REPUBLIC OF KENYA

BUSIA COUNTY NUTRITION ACTION PLAN

2023/24 - 2027/28

VISION

A well-nourished, healthy, and productive County population.

MISSION

To promote optimal nutrition through evidence-based, multi-sectoral and life-course approaches ensuring equitable access to quality nutrition services and creating an enabling environment for good nutrition for all residents of Busia County.

VALUES

- Equity and Inclusivity
- Professionalis m and Integrity
- Collaboration and Partnership
- Evidence-Based Decision Making
- People-Centred Approach
- Resilience and Sustainability
- Excellence and Innovation

FOREWORD

The Constitution of Kenya article 43 (1) gives every person the right to: the highest attainable standard of health, freedom from hunger and access to adequate food of acceptable quality. The national and county governments are committed to creating an enabling environment for citizens to realize these rights as evidenced in the Vision 2030, Kenya Health Policy (2014–2030), National Social Protection Policy, 2011, the National Food and Nutrition Security Policy, 2012 and other relevant policies.

Busia County Nutrition Action Plan (CNAP) 2023/24 - 2027/28 is aligned with the Kenya Nutrition Action Plan (KNAP 2023 - 2028), Busia County Sectors Strategic Plans and County Integrated development Plan (CIDP) 2023 – 2027. The plan recognizes the role of nutrition as a fundamental human right and a driver to economic development as envisioned in Vision 2030. To achieve this, there is need to engage all key sectors in the county in designing a tailor-made nutrition programming while equitably building on their capacities.

The CNAP provides practical guidance to implementation of Busia County commitments to nutrition interventions. It's a framework for coordinated implementation of High Impact Nutrition Inventions (HINI) and nutrition sensitive programs. The alignment of CNAP to other County Strategic Documents facilitates mainstreaming of nutrition budgeting process into County budget. The document also emphasizes multi-sectoral coordination and collaboration approach in planning, fostering departure from past trends in addressing the nutrition agenda within the County.

The implementation of the Second Generation CNAP will cover five years beginning July 2023 to June 2028. The department of health and sanitation will monitor implementation of the CNAP, conduct annual review to assess progress and end term evaluation to inform priorities for the subsequent CNAP planning period.

This CNAP demonstrates the County government's commitment to its vision of making Busia a healthy, productive and internationally competitive County.

H.E. Arthur Papa Odera,

Deputy Governor & County Executive Committee Member

Department of Health Services and Sanitation

County Government of Busia.

PREFACE

Busia CNAP 2023/24 - 2027/28 is a comprehensive and overarching framework for coordination, implementation and mobilization of resources for nutrition interventions in health and other key line county departments. The CIDP 2023 - 2027 and County Health Sector Strategic and Implementation Plan 2024-2029 that informs subsequent nutrition annual work plans.

CNAP 2023/24-2027/28 outlines high impact nutrition specific interventions and nutrition sensitive interventions to be undertaken at all levels in health sector and other county line departments. In line with the SDGs, The Constitution of Kenya 2010, CIDP 2023-2027 and CNAP has integrated other cross cutting nutrition sensitive sector-based legislations, policies, plans and guidelines to support an enabling environment for optimal food and nutrition security in the county. This is with a major aim to achieving effective and sustainable food and nutrition security leading to improved nutrition and health related outcomes. The document will be reviewed periodically as new ideas, innovations, programs and policies are developed. We urge all partners, line departments and stakeholders to familiarize themselves with the content to achieve the overall CNAP objective. The department of health services and sanitation will provide the required stewardship and oversight to ensure full implementation of this plan.

The department is committed to foster coordination, collaboration and partnerships to enhance efficiency in the utilization of existing resources with the relevant arms of the County and National Government on the need for additional resources. We encourage Donors, UN Agencies, Development & Implementation Partners and other Stakeholders to complement the department's resource mobilization efforts to fully realize the plan.

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Chief Officer Public Health and Sanitation

Department of Health Services and Sanitation

County Government of Busia

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ACKNOWLEDGMENT

Busia County Department of Health and Sanitation acknowledges the contribution of the County government leadership, development and implementing partners and all other stakeholders who participated in the development of County Nutrition Action Plan (CNAP) 2023/24-2027/28.

This CNAP was developed with financial support from County Government of Busia, Nutrition in City Ecosystems (NICE) Project, Nutrition International (NI), and United Nations Children's Fund (UNICEF). Special thanks go to UNICEF staff for their technical support in the entire process of developing the CNAP 2023/24-2027/28. We appreciate the Directorate of Family wellness, Nutrition and Dietetics in the Ministry of Health for their technical contribution in the development process.

Special thanks to the County Nutrition Coordinator for the steadfast coordination and leadership in the development of this document. The contributions of the following departments in providing technical inputs to the CNAP are also highly appreciated: This particularly goes to Departments of Early childhood development education and Industrial skills, Water, Irrigation, Environment, Natural Resources, Climate Change and Energy, Ministry of Labour and social protection State department for children welfare services, Department of Smart Agriculture Livestock, fisheries, Blue Economy and Agribusiness. The contribution of the County Executive Committee Member (CECM) Health and Sanitation, Chief Officers of Health, the County Health Management Team (CHMT) and Sub-County Nutrition Coordinators (SCNCs) during the development of the CNAP is gratefully acknowledged. We recognise the tireless efforts of the multisectoral and multidisciplinary CNAP drafting taskforce who ensured the document was completed within the stipulated timelines.

Finally, we appreciate the technical support of Ms. Clementine Ngina, who devoted her personal time to provide valuable insights and reviews in the development process of CNAP II.

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Ag. County Director of Health

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Table of Contents

LIST OF TABLES

LIST OF FIGURES

ACRONYMS AND ABREVIATIONS

Acronym	Definition
ANC	Antenatal Care
BCC	Behaviour Change Communication
BFHI	Baby-Friendly Hospital Initiative
BETA	Bottom-Up Economic Transformation Agenda
BMS	Breast Milk Substitutes
BFCI	Baby-Friendly Community Initiative
CANIS	County Agri-Nutrition Implementation Strategy
CASSCOM	County agriculture sector steering committee
CBO	Community-Based Organization
CDOHS	County Department of Health and Sanitation
CHMT	County Health Management Team
CHPs	Community Health Promoters
CDF	Competency Development Framework
CIDP	County Integrated Development Plan
CME	Continuous medical education
CNAP	County Nutrition Action Plan
CNTF	County nutrition technical forum
COVID 19	Corona Virus Disease 2019
DQA	Data quality Audits
DND	Division of Nutrition and Dietetics
ECDE	Early Childhood Development and Education
EBF	Exclusive Breastfeeding
ETR	End-Term Review
GIS	Geographical Information System
HINI	High Impact Nutrition Interventions
HIV	Human Immunodeficiency Virus
IDSR	Integrated Disease Surveillance and Response
IFAS	Iron and Folic Acid Supplementation
IMAM	Integrated Management of Acute Malnutrition
KEPH	Kenya Essential Package for Health
KHIS	Kenya Health Information System
KDHS	Kenya Demographic and Health Survey
KNAP	Kenya Nutrition Action Plan
KNBS	Kenya National Bureau of Statistics
KRA	Key Result Area
M&E	Monitoring and Evaluation
MIYCN	Maternal, Infant, and Young Child Nutrition
MIYCN-E	Maternal, Infant, Young Child, and Emergency Nutrition
MOH	Ministry of Health
MOPC	Medical Outpatient Clinic
MUAC	Mid Upper Arm Circumference
NASCOP	National AIDS and STI Control Programme

NCD	Non-Communicable Disease
NICHE	Nutrition Improvements through Cash and Health Education
NSA	Nutrition-Sensitive Agriculture
OTP	Outpatient Therapeutic Program
PD Hearth	Positive Deviance Hearth
PIC4C	Primary Health Integrated Care for Four Chronic Diseases
PLW	Pregnant and Lactating Women
SAM	Severe Acute Malnutrition
SFP	Supplementary Feeding Program
SMART	Standardized Monitoring and Assessment of Relief and Transitions
SOPs	Standard Operating Procedures
STH	Soil-Transmitted Helminths
SUN	Scaling Up Nutrition
ToT	Trainer of Trainers
UHC	Universal Health Coverage
UNICEF	United Nations Children's Fund
VAD	Vitamin A Deficiency
VAS	Vitamin A Supplementation
WASH	Water, Sanitation, and Hygiene
WHA	World Health Assembly
WHO	World Health Organization

DEFINITION OF TERMS

1. **Nutrition-Sensitive Interventions**: Programs and actions that address underlying determinants of nutrition, such as agriculture, water, sanitation, education, and social protection, to improve nutrition outcomes indirectly.
2. **Nutrition-Specific Interventions**: Targeted interventions aimed directly at addressing nutritional deficiencies, such as breastfeeding promotion, vitamin supplementation, and the treatment of severe malnutrition.
3. **Food and Nutrition Security**: The physical and economic access to sufficient, safe, and nutritious food that meets dietary needs and preferences for an active and healthy life for all individuals.
4. **High-Impact Nutrition Interventions (HINI)**: Evidence-based interventions focused on preventing and treating malnutrition, such as exclusive breastfeeding, complementary feeding practices, and management of acute malnutrition.
5. **Maternal, Infant, and Young Child Nutrition (MIYCN)**: A set of interventions focused on improving the nutritional status of pregnant and lactating women, infants, and young children during critical growth periods.
6. **Integrated Management of Acute Malnutrition (IMAM)**: A strategy that integrates community and facility-based approaches for the prevention, detection, and treatment of acute malnutrition in children under five.
7. **Baby-Friendly Hospital Initiative (BFHI)**: A global program by WHO and UNICEF to encourage and recognize hospitals that provide optimal care for breastfeeding mothers and their babies.
8. **Stunting**: A condition caused by chronic malnutrition that results in reduced growth and height-for-age, often reflecting long-term nutritional deprivation.
9. **Wasting**: A form of malnutrition characterized by rapid weight loss or failure to gain weight, indicated by a low weight-for-height ratio.
10. **Food Fortification**: The process of adding essential vitamins and minerals to commonly consumed foods to improve nutritional quality and address nutrient deficiencies.
11. **Bio fortification**: The process of improving the nutritional quality of food crops through biological methods such as breeding and genetic modification, to enhance the levels of essential nutrients.
12. **Nutritional Surveillance**: Ongoing collection, analysis, and interpretation of nutrition-related data for the purpose of improving public health and addressing malnutrition trends.
13. **County Nutrition Action Plan (CNAP)**: A strategic framework developed to guide and coordinate the implementation of nutrition interventions at the county level, aligned with national nutrition goals.
14. **Community Health Promoters (CHPs)**: Trained community-level health workers who support health promotion, disease prevention, and the delivery of basic healthcare services, including nutrition interventions.
15. **Micronutrient Deficiencies**: A lack of essential vitamins and minerals in the diet, leading to health problems such as anaemia, weakened immunity, and developmental delays.
16. **Nutrition-Sensitive Agriculture (NSA)**: Agricultural practices and policies designed to promote the production, availability, and consumption of nutritious and diverse foods to enhance food security and nutrition outcomes.
17. **Nutrition sensitive water infrastructure**: Water systems and facilities that are designed and implemented with the aim of improving nutrition outcomes by ensuring access to safe, adequate, and reliable water for drinking, cooking, hygiene, and sanitation.
18. **Multisectoral Approach**: A coordinated effort involving multiple sectors, such as health, education, agriculture, and social protection, to address complex public health challenges like malnutrition.
19. **Universal Health Coverage (UHC)**: A health system goal where all individuals and communities receive essential health services without suffering financial hardship.

EXECUTIVE SUMMARY

Busia County, over the years has witnessed tremendous improvement in the nutrition status of its population more so of children below five years. The reduction of stunting and underweight from 22.2% to 15%, 9.7% to 6.3% respectively over the last 7 years is highly commendable. However, the stunting rates are below the global recommended rates of below 10%. Wasting though below the 5%, witnessed a slight increase in 2022 by 0.8% an indication of inadequate coping mechanism by households to cushion them on food insecurity and other drivers to malnutrition.

The County Nutrition Action Plan II (CNAP II) 2023/24–2027/28 provides a comprehensive framework that aligns with the Kenya Nutrition Action Plan (KNAP) 2023–2027 and the County Integrated Development Plan (CIDP) 2022/23–2026/27 to address malnutrition. It focuses on promotion of optimal nutrition through evidence based multisectoral and life course approaches by prioritising high-impact low-cost nutrition interventions (HINI) across sectors to improve nutrition and health outcomes of Busia residents. The review of the first Busia CNAP (2018/19 -2022/23) highlighted progress, including reduction in childhood stunting and underweight, improved human resource for nutrition, increased access to nutrition services, enhanced nutrition financing in health sector and strengthened multisectoral coordination. However, limitation to optimal achievement was due to inconsistency in nutrition funding, coordination gaps, limited county specific survey data, and disruptions from emergencies (COVID-19 pandemic). This CNAP II emphasizes on commitment to investing in nutrition through a multidisciplinary and multisectoral approach in addressing malnutrition in all its forms in line with the Governor's manifesto and National bottom economic transformation agenda (BETA) agenda.

The document adopts a life-course approach to address the nutritional needs under Key result areas (KRAs) listed below.

1. Maternal, Infant, and Young Child nutritional well-being enhanced.
2. Improved nutritional well-being of older children, adolescents, adults, and older persons.
3. Enhanced Surveillance on Industrial Fortification and promotion of fortified and bio fortified foods.
4. Enhanced clinical nutrition and dietetic services across all levels of health care.
5. Sustained nutritional well-being of individuals and communities during emergencies and climate-related shocks.

6. Enhanced integration of nutrition into agriculture, livestock, fisheries and agribusiness sectors.
7. Nutrition integrated and strengthened across all levels of the health sector.
8. Enhanced integration of nutrition in the education sector.
9. Enhanced integration of nutrition within the Water, Sanitation and Hygiene (WASH) sector.
10. Nutrition is integrated across Social Protection programs.
11. Enhanced sectoral and multisectoral nutrition governance - coordination, partnerships, advocacy, and community engagement
12. Strengthened sectoral and multisectoral nutrition information, monitoring & evaluation, learning research systems and Knowledge management.
13. Enhanced Nutrition development capacity for improved service provision.
14. Strengthened Supply chain management for nutrition commodities and equipment

The document highlights a robust monitoring and evaluation framework, with specific outcome indicators across the 14 KRAs geared to change practice, behaviour and attitude across all levels of leadership and governance and among the recipients of the services. The outcome indicators include and not limited to: Reducing childhood stunting from 15% to <10% by 2027/2028, Increasing exclusive breastfeeding coverage to at least 90% within the five years, 100% of health facilities with adequate nutrition commodities and functional equipment, nutrition integration in 80% of schools and community platforms by 2027, Strengthened multisectoral coordination and mainstream monitoring and evaluation system to produce timely, reliable nutrition data that is accessible to all stakeholders for evidence based decision making

The documents stipulate the resources required and strategies in resource mobilization. The estimated cost of full implementation of the prioritized interventions for a period of five years is Kes.550, 914,240.00

CNAP II reflects the County's commitment to improving food and nutrition security, prevent/ reducing malnutrition in all its forms, and foster a well-nourished healthy and productive county population.

CHAPTER ONE

1

Introduction

1. CHAPTER ONE

1.1. Background

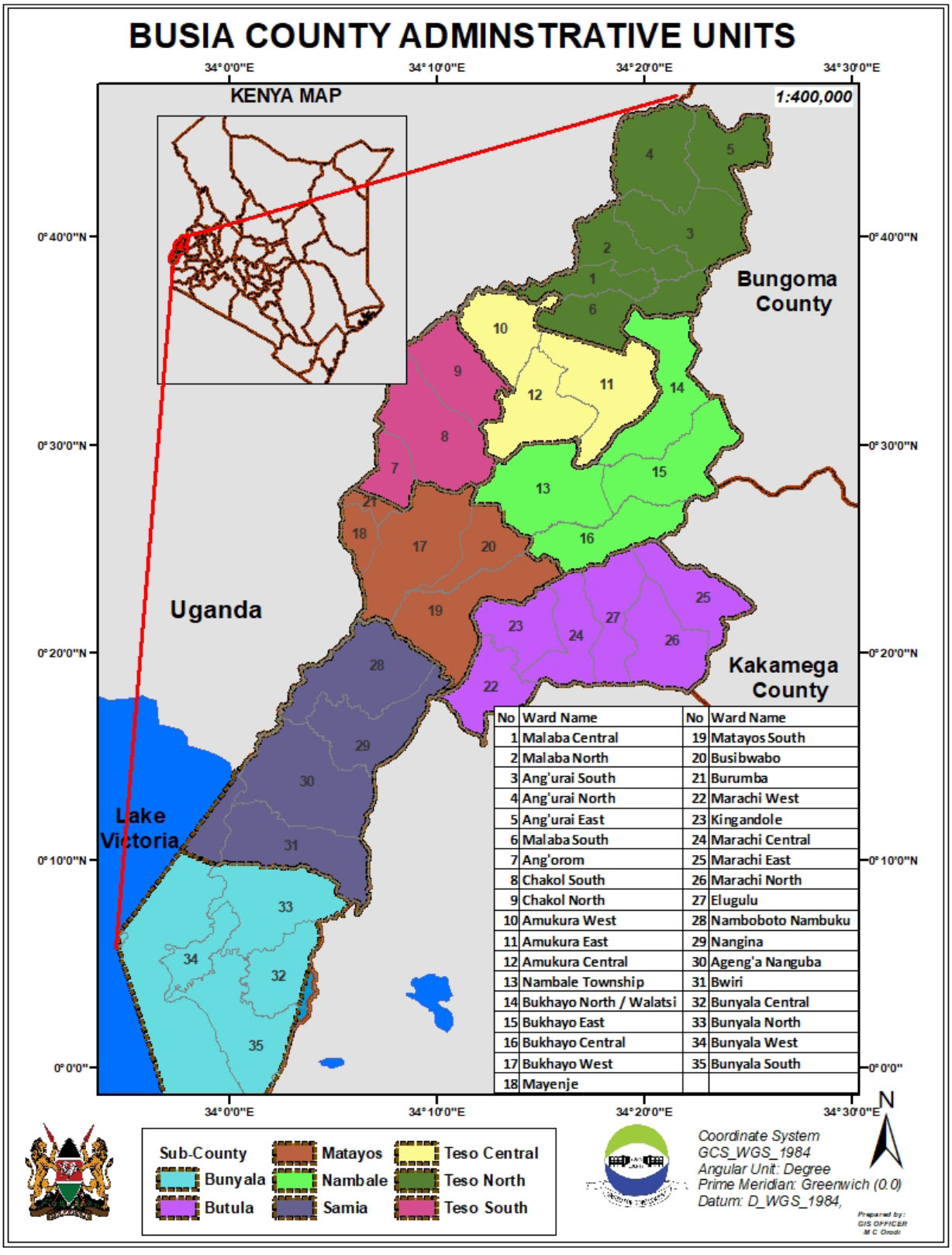
Busia is one of the 47 Counties located in the western part of Kenya. It shares a border with Republic of Uganda to the west, Bungoma County to the North, Kakamega County to the East, and Siaya County to the East. The county covers approximately 1694.5 square kilometres (km2) at latitudes 0º and 0º 45' N and longitude 34º 25' east *(see Figure 1)*. Its headquarters is in Busia town along Busia-Kisumu Road. Busia is a cosmopolitan county whose residents are dominantly of Luhya and Teso ethnicities. Others include Luo, Somali, Kisii, and Kikuyu, among others. The main economic activities are agriculture, fishing, and trade. Agriculture being the backbone of the economy, is done majorly on a small scale for subsistence use. Sugarcane, rice and sunflower farming is done for commercial purposes and to a lesser extent cotton is planted as a cash crop. Livestock farming is also done to some extent. Fishing is majorly done along the southern part of the county courtesy of Lake Victoria being the main source of both Nile and Tilapia. The county enjoys cross-border trade along Busia and Malaba borders and is a member of the 14 counties of the Lake Region Economic Bloc (LREB) situated around Lake Victoria and its environs.

1.1.1. Physiographic and Natural Conditions

The County falls under the Lake Victoria Basin that supports over 25 million livelihoods. The County's altitude varies from about 1,130 meters above sea level at the shores of Lake Victoria to a maximum of about 1,500 meters in the Samia and Teso Hills**.** Busia County is hot and moist. The mean temperature range in the County is 21-27° C whereas the annual rainfall is about 750-2000mm. There is a strong precipitation gradient with the northern areas receiving the most precipitation greater than 1750 mm, and the southern areas closer to Lake Victoria receiving between 760 and 1,250 mm of precipitation. The temperature is consistently warm throughout the year. Intense precipitation and heat stress are both hazards that contribute to agricultural and health risks throughout the county throughout the year, whereas dry spells are more of an issue in the second season.

1.1.2 Administrative and Political Units

The administrative units of Busia County are the managerial and decision-making structures of the county that are used in handling socioeconomic development issues affecting county residents. Busia County is divided into eight sub counties namely Bunyala, Butula, Matayos, Nambale, Samia, Teso North, Teso Central and Teso South *(See Figure 1.1).*, 35 wards, and 120 county administered village units. The county headquarters is domiciled in Busia Town, Matayos Sub-County.



No	Ward Name	No	Ward Name
1	Malaba Central	19	Matayos South
2	Malaba North	20	Busibwabo
3	Ang'urai South	21	Burumba
4	Ang'urai North	22	Marachi West
5	Ang'urai East	23	Kingandole
6	Malaba South	24	Marachi Central
7	Ang'orom	25	Marachi East
8	Chakol South	26	Marachi North
9	Chakol North	27	Elugulu
10	Amukura West	28	Namboboto Nambuku
11	Amukura East	29	Nangina
12	Amukura Central	30	Ageng'a Nanguba
13	Nambale Township	31	Bwiri
14	Bukhayo North / Walatsi	32	Bunyala Central
15	Bukhayo East	33	Bunyala North
16	Bukhayo Central	34	Bunyala West
17	Bukhayo West	35	Bunyala South
18	Mayenje		

1.1.3 Demographic Profile

Busia County has a projected population of 1,037,985 as per the 2024 (County population projections), whose male-to-female ratio is 1:1 (48.6% male and 51.4% female) and a fertility rate of 4.7%. The estimated number of households stands at 207,597 with an average family size of 5. The distribution of the population as per the KEPH II cohorts is as tabulated in *Table 1-1* below: Under one, 2.93%; Under-fives 12.62%; Adolescents 21.71%, Under 15 years population is 42.06%, women of reproductive age

are 24.30%. The adult population is 27.04% and 5.46% of the total population is 60 years and above. Out of the eight sub-counties, Butula sub-county is the most populated contributing 16% of the total population followed by Matayos sub-county (15.7%) and then Teso North sub-county (15.2%) in descending order.

Table 11: Population breakdown and description

	Description	Population segment estimates	County projected population
1	Total population in the county		1,037,985
2	Number of households		207,597
3	Children under one year (12 months)	2.93%	30,413
4	Children under five years (60 months)	12.6%	130,994
5	Under fifteen-year population	42.06%	436,576
6	Women of childbearing age (15 – 49 years)	24.3%	252,230
7	Estimated number of pregnant women	3.11%	32,281
8	Estimated number of deliveries	3.02%	31,347
9	Estimated live births	3.02%	31,347
10	Number of adolescents (15-24)	21.71%	225,347
11	Adults (25-59)	27.04%	280,671
12	Elderly (60+)	5.46%	56,674

1.1.4 Health facility distribution

The county has a total of 94 GOK, 60 privates, and 8 faith-based facilities, totalling 163 health facilities across all levels of care. The County is 100% community health services compliant with a total of 233 community units that have a functional governance structure of community health committees, manned by 2190 community health promoters offering health and nutrition services at level one of care. All these work within 8 primary care networks in Busia County. Cognizant of the national government's strategic direction of achieving universal coverage, the county has currently established 5 primary care networks out of the expected 8.

1.1.5 Human resources for nutrition

The county government has over the years gradually increased the human resource for health which currently stands at 1408, of which 31 are nutritional personnel giving a proportion of 2.2% of the total health workforce. Despite the gradual increase, the nutrition workforce is way below the recommended WHO norms and standard guidelines on the number of health personnel required to serve a given population (466 in the community units, 128 in the dispensaries, 128 in health centres and 312 in hospitals). The line departments of agriculture and early childhood education have also seen an improvement in the total workforce over the devolution period. The Department of Agriculture has recruited 100 agricultural extension officers who are critical for advancing food security in the county and they complement the work carried out by the community health extension workers. Additionally, in the Department of Education, 984 early childhood education teachers have been employed on permanent and pensionable terms across the county providing an additional human resource to leverage in the implementation of nutrition-sensitive interventions within the education sector.

1.1 Policy and legal frameworks in the county

Kenya is a signatory of key global and regional initiatives to address malnutrition in all its forms and is committed to their realization and implementation through sector-specific action plans. Key global frameworks that the country is a signatory to include: The six World Health Assembly (WHA) 2025 nutrition targets endorsed by WHO Member States in 2012 for improving Maternal, Infant, and Young Child Nutrition (IYCN). As a SUN member, Kenya subscribes to the Movement's vision of a world without hunger and malnutrition and its 10 principles of engagement which guide actors as they effectively work in a multi-sectoral and multi-stakeholder space to end malnutrition in all its forms. The 2030 global agenda on Sustainable Development Goals (SDGs) adopted in September 2015, goal 2 is specifically on nutrition: End hunger, achieve food security, improve nutrition and promote sustainable agriculture, with target 2.2 calling for ending all forms of malnutrition. The 2063 African Union Agenda framework prioritized the goal of a healthy and well-nourished citizenry in member states of which Kenya is a signatory. The strategy aims at reducing maternal and child malnutrition within the first ten years (2015-2025).

The constitution of Kenya 2010 recognizes the right to adequate food of acceptable quality while the KNAP 2023- 2028 gives a roadmap that the counties used in the development of CNAP 2023-2028. Other policies and guidelines include the Food and Nutrition Security Policy and National Social Protection Policy which outline safety net programs that ensure vulnerable people are protected within society, while at the same time supporting household economic strengthening and livelihoods.

Busia County nutrition agenda is well outlined in the current governor's manifesto as one of the flagship projects focusing majorly on children below the age of five years, women, and people abled differently in society. The county government has been able to develop/ domesticate and enact several nutrition-sensitive policies/ strategic documents and acts contributing to the nutrition agenda in the county. Such documents include and are not limited to the county integrated development plan (CIDP) 2023-2027, Busia County Agri-nutrition Implementation Strategy 2024-2029, the Community Health Services Act, Health Facility Improvement Funding Act, Busia County ECDE School Meals and Nutrition policy, Busia County Children's Policy, Busia county Environmental Health Act, The County Climate Change Act, The County Climate Change Fund and Regulations and County Environment policy among others. Equally, the County Government continues to align with the health sector UHC reforms that will reduce catastrophic expenditure on health thus allowing the people to have resources for other activities including nutrition support.

1.2 Process of Developing CNAP

1.1.1 CNAP11 development roadmap

CNAP development followed the following roadmap.

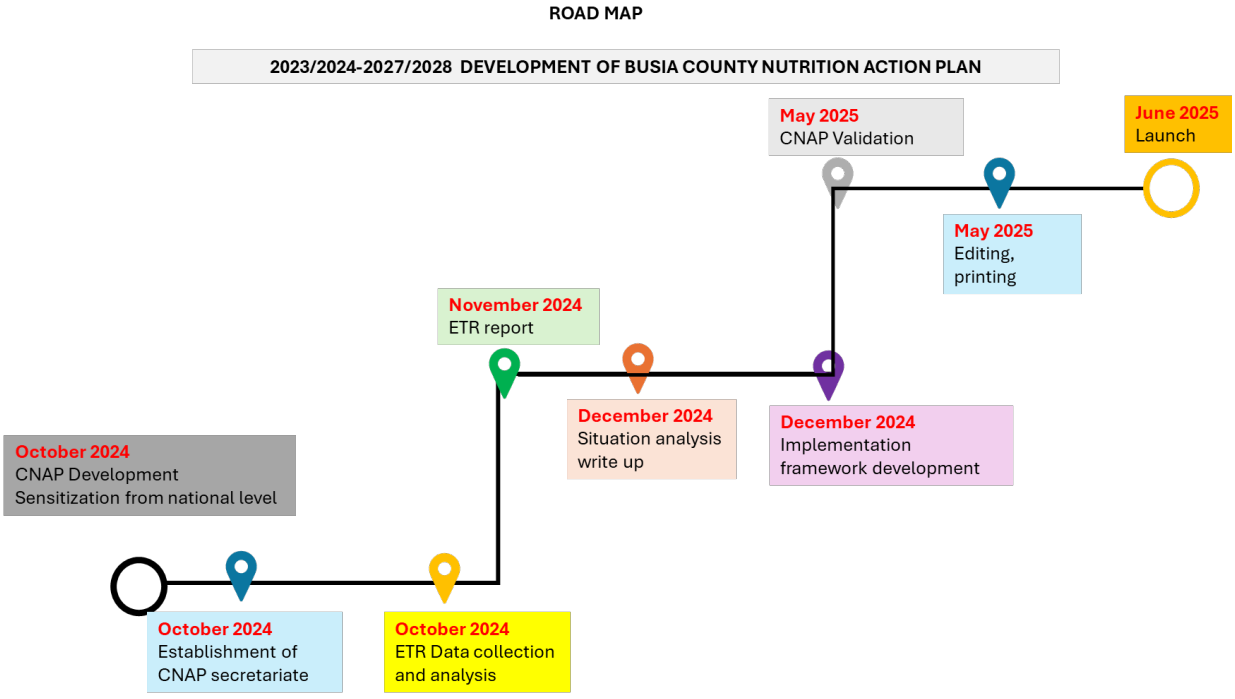


Figure 1.2: Roadmap for CNAP development.

1.1.2 Review of the CNAP 2018/2019-2022/2023

Sensitization by the national office and the Division of Nutrition and Dietetics led to the formation of a CNAP development secretariat, which began its work with the end-term review of the CNAP 2018/19–2022/23. The review highlighted significant achievements, challenges, and lessons for future nutrition strategies. The life course approach, multisectoral design, and well-structured framework provided a solid foundation for comprehensive nutrition implementation. CNAP indicators were aligned with major global and national targets, including the World Health Assembly 2025 aims, Non-communicable Diseases 2025 targets, Kenya Food and Nutrition Strategic Plan 2022, and the KNAP 2018-2022 targets. The End-Term Review (ETR) utilized data from the 2022 Kenya Demographic and Health Survey, KHIS, county surveys, and activity reports.

However, the absence of key Busia County specific surveys (SMART surveys, KAP surveys, MIC survey) hindered a full assessment of progress in some areas, such as dietary diversity and micronutrient deficiencies. Despite these data constraints, Busia County demonstrated clear progress on critical global indicators, including reductions in childhood stunting from 22% to 15%, and underweight from 9.7% to 6.3%. The CNAP 2018/19-2022/23 set ambitious targets for both nutrition-specific and nutrition-sensitive outcomes, as well as creating an enabling environment. Overall, 43% of the targeted indicators were met. Notably, nutrition capacity was strengthened, multisectoral coordination structures were established, and the monitoring and evaluation framework was refined. These achievements were critical for advancing Busia County's nutrition agenda. More details are as highlighted in the table below.

Table 12: achievements of CNAP 1

	Indicator	Achievement	Target
1	Vitamin A supplementation coverage (6–59 months)	98%	83.40%
2	Weekly Iron and Folic Acid Supplementation (WIFS) for girls	88% of adolescent girls in schools	95%
3	Stunting in children under 5	Reduced to 15%	From 22.2%
4	ECDE teachers trained on nutrition & growth monitoring	470 teachers (118% achieved)	400 teachers
5	Schools conducting nutrition education	583 schools	63 schools
6	Adolescents reached with nutrition education	92,216 adolescents (76.8% coverage)	120,000
7	Community groups trained on Agri-nutrition	230 groups (219% achieved)	105 groups
8	Department of Health budget allocated to nutrition	1.13%	Baseline 0.6%

Nevertheless, the county still experienced setbacks in implementation. The ambitious scope, preferred data sources, and limited timelines posed implementation hurdles. The multisectoral approach while beneficial for delivering results, required stronger coordination mechanisms particularly at the county and sub-county levels. The silo implementation of activities by different sectors was prevalent and resulted in poor tracking during evaluation.

1.1.3 Challenges in the implementation of CNAP 2018-2023

The review concluded that the implementation of CNAP 2018-2023 faced numerous challenges that impeded the achievement of its ambitious targets and desired outcomes. Below is an outline of the key challenges encountered during the plan's implementation:

1. Inadequate allocation and disbursement of funds in line departments hindered the implementation of planned nutrition intervention while nutrition-sensitive departments lacked distinct vote heads dedicated to nutrition services. Partner dependency led to the interruption of program activities upon the closure of a project.
2. Social factors highly contributed to poor health-seeking behaviour limiting the uptake of interventions like medical camps and adoption of recommended nutrition practices.
3. Shortage of nutrition personnel led to significant gaps in service delivery. Labour unrest and industrial actions disrupted healthcare services leading to missed opportunities for nutrition services.
4. Inadequate data collation tools led to poor documentation of activities hence missing data, and data sharing of the studies done by projects and partners not done. Additionally, the use of fragmented reporting systems by various stakeholders led to inconsistencies in data collection and analysis.

5. Delays in the supply chain for essential nutrition commodities, such as therapeutic feeds and micronutrients undermined the effectiveness of interventions.
6. Gaps multi-sectoral collaboration limited coordination between key departments such as agriculture, education, and health, resulting in fragmented approaches to addressing malnutrition.
7. Dry spells, floods, and other climate-related disasters disrupted agricultural productivity, exacerbating food insecurity and malnutrition. The COVID-19 pandemic further disrupted service delivery and diverted critical resources from nutrition programs.

1.1.4 Recommendations for review report for CNAP 2018/19-2022/23

To address the challenges identified during the implementation of CNAP 2018/19 - 2022/23, the following recommendations are proposed to strengthen the foundation for effective and sustainable nutrition interventions:

1. Advocate for enhancement in budgetary allocation and continuous ring-fencing county budgets for nutrition to ensure dedicated funding for related initiatives
2. Strengthen community-based health education and social mobilization efforts to address cultural barriers and misconceptions, while integrating cash transfer programs and livelihood support initiatives to alleviate poverty and enhance household food security, thereby improving the uptake of nutrition services.
3. Prioritize recruitment and training of skilled nutrition personnel to address staff shortages and improve program delivery.
4. Strengthen the nutrition monitoring and evaluation system, especially in the provision of data collation tools and county-specific surveys to strengthen data-driven programming.
5. Improve procurement and distribution systems to ensure consistent availability, especially for commodity and equipment supply to ensure continued and quality nutrition care services.
6. Sustain a life-course approach to nutrition programming with cross-sectoral collaborations to address diverse population needs.
7. Develop flexible and adaptive strategies to sustain progress amid challenges like health epidemics and climate change.

1.1.5 Development of CNAP II

The CNAP 2023/24-2027/28 is the 2nd generation of county action plans anchored in the Kenya Food and Nutrition Policy (FNSP 2011), and KNAP 2023/24-2027/28 and is developed to progressively tackle the challenges of malnutrition in Busia County. The basis for its development is the persisting challenge of the burden of malnutrition in Busia which manifests as under nutrition (Stunting, Wasting, and Underweight), Micronutrient deficiencies, overweight/obesity, and sub-optimal management of nutrition-related diseases. It builds on the success in the implementation of the CNAP 2018/19-2022/23 which utilized a results-based theory of change to address malnutrition basing interventions on the 2020 UNICEF conceptual framework on the causality of Malnutrition.

The development of CNAP II 2023/24-2027/28 adopted a multisectoral approach, being a lesson learned, and recommendation documented in the end-term review of the first-generation CNAP. The drafting was spearheaded by the county CNAP writing secretariat that comprised both county and national ministries /departments i.e. Ministry of Education, Department of Education and Industrial Skills Development, Department of Water, Irrigation, Environment, Natural Resources, Climate Change and Energy, Smart Agriculture, Livestock, Fisheries, Blue Economy and Agribusiness, Finance and Economic Planning. The writing was possible with technical support from the Ministry of Health, the Division of Family Wellness Nutrition and Dietetics, and UNICEF. The initial process was preceded by sensitization meeting of the secretariat both virtually and physically. Following the

nutrition situation analysis write-up, the secretariat then agreed to adopt the 14 KRAs as outlined in the KNAP 2023/24-2027/28. The sequence of the writing of the document adopted the logic framework/results-based management principles. It involved the description of the defining of the KRAs, objectives, strategies, interventions and outputs, indicators and targets, and the implementation plan, and costing of the CNAP using a standard Excel template provided by DND at the county level with leadership from the county nutrition coordinator. Later, the word write-up of the CNAP workshop was convened involving the write-up secretariat. The document was later subjected to key stakeholders' review at the county level for validation. The stakeholders included high-level decision-makers and policy formulators at the county level for purposes of buy-in.

1.1.6 Target Audience

The targeted audience for the County Nutrition Action Plan II (CNAP II) comprises policymakers at the county level, development and implementing partners, Donors and UN agencies, Civil Society Organizations, Faith-based organizations, National government line ministries and county departments that include:

a) Health Services and Sanitation
b) Smart Agriculture, Livestock, Fisheries, Blue Economy and Agribusiness
c) Education and Industrial Skills Development
d) Water, Irrigation, Environment, Natural Resources, Climate Change and Energy
e) The County Treasury and Economic Planning
f) Strategic Partnership and Digital Economy
g) Youth, Sports, Gender, Creative Arts and Social Services

The beneficiaries are also part of the targeted audience and comprise frontline service providers across all key sectors including healthcare workers, community health promoters, and other community extension workers in the community. Such cohort of beneficiaries include Children under 5 years old, Adolescents, Adults, Pregnant and lactating women, Child-headed households, People with Disabilities (PWDs), the elderly, and Persons with Chronic Illness.

1.1.7 Guiding principles of the CNAP II

The CNAP will be implemented through the following guiding principles

- Human Rights-Based Approach
- Multisectoral Collaboration
- Equity and Inclusion
- Life-Course Approach
- Evidence-Based Programming
- Community Participation and Ownership
- Resilience and Adaptation to Climate Change
- Accountability and Transparency
- Innovation and Continuous Learning
- Gender Responsiveness

CHAPTER TWO

County Nutrition Situation

1. CHAPTER TWO

1.1. Introduction

This chapter comprehensively analyses the nutrition situation, in the national and county context. It examines nutrition across the lifecycle by highlighting the needs and challenges at different stages, alongside an evaluation of dietary diversity and its health implications. The chapter also explores trends in morbidity and mortality, shedding light on their relationship with nutrition status. Furthermore, it emphasizes the critical role of nutrition-sensitive sectors, such as agriculture, education, WASH, and social protection, in addressing nutrition challenges and improving overall health outcomes.

1.2 The Kenya context

Kenya has made considerable progress in reducing malnutrition in recent years. Stunting rates have halved from 36% in 2003 to 18% in 2022, attributed to interventions like the implementation of the National Nutrition Action Plans and improvements in healthcare and food security. However, persistent wasting during drought and public health emergencies highlights the need for sustained efforts against acute malnutrition. Further, micronutrient deficiencies remain a significant concern, as evidenced by high rates of anaemia (26.3% in preschool children), zinc deficiency (83.3% in preschool children), and vitamin A deficiency (9.2% in preschool children). Notably, rural children face higher risks of micronutrient deficiency than their urban counterparts. Among adolescents (15–19 years), 18% of women and 43% of men are thin, while 11% of women are overweight or obese. In adults (20–49 years), **7**% of women are undernourished**,** 28% are overweight and 17% obese, reflecting a growing burden of over nutrition linked to urbanization, processed foods, and sedentary lifestyles. Geographical disparities persist, with malnutrition disproportionately affecting ASAL regions**.** Rural areas report higher stunting (20%) compared to urban areas (12%). Key determinants of malnutrition include maternal education, household wealth, gender roles, and access to healthcare.

1.3 Busia County Context

The burden of malnutrition in Busia County is characterized by the co-existence of under nutrition (as manifested by stunting, wasting, and underweight), micronutrient deficiencies, and over nutrition (as manifested by overweight and obesity). Targeted, localized interventions through County Nutrition Action Plans are thus crucial for addressing these challenges and promoting sustainable nutritional improvements

According to KDHS results of 2022, the rates of stunting and underweight have reduced to 15% and 6.3% from 22.2% and 9.7% respectively, while there was a slight increase in wasting from 2.2% in 2014 to 2.8% in 2022 *(see figure 2.1 and 2.2*). While great progress has been made, stunting rates in Busia County are categorized as medium when compared with the global public health threshold set by WHO.

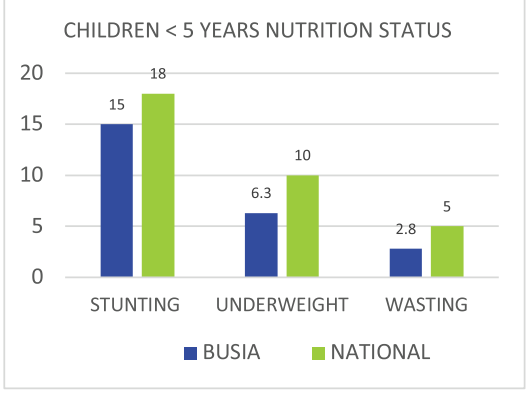


Figure 2.1: <5years Nutrition status

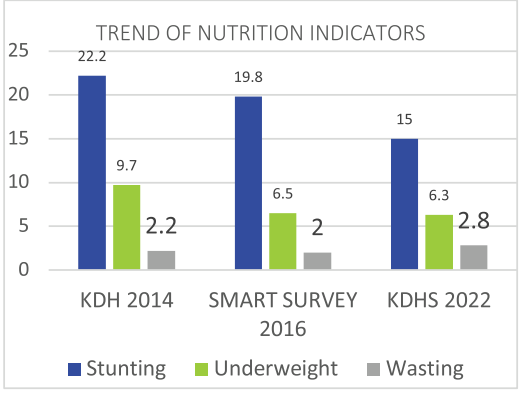


Figure 2.2: Trend of nutrition indicators

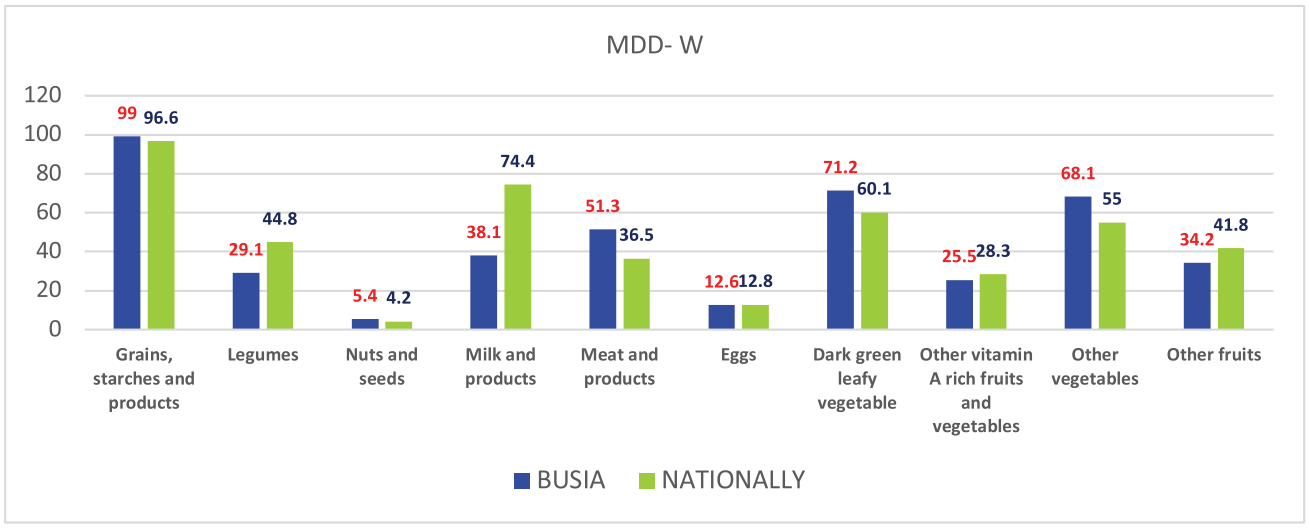


Figure 2.3: Minimum dietary diversity

Iron deficiency anaemia is the third cause of maternal mortality in the county (Kenya mortality survey, 2017). The KDHS of 2022 indicates low Consumption of Iron and Folic acid supplements among pregnant women for 90 plus days at 30.3% (*see figure 2.4 and 2.5*). Furthermore, routine data (KHIS) across the years has shown a decline in the issuance of the IFAS while anaemia in pregnancy is on the rise.

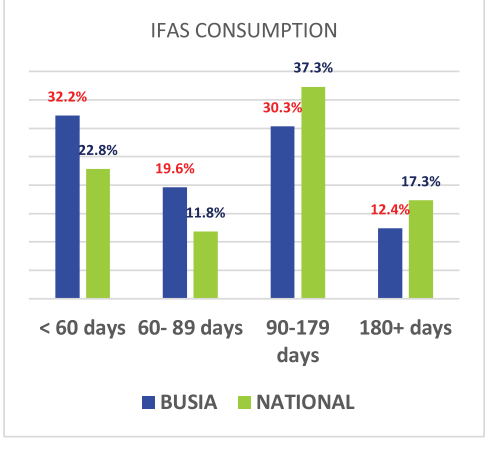


Figure 2.4: IFAS consumption Source: KDHS 2022)

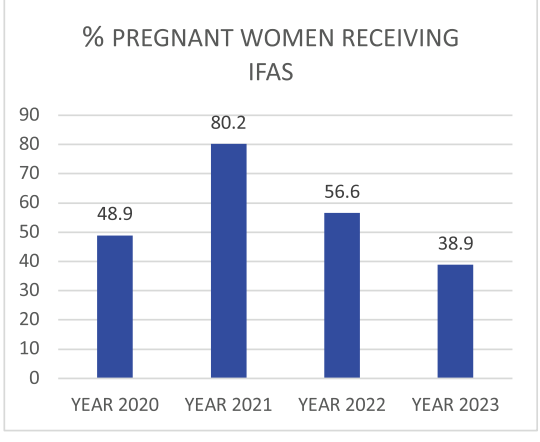
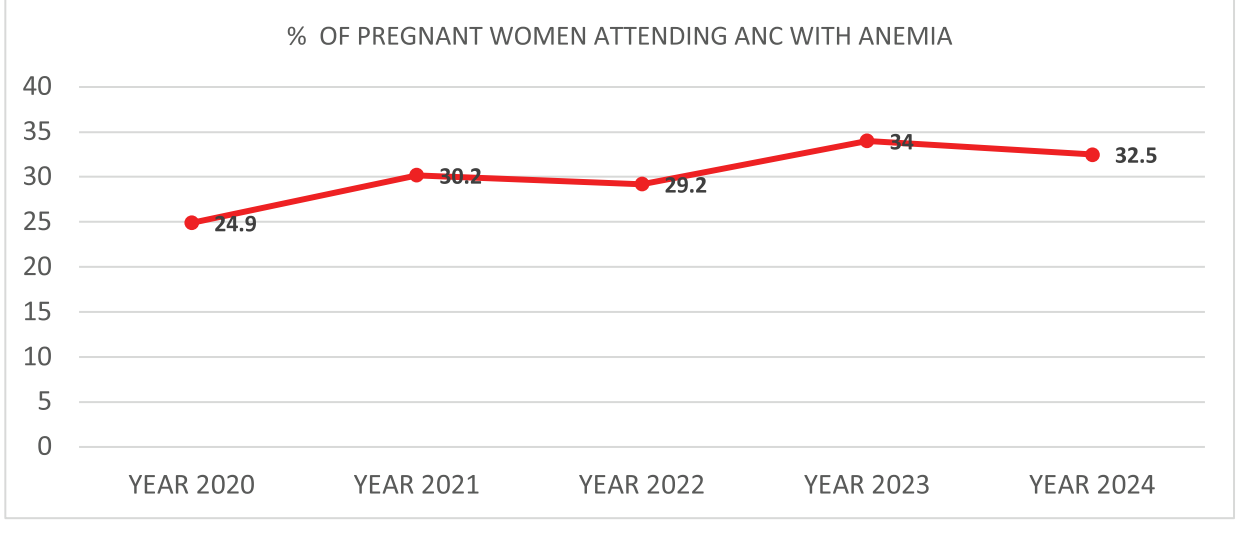


Figure 2.5: Anaemia vs. IFAS uptake over the years (Source: KHIS)



Nutritional status among adults shows notable gender differences, with women aged 20–49 years experiencing higher rates of overweight and obesity compared to men in the same age group. Among adolescents aged 15–19 years, most of whom are still in school, underweight is more common among boys than their female peers (*see figure 2.6 and 2.7*).

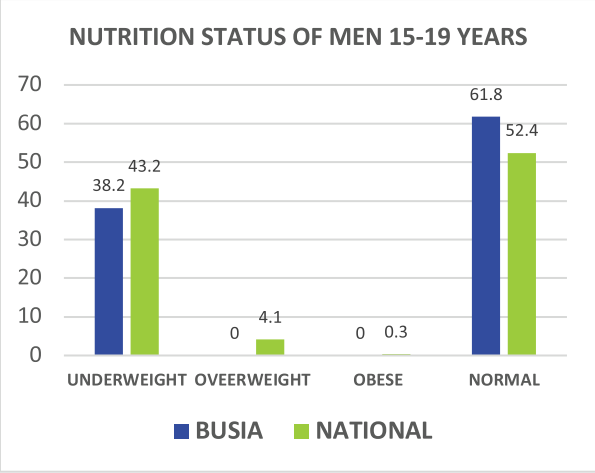


Figure 2.6: Nutrition status of men 15 -19 years

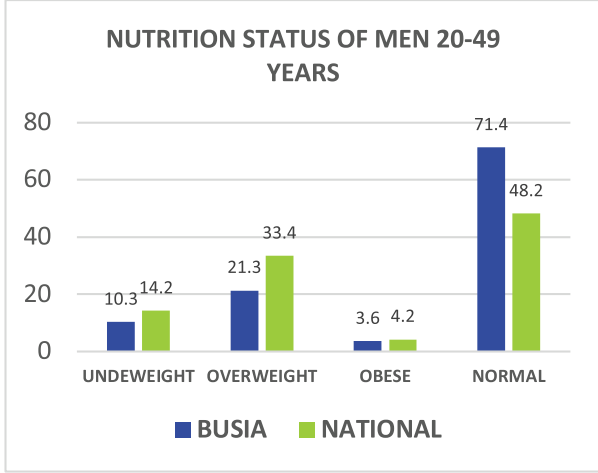


Figure 2.7: Nutrition status of men 20-49 years

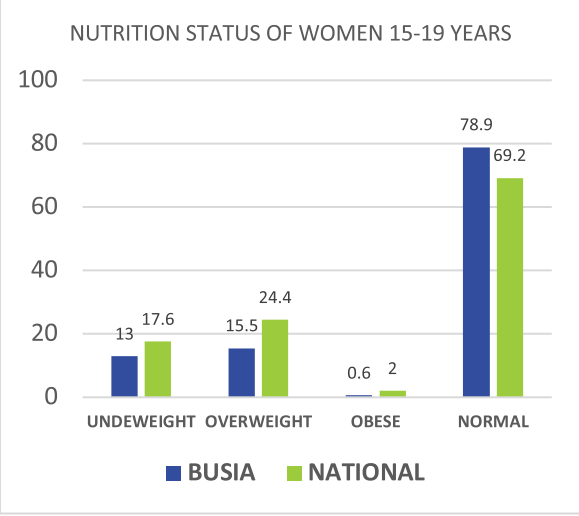


Figure 2.8: nutrition status for women 15-19 yr

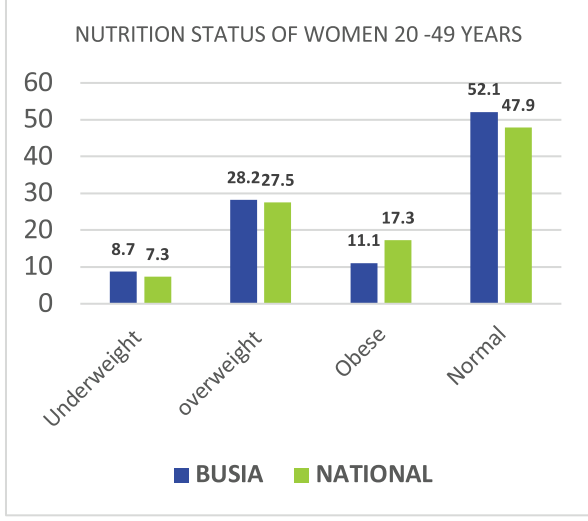


Figure2.9 nutrition status of women 20-49yrs

The prevalence of non-communicable diseases, specifically diabetes and hypertension, are on the rise among these cohorts as illustrated in the *figure 2.10* below.

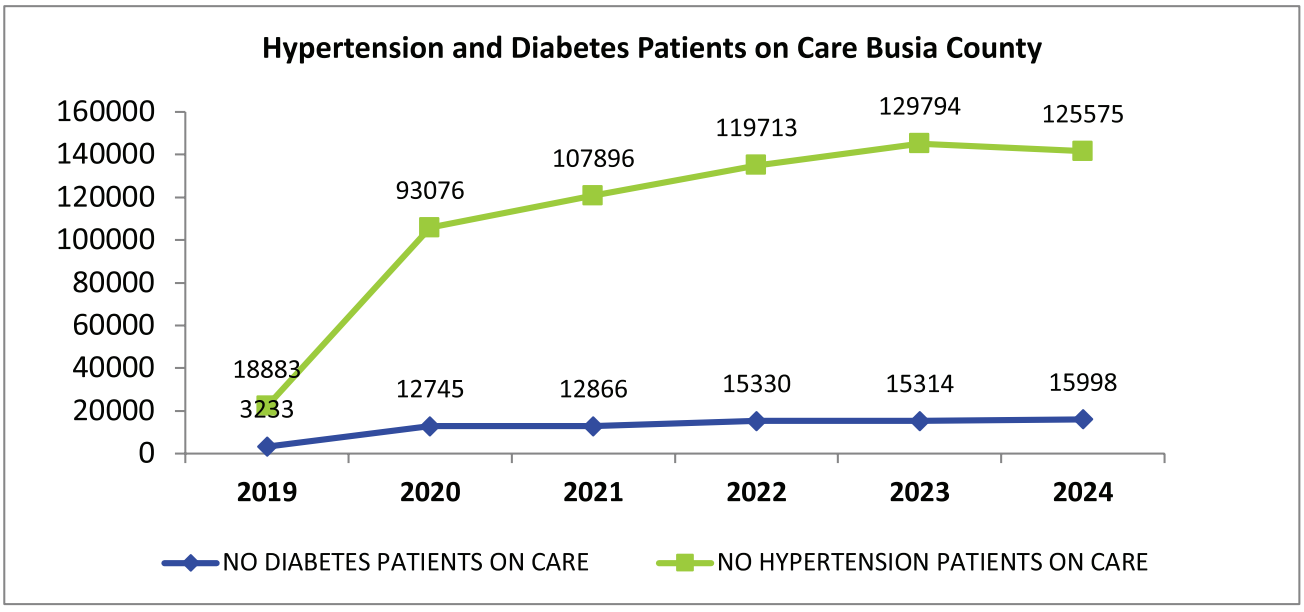


Figure 2.10 trend of hypertension and diabetes patients on care in Busia County Source: KHIS 2025

1.4 Morbidity and Mortality Trends

Disease is an immediate cause of malnutrition as per the UNICEF conceptual framework. The analysis in trends of morbidity and mortality are critical to understanding the link with malnutrition. The county witness both high burden of communicable and non-communicable diseases with deaths associated with them. HIV/AIDS continues to be a major public health issue in Busia County, with a prevalence rate of 6.5%, which is higher than the national average of 4.9%. Although there has been a reduction in recent years, the county remains one of the highest in HIV burden. TB continues to significantly contribute to the burden of diseases in the county. Busia County is classified as a high-burden TB area. In 2022, the Busia County TB case notification rate rose to 130 per 100,000 people, a significant increase from 90 per 100,000 in 2021. Malaria is endemic in the region, with a prevalence rate of 39%. Diarrhoea is a common health issue in Busia County, especially affecting children under five. It is driven by inadequate access to clean water and basic sanitation facilities. According to the 2022 Kenya Demographic and Health Survey (KDHS), about 15% of children under five experienced diarrhoeas in the two weeks preceding the survey. Sporadic Cholera outbreaks in Bunyala Sub-County, particularly in areas around Lake Victoria that experience seasonal flooding. These outbreaks have seen case fatality rates ranging from 2.5% to 4%, depending on the severity of the flooding. Typhoid fever is another significant WASH-related disease with an incidence rate of approximated at 70 per 100,000 people. The prevalence of schistosomiasis in the county is 7.1%, and soil-transmitted helminths (STH), is at 17% posing a considerable threat to both children and adults.

While infectious diseases continue to be a major public health issue in Busia County, non-communicable diseases such as cardiovascular diseases, diabetes and cancer are becoming more prominent. Nutrition plays a key role in the prevention, control and management of NCDs through appropriate feeding practices in the populations and adherence to dietary prescriptions in the clinical setup. The prevalence of hypertension and diabetes according to the Primary Health Integrated Care for Four Chronic Diseases (PIC4C) study in Busia County in the year 2019 was rated at 1.7% and 33.6%, respectively. Diabetes was most prevalent among individuals aged 45 to 59 years, whereas

hypertension was more common in those aged 70 and above. Micronutrient deficiencies significantly affect vulnerable groups, including children under five, school-aged children, adolescents and pregnant or breastfeeding women.

The county registers a crude death rate of 126/1000 persons, a neonatal mortality rate at 8.2/1000 lives births, and a 96/100,000 maternal mortality rate. The infant mortality rate and crude mortality rate are at 84/1000 and 46/1000 live births respectively. Diarrhea is among the top five causes of morbidity and mortality among under-fives while hypertension is among the top 5 causes of morbidity and mortality among over five.

1.5 Trends in access to food, care and health services

Busia County faces significant challenges in food security, with a substantial portion of its population experiencing food insecurity. Nearly 88.7% of households were food insecure in 2021, a situation exacerbated by the COVID-19 pandemic (county crops directorate report). Food access is affected by cropping periods, where the months of April to June are usually considered a lean period in most households because most of the harvest has been depleted. The county is maize insecure for 2 months in a year. The months of February to April have a deficit in vegetables. This is due to the dry period that is experienced across the county. Protein (milk, eggs, and meat) is not sufficient for the population in the county (MoA report 2023).

Access to health services in Busia County has shown notable improvements between 2014 and 2022. In 2014, 50% of births in Busia County were attended by skilled health personnel which increased to 88% in 2022. Similarly, children who were fully immunized rose from 70% in 2014 to 80% in 2022. Busia County health facility density is at 14.8 per 100,000 people resulting in 100% population living within one hour of travel to health facility. Health insurance coverage, which was less than 10% of the population in 2014, increased marginally to 20% in 2022. In 2022, both antenatal and postnatal care services had seen increased utilization, indicating better access to maternal health services**.**

1.6 Drivers of Malnutrition

Child poverty is a significant driver of malnutrition in Busia County and documented as the underlying cause of 45% of under-5 mortality. In Busia County, 29% of children under 5 years are deprived of their development milestones. This puts them at risk of poor physical development, cognitive growth, and intellectual development. The impact of brain development has implications for future learning, productivity, and wage-earning potential. Whereas the damaging effects of malnutrition are transferable from one generation to the next, the benefits can be compounded intergenerational. The high food prices negate the ability of poor households to have a healthy diet since it is not affordable. Inadequacy in the food environment compounded by farmers and value chain experts not always accounting for the nutrition needs of children when selecting value chains of priority is also a key driver to malnutrition. The need to address this inadequacy in the food environment is key because zero hunger is a constitutional right, and SDG priority.

The monetary poverty rate of Busia County is at 68.2% which is nearly twice the national rate of 35.7%. The multidimensional poverty rate stands at 70% with key drivers being nutrition, housing, information, and sanitation. The recent estimates have shown a rise in poverty to 58.3% (KNBS 2021.

Poor feeding practices, heightened morbidity low food production and limited access to care are the immediate triggers of malnutrition. Gender and age-related disparities and cultural norms influence food behaviours, sharing, and adoption. Challenges such as restricted access to clean water, inadequate hygiene and sanitation, suboptimal health-seeking behaviour, and care practices across

diverse genders and age groups contribute to malnutrition. This is exacerbated by insufficient male support in alleviating women's maternal responsibilities. Land degradation, climate change, high cost of production, uncontrolled land fragmentation, and inadequate implementation of policies are factors contributing to household food and nutrition insecurity in the county. Other factors include food wastages and losses (post-harvest losses), inadequate food reserves and enterprise diversification, cash crop cultivation (sugarcane), inadequate extension services, and low levels of bio fortification

1.7 Nutrition actions in the county development context

In the County Integrated Development Plan 2022-2027 (CIDP), Busia County's administration placed a high priority on addressing food and nutrition security due to the persistent challenge of malnutrition that obstructs the realization of development goals. Agriculture contributes 58% to the county's GDP and contributes 50% to primarily household-level incomes (CIDP 2022). Food crop production rates in the county stand at: Maize 75%, beans 52%, cassava 39%, finger millet 31%, Sorghum 24%, groundnuts 17%, and sweet potatoes 17%. Cage fish farming, backyard ponds, land-based fish farming in addition to captured fish in Lake Victoria and rearing of small livestock are prioritized since they play an integral role in household incomes.

In the education sector, the proactive efforts of ECDE parents have supported the implementation of school feeding programs in all public ECDE centres, to provide a hot nutritious meal of rice and beans, twice a week, to address the nutrition status of the learners, improve enrolment and retention rates.

Access to clean and safe water in both rural and urban areas is on the upward trajectory. On average, the County water coverage stands at 60%. Urban water access has since increased from 19% to 47% while rural water coverage increased from 56% to 76.4%. The average distance covered by households to the nearest water point was reduced from 1.2km to 0.5km against a target of 0.5km. (*Busia CIDP 2023-2027).* In a move to cut electricity costs by 40% and improve climate resilience, the Financing Locally Led Climate Action (FLLoCA) program has financed the upgrading of the Solar Tie Grid System to a full hybrid system as well as the solarization of boreholes thus increasing intergovernmental collaboration access. (*Busia County Department of Water, 2024).*

Busia County achieved open defection free status in 2015, however, recent survey revealed 92% of the households have access to basic sanitation of which 40% have access to improved sanitation. Fifty-one (51%) of the population have basic facilities for hand washing (KDHS, 2022). To combat the sub optimal coverage, the county is promoting market-based sanitation (MBS), building decentralized wastewater treatment systems, and enhancing sewer systems. and creating awareness proper waste disposal, and hygiene practices.

Approximately 11,815 households with Orphan and Vulnerable Children, 24,898 older persons and 1,620 Persons with Severe Disability are on cash transfers (CCTPIMS 2025). However, a larger number of needy households with OVCs face a myriad of challenges such as limited targeted numbers annually, delayed disbursements of funds, and skewed targeted population for the donor-funded programs. Additionally, most of the caregivers lack adequate information about existing social protection programs funds.

1.8 Conceptual framework for addressing malnutrition in all its forms

The updated UNICEF framework on maternal and child nutrition identifies inadequate diets and caregiving as the primary immediate determinants of malnutrition which resonates with the county context, as outlined in Section 2.5.

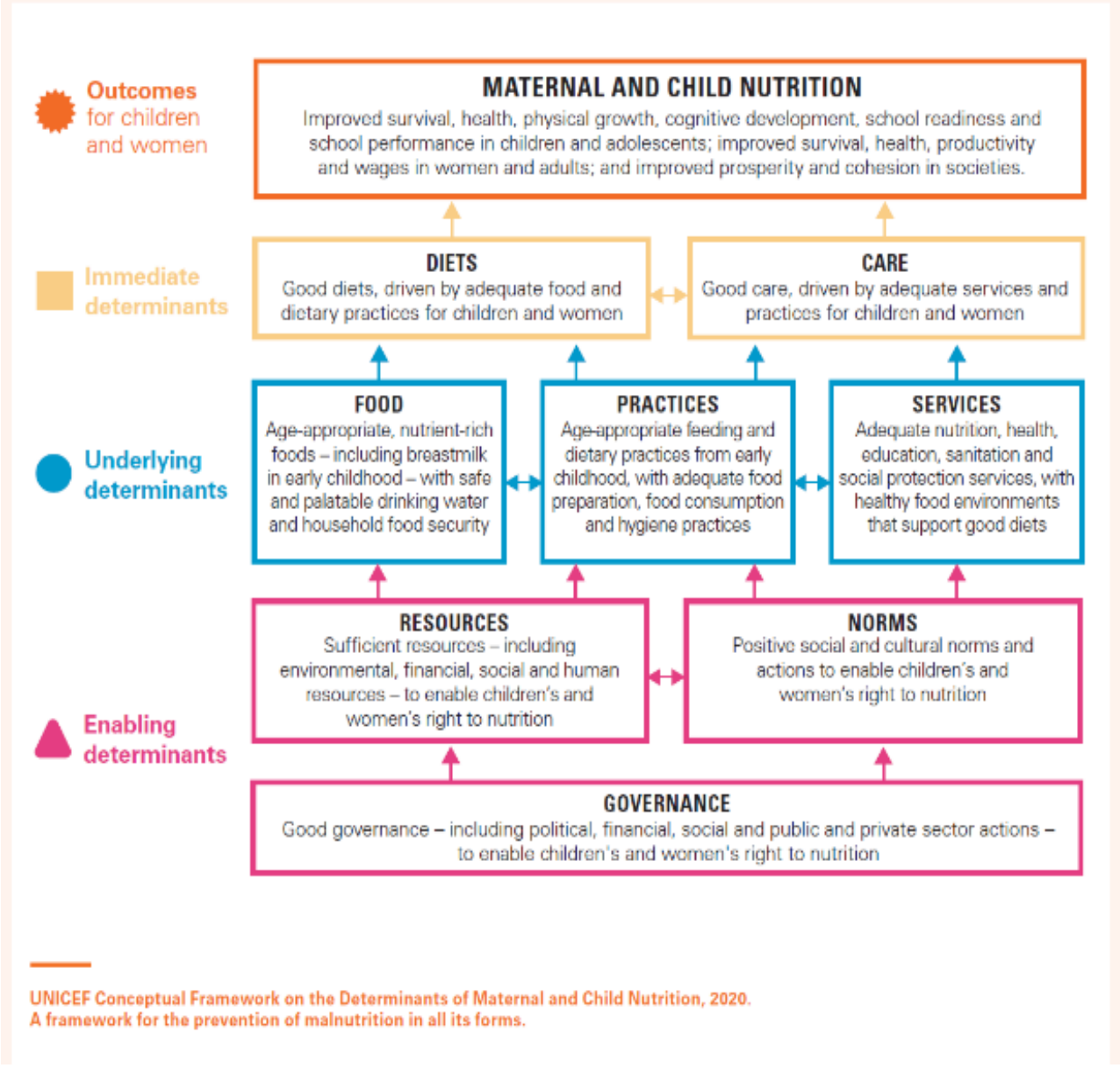


Figure 2.11: UNICEF framework on the determinants of maternal and child nutrition

This conceptual framework aligns directly with the 14 Key Result Areas adapted in this CNAP. Specifically:

I. KRAs 1–4 respond to the immediate causes of malnutrition by promoting optimal maternal, infant, and child nutrition, improving nutrition for adolescents and older persons, addressing micronutrient deficiencies, and strengthening clinical nutrition services.

II. KRAs 5–10 tackle the underlying causes by mainstreaming nutrition in agriculture, WASH, education, and social protection sectors, while enhancing resilience in emergencies and climate shocks.

III. KRAs 11–14 address the basic causes by reinforcing governance, coordination, M&E systems, capacity development, and supply chain management.

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CHAPTER THREE

Strategic Priorities: Strategic Objectives, Key Result Areas and Interventions

2. CHAPTER THREE

This chapter identifies and discusses Key Result Areas (KRAs) by defining the overall goal, strategic objectives, strategies, interventions and projected outcomes that will steer CNAP's implementation over the next five years. The 14 KRAs shown in *Table 3-1* were adapted from the KNAP 2023-2028 through rigorous stakeholder engagements and situation analysis in reference to the UNICEF conceptual framework on determinants of malnutrition.

Table 31: CNAP II Key Result Areas

KRA Number	Definition of KRA
KRA 1	Maternal, Infant, and Young Child (MIYC) nutritional well-being enhanced
KRA 2	Improved nutritional well-being of older children, adolescents, adults, and older persons
KRA 3	Enhanced Surveillance on Industrial fortification and promotion of fortified and bio fortified foods
KRA 4	Enhanced clinical nutrition and dietetic services across all levels of health care
KRA 5	Sustained nutritional well-being of individuals and communities during emergencies and climate-related shocks
KRA 6	Enhanced integration of nutrition into agriculture, livestock, fisheries, and agribusiness sectors
KRA 7	Nutrition integrated and strengthened across all levels of the health sector in the county
KRA 8	Enhanced integration of nutrition in the education sector
KRA 9	Enhanced integration of nutrition within the Water, Sanitation, and Hygiene (WASH) sector
KRA 10	Nutrition integrated across social protection programs
KRA 11	Enhanced sectoral and multisectoral nutrition governance, coordination, partnerships, advocacy and community engagement
KRA 12	Strengthened sectoral and multisectoral nutrition information monitoring and evaluation, learning, research systems, and knowledge management
KRA 13	Enhanced nutrition capacity development for improved service provision
KRA 14	Strengthened supply chain management for nutrition commodities and equipment

2.1. Key Result Area 1: Maternal, Infant, and Young Child (MIYC) nutritional well-being enhanced.

Maternal infant and young child nutrition indicators have gradually improved in the county over the years. According to KDHS 2022 findings showed improvement in stunting and underweight among children below the age of five years from 22.2% to15% and 9.7% to 6.3% respectively. However, wasting recorded a slight increase from 2.2% to 2.8% attributed to emerging COVID 19 pandemics. The WHO recommended infant and young child feeding practices of exclusive breastfeeding, early initiation of breastfeeding and continued breastfeeding beyond two years has gradually improved due to the advocacy efforts in the county to promote, protect and support breastfeeding. Routine data collected monthly from health facilities have witnessed sustained coverage of over 90%. Other high impact nutrition interventions geared to improve the nutrition status of infants and young children that include vitamin A supplementation, growth monitoring and deworming have routinely improved over the years through multisectoral collaboration within the county departments and implementing

partners. Vitamin A supplementation coverage stands at 81.9%, growth monitoring at 44.7% and deworming of children 12- 59 months coverage at 31%, (KHIS 2022). Survival of the infant highly depends on the mother hence maternal nutrition is critical for consideration. Minimum dietary diversity for women (MDD-W) is a key pointer on household dietary diversity. The county MDD-W stands at 41.2% below the national average of 45% while the consumption of unhealthy foods among women of childbearing age is on the rise standing at 33.9%. IFAS consumption for 90+ days coverage is at 30.3%. Poor maternal nutrition indicators pose a risk to nutrition outcomes on infants.

The county has a pool of technical expertise to offer technical assistance at all levels of care on national and county prioritized interventions to scale up implementation. The expertise includes trainers of trainers on BFHI, BFCI, MIYCN, MIYCN - E and VASD. Routine data reported on the Kenya health information system (KHIS) indicates progress of key nutrition indicators defined in this cohort described in the KRA. Visibility of budget lines across the sectors though improved multisectoral collaboration cannot be over emphasized as potential to unlock scaled implementation, effective and efficient resource utilization. The functional community strategy provides an opportunity to leverage on implementation of prioritized MIYCN interventions within the department of health and sanitation and across sectors/departments.

Low scale implementation of packages that promote optimal service delivery such as baby friendly hospital initiative and baby friendly community initiative attributed to donor dependency and limited county budgetary allocation. Lack of routine surveys to inform programming and implementation, varied levels of knowledge and skill among frontline service providers and lack of an MIYCN communication strategy to address poor feeding practices and their causes are among the key challenges in implementation of this KRA. There is minimal workplace support for breastfeeding with 5 health facilities having breast feeding corners (3 hospitals, 1 health centre and 1 dispensary) and none in the informal sector and private health facilities. The county has 11 trained BMS Act monitors and enforcers. However, the enforcement is still at a very low level due to the minimal number of trained enforcers and monitors. Availability of national policies and guidelines in the implementation of MIYCN interventions, potential of partnerships, research and institutions of higher learning provides a platform to upscale implementation, innovate and use data for decision making. Commemoration of world food and nutrition days across the sectors provides a rich opportunity for awareness creation at community level. Inclusion of nutrition indicators in the eCHIS and mainstreaming nutrition with the nurturing care framework for early childhood development and other projects like NICHE within the social protection is a rich opportunity to scale implementation of MIYCN interventions. Poor health seeking behaviour among the caregivers, high multidimensional poverty level among children 0-59 months, inadequate capture and reporting of MIYCN indicators and unsupportive working environment among caregivers are the key factors that hinder the delivery of MIYCN interventions. Natural and man-made disasters like floods in Bunyala Sub County increase vulnerability to poor infant feeding practices negating the achievements made.

KRA 1 is geared towards strengthening MIYCN policy legal and regulatory environment in the County, enhancing knowledge, skills and competence of healthcare workers, CHPs and nutrition stakeholders for improved quality of care for pregnant and lactating mothers and children <5 years. This will be complemented by the adoption of MIYCN social behaviour change and mainstreaming evidence-based decision making for MIYCN Programming.

Strategic Objective: Enhance maternal, infant and young child nutrition status in the county.

Output 1.1: Strengthened MIYCN policy, legal and regulatory environment

Strategy: Advocacy.

Intervention

1. Create awareness on MIYCN policy summary statement, MIYCN strategy, BMS Act 2012 and its regulation 2021, Workplace Support for breastfeeding mothers.
2. Create awareness on breastfeeding during Global/National nutrition events

Output 1.2: Enhanced knowledge, skills and competence on MIYCN initiatives among HCWs, CHPs and nutrition stakeholders

Strategy: Capacity building.

Interventions

1. Develop a pool of TOT in MIYCN (MIYCN, MIYCN-e, BFHI, BFCI) and VAS +D
2. Strengthen the capacity of Health Care Workers service delivery on MIYCN initiatives (HCWs) on MIYCN (MIYCN, MIYCN-e, BFHI, BFCI, CBFCI, BMS Act, Breastfeeding workplace Support)
3. Strengthen the capacity of Health Care Workers (HCWs) on delivery of micronutrient supplementation in young children and pregnant women (VAS+D and IFAS)
4. Mainstream growth monitoring and promotion, VAS+D within the community structures.

Output 1.3: Increased access to quality nutrition care for Pregnant and Lactating Women and children 0-59 months

Strategy: Service delivery

Interventions:

1. Scale up health facilities at all levels to carry outgrowth monitoring, nutrition education and counselling for Infants and young children on optimal breastfeeding and complementary feeding.
2. Scale up health facilities at all levels to carry out VAS +D to children 6-59 months.
3. Scale up IFAS and deworming uptake among pregnant women at all levels
4. Create awareness to PLW on importance of consuming diversified foods to address micronutrient deficiencies at community level

Output 1.4: Evidence based decision making for MIYCN Programming

Strategy: Evidence generation

Interventions:

1. Documentation of best practices and innovations
2. Engage in MIYCN learning forums at national, regional and international levels.

2.2. Key Result Area 2: Improved nutritional well-being of older children, adolescents, adults, and older persons.

Nutrition in the life cycle approach provides an opportunity to break the cycle of intergenerational malnutrition. The period of early childhood and adolescence is a high growth spurt period with both physical and psychological changes occurring in the body. The nutrition requirements increase with the increased growth spurt and physiological changes. These stages in the life cycle provide a second window of opportunity for nutrition intervention for better outcomes in adulthood and older people. The nutritional requirements decline as individuals grow older, however there are specific considerations that come with the physiological changes that occur in adulthood that must be highlighted.

The needs also vary with the gender and gender roles in society that could pose as risk factors or causes of vulnerability that may perpetuate declining nutrition status in these cohorts if not addressed. There is evidence of a triple burden of malnutrition across these cohorts.

According to KDHS 2022, women and men between 15-49 years exhibit both forms of under and over nutrition. Notably, 38.2% of men 15-19 years are underweight, with the trend declining as they age with only 10.3% being underweight at the age of 20-49 years with a slight overweight rate of 12.9%. Contrary to this, women of ages 20-49 years exhibit over nutrition at 39.3%. Implementation of nutrition education and the weekly iron and folic acid project among adolescent girls and boys in school sought to improve behaviour change to healthy eating. The department of health has integrated youth friendly services within the healthcare system as an avenue to integrate nutrition programs for adolescents. The county has since piloted the adolescent health and nutrition education project as a basis of integrating nutrition in the school curriculum. Existence of various forums like WASH forums are an opportunity to leverage on to scale nutrition interventions within this KRA. The national government has policies and guidelines in place to inform programming and implementation of nutrition thought life cycle. Partnership with local media and national media for awareness campaigns and advocacy will optimize population reach. Minimal data on nutrition indicators of these cohorts at country and county level to inform programming is a setback. Social media infiltration among adolescents, peer pressure poses a threat to nutrition programming. The high rates of teenage pregnancy and urbanization have a direct relationship with nutrition status across these cohorts.

This KRA prioritizes interventions that will create awareness on nutrition policy for older children (5-9), adolescents (10-19yrs), adults and older people and enhance the knowledge and skills on healthy diets and physical activity among stakeholders with aim of changing practices in the community in relation to nutrition health and Enhanced quality of nutrition status across the life cycle.

Strategic Objective: Improve nutrition status and dietary practices of older children, adolescents, adults, and older persons

OUTPUT 2.1: Increased awareness on recommended healthy diets and physical practices for older children, adolescents, adults and older person among stakeholders.

Strategy: Advocacy and communication

Interventions

1. Create awareness on the existing school health and adolescent health and nutrition policies to stakeholders
2. Create community awareness on healthy diets and physical activity

Output 2.2: Improved quality of nutrition service delivery for older children, adolescents, adults and older persons.

Strategy: Service delivery

Interventions:

1. Capacity build health care workers, teachers and community health promoters on healthy diets and physical activity guidelines
2. Comprehensive nutritional service for older children, adolescents, older persons and adult

2.3. Key Result Area 3: Enhanced Surveillance on industrial fortification and promotion of fortified and bio-fortified foods

This KRA intends to enhance surveillance on industrial fortification and promotion of fortified and bio-fortified food consumption. There are opportunities in scaling up production of bio fortified

foods through; promotion of crops in the community and 4k clubs, encouraging fortification of agro processed products in Nasewa industrial park and cottage industries and engaging local maize millers in fortification of maize flour. Additionally, there have been efforts to grow bio fortified crops (iron rich beans) with support from implementing partners. Currently the county has a food safety lab for surveillance. The results of KDHS 2022 indicate 100% of households consume iodized salt hence need to maintain the good coverage. Limited county specific survey on micronutrient deficiency across the population is a hindrance to evidenced based decision making. Consequently, absence of deliberate initiatives to promote and sensitize cottage and food processing industries on fortification of their products with micronutrients further compounds the current situation. Collaboration with government parastatals e.g. KALRO provides a favourable opportunity to leverage in actualizing the implementation of this key result area. The release of varieties of Bio fortified crops by KALRO has attracted farmers to cultivate though at low scale due to low community engagement. The county also lacks policy guidelines on fortification and bio fortification coupled with low technical knowledge of extension workforce on food fortification.,

The KRA intends to strengthen food environments that promote consumption, improve availability and access of fortified and bio fortified foods by capacity building and strengthening surveillance and monitoring systems on food fortification and bio fortification

Strategic Objective: Increased access and consumption of safe and adequately fortified and bio fortified foods in line with existing standards

OUTPUT 3.1: Consumption of fortified and bio fortified foods.

Strategy: Awareness creation

Interventions

1. Adopt and disseminate policies and regulations that mandate the fortification of foods.
2. Capacity builds technical officers, and food Processing actors on fortification and bio fortification
3. Promote consumption of bio fortified foods and fortified foods.
4. Promote production of bio fortified foods.
5. Enhance Market surveillance, supervision, reporting and documentation.

2.4. Key Result Area 4: Enhanced clinical nutrition and dietetic services across all levels of health care.

The county has one Levels 5 and twelve level 4 hospitals with at least one nutritionist assigned to each of this facility. However, a total of 81 level 3 and 2 that do not have designated nutritionists. While all level 5 and 4 hospitals offer Medical Outpatient Clinic (MOPC) services, no designated nutritionist is stationed at the service points. Currently, one nutritionist in the county has been trained in renal preceptor ship, and two have received orientation in critical care nutrition. Additionally, all hospitals in the county have at least one nutritionist trained in IMAM. However, only 27 healthcare workers (10 of whom are nutritionists) across the county have undergone IMAM training, with two trainers (TOTs) available. Minimal IMAM services, such as supplementary feeding, are offered at Level 2 and Level 3 facilities due to inadequate knowledge and skills.

The county has strengths in its clinical nutrition and dietetic services through highly skilled healthcare personnel trained in the Integrated Management of Acute Malnutrition (IMAM). Two county-level trainers (TOTs) for IMAM enhance capacity building, and qualified healthcare workers deliver effective nutritional care. The inpatient feeding committees in health facilities and integration of nutrition services into specialized clinics such as HIV/TB, diabetes, cancer, and hypertension provide a holistic approach to addressing the diverse needs of patients. Opportunities include leveraging the national guidelines and standard operating procedures to improve services, strengthening partnerships, and integrating nutrition into Social Health Insurance Fund (SHIF). Several factors hinder provision of comprehensive and quality nutrition care. These include inadequate nutrition staffing, low awareness and utilization of clinical nutrition policies and guidelines across all levels

of healthcare. Furthermore, limited IMAM training and hence sub-standard services at lower levels of care. Others include inadequate equipment and limited resources for clinical nutrition training, budget constraints for purchasing nutrition commodities and the absence of a county TOT for clinical nutrition. Poor documentation of successful practices, high poverty levels, and a shortage of nutritionists for specialized care also limit service impact.

Key focus area for KRA 4 will be enhancing the awareness and utilization of clinical nutrition, while improving the skills and competencies of healthcare workers, to ensure quality care in the management of nutrition-related illnesses.

Strategic Objective 1: Decrease dietary related malnutrition across the life cycle

OUTPUT 4.1: Utilization of clinical nutrition policies and guidelines

Strategy: Awareness creation

Interventions

1. Create awareness on nutrition and dietetics related clinical guidelines, protocols and SOPs, to health care workers.
2. Create awareness in-patient feeding protocol to health managers and other relevant stakeholders

OUTPUT 4.2: Improved knowledge and skill on nutrition care process

Strategy: Capacity building

Interventions

1. Adoption of standardized nutrition protocol for different health conditions
2. Scale up IMAM services
3. Scale up Positive Deviance Hearth (PDHearth)
4. Integrate nutrition services in outpatient special clinics

OUTPUT 4.3: Provision of adequate quality meals to inpatient

Strategy: Inpatient feeding

Interventions

1. Standardize inpatient feeding program in health facilities
2. Promotion of local hospital production to complement the hospital menus

OUTPUT 4.4: Improved prevention, detection and treatment of malnutrition at community level

Strategies: Community engagement

Interventions

1. Implement PDHearth at community level
2. generate evidence on the impact of PDHearth approach
3. Promote the use of Family MUAC approach at community level

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

This Key Result Area (KRA) focuses on ensuring the sustained nutritional well-being of individuals and communities during emergencies and climate-related shocks. Natural disasters and health emergencies such as COVID-19, disproportionately affect vulnerable populations in Busia County especially mothers, infants and young children. Notably, seasonal river flooding and lake surge in Busia County have led to permanent and seasonal displacement of approximately 1,500 households and 6000 children (*UNICEF Busia Flood Response Report April 2024)*. Destruction of property such experienced further increases food insecurity and malnutrition risks for the affected population.

Soil acidity and erratic weather patterns result in low food production. Cyclic dry spells in January and February often affect vegetable production, thus leading to a low supply of micronutrients from vegetables. Reduced food stocks due to low production in March and April further increases vulnerabilities in many households. The KRA seeks to reduce these effects by introducing measures that promote sufficient nutrition during emergencies. This involves sustaining essential nutrition indicators such as early initiation of breastfeeding, vitamin A supplementation and deworming while also tackling issues like poor dietary habits. The KRA will also build resilience and secure sustained access to nutrition during crises by promoting multi-sectoral collaboration, reinforcing community-based nutrition screening and enhancing emergency preparedness. It also highlights the importance of increased funding for both nutrition-specific and nutrition-sensitive interventions in emergency settings.

Busia County benefits from several strengths that support food security including fertile soils, robust community networks, support from both the government, partners and better access to water. There are also key opportunities such as the adoption of climate-smart agriculture, strengthened partnerships, improved health systems and broader market access. Despite these, the county faces significant challenges like climate vulnerability, poor infrastructure, limited healthcare services, widespread poverty and low levels of nutrition awareness. Additionally, threats such as worsening climate variability, economic disruptions, and population pressure and pest infestations intensify food insecurity and malnutrition. Tackling these challenges calls for greater resilience through infrastructure development, enhanced nutrition programs and increased financial investment in emergency nutrition interventions.

The strategy focuses on boosting community resilience and enhancing multi-sector emergency coordination through regular joint planning and response meetings. Strengthening preparedness for nutrition emergencies involves developing comprehensive response plans and building local capacity. A timely and well-coordinated emergency response will facilitate the swift distribution of nutrition supplies and resource mobilization. Additionally, raising community awareness about resilience and early recovery efforts will equip them to manage shocks more effectively. Finally, increasing funding for both nutrition-specific and nutrition-sensitive interventions is crucial to maintain and expand nutrition services thereby improving resilience and outcomes during crises.

Strategic Objective 1: Strengthen nutritional well-being and reduce malnutrition-related mortality and morbidity among affected populations during emergencies

OUTPUT 5.1: Enhanced an emergency nutrition preparedness, response and recovery.

Strategy: Capacity building

Interventions

1. Awareness creation for healthcare workers and CHPs on MIYCN-E, BMS act of 2012 and WASH in emergency.,
2. Advocate for resource allocation for nutrition resilience and early recovery interventions

Strategy: Assessment and surveillance

Interventions

1. Stakeholder coordination and engagement.
2. Nutrition assessment and screening of vulnerable population in emergencies
3. Targeted nutrition support in emergencies

2.6. Key Result Area 6: Enhanced integration of nutrition into agriculture, livestock fisheries and agribusiness.

This KRA intends to enhance integration of nutrition into agriculture, livestock, fisheries and agribusiness with an outcome of having improved household food and nutrition security in the county.

Nutrition sensitive agriculture contributes to preventing and reducing malnutrition cases. Scaling up nutrition sensitive agriculture will largely contribute to the reduction of malnutrition cases in the county. Fruits and vegetables play a key role in addressing micronutrient deficiencies in the community; however, the county is still deficient in production of horticulture crops hence affecting the accessibility and affordability. There are still very few schools that have adopted 4k clubs and young farmers clubs. To be able to achieve food accessibility and affordability, there is need to adopt appropriate modern technologies that are nutrition sensitive, such as mini-irrigation, kitchen gardening technologies, backyard fish farming and poultry production. First CNAP rallied the sector in capacity building of farmers to be able to adopt these technologies. However, there is a need to scale up production with above technologies and continuous training through demonstrations Food waste and losses is still a major challenge because of low adoption of appropriate post-harvest management technologies as well as biological and chemical contaminants therefore promotion of postharvest management cold chain infrastructure, agro-processing plants and value addition is critical.

The county has programmed that support nutrition sensitive interventions such as input subsidy programme, additionally, NAVCDP, KeLCoP and ABDP programmes are being implemented with the support of the national government and development partners. The f agriculture sector has policies, legal frameworks and collaborative partners that recognize the importance of nutrition sensitive interventions coupled with t trained extension workforce who build the capacity of farmers for increased production and productivity despite the low technical capacity.

The KRA aims to increase availability, accessibility and consumption of diverse, nutritious, safe and affordable foods throughout the food chain. Some of the interventions put in place include post-harvest management, value addition, and capacity building of communities to increase production. Additionally, there is need for Improved coordination, regulatory, legal, and policy environment and advocacy for resource mobilization for NSA activities.

Strategic Objective: Promote implementation of nutrition sensitive agriculture interventions in the food system

OUTPUT 6.1: Increased Utilization of diverse, safe and nutrient dense foods

Strategy: Capacity Building

Interventions

1. Awareness creation on utilization of diverse, safe and nutrient-dense food
2. Digital Market Information on diverse and nutritious foods
3. value addition and processing technologies for diverse and nutritious food
4. Promotion of energy saving technologies
5. Integration of NSA technologies in all major food and nutrition events/ days

Output 6.2: Enhanced knowledge management and dissemination of NSA practices

Strategy: Evidence generation on NSA

Interventions

1. dissemination of NSA Knowledge and practices
2. joint monitoring
3. periodic reviews

4. Promote behavioural change communication.

Output: 6.3 Enhanced synergy in implementation of NSA

Strategy: Multisectoral collaboration

Interventions:

1. Joint implementation of CANIS
2. Create awareness on CANIS to NSA actors at county and sub county levels

Output 6.4: Increased financial resource allocation for NSA activities

Strategy: Resource mobilization

Interventions:

1. Advocate for resource allocation for NSA both domestic and partners
2. Streamline co-creation with development and implementing partners.

2.7. Key Result Area 7: Nutrition integrated and strengthened across all levels of the health sector in the County

Mainstreaming nutrition interventions across all levels of care in the county provides a holistic approach to improve health outcomes. Currently, nutritionists offer services in level 5 and 4 hospitals, while leveraging the other cadres for level 3 and 2 health facilities, hence the need for capacity building of health workers to enhance nutrition service delivery at all relevant points of care. Nutrition representation at across all management levels is essential in ensuring equity in resource allocation and decision making.

Busia County has existing nutrition policies and guidelines that provide a solid foundation for integrating nutrition across all levels of health sector. Integrating nutrition in all points of healthcare service delivery and routine screenings will improve nutrition outcomes and the sustainability of services. However, weaknesses include limited financing, knowledge gaps among providers, inadequate human resource for health and frequent stock-outs of essential nutrition commodities which are among the six key pillars of quality healthcare. Opportunities include the growing momentum for nutrition advocacy and partnerships with the private sector, NGOs, and international agencies. These will improve nutrition technical capacity and leverage the electronic medical records for efficient data capture and tracking to boost efficiency and expand reach. Threats to these efforts include competing health priorities, political and economic instability, and high healthcare worker turnover that may disrupt funding, commitment, and capacity-building efforts.

This KRA aims to improve nutrition service delivery across all levels of care in the health sector and programs by fostering interdepartmental collaboration and upholding the quality of nutrition service.

Strategic Objective One: Strengthen nutrition service delivery at all levels of care

OUTPUT 1: Increased access to Nutrition services across health programs

Strategies: Service delivery

Interventions

1. Awareness creation among health care workers on nutrition assessment, counselling support, and Standard Operating Procedures in outpatient and inpatient settings
2. Integrate nutrition services in primary health care networks
3. Nutrition inclusivity in technical working groups.

2.8. Key Result Area 8: Enhanced integration of nutrition in the education sector.

Access to free and compulsory Education, basic nutrition, shelter and health care are basic rights

for all children. (Departmental report 2024). Nutrition integration in the education aims to reduce vulnerability to malnutrition. The county government developed school meals and nutrition policy and implementation guidelines for effective and efficient implementation of ECDE meals and nutrition program. The primary objective of the school feeding program is to alleviate short-term hunger with secondary benefits of increased enrolment, attention span and improved school attendance. (UNICEF, 2005)

The school meals and nutrition program have a monitoring and evaluation framework that documents the implementation status of the program.

Integration of nutrition in learning institutions requires robust advocacy among the political leaders to enhance the budgetary allocation. Partnership with development partners, civil societies and other key stakeholders optimizes utilization of the learning institution platform for delivery of nutrition interventions. Community engagement in nutrition programming enhances ownership and sustainability of the program. The current limiting factors such as inadequate funds, limited research and poor dietary habits further reduce efforts of integrating nutrition in learning institutions. This KRA focuses **on** enhancing implementation of school meals and nutrition programs and offering technical assistance in learning institution.

Strategic Objective: Integrate Nutrition in the Education Sector

OUTPUT 1: Mainstreamed nutrition interventions in learning institutions

Strategy: Advocacy

Interventions

1. Create awareness of the school meals and nutrition policy and implementation guidelines
2. Scale up Agri nutrition interventions in learning institutions
3. Integrate nutrition education within the institutions academic and co-curriculum programs
4. Joint monitoring and evaluation of nutrition activities in learning institutions
5. Increase the uptake of health and nutrition specific interventions in learning institutions
6. Workplace support for breastfeeding mothers within the learning institutions

OUTPUT 2: Consumption of nutritious and safe foods among ECDE learners

Strategies: School meals

Interventions

1. Provision of nutritious quality and safe foods for children in learning institutions
2. Upscale the number of days for meals provision in the ECDE centres
3. Awareness creation on school meals among stakeholders in education sector

2.9. Key Result Area 9: Enhanced integration of nutrition within Water, Sanitation, and Hygiene (WASH) sector.

Busia County faces significant public health challenges stemming from inadequate access to clean water and poor sanitation. The KRA aims to integrate nutrition within WASH (Water, Sanitation, and Hygiene) and environment sector in Busia County, where challenges like inadequate water supply, poor sanitation, and limited program impact contribute to public health issues such as malnutrition, diarrhoea and waterborne diseases. The county's clean water coverage is 60%, with urban access at 47% and rural access at 76.4%. Only 51% of the population has basic hand washing facilities, and 40% have improved sanitation. The urban sewerage coverage stands at just 0.6% (Busia CIDP 2022/2023-2026/2027). Improved access to clean water, better waste management and irrigation infrastructure are essential for reducing diseases and improving nutrition.

The WASH sector has potential to sustainably utilize available natural water resources, well-designed WASH programs and a skilled workforce to provide clean and safe water. Leveraging existing legislation on waste management, environmental conservation and international partnerships can significantly improve access to clean water and financing for WASH activities. Other opportunities include technological innovations (smart meters, GIS mapping, and solar pumping systems). Policy reforms and community engagement are key to strengthening regulations and empowering local stakeholders in water resource management. Despite available opportunities, inadequate infrastructure, aging water and sewage systems, limited financial resources, high non-revenue water losses illegal connections, low adoption of new technologies and land use conflicts in water catchment areas pose a great challenge to WASH service provision. Rising water demand, increasing water pollution, and climate change-related shock (prolonged dry spells and flooding) pose threat to access to quality WASH services.

Strategic Focus of this KRA is to improve access to clean water, strengthening governance, promoting sanitation, hygiene and behaviour change. There is evidence that WASH-nutrition linkages reduce malnutrition, waterborne diseases and foster healthier communities.

Strategic Objective I: increase proportion of population with access to adequate and safe water

OUTPUT 1: Increased access and use of clean and safe water

Strategy: water Infrastructure

Interventions

1. Advocate for the provision of clean and safe water to public facilities and institutions
2. Promote rainwater harvesting techniques
3. Promote the adoption of nutrition-sensitive water infrastructure designs
4. Promote the adoption of water treatment technologies in community water sources

OUTPUT 2: Improved management of water resource and systems

Strategy: water governance and leadership

Interventions

1. Community engagement in water management
2. Promote Nutrition sensitivity in water sector legal frameworks in the county

Strategic Objective II: Increase proportion of population with access to basic sanitation and hygiene services

OUTPUT 1: Increased awareness on sanitation and hygiene practices

Strategy: linkages

Interventions

1. Promote participation of nutrition actors in WASH forums
2. Awareness creation on hygiene practices and behaviour change
3. Integrate nutrition in WASH innovations
4. Integrate nutrition interventions into WASH
5. partnership in commemoration of Nutrition sensitive events and national days

2.10. Key Result Area 10: Nutrition integrated across Social Protection programmes.

Social protection is a set of programs and policies that aim to protect population from poverty, vulnerability and social exclusion. Household economic strengthening programs implemented in the social sector in collaboration with relevant county governments and stakeholders are skewed to few

vulnerable groups. The social safety net programs implemented in the county in collaboration with the national government target orphans and vulnerable children, persons with severe disability and older persons. A total of 11815 households with OVCs, 1620 persons with severe disability and 24898 older persons are on cash transfer to complement their nutritional needs.

Targeted beneficiaries have access to subsidized agricultural inputs for increased food production. Limited number of vulnerable households and individuals reached with social protection programs, delayed disbursement of funds and overdependence on donor-funded programs are some of the challenges affecting the social protection sector.

The strategic focus is to enhance multisectoral collaboration for resource mobilisation, strengthen M&E system for social protection program and enhance utilisation of single registry.

OUTPUT 1: Enhance multi-sectoral collaboration and partnership in implementation of nutrition and social protection programs

Strategy: Multi-sectoral coordination

Interventions

1. Mainstream nutrition into social protection and child welfare frameworks
2. Integration of nutrition into social protection projects

OUTPUT 2: Improved nutrition outcomes for social protection beneficiaries

Strategy: Service delivery

Interventions

1. Awareness creation among social protection stakeholders
2. Capacity building of frontline service providers

OUTPUT 3: Increased uptake of nutrition services among social protection beneficiaries

Strategy: Community engagements

Intervention

1. Create awareness on positive parenting
2. Behaviour changes communication information sharing
3. Advocate for model nutrition sensitive childcare facilities.

OUTPUT 4: Evidence-based nutrition programming for vulnerable populations

Strategy: Monitoring and Evaluation

Intervention

1. Utilization of single registry in program tracking
2. Incorporate nutrition data in monitoring and evaluation

2.11. Key Result Area 11: Enhanced sectoral and multisectoral nutrition governance, coordination, partnerships, advocacy and community engagement

Busia County aims to provide an optimal strategic approach to nutrition governance that effectively engages communities, aligns policies and programs, and leverages resources and expertise across various sectors. The county has established nutrition coordination structures that include County nutrition technical forum (CNTF), Sub County nutrition technical forums (SCNTF), County

agriculture sector steering committee (CASSCOM), Multisectoral team on nurturing care for early childhood development (MST-NCfECD), WASH forum for effective and efficient coordination and implementation of nutrition interventions. All the above coordination structures feed into the county multisectoral platform (MSP) for food and nutrition security.

The efficiency and effectiveness of the coordination structure builds on high level advocacy meetings, Partner support, Multisectoral development of CNAP II, CIDP 2022/23-2026/27, establishment of domestic resource mobilization (DRM) framework and Governor's manifesto. Use of mass media and social media for nutrition education and advocacy targeting the community complements the available opportunities. However, there is limited joint planning with the other sectors, lack of County Nutrition Policy, lack of County Nutrition Champions and delayed operationalization of MSP for food and nutrition security.

Low compliance with existing Domestic Resource Mobilization (DRM) commitments, Overreliance on partner support for nutritional activities and declining donor funding remains a major threat.

The focus of this KRA is to strengthen multisectoral coordination, improve nutrition financing, leadership and stakeholder engagements

Strategic Objective; Strengthen multi-sectoral nutrition governance, coordination, partnerships, advocacy and community engagement for optimum nutrition impact

OUTPUT 1: Effective sectoral and multi-sectoral collaboration and partnerships across levels

Strategy: Coordination, collaboration and partnership

Interventions

1. Engage in sectoral and multi-sectoral nutrition coordination structures at all levels
2. Advocate for operationalization of multi-sectoral platform for food and nutrition security
3. Mainstream joint multi-sectoral nutrition planning

OUTPUT 2: Increased nutrition financing across sectors

Strategy: Nutrition financing

Interventions

1. Adoption of domestic resource mobilization model (DRM) for nutrition financing
2. Advocate for enhanced county budget allocation for nutrition financing across departments

OUTPUT 3: Improved leadership skills among nutrition professionals

Strategy: Nutrition Leadership

Interventions

1. Advocate for leadership training programs opportunities for nutrition and dietetics officers
2. Lobby for creation of a directorate of nutrition and dietetics services
3. In-service capacity development

OUTPUT 4: Improved visibility of nutrition at levels of leadership and governance in the county

Strategy: Stakeholder engagement.

Interventions

1. Develop a pool of nutrition advocates in the county,
2. Engage national and local media for nutrition visibility
3. Develop nutrition communication strategy

2.12. Key Result Area 12: Strengthened sectoral and multisectoral Nutrition Information, M&E systems, learning, research, and Knowledge management

The KRA focuses on strengthening sectoral and multisectoral nutrition information, monitoring and evaluation, accountability, learning systems, research, and knowledge management. The goal is to enhance data collection, reporting, and analysis for evidence-based decision-making while ensuring collaboration among sectors and stakeholders. Key interventions include the adoption of a nutrition dashboard, periodic data quality audits (DQAs), mentorship for healthcare workers on data management, and dissemination of findings, factsheets, and reports. Efforts also include integrating nutrition into annual plans and a comprehensive evaluation of nutrition programs. Available routine reporting platforms for nutrition data are KHIS and ECHIS though with limitations on quality, completeness and timeliness. In 2023, only 39% of health facilities had nutrition data capture tools with no mentorships and capacity-building sessions on nutrition indicators in KHIS and eCHIS.

Availability of a comprehensive nutrition MEAL Framework, nutrition dashboard/scorecard and integration of nutrition into the annual sector plans enables tracking of nutrition indicators. Development of a nutrition investment case provided an opportunity to advocate for nutrition financing. Limitations in data collation is a major weakness across all sectors leading to low utilization of the nutrition data repository and tracking progress. Over-reliance on partner support pose a major threat to the continuity of services in the face of declining donor support.

Key focus for KRA 12 is comprehensive and accurate nutrition data capture, reporting and knowledge sharing for evidence-based decision making.

Strategic Objective: Enhance the quality, consistency, and utilization of nutrition data

Output 1: Improved data quality and reliability

Strategy 1: Nutrition documentation

Interventions

1. Dissemination of revised standards nutrition data collection tools
2. Enhance Nutrition Data Quality Audits (DQA)
3. Strengthen capacity of HCWs on use of KHIS and eCHIS
4. Develop standardized nutrition data-sharing protocols between sectors.

Output 2: Enhanced evidence generation and dissemination

Strategy 1: Evidence generation

Interventions Enhance knowledge generation

Strengthen knowledge dissemination and access

Strategy 2: Monitoring and Evaluation

Interventions

1. Strengthen periodic review of nutrition indicators across all sectors
2. Integrate nutrition in sector annual plans

2.13. Key Result Area 13: Enhanced Nutrition Capacity for improved service provision

Enhanced nutrition capacity encompasses strengthening the health system, improving nutrition policy environment, foster collaboration with academic institutions, skill development and encourage peer learning for improved nutrition services delivery

Training of nutrition workforce in management and leadership skills, availability of third-level colleges currently offering courses in Health Bridge the gap in nutrition capacity service delivery. Utilization of radio stations provided a platform for community nutrition education. Multisectoral collaboration scaled community reach on health and nutrition messages. Inadequate resources, weak M&E framework and weak succession management for skill and knowledge sustainability for staff are the negating factors to nutrition capacity for improved service delivery.

The strategic focus is to strengthen the capacity to institutionalize nutrition programs and policies, improve quality and delivery of nutrition services across all levels of care.

Strategic objective: Strengthen Nutrition Capacity Development

Output 1: Increased health workforce capacity and competency in nutrition services

Strategy 1: Policy and guideline

Interventions

1. Create awareness on the capacity development framework for nutrition
2. Advocate for the implementation of the capacity development framework

Strategy 2: Capacity and competency development

Interventions

1. Advocate for the recruitment of more nutrition personnel
2. Advocate for personnel training on management and leadership
3. Performance based management
4. Continuous training and skill building of personnel

2.14. Key Result Area 14: Strengthened Supply chain management for nutrition commodities and equipment

The cost of nutrition health products and technologies (HPT) is estimated at Kes. 350 million (county HPT, 2016) for optimal supply. Over the years procurement and distribution of these commodities is handled through specific programs managed by the national government via the Kenya Medical Supplies Agency (KEMSA). However, with the full devolution of health services, counties are now tasked with the procurement and distribution of nutrition commodities, just like other medical supplies. Although the county has progressively increased its funding for these items, delays in fund disbursement continue to affect the consistent availability of commodities at health facilities and undermine effective supply chain management

The nutrition unit has designated an officer within the Health Products and Technologies Unit (HPTU) to handle forecasting and quantification of nutrition commodities and equipment. In the 2023/2024 financial year, the county government allocated KES 3.5 million for the procurement of nutrition commodities and KES 3 million for nutrition equipment. UNICEF, through the Kenya Red Cross, has played a key role in supplying commodities, particularly for the inpatient treatment of severe acute malnutrition. Additionally, the Division of Nutrition, in collaboration with its partners, has continued to support the distribution of vitamin A supplements and the sharing of coverage data. The Health Information System (HIS) includes a reporting mechanism for tracking commodity data. However, inconsistency in budgetary allocation and knowledge gap among service providers on logistical management pose challenges to effective commodity management. Donor fatigue and close-out pose a great threat to the availability of commodities across the county. The disaster and emergencies within the county stretch on the commodities available, causing artificial shortages and increasing vulnerabilities.

This KRA focuses on streamlining supply chain management through capacity building, advocacy for commodity financing by the county government while leveraging on the existing partnership, to reduce stock outs at the health facility level for effective management of clients with nutritional needs. This will ensure there are sustainability measures for the continuity of supplies and maintenance of equipment.

Strategic Objective: Strengthen the supply chain management systems for nutrition health Products and Technologies.

OUTPUT 1: Increased knowledge, skills, and competence on the management of nutrition products and technologies among health care workers

Strategy: Capacity building

Interventions

1. Integrated commodity management training
2. Continuous knowledge and skill development on commodity management
3. Integrated commodity management surveillance.

OUTPUT 2: Enhanced Availability of Nutrition products and technologies in all health facilities

Strategy: Nutrition commodity supply chain management

Interventions:

1. Integration of nutrition commodities in the HPTU procurement plan
2. Advocate for adequate funding for nutrition HPTs.
3. Procure nutrition commodities
4. Supply and maintenance of nutrition HPTs in the CHP kit

OUTPUT 3: Streamlined data management of nutrition HPT**.**

Strategy: Monitoring and Evaluation

Interventions

1. Integrate nutrition HPT data in quarterly CNTF meetings
2. Maintain a database of nutrition HTPs

OUTPUT 4: Enhanced availability and functionality of anthropometric equipment in all health facilities

Strategy: Functional Nutrition equipment

Interventions

1. Procure nutrition equipment
2. Inventory management of nutrition equipment
3. Maintenance plan for nutrition equipment

CHAPTER THREE

Implementation and Coordination

3. CHAPTER FOUR

4.1 IMPLEMENTATION AND COORDINATION FRAMEWORK

This chapter details how each key result will be implemented by aligning strategies to intervention activities, expected output and the output indicators. It also details the baseline for the various interventions and the targets across the implementation period

4.1.1 Stakeholder mapping

There are several development and implementing partners in the space of nutrition-specific and nutrition-sensitive interventions operating within the county. The table below details the stakeholders' area of interest and current scope of coverage.

Table 41: Nutrition stakeholders' matrix

Partner	Area of interest	Scope of coverage
UNICEF	Maternal child health and nutrition WASH and nutrition Nutrition in child protection School health and nutrition Early childhood development Policy and legal framework environment Leadership and governance Nutrition in Emergency Management of acute malnutrition Nutrition commodity management Strategic documents development Budget Advocacy Social safety nets programmes	County
Kenya Red Cross	Nutrition in Emergency Nutrition and WASH Nutrition commodity management in emergency Livelihood Support Mental health and psychosocial support Sexual and GBV	County with special interest in Bunyala sub county
Nutrition international	Maternal new-born child and adolescent health and nutrition Policy and legal framework environment Budget advocacy	County
Community Empowerment Development Centre (CEDC)	Leadership and governance Nutrition financing through budget advocacy Partnership and coordination Public participation	County

Sustainable Agriculture foundation Africa	Agri nutrition interventions Community engagement Gender and youth engagement Policy and legal framework environment Leadership and Governance School Feeding Program	Four sub counties – Bunyala, Matayos, Nambale, Teso south
Scaling Up Nutrition Civil Society Organisation (SUN CSO) Busia Chapter	Community awareness creation Partnership and coordination Advocacy	County
Interreligious Council of Kenya Busia chapter	Public private partnership Awareness creation and community engagement Nutrition Advocacy Positive parenting	County
Kidogo Early years	Early childhood development Child nutrition	Matayos Sub County and Teso south
Child Fund	Early childhood development Community engagement Awareness creation	Bunyala sub county
World Vision	Child health and nutrition WASH School feeding program Agri-nutrition	Teso North and Samia sub county
Catholic Relief Services (CRS)	Awareness creation Promote PPPs	County
Evidence Action	WASH Deworming in schools	County
Dumisha Afya	Nutrition in HIV, TB, commodity management	County
Living Goods	Community health services	County
Self Help Africa (SHA)	Sustainable food systems WASH Market enterprise development Gender equity Strengthened policy regulatory environment	Teso North, Teso South, Butula, Nambale and Samia
Government line ministries and departments	Provide technical assistance and workforce	National County
Community	Avail land for food production Avail the community's resource persons Implement key nutrition interventions	community
Mainstream media and local FM	Awareness creation Community engagement	County

The prioritized interventions across the financial years will be integrated with the departmental annual work plans each year during the implementation period as per the lead department. The CNAP links with the priorities in the CIDP 2022/23-2026/27, ADPs, and AWPs for the Department of Health and Sanitation and other key line departments. The output indicators will be tracked annually through the monitoring and evaluation units in each department and shared in nutrition coordination structures at the county level.

4.2 COORDINATION FRAMEWORK

The coordination will be domiciled in the department of health and sanitation, linking to the county MSP once it is operationalized, which has supra decision-making powers in matters of food and nutrition security in the county as stipulated in the terms of reference. Departmental technical working groups will be linked to the MSP and meet every quarter to take stock of achievements, challenges and recommendations towards achieving the set targets, The MSP will be expected to meet biannually to deliberate on the reports shared by the various technical working groups in matters of food and nutrition security.

The implementation of the priorities will be executed by health care workers across cadres in health with leadership from the nutrition unit, community health extension workers, community health assistants, and the community health promoters as frontline service providers. The ECDE teachers, agriculture extension officers, child protection volunteers and other community resource persons in the community (lead mothers and fathers) will play a key role in the implementation of various interventions.

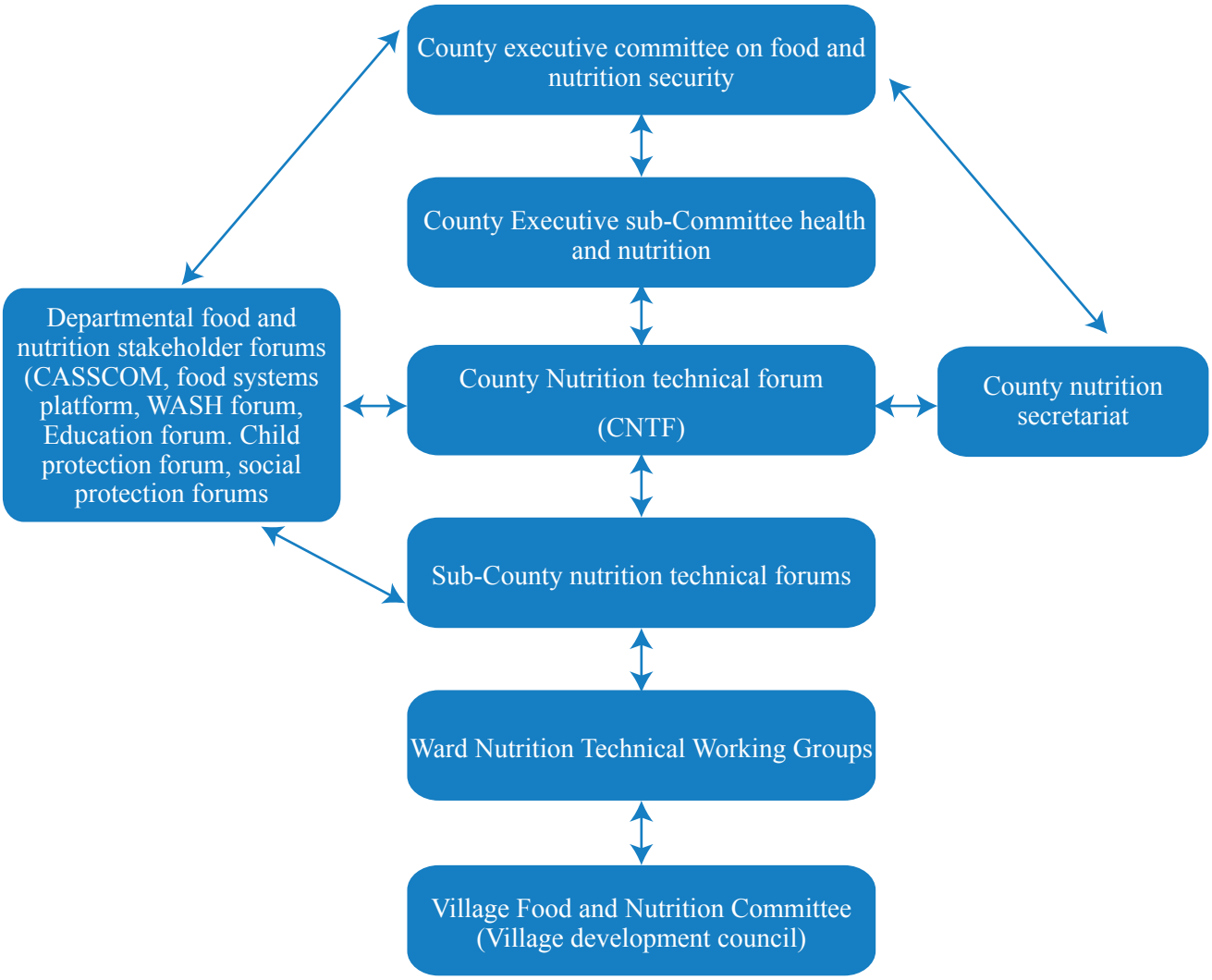

Figure 4.1: coordination structure

4.3 NUTRITION STAFF ESTABLISHMENT

Table 4-2 below indicates the nutrition staff establishment in Busia County.

Table 42: Nutrition staff establishment

Designation	GRADE/ JG	WHO NORMS & STANDARDS	AUTHORIZED ESTABLISHMENT	PROPOSED	GAP/VARIANCE (btw Authorized and Proposed)	IN-POST	ADJUSTED GAP/VARIANCE (btw Authorised and in post)
Deputy director nutrition and dietetics officer	R	1	1	1	0	0	1
Senior assistant director nutrition and dietetics officer	Q	1	2	2	0	0	2
Assistant director nutrition and dietetics officer	P	1	4	2	2	0	2
Principal Nutrition and Dietetics Officer	N	2	0	2	-2	3	-1
Chief nutrition and dietetics officer	M	4	0	2	-2	2	0
Senior nutrition and dietetics officer	L	8	0	8	-8	2	6
Nutrition And Dietetics Officer	K	14	206	16	190	4	12
Principal Nutrition and Dietetics Technologist	N		0	1	-1	0	1
Chief Nutrition and Dietetics Technologist	M		0	3	-3	2	1
Senior Nutrition and Dietetics Technologist	L		0	4	-4	3	1
Nutrition And Dietetics Technologist I	K		0	6	-6	6	0
Nutrition And Dietetics Technologist II	J		0	9	-9	5	4
Nutrition And Dietetics Technologist III	H	13	483	34	449	2	32
Senior Nutrition and Dietetics Technician	K		0	1	-1	1	0
Nutrition And Dietetics Technician I	J		0	1	-1	0	1
Nutrition And Dietetics Technician II	H		0	1	-1	1	0
Nutrition And Dietetics Technician III	G	6	324	63	261	0	63

Source: Department of health staff establishment 2025

4.4 RISK MANAGEMENT FRAMEWORK

Through a consultative process and the end-term review analysis, risk factor framework was developed to identify and manage potential challenges that could impede the implementation of this Action Plan. This framework categorizes and prioritizes risks based on their likelihood of occurrence and potential impact on program outcomes. It also outlines targeted mitigation strategies to enhance resilience and ensure successful delivery. The framework is summarized in the table below.

Table 43: Risk Management Framework

S/No	Type of risk	Risk	Risk likelihood (L/M/H)	Severity (L/M/H)	Overall Risk Level (L/M/H)	Mitigation Measures
1	**Political**	Political e.g. General elections	**M**	**M**	**M**	Strategic planning and contingencies enacted
		Governance risk factors e.g. weak political commitment and bureaucratic delays	**M**	**M**	**M**	Conduct advocacy targeting policy makers prioritizing nutrition
2	**Economic**	High poverty levels affect the households' purchasing power	**H**	**M**	**M**	Advocacy for social protection programs to support vulnerable population and
		Economic shocks like inflation and fluctuating food prices	**M**	**M**	**M**	Support local food production and reduce dependence on imported food
3	**Financial**	Insufficient funding and budget allocation	**M**	**M**	**M**	Strengthen partnerships with development partners, advocate for increased budgetary allocation and develop cost effective and phased work plans.

4	**Disasters**	Disasters e.g. pandemics, locust invasions, prolonged dry spells, floods, hailstorms	**L**	**H**	**M**	Use of digital tools for monitoring, collaboration, communication and knowledge sharing. Preparedness, risk mitigation and Response planning and support to preposition some supplies.
5	**Operational**	Inadequate Human Resources	**M**	**M**	**M**	Skills mapping to identify gaps Recruitment and training
		Poor data and monitoring systems	**M**	**H**	**M**	Invest in digital data collection tools and dashboards
6	**Socio-cultural**	Cultural beliefs and practices	**L**	**M**	**M**	Use CHPs to drive behaviour change
		Gender Inequalities	**M**	**M**	**M**	Empower women through trainings Include men in nutrition education to shift household decision making dynamics
7	**Technological**	Slow adoption of technological changes	**L**	**L**	**L**	Advocacy and resource Mobilization for Research and proof of concept working with research institutions and academia.
8	**legal**	Legal challenges	**M**	**L**	**M**	Enforcement of nutrition related laws like food safety, fortification and marketing of breast milk substitutes
9	**Environment/ climate**	Environmental: global and local e.g. climate change impact	**M**	**H**	**M**	Advocacy for Interventions on resilience.
		Inadequate legislation and policy framework	**M**	**L**	**M**	Review of legislation and policies

CHAPTER FIVE

Costed Implementation Plan and Mobilization Strategies

5. CHAPTER FIVE:

5.1 COSTED IMPLEMENTATION PLAN AND MOBILIZATION STRATEGIES

This chapter details the financial resources required for implementation of prioritized interventions in the document for the financial years 2023/24 -2027/28. It also provides the approximated available resources across the departments as per the CIDP and potential partner contribution. The chapters also provide possible strategies in mobilization of financial resources within the county government and stakeholders in the field of nutrition

Table 51: CNAP Resource requirements

KEY RESULT AREA	ANNUAL COST OF IMPLEMENTATION IN KENYA SHILLINGS				
	2024/25	2025/26	2026/27	2027/28	TOTAL BUDGET
Key Results Area 1: Maternal, Infant, and Young Child (MIYC) nutritional well-being enhanced.	8,164,000.00	10,296,000.00	9,512,000.00	2,401,000.00	**30,373,000.00**
Key Result Area 2: Improved nutritional well-being of older children, adolescents, adults, and older persons.	30,500.00	17,532,000.00	12,424,840.00	15,077,220.00	**45,064,560.00**
Key Result Area 3: Enhanced surveillance on Industrial Fortification and promotion of fortified and biofortified foods	1,686,000.00	14,601,453.00	7,018,453.00	6,688,194.00	**29,994,100.00**
Key Result Area 4: Enhanced clinical nutrition and dietetic services across all levels of health care.	6,921,600.00	13,358,350.00	13,814,850.00	6,957,600.00	**41,052,400.00**
Key Result Area 5: Sustained nutritional well-being of individuals and communities during emergencies and climate-related shocks.	3,172,000.00	3,172,000.00	3,172,000.00	3,172,000.00	**12,688,000.00**
Key Result Area 6: Enhanced integration of nutrition into agriculture, livestock, fisheries and agribusiness sectors.	5,073,000.00	7,473,000.00	5,073,000.00	5,003,000.00	**22,762,000.00**
Key Result Area 7. Nutrition integrated and strengthened across all levels of the health sector in the county.	1,694,060.00	2,174,060.00	1,694,060.00	2,174,060.00	**7,736,240.00**
Key Result Area 8: Enhanced integration of nutrition in the education sector.	12,112,000.00	12,862,000.00	12,112,000.00	12,112,000.00	**49,198,000.00**
Key Result Area 9: Enhanced integration of nutrition within the Water, Sanitation, and Hygiene (WASH) sector.	1,179,500.00	1,599,500.00	1,149,500.00	1,149,500.00	**5,078,000.00**

Key result Area 10: Nutrition integrated across Social Protection programs.	-	12,526,317.60	11,481,211.20	10,975,111.20	**34,982,640.00**
Key Results Area 11: Enhanced sectoral and multisectoral nutrition governance, coordination, partnerships, advocacy and community engagement.	2,403,600.00	6,206,100.00	2,403,600.00	1,652,300.00	**27,536,300.00**
Key Result Area 12: Strengthened multisectoral Nutrition Information, M&E systems, research and Knowledge management.	6,420,000.00	8,232,000.00	8,155,000.00	8,654,500.00	**31,461,500.00**
Key Result Area 13: Enhanced Nutrition Capacity development for improved service provision.	1,928,625.00	2,735,765.00	2,244,765.00	2,745,345.00	**9,654,500.00**
Key Result Area 14: Strengthened Supply chain management for nutrition commodities and equipment	48,360,000.00	49,489,550.00	55379550.00	50103900.00	**203,333,000.00**
TOTAL	**99,144,885.00**	**162,258,095.60**	**145,634,829.20**	**128,865,730.20**	**550,914,240.00**

5.2 AVAILABLE RESOURCES AND PROJECTED RESOURCES

The table below is an excerpt from the current county budget projection for department of health and sanitation and key nutrition sensitive departments. However, these are not sure commitments but just budgetary estimates that are subject to change depending on what the county collects for a given financial year. The budget items listed has either a direct or indirect effect to implementation of the county prioritized nutrition interventions in the CNAP. The estimated budgetary contribution of non-governmental stakeholders listed in *table 4.1* could not be documented.

Table 5.2: estimated departmental resource envelope

	REVISED BUDGET	PROJECTION		
BUDGET ITEM	**FY 2024-2025**	**FY 2025-2026**	**FY 2026-2027**	**FY 2027-2028**
SMART, AGRICULTURE, LIVESTOCK, FISHERIES, BLUE ECONOMY & AGRIBUSINESS				
Crop Development (Inputs)	46,000,000.00	50,600,000.00	55,660,000.00	61,226,000.00
Food & Horticulture Crop Development	4,000,000.00	4,400,000.00	4,840,000.00	5,324,000.00
County wide small holders fish farmers support project	22,163,872.00	24,380,259.20	26,818,285.12	29,500,113.63
Aqua-Culture Business development project	1,000,000.00	1,100,000.00	1,210,000.00	1,331,000.00
Kenya livestock commercialization project	5,000,000.00	5,500,000.00	6,050,000.00	6,655,000.00
Sub -Total	**78,163,872.00**	**85,980,259.20**	**94,578,285.12**	**104,036,113.63**
EDUCATION & INDUSTRIAL SKILLS DEVELOPMENT				
School Meals Nutrition intervention project	27,887,151.00	30,675,866.10	33,743,452.71	37,117,797.98
Sub -Total	**27,887,151.00**	**30,675,866.10**	**33,743,452.71**	**37,117,797.98**
YOUTH, SPORTS, CULTURE, GENDER, CREATIVE ARTS & SOCIAL SERVICES				
Community Sensitization & Stakeholder Engagement on Child Protection	500,000.00	550,000.00	605,000.00	665,500.00
Support to vulnerable groups	1,000,000.00	1,100,000.00	1,210,000.00	1,331,000.00
Sub -Total	**1,500,000.00**	**1,650,000.00**	**1,815,000.00**	**1,996,500.00**
HEALTH SERVICES & SANITATION				
Food & Ration	54,628,721.00	60,091,593.10	66,100,752.41	72,710,827.65

Nutrition Services County Contribution	12,000,000.00	13,200,000.00	14,520,000.00	15,972,000.00
School Health Programme	505,869.00	556,455.90	612,101.49	673,311.64
Supplementary feeds for children	400,540.00	440,594.00	484,653.40	533,118.74
Sub -Total	**67,535,130.00**	**74,288,643.00**	**81,717,507.30**	**89,889,258.03**
WATER, ENVIRONMENT, IRRIGATION, NATURAL RESOURCES &CLIMATE CHANGE				
Urban Water Infrastructure	18,945,000.00	20,839,500.00	22,923,450.00	25,215,795.00
Rural Water Infrastructure	289,434,310.00	318,377,741.00	350,215,515.10	385,237,066.61
Operations & Maintenance of water Systems	14,338,369.00	15,772,205.90	17,349,426.49	19,084,369.14
Catchment Conservation (bamboo)	1,925,000.00	2,117,500.00	2,329,250.00	2,562,175.00
Protection of Springs	6,395,000.00	7,034,500.00	7,737,950.00	8,511,745.00
Climate Change -County Contribution	52,000,000.00	57,200,000.00	62,920,000.00	69,212,000.00
Irrigation Farmer Institution Support Service	3,925,275.00	4,317,802.50	4,749,582.75	5,224,541.03
Sub -Total	**324,642,679.00**	**357,106,946.90**	**392,817,641.59**	**432,099,405.75**
GRAND TOTAL	**499,728,832.00**	**549,701,715.20**	**604,671,886.72**	**665,139,075.39**

Source: County revised budget estimate 2024/2025

5.3 RESOURCE MOBILIZATION STRATEGIES

Resources mobilization will be done through the following mechanisms:

1. County Government Budget Allocation

Prioritizing nutrition interventions in the County Department of Health and Sanitation budget and other relevant sector budgets (e.g., agriculture, education, water and sanitation, social protection).

Ring-fencing and progressively increasing allocations for nutrition programs within annual county budgets.

2. National Government Support

Leveraging technical and financial support from the Ministry of Health and other national agencies through grants, conditional transfers, and nutrition-specific funding windows.

3. Development Partners and Donor Funding

Engaging bilateral and multilateral development partners (e.g., UNICEF, Nutrition International, WHO, World Bank, WFP) to secure technical assistance, grants, and programmatic funding aligned with CNAP priorities.

4. Public-Private Partnerships

Establishing partnerships with the private sector, including food industries, agribusinesses, and local enterprises, to support nutrition-sensitive value chains, food fortification initiatives, and health promotion campaigns.

5. Civil Society Organizations and Faith-Based Organizations

Collaborating with NGOs, CBOs and faith-based groups already implementing nutrition or related programs to leverage additional resources and scale up interventions.

6. Resource Mobilization Committees

Strengthening the CNTF to act as a platform for coordinated resource mobilization, resource tracking, and joint planning for CNAP implementation.

7. Advocacy for Increased Investment in Nutrition

Sustained advocacy targeting county leadership, the County Assembly, development partners and other decision-makers to prioritize nutrition as a key driver of economic growth and human development.

8. Community resource mobilization

Map and mobilize community resources to support nutrition interventions.

9. Inter-county collaboration

Inter-county shared nutrition action plans and cross county monitoring of nutrition activities

5.4 FUNDING OPPORTUNITIES AND RESOURCE MOBILIZATION STRATEGIES FOR CNAP

- The implementation of CNAP will be financed by the county government across the key line departments and stakeholders within the public and private sector.
- Advocacy for institutionalization of domestic resource mobilization model with development and implementing partners.
- Joint planning and implementation to foster efficient and effective resource management
- Development of memorandum of understanding with partners to strengthen partnership and collaboration
- Public participation and community engagement in project designs and implementation to enhance community contribution both in cash and kind.

5.5 Resource management Strategies

- Transparency and accountability in resource utilization, including financial tracking through application of UNICEF's standard financial tracking tools geared towards improving financial management.
- Development of investment case as an advocacy tool for resource allocation from the county government and stakeholder.

CHAPTER SIX

Monitoring, Evaluation, Accountability and Learning (MEAL) and Reporting Framework

6. CHAPTER SIX:

6.1 CNAP MONITORING, EVALUATION, ACCOUNTABILITY AND LEARNING (MEAL) AND REPORTING FRAMEWORK

This section outlines the Monitoring, Evaluation, Accountability, and Learning (MEAL) framework for the Busia County Nutrition Action Plan (CNAP II) 2023/24–2027/28. It provides a comprehensive structure for tracking implementation progress, ensuring accountability, supporting evidence-based decision-making, and promoting continuous learning among all stakeholders.

The CNAP II MEAL framework aims to achieve the following objectives:

1. Continued progress monitoring and reporting through regular and systematic tracking of implementation activities and results.
2. Align stakeholder resources and actions to strengthen multisectoral nutrition interventions and foster coordinated service delivery.
3. Promote evidence-based decision-making through timely availability and effective dissemination of high-quality actionable data.
4. Facilitate learning and institutional memory through the documentation of lessons learned.
5. Promoting adaptive management and integration of research and training into program implementation.

6.2 MONITORING FRAMEWORK

The monitoring of the CNAP II implementation will be spearheaded by the Department of Health Services and Sanitation, working in close collaboration with relevant line departments, sub-county health management teams, implementing partners and other stakeholders. Monitoring will be through various laid down coordination structures at all levels of operation and culminate at the CNTF level who cascade to the MSP for informed decision making on areas that need legislations or executive orders/decisions.

1.1.1 Routine Data Collection and reporting

Data collection and reporting will rely on established systems, particularly Kenya electronic medical records (KEMR), Kenya Health Information System (KHIS), electronic Community Health Information System (eCHIS), and other digital platforms.

1.1.2 Supportive Supervision

Joint sectoral and multisectoral supportive supervisions will be conducted periodically and leverage the quarterly joint supportive supervision undertaken by CHMT, SCHMT, and development partners. These visits will:

1. Validate reported data,
2. Assess service quality,
3. Monitor compliance with set standards,
4. Provide on-site mentorship to frontline workers.

During the supervisory visits standardized/ harmonized tools aligned with CNAP II performance indicators will be used. Findings/ observations will be documented and tracked for follow-up.

6.3 REPORTING FRAMEWORK AND FEEDBACK MECHANISM

Effective oversight and accountability in the implementation of the Busia County Nutrition Action Plan (CNAP II) 2023/24–2027/28, requires a comprehensive reporting framework and feedback mechanism that will be established by the nutrition unit. This framework will be operationalized

through annual work plans involving multi-layered reporting and evaluation by utilizing prescribed templates to ensure consistency and comprehensiveness.

1.1.3 Quarterly Progress Report

Quarterly progress reports will be shared at County Nutrition Technical Forums (CNTFs) involving stakeholders from sectors including Health, Agriculture, Education, Water and Sanitation, and Social Services. Reports will document:

- Key activities implemented, achievements, and emerging challenges,
- Progress against Common Results and accountability Framework indicator targets.
- Financial and human resource utilization.
- Findings from supportive supervision visits.
- Partner-specific contributions and innovations.
- Community feedback from participatory platforms.
- Action points and recommendations to address gaps and improve outcomes.

Quarterly reports will provide updates based on the Quarterly Progress Reporting Template below These reports will be instrumental in tracking the timely delivery of activities and utilization of allocated resources.

Table 6.1Quarterly Progress Reporting Template

Expected output	**Output indicator**	**Annual Target**	**Quarterly for Year**	**Cumulative to Date**	**Remarks**
			Target	Actual	Variance

Annual Progress Report

Annual review forums will bring together county and sub-county stakeholders to evaluate progress against set targets. These sessions will:

- Analyse trends in performance data.
- Identify implementation gaps.
- Showcase best practices and lessons learned.
- Recommend adjustments to improve efficiency and relevance.

Annual Work Plan reports will comprehensively assess the achievements and outcomes of CNAP interventions over the course of each year, utilizing the Annual Progress Reporting Template below:

*Table 6.1A*nnual Progress Reporting Template

Expected output	**Output Indicator**	**Achievement for years**	**Cumulative to Date (Years)**	**Remarks**
		Target	Actual	Variance

Evaluation Reports

Evaluation reports will be based on the following.

1. *Mid-term review*

The Mid-Term Review will assess progress toward targets and recommend adjustments to programmes and projects as needed for the remaining CNAP period.

2. *End-of-Term Review*

At the end of the strategic plan period, a final review will evaluate achievements, identify challenges, and provide recommendations for future planning.

Both reviews will be done using the evaluation templates below

Table 6.1 Outcome Reporting Template

Key Result Area	Outcome	Outcome Indicators	Baseline	Mid-Term Evaluation	End of Plan Period Evaluation	Remark	Corrective Intervention
			Value	Year	Target	Achievement	Target

1.1 COMMON RESULTS AND ACCOUNTABILITY FRAMEWORKS

The Common Results and Accountability Framework (CRAF) is a critical tool designed to guide and measure the implementation of the County Nutrition Action Plan (CNAP II 2023/24–2027/28). It provides a structured results-based framework that aligns strategic objectives, outcome indicators, and targets, enabling continuous tracking of progress and fostering a culture of accountability and performance-based management.

Table 6.11CRAF Matrix

S/N	Framework for Targets	Expected Results (Targets customized for Busia County)	Objectively Verifiable Performance Indicators	Baseline Value (Busia County, Source/Year)	Target (2027/28)	Means of Verification	Accountable Organization(s)
1	WHA Target 1	Reduce stunting among children under five by 40%	Prevalence of stunting (%)	15% (KDHS 2022)	9%	KDHS, KHIS	CDOHS, CHMT, KNBS
2	WHA Target 2	Reduce anaemia in women of reproductive age by 30%	Prevalence of anaemia in women 15-49 years (%)	30.3% (KDHS 2022)	21%	KDHS, KHIS	CDOHS, CHMT
3	WHA Target 3	Reduce low birth weight by 30%	% of births <2.5kg	8.5% (KDHS 2022)	6%	KDHS, KHIS	CDOHS, CHMT
4	WHA Target 4	No increase in overweight/ obesity among children <5 years	Prevalence of overweight/ obesity in under-5s (%)	3.2% (KDHS 2022)	<4%	KDHS, KHIS	CDOHS, CHMT
5	WHA Target 5	Increase exclusive breastfeeding rates to 75%	Prevalence of EBF 0-6 months (%)	59.9% (KDHS 2022)	75%	KDHS, KHIS	CDOHS, CHMT
6	WHA Target 6	Reduce and maintain wasting to <4%	Prevalence of wasting (%)	2.8% (KDHS 2022)	< 2.8%	KDHS, KHIS	CDOHS, CHMT

7	NFNSP-IF	Reduce underweight prevalence to <10%	Prevalence of underweight (%)	6.3% (KDHS 2022)	<6%	KDHS, KHIS	CDOHS, CHMT
8	NFNSP-IF	Maintain mortality <2% for MAM, <10% for SAM	% mortality in IMAM programs	MAM: 0.2%; SAM: 1.7% (KHIS 2022)	MAM: <1%; SAM: <2%%	KHIS	CDOHS, CHMT
9	NFNSP-IF	Reduce anaemia in children 6-59 months by 30%	Prevalence of anaemia in under-5s (%)	26% (KNMS 2011 est.)	18%	KNMS, KDHS	CDOHS, CHMT
10	NFNSP-IF	Reduce anaemia in pregnant women by 40%	Prevalence of anaemia in pregnant women (%)	36% (KNMS 2011)	22%	KNMS, KDHS	CDOHS, CHMT

1.2 EVALUATION FRAMEWORK

Evaluation of CNAP II will be conducted through two main phases:

1.2.1 Annual Review (2025/26, 2026/27, 2027/28)

This will assess the progress made towards key milestones, identify challenges, and inform mid-course adjustments. The annual review will involve desk reviews, field assessments, and stakeholder consultations.

1.2.2 End-Term Evaluation (2027/28)

The final evaluation will measure the effectiveness, efficiency, sustainability, and impact of the CNAP II interventions. It will employ a mixed-methods approach, including household surveys, facility assessments, and stakeholder interviews.

Both evaluations will be led by the County Department of Health with technical support from partners and independent evaluators to ensure objectivity.

ANNNEX I

ANNEX I

7.1 outcome matrix

Table 71: Outcome matrix

Key Result Area	Outcome	Outcome Indicator	Baseline		Target Verification		Means of	Sources of Data
KRA 1: Maternal and infant and young child (MIYC) nutritional well-being enhanced	**Outcome1:** Improved care, practices and services for enhanced maternal infant and young child nutrition	**Indicator 1:1**: % of WRA who meet the minimum dietary diversity for women (MDDW)	41.2	2022	47	50	Survey data activity reports	KDHS, KABP Survey
		Indicator 1.2: % of infants < 6 months who are exclusively breastfed	59.7	2022	70	80	Survey data activity reports	KDHS, KABP Survey
		Indicator 1.3: % of children 6 - 23 months who are stunted	15	2022	13	10	Survey data activity reports	KDHS, KHIS
		Indicator 1.4: % of children 6-23 months who are wasted	2.8	2022	2.5	2	activity reports, survey data	KDH
Key Result Area 2: Improved nutritional well-being of older children, adolescents, adults, and older persons.	Outcome 2: Improved nutrition status of older children, adolescents, adults and older persons	**Indicator 2.1**: proportion of underweight men (15-19)	38.20%	2022	37%	35%	survey report	KDHS
		indicator 2.2: proportion of overweight women (20-49)	68%	2022	65%	60%	survey report	KDHS
		Indicator 2.3: Proportion of clients attending outpatient with BMI above 25	0%				monthly report	KHIS
		Indicator 2.4: Proportion of women consuming unhealthy foods	33.90%	2023	32%	31%	survey report	KDHS

Key Result Area 3: Enhanced surveillance of Industrial Fortification and promotion of fortified and biofortified foods	Outcome 3: Reduced rate of micronutrient deficiencies	**Indicator 3.1**: Proportion of pregnant women with HB<11g/dl	33.90%	2022	32%	31%	survey report	KDHS
		Indicator 3.2: proportion of households consuming iodized salt	100%	2022	100%	100%	survey report	Surveillance reports KDHS
		Indicator 3.3:ISO certified food safety lab	0	2023	1	1	survey report	County report
Key Result Area 4: Enhanced clinical nutrition and dietetics services across all levels of health care	**Outcome: 4** Improved clinical nutrition and dietetic services for prevention and control and management of nutrition related conditions.	**Indicator 4.1**: Number of health facilities with capacity for IMAM service delivery (inpatient and outpatient)	16	2023	22	27	Monthly reports	KHIS
		Indicator 4.2: cure rate of >75%	0	2023	> 75%	>75%	Monthly report	KHIS
		Indicator 4.3: Death rate < 3%	0	2023	< 3	<3	Monthly	KHIS
		Indicator 4.4: Proportion of inpatients receiving nutrition assessments and individualised feeding plans within 24 hrs of admission	0	2023	70	100	Survey	Departmental report
KRA 5: Sustained nutritional well-being of individuals and communities during emergencies and climate related shocks	Outcome 5: Improved community and individual resilience to climate related shocks and emergencies	**Indicator 5. 1;** Proportion of funding received for the nutrition contingency plan	0%	2024	35%	70%	CGB-MOH	Program Reports
		Indicator 5.2: Recovery rate of malnourished individual during emergency	0%	2024	50%	70%	CGB-MOH	Reports

KRA 6: Enhance integration of nutrition into Agriculture, livestock, agribusiness and fisheries sector	Outcome 6: Increased access and utilization of diverse, safe and nutrient dense foods	**Indicator 6.1.:** Proportion of the households consuming diverse, safe, and nutrient-dense foods	505	2022	70%	80%	Survey report	Departmental Survey reports
		Indicator 6.2.: Proportion of households meeting the Minimum Dietary Diversity Score (MDDS)	50%	2022	70%	80%	Reports Reports on food items, consumer info report	Departmental reports (Agriculture)
.								
		Indicator 6.3.: Proportion of the households utilizing energy saving technologies	20	2019	50%	70%	KNBS	Census Report
KRA 7. Nutrition integrated and strengthened across all levels of the health sector in the county	Outcome 7: Mainstreaming nutrition services at all levels of care	**Indicator 7.1**.: % of clients receiving nutrition services	0	2023	50%	80%	Routine report	KHIS
		Indicator 7.2.: % of households visited by CHPs receiving nutrition information	5%	2022	-	50%	Survey report Partners	KDHS
KRA 8: enhanced integration of nutrition in the education sector	Outcome 8: Enhanced nutrition interventions within the education sector	Indicator 8.1: Proportion of children 6-59 months receiving 2 doses of vitamin A	81.9	2023	-85	98-	Routine report	KHIS
		Indicator 8.2: Proportion of 12-59 months dewormed2	31%	2022	60%	80%	Survey	KHIS

KRA 9. Enhanced integration of nutrition within the Water, Sanitation and Hygiene (WASH) sector.	Outcome 9: Increased access to improved nutrition sensitive WASH services	**Indicator 9.1**: % of population with access to clean and safe water	57%	2022	65%	70%		KDHS
		Indicator 9.2 % of households consistently appropriate water treatment methods	63.80%	2022	75%	100%	Survey Report	KDHS
		Indicator 9.3: % of population with access to Improved sanitation facilities	55.40%	2022	60%	65%	Survey Report	KDHS
		Indicator 9.4: % of population with access to basic hand washing Facilities.	62.30%	2022	90%	100%	Survey Report	KDHS
KRA 10: Nutrition integrated across Social Protection programs.	Outcome 10: Improved care, practices and services for enhanced nutrition status for vulnerable population	**Indicator 10.1**: % of Vulnerable household on Safety Net programmes	46%	2019	53%	60%	Survey	KNBS/CCTPIMS

Key Results Area 11: Enhanced sectoral and multisectoral nutrition governance, coordination, partnerships, advocacy, and community engagement	Outcome 11: Improved sectoral and multisectoral nutrition governance, coordination, partnerships, advocacy, and community engagement	**Indicator 11.1:** Functional multi-sectoral platform for food and nutrition security	0	2023	1	1	Depart. of Health and, Other key Line Departments & Ministries at County Level	Quarterly and Annual Program Reports
		Indicator 11.2: Percentage (%) of County Budget allocated to Nutrition interventions across Departments	2	2023	3.5	5	Depart. of Health and, Other key Line Departments & Ministries at County Level	Approved County Budget estimates
KRA12: Strengthened sectoral and multisectoral Nutrition Information, Monitoring &Evaluation, learning, research systems, and Knowledge management.	**Outcome 12:** Enhanced sectoral and multisectoral nutrition information systems, robust monitoring and evaluation frameworks, increased research uptake, and effective knowledge management.	**Indicator 12.1:** Percentage of health facilities submitting complete and timely nutrition reports through the DHIS 2 system	39%	2023	70%	100%	Reports	KHIS

KRA 13: Enhanced Nutrition Capacity development for improved service provision.	**Outcome 13:** Improved capacity for human resource for nutrition and specialization	**Indicator 13.1** Percentage of nutritionists that completed accredited management and leadership training programs	16%	2023	25%	48%	HR reports	Department of Health
		Indicator 13.2: Established functional Nutrition Directorate	0	2023	0	1	Nutrition Unit Report	Department of Health
		Indicator 13.3: Nutrition Staff to population served ratio	1:33483	2023	1:23066	1:15969	Human resource report	Department of Health
KRA 14: Strengthened supply chain management for nutrition commodities and equipment	**Outcome 14**: Consistent sustained supply of nutrition commodities and equipment	**Indicator 14.1**: Percentage of health facilities without stock outs of essential nutrition commodities	10	2024	40	90	Monthly reports, HPTU	Department of health

ANNEX II

1.2 ANNEX II

7.2 Implementation matrix

Table 72 Implementation matrix

strategy	Interventions	Key Activities	Expected Outputs	Output Indicators	Targets for 5 years	Target					Budget (Kshs. Mn)					Responsibility	
						2023/24	2024/25	2025/26	2026/27	2027/28	2023/24	2024/25	2025/26	2026/27	2027/28	Lead	Support
Strategic Issues: The persisting challenge of undernutrition, overweight/obesity, and micronutrient deficiencies among mothers, infants, and young children compounded by sub-optimal feeding practices and characterised by significant regional disparities.																	
Strategic Goals: To enhance maternal, infant, and young child nutrition and prevent undernutrition.																	
KRA 1: Maternal, Newborn, Infant, and Young Child (MNIYC) nutritional well-being enhanced.																	
Outcome 1: Improved care practices and services for enhanced maternal, infant, and young child nutrition and undernutrition prevented.																	
Strategic Objective 1.1: Enhance maternal, infant and young child nutrition status in the county																	
Advocacy for MIYCN policy, legal and regulatory environment.	Create awareness on MIYCN policy summary statement, MIYCN strategy, BMS Act 2012 and its regulation 2021, Workplace Support for breastfeeding mothers.	Sensitize and Disseminate MIYCN policy summary statement, MIYCN strategy, BMS Act 2012 and its regulation 2021, Workplace Support for breastfeeding mothers and growth standards to all policy makers	Strengthened MIYCN policy, legal and regulatory environment	No. of policy makers (CECMs, COs, CDs, CHMT, HMT, and SCHMT Sensitized on MIYCN policy summary statement, BMS Act 2012 and its regulation 2021and Workplace Support for breastfeeding mothers and growth standards.	320		80	80	80	80	-	240,000	300,000	240,000	300,000		

		Dissemination of breastfeeding policies		No of breastfeeding policies disseminated (MIYCN policy statement, BMS act 2012, It's regulation of 2012 and workplace support for breastfeeding	4			4			0	0	0	0	0		
		Establish breastfeeding corners in both formal workplaces.		No of breastfeeding corners established in formal workplaces.	7		2	2	2	1	-	252,000	252,000	252,000	84,000		
		Establish breastfeeding corners in non-formal workplaces		No of breastfeeding corners established in informal workplaces.	7		2	2	2	1	-	420,000	420,000	420,000	140,000		
Capacity building on (MIYCN) Maternal infant and young child nutrition initiatives.	Develop a pool of TOT in MIYCN (MIYCN, MIYCN-e, BFHI, BFCI) and VAS +D	Train TOTS in MIYCN, MIYCN-e, BFHI. BFCI)	Enhanced knowledge, skills and competence on MIYCN initiatives among HCWs, CHPs and nutrition stakeholders	No. of TOTs trained in MIYCN (MIYCN, MIYCN-e, BFHI, BFCI) and VAS + D	30			30			-	-	1,587,000	-	-		
0	Strengthen the capacity of Health Care Workers service delivery on MIYCN initiatives (HCWs) on MIYCN (MIYCN, MIYCN-e, BFHI, BFCI, CBFI, BMS Act, Breastfeeding workplace Support)	Train HCWs on MIYCN, NIYCN, e, BFHI, BFCI, BMS ACT	0	No of Health Care Workers (HCWs) trained on MIYCN (MIYCN, MIYCN-e, BFHI, BFCI, CBFI, BMS Act, Breastfeeding workplace Support)	280		70	70	70	70	0	3590000	5860000	0	0		

0	Strengthen the capacity Health Care Workers (HCWs) on delivery of micronutrient supplementation in young children and women (VAS+D and IFAS)	Train health care workers in VAS +D	0	No of Health Care Workers (HCWs) trained on micronutrients (VAS+D and IFAS	360				360		0	0	0	4938000	0		
0	Mainstream growth monitoring and promotion, VAS+D within the community structures	Sensitize CHAs on growth monitoring and promotion and VAS +D	0	No of CHAs sensitized on growth monitoring and promotion, VAS+D.	1920		960		960		0	712000	0	712000	0		
		Sensitize CHPs on growth monitoring and promotion and VAS +D		No of CHPs sensitized on growth monitoring and promotion, VAS+D.							0	1073000	0	1073000	0		
Accessible quality maternal, Infant and Young Child nutrition services	Scale up health facilities at all levels to carry outgrowth monitoring, nutrition education and counselling for Infants and young children on optimal breastfeeding and complementary.	On site mentorship/ OJT to facility staff on growth monitoring and promotion, nutrition education and counselling for infants and young children on optimal breastfeeding and complimentary feeding	Increased access to quality nutrition care for PLWS and children 0-59 months)	percentage of health facilities at all levels reporting in MOH 711	16.5		4.2	4.1	4.1	4.1	0	160000	160000	160000	160000		
0	Scale up health facilities at all levels to carry out VAS +D to children under 5 years.	On site mentorship and OJT on VAS +D to children 6-59months to facility staff	0	percentage of health facilities at all levels carrying out VAS +D to children under 5 years.	35.7		8.9	8.9	8.9	8.9	0	240000	240000	240000	240000		

0	Scale up IFAS and deworming uptake among pregnant women at all levels	On site mentorship and OJT on IFAS to Pregnant women to facility staff.	0	percentage of health facilities carrying out IFAS and deworming among pregnant women	16.5		4.2	4.1	4.1	4.1	0	240000	240000	240000	240000		
0	Create awareness to PLWs on importance of consuming diversified foods to address micronutrient deficiencies at community level	Conduct nutrition dialogue days	0	No of PLWs reached with information on importance of consuming diversified foods.	3200		800	800	800	800	0	140000	140000	140000	140000		
		Hold community action days		No of community action days held							0	175000	175000	175000	175000		
Strengthen Advocacy, communication and social mobilization for MIYCN	Create awareness on breastfeeding during Global/ National nutrition events	commemorate world breastfeeding week (launch)	Increased community awareness on MIYCN global and country recommended practice	No of awareness meetings on breastfeeding during world breastfeeding week held	4		1	1	1	1	0	922000	922000	922000	922000		
Strengthen evidence generation in MIYCN programming	Documentation of best practices and innovations	Develop a documentary on MIYCN interventions	Evidence based decision making for MIYCN Programming	No of best practices and innovations documented	4		1	1	1	1	0	0	0	0	0		
0	Engage in MIYCN learning forums at national, regional and international levels.	Participate in MIYCN learning forums at national, regional and international levels	0	Number of staff attending MIYCN learning forums at national, regional and international levels attended	32		8	8	8	8	0	0	0	0	0		
strategy	**Interventions**	**Key Activities**	**Expected Outputs**	**Output Indicators**	**Targets for 5 years**	**Target**					**Budget (Kshs. Mn)**					**Responsibility**	
						2023/24	**2024/25**	**2025/26**	**2026/27**	**2027/28**	**2023/24**	**2024/25**	**2025/26**	**2026/27**	**2027/28**	**Lead**	**Support**

Strategic Issues: The absence of nutrition data for older children, along with thinness, overweight/obesity, and micronutrient deficiencies in adolescents and adults, and the rising incidence of diet-related non-communicable diseases (NCDs) among adults and older persons.																	
Strategic Goals: To increase awareness and adoption of healthy dietary practices among older children, adolescents, adults, and older individuals.																	
KRA 2: Improved nutritional well-being of older children, adolescents, adults, and older persons.																	
Outcome 2: Increased awareness and adoption of healthy dietary practices and uptake of nutrition services by older children, adolescents, adults and older persons																	
Strategic Objective 2.1: Improve nutrition status and dietary practices of older children, adolescents, adults, and older persons																	
Policy environment	Create awareness on the existing policies and guidelines to stakeholders.	Disseminate policies and guidelines on healthy diets and physical activity to key stakeholders (health, education and other line ministries)	Increased awareness of nutrition policies and guidelines for older children and adolescents among stakeholders	Number of stakeholders (gov't leaders, health, education and other line ministries) sensitized on policies on healthy diet and physical activity	480		240		240		-	-	1,320,000	-	-		
Advocacy and communication	Create community awareness on healthy diet and Physical activity	Community nutrition education	Increased awareness at community level on recommended healthy and physical practices	Number of community members sensitized on healthy diets and physical activity through dialogues and community activities	4800			1600	1600	1600	-	-	1,399,200	1,441,600	1,399,200		
				Number of cooking Demos conducted							-	-	6,890,400	6,890,400	7,099,200		
		Hold radio shows		number of radio shows held	12		4	4	4	4	-	30,500	30,500	30,500	30,500		
				Number of community members sensitised on healthy diets and physical activities interventions through community groups				1600	1600	1600	-	-	2,993,760	136,000	132,000		

Service delivery	Capacity build health care workers, teachers and community health promoters on healthy diets and physical activity guidelines	Sensitise health care workers, chps and teachers on healthy diets and physical activity.	Improved quality of nutrition service delivery for older children, adolescents, adults and older persons	Number of health care workers sensitised on guidelines for healthy diets and physical activity	120			60		60	-	-	1,239,000	-	1,239,000		
				Number of CHPs sensitized on healthy diets and physical activity	2190			730	730	730	-	-	3,451,140	3,451,140	3,555,720		

				Number of teachers sensitised on healthy diets and physical activities for adolescents	120			60		60	-	-	1,132,000	-	1,132,000		
0	comprehensive nutrition service for older children, adolescents, older person and adults	Nutrition screening of older children, adolescents, adults and elderly persons in the facility	0	Number of older children, adolescents, adults and older persons assessed for nutritional status in outpatient department	100%			100%	100%	100%	-	-	-	-	-		
0	0		0	Number of people in the community who were assessed during mass nutrition screenings	3200%		800	800	800	800	-	-	126,720	126,720	130,560		
0	0		0	proportion of older children screened in childcare centres	100%		100%	100%	100%	100%	-	-	126,720	126,720	130,560		
0	0		0	proportion of older person screened in home for the aged	100%		100%	100%	100%	100%	-	-	126,720	126,720	130,560		
0	0		0	Proportion of older children, adolescents, adults and elderly persons reached through health talk in health facilities	100%		100%	100%	100%	100%	-	-	-	-	-		
0	0		0	Number of caregivers in homes for the aged reached with information on healthy diets and physical activity	360			120	120	120	-	-	95,040	95,040	97,920		
	Interventions	**Key Activities**	**Expected Outputs**	**Output Indicators**	**Targets for 5 years**	**Target**					**Budget (Kshs. Mn)**					**Responsibility**	
						2023/24	**2024/25**	**2025/26**	**2026/27**	**2027/28**	**2023/24**	**2024/25**	**2025/26**	**2026/27**	**2027/28**	**Lead**	**Support**

Strategic Issues: The existence of micronutrient deficiencies, in the population and the limited awareness, availability and access to fortified food products.																
Strategic Goals: To improve availability and promote demand and consumption of fortified foods in Kenya for reduction of micronutrient deficiencies.																
Key Result Area 3: Enhanced Industrial Fortification for Prevention and control of micronutrient deficiencies.																
Outcome 3: To improve availability and promote demand and consumption of fortified foods in Kenya for reduction of micronutrient deficiencies.																
Strategic Objective 3.1 S Increase access and consumption of safe and adequately fortified and bio fortified foods.																
Awareness creation	Adopt and disseminate policies and regulations that mandate fortification of foods.	Dissemination of policy	Utilisation of Food fortification and biofortification policies, regulations and standards	Number of County and sub county leaders sensitised on policies and regulations on food fortification.	60			1				336,000	-	-	-		
0	capacity build technical officers, and food Processing actors on fortification and bio fortification	Training and sensitisation of implementers	0	Number of agricultural officers and Health Care Workers trained on fortification and bio fortification	72			24	24	24	0	0	467,775	467,775	481,950		
				Number of extension officers sensitised on food fortification and bio fortification	300			100	100	100	0	0	539,352	539,352	555,696		
				Number of CHPs sensitised on food fortification and bio fortification	2190			730	730	730	0	0	682,308	682,308	702,984		
Community engagement	Promote consumption of bio fortified foods and fortified foods	create awareness on consumption of fortified and bio fortified foods	0	Number of community members reached during community dialogue on consumption of fortified foods and bio fortified foods	4800			1600	1600	1600	0	0	661,518	661,518	681,564		
0	0		0	number of radio shows conducted	12			4	4	4	0	0	166,320	166,320	171,360		
			0	number of road shows conducted	3			1	1	1	0	0	66,000	66,000	68,000		
			0	Number of households reached during agricultural field days	1200			400	400	400	0	0	39600	39600	40800		
				Number cooking demonstrations done	28				14	14	0	0	0	99,500	99,500		

0	promote production of bio fortified foods	create awareness on production of bio fortified foods	0	Number of people reached during agricultural field days to create awareness on production of fortified foods and bio fortified foods	1200			400	400	400			39,600	39,600	40,800		
				number of radio shows conducted	12			3	3	3	0	0	49,500	49,500	51,000		
				Number of agro processors sensitised on fortification and bio fortification	120			40	40	40			235,620	235,620	242,760		
				Number of demonstration plot on production of biofortified foods	28				14	14			-	817,500	817,500		
0	0		0	Number of surveillance reports on fortification and biofortification interventions	16			4	4	4			126,720	126,720	130,560		
0	0	Food safety monitoring	0	Number of food safety review meetings convened	12			4	4	4				1,900,800	1,958,400		
0	0		0	Food safety laboratory equipped in 4 phases to support food quality tests for fortified and bio fortified foods	4			1	1	1		1,350,000	9,000,000	500,000	-		
0	0		0	Number of reports on salt iodisation monitoring	3			1	1	1	0	0	586,740	586,740	604,520		
strategy	**Interventions**	**Key Activities**	**Expected Outputs**	**Output Indicators**	**Targets for 5 years**	**Target**					**Budget (Kshs. Mn)**					**Responsibility**	
						2023/24	**2024/25**	**2025/26**	**2026/27**	**2027/28**	**2023/24**	**2024/25**	**2025/26**	**2026/27**	**2027/28**	**Lead**	**Support**
Strategic Issues: The inadequate prevention, detection, documentation and clinical management of disease related malnutrition and in the management of wasting.																	
Strategic Goals: To prevent, control, detect and manage disease related malnutrition and prevent under nutrition.																	
Key Result Area 4: Enhanced clinical nutrition and dietetics services across all levels of health care and improved coverage of services for the management of wasting in the county																	
Outcome 4: Expanded and strengthened clinical nutrition and dietetic services for the prevention, management and control of disease-related malnutrition and for management of wasting.																	
Strategic Objective 4.1: Decrease dietary related malnutrition across the life cycle																	
Clinical nutrition policy and guidelines implementation.	Create awareness on nutrition and dietetics related clinical guidelines, protocols and SOPs, to health care workers.	Disseminate nutrition and dietetics related guidelines, protocols and SOPs, to CHMT, SCHMT,	utilisation of clinical nutrition policies and guidelines	Number of health care's workers and health managers reached with nutrition and dietetics related guidelines, protocols and SOPs	200		100	100	0	0	0	0	600,000	600,000	0		

		Disseminate nutrition and dietetics related guidelines, protocols and SOPs, health care workers.		Number of nutrition and dietetics related guidelines, protocols and SOPs disseminated	4		0	2	2	0	0	0	600,000	600,000	0		
0	Awareness creation on Integrated management of acute malnutrition (IMAM) guideline to health care workers and partners.	conduct CMEs on clinical nutrition in Health facilities	0	Number of health care workers attending the CME on IMAM.	200		50	50	50	50	0	512,000	512,000	512,000	512,000		
		conduct mentorship on clinical nutrition in Health facilities		Number of mentorships on nutrition and dietetics related guidelines, protocols and SOPs in Health facilities done							0	768,000	768,000	768,000	768,000		
		sensitize health care workers on clinical nutrition data collection and reporting tools		Number of health care workers sensitized on clinical nutrition data collection and reporting tools							0	144,000	144,000	144,000	144,000		
		carryout nutrition assessment counselling and support to eligible individuals seeking health care services in the health facilities		Number of health facilities conducting nutrition assessment counselling and support to eligible individuals seeking health care services								-	-	-	-		
0	Create awareness in-patient feeding protocol to health managers and other relevant stakeholders	Advocate for establishment inpatient feeding committee in facilities offering in-patient care (public/ private / FBO)	0	Number of health managers sensitised on the inpatient feeding protocol	80		20	20	20	20	0	0	162,500	0	0		

Strengthened clinical nutrition services	Capacity build health care workers on standardized nutrition protocol for different health conditions	Sensitize health care workers on nutrition protocol for different health conditions (SOPS)	Improved knowledge and skill on nutrition care process	Number of health care workers sensitized on nutrition protocols for different health conditions	400			200	200		0	0	271,250	271,250	0		
0	capacity build health care workers on IMAM	train health care workers on updated IMAM guidelines	0	Number of health care workers trained on updated IMAM guidelines	200		50	50	50	50	0	0	830,250	830,250	0		
		conduct quarterly mentorship and OJT on IMAM to health care workers in health facilities		Number of quarterly mentorship and OJT conducted on IMAM to health care workers in health facilities							0	768,000	768,000	768,000	768,000		
		Disseminate IMAM guideline to CHMT, SCHMT and partners.		Number health care workers disseminated with IMAM guideline to CHMT, SCHMT and partners.							0	195,000	195,000	195,000	195,000		
		Scale up IMAM services in all sub county hospital in the county.		number of sub county hospitals in the county scaled up for IMAM SERVICES	20				20			-	-	-	-		
0	Capacity build health care workers on Positive Deviance Hearth (PDHearth)	Train TOTs on PD HEARTH	0	Number of TOTs trained on PD HEARTH	204		102	102	102	102			-	619,000			
		Train HCWs on PD hearth		Number of HCWs trained on PD hearth							0	0	3,399,000	3,399,000	0		
		Train HCWs on IMAM surge model		Number of HCWs trained on IMAM surge model							0	912,500	912,500	912,500	912,500		
		train HCWs on family MUAC		Number HCWs trained on family MUAC	2190			730	730	730	0	1,380,000	1,380,000	1,380,000	1,380,000		

0	Integrate nutrition services in outpatient special clinics	carryout nutrition assessment counselling and support to eligible individuals seeking health care services in the health facilities	0									-	-	-	-		
Streamline inpatient feeding protocols	Standardize inpatient feeding program in health facilities	adoption of the national inpatient feeding policy	Provision of adequate quality meals to inpatient	Number of health facilities providing standard meals	21		7	7			0	0	302,500	302,500	0		
0	Promotion of local hospital production to complement the hospital menus	establish and sustain local production farms in the hospital	0	Number of health facility with integrated kitchen gardens complementing the hospital menu	21		0	10	10	0		-	-	-	-		
0	Adaptation of inpatient feeding policy for health facilities [sub activity]	adoption of the national inpatient feeding policy	0	Number of health facilities with contextualised inpatient feeding policy	0		0	0	21	0		-	-	-	-		
Adopt alternative approaches to prevention, detection and treatment of malnutrition	Implement PDHearth at community level	Sensitize CHP son family MUAC	improved prevention, detection and treatment of malnutrition at community level	Number of CHPs sensitized on family MUAC	288		72	72	72	72		1,251,600	1,251,600	1,251,600	1,251,600		
0	generate evidence on the impact of PDHearth approach	Prepare documentary for PDHEARTH case studies	0	Number of documentaries for PDHEARTH case studies developed	4000		1000	1000	1000	1000					36,000		
0	Promote the use of Family MUAC approach at community level	conduct mass screening in malnutrition hotspots	0	Number of mass screening in malnutrition hotspots done	2000		500	500	500	500		78,000	78,000	78,000	78,000		
0	0	Support CHPs to conduct defaulter tracing and referrals for malnutrition cases.	0	Number of CHPs to conducting defaulter tracing and referrals for malnutrition cases.								-	-	-	-		
0	0	support CHPs to conduct active case finding malnutrition cases	0	Number of CHPs to conducting active case finding malnutrition cases								-	-	-	-		

0	0	link and refer IMAM clients with other programs within the community (WASH, MIYCN support groups, social protection and food security)	0	Number of IMAM clients linked and referred with other programs within the community (WASH, MIYCN support groups, social protection and food security)								-	-	-	-		
0	0	Conduct weekly PDHEARTH sessions	0	Number of weekly PDHEARTH sessions conducted								-	-	-	-		
strategy	**Interventions**	**Key Activities**	**Expected Outputs**	**Output Indicators**	**Targets for 5 years**	**Target**					**Budget (Kshs. Mn)**					**Responsibility**	
						2023/24	**2024/25**	**2025/26**	**2026/27**	**2027/28**	**2023/24**	**2024/25**	**2025/26**	**2026/27**	**2027/28**	**Lead**	**Support**
Strategic Issues: Inconsistent access to nutritious food and sub-optimal preparedness and response strategies leading to inability to maintain nutritional wellbeing of individuals and communities in the face of emergencies and climate-related shocks																	
Strategic Goals: To strengthen community and individual resilience to climate-related shocks and emergencies to achieve improved nutrition outcomes.																	
Key Result Area 5. Sustained nutritional well-being of individuals and communities during emergencies and climate-related shocks.																	
Outcome: Strengthened community and individual resilience to climate-related shocks and emergencies																	
Strategic Objective 5.1: strengthen nutritional well-being and reduce malnutrition related mortality and morbidity among affected populations during emergencies.																	
Capacity building and coordination for emergencies preparedness, early recovery and resilience	Training of healthcare workers on MIYCN-E, BMS act in emergency	Train response teams and health care workers on MIYCN-E, BMS act, and WASH in emergency	Enhanced and informed emergency nutrition response	number of health care workers trained on MIYCN-E, BMS act, WASH	120		30	30	30	30		1,827,000	1,827,000	1,827,000	1,827,000		
0	Sensitisation to CHPs on (MIYCN-E, BMS act, WASH In emergency	Sensitise CHPs on MIYCN-E, BMS act in emergency	0	number of CHPS sensitised on emergency preparedness	360		90	90	90	90		184,000	184,000	184,000	184,000		
0	Enhance coordination with stakeholders	Conduct multisectoral emergency co-ordination meetings	0	Number of multisectoral emergency co-ordination meetings held	4		1	1	1	1		300,000	300,000	300,000	300,000		
Assessment and surveillance	Conduct rapid survey	Conduct baseline survey	0	number of rapid surveys done and reports available	4		1	1	1	1		513,000	513,000	513,000	513,000		

	conduct training to health care workers on assessment and screening for malnutrition	conduct training of health care workers on assessment and screening for malnutrition		number of health care workers trained on assessment in emergencies	120		1	1	1	1		207,000	207,000	207,000	207,000		
	conduct sensitisation to CHPs on assessment and screening for malnutrition	Conduct sensitisation to CHPS on assessment and screening for malnutrition		Number of CHPs sensitised on emergency assessment and screening for malnutrition	360		1	1	1	1		29,000	29,000	29,000	29,000		
	Conduct Nutrition assessment for vulnerable population	Conduct nutrition assessment	0	proportion of vulnerable people assessed for malnutrition	100%		25%	25%	25%	25%							
	strengthen referrals	Conduct referrals		proportion of malnourished vulnerable people referred to health facilities	100%		25%	25%	25%	25%							
	promote linkages	Link malnourished vulnerable to community and support groups		proportion of malnourished vulnerable people linked to other departments and community support groups	100%		25%	25%	25%	25%							
Treatment and management of malnutrition	Provide targeted nutrition support for acute malnutrition cases	Set up stabilization centres for malnourished vulnerable population	functional outpatient/ inpatient treatment centres and increased recovery rates	number of stabilization centres established	4		1	1	1	1		112,000	112,000	112,000	112,000		
0	0		0	number of eligible populations stabilised	100		25	25	25	25		-	-	-	-		
				proportion of malnourished vulnerable population treated for SAM and Discharged	75%		75%	75%	75%	75%		-	-	-	-		
strategy	**Interventions**	**Key Activities**	**Expected Outputs**	**Output Indicators**	**Targets for 5 years**	**Target**					**Budget (Kshs. Mn)**					**Responsibility**	
						2023/24	**2024/25**	**2025/26**	**2026/27**	**2027/28**	**2023/24**	**2024/25**	**2025/26**	**2026/27**	**2027/28**	**Lead**	**Support**
Strategic Issues: Inadequate production, access and consumption of dietary diverse, safe and nutrient-rich foods for individuals across the life cycle																	
Strategic Goal: To increase production, access, and utilisation of diverse, safe, and nutrient-rich foods at the household level for improved nutrition of the population.																	
Key Result Area 6. Enhanced integration of nutrition into agriculture, livestock, and fisheries sectors.																	

Outcome 6: Increased production, access, and utilisation of diverse, safe, nutrient-dense foods at the household level																
Strategic Objective 6.1: Promote implementation of nutrition sensitive agriculture interventions in the food system																
Capacity Building	Awareness creation on utilization of diverse, safe and nutrient-dense food	Sensitization of households on utilization of diverse, safe and nutrient-dense foods	Increased Utilization of diverse, safe and nutrient dense foods	No. of farmers sensitized on utilization of diverse, safe and nutrient-dense food	14000		3500	3500	3500	3500		840,000	840,000	840,000	840,000		
				Number of farmers trained to establish kitchen gardens	14000		3500	3500	3500	3500		420,000	420,000	420,000	420,000		
				Number of farmers trained to establish backyard ponds	4000		1000	1000	1000	1000		140,000	140,000	140,000	140,000		
				Number of farmers trained on small stock production	14000		3500	3500	3500	3500		-	-	-	-		
				Number of farmers groups benefited from placement of small stock	72		18	18	18	18		570,000	570,000	570,000	570,000		
				Number of Radio talk shows			1	1	1	1		64,000	64,000	64,000	64,000		
				Number of Community dialogue days conducted								140,000	140,000	140,000	140,000		
0	Digital Market Information on diverse and nutrition foods	Sensitization of households on accessing diverse, safe and nutrient-dense foods through digital markets	0	No. of farmers accessing digital market information on diverse foods	14000		3500	3500	3500	3500		4,000	4,000	4,000	4,000		
0	Sensitization of farmers on value addition and processing technologies for diverse and nutritious food	Training of farmers on value addition and processing technologies	0	No. of farmers sensitized on value addition and processing technologies for diverse and nutritious food	14000		3500	3500	3500	3500		840,000	840,000	840,000	840,000		
0	Sensitization of farmers on energy saving technologies	Sensitize households on energy saving technologies	0	No. of farmers sensitized on energy saving technologies	14000		3500	3500	3500	3500		140,000	140,000	140,000	140,000		

				Proportion of households that have adopted energy saving technologies	20		5	5	5	5		-	-	-	-		
0	Showcase NSA technologies in all major nutrition events/ days	Demonstrations on NSA to promote technologies on preparation, preservation and utilization of diverse and nutritious food	0	Number of demos on NSAs to promote technologies on preparation, preservation and utilization of diverse and nutritious food	4		1	1	1	1		80,000	80,000	80,000	80,000		
NSA Knowledge Management and Learning	Sensitization and dissemination of NSA Knowledge and practices	Sensitization of farmers and dissemination of NSA information and practices	Enhanced knowledge management and dissemination of NSA practices	Number of farmers reached through the sensitization and dissemination forums	14000		3500	3500	3500	3500		140,000	140,000	140,000	140,000		
0	Conduct joint monitoring with the nutrition unit on NSA interventions to support adoption of evidence-based NSA practices	Convene joint monitoring visits	0	No. of joint monitoring visits held and reported	8		2	2	2	2		700,000	700,000	700,000	700,000		
0	Conduct annual review meeting on NSA /FS interventions with the nutrition unit	Conduct annual review meeting on NSA /FS interventions	0	Number of review meetings held	16		4	4	4	4	0	540,000	540,000	540,000	540,000		
0	Promote behavioural change and communication on utilization of nutritious and diverse food	Establishment of kitchen gardens in schools and health facilities for production and utilization of nutritious and diverse food	0	No. of sensitization forums for BCC conducted	16		4	4	4	4		140,000	140,000	140,000	140,000		
		Sensitization of 4K clubs, Health clubs and young farmers club on production and utilization of diverse and nutrient dense foods		Number of 4K clubs, Health clubs and young farmers club sensitized							140,000	140,000	140,000	140,000	70,000		

Policy and regulatory framework	Joint implementation of CANIS	Support implementation of CANIS	Enhanced implementation of CANIS	Progress Reports	4		1	1	1	1								
0	Disseminate CANIS to NSA actors at county, sub county levels	Convene dissemination meetings at county and sub county level	0	Number of dissemination forums held	2		1	0	0	1			2,400,000					
Resource mobilization	Advocate for increased financial resource allocation for NSA by the county decision makers and partners	Conduct annual advocacy meetings with the county executive, legislature and no-state actors on resources allocation for NSA activities.	Increased Financial resource allocation for NSA activities	Number of advocacy meetings on NSA held with the legislature and executive	4		1	1	1	1		175,000	175,000	175,000	175,000		
strategy	**Interventions**	**Key Activities**	**Expected Outputs**	**Output Indicators**	**Targets for 5 years**	**Target**					**Budget (Kshs. Mn)**					**Responsibility**	
						2023/24	**2024/25**	**2025/26**	**2026/27**	**2027/28**	**2023/24**	**2024/25**	**2025/26**	**2026/27**	**2027/28**	**Lead**	**Support**
Strategic Issues: Inadequate integrated, coordinated, and comprehensive interventions across the health sector to address the multifaceted nature of nutrition.																	
Strategic Goals: To ensure integrated, coordinated, and comprehensive interventions across the health sector that address the multifaceted nature of nutrition challenges.																	
Key Result Area 7. Nutrition integrated and strengthened across all levels of the health sector in the County																	
Outcome 7: Nutrition mainstreamed in policies, strategies, and interventions of the health sector																	
Strategic Objective 7.1: Strengthen nutrition service delivery at all levels of care																	
Nutrition service delivery at all levels of care	Awareness creation to health care workers on nutrition assessment, counselling support, and Standard Operating Procedures in outpatient and inpatient settings	Sensitization of health care workers	Improved knowledge and skills of healthcare workers	Number of healthcare workers sensitized on nutrition assessment, counselling support, and Standard Operating Procedures in outpatient and inpatient settings	200		50	50	50	50		150,000	150,000	150,000	150,000		
		Distribution of SOPs in outpatient and inpatient service areas in all health facilities		Number of health facilities with guidelines and protocols available at service delivery points	106			106				-	-	-	-		

		Review facility reports on nutrition services integration and gives feedback		Number of health facilities integrating nutrition services as per the guidelines and protocols	106		25	25	25	31		413,060	413,060	413,060	413,060		
Nutrition integration in healthcare programs	Intergrade nutrition services in primary health care networks	Sensitize PCN multidisciplinary teams on nutrition guidelines, protocol and SOPs to address nutrition from a holistic perspective	Increased access to Nutrition services across health programs	Number of nutrition reverse referrals (in reaches) conducted by the Multidisciplinary team	4000		1000	1000	1000	1000		240,000	720,000	240,000	720,000		
		Participate in Integrated Outreach Services		Number of nutrition Integrated outreaches conducted	48		12	12	12	12		32,000	32,000	32,000	32,000		
		Conduct in reach in health facilities (SPOKE)		Number of nutrition Integrated in reaches conducted								384,000	384,000	384,000	384,000		
		Conduct joint Support supervision		Number of joint support supervisions conducted	16		4	4	4	4		400,000	400,000	400,000	400,000		
0	Engage nutritionist in departmental program technical working groups	Hold meeting with program leads on nutrition mainstreaming in healthcare programs	0	Number of technical working groups engaging nutrition unit	8		8	8	8	8		75,000	75,000	75,000	75,000		
strategy	**Interventions**	**Key Activities**	**Expected Outputs**	**Output Indicators**	**Targets for 5 years**	**Target**					**Budget (Kshs. Mn)**					**Responsibility**	
						2023/24	**2024/25**	**2025/26**	**2026/27**	**2027/28**	**2023/24**	**2024/25**	**2025/26**	**2026/27**	**2027/28**	**Lead**	**Support**
Strategic issues: Limited nutritional awareness, inappropriate dietary habits and poor overall food environment within in the education system.																	
Strategic Goals: To integrate and expand nutrition interventions within the education sector for improved nutrition of learners.																	
Key Result Area 8: Enhanced integration of nutrition in the education sector.																	
Outcome 8: Enhanced integration of nutrition interventions within the Education sector.																	
Strategic Objective 8.1: Integrate Nutrition in The Education sector																	
Build Capacity	Create awareness on the school meals and nutrition policy and implementation guidelines	Disseminate school meals and nutrition policy to stakeholders	Adoption of recommended practices on the food environment in learning institutions	Number of stakeholders sensitized on ECDE school meals and nutrition policy and implementation guidelines	1380		249	249	249	249	0	1,269,000	1,269,000	1,269,000	1,269,000		

		Sensitize BOMs on school meals implementation guidelines and food safety standard measures of handling food		Number of education stakeholders sensitized on school meals implementation guidelines and food safety standard measures of handling food	1380		249	249	249	249	0	1,269,000	1,269,000	1,269,000	1,269,000		
		Sensitize ECDE teachers on health diets and physical activity, vitamin A supplementation, deworming and growth monitoring.		Number of school meals coordination meetings held	4		1	1	1	1		2,538,000	2,538,000	2,538,000	2,538,000		
		Hold nutrition coordination meetings		Number of meetings held with school unions and associations (KUPPET, KNUT,KEPSHA,KESSA)	4		1	1	1	1		500,000	500,000	500,000	500,000		
Intensify Nutrition interventions	Increase Agri nutrition interventions in 4K clubs and young farmers clubs in schools	Revive 4K clubs in schools	Increased uptake of Agri nutrition interventions in learning institutions	number of revived 4K clubs and young farmers clubs in schools	704		176	176	176	176	0	587,000	587,000	587,000	587,000		
		Revive Young farmers clubs in schools		Number of patrons sensitised on 4K and young farmers clubs	128		32	32	32	32		329,000	329,000	329,000	329,000		
0	Advocate for establishment of integrated school gardens.	Lobby for the integration of nutrition aspects in 4K clubs and young farmers clubs in schools	0	Number of teachers sensitized on integrated school gardens	128		32	32	32	32		904,000	904,000	904,000	904,000		

0	Lobby for planting of fruit trees in schools and TVETS	Lobby for the integration of nutrition aspects in 4K clubs and young farmers clubs in schools	0	Number of lobby meeting with stakeholders done								904,000	904,000	904,000	904,000		
		plant fruit trees in schools		Number of fruit trees planted	94000		23500	23500	23500	23500		-	-	-	-		
0	Integrate nutrition education within the institutions academic and co-curriculum programs	Conduct multisectoral meetings with agriculture to promote school gardens and orchards in schools to complement school feeding program	0	Number teachers reached with nutrition education and counselling	960		240	240	240	240		689,000	689,000	689,000	689,000		
0	Increase the uptake of health and nutrition specific interventions	Conduct Vitamin A supplementation and deworming in ECDE centres in collaboration with teachers.	Enhance nutrition services in learning institutions.	Number of learners in ECDE centres supplemented with Vitamin A and dewormers.	74,020		74,020	74,020	74,020	74,020		-	-	-	-		
0	undertake creative activities with nutrition themes	create nutrition awareness in schools	0	Number of school patrons sensitized on creative activities for nutrition.	160		40	40	40	40	0	587,000	587,000	587,000	587,000		
				Number of school events with nutrition themes	16		4	4	4	4		-	-	-	-		
				Number of young farmers teachers sensitised on nutrition theme creative activities	480		120	120	120	120	0	587,000	587,000	587,000	587,000		
0	create workplace support for breastfeeding mothers within the learning institutions	Establish lactation centres in schools	0	Number of learning institutions with established breastfeeding corners	32		8	8	8	8		400,000	400,000	400,000	400,000		
				Number of BOM sensitised on breastfeeding corners	1440		360	360	360	360	0	1,836,000	1,836,000	1,836,000	1,836,000		

0	Advocate for joint monitoring ad evaluation of nutrition activities in learning institutions	Develop a joint monitoring and data capture tools for nutrition activities in schools.	enhanced monitoring and evaluation of nutrition interventions in learning institution	Number of joint support supervisions done	4		1	1	1	1	0	0	750,000	0	0	750000	
School Meals	Provision of quality nutritious and safe foods for children in learning institutions	Conduct joint supportive supervision of education activities that have integrated nutrition with the nutrition team	Increased consumption of nutritious and safe foods among children in learning institutions	Number of schools providing nutritious and safe food for learners	960	240	240	240	240	240			-	-	-		
		document and report on integrated education and nutrition activities		Number of spot-checks for safe food storage done in learning institution	80	20	20	20	20		0	30000	30000	30000	30000		
		regulate the food environment to control marketing of unhealthy food in learning institutions by development of guidelines on marketing of healthy foods		number of food sampling and testing for safety done at the county store	12	3	3	3	3		0	54,000	54,000	54,000	54,000		
0	Advocate for upscale of number of additional days for meals in the ECDE centres	Advocate for Provision of additional days for school meals (from 2 to 5 days) in ECDE centres.	0	Proportion of ECDE centres providing meals more than twice a week	460		115	115	115	115		587,000	587,000	587,000	587,000		
strategy	**Interventions**	**Key Activities**	**Expected Outputs**	**Output Indicators**	**Targets for 5 years**	**Target**					**Budget (Kshs. Mn)**					**Responsibility**	
						2023/24	**2024/25**	**2025/26**	**2026/27**	**2027/28**	**2023/24**	**2024/25**	**2025/26**	**2026/27**	**2027/28**	**Lead**	**Support**

Strategic Issues: Insufficient impact of WASH programs in reducing malnutrition, incidences of diarrheal and other waterborne diseases																	
Strategic Goals: To expand access to improved Water Sanitation and Hygiene (WASH) services for improved nutrition.																	
Key Result Area 9: Enhanced integration of nutrition within the Water, Sanitation, and Hygiene (WASH) sector.																	
Outcome 9: Increased access to improved nutrition sensitive WASH services																	
Strategic Objective 9.1: Increase proportion of population with access to adequate and safe water																	
Integration of Nutrition sensitivity in water Infrastructure development and expansion	Advocate for the provision of clean and safe water to public facilities and institutions	Sensitise public institution managers on the importance clean and safe water in institution	Increased access to clean safe water	Number of public institution managers sensitised	200		50	50	50	50			225,000				
		Sensitise water service providers on the importance safe water provision in public institutions		Number of water service provision managers sensitised	40		40	0	0	0			225,000				
		Conduct advocacy meetings with public institutions managers and water service providers to support the construction of water infrastructure projects in public institutions		Number of public institutions with access to clean and safe water	200		50	50	50	50		225,000	225,000	225,000	225,000		
0	Promote rainwater harvesting techniques	Conduct Promotion meetings in the communities on the rainwater harvesting techniques	0	Number of promotion campaigns on rainwater harvesting held	32		8	8	8	8		440,000	440,000	440,000	440,000		
0	Promote the adoption of nutrition-sensitive water infrastructure designs	Participate in design meetings with WASH sector design teams to promote nutrition sensitive designs for water infrastructures	0	Number water systems with nutrition sensitive designs	40		10	10	10	10		15,000	15,000	15,000	15,000		
0	0	Train farmers on efficient small-scale irrigation techniques and technologies	0	Number Of Farmers trained on small sale irrigation techniques	1280		320	320	320	320		8,000	8,000	8,000	8,000		

Strengthen use of safe water	Promote the adoption of water treatment technologies in community water sources	Conduct awareness campaigns on available water treatment technologies	Increased use of clean and safe water	Proportion of community water sources with water treatment technologies	95		5	5	5	5		136,000	136,000	136,000	136,000		
Strengthen nutrition integration in water governance, and leadership	Sensitize community water management committees on nutrition integration in water management	Conduct Sensitization meetings on the importance of integrating nutrition aspects into water management to water management committee member	Improved management of water resource and systems	Number of water management committees sensitized on nutrition integration in water management	120		30	30	30	30		8,000	8,000	8,000	8,000		
0	Promote Nutrition sensitivity in water sector legal frameworks in the county	Conduct advocacy meetings with the policy makers in wash sector for the inclusion of nutrition-sensitive interventions in water sector policies and regulatory frameworks.	0	Number of water sector policies and regulatory frameworks developed with integrated nutrition-sensitive interventions.	1		0	1	0	0		30,000					
Strategic Objective 9.2: Increase proportion of population with access to basic sanitation services																	
Strengthen Sanitation and nutrition linkages	Promote participation of nutrition actors in WASH forums	Facilitate the participation of nutrition sector players in WASH forums and conferences.	Increased awareness on hygiene practices	Number of WASH forums participated by the nutrition sector players	14		2	4	4	4		-	-	-	-		
0	Promote Awareness creation on hygiene practices and behaviour change	Conduct awareness campaign on adoption of food hygiene practices in households.	0	Proportion of households adopting food hygiene practices	90		6	7	7	7		168,000	168,000	168,000	168,000		
0	integrate nutrition in Market Based Sanitation (MBS)	Facilitate the nutrition sector's participation in Market Based Sanitation (MBS) promotion programs.	0	Number of MBS promotion programs participated by the nutrition sector players	10		2	2	2	2		22,000	22,000	22,000	22,000		

0	integrate nutrition interventions into WASH	Integrate Nutrition messages into existing WASH interventions	0	Number of nutrition interventions with integrated WASH messages	5		1	1	1	1		112,500	112,500	112,500	112,500		
0	Enhance partnership in commemoration of Nutrition sensitive events and national days	Facilitate participation of nutrition actors' innutrition sensitive events in national days	0	Number of Nutrition sensitive events and national days participated in by the nutrition sector players	20		4	4	4	4		15,000	15,000	15,000	15,000		
Strategy	**Interventions**	**Key activities**	**Expected outputs**	**Output indicators**	**Targets for 5 years**	**Target**					**Budget (kshs. Mn)**					**Responsibility**	
						2023/24	**2024/25**	**2025/26**	**2026/27**	**2027/28**	**2023/24**	**2024/25**	**2025/26**	**2026/27**	**2027/28**	**Lead**	**Support**
Strategic Issues: The lack of a comprehensive approach and insufficient scale up of social protection initiatives that adequately addresses nutritional needs of vulnerable populations faced with high levels of food insecurity and malnutrition																	
Strategic Goals: To integrate nutrition into social protection policies and strategies and expand social protection interventions for improved nutrition of vulnerable populations.																	
Key Results Area 10: Nutrition integrated across Social Protection programmes.																	
Outcome 10: Nutrition mainstreamed and functional within social protection policies, strategies and interventions																	
Strategic Objective 10.1: integrate Nutrition into social protection policies and strategies.																	
Strategy	**Intervention**	**Key Activities**	**Expected Outputs**	**Output Indicators**	**Target**	**2023/24**	**2024/25**	**2025/26**	**2026/27**	**2027/28**	**2023/24**	**2024/25**	**2025/26**	**2026/27**	**2027/28**		
Coordination and partnership.	Integrate planning of social protection in nutrition programmes and projects	Hold joint planning meetings for integration of social protection and nutrition	Enhanced multisectoral collaboration and partnership in implementation of nutrition and social protection programs	Number of joint work plans developed	3		0	1	1	1			787,500	787,500	675,000		
0	In cooperate nutrition in children service Technical Workings Groups	conduct children TWGs with Nutrition Units	0	Number of TWGS incorporating nutrition Unit	12		0	4	4	4			655,200	655,200	561,600		
capacity building of social protection stakeholders	create awareness among frontline service providers	Training of heath care workers on NICHE	Improved nutrition outcomes for cash transfer beneficiaries	Number of frontline Health Care Workers Sensitized on NICHE	150			50	50	50			1,050,000	-	-		
		sensitization of social work force on NICHE		Number of Social Workforce Sensitized on NICHE	240			120	120	120			816,000	792,000	792,000		

0	creating awareness among the community structures	hold sensitization meetings with CPVs and CHPs on NICHE	0	Number of CHPs and CPVs Sensitized on NICHE	2290			765	765	765			1,883,430	1,828,035	1,828,035		
		hold sensitization meetings with the support groups on NICHE		Number of cash transfer beneficiaries sensitized on good nutrition practices (OVC, OPCT, PWSD)	38333			12780	12780	12780			920,448	893,376	893,376		
		hold sensitization meetings with the support groups on NICHE		Number of support groups sensitized on best nutrition practices	180			60	60	60							
community engagements	Household Nutrition screening and referral	Nutrition screening of social protection beneficiaries	Enhanced linkages between nutrition and social protection programmes	Number of beneficiaries and caregivers screened	38333								714,000	693,000	693,000		
		Enrolment of caregivers and beneficiaries into Enhanced Single Registry (ESR) Data base		number of caregivers and beneficiaries referred	38333			12780	12780				1,517,760	1,473,120	1,473,120		
		sensitize parents and caregivers on positive parenting		Number of cash transfer beneficiaries sensitized on good nutrition practices (OVC, OPCT, PWSD)	3833			12780	12780	12780			612,000	594,000	594,000		
				Number of support groups sensitized on best nutrition practices	180			60	60	60							
0	Create awareness on positive parenting skills and Family MUAC		0	Number of beneficiaries and caregivers reached with positive parenting	2290			12780	12780	12780							
		sensitize parents and caregivers on family MUAC		Number of beneficiaries and caregivers reached with family MUAC	38333			12780	12780	12780			1,224,000	1,188,000	1,188,000		

policy environment and Guidelines	Nutrition integration in outreach strategy of beneficiaries and caregivers		Enhanced integration of nutrition-sensitive approaches within social protection systems	Number of outreach strategy reviewed	1			1	0	1							
0	BCC information sharing	sharing bulky SMS on Nutrition sensitive massages	0	number of households reached with bulky SMS	38333			38333	38333	38333			2,345,980	2,276,980	2,276,980		
0	Advocate for model nutrition sensitive childcare centres	advocating for nutrition sensitive childcare centres	0	Number of nutrition sensitive childcare centres	8			3	3	2			-	150,000	-		
Monitoring and Evaluation	Mainstreaming Single Registry utilization	hold data review meeting with consumers of social protection data	Improved evidence-based nutrition programming for vulnerable population	Number of stakeholders utilizing single registry data	20			8	8	4			-	150,000	-		
strategy	**Interventions**	**Key Activities**	**Expected Outputs**	**Output Indicators**	**Targets for 5 years**	**Target**					**Budget (Kshs. Mn)**					**Responsibility**	
						2023/24	**2024/25**	**2025/26**	**2026/27**	**2027/28**	**2023/24**	**2024/25**	**2025/26**	**2026/27**	**2027/28**	**Lead**	**Support**
Strategic Issues: Suboptimal coordination and absence of a strategic approach for nutrition that effectively engages communities, aligns policies and programs, and leverages resources and expertise across various sectors.																	
Strategic Goals: To strengthen nutrition governance, financing, coordination, partnerships, and community participation for optimum nutrition impact																	
Key Results Area 11: Enhanced sectoral and multisectoral nutrition governance -planning, legal, regulatory framework, financing, coordination, partnerships, advocacy, communication and community engagement																	
Outcome 11: Improved governance, financing, coordination, partnerships and community participation in Multisectoral nutrition programmes																	
Strategic Objective 11.1: Strengthen multisectoral nutrition governance, coordination, partnerships, advocacy, and community engagement for optimum nutrition impact.																	
Coordination, collaboration and partnerships	Engage in nutrition specific and nutrition sensitive coordination structures at county and sub county level	Hold quarterly Sub County Nutrition Technical forums	Effective multisectoral collaboration and partnerships across all levels of governance.	Number of Nutrition coordination forums held	16		6	8	8	8	0	680,000	680,000	680,000	680,000		
		Hold quarterly County Nutrition Technical Forums										440,000	440,000	440,000	440,000		

		Hold Quarterly Scaling Up Nutrition Civil Society Associations (SUNCSA) advocacy meetings		Number of Scaling Up Nutrition Civil Society Associations (SUNCSA) advocacy meetings held	12		4	4	4	4	0	440,000	440,000	440,000	440,000		
0	Advocate for operationalization of the multisectoral platform for Food and nutrition security	Hold biannual multistakeholder food and nutrition security platforms	0	Number of multistakeholder platform for food and nutrition security meetings held	8		0	2	2	2	0	220,000	220,000	220,000	220,000		
0	Mainstream joint multisectoral nutrition planning	Participate in relevant coordination mechanisms within health and other sectors	0	Number of joint plans developed and implemented	16		4	4	4	4	0	249,600	249,600	249,600	249,600		
Financial resource mobilization for nutrition financing	Domesticate the domestic resource mobilization model (DRM) for nutrition financing	Hold high level advocacy meeting on resource mobilization with the County Executive and County Assembly leadership.	Increased nutrition financing across sectors	Proportion of nutrition budget allocated in the health department	5%		1	1	1	1		125,000	125,000	125,000	125,000		
				Proportion of budget allocated to nutrition sensitive departments for nutrition sensitive interventions	5%		2%	3%	4%	5%		-	-	-	-		
0	Advocate for enhanced county budget allocation for nutrition financing across departments	Hold a sensitization meeting for the health department and other sectors' managers	0	Number of advocacy sessions held on enhanced budget allocation to nutrition	1			1			0	100,000	100,000	100,000	100,000		
0	0		0	Number of nutrition champions identified and capacity build	9		9					-	-	-	-		
Advocacy for Nutrition Interventions	Advocate for leadership training program opportunities for nutrition and dietetics officers	Advocacy meetings for leadership training programs (Supervisory course, Senior management course, Strategic leadership development program) – KSG	Improved leadership skills among nutrition professionals	Number of nutritionists trained on leadership courses	10		1	1	1	1		125,000	125,000	125,000	125,000		

0	Advocate for creation of a directorate of nutrition and dietetics services	Hold a high-level advocacy meeting on creation of directorate of nutrition and dietetics services	0	Number of advocacy meetings held	4			1	1	1		-	150,000	-	-		
0	Advocate for in-service capacity development	Advocate for in-service training programs for nutrition department staff	0	Number of nutrition personnel trained in in-service courses	35					1		-	250,000	-	-		
Stakeholder engagement at all levels of leadership and governance	Develop a pool of nutrition advocates in the county	Identification of nutrition champions at sub county and county levels	Improved visibility of nutrition at levels of leadership and governance in the county	Number of nutrition champions identified and engaged	9					1		-	300,000	-	-		
0	Engage national and local media for nutrition visibility	Engage mass media on key nutrition related events like malezi bora, World Breastfeeding Week, Diabetes Day and any other emerging issue	0	Number of mass media nutrition education programs held	1		0	0	0	1		-	50,000	-	-		
0	Develop Strategic Documents for stakeholder engagement	Develop County Nutrition Advocacy Package	0	Number of strategies developed and disseminated	3		0	1	0	0		-	960,000	-	-		
0	0	Develop 3rd generation CNAP	0		#		3	4	4	4	0	0	0	0	2,706,400		
0	0	Develop Nutrition Policy	0		#			25		25	0	0	0	0	8,813,000		
0	0	Disseminate CNAP and Nutrition Policy	0		#			10		10	0	0	0	0	950,000		
		Development of Communication Strategy for Advocacy Nutrition Package			#			9			0	24,000	2,116,500	24,000	1,674,000		

strategy	Interventions	Key Activities	Expected Outputs	Output Indicators	Targets for 5 years	Target	Budget (Kshs. Mn)					Responsibility	
							2023/24	2024/25	2025/26	2026/27	2027/28	2023/24	2024/25	2025/26	2026/27	2027/28	Lead	Support
Strategic Issues: Insufficient Monitoring, Evaluation, Accountability and Leaning in the nutrition sector compounded by inadequate research capacity and weak knowledge management.																		
Strategic goals: To integrate nutrition into multi-sectoral information systems, and enhance monitoring, evaluation accountability and learning frameworks (MEAL), research uptake, and knowledge management for efficiency and evidence-based decision-making.																		
Key Result Area 12: strengthened multisectoral Nutrition Information, M&E systems, research and Knowledge management.																		
Outcome 12: Enhanced multi-sectoral nutrition information systems, robust monitoring and evaluation frameworks, increased research uptake, and effective knowledge management.																		
Strategic Objective 12.1: Enhance the quality, consistency, and utilization of nutrition data																		
Strengthen nutrition data collection, documentation and reporting systems	Collaborate with the national, and county governments and partners in the dissemination of revised standard nutrition data collection tools	Procuring and distribution of nutrition capture and reporting tools	Improved data quality and reliability	% of health facilities receiving printed nutrition data capture and reporting tools.	0.75		0.48	0.57	0.66	0.75	0	800,000	800,000	800,000	800,000		
	Enhance Nutrition Data Quality Audits (DQA) indicated in all KRAs in the CNAP	Conduct Quarterly nutrition RDQAs		Number of RDQAs conducted	16		4	4	4	4	0	424,000	424,000	424,000	424,000		
		Conduct HCW Nutrition indicator mentorship		Number of healthcare workers mentored	64		16	16		16	0	960,000	960,000	960,000	960,000		
		Conduct data review meeting		Number of nutrition data reviews conducted	16		4	4	4	4	0	344,000	344,000	344,000	344,000		
	Capacity build Health Care Workers on the use of Kenya Health Information System, Electronic Community Health Information System	Conduct Mentorship for nutritionists on KHIS, ECHIS		Number of nutritionists mentored on KHIS and ECHIS	31			10	10	11	0	384,000	384,000	384,000	384,000		

Strategic Objective 12.2: Improve the generation, dissemination, and access of nutrition knowledge and evidence																
Strengthen nutrition evidence generation and knowledge sharing	Enhance knowledge generation	Utilization of dashboard/ scorecard	Enhanced generation, dissemination, and accessibility of nutrition knowledge and evidence	Number of adopted nutrition dashboards/score cards used	16		4	4	4	4	-	-	-	-	-		
		Develop nutrition briefs and fact sheets		Number of nutrition briefs and factsheets developed and disseminated	4		1	1	1	1	0	180,000	180,000	180,000	180,000		
	Strengthen knowledge dissemination and access	Attend conference for nutrition data dissemination and learning		Number of conferences attended by members from nutrition sensitive and specific sectors	4		1	1	1	1	0	500,000	500,000	500,000	500,000		
		Upload Reports to the nutrition Repository on quarterly basis		Number of reports and briefs uploaded in the nutrition repository	31		7	7	7	10	-	-	-	-	-		
		Conduct SMART survey		Number of SMART surveys conducted	1		0	0	1	0	0	0	1,812,000	0	0		
		conduct KAP survey		Number of nutrition operational research and assessments conducted	4		1	1	1	1	0	0	0	1,735,000	0		
		Conduct Nutrition capacity assessment		% of public facilities assessed for nutrition capacity	0.75		0.48	0.57	0.66	0.75	0	982,000	982,000	982,000	982,000		
	Strengthen periodic review of nutrition indicator across all nutrition sensitive sectors	Conduct annual CNAP review	Improved nutrition programming learning and accountability.	Number of annual CNAP reviews conducted	4		1	1	1	1	0	678,000	678,000	678,000	678,000		

	Integrate nutrition in sector annual plans	integrate interventions for nutrition sensitive and nutrition specific indicators in respective sector annual work plans	0	Number of sector annual work plans with integrated nutrition sensitive interventions	4		1	1	1	1	-	-	-	-	-		
		Conduct end-term CNAP review	0	Completion of end-term CNAP review report	1		0	0	0	1	0	0	0	0	2,234,500		
			0	Number of joint evaluations on nutrition programmes conducted	4		1	1	1	1	-	-	-	-	-		
		Carry out budget tracking for nutrition sensitive and nutrition specific activities	0	% of financial resources allocated to nutrition-specific and nutrition-sensitive interventions in the budget	4%		1%	2.00%	3%	4%	0	100,000	100,000	100,000	100,000		
		Conduct nutrition investment case assessment	0	Number of nutrition investment case reports done	1		0	0	0	1	0	1,068,000	1,068,000	1,068,000	1,068,000		
strategy	**Interventions**	**Key Activities**	**Expected Outputs**	**Output Indicators**	**Targets for 5 years**	**Target**					**Budget (Kshs. Mn)**					**Responsibility**	
						2023/24	**2024/25**	**2025/26**	**2026/27**	**2027/28**	**2023/24**	**2024/25**	**2025/26**	**2026/27**	**2027/28**	**Lead**	**Support**

Strategic Issues: Suboptimal service delivery for nutrition and low demand for nutrition services by communities.																
Strategic Goals: To strengthen the capacity to deliver nutrition services and to increase demand for quality nutrition services in Kenya																
Key Result Area 13: Enhanced Nutrition Capacity for improved service provision.																
Outcome 13: Enhanced Capacity to demand and deliver nutrition services																
Strategic Objective 13.1: Strengthen Nutrition Capacity Development to Enhance Workforce Competence and Service Delivery																
Nutrition Capacity policy dissemination and competency development	Disseminate nutrition capacity development framework to CHRAC, DCHRAC and CHMT.	Hold dissemination meetings on nutrition capacity development framework	Improved nutrition staffing and competency in service delivery levels	No. of committee members reached	40			40		40			223,000		223,000		
0	advocate for the recruitment of more nutrition personnel	Recruitment of nutrition staff	0	No. of nutrition personnel recruited and deployed in service areas	35		5	10	10	10		-	-	-	-		
	Advocate for a nutrition directorate at CHMT level	Write and disseminate a nutrition staffing cabinet brief and county assembly memoranda		Nutrition Directorate established								168,000	168,000	168,000	168,000		
0	Management and leadership training (Supervisory skills, SMC, SLDP)	Recommend personnel to attend management and leadership trainings	Improved knowledge and practices	% of nutrition personnel that have attended management and leadership trainings (Supervisory kills, SMC, SLDP)	59%			15%	15%	15%			316,140	316,140	325,720		
0	Implement Training needs assessment report	Dissemination of training needs assessment report	0	Number of recommendations of training needs assessment implemented	1					1		35,625	35,625	35,625	35,625		
	Establish a performance-based Incentive system for nutritionist	Conduct performance appraisal for nutrition staff		Joint experiential learning through exchange programs and internships	10			5		5		727,000	727,000	727,000	727,000		

	Collaborate with local and international learning institutions for staff trainings	Sign MOUs with collaborating learning institutions for staff training		Number of MOUs signed								-	268,000	-	268,000		
0	Advocate for Joint experiential learning through exchange programs and internships	Joint experiential learning through exchange programs and internships	0	Number of exchange programs and Internships	8		2	2		2		-	-	-	-		
0	Participate in conferences, seminars, and webinars hosted by partner institutions	Participate in conferences, seminars, and webinars hosted by partner institutions	0	Number of nutritionists attending conferences	8		8	8	8	8		528,000	528,000	528,000	528,000		
Strengthen health workforce capacity on clinical nutrition services	Advocate for nutritionists to be trained on specialized clinical nutrition related courses (enteral/ parenteral nutrition, critical care, renal, oncology and metabolic disorders)	advocate for nutritionists to be trained on specialized clinical nutrition related courses (enteral/ parenteral nutrition, critical care, renal, oncology and metabolic disorders)	Strengthened advocacy,	No of Nutritionists trained on specialized clinical nutrition related courses (enteral/ parenteral nutrition, critical care, renal, oncology and metabolic disorders)	8		2	2	2	2		470,000	470,000	470,000	470,000		
			communication and social														
			Mobilization														
strategy	**Interventions**	**Key Activities**	**Expected Outputs**	**Output Indicators**	**Targets for 5 years**	**Target**					**Budget (Kshs. Mn)**					**Responsibility**	
						2023/24	**2024/25**	**2025/26**	**2026/27**	**2027/28**	**2023/24**	**2024/25**	**2025/26**	**2026/27**	**2027/28**	**Lead**	**Support**

Strategic Issues: Suboptimal performing supply chain for Nutrition HPTs.																
Strategic Goals: To strengthen the supply chain management system for nutrition health Products and Technologies (NHPTs) for efficient and reliable delivery of nutrition services																
Key Result Area 14: Strengthened Supply chain management for nutrition commodities and equipment																
Outcome: Improved supply chain management system for nutrition health products and technologies.																
Strategic Objective 14.1: Strengthen the supply chain management system for nutrition health Products and Technologies (NHPTs) in the county.																
capacity building	Integrated commodity management training - including nutrition commodities, and LMIS for HCWs	Train HCWs on commodity and LMIS	Increased knowledge skills and competence on management of nutrition products and technologies among health care workers	Number of HCWs trained on commodity management and LMIS	200		50	50	50	50	0	0	750,000	0	750,000		
0	CME/OJT / Mentorship on commodity management	conduct CME/ OJT/Mentorship on commodity management and correct use and maintenance of nutrition equipment	0	Number of HCWs reached with OJT/Mentorship on commodity management	200		50	50	50	50	0	0	179,550	179,550	153,900		
0	Integrated commodity support supervision and OJT in health facilities	Participate in quarterly integrated commodity support supervision	0	Number of health facilities reached with commodity support supervision	160		40	40	40	40		-	-	-	-		
Nutrition commodity supply and management	Integration of nutrition commodities in the HPTU procurement plan	Participate in commodity forecasting and quantification	Enhanced Availability of Nutrition products and technologies across all health facilities	proportion of public health facilities with adequate nutrition commodities	100		100	100	100	100		-	-	-	-		
0	Advocate for adequate funding for nutrition HPTs.	Preparation and dissemination of a policy brief on funding for nutrition commodities	0	% increase in budget allocation for nutrition commodities and equipment	20		20	20	20	20		-	-	-	-		

0	Procure and distribute nutrition commodities (RUTF, RUSF, FBP, CSB, IFAS, Vitamin A +Deworming tablets, TPN, F100, F75, infant formula for indicated cases, RESOMAL)	procure and distribute nutrition commodities	0	% of facilities with standard SOPs for nutrition commodities	1		1	1	1	1	0	48,360,000	48,360,000	48,360,000	48,360,000		
0	0		0	Proportion of health facilities without stock outs of tracer essential nutrition commodities	100		100	100	100	100		-	-	-	-		
0	supply and maintenances of nutrition HPTs in CHP kit	Replenish CHP kits	0	Proportion of CHP kits with nutrition commodities and equipment	100		100	100	100	100		-	-	-			
Monitoring and evaluation	Integrate nutrition HPT data in quarterly CNTF meetings	Data sharing of nutrition HPT in CNTF meeting	Streamlined data management of nutrition HPT.	Number of CNTF meetings with integrated nutrition HPT data held	16		4	4	4	4		-	-	-	-		
0	Maintain a database of nutrition HTPs	Develop and maintain nutrition HPT database.	0	Number of nutrition HPT developed and maintained	1		1	1	1	1		-	-	-	-		
Functional Nutrition equipment	Procure and distribute nutrition equipment	Procure and distribute anthropometric equipment	Enhanced availability of anthropometric equipment across all health facilities	% of health facilities with adequate anthropometric equipment	100		100	100	100	100	-	-	-	-	-		
0	Inventory management of nutrition equipment	Procurement of anthropometric equipment	0	proportion of health facilities with updated inventory of anthropometric equipment	100		100	100	100	100				6,840,000	6,840,000		
		Develop an inventory for anthropometric equipment										200,000	200,000	200,000	200,000		

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