of adverse birth outcomes. With increasing access to facility-based deliveries and routine supplementation of iron and folic acid, maternal health indicators in Baringo are likely improving, but continued investments are needed to reach national targets and ensure equitable maternal survival.

2.6.1 Cause-Specific Mortality and Nutrition Link

Major causes of child mortality in Baringo—pneumonia, diarrhea, malaria, and neonatal conditions— are all exacerbated by poor nutritional status. Undernourished children are far more susceptible to infection, more likely to experience severe disease, and less likely to recover. In this context, malnutrition acts as a multiplier of mortality risk. Baringo has also experienced health system disruptions and climate shocks, such as the 2022–2023 drought, which not only worsened food insecurity but also increased child morbidity and likely mortality, particularly in vulnerable pastoralist communities. While humanitarian responses averted famine-level deaths, the situation highlights the ongoing fragility of child survival in the county.

Mortality indicators in Baringo are gradually improving, reflecting national health gains and the impact of nutrition and primary healthcare interventions. However, they remain above optimal levels, especially in underserved sub-counties. The data reveal a critical truth: well-nourished children are more likely to survive common illnesses, thrive in school, and reach their full potential. Therefore, further reductions in child and maternal mortality hinge on accelerated action to address malnutrition. Areas with persistent malnutrition, such as Tiaty, have historically shown worse child survival rates— reinforcing the malnutrition-mortality link and the need for geographically targeted interventions.

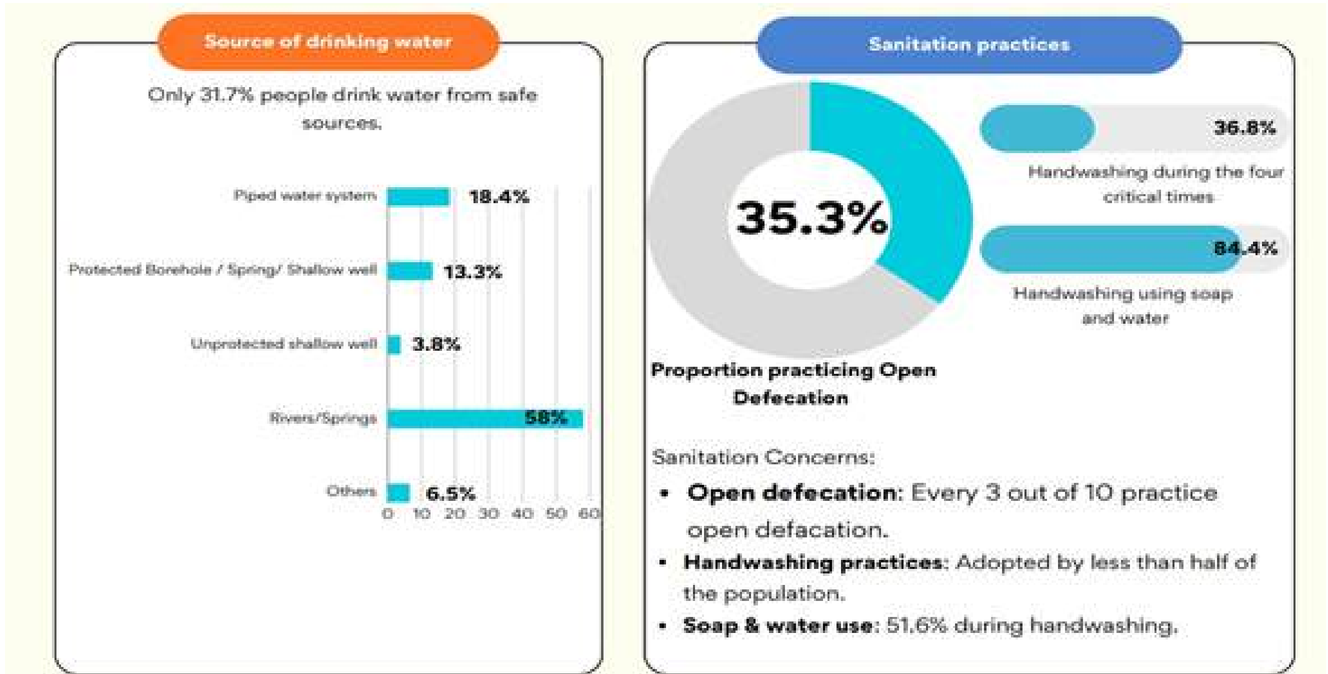
2.7 Morbidity Trends

The health status of a population is intricately linked to its nutritional profile. In Baringo County, patterns of morbidity—particularly among children and women—continue to influence nutrition outcomes. While some progress has been made in disease control and healthcare access, the burden of infectious diseases, limited access to clean water and sanitation, and rising non-communicable diseases (NCDs) remain major contributors to malnutrition. Understanding these trends is critical to designing effective, integrated interventions in the County Nutrition Action Plan (CNAP).

2.8 Common Childhood Illnesses and the Infection-Malnutrition Cycle

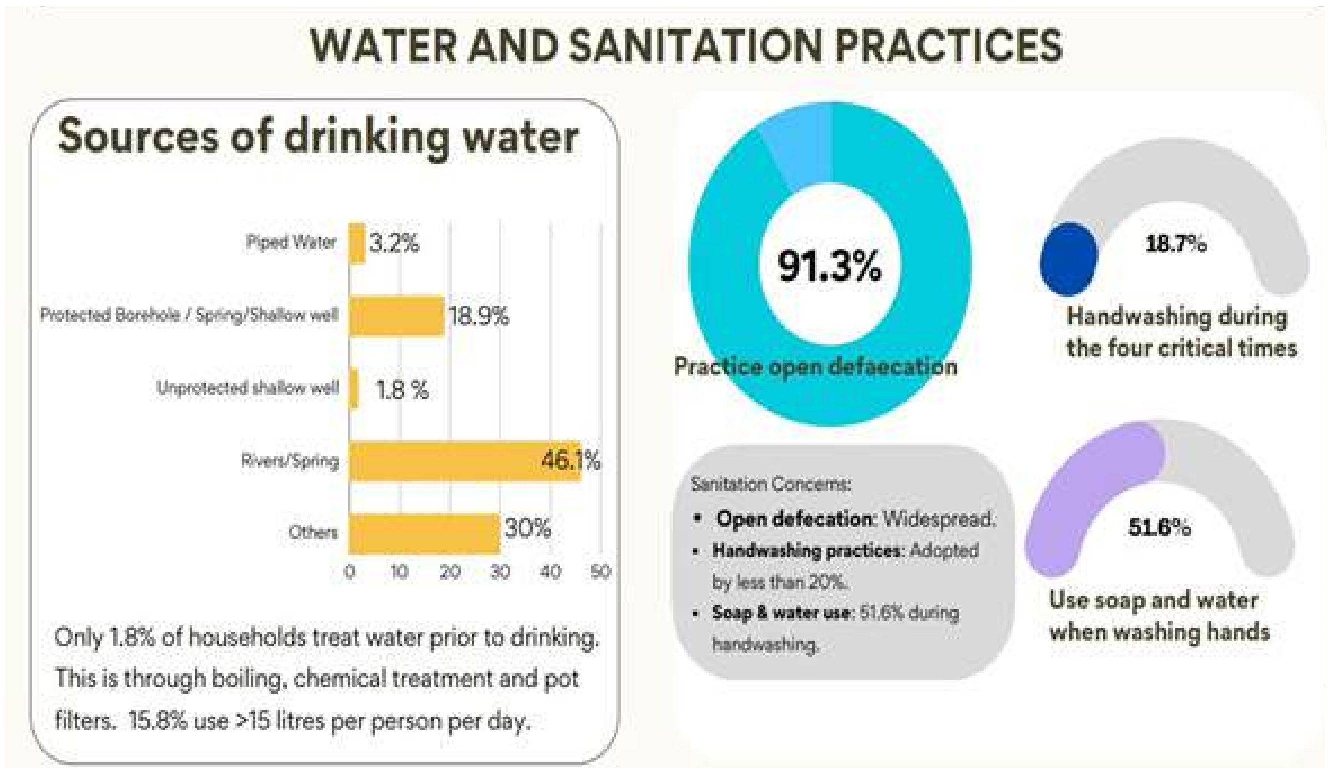
In Baringo, diarrhea, acute respiratory infections (ARIs), malaria, and measles remain the leading causes of illness in children under five, closely linked to both the onset and exacerbation of malnutrition. According to national trends, the prevalence of diarrhea in the two weeks preceding the survey dropped nationally from 17% in 2014 to 15% in 2022 (KDHS). Qualitative assessments and health facility records suggest that diarrheal illnesses remain high in Baringo, particularly in sub- counties with poor water and sanitation infrastructure such as Tiaty and parts of Baringo North. Waterborne diseases frequently spike during the rainy season, when flooding contaminates water sources and heightens cholera risk. Conversely, during droughts, water scarcity and poor hygiene conditions lead to unsafe water use and handwashing practices, increasing diarrheal disease. Repeated infections—especially diarrhea and pneumonia—worsen nutritional status by reducing nutrient absorption, increasing energy demands, and diminishing appetite, thus fueling the vicious cycle between infection and undernutrition.

Figure 16:WASH situation in Baringo North.



Source: SMART survey 2024

Figure 17: WASH situation in Tiaty.



Source: SMART survey 2024

2.9 Impact of Drought and Food Insecurity on Morbidity

During the 2019–2022 drought, Baringo experienced a surge in child morbidity, with higher reports of febrile illness, diarrhea, and measles outbreaks among malnourished populations. These illnesses were particularly prevalent in communities facing acute food shortages and displacement, further straining their nutritional resilience. For instance, nutrition surveys conducted during this period in ASAL regions—including Baringo—reported increases in both Global Acute Malnutrition (GAM) and common illness episodes. Recent cholera alerts in neighboring counties also underscore the persistent vulnerability of the region's water and sanitation systems. Poor access to clean water, high rates of open defecation (above 90% in East Pokot as of 2017), and inadequate hygiene practices continue to elevate the risk of enteric diseases, particularly among children.

2.9.0 Healthcare Utilization and Preventive Services

Improved access to primary healthcare has contributed to better management of childhood illnesses and prevention of severe complications. National immunization coverage stands at 80% (KDHS 2022), and Baringo has seen steady improvements in immunization uptake, though remote areas still face access barriers due to terrain, insecurity, and staffing shortages, the county has managed to ensure that 81% of children have achieved FIC status. Community-level case management has also improved. Increased availability of Oral Rehydration Salts (ORS), zinc supplementation for diarrhea, antibiotics for pneumonia, and community referrals have contributed to reducing the duration and severity of childhood illnesses. Deworming initiatives, especially those linked to school health days, have helped reduce intestinal parasite burdens that exacerbate micronutrient deficiencies, especially iron.

2.9.1 Women's Health and Nutrition-Related Morbidity

Women in Baringo face a unique set of health challenges that directly impact maternal and child nutrition. Frequent pregnancies, short birth intervals, and adolescent pregnancies 20% compared to a national rate of 15% are common and associated with maternal nutrient depletion. Pregnant women often present with anemia, malaria, and poor weight gain, increasing the risk of low birth weight and neonatal mortality. In addition, limited antenatal care attendance and delayed first visits reduce opportunities for early intervention. However, improvements in facility-based deliveries and iron- folic acid supplementation coverage have had a modest impact on reducing maternal morbidity in the county.

2.9.2 HIV/AIDS and Nutrition

Though HIV prevalence in Baringo is moderate compared to national hotspots, the disease still poses a threat to maternal and child nutrition. Prevention of Mother-To-Child Transmission (PMTCT) services are increasingly integrated with maternal and child health and nutrition services, enhancing early identification and support for HIV-positive mothers and their children. Nutritional care and support through these platforms are essential in maintaining health and immunity among affected populations. PMTCT testing coverage is 10284, with PMTCT Kwon positive of 169 with the percentage coverage of 1.6% among the pregnant and breast-feeding mothers in the county. Currently the prevalence rate of PMTCT in Baringo is 16%.

2.9.3 Access to Food, Care, and Health Services: Enabling Environment for Nutrition in Baringo County

Drivers of Malnutrition (Nutrition specific and Nutrition sensitive) in Baringo County Malnutrition in Baringo County remains a complex and persistent challenge, driven by a range of immediate, underlying, and basic factors that span across individual, household, community, and systemic levels. This section synthesizes these drivers to explain why malnutrition continues to affect children and families in the county, and why a coordinated, multi-sectoral approach is essential for lasting solutions.

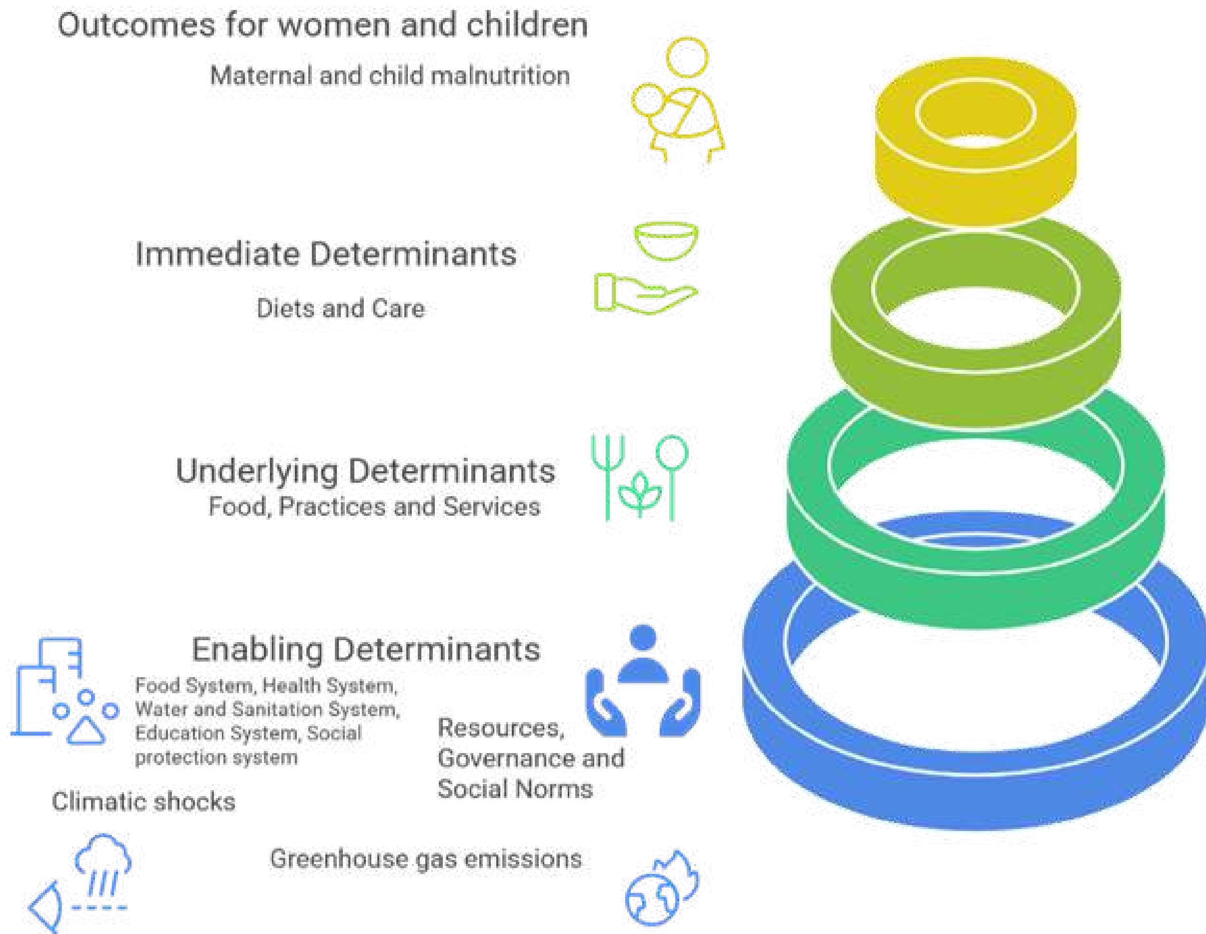


Figure 18: conceptual framework for maternal and child malnutrition.

1. Immediate Causes (Individual-Level)

At the most direct level, malnutrition is caused by inadequate dietary intake and recurrent illness, which interact in a vicious cycle:

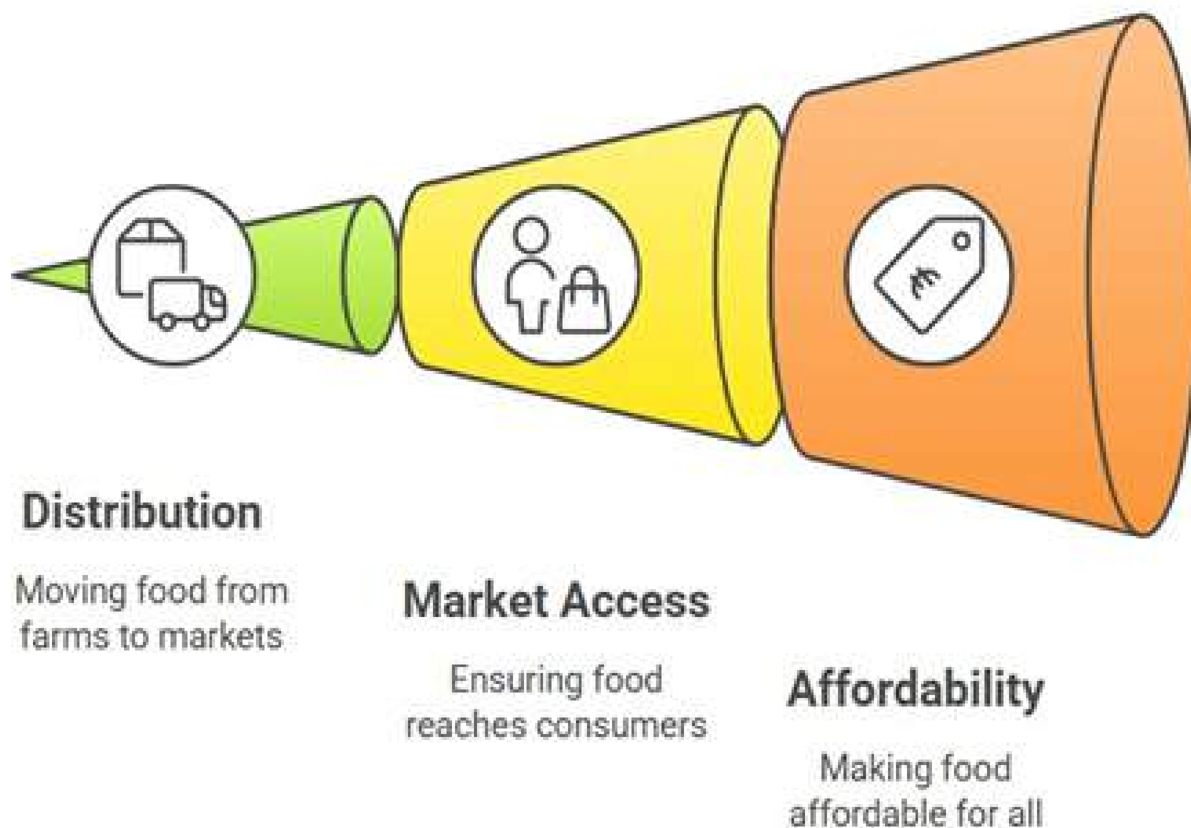
- **Inadequate Dietary Intake:** Many children in Baringo do not receive enough food— either in quantity or nutritional quality. Only 31.6% of infants are exclusively breastfed, and just 26.2% receive timely complementary feeding, while less than 32% meet the Minimum Acceptable Diet (MAD) standards. These poor infant and young child feeding (IYCF) practices are driven by lack of knowledge, cultural beliefs, and limited access to diverse foods, directly leading to energy and micronutrient deficiencies.

- **High Disease Burden:** Frequent illness, especially diarrhea, respiratory infections, and malaria, impairs appetite, increases nutrient losses, and hinders growth. Infections and inadequate diets reinforce each other. For example, a child with repeated diarrhea may become severely wasted, even when food is available. Unsafe water, poor sanitation, and low immunization coverage in remote areas further exacerbate this cycle.

2. Underlying Causes (Household and Community-Level)

The nutritional status of children and families in Baringo County is deeply shaped by their access to food, the quality of care and caregiving environments, and the availability of essential health, water, sanitation, and hygiene (WASH) services. These underlying determinants— central to the UNICEF conceptual framework—form the foundation for sustainable nutrition outcomes. In Baringo, trends across all three pillars show gradual progress, but persistent gaps remain, especially in vulnerable, remote, and pastoralist communities.

Food Access and Availability

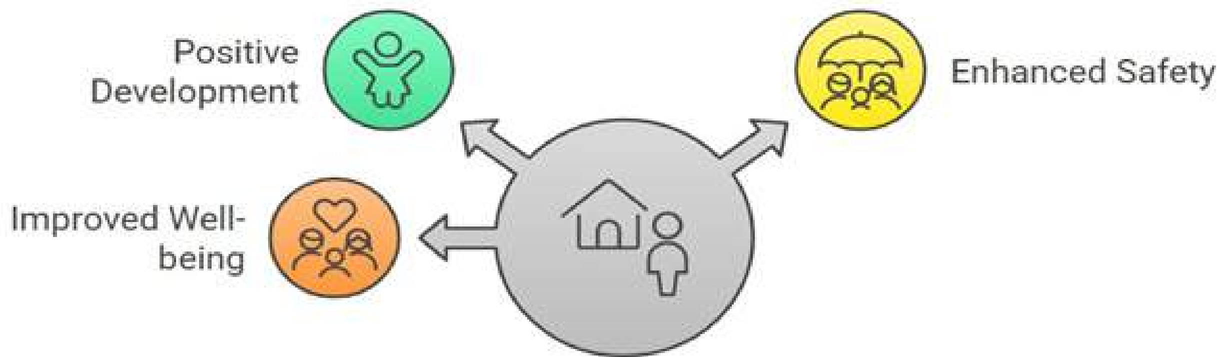


Baringo's food security situation is highly sensitive to climatic shocks and market dynamics. The county experienced severe food insecurity during the prolonged drought of 2021–2022, which led to widespread crop failures, livestock deaths, and spikes in staple food prices. At the drought's peak, several sub-counties—including East Pokot and parts of Baringo North—were classified in Crisis (IPC Phase 3) by humanitarian assessments, with many households requiring food assistance to survive. Humanitarian food and cash assistance played a critical role in averting famine-level malnutrition. However, the return of favorable rains in 2023 restored pasture and water sources, and household food access improved significantly. According to the NDMA's 2023 long rains assessment, dietary diversity increased due to the availability of green vegetables and fruits, particularly in mixed farming areas. This translated to a drop in households with poor food consumption scores, signaling nutritional recovery.

Efforts to boost resilience through irrigated agriculture, small livestock keeping, beekeeping, and horticulture have gained traction in selected sub-counties like Baringo Central and Marigat. Improvements in rural market access and road infrastructure have also supported household purchasing power. However, about

52% of the population still lives below the poverty line, and food affordability remains a challenge for many families. Baringo's diverse livelihoods— pastoralism, agro-pastoralism, and small-scale farming—make nutrition outcomes highly variable across the county. Frequent climate shocks undermine food systems, but with increasing uptake of safety nets such as cash transfers, relief food, and subsidized inputs, there is potential for a shift from reactive responses to more resilient food security investments. CNAP must align with ongoing agricultural, social protection, and climate adaptation efforts to ensure year-round access to affordable, diverse, and nutritious foods.

Care Environment: Maternal and Childcare Practices



The caregiving environment—comprising maternal education, time, support systems, and cultural norms—has a direct influence on children's nutrition and health outcomes.

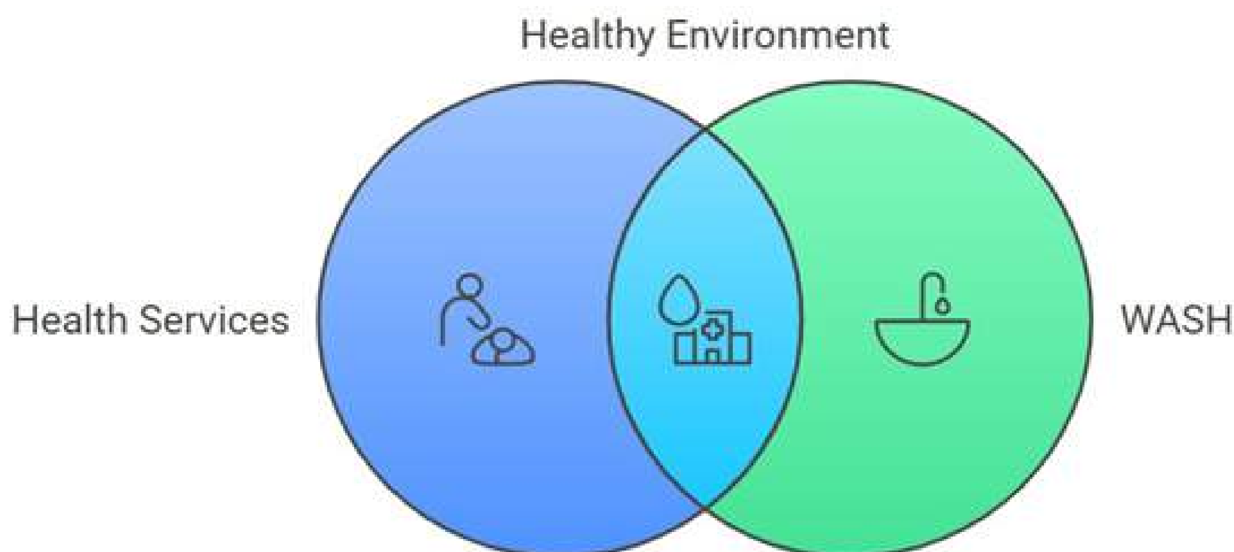
- **Women's Education and Empowerment:** Literacy and education levels among women in Baringo have improved steadily over the last decade. Younger women are more likely to have completed primary or secondary education than previous generations, which positively correlates with improved child feeding and health- seeking behavior. Nationally, only 6% of women have no formal education, and while Baringo's rural sub-counties may still lag, girls' school enrollment and female literacy are on an upward trend.

- **Caregiving Capacity:** Women remain the primary caregivers, but many face a triple burden of care, productive work, and community roles. Daily responsibilities such as fetching water, tending farms, or selling goods reduce time for child feeding and care. Nonetheless, there are encouraging signs—more women are participating in mother support groups, savings groups, and health education sessions, increasing their capacity to care for young children.

- **Household Dynamics and Cultural Norms:** Large and polygamous households are common in some areas, stretching food and care resources. Over time, increased uptake of family planning (modern contraceptive use is ~57% nationally) has begun to reduce fertility rates and improve child spacing. Baringo has seen incremental gains in family planning access, which may lead to better care per child in the long term.

- **Positive Shifts in Practices:** Community behavior is changing—more families now seek care for sick children earlier, and participation in Mother-to-Mother Support Groups and Baby-Friendly Community Initiative (BFCI) platforms has grown, enhancing peer learning around breastfeeding and complementary feeding. In some wards, Early Childhood Development (ECD) centers provide not only meals but also routine growth monitoring, supporting both nutrition and early learning.

Poor Health and Unhealthy environment (WASH Access)



Since the 2013 devolution, Baringo County has significantly expanded health infrastructure, improving access to essential nutrition and healthcare services.

- **Health Facilities:** The county currently operates 250 health facilities, that include hospitals, health centers, dispensaries, and community units, distributed across its six sub-counties. Mobile outreaches and Community Health Promoters (CHPs) have extended basic services to remote areas such as Tiaty and East Pokot, reducing barriers to early diagnosis and treatment. Currently the coverage of CUs is 66% (n=129) and the county is working towards establishing the remaining 65 to achieve a CU coverage of 100%.

- **Nutrition Services:** High Impact Nutrition Interventions (HINI) have expanded. By 2025, 100 health facilities offer outpatient therapeutic programs (OTP) for managing severe acute malnutrition (SAM), up from 100 health facilities in 2018. Malezi Bora campaigns accelerate biannual vitamin A supplementation and deworming, while growth monitoring coverage has improved, particularly where functional CHPs and caregiver support platforms are active.

- **Maternal Health Services:** Most health facilities offer antenatal care with iron and folic acid supplementation, yet adherence remains a challenge due to side effects and stockouts. Increasing rates of facility-based deliveries and skilled attendance at birth are reducing maternal and neonatal risks.

- **WASH (Water, Sanitation and Hygiene):** Access to safe drinking water in Baringo is improving but remains inadequate. While Kenya's rural average for basic water access is 56%, Baringo lags behind in remote areas. Borehole drilling, spring protection, and water pans have improved access in places like Mogotio and Baringo South. However, many households—especially in East Pokot—still rely on contaminated water sources like rivers and dams.

- **Sanitation coverage is particularly low.** Open defecation (OD) is practiced in 91% of households in Tiaty, but ongoing Community-Led Total Sanitation (CLTS) campaigns have led 636/2626 villages being declared Open Defecation Free (ODF) since 2021. Improved WASH is critical to reducing diarrheal diseases and supporting child growth.

- **Education and Social Protection:** Rising school enrollment and social safety nets— such as cash transfers for orphans and vulnerable children, and elderly households— have provided additional support for household food and healthcare spending. While the Hunger Safety Net Programme (HSNP) is limited to northern ASALs, Baringo has benefited cash transfers during the severe drought in 2023.

3. Basic Causes (Societal and Structural-Level)

These systemic issues shape the broader context in which underlying and immediate causes unfold:

A. Poverty and Inequality

- 46.9% of Baringo's population lives below the poverty line, severely restricting access to food, healthcare, and education. 34.3% Households are living in poverty.
- Food poverty at individual level is 36.3% and 25.2% at household level.
- Unemployment, low agricultural productivity, and limited livelihood diversification contribute to chronic household poverty.
- Geographic and infrastructural marginalization, especially in historically underserved areas like East Pokot, reflects deep-rooted inequalities in service delivery and development investment.

B. Climate Change and Environmental Shocks

- Baringo is a climate-vulnerable county, with frequent droughts, occasional floods, and even resource-based conflicts (e.g., over pasture) that disrupt food production and health services.
- Climate variability has become more unpredictable, eroding household resilience and increasing the frequency of nutrition crises.

C. Education and Literacy Gaps

- Although improving, female literacy and educational attainment remain lower in rural sub-counties, limiting uptake of health and nutrition information and restricting women's empowerment.
- Communities with low literacy may be slower to adopt optimal nutrition behaviors or utilize available services.

D. Cultural Norms and Gender Inequities

- In some communities especially among the Tugens, men eat first or receive the most nutritious food, while women and children may be left with limited portions. Among the Pokot the animal flesh especially eggs and liver are consumed by men.
- Low decision-making power among women, coupled with labor-intensive roles, limits their ability to prioritize and act on nutrition needs for themselves and their children.
- Resistance to formal education, especially for girls, still exists in pockets of the county, reducing future generational gains in nutrition literacy.

E. Governance and Resource Allocation

- While Baringo has shown commitment to nutrition evidenced by the development of its CNAP and expansion of health infrastructure budget allocations for nutrition and inter-sectoral collaboration remain limited.
- Health systems are still under-resourced, with gaps in staffing, stockouts of critical supplies like Ready-to-Use Therapeutic Food (RUTF), and inadequate coverage of nutrition outreach in hard-to-reach areas.
- The county still relies heavily on external development partners to fund key nutrition programs, which raises sustainability concerns unless domestic resources and political will are scaled up.

Complex Web of Drivers of Malnutrition Require Coordinated Action

Malnutrition in Baringo is not caused by a single factor, but by the interplay of biological, environmental, social, and systemic factors. From a malnourished child lacking access to nutritious food and exposed to repeated illnesses, to a young mother with low education and multiple responsibilities, to a community isolated by drought and underinvestment—these scenarios reflect a multifactorial, deeply embedded problem.

CHAPTER THREE

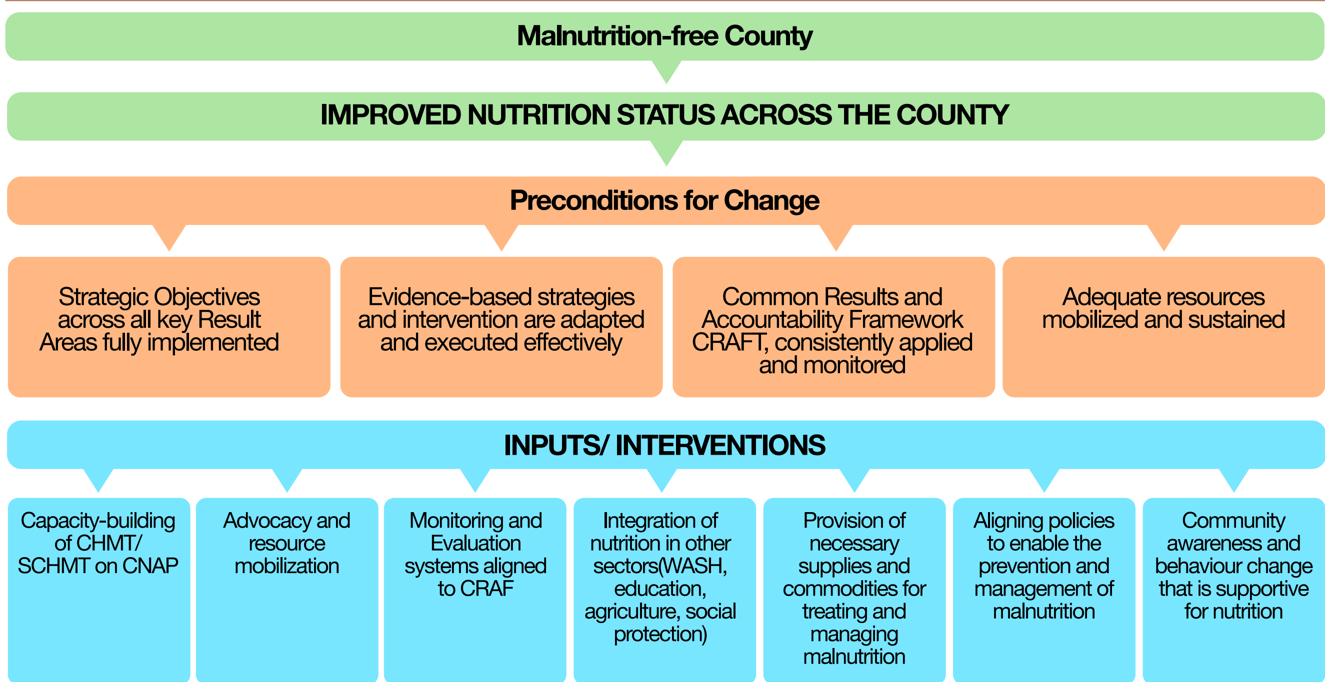
Strategic Priorities: Strategic Objectives, Key Result Areas & Interventions

3.1 Introduction

Baringo CNAP 2023–2027 framework, is central to its theory of change. This approach prioritizes the achievement of measurable outcomes by aligning interventions directly with expected results. It begins with the formulation of clear, evidence-based objectives aimed at addressing the triple burden of malnutrition. To achieve the expected result a total of 13 key result areas (KRAs) have been defined as below;

KRA Number	Key Result Area definition
KRA 1	Maternal, Infant, and Young Child (MIYCN) nutritional well-being improved
KRA 2	Improved nutritional well-being of older children, adolescents, adults, and older people
KRA 3	Enhanced industrial fortification for prevention and control of micronutrient deficiencies
KRA 4	Enhanced clinical nutrition and dietetic services across all levels of health care
KRA 5	Sustained nutritional well-being of individuals and communities during emergencies and climate-related shocks
KRA 6	Enhanced integration of nutrition into agriculture, livestock, and fisheries sectors
KRA 7	Nutrition integrated and strengthened across all levels of the health sector
KRA 8	Enhanced integration of nutrition in the education sector
KRA 9	Enhanced integration of nutrition within the Water, Sanitation, and Hygiene (WASH) sector
KRA 10	Nutrition integrated across social protection programmes
KRA 11	Enhanced multi-sectoral nutrition governance, coordination, partnerships, advocacy, and community engagement
KRA 12	Strengthened multisectoral nutrition information, M&E systems, learning, research and knowledge management
KRA 13	Strengthened supply chain management for nutrition commodities and Equipment

3.2 Theory of change for Baringo CNAP



The Theory of Change (ToC) serves as a roadmap for achieving long-term outcomes by first defining the desired goal and then identifying the necessary preconditions and actions to reach it. It offers a structured and evidence-informed explanation of how change is expected to happen within a specific context.

For Baringo County, the pathway to achieving a malnutrition-free future is outlined through this Theory of Change. The central hypothesis guiding this change is as follows:

Central Hypothesis Guiding change

1. If the county successfully implements the Strategic Objectives across all key result areas,
2. And if the proposed strategies and interventions are effectively adopted and executed,
3. And if the Common Results and Accountability Framework (CRAF) is applied consistently and subjected to regular monitoring,
4. And if adequate resources are mobilized and sustained to support CNAP implementation,
5. Then significant improvements in the county's nutrition status will be achieved.
6. This Theory of Change forms the foundation for coordinated, results-driven actions aimed at eliminating malnutrition in Baringo County.

KRA 1: Maternal, Infant and Young Child (MIYCN) nutritional well-being enhanced.

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

In Baringo County, optimal maternal and child feeding practices are largely influenced by availability, access, affordability and sustainability of food resulting to poor feeding behavior and practices. Infant and young child feeding practices in Baringo have remained sub-optimal over the past years. This is attributed to the cyclic climate shocks as households adopt stressful coping strategies to perceived or confirmed household food insecurity. Data from recent IPC surveys shows that 34.4% of the children in Tiaty are in severe child poverty score (consuming ≤2 food groups) and 54.9% in the moderate child poverty score (consuming 3-4 food groups). Poor childcare practices including sub-optimal breastfeeding and complementary feeding happen when mothers spend long hours away from their infants due to increased workload as they seek alternative livelihoods to secure food and water. The frequent cross-border insecurity has further worsened the situation due to household displacement and family separation. Caregivers of young children are also exposed to inappropriate Breast Milk Substitutes (BMS) marketing as access to diverse diets is challenged further by bringing changes to child feeding practices at the household level. Minimum Dietary Diversity (MDD- more than 5 food groups consumed) for women was at 10.1% for Baringo. Further, women are faced with countless challenges ranging from high maternal workload to retrogressive cultural practices like polygamy to poor economic position, all increasing their vulnerability.

Strategic Objective 1.1: Improve maternal, infant and young child nutrition practices

Output 1.1: Enhanced knowledge, skills and competence on MIYCN among HCWs, CHPs and management

Strategy: Strengthen the capacity of health managers, health care workers and CHPs to adequately offer quality maternal, infant and young child nutrition services

Proposed interventions

a. Train County ToTs in MIYCN, BFCI, MIYCN-E, PDH, BFHI, BMS Act 2012 and its regulations, breastfeeding workplace support and BFHI.
b. Train/sensitize health workers on MIYCN, BFCI, BFHI, CBFCI, MIYCN-E, breastfeeding workplace support, PDH, BMS Act 2012 and its regulations
c. Train/sensitize CHPs on MIYCN, CBFCI, MIYCN-E, PDH, breastfeeding workplace support, BMS Act 2012 and its regulations
d. Promote OJT/CMEs and Mentorship sessions to health workers on BFCI, MIYCN,PDH, breastfeeding workplace support and BMS Act 2012 and its regulations
e. Sensitize health managers (CHMT, SCHMTs, HMTs) on BFHI, BFCI, MIYCN, BMS Act 2012 and its regulations 2021, Breastfeeding workplace Support and PDH

Output 1.2: Strengthened quality of nutrition services targeting women of reproductive age and children under 5 years

Strategy: Strengthen implementation of BFHI, GMP BFCI and PD Hearth towards improved nutritional status of Women of reproductive age and children under five

Proposed interventions

a. Implement BFHI in health facilities offering maternal and child health services- public, private and FBOs
b. Implement PD Hearth model targeting households with children 6-59 months
c. Implement BFCI model in community units
d. Promote and Implement workplace support for breastfeeding mothers
e. Implement BMS Act 2012 and its regulations
f. Promote GMP among children 0-59 months

Output 1.3: Enhance micronutrient supplementation coverage

Strategy: Strengthen micronutrient supplementation

Proposed interventions

a. Promote routine VAS+D supplementation targeting children for 6-59 months in health facilities, outreach sites, ECDE centers and other hard-to-reach areas
b. Train/sensitize healthcare workers on IFAS and MNPs
c. Provide IFAS/MMS to pregnant women during ANC visits
d. Advocate for purchase and distribution of MNPs, VAS+D and IFAS/MMS in the County

Output 1.4: Improved adoption of MIYCN practices

Strategy: Strengthen MIYCN policy, legal and regulatory environment

Proposed interventions

a. Sensitize the County executive (CECMs, Chief Officers, Directors) and selected committees (health, trade etc) at the county assembly on the MIYCN policy, BMS Act 2012 and its regulations and workplace support for breastfeeding mothers

Output 1.5: Improved nutritional status of children 6-59 months and pregnant and lactating mothers

Strategy: Strengthen Advocacy, communication and social mobilization for MIYCN

Proposed interventions

a. Advocate and conduct awareness on breastfeeding during Global/National events (World Breastfeeding week etc)
b. Adopt, contextualize, disseminate and implement the SBC package for MIYCN and micronutrient supplementation
c. Promote advocacy in both formal (County Departments, banks, NGOs and FBOs) and informal sectors (markets etc) to position breastfeeding agenda

Output 1.6: Improved evidence-based decision making for MIYCN and micronutrient programming

Strategy: Strengthen evidence generation to inform MIYCN and micronutrient supplementation programming

Proposed interventions

a. Conduct MIYCN assessment and surveys for evidence generation to inform programming (MIYCN KABP survey and MIYCN-E Assessments)
b. Generate evidence and participate in Micronutrient and MIYCN learning forums at County, national, regional and international levels to share best practices on MIYCN and micronutrient supplementation
c. Advocate to the county executive on the prioritization of MIYCN assessments and surveys
d. Promote research areas around MIYCN and micronutrient programming

Output 1.7: Performance of MIYCN and micronutrient indicators visualized Strategy: Strengthen monitoring and evaluation of the MIYCN and micronutrient interventions

Proposed interventions

a. Integrate MIYCN and micronutrient supplementation into ongoing RDQAs and data review meetings
b. Conduct monitoring and reporting of the BMS Act violation and enforcement
c. Document and report MIYCN and micronutrient activity indicators in the health information system (KHIS, ECHIS)
d. Promote research areas around MIYCN and micronutrient programming

Output 1.8: MIYCN interventions integrated in key ministries departments

Strategy: Enhance sectoral and Multisectoral collaboration and partnership

Proposed interventions

a. Integrate MIYCN interventions and micronutrient supplementation into annual work plans or strategic documents of key line departments

KRA 2: Improved nutritional well-being of older children, adolescents, adults, and older persons.

This KRA focuses on older children (5-9 years), adolescents (10-19), adults (20-59) and older persons (≥ 60 years). Good nutrition is a lifelong journey that plays a vital role in every stage of life, impacting growth, development, health, and overall well-being.

Older children (5-9 years) have increased nutrient requirements due to higher basal metabolic rates and physical activity, growth, cognitive development, social and emotional growth and well-being. As school-going children, they undergo a steady increase in height and weight, participate actively in sports and become more independent. To support their rapid growth, increased activity levels and prepare for the growth spurt of adolescence, school-aged children require a balanced and nutritious diet rich in energy, proteins, vitamins, and minerals. It is also imperative to avoid suboptimal feeding practices in young children

as these can lead to excessive weight gain and displace nutritious foods that provide essential nutrients for their development. In addition, for young children, the consumption of sweet foods and beverages increases the risk of dental caries and childhood obesity.

Adolescents (10-19 years): Adolescence is characterized by hormonal changes and rapid growth in height, weight, and muscle mass, which increase the body's demand for nutrients. This stage also involves puberty, emotional and social transitions from childhood to adulthood. Adolescent girls are particularly vulnerable to teenage pregnancies and may experience issues related to malnutrition, such as delayed menarche, growth impairment, intergenerational malnutrition, anemia, and preterm births. It is therefore crucial to ensure that adolescents have access to healthy food choices and nutrition education to prevent both under nutrition and non- communicable diseases (NCDs). Addressing micronutrient deficiencies, such as iron, folate and vitamin A, is especially important during this period to support reproductive health, cognitive function, and overall vitality.

Adults 20-50 years: Adults 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 nutrition 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. Poor dietary practices, including low consumption of fruits and vegetables and high intake of processed foods, contribute to the prevalence of NCDs such as diabetes, hypertension, and cardiovascular diseases.

Older Persons ≥ 60: Older persons are particularly vulnerable to malnutrition. Since both lean body mass and basal metabolic rate decline with age, an older person's energy requirement per kilogram of body weight is also reduced. They are at higher risk of developing diet-related degenerative diseases such as cardiovascular and cerebrovascular disease, diabetes, osteoporosis and cancer. Micronutrient deficiencies are common, exacerbated by factors such as reduced food intake, lack of dietary diversity, decreased immune function. Additionally, age-related cognitive decline and deteriorating vision can further impair dietary habits. Food security and good nutrition are prerequisites for healthy ageing and lack thereof is a threat to healthy ageing

Outcome 2: Increased awareness and adoption of healthy dietary practices and uptake of nutrition services by older children, adolescents, adults and older persons

Strategic Objective 2.1: To improve nutritional status of older children (5-9 yrs.) Adolescents (10-19 Yrs.) Adults and older persons

Output 2.1: Increased nutrition awareness and uptake of nutrition services among stakeholders.

Strategy: Enhance the nutritional status of older children (5-9 yrs.) Adolescents (10-19 Yrs) Adults and older persons

Proposed interventions

a. Disseminate nutrition policies, guidelines (food-based dietary guidelines; menu guidelines; sports nutrition guidelines; healthy diet and physical activity to stakeholders (CHMT, SCHMT, and HMT)
b. Sensitize key influencers (Media), policy makers (MCAs, health /education committee) and nutrition champions (county first lady- patron) on nutrition for older children and adolescents

Output 2.2: Increased awareness on healthy diets among stakeholders Strategy: Capacity-build stakeholders on healthy diets and physical activity

Proposed interventions

a. Train/sensitize HCWs and CHPs healthy diets and physical activity.
b. Sensitize older children, adolescents on healthy diets and physical activity using context-specific communication channels such as youth camp/church, sports in both rural and urban setups
c. Create awareness of healthy diets and physical to Parents/guardians using effective communication channels such as local media, churches/Mosque, and public barazas.

Output 2.3: Early detection of NCDs for proper management

Strategy: Strengthen access to preventive and promotive and nutrition services for adults and older persons

Proposed interventions

a. Promote nutrition assessment and screening for NCDs among adults and older persons through integrated medical camps and refer appropriately
b. Promote nutrition assessment and referral for malnutrition among adult and older persons during household visits by CHPs.

KRA 3: Enhanced Industrial Fortification for Prevention and control of micronutrient deficiencies

This KRA elaborate mainly on food fortification. Food fortification is a process of adding select micronutrients to commonly consumed staple foods as an intervention to reduce micronutrient deficiencies by improving the nutritional quality of the food supply with minimal risk to health. This is in line with world health assembly 2025 targets in reducing stunting and wasting. Food fortification is a valuable public health strategy to help fill nutrient gaps. Example of foods fortified include Iodized salt, wheat flour, maize flour, cooking oils ad fats among others.

Outcome 3: Improved compliance of fortified foods to standards and regulations

Strategic Objective 3.1: To Increase access to safe and adequately fortified foods in line with existing standards

Output 3.1: Improved compliance of fortified foods to standards and regulations

Strategy: Implement policies and regulations that mandate fortification of staple foods (e.g., flour, rice, oil)

Proposed interventions

a. Adopt and Disseminate food fortification strategic plan to (CECs, Cos, CDs, CHMTs, HMTs, SCHMTs)

Output 3.2: Increased knowledge on food fortification and iodine testing among HCWs, CHPS, and representatives of KMTCs, TVETs, Agricultural institutions on Food fortification.

Strategy: Capacity building of all relevant stakeholders(HCWs, CHPs, KMTCs, TVETs, Agricultural institutions) on Food fortification.

Proposed interventions

a. Train /sensitize HCWs and CHPs on food fortification
b. Train/sensitize Institution (KMTCs, TVETs, Agricultural institutions) representatives on Food fortification
c. Sensitize Nutritionists/ Dieticians and PHOs on Iodine testing on table salt.

Output 3.3:Increased use of fortified foods

Strategy; Behavior Change and Communication on food fortification

Proposed interventions

a. Develop and distribute nutrition education materials on food fortification that resonate with the cultural values, beliefs, and language of the local population.
b. Promote health and nutrition education through campaigns (banners, road/market show)
c. Create awareness on fortified foods to the public using various channels, including radio, television, and social media.

Output 3.4: Improved Surveillance and Monitoring Systems of food fortification activities in the county

Strategy: Strengthen Surveillance and Monitoring Systems on food fortification in the county

Proposed interventions

a. Integrate food fortification indicators into support supervision tool.
b. Document and report on food fortification activities on monthly basis.
c. Integrate food fortification in data review meetings.
d. Conduct annual salt iodization monitoring in the county

Output 3.5: Strengthened partnerships and coordinated actions for food fortification

Strategy: Partnerships and collaboration on food fortification

Proposed interventions

a. Map micro and small millers for food fortification purposes in the county
b. Sensitize small millers on food fortification
c. Establish comprehensive food fortification committee

KRA 4: Enhanced clinical nutrition and dietetic services across all levels of health care.

Clinical nutrition and dietetics play a crucial role in the overall health and well-being of individuals, especially in the management and prevention of chronic diseases, malnutrition, and various health conditions. KRA 4 (Key Result Area 4) focuses on enhancing clinical nutrition and dietetic services across all levels of health care, recognizing that proper nutrition is essential for optimal health outcomes. This initiative aims to ensure that nutrition services are effectively integrated into health care systems, providing comprehensive, evidence-based dietary advice, management, and interventions for patients.

With the increasing burden of diet-related diseases, including obesity, diabetes, hypertension, and other non-communicable diseases, it is essential that nutrition services be accessible at all levels of health care—from primary health care centers to specialized tertiary hospitals. This enhanced approach seeks to strengthen the capacity of health professionals in nutrition assessment, counseling, and intervention. It also

aims to foster interdisciplinary collaboration within healthcare teams to promote better patient outcomes.

The implementation of this KRA involves improving the availability and accessibility of qualified dietitians, advancing training programs, upgrading nutritional care infrastructure, and ensuring that nutrition services are integrated into routine health care practices. Ultimately, the goal is to empower healthcare providers with the tools and knowledge needed to deliver quality nutrition care to diverse populations, addressing both individual and community health needs effectively.

Outcome 4; Expanded and strengthened clinical nutrition and dietetics services for the prevention, management, and control of diseases and related conditions
Strategic Objective 4.1: To improve and scale up clinical nutrition and dietetics services across all levels of healthcare.

Output 4.1: Enhanced awareness of clinical nutrition guidelines, protocols and SOPs (clinical nutrition, HIV, TB, IMAM) among CHMT, SCHMT, HMT and health care workers.

Strategy: Strengthen policy environment for clinical nutrition and dietetics services

Proposed intervention.

a. Disseminate nutrition and dietetics related guidelines, protocols and SOPs (clinical nutrition, HIV, TB, IMAM) to CHMT, SCHMT and HMT

Output 4.2: Improved knowledge and skills in clinical nutrition services Strategy: Strengthen health workforce capacity on clinical nutrition services **Proposed interventions**

a. Train nutritionists on specialized clinical nutrition related courses (enteral/ parenteral nutrition, critical care, renal, oncology and metabolic disorders)
b. Promote CMEs on clinical nutrition (HIV, TB, DRNCDs, IMAM) in Health facilities
c. Train HCWs on Nutrition in TB/HIV, IMAM, management and control of DRNCD
d. Sensitize CHPS and peer educators on Nutrition in TB/HIV
e. Sensitize CHPs on prevention, management and control of DRNCD

Output 4.3: Improved management of nutrition care for patients

Strategy: Enhance quality clinical nutrition services

Proposed interventions

a. Promote nutrition assessment counselling and support to all individuals seeking health care services in the health facilities (CCC, TB, DRNCDs and Outpatient therapeutic Clinics and in-patient care,)
b. Adopt and disseminate clinical nutrition IEC/BCC materials to HCWs and patients
c. promote the establishment of inpatient feeding committees in healthcare facilities offering inpatient care, including public, private, and faith-based organizations (FBOs)
d. Implement standardized nutrition protocols and Standard Operating Procedures (SOPs) for managing key health conditions (such as diabetes, cardiovascular disease, malnutrition, and renal disease) across all healthcare facilities
e. Integrate nutrition services into all specialized clinics (including Diabetes, CCC, TB,CWC, Hypertension, Renal, and Oncology) across healthcare facilities
f. Scale up IMAM services in 10 new facilities

Output 4.4: Improved supply chain for clinical nutrition and dietetic services

Strategy: strengthen supply chain management for clinical nutrition and dietetic services

Proposed interventions:

a. Advocate for procurement specialized nutrition commodities for nutrition management (IMAM commodities, parenteral and enteral feeds)
b. Advocate for procurement of anthropometric equipment (MUAC tapes, infant scales, height boards, 2 in 1 weighing scales) and pallets

Output 4.5: Enhanced awareness on clinical nutrition and dietetics among the public
Strategy: Advocacy communication and social mobilization communication for clinical nutrition and dietetic services
Proposed interventions:
a. Disseminate nutrition specific messages that promotes positive behaviour for TB/ PLHIV, DRNCDs, through local media to the public
b. Participate in health thematic days (diabetes, hypertensive, cancer and kidney) to create awareness on nutrition in the management of diet related NCDs
c. Advocate for establishment of DRNCD support group for DM and cancer patients in health care facilities
d. Advocate for establishment of nutrition wellness clinics in 7 facilities

Output 4.5: Improved performance of clinical nutrition and dietetic services
Strategy: Strengthen monitoring and evaluation for clinical nutrition and dietetic services
Proposed interventions:
a. Monitor and evaluate the quality of nutrition services using established standards based on guidelines, protocols and SOPs.
b. Documentation and reporting on clinical nutrition
c. Integrate clinical nutrition interventions (HIV, TB, DRNCDs, IMAM) during RDQA
d. Integrate clinical nutrition interventions (HIV, TB, DRNCDs, IMAM) during data review meetings

Output 4.6: Improved patient care, better clinical outcomes, and more efficient use of resources
Strategy: Strengthen partnerships and collaborations for clinical nutrition and dietetic services
Proposed interventions:
a. Link and refer IMAM clients with other programs within the community (WASH, MIYCN support groups, social protection and food security)
b. Advocate for public private partnership in the implementation of clinical nutrition and dietetic services

KRA 5: Sustained nutritional well-being of individuals and communities during emergencies and climate-related shocks.

Emergencies and climate-related shocks continue to threaten the nutritional well-being of vulnerable populations across the country. This KRA seeks to ensure that both individuals and communities maintain adequate nutrition during such periods by enhancing emergency preparedness, response, and recovery mechanisms through coordinated efforts. This key result area aligns with the broader vision of building resilient communities capable of withstanding and recovering from nutrition-related emergencies.

Outcome 5: Sectoral and multisectoral capacities for risk preparedness, emergency response, and the management of wasting enhanced
Strategic Objective 5.1: To strengthen coordination, partnership, advocacy and policy for integrated preparedness, response and recovery initiatives

Output 5.1: Improved coordinated emergency response
Strategy: Strengthen Coordination and partnership for nutrition preparedness, response and recovery
Proposed interventions
a. Participate in the existing emergency forums (CSG, CWTC, WASH)
b. Participate in the participatory scenario planning meetings.
c. Develop Nutrition contingency plan

Output 5.2 Strengthened capacity of systems and individuals to undertaken emergency

preparedness actions.

Strategy: Strengthen preparedness capacity for nutrition sector

Proposed interventions

a. Disseminate Nutrition SOPs for emergency response to emergency response team
b. contract storage hub for nutritional commodities
c. Sensitization of NDMA monitors on nutrition assessment, family MUAC and referrals during emergencies
d. Training/Sensitize of health managers (CHMTs, SCHMTs and HMTs) and HCWs on IMAM surge.
e. Sensitize HCWs, CHPs and community disaster response teams on nutrition emergency policies.

Output 5.3: Save life's without doing no harm and reduction cases of malnutrition.

Strategy: Strengthen Response capacity for nutrition sector

Proposed interventions

a. participate in rapid assessments (KIRA)
b. Conduct in MIYCN-E assessment
c. Scale up of facilities implementing IMAM surge approach.
d. Participate in joint emergency coordination fora
e. Scale up of integrated medical outreaches during emergencies

Output 5.4 Reduced cases of malnutrition spike during emergencies.

Strategy: Strengthen Nutrition recovery and resilience interventions

Proposed interventions

a. Referral linkages to other programs such as livelihood, social protection, education
b. Advocate for key assessments (SMART, KAP, sitreps) during recovery phases

KRA 6: Enhanced integration of nutrition into agriculture, livestock, and fisheries sectors.

The agriculture, livestock, and fisheries sectors play a pivotal role not only in food production but also in shaping the nutritional status and livelihoods of communities. This KRA seeks to deepen the integration of nutrition into these sectors, recognizing that sustainable improvements in food and nutrition security require coordinated, cross-sectoral strategies. This approach aims to ensure that agricultural and food systems contribute directly to improved nutritional outcomes at household and community levels.

Outcome 6: Household Food and Nutrition security enhanced

Strategic Objective 6.1: Enhance food & Nutrition security and improve livelihood

Output 6.1: Improve household dietary diversification at community level.

Strategy: Diversification of farm production

Proposed interventions

a. Promote production of safe, diverse and nutritious food such as traditional high value crops (THVCs) Ie..Cowpeas, beans, sweet potatoes, Cassava, Millet and sorghum.
b. Excavate farm ponds to enhance fish production and vegetable production.
c. Restocking of community water pans and dams with fingerlings in collaboration with Fisheries & Water departments towards increased food production
d. Support affruitation; mangoes, pawpaw's for sale in collaboration with department of agriculture
e. Promote small stock; shoats, poultry and rabbits.
f. Advocate for nutrition sensitive agricultural production to key decision makers (CECM, CO, CDA)

Output 6.2: Enhanced knowledge and skills on Nutrition Sensitive Agriculture (NSA) and food systems among different stakeholders.

Strategy: Enhance capacity of different stakeholders on nutrition sensitive agriculture (NSA) and food systems (FS)

Proposed interventions

a. Sensitize extension staff (men and women), lead farmers, on Nutrition Sensitive Agriculture (NSA) and food systems in collaboration with nutrition
b. Train/sensitize Health care workers (HCWs) and Community Health Promoters (CHPs) on Agri nutrition.
c. Train farmers on good agricultural practices (GAP) to improve productivity.
d. Train community groups, caregivers on Food system approach and integration to Positive Deviance Hearth (Rehabilitation of Malnutrition through local solution).
e. Organize farmer demonstrations on NSA and FS in forums like ASK, Trade Fairs etc.
f. Train decision makers (CECM, Cos and Directors) in the agriculture department and stakeholders on nutrition-sensitive agriculture and food systems

Output 6.3: Improved access to safe nutritious food.

Strategy: Promote increased access to nutritious and safe food along the food value chain pathways.

Proposed interventions

a. Promote Biofortified food processing, preservation, and storage technologies Food safety & Quality (FSQ) at community level.

Output 6.4: Improved Uptake of various technologies in agricultural production.

Strategy: Promote agricultural technologies towards enhanced food security

Proposed interventions

a. Promote use of certified seeds, energy saving, small scale irrigation, integrated pest management (IPM) hermetic bags/metal silos.
b. Promote the establishment of kitchen gardens in schools, homes, and institutions… i.e, water bottles, containers, tyres, and bags for growing vegetables.
c. Promote nutrition-sensitive extension methodologies like Pastoral/Farmer field schools

Output 6.5: Improved coordination and collaboration on agriculture and nutrition

Strategy: strengthen Linkages between nutrition, agriculture and food security

Proposed interventions

a. Advocate for the formation of an Agri nutrition Technical Working Group (TWG) at county level.
b. Hold joint planning meetings in collaboration with the nutrition department with relevant departments.
c. Participate in Multi Stakeholder platforms (MSP).

Output 6.6: Enhanced joint integration of nutrition activities

Strategy: Strengthen M&E mechanism for scaling up nutrition in agriculture

Proposed interventions

a. Conduct joint support supervision and follow-up of integrated activities at the community level in collaboration with the nutrition department

KRA 7: Nutrition integrated and strengthened across all levels of the health sector.

Strategic Objective 7.1: To mainstream nutrition interventions across all levels of the health sector in Baringo County

Output 7.1: Nutrition services integration enhanced in all levels of the health sector Strategy: Enhance Nutrition integration enabling environment across different levels of the health sector in the county.

Proposed interventions

a. Integration of nutrition county planning, review of county policies, guidelines and documents (Community Health strategy Bill, AWP, CIDP, CHSP, ADP and FIF bill
b. Review the nutrition component within the school health program

Output 7.2: Improved participation, planning and financing of nutrition services Strategy: Sstrengthen the capacity of County leadership (CHMT, SCHMT and HMT on nutrition inclusion in all county documents

Proposed interventions

a. Sensitize CHMT, SCHMT on the Integration of nutrition in County planning documents in all levels of the health sector

Output 7.3: Improve Nutrition services integration and adherence at all levels

Strategy: Strengthen adherence on Nutrition integration across all levels of the health sector

Proposed interventions

a. Advocate for restructuring of client flow in facilities, triage stations to redirect eligible clients to the nutrition clinic in all levels of the health sector
b. Monitor adherence on nutrition integration in public hospitals and health centres

Output 7.4: Improved participation, coordination and collaboration within the health system
Strategy: Strengthen coordination and collaboration on nutrition in other units in the health sector

Proposed interventions

a. Involve the Nutrition section in the health stakeholder's forum and other Health units Technical working group (TB, Community Health TWG, RNMCH, HIV TWG, Sector working groups and Health stakeholder's forum)
b. Engage other units in County Nutrition Technical Forum (CNTF)

Output 7.5: Improve nutrition integration of nutrition activities in PCN

Strategy: Strengthen integration of nutrition services in Primary Care Networks (PCNs)

Proposed intervention

a. IncludeNutritionists into all Primary Care Health Networks (PCNs)activities, MDT and support supervision

Output 7:6: Improve capacity of the health workforce to deliver integrated services that include nutrition

Strategy: Strengthened capacity of the health workforce to deliver integrated services that include nutrition

Proposed interventions

a. Train community health promoters on nutrition technical modules to provide nutrition
services at community level during dialogue days, baraza's and home visits
b. Train health workers in Integrated Management of newborn and Childhood Illnesses (IMNCI), KMC that involve the nutritionist

KRA 8: Enhanced integration of nutrition in the education sector.

Nutrition plays a critical role in the cognitive development, learning outcomes, and overall well-being of children. Schools and early childhood development centers offer a strategic platform to reach children with essential nutrition services and education, making the education sector a vital entry point for long-term nutritional improvements. This KRA focuses on the integration of nutrition into the education system, aiming to build healthier school environments and promote lifelong healthy habits among learners.

Outcome 8: Enhanced nutrition interventions within the education sector
Strategic Objective 8.1: Nutrition mainstreamed in education sector

Output 8.1: Improved knowledge among ECDE teachers on healthy diets and physical activity, nutrition assessment and VAS+D

Strategy: Capacity Building of ECDE teachers on healthy diets and physical activity, nutrition assessment, VAS+D

Proposed interventions

a. Train ECDE teachers on healthy diets and physical activity
b. Sensitize ECDE teachers on nutrition assessments, VAS+D in schools

Output 8.2: Improved integration of nutrition interventions in schools

Strategy: Strengthen nutrition interventions in schools

Proposed interventions

a. Provide VAS+D in ECDE/ primary school
b. Conduct periodic nutritional status assessments in schools and other learning institutions
c. Refer children with nutritional cases in schools to link health facilities.
d. Implement ECDE meals and nutrition and school meals guidelines.
e. Promote establishment and improvement of existing school demonstration gardens, small animals and revive 4Kclubs, school health clubs in collaboration with department of Agriculture, livestock and fisheries
f. Inclusion of nutrition and physical activity themes in co-curricular school activities (drama, music, talent shows, contests, symposia)
g. Promote health and nutrition programs in schools

Output 8.3: Improved stakeholders' awareness on healthy diets, safe food environment and WASH in schools

Strategy: Partnership and collaboration in schools

Proposed interventions

a. Sensitize stakeholders including, curriculum support officers, Principal Education Officers, food service providers and handlers, Parent–Teacher Associations (PTA) on healthy diets and safe food environment in schools
b. Advocate for improved WASH services in schools in collaboration with department of water and Health
c. Include ECDE stakeholder's in multisectoral nutrition coordination forum.

Output 8.4: Improved collaboration and partnership

Strategy: Strengthen monitoring, evaluation and learning of nutrition interventions in schools

Proposed interventions

a. Document and report on nutrition activities conducted in schools.
b. Joint Support supervision on the implementation of nutrition interventions in schools
c. Share best practices with CHMT/SCHMT on the implementation of nutrition interventions in schools

KRA 9: Enhanced integration of nutrition within the Water, Sanitation, and Hygiene (WASH) sector.

Improving health outcomes in communities requires an integrated approach that addresses the root causes of malnutrition, poor sanitation, and limited access to clean water. Recognizing the strong interconnection between nutrition and Water, Sanitation, and Hygiene (WASH), is important in developing interventions to enhance the synergy between these sectors. Arid and semi-arid parts of Baringo which is 75% of the land mass faces serious water challenges in terms of access, safety and utilization. According to SMART survey conducted in 2024, 22.1% of households in Tiaty access water from safe/improved sources. Additionally, 65% of households in Tiaty trek for between 30-60 mins to the main source of water, in contrast to Baringo north where 60% of households trek for less than 500m to the water sources.

Although 92.3% of the households are aware of hand washing practices, in Baringo North and Baringo South, only 36.8% practice hand washing in 4 critical times (SMART survey 2024). Sanitation remains a challenge in Baringo with 3 in10 households practicing open defecation. 88.2% and 86% of households in Tiaty East and Tiaty West practice open defecation respectively while 22.4% of HH in Baringo North practice open defecation. To reduce cases of diarrheal diseases, helminths and achieve environmental sanitation, concerted efforts bringing together other sectors to reduce prevalence of open defecation through community led total sanitation is required.

Outcome 9: Increased access to improved nutrition sensitive WASH services
Strategic Objective 9.1: Provision of adequate safe water, sanitation and hygiene for communities

Output 9.1: Improved water access among the community members
Strategy: Promote Water production and harvesting in the communities
Proposed interventions

a. Promote Water production and harvesting in communities
b. Promote hygiene practices in the communities
c. Promote sanitation practices in the communities
d. Promote WASH and nutrition linkages
e. Undertake Protection of water catchment areas within the county
f. Train community members on water protection in the catchment areas.

Output 9.2: Behavior change leading to reduction of hygiene related infections
Strategy: Promotion of hygiene practices
Proposed interventions

a. Sensitize the community on handwashing in critical times using existing channels using dialogue days
b. Sensitize community on water treatment and storage
c. Sensitize the community on environmental sanitation using local radio stations

Output 9.3: Proper waste management Strategy: Promotion of sanitation practices **Proposed interventions**

a. Promote Construction and use of Latrines using locally available materials using community barazas
b. Advocate for expansion of Sewer system coverage in the county
c. Sensitize the community on proper handling and disposal of wastes

Strategic Objective 9.4: Promotion of hygiene practices

Output 9.4: Integrated programming on WASH/Nutrition

Strategy: Strengthen WASH and nutrition linkages

Proposed interventions

a. Participate in WASH forums
b. Carry out joint planning and review meetings with the WASH team with presence of Nutrition Reps
c. Conduct joint support supervision on integrated WASH/Nutrition intervention

Output 9.5: Water catchment conserved

Strategy: Strengthen WASH and nutrition linkages

Proposed interventions

a. Promote and advocate for fruit tree planting in water catchment areas
b. Promote and advocate demarcation and fencing of gazette water catchments

Output 9.6: Improved techniques on water harvesting, treatment and integration of nutrition initiative

Strategy: Capacity building on water access

Proposed interventions

a. Sensitize community members and Train water management committees on techniques for water harvesting, treatment, & nutrition initiatives at household level
b. Integrated kitchen garden, demo farms at water points
c. Integrated kitchen garden, demo farms at water points

KRA 10: Nutrition integrated across Social Protection programmes.

Social protection is a key result area in Baringo County's development agenda and plays a critical role in improving nutrition outcomes among vulnerable populations. Through interventions such as income support, social health protection, and shock-responsive mechanisms, social protection enables households to better withstand economic pressures that often lead to food insecurity and poor nutritional choices. By reducing poverty and enhancing access to essential services, these interventions empower individuals and families—especially children, pregnant and lactating women, and persons with disabilities—to access adequate and nutritious food, essential health care, and other basic needs. Baringo County's Social Protection Policy, with its cross-cutting focus on human rights, gender, and disability mainstreaming, ensures that nutrition-sensitive social protection measures are inclusive and equitable. This makes social protection a strategic pillar in the formulation and implementation of the County Nutrition Action Plan, providing the foundation for integrated, sustainable, and resilient nutrition programming across the county.

Outcome 10: Nutrition mainstreamed within social protection policies, strategies and interventions.

Strategic Objective 10.1: To strengthen Nutrition integration in social protection

Output 10.1: Enhanced nutrition awareness and practices among vulnerable populations in social protection programmes

Strategy: Increased awareness on safe and nutritious foods as a component of social protection.

Proposed interventions

a. Conduct Sensitization for the caregivers on Cash transfer programmes on nutrition
b. Develop and integrate nutrition key messages with Social protection programmes

Output 10.2: Strengthened integration of nutrition into social protection programme.
Strategy: Promote and enhance Nutrition linkages in social protection programs including in crisis
Proposed interventions

a. Sensitize HCWs on the existing social protection programmes (cash transfers, hunger safety nets, and others).
b. Sensitize CHPs on the existing social protection programmes (cash transfers, hunger safety nets, and others).
c. Integrate nutrition interventions in social protection programmes
d. Conduct a gender integrated baseline survey/situation analysis on status of nutrition and health for the vulnerable groups in social protection programs
e. Advocate for scale up social safety nets on nutrition in times of crises /emergencies targeting the vulnerable groups
f. Map and assess nutritional and health needs for adults, and older persons to inform policy and programming

Out Put 10.3: Enhanced Awareness and understanding of the connection between social protection (e.g., cash transfers, food assistance) and nutrition outcomes for vulnerable populations
Strategy: Capacity building on the importance of integrating nutrition in social protection
Proposed interventions

a. Sensitize county leadership (Executive &Legislature) on importance of social protection programme on linkages between social protection and nutrition.
b. Sensitize stakeholders in social protection programme on linkage between social protection and nutrition
c. Sensitize institutional correctional facilities on optimal nutrition

KRA 11: Enhanced multisectoral nutrition governance, coordination, partnerships, advocacy, and community engagement

Effective coordination and leadership are essential to the success of this Nutrition Action Plan, particularly as multisectoral collaboration expands. With an increasing number of stakeholders and platforms, the ability to monitor coordination efforts becomes equally critical. Achieving meaningful nutrition outcomes requires a whole-system approach where sectors align their actions through shared accountability and joint ownership of results. Currently, coordination is supported by structures such as the County Steering Group (CSG), County/Sub-County Nutrition Technical Forum (S/CNTF), and sector-specific working groups. CNAP seeks to enhance these mechanisms through stronger, cross-sector collaboration and sustained commitment.

Advocacy and resource mobilization efforts at the County are mainly supported by civil society, UN agencies, and other stakeholders with efforts dedicated towards increased budgetary allocation for nutrition programs. However, there are challenges in disseminating advocacy materials and skills in the County and tracking and mobilizing resources effectively.

To strengthen advocacy, planning, and resource mobilization, several strategies are recommended. These include investing in capacity building for advocacy, planning, and financial tracking, developing evidence to support these efforts, and sustaining the gains made in nutrition through ongoing advocacy. Additionally, anchoring nutrition in various laws, strategies, and policies across sectors and developing guidelines and strategies for effective implementation and financial tracking will be crucial.

Outcome 11: Strengthened multisectoral governance, planning, financing, and partnerships for improved coordination, resource mobilization, and effective implementation of nutrition interventions

Strategic Objective 11.1 To strengthen multisectoral governance, planning, financing and partnerships for nutrition.

Output 11.1 County nutrition documents (AWP, CNAP, Nutrition Policy) disseminated and stakeholders sensitized.

Strategy: Awareness creation and budget/policy formulation

Proposed interventions

a. Disseminate the county nutrition related documents (AWP, CNAP and Nutrition Policy etc) to CHMT, SCHMT and other stakeholders.
b. Sensitize Health care workers on nutrition related documents (CNAP and Nutrition policy)
c. Participate in the departmental and county budget formulation sessions (Annual Development Plans, County Fiscal Strategy Papers, Budget Estimates etc)
d. Participate in the County budget related public participation processes

Output 11.2 Robust coordination and planning mechanisms

Strategy: Coordination and collaboration

Proposed interventions

a. Establish and Operationalize Multistakeholders Nutrition Platform (develop TORs,)
b. Revitalize Nutrition allied coordination forums (CNTF and SCNTF)

Output 11.3 Strengthened advocacy for capacity development and increased budgetary allocation towards human and financial resources in nutrition

Strategy: Capacity building and advocacy

Proposed interventions

a. Conduct leadership training programs for nutritionists (Supervisory course, Senior management course, Strategic leadership development program)
b. Advocate for effective implementation of the (CNAP) through increased allocation of financial and human resources, and the clear itemization of nutrition-related activities within county budgets
c. Advocate for the creation of directorate of nutrition and dietetics services
d. Conduct advocacy meetings with the County Assembly and executives for increased human and financial allocation for nutrition

Output 11.4 Enhanced integration of nutrition in community forums

Strategy: Awareness creation

Proposed interventions

a. Include nutrition in the community forums (Dialogues, action days, chief's barazas etc.)
b. Engage community leadership in the planning and coordination of nutrition activities in the community

KRA 12: Strengthened sectoral and multisectoral Nutrition Information, M&E systems, research, and Knowledge management.

This Key Result Area aims to bolster sectoral and multisectoral nutrition information systems, along with monitoring and evaluation (M&E), research, and knowledge management, to enhance evidence-based decision-making in Baringo County. It strives to improve the generation, analysis, and use of high-quality nutrition data across health and connected sectors like agriculture, WASH, education, and social protection. This KRA also encourages better integration of data systems (for example, KHIS), promotes accountability through routine reviews and learning forums, and backs operational research and the documentation of best practices. Fortifying these elements is crucial for informing policy, enhancing implementation, and achieving sustainable nutrition results.

Outcome 12: Enhanced Sectoral and multi-sectoral nutrition information systems, robust monitoring and evaluation frameworks, increased research uptake, and effective knowledge management.

Strategic Objective 12.1: To Strengthen sectoral and multisectoral nutrition information for evidence-based programming

Output 12.1: Availability of quality nutrition data

Strategy: Strengthen Nutrition data quality

Proposed interventions

a) Adopt/procure standardized Nutrition tools
b) Conduct DQAs for nutrition data
c) Integrate nutrition indicators into the existing joint Support supervision tool
d) integrate nutrition into the existing data review meeting

Output 12.2: Nutrition data monitoring and evaluation mechanisms strengthened

Strategy: Monitoring and evaluation of nutrition data

Proposed interventions Proposed interventions

a) Evaluate the implementation of AWP, CNAP and M&E framework for nutrition
b) conduct MIYCN KAP Survey, SMART survey, nutrition capacity assessment, LRA and SRA and Coverage surveys (SQUEAC, PECs etc)
c) Roll out and utilize the Kenya Nutrition Scorecard to monitor key indicators

Output 12.3: Improved knowledge and skills on data management processes

Strategy: Capacity building on data management

Proposed interventions

a) Train health care workers on KHIS, and ECHIS
b) Train health care workers on nutrition data collection and reporting tools
c) Train healthcare workers on basic data analysis and report writing
d) Sensitize/OJT health care workers on nutrition data collection and reporting tools
e) Train healthcare workers on Long Rain and Short Rain Assessments, research methodologies, and scientific writing

Output 12.4: Availability of nutrition evidence to inform program decisions

Strategy: Strengthen research in nutrition and Knowledge management

Proposed interventions

a) Map nutrition research priority areas

b) Collaborate with academia/stakeholders to conduct nutrition research
c) Promote knowledge sharing and learning by holding key learning events (research conferences, webinars to disseminate research findings, generation of policy briefs, and documentation of best practices

KRA 13: Strengthened Supply chain management for nutrition commodities and equipment

An effective and efficient supply chain is essential to the successful delivery of nutrition services. This KRA aims to strengthen the management of nutrition commodities, equipment, and tools to ensure consistent availability, optimal stock levels, functionality of equipment, and high-quality data to inform decision-making. It recognizes that without a reliable supply chain, even the best-designed nutrition interventions risk failure due to stock-outs, poor maintenance of equipment, and weak data systems.

Outcome 13: Improved supply chain management system for nutrition

Strategic Objective 13.1 To strengthen supply Chain management of Nutrition Commodities, Equipment and tools

Output 13.1 Increased knowledge skills and Management of Nutrition Commodities, equipment and tools

Strategy Strengthen the capacity of HCWs on Commodity Management

Proposed interventions

a. Promote trainings on commodity management training - including Commodity management and warehousing practices and LMIS for CHMT, SCHMT and HCWs and CHP's.
b. Promote CMEs/OJTS and mentorship sessions on commodity management in health facilities
c. Sensitize HCWs on correct use and maintenance of nutrition equipment in all health facilities
d. Train biomedical engineers on operation, maintenance and repair of nutrition equipment.
e. Facilitate biomedical engineers to repair and maintain nutrition equipment

Output 13.2 Improved nutrition commodity management practices

Strategy: Strengthen Nutrition commodity management practices

Proposed interventions

a. Develop Standard operating procedures (SOPs) on receipt, storage, requisition and reporting of nutrition commodities (IFAS, RUTF, RUSF, CSB, MNP's FBF, Vitamin A, TPN, dewormers)

Output 13.3 Improved nutrition commodities, equipment and tools budgetary allocation in the county.

Strategy: Enhance advocacy and resource mobilization for Nutrition supply chain.

Proposed interventions

a. Advocate for adequate funding for nutrition commodities (RUSF, CSB, RUTF, Resomal IFAS, Vitamin A +D, TPN, MNPs F100, F75, PRE-NAN), equipment and tools at the county treasury and County Assembly (County annual development plan- CADP, Sector Engagements, County fiscal Strategy Paper-CFSP, Budget Estimates)
b. Integrate nutrition commodities and equipment budget into the Medium-Term Review (MTR) secretariat for timely and adequate Budgetary allocation.

Output 13.4 Improved optimal stock levels and reduced nutrition commodities expiry.

Strategy: Promote proper forecasting and quantification of nutrition commodities and equipment.

Proposed interventions:

a. Sensitize HCW's on Accurate Forecasting and Quantification.

b. Conduct routine Data Quality Audit to Enforce proper documentation of all commodity data in the registers and summary tools
c. Integrate nutrition in the annual commodity forecasting and quantification workshop
d. Empower and train County Nutrition Coordinator in the Health Products and Technologies Unit (HPTU) to oversee the Supply Chain Management system in Nutrition Department.

Output 13.5 Improved availability of nutrition commodities and assessment tools

Strategy: Enhance Availability of Nutrition equipment, commodities and reporting tools

Proposed interventions:

a. Incorporate Nutritionists into the County and hospital medicines and therapeutic committees (MTCs) to spearhead the inclusion of Nutrition commodities in all county formularies
b. Procure and distribute nutrition commodities (RUTF, RUSF, FBF, CSB, IFAS,
Vitamin A +D, TPN, F100, F75, RESOMAL) and assessment tools
c. Promote needs assessment mapping of nutrition equipment's and reporting tools for
respective health facilities
d. Procure and distribute nutrition equipment (bedside weighing machine, Body composition analyzer, pediatric weighing scale, length board, 2 in 1 weighing scale- height meters, Breast models, baby dolls, cleft palate shield
e. Promote the use of HMIS/LMIS to guide on stock status and (re)distribution
f. Promote preparation of a budget for the purchase of Anthropometric equipment and tools based on need, utility and level of use by all Nutrition SDPs at all healthcare levels.

Output 13.6 Functional nutrition equipment in use.

Strategy: Maintain functionality and accuracy of nutrition equipment.

Proposed interventions:

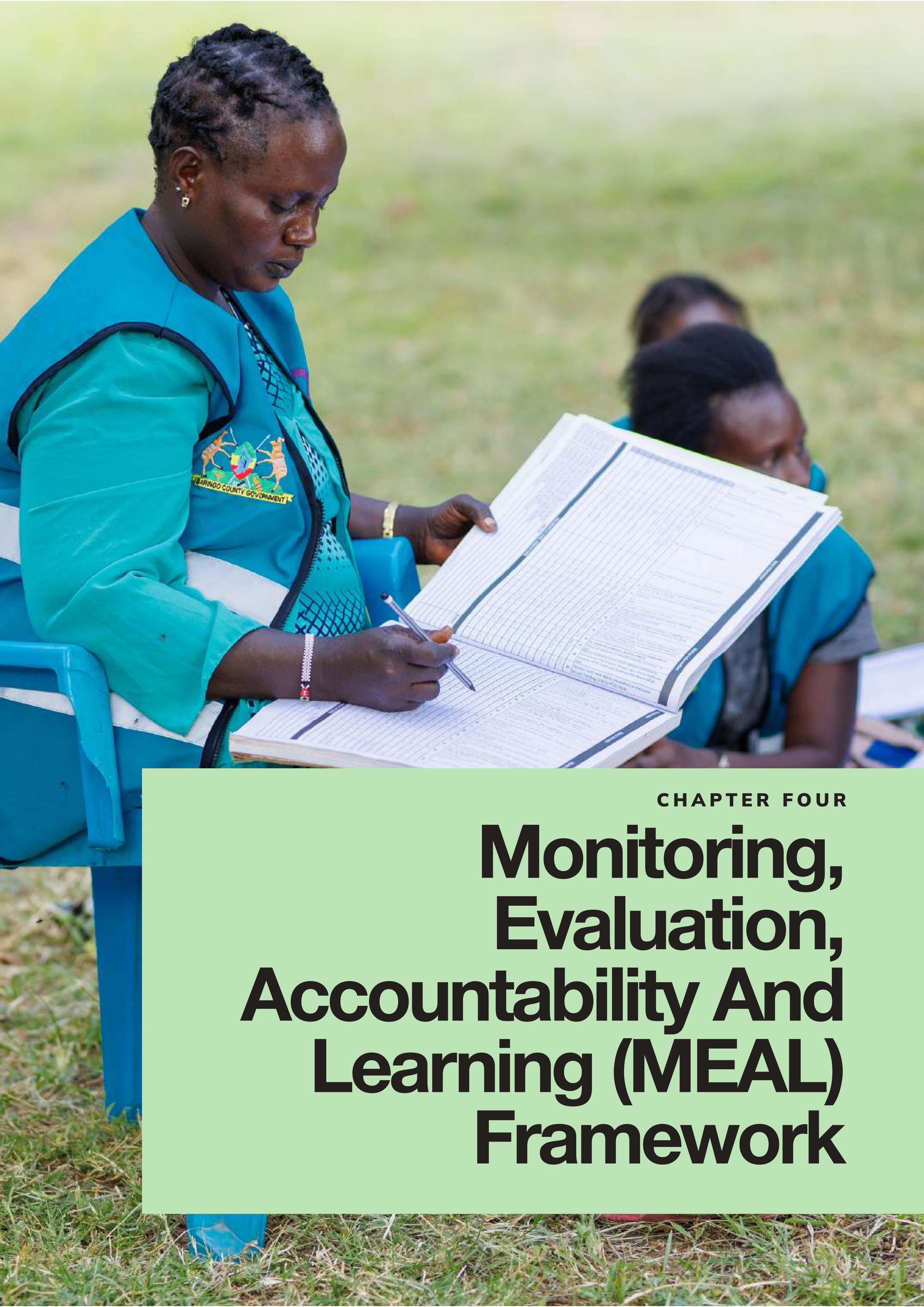
a. Develop and effect an equipment maintenance plan for nutrition equipment
b. Develop and effect an equipment calibration plan for nutrition equipment

Output 13.7 Enhanced quality of nutrition data for decision making.

Strategy: Strengthen monitoring and evaluation of nutrition commodities, equipment and reporting tools

Proposed interventions:

a. Participate in support supervision and OJT to all health facilities on documentation, commodity management and reporting
b. Procure and distribute Laptops, printers and projectors for data capture, processing and reporting
c. Integrate nutrition data in quarterly commodity TWG review meetings



CHAPTER FOUR

Monitoring, Evaluation, Accountability And Learning (MEAL) Framework

4.1 Introduction

Monitoring, Evaluation, Accountability, and Learning (MEAL) serve as fundamental components for the successful execution of nutrition programs. They provide a systematic approach to track advancements, guarantee transparency, foster adaptive learning, and improve overall impact. This framework aims to establish strong, sector-integrated systems for data collection, performance assessment, and evidence-based decision-making. The End-Term Review of Baringo CNAP identified significant deficiencies in the integration of M&E, data standardization across sectors, and feedback mechanisms for learning, underscoring the necessity for a cohesive MEAL system that encompasses not only health but also agriculture, WASH, education, and social protection.

On a global scale, effective MEAL systems are acknowledged as vital for promoting accountability and equity in nutrition initiatives, especially within decentralized governance frameworks. Reports from UNICEF (2019) and the Global Nutrition Report (2020) emphasize that multisectoral information systems are essential for tackling the intricate, interconnected causes of malnutrition. Nevertheless, numerous subnational areas, including Baringo, encounter challenges such as disjointed data systems, inadequately funded M&E units, limited research application, and insufficient collaboration across sectors.

This chapter presents a MEAL framework specifically designed for Baringo County, focusing on synchronized data collection and analysis, consistent performance evaluations, participatory accountability processes, and a learning agenda that informs planning and execution. The framework draws on insights from previous CNAP implementations in Baringo, aligns with national initiatives like the Kenya Nutrition Action Plan (KNAP 2018–2022), and integrates successful strategies from other counties facing similar challenges. Ultimately, enhancing MEAL is crucial for developing responsive, resilient, and outcome-oriented nutrition systems in Baringo County.

4.2 Purpose of MEAL

The Monitoring, Evaluation, Accountability, and Learning (MEAL) plan provides strategic information to support evidence-based decision-making at the county level. It outlines the key results and indicators that all sectors involved in implementing CNAP will track and report on. By using a Common Results and Accountability Framework (CRAF), the MEAL system ensures the integration of nutrition-related data across sectors enhancing coordination, transparency, and accountability.

MEAL serves as a comprehensive mechanism to monitor implementation, evaluate outcomes, and ensure that CNAP achieves its intended goals. It helps identify areas of success, highlight challenges, and supports the effective use of resources to improve nutrition outcomes county- wide.

The integration of MEAL into Baringo CNAP aims to:

1. Monitor Progress:
Continuously track activities, outputs, and outcomes to ensure alignment with program objectives and timelines.

2. Evaluate Impact:
Assess the effectiveness of interventions in improving nutritional status, and identify factors that support or hinder success.

3. Ensure Accountability:
Provide transparent and verifiable evidence to stakeholders— including donors, partners, and beneficiaries—on resource use and results achieved.

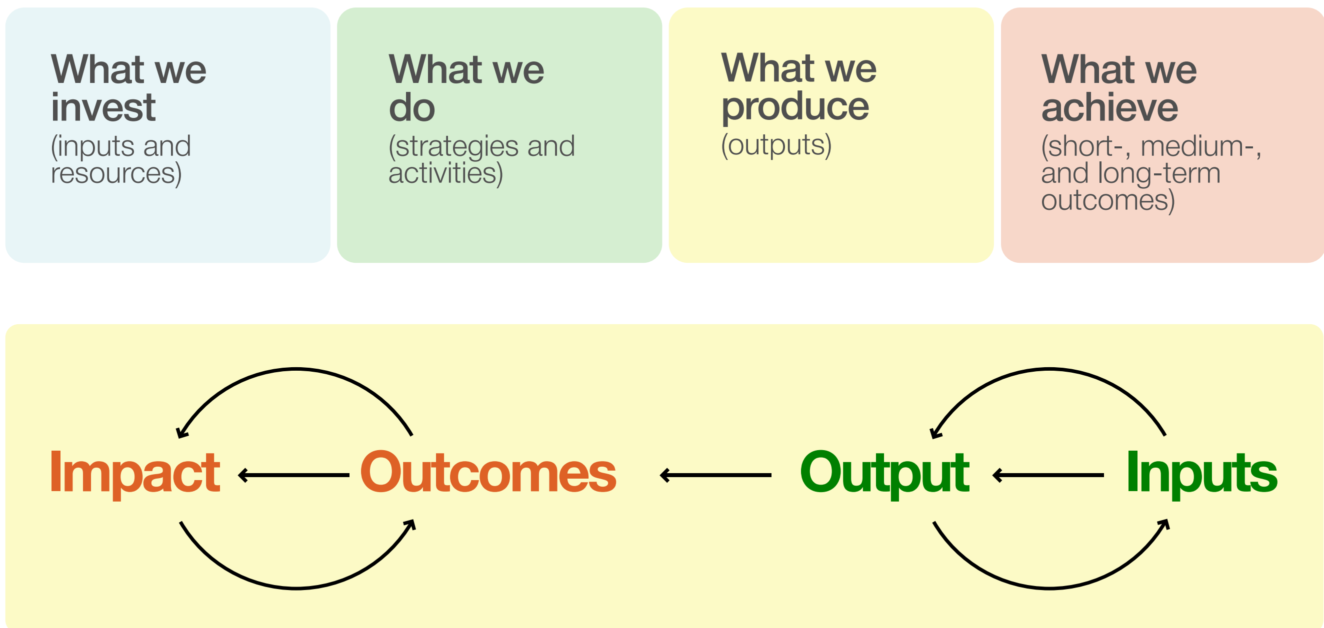
4. Facilitate Learning:
Capture lessons learned and best practices to improve current implementation, inform future planning, and adapt to changing needs and contexts.

Gender Integration

To promote gender equity within Baringo CNAP, all data collected, analyzed, and reported will be disaggregated by sex and age. This will illuminate the distinct experiences and outcomes for men and women, enabling the identification of any gender-specific disparities or unintended negative impacts. It also ensures that nutrition programs are equitably targeted and responsive to all populations. Positive impacts of gender-sensitive interventions will be documented to inform and strengthen future programming.

4.3 Logic Model

The logic model outlines what is required to achieve the intended results by clearly linking expected outcomes with the necessary inputs, activities, and outputs. It fosters a shared understanding of how resources and actions are strategically aligned to produce the desired impact. It serves as a valuable tool for planning, implementation, monitoring, and evaluation by showing:



4.4 CNAP Monitoring process

A strong and effective monitoring system is essential for the successful implementation of BCNAP. This requires well-defined policies, standardized tools, clear processes, and functional systems, along with effective dissemination mechanisms to ensure stakeholders are well-informed. Crucially, the collection, tracking, and analysis of data disaggregated by sex, age, and other relevant diversity factors are vital for informed decision-making and equitable service delivery. Comprehensive monitoring depends on the collaboration of all stakeholders and focuses on capturing key program elements.

Key Monitoring Elements

The monitoring framework will focus on the following components:

- **Inputs (Resources):** Financial, human, and material resources invested in the program.
- **Service Delivery Statistics:** Data on the provision and uptake of services.
- **Service Coverage and Outcomes:** Reach and effectiveness of services delivered.
- **Client/Patient Outcomes:** Behavioral changes, health improvements, and reduction in morbidity.
- **Investment Outputs:** Tangible results from investments made.

- **Access and Equity:** Client access to services, including by gender, age, and other variables.
- **Quality of Service Provision:** Adherence to standards and user satisfaction.
- **Impact Assessment:** Long-term changes in nutritional status and well-being.

Monitoring Process

1. **Data Collection**
   Data will be gathered from multiple sources, including routine service records, surveys, and periodic assessments. This information will be compiled and summarized from primary sources, then aggregated at national or county levels following established Standard Operating Procedures (SOPs).

2. **Data Validation**
   Once collected, data will be validated to ensure accuracy, consistency, and reliability. This involves cross-referencing sources, verifying records, and correcting discrepancies to maintain the integrity of the data used for decision-making.

3. **Data Analysis**
   Validated data will be analyzed to identify trends, measure performance against key indicators, and assess the effectiveness of interventions. This step supports the evaluation of whether program objectives are being achieved.

4. **Information Dissemination**
   Analysis results will be shared with relevant stakeholders through clear, accessible formats such as reports, dashboards, presentations, and policy briefs. Timely dissemination ensures stakeholders are informed and can act accordingly.

5. **Stakeholder Engagement**
   Active engagement of stakeholders from relevant sectors and agencies will be maintained throughout the monitoring cycle. This promotes transparency, encourages joint accountability, and ensures that insights from monitoring are used to adapt and improve program implementation.

4.5 Monitoring Reports

The County will implement a structured reporting mechanism to track health and nutrition indicators. Data will be collected and submitted using standardized Ministry of Health (MOH) reporting tools across health facilities and programs. These reports will serve as a critical resource for monitoring progress, guiding policy, and informing decision-making. To address data quality challenges such as inaccuracies, incomplete entries, and inconsistencies in reporting quarterly data quality audits will be carried out. These audits will help ensure that the information used is reliable and actionable. In addition to routine reporting, the County will undertake regular research studies and comprehensive surveys to gain deeper insights into emerging health and nutrition issues and to support evidence-based planning and intervention.

The key monitoring reports and their reporting frequency are outlined below:

Table 7: key monitoring reports and their reporting frequency

Process/ Report	Frequency	Responsible	Timeline
Annual work plans	Yearly	All Departments	End of June
MOH Standardized Monthly Reports submissions	Monthly	Facility Incharges, CUs	5th of every Month
Health Data Reviews	Quaterly	All Departments	End of each quarter
Quaterly Reports	Quaterly	All Departments	After 21st of the preceding month after end of quater
Bi-annual Performance Reviews	Every Six months	All Departments	End of January and end of July
Annual Performance Reports and reviews	Yearly	All Departments	Begins July and ends November
Expenditure Returns	Monthly	All Levels	5th of every month
Surveys and assessments	As per need	Nutrition	Periodic surveys

4.6 Evaluation of the Baringo CNAP

Evaluation is a critical component of the Baringo CNAP, aimed at measuring progress toward achieving its objectives and assessing the collective efforts of all stakeholders throughout the implementation period. This process not only reinforces accountability but also promotes continuous learning, helping to refine strategies and enhance the overall performance and relevance of nutrition and health interventions in the county. To ensure a comprehensive and evidence-based evaluation, both a Midterm Review (MTR) and an End-Term Review (ETR) will be conducted. These evaluations will examine the extent to which the CNAP's objectives have been achieved, the effectiveness of implementation strategies, and the long-term viability of results. The evaluation process will be guided by clear, focused questions and structured around five key criteria:

Evaluation Criteria

1. **Relevance**
   Assesses the degree to which CNAP's objectives address the nutritional needs of the Machakos population, particularly vulnerable groups such as women, children, and marginalized communities. This criterion also examines the plan's adaptability and responsiveness to emerging challenges and contextual changes.

2. **Efficiency**
   Evaluates how well resources—financial, human, and logistical—have been used to achieve CNAP goals. It considers whether the interventions were implemented in a cost-effective and timely manner, and whether resource allocation was appropriate and optimized.

3. **Effectiveness**
   Measures the extent to which CNAP interventions have achieved their intended outputs and outcomes. This includes assessing improvements in nutrition and health indicators and determining whether interventions have led to meaningful and measurable change.

4. **Sustainability**
   Examines the likelihood that the benefits of the CNAP will endure beyond the implementation period. This includes evaluating the strength of institutional systems, community ownership, capacity building, policy support, and funding mechanisms that contribute to the long-term continuation of successful interventions.

5. **Impact**
   Analyzes the overall effect of the CNAP interventions on health and nutrition outcomes across the county. It identifies both positive and unintended consequences, providing a holistic view of the plan's contribution to improving the well-being of the population.

4.7 CNAP Accountability Process

The accountability process within the BCNAP is designed to ensure that all stakeholders are responsible for fulfilling their roles and commitments throughout implementation. This involves systematically tracking contributions, monitoring progress, and evaluating the effective use of resources against set timelines and targets.

Transparent reporting mechanisms will be in place, requiring stakeholders to regularly submit progress updates, highlight challenges encountered, and report on any deviations from the implementation plan. These reports will inform performance assessments and decision-making processes. By embedding a culture of accountability, the BCNAP aims to strengthen trust, ensure responsiveness, and enable timely corrective actions to address any gaps or inefficiencies. This approach enhances the credibility and effectiveness of the nutrition response and fosters a results-driven implementation environment.

4.8 CNAP Learning Process

The learning process in the Baringo CNAP is designed to support continuous improvement by systematically capturing, analyzing, and applying lessons learned throughout the implementation cycle. It focuses on understanding which strategies and interventions are effective, identifying areas for refinement, and adapting program approaches based on real- time evidence.

Learning will be facilitated through regular review meetings, stakeholder feedback sessions, reflection workshops, and documentation of both successes and challenges. The process encourages cross-sectoral knowledge-sharing and collaboration, ensuring that insights gained are integrated into ongoing and future programming. By promoting a culture of adaptive learning, the BCNAP will foster innovation, enhance implementation quality, and contribute to the long-term sustainability and impact of nutrition interventions across Baringo County.

4.9 Critical Assumptions

The successful implementation of the BCNAP is based on the following key assumptions:

- **Adequate Resource Availability:** Sufficient financial, human, and material resources will be mobilized and sustained throughout the implementation period.
- **Sectoral Ownership and Engagement:** All relevant sectors will adopt the CNAP and take full responsibility for monitoring and evaluating their respective action points as outlined in the plan.
- **Effective Multi-Sectoral Coordination:** Strong collaboration among stakeholders— including government departments, development partners, civil society, and the private sector—will enhance synergies and positively impact nutrition outcomes.
- **Stable Political Environment:** A supportive and stable political climate will be maintained, enabling uninterrupted implementation of the CNAP.
- **Logical Results Chain:** The planned investments (inputs) will effectively lead to the intended outputs and outcomes, contributing to the achievement of the CNAP's overarching goals.
- **Reliable Data Systems:** The data and information used for planning, implementation, and monitoring will be accurate, timely, and dependable to support evidence-based decision-making

4.9.10 Implementation Framework for the Baringo CNAP

The implementation framework serves as a structured and strategic guide for translating the BCNAP into practical, coordinated action. It defines the processes, roles, responsibilities, timelines, and resources required to ensure that planned interventions are executed effectively and that the plan's objectives are achieved efficiently.

This framework provides a clear roadmap for how different components of the CNAP will be aligned, coordinated, and integrated across sectors. It supports systematic planning, execution, and monitoring of activities, ensuring that efforts are not only strategic but also results-oriented.

By fostering collaboration among stakeholders, optimizing the use of available resources, and enabling early identification of risks and implementation challenges, the framework strengthens accountability and adaptability. It also provides mechanisms for real-time learning and course correction to improve performance and outcomes over time.

Ultimately, the implementation framework is essential for turning strategic commitments into tangible, measurable results, ensuring alignment with county priorities, and driving sustained improvements in nutrition and health outcomes.

The following tables present the implementation framework across the Key Result Areas (KRAs), including outcomes, key performance indicator, type of indicator, source of data, periodicity and timelines:

Expected output results	Indicator	Target	Baseline 2023	Mid Term 2025	End Term 2027	Means of Verification	Lead Agency	Associated Partners
KRA 1: Maternal, Infant, and Young Child (MIYCN) nutritional well-being improved.								
Outcome: Improved care practices and services for enhanced maternal, infant, and young child nutrition and undernutrition prevented								
Output 1.1: Enhanced knowledge, skills and competence of MIYCN among HCWs, CHPs and management	1.1.1 No. of County ToTs participating in National trainings and trained on MIYCN, BFCI, BFHI, MIYCN-E, breastfeeding workplace support, PDH, BMS Act 2012 and its regulations	MIYCN-E-6 BFHI-6;BFCI-6; PDH-6; BMS Act-6; MIYCN- 6; Breastfeeding support-4;	MIYCN-2; BFCI- 8;BFHI-2, CBFCI-5, MIYCN E-4, PDH-4; breastfeeding support-2	16	34	Program reports	BCG- DoH	MOH other Departments. Development Partners
	1.1.2 No. of health workers trained/sensitized on MIYCN,BFCI,BFHI,CB FCI,MIYCNE,PDH, BMS	MIYCN-E-60 BFHI-60;BFCI- 60; PDH-80; BMS Act-40; MIYCN-80; Breastfeeding support-30; BMS-30	MIYCN-EW-40 BFHI-30;BFCI- 60; PDH-30; BMS Act-0; MIYCN-60; breastfeeding support-7	220	440	Programme reports	BCG- DoH	MOH other Departments. Development Partners
	1.1.3 No. of CHPs trained/ sensitized on MIYCN,BFCI, CBFCI,MIYCN-E,breastfeeding	MIYCN-E-200 BFHI-100;BFCI-150; PDH-160; BMS Act-40;	MIYCN-E-60 BFHI-40;BFCI- 50; PDH-80; BMS Act-0; MIYCN-50	475	950	Surveys, program reports	BCG- DoH	MOH other Departments. Development Partners
	1.1.4 No of facilities targeted with OJTs and mentorship on BFCI, MIYCN, BMS Act and its regulations, breastfeeding workplace support and PDH	200	40	100	200	Programme reports	BCG- DoH	MOH other Departments. Development Partners
	1.1.5 No of health managers sensitized on BFHI, MIYCN, BMS Act, breastfeeding workplace support and PDH	200	30	100	200	Program reports	BCG- DoH	MOH other Departments. Development Partners

Expected output results	Indicator	Target	Baseline 2023	Mid Term 2025	End Term 2027	Means of Verification	Lead Agency	Associated Partners
KRA 1: Maternal, Infant, and Young Child (MIYCN) nutritional well-being improved.								
Outcome: Improved care practices and services for enhanced maternal, infant, and young child nutrition and undernutrition prevented								
Output 1.2: Strengthened quality of nutrition services targeting women of reproductive age and children under 5 years	1.2.1 No of facilities accredited as BFHI complaint	12	1	5	12	Medical camp reports	BCG- DoH	MOH other Departments. Development Partners
	1.2.2 Number/proportion of children who have graduated/ recovered after 90 days. (SPHERE standards->75%)	75%	40%	75%	75%	ECHIS reports	BCG- DoH	MOH other Departments. Development Partners
	1.2.3 No of CUs implementing BFCI	70	10	35	70	Program reports	BCG- DoH	MOH other Departments. Development Partners
	1.2.4 Number of sub-counties monitoring, reporting and documenting compliance of workplace support	7	0	5	7	Program reports	BCG- DoH	MOH other Departments. Development Partners
	1.2.5 Proportion of sub-counties monitoring, reporting and documenting compliance of BMS Act	50%	0	30%	50%	Program reports	BCG- DoH	MOH other Departments. Development Partners
	1.2.6 Proportion of facilities promoting Nutrition assessment, education and counselling among children under five	90%	60%	70%	90%	Program reports	BCG- DoH	MOH other Departments. Development Partners
	1.3.2 No. of healthcare workers trained on IFAS/ MNPs/MMS	15%	1.7%	7%	15%	Program reports	BCG- DoH	MOH other Departments. Development Partners

Expected output results	Indicator	Target	Baseline 2023	Mid Term 2025	End Term 2027	Means of Verification	Lead Agency	Associated Partners
KRA 1: Maternal, Infant, and Young Child (MIYCN) nutritional well-being improved.								
Outcome: Improved care practices and services for enhanced maternal, infant, and young child nutrition and undernutrition prevented								
	1.3.3 Proportion of pregnant women who took/consumed some form of iron containing supplements for 180 days or more	15%	1.7%	7%	15%	Program reports	BCG- DoH	MOH other Departments. Development Partners
	1.3.4 No. of meetings conducted to advocate for purchase and distribution of MNPs, VAS+D and IFAS/MMS in the County	4	4	2	4	Program reports	BCG- DoH	MOH other Departments. Development Partners
Output 1.4: Improved adoption of MIYCN practices	1.4.1 No of County executive and Assembly sensitized on MIYCN policy, BMS Act and workplace support to breastfeeding mothers	70	20	40	70	Program reports	BCG- DoH	MOH other Departments. Development Partners
Output 1.5: Improved nutritional status of children 6-59 months and pregnant and lactating mothers	1.5.1: Proportion of mothers practicing exclusive breastfeeding	85%	80%	82%	85%	Program reports	BCG- DoH	MOH other Departments. Development Partners
	1.5.2 No. of SBC package for MIYCN and micronutrient supplementation contextualized and disseminated	2	_	1	1	Program reports	BCG- DoH	MOH other Departments. Development Partners
	1.5.3 No. of advocacy meetings in both formal and informal meetings to position breastfeeding agenda and the workplace	4	4	1	4	Program reports	BCG- DoH	MOH other Departments. Development Partners

Expected output results	Indicator	Target	Baseline 2023	Mid Term 2025	End Term 2027	Means of Verification	Lead Agency	Associated Partners
KRA 1: Maternal, Infant, and Young Child (MIYCN) nutritional well-being improved.								
Outcome: Improved care practices and services for enhanced maternal, infant, and young child nutrition and undernutrition prevented								
Output 1.6: Improved evidence-based decision making for MIYCN and micronutrient programming	1.6.1 No. of MIYCN assessments and surveys conducted (MIYCN KABP survey and MIYCN-E Assessments)	4	4	1	4	Program reports	BCG- DoH	MOH other Departments. Development Partners
	1.6.2 No. of micronutrient and MIYCN learning forums at the county, national, regional and international levels participated in	4	0	2	4	Program reports	BCG- DoH	MOH other Departments. Development Partners
	1.6.3 No of advocacy meetings held on prioritization of MIYCN assessments and surveys	4	0	1	4	Program reports	BCG- DoH	MOH other Departments. Development Partners
	1.6.4 No. of research areas around MIYCN and micronutrient programming identified	2	0	1	1	Program reports	BCG- DoH	MOH other Departments. Development Partners
Output 1.7: Performance of MIYCN and micronutrient indicators visualized	1.7.1 No of RDQAs/data review meetings with MIYCN and micronutrient integrated	6 (NDMA, Education, Agriculture, Child health, Community health)	16	8	16	Program reports	BCG- DoH	MOH other Departments. Development Partners
	1.7.2 No of new MIYCN and micronutrient indicators captured in the health information system(KHIS, ECHIS)	20	10	10	20	Program reports	BCG- DoH	MOH other Departments. Development Partners

Expected output results	Indicator	Target	Baseline 2023	Mid Term 2025	End Term 2027	Means of Verification	Lead Agency	Associated Partners
KRA 1: Maternal, Infant, and Young Child (MIYCN) nutritional well-being improved.								
Outcome: Improved care practices and services for enhanced maternal, infant, and young child nutrition and undernutrition prevented								
Output 1.8: MIYCN interventions integrated in key ministries departments	1.8.1 No. of key departments with MIYCN interventions integrated into the annual work plans and strategic documents	6 (NDMA, Education, Agriculture, Child health, Community health)	1	3		Program reports	BCG- DoH	MOH other Departments. Development Partners

Expected output results	Indicator	Target	Baseline 2023	Mid Term 2025	End Term 2027	Means of Verification	Lead Agency	Associated Partners
KRA 2: Improved nutritional well-being of older children, adolescents, adults, and older persons.								
Outcome: Increased awareness and adoption of healthy dietary practices and uptake of nutrition services by older children, adolescents, adults and older persons								
2.1: Increased nutrition awareness and uptake of nutrition services among stakeholders.	2.1.1 No of CHMT, SCHMT and HMT members sensitized on Nutrition	140	0	0	140	Program reports	DND	MOH other Departments. Development Partners
	2.1.2 Number of key stakeholders (caregivers, social influencers, older children and adolescents) trained on health diets and physical activity for older children and adolescents	120	0	30	120	Programme reports	DND	MOH other Departments. Development Partners
Output 2.2: Increased awareness on healthy diets among stakeholders	2.2 1 Number of HCWs and CHPs trained on healthy diets and physical activity	1000	0	200	1000	Surveys, program reports	DND	MOH other Departments. Development Partners

Expected output results	Indicator	Target	Baseline 2023	Mid Term 2025	End Term 2027	Means of Verification	Lead Agency	Associated Partners
KRA 2: Improved nutritional well-being of older children, adolescents, adults, and older persons.								
Outcome: Increased awareness and adoption of healthy dietary practices and uptake of nutrition services by older children, adolescents, adults and older persons								
	2.2. 2 Number of older children and adolescents sensitized on healthy diets and physical activity	10000	0	2000	10000	Programme reports	DND	MOH other Departments. Development Partners
	2.2.3. Proportion of parents/guardians reached using effective communication channels such as local media, religious institutions and public barazas	100	0	20	100	Program reports	DND	MOH other Departments. Development Partners
Output 2.3: Early detection of NCDs for proper management	2.3.1 Number of adults and older persons screened for NCDs and have had nutrition assessment during medical camps	100000	0	20000	100000	Medical camp reports	DND	MOH other Departments. Development Partners
	2.3.2 Number of adults and older persons screened for NCDs and have had nutrition assessment during household visits	400000	0	80000	400000	ECHIS reports	DND	MOH other Departments. Development Partners

Expected output results	Indicator	Target	Baseline 2023	Mid Term 2025	End Term 2027	Means of Verification	Lead Agency	Associated Partners
KRA 3: Prevention and control of micro-nutrient deficiencies through effective industrial fortification								
Outcome: Improved compliance of fortified foods to standards and regulations								
Output 3.1: Improved compliance of fortified foods to standards and regulations	3.1.1 No. of leaders and managers disseminated on food fortification regulations and standards.	150	0	50	150	Dissemination reports	BCG- DoH	MOH other Departments. Development Partners
Output :3.2 Increased knowledge on food fortification and iodine testing among HCWs, CHPS, and representatives of tertiary institutions	3.2.1 No. of HCWs trained/sensitized on food fortification	320	0	160	320	Training/ sensitization reports	BCG- DoH	MOH other Departments. Development Partners
	3.2.2 No. of CHPs trained/ Sensitized on food fortification	2000	0	1000	2000	Training/ sensitization	BCG- DoH	MOH other Departments. Development Partners
	3.2.3 No. of Institutions(KMTCs, TVETs, Agricultural institutions) representatives trained/ sensitized on Food fortification	10	0	5	5	Training/ sensitization reports	BCG- DoH	MOH other Departments. Development Partners
	3.2.4 No of Nutritionists/ Dieticians and PHOs sensitized on Iodine testing on table salt.	150	0	50	150	Training/ sensitization reports	BCG- DoH	MOH other Departments. Development Partners
Output 3.3:Increased use of fortified foods	3.3.1 No.of nutrition education materials on food fortification developed and distributed	600	0	300	600	Nutrition sensitization reports	BCG- DoH	MOH other Departments. Development Partners

Expected output results	Indicator	Target	Baseline 2023	Mid Term 2025	End Term 2027	Means of Verification	Lead Agency	Associated Partners
KRA 3: Prevention and control of micro-nutrient deficiencies through effective industrial fortification								
Outcome: Improved compliance of fortified foods to standards and regulations								
	3.3.2 Number of campaigns held	4	0	2	4	Nutrition health education report	BCG- DoH	MOH/ Partners
	3.3.3 No. of awareness on food fortifications radio sessions held	8	0	4	8	Dessimination reports	BCG- DoH	MOH/ Partners
Output 3.4: Improved Surveillance and Monitoring Systems of food fortification activities in the county	3.4.1 Number of surveillance session held	8	0	4	8	Surveillance reports	BCG- DoH	MOH/ Partners
	3.4.2 No. of food fortification indicators integrated in support supervision tool.	6	0	3	6	Supervision reports	BCG- DoH	MOH/ Partners
	3.4.3 No. of reports on food fortification activities on monthly basis	6	0	2	6	Advocacy and nutrition report	BCG- DoH	MOH and partners/ stakeholders
	3.4.4 No. of review meetings integrated with food fortification.	10	0	4	10	Review meetings reports	BCG- DoH	MOH and partners/ stakeholders
Output 3.5: Strengthened partnerships and coordinated actions for food fortification	3.5.1 No. of small millers for food fortification mapped in the county.	50	0	30	50	Small millers mapping reports	BCG- DoH	MOH/ partners
	3.5.2 No. of small millers sensitized on food fortification	80	0	40	80	Sensitization reports	BCG- DoH	MOH/ Partners

Expected output results	Indicator	Target	Baseline 2023	Mid Term 2025	End Term 2027	Means of Verification	Lead Agency	Associated Partners
KRA 3: Prevention and control of micro-nutrient deficiencies through effective industrial fortification								
Outcome: Improved compliance of fortified foods to standards and regulations								
	3.5.3 No. of food fortification committee established	60	0	20	60	Nutrition reports	BCG- DoH	MOH/ Partners

Expected output results	Indicator	Target	Baseline 2023	Mid Term 2025	End Term 2027	Means of Verification	Lead Agency	Associated Partners
KRA 4: Clinical nutrition and dietetic services across all level of health care Improved								
Outcome: Expanded and strengthened clinical nutrition and dietetics services for the prevention, management, and control of diseases and related conditions								
Output 4.1: Awareness of clinical nutrition guidelines, protocols and SOPs (clinical nutrition, HIV, TB, IMAM) among CHMT, SCHMT, HMT and health care workers	4.1.1 No. of CHMT, SCHMT and HMT members who attended dissemination meetings for nutrition and dietetics related guidelines, protocols and SOPs (clinical nutrition, HIV, TB, IMAM)	CHMT-15 SCHMT-98 HMT-105 Total for two yrs.=436	SCHMT -98	218	436	Dissemination reports	BCG- DoH	MOH other Departments. Development Partners
Output 4.2: Improved knowledge and skills in clinical nutrition services	4.2.1 Number of nutritionists trained on specialized clinical nutrition related courses (Enteral/ Parenteral, critical care, renal, oncology, metabolic disorders and mental Health)	Enteral and parenteral- 30 Critical Care – 30 Renal- 30 Oncology- 30 Metabolic disorders- 30 total 30	0	2	5	Training reports	BCG- DoH	MOH other Departments. Development Partners
	4.2.2. Number of CMES on clinical nutrition conducted (HIV, TB, DRNCDs, IMAM) in Health facilities	HIV/TB 2 DRNCD 2 IMAM 2 6 per year, total 18 CMES	0	6	18	CMES/ s conducted, participants lists	BCG- DoH	MOH other Departments. Development Partners

Expected output results	Indicator	Target	Baseline 2023	Mid Term 2025	End Term 2027	Means of Verification	Lead Agency	Associated Partners
KRA 4: Clinical nutrition and dietetic services across all level of health care Improved								
Outcome: Expanded and strengthened clinical nutrition and dietetics services for the prevention, management, and control of diseases and related conditions								
	4.2.4. number of CHPS and Peer educators sensitized on nutrition in TB/HIV	CHPS 1800 Peer educators 300	0	CHPs 600 Peer Educat ors 100	CHPs 1800 Peer educators 300	Training reports	BCG- DoH	MOH other Departments. Development Partners
	4.2.5. Number of CHPS sensitized on prevention, management and control of DRNCD	1800 CHPs	0	600	1800	Training reports	BCG- DoH	MOH other Departments. Development Partners
Output 4.3: Improved management of nutrition care for patients	4.3.1. Number of nutrition assessment counseling and support to all individuals seeking health care services in the health facilities (CCC, TB, DRNCDs and Outpatient therapeutic Clinics and in-patient care,)	CCC 250 TB Clients 125 DRNCD 100 OTP clients 333	0	CCC 3000 TB Clients 1500 DRNC D 1200 OTP clients 4000	CCC 9000TB Clients 4500 DRNCD 3600 OTP clients 12,000	counseling reports	BCG- DoH	MOH other Departments. Development Partners
	4.3.2 Proportion of HCW and patients reached with IEC/BCC materials	HCW/ Patients	0	50%	80%	IEC/ BCC dissemination reports	BCG- DoH	MOH other Departments. Development Partners
	4.3.3 Number of facilities with established inpatient feeding committees in healthcare facilities offering inpatient care, including public, private, and faith-based organizations (FBOs)	20 facilities offering in patient care	0	4	20	Facility inpatient committee reports	BCG- DoH	MOH other Departments. Development Partners

Expected output results	Indicator	Target	Baseline 2023	Mid Term 2025	End Term 2027	Means of Verification	Lead Agency	Associated Partners
KRA 4: Clinical nutrition and dietetic services across all level of health care Improved								
Outcome: Expanded and strengthened clinical nutrition and dietetics services for the prevention, management, and control of diseases and related conditions								
	4.3.4 Number of facilities Implementing standardized nutrition protocols and Standard Operating Procedures (SOPs) for managing key health conditions (such as diabetes, cardiovascular disease, malnutrition, and renal disease) across all healthcare facilities	15 health facilities	0	5	15	Facility supervision reports	BCG- DoH	MOH other Departments. Development Partners
	4.3.5 Number of facilities with Integrated nutrition services into all specialized clinics (including Diabetes, CCC, TB, CWC, Hypertension, Renal, and Oncology) across healthcare facilities	7 facilities offering specialized clinics	1	2	7	Nutrition program reports	BCG- DoH	MOH other Departments. Development Partners
	4.3.6 Number of new facilities implementing IMAM	10 New IMAM facilities	103 facilities offering IMAM	3	10	LMIS, MOH 713, 734, KHIS	BCG- DoH	MOH other Departments. Development Partners
Output 4.4 Improved supply chain for clinical nutrition and dietetic services	4.4.1 Number of facilities offering specialized nutrition commodities (IMAM commodities, parenteral and enteral)	113 IMAM Sites 7 sub county/ BCRH hospital	103(IM AM),1 BCRH specialized	106 IMAM sites 2 sub county hospita l	113 IMAM sites 7 sub county/ BCRH hospital	LMIS, MOH 713, 734, KHIS	BCG- DoH	MOH other Departments. Development Partners

Expected output results	Indicator	Target	Baseline 2023	Mid Term 2025	End Term 2027	Means of Verification	Lead Agency	Associated Partners
KRA 4: Clinical nutrition and dietetic services across all level of health care Improved								
Outcome: Expanded and strengthened clinical nutrition and dietetics services for the prevention, management, and control of diseases and related conditions								
	4.4.2 Number of anthropometric tools procured (MUAC tapes, infant scales, Height boards, 2 in 1 weighing scales) and pallets	(200 bundles of adults/ children MUAC tapes, 150 infant scales, 100 height boards, 100 2 in 1 weighing scales) and 90 pallets	(50 bundles of adults/ children MUAC tapes, 50 infant scales, 60 height boards, 60 2 in 1 weighin g scales) and 30 pallets	0	(200 bundles of adults/ children MUAC tapes, 150 infant scales, 100 height boards, 100 2 in 1 weighing scales) and 90 pallets	facilities inventory reports	BCG- DoH	MOH other Departments. Development Partners
Output 4.5 Enhanced awareness on clinical nutrition and dietetics among the public	4.5.1 Number of local media sessions held that promotes positive behavior for TB/ PLWHIV, DRNCDs	Alpha radio-6	0	2	Alpha radio-6	surveys, NDMA reports	BCG- DoH	MOH other Departments. Development Partners
	4.5.2 proportion of participants attending health thematic days (diabetes, hypertensive, cancer and kidney) to create awareness on nutrition in the management of diet related NCDs	HCW, community members, stakeholders	0%	60%	90%	Thematic days reports	BCG- DoH	MOH other Departments. Development Partners
	4.5.3 number of health facilities with DRNCD support groups	7 facilities offering specialized clinics	0	2	7	Nutrition program reports	BCG- DoH	MOH other Departments. Development Partners

Expected output results	Indicator	Target	Baseline 2023	Mid Term 2025	End Term 2027	Means of Verification	Lead Agency	Associated Partners
KRA 4: Clinical nutrition and dietetic services across all level of health care Improved								
Outcome: Expanded and strengthened clinical nutrition and dietetics services for the prevention, management, and control of diseases and related conditions								
	4.5.4 number of facilities with nutrition wellness clinics	7 facilities offering specialized clinics	0	2	7	Nutrition program reports	BCG- DoH	MOH other Departments. Development Partners
Output 4.6 Improved performance of clinical nutrition and dietetic services	4.6.1 Number of facilities using established nutrition services using established standards based on guidelines, protocols and SOPs	all 103 IMAM facilities	0	40	103	Nutrition reports	BCG- DoH	MOH other Departments. Development Partners
	4.6.2 Facilities reporting on clinical nutrition	7 county/ sub county hospitals	1	3	7	Nutrition reports	BCG- DoH	MOH other Departments. Development Partners
	4.6.3 no of facilities Integrating clinical nutrition interventions (HIV, TB, DRNCDs, IMAM) during RDQA	all 15facilities offering clinical nutrition services	0	6	15	RDQA, supervision checklist	BCG- DoH	MOH other Departments. Development Partners
	4.6.4 using clinical nutrition intervention template during data review meetings	105 SCHMT, 278 facility in charges	3	3	10	data review reports, facility reports	BCG- DoH	MOH other Departments. Development Partners
Output 4.7 Improved patient care, better clinical outcomes, and more efficient use of resources	4.7.1 Proportion of Linked and referred IMAM clients with other programs within the community (WASH, MIYCN support groups, Social protection and food security)	All IMAM clients	20%	40%	100%	Nutrition registers	BCG- DoH	MOH other Departments. Development Partners
	4.7.2 Proportion of public private partners supporting clinical nutrition programs	All the public/ private organizations	0	30%	70%	activities/ program me reports	BCG- DoH	MOH other Departments. Development Partners

Expected output results	Indicator	Target	Baseline 2023	Mid Term 2025	End Term 2027	Means of Verification	Lead Agency	Associated Partners
KRA 5: Sustained nutritional well-being of individuals and communities during emergencies and climate-related shocks.								
Outcome: Sectoral and multisectoral capacities for risk preparedness, emergency response, and the management of wasting enhanced								
Output 5.1: Strengthen Coordination and partnership for nutrition preparedness, response and recovery	5.1.1 No.of coordination forum with a representation of nutrition section	CSG-16 CWTC-16 WASH-16 Total-48	4	24	48	Activity report/ minutes	Department of Health	MOH and other Departments. Development Partners
	5.1.2 Number of participatory scenario planning meetings with representation from nutrition section	4	3	2	4	Activity report/ minutes	Department of Health	MOH and other Departments. Development Partners
	5.1.3 No of nutrition contingency plan developed	4	4	2	4	Validated plans	Department of Health	MOH and other Departments. Development Partners
	5.1.4 No. of joint emergency coordination Fora participated	4	3			Departmental reports	Department of Health	MOH and other Departments. Development Partners
Output 5.2: Strengthened capacity of systems and individuals to undertaken emergency preparedness actions.	5.2.1 No of dissemination forums for nutrition emergency SOPs held	4	0	2	4	Nutrition annul progress report	Department of Health	MOH and other Departments. Development Partners
	5.2.2 No. of storage hub contracted.	4	0	2	4	Annual progress report for nutrition	Department of Health	MOH and other Departments. Development Partners

Expected output results	Indicator	Target	Baseline 2023	Mid Term 2025	End Term 2027	Means of Verification	Lead Agency	Associated Partners
KRA 5: Sustained nutritional well-being of individuals and communities during emergencies and climate-related shocks.								
Outcome: Sectoral and multisectoral capacities for risk preparedness, emergency response, and the management of wasting enhanced								
	5.2.3 No. of NDMA Monitors sensitized on nutrition assessment, Family MUAC and referrals during emergencies.	9	0	9	9	Nutrition program report	Department of Health	MOH and other Departments. Development Partners
	5.2.4 No. of CHMTs, SCHMTs, and HCWs trained/sensitized on IMAM Serge	HCWs-35 SCHMT-70 HCW-30 Total= 135	0	65	135	Annual progress report for nutrition	Department of Health	MOH and other Departments. Development Partners
	5.2.5 No. of HCWs, CHPs and disaster response team sensitized on nutrition emergency policy.	HCW-300 CHP-1070 Disaster response Teams-30 total 1400	50	700	1400	Annual progress report for nutrition	Department of Health	MOH and other Departments. Development Partners
Output 5.3: Informed emergency nutrition response.	5.3.1 No. of rapid assessments KIRA participated in	KIR1 -4	10	2	4	Activity report/ minutes	Department of Health	MOH and other Departments. Development Partners
	5.3.2 No. of MYCN-E assessment conducted	1	0	0	1	Activity report/ minutes	Department of Health	MOH and other Departments. Development Partners
Output 5.4. Reduced cases of malnutrition spike during emergencies	5.4.1 No. of integrated medical outreach conducted during emergencies	50	10	25	50	Departmental reports, Nutrition program report	Department of Health5	MOH and other Departments. Development Partners
	5.4.2 Number of referral linkages done to programs-livelihood, social protection and education	4	4	2	4	Departmental reports, Nutrition program report	Department of Health	MOH and other Departments. Development Partners

Expected output results	Indicator	Target	Baseline 2023	Mid Term 2025	End Term 2027	Means of Verification	Lead Agency	Associated Partners
KRA 5: Sustained nutritional well-being of individuals and communities during emergencies and climate-related shocks.								
Outcome: Sectoral and multisectoral capacities for risk preparedness, emergency response, and the management of wasting enhanced								
	5.4.3 Number of advocacy meetings held to discuss assessments during recovery phases	4	1	2	4	Departmental reports, Nutrition program report	Department of Health	MOH and other Departments. Development Partners
	5.4.4 No of facilities with IMAM surge scaled up	35	28	14	35	IMAM surge dashboard	Department of Health	MOH and other Departments. Development Partners

Expected output results	Indicator	Target	Baseline 2023	Mid Term 2025	End Term 2027	Means of Verification	Lead Agency	Associated Partners
KRA 6: Enhanced integration of nutrition into agriculture, livestock, and fisheries sectors								
Outcome; Household Food and Nutrition security enhanced								
Output 6.1: Improve household dietary diversification at community level	6.1.1 Number of farmers reached for production of safe, diverse and nutritious food	3000	1000	2000	3000	Food situation reports	BCG- DoH	MOH other Departments. Development Partners
	6.1.2 Number of ponds promoted to enhance fish production	300	50	250	300	Food situation reports	BCG- DoH	MOH other Departments. Development Partners
	6.1.3 Number of fingerlings promoted to increase food production	300000	100000	200000	300000	Food situation reports	BCG- DoH	MOH other Departments. Development Partners
	6.1.4 Number of nurseries promoted for increased number of fruit trees	60	34	26	60	Extension reports	BCG- DoH	MOH other Departments. Development Partners

Expected output results	Indicator	Target	Baseline 2023	Mid Term 2025	End Term 2027	Means of Verification	Lead Agency	Associated Partners
KRA 6: Enhanced integration of nutrition into agriculture, livestock, and fisheries sectors								
Outcome; Household Food and Nutrition security enhanced								
	6.1.5 Number of small stocks promoted to enhance food diversification	4000	200	2800	4000	Food situation reports	BCG- DoH	MOH other Departments. Development Partners
	6.1.6 No. of advocative meetings conducted on nutrition sensitive agricultural production.	16	4	12	16	Food situation reports	BCG- DoH	MOH other Departments. Development Partners
	6.1.7 Number of staff sensitized on NSA and food systems.	90	30	60	90	Food situation reports	BCG- DoH	MOH other Departments. Development Partners
	6.1.8 Number of lead farmers sensitized on NSA and food systems.	1200	496	704	1200	Food situation reports	BCG- DoH	MOH other Departments Development Partners
Output 6.2: Enhanced knowledge and skills	6.2.1 Number of officers sensitized on agri-nutrition	60	10	50	60	Food situation reports	BCG- DoH	MOH other Departments. Development Partners
	6.2.2 Number of farmers trained on GAP to improve productivity	14000	600	13400	14000	Training reports	BCG- DoH	MOH other Departments. Development Partners
	6.2.3 Number of community groups trained.	496	122	374	496	Reports, Participants list	BCG- DoH	MOH other Departments. Development Partners
	6.2.4 Number of Care givers trained.	120	20	100	120	Reports, Participants list	BCG- DoH	MOH other Departments. Development Partners

Expected output results	Indicator	Target	Baseline 2023	Mid Term 2025	End Term 2027	Means of Verification	Lead Agency	Associated Partners
KRA 6: Enhanced integration of nutrition into agriculture, livestock, and fisheries sectors								
Outcome; Household Food and Nutrition security enhanced								
	6.2.5 Number of farmer demonstrations conducted	120	30	90	120	Reports, Participants list	BCG- DoH	MOH other Departments. Development Partners
	6.2.6 Number of key decision makers and stakeholders trained on NSA and food systems	12	4	8	12	Reports, Participants list	BCG- DoH	MOH other Departments. Development Partners
Output 6.3: Improved access to safe nutritious food.	6.3.1 Number of food processing and preservation units promoted.	24	8	16	24	Program reports	BCG- DoH	MOH other Departments. Development Partners
Output 6.4: Improved Uptake of various technologies in agricultural production	6.4.1 Number of seeds, energy saving devices, and hermatic bags promoted to enhance food security.	2500	350	1750	2500	Reports, Participants list	BCG- DoH	MOH other Departments. Development Partners
	6.4.2 Number of kitchen gardens established using waste materials to enhance food security.	4000	1050	2950	4000	Reports, Participants list	BCG- DoH	MOH other Departments. Development Partners
Output 6.5 Improved coordination and collaboration on agriculture and nutrition	6.5.1 Number of TWGs formed to strengthen linkages on nutrition	8	2	6	8	Reports, Participants list	BCG- DoH	MOH other Departments. Development Partners
	6.5.2 Number of meetings held with nutrition to enhance collaboration	12	4	8	12	Reports, Participants list	BCG- DoH	MOH other Departments. Development Partners

Expected output results	Indicator	Target	Baseline 2023	Mid Term 2025	End Term 2027	Means of Verification	Lead Agency	Associated Partners
KRA 6: Enhanced integration of nutrition into agriculture, livestock, and fisheries sectors								
Outcome; Household Food and Nutrition security enhanced								
	6.5.3 Number of coordination meetings attended to enhance collaboration	12	1	11	12	Reports, Participants list	BCG- DoH	MOH other Departments. Development Partners
Output 6.6 Enhanced joint integration of nutrition activities	6.6.1 Number of supervisions and follow ups conducted to scale up nutrition	12	0	12	12	Reports, Participants list	BCG- DoH	MOH other Departments. Development Partners

Expected output results	Indicator	Target	Baseline 2023	Mid Term 2025	End Term 2027	Means of Verification	Lead Agency	Associated Partners
KRA 7: Nutrition integrated and strengthened across all levels of the health sector.								
Outcome: Enhanced integration and implementation of nutrition interventions across health sector policies, strategies, and action plans								
Output 7.1 Nutrition services integration enhanced in all levels of the health sector	7.1.1 Number of County Policies, Guidelines and documents	7	7	3	7	County documents	BCG- DoH	MOH other Departments. Development Partners
	7.1.2 Number of Reviewed nutrition component within the school health program	1	1	1	1	County documents	BCG- DoH	MOH other Departments. Development Partners
Output 7.2: Improved participation, planning and financing of nutrition services	7.2.1. Number of CHMT, SCHMT sensitizedon integration of nutrition in planning documents	60	0	30	60	Count document Reports	BCG- DoH	MOH other Departments. Development Partners

Expected output results	Indicator	Target	Baseline 2023	Mid Term 2025	End Term 2027	Means of Verification	Lead Agency	Associated Partners
KRA 7: Nutrition integrated and strengthened across all levels of the health sector.								
Outcome: Enhanced integration and implementation of nutrition interventions across health sector policies, strategies, and action plans								
Output 7.3: Improve Nutrition services integration and adherence at all levels	7.3.1 Number of facilities restructuring client flow to redirect eligible nutrition clients to the nutrition clinic in different levels of health sector	250	50	50	250	Nutrition / administrative reports	BCG- DoH	MOH other Departments. Development Partners
	7.3.2 Number of hospitals and health facilities integrating nutrition services	250	25	50	250	Nutrition programme reports	BCG- DoH	MOH other Departments. Development Partners
Output 7.4: Improved participation, coordination and collaboration within the health system	7.4.1 Number of stakeholder's forums and other Technical working group attended by Nutrition staff	7	2	2	7	Nutrition reports	BCG- DoH	MOH other Departments. Development Partners
	7.4. 2 Number of county nutrition technical forums participated by other programmed section officers	12	12	12	12	Administrative reports	BCG- DoH	MOH other Departments. Development Partners
Output 7.5: Improve nutrition integration of nutrition activities in PCN	7.5.1 Number of Joint PCN MDT interventions and activities conducted in collaboration with nutritionist	60	0	60	60	Administrative reports	BCG- DoH	MOH other Departments. Development Partners
Output 7:6: Improve capacity of the health workforce to deliver integrated services that include nutrition	7.6.1 No. of community Health Promoters Trained on nutrition Technical modules	2000	325	1000	2000	Nutrition reports	BCG- DoH	MOH other departments Development Partners

Expected output results	Indicator	Target	Baseline 2023	Mid Term 2025	End Term 2027	Means of Verification	Lead Agency	Associated Partners
KRA 7: Nutrition integrated and strengthened across all levels of the health sector.								
Outcome: Enhanced integration and implementation of nutrition interventions across health sector policies, strategies, and action plans								
	7.6.2 No. of nutrition officers trained on Integrated Management of newborn and Childhood Illnesses and KMC, HIV, TB with other health care workers	29	0	15	29	Nutrition administrative reports	BCG- DoH	MOH other departments Development Partners

Expected output results	Indicator	Target	Baseline 2023	Mid Term 2025	End Term 2027	Means of Verification	Lead Agency	Associated Partners
KRA 8: Enhanced integration of nutrition in the education sector.								
Outcome: Enhanced nutrition interventions within the education sector								
Output 8.1: Improved knowledge among ECDE teachers on healthy diet and physical activity, nutrition assessment and VAS+D	8.1.1 Number of ECDE teachers trained on healthy diets and physical activities	1588	0	750	1588	No	BCG- DoH	Department of Edu,VT&LS, Dept. Water, Partners- WFP, UNICEF,NDMA
	8.1.2 Number of ECDE teachers Sensitized on nutrition assessments and VAS+D	1588	0	1588	1588	No	BCG- DoH	Department of Edu,VT&LS, Dept. Water, Partners- WFP, UNICEF,NDMA
Output 8.2: Improved integration of nutritional interventions in schools	8.2.1 Number of Children received VAS+D Supplements	62,000	62,000	62,000	62,000	No	BCG- DoH	Department of Edu,VT&LS,
	8.2.2 Availability of Nutritional assessment report	16	4	8	16	No	BCG- DoH	Department of Edu,VT&LS,
	8.2.3 Number of children referred to health facilities cases done	100	100	50	100	No	BCG- DoH	Department of Edu,VT&LS,

Expected output results	Indicator	Target	Baseline 2023	Mid Term 2025	End Term 2027	Means of Verification	Lead Agency	Associated Partners
KRA 8: Enhanced integration of nutrition in the education sector.								
Outcome: Enhanced nutrition interventions within the education sector								
	8.2.4 Number of schools implementing ECDE meals and Nutrition program	1045	381	750	1045	No	Department of Edu,VT&LS,	BCG- DoH, Water, Partners-WFP, UNICEF,NDMA
	8.2.5 Number of demonstration gardens established in ECDE/ schools	1045	0	522	1045	No	Department of Edu,VT&LS,	Department of Edu,VT&LS, Dept. Water, Dept. Agri,Livestock & FisheriesPartners- WFP, UNICEF,NDMA
	8.2.6 Number of Schools with active 4K clubs	1045		522	1045	No	Department of Edu,VT&LS,	Department Health Dept. Water, Dept. Agri,Livestock & FisheriesPartners- WFP, UNICEF,NDMA
	8.2.7 Number of Schools with active school health clubs	100%	0	50%	100%	No	Department of Edu,VT&LS,	Department Health Dept. Water, Dept. Agri,Livestock & FisheriesPartners- WFP, UNICEF,NDMA
	8.2.8 No. of ECDE/school including Nutrition in their co-curricular activities.	100%	0	50%	100%	No	Department of Edu,VT&LS,	Department Health Dept. Water, Dept. Agri,Livestock & FisheriesPartners- WFP, UNICEF,NDMA
	8.2.9 Availability of reports on Health and Nutrition program	1045	0	50%	1045	No	Department of Edu,VT&LS,	Department Health Dept. Water, Dept. Agri,Livestock & FisheriesPartners- WFP, UNICEF,NDMA
Output 8.3: Improved stakeholders' awareness on healthy diet, safe food environment and WASH in schools	8.3.1 No. of stakeholders including, curriculum support officers, Principal Education Officers, food service providers and handlers, Parent–Teacher Associations (PTA) sensitized on healthy diets and safe food environment in schools	2,280	100%	727	2280	No	Department of Health,	Department Health Dept. Water, Dept. Agri,Livestock & FisheriesPartners- WFP, UNICEF,NDMA

Expected output results	Indicator	Target	Baseline 2023	Mid Term 2025	End Term 2027	Means of Verification	Lead Agency	Associated Partners
KRA 8: Enhanced integration of nutrition in the education sector.								
Outcome: Enhanced nutrition interventions within the education sector								
	8.3.2 Number of ECDE/Schools with toilets	1,045	178	657	1045	No	Department of Edu,VT&LS,	Department Health Dept. Water, Dept. Agri,Livestock & FisheriesPartners- WFP, UNICEF,NDMA
	8.3.5 Number of ECDE/Schools with water tanks	1045	197	479	1045	No	Department of Edu,VT&LS,	Department Health Dept. Water, Dept. Agri,Livestock & FisheriesPartners- WFP, UNICEF,NDMA
	8.3.6 Number of nutrition Multisectoral stakeholders' coordination forum meetings attended	12	0	6	12	No	Department of Health	Department Health Dept. Water, Dept. Agri,Livestock & FisheriesPartners- WFP, UNICEF,NDMA
Output 8.4: Improved collaboration and partnership	8.4.1 Availability of reports	16	0	8	16	No	Department of Edu,VT&LS, DoH	Department Health Dept. Water, Dept. Agri,Livestock & FisheriesPartners- WFP, UNICEF,NDMA
	8.4.2 Availability of reports	16	0	8	16	No	Department of Edu,VT&LS, DoH	Department Health Dept. Water, Dept. Agri,Livestock & Fisheries, Partners- WFP, UNICEF,NDMA
	8.4.3 Availability of reports	16	0	8	16	No	Department of Edu,VT&LS, DoH	Department Health Dept. Water, Dept. Agri,Livestock & FisheriesPartners- WFP, UNICEF,NDMA

Expected output results	Indicator	Target	Baseline 2023	Mid Term 2025	End Term 2027	Means of Verification	Lead Agency	Associated Partners
KRA 9: Enhanced integration of Nutrition within the Water, Sanitation, and Hygiene (WASH) sector.								
Outcome: Increased access to improved nutrition sensitive WASH services								
Output 9.1: Improved water access	9.1.1 No. of advocacy meeting done for construction of dams.	15	12	3	15	Program reports	BCG- DoH	MOH other Departments. Development Partners

Expected output results	Indicator	Target	Baseline 2023	Mid Term 2025	End Term 2027	Means of Verification	Lead Agency	Associated Partners
KRA 9: Enhanced integration of Nutrition within the Water, Sanitation, and Hygiene (WASH) sector.								
Outcome: Increased access to improved nutrition sensitive WASH services								
	9.1.2 No. of water pans constructed	12	0	4	12	Program reports	BCG- DoH	MOH other Departments. Development Partners
	9.1.3 No. of water pans desilted	12	0	6	12	Program reports	BCG- DoH	MOH other Departments. Development Partners
	9.1.4 Percentage of households doing water harvesting	30	20	10	20	Program reports	BCG- DoH	MOH other Departments. Development Partners
	9.1.5 No. of boreholes drilled	12	0	6	12	Program reports	BCG- DoH	MOH other Departments. Development Partners
	9.1.6 No. of boreholes rehabilitated	20	15	10	20	Program reports	BCG- DoH	MOH other Departments. Development Partners
	9.1.7 No. of fuel pumping systems/electric usage upgraded to solar power system	20	100	10	20	Program reports	BCG- DoH	MOH other Departments. Development Partners
Output 9.2: Behavior changes and therefore reduced hygiene related infections	9.2.1 No. of HHs sensitized on hand washing at critical time	54,600	0	27,300	54,600	Program reports	BCG- DoH	MOH other Departments. Development Partners
	9.2.2 No. of dialogue days held to sensitize public on hand washing in critical times	20	20	10	20	Program reports	BCG- DoH	MOH other Departments. Development Partners
	9.2.3 Proportion of households practicing water treatment and safe storage	35	20	17	35	Program reports	BCG- DoH	MOH other Departments. Development Partners
	9.2.4 No. of public awareness sessions held through radio spots on practicing environmental sanitation	32	0	16	32	Program reports	BCG- DoH	MOH other Departments. Development Partners
Output 9.3 Proper waste management	9.3.1 No. of Households using toilets and latrines	13,869	0	6,934	13,869	Program reports	BCG- DoH	MOH other Departments. Development Partners

Expected output results	Indicator	Target	Baseline 2023	Mid Term 2025	End Term 2027	Means of Verification	Lead Agency	Associated Partners
KRA 9: Enhanced integration of Nutrition within the Water, Sanitation, and Hygiene (WASH) sector.								
Outcome: Increased access to improved nutrition sensitive WASH services								
	9.3.2 No. of sewer water treatment systems constructed in every sub county	5	0	3	5	Program reports	BCG- DoH	MOH other Departments. Development Partners
	9.3.3 Percentage of HHs practicing proper waste handling	40	0	20	40	Program reports	BCG- DoH	MOH other Departments. Development Partners
Output 9.4 Integrated programming on WASH/Nutrition	9.4.1 No. of WASH forums participated	16	4	8	16	Program reports	BCG- DoH	MOH other Departments. Development Partners
	9.4.2 No. of joint planning & review meetings done with the WASH team	20	0	10	20	Program reports	BCG- DoH	MOH other Departments. Development Partners
	9.4.3 No. of Support Supervision forums on WASH/Nutrition done	16	0	8	16	Program reports	BCG- DoH	MOH other Departments. Development Partners
	9.4.4 No. of Fruit trees planted for catchment conservation	16,000	0	8,000	16,000	Program reports	BCG- DoH	MOH other Departments. Development Partners
	9.4.5 No. of Water Catchments gazette and fenced	30	0	15	30	Program reports	BCG- DoH	MOH other Departments. Development Partners
	9.4.6 No. of community members sensitized	22,400	0	11,200	22,400	Program reports	BCG- DoH	MOH other Departments. Development Partners
	9.4.7 No. of water management committees trained	36	0	18	36	Program reports	BCG- DoH	MOH other Departments. Development Partners
	9.4.8 No. of Kitchen Garden/ demo farms established at Water Points	36	0	18	36	Program reports	BCG- DoH	MOH other Departments. Development Partners

Expected output results	Indicator	Target	Baseline 2023	Mid Term 2025	End Term 2027	Means of Verification	Lead Agency	Associated Partners
KRA 10: Nutrition integrated across Social Protection programs.								
Outcome: Nutrition mainstreamed within social protection policies, strategies and interventions.								
Output 10.1: Enhanced nutrition awareness and practices among vulnerable populations in social protection programs	10.1.1 No. of cash transfer programs caregivers sensitized on Nutrition	20,000	5,000	10,000	20,000	Department reports (Cash transfer beneficiary list)	Department of health	MOH and Development Partners
	10.1.2 No of Nutrition key messages developed that integrate with social protection programs	One key message package	1	0	1	Department reports (Nutrition key messaging)	Department of health	MOH and Development Partners
Output 10.2: Strengthened integration of nutrition into social protection programme	10.2.1 No of HCWs sensitized on the existing social protection programs	40	12	20	40	Departmental reports (Health Services, Social Protection)	Department of health	MOH and Development Partners
	10.2.2 No of CHPs trained on existing Social Protection programs	750	82	375	750	Departmental reports (Health Services, Social Protection)	Department of health	MOH and Development Partners
	10.2.3 Number of nutrition sensitive social protection programs implemented in the county	4	1	2	4	Departmental reports (Health Services, Social Protection)	Department of health	MOH and Development Partners
	10.2.4 No of baseline conducted on Gender integration	1	0	0	1	Departmental Reports, Baseline assessment Report, KIRA,	Department of health	MOH and Development Partners
	10.2.5 No. of Social safety nets advocacy campaigns held during emergency	4	1	0	1	Departmental Reports, CSG Minutes	Department of health	MOH and Development Partners
	10.2.6 No. of Assessment Conducted on Nutritional and Health Needs of Adults and older persons on Social Protection	4	1	2	4	Departmental reports (Nutrition, Social Protection), assessment report	Department of health	MOH and Development Partners

Expected output results	Indicator	Target	Baseline 2023	Mid Term 2025	End Term 2027	Means of Verification	Lead Agency	Associated Partners
KRA 10: Nutrition integrated across Social Protection programs.								
Outcome: Nutrition mainstreamed within social protection policies, strategies and interventions.								
Output 10.3: Enhanced Awareness and understanding of the connection between social protection (e.g., cash transfers, food assistance) and nutrition outcomes for vulnerable populations	10.3.1 No of sensitization meeting held on importance of social protection Linkages between Social protection and Nutrition	1	1	0	1	Departmental reports, Minutes	Department of health	MOH and Development Partners
	10.3.3 No of Institutional on correction facilities sensitized on optimal nutrition	8	2	6	8	Departmental reports (Health Services, Social Protection)	Department of health	MOH and Development Partners

Expected output results	Indicator	Target	Baseline 2023	Mid Term 2025	End Term 2027	Means of Verification	Lead Agency	Associated Partners
KRA 11: Enhanced multisectoral nutrition governance, coordination, partnerships, advocacy, and community engagement								
Expected Outcome: Strengthened multisectoral governance, planning, financing, and partnerships for improved coordination, resource mobilization, and effective implementation of nutrition interventions.								
Output 11.1: County nutrition documents (AWP, CNAP, Nutrition Policy) developed, disseminated, and stakeholders sensitized.	11.1.1 Number of nutrition documents developed	5	1	4	6	Nutrition office annual progress reports	Nutrition Coordinator office	MOH other Departments. Development Partners
	11.1.2 Number of Health care workers sensitized	360	0	270	360	Nutrition office annual progress reports	Nutrition Coordinator office	MOH other Departments. Development Partners
Output 11.2: Robust coordination and planning mechanisms	11.2.1 Multisectoral Platform established and operationalized	8	2	6	10	Nutrition office annual progress reports	Nutrition Coordinator office	MOH other Departments. Development Partners
	11.2.2 No of nutrition technical forum(s) held	16	0	12	16	Nutrition office annual progress reports	Nutrition Coordinator office	MOH other Departments. Development Partners

Expected output results	Indicator	Target	Baseline 2023	Mid Term 2025	End Term 2027	Means of Verification	Lead Agency	Associated Partners
KRA 11: Enhanced multisectoral nutrition governance, coordination, partnerships, advocacy, and community engagement								
Expected Outcome: Strengthened multisectoral governance, planning, financing, and partnerships for improved coordination, resource mobilization, and effective implementation of nutrition interventions.								
Output 11.3: Strengthened advocacy for leadership development, dedicated funding, structured budget lines, and establishment of a nutrition directorate, resulting in increased resource allocation and human capital for CNAP implementation	11.3.1 No. of concepts and proposals raised for financial support	8	0	6	8	Nutrition office annual progress reports	Nutrition Coordinator office	MOH other Departments. Development Partners
	11.3.2 Advocacy meetings held	4	0	3	4	Nutrition office annual progress reports	Nutrition Coordinator office	MOH other Departments. Development Partners
	11.3.3 Advocacy meetings held	1	0	1	0	Nutrition office annual progress reports	Nutrition Coordinator office	MOH other Departments. Development Partners
Output 11.4: Enhanced integration of nutrition in community forums. through active engagement of local leadership in planning and coordination of nutrition activities.	11.4.1 Number of community forums held	16	0	12	16	Nutrition office annual progress reports	Nutrition Coordinator office	MOH other Departments. Development Partners
	11.4.2 Number of engagement meetings held	16	0	12	16	Nutrition office annual progress reports	Nutrition Coordinator office	MOH other Departments. Development Partners

Expected output results	Indicator	Target	Baseline 2023	Mid Term 2025	End Term 2027	Means of Verification	Lead Agency	Associated Partners
KRA 12: Strengthened sectoral and multisectoral Nutrition Information, M&E systems, research, and Knowledge management.								
Outcome: Enhanced Sectoral and multi-sectoral nutrition information systems, robust monitoring and evaluation frameworks, increased research uptake, and effective knowledge management.								
Output 12.1. Availability of quality nutrition data	12.1.1 Proportion of facilities utilizing standardized nutrition tools(Registers/summary reporting tools)	100%	99.52%	32.13%		KHIS	BCG- DOH	MOH other Departments. Development Partners
	12.1.2: No.of DQA's for nutrition conducted	4				Program/DQA reports	BCG- DOH	MOH other Departments. Development Partners
	12.1.3; No. of nutrition indicators included in the joint support supervision tool	3	0	3	3		BCG- DOH	MOH, Other departments and Development Partners
	12.1.4; No. of data review meetings held	13	1	3	13	Data Review meeting minutes	BCG-DOH	MOH, Other departments and Development Partners
Output 12.2; Nutrition data monitoring and evaluation mechanisms strengthened	12.2.1: No. of evaluation conducted on implementation of CNAP, AWP and M&E framework	4	1	1	2	Midterm CNAP Reports, End term CNAP Reports and M&E framework	BCG-MOH	

Expected output results	Indicator	Target	Baseline 2023	Mid Term 2025	End Term 2027	Means of Verification	Lead Agency	Associated Partners
KRA 12: Strengthened sectoral and multisectoral Nutrition Information, M&E systems, research, and Knowledge management.								
Outcome: Enhanced Sectoral and multi-sectoral nutrition information systems, robust monitoring and evaluation frameworks, increased research uptake, and effective knowledge management.								
	12.2.2: No. of Surveys or assessments conducted	7 – MIYCN KAP Survey 1, SMART survey 4, nutrition capacity assessment 1, and Coverage surveys (squeac, PECs)1	1	2	4	Survey report	BCG- DOH	MOH other Departments. Development Partners
	12.2.3: Number of sub-counties utilizing nutrition score card	7	0	2	5	KHIS, Roll out reports	BCG- DOH	MOH other Departments. Development Partners
Output 12.3:Improved knowledge and skills on data management processes	12.3.1: Number of health care workers trained on KHIS	130	35	95	130	Training log reports	BCG- DOH	MOH other Departments. Development Partners
	12.3.2: Number of health care workers trained on Echis	130	35	95	0	Training log reports	BCG- DOH	MOH other Departments. Development Partners
	12.3.3: Number of health care workers trained on nutrition MOH reporting tools	104	30	37	37	Attendance lists, Training reports	BCG- DOH	MOH other Departments. Development Partners
	12.3.4: Number of health care workers trained on basic data analysis and report writing	16	7	0	16	Attendance lists, Training reports	BCG- DOH	MOH other Departments. Development Partners

Expected output results	Indicator	Target	Baseline 2023	Mid Term 2025	End Term 2027	Means of Verification	Lead Agency	Associated Partners
KRA 12: Strengthened sectoral and multisectoral Nutrition Information, M&E systems, research, and Knowledge management.								
Outcome: Enhanced Sectoral and multi-sectoral nutrition information systems, robust monitoring and evaluation frameworks, increased research uptake, and effective knowledge management.								
	12.3.5: Number of health care workers Sensitized/OJT on nutrition data collection and reporting tools	104	30	37	37	Attendance lists, Training reports	BCG- DOH	MOH other Departments. Development Partners
	12.3.5: No. of healthcare workers trained on Long Rain and Short Rain Assessments, research methodologies and scientific writing	50	0	50	50	Attendance lists, Training reports	BCG- DOH	MOH other Departments. Development Partners
Output 12.4: Availability of nutrition evidence to inform program decisions	12.4.1: No. of nutrition research priorities identified	2	0	0	2	Research reports	BCG- DOH	MOH other Departments. Development Partners
	12.4.2: Number of nutrition related research conducted (operational etc)	2	0	0	2	Research reports	BCG- DOH	MOH other Departments. Development Partners
	12.4.3: Number of knowledge sharing events held:(Malezi bora, World breastfeeding day, world food day etc)	1	0	3	3	Post events reports	BCG- DOH	MOH other Departments. Development Partners

Expected output results	Indicator	Target	Baseline 2023	Mid Term 2025	End Term 2027	Means of Verification	Lead Agency	Associated Partners
KRA 13: Strengthened Supply chain management for nutrition commodities and equipment								
Outcome: Improved supply chain management system for nutrition								
Output 13.1 Increased knowledge skills and Management of Nutrition Commodities, equipment and tools	13.1.1 Number of CHMT and SCHMT trained on commodity management	40	10	15	40	Activity report	BCG- DoH	MOH other Departments. Development Partners
	13.1.2Number of HCW's trained on commodity management	235	0	78	235	Activity report	BCG- DoH	MOH other Departments. Development Partners
	13.1.3Number of CHP's trained on commodity management	45	0	15	45	Activity report	BCG- DoH	MOH other Departments. Development Partners
	13.1.4 Number of CHMT and SCHMT trained on LMIS	40	20	15	40	Activity report	BCG- DoH	MOH other Departments. Development Partners
	13.1.5Number of HCW's trained on LMIS	235	0	78	235	Activity report	BCG- DoH	MOH other Departments. Development Partners
	13.1.6 Number of CMES conducted in facilities including commodity management sessions.	114	0	38	114	Activity report	BCG- DoH	MOH other Departments. Development Partners
	13.1.7 Number of HCW's reached with OJT sessions on commodity management	197	0	65	197	Activity report	BCG- DoH	MOH other Departments. Development Partners

Expected output results	Indicator	Target	Baseline 2023	Mid Term 2025	End Term 2027	Means of Verification	Lead Agency	Associated Partners
KRA 13: Strengthened Supply chain management for nutrition commodities and equipment								
Outcome: Improved supply chain management system for nutrition								
	13.1.8 Number of HCW's reached with commodity management mentorship sessions	102	0	34	102	Activity report	BCG- DoH	MOH other Departments. Development Partners
	13.1.9 number of hcw's sensitized on correct use and maintenance of nutrition equipment	235	0	78	235	Activity report	BCG- DoH	MOH other Departments. Development Partners
	13.1.10 Number of biomedical engineers trained on operation, maintenance and repair of equipment	14	7	14	14	Activity report	BCG- DoH	MOH other Departments. Development Partners
	13.1.11 Number of successful maintenance and repairs engagements done by biomedical engineers facilitated	16	0	4	16	Activity report	BCG- DoH	MOH other Departments. Development Partners
Output 13.2 Improved nutrition commodity management practices	13.2.1 number of SOP's on receipt, storage, requisition and reporting of nutrition commodities developed printed and displayed in the facilities.	235	0	78	235	Monitoring report	BCG- DoH	MOH other Departments. Development Partners
Output 13.3 Improved nutrition commodities, equipment and tools budgetary allocation in the county.	13.3.1 Number of advocacy meetings held at the County Health Management Team	4	0	1	4	Meeting minutes	BCG- DoH	MOH other Departments. Development Partners
	13.3.3 Number of advocacy meetings held at the county treasury and County Assembly Sector Working Group (SWG)	4	0	1	4	Meeting minutes	BCG- DoH	MOH other Departments. Development Partners

Expected output results	Indicator	Target	Baseline 2023	Mid Term 2025	End Term 2027	Means of Verification	Lead Agency	Associated Partners
KRA 13: Strengthened Supply chain management for nutrition commodities and equipment								
Outcome: Improved supply chain management system for nutrition								
	13.3.4 Number of advocacy meetings held at the county treasury and County Assembly, County fiscal Strategy Paper (CFSP)	4	0	1	4	Meeting minutes	BCG- DoH	MOH other Departments. Development Partners
	13.3.5 Number of advocacy meetings held at the county treasury and County Assembly, Budget Estimates	4	0	1	4	Meeting minutes	BCG- DoH	MOH other Departments. Development Partners
	13.3.6Number of submissions of nutrition commodities and equipment's budget included in the Medium-Term Review (MTR) secretariat.	1	0	1	1	CIDP report	BCG- DoH	MOH other Departments. Development Partners
Output 13.4 Improved optimal stock levels and reduced nutrition commodities expiry	13.4.1 Number of HCW's sensitized on accurate F&Q	235	0	78	235	Training report	BCG- DoH	MOH other Departments. Development Partners
	13.4.2 Number of routine data quality audits done	6	0	2	6	DQA report	BCG- DoH	MOH other Departments. Development Partners
	13.4.3 Number of nutritionists attending commodity forecasting and quantification workshop	15	0	5	15	Activity report	BCG- DoH	MOH other Departments. Development Partners
	13.4.4 Number of HPTU trainings attended by the CNC	1	0	1	1	Training report	BCG- DoH	MOH other Departments. Development Partners

Expected output results	Indicator	Target	Baseline 2023	Mid Term 2025	End Term 2027	Means of Verification	Lead Agency	Associated Partners
KRA 13: Strengthened Supply chain management for nutrition commodities and equipment								
Outcome: Improved supply chain management system for nutrition								
Output 13.5 Improved availability of nutrition commodities and assessment tools	13.5.1Number of nutritionists attending county MTC meetings	12		4	12	Meeting minutes	BCG- DoH	MOH other Departments. Development Partners
	13.5.2 Number of nutritionists attending Sub County hospital MTC meeting	84	7	28	84	Meeting minutes	BCG- DoH	MOH other Departments. Development Partners
	13.5.3 Quantity Iin cartons of RUTF procured as per request.	108167	90000	26769	108167	Delivery notes	BCG- DoH	MOH other Departments. Development Partners
	13.5.4 Quantity in cartons of RUSF procured as per request.	75520	50000	18689	75520	Delivery notes	BCG- DoH	MOH other Departments. Development Partners
	13.5.5 Quantity of CSB cartons procured as per request	111877	60000	27687	111877	Delivery notes	BCG- DoH	MOH other Departments. Development Partners
	13.5.6 Quantity of F75 tins procured as per request	21614	5000	5349	21614	Delivery notes	BCG- DoH	MOH other Departments. Development Partners
	13.5.7 Quantity of F100 tins procured as per request	30261	7000	7489	30261	Delivery notes	BCG- DoH	MOH other Departments. Development Partners
	13.5.8 Quantity of Vitamin A 100000IU tins procured as per request	1278	300	316	1278	Delivery notes	BCG- DoH	MOH other Departments. Development Partners

Expected output results	Indicator	Target	Baseline 2023	Mid Term 2025	End Term 2027	Means of Verification	Lead Agency	Associated Partners
KRA 13: Strengthened Supply chain management for nutrition commodities and equipment								
Outcome: Improved supply chain management system for nutrition								
	13.5.9 Quantity of Vitamin A 200000IU tins procured as per request	1690	400	418	1690	Delivery notes	BCG- DoH	MOH other Departments. Development Partners
	13.5.10 Quantity of Dewormers tablets procured as per request	254840	63000	63067	254840	Delivery notes	BCG- DoH	MOH other Departments. Development Partners
	13.5.11 Quantity of Resomal boxes procured as per request	219	50	54	219	Delivery notes	BCG- DoH	MOH other Departments. Development Partners
	13.5.12 Quantity of combined IFAS packets procured as per request	344031	85000	85139	344031	Delivery notes	BCG- DoH	MOH other Departments. Development Partners
	13.5.13 Quantity of TPN Feeds procured as per request	14838	3500	3672	14838	Delivery notes	BCG- DoH	MOH other Departments. Development Partners
	13.5.14 Quantity of nutrition commodities delivered to Health Facilities versus procured.	16	3	4	16	Waybills	BCG- DoH	MOH other Departments. Development Partners
	13.5.15 Number of needs assessments mapping done on nutrition commodities, equipment and reporting tools	16	3	4	16	Needs assessment report	BCG- DoH	MOH other Departments. Development Partners
	13.5.16 Number of 2 in 1 weighing scales procured	235	200	235	235	Delivery notes	BCG- DoH	MOH other Departments. Development Partners

Expected output results	Indicator	Target	Baseline 2023	Mid Term 2025	End Term 2027	Means of Verification	Lead Agency	Associated Partners
KRA 13: Strengthened Supply chain management for nutrition commodities and equipment								
Outcome: Improved supply chain management system for nutrition								
	13.5.17 Number of Bioelectric Impedance analyzers procured	7	0	7	7	Delivery notes	BCG- DoH	MOH other Departments. Development Partners
	13.5.18 Number of baby scales procured	20	4	5	20	Delivery notes	BCG- DoH	MOH other Departments. Development Partners
	13.5.19 Number of height boards procured	235	50	59	235	Delivery notes	BCG- DoH	MOH other Departments. Development Partners
	13.5.20 Number of tape measures procured	235	0	59	235	Delivery notes	BCG- DoH	MOH other Departments. Development Partners
	13.5.21 Number of breast models procured	35	0	35	35	Delivery notes	BCG- DoH	MOH other Departments. Development Partners
	13.5.22 Number of Baby Dolls procured	35	0	10	35	Delivery notes	BCG- DoH	MOH other Departments. Development Partners
	13.5.23 Number of cleft pallet nipple shields procured	70	0	24	70	Delivery notes	BCG- DoH	MOH other Departments. Development Partners
	13.5.24 Number of reporting tools procured MoH,409,410a and b,704,407 a and b.	1836	50	612	1836	Delivery notes	BCG- DoH	MOH other Departments. Development Partners

Expected output results	Indicator	Target	Baseline 2023	Mid Term 2025	End Term 2027	Means of Verification	Lead Agency	Associated Partners
KRA 13: Strengthened Supply chain management for nutrition commodities and equipment								
Outcome: Improved supply chain management system for nutrition								
	13.5.25 Number of monthly summary reporting tools procured MoH 734, 713 and 731	918	0	306	918	Delivery notes	BCG- DoH	MOH other Departments. Development Partners
	13.5.26 Quantity of nutrition equipment's and reporting tools delivered to the Health Facilities	12	0	4	12	Waybills	BCG- DoH	MOH other Departments. Development Partners
	13.5.27 Number of HMIS/LMIS reports generated to guide on stock status and redistributed	39	7	12	39	LMIS Report	BCG- DoH	MOH other Departments. Development Partners
	13.5.28 Number of Nutrition service delivery points with prepared budgets for procurement of nutrition equipment's	SDP's budget per subcounty-7	0	28	SDP's budget per subcounty-7	Budgets	BCG- DoH	MOH other Departments. Development Partners
Output 13.6 Functional nutrition equipment in use.	13.6.1 Number of equipment maintenance plans prepared and effected	3	0	1	3	Equipment maintenance plan	BCG- DoH	MOH other Departments. Development Partners
	13.6.2 Number of Nutrition equipment's accurately calibrated	100	10	20	100	Activity Report	BCG- DoH	MOH other Departments. Development Partners
Output 13.7 Enhanced quality of nutrition data for decision making.	13.7.1 Number of support supervision integrated with nutrition commodity management and reporting	12	0	4	12	Activity report	BCG- DoH	MOH other Departments. Development Partners
	13.7.2 Number of HCW's reached with OJT sessions done on documentation, commodity management and reporting	60	0	20	60	Activity report	BCG- DoH	MOH other Departments. Development Partners

Expected output results	Indicator	Target	Baseline 2023	Mid Term 2025	End Term 2027	Means of Verification	Lead Agency	Associated Partners
KRA 13: Strengthened Supply chain management for nutrition commodities and equipment								
Outcome: Improved supply chain management system for nutrition								
	13.7.3 Number of Laptops, Printers, and projectors procured for data capture processing and reporting	50	0	50	50	Delivery notes	BCG- DoH	MOH other Departments. Development Partners
	13.7.4 Number of Laptops, Printers, and projectors distributed for data capture processing and reporting	1	0	1	1	Waybills	BCG- DoH	MOH other Departments. Development Partners
	13.7.5 Number of quarterly commodities TWG review meetings held with nutrition data integrated	12	0	4	12	Activity report	BCG- DoH	MOH other Departments. Development Partners

CHAPTER 5:

Costing Framework For Baringo CNAP

5.1 Introduction

Costing is the process of determining, in monetary terms, the value of inputs required to produce a specific output. It involves estimating both the quantity and cost of resources needed to implement a particular activity or programme. Costing is a quantitative exercise that captures both operational (recurrent) and capital expenditures, ensuring that the resources allocated for service delivery are both cost-effective and affordable.

This process assigns the cost of inputs to specific interventions and activities with the aim of achieving defined goals or results. It also seeks to identify cost drivers—the factors that cause costs to vary. By tracing and assigning all activity-related costs to the relevant interventions or services, costing provides a transparent view of resource use.

This chapter outlines the resource requirements for implementing the County Nutrition Action Plan over the planned period. It details the total resources needed, the currently available resources, and the financing gap between what is required and what is anticipated to be available.

5.2 Cost Requirements for CNAP Implementation

The costing of Baringo County Nutrition Action Plan (BCNAP) 2024/2025–2027/2028 is a critical component that ensures the effective implementation of planned nutrition interventions. It provides a structured financial framework that translates strategic objectives into actionable investments, aimed at addressing malnutrition and enhancing the health and well-being of Baringo County residents.

The costing exercise was conducted through a participatory and multi-sectoral process involving stakeholders from key sectors including health, agriculture, Economic planning, education, water, and social protection. Guided by national costing tools and aligned with both the County Integrated Development Plan (CIDP) and the Medium-Term Expenditure Framework (MTEF), the costing ensures alignment with existing government priorities and budget cycles. This integration enhances ownership, transparency, and sustainability of nutrition programming at the county level.

The CNAP outlines the estimated financial requirements for delivering high-impact, evidence- based nutrition-specific and nutrition-sensitive interventions over the plan period. These investments are expected to yield significant returns in terms of improved maternal and child health, reduced stunting and wasting, increased school performance, and enhanced productivity.

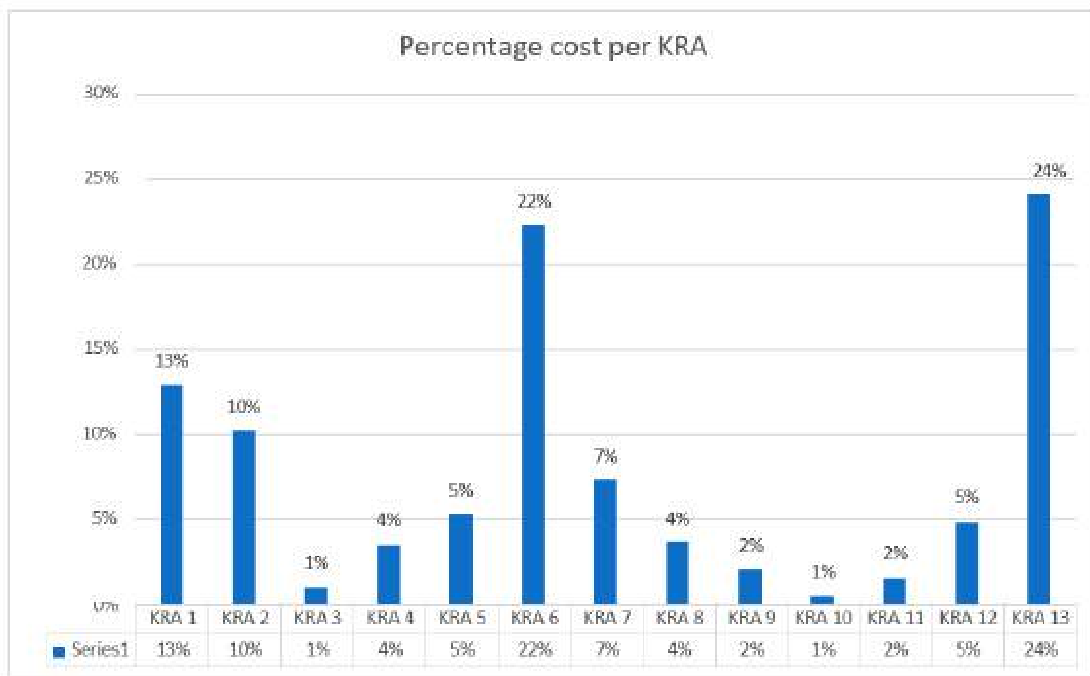
The successful implementation of the BCNAP will require coordinated financing and strategic partnerships. While the county government is committed to allocating resources and providing institutional support, additional investments from development partners and donors are essential to bridge the funding gap and scale up interventions. Baringo County offers a conducive environment for collaboration, with established monitoring and accountability systems to ensure transparency and impact.

5.3 Total Resource Requirements (2023/24 – 2027/28)

The framework was costed using the Activity-Based Costing (ABC) approach. ABC applies a bottom-up, input-based methodology that identifies the cost of all resources required to meet planned targets for the financial years 2023/24 to 2027/28. This approach enables detailed cost estimation across all pillars of the framework, providing essential information for dialogue among stakeholders and development partners to support priority-setting and ensure efficient resource allocation.

Each pillar outlines specific targets to be achieved during the plan period, along with the corresponding inputs necessary for their realization. Using these targets and the unit costs of inputs, the total cost of implementing the framework was calculated. Based on the ABC analysis, an estimated KES 1.3 billion is required to fully implement the strategic plan, as illustrated in the figure below. A detailed annual cost breakdown is also provided to guide planning and budgeting throughout the implementation period.

Table 8:Summary of CNAP Resource Requirements (KES Millions)



5.4 Resource Requirements by Key Result Areas

According to the costing estimates, the Baringo CNAP requires a total investment of KES 1,597,215,607 over the implementation period to support nutrition interventions. The breakdown of this investment across the key result areas is presented in the table below;

Table 9: Summary of Resource Requirements by Key Result Areas (KES Millions)

KRA	Year 1	Year 2	Year 3	Year 4	Year 5	Total	%
KRA 1	3, 500, 000	50,242,890	51,580,490	51,580,490	50,242,890	207,146,760	13%
KRA 2	29,728,000	29,728,000	34,795,400	34,795,400	34,620,400	163,667,200	10%
KRA 3	3,343,000	3,811,000	4,758,000	4,876,000	0	16,788,000	1%
KRA 4	0	0	2,7230,000	20,370,000	8,520,000	56,120,000	4%
KRA 5	0	20,602,000	20,680,000	23,394,300	20,812,300	85,488,600	5%
KRA 6	0	0	133,100,000	116,990,000	106,990,000	357,080,000	22%
KRA 7	8,350,000	22,250,000	29,575,000	29,575,000	28,680,000	118,430,000	7%
KRA 8	0	0	30,041,543	30,041,543	0	60,083,086	4%
KRA 9	0	33,860,675	0	0	33,995,075	33,995,062	2%
KRA 10	3,594,000	170,400	52,564,00	170,400	170,400	9,191,200	1%
KRA 11	0	5,696,620	8,426,620	5,696,620	5,696,620	25,516,480	2%
KRA 12	0	10,204,575	26,002,477	13,557,077	28,049,177	77813306	5%
KRA 13	106,865,000	248,816,160	332,664,530	313,631,830	284,574,462	385,895,913	24%
	155,380,000	425,382,320	698,854,060	644,678,660	602,351,324	1,597,215,607	100%

5.5 Strategies to ensure available resources are sustained

To ensure the successful implementation of the County Nutrition Action Plan (CNAP), it is essential to expand the resource base beyond traditional funding streams. The following strategies will be pursued to mobilize resources from new sources, enhance financial sustainability, and strengthen multi-stakeholder engagement:

- **Advocate for a Legislative Framework on Resource Mobilization and Allocation**
  Lobby for the development and enactment of a county-level legislative and policy framework that institutionalizes resource mobilization efforts, allocates dedicated budget lines for nutrition, and integrates nutrition financing into broader county development plans.
- **Identify and Engage Potential Donors (Bilateral, Multilateral, and Private Sector)**
  Systematically map and approach potential donors—including international development agencies, philanthropic foundations, and the private sector—who have a strategic interest in nutrition, health, and human capital development.
- **Conduct Comprehensive Stakeholder Mapping and Analysis**
  Undertake detailed mapping of stakeholders to identify key influencers, funding partners, implementing agencies, and community-based organizations. This will help to align interests, build coalitions, and leverage complementary resources and expertise.
- **Convene Resource Mobilization Forums and Partnership Dialogue**
  Organize high-level resource mobilization meetings with development partners, the private sector, civil society, and government agencies. These platforms will be used to present the CNAP investment case, showcase impact opportunities, and secure financial or in-kind commitments.
- **Appoint and Accredit Eminent Community Figures as Resource Mobilization Ambassadors**
  Identify respected and influential members of the community—including business leaders, professionals, and cultural icons—and formally appoint them as goodwill ambassadors for nutrition. Their involvement will raise the profile of the CNAP and attract wider public and private support.
- **Leverage Public-Private Partnerships (PPPs)**
  Explore and initiate strategic partnerships with the private sector to co-finance targeted interventions, support supply chains for nutrition commodities, or implement workplace nutrition programs.
- **Develop Compelling Investment Cases and Donor Briefs**
  Prepare evidence-based investment cases and tailored briefs that clearly demonstrate the return on investment in nutrition, link interventions to broader development goals, and outline co-financing or funding modalities.
- **Explore Innovative Financing Mechanisms**
  Investigate alternative funding models such as results-based financing, social impact bonds, or diaspora contributions to diversify funding streams and increase long-term sustainability.

5.6 Strategies to Ensure Efficient Utilization of Resources

To maximize the impact of available resources and ensure value for money in the implementation of the Baringo CNAP, the following strategies will be adopted to promote efficiency, accountability, and results-driven programming:

- **Strategic Planning Using SWOT Analysis**
  Conduct a Strengths, Weaknesses, Opportunities, and Threats (SWOT) analysis during the planning phase to inform the allocation and prioritization of resources. This will help identify potential risks and opportunities, allowing for more targeted and efficient use of funds.
- **Development of Detailed Annual Plans with Timelines and Budgets**
  Prepare comprehensive annual plans that outline specific activities, responsible parties, timelines, and budget allocations. This approach facilitates coordinated execution, avoids duplication of efforts, and enhances tracking of progress and expenditures.
- **Gender Mainstreaming for Equitable and Effective Interventions**
  Ensure that all nutrition interventions are gender-sensitive by integrating gender analysis into planning, implementation, and evaluation. This promotes inclusivity, addresses gender- specific needs, and enhances the overall impact of the interventions, particularly for women, children, and vulnerable groups.
- **Continuous Monitoring of Process and Impact Indicators**
  Establish a robust monitoring and evaluation (M&E) system to track process indicators (e.g., activity completion rates, coverage levels) and impact indicators (e.g., nutrition status improvements). Real-time data will be used to inform decision-making and reallocate resources where necessary for maximum efficiency.
- **Periodic Evaluation of Progress Against Objectives**
  Conduct regular evaluations—mid-term and end-term reviews—to assess whether planned objectives are being achieved. These evaluations will identify bottlenecks, highlight best practices, and inform adjustments to improve program performance and resource use.
- **Use of Performance-Based Accountability Mechanisms**
  Introduce performance-based budgeting and accountability systems that link resource allocation to measurable outcomes. Departments and implementing partners will be held accountable for delivering results within the allocated budgets.
- **Capacity Building for Efficient Financial and Program Management**
  Train staff and implementing partners on financial management, procurement, and results-based programming to strengthen capacity and reduce inefficiencies related to poor planning or mismanagement of funds.
- **Leveraging Technology for Real-Time Tracking and Reporting**
  Utilize digital tools and platforms to streamline data collection, financial reporting, and program monitoring. Technology-enabled systems enhance transparency, reduce administrative costs, and facilitate faster decision-making.
- **Regular Stakeholder Feedback and Adaptive Management**
  Engage stakeholders, including communities, in providing feedback on implementation progress and resource use. This participatory approach helps ensure accountability, builds trust, and allows for flexible adaptation of strategies to improve efficiency.

Expected Outputs	Strategy	Intervention	Budget (Ksh.)					Responsibility	
			Y1	Y2	Y3	Y4	Y5	Lead	Support
KRA 1: Maternal Infant and Young Child (MIYC) Nutritional wellbeing									
Strategic Objective 1: To improve maternal nutrition practices and services.									
Output 1.1: Enhanced knowledge, skills and competence of MIYCN among HCWs, CHPs And management	Capacity Building and awareness creation	Train County ToTs on BFCI		707,200	707,200	707,200	707,200	BCG-DOH	MOH other Departments Development Partners
		Train County ToTs on BFHI		740,800	740,800	740,800	740,800	BCG-DOH	MOH other Departments Development Partners
		Train County ToTs on BMS Act and its regulations		459,200	459,200	459,200	459,200	BCG-DOH	MOH other Departments Development Partners
		Train County ToTs on PD Hearth Model		735,200	735,200	735,200	735,200	BCG-DOH	MOH other Departments Development Partners
		Train County ToTs on MIYCN-E		736,800	736,800	736,800	736,800	BCG-DOH	MOH other Departments Development Partners
		Sensitize County ToTs on Workplace support for breastfeeding mothers		98,200	98,200	98,200	98,200	BCG-DOH	MOH other Departments Development Partners
		Train health care workers on MIYCN		3,596,800	3,596,800	3,596,800	3,596,800	BCG-DOH	MOH other Departments Development Partners
		Train health care workers on BFCI		3,596,800	3,596,800	3,596,800	3,596,800	BCG-DOH	MOH other Departments Development Partners
		Train health care workers on BFHI		3,596,800	3,596,800	3,596,800	3,596,800	BCG-DOH	MOH other Departments Development Partners
		Train health care workers on MIYCN-E		1,187,000	1,187,000	1,187,000	1,187,000	BCG-DOH	MOH other Departments Development Partners
		Train health care workers on PDH model		4,740,800	4,740,800	4,740,800	4,740,800	BCG-DOH	MOH other Departments Development Partners
		Sensitize healthcare workers on breastfeeding workplace support		840,200	840,200	840,200	840,200	BCG-DOH	MOH other Departments Development Partners
		Sensitize CHPs on MIYCN		2,367,000	2,367,000	2,367,000	2,367,000	BCG-DOH	MOH other Departments Development Partners

Expected Outputs	Strategy	Intervention	Budget (Ksh.)					Responsibility	
			Y1	Y2	Y3	Y4	Y5	Lead	Support
KRA 1: Maternal Infant and Young Child (MIYC) Nutritional wellbeing									
Strategic Objective 1: To improve maternal nutrition practices and services.									
		Sensitize CHPs on c-BFCI		1,832,000	1,832,000	1,832,000	1,832,000	BCG-DOH	MOH other Departments Development Partners
		Sensitize CHPs on MIYCN-e		2,319,000	2,319,000	2,319,000	2,319,000	BCG-DOH	MOH other Departments Development Partners
		Sensitize CHPs on breastfeeding workplace support		648,500	648,500	648,500	648,500	BCG-DOH	MOH other Departments Development Partners
		Sensitize CHPs on PDH model		1,893,600	1,893,600	1,893,600	1,893,600	BCG-DOH	MOH other Departments Development Partners
		Sensitize CHPs on the BMS Act and its regulations		580,400	580,400	580,400	580,400	BCG-DOH	MOH other Departments Development Partners
		Conduct OJTs/CMEs/ mentor ship session to health care workers at the facility level on MIYCN, BFCI, BMS Act and the PDH		0	0	0	0	BCG-DOH	MOH other Departments Development Partners
		Sensitize CHMTs and SCHMTs on BFHI		492,500	492,500	492,500	492,500	BCG-DOH	MOH other Departments Development Partners
		Sensitize HMTs on BFHI		548,500	548,500	548,500	548,500	BCG-DOH	MOH other Departments Development Partners
		Sensitize CHMTs and SCHMTs on BFCI		492,500	492,500	492,500	492,500	BCG-DOH	MOH other Departments Development Partners
		Sensitize HMTs on BFCI		548,500	548,500	548,500	548,500	BCG-DOH	MOH other Departments Development Partners
		Sensitize CHMTs, SCHMTs on BMS Act		492,500	492,500	492,500	492,500	BCG-DOH	MOH other Departments Development Partners
		Sensitize HMTs on the BMS Act		548,500	548,500	548,500	548,500	BCG-DOH	MOH other Departments Development Partners

Expected Outputs	Strategy	Intervention	Budget (Ksh.)					Responsibility	
			Y1	Y2	Y3	Y4	Y5	Lead	Support
KRA 1: Maternal Infant and Young Child (MIYC) Nutritional wellbeing									
Strategic Objective 1: To improve maternal nutrition practices and services.									
		Sensitize CHMTs and SCHMTs breastfeeding workplace support		492,500	492,500	492,500	492,500	BCG-DOH	MOH other Departments Development Partners
		Sensitize HMTs on breastfeeding workplace support		548,500	548,500	548,500	548,500		
		Sensitize CHMTs, SCHMTs PDH		492,500	492,500	492,500	492,500	BCG-DOH	MOH other Departments Development Partners
		Sensitize HMTs on PDH		548,500	548,500	548,500	548,500	BCG-DOH	MOH other Departments Development Partners
Output 1.2: Strengthened quality of nutrition services targeting women of reproductive age and children under 5 years	Service Delivery, Awareness Creation	Formation of BFHI committee at the health facility level		0	0	0	0	BCG-DOH	MOH other Departments Development Partners
		Sensitization of the BFHI committee and the non-technical staff in the health		0	0	0	0	BCG-DOH	MOH other Departments Development Partners
		Conduct a BFHI baseline assessment		82,800	82,800	82,800	82,800	BCG-DOH	MOH other Departments Development Partners
		Monitoring and follow up of BFHI activities		0	0	0	0	BCG-DOH	MOH other Departments Development Partners
		Conduct internal and external BFHI assessments		84,000	221,600	221,600	84,000	BCG-DOH	MOH other Departments Development Partners
		Accreditation of the facilities as BFHI compliant		0	0	0	0	BCG-DOH	MOH other Departments Development Partners
		Community mobilization in readiness for PD hearth		0	0	0	0	BCG-DOH	MOH other Departments Development Partners
		Mapping and enrollment of households with underweight children 6-59 months into PD- Hearth		720,000	720,000	720,000	720,000	BCG-DOH	MOH other Departments Development Partners

Expected Outputs	Strategy	Intervention	Budget (Ksh.)					Responsibility	
			Y1	Y2	Y3	Y4	Y5	Lead	Support
KRA 1: Maternal Infant and Young Child (MIYC) Nutritional wellbeing									
Strategic Objective 1: To improve maternal nutrition practices and services.									
		Conduct hearth sessions		0	0	0	0	BCG-DOH	MOH other Departments Development Partners
		Situational analysis		55,800	55,800	55,800	55,800	BCG-DOH	MOH other Departments Development Partners
		Monitoring of PDH		30,000	30,000	30,000	30,000	BCG-DOH	MOH other Departments Development Partners
		Mapping of households with children 6-23 months-BFCI targeting		720,000	720,000	720,000	720,000	BCG-DOH	MOH other Departments Development Partners
		Formation of CMSGs		0	0	0	0	BCG-DOH	MOH other Departments Development Partners
		Formation of the M2MSGs/ F2FSGs		0	0	0	0	BCG-DOH	MOH other Departments Development Partners
		Monthly CHP review meetings		180,000	180,000	180,000	180,000	BCG-DOH	MOH other Departments Development Partners
		Bi-monthly CMSGs meetings		112,500	112,500	112,500	112,500	BCG-DOH	MOH other Departments Development Partners
		Weekly M2MSG meetings		4,875,000	4,875,000	4,875,000	4,875,000	BCG-DOH	MOH other Departments Development Partners
		Monthly baby friendly community gatherings		1,125,000	1,125,000	1,125,000	1,125,000	BCG-DOH	MOH other Departments Development Partners
		Follow ups and monitoring		30,000	30,000	30,000	30,000		
		Internal and external BFCI assessments		237,600	237,600	237,600	237,600	BCG-DOH	MOH other Departments Development Partners
		Accreditation of CUs as BFCI compliant		0	0	0	0		
Output 1.3: Promote micronutrient supplementati on coverage	Service delivery and awareness creation	Promote routine VAS+D supplementation targeting children 6-59 months in health facilities, outreach sites, ECDE centres and other hard-to-reach areas	1,400,000	1,855,000	1,855,000	1,855,000	1,855,000	BCG-DOH	MOH other Departments Development Partners

Expected Outputs	Strategy	Intervention	Budget (Ksh.)					Responsibility	
			Y1	Y2	Y3	Y4	Y5	Lead	Support
KRA 1: Maternal Infant and Young Child (MIYC) Nutritional wellbeing									
Strategic Objective 1: To improve maternal nutrition practices and services.									
		Train/sensitize healthcare workers on IFAS/MMS and MNPs	100,000	30,000	30,000	30,000	30,000	BCG-DOH	MOH other Departments Development Partners
		Provision of IFAS/MMS to pregnant women during ANC visits	-					BCG-DOH	MOH other Departments Development Partners
		Advocate for purchase and distribution of MNPs, VAS+D and IFAS/MMS in the County	2,000,000	450,000	450,000	450,000	450,000	BCG-DOH	MOH other Departments Development Partners
Output 1.4: Improved adoption of MIYCN Practices	Awareness creation	Sensitize County Executives and County Assembly members on MIYCN policy, BMS Act and workplace support for breastfeeding mothers		599,940	599,940	599,940	599,940	BCG-DOH	MOH other Departments Development Partners
Output 1.5: Improved nutritional status of children 6-59 months and pregnant and lactating mother	Awareness creation	Advocate for/conduct awareness on breastfeeding during Global/National events (World Breastfeeding week etc)		435,950	435,950	435,950	435,950	BCG-DOH	MOH other Departments Development Partners
		Adopt, contextualize and disseminate the SBC package for MIYCN and micronutrient supplementation		770,000	1,970,000	1,970,000	770,000	BCG-DOH	MOH other Departments Development Partners
		Hold advocacy meetings in both formal and informal sectors to position breastfeeding agenda at the workplace		470,000	470,000	470,000	470,000	BCG-DOH	MOH other Departments Development Partners

Expected Outputs	Strategy	Intervention	Budget (Ksh.)					Responsibility	
			Y1	Y2	Y3	Y4	Y5	Lead	Support
KRA 1: Maternal Infant and Young Child (MIYC) Nutritional wellbeing									
Strategic Objective 1: To improve maternal nutrition practices and services.									
Output 1.6: Improved evidence- based decision making for MIYCN and micronutrient programming	Service Delivery, Evidence Generation	Conduct MIYCN assessment and surveys for evidence generation to inform programming (MIYCN KABP survey and MIYCN-E Assessments) national, regional and international levels to share best practices		800,000	800,000	800,000	800,000	BCG-DOH	MOH other Departments Development Partners
		Participate in Micronutrient and MIYCN learning forums at County,		450,000	450,000	450,000	450,000	BCG-DOH	MOH other Departments Development Partners
		Hold advocacy meetings for prioritization of MIYCN assessments and surveys		220,000	220,000	220,000	220,000	BCG-DOH	MOH other Departments Development Partners
		Hold meetings to identify research areas around MIYCN and micronutrient programming		0	0	0	0	BCG-DOH	MOH other Departments Development Partners
Output 1.7: Performance of MIYCN and micronutrient indicators visualized	Service delivery	Integrate MIYCN and micronutrient supplementation into ongoing RDQAs		0	0	0	0	BCG-DOH	MOH other Departments Development Partners
		Conduct monitoring, surveillance and reporting of the BMS Act violation and enforcement		28,000	28,000	28,000	28,000	BCG-DOH	MOH other Departments Development Partners
		Track number of MIYCN and micronutrient activity indicators captured in the health information system (KHIS, ECHIS)		0	0	0	0	BCG-DOH	MOH other Departments Development Partners

Expected Outputs	Strategy	Intervention	Budget (Ksh.)					Responsibility	
			Y1	Y2	Y3	Y4	Y5	Lead	Support
KRA 1: Maternal Infant and Young Child (MIYC) Nutritional wellbeing									
Strategic Objective 1: To improve maternal nutrition practices and services.									
Output 1.8: MIYCN interventions integrated in key ministries departments	Capacity building	Participate in Micronutrient and MIYCN learning forums at County, national, regional and international levels to share best practices		0	0	0	0	MOH	MOH other Departments Development Partners
Total			**3,500,000**	**50,242,890**	**51,580,490**	**51,580,490**	**50,242,890**		**207,146,760**

Expected Outputs	Strategy	Intervention	Budget (Ksh.)					Responsibility	
			Y1	Y2	Y3	Y4	Y5	Lead	Support
KRA 2: Improved nutritional well-being of older children, adolescents, adults, and older persons.									
Strategic Objective 1: To improve maternal nutrition practices and services.									
Output 2.1: Increased nutrition awareness and uptake of nutrition services among stakeholders.	Enhance the nutritional status of older children (5-9 yrs.) Adolescents (10-19 Yrs.) Adults and older persons	Disseminate nutrition policies, guidelines (food-based dietary guidelines; menu guidelines; sports nutrition guidelines; healthy diet and physical activity to stakeholders (CHMT, SCHMT, and HMT)	5,344,000	5,344,000	5,344,000	5,344,000	5,344,000	BCG-DOH	MOH other Departments Development Partners
		Sensitize key influencers (Media), policy makers (MCAs, health /education committee) and nutrition champions (county first lady- patron) on nutrition for older children and adolescents	1,444,000	1,444,000	1,444,000	1,444,000	1,444,000	BCG-DOH	MOH/other Departments/ Development Partners

Expected Outputs	Strategy	Intervention	Budget (Ksh.)					Responsibility	
			Y1	Y2	Y3	Y4	Y5	Lead	Support
KRA 2: Improved nutritional well-being of older children, adolescents, adults, and older persons.									
Strategic Objective 1: To improve maternal nutrition practices and services.									
Output 2.2: Increased awareness on healthy diets among stakeholders	Capacity- build stakeholders on healthy diets and physical activity	Train/sensitize HCWs and CHPs healthy diets and physical activity	22,240,000	22,240,000	42,415,000	42,415,000	22,240,000	BCG-DOH	MOH/other Departments/ Development Partners
		Sensitize older children, adolescents on healthy diets and physical activity using context- specific communication channels such as youth camp/ church, sports in both rural and urban setups	50,700,000	50,700,000	50,700,000	50,700,000	50,700,000	BCG-DOH	MOH/other Departments/ Development Partners
		Create awareness of healthy diets and physical to Parents/ guardians using effective communication channels such as local media, churches/Mosque, and public barazas	0	0	2,494,800	2,494,800	2,494,800	BCG-DOH	MOH/other Departments/ Development Partners
Output 2.3: Early detection of NCDs for proper management	Strengthen access to preventive and promotive and nutrition services for adults and older persons	Promote nutrition assessment and screening for NCDs among adults and older persons through integrated medical camps and refer appropriately	0	0	2,397,600	2,397,600	2,397,600	BCG-DOH	MOH/other Departments/ Development Partners

Expected Outputs	Strategy	Intervention	Budget (Ksh.)					Responsibility	
			Y1	Y2	Y3	Y4	Y5	Lead	Support
KRA 2: Improved nutritional well-being of older children, adolescents, adults, and older persons.									
Strategic Objective 1: To improve maternal nutrition practices and services.									
		Promote nutrition assessment and referral for malnutrition among adult and older persons during household visits by CHPs	0	0	0	0	0	BCG-DOH	MOH/other Departments / Development Partners
Total			**29,728,000**	**29,728,000**	**34,795,400**	**34,795,400**	**34,620,400**	**163,667,200**	

Expected Outputs	Strategy	Intervention	Budget (Ksh.)					Responsibility	
			Y1	Y2	Y3	Y4	Y5	Lead	Support
KRA 3: Enhanced Industrial Fortification for Prevention and control of micro-nutrient deficiencies									
Strategic Objective 1:To Increase access to safe and adequately fortified foods in line with existing standards									
Output 3.1: Improved compliance of fortified foods to standards and regulations	policies and regulations Implementation	Disseminate food fortification strategic plan to (CECs, Cos, CDs, CHMTs, HMTs, SCHMTs)	0	270,000	270,000	270,000	0		MOH other Departments Development Partners
Output :3.2 Increased knowledge on food fortification and iodine testing among HCWs, CHPS, and representatives of tertiaty instituitions	Capacity building of stakeholders	Sensitize CHPs on food fortification and fortified foods in the local market	575,000	575,000	575,000	575,000	-	BCG-DOH	MOH/other Departments/ Development Partners
		Train HCW on food fortification	400,000	400,000	400,000	400,000	-	BCG-DOH	MOH/ other Departments/ Development Partners
		Sensitize Nutritionists/ dieticians and PHOs on Iodine testing for table salts	0	0	1,065,000	1,065,000	0	BCG-DOH	MOH other Departments Development Partners

Expected Outputs	Strategy	Intervention	Budget (Ksh.)					Responsibility	
			Y1	Y2	Y3	Y4	Y5	Lead	Support
KRA 3: Enhanced Industrial Fortification for Prevention and control of micro-nutrient deficiencies									
Strategic Objective 1:To Increase access to safe and adequately fortified foods in line with existing standards									
Output 3.3: Increased use of fortified foods	Advocacy on Behavior Change and Communication	Conduct nutrition health talks on food fortification in health facilities	150,000	150,000	150,000	150,000		BCG-DOH	MOH other Departments Development Partners
		Disseminate nutrition education materials	750,000	750,000	750,000	750,000		BCG-DOH	MOH other Departments Development Partners
		Awareness creation radio talk shows	100,000	100,000	100,000	100,000		BCG-DOH	MOH other Departments Development Partners
		Conduct support supervision with food fortification indicators	1,068,000	1,068,000	1,068,000	1,068,000		BCG-DOH	MOH other Departments Development Partners
Output 3.4: Improved Surveillance and Monitoring Systems of food fortification activities in the county	Surveillance and Monitoring	Conduct review meetings to be integrated with food fortification		30,000	30,000	30,000		BCG-DOH	MOH other Departments Development Partners
		Conduct monitoring activity on salt iodization		20,000	20,000	20,000		BCG-DOH	MOH other Departments Development Partners
		Conduct market surveillance on food fortification		148,000		148,000		BCG-DOH	MOH other Departments Development Partners
Output 3.5: Strengthened partnerships and coordinated actions for food fortification	Partnerships and collaboration on food fortification	Sensitize small millers on food fortification	300,000	300,000	300,000	300,000		BCG-DOH	MOH other Departments Development Partners

Expected Outputs	Strategy	Intervention	Budget (Ksh.)					Responsibility	
			Y1	Y2	Y3	Y4	Y5	Lead	Support
KRA 3: Enhanced Industrial Fortification for Prevention and control of micro-nutrient deficiencies									
Strategic Objective 1:To Increase access to safe and adequately fortified foods in line with existing standards									
		Establish food safety and fortification committee			30,000			BCG-DOH	MOH other Departments Development Partners
Total			**3,343,000**	**3,811,000**	**4,758,000**	**4,876,000**	**0**	**16,788,000**	

Expected Outputs	Strategy	Intervention	Budget (Ksh.)					Responsibility	
			Y1	Y2	Y3	Y4	Y5	Lead	Support
KRA 4: Clinical nutrition and dietetic services across all level of health care Improved									
Strategic Objective 1: To improve and scale up clinical nutrition and dietetics services across all levels of healthcare.									
Output 4.1. Enhanced awareness of clinical nutrition guidelines, protocols and SOPs (clinical nutrition, HIV, TB, IMAM) among CHMT, SCHMT, HMT and health care workers.	Strengthen policy environment for clinical nutrition and dietetics services	Disseminate nutrition and dietetics related guidelines, protocols and SOPs (clinical nutrition, HIV, TB, IMAM) to CHMT, SCHMT and HMT	0	0	0	0	0	BCG-DOH	MOH other Departments Development Partners
4.2. Improved knowledge and skills in clinical nutrition services	Strengthen health workforce capacity on clinical nutrition services	Train nutritionists on specialized clinical nutrition related courses (enteral/ parenteral nutrition, critical care, renal, oncology and metabolic disorders)	0	0	8,380,000	0	0	BCG-DOH	MOH/other Departments/ Development Partners
		Conduct CMEs on clinical nutrition (HIV, TB, DRNCDs, IMAM) in Health facilities	0	0	0	0	0	BCG-DOH	MOH/ other Departments/ Development Partners

Expected Outputs	Strategy	Intervention	Budget (Ksh.)					Responsibility	
			Y1	Y2	Y3	Y4	Y5	Lead	Support
KRA 4: Clinical nutrition and dietetic services across all level of health care Improved									
Strategic Objective 1: To improve and scale up clinical nutrition and dietetics services across all levels of healthcare.									
		Train HCWs on Nutrition in TB/HIV, IMAM, management and control of DRNCD	0	0	8,380,000	10,200,000	0	BCG-DOH	MOH/ other Departments/ Development Partners
		Sensitize CHPS and peer educators on Nutrition in TB/HIV	0	0	8,520,000	8,520,000	8,520,000	BCG-DOH	MOH/ other Departments/ Development Partners
4.3 Improved management of nutrition care for patients	Enhance quality clinical nutrition services	Promote nutrition assessment counseling and support to all individuals seeking health care services in the health facilities (CCC, TB, DRNCDs and Outpatient therapeutic Clinics and in-patient care,)	0	0	0	0	0	BCG-DOH	MOH/ other Departments/ Development Partners
		Adopt and disseminate clinical nutrition IEC/BCC materials to HCWs and patients	0	0	0	0	0	BCG-DOH	MOH/ other Departments/ Development Partners
		Establishment of inpatient feeding committees in healthcare facilities offering inpatient care, including public, private, and faith-based organizations (FBOs)	0	0	0	0	0	BCG-DOH	MOH/ other Departments/ Development Partners

Expected Outputs	Strategy	Intervention	Budget (Ksh.)					Responsibility	
			Y1	Y2	Y3	Y4	Y5	Lead	Support
KRA 4: Clinical nutrition and dietetic services across all level of health care Improved									
Strategic Objective 1: To improve and scale up clinical nutrition and dietetics services across all levels of healthcare.									
		Implement standardized nutrition protocols and Standard Operating Procedures (SOPs) for managing key health conditions (such as diabetes, cardiovascular disease, malnutrition, and renal disease) across all healthcare facilities	0	0	300,000	0	0	BCG-DOH	MOH/ other Departments/ Development Partners
		Integrate nutrition services into all specialized clinics (including Diabetes, CCC, TB, CWC, Hypertension, Renal, and Oncology) across healthcare facilities	0	0	0	0	0	BCG-DOH	MOH/ other Departments/ Development Partners
		Scale up IMAM services in 10 new facilities	0	0	0	0	0	BCG-DOH	MOH/ other Departments/ Development Partners
4.4 Improved supply chain for clinical nutrition and dietetic services	strengthen supply chain management for clinical nutrition and dietetic services	Advocate for procurement specialized nutrition commodities for nutrition management (IMAM commodities, parenteral and enteral feeds)	0	0	0	0	0	BCG-DOH	MOH/ other Departments/ Development Partners
		Advocate for procurement of anthropometric equipment (MUAC tapes, infant scales, height boards, 2 in 1 weighing scales) and pallets	0	0	0	0	0	BCG-DOH	MOH/ other Departments/ Development Partners

Expected Outputs	Strategy	Intervention	Budget (Ksh.)					Responsibility	
			Y1	Y2	Y3	Y4	Y5	Lead	Support
KRA 4: Clinical nutrition and dietetic services across all level of health care Improved									
Strategic Objective 1: To improve and scale up clinical nutrition and dietetics services across all levels of healthcare.									
4.5 Enhanced awareness on clinical nutrition and dietetics among the public	Advocacy communication and social mobilization communication for clinical nutrition and dietetic services	Disseminate nutrition specific messages that promotes positive behavior for TB/ PLHIV, DRNCDs, through local media to the public	0	0	1,650,000	1,650,000	0	BCG-DOH	MOH/ other Departments/ Development Partners
		Participate in health thematic days (diabetes, hypertensive, cancer and kidney) to create awareness on nutrition in the management of diet related NCDs	0	0	0	0	0	BCG-DOH	MOH/ other Departments/ Development Partners
		Advocate for establishment of DRNCD support group for DM and cancer patients in health care facilities	0	0	0	0	0	BCG-DOH	MOH/ other Departments/ Development Partners
		Advocate for establishment of nutrition wellness clinics in 7 facilities	0	0	0	0	0	BCG-DOH	MOH/ other Departments/ Development Partners
4.6. Improved performance of clinical nutrition and dietetic services	Strengthen monitoring and evaluation for clinical nutrition and dietetic services	Monitor and evaluate the quality of nutrition services using established standards based on guidelines, protocols and SOPs.	0	0	0	0	0	BCG-DOH	MOH/ other Departments/ Development Partners
		Documentation and reporting on clinical nutrition	0	0	0	0	0	BCG-DOH	MOH/ other Departments/ Development Partners

Expected Outputs	Strategy	Intervention	Budget (Ksh.)					Responsibility	
			Y1	Y2	Y3	Y4	Y5	Lead	Support
KRA 4: Clinical nutrition and dietetic services across all level of health care Improved									
Strategic Objective 1: To improve and scale up clinical nutrition and dietetics services across all levels of healthcare.									
		Integrate clinical nutrition interventions (HIV, TB, DRNCDs, IMAM) during RDQA	0	0	0	0	0	BCG-DOH	MOH/ other Departments/ Development Partners
		Integrate clinical nutrition interventions (HIV, TB, DRNCDs, IMAM) during data review meetings	0	0	0	0	0	BCG-DOH	MOH/ other Departments/ Development Partners
4.7 Improved patient care, better clinical outcomes, and more efficient use of resources	Partnerships and collaborations for clinical nutrition and dietetic services	Link and refer IMAM clients with other programs within the community (WASH, MIYCN support groups, social protection and food security)	0	0	0	0	0	BCG-DOH	MOH/ other Departments/ Development Partners
		Advocate for public private partnership in the implementation of clinical nutrition and dietetic services	0	0	0	0	0	BCG-DOH	MOH/ other Departments/ Development Partners
Total			**0**	**0**	**27,230,000**	**27,230,000**	**8,520,000**	**56,120,000**	

Expected Outputs	Strategy	Intervention	Budget (Ksh.)					Responsibility	
			Y1	Y2	Y3	Y4	Y5	Lead	Support
KRA 5: Sustained nutritional well-being of individuals and communities during emergencies and climate-related shocks.									
Strategic Objective 1: To strengthen coordination, partnership, advocacy and policy for integrated preparedness, response and recovery initiatives									
Strengthen Coordination and partnership for nutrition preparedness, response and recovery	Participate in CSG		-	-	-	-	-	Department of Health	MOH and other Departments. Development Partners
	Participate in the participatory scenario planning meetings.		-	-	-	-	-	Department of Health	MOH and other Departments. Development Partners
	Develop Nutrition contingency plan		-	-	-	-	-	Department of Health	MOH and other Departments. Development Partners
	Participate in joint emergency coordination forum		-	1,156,500	1,156,500	1,156,500	1,156,500	Department of Health	MOH and other Departments. Development Partners
Strengthened capacity of systems and individuals to undertaken emergency preparedness actions.	Disseminate Nutrition SOPs for emergency response to emergency response team		-	75,000	75,000	75,000	75,000	Department of Health	MOH and other Departments. Development Partners
	Contract storage hub for nutritional commodities		-	700,000	700,000	700,000	700,000	Department of Health	MOH and other Departments. Development Partners
	Sensitization of NDMA monitors on nutrition assessment, family MUAC and referrals during emergencies		-	-	78,000	-	-	Department of Health	MOH and other Departments. Development Partners

Expected Outputs	Strategy	Intervention	Budget (Ksh.)					Responsibility	
			Y1	Y2	Y3	Y4	Y5	Lead	Support
KRA 5: Sustained nutritional well-being of individuals and communities during emergencies and climate-related shocks.									
Strategic Objective 1: To strengthen coordination, partnership, advocacy and policy for integrated preparedness, response and recovery initiatives									
	Training/Sensitize of health managers (CHMTs) on IMAM surge.		-	2,393,000	2,393,000	2,393,000	2,393,000	Department of Health	MOH and other Departments. Development Partners
	Sensitize HWCs, CHPs and disaster response teams on nutrition emergency policies		-	1,752,500	1,752,500	1,542,200	1,962,800	Department of Health	MOH and other Departments. Development Partners
Informed emergency nutrition response.	Participate in rapid assessments (KIRA)		-	-	-	-	-	Department of Health	MOH and other Departments. Development Partners
	Conduct MIYCN- E assessment		-	-	-	1,406,100	-	Department of Health	MOH and other Departments. Development Partners
Reduced cases of malnutrition spike during emergencies	Referral linkages to other programs such as livelihood, social protection, education		-	-	-	-	-	Department of Health	MOH and other Departments Development Partners
	Scale up of integrated medical outreaches during emergencies		-	14,525,000	14,525,000	14,525,000	14,525,000	Department of Health	MOH and other Departments Development Partners
	Advocate for key assessments (SMART, KAP, sitreps) during recovery phases		-	-	-	-	-	Department of Health	MOH and other Departments. Development Partners
	Scale up of facilities implementing IMAM surge approach		-	-	-	1,596,500	-	Department of Health	MOH and other Departments. Development Partners
Total			**0**	**20,602,000**	**20,680,000**	**23,394,300**	**20,812,300**	**85,488,600**	

Expected Outputs	Strategy	Intervention	Budget (Ksh.)					Responsibility	
			Y1	Y2	Y3	Y4	Y5	Lead	Support
KRA 6. Enhanced integration of nutrition into agriculture, livestock, and fisheries sectors.									
Strategic Objective 1: To improve maternal nutrition practices and services.									
Output 6.1. Improve Household dietary diversification at community level.	Diversification of farm production	Promote production of safe, diverse and nutritious food such as traditional high value crops (THVCs) Ie..Cowpeas, beans, sweetpotatoes, Cassava, Millet and sorghum.	0	0	14,600,000	14,600,000	14,600,000	DALBE, MOH	Development Partners
		Promote Excavation of farm ponds to enhance fish production and vegetable production.	0	0	63,120,000	63,120,000	63,120,000	DALBE,	Development Partners, DALBE
		Promote Restocking of community water pans and dams with fingerlings in collaboration with Fisheries & Water departments towards increased food production	0	0	26,400,000	26,400,000	26,400,000	DALBE,	Development Partners, DALBE
		Advocate for affruitation; mangoes, pawpaws for sale in collaboration with department of agriculture	0	0	3,150,000	180,000	180,000	DALBE,	KALRO, KVDA, DALBE
		Promote small stock; shoats, poultry and rabbits for dietary diversification	0	0	126,300,000	126,300,000	126,300,000	DALBE, MOH	Development Partners, DALBE
		Support affruitation; mangoes, pawpaws for sale in collaboration with department of agriculture	0	0	3,150,000	3,150,000	3,150,000	DALBE	KALRO, KVDA, DAL BE
Output 6.2 Enhanced knowledge and skills on Nutrition Sensitive Agriculture (NSA) and food systems among different stakeholders.	Enhance capacity of different stakeholders on nutrition sensitive agriculture (NSA) and food systems (FS)	Advocate for nutrition sensitive agricultural production to key decision makers (CECM, CO, CDA)	0	0	7,450,000	0	0	DALBE	Development Partners and other partners
		Sensitize extension staff (men and women), lead farmers, on Nutrition Sensitive Agriculture (NSA) and food systems in collaboration with nutrition	0	0	2,960,000	2,890,000	2,890,000	DALBE	Development Partners and other partners

Expected Outputs	Strategy	Intervention	Budget (Ksh.)					Responsibility	
			Y1	Y2	Y3	Y4	Y5	Lead	Support
KRA 6. Enhanced integration of nutrition into agriculture, livestock, and fisheries sectors.									
Strategic Objective 1: To improve maternal nutrition practices and services.									
		Train/sensitize Health care workers (HCWs) and Community Health Promoters (CHPs) on Agrinutrition	0	0	11,920,000	0	0	MOH, DALBE	MOH, Development Partners and others
		Train decision makers (CECM, Cos and Directors) in the agriculture department and stakeholders on nutrition-sensitive agriculture and food systems	0	0	7,450,000	0	0	DALBE,	Development Partners and other partners
Output 6.3 Improved access of safe nutritious food.	Promote increased access to nutritious and safe food along the food value chain pathways	Promote Biofortified food processing, preservation, and storage technologies Food safety & Quality (FSQ) at community level	0	0	16,350,000	16,350,000	16,350,000	MOH, DALBE	MOH, Development Partners and others
Output 6.4: Improved Uptake of various technologies in agricultural production	Promote agricultural technologies towards enhanced food security	Promote use of certified seeds, energy saving, small scale irrigation,intergrated pest management (IPM) hermatic bags/ metal silos	0	0	5,4000,000	5,4000,000	5,4000,000	DALBE	DALBE, Development Partners
		Promote the establishment of kitchen gardens in schools, homes, and institutions... i.e, water bottles, containers, tyres, and bags for growing vegetables	0	0	250,000	0	0	DALBE	DALBE, Development Partners
Output 6.5 Improved coordination and collaboration on agriculture and nutrition	Strengthening Linkages between nutrition, agriculture and food security.	Advocate for formation of Agri nutrition technical working group (TWG) at county level	0	0	6,270,000	6,270,000	6,270,000	DALBE	DALBE, Development Partners
		Hold joint planning meeting in collaboration with nutrition department with relevant departments	0	0	6,570,000	6,570,000	6,570,000	MOH, DALBE	MOH, Development Partners and others
		Participating in Multistakeholder platforms (MSP)	0	0	1,110,000	1,110,000	1,110,000	DALBE, MOH	MOH, Development Partners and others

Expected Outputs	Strategy	Intervention	Budget (Ksh.)					Responsibility	
			Y1	Y2	Y3	Y4	Y5	Lead	Support
KRA 6. Enhanced integration of nutrition into agriculture, livestock, and fisheries sectors.									
Strategic Objective 1: To improve maternal nutrition practices and services.									
Output 6.6 Enhanced joint integration of nutrition activities	Strengthening M&E mechanism for scaling up nutrition in agriculture	Conduct joint support supervision and follow up of integrated activities at community level in collaboration with nutrition department	0	0	2,910,000	2,910,000	2,910,000	MOH, DALBE	DALBE, Development Partners
Total			**0**	**0**	**133,100,000**	**116,990,000**	**106,990,000**	**357,080,000**	

Expected Outputs	Strategy	Intervention	Budget (Ksh.)					Responsibility	
			Y1	Y2	Y3	Y4	Y5	Lead	Support
KRA 7: Nutrition integrated and strengthened across all levels of the health sector.									
Strategic Objective 1: To improve maternal nutrition practices and services.									
Output 7.1 Nutrition services integration enhanced in all levels of the health sector	Enhance Nutrition integration enabling environment across different levels of the health sector in the county.	Integration of nutrition county planning, review of county policies, guidelines and documents (Community Health strategy Bill, AWP, CIDP, CHSP, ADP and FIF bill	0	0	895,000	895,000	0	BCG-DOH	MOH other Departments Development Partners
		Review the nutrition component within the school health program	0	0	0	0	0	BCG-DOH	MOH other Departments Development Partners
Output 7.2: Improved participation, planning and financing of nutrition services	Strengthen the capacity of County leadership (CHMT, SCHMT and HMT on nutrition inclusion in all county documents	Sensitize CHMT, SCHMT on the Integration of nutrition in County planning documents in all levels of the health sector	0	0	6,430,000	6,430,000	6,430,000	BCG-DOH	MOH other Departments Development Partners
Output 7.3: Improve Nutrition services integration and adherence at all levels	Strengthen adherence on Nutrition integration across all levels of the health sector Proposed interventions	Advocate for restructuring of client flow in facilities, triage stations to redirect eligible clients to the nutrition clinic in all levels of the health sector	0	0	0	0	0	BCG-DOH	MOH other Departments Development Partners

Expected Outputs	Strategy	Intervention	Budget (Ksh.)					Responsibility	
			Y1	Y2	Y3	Y4	Y5	Lead	Support
KRA 7: Nutrition integrated and strengthened across all levels of the health sector.									
Strategic Objective 1: To improve maternal nutrition practices and services.									
		Monitor adherence on nutrition integration in public hospitals and health centers	0	0	0	0	0	BCG-DOH	MOH other Departments Development Partners
Output 7.4: Improved participation, coordination and collaboration within the health system	Strengthen coordination and collaboration on nutrition in other units in the health sector	Involve the Nutrition section in the health stakeholder's forum and other Health units Technical working group (TB, Community Health TWG, RNMCH, HIV TWG, Sector working groups and Health stakeholder's forum)	8,350,000	8,350,000	8,350,000	8,350,000	8,350,000	BCG-DOH	MOH other Departments Development Partners
		Engage other units in County Nutrition Technical Forum (CNTF)	0	0	0	0	0	BCG-DOH	MOH other Departments Development Partners
Output 7.5: Improve nutrition integration of nutrition activities in PCN	Strengthen integration of nutrition services in Primary Care Networks (PCNs) Proposed intervention	Include Nutritionists into all Primary Care Health Networks (PCNs)activities, MDT and support supervision	0	300,000	300,000	300,000	300,000	BCG-DOH	MOH other Departments Development Partners
Output 7:6: Improve capacity of the health workforce to deliver integrated services that include nutrition	Strengthened capacity of the health workforce to deliver integrated services that include nutrition	Train community health promoters on nutrition technical modules to provide nutrition services at community level during dialogue days, baraza's and home visits	`0	5,400,000	5,400,000	5,400,000	5,400,000	BCG-DOH	MOH other Departments Development Partners
		Train health workers in Integrated Management of newborn and Childhood Illnesses (IMNCI), KMC that involve the nutritionist	0	8,200,000	8,200,000	8,200,000	8,200,000	BCG-DOH	MOH other Departments Development Partners
Total			**8,350,000**	**22,250,000**	**29,575,000**	**29,575,000**	**28,680,000**	**118,430,000**	

Expected Outputs	Strategy	Intervention	Budget (Ksh.)					Responsibility	
			Y1	Y2	Y3	Y4	Y5	Lead	Support
KRA 8: Enhanced integration of nutrition in the education sector.									
Strategic Objective 8.1: Nutrition mainstreamed in education sector									
Output 8.1. Improved knowledge among ECDE teachers on healthy diet and physical activity, nutrition assessment and VAS+D	Capacity Building, awareness creation	Train ECDE teachers on healthy diet and physical activities.	0	0	6,590,200	6,590,200	0	BCG- MOE	Department of Edu,VT&LS, Dept. Water, Partners- WFP, UNICEF,NDM A
		Sensitize ECDE teachers on nutrition assessments, VAS+D in schools	0	0	2,707,540	2,707,540	0	BCG- MOE	Department of Edu,VT&LS, Dept. Water, Partners- WFP, UNICEF,NDMA
Output 8.2: Improved integration of nutrition interventions in schools	Nutrition service delivery	Provide VAS+D in ECDE/ primary school	0	0	0	0	0	BCG- MOE	Department of Edu,VT&LS,
		Conduct periodic nutritional status assessments in schools and other learning institutions	0	0	0	0	0	BCG- MOE	Department of Edu,VT&LS, MoE
		Refer children with nutritional cases in schools to link health facilities.	0	0	0	0	0	BCG- MOE	Department of Edu,VT&LS, MoE
		supply and delivery of ECD Meals to ECD Centres/schools	0		15,753,653	15,753,653	0	Department of Edu,VT&LS,	Department of Edu,VT&LS,
		Establish demonstration gardens ECDE/Schools	0	0	126,000	126,000	0	BCG- MOE	Department of Edu,VT&LS, Dept. Water, Dept. Agri, Livestock & Fisheries Partner s- WFP, UNICEF,NDMA
Output 8.3 Improved stakeholders' awareness on healthy diet, safe food environment and WASH in schools	Partnership and collaboration	Supervision of Co- Curriculum themes on implementation of Nutrition and Physical activities in schools			53,150	53,150	-	BCG- MOE	Department of Edu, VT&LS, Dept. Water, Dept. Agri, Livestock & Fisheries Partner s- WFP, UNICEF,NDMA
		Sensitize curriculum support officers and Principal Education officers on safe food Environment and WASH			526,000	526,000	0	BCG- MOE	Department of Edu, VT&LS, MoE

Expected Outputs	Strategy	Intervention	Budget (Ksh.)					Responsibility	
			Y1	Y2	Y3	Y4	Y5	Lead	Support
KRA 8: Enhanced integration of nutrition in the education sector.									
Strategic Objective 8.1: Nutrition mainstreamed in education sector									
		Sensitization of parents and food handlers on safe food Environment and WASH	0	0	882,000	882,000	0	BCG- MOE	Department of Edu, VT&LS, Dept. Water, Dept. Agri, Livestock & Fisheries Partner s- WFP, UNICEF,NDMA
Output 8.4: Improved collaboration and partnership	Monitoring and valuation	Documentation of number of ECDE/ Schools with improved sanitation facilities	0	0	1,400,000	1,400,000	0	BCG- MOE	Department of Edu, VT&LS, Mo E, Dept. Water, Dept. Agri, Livestock & Fisheries, Partner s- WFP, UNICEF,NDMA
		Integrated supervision Department of Health and Education	0	0	882,000	882,000	0	BCG- MOE	Department of Edu, VT&LS, Mo E, Dept. Water, Dept. Agri, Livestock & Fisheries, Partner s- WFP, UNICEF,NDMA
		Integrated supervision Department of Health and Education	0	0	882,000	882,000	0	BCG- MOE	Department of Edu, VT&LS, Mo E, Dept. Water, Dept. Agri, Livestock & Fisheries, Partner s- WFP, UNICEF, NDMA
		Sensitization of Best practices with CHMT/SCHMT on Nutrition interventions in schools	0	0	239,000	239,000	0	BCG- MOE	Department of Edu, VT&LS, Mo E, Dept. Water, Dept. Agri, Livestock & Fisheries, Partner s- WFP, UNICEF,NDMA
Total			**0**	**0**	**30,041,543**	**30,041,543**	**0**	**60,083,086**	

Expected Outputs	Strategy	Intervention	Budget (Ksh.)					Responsibility	
			Y1	Y2	Y3	Y4	Y5	Lead	Support
KRA 9: Enhanced integration of Nutrition within the Water, Sanitation, and Hygiene (WASH) sector.									
Strategic Objective 1: Promote Water production and harvesting									
Improved water access	Advocate for construction and rehabilitation of dams	Improved water access	-	-	-	-	-	BCG-DOH	MOH/other Departments/ Development Partners
	Desilting of Water pans		-	10,307,500	10,441,900	10,441,887	10,441,887	BCG-DOH	MOH/other Departments/ Development Partners
	Community sensitization on rainwater harvesting		-	1,670,025	1,670,025	1,670,025	1,670,025	BCG-DOH	MOH/other Departments/ Development Partners
	Advocate for drilling and equipping of boreholes		-	-	-	-	-	BCG-DOH	MOH/other Departments/ Development Partners
	Upgrading of pumping system to solar		-	10,472,750	10,472,750	10,472,750	10,472,750	BCG-DOH	MOH/other Departments/ Development Partners
Strategic Objective 2: Promotion of hygiene practices									
Behavior changes and therefore reduced hygiene related infections	Sensitization on handwashing at critical times	Behavior changes and therefore reduced hygiene related infections	-	1,225,000	1,225,000	1,225,000	1,225,000	BCG-DOH	MOH/other Departments/ Development Partners
	Sensitization on proper water treatment and storage		-	947,000	947,000	947,000	947,000	BCG-DOH	MOH/other Departments/ Development Partners
	Sensitize the community on environmental sanitation		-	693,000	693,000	693,000	693,000	BCG-DOH	MOH/other Departments/ Development Partners
Proper waste management	Sensitize the communities on construction and usage of pit latrines	Proper waste management	-	3,683,600	3,683,600	3,683,600	3,683,600	BCG-DOH	MOH/other Departments/ Development Partners
	Sewer system expansion		-	-	-	-	-	BCG-DOH	MOH/other Departments/ Development Partners
Strategic Objective 3: Strengthen WASH and nutrition linkages									
Integrated programming on WASH/Nutrition	Sensitize the community on proper handling and waste disposal		-	1,030,000	1,030,000	1,030,000	1,030,000	BCG-DOH	MOH/other Departments/ Development Partners

Expected Outputs	Strategy	Intervention	Budget (Ksh.)					Responsibility	
			Y1	Y2	Y3	Y4	Y5	Lead	Support
KRA 9: Enhanced integration of Nutrition within the Water, Sanitation, and Hygiene (WASH) sector.									
	Participate in WASH forums	Integrated programming on WASH/ Nutrition	-	105,600	105,600	105,600	105,600	BCG-DOH	MOH/other Departments/ Development Partners
	Attend joint planning and review meeting with WASH team		-	195,200	195,200	195,200	195,200	BCG-DOH	MOH/other Departments/ Development Partners
Strategic Objective 4: Undertake Protection of water catchment areas									
	Plant fruit trees		-	1,207,200	1,207,200	1,207,200	1,207,200	BCG-DOH	MOH/other Departments/ Development Partners
	Water catchment demarcation and fencing		-	-	-	-	-	BCG-DOH	MOH/other Departments/ Development Partners
	Sensitization of communities on water harvesting techniques and waste management		-	697,400	697,400	697,400	697,400	BCG-DOH	MOH/other Departments/ Development Partners
	Establish Kitchen gardens/ demo farms at water points		-	1,626,400	1,626,400	1,626,400	1,626,400	BCG-DOH	MOH/other Departments/ Development Partners
Total				**33,860,675**	**33,995,075**	**33,995,062**	**33,995,062**	**Grand total**	**159,845,874**

Expected Outputs	Strategy	Intervention	Budget (Ksh.)					Responsibility	
			Y1	Y2	Y3	Y4	Y5	Lead	Support
KRA 10: Nutrition integrated across Social Protection programs.									
Strategic Objective 1: To strengthen Nutrition integration in social protection									
Enhanced nutrition awareness and practices among vulnerable populations in social protection programs	Enhance awareness on safe and nutritious foods as a component of social protection.	Conduct Sensitization for the caregivers on Cash transfer programs on nutrition	-	-	-	-	-	Department of health	MOH and Development Partners

Expected Outputs	Strategy	Intervention	Budget (Ksh.)					Responsibility	
			Y1	Y2	Y3	Y4	Y5	Lead	Support
KRA 10: Nutrition integrated across Social Protection programs.									
Strategic Objective 1: To strengthen Nutrition integration in social protection									
	Develop and integrate nutrition key messages with social protection programs		-	-	-	-	-	Department of health	MOH and Development Partners
Strengthened integration of nutrition into social protection programs.	Sensitize HCWs on the existing social protection programs (cash transfers, hunger safety nets, and others).	Strengthened integration of nutrition into social protection programs.	-	-	-	-	-	Department of health	MOH and Development Partners
	Sensitize CHPs on the existing social protection programs (cash transfers, hunger safety nets, and others).		-	-	-	-	-	Department of health	MOH and Development Partners
	Integration of nutrition interventions in social protection programs		-	-	-	-	-	Department of health	MOH and Development Partners
	Conduct a gender integrated baseline survey/situation analysis on status of nutrition and health for the vulnerable groups in social protection programs		-	-	5,086,000	-	5,086,000	Department of health	MOH and Development Partners
	Advocate for scale up social safety nets on nutrition in times of crises /emergencies targeting the vulnerable groups		-	-	-	-	-	Department of health	MOH and Development Partners

Expected Outputs	Strategy	Intervention	Budget (Ksh.)					Responsibility	
			Y1	Y2	Y3	Y4	Y5	Lead	Support
KRA 10: Nutrition integrated across Social Protection programs.									
Strategic Objective 1: To strengthen Nutrition integration in social protection									
Enhanced Awareness and understanding of the connection between social protection (e.g., cash transfers, food assistance) and nutrition outcomes for vulnerable populations	Mapping and assessment on nutritional and health needs for adults, and older persons to inform policy and programming		-	-	-	-	-	Department of health	MOH and Development Partners
	Sensitize county leadership (Executive &Legislature) on importance of social protection programs on linkages between social protection and nutrition.	Enhanced Awareness and understanding of the connection between social protection (e.g., cash transfers, food assistance) and nutrition outcomes for vulnerable populations	2,494,000	-	-	-	2,494,000	Department of health	MOH and Development Partners
	Conduct sensitization of stakeholders in social protection programs on linkage between social protection and nutrition		1,100,000	-	-	-	1,100,000	Department of health	MOH and Development Partners
	sensitize institutional correctional facilities on optimal nutrition		-	170,400	170,400	170,400	681,600	Department of health	MOH and Development Partners
Total			**3,594,000**	**170,400**	**52,564,00**	**170,400**	**170,400**	**Grand total**	**9,191,200**

Expected Outputs	Strategy	Intervention	Budget (Ksh.)					Responsibility	
			Y1	Y2	Y3	Y4	Y5	Lead	Support
KRA 11: Enhanced multisectoral nutrition governance, coordination, partnerships, advocacy, and community engagement									
Strategic Objective 11.1 To strengthen multisectoral governance, planning, financing and partnerships for nutrition.									
County nutrition documents (AWP, CNAP, Nutrition Policy) developed, disseminate d, and stakeholders sensitized.	Policy, formulation, legal, and regulatory environme nt, Capacity building	Develop and disseminate CNAP	0	0	2.5m		0	CDH	MoH, Development Partners
Robust coordination and planning mechanisms		"Sensitization of CHMTS, SCHMTS and HCW's,		857,500	857,500	857,500	857,500	CDH	MoH, Development Partners
		Establishment and operationalization of Multistakeholders Platform		700,000	700,000	700,000	700,000	CDH	MoH, Development Partners
		Revitalization of CNTF and SCNTF		1,760,000	1,760,000	1,760,000	1,760,000	CDH	MoH, Development Partners
Strengthene d advocacy for leadership developmen t, dedicated funding, structured budget lines, and establishme nt of a nutrition directorate, resulting in increased resource allocation and human capital for CNAP implementation		Development of concepts and proposals for resource mobilization		0				CDH	MoH, Development Partners
		Holding Advocacy meeting with Finance department & County Assembly health committee		125,000	125,000	125,000	125,000	CDH	MoH, Development Partners

Expected Outputs	Strategy	Intervention	Budget (Ksh.)					Responsibility	
			Y1	Y2	Y3	Y4	Y5	Lead	Support
KRA 11: Enhanced multisectoral nutrition governance, coordination, partnerships, advocacy, and community engagement									
Strategic Objective 11.1 To strengthen multisectoral governance, planning, financing and partnerships for nutrition.									
		Development of concepts and proposals for resource mobilization		0				CDH	MoH, Development Partners
		Holding Advocacy meeting with Finance department & County Assembly health committee		125,000	125,000	125,000	125,000	CDH	MoH, Development Partners
		Holding Advocacy meetings with the Cabinet			230,000			CDH	MoH, Development Partners
		Holding community forums		1,113,560	1,113,560	1,113,560	1,113,560	CDH	MoH, Development Partners
		Holding community engagement meetings with community leaders		1,015,560	1,015,560	1,015,560	1,015,560	CDH	MoH, Development Partners
Total			**0**	**5,696,620**	**5,696,620**	**5,696,620**	**5,696,620**	**25,516,480**	

Expected Outputs	Strategy	Intervention	Budget (Ksh.)					Responsibility	
			Y1	Y2	Y3	Y4	Y5	Lead	Support
KRA 12: Strengthened sectoral and multisectoral Nutrition Information, M&E systems, research, and Knowledge management.									
Strategic Objective 1: Enhance nutrition data across sectors for informed decision- making.									
Output Output 12.1: Availability of quality nutrition data	Enhance the quality and reliability of nutrition data	Preparation of nutrition procurement plan for standardized nutrition tools	0	0	0	0	0	BCG- DOH	MOH, Department of Nutrition and Nutritional Implementing Partners

Expected Outputs	Strategy	Intervention	Budget (Ksh.)					Responsibility	
			Y1	Y2	Y3	Y4	Y5	Lead	Support
KRA 12: Strengthened sectoral and multisectoral Nutrition Information, M&E systems, research, and Knowledge management.									
Strategic Objective 1: Enhance nutrition data across sectors for informed decision- making.									
		Conduct nutrition DQA	0	24,375	24,375	24,375	24,375	BCG- DOH	MOH, Department of Nutrition and Nutritional Implementing Partners
		Integration of nutrition indicators into the existing joint supervision tool	0	-	29,250	-	29,250	BCG- DOH	MOH, Department of Nutrition and Nutritional Implementing Partners
		integrate nutrition into the existing data review meeting	0	24,375	24,375	24,375	24,375	BCG- DOH	MOH, Department of Nutrition and Nutritional Implementing Partners
Output 12.2: Nutrition data monitoring and evaluation mechanisms strengthened	Monitoring and evaluation of nutrition data	Track AWP implementation process	0	-	11,000	11,000	11,000	BCG- DOH	MOH, Department of Nutrition and Nutritional Implementing Partners
		Conduct CNAP end term review (ETR)	0		377929	377929	377929	BCG- DOH	MOH, Department of Nutrition and Nutritional Implementing Partners

Expected Outputs	Strategy	Intervention	Budget (Ksh.)					Responsibility	
			Y1	Y2	Y3	Y4	Y5	Lead	Support
KRA 12: Strengthened sectoral and multisectoral Nutrition Information, M&E systems, research, and Knowledge management.									
Strategic Objective 1: Enhance nutrition data across sectors for informed decision- making.									
		Review of M&E nutrition framework	0		345,000	345,000	345,000	BCG- DOH	MOH, Department of Nutrition and Nutritional Implementing Partners
		Conduct MIYCN KAP survey	0	-	2,335,250	-	2,335,250	BCG- DOH	MOH, Department of Nutrition and Nutritional Implementing Partners
		Conduct SMART Survey	0	4,374,125	4,374,125	4,374,125	4,374,125	BCG- DOH	MOH, Department of Nutrition and Nutritional Implementing Partners
		Conduct Coverage assessment	0	-	6,182,200	-	6,182,200	BCG- DOH	MOH, Department of Nutrition and Nutritional Implementing Partners
		Conduct Nutrition capacity assessment	0	2,046,700			2,046,700	BCG- DOH	MOH, Department of Nutrition and Nutritional Implementing Partners

Expected Outputs	Strategy	Intervention	Budget (Ksh.)					Responsibility	
			Y1	Y2	Y3	Y4	Y5	Lead	Support
KRA 12: Strengthened sectoral and multisectoral Nutrition Information, M&E systems, research, and Knowledge management.									
Strategic Objective 1: Enhance nutrition data across sectors for informed decision- making.									
		hold a sensitization meeting to roll out the nutrition scorecard	0	459,000	459,000	459,000	459,000	BCG- DOH	MOH, Department of Nutrition and Nutritional Implementing Partners
Output 12.3: Improved knowledge and skills on data management processes	Capacity building on data management	Train HCWS at facility level on KHIS	0	-	1,163,000	-	1,163,000	BCG- DOH	MOH, Department of Nutrition and Nutritional Implementing Partners
		Train HCWS at facility level on Echis	0	-	687,000	-	687,000	BCG- DOH	MOH, Department of Nutrition and Nutritional Implementing Partners
		Train HCWS on nutrition data collection and reporting tools	0	-	1,813,315	1,813,315	1,813,315	BCG- DOH	MOH, Department of Nutrition and Nutritional Implementing Partners
		Train HCWS on basic data analysis and report writing	0	-	2,720,000	-	2,720,000	BCG- DOH	MOH, Department of Nutrition and Nutritional Implementing Partners

Expected Outputs	Strategy	Intervention	Budget (Ksh.)					Responsibility	
			Y1	Y2	Y3	Y4	Y5	Lead	Support
KRA 12: Strengthened sectoral and multisectoral Nutrition Information, M&E systems, research, and Knowledge management.									
Strategic Objective 1: Enhance nutrition data across sectors for informed decision- making.									
		Sensitize/OJT HCWS on nutrition data collection and reporting tools	0	-	50,599	50,599	50,599	BCG- DOH	MOH, Department of Nutrition and Nutritional Implementing Partners
		Train healthcare workers on Long Rain and Short Rain Assessments	0	3,276,000	3,276,000	3,276,000	3,276,000	BCG- DOH	MOH, Department of Nutrition and Nutritional Implementing Partners
		Train healthcare workers on research methodologies	0	-	754,659	754,659	754,659	BCG- DOH	MOH, Department of Nutrition and Nutritional Implementing Partners
		Train healthcare workers on scientific writing	0	-	1,375,400	-	1,375,400	BCG- DOH	MOH, Department of Nutrition and Nutritional Implementing Partners
Output 12.4: Availability of nutrition evidence to inform program decisions	Strengthen research in nutrition and Knowledge management	Research priority identification	0	0	0	0	0	BCG- DOH	MOH, Department of Nutrition and Nutritional Implementing Partners

Expected Outputs	Strategy	Intervention	Budget (Ksh.)					Responsibility	
			Y1	Y2	Y3	Y4	Y5	Lead	Support
KRA 12: Strengthened sectoral and multisectoral Nutrition Information, M&E systems, research, and Knowledge management.									
Strategic Objective 1: Enhance nutrition data across sectors for informed decision- making.									
		Conduct nutrition research		-	-	2,046,700	-	BCG- DOH	MOH, Department of Nutrition and Nutritional Implementing Partners
		Organize and hold knowledge sharing and learning events	0	0	0	0	0	BCG- DOH	MOH, Department of Nutrition and Nutritional Implementing Partners
TOTALS			0	10,204,575	26,002,477	13,557,077	28,049,177	77,813,306	

Expected Outputs	Strategy	Intervention	Budget (Ksh.)					Responsibility	
			Y1	Y2	Y3	Y4	Y5	Lead	Support
KRA 13: Strengthened Supply chain management for nutrition commodities and equipment									
Strategic Objective 13.1 To strengthen supply Chain management of Nutrition Commodities, Equipment and tools									
Output 13.1 Increased knowledge skills and Manageme nt of Nutrition Commoditi es, equipment and tools.	Strategy Strength en the capacity of HCWs on Commod ity Manage ment Proposed intervent ions	Promote trainings on commodity management training - including Commodity management and warehousing practices and LMIS for CHMT, SCHMT and HCWs and CHP's.	0	2,696,000	2,696,000	2,696,000	2,696,000	BCG- DOH	MOH other Departments Development Partners
		Promote CMEs/OJTS and mentorship sessions on commodity management in health facilities	870,000	870,000	870,000	870,000	870,000	BCG- DOH	MOH other Departments Development Partners

Expected Outputs	Strategy	Intervention	Budget (Ksh.)					Responsibility	
			Y1	Y2	Y3	Y4	Y5	Lead	Support
KRA 13: Strengthened Supply chain management for nutrition commodities and equipment									
Strategic Objective 13.1 To strengthen supply Chain management of Nutrition Commodities, Equipment and tools									
		Sensitize HCWs on correct use and maintenance of nutrition equipment in all health facilities Train biomedical	0	0	796,000	796,000	796,000	BCG-DOH	MOH other Departments Development Partners
		engineers on operation, maintenance and repair of nutrition equipment.							
		Facilitate biomedical engineers to repair and maintain nutrition equipment	0	560,000	560,000	560,000	560,000	BCG-DOH	MOH other Departments Development Partners
Output 13.2 Improved nutrition commodity manageme nt practices	Strength en Nutrition commodi ty manage ment practices	Develop Standard operating procedures (SOPs) on receipt, storage, requisition and reporting of nutrition commodities (IFAS, RUTF, RUSF, CSB, MNP's FBF, VitaminA, TPN, dewormers)	0	0	0	0	0	BCG-DOH	MOH other Departments Development Partners
Output 13.3 Improved nutrition commoditi es, equipment and tools budgetary	Enhance advocacy and resource mobilizat ion for Nutrition supply chain	Advocate for adequate funding for nutrition commoties (RUSF, CSB, RUTF, Resomal IFAS, Vitamin A +D, TPN, MNPs F100, F75, PRE-NAN), equipment and tools at the county treasury and County	0	500,000	500,000	500,000	500,000	BCG-DOH	MOH other Departments Development Partners
allocation in the county.		Assembly (County annual development plan-CADP, Sector Engagements, County fiscal Strategy Paper- CFSP, Budget Estimates							

Expected Outputs	Strategy	Intervention	Budget (Ksh.)					Responsibility	
			Y1	Y2	Y3	Y4	Y5	Lead	Support
KRA 13: Strengthened Supply chain management for nutrition commodities and equipment									
Strategic Objective 13.1 To strengthen supply Chain management of Nutrition Commodities, Equipment and tools									
Output 13.4 Improved optimal stock levels and reduced nutrition commoditi es expiry	Promote proper forecasti ng and quantific ation of nutrition commodi ties and equipment	Sensitize HCW's on Accurate Forecasting and Quantification	0	870,000	870,000	870,000	870,000	BCG-DOH	MOH other Departments Development Partners
		Conduct routine Data Quality Audit to Enforce proper documentation of all commodity data in the registers and summary tools.	0	2,870,000	2,870,000	2,870,000	2,870,000	BCG-DOH	MOH other Departments Development Partners
		Integrate nutrition in the annual commodity forecasting and quantification workshop	0	0	0	0	0	BCG-DOH	MOH other Departments Development Partners
		Empower and train County Nutrition Coordinator in the Health Products and Technologies Unit (HPTU) to oversee the Supply Chain Management system in Nutrition Department.	0	1,880,000	1,880,000	1,880,000	1,880,000	BCG-DOH	MOH other Departments Development Partners
Output 13.5 Improved availability of nutrition commodities and assessment tools	Enhance Availabil ity of Nutrition equipme nt, commodi	Incorporate Nutritionists into the County and hospital medicines and therapeutic committees (MTCs) to spearhead the inclusion of	0	0	0	0	0	BCG-DOH	MOH other Departments Development Partners
		Procure and distribute nutrition commodities (RUTF, RUSF, FBF, CSB, IFAS, Vitamin A +D, TPN, F100, F75, RESOMAL) and assessment tools	0	230,491,797	231,395,658	231,395,658	231,395,658	BCG-DOH	MOH other Departments Development Partners

Expected Outputs	Strategy	Intervention	Budget (Ksh.)					Responsibility	
			Y1	Y2	Y3	Y4	Y5	Lead	Support
KRA 13: Strengthened Supply chain management for nutrition commodities and equipment									
Strategic Objective 13.1 To strengthen supply Chain management of Nutrition Commodities, Equipment and tools									
		Promote needs assessment mapping of nutrition equipment's and reporting tools for respective health facilities	0	165,000	165,000	165,000	165,000	BCG-DOH	MOH other Departments Development Partners
		Procure and distribute nutrition equipment (bedside weighing machine, Body composition analyzer, pediatric weighing scale, length board, 2 in 1 weighing scale-height meters, Breast models, baby dolls, cleft palate shield	0	5,027,700	5,027,700	5,027,700	5,027,700	BCG-DOH	MOH other Departments Development Partners
		Promote the use of HMIS/LMIS to guide on stock status and (re) distribution	0	0	0	0	0	BCG-DOH	MOH other Departments Development Partners
		Promote preparation of a budget for the purchase of Anthropometric equipment and tools based on need, utility and level of use by all Nutrition SDPs at all Healthcare Levels.	0	500,000	500,000	500,000	500,000	BCG-DOH	MOH other Departments Development Partners
Output 13.6 Functional nutrition equipment in use	Maintain functiona lity and accuracy of nutrition equipment.	Develop and effect an equipment maintenance plan for nutrition equipment	0	0	0	0	0	BCG-DOH	MOH other Departments Development Partners
		Develop and effect an equipment calibration plan for nutrition	0	800,000	800,000	800,000	800,000	BCG-DOH	MOH other Departments Nutrition

Expected Outputs	Strategy	Intervention	Budget (Ksh.)					Responsibility	
			Y1	Y2	Y3	Y4	Y5	Lead	Support
KRA 13: Strengthened Supply chain management for nutrition commodities and equipment									
Strategic Objective 13.1 To strengthen supply Chain management of Nutrition Commodities, Equipment and tools									
Output 13.7 Enhanced quality of nutrition data for decision making	Strength en monitori ng and evaluatio n of nutrition commodi ties, equipme nt and reporting tools	Participate in support supervision and OJT to all health facilities on documentation, commodity management and reporting	0	600,000	600,000	600,000	600,000	BCG-DOH	MOH other Departments Development Partners
		Procure and distribute Laptops, printers and projectors for data capture, processing and reportin Integrate nutrition data in quarterly commodity TWG review meetings	0	10,000,000	10,000,000	10,000,000	10,000,000	BCG-DOH	MOH other Departments Development Partners
Total			**106,865,000**	**248,816,160**	**332,664,530**	**313,631,830**	**284,574,462**	**385,895,913**	

Annexes

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BARINGO COUNTY
NUTRITION ACTION PLAN (CNAP) 2023-2027

Working Together Towards Reduction of Malnutrition in our County

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