REPUBLIC OF KENYA

MINISTRY OF PUBLIC HEALTH
AND SANITATION

National Nutrition Action Plan

2012-2017

Contents

Tables and Figures

List of Abbreviations and Acronyms

ACSM	Advocacy Communication and Social Mobilization
AWP	Annual Work Plan
COTU	Central Organization of Trade Unions
BCC	Behavior Change Communication
BFCI	Baby Friendly Community Initiative
BFHI	Baby Friendly Hospital Initiative
BMI	Body Mass Index
CBO	Community Based Organization
CHANIS	Child Health and Nutrition Information System
CHEWs	Community Health Extension Workers
CHMT	County Health Management Committee
CHW	Community Health worker
CSO	Civil Society Organization
EBF	Exclusive Breastfeeding
ECD	Early Childhood Development
ERS	Economic Recovery Strategy
FKE	Federation of Kenya Employers
FNSS	Food and Nutrition Security Strategy
GoK	Government of Kenya
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information Systems
HW	Health Worker
ICN	International Conference on Nutrition
IDA	Iron Deficiency Anemia
IEC	Information, Education and Communication
IFA	Iron Folic Acid
IYCF	Infant and Young Children Feeding

IYCN	Infant and Young Children Nutrition
KARI	Kenya Agricultural Research Institute
KDHS	Kenya Demographic and Health Survey
KEBS	Kenya Bureau of Standards
KEMRI	Kenya Medical Research Institute
KEPSA	Kenya Private Sector Alliance
KIHBS	Kenya Integrated Household Budget Survey
KIRDI	Kenya Industrial Research and Development Institute
KNBS	Kenya National Bureau of Statistics
M&E	Monitoring and Evaluation
MDG	Millennium Development Goals
MOA	Ministry of Agriculture
MOF	Ministry of Fisheries
MOGC&SS	Ministry of Gender, Children and Social Development
MOH	Ministry of Health
MOLD	Ministry of Livestock Development
MOT	Ministry of Trade
MTEF	Medium Term Expenditure Framework
MTP	Medium Term Plan
MUAC	Mid-Upper Arm Circumference
NFNSP	National Food and Nutrition Security Policy
NGO	Non-Governmental Organization
NNAP	National Nutrition Action Plan
SO	Strategic Objective
UN	United Nations
UNICEF	United Nations Children Fund
VAD	Vitamin A Deficiency

Foreword

Malnutrition in Kenya remains a big public health problem. Kenya has high stunting rates (35%) and is currently experiencing a rise in diet-related non-communicable diseases, such as diabetes, cancers, kidney and liver complications that are attributed to the consumption of foods low in fibre and high in fats and sugars. This double burden on malnutrition is serious and without deliberate and concerted effort, will lead to increased loss of productivity and lives.

The high burden of malnutrition in Kenya is not only a threat to achieving Millennium Development Goals (MDGs) and Vision 2030 but also a clear indication of inadequate realization of human rights. Reducing malnutrition in Kenya is not just a health priority but also a political choice that calls for a multi-sectoral focus driven by a political will that acknowledges the integral role that nutrition plays in ensuring a healthy population and productive workforce. Communities must be empowered to claim their right to good nutrition and guided to play their role towards realizing this right.

The solutions to malnutrition are practical, basic and have to be applied at scale and prioritized in the national development agenda. Kenya has shown renewed commitment to nutrition which is well articulated in the Food and Nutrition Security Policy and Kenya Health Strategic Plan. Therefore, development of this National Nutrition Action Plan (NNAP) provides practical guidance to implementation of Kenya's commitments to nutrition. The NNAP provides a framework for coordinated implementation of high impact nutrition intervention by government and nutrition stakeholders for maximum impacts at all levels. Most of these interventions are part of Scaling Up Nutrition (SUN) actions that are being implemented globally to accelerate efforts towards meeting MDG 4 and 5. The NNAP is aligned to government's Medium Term Plans (MTPs) to facilitate mainstreaming of the nutrition budgeting process into national development plans, and hence, allocation of resources to nutrition programmes.

The Ministry of Public Health and Sanitation shall be directly in charge of coordinating the implementation of the plan at the national level. However, under the new governance system in Kenya, there will be devolved coordination systems at the county levels, which will feed into the national level coordination unit. At each of the two levels, nutrition stakeholders will play a crucial role in execution of the plan. I call upon all of us to take action now.

Hon. Beth Mugo E.G.H., MP
Minister for Public Health and Sanitation

Acknowledgement

The Division of Nutrition acknowledges the valuable contributions of various stakeholders in the development of the National Nutrition Action Plan 2012-2017. We express our sincere gratitude and indebtedness to UNICEF Kenya, USAID/MCHIP and Micronutrient Initiative, Save the Children UK and World Vision for the technical and financial support in developing and finalizing of this nutrition action plan. Further, we highly appreciate European Commission Humanitarian Aid Office (ECHO) for the financial support.

This action plan started with preliminary nutrition situation analysis which provided guidance on key areas of focus and contributed to the development of the first draft for review during the stakeholder workshop. We also acknowledge contributions from all the partners who participated in the stakeholder workshops to contribute to the situation analysis and build consensus on the strategic areas of the action plan, who included Development partners GAIN, World Food Programme, and World Health Organization: the following universities Egerton, University of Nairobi, Paediatrics, Community Health and Nursing departments, Kenyatta University, Jomo Kenyatta University of Agriculture and Technology, Kenya Methodist, Moi University and Mount Kenya. The Ministries of Agriculture, Education, Gender and Social Services, Planning and National Development, Medical Services, Northern Kenya and Other Arid Lands: The National Council for Children's Services, Kenya Medical Training College, the Private Sector through Kenya National Fortification Alliance and the following government and non-governmental organizations: Kenya Medical Research Institute, Kenyatta National Hospital. Kenya Bureau of Standards, Kenya Nutritionists and Dieticians Institute, Implementing partners namely, Concern Worldwide, World Vision, Merlin, Kenya Red Cross, Action Aid, Action Against Hunger, Non Governmental organizations: Path IYCN, ICS Africa, International Baby Food Action Network, Central Organization of Trade Union, Kenya Human Rights Commission and Consumer Information Network, Kenya Network for Women with Aids.

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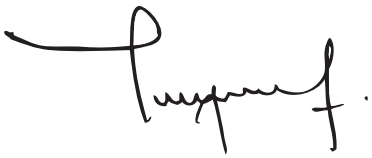
Last, but not least, the Division of Nutrition greatly appreciates the enabling environment provided by the Permanent Secretary, Mr. Mark Bor, the Director Public Health and Sanitation, Dr. Sharif and the Head, Department of Family Health, Dr. Wamae, that enabled us to mobilize the necessary resources to accomplish this task.



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Executive Summary

Kenya's food and nutrition security agenda espoused in the Food and Nutrition Security Policy (FNSP) developed Food and Nutrition Security Strategy (FNSS) identifies key priority areas which if implemented could greatly contribute to realization of optimal nutrition in Kenya. This 2012-2017 National Nutrition Action Plan (NNAP) is based on these blue prints, conducted nutrition situation analysis and proposals from extensive consultations with nutrition stakeholders. That informed the development of strategic objectives and corresponding intervention activities.

The purpose of the NNAP is to provide a framework for coordinated implementation of nutrition intervention activities by the government and nutrition stakeholders. The Plan has been developed at a time when the government of Kenya is stepping up efforts to realize Millennium Development Goals through implementation of High impact Nutrition interventions (HiNi). The HiNi interventions include: exclusive breastfeeding, timely complementary feeding, iron folate, vitamin A and zinc supplementation, hand washing, deworming, food fortification and management of moderate and severe acute malnutrition. Therefore, the proposed activities have been aligned to the overall efforts of meeting these Goals. However, greater emphasis is on the activities that are expected to result in achievement of MDGs 1,2,3,4,5 and 6 that have direct impact on the health of children and women of reproductive age (15-49 years). It is expected that implementation of the Plan will contribute to increased commitment, partnerships and networking as well as resource mobilization efforts among nutrition stakeholders towards achieving these goals. Also the NPA is aligned to government's Medium Term Plans (MTPs) in facilitating mainstreaming of the nutrition budgeting process into national development plans and allocation of resources to nutrition programmes.

The Plan has been organized into chapters as follows: Chapter 1 provides introduction whereby there is presentation of the nutrition situation analysis in Kenya, on-going and recent responses and the main challenges. The strategic issues lead activities, and their expected outcomes are presented in Chapter 2. Chapter 3 describes the monitoring and evaluation approach including target setting for the Plan. The financial arrangements and the estimated budget are covered in Chapter 4. In Annex I, a matrix of strategic objectives, indicators and implementers as well as main interventions proposed for each of the 8 strategic issues is provided. In Annex II, the matrix of M & E targets and time-frames are presented for each strategic objective.

The 14 priority nutrition areas spelt out in the Food and Nutrition Security Strategy (FNSS) provided a conceptual guide to the development of this Plan of Action, which further identifies 11 strategic objectives each with corresponding activities and expected outcomes as follows:

i. **Improve nutritional status of women of reproductive age (15-49 years):** Improving the health of women of reproductive age is prioritized against the backdrop of worrying health trends among women. Nationally, one-quarter (25%) of women aged 15-49 are overweight or obese. This condition is largely associated with non-communicable dietary diseases such as hypertension and diabetes mellitus. Other nutritional conditions of concern among women include micronutrient deficiency. Intervention activities contributing to this strategic objective include; carrying out nutrition education on consumption of healthy foods during pregnancy and strengthening supplementation of iron and folate in pregnant women. These activities are expected to result in; reduced mortality, anemia, micronutrient deficiency, low birth weight and obesity.

ii. **Improve nutrition status of children under five:** This is to be achieved through lead activities such as enhanced exclusive breastfeeding, timely introduction of complementary foods and micronutrient supplementation. The expected net effect of these interventions is reduced stunting, wasting, anemia, obesity, underweight and ultimately, infant mortality.

iii. **Reduce the prevalence of micronutrient deficiencies in the population:** Prevalence of micronutrient deficiencies in the population is becoming a matter of concern to the government. This concern is the basis of inclusion of this strategic issue in the plan. Among the activities to be implemented to respond to this issue include; creating awareness on food fortification, supplementation and food based approaches as well as scaling up fortification of widely consumed food stuffs.

iv. **Prevent deterioration of nutritional status and save lives of vulnerable groups in emergencies.** The population in ASAL areas, whom a large proportion are nomadic livestock keepers, are almost wholly dependent on their livestock for food security. In order to address the underlying causes of food insecurity and vulnerability for these populations, activities must be implemented which take into account the seasonality of food availability and the extent to which the health of livestock, conflict and migratory patterns influence their nutritional status. Some of these activities could include supplementation of livestock feed and water to enhance milk production and working closely with other ministries to enhance livelihood diversification and the safeguarding of animal health.

v. **Improve access to quality curative nutrition services.** Nutrition care and support during illness is a key component of care which aims at preventing further deterioration of nutritional status and saving lives of persons affected. There is need to strengthen the capacity of institutions to provide optimal curative nutrition services.

vi. **Improve prevention, management and control of diet related NCDs.** The Kenya Health Sector Development Plan has outlined a key objective on halting and reversing the rising burden of non communicable conditions. This it is to be achieved by ensuring clear strategies for implementation to address all the identified non communicable conditions in the country. It has been recognized that some of these NCDs are diet related and hence the need to provide guidance on prevention and control measures to reduce morbidity and mortality and save on health costs.

vii. **Improve nutrition in schools and other institutions:** Improved nutrition in schools and other institutions is expected to contribute to the overall national efforts of promoting optimal nutrition. The activities proposed for action include; conducting a situation analysis on school/ institutional feeding and reviewing existing guidelines for school/institutional feeding to promote adequate nutrition.

viii. **Improve knowledge, attitudes and practices on optimal nutrition:** The importance of this strategic issue is to have provision of information as a precursor in adoption of positive attitude and practices on optimal nutrition by Kenyans. This is to be realized through development, dissemination and implementation of a national nutrition Information, Education and Communication/Behavior Change Communication (IEC/BCC) strategy. In addition, this would involve training service providers on IEC/BCC and advocacy skills. This strategic issue is expected to contribute to improved nutrition practices in the lifecycle/lifespan.

ix. **Strengthen the nutrition surveillance, monitoring and evaluation systems:** Nutrition monitoring and evaluation systems will be strengthened to enhance benefits of standardized M&E tools for effective reporting and planning. Among the activities to be implemented include finalizing M & E framework for the nutrition sector based on this National Nutrition Action Plan (2012-2017).

x. **Enhance evidence-based decision-making through operations research:** Evidence-based decision-making through operations research is to be enhanced for purposes of strengthening the foundation of informed nutrition programme development and service provision.

xi. **Strengthen coordination and partnerships among the key nutrition actors:** The importance of harnessing synergy in the efforts of the nutrition stakeholders is recognized in this strategic issue. Identification of partners in WASH, education, health and livelihoods sectors with which partnerships can be formed will result in greater impact of nutrition activities implemented across the stakeholder sectors.

All of the strategic issues presented as strategic objectives, their corresponding activities, indicators, implementers and time-frame are detailed in the matrix (Annex 1) in the plan.

Coordination of implementation of this Plan falls within the coordination mechanism of the agreed upon Food Security and Nutrition Strategy 2008. Under this Strategy, the Ministry responsible for health shall be directly in charge of coordinating the implementation of the Plan at national level. However, under the new governance system in Kenya, there will be devolved coordination systems at the county levels, which will feed into the national level coordination unit. At each of the two levels, nutrition stakeholders will play a crucial role in the execution of the Plan.

A national system for monitoring and evaluating (M&E) of the Plan is an important component and is detailed in the matrix (Annex 2) in the plan. The M&E framework aims at meeting information needs of different stakeholders and will be implemented through a national structure comprising a Technical Working Group under the direction of the Division of Nutrition. The M&E framework present targets to be achieved for each strategic objective's expected outcomes and outputs and for some strategic objectives, the outputs only.

The targets have been arrived at based on analysis of the target trends in health sector in Kenya and other countries.

This Nutrition Action Plan also provides an estimation of the total resources required to achieve the goal and objectives outlined in the Food Security and Nutrition Policy. The cost estimates cover the five years (2012-2017) of implementation. The costs are based on an ideal situation and standard costing models rather than past and ongoing programmatic experiences. Overall, the projected total cost for implementing the activities of the Plan for next five years is KSH 69 billion.

Chapter 1.0
Introduction

1.1 National Context Policy Framework

Since the year 2003, Kenya has been building a solid foundation of becoming globally competitive and prosperous in its economy. These efforts have been realized through implementation of the Economic Recovery Strategy (ERS) covering the period 2003-2007. This strategy focused on restoration of economic growth, rehabilitation and expansion of infrastructure, equity and poverty reduction, and improving governance. It is the successful implementation of ERS that paved way for Vision 2030, which aims to transform Kenya into a globally competitive and prosperous nation with a high quality of life. The Vision 2030 has social, political governance and economic pillars. Under the social pillar, the health sector is identified as critical in maintaining a healthy working population, necessary for the increased labor production that Kenya requires in order to match its global competitors. Similarly, Kenya's commitment to the realization of health-focused Millennium Development Goals (MDGs) 1, 3, 4, 5, 6 and 7 is expected to contribute to the goal of having a healthy population. Nutrition is critical for survival, health and development. Investing in nutrition will enable the country to make significant progress in achieving targets of MDGs 1, 4, 5, and 6 which are directly related to improvement of nutrition status of children and women the political governance pillar too, has direct bearing on the Kenyans' health in general and nutrition in particular. One of the pillar's successful flagship projects has been promulgation of the new constitution. Under the economic and social bill of rights, every Kenyan has a right to adequate food of acceptable quality as well as clean and safe water in adequate quantities. Further, the constitution stipulates that every child has the right to basic nutrition, shelter and healthcare. Enshrining the right to food, basic nutrition and healthcare in the constitution marks a radical shift in programme development and implementation around these issues. And the government takes greater responsibility in ensuring that the right is enjoyed by the Kenyans.

Government of Kenya has developed the food and nutrition security policy an overarching policy to address nutrition security in the country. This policy places nutrition central to human development in the country; emphasizes the need to ensure of right to nutrition as a constitutional right, recognizes disparities in nutrition and provides relevant policy directions; ensures multi-sectoral approach to addressing malnutrition in the country; ensures life-cycle approach to nutrition security and ensures evidence based planning and resource allocation.

The KHSSP's goal is **'accelerating attainment of health impact goals'.** The sector aims to attain this through focusing on implementation of a broad base of health and related services that will impact on health of Kenya. Indeed the main emphasis will be placed on implementing interventions, and

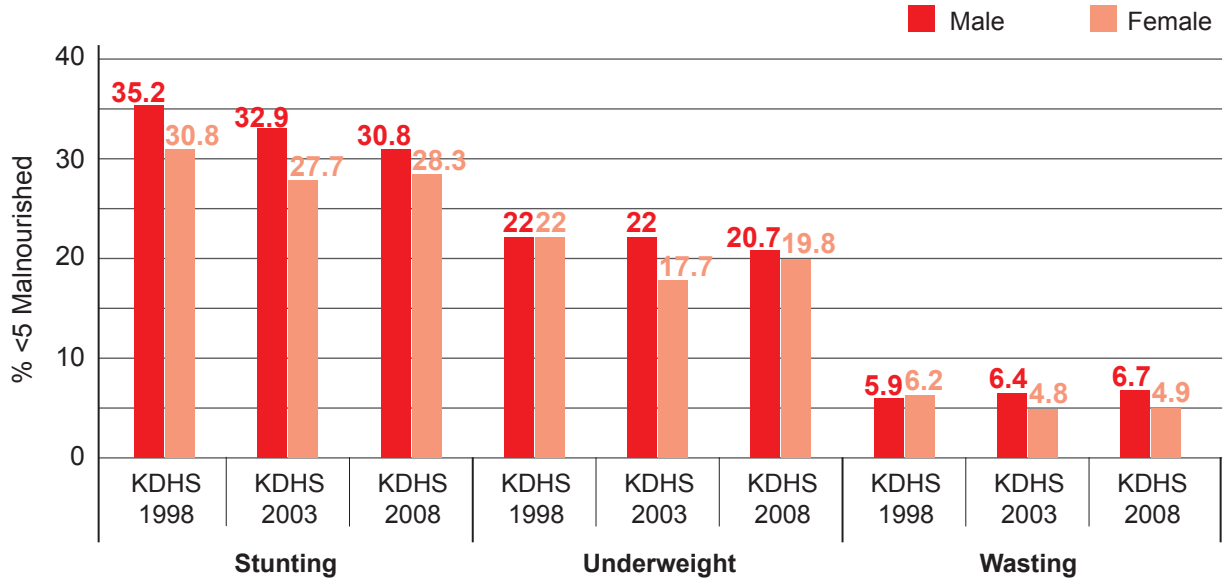
prioritizing investments relating to maternal and newborn health, as it is the major impact area for which progress was not attained in the previous strategic plan. This Nutrition action plan recognizes the importance of the first 1000 days of a child's life and aims to prioritize high impact nutrition interventions which will impact on reduction of morbidity and mortality. The High impact Nutrition interventions are recommended as part of Scaling Up Nutrition (SUN) Framework, with evidence from the Lancet series 2008 of well tested and low cost interventions which protect the nutrition of vulnerable individuals and communities and benefit millions of people if incorporated in food security, agriculture, social protection, health and educational programmes.

With the growing burden of over nutrition, Kenya is committed to the 63rd WHA resolution to reduce 25% of premature deaths as result of NCDs by 2025, promote active aging and engage in partnerships to reduce NCDs. Reversing NCDs is also central to the KHSSP III health outcomes.

1.2 Nutrition Situation in Kenya

According to the 2008-09 Kenya Demographic and Health Survey (KDHS), 35% of children under age of five years are stunted, 16% are underweight and 7% are wasted. Figure 1 indicates the trends of malnutrition among children under the age of five years from 1993 to 2008/09 which shows little or no improvement. Today in Kenya, an estimated 2.1 million children are stunted which is a serious national development concern as these children will never reach their full physical and mental potential. Regional disparities in nutrition indicators in Kenya are significant with North Eastern province having the highest proportion of children exhibiting severe wasting (8%) while Eastern province has highest level of stunted children (44%). As in many other parts of the world, children living in rural areas and children from poorer households in Kenya are more likely to be malnourished (KDHS 1998- 2008). In addition the proportion of wasted and underweight children is negatively correlated with the level of education, wealth and nutrition status of the mother.

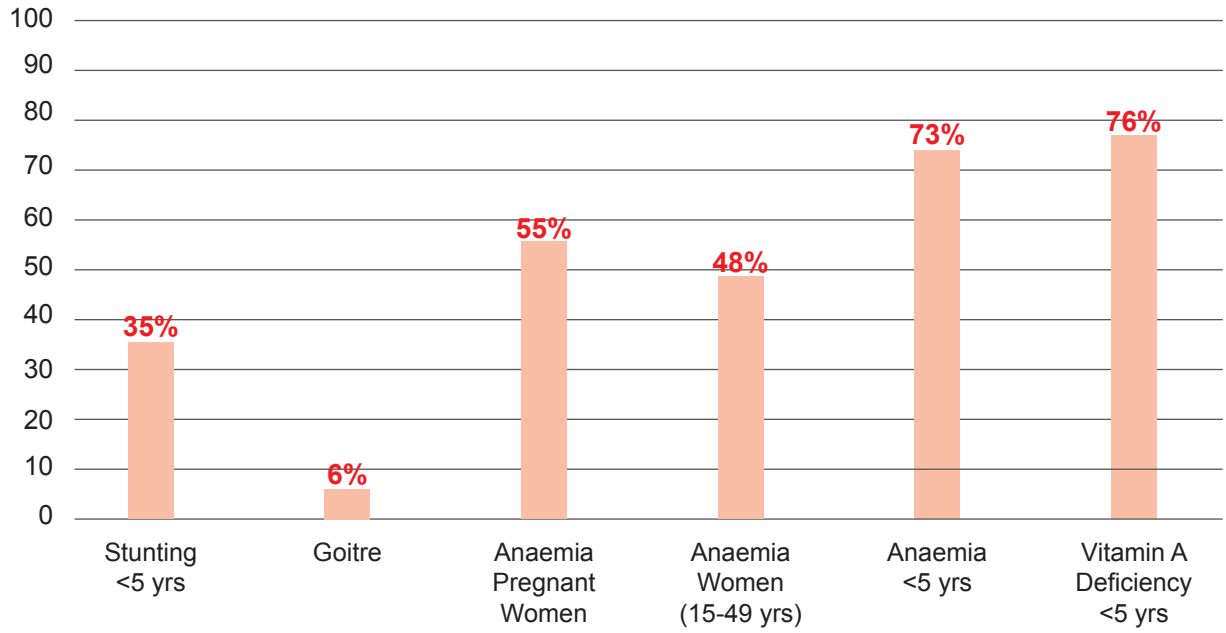
Figure 1: Malnutrition trends in Kenya by gender



Kenya is increasingly faced with diet-related non-communicable diseases, especially in urban areas. These are mainly caused by excessive energy intake associated with purchased meals and processed foods, and decreasing levels of physical activity in urban settings. Changing lifestyles and eating habits have resulted in non-communicable diseases including cardiovascular, cancers, diabetes which are closely related to obesity and represent a significant development challenge. The health consequences of obesity related diseases range from premature death to disabilities that reduce the quality of life. Evidence from the KDHS (2008-09) indicates increasing prevalence of overweight and obesity. Analysis of obesity among pre-school children indicates that approximately 18% are overweight while 4% are obese. The proportion of women aged 15-49 who are overweight and obese has increased from 23% in 2003 to 25% in 2008-09. Nairobi has the highest prevalence of overweight and obese at 41% among women and 3rd to 5th wealth quintile being the most affected. Being overweight and obese are risk factors for non-communicable diseases such as hypertension, diabetes and cardiovascular diseases. According to WHO 28 % of all deaths result from NCD's. Currently, the prevalence of diabetes is 4.2%, while 12.7% of the population is hypertensive. Cancer incidence is estimated to be 28,000 annually, while the annual mortality is 21,000 people.

Micronutrient deficiencies are highly prevalent among children under the age of five years and women. According to 1999 national micronutrient survey in Kenya, the most common deficiencies include vitamin A deficiency (VAD), iron deficiency anemia (IDA), iodine deficiency disorders (IDD) and zinc deficiency. Data on these deficiencies is as presented in figure 2. VAD among under fives (84.4%); IDA among 6-72 month olds (69%) and among pregnant women (55.1%); IDD (36.8%); and zinc deficiency among mothers (52%) and among children under 5 years (51%). Iron deficiency is emerging as the most common condition among non-target groups with the prevalence of the deficiency among adolescents in refugee camps estimated at 46% and 21.1% among school girls in western Kenya.

Figure 2: Micronutrient Deficiencies in Kenya (National Micronutrient survey 1999)



With reference to data on infant and young child nutrition, KDHS 1998, 2003 and 2008-09 show that the median duration of breastfeeding has remained at 21 months. KDHS 2008/09 also indicates a significant improvement in exclusive breastfeeding (EBF) of children less than six months of age at32%compared to 11% in 2003.

Malnutrition is the single greatest contributor to child mortality at 53% (WHO 2010). The immediate causes of malnutrition are inadequate food intake and disease while the underlying causes include poor maternal/child care practices, household food insecurity, inadequate health services.

1.3 National Nutrition Response

There have been several policy and programmatic efforts aimed at addressing the nutrition problems in Kenya. The FNS policy is in place as a sessional paper No 1 of 2012 and has been used to develop the FNSS 2012-2017 and the National Nutrition Action Plan 2012-2017. In 2010, the government and partners agreed to focus additional resources in the country to scale-up evidence-based High Impact Nutrition Interventions. The nutrition sector is being coordinated through Nutrition Interagency Coordinating Committee (NICC) with four subcommittees, namely, Maternal Infant and Young Child Nutrition, Nutrition Technical Forum, National Micronutrient Deficiency Control Council, Healthy Diets and Lifestyle plus Research, Monitoring and Evaluation. The NICC has mobilized resources from the developmental partners to support implementation of nutrition interventions. Government resources allocation for nutrition is at 2.0% of the health budget.

1.4 Challenges

There is low understanding of linkage between national food security, basic education, and water and sanitation strategies on one hand and nutrition on the other. Furthermore, programme strategies are vertical in nature and lack nutrition as an outcome indicator. As a result, there is need to sensitize policy makers and programmers on the causal factors of malnutrition and influence them to address malnutrition in a holistic approach and broad manner. There is also need for organized coordination and collaboration of the different sectors in relation to nutrition objectives. Moreover, some pieces of legislations, nutrition-related policies, strategies and guidelines need urgent review to align them to the current Constitution.

In spite of the high malnutrition rates and disease burden in the country, the government's budgetary allocation for health sector, at 7% for financial year 2009/2010, still falls below the 15% standard stipulated in the Abuja declaration. This compares poorly with countries such as Rwanda and Botswana with over 15% health financing. The government's contribution to health financing has remained low and unchanging, resulting in increased reliance on donor financing especially for programmes targeting children and women. The budgeting processes of Medium Term Expenditure Framework (MTEF) and Annual Operations Plan (AWPs) are elaborate and provide good opportunity for the Nutrition Division to lobby for increased funding towards nutrition programmes. Therefore, there is need to streamline the top-bottom Resource Allocation Criteria Formula and consequent adoption of bottom-up Annual Operation Plan process by the government.

The human resource gap for nutritionists and dieticians within public health facilities and at community level is critical and needs immediate action. According to the Kenya Nutrition and Dieticians Institute, there are 1290 nutritionists, with 600 of them in public health facilities. This translates to 1 nutritionist for every 31,000 people.

Kenya has numerous nutrition stakeholders including government ministries, United Nations (UN) agencies, donors, private and public teaching and research institutions, nutrition working groups and professional associations, and the private sector. However, even with so many players in nutrition, little positive impact, including impact from implementation of high impact nutrition interventions, has been realized from nutrition interventions. This, in part, is attributed to challenges arising from coordination of the nutrition programmes in different sectors, the short-term nature of interventions which mainly target emergency situations and the lack of holistic programming leading to interventions with limited scope and impact. These issues call for sector-wide approaches to nutrition programming in the country.

Chapter 2
Nutrition Action Plan (2012-2017)

2.1 Background Information

Since independence in 1963, the government of Kenya (GoK) has developed policies and programmes to address nutrition issues based on the national situation analysis. International initiatives, too, have been crucial in shaping the direction of nutrition efforts in the country. For instance, the International Conference on Nutrition (ICN) held in Rome in December 1992, provided an opportunity for re-assessment of Kenya's nutrition strategies, thereby forming a strong basis for the development of 1994-1997 National Nutrition Action Plan (NNAP) for Kenya. Lessons learnt from the implementation of the 1994-1997 NPA as well as the assessment of the existing and emerging nutrition issues led to the formulation of the Food and Nutrition Security Policy (FNSP) and implementing of its strategy in the year 2008.

The Food and Nutrition Security Strategy highlights fourteen (14) priority nutrition areas to be addressed towards achieving the bigger nutrition agenda in Kenya. The priority areas include; micronutrient deficiency prevention and control, nutrition promotion, Institutional feeding, nutrition and infection, diet-related non-communicable diseases, emergency management, recovery and long term management; and data collection and management on nutrition, cross-sectoral data analysis on food and nutrition and information, education and communication. The Strategy proposes implementation of nutrition interventions through a life-cycle approach. Lifecycle approach to nutrition challenges is defined as an evidence-based approach that explores nutritional foundations, the growth, development and normal functioning of individuals through each stage of life and/or at all age groups. The approach provides a detailed account of the nutritional needs throughout the life cycle and highlights the special nutritional features of each of these stages. The objectives of life cycle are to improve women's nutrition throughout their lifecycle; promote optimal infant and young child feeding practices; promote appropriate nutrition for school children and adolescents; promote healthy lifestyles across the population; and improve nutrition care and support for the elderly. FSNS provides a conceptual guide to the development of this nutrition action plan which has further identified eleven (11) strategic objectives each with corresponding activity and expected outcomes.

2.2 Rationale

Situation analysis rates of child/infant mortality rates and maternal mortality) Maternal deaths have increased from 414/100,000 live births (KDHS 2003) to 488/100,000 live birth (KDHS 2008/9). No significant positive change is observed in most nutrition indicators over the last 10 years. This leads to not only mortality but also poor quality of lives. Improving nutritional status and reducing vitamin and mineral deficiencies are integral to achieving the Millennium Development Goals and the Kenya's Vision 2030.

While Kenya has adopted a set of high impact nutrition interventions[1], the coverage of these interventions remains very low due to inadequate resources and low prioritization of nutrition as reflected by low investment in nutrition. Investment in nutrition programmes is not commensurate to its critical role in reducing child mortality. It has to be recognized that attainment of MDG Goals, meaningful economic development and achievement of the 2030 vision will not happen without an urgent improvement in nutrition. Nutrition interventions that have proven to be cost effective, feasible and to have impact by preventing malnutrition before it happens should be brought to scale. Therefore the Nutrition Action Plan is practical tool that presents an opportunity to accelerate action towards achieving MDGs and Vision 2030. The Nutrition Action Plan will also be used as a resource mobilization tool by nutrition stakeholders and a guide to investment to cost effective nutrition interventions.

It is however appreciated that the achievement of the targeted MDGs by this Plan can only be realized if synergy in nutrition and other health programmes including water and sanitation, HIV&AIDS and malaria prevention and control is harnessed. This Plan is, therefore, to be implemented within the framework of integrated approach by the Ministry responsible for health. In addition, linkages with efforts in other development sectors notably agriculture, water, education and industry will be strengthened so as to contribute to the realization of targeted achievements by this Plan to address underlying causes of malnutrition.

For each of the key intervention activities identified in the activity matrix of the Plan, there are lead implementing and supporting agencies. This is to ensure that lead agencies are held accountable for the implementation of the Plan. The Plan is aligned to the government's Medium Term Plans (MTPs) to ensure that the government factors the Plan's intervention activities into its planning and budgeting processes, leading to allocation of financial resources to nutrition programme activities.

1 High Impact Interventions adopted in Kenya include: Breastfeeding promotion, complementary feeding for infants after the age of six months, improved hygiene practices included hand washing, Vitamin A supplementation, zinc supplementation for diarrhea management, multiple micronutrient, de-worming, iron-folic acid supplementation for pregnant women, salt iodization , iron fortification of staple foods, prevention or treatment for moderate under nutrition and treatment of severe acute malnutrition

2. 3 Purpose of Nutrition Action Plan

This Plan has been developed to operationalize the strategies outlined in the Food Security and Nutrition policy 2012. It serves as a road map for coordinated implementation of nutrition interventions by the government and nutrition stakeholders across development sectors for maximum impact.

2.4 Strategic Objectives

This section highlights 11 strategic objectives that need to be addressed in order to realize the goal of promoting and improving nutrition status of all Kenyans. These objectives include the following:

i. To improve the nutritional status of women of reproductive age (15-49 years)
ii. To improve the nutritional status of children under 5 years of age
iii. To reduce the prevalence of micronutrient deficiencies in the population
iv. To prevent deterioration of nutritional status and save lives of vulnerable groups in emergencies
v. To improve access to quality curative nutrition services
vi. To improve prevention, management and control of diet related NCDs
vii. To improve nutrition in schools, public and private institutions
viii. To improve nutrition knowledge attitudes and practices among the population
ix. To strengthen the nutrition surveillance, monitoring and evaluation systems
x. To enhance evidence-based decision-making through research
xi. To Strengthen coordination and partnerships among the key nutrition actors and mobilize essential resources.

2.4.1 Strategic Objective 1

To improve the nutritional status of women of reproductive age (15-49 years)

Improving the nutritional status of women of reproductive age while delaying pregnancy could reduce risk factors that affect the health and survival chances of both mother and child. Stunting and anaemia during pregnancy are risk factors for low birth weight babies. These babies are more susceptible to infectious diseases and death, and as adults they may face a higher risk of chronic illness such as diabetes and heart disease.

The main causes of malnutrition among WRA include sub-optimal feeding practices especially during pregnancy, heavy workload, and low micronutrient intake during pregnancy. The plan focuses on activities that will ensure that women of reproductive age receive adequate micro and macro nutrients.

Priority Areas

- Promote healthy dietary practices among WRA
- Promote adequate micronutrient intake
- Promote routine weight monitoring and appropriate counseling for pregnant women
- Promote appropriate management of malnutrition of pregnant and lactating women
- Ensure that all HIV positive mothers are counseled on good nutrition practices.
- Strengthen the capacity of health facilities to adequately offer maternal nutrition services.

Expected outcome: Improved nutritional status of women of reproductive age.

2.4.2 Strategic Objective 2

To improve the nutritional status of children under 5 years of age

Malnutrition remains a major threat to the survival, growth and development of children in Kenya. Poor nutrition in infancy and early childhood increases the risk of infant child morbidity and mortality, diminished cognitive and physical development marked by poor performance in school. Malnutrition also impacts on productivity later in life. One of the indicators used to assess progress towards MDG 1 and 4 is the prevalence of underweight among children under the age of 5 years old. Malnutrition in children can be attributed to a variety of factors including poor infant and young child feeding practices, poor maternal nutrition, low access to adequate and diversified diets, childhood illnesses and inadequate access to health and nutrition services.

This Plan focuses on activities that will contribute to the exploitation of the critical 'window of opportunity' from pre-pregnancy until two years of age as endorsed in the 2010 UN summit resolution on nutrition. According to Lancet Nutrition Series published in 2008, if the package of Essential Nutrition Interventions is effectively accessed by mothers from the conception period and children up to two years of age and implemented on a wider scale, in the short run, infant mortality would reduce by 25%, maternal mortality by 20% and chronic malnutrition/stunting in children by 30%.

Priority Areas

- Promote exclusive breastfeeding for the first six months of baby's life
- Promote optimal complementary feeding with continued breastfeeding for at least two years
- Provide appropriate micronutrient supplements to children under five years
- Strengthen growth monitoring and promotion for children under five years of age
- Strengthen referral mechanism and linkage between the community and health facility.
- Develop a national monitoring plan for nutrition commodities
- Ensure food safety of nutrition commodities.

Expected outcome: Improvement in nutritional status of children under the age of five years.

2.4.3 Strategic Objective 3

To reduce the prevalence of micronutrient deficiencies in the population

Micronutrient deficiencies are of public health concern due to their devastating effect on the physical and mental well-being of the population. They are also a risk factor for increased morbidity and mortality among children under five years, pregnant and lactating women. The main causes of micronutrient deficiencies include poor dietary diversification, infections such as malaria and food insecurity. There are national micronutrient guidelines highlighting key strategies used in prevention and control of micronutrient deficiencies. These include supplementation, food fortification, and promotion of dietary diversification and public health measures such as de-worming and malaria control. The National Micronutrient Deficiency Control Council and the Kenya National Food Fortification Alliance are the national coordinating structures for the micronutrient deficiency control program.

Some of the programmatic challenges experienced are inadequate resources, documentation and monitoring, stock outs of commodities and inadequate knowledge on importance of micronutrients among health service providers and the general population. This strategic objective, therefore, focuses on the need to ensure that the population receives adequate amounts of micronutrients, through dietary diversification, supplementation and fortification at all levels in the country.

Priority areas

- Review, develop and implement national micronutrient deficiency control strategy and guidelines
- Capacity building of service providers on micronutrients deficiency prevention and control
- Advocate and create awareness on food fortification, supplementation and dietary diversification
- Strengthen the national food fortification program
- Strengthen the national micronutrient supplementation program
- Strengthen monitoring and evaluation systems for the micronutrient strategies
- Integrate micronutrient prevention and control strategies in the community strategy

Expected Outcome: Reduced prevalence of micronutrient deficiencies in the population.

2.4.4 Strategic Objective 4

To prevent deterioration of nutritional status and save lives of vulnerable groups in emergencies

The main catastrophes that lead to emergencies in Kenya include drought, flood, fires, landslides and internal and cross-border civil strife. These emergencies result in loss of human lives, livestock, and livelihoods, and deterioration of health and nutrition status of the affected population. Children, women and the elderly are most vulnerable groups during the crisis period and therefore require urgent attention. Nutrition Technical Forum (NTF) is the national coordinating structure for the food security and emergency nutrition program in the nutrition sector. At district level, the districts NTFs have the same mandate. However, these structures require strengthening for effective emergency preparedness and response. Other challenges that require attention include weak multi-sectoral coordination of efforts

by government, partners and key stakeholders, inadequate disaster preparedness, delayed response to emergencies, poor adherence to guidelines on emergency commodities, resource constraints and poor linkages of short term efforts with long term programs such as food security initiatives, High Impact Nutrition Interventions and disease control.

This strategic objective will focus on effective disaster preparedness, response and management of nutrition emergencies. This calls for the need to harness all the required resources from all stakeholders to plan implement and monitor the response plan put in place.

Priority areas

- Review, develop and implement guidelines for disaster preparedness, response and management of nutrition emergencies.
- Strengthen the capacity of county NTF to develop and implement emergency response plans
- Create public awareness on the importance of nutrition in emergency at all level
- Strengthen coordination mechanisms in emergency situations at national and county level
- Strengthen monitoring and evaluation systems in emergency situations.
- Strengthen logistics management and supply chain system for food and non-food items
- Resource mobilization for timely response

Expected Outcome: Timely and coordinated response to minimize consequences of emergency on health and nutritional status of affected populations.

Expected output: Nutrition monitoring and evaluation systems will be strengthened, allowing more programme managers to appreciate the benefits of standardized M&E tools for effective reporting and planning.

2.4.5 Strategic Objective 5

To improve access to quality curative nutrition services

Under-nutrition compromises body immune system leading to repeated bouts of infectious diseases which in turn causes preventable deaths. On the other hand, treatment of infections and adherence to long term therapy is often affected by poor nutrition status. The problem is compounded by weak implementation of the nutrition components in the existing national guidelines on management of infections as well as inadequate nutritional support for people with infections. There is inadequate capacity in the health care system to provide quality curative nutrition services. Curative efforts are rendered ineffective owing to inadequate knowledge on appropriate diets and safe nutrition practices.

Priority Areas

- Review, develop and implement national guidelines and standards of nutritional care in management of common diseases.
- Strengthen the capacity of health care systems to provide optimal curative nutrition services
- Resource mobilization for nutritional care and treatment for infections
- Strengthen monitoring and evaluation of curative nutrition services
- Ensure food safety of nutrition commodities.

Expected Outcome:

- Improved access to quality curative nutrition services
- Improved cure rate.

2.4.6 Strategic Objective 6

To improve prevention, management and control of diet related Non Communicable Diseases

The prevalence of diet related non-communicable diseases has been on the increase, especially in urban area. This increase has been caused by lifestyle changes characterized by excessive intake of highly refined and high-fat foods, sugar and salt, coupled with limited physical activity. As a result, the burden of morbidity, disability and mortality attributable to these diseases is high. Being overweight and obese are risk factors for non-communicable diseases such as hypertension, diabetes and cardiovascular diseases. Some of the key programmatic challenges include inadequate data collection and reporting, limited screening of the population, inadequate knowledge among health care provider and general population, resource constraints and lack of comprehensive strategy and guidelines for prevention, management and control of diet related NCD.

This strategic objective addresses the need to promote healthy diets and physical activity across the population using the lifecycle approach with the view of reversing the rising trends of non communicable diseases.

Priority Areas

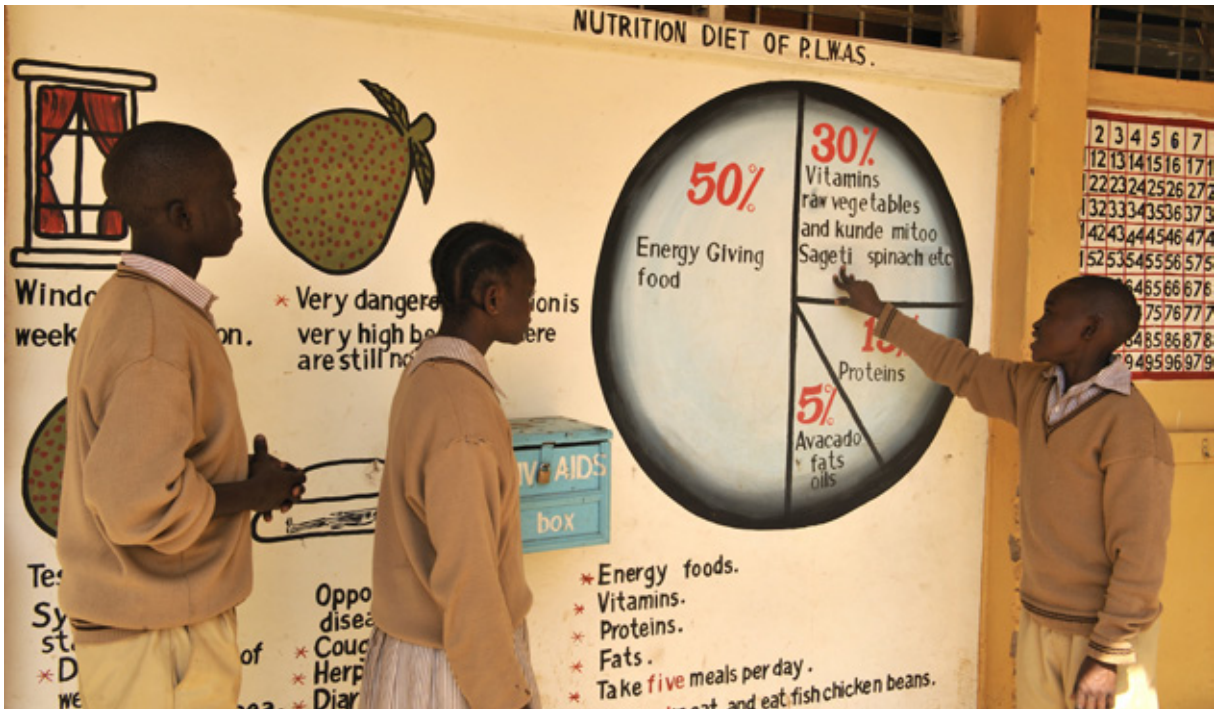
- Review, develop and implement comprehensive strategy and guidelines for prevention, management and control of diet related NCDs
- Capacity building for service providers on prevention, management and control of diet related NCDs
- Create public awareness on the importance of prevention, management and control of diet related NCDs using the national ACSM
- Strengthen coordination mechanisms for healthy diet and lifestyle programs at national and county level
- Strengthen monitoring and evaluation systems for diet related NCDs.

Expected outcome: Improved prevention, management and control of diet related NCDs.

2.4.7 Strategic Objective 7

To improve nutrition in schools, public and private institutions

Though policies and guidelines exist, they are inadequate in coverage of the institutions. In addition, the guidelines are not adequately adhered to in realization of optimal nutrition in schools and other institutions in Kenya, therefore, presenting a serious challenge. This may partly be attributed to inadequacy in adherence to nutrition policies and guidelines that are in place. In addition, it is possible that there is inadequate knowledge on optimal nutrition within institutions. Malnutrition in early childhood affects school enrolment, retention, and overall performance. Good nutrition is therefore, essential to realize the learning potential of children and to maximize returns to educational investments.



Nutrition education and promotion of good nutrition practices in schools are known to have a significant effect in fostering healthy eating habits. Schools provide an ideal setting to promote good nutrition practices early in life since they reach a high proportion of children and adolescents. The School Health and nutrition policy emphasizes the promotion of school gardens to enhance integration of nutrition interventions into routine school activities. However there is need to fully implement the school health and nutrition policy and scale up activities in the counties in order to strengthen the nutrition component. The nutritional challenge facing various institutional dietary needs are related to the quantities and types of food provided (quality). There is need to ensure that energy, protein, vitamin and minerals are provided in the diets, to meet the Recommended Dietary Allowances (RDA) of individuals.

In the face of these challenges, schools and other institutions need support to provide effective nutrition knowledge, care and nutritious food. Working with local communities to involve administrators, civil society, private sector and media is also vital in addressing these challenges.

Priority areas

- Review, develop and implement nutritional guidelines for schools and other institutions.
- Mobilize nutrition stakeholders' commitment towards sustaining institutional feeding programmes
- Integrate nutrition education in school curriculum at all levels.
- Mainstream basic nutrition training in all schools and other institutions
- Implement appropriate nutrition interventions in schools and other institutions
- Strengthen monitoring and evaluation of nutrition interventions in school and other institutions

Expected outcome: Improved nutritional status of the population in schools and other institutions.

2.4.8 Strategic Objective 8

To improve nutrition knowledge attitudes and practices among the population

Nutrition knowledge is a key aspect in confronting the problem of malnutrition at all levels of society and in all sectors. It enables families and individuals to enhance their understanding of the importance of nutrition and as a result to improve their nutritional situation. Myths and misconceptions about nutrition exist within the communities that affect the health of populations. There is often a misconception that food availability is equal to nutritional adequacy and better levels of nutritional status. There is inadequate understanding of appropriate care practices and linkage with actual illnesses and death, not only in the general community but also among health workers. Specifically, when children fall sick or die, the causes are not attributed to malnutrition but broadly associated with diarrhoea, pneumonia, infections or other cultural beliefs.

Education systems at various levels do not transfer adequate nutrition knowledge aimed at influencing life-long dietary practices. Improving nutrition will require enhancing knowledge, attitude and practices of all stakeholders and of the general public. This will require building the capacity of frontline field staff, including teachers, extension agents, health practitioners and other service providers to incorporate nutritional and food safety considerations and messages into their routine work. Their knowledge and understanding must be adequate in both depth and scope to handle the many facets of nutrition issues. To address these challenges, an advocacy and communication strategy focusing on appropriate diets and lifestyles will be developed and disseminated to the community.

Priority areas

- Conduct formative and periodic assessments on the status of nutrition knowledge, attitude and practices in the general population.
- Develop, disseminate and implement national nutrition advocacy, communication and social mobilization (ACSM) strategy at all levels.
- Capacity building for service providers on nutrition, including communication and advocacy skills.
- Nutrition Days marked nationally and in all counties (World Breastfeeding Week, African Food and Nutrition Security Day, Iodine Deficiency Disorders Day, *Malezi Bora*, among others)
- Promote measures to ensure food safety at all levels

Expected outcome: Improved nutrition knowledge, attitudes and practices in the general population.

2.4.9 Strategic Objective 9

To strengthen nutrition surveillance, monitoring and evaluation systems

Nutrition monitoring and evaluation systems are essential in measuring program performance and evaluating the impact of interventions. These systems include routine recording and reporting of nutrition services integrated in the existing health information system and periodic surveys and also assessments. Nutrition surveillance provides information for routine monitoring of nutritional status and early warning for disaster mitigation.

There are nutrition indicators and data elements that are being collected through the District Health Information System; however there are awareness gaps on these indicators among the health care workers and the data managers resulting in incomplete reporting. Routine monitoring of nutritional status requires improvement in data tools and management (collection, analysis, reporting and dissemination). In addition, the early warning system in Arid and Semi arid areas and the national early warning systems require strengthening.

Feedback on surveillance, monitoring and evaluation is necessary to ensure that this information contributes towards identifying specific nutrition requirements and timely provision of services to the areas of greatest need. Actions under this strategic objective therefore aim at addressing these problems in nutrition surveillance, monitoring and evaluation systems in the country.

Priority areas

- Operationalise the nutrition Monitoring and evaluation framework for the nutrition sector.
- Review, develop and disseminate guidelines and tools on surveillance, monitoring and evaluation
- Strengthen feedback mechanisms on nutrition information among nutrition stakeholders
- Train managers and service providers on use of DHIS and interpretation of M&E data.
- Strengthen the integration of nutrition indicators in the existing integrated disease surveillance system.
- Promote use of appropriate technology to enhance quality of data collected

Expected outcome: Enhanced quality and timeliness of data collected for effective decision making.

2.4.10 Strategic Objective 10

To enhance evidence-based decision-making through research

Evidence of best practices has to be generated involving research for better solutions to nutrition problems. Programme design should therefore, be based on assessment of the nutrition situation and of the resources that can be mobilized to address the gaps. One of the gaps is that research findings are not adequately used to inform nutrition program design and implementation. There are many nutrition-related studies that have been conducted that have not been widely disseminated to assist in decision making at all levels. With decentralization of nutrition care and services in Kenya, there is need to conduct research at county level to guide in designing specific programs. Under this strategic objective, specific focus will be the identification of priority research areas and advocacy to expand evidence-based solutions at all levels.

Priority areas

- Strengthen/establish research coordination mechanisms at national and county levels
- Resource mobilization to address critical gaps in nutrition research
- Conduct need-based research to inform policy, programme design and implementation
- Strengthen the capacity of relevant research institutions to conduct nutrition research.

Expected outcome: Enhanced evidence-based decision-making through research in program design and implementation.

2.4.11 Strategic Objective 11

To strengthen coordination and partnerships among the key nutrition actors

The causes of malnutrition are multi-sectrol in nature and therefore require a broad range of actors including; Planning (human development), Agriculture (food security), Industry and Trade (food availability), Economy (purchasing power), Women and Children Development (family empowerment), Education (knowledge and skill), Manpower/Workforce (productivity) and Socio-culture (nutritional behavior).

Implementation of nutrition interventions by different sectors is not well coordinated resulting in duplication of efforts. Nutrition programmes therefore need to look beyond the health sector and must be addressed through integrated approach for successful achievement of its goal.

The success of this Nutrition Plan therefore depends, to a large degree, on multi-sectoral coordination of actions in nutrition at all levels.

Priority Areas

- Strengthen multi-sectoral coordination mechanisms and networks for nutrition at all levels.
- Setting of clear mandates and responsibilities for nutrition stakeholders at different levels.
- Advocate and mobilize financial and human resources for nutrition coordination and partnership activities at all levels
- Hold and document regular joint planning and review meetings to align the annual nutrition planning process to the nutrition action plan.

Expected outcome

Increased human, financial and material resource allocation for nutrition interventions.

2.4 Coordination

Coordination of implementation of this Plan shall fall within the coordination mechanism of the agreed upon Food and Nutrition Security Strategy 2012. Under this Strategy, the Ministry responsible for health shall be directly in charge of coordinating the implementation of this National Nutrition Action Plan at national level through Nutrition Interagency Coordinating Committee (NICC) and the technical working groups. However, under the new governance system in Kenya, there will be devolved coordination mechanisms at the county levels. Each county and ward will have its own Food and Nutrition Security Secretariats. The role of the county and ward Secretariats will be to coordinate and monitor all food and nutrition activities in their respective geographical areas. Ward secretariat will report to the County secretariat which in turn will report to the National Food and Nutrition Security Secretariat. At all the levels, nutrition stakeholders will play a crucial role in the execution of this NNAP through established coordination structures.

The coordination activities will entail, among others;

- Receiving progress report on the implementation of the Plan and organizing for dissemination among the stakeholders for informed decision-making
- Organizing forums for experience sharing by the stakeholders on best-practices
- Monitoring and Evaluation of the implementation of NNAP
- Providing enabling environment for the implementation of the NNAP by the stakeholders; this will entail resource mobilization towards implementation of the Plan as well as influencing policies and legislations that support implementation of the Plan.

Chapter 3
Monitoring and Evaluation Plan

A system for monitoring and evaluation (M&E) is a critical component of the implementation of this Action Plan as such a system will enable tracking of programme implementation. The Nutrition M&E framework 2012-2017 developed in line with this action plan will aim at meeting the information needs of different stakeholders; that is policy makers, donors, Civil Society Organization (CSOs), research and academic institutions, development partners, media and the general public. The objective of M&E is to inform decision-making in the areas of accountability, activity implementation, allocation of resources and policy at National, County, sub-county and Health facility level. In order to achieve this objective various stakeholders in the implementation of the Plan of Action, will be encouraged to;

- Ensure timely availability of data
- Analyze the data, disseminate and promote use of the findings
- Ensure proper storage, reliable access and ease retrieval by different users

Further, the M&E for this action plan;

- Integrates and utilizes National M & E systems including District Health Information software (DHIS) and Kenya demographic health surveys (KDHS) to ensure adequate provision of more disaggregated data so as to facilitate monitoring and evaluation at all levels.
- Aims to collect and analyze qualitative information and increase participatory monitoring.
- Is guided by operational research and analysis programmes to evaluate changes towards desired outcomes and targets

3.1 Monitoring

Monitoring is the process of collecting data on on-going programme/project/activity analyzing, interpreting and using it to modify implementation so that it (implementation) proceeds according to plan. Monitoring of the activities in the action plan will be done through routine collection, collation, analyzing, interpretation and dissemination of data using standardized tools. The frequency of monitoring the activities will be undertaken monthly, quarterly and annually.

3.2 Evaluation

Evaluation is the process of collecting data on on-going, completed or yet-to-start programme, analyzing and interpreting the data for purposes of determining the value of the programme. Evaluation for the activities in the plan will be done at formative stage, mid-way and end of project. Methods for evaluation will include assessments and surveys. Where possible emphasis will be on integrated nutrition evaluations with other national surveys like the KDHS, Kenya Integrated Household Budget Survey (KIHBS)

Annex 2 presents performance-target based monitoring and evaluation plan. The plan highlights both output and outcome indicators to be tracked, the year and value of the baseline situation of the indicator parameter, targets to be achieved in each year of the Action Plan implementation, source of M&E data and the agency responsible for M&E activities. Both the output and outcome indicators are derived from the strategic objectives of the Action Plan. The indicators have been arrived at through analysis of trends of the targets in the health sector in Kenya and other countries. Specifically, the analysis takes into account targets set previously, efforts that were put in place to achieve the targets including policy, legislations programmes, institutional arrangements and financial resources. The analysis focused on efforts in health sector as set out in the KHSSP and the FNSP and other sectors notably agriculture, water, livestock, education and fisheries that contribute to realization of the goals of national nutrition agenda.

The following are brief definitions of elements that comprise a sound monitoring and evaluation framework:

Inputs—all those resources that go into the programme at the onset or start-up phase or during the implementation to help the programme achieve its objectives. The inputs (the number and qualifications of personnel, the financial resources, the institutional set-up, timing, etc.) must be designed as to meet the problem. The inputs should be distributed to meet all needy groups and be accessible financially, socially and technically. If this does not happen the outputs may not be met.

Outputs—all the goods and services delivered to the target population by the programme. Programme inputs have to be transformed into outputs. The quantity and quality of the outputs is very important. For instance, if one programme input were the training of nutrition service providers, the outputs are the number of trained nutrition service providers. The quality of the training should also be "adequate," otherwise just training them would not help in effectively meeting the needs of the community.

It should also be understood that having very well-trained staff or people does not necessarily generate programme delivery nor impact. Success and impact are created by making sure that the trained personnel are enabled to do the work that they were trained for.

Outcomes—changes in behaviors/practices as a result of programme activities. The outputs, if of the right quantity and quality, should produce an outcome. The skills of the nutrition service providers should change, and if they do their tasks well, the detrimental behaviour/practices of the mothers should change for the better of their children's health. The change in skills of the nutrition service providers and/or the change in behaviour/practices of the mothers is the outcome of the programme. The outcome is expected to influence the problem, as defined initially.

Impacts—the effect of the programme on the beneficiaries. The change in the problem is the impact of the program on the beneficiaries/clients.

Assumptions—the external factors, influences, situations or conditions which are necessary for project success. They are important for the success of the programme but are largely or completely beyond the control of programme management. For example, in nutrition education, we may assume that community workers who are trained will understand the training and be motivated to do what they have been trained to do. However, we cannot be sure that this actually will happen. Accordingly, it is necessary to make assumptions explicit and list them in the framework as elements to be monitored or evaluated.

Chapter 4
Annexes

Annex 1: Activity Implementation Matrix

Strategic Objective 1: To improve the nutritional status of women of reproductive age (15-49 years)					
Outcome Indicator	**Output Indicator**	**Activity**	**Implementation level**	**Lead Agency**	**Other Agencies**
% reduction of Vitamin A deficiency among women of reproductive age. % reduction of iron deficiency among women of reproductive age. % reduction of iodine deficiency among women of reproductive age. % reduction of overweight and obesity among women of reproductive age. % reduction of zinc deficiency among women of reproductive age. % reduction underweight among women of reproductive age.	% of pregnant women who take iron and folic acid supplements for at least 90 days during pregnancy.	• Provide IFA supplements to adolescent girls and pregnant women.	County	MOH	MoE, Development , Implementing partners
	% of pregnant and lactating women with MUAC < 21 cm receiving supplementary food.	• Provide supplementary foods to pregnant and lactating women according to the admission criteria on integrated management of acute malnutrition guidelines.	County	MOH	KEMSA, Development , Implementing partners
	% of pregnant women monitored for their weight.	• Conduct routine weight Monitoring and appropriate counseling for the pregnant women	County	MOH	Development , Implementing partners,
	Proportion of health facilities with nutrition commodities and equipment for maternal nutrition interventions	• Procure and distribute nutritional commodities and equipment to health facilities.	National / County	MOH	KEMSA, Development , Implementing partners,
		• Conduct nutrition education on healthy dietary practices to Women of reproductive age.	County	MOH	Development , Implementing partners, Media
	No. of maternal nutrition guidelines disseminated in use at county level	• Review, develop, print and disseminate and distribute guidelines	National	MOH	Development , Implementing partners, Media

Strategic Objective 2: To improve the nutritional status of children under 5 years of age					
Outcome Indicator	**Output Indicator**	**Activity**	**Implementation level**	**Lead Agency**	**Other Agencies**
% reduction of children <5 years with malnutrition (stunting, wasting, underweight , obesity) % reduction of children< 5 years who are micronutrient deficient (iron, vitamin A, zinc, Iodine),	% of Health facilities certified as Baby Friendly % of community units that are implementing Baby Friendly Community Initiative % of infants who are breastfed within one hour of birth % of children < 6 months who are breastfed exclusively % of companies/ suppliers complying with the Code of Marketing of Breast Milk Substitutes % of agencies/ companies which support breastfeeding in the workplace	• Scale up Baby Friendly Hospital Initiative (BFHI)	Health facility Community	MOH	Implementing & Development partners
		• Baby Friendly Community Initiative (BFCI)	Health facility/	MOH	Development , Implementing partners, Ministry of Gender & Social Services, Media Civil Society
		• Sensitize women of reproductive age (WRA)	Community	MOH	Development , Implementing partners, Ministry of Gender & Social Services, Media Civil Society
		• Sensitization on the importance of exclusive breastfeeding for the first six months of baby's life	County	MOH	Development , Implementing partners, Ministry of Gender & Social Services, Media Civil Society
		• Support monitoring of the Code of Marketing of Breast milk Substitutes	Health facility/ Community	MOH	Development , Implementing partners, Ministry of Gender & Social Services, Media, Justice Civil Society
		• Advocate workplace support of breastfeeding mothers.	National /County	MOH	Development , Implementing partners, Ministry of Gender & Social Services, Media, Justice Civil Society

Strategic Objective 2: To improve the nutritional status of children under 5 years of age					
Outcome Indicator	**Output Indicator**	**Activity**	**Implementation level**	**Lead Agency**	**Other Agencies**
% reduction of children <5 years with malnutrition (stunting, wasting, underweight , obesity) % reduction of children< 5 years who are micronutrient deficient (iron, vitamin A, zinc, Iodine),	% of health workers trained on appropriate infant feeding practices per county % of health facilities per county provided with Behaviour Change Communication/ Information, Education and Communication (BCC/IEC) materials % of children aged 6-23 months who are consuming 3+ or 4+ food groups per day (dietary diversity)	• Train and equip health workers to promote appropriate infant and young child feeding practices	National /County	MOH	Development , Implementing partners,
		• Provision of BCC/IEC (ACSM) materials to the Health facilities and communities.	Health facility/ Community	MOH	Development , Implementing partners,
		• Sensitize WRA on timely introduction of optimal complementary foods with continued breastfeeding for at least two years.	County	MOH	MoA, MoL, MoF, Development , Implementing partners, Ministry of Gender & Social Services, Media Civil Society
		• Promote proper hygiene practices, and timely seeking of health care.	County	MOH	MoW, Development , Implementing partners, Ministry of Gender & Social Services, Media Civil Society
	% of children < 5 years whose growth is monitored % of children < 5 years screened at community level and referred for nutrition management Proportion of health facilities equipped with anthropometric equipment and reporting tools	• Train HWs, CHEWs and CHWs on new growth standards and CHANIS • Equip Health Facilities and community units with anthropometric equipment • Provide monitoring and reporting tools	County	MOH	Development , Implementing partners,
		• (CHANIS, MCH booklet and job aids).		MOH	Development , Implementing partners,

Strategic Objective 2: To improve the nutritional status of children under 5 years of age					
Outcome Indicator	**Output Indicator**	**Activity**	**Implementation level**	**Lead Agency**	**Other Agencies**
% reduction of children <5 years with malnutrition (stunting, wasting, underweight , obesity) % reduction of children< 5 years who are micronutrient deficient (iron, vitamin A, zinc, Iodine),	% of children aged 6-59 months receiving Vitamin A supplements twice a year % of children < 5 years with diarrhoea who are treated with zinc supplements % of children aged 6-59 months receiving multiple micronutrient powders as per recommended dose.	• provide children aged 6-59 months with two doses a year of Vitamin A supplements	County	MOH	KEMSA, MoE, Development , Implementing partners,
		• Provide multiple-micronutrients powder for children 6-59 months	County	MOH	KEMSA, Development , Implementing partners, Industry
	No of infant and young child feeding guidelines in use at County level	• Review, develop, print and disseminate and distribute guidelines	National	MOH	Development , Implementing partners,

Strategic Objective: 3. To reduce the prevalence of micronutrient deficiencies in the population					
Outcome Indicator	**Output Indicator**	**Activity**	**Implementation level**	**Lead Agency**	**Other Agencies**
decreased prevalence of micronutrients deficiencies decreased prevalence of Vitamin A deficiency by 5% decreased prevalence of iron deficiency by 10% decreased prevalence of iodine (goiter rate) deficiency by 1% Increase in the population knowledge on micronutrient deficiency and curative and preventive measures	# of health workers at all levels trained on prevention, management and control of micronutrient deficiencies.	• Review, develop and disseminate national micronutrient deficiency prevention and control strategy and guidelines.	National and County	MOH	KEMRI, KNBS Institutions of Higher Learning, Development , Implementing partners,
		• Train service providers on micronutrients deficiency prevention and control strategies including logistic and supply chain management	County	MOH	Institutions of Higher Learning, Development , Implementing partners
	No. of advocacy workshops on micronutrient interventions conducted at all levels No. of micronutrient intervention campaigns (Radio, TV, Community etc) launched.	• Advocate and create public awareness on food fortification, supplementation and dietary diversification.	County	MOH	KNFFA members, Media , Industry
	Proportion of U5 children who receive multiple micronutrient supplements % U5 children supplemented with vitamin A % of women of reproductive age supplemented with iron and folic acid	• Scale up and strengthen the existing strategies of micronutrient supplementation at all levels.	County	MOH	CHMT, County Government, MOA, MOL, MOF, MOW, MoGC&SS, MoE, Development , Implementing partners
		• Procure and distribute micronutrient supplements (VAS, MNPs and IFA).	National and County	MOH	KEMSA, CHMT, County Government, Development , Implementing partners

Strategic Objective: 3. To reduce the prevalence of micronutrient deficiencies in the population					
Outcome Indicator	**Output Indicator**	**Activity**	**Implementation level**	**Lead Agency**	**Other Agencies**
decreased prevalence of micronutrients deficiencies decreased prevalence of Vitamin A deficiency by 5% decreased prevalence of iron deficiency by 10% decreased prevalence of iodine (goiter rate) deficiency by 1% Increase in the population knowledge on micronutrient deficiency and curative and preventive measures	% of households consuming adequately fortified foods in the country	• Scale up fortification of widely consumed food stuffs.	National /County	Kenya National Fortification Alliance	MOH, MOT, MOF, Media.
	% of widely consumed basic commodities which are fortified with necessary micronutrients	• Monitor the quality of fortified foods regularly at all levels.	National and County	KEBS	MOH, Media.
	No. of private sector actors/industries fortifying their foods products as per the national guidelines.	• Conduct M&E of micronutrient deficiency prevention and control interventions	County	KEMRI	MOH, CHMT, County Government, Development , Implementing partners
		• Train CHEWs and CHWs on micronutrient deficiency prevention and control strategies.	County	MOH	CHMT, County Government, Academia, Development , Implementing partners
		• Review of policy to include use of CHWs in delivery of micronutrient supplements.	National	MOH	Academia, Development , Implementing partners

Strategic objective 4: To prevent deterioration of nutritional status and save lives of vulnerable groups in emergencies					
Outcome Indicator	**Output Indicator**	**Activity**	**Implementation level**	**Lead Agency**	**Other Agencies**
Improved nutritional status of populations in emergencies. Reduced morbidity and mortality of the affected population	Proportion of counties with emergency nutrition response plans	• Build the capacity of the counties to develop nutrition response plans	National and County	MOH	CHMT, County Government, Academia, Development , Implementing partners
		• Review, develop and disseminate guidelines for disaster preparedness, response and management of nutrition emergencies	National and County	MOH	CHMT, County Government, Academia, Development , Implementing partners
	Number of counties reporting on a timely basis on nutrition surveillance	• Conduct nutrition surveillance in emergency affected areas	County	MOH	Implementing partners
	Number of counties holding regular coordination meetings.	• Map partners, review and develop TORs	County	MOH	CHMT, County Government, Academia, Development , Implementing partners
		• Hold and document regular joint planning and review meetings	County	MOH	CHMT, County Government, Development , Implementing partners
	Proportion of facilities experiencing no stock-outs of essential nutrition commodities	• Timely provision of food and non-food items	County	MOH	MOF, KEMSA CHMT, County Government, Academia, Development , Implementing partners

Strategic objective 4: To prevent deterioration of nutritional status and save lives of vulnerable groups in emergencies					
Outcome Indicator	**Output Indicator**	**Activity**	**Implementation level**	**Lead Agency**	**Other Agencies**
Improved nutritional status of populations in emergencies. Reduced morbidity and mortality of the affected population	Proportion of health facilities offering the essential nutrition services package.	• Scale up delivery of essential nutrition services (High Impact Nutrition Interventions)	County	MOH	MOF, KEMSA, CHMT, County Government, MOF, MOA, MOE, MOW, Development , Implementing partners
	Number of health workers in emergency districts trained on essential nutrition services package.	• Capacity strengthening of health workers to provide nutrition care and support at all levels.	County	MOH	CHMT, County Government, Academia Development , Implementing partners
	Proportion of counties mobilizing resources for nutrition emergency response	• Mobilize resources for emergency response	County	MOH	MOF, CHMT, County Government, MOA, MOE, MOW, Development , Implementing partners
	Number of counties meeting the SPHERE standards on IMAM and national targets on IFE				
	National nutrition commodities monitoring plan developed and disseminated for use by the counties	• Develop, disseminate and implement the national monitoring plan for nutrition commodities in emergency	National	MOH	MOF, Development , Implementing partners
	Proportion of counties implementing the nutrition commodities monitoring plan used during emergencies	• Monitor food safety of nutrition commodities for use in emergencies	County	MOH	CHMT, County Government, Development , Implementing partners

Strategic objective 4: To prevent deterioration of nutritional status and save lives of vulnerable groups in emergencies					
Outcome Indicator	**Output Indicator**	**Activity**	**Implementation level**	**Lead Agency**	**Other Agencies**
		• Create public awareness on importance of nutrition in emergencies	County	MOH	CHMT, County Government, Development , Implementing partners, Media Civil Society

Strategic objective 5: To improve access to quality curative nutrition services					
Outcome Indicator	**Output Indicator**	**Activity**	**Implementation level**	**Lead Agency**	**Other Agencies**
Proportion of population accessing curative nutrition services	Number of agencies integrating nutritional care standards in their plans Proportion of resources committed to nutrition care services Number of health workers trained on curative nutrition services Number of community individuals and private sector players sensitized on quarterly basis Proportion of health facilities providing curative nutrition services Proportion of facilities experiencing no stock-outs of essential nutrition commodities Reduced inpatient length of stay	• Review, develop and disseminate national guidelines on nutritional care in the management of common diseases	National	MOH	MOF, KEMSA, CHMT, County Government, MOF, MOA, MOE, MOW, Development , Implementing partners
		• Mobilize resources for nutritional care and treatment for common diseases	National	MOH	CHMT, County Government, Academia Development , Implementing partners
		• Train health workers on clinical nutrition management	National and County	MOH	MOF, CHMT, County Government, MOA, MOE, MOW, Development , Implementing partners
		• Procure and distribute essential nutrition commodities (micronutrient supplements, therapeutic milks and feeds) and equipments (anthropometric and others)	National	MOH	MOF, KEMSA Development , Implementing partners
	National nutrition commodities monitoring plan developed and disseminated for use by the counties	• Develop and disseminate nutrition commodities monitoring plan	National	MOH	KEMSA, Development , Implementing partners

Strategic objective 5: To improve access to quality curative nutrition services					
Outcome Indicator	**Output Indicator**	**Activity**	**Implementation level**	**Lead Agency**	**Other Agencies**
Proportion of population accessing curative nutrition services	Proportion of counties implementing the nutrition commodities monitoring plan	• Monitor food safety of nutrition commodities	National and County	MOH	KEMSA, CHMT, County Government, Academia Development , Implementing partners
		• Conduct M&E of curative nutrition services	County	MOH	KEMRI, Development , Implementing partners

Strategic objective 6: Halt and reverse the prevalence of diet related non communicable diseases.					
Outcome Indicator	**Output Indicator**	**Activity**	**Implementation level**	**Lead Agency**	**Other Agencies**
% reduction of incidences of non-communicable diseases. % of population screened for non-communicable diseases % reduction of population prevalence rates for obesity and overweight. % of population with normal range BMI. % of households consuming diversified diets.	Proportion of counties implementing nutrition guidelines on NCDs Proportion of the population who are screened for non-communicable diseases. Proportion of Counties conducting sensitization meetings on healthy diets and physical activity % no. of population whose BMI is monitored regularly	• Review, develop and disseminate a comprehensive strategy and guidelines for prevention, management and control of diet-related NCDs	Health facility/ Community	MOH	Academia, MOA, Development , Implementing partners
		• Train service providers on prevention, management and control of diet-related NCDs	Health facility/ Community	MOH	Academia, MOA, Development , Implementing partners
		• Create public awareness on the importance of prevention, management and control of diet-related NCDs	County Health facility/	MOH	Academia, MOA, Media Development , Implementing partners

Strategic objective 6: Halt and reverse the prevalence of diet related non communicable diseases.					
Outcome Indicator	**Output Indicator**	**Activity**	**Implementation level**	**Lead Agency**	**Other Agencies**
% reduction of incidences of non-communicable diseases. % of population screened for non-communicable diseases % reduction of population prevalence rates for obesity and overweight. % of population with normal range BMI. % of households consuming diversified diets.	Proportion of counties implementing nutrition guidelines on NCDs Proportion of the population who are screened for non-communicable diseases. Proportion of Counties conducting sensitization meetings on healthy diets and physical activity % no. of population whose BMI is monitored regularly	• Map partners, review and develop TORs	Community	MOH	CHMT, Academia, Development , Implementing partners
		• Hold and document regular joint planning and review meetings	National /County	MOH	CHMT, County Governments Development , Implementing partners
		• Conduct M&E of diet related NCDs	National /County	MOH	KEMRI, Development , Implementing partners
		• Conduct screening for non-communicable diseases	County	MOH	MOE, Development , Implementing partners,
		• Scale up community screening for BMI and waist circumference	National /County	MOH	MOE, MOGC&SS, Development , Implementing partners,

Strategic objective 7: To improve nutrition in schools, public and private institutions					
Outcome Indicator	**Output Indicator**	**Activity**	**Implementation level**	**Lead Agency**	**Other Agencies**
% of pupils in Primary Schools with adequate nutrition status. % population in public institutions with adequate nutrition status	Situation analysis on school/ institutional feeding conducted, documented and disseminated	• Conduct situation analysis on school/ institutional feeding including the Early Childhood Development Education Centres(ECDE), Daycare centres	County	MOH	MoE, KEMRI, KNBS, Children Department, Development , Implementing partners
	School/institutional feeding guidelines reviewed and disseminated Proportion of schools and institutions mainstreaming basic nutrition in their operations	• Review, develop and disseminate nutrition guidelines for school and other institutions	National	MOH	MoE, Children Department, Development , Implementing partners
		• Mainstream basic nutrition training in all schools and other institutions	County	KIE	MOH MoE, Children Department, Development , Implementing partners
		• Implement appropriate nutrition interventions (school meals, micronutrient supplementation, nutrition assessment, de-worming among others) in schools and other institutions	County	MOE/ MOH	Children Department, Development , Implementing partners

Strategic objective 7: To improve nutrition in schools, public and private institutions					
Outcome Indicator	**Output Indicator**	**Activity**	**Implementation level**	**Lead Agency**	**Other Agencies**
% of pupils in Primary Schools with adequate nutrition status. % population in public institutions with adequate nutrition status	Number of counties holding stakeholders' meetings on sustainable institutional feeding programmes	• Mobilize resources to sustain optimal institutional feeding programmes	County	MOE	MOH, MOF, Children Department, Development , Implementing partners
		• Integrate nutrition education in school curricula at all levels	National	KIE	MOH, MoE, Children Department, Development , Implementing partners
	Proportion of counties monitoring nutrition interventions in schools and institutions	• Conduct M&E of nutrition interventions in schools and other institutions	County	MOE	MOH, Children Department, Development , Implementing partners

Strategic objective 8: To improve nutrition knowledge attitudes and practices among the population					
Outcome Indicator	**Output Indicator**	**Activity**	**Implementation level**	**Lead Agency**	**Other Agencies**
% of population adopting healthy diets and lifestyle	Formative and periodic assessment reports available and disseminated	• Conduct situation analysis on school/ institutional feeding including the Early Childhood Development Education Centres(ECDE), Daycare centres	National and County	MOH	KEMRI, KNBS Institutions of Higher Learning, Development , Implementing partners,
	Proportion of Counties implementing ACSM strategy	• Develop, print and disseminate national nutrition advocacy, communication and social mobilization (ACSM) strategy at all levels	National	MOH	Development , Implementing partners
	Proportion of service providers trained on nutrition communication and advocacy skills	• Train service providers on communication and advocacy skills	County	MOH	Development , Implementing partners
	Number and type of nutrition communication materials developed and disseminated at all levels	• Review, develop, print, disseminate and distribute IEC materials	National / County	MOH	Development , Implementing partners
	Proportion of counties marking Nutrition Days	• Mark national/ international Nutrition Days (World Breastfeeding Week, African Food and Nutrition Security Day, Iodine Deficiency Disorders Day, Malezi Bora among others)	National / County	MOH	Development , Implementing partners, Media Civil Society
	Proportion of media houses disseminating nutrition messages	• Promote optimal nutrition through all channels of communication at all levels	National and County	MOH	Development , Implementing partners, Media Civil Society

Strategic objective 9: To strengthen the nutrition surveillance, monitoring and evaluation systems					
Outcome Indicator	**Output Indicator**	**Activity**	**Implementation level**	**Lead Agency**	**Other Agencies**
% health facilities nationwide conveying accurate and complete monitoring data to central level # Of core nutrition indicators included in HIS, NMEF, MTEF planning and budgeting framework. Coordination and information exchange strengthened among nutrition stakeholders.		• Launch and Implement M & E framework for the nutrition sector	National	MOH	KEMRI, KNBS Development , Implementing partners
	# Core nutrition indicators integrated into HIS, KNBS, NMEF for Vision 2030	• Define and Integrate core Nutrition indicators in HIS/ KNBS/NMEF- VISION 2030	National	MOH	KEMRI, KNBS Development , Implementing partners
	Surveillance protocol and reporting formats disseminated and implemented.	• Review, develop and disseminate guidelines and tools on surveillance, M&E.	National	MOH	KEMRI, KNBS Development , Implementing partners
	Surveillance protocol and M&E tools (reporting formats etc.) available online.	• Conduct data audits at all levels.	National and County	MOH	KEMRI, KNBS Development , Implementing partners
	Number of nutrition bulletins disseminated annually # of nutrition stakeholder forum held at county level to support and strengthens feedback mechanisms.	• Develop and disseminate quarterly nutrition bulletins.	National and County	MOH	KEMRI Development , Implementing partners
		• Hold feedback meetings among nutrition stakeholders at all levels	National and County	MOH	Development , Implementing partners
		• Update and maintain national n utrition website	National	MOH	Development , Implementing partners
	Number of nutrition M&E tools disseminated	• Review, and disseminate Nutrition M&E tools based on new information.	National	MOH	KEMRI Development , Implementing partners

Strategic objective 9: To strengthen the nutrition surveillance, monitoring and evaluation systems					
Outcome Indicator	**Output Indicator**	**Activity**	**Implementation level**	**Lead Agency**	**Other Agencies**
% health facilities nationwide conveying accurate and complete monitoring data to central level # Of core nutrition indicators included in HIS, NMEF, MTEF planning and budgeting framework. Coordination and information exchange strengthened among nutrition stakeholders.	Proportion of health facilities reporting quality nutrition data Proportion of counties conducting scheduled support supervision visits Proportion of county health facilities equipped with facilities for data entry and analysis	• Train all health managers and service providers on use of DHIS and interpretation of M&E data	National / County	MOH	KEMRI Development , Implementing partners
		• Conduct support supervision at all level.	National / County	MOH	Development , Implementing partners

Strategic objective 10: To enhance evidence-based decision-making through research					
Outcome Indicator	**Output Indicator**	**Activity**	**Implementation level**	**Lead Agency**	**Other Agencies**
Evidence based nutrition interventions planned and programmed	Nutrition Research Coordinating Committee established and executing its appropriate mandate	• Establish nutrition research committee with clear terms of reference at county level	National	KEMRI	MOH, Development , Implementing partners
	Number and type of nutrition priority research studies conducted and disseminated among relevant nutrition stakeholders	• Conduct need-based research to inform policy, programme design and implementation • Mobilize resources to address critical gaps in nutrition research	National	KEMRI/ KNBS	MOH, MOF, Development , Implementing partners
	Number of agencies and institutions making decisions based on empirical evidence for nutrition intervention programming and planning	• Disseminate research findings to key stakeholders at all levels	National/County	MOH	CHMT, County Government, MOA, MOL, MOF, MOW, MoGC&SS, MoE, Development , Implementing partners
	Number and type of best-practices documented and disseminated for evidence-based programming	• Support relevant research institutions (equipment, laboratory supplies and technical support) to conduct nutrition research	National	MOH	MOF, Development , Implementing partners
	Facilities equipped with facilities for data entry and analysis	• Procure and distribute equipment (Computers, printers, copiers, scanners and external hard discs)	National and County	MOH	Development , Implementing partners

Strategic objective 11: To Strengthen coordination and partnerships among the key nutrition actors					
Outcome Indicator	**Output Indicator**	**Activity**	**Implementation level**	**Lead Agency**	**Other Agencies**
Increased human, financial and material resources allocation by government and partners to support nutrition activities.	Number of inter- and intra-sectoral coordination meetings held at all levels	• Map partners, review and develop TORs	National and County	MOH	MOA, MOL, MOF, MOW, MoGC&SS, MoE, Development , Implementing partners
	Number of functional nutrition coordination committees in place and executing their mandates at all levels Number of new partners supporting nutrition activities at all levels. Proportion of counties integrating nutrition priorities in their county plans	• Hold and document regular joint planning and review meetings to align the annual nutrition planning process to the nutrition action plan.	National / County	MOP	MOH, MOA, MOL, MOF, MOW, MoGC&SS, MoE, Development , Implementing partners
	% of the resource mobilized for nutrition activities from government and partners against the budget activities.	• Mobilize financial and human resources for nutrition interventions at all levels	National / County	MOH	CHMT, County Government, MOA, MOL, MOF, MOW, MoGC&SS, MoE, Development , Implementing partners

Annex 2: Performance Monitoring and Evaluation Plan

Output indicators	Outcome indicators	Baseline Year	Baseline Value	2011/12 Target	2012/13 Target	2013/14 Target	2014/15 Target	2015/16 Target	2016/17 Target	Source of data
	% of children < 5 years stunting	2008/9	35	30	25	20	15	14	14	KDHS 2008/9 WHO 2010 MDG status report 2010: p9
	% of children < 5 years wasting	2008/9	6	5	4	3.5	3	2	2	KDHS
	Under-weight lev-els among children <5 years	2008/9	16	15	13.5	12	11.5	10.5	10	KDHS
	Children <5 years with obes-ity	2008/9	22	22	21.8	21.6	21.3	21.0	19.5	KDHS
	Iron deficiency among children <5 years	1999	69	50	45	40	35	30	25	MI Survey * Targets to be set based on findings of proposed MI survey of 2011
	Vitamin A deficiency among children<5 years	1999	84.4	60	50	40	30	20	15	MI surveys * Targets to be set based on findings of proposed MI survey of 2011
	Zinc deficiency among children<5 years	1999	51	45	40	35*	30	25	20	MI surveys * Targets to be set based on findings of proposed MI survey of 2011

Output indicators	Outcome indicators	Baseline Year	Baseline Value	2011/12 Target	2012/13 Target	2013/14 Target	2014/15 Target	2015/16 Target	2016/17 Target	Source of data
% of health facilities that are BFHI certified		Carry out baseline assessment	Set baseline value based on the assessment	8	12	16	20	24	28	Periodical nutrition assessments. -IYCF draft strategy (2011-2015)
% community units that are implementing BFCI		Carry out baseline assessment	baseline value based on the assessment	8	12	16	20	24	28	Periodical nutrition assessments
-% of infants initiated on breastfeeding within one hour of birth		2008/09	58	64	66	68	70	72	74	Periodical nutrition assessments; KDHS
-% of children under six months on exclusive breastfeeding		2008/09	32	41	44	47	50	53	56	Periodical nutrition assessments KDHS
% of children (6-8) months) who are introduced to complementary foods		2008/09	83.9	88	89.7	91.4	93.1	94.8	96.5	Periodical nutrition assessments
% of children 6 to 23 months consuming 3+ or 4+ food groups in a day (dietary diversity)		2008/09	39	49.5	53	56.5	60	63.5	67	Periodical nutrition assessments KDHS
% of children continued with breastfeeding up to 24 months		2008/09								Periodical nutrition assessments
% of children under five years whose growth is tracked by health facilities		Carry out assessment to determine baseline	Set baseline value from assessment	Set AWP targets towards achieving year 2015 target			Health facilities track growth of 15 % of the under five children	Set AWP target towards year 2017 target	Health facilities track growth of 18 % of the under five children	Periodical nutrition assessments

Output indicators	Outcome indicators	Baseline Year	Baseline Value	2011/12 Target	2012/13 Target	2013/14 Target	2014/15 Target	2015/16 Target	2016/17 Target	Source of data
% of trained facility and community-based health workers sensitizing women on optimal infant and young child nutrition		Carry out baseline situation assessment	Set baseline value from assessment	Set AWP targets towards achieving year 2015 target			15 % 0f health workers trained and sensitizing women on optimal IYCN		17 % 0f health workers trained and sensitizing women on optimal IYCN	Periodical nutrition assessments KDHS
% of women who adopt optimal infant and young children nutrition practices							10 % of women adopting optimal IYCN practices		13 % of women adopting optimal IYCN practices	Periodical nutrition assessments KDHS
Proportion of employing agencies that support breastfeeding at work places			Open inventory of KEPSA, FKE and COTU members				30% of KEPSA, FKE and COTU members support breastfeeding at work place		35 %of KEPSA and COTU members support breastfeeding at work place	Periodical nutrition assessments
% of health facilities complying with IYCN guidelines		Carry out baseline situation assessment	Set baseline value from assessment	Set AWP targets towards achieving year 2015 target			20% of health facilities complying with IYCN guidelines	Set AWP target towards achieving year 2017 target	25% of health facilities complying with IYCN guidelines	Periodical nutrition assessment KDHS
% of children aged 6-59 months receiving vitamin A supplements twice yearly		2008/09	62	71	74	77	80	83	86	Periodical nutrition assessment KDHS
% of children under 5 years old with diarrhea treated with zinc supplements		2008/09	0.2	20	60	80	80	80	80	Periodical nutrition assessments

Output indicators	Outcome indicators	Baseline Year	Baseline Value	2011/12 Target	2012/13 Target	2013/14 Target	2014/15 Target	2015/16 Target	2016/17 Target	Source of data
Proportion of firms complying with the Code in marketing breast milk substitutes		Open inventory of firms marketing breast milk substitutes	Set baseline value from inventory	Set AWP targets towards achieving year 2015 target			25% of the firms marketing milk substitutes comply with Code on marketing substitutes	Set AWP targets towards achieving year 2017 target	30 % of the firms marketing milk substitutes comply with Code on marketing substitutes	Periodical nutrition assessment KDHS
% of < 5 year children screened at community level and referred for nutrition management		Carry out baseline assessment	Establish baseline value from the assessment				10 % of under five children screened and referred for nutrition management	Set AWP targets towards achieving year 2017 target	13 % of under five children screened and referred for nutrition management	Periodical nutrition assessments
	Vitamin A deficiency among women	1999	51	40	35	30	25	20	15	MI Survey
	Iron deficiency	1999	55	50	*45	*40	*35	*30	*25	MI Survey
	Iodine deficiency	1999	6	5	4	3	2	2	1	MI Survey
	Obesity among women	2008/9	25							KDHS
	Zinc deficiency among women	1999	52	47	42	37	32	27	15	MI Survey
Proportion of pregnant women who take iron and folate supplements for at least 90 days		2008/9	3	50	60	70	75	80	80	Periodical nutrition assessments
% of HIV positive mothers receiving supplementary food		Carry out baseline assessment in 2011	Establish baseline value from the assessment	Set AWP targets towards achieving year 2015 target			10% of HIV positive mothers receiving supplementary foods	Set AWP targets towards achieving year 2017 target	15% of HIV positive mothers receiving supplementary foods	Periodical nutrition assessments
% of HIV positive mothers counseled and who adopt good nutrition practices		Open invention of HIV positive mother who are counseled and adopt good nutrition practices in 2011	Establish baseline value from inventory	Set AWP targets towards achieving year 2015 target			10% of HIV positive mothers counseled and having practiced good nutrition in the last six months preceding assessment	Set AWP targets towards achieving year 2017 target	15% of HIV positive mothers counseled and having practiced good nutrition in the last six months preceding assessment	Periodical nutrition assessments

Output indicators	Outcome indicators	Baseline Year	Baseline Value	2011/12 Target	2012/13 Target	2013/14 Target	2014/15 Target	2015/16 Target	2016/17 Target	Source of data
% of pregnant and lactating mothers with MUAC< 21cm receiving supplementary food		Conduct baseline assessment	Establish baseline value from the assessment	Set AWP targets towards achieving year 2015 target			12% of pregnant and lactating mothers (MUAC<21cm) having received supplementary food for the last six months preceding the assessment	Set AWP targets towards achieving year 2017 target	12% of pregnant and lactating mothers (MUAC<21cm) having received supplementary food for the last six months preceding the assessment	Periodical nutrition assessments
% of people who adopt positive nutrition practices		Conduct baseline assessment to determine KAP on nutrition	Set nutrition KAP baseline value from the assessment				3% of the population adopt positive nutrition practices	Set AWP targets towards achieving year 2017 target	4% of the population adopt positive nutrition practices	KDHS
Number of nutrition service providers trained and carrying out nutrition IEC/ BCC and advocacy activities		Conduct inventory of nutrition service providers trained and carrying out nutrition IEC/BCC activities	Set baseline value from inventory				15% nutrition service providers trained and carrying out IEC/ BCC activities		20% nutrition service providers trained and carrying out IEC/ BCC activities	Periodical nutrition surveys
Reviewed national nutrition M & E framework in place					Fully-functional M&E framework is in place					Programme implementation Progress reports
Core nutrition indicators integrated into HMIS/ KNBS/ MEF-Vision 2030.							Core nutrition indicators in identified national M&E systems			Programme implementation Progress reports
Surveillance guidelines developed & disseminated						All surveillance guidelines developed				Programme implementation Progress reports
Guidelines on validation, dissemination and utilization of surveillance results in place						All guidelines in place				Programme implementation Progress reports

Output indicators	Outcome indicators	Baseline Year	Baseline Value	2011/12 Target	2012/13 Target	2013/14 Target	2014/15 Target	2015/16 Target	2016/17 Target	Source of data
A functional M&E website in place					Functional M&E website in place					Programme implementation Progress reports
Number of tools designed and utilized					All target tools developed and being used					Programme implementation Progress reports
Number of nutrition managers and service providers trained and using M&E tools		Open inventory of nutrition managers and service providers who will use the M&E tools	Set the baseline from the inventory	Set AWP targets towards achieving year 2015 target			7% of the nutrition managers and service providers using the M&E tools	Set AWP targets towards achieving year 2017 target	10 % of the nutrition managers and service providers using the M&E tools	Programme implementation Progress reports
Number of pupils and in-mates in institutions who receive nutritionally adequate meals		Carry out baseline assessment to establish current prison and pupil population	Set baseline value based on baseline assessment				5% of pupils and in-mates in institutions each receive nutritionally adequate meals at all times	Set AWP targets towards achieving year 2017 target	10 % of pupils and in-mates in institutions each receive nutritionally adequate meals at all times	KDHS, Periodical nutrition assessments
Teachers pre-service curriculum with basic nutrition component					Teachers pre-service Curriculum with basic nutrition component in place					Periodical nutrition assessment
Number of ECD centers carrying out growth monitoring		Carry out baseline assessment	Set baseline value based on baseline assessment	Set AWP targets towards achieving year 2015 target			7 % of ECD centers carrying out growth monitoring	Set AWP targets towards achieving year 2017 target	10 % of ECD centers carrying out growth monitoring	KDHS, Periodical nutrition assessments
Number of functional nutrition coordinating committees in place and executing their mandate		Open invention of nutrition coordinating committee and executing their mandate	Set baseline based on the inventory				75% of coordinating committees in place and executing their mandate	Set AWP targets towards achieving year 2017 target	100% of committees in place and executing their mandate	Programme progress implementation reports

Output indicators	Outcome indicators	Baseline Year	Baseline Value	2011/12 Target	2012/13 Target	2013/14 Target	2014/15 Target	2015/16 Target	2016/17 Target	Source of data
Amount of different kinds of resources (funds* and human) available for implementation of the Plan of Action		Open inventory of resources (human and financial) going towards implementation of Action Plan	Set baseline based on the inventory	Set AWP targets towards achieving year 2015			75 % of the resources needed available for implementation of the Plan of Action	Set AWP targets towards achieving year 2017 target	85 % of the resources needed available for implementation of the Plan of Action	Programme progress implementation reports ** refer to the budget of the Plan of Action*
Number of nutrition networks established at national and county levels		Conduct rapid assessment to determine status of networks	Establish the baseline from assessment				75% of the target nutrition networks to have been formed at national and county levels	Set AWP targets towards achieving year 2017 target	85% of the target nutrition networks to have been formed at national and county levels	Programme progress implementation reports
Number and type of nutrition priority research studies conducted and disseminated among relevant nutrition stakeholders		Carry out assessment to determine baseline situation	Set baseline value based on assessment				Research carried out on 40% of priority nutrition areas and the findings disseminated among nutrition stakeholders	Set AWP target towards achieving year 2017 target	Research carried out on 60% of priority nutrition areas and the findings disseminated among nutrition stakeholders	Periodical nutrition programme assessments
Number of institutions using evidence-based data for decision-making and programming on nutrition		Carry out assessment to determine baseline situation	Set baseline value based on assessment				45% of institutions make decisions on nutrition programming based on information from nutrition operations research	Set AWP targets towards achieving year 2017 target	55% of institutions make decisions on nutrition programming based on information from nutrition operations research	KDHS Periodical nutrition programme assessments
Number of nutrition-based decisions made by agencies using information generated through operations research		Carry out assessment to determine baseline situation on key nutrition decisions made	Set baseline value based on assessment				45% of nutrition based decisions made by agencies are informed by findings of nutrition operations research	Set AWP targets towards achieving year 2015 target	65% of nutrition based decisions made by agencies are informed by findings of nutrition operations research	KDHS Periodical nutrition programme assessments

Output indicators	Outcome indicators	Baseline Year	Baseline Value	2011/12 Target	2012/13 Target	2013/14 Target	2014/15 Target	2015/16 Target	2016/17 Target	Source of data
Research coordinating committee established and executing their mandate according to terms of reference		Carry out assessment on existing nutrition research coordinating committees	Set baseline based on assessment	Set AWP targets towards achieving year 2015 target			75% of fully functional research coordinating committees established	Set AWP targets towards achieving year 2015 target	85% of fully functional research coordinating committees established	Programme progress implementation reports
Proportion of population that adopt consumption of micronutrient rich foods including the fortified foods.		Carry out population –based assessment to determine baseline situation	Set baseline value based on the assessment results				Increase by 5% of the population that consumed micronutrient rich foods including fortified foods for the last six months preceding the target evaluation survey	Set AWP targets towards achieving year 2017 target	Increase by 8% of the population that consumed micronutrient rich foods including fortified foods for the last six months preceding the target evaluation survey	KDHS. Periodical nutrition programme assessments
Number of institutions incorporating micronutrient issues in their training curricula		Carry out assessment determine target number and type of institutions	Set baseline value based on the assessment				75% of target training institutions incorporating micronutrient issues in their curricula	Set AWP targets towards achieving year 2017 target	85% of target training institutions incorporating micronutrient issues in their curricula	KDHS, Periodical nutrition programme assessments
Proportion of salt manufacturing industries complying with SoPs on salt iodization		Open inventory of salt manufacturing industries	Set baseline based on the inventory				95% of the existing salt manufacturing industries comply with SoPs on salt iodization	Set AWP targets towards achieving year 2017 target	100% of the existing salt manufacturing industries comply with SoPs on salt iodization	Periodical nutrition programme assessments
Proportion of households with recommended iodine content in the salt		Carry out assessment on iodine content in salts at house-hold levels	Set baseline value based on the assessment				95% of the households having recommended iodine content in the salt	Set AWP targets towards achieving year 2017 target	100% of the households having recommended iodine content in the salt	KDHS Periodical nutrition programme assessments

Output indicators	Outcome indicators	Baseline Year	Baseline Value	2011/12 Target	2012/13 Target	2013/14 Target	2014/15 Target	2015/16 Target	2016/17 Target	Source of data
Proportion of fortified foods at the household level with recommended content of the fortificant		Carry out assessment on content of fortificants in fortified foods available at house-hold levels	Set baseline based on the assessment	Set AWP targets towards achieving year 2015 target			95% of the fortified foods at household level to have recommended content of fortificants	Set AWP targets towards achieving year 2017 target	100 % of the fortified foods at household level to have recommended content of fortificants	KDHS, Periodical nutrition programme assessments
No of trainings for healthy diets and physical activity conducted for health workers.					2%	5%	7%	9%	10%	Nutrition surveillance matrix
Proportion of population screened for non communicable diseases.					5%	7%	10%	12%	15%	KDHS
Proportion of people whose BMI is monitored regularly.					5%	7%	10%	12%	15%	KDHS/ nutrition surveillance matrix
Proportion of CHWs trained on healthy diets and lifestyles.					5%	8%	12%	17%	20%	Nutrition surveillance
Proportion of population who adopt healthy diets and physical activity.		Conduct a baseline survey to determine nutrition KAP	Set a nutrition KAP value from the survey		2%	5%	7%	12%	15%	KDHS

Note: Outcome targets are set on the basis of existing information drawn from WHO Child Growth Standards as well as analysis of data on malnutrition trends in the country. For output indicators, target setting is based on analysis of data on Global Malnutrition trends as well as the performance of national nutrition programmes. Target setting has also taken into consideration influencing factors notably political commitment, availability of resources and drought, among others.

Annex 3: Financial Resources Input in Kenya Shillings in Million

Activities	2012/13	2013/14	2014/15	2015/16	2016/17	TOTAL
Strategic Objective 1: To improve the nutritional status of women of reproductive age (15-49 years)						
Provide IFA supplements to adolescent girls and pregnant women.	275	305	315	315	315	1525
Provide supplementary foods to pregnant and lactating women according to the admission criteria on integrated management of acute malnutrition guidelines.	530	850	770	690	600	3440
Conduct routine weight Monitoring and appropriate counseling for the pregnant women	105	160	155	120	130	670
Procure and distribute nutritional commodities and equipment to health facilities.	950	1,400	1,300	1,300	1,150	6,100
Conduct nutrition education on healthy dietary practices to Women of reproductive age.	20	20	20	10	10	80
Review, develop, print and disseminate and distribute guidelines	25	30	20	20	10	105
Strategic Objective: 2. To improve the nutritional status of children under 5 years of age						
Scale up Baby Friendly Hospital Initiative (BFHI)	200	200	80	60	50	590
Baby Friendly Community Initiative (BFCI)	250	200	150	100	100	800
Sensitize women of reproductive age (WRA) on the importance of exclusive breastfeeding for the first six months of baby's life	35	30	30	30	25	150
Support monitoring of the Code of Marketing of Breastmilk Substitutes	10	6	7	8	10	41
Advocate workplace support of breastfeeding mothers.	20	10	10	10	10	60
Train and equip health workers to promote appropriate infant and young child feeding practices	200	110	115	120	125	670
Provision of BCC/IEC (ACSM) materials to the Health facilities and communities.	70	50	30	10	10	170
Sensitize WRA on timely introduction of optimal complementary foods with continued breastfeeding for at least two years.	160	160	120	110	130	680
Promote proper hygiene practices, and timely seeking of health care.	25	25	25	25	25	125
Train HWs, CHEWs and CHWs on new growth standards and CHANIS	25	40	45	40	45	195
Equip Health Facilities and community units with anthropometric equipment	350	460	500	520	493	2,323
Provide monitoring and reporting tools (CHANIS, MCH booklet and job aids).	22	30	30	30	30	142
Increase coverage of children aged 6-59 months receiving Vitamin A supplements	80	120	140	130	140	610
Provide multiple-micronutrients powder for children under five years	500	650	680	750	753	3,333
Review, develop, print and disseminate and distribute guidelines	25	35	20	15	15	110
Train all health managers and service providers on use of DHIS and interpretation of M&E data	200	100	100	100	100	600
Conduct support supervision at all level.	100	50	50	50	50	300
Procure and distribute equipment (Computers, printers, copiers, scanners and external hard discs)	200	150	150	50	50	600

Activities	2012/13	2013/14	2014/15	2015/16	2016/17	TOTAL
Strategic objective 3: To reduce the prevalence of micronutrient deficiencies in the population						
Review, develop and disseminate national micronutrient deficiency prevention and control strategy and guidelines.	5	5	0	0	0	10
Train service providers on micronutrients deficiency prevention and control strategies including logistic and supply chain management	100	100	100	50	50	400
Advocate and create public awareness on food fortification, supplementation and dietary diversification.	20	15	10	5	5	55
Scale up and strengthen the existing strategies of micronutrient supplementation at all levels.	100	150	150	100	100	600
Procure and distribute micronutrient supplements (VAS, MNPs and IFA).	1,800	2,000	2,100	2,300	2,500	10,700
Scale up fortification of widely consumed food stuffs.	152	204	356	508	660	1880
Monitor the quality of fortified foods regularly at all levels.	20	25	30	40	50	165
Conduct M&E of micronutrient deficiency prevention and control interventions	10	5	200	5	5	225
Train CHEWs and CHWs on micronutrient deficiency prevention and control strategies.	100	100	90	90	50	430
Review of policy to include use of CHWs in delivery of micronutrient supplements.	5	5	0	0	0	10
Strategic objective 4: To prevent deterioration of nutritional status and save lives of vulnerable groups in emergencies						
Build the capacity of the counties to develop nutrition response plans	50	50	0	0	0	100
Review, develop and disseminate guidelines for disaster preparedness, response and management of nutrition emergencies	30	35	15	15	10	105
Conduct nutrition surveillance in emergency affected areas	70	80	90	100	110	450
Map partners, review and develop TORs	12	2	2	2	3	21
Hold and document regular joint planning and review meetings	30	30	30	30	30	150
Timely provision of food and non-food items	950	1,200	1,350	1,400	1,350	6,250
Scale up delivery of essential nutrition services (High Impact Nutrition Interventions)	80	120	140	150	140	630
Capacity strengthening of health workers to provide nutrition care and support at all levels	50	60	60	80	80	330
Mobilize resources for emergency response	7	5	5	6	7	30
Develop, disseminate and implement the national monitoring plan for nutrition commodities in emergency	5	0	0	0	0	5
Monitor food safety of nutrition commodities for use in emergencies	10	5	5	10	10	40
Create public awareness on importance of nutrition in emergencies	5	2	3	3	3	16

Activities	2012/13	2013/14	2014/15	2015/16	2016/17	TOTAL
Strategic Objective 5: To improve access to quality curative nutrition services						
Review, develop and disseminate national guidelines on nutritional care in the management of common diseases	25	30	20	20	10	105
Mobilize resources for nutritional care and treatment for common diseases	5	3	4	5	6	23
Procure and distribute essential nutrition commodities (micronutrient supplements, therapeutic milks and feeds) and equipments (anthropometric and others)	2,300	2,600	2,700	2,900	3,130	13,630
Monitor food safety of nutrition commodities	8	5	5	5	5	28
Conduct M&E of curative nutrition services	11	7	8	9	10	45
Strategic objective 6: Halt and reverse the prevalence of diet related non communicable diseases.						0
Review, develop and disseminate a comprehensive strategy and guidelines for prevention, management and control of diet-related NCDs	25	25	15	20	20	105
Train service providers on prevention, management and control of diet-related NCDs	100	100	100	50	50	400
Create public awareness on the importance of prevention, management and control of diet-related NCDs	150	150	150	75	75	600
Map partners, review and develop TORs	10	0	0	0	0	10
Hold and document regular joint planning and review meetings	10	5	0	0	0	15
Conduct M&E of diet related NCDs	15	15	15	15	10	70
Conduct screening for non communicable diseases.	150	150	100	100	100	600
Scale up community screening for BMI and waist circumference	150	150	150	150	150	750
Strategic Objective 7: To improve nutrition in schools, public and private institutions						
Conduct situation analysis on school/ institutional feeding including the Early Childhood Development Education Centres(ECDE), Daycare centres	12	2	2	2	2	20
Review, develop and disseminate nutrition guidelines for school and other institutions	30	30	20	10	10	100
Mainstream basic nutrition training in all schools and other institutions	10	10	0	0	0	20
Implement appropriate nutrition interventions (school meals, micronutrient supplementation, nutrition assessment, de-worming among others) in schools and other institutions	700	800	500	500	500	3,000
Mobilize resources to sustain optimal institutional feeding programmes	8	7	5	3	3	26
Integrate nutrition education in school curricula at all levels	10	10	0	0	0	20
Conduct M&E of nutrition interventions in schools and other institutions	25	25	25	25	20	120

Activities	2012/13	2013/14	2014/15	2015/16	2016/17	TOTAL
Strategic objective 8: To improve nutrition knowledge attitudes and practices among the population						
Conduct formative and periodic assessments on the status of nutrition knowledge, attitude and practices in the general population	100	140	130	80	80	530
Develop, print and disseminate national nutrition advocacy, communication and social mobilization (ACSM) strategy at all levels	140	170	170	120	120	720
Train service providers on communication and advocacy skills	130	80	90	100	100	500
Review, develop, print, disseminate and distribute IEC materials	50	20	20	20	20	130
Mark national/international Nutrition Days (World Breastfeeding Week, African Food and Nutrition Security Day, Iodine Deficiency Disorders Day, Malezi Bora among others)	35	20	25	25	30	135
Promote optimal nutrition through all channels of communication at all levels	70	60	70	80	90	370
Strategic objective 9: To strengthen the nutrition surveillance, monitoring and evaluation systems						
Launch and Implement M & E framework for the nutrition sector	10	0	0	0	0	10
Define and Integrate core Nutrition indicators in HIS/KNBS/NMEF- VISION 2030	15	5	5	5	5	35
Review, develop and disseminate guidelines and tools on surveillance, M&E.	30	20	10	5	5	70
Conduct data audits at all levels.	60	70	60	50	20	260
Develop and disseminate quarterly nutrition bulletins.	4	2	2	2	2	12
Hold feedback meetings among nutrition stakeholders at all levels	30	30	20	20	20	120
Update and maintain national nutrition website	4	2	2	2	2	12
Review, and disseminate Nutrition M&E tools based on new information.	25	5	20	5	5	60
Train all health managers and service providers on use of DHIS and interpretation of M&E data	200	100	100	100	100	600
Conduct support supervision at all level.	100	50	50	50	50	300
Procure and distribute equipment (Computers, printers, copiers, scanners and external hard discs)	200	150	150	50	50	600
Strategic objective 10: To enhance evidence-based decision-making through research						
Establish nutrition research committee with clear terms of reference at county level	30	30	5	5	5	75
Conduct need-based research to inform policy, programme design and implementation	35	40	45	45	40	205
Mobilize resources to address critical gaps in nutrition research	8	8	8	9	10	43
Disseminate research findings to key stakeholders at all levels	15	20	15	15	15	80
Support relevant research institutions (equipment, laboratory supplies and technical support) to conduct nutrition research	40	30	25	25	15	135
Strategic Objective 11: To Strengthen coordination and partnerships among the key nutrition actors						
Map partners, review and develop TORs	52	2	2	2	2	60
Hold and document regular joint planning and review meetings to align the annual nutrition planning process to the nutrition action plan.	60	60	60	60	60	300
Mobilize financial and human resources for nutrition interventions at all levels	8	9	7	7	8	39
Total	**12,693**	**14,336**	**14,208**	**14,078**	**14,294**	**69,609**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