

REPUBLIC OF KENYA



MINISTRY OF HEALTH

# KENYA NATIONAL NUTRITION ACTION PLAN 2018-2022

POPULAR VERSION



December 2018



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2018-2022

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# CHAPTER 1: OVERVIEW AND INTRODUCTION

## TO THE KNAP 2018-2022

### 1.1 Introduction

The KNAP 2018 - 2022 is the second National Nutrition Action Plan that operationalizes the National Food and Nutrition Security Policy 2012 and its implementation framework (NFNSP-IF) 2017–2022.



**Figure 1: SDGs related to nutrition (Source: Global Nutrition Report 2017)**

The plan is anchored on existing Country level policy and legal frameworks as well as other global and regional frameworks including the African Regional Nutrition Strategy (ARNS) 2015–2025, AU Policy Framework and Plan of Action on Ageing (2002) World Health Assembly (WHA) 2025 nutrition targets and the Sustainable Development Goals (SDGs) as shown in figure 1.

The KNAP is a framework that spells out the investment required for Kenya to address malnutrition in all its forms and for all ages. The plan adopts a multisectoral

approach and promotes cross-sectoral collaboration to address the social determinants of malnutrition sustainably. In light of devolution and the functions ascribed to the two levels of government, the Kenya Nutrition Action Plan (KNAP) 2018–2022 provides an umbrella framework and guidance to counties, who will in turn develop aligned County Nutrition Action Plans (CNAPs). The KNAP also defines both the National and County government roles relating to the provision of technical support, advocacy, guidance and development of capacity for nutrition for the county governments who are

directly responsible for implementation of actions spelt out in the plans.

## 1.2 Rationale for the Kenya Nutrition Action Plan

The second Kenya Nutrition Action Plan was developed to further accelerate and scale up efforts towards the elimination of malnutrition as a problem of public health significance in Kenya by 2030, focusing on specific achievements by 2022. The three basic rationales for the action plan are: (a) the health consequences – improved nutrition status leads to a healthier

population and enhanced quality of life; (b) economic consequences – improved nutrition and health is the foundation for rapid economic growth; and (c) the ethical argument – optimal nutrition is a human right. There is overwhelming evidence that improving nutrition contributes to economic productivity and development poverty reduction by improving physical work capacity, mental capacity and school performance.



## 1.3 Kenya Nutrition Action Plan Development Process

The process of development of KNAP 2018-2022 was driven by government, specifically the Nutrition and Dietetics Unit (NDU) of the Ministry of Health, and was widely consultative, involving all key nutrition stakeholders through a multisectoral process that was open, inclusive and built on existing and emerging alliances, institutions and initiatives. At the national level key line ministries with nutrition-sensitive programs, development partners, civil society organizations, NGOs and the

private sector and Counties participated in the process. The process ensured that the plan is evidence-informed and recognized successes, challenges and lessons learnt from the implementation of the 2012–2017 NNAP. Evidence was gathered through desk reviews of relevant documents and information from key sectors. The process also ensured that the KNAP is results-based and provides for a common results and accountability framework for performance-based M&E.

As shown in figure 2, the KNAP development process commenced in mid 2017 with a review of NNAP 2012-2017 and was finalised in April 2019.



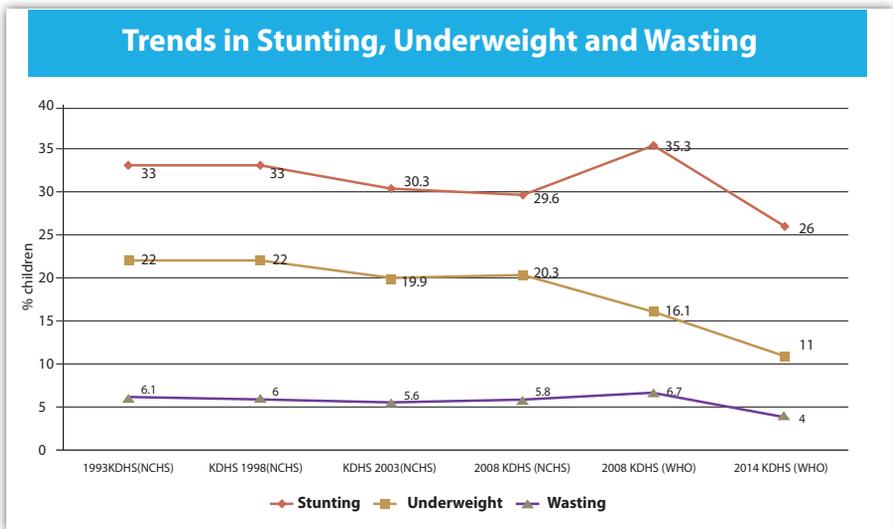
Figure 2: Snapshot of key milestone during development of KNAP 2018-2022

# CHAPTER 2: KENYA NUTRITION SITUATION

## ANALYSIS

### 2.1 Introduction

Globally, malnutrition levels remain unacceptably high and is responsible for ill health than any other cause. According to the Global Nutrition Report, 2018, it is estimated that the total cost of malnutrition is about 3.5 trillion USD per year globally.



**Figure 3: Trends in stunting, underweight and Wasting 1998-2014**

Kenya is experiencing triple burden of malnutrition characterized by the coexistence of (i) undernutrition as manifested by stunting, wasting, underweight; (ii) micronutrient deficiencies; (iii) overweight and obesity including diet-related non-communicable diseases (DRNCD). Data from the Kenya Health Demographic Survey (KDHS) 2014 indicates that out of 7.22 million under five children, nearly 1.9 million are stunted (26 per cent); 290,000 wasted (4 per cent); 794,200 (11 per cent) underweight (See figure 3). Notwithstanding this, there

are notable geographical and social demographic variations in the severity of malnutrition in the country.

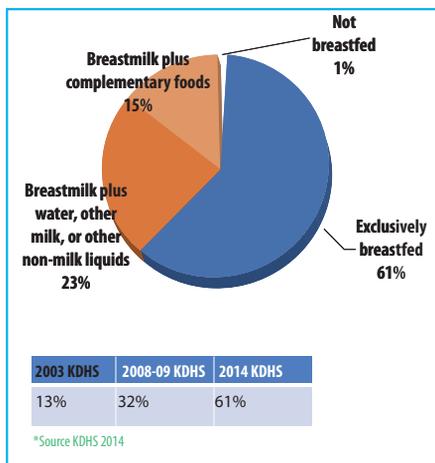
Out of the 47 counties, 9 (19%) have prevalence of stunting above 30%, a level categorized as “severe” and of public health significance. Annual costs for malnutrition related to health, education and labor productivity is estimated between 1.9 and 16.5% GDP.

The Kenya 2015 STEP wise Survey<sup>1</sup> confirmed an increasing rate of

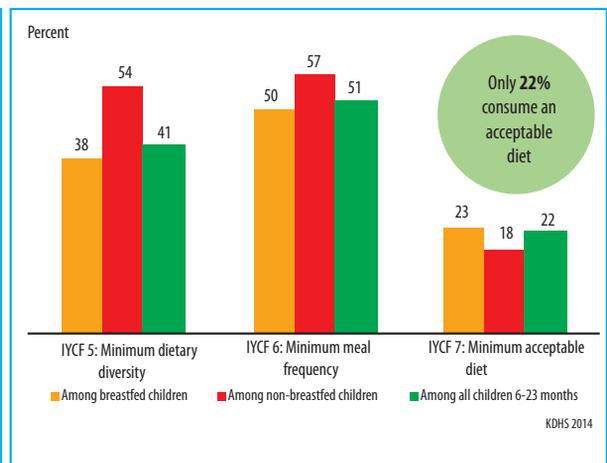
<sup>1</sup>Ministry of Health, Kenya, STEPwise Survey for Non-communicable Diseases Risk Factors, Nairobi, 2015

overweight/obesity and diet-related non-communicable diseases (DRNCDs) in adults. A total of 28 per cent of adults aged 18–69 years were either overweight or obese, with the prevalence in women being 38.5 per cent and men 17.5 per cent. Similar trends are seen when comparing the 2008–2014 KDHS. The proportion of women who were overweight or obese increased from 25 per cent to 33 per cent and those who were obese increased from 7 per cent to 10 per cent. The prevalence of overweight or obesity is higher in urban areas (43 per cent) than in rural areas (26 per cent).

According to the Kenya National Micronutrient Survey of 2011<sup>2</sup> considerable progress is being made in reducing the prevalence of micronutrient deficiencies, except for zinc deficiency. The prevalence of anaemia was highest in pregnant women (41.6 per cent), followed by children 6–59 months (26.3 per cent) and school-age children (5–14 years) at 16.5 per cent. the prevalence of zinc deficiency was high across the population, averaging at about 70 per cent, with pre-school children being 81.6 per cent, school-age children 79.0 per cent, pregnant women 67.9 per cent and non-pregnant women 79.9 per cent. Zinc is a vital trace element with many health benefits.<sup>3</sup> Deficiency in children can lead to growth impediments and an increased risk of infection.



**Figure 4: Breastfeeding status**



**Figure 5: Status of complementary feeding**

An analysis of feeding and care practices in Kenya shows that exclusive breastfeeding rates have markedly improved from 32 per cent in 2008–9 to 61 per cent in 2014 as shown in figure 4. Timely introduction of appropriate, adequate, and safe complementary foods is critical at six months when breast milk alone is no longer sufficient to meet the nutritional requirements. The 2014 KDHS found that 81 per cent of breastfed children aged 6–9 months received complementary foods in addition to breastfeeding, indicating timely complementary feeding. However, only 22 per cent of children aged 6 to 23 months consume a minimum acceptable diet, indicating a dire nutritional situation in this age group (see figure 5). Furthermore, 49 per cent of children aged 6 to 23 months do not

<sup>2</sup>Ministry of Health, Kenya National Micronutrient Survey, Nairobi, 2011

<sup>3</sup>Joseph Nordqvist, What are the health benefits of zinc?, NEWSLETTER Medical News Today, 2017. <https://www.medicalnewstoday.com/articles/263176.php>

consume the minimum required number of meals per day, while 59 per cent do not consume an adequately diversified diet indicating restriction in access to quality diets.<sup>4</sup>

According to the 2015 STEP wise Survey, 95 per cent of adults aged 18–69 years did not consume the WHO daily recommended five servings of fruits and/or vegetables; fruits were consumed on average about 2.4 days in a week, and vegetables were consumed five days in a week.<sup>5</sup> Approximately 20 per cent of adults in this group add salt or salty sauce to their food before eating; 3.7 per cent consume processed foods high in salt; 83.5 per cent often add sugar when cooking or preparing beverages at home; and 28 per cent always add sugar to beverages. About 6.5 per cent do not engage in the WHO recommended level of physical activity.<sup>6</sup>

## 2.2 Causes of malnutrition

Malnutrition is caused by factors which are broadly categorized as immediate, underlying and basic as shown in figure 6 below.

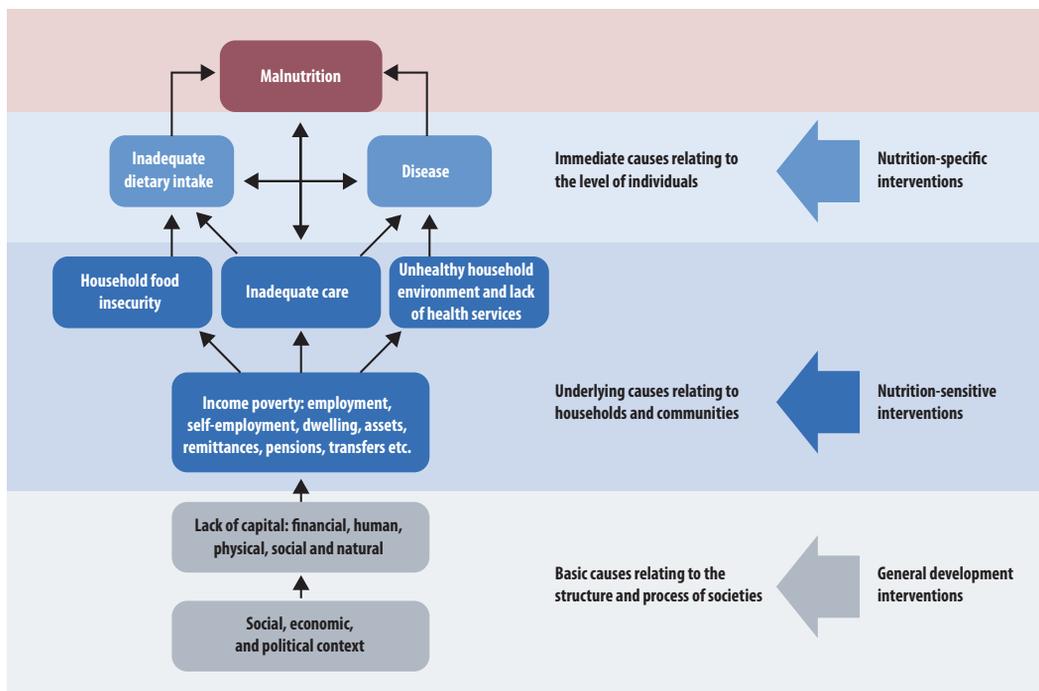


Figure 6: Conceptual framework for malnutrition

### 2.2.1 Immediate causes of malnutrition

The immediate causes include disease and inadequate food intake; this means that disease can affect nutrient intake and absorption, leading to malnutrition, while not taking sufficient quantities and the right quality of food can also lead to malnutrition.

<sup>4</sup>Ibid

<sup>5</sup>Ministry of Health, Kenya, STEPwise Survey for Non-Communicable Diseases Risk Factors, Nairobi, 2015

<sup>6</sup>WHO, Global Recommendations for Physical Activity for Health, 2010

## 2.2.2 Underlying Causes of Malnutrition in Kenya

The underlying causes are food insecurity—including availability, economic access and use of food; feeding and care practices at individual, household and community level; environment and access to and use of health services (World Health Organization, & The World Bank, 2012).

Although trends in household food security (availability, accessibility and stability) have generally improved over the last three decades in Kenya, food insecurity continues to persist due to the stagnation of agricultural production, low use of agricultural technology, high food prices, frequent disasters and the effects of climate change on the mainly rain-fed agriculture and a decline in resilience of pastoral livelihoods, especially in the Northern frontier counties. The food security situation is further affected by seasonality, with rapid deterioration during drought years resulting in emergency levels of acute malnutrition.

The KDHS 2014 indicated that only 44.5 per cent of households treated their water using an appropriate treatment method, however 54 per cent of households did not treat their water before consumption. Approximately two thirds of Kenyans (66 per cent) normally use non-improved toilet facilities. A handwashing station with soap and water was observed in only 49.5 per cent of households. Poor access to water and sanitation services are a major factor for morbidity.

## 2.2.3 Basic causes of Malnutrition:

The basic causes of malnutrition which act at the enabling environment on macro level include issues such as knowledge and education (literacy), politics and governance, leadership, infrastructure and financial resources. Significant challenges face the country in relation to governance and resource allocation to social sectors and indeed development in general limiting the sustainable reduction of malnutrition. Maternal education has been seen to vary across regions and is a key determinant of child survival and development as intimated in the Kenya demographic health survey report of 2014. The distribution of resources further points to equity challenges especially in the most disadvantaged counties.

In general nutrition specific interventions address the immediate causes; nutrition sensitive interventions address the underlying causes while enabling environment interventions deals with the basic or root causes of malnutrition. Addressing all forms of malnutrition at all three levels of causation (immediate, underlying and basic) requires Triple-duty actions that have the potential to improve nutrition outcomes across the spectrum of malnutrition, through integrated initiatives, policies and programmes<sup>7</sup>. The potential for triple-duty actions emerges from the shared drivers behind different forms of malnutrition, and from shared platforms that can be used to address these various forms. Examples of shared platforms for delivering triple-duty actions include **health systems, agriculture and food security systems, education systems, social protection systems, WASH systems and nutrition sensitive policies, strategies and programs.**

<sup>7</sup>WHO: Double-duty actions for nutrition. Policy Brief WHO/NMH/NHD/17.2

# CHAPTER 3: THE KENYA NUTRITION ACTION PLAN DESIGN FRAMEWORK

## 3.1 Introduction

The Kenya National Nutrition Action Plan (KNAP) 2018-2022 is organized into three focus areas: Nutrition-specific, Nutrition-sensitive and Enabling environment. Within the three focus areas are a set of key results areas with corresponding outcomes, outputs, strategies, interventions and activities that are further costed and presented within an implementation matrix. A detailed monitoring, evaluation, accountability and learning framework (MEAL) that will be mutually tracked and reported on by all sectors responsible for the implementation of the KNAP was developed with set targets and a summary of select results and indicators (referred to as the Common Results and Accountability Framework (CRAF)) put in place to measure the progress in implementation of the result areas. Further an institutional and legal framework and a risk mitigation plan is also included to strengthen governance for the KNAP over the five-year period over which the KNAP will be implemented.

The development of the framework was further informed by a theory of change (figure 8) which was a methodology that sought to link actions with each other to realize an intended result or outcome. The theory of change was useful in answering “the what,

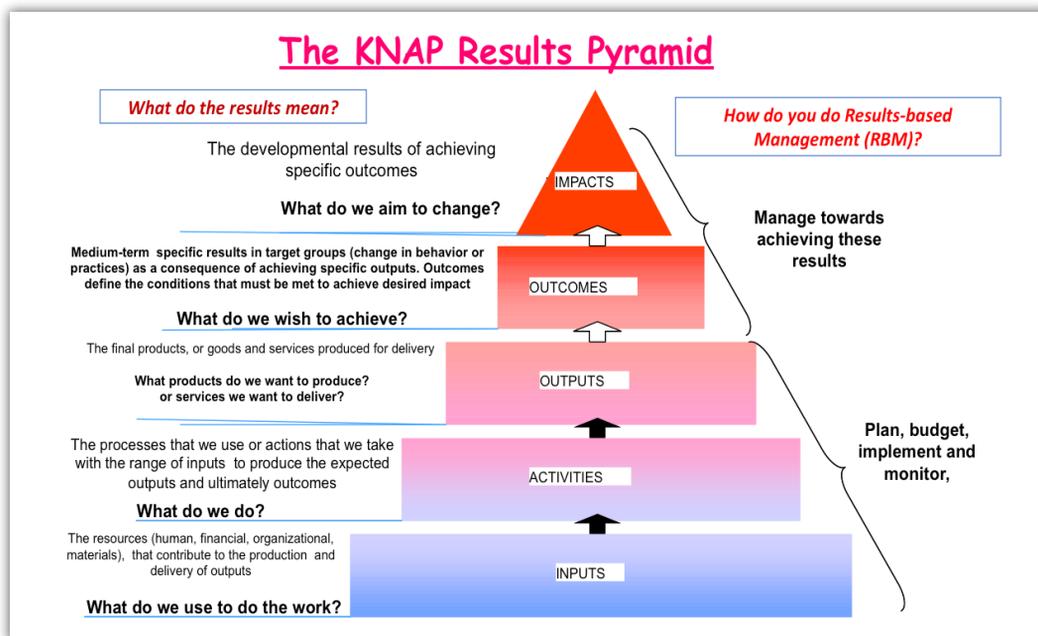


Figure 7: Theory of change

**the how, when and result.”** The theory of change was used to develop a set of result areas such that if certain inputs were in place, and certain activities implemented then a set of results would be realized and, if carried out at scale, contribute to improved nutritional status of all Kenyans. To achieve the ultimate success of improved health and socio-economic development in Kenya, there are key assumptions and parameters that will be put in place in the KNAP.

## 3.2 Vision

A malnutrition-free Kenya.

## 3.3 Mission

To reduce all forms of malnutrition in Kenya using well-coordinated multisectoral and community-centered approaches for optimal health of all Kenyans and the country's economic growth.

## 3.4 Core values and guiding principles

- Professionalism
- Integrity
- Accountability
- Partnership
- Teamwork, collaboration
- Innovativeness
- Ethics
- Equity
- Efficiency and effectiveness
- Quality
- Risk management
- Sustainability and ownership

## 3.5 Objective of the KNAP

To accelerate and scale up efforts towards the elimination of malnutrition in Kenya

in line with Kenya's Vision 2030 and sustainable development goals, focusing on specific achievements by 2022.

## 3.6 Expected result or desired change for the KNAP

'All Kenyans achieve optimal nutrition for a healthier and better quality of life and improved productivity for the country's accelerated social and economic growth.'

## 3.7 Key strategies used in KNAP development

- **Life-course approach to nutrition programming:** a holistic approach to nutrition issues for all population groups
- **Coordination and Partnerships:** sectoral and multisectoral approaches to enhance programming across various levels and sectors, and within the SUN movement platforms
- **Integration:** this takes into account the various platforms in place to deliver nutrition, e.g., health centres and schools
- **Capacity Strengthening** for implementation of nutrition services targeting service providers and related systems
- **Advocacy, Communication and Social mobilization:** acknowledging that nutrition improvements require political goodwill for increased investments and raising population-level awareness
- **Equity and human rights**

- **Resilience and Risk-informed programming:** focus on anticipating, planning and reducing disaster risks to effectively protect persons, communities, livelihoods and health
- **Monitoring, Evaluation, Accountability and Learning:** promotion of use of the triple A (assessment, analysis & action) cyclic process to provide feedback, learn lessons and adjust strategy as appropriate
- **Sustainability:** empowerment for sustainability of results – the need to ensure predictable flow of resources, develop technical and managerial capacity of implementers, motivate implementers, ensure vertical and horizontal linkages, and gradual exit when exiting an intervention.

# CHAPTER 4: KEY RESULT AREAS

## KRA 1: Maternal, new born, infant and young child nutrition (MNIYCN) scaled up

Optimal maternal nutrition is crucial for the health and development of both the foetus and the mother. It has further been shown to have an impact on birth outcomes, with better nourished mothers having increased chances of delivering healthier infants

Substantial research has confirmed that breastfeeding improves the health, development and survival of infants, children and mothers, with the Lancet series 2016 showing that improving breastfeeding practices could save 823,000 deaths and would prevent 20,000 cases of cancer among mothers annually.

Additionally, 72% of diarrhoea episodes and 57% of respiratory infections would be

prevented through optimal breastfeeding. Longer breastfeeding is associated with a 13 per cent reduction in the likelihood of overweight and/or prevalence of obesity and a 35 per cent reduction in the incidence of type 2 diabetes. Exclusive breastfeeding combined with optimal complementary feeding has the potential to avert up to 19% deaths for under-five thus improved child survival. The quality of diets for young children is of great importance in the early years given the increased growth and development needs of the group.

Investing in the early years, the first 1,000 days of life – between a woman’s pregnancy and her child’s second birthday – is critical for child survival, growth and development. It is the period when the physiological needs of both the mother and child are at their highest and the child is highly dependent on the mother for nutrition and other needs.

### KRA 1: Maternal, new born, infant and young child nutrition (MNIYCN) scaled up

#### Outcome:

Strengthened care practices and services for improved maternal, new born, infant and young child nutrition (MNIYCN).

#### Outputs:

1. Increased proportion of women of reproductive age (15–49 years) and caregivers who practise optimal behaviors for improved nutrition
2. Increased proportion of caregivers who practice optimal behaviors for improved nutrition of young children under five years
3. MNIYCN advocated for at global, national and county levels
4. Enhanced capacity for implementation of MNIYCN activities at all levels.
5. Improved MNIYCN policy environment at national and county level

#### Strategies:

1. Strengthen delivery of MNIYCN services
2. Scale up advocacy, communication, social mobilization and resource mobilization
3. Technical capacity development for delivery of quality MNIYCN services
4. Strengthen enabling policy, legal and regulatory environment/framework for multi-sectoral response to MNIYCN
5. Performance monitoring and quality assurance
6. Utilization of nutrition information, evidence and learning for MNIYCN programme improvement and decision making.

## KRA 2: Nutrition of older children and adolescents promoted

This KRA focuses on older children (those aged 5-9 years) and adolescents (those aged 10-19 years). These cohorts are faced with significant transitions in their growth, high rate of cognitive, social and emotional development. Furthermore, this group is faced social and nutrition challenges all of which have an impact on their overall well-being.

Older children and adolescents are grouped together to emphasize their transition from one stage to another and the importance of addressing their nutritional needs in ways that align with their developmental stages. Adolescents have increased nutrient needs for their accelerated growth spurt, and for the emotional and social transition from childhood to adulthood

KRA 2: Nutrition of older children and adolescents promoted	
<b>Outcome:</b> Increased nutrition awareness and uptake of nutrition services for improved nutritional status of older children (5–9 years) and adolescents (10–15 years).	
<b>Outputs:</b>	<b>Strategies:</b>
<ol style="list-style-type: none"> <li>1. Improved policy environment at national and county level for older children (5–9 years) and adolescents (10–19 years).</li> <li>2. Increased awareness of healthy diets among caregivers, social influencers, older children and adolescents themselves.</li> <li>3. Reduction of marketing of unhealthy foods among older children and adolescents</li> <li>4. Enhanced linkages and collaboration with relevant sectors to promote the health and nutrition of the older child and adolescents</li> </ol>	<ol style="list-style-type: none"> <li>1. Formulate/review policies, develop guidelines and advocate for the nutrition of older children and adolescents</li> <li>2. Facilitate participation of adolescents in policies, strategies and plans that affect them</li> <li>3. Capacity-build stakeholders on healthy diets and physical activity, sensitize communities and increase diversity of food production in kitchen gardens.</li> <li>4. Promote consumption and marketing of healthy foods for older children and adolescents</li> <li>5. Establish collaboration with stakeholders and sensitize them to promote good nutrition in older children and adolescents.</li> </ol>

## KRA 3: Nutrition status of adults and older persons promoted

In the life-course approach, adults comprise men and women in the 20–59 age group. It is important to note that adults also face several nutritional challenges including inadequate energy and micronutrient intake due to poverty, inadequate dietary diversity, poor access to nutrition information, and poor lifestyles often adopted during

adolescence. Poor nutritional and lifestyle practices range from overconsumption of fats, sugars and salt to smoking, excessive consumption of alcohol, and low physical activity – all of which increase the risk of diet-related NCDs; for example, diabetes, cardiovascular diseases, hypertension and cancers, often leading to premature death. Moreover, they also constitute the group most vulnerable to HIV and AIDS. Promotion of physical activity and the adoption of healthy lifestyles are critical in addressing the nutritional challenges faced by adults.

### KRA 3: Nutrition status of adults and older persons promoted

#### Outcome:

Improved nutrition status of adults and older persons.

#### Outputs:

1. Legislations, policies and guidelines, on nutrition of adults and older persons formulated
2. Improved utilization of nutrition information, evidence and learning for programme improvement and decision making
3. Access to quality, timely, affordable health care and nutrition support to older persons promoted
4. Strengthened coordination mechanism and systems for health and nutrition of older persons
5. Improved food and nutrition security for older persons
6. Improved financing and human resource for nutrition in older persons
7. Advocacy, communication and social mobilization of nutrition of older persons strengthened and promoted.
8. Mechanisms for research and surveillance on nutrition for older persons strengthened

#### Strategies:

1. Develop/review relevant policies and guidelines to include nutrition of adults and older persons
2. Enhanced decision making using information and programme evidence
3. Develop capacity for health workers to provide quality nutrition services targeting adults and older persons
4. Enhanced service provision for older persons
5. Strengthened food security and nutrition systems for older persons
6. Strengthened financing and human resource capacity mechanisms for nutrition interventions for older persons
7. Enhanced participation of older persons in their health and nutrition programmes
8. Establish a mechanism for assessment, research and monitoring of the nutrition of older persons

### KRA 4: Prevention, control and management of micronutrient deficiencies scaled up

Micronutrient deficiencies are of public health concern due to their devastating effect on the physical and mental well-being of the population. The most common deficiencies are of iron, folate, zinc, iodine and vitamin A. They are risk factors for increased morbidity and mortality among children under five years, pregnant and lactating women. Folic acid deficiency in pregnancy is a

risk factor to neural tube defects (NTD) in newborns and iodine deficiency during pregnancy is the commonest risk factor for preventable brain damage in the newborn. Iron deficiency during pregnancy is a risk factor for anaemia and postpartum haemorrhage among women of reproductive age. VAD is the leading cause of preventable childhood blindness and increases the risk of death from common childhood illnesses such as diarrhea. Periodic, high-dose VAS is a proven, low-cost intervention which has been shown to reduce all-cause mortality by 12 to 24 per cent, and is therefore an important programme in support of efforts to reduce child mortality.

#### KRA 4: Prevention, control and management of micronutrient deficiencies scaled up

##### Outcome:

Improved micronutrient status for children, adolescents, women of reproductive age, men and older persons

##### Outputs:

1. Strengthened routine micronutrient supplementation (vitamin A, iron and folate and micronutrient powders) for targeted groups
2. Increased dietary diversity and Bio-fortification of food plants
3. Strengthened compliance, production and consumption of fortified foods
4. Integrated public health measures with micronutrient deficiency prevention and control interventions
5. Improved policy, legislation, leadership and governance for micronutrient programme.

##### Strategies:

1. Enhance systems for delivery of micronutrient supplementation
2. Enhance uptake of diversified, and bio-fortified foods
3. Promote compliance, production and consumption of fortified foods
4. Integrate micronutrient deficiency prevention and control measures within public health systems
5. Provision of supportive policy environment for micronutrient supplementation

### KRA 5: Prevention, control and management of diet-related risk factors for non-communicable diseases scaled up

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

Most of these premature deaths from NCDs are largely preventable by enabling health systems to respond more effectively and equitably to the health-care needs of people with NCDs, and influencing public policies in sectors outside health that tackle shared risk factors—namely tobacco use, unhealthy diet, physical inactivity, and the harmful use of alcohol. Diet and physical exercise is a powerful tool for prevention of NCDs. To reduce the preventable and avoidable burden of morbidity, mortality and disability due to noncommunicable diseases multisectoral collaboration is key.

Health care workers play a major role in the prevention and care of non-communicable diseases by educating their clients on the need to adopt healthy lifestyles.

## KRA 5: Prevention, control and management of diet-related risk factors for non-communicable diseases scaled up

### Outcome:

Prevention, management and control of non-communicable diseases is improved through nutrition therapy.

### Outputs:

1. Improved policy and legal environment for nutrition in NCDs
2. Established mechanisms to raise the priority accorded to nutrition therapy for prevention and management of NCDs at national and county levels
3. Strengthened national and county capacity to accelerate nutrition response for prevention and control of NCDs
4. Behavior change communication strategies developed and implemented to promote primary and secondary prevention of diet-related risk factors for non-communicable diseases
5. Quality and timely provision of nutrition therapy in management of NCDs
6. Improved monitoring and evaluation for diet-related NCDs

### Strategies:

1. Advocate for integration of nutrition therapy in prevention and control of NCDs into policies across all sectors
2. Integrate nutrition agenda for prevention and control of NCDs into relevant policies across all government and private sectors
3. Integrate nutrition services in NCDs programs at national and county level
4. Advocate for inclusion of nutrition content in both print and electronic media
5. Strengthen behavior change communication on the consumption of healthy diets among the populations
6. Enhanced integrated nutrition services for NCDs management
7. Monitor trends of nutrition-related risk factors for NCDs

## KRA 6: Prevention and integrated management of acute malnutrition (IMAM) strengthened

Acute malnutrition results from inadequate dietary intake and/or disease as the two immediate causes. A deadly vicious cycle is often created between acute malnutrition and infection, whereby acutely malnourished children are predisposed to infection, and vice versa. Children with acute malnutrition are at a five to nine times higher risk of death when compared to well-nourished children.

In Kenya, there are large disparities in the prevalence of acute malnutrition, with several arid areas (Turkana, Mandera, North Horr, Samburu and East Pokot) reporting acute malnutrition levels

that are persistently above emergency levels (Global Acute Malnutrition (GAM) by WHZ  $\geq 15$  per cent based on WHO cut-offs) followed by several semi-arid areas reporting poor to serious levels of acute malnutrition. Programs for the management of acute, severe and moderate malnutrition are implemented in the country albeit with significant challenges.

Coverage of IMAM services, especially in arid and semi-arid counties, has remained relatively low mainly due to distance from health facilities, programme challenges like erratic supplies, lack of staff who can offer the services, poor health-seeking behaviors by the community, prioritization of other competing activities over health seeking, migration of families leading to early defaulting from IMAM programme, and little or no IMAM programme awareness.

While those requiring 24-hour care are relatively few, they are at very high risk of death unless managed correctly. Most cases of acute malnutrition are managed in the supplementary feeding programme (SFP) and outpatient therapeutic programme (OTP) while about 7 per cent of cases with severe acute malnutrition (with complications) receive inpatient care before being discharged for outpatient care programmes. Generally key programme performance indicators have met the sphere standards, with SFP/OTP coverage of over 50 per cent in most areas.

<b>KRA 6: Prevention and integrated management of acute malnutrition (IMAM) strengthened.</b>	
<b>Outcome:</b> Increased coverage of integrated management of acute malnutrition (IMAM) services	
<b>Outputs:</b>	<b>Strategies:</b>
<ol style="list-style-type: none"> <li>1. Policy, standards and guidelines for the IMAM programme developed/reviewed</li> <li>2. Scaled-up access to delivering IMAM services in ASAL, urban and non-ASAL counties</li> <li>3. IMAM programme performance monitored, and quality of services improved</li> <li>4. Strengthened partnerships including public-private partnership (PPP) to improve access and coverage of IMAM services and linkages with other interventions</li> <li>5. Scaled-up advocacy, communication, social mobilization and resource mobilization for IMAM programme</li> <li>6. Innovative approaches to improve IMAM quality and coverage implemented</li> <li>7. Enhanced early case identification through community mobilization and referral, including ICCM</li> <li>8. Improved utilization of IMAM data for informed decision making</li> <li>9. Capacity enhanced for IMAM service delivery and programming.</li> </ol>	<ol style="list-style-type: none"> <li>1. Develop/review and disseminate IMAM policies, standards and guidelines</li> <li>2. Develop a module for full coverage of IMAM services starting with the ASAL areas which have emergency levels of acute malnutrition and rolling over to other areas (non ASAL) within a period of 2-3 years</li> <li>3. Regularly monitor the performance and quality of services provided by the IMAM programme</li> <li>4. Link IMAM services with other programmes (WASH, livelihood, social protection, food security)</li> <li>5. Advocate for a scaled-up IMAM strategy that is geographically rolled up for full coverage</li> <li>6. Effectively use available approaches and, where appropriate, develop innovative approaches to improve quality and coverage of IMAM services</li> <li>7. Develop capacity for improved screening and referral of acute malnutrition at community and health facilities</li> <li>8. Use IMAM data to ensure evidence-based decision making regarding IMAM</li> <li>9. Develop infrastructure and capacity of health workers for service delivery.</li> </ol>

### **KRA 7: Nutrition in emergencies strengthened**

Kenya experiences frequent emergencies such as drought, floods and electoral violence, among others, that often causes disruption and affects the health and nutrition of the most vulnerable groups who include pregnant and lactating women, infants and young children, older persons as well as persons with disabilities. Kenya government have made efforts at policy level to put mechanisms in place for disaster risk reduction as well as emergency response and recovery. Nutrition has an annual contingency plan, as well as contingency plans for specific hazards, preparedness and response plan that is updated following regular seasonal assessments (Short and Long Rains Assessment)

## KRA 7: Nutrition in emergencies strengthened

### Outcome:

Improved multi-level and multisectoral capacity for risk preparedness, reduction and mitigation against impact of disasters

### Outputs:

1. Strengthened coordination and partnerships for integrated preparedness and response initiatives
2. Strengthened preparedness capacity for the nutrition sector
3. Improved access to timely multi-sectoral high-impact interventions to populations affected by emergencies to prevent deterioration of nutritional status and avert excess morbidity and mortality
4. Strengthened implementation of recovery interventions to enhance 'build back better' approaches

### Strategies:

1. Integrate risk reduction and mitigation in functions of coordinating structures
2. Enhance risk analysis and articulation
3. Build capacity of systems and individuals to undertake preparedness functions
4. Roll out a package of high-impact interventions to affected population
5. Strengthen utilization of data/ information to enhance decision making
6. Mainstreaming nutrition in resilience programmes

## KRA 8: Nutrition in HIV and TB promoted

The burden of HIV in Kenya has been on a modest decline since 2010 with the adult HIV prevalence rate estimated at 4.9 per cent (women 5.2 per cent and men 4.5 per cent) in 2017. Annual HIV incidences number approximates 52,800; 44,800 among adults aged 15+ years and 8,000 among children aged <14 years. HIV prevalence varies geographically. The overall goals of medical management of HIV are to reduce HIV-related morbidity and mortality, improve the quality of life, restore and preserve immunological function, and maximize suppression of viral replication. Malnutrition is an important and complicated consequence of HIV infection.

## KRA 8: Nutrition in HIV and TB promoted

### Outcome:

Reduced impact of HIV-related co-morbidities among people living with HIV through targeted nutrition therapy

### Outputs:

1. Improved routine screening for nutrition-related problems and referral for all PLHIV and TB patients
2. Increased coverage for nutrition screening and referral of PLHIV and TB patients
3. Strengthened integration of nutrition interventions for home-based care at community level for PLHIVs towards the 90.90.90
4. Enhanced use of implementation research to generate evidence for cost-effective nutrition TB and HIV programming

### Strategies:

1. Build and maintain a skilled, competent and resourceful public and private health workforce to provide support activities for patient-focused nutrition therapies
2. Address information gaps and systemic gaps in service delivery of HIV, TB Nutrition therapy
3. Optimize nutrition assessment counselling and support for reduced viral load and improved quality of life in HIV/TB patients
4. Develop and disseminate context-specific interpersonal communication on nutrition management for PLHIV and TB patients
5. Utilization of nutrition TB and HIV strategic information for monitoring evaluation and learning
6. Strengthen the generation and use of nutrition assessment, counselling and support (NACS) data for surveillance and decision making towards achievement of key result area goals
7. Strengthen capacity for use of implementation research to inform future NACS programming

## KRA 9: Clinical nutrition and dietetics strengthened

Clinical nutrition practice has emerged as an important discipline in modern medicine. It entails the use of diets and nutrients in prevention of diseases and as an essential component of the medical treatment. An increase in the prevalence of diseases, co-morbidities and related conditions has increased the demand for clinical nutrition and dietetics services at all levels of health care including community-level services. Malnutrition as a result of disease is an area of concern worldwide, with global prevalence of hospital-based malnutrition nearly 50 per cent. The performance of clinical nutrition and dietetics is hindered by inadequate financial resources, which results in lack of nutrition tools, equipment and therapeutic feeds, supplements and other nutrition commodities among others.

### KRA 9: Clinical nutrition and dietetics in disease management strengthened

#### Outcome:

Improved and scaled-up services and practices related to clinical nutrition and dietetics for disease prevention, control and management

#### Outputs:

1. Nutrition and dietetics guidelines, standards, screening and assessment tools developed and implemented
2. Nutrition screening, assessment and triage to all individuals seeking health care promoted  
Improved referral services between facility to facility, community to facility and vice versa
3. Improved quality of clinical nutrition and dietetics care in management of diseases
4. Improved food procurement, supply, hygiene and safety in health care institutions
5. Strengthen M&E for clinical nutrition and dietetics in disease management
6. Improved advocacy for nutrition and dietetics

#### Strategies:

1. Develop and disseminate standard operating procedures (SOP) for nutrition and dietetics: protocol on nutrition management in diseases and conditions; inpatient feeding protocol
2. Develop and disseminate clinical nutrition tools: screening, inter-facility referral, patient feeding monitoring and service quality management tools
3. Develop and disseminate basic training and patient safety package for clinical nutrition and dietetics
4. Develop and disseminate guidelines, strategies and policies on clinical nutrition and dietetics: guidelines for nutritional management of patients in disease and illness; home-based care guidelines for nutrition; guidelines on therapeutic food production units
5. Promote nutrition screening, assessment and triage to all individuals seeking health care
6. Strengthened inter-facility referral system for clinical nutrition and dietetics services
7. Improved technical capacity for clinical nutrition and dietetics in disease management
8. Strengthen clinical nutrition and dietetics services in management of diseases
9. Strengthen the procurement system for food supplies
10. Assessment of quality of nutrition care in facilities
11. Sensitization on nutrition medical errors
12. Sustained advocacy for resource allocation

## KRA 10: Nutrition in agriculture and food security scaled up

The entire food system from production to consumption has an influence on the nutritional status of a population. Challenges in chain of food production to the consumer affects dietary adequacy that leads to nutritional problems at household level. The Ministry of Health will collaborate with the Ministry of Agriculture, Livestock, Fisheries and Irrigation to support food systems to improve access nutritious foods.

KRA 10: Nutrition in agriculture and food security scaled up	
<b>Outcome:</b> Linkages between nutrition, agriculture and food security strengthened	
<b>Outputs:</b>	<b>Strategies:</b>
<ol style="list-style-type: none"> <li>1. Strengthened sustainable and inclusive food systems that are diverse, productive and profitable for improved nutrition.</li> <li>2. Improved access to nutritious and safe foods along the food value chain</li> <li>3. Consumption of safe, diverse, and nutritious foods promoted</li> <li>4. Strengthened agri-nutrition capacities and coordination at national and county level</li> </ol>	<ol style="list-style-type: none"> <li>1. Advocate for joint planning with nutrition-sensitive sectors</li> <li>2. Promote increased access to nutritious and safe food along the food value chain pathways</li> <li>3. Promote increased consumption of safe, diverse, nutritious foods</li> <li>4. Contribute to strengthening of agri-nutrition capacities and coordination at national and county levels</li> </ol>

## KRA 11: Nutrition in the health sector strengthened

The Nutrition and Dietetics Unit is positioned in the Ministry of Health and is the custodian of the nutrition policy as assigned by the Government Executive Order of 2017. It is the largest formal employer for nutritionists and dieticians in the country at both national and county level, and hence remains one of the most crucial sectors for nutrition service delivery. Key components of the health system including the District Health Information System (DHIS), Integrated Human Resource Management System (IHRIS) and the Logistics Management Information System (LMIS) are in place and are critical for data, human resource and supply chain management processes. Leveraging the health budgets at national and county level remains critical for nutrition in health.

KRA 11: Nutrition in the health sector strengthened	
<b>Outcome:</b> Nutrition mainstreamed in health policies, strategies and action plans	
<b>Outputs:</b>	<b>Strategies:</b>
<ol style="list-style-type: none"> <li>1. Nutrition articulated in health policy documents and represented in health sector policy development forums</li> <li>2. Enhanced integration of nutrition within the health sector</li> <li>3. Nutrition strengthened and integrated in health monitoring, evaluation, research, accountability and learning systems of the health sector</li> <li>4. Strengthened capacity of the health workforce to deliver integrated services to include nutrition</li> </ol>	<ol style="list-style-type: none"> <li>1. Raise nutrition profile in the health sector</li> <li>2. Mainstream nutrition in all policy, planning and strategy documents</li> <li>3. Review health sector M&amp;E systems and the HMIS to ensure inclusion of nutrition indicators</li> <li>4. Develop capacity of the health workforce to deliver integrated services including nutrition</li> </ol>

## KRA 12: Nutrition in the education sector strengthened

Good nutrition is essential to realize the learning potential of children and maximize returns on educational investments. Nutrition education in schools is known to foster healthy eating habits in children and later in their families in the short and longer terms. There is inadequate integration of nutrition in the school curriculum – especially for adolescents.

KRA 12: Nutrition in the education sector strengthened	
<b>Outcome:</b> Nutrition mainstreamed in education sector policies, strategies and action plans	
<b>Outputs:</b>	<b>Strategies:</b>
<ol style="list-style-type: none"> <li>1. Policies, strategies, standards and guidelines on nutrition and physical activity in schools and other learning institutions developed and promoted</li> <li>2. Nutrition assessments in schools and other learning institutions conducted</li> <li>3. Healthy and safe food environment promoted in schools and other learning institutions</li> </ol>	<ol style="list-style-type: none"> <li>1. Improved school curriculum to reinforce and promote nutrition and physical activity</li> <li>2. Integrate nutrition and physical activity in curricular and co-curricular frameworks</li> <li>3. Promote capacity for nutrition assessment in schools and other learning institutions</li> <li>4. Promote health and safe food environment in schools and other learning institutions</li> </ol>

## KRA 13: Nutrition in water, sanitation and hygiene (WASH) sector promoted

Access to safe drinking water, sanitation and hygiene (WASH) services is a fundamental element of healthy communities and has an important positive impact on nutrition. Kenya is committed to an upscale of WASH under SDG 6 on achieving universal and equitable access to safe and affordable drinking water, access to adequate and equitable sanitation and hygiene and an end to open defecation for all. To achieve the desired outcome, a series of strategies and interventions with related outputs will be prioritized for implementation over the plan period.

KRA 13: Nutrition in water, sanitation and hygiene (WASH) sector promoted	
<b>Outcome:</b> Nutrition integrated into WASH policies, strategies, plans and programmes	
<b>Outputs:</b>	<b>Strategies:</b>
<ol style="list-style-type: none"> <li>1. Collaboration with relevant stakeholders on WASH strengthened</li> <li>2. Optimal WASH practices promoted</li> </ol>	<ol style="list-style-type: none"> <li>1. Advocate with WASH sector to promote establishment of WASH facilities and provision of safe drinking water</li> <li>2. Strengthen mechanisms for collaboration and promote participation of stakeholders in WASH forums</li> <li>3. Advocate and promote adequate WASH in households and institutions</li> </ol>

## KRA 14: Nutrition in social protection programmes promoted

Social protection policies and programmes hold immense potential for improving the nutrition situation of vulnerable populations. To ensure that these policies holistically combat malnutrition, a nutrition-sensitive approach needs to be employed in their design and implementation. In this regard, key strategies and interventions with related outputs will be prioritized for implementation over the plan period.

### KRA 14: Nutrition in social protection programmes promoted

**Outcome:**

Integration of nutrition in social protection programmes strengthened

**Outputs:**

1. Nutrition promoted, and linkages enhanced in social protection programmes including in crisis
2. Resources for nutrition in social protection programmes mobilized
3. Strengthened advocacy, communication and social mobilization for social protection

**Strategies:**

1. Incorporate explicit nutrition objectives, target criteria and indicators in policies and strategies to enhance the positive impact of social protection interventions on nutrition
2. Mobilize resources for social protection that address the nutrition needs of vulnerable groups
3. Integrate nutrition education and promotion into social protection interventions

## KRA 15: Sectoral and multisectoral nutrition governance (MNG) including coordination and legal/regulatory framework strengthened

Coordination in Kenya for nutrition has been credited as a key enabler of success in programming – a factor that is validated by the 2014 Kenya Demographic Health Survey, which showed a steady improvement in the nutritional status of Kenyan children. It is against this backdrop that coordination in Kenya is cited as largely being successful at sector level in supporting key processes around advocacy and resource mobilization, capacity strengthening, monitoring, evaluation and accountability, as well providing opportunities for engagement in strategic decision making processes. Despite the success and progress, a lot more needs to be done to sustain the gains and strengthen coordination and collaboration with other sectors at national and county levels. The capacity to coordinate and provide leadership in nutrition remains critical in this KNAP. To achieve the desired outcome a series of strategies and interventions with related outputs will be prioritized for implementation over the plan period.

### KRA 15: Sectoral and multisectoral nutrition governance (MNG) including coordination and legal/regulatory framework strengthened

**Outcome:**

Efficient and effective nutrition governance, coordination and legal frameworks in place

**Outputs:**

1. Enhanced existing nutrition coordination and collaborating mechanisms and linkages between national and county governments
2. Regional and global international cooperation on nutrition enhanced
3. Enhanced coordination in development and implementation of nutrition-relevant regulatory frameworks
4. Strengthened partnerships and collaboration for nutrition
5. Nutrition resource mobilization and accountability tracked

**Strategies:**

1. Strengthen coordination mechanisms for programme implementation, knowledge sharing and learning at national and county levels
2. Sustained engagement in regional and global commitment for nutrition
3. Strengthen mechanisms for policy, legal and regulatory framework engagement and processes
4. Strengthen and diversify partnerships in nutrition
5. Develop and implement a resource mobilization strategy for nutrition covering all aspects of resources – financial, human and organizational

### KRA 16: Sectoral and multisectoral nutrition information systems, learning and research strengthened

The current nutrition M&E is built on the existing infrastructure that collects, collates and analyses surveillance and service delivery data from various service delivery points (SDP). Though there has been significant improvement in the nutrition M&E systems, challenges still exist such as: Limited allocation of financial resources to nutrition information, stock outs of nutrition MoH tools in health facilities, poor documentation of nutrition data and reporting and; inadequate population-level data, especially in non-ASAL areas where surveys are not conducted regularly. In addition, research work in nutrition is not adequately coordinated and this affects the prioritization of research areas and the use of the research findings. Addressing these challenges requires continued engagement, and concerted efforts through multisectoral linkages and support at all levels. To achieve the desired outcome a series of strategies and interventions with related outputs will be prioritized for implementation over the plan period.

### KRA 16: Sectoral and multisectoral nutrition information systems, learning and research strengthened

**Outcome:**

Sectoral and multisectoral nutrition information systems, learning and research strengthened

**Outputs:**

1. Nutrition sector plans progress reviewed
2. Strengthened nutrition sector capacity in NIS and evidence-based decision-making
3. Improved access to and use of nutrition information to inform program quality, adjustment and learning

**Strategies:**

1. Monitor implementation of KNAP and M&E framework for nutrition sector and evaluate the impact of nutrition interventions in the country to inform program planning and adjustment
2. Improve capacity for quality nutrition data collection, analysis and dissemination

<p><b>Outputs:</b></p> <ol style="list-style-type: none"> <li>4. Standardized and harmonized nutrition data collection methodologies, management, and reporting at all levels</li> <li>5. Quality nutrition data generated for evidence-based programming</li> <li>6. Enhanced multisectoral linkages result in improved nutrition information efficiencies and cost-effectiveness</li> <li>7. Improved decision making through research evidence</li> </ol>	<p><b>Strategies:</b></p> <ol style="list-style-type: none"> <li>3. Timely generation, dissemination and utilization of nutrition situation updates to inform programme planning and response</li> <li>4. Strengthen systems for managing nutrition information Integrate data quality into the M&amp;E framework</li> <li>5. Mainstream nutrition M&amp;E in the relevant sector information systems and technical working groups</li> <li>6. Enhance evidence-based decision making through research</li> </ol>
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## KRA 17: Advocacy, communication and social mobilization (ACSM) strengthened

Advocacy is an important key result area if a good nutrition outcome is to be achieved in the country. The result area aims to ensure improved and strengthened governance, capacity to deliver, increased awareness, increased demand and adoption of nutrition services and practices at all levels within the country. This key results area aims to ensure that advocacy and communication is strengthened among the nutrition-specific and nutrition-sensitive actors to achieve the good nutrition outcome. To achieve the desired outcome a series of strategies and interventions with related outputs will be prioritized for implementation over the plan period.

### KRA 17: Advocacy, communication and social mobilization (ACSM) strengthened

**Outcome:**

Enhanced political commitment and continued prioritization of nutrition in national and county agenda

**Outputs:**

1. Political commitment and prioritization of nutrition at national and county level enhanced
2. Enhanced and sustained multisectoral collaboration, social accountability and financial resources allocated across relevant sectors at national and county levels
3. Increased and strengthened human capital and capacity for nutrition advocacy
4. Evidence-based nutrition advocacy and knowledge management promoted
5. Effective engagements with media built and maintained
6. Community engagement in nutrition strengthened

**Strategies:**

1. High-level advocacy for national and county governments
2. Advocate for relevant sectors to support establishment of multisectoral nutrition platforms
3. Advocate for adequate financial resources for sustained and quality nutrition services including domestic resource mobilization
4. Participate in national and county planning process ensuring nutrition representation and mainstreaming nutrition in the national and county plans
5. Strengthen capacity for nutrition advocacy at national and county levels
6. Support effective knowledge management and strengthen evidence-based advocacy
7. Build and maintain stronger relationships with media houses and journalists
8. Strengthen community engagement, participation and feedback mechanisms for nutrition services and decision making processes

## KRA 18: Capacity for nutrition developed

Capacity development for nutrition is a critical element for achieving nutrition and health objectives. The Kenya Nutrition Capacity Development Framework (KNCDF) categorizes capacity development in four broad categories: Systemic capacity, organizational capacity, technical capacity and community capacity. Nutrition capacity assessment conducted in 16 counties by mid-2018 indicated critical gaps across the four capacity domains. At system levels gaps were noted in policy, leadership and management competencies of the workforce while at organizational level, gaps were noted in sub optimal coordination and weak systems for service delivery. Stock outs in essential commodities and equipment was noted and linked to inadequate knowledge to forecast and quantify the items. Similarly, the ability of the management to resource mobilize was limited as seen in very low budgetary allocation for nutrition in the assessed counties. At technical level, skills of staff at facility level were not optimal and did not match nutrition needs and services required at the various levels of health care. There was inadequate number of nutrition personnel further noted in addition to very few of those in place being adequately trained. Opportunities for enhancing technical skills were further limited by weak linkages between the implementers and the training institutions. At community level, limited community units were noted with limited skills of the community health workforce further resulting in a weak referral system. To achieve improved nutrition capacity, a series of strategies and interventions with related outputs will be prioritized for implementation over the plan period.

### KRA 18: Capacity for nutrition developed

#### Outcome:

Capacity to deliver and demand nutrition services enhanced

#### Outputs:

1. Capacity for nutrition developed at national and county level
2. Enhanced systems for skills and competency development for nutrition workforce
3. Strengthened capacity for community-level demand generation and utilization of integrated services

#### Strategies:

1. Conduct nutrition capacity assessment
2. Adopt competency-based approach in skill development
3. Optimize functioning of community structures to facilitate demand generation for uptake of nutrition services

## KRA 19: Supply chain management for nutrition commodities and equipment strengthened

Nutrition commodities and equipment are a key component for prevention and management of malnutrition along the life course. The key objective is to ensure uninterrupted supply by facilitating integration into a single more effective and efficient Government led supply chain system with KEMSA as the key warehousing and distribution agency of nutrition commodities directly to the health facilities. There are, however, limitations in the full range and quality of commodities that KEMSA is currently able to stockpile. Similarly, the ability of counties to forecast, quantify and procure commodities from KEMSA is of great importance in maintaining the integrity of the supply chain. To achieve the desired outcome a series of strategies and interventions with related outputs will be prioritized for implementation over the plan period.

## KRA 19: Supply chain management for nutrition commodities and equipment strengthened

### Outcome:

Strengthened integrated supply chain management system for nutrition commodities, equipment and allied tools

### Outputs:

1. Increased government budget allocation for nutrition commodities and allied tools
2. Strengthened coordination and management capacity of supply chain of nutrition commodities and equipment
3. Quality of all nutrition commodities and equipment
4. Improved availability of nutrition commodities, equipment, resources and management of supply chain ensured

### Strategies:

1. Advocate for increased government budget allocation for nutrition commodities and allied tools
2. Optimize functioning of National and County Nutrition Commodity Steering Committees
3. Develop a mechanism to monitor quality of nutrition supplies
4. Advocacy and resource mobilization for nutrition supply chain

# CHAPTER 5: COSTED ACTION PLAN OF THE

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## KNAP

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The method used to cost KNAP is referred to as results-based costing and it emphasized on results rather than spending. The steps followed in estimating KNAP costing was by:

- Costing all the activities necessary to achieve each of the expected outputs in each key result area (KRA).
- Costing inputs with the intuition that activities require inputs which are required in certain quantities, and with certain frequencies.
- The sum of all the input costs gave the activity cost.
- The activities are added up to arrive at the output cost, KRA cost, and eventually the total cost of achieving results outlined in the KNAP.

The KNAP budget is costed at the National level and Counties are expected to customize and develop their Costed County specific action plans. The total budget cost to achieve the 19 key results areas outlined in the KNAP from 2018 to 2022 will be **KES 38.4 billion (USD379.88 million)**. There is variation in the financial need across various KRAs, with KRA 19 on nutrition commodities accounting for more than half (57.6 per cent) of the total resource needs for the KNAP. This is attributed to the high resources need for nutrition commodities. For the past several years, expenditure on nutrition has been relatively low with a percentage of GDP nutrition expenditure almost zero (0) per cent in the FY 2012/13 and 2015/16 respectively. Recognizing efforts made by the government of Kenya, nutrition financing heavily depends on donor funding constituting the largest sources of revenue of health care financing at 52 per cent (Ministry of Health. 2017. Kenya National Health Accounts 2015/2016. Nairobi, Kenya).

Investing in nutrition has social and economic benefits. According to a cost-benefit analysis conducted in Kenya in 2016 by UNICEF, the World Bank and Ministry of Health, every one (1) US dollar invested in scaling up high-impact nutrition interventions has the potential return of USD 22, higher than the global estimates of USD16–18.

**Table 1: Summary of financial resource needs for the KNAP 2018–2022 Per Key Result Area**

CATEGORY OF INTERVENTION	ESTIMATED BUDGET (Ksh millions)					TOTAL	TOTAL
	2018/2019 KES (million)	2019/2020 KES (million)	2020/2021 KES (million)	2021/2022 KES (million)	2022/2022 KES (million)	KES (million)	USD (million)
<b>NUTRITION SPECIFIC</b>	KRA 1: Maternal, new-born, infant and young child nutrition (MNIYCN) scaled up						
	419.80	488.01	394.31	408.06	490.67	2,200.85	21.79
	KRA 2: Nutrition of older children and adolescents promoted						
	63.92	158.42	145.19	120.64	101.58	589.74	5.84
	KRA 3: Nutrition status of adults and older persons promoted						
	20.37	69.86	107.61	29.42	7.72	234.98	2.33
	KRA 4: Prevention, control and management of micronutrient deficiencies scaled up						
	85.36	308.54	114.63	131.57	129.03	769.12	7.62
	KRA 5: Prevention, control and management of diet-related risk factors for non-communicable diseases scaled up						
148.08	223.38	146.91	119.99	125.61	763.97	7.56	
KRA 6: Prevention and Integrated Management of Acute Malnutrition (IMAM) Strengthened							
579.46	571.98	531.21	567.10	560.48	2,810.24	27.82	
KRA 7: Nutrition in Emergencies Strengthened							
128.72	160.33	112.85	100.60	148.64	651.13	6.45	
KRA 8: Nutrition in HIV and TB							
378.22	371.11	328.78	320.61	325.60	1,724.32	17.07	
KRA 9: Clinical Nutrition and Dietetics in Disease Management Strengthened							
15.51	75.37	100.54	47.94	40.08	279.44	2.77	
<b>NUTRITION SENSITIVE</b>	KRA 10: Nutrition in Agriculture and Food Security Scaled up						
	188.93	203.64	185.60	269.58	205.44	1,053.19	10.43
	KRA 11: Nutrition in the Health Sector Strengthened						
	31.67	32.34	20.57	18.71	20.17	123.46	1.22
	KRA 12: Nutrition in the Education Sector Strengthened						
	45.05	58.65	75.28	54.68	46.79	280.44	2.78
KRA 13: Nutrition in Water, Sanitation And Hygiene (WASH) Sector Promoted							
121.77	88.41	78.16	126.71	77.94	492.99	4.88	
KRA 14: Nutrition in Social Protection Programmes promoted							
10.67	47.34	67.59	39.48	12.03	177.11	1.75	
<b>CROSS-CUTTING</b>	KRA 15: Sectoral and Multi-Sectoral Nutrition Governance (MNG) Including Coordination and Legal/Regulatory Framework Strengthened						
	615.36	646.22	610.63	609.45	659.59	3,141.26	31.10
	KRA 16: Sectoral and Multi-sectoral Nutrition Information Systems, Learning and Research Strengthened						
	157.12	197.40	271.67	154.56	241.15	1,021.90	10.12
	KRA 17: Advocacy, Communication and Social Mobilization (ACSM) Strengthened						
	110.75	108.46	84.28	57.91	56.62	418.00	4.14
KRA 18: Capacity for Nutrition Developed							
58.97	76.70	34.79	61.79	61.79	294.05	2.91	
KRA 19: Supply Chain Management for Nutrition Commodities and Equipment Strengthened							
3,748.71	4,011.19	4,266.57	4,532.88	4,782.29	21,341.65	211.30	
<b>TOTAL</b>	<b>6,928.43</b>	<b>7,897.34</b>	<b>7,677.18</b>	<b>7,771.66</b>	<b>8,093.22</b>	<b>38,367.83</b>	<b>379.88</b>

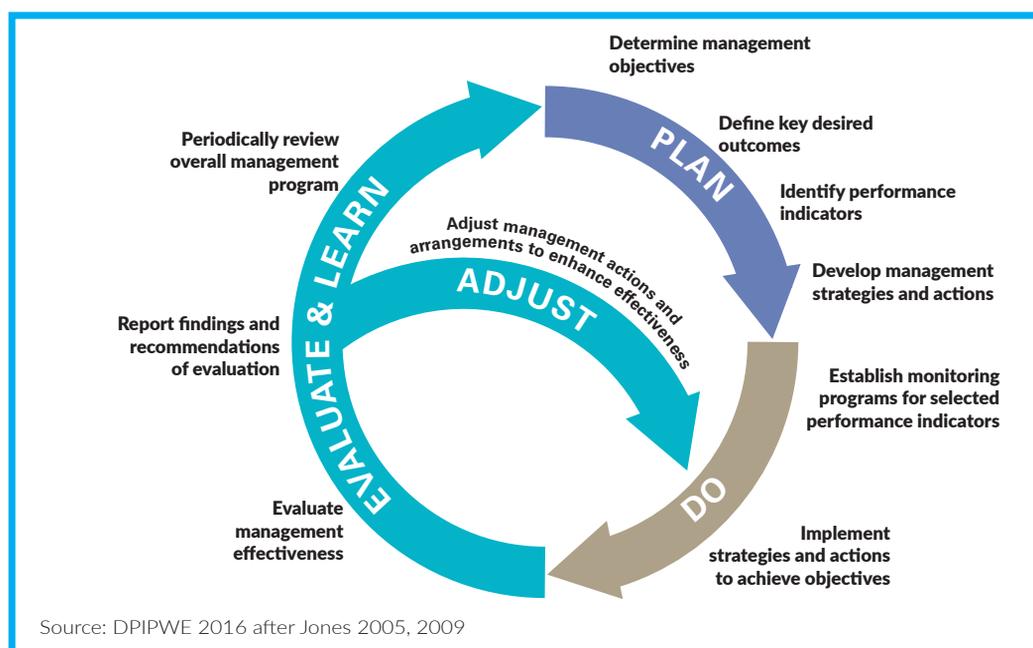
# CHAPTER 6: KNAP MONITORING, EVALUATION, ACCOUNTABILITY AND LEARNING (MEAL)

The Monitoring, Evaluation, Accountability and Learning (MEAL) framework as detailed in the KNAP 2018/2022 will facilitate tracking and evaluation of performance against set targets, as well as serve as an accountability and learning framework for the various nutrition stakeholders. MEAL framework gives a list of selected results and indicators that will be mutually tracked and reported on by all sectors responsible for the implementation of KNAP and a detailed monitoring and evaluation logical framework that has been provided in the KNAP to guide monitoring and evaluation of inputs against outputs, outcomes and impacts. Kenya has identified and selected 29 nutrition indicators and their targets that if achieved will contribute significantly to the desired change. These indicators are provided in Table 1 which also gives the baseline data, and end-term target as well as the sources for these indicators. Largely, the impact targets are derived from three sources: the World Health Assembly (WHA) six targets for 2025; the global Non-Communicable Diseases (NCD) nine voluntary 2025 targets and the National Food and Nutrition Security Policy Implementation (NFNSP-IF) results matrix.

Overall progress review of the KNAP will be conducted at midterm and end term to determine the extent to which the objectives of the action plan are met while regular progress review will be conducted quarterly and annually through the annual plans developed to implement KNAP. Evaluations will provide credible evidence on the performance of the KNAP and document what worked and did not work and will also test the effectiveness of the suggested interventions, against practices in the areas with similar challenges. A nutrition scorecard will be developed as a management tool to track performance and identify areas requiring improvement and the specific actions required to improve performance.

An important aspect in measuring the performance of the KNAP will involve tracking the nutrition investments made through the KNAP regularly and transparently. This will help in better use of finance data (allocations vs expenditures) to mobilize increased resources for improved nutrition and for purposes of advocacy and better planning.

There will be a transparent system of joint periodic data and performance reviews



**Figure 8: K NAP learning cycle**

that involves key nutrition stakeholders which will produce targeted and actionable recommendations with a tracking plan. A comprehensive and inclusive feedback mechanism will also be elaborated in the M&E framework and guidelines.

The learning process of the K NAP will follow an adaptive management cycle approach, which involves improving outcomes through learning. Learning will involve assessing and documenting what works well or does not work well in a particular context, which aspects have more influence on the achievement of results and which strategies can be replicated as indicated in Figure 9.

**Table 2: Kenya nutrition targets for 2022/23**

K NAP ADOPTED NUTRITION TARGETS BY 2022					
S/N	K NAP expected results (Global targets used where applicable)	Indicator	Baseline 2014	Target 2022	Framework for targets
1	Reduce the prevalence of stunting among children under five years by 40%	Prevalence of stunting in children 0-59 months (%)	26	17	WHA target 1 NFNSP-IF
			KDHS 2014		
2	Reduce the prevalence of anaemia in women of reproductive age by 30%	Prevalence of anaemia in women 15-49 years (%) –	27	17	WHA target 2 NFNSP-IF
			KDHS 2014		
3	Reduce the prevalence of low birthweight by 30%	Prevalence of low birth weight of 2.5 kg and below (%)	8	5	WHA target 3
			KDHS 2014		

4	No increase in childhood overweight/obesity	Prevalence of overweight/obesity (W/A >2SD) of children 0-59 months (%)	4	<4	WHA target 4 & NFNSP-IF	
			KDHS 2014			
5	Increase the rate of exclusive breastfeeding in the first six months by 20% and above	Prevalence of exclusive breastfeeding in children 0-6 months (%)	61	75	WHA target 5 & NFNSP-IF	
			KDHS 2014			
6	Maintain childhood wasting at less than 4%	Prevalence of wasting (W/H <2SD) in children 0-59 months (%)	4	<4	WHA target 6 & NFNSP-IF	
			KDHS 2014			
7	Reduce childhood underweight by 30%	Prevalence of underweight (W/A <2SD) in children 0-59 months	11	7	NFNSP-IF	
			KDHS 2014			
8	Maintain proportion of deaths at below 3% for MAM and 10% for SAM	Proportion (%) of discharges from treatment program who have died	0.2% for MAM	<0.2% MAM	NFNSP-IF	
		(among acutely malnourished children for MAM and SAM)	1.7% for SAM			<1.7 SAM
			DHIS 2			
9	Reduce anaemia in children 6-59 months by 30%	Prevalence of anaemia in children 0-59 months (%)	26	18	KNAP	
10	Reduce anaemia in pregnant women by 40% or more	Prevalence of anaemia in pregnant women (%)	36	20	NFNSP-IF	
			KNMS			
11	Reduce anaemia in adolescent girls by 30%	Prevalence of anaemia in girls 15-19 years (%)	21	15	KNAP	
			KNMS			
12	Reduce folic acid deficiency among non-pregnant women by 50%	Proportion of non-pregnant women with folic acid deficiency (%)	39	20	NFNSP-IF	
			KNMS			
13	Reduce vitamin A deficiency in children by 50%	Prevalence of VAD in children 0-59 months (%)	9	4	NFNSP-IF	
			KNMS			
14	Reduce iodine deficiency among children <5 years by over 50%	Prevalence of iodine deficiency in children <5 years (%)	22	<10	NFNSP-IF	
			KNMS			
15	Reduce iodine deficiency among non-pregnant women by over 50%	Prevalence of iodine deficiency in non-pregnant women (%)	26	<10	NFNSP-IF	
			KNMS			
16	Reduce prevalence of zinc deficiency in pre-school children by 40%	Prevalence of zinc deficiency in children <5 years (%)	83	50	NFNSP-IF	
			KNMS			
17	Reduce prevalence of zinc deficiency among pregnant women by 40%	Prevalence of zinc deficiency among pregnant women (%)	60	36	NFNSP-IF	
			KNMS			
18	A 10% relative reduction in prevalence of insufficient physical activity	Prevalence of insufficient physical activity in adults 18-64 years of age (%)	6.5	5	NCD target 3	
			Stepwise survey			

19	Reduce proportion of population with raised blood pressure or currently on medication by 25%	Proportion of population with raised blood pressure or currently on medication (%)	24	18	NCD target 6
			Stepwise survey		NFNSP-IF
20	Reduce proportion of population with raised fasting blood sugar	Proportion of adults 18-69 years with raised fasting blood sugar (%)	1.9	1.5	NFNSP-IF
			Stepwise survey		
21	Increased proportion of men with normal waist: hip ratio	Proportion of men with normal waist: hip ratio (%)	73	78	NFNSP-IF
			Stepwise survey		
22	Increased proportion of women with normal waist: hip ratio	Proportion of women with normal waist: hip ratio (%)	64	75	NFNSP-IF
			Stepwise survey		
23	A 30% relative reduction in mean population intake of salt/sodium	Mean intake of sodium salt (g/day)	3	<3	NCD target 4
24	Halt and reverse the rise in obesity by 30%	Prevalence of overweight/obesity in adults (18-69 years)	28	20	NCD target 7
					NFNSP-IF
25	10% of Population accessing health care services screened and assessed for nutrition status	Proportion of population screened and assessed for nutrition status while accessing healthcare services	No Data	10%	Clinical Nutrition target 2b
26	Increase access by the population to clinical nutrition and dietetics services	Proportion of population with access to clinical nutrition and dietetics services	No Data	10%	Clinical Nutrition target 3
27	Increased budgetary allocation towards nutrition	Percentage of nutrition budget in national health budget	2%	8%	Financing of nutrition
28	Increase coverage of nutrition assessment counselling and support for people living with HIV	Percentage of People Living with HIV (PLHIV) in care and treatment who were nutritionally assessed	< 50% NASCOP Quantification 2018	90%	HIV Nutrition targets as indicated in quantification plan
29	Increase access to therapeutic and or supplemental food for clinically undernourished people living with HIV	Proportion of clinically undernourished PLHIV who received therapeutic or supplementary food	< 50% NASCOP Quantification 2018	90%	HIV Nutrition targets as indicated in quantification plan

# CHAPTER 7: LEGAL, INSTITUTIONAL AND COORDINATION FRAMEWORKS FOR THE KNAP

## 7.1: Introduction

The broad-ranging determinants of malnutrition as articulated in the key result areas will require strong coordination within the nutrition sector and between other sectors to catalyse collaboration which is critical for the successful implementation of this KNAP. Overall the KNAP 2018 to 2022 is anchored on and linked to key legal and institutional frameworks as presented in boxes 1 and 2 respectively.

## 7.2 Legal framework

### Global related frameworks

- In 1948, The United Nations formally recognized the right to good food and nutrition as a human right with the Universal Declaration of Human Rights (UDHR) with Article 25, protecting the right for people to feed themselves in dignity.
- Further, at the UN World Food Summit of 1996, the Heads of States and Governments reaffirmed the right of everyone to have access to safe and nutritious food, consistent with the right to adequate food and the fundamental right of everyone to be free from hunger. They pledged their political will and commitment to achieving food security for all and eradicating poverty and hunger in all countries.
- In 1990, the United Nations set the Millennium Development Goal to halve the number of people suffering from hunger by 2015.
- In 2012 Scaling-Up Nutrition (SUN) movement was launched
- In 2012 Comprehensive Integrated Plan on Infant and Young Child Nutrition (CIP-IYCN) and 6 Global Nutrition Targets by WHA was adopted
- In 2014, 2nd International Conference on Nutrition was held in Rome, and this led to the adoption of the 9 voluntary Global NCD Targets and Global NCD Action Plan by WHA
- On 25 September 2015, the UN General Assembly adopted the 2030 Agenda for Sustainable Development, among them the common goal to eradicate hunger - Kenya was among the 153 countries.
- The UN General Assembly proclaimed 2016-2025 as the Decade of Action on Nutrition

## Kenya specific frameworks

- Nutrition is anchored in the Constitution of Kenya 2010: Article 43 (1) (c), Article 53 (I) (c), Article 21 and Article 27 guarantees the right to food and adequate nutrition and the universal right to food and nutritional health, and protection from discrimination.
- Vision 2030 and forms a key component of the Medium Term III (MTP III) flagship projects and as a key component of the other priority projects of the MTP III. It has been mainstreamed in some of the County Integrated Development Plans (CIDPS).
- President's Big Four Agenda on Food and Nutrition Security pillar.
- The Kenya Food and Nutrition Security Policy 2012 and its corresponding Implementation Framework 2017 to 2022 The implementation process of the KNAP will involve rollout of existing legislation, revision of existing legislation and formulating new laws, regulations and guidelines to ensure availability and access of adequate, safe and quality nutrition services; and adherence to internationally recognized standards and guidelines.

The Kenya Food and Nutrition Security Policy 2012 and its corresponding Food and Nutrition Security Policy Implementation Framework 2017 to 2022 further recognize nutrition as a key outcome to be achieved.

The implementation process of the KNAP will involve rollout of existing legislation, revision of existing legislation and formulating new laws, regulations and guidelines to ensure availability and access of adequate, safe and quality nutrition services; and adherence to internationally recognized standards and guidelines.

## 7.3 Institutional Frameworks

Governance and leadership are core to the successful engagement with various institutions within the provided legal framework. The leadership and governance result areas in this plan will focus broadly on: stewardship, advocacy, partnerships and effective governance structures. This will be even more critical given devolution and the need to have functional governance mechanisms at both national and county levels to the grass root.

This action plan promotes stronger institutional coherence and linkages between sectors, including the optimization of coordination structures to facilitate and drive service delivery, capacity strengthening, evidence generation and utilization, advocacy, resource mobilization, resource tracking and social accountability. The establishment of multi-sectoral coordination structures as stipulated in the Food and Nutrition Security Policy 2012 and the Food and Nutrition Security Policy Implementation Framework 2017–2022.

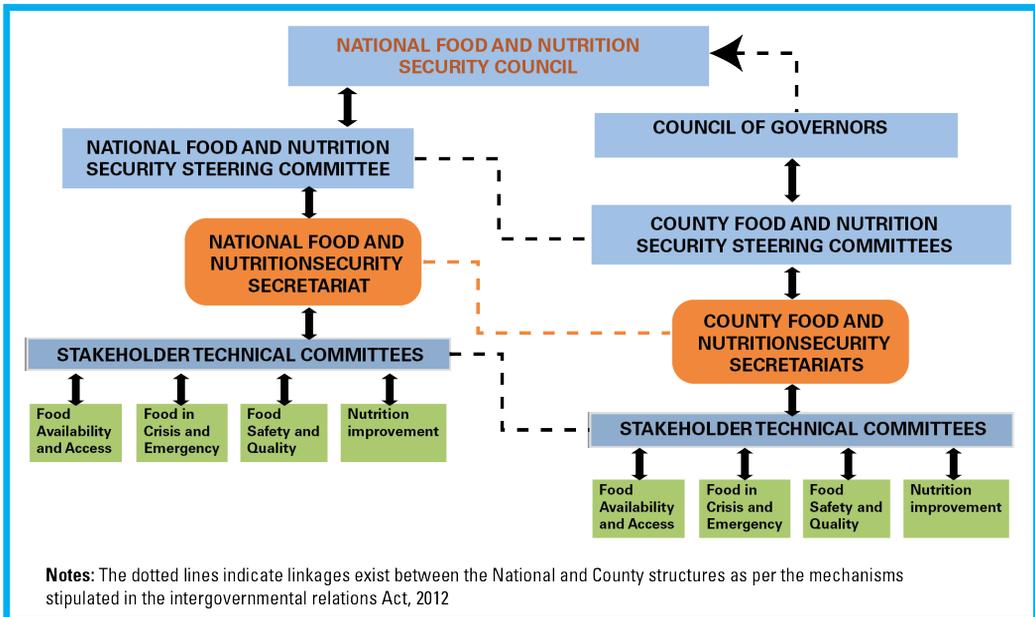


**Figure 9: Elements of sector wide partnership**

a) Sector-wide partnerships are critical in the execution of the Kenya Nutrition Action Plan both at national and county level. The key principles promoted under this approach include: ONE plan; ONE coordinating authority and ONE Monitoring and Evaluation framework as presented in figure 10.

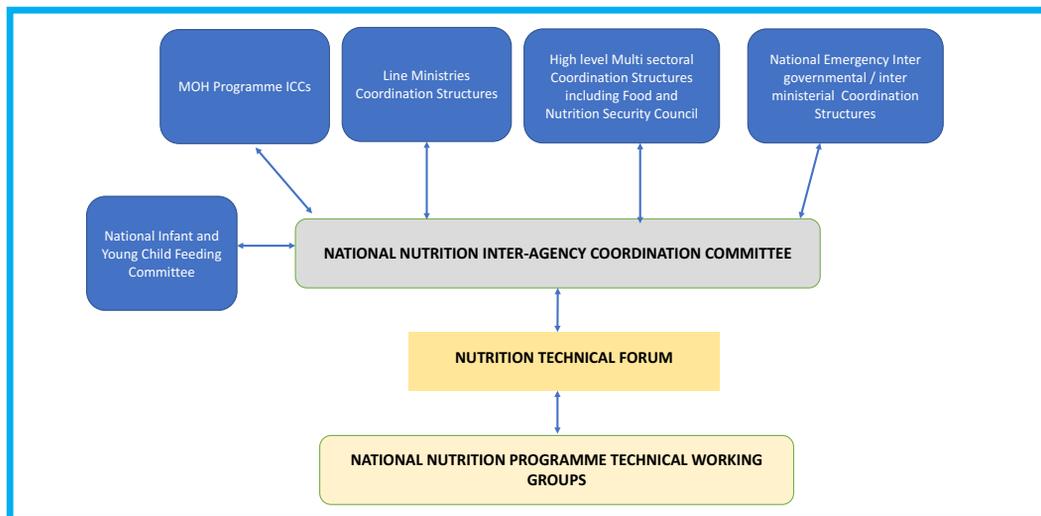
The implementation of nutrition interventions in Kenya has been addressed predominantly and directly by the Ministries of Health, Agriculture, social protection and Education; however, there are several ministries with policy measures and strategic plans in place that have an indirect impact on food security and nutrition improvement. Harnessing the synergy therefore calls for greater stewardship and leadership from the nutrition sector as a collective.

b) The establishment of multi-sectoral coordination structures as stipulated in the Food and Nutrition Security Policy 2012 and the Food and Nutrition Security Policy Implementation Framework 2017–2022. These include the National Food and Nutrition Security Council, Food and Nutrition Security Steering Committees and Secretariats; and Food and Nutrition Security Stakeholder Technical Committees at both national and county levels as shown in figure 11.



**Figure 10: Coordination structure for food and nutrition security implementation framework**

- c) The present coordination mechanisms for the nutrition sector under the leadership of the Nutrition Interagency Coordination Committee (NICC), which has representation from various agency heads and government line ministries. Various programme-related steering committees and working groups have also been established to guide on the implementation of key programmes that contribute to nutrition. – See figure 12 for more details.



**Figure 11: Coordination Organogram**

Further, Kenya is a signatory to the Scaling Up Nutrition (SUN) Movement and signed up to SUN in the year 2012. As part of the coordination arrangements under SUN in the country, various SUN Networks namely Government, United Nations (UN), Civil Society Alliance (CSA), Donor, Academia and Research, and Business have been established. The various networks draw membership from various sectors and this greatly contributes to enhancing multi-sectoral engagement for nutrition. As shown on Figure 20, the various Networks are coordinated under the leadership of the SUN Focal Point who is supported by a SUN Technical Team and SUN Advisory Committee. The various SUN Networks are further all brought together under the ALL SUN Network biannual meetings.



**Figure 12: SUN Coordination Structures**





REPUBLIC OF KENYA



MINISTRY OF HEALTH