MINISTRY OF HEALTH

Kenya Nutrition Monitoring and Evaluation Framework

2018 to 2022

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FOREWORD

Good nutrition is fundamental for achieving right to health, embodied in article 43 in the Kenya Constitution, 2010. Therefore, the Kenya Health Policy 2014-2030 has prioritized implementation of essential nutrition actions under most of its strategic objectives. Further, nutrition has been identified as one of the essential health services under the primary health care, key driver in the realization of Universal Health Coverage envisioned in the Big Four Agenda.

The Ministry is implementing the Kenya Nutrition Action Plan (KNAP) 2018-2022 whose objective is to accelerate and scale up efforts towards the elimination of malnutrition. KNAP identified Monitoring, Evaluation, Accountability and Learning (MEAL) as the mechanism that will facilitate tracking and evaluation of performance of KNAP implementation. Therefore, the Kenya Nutrition Monitoring and Evaluation (M&E) Framework 2018-2022 has been developed to serve this purpose and provides further guidance on M&E, strengthening of multi-sectoral nutrition information systems (NIS), learning and research for actors engaged in the implementation of the KNAP at the National, County and sub-county levels.

The development of the M & E Framework 2018-2022 was done through a consultative process of all the stakeholders in the nutrition specific and nutrition sensitive sectors. The framework is based on the review and input from various documents in the health sector namely: The National Food and Nutrition Security Policy 2011, Kenya Nutrition Action Plan 2018- 2022, Nutrition Monitoring and Evaluation Framework 2013 among others. The framework is also aligned to the Kenya Health Information System (HIS) with focus on strengthening nutrition indicators and information systems.

The M&E framework offers clarity on: *What* is to be monitored and evaluated; *who* is responsible; *when* M & E activities are planned and carried out. The framework contains a comprehensive M&E guidance, associated indicators and toolkits and provides a harmonized approach and understanding of nutrition M&E. The framework also provides a benchmark for planning, budgeting, reporting and re-strategizing of nutrition interventions at national and county levels. Additionally, the framework will ensure continuous tracking of progress, documentation of lessons learned and replication of best practices as outlined in the KNAP 2018-2022.

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ACKNOWLEDGEMENT

The Kenya Nutrition Monitoring and Evaluation Framework has been developed through leveraging a broad range of expertise from government and partner organizations who are members of various nutrition programmes technical working groups under the Division of Nutrition and Dietetics (DND) in the Ministry of Health (MOH) Nutrition Information technical working group (NITWG), National Micronutrient Deficiency Control Committee (NMDCC), Food and Nutrition Linkages Working Group, Nutrition Capacity Development TWG and Nutrition Advocacy and Communication TWG.

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ACSM	Advocacy, Communication and Social Mobilization
AFI	Acute Food Insecurity
AMN	Acute Malnutrition
AMNR	Annual Multi-Stakeholder Nutrition Reviews
ASAL	Arid and Semi-Arid Lands
BMI	Body Mass Index
CDs	Computer Disks
CECM	County Executive Committee Member
CHIS	Community Health Information System
CHMT	County Health Management Team
CHS	Community Health Strategy
CHSSIP	County Health Sector Strategic and Investment Plan
CHV	Community Health Volunteer
CNAP	County Nutrition Action Plan
CNC	County Nutrition Coordinator
CNTF	County Nutrition Technical Forum
CoG	Council of Governors
CRAF	Common Results and Accountability Framework
CUs	Community Units
DND	Division of Nutrition and Dietetics
DNCD	Division of Non-Communicable Diseases
DHIS	District Health Information System
DQA	Data Quality Assurance
EML	Essential Medicines List
ETR	End term Review
EWS	Early Warning System
FAO	Food and Agriculture Organization
FEWSNET	Famine Early Warning Systems Network
FCS	Food Consumption Score
FNSP	Food and Nutrition Security Policy (FSNP)
GAIN	Global Alliance for Improved Nutrition
GBD	Global Burden of Disease
GDP	Gross Domestic Product
GNR	Global Nutrition Report
HDSS	Health and Demographic Surveillance System
HIS	Health Information System
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
HRH	Human Resources for Health
IFAS	Iron Folic Acid Supplement
IMAM	Integrated Management of Acute Malnutrition
IPC	Integrated Phase Classification
JFFLS	Junior Farmer Field and Life School of the Ministry of Agriculture

KABP	Knowledge Attitude Behavior and Practices
KAP	Knowledge Attitude and Practices
KDHS	Kenya Demographic and Health Survey
KEBS	Kenya Bureau of Standards
KEMRI	Kenya Medical Research Institute
KEMSA	Kenya Medical Supplies Authority
KHIS	Kenya Health Information System
KHO	Kenya Health Observatory
KHSSP	Kenya Health Strategic and Investment Plan
KIHBS	Kenya Integrated Household Budget Survey
KNAP	Kenya Nutrition Action Plan
KNBS	Kenya National Bureau of Statistics
KNMS	Kenya National Micronutrient Survey
KRA	Key Result Area
KRCS	Kenya Red Cross Society
LMIS	Logistic Management Information System
LQAS	Lot Quality Analysis Sampling
MAM	Moderate Acute Malnutrition
M&E	Monitoring and Evaluation
MCA	Member of County Assembly
MCNP	Maternal and Child Nutrition Program
MEAL	Monitoring Evaluation, Accountability and Learning
MICS	Multiple Indicators Cluster Survey
MIYCN	Maternal Infant and Young Child Nutrition
MIYCN-E	Maternal Infant and Young Child Nutrition-Emergency
MoALC	Ministry of Agriculture, Livestock and Cooperatives
MDA	Ministries, Departments and Agencies
MNP	Micronutrient Powder
MODA	Ministry of Devolution and ASAL
MoE	Ministry of Education
MOH	Ministry of Health
MoV	Means of verification
MTR	Mid Term Review
MUAC	Mid Upper Arm Circumference
NASCOP	National AIDS and STIs Control Programme
NCD	Non-Communicable Diseases
NCTWG	Nutrition Capacity Technical Working Group
NDMA	National Disaster Management Authority
NGO	Non-Governmental Organization
NFNSP-IF	National Food and Nutrition Security Policy Implementation Framework
NiPN	National Information Platform for Nutrition
NI	Nutrition International
NIS	Nutrition Information System

NITWG	Nutrition Information Technical Working Group
NNAP	National Nutrition Action Plan
NPW	Non-Pregnant Women
ODK	Open Data Kit
OJT	On Job Training
OECD-DAC	Organization for Economic Co-operation and Development's (OECD) Development Assistance Committee (DAC)
PC	Performance Contract
PL-HIV	People Living With Human Immunodeficiency Virus
PSC	Public Service Commission
RMNCAH	Reproductive, Maternal, Newborn, Child and Adolescent Health
RDQA	Routine Data Quality Assessment
RNTWG	Research in Nutrition Technical Working Group
SAM	Severe Acute Malnutrition
SDGs	Standard Deviation
SD	Sustainable Development Goals
SLEAC	Simplified Lot Quality Assurance Sampling Evaluation of Access and Coverage
SMART	Standardized Monitoring Assessment on Relief and Transition
SQUEAC	Semi Quantitative Evaluation on Access and Coverage
SUN	Scaling Up Nutrition
TB	Tuberculosis
ToC	Theory of Change
TWG	Technical Working Group
UN	United Nations
UNICEF	United Nations Children Fund
VAD	Vitamin A Deficiency
W/A	Weight for Age
WASH	Water Sanitation and Hygiene
WFP	World Food Programme
W/H	Weight for Height
WHA	World Health Assembly
WRA	Women of Reproductive Age
WVK	World Vision Kenya

Term	Operational Definition
Stakeholders	Refers to a group of agencies or persons with a similar interest in a particular field e.g. nutrition.
Research	Refers to the generation of knowledge that can be used to prevent disease, promote, restore, maintain, protect and improve the population's development and well-being.
Surveys	Periodic, focused assessments that collect data from a population. Surveys are used to assess the perceptions, behaviour, knowledge, attitudes and infection status of targeted populations
Surveillance	Ongoing, systematic collection, collation, analysis and interpretation of trends and dissemination of data regarding a health-related event for use in public health action to reduce morbidity and mortality and to improve health. Nutrition surveillance is a systematic approach used to detect malnutrition and identify populations at risk of suffering from it for action.
Relevance	Only data that meets the information needs is collected, to inform project management and decision-making. Data captured should be used for the purposes for which it is collected.
Validity	Data use should be able to measure the changes being tracked. Data should be recorded and used in compliance with relevant requirements, including the correct application of any rules or definitions. This will ensure consistency between periods and with similar activities. Where proxy data is used to compensate for an absence of actual data, activities must consider how well this data is able to satisfy the intended purpose
Accuracy	Data should represent the actual population and their situation. Data should be sufficiently accurate for its intended purposes, representing clearly and in sufficient detail the interaction provided at the point of activity
Completeness	Data requirements should be clearly specified based on the information needs of the activities and data collection processes matched to these requirements
Reliable	Data should be verifiable, producing the same results when used repeatedly to measure the same thing over time. Data should reflect stable and consistent data collection processes across collection points and over time, whether using manual or computer-based systems, or a combination
Timeliness	Data should be captured as quickly as possible after the event or activity and must be available for the intended use within a reasonable period. Data must be available quickly and frequently enough to support information needs and to influence the appropriate level of service or management decisions

EXECUTIVE SUMMARY

Kenya is facing a triple burden of malnutrition in the form of under nutrition, micronutrient deficiencies and over-nutrition. The Ministry of Health in collaboration with stakeholders developed the Kenya Nutrition Action Plan (KNAP) 2018-2022. The overarching objective of the plan is accelerating and scaling up efforts towards the elimination of malnutrition in Kenya in line with Kenya's Vision 2030 and Sustainable Development Goals (SDGs) with focus on specific achievements by 2022. The action plan is organized into three category focus areas namely; Nutrition-specific and Nutrition-sensitive Interventions and, Enabling Environment. The Kenya Nutrition Monitoring and Evaluation Framework 2018-2022 has been developed to align with the needs of the Kenya Nutrition Action Plan 2018-2022. A review of the Nutrition Monitoring and Evaluation Framework 2013 and other relevant documents was conducted to inform the development of this framework. The development was conducted through a consultative process involving deliberations by task teams, stakeholder consultations, and online survey and review and validation workshops.

The rationale of this framework is to ensure continuous tracking of progress, document lessons learned and replicate best practices of nutrition interventions as outlined in the KNAP 2018-2022. It highlights the goal and the objectives and the guiding principles which are expected to ensure a systematic implementation of the monitoring and evaluation framework. The framework describes the basic principles of Monitoring, Evaluation, Accountability and Learning (MEAL) the sources of nutrition information and data analysis and reporting. In addition, the Nutrition Information System monitoring toolkit repository comprising of a variety of guidelines, training packages, tools for data collection and guidance on data analysis and reporting for different sources of information has been developed to provide ease of accessibility to these tools and documents.

The framework also covers the Common Results and Accountability Framework (CRAF) for the 19 Key Result Areas (KRAs) and elaborates the process of Monitoring, Evaluation, Accountability and Learning. The key result areas are categorized into nutrition specific, nutrition sensitive and enabling environment with their indicators, definitions, thresholds, means of verification, frequency of reporting and operational research to be conducted. The indicators will be measured and reported through existing systems such as Kenya Health Information System (KHIS), the National Drought Management Authority (NDMA) early warning system, program reports and population-based surveys. Reporting and communication of results will adhere to standard guidelines and use effective communication channels to ensure improved uptake of findings.

Evaluation and operational research will be implemented to provide evidence for informing programme decisions that lead to effective coverage of interventions. Finally, accountability will be mainstreamed to ensure service providers or duty bearers are accountable for resources and results. Learning and application of best practices will contribute to adaptation of approaches that are known to produce results.

The actualization of the M&E Framework will help build a chain of evidence that will provide the metrics of change. The burden of proof lies with the various stakeholders whose responsibility is to demonstrate that the commitment made in the KNAP 2018-2022 shall indeed be realized and that there is evidence to back up the claim of progress. The implementation strategy therefore shall be driven by human resource development and system readiness and funding mechanisms that will boost M&E human resource and systems at National and County levels.

CHAPTER 1

INTRODUCTION

1.1 Nutrition Status

Nutrition is a vital component in human growth and development. Globally, at least one in three people is experiencing malnutrition in one form or another. Almost every country in the world is facing a nutrition-related challenge characterized by undernutrition (stunting, wasting and underweight), micronutrient deficiencies and over-nutrition (overweight/ obesity); that is triple burden of malnutrition. The 2018 Global Nutrition Report (GNR) estimates that 150.8 million children under the age of five (22.2 per cent) are stunted and 50.5 million children (7.4 per cent) are wasted. The anaemia prevalence in girls and women of reproductive age (15-49 years) remains high at 32.8 percent, having increased from 31.6 percent in 2000. Slightly over two billion adults are overweight, of whom 678 million are obese; and 38.3 million children are overweight[1].

In different regions, the proportion of stunting among children under the age of five has declined: for example, in Asia from 38.1 percent to 23.2 percent; Latin America and the Caribbean from 16.9 percent to 9.6 percent; and Africa from 38.3 percent to 30.3 percent. Despite the decreased prevalence of stunting in Africa, the number of stunted children increased steadily from 50.6 million in 2000 to 58.7 million in 2017. Sub-Saharan Africa (SSA) contributes the highest burden of malnutrition in Africa. There are 17.6 million children in sub-Saharan Africa who suffer from acute malnutrition[2].

In Kenya, the situation of undernutrition is very similar to the global outlook. Out of 7.22 million children less than five years old, nearly 1.8 million are stunted (26 percent); 290,000 are wasted (4 percent) and 794,200 (11 percent) are underweight. However, there are geographical variations in the severity of malnutrition (See Figures 1, 2 and 3).

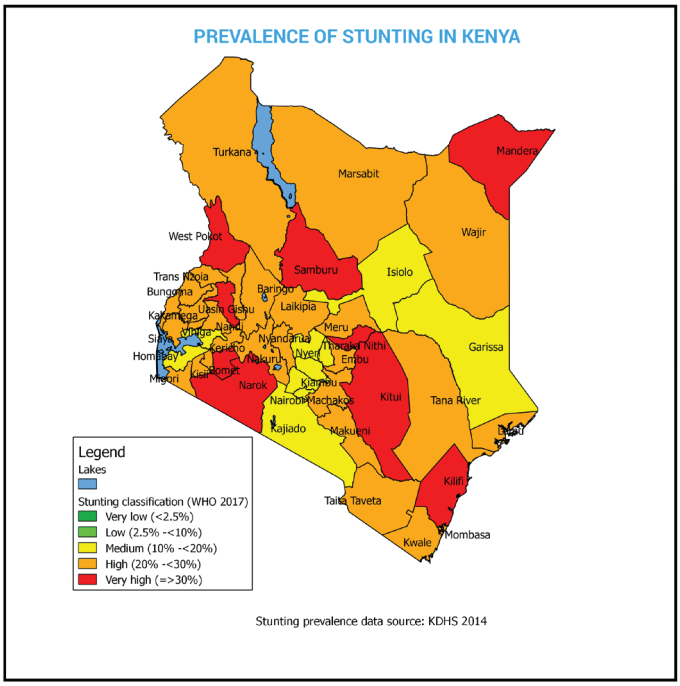


Figure 1:Prevalence of Stunting in Kenya

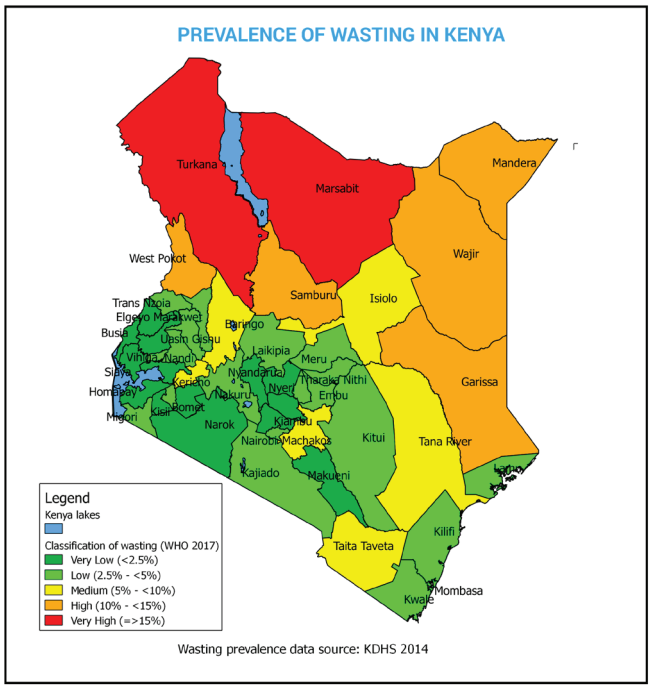


Figure 2: Prevalence of wasting in Kenya

1 2018 Global Nutrition Report
2 2018 Global Nutrition Report

The Kenya Demographic Health Survey (KDHS) 2014 showed a decline in stunting from 35.3 percent in 2008 to 26 percent in 2014 as shown in Figure 4. Though the country has made a lot of progress towards reduction of stunting, the country is classified as having high (20-<30 percent) levels of malnutrition based on the new WHO 2017 classification thresholds[3]. All counties in Kenya are now classified as being in medium (10-<20 percent) or high (20-<30 percent) category and need to prioritize interventions to achieve low (2.5-<5 percent) or very low <2.5 percent) levels of stunting. Stunting is very high (>30 percent) in 9 counties[4]. Nationally, stunting peaks at 18-23 months where 35.3 percent of the children are stunted. More boys than girls are stunted (30 percent compared to 22 percent respectively).

In terms of wasting, there has been modest decline from 6.7 percent in 1993 to 4 percent in 2014 (Figure 4). Kenya is now classified in the 'low' category based on the new WHO thresholds. Huge disparities however exist within the country with arid counties in **very high** (>15 percent) category. Wasting is highest in Turkana at 23 percent and lowest at 0.2 percent in Siaya (KDHS 2014).

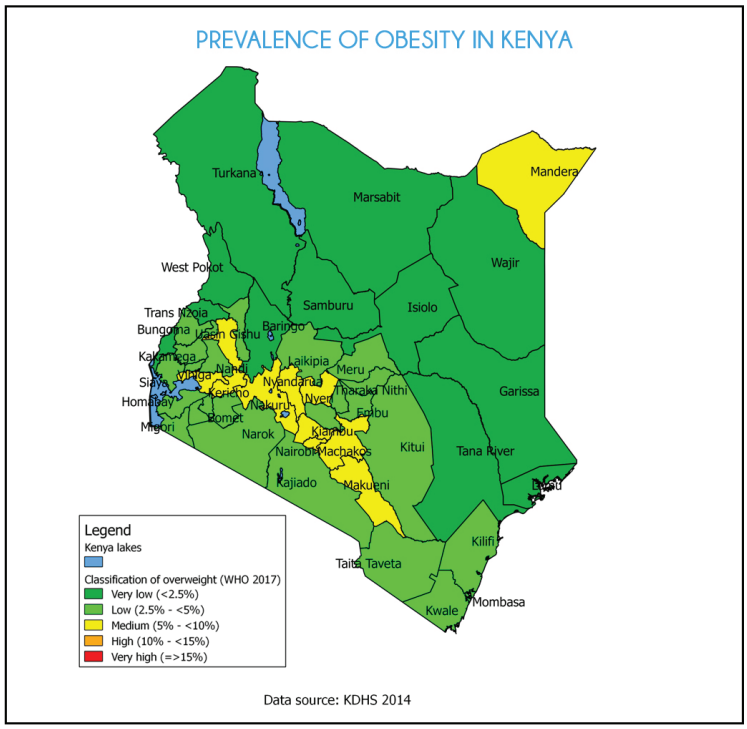


Figure 3: Prevalence of Obesity in Kenya

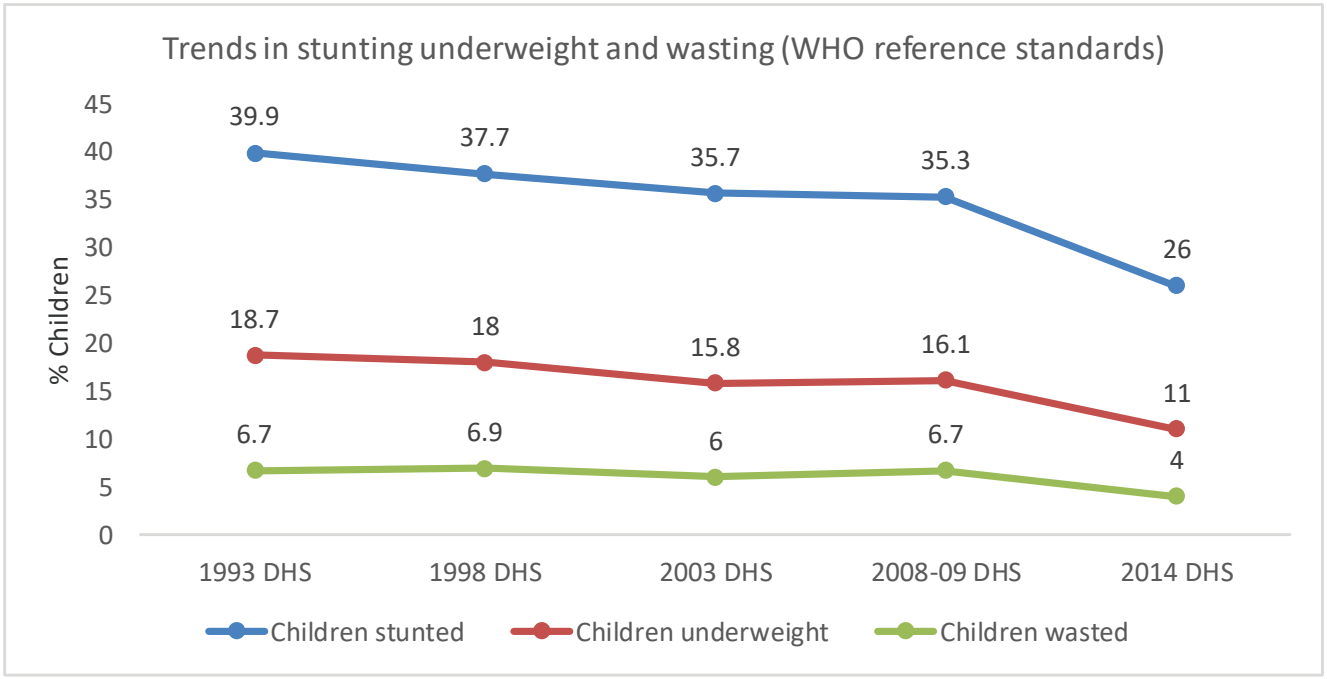


Figure 4: Trends in Stunting, Underweight and Wasting 1993-2014

Although the KDHS 2014 showed that poor nutrition status of women of reproductive age (WRA) was a triple burden, the trend indicated a reduction of undernutrition while overweight and obesity increased. Higher prevalence of obesity is observed in the central region of the country. Comparing the 2008–9 and 2014 KDHS, the proportion of women with a Body Mass Index (BMI) ≥18.5 reduced from 12 percent to 9 percent.

3 Annex 1: Nutrition Indicators Thresholds
4 West Pokot, Kitui, Kilifi, Samburu, Narok, Uasin Gishu, Tharaka Nithi, Mandera and Bomet

Micronutrient deficiency among children and women

Micronutrient deficiency not immediately evidenced by clinical symptoms affects body function and productivity of an individual. Micronutrient deficiencies of public health importance affects mainly the vulnerable sub-populations (children and women). The deficiencies can be addressed through dietary diversification, food fortification, supplementation and other public health interventions. According to the Kenya National Micronutrient Survey 2011 significant progress was made in reducing the prevalence of micronutrient deficiencies, except for zinc deficiency[5].

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 iron deficiency was 21.8 per cent, 9.4 per cent and 36.1 per cent in the same groups respectively (Table 1). The prevalence of Vitamin A deficiency (VAD) had reduced considerably with preschoolers at 9.2 percent and pregnant women 4.7 percent. The prevalence of zinc deficiency was high across the population groups; 83.3 percent among all the population sub-groups; 81.6 percent among the pre-schoolers, 79.9 percent among non-pregnant women, 67.9 percent among pregnant women and 77.4 among men (Table 1).

Table 1: Prevalence of micronutrient deficiencies among Children(6-59 months) and Women (15-49 years)

Indicators	National Prevalence			
	n	%	95%	CI
Anaemia (based on age specific Hb cut-offs. Hb adjusted for altitude)				
Pre-School Children	827	26.3	23.3	29.3
School Age Children (Children 5-14 years)	872	16.5	14.0	19.0
Pregnant Women	104	41.6	32.1	51.1
Non-pregnant Women	592	21.9	18.57	25.23
Men	240	9.3	5.87	13.33
Iron Deficiency (based on age specific serum ferritin cut-offs. Serum ferritin corrected for inflammation)				
Pre-School Children	918	21.8	19.1	24.5
School Age Children	942	9.4	7.5	11.3
Pregnant Women	111	36.1	27.2	45.0
Non-pregnant Women	633	21.3	18.11	24.49
Men	247	3.6	1.28	5.92
Iron Deficiency Anaemia (based Hb and serum ferritin cut-offs)				
Pre-School Children	827	13.3	11.0	15.6
School Age Children	942	4.9	3.5	6.3
Pregnant Women	104	26.0	17.6	34.4
Non-pregnant Women	592	14.0	11.20	16.80
Men	243	2.9	0.79	5.01
Vitamin A Deficiency (based on RBP cut-offs)				
Pre-School Children	918	9.2	7.3	11.1
School Age Children	942	4.7	3.4	6.1
Pregnant Women	111	5.4	1.2	9.6
Non-pregnant Women	632	2.0	0.9	3.1
Men	111	0.0	0	0

5 The Ministry of Health, Kenya National Micronutrient Survey 2011

Indicators	National Prevalence			
	n	%	95%	CI
Pregnant Women	78	32.1	21.7	42.5
Non-pregnant Women	445	30.9	26.6	35.2
Pregnant Women	78	7.7	1.8	13.6
Non-pregnant Women	445	34.7	30.3	39.1
(Serum zinc corrected for inflammation)				
Pre-School Children	711	81.6	78.8	84.5
School Age Children	901	79.0	76.3	81.7
Pregnant Women	109	67.9	59.1	76.7
Non-pregnant Women	617	79.9	76.7	83.1
Men	239	77.4	72.1	82.7
School age Children	951	22.1	19.5	24.7
Non-pregnant Women	623	25.6	22.2	29.0

Source: Kenya National Micronutrient Survey, 2011

1.2 Vision, Mission and Mandate of Division of Nutrition and Dietetics

The Division of Nutrition and Dietetics (DND) is in the Department of Family Health, Ministry of Health. The vision, mission and mandate of DND are as follows:

Vision

Malnutrition free Kenya.

Mission

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

Mandate

The mandate includes:

- Policy formulation, standards development and strategic planning;
- Provision of nutrition services;
- Coordination and resource mobilization;
- Nutrition assessments and surveillance;
- Capacity strengthening of health and other workers on food and nutrition;
- Creation of awareness to the public on food and nutrition;
- Procurement and distribution of equipment and supplies for nutrition service delivery;
- Food and nutrition operations research;
- Administration of the scheme of service for nutrition officers and assistants; and
- Monitoring and evaluation of nutrition programmes.

1.3 Core Values and Guiding Principles

The Division of Nutrition and Dietetics core values are:

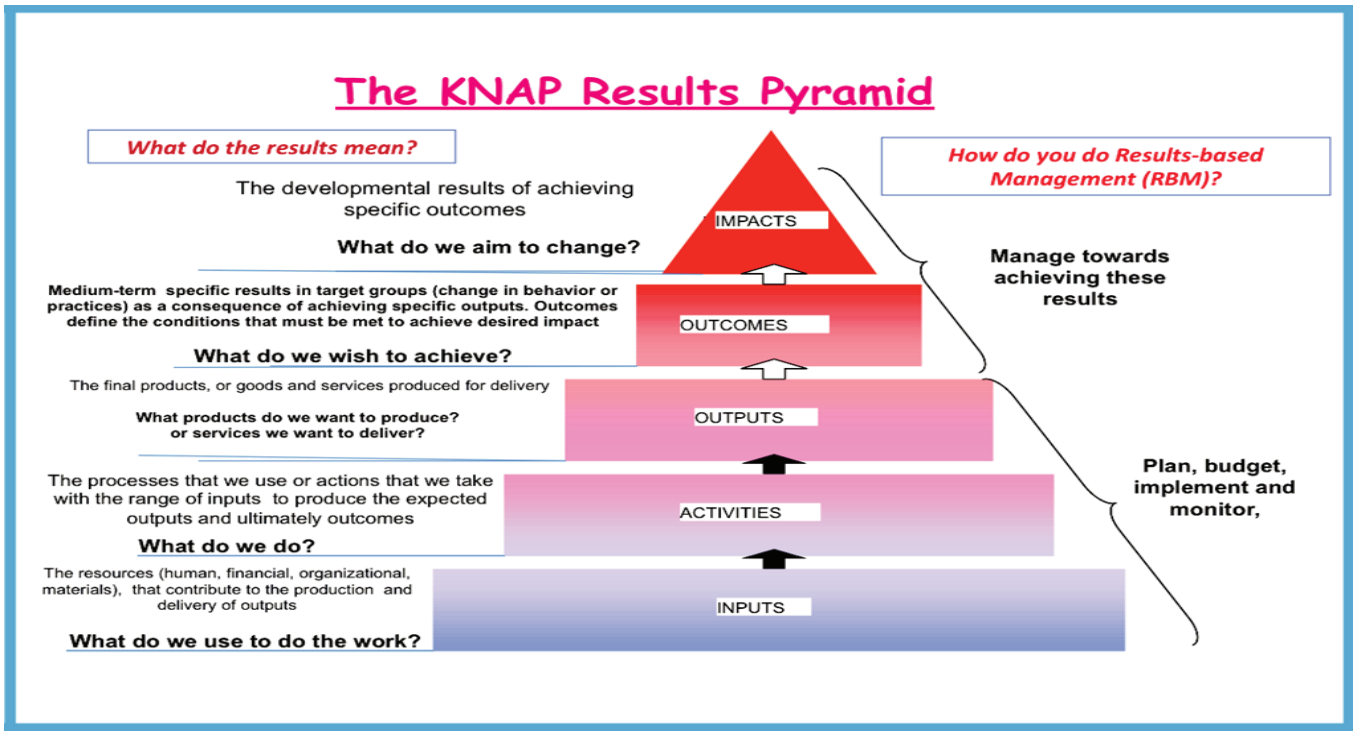
- Efficiency and Effectiveness
- Accountability
- Professionalism
- Integrity.
- Partnership
- Teamwork and collaboration
- Innovativeness
- Ethics-
- Equity Quality
- Risk management
- Sustainability and ownership

1.4 The Kenya Nutrition Action Plan 2018-2022

The overarching objective of the KNAP 2018-2022 is 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. The KNAP 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 (KRAs) with corresponding outcomes, outputs, strategies, interventions and activities that are costed and presented within an implementation matrix.

The activities/interventions outlined in the KNAP will be implemented twith an aim to produce a series of results that contributes to the desired goal (**impact**) for the KNAP which is *'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'.* Figure 5 depicts the results logic pyramid of the KNAP combining theory of change and logic framework approaches. The results pyramid framework ensures results-based planning, budgeting, and implementation and performance M&E, and facilitates results-based management of the KNAP.

Figure 5: Results Logical Pyramid of the KNAP



A Monitoring, Evaluation, Accountability and Learning framework (MEAL) has been developed and targets put in place to measure the progress in implementation of the KNAP over the five-year period during which the KNAP will be implemented. The MEAL framework provides a summary of select results and indicators that will be mutually tracked and reported on by all sectors responsible for the implementation of the KNAP referred to as the Common Results and Accountability Framework (CRAF). The Nutrition Monitoring and Evaluation Framework will therefore provide further guidance on monitoring and evaluation and strengthen multi-sectoral nutrition information systems (NIS), learning and research for players engaged in the implementation of the KNAP at all levels.

1.5 County Nutrition Action Plans (CNAPs) 2018-2022

Counties have adopted the KNAP to develop County Nutrition Action Plans (CNAPs) that address County-specific nutrition issues and interventions that are appropriate for their local context. Through these action plans, Counties will identify priority multi-sectoral nutrition actions, define targets for each intervention and cost interventions which County governments can use for subsequent planning and budgeting. More so, to ensure tracking of these activities, CNAPs will provide a monitoring and accountability framework. Based on the CNAPs and the National Nutrition Monitoring and Evaluation Framework 2018-2022, the counties will develop county level M&E frameworks for tracking of nutrition activities and results as outlined in the respective CNAPs. The M&E frameworks will be integrated in the CNAPs and the yearly M&E activities included in the County Annual Work Plans. Furthermore, mechanisms will be put in place to ensure there is linkage between national and county action plans, effective multisectoral collaboration as well as functioning stakeholder coordination and accountability. The framework will also provide for mechanisms for communication and information sharing within the county and between the two levels of government.

1.6 Process of Development of Monitoring and Evaluation Framework 2018-2022

The Nutrition Monitoring and Evaluation Framework 2018-2022 is the second after the first one which was developed in 2013. The framework is anchored on the ideals of the Kenya Food and Nutrition Security Policy (FSNP) that are unpacked in the KNAP 2018-2022.The framework was developed through a comprehensive participatory and consultative process guided by the Ministry of Health Division of Nutrition and Dietetics through the Kenya National Information Technical Working Group (NITWG). A team of Nutrition and M&E professionals from government agencies, development and implementing partners participated in the development of the framework[6].

The development process was preceded by a review of the existing health and nutrition M&E/information system and use of the 2013 nutrition M&E framework to identify gaps and develop recommendations to inform the process. A detailed and extensive desk review of relevant documents including policy documents, KNAP 2018-2022, National Nutrition M&E Framework 2013 was conducted. Stakeholder consultations with donors, development and implementing partners as well as county officials were conducted through Key Informant Interviews. In addition, an online survey was conducted targeting national and county government officials and technical staff in partner agencies. This M&E framework was developed through deliberations of various task review groups and validation workshops to ensure all the key M&E elements in the KNAP 2018-2022 were taken care of. The Framework builds on learning, success, limitations and opportunities of the 2012-2017 NNAP and 2013 M&E Framework period.

1.7 Status of the nutrition M&E and information system

According to the M&E system review, Kenya has made commendable progress in establishing a functional nutrition information system though gaps exist especially in monitoring implementation of nutrition plans and programs at process level. The first M&E Framework was finalized in 2013 with an overall goal of guiding monitoring and evaluation of the 2012-2017 National Nutrition Action Plan and to provide quality information for effective planning, decision making, monitoring and evaluation of nutrition interventions in the country.

6 See annex 7 for list of contributors in technical review workshops.

The objectives of the framework were:

- To provide guidelines on data collection, reporting, feedback and nutrition programming.
- To monitor and evaluate quality of nutrition data and activities
- To promote data use at all levels to inform decision making and nutrition programming
- To produce and disseminate program implementation reports at all levels
- To monitor the health sector's response to nutrition
- To contribute towards strengthening of the nutrition information component of health systems
- To develop a supervisory framework to facilitate high quality data collection, collation, analysis, reporting and use at all levels and,
- To provide a framework for the systematic linkage of nutrition and food security indicators at National and County level.

Nutrition M & E is recognized as a critical function of the Division of Nutrition and Dietetics and the nutrition sector. There is a distinct program in the Division that is responsible for national and county level nutrition monitoring, evaluation, accountability and learning. The functions of the program is coordinated through the Nutrition Information Technical Working Group (NITWG). The key functions of the NITWG include:

- Development of standards and guidelines for nutrition information including adoption and adaption of relevant international guidelines
- Development, review and validation of nutrition data collection, procedures/ methodologies, analysis and reporting.
- Produce nutrition situation reports and other information products
- Data dissemination for action, maintaining an up to data nutrition information portal in the nutrition website and ensuring common repository
- Capacity strengthening and technical support on nutrition information when and as needed especially to the counties
- Strengthen multi-sectoral linkages on nutrition information through direct participation in various sectoral and multi-sectoral forums
- Promotion of knowledge management; documentation of success and lessons learnt
- Strengthen continuity of NITWG partnership with key stakeholders such as NDMA, Kenya National Bureau of Statistics (KNBS) and enhance linkages with other working groups within the sector.
- Quality assurance, technical oversight and supervision.

The M&E framework 2013 contributed to addressing the problem of malnutrition. It was essential for tracking the implementation of the NNAP 2012-2017 which was critical towards the improvement of nutrition outcomes. One measure of success was availability of M&E information from various sources and databases which was useful for informing decision making for programme improvement. Nutrition indicators were integrated in the monthly facility-based Kenya Health Information System (KHIS aggregate/ KHIS) and provided data on nutrition programs coverage such as vitamin A supplementation and iron & folic acid supplementation. The large-scale population-based surveys (e.g. KDHS, KNMS), the more frequent small-scale population-based surveys (e.g., Integrated nutrition SMART surveys and Integrated Management of Acute Malnutrition (IMAM) program coverage assessment) also provided information for monitoring and evaluation of nutrition programmes.

The challenges of implementing the 2013 Nutrition M&E Framework and activities included:

- Limited funding for M&E activities such as technical supervision, capacity development, conducting of review forums and integration of technology in the M&E systems.
- Understaffing and inadequate capacity for nutrition and M&E programmes both at the national and county levels.
- Gaps in technical knowledge in M&E as a result of inadequate capacity development and technical supervision.
- Inefficient M&E practices such as delayed dissemination of information and inadequate utilization of data.
- Inadequate stakeholder co-ordination and accountability mechanisms

Recommendations from the review of the NIS/ M&E system:

In summary the following recommendations were made as the major considerations for the development of the M&E framework 2018-2022:

- Strengthening and improving the quality of the KHIS data, in terms of comprehensiveness, reporting and utilization.
- Strengthen the evaluation of the KNAP 2018-2022 by including mid-term and end-term reviews and operational research to track the progress and performance of the KNAP and inform programming.
- Improve implementation of the M&E system and NIS by improving multi-sectoral coordination, technical supervision, capacity building on M&E and NIS, dissemination and utilization of M&E data.
- Put in place a central repository for all NIS tool/kit for easy accessibility.
- Emphasize the use of technology in M&E such as digitalize trainings (online trainings on NIS and M&E), dissemination and review of M&E data processes.
- Improve and strengthen Advocacy, Communication and Social Mobilization (ACSM) to lobby for profiling and funding for nutrition programmes and M&E.
- Strengthen stakeholder co-ordination and accountability mechanisms at national and county levels

These gaps and challenges identified during the M&E system review and the resulting recommendation necessitates development of the 2018-2022 Nutrition M&E Framework while taking into consideration the key lessons learnt, field experiences, emerging knowledge and alignment to the 2018-2022 KNAP.

CHAPTER 2

DEVELOPMENT OF THE KENYA NUTRITION MONITORING AND EVALUATION FRAMEWORK

2.1 Rationale

Kenya has numerous nutrition stakeholders including government ministries, development agencies, implementing partners, teaching and research institutions, nutrition working groups and professional associations, as well as the private sector. However, even with many players in nutrition, there has been sub-optimal impact, from implementation of high impact nutrition interventions. This, in part, is attributed to challenges arising from coordination ofnutrition programs in different sectors, the short-term nature of interventions which mainly target emergency situations and inadequate holistic programming leading to interventions with limited scope and impact.

These challenges call for sector-wide approaches to nutrition programming in the country in order to meet the SDGs. In this regard, the Kenya Nutrition Action Plan 2018-2022 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 main purpose of the M&E framework is to ensure continuous tracking of progress, document lessons learned and replicate best practices of nutrition interventions as outlined in the KNAP 2018-2022. Monitoring and evaluation will be an integral part of all aspects of the nutrition interventions. The framework is aligned to the Health Information System (HIS) with focus on strengthening nutrition indicators and systems.

Chapter 6 of the KNAP 2018-2022 broadly defined Monitoring, Evaluation, Accountability and Learning (MEAL) which will facilitate tracking and evaluation of performance, as well as serving as an accountability and learning framework for the various nutrition stakeholders. The M&E framework will provide further guidance on monitoring and evaluation of the KNAP 2018-2022 and Nutrition Information Systems (NIS). The framework will serve as a plan for monitoring and evaluation and will clarify:

1. What is to be monitored and evaluated;
2. What activities need to be monitored and evaluated;
3. Who is responsible for monitoring and evaluation of the activities;
4. When monitoring and evaluation activities are planned; and
5. How monitoring and evaluation will be carried out.

The framework will put in place a comprehensive guidance and a harmonized approach to nutrition information management, monitoring and evaluation.

The Framework will enable real time improvement; identify unintended consequences; facilitate the learning of best practices and communication of results. The outputs of the M&E system will help to answer questions relating to delivering on commitments, accountability to right-holders, donors and other players, effectiveness of interventions and consistency of planned interventions with targets. The framework will define progress review and feedback mechanism for results-based accountability between the national and county levels and provide guidance on data collection, analysis, use and reporting of nutrition information for improved programming.

2.2 Goal and Objectives of the M&E Framework

2.2.1 Goal

The goal of the Monitoring and Evaluation Framework is to ensure a systematic monitoring and evaluation of nutrition sector activities in Kenya in line with the Key Result Areas (KRAs) as derived from the Kenya Nutrition Action Plan 2018-2022 and serve as an accountability and learning framework for nutrition stakeholders.

2.2.2 Objectives

- To provide guidelines on data collection, reporting, feedback and use for nutrition programmes.
- To monitor and evaluate quality of nutrition data and activities.
- To facilitate tracking and evaluation of performance of set targets
- To produce and promote data for use at all levels to inform decision making and nutrition programming.

- To produce and disseminate programmes implementation reports at all levels.
- To monitor the health sector's response to nutrition.
- To contribute towards strengthening of the nutrition information component of health systems.
- To develop a supervisory framework to facilitate high quality data collection, collation, analysis, reporting and use at all levels.
- To strengthen the operational research capacity and coordination mechanism at national and county levels to generate evidence to inform decision making.
- To provide a framework for the systematic linkage of nutrition and food security indicators at national and county levels.
- Rally partners and stakeholders to a common approach to reporting
- To provide an accountability and learning framework for the various nutrition stakeholders both at national and county levels.

2.3 Guiding Principles

The M&E framework is guided by the following principles:

1. Three Ones Principle:
   a. One national coordinating authority, with a broad-based multi-sector mandate.
   b. One agreed comprehensive Kenya nutrition plan of action.
   c. One agreed country level nutrition monitoring and evaluation framework.
2. Mainstreaming of M&E in all nutrition interventions at all levels.
3. Decentralization, analysis and storage of data at the operational level.
4. Gender and disability mainstreaming, attention to vulnerable groups and regional disparities.
5. Participatory approach; consultation of key stakeholders for ownership and use.
6. Adherence to national, regional and global standards and M&E ethics.
7. Integration and complementarity to existing M&E systems where new data collection may be required or recommended.
8. Efficient use of resources while ensuring quality M&E products are generated.
9. Review and validation of the M&E products through the existing relevant structures.

2.4 Components of the Nutrition Information System (NIS)

NIS is a system of continuous collection, analysis and interpretation of nutrition-related data for making timely and effective decisions to improve the nutritional health of the population. It requires the availability of, access to, and analysis of accurate and adequate information that address national, sub-national and institutional development as well as implementation challenges. NIS comprises of several components (Figure 6):

Resources: These include the legislative, regulatory, and planning frameworks required for system functionality and also include personnel, financing, logistics support, information and communications technology (ICT), and mechanisms for coordinating both within and between the components.

Indicators: This includes a complete set of indicators and relevant targets, including inputs, outputs, and outcomes, determinants of health and nutrition, and nutrition status indicators.

Data sources: These include population-based surveys, sentinel surveillance systems, routine administrative data among others

Data management: This includes collection and storage, quality assurance, processing and flow, and compilation and analysis.

Information products: This refers to data which has been analyzed and presented as actionable information.

Dissemination and use: This is the process of making data available to decision-makers and facilitating the use of that information.

Figure 6: Components of Nutrition Information System

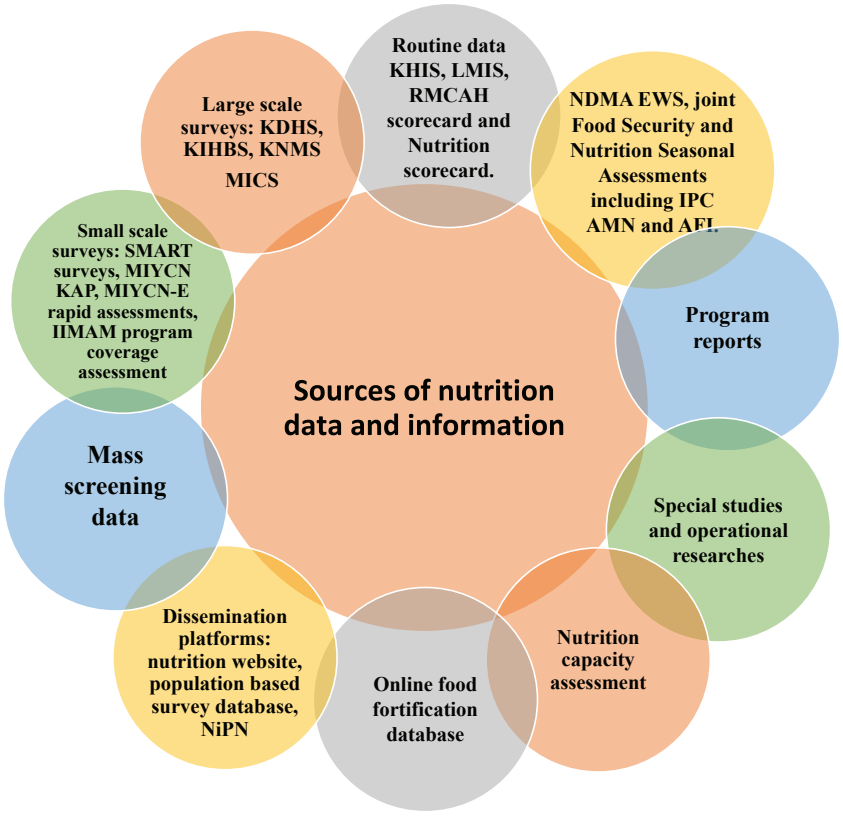
2.5 Sources of nutrition data and information

Nutrition programs draws data and information from direct sources as well as from other information systems within and outside the health sector (Figure 7). The main nutrition data and information sources include:

1. **Routine data** collected through the Health Information System (HIS). This includes data from KHIS, Logistic Management Information System (LIMIS), Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCAH) scorecard and Nutrition scorecard.
2. **Population based data** includes large scale surveys such as Kenya Demographic and Health Survey, Kenya Integrated Household Budget Survey (KIHBS), Kenya National Micronutrient Survey, Multiple Indicator Cluster Surveyand small scale surveys such as Integrated nutrition SMART surveys, Maternal Infant and Young Child (MIYCN) Knowledge, Attitudes and Practices (KAP) assessments, MIYCN-E rapid assessments and IMAM program coverage surveys among others.
3. **NDMA Early Warning System** - Sentinel Surveillance
4. Joint Food Security and Nutrition Seasonal Assessments including situation analysis with Integrated Phase Classification for acute malnutrition and food Insecurity (IPC AMN and AFI) protocols.
5. Mass screening data
6. Special studies and operational researches
7. Project and program reports
8. Nutrition capacity assessment conducted to assess system capacity to deliver nutrition services
9. The online food fortification database
10. The Kenya Nutrition Website[7],
11. The interactive Population Based Survey Database[8]
12. The multisectoral National Information Platform for Food and Nutrition (NiPFN)[9].

7 www.nutritionhealth.or.ke
8 http://www.nutritionhealth.or.ke/nutrition-reports-on-maps/
9 NiPFN is Under development

Figure 7: Sources of Nutrition Information and Dissemination platforms



2.6 Nutrition Information System (NIS) and M&E Toolkit

Standardized tools and methods of collection are essential to ensure that the data generated within the NIS/ M&E is of good quality. When utilized in a systematic and coordinated manner, these resources help to ensure that indicators are comparable across counties and achieve compatible degrees of disaggregation. Updated training materials, technical guidelines, manuals, forms, registers and report template used in the NIS have been consolidated in a toolkit to allow easy access and are uploaded on the nutrition website (http://www.nutritionhealth.or.ke/resources/).

2.7 Data analysis

Nutrition data from the various sources will be analyzed for use in decision making at all levels of the health system. Analysis will involve systematic data quality assessment and if necessary, adjustment will be done where appropriate. Identifying and accounting for biases because of incomplete reporting, inaccuracies and non-representatives are essential measures and will greatly enhance the credibility of the results for users. The analyses will be transparent and in line with national data analysis standards.

The data will be analyzed by comparing achievements against the set targets or baselines (as well as with international standards e.g. SPHERE standards and MOH guidelines/standards (Annex 1). Analysis will also be done by establishing if the implementations of activities in the nutrition action plan have been conducted to determine whether progress is being made and inform the required adjustment. Data analysis will also be conducted to compare trends of the nutrition situation and interventions at various levels over time.

Nutrition information analysis will be complemented by more complex analyses that provide estimates of the burden of malnutrition, nutrition service coverage, trends in nutrition indicators, and health system performance. In addition, use of nutrition research as well as qualitative data gathered through systematic processes of analyzing nutrition systems characteristics and changes will be considered.

2.8 Data Dissemination

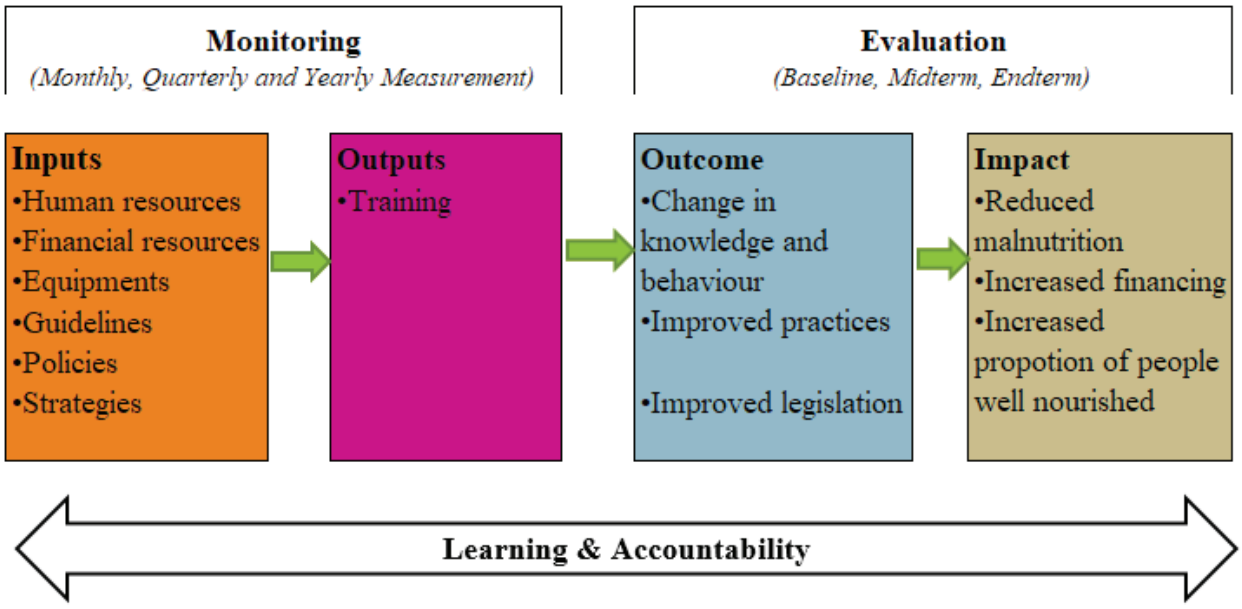
Data and information dissemination refer to targeted distribution of information to a specific audience. It is the process of transfer of data between users with the intention of spreading knowledge and the associated evidence-based interventions for use in policy development, decision making, and programming. Analyzed information will be disseminated through technical forums and meetings, bulletins, quarterly and annual reports and the nutrition website (http://www.nutritionhealth.or.ke/). To ensure effective dissemination use of visuals and dashboards will be employed. Analyzed nutrition information presented in a precise and visual manner is anticipated to enhance:

- The use of information for planning,
- Re-strategizing of programme activities,
- Forming conclusions and anticipating how to deal with problems,
- Replicating best practices,
- Accountability,
- Advocacy
- Documentation of lessons learnt and
- Documentation of Human-interest stories.

2.9 Basic Concepts of Monitoring, Evaluation, Accountability and Learning (MEAL)

The logical framework identifies and illustrates the linear relationships flowing from program inputs, processes, outputs, outcomes and impacts. Inputs or resources affect processes or activities which produce immediate results or outputs, ultimately leading to long term or broad results, or outcomes and impacts. Indicators are used to measure performance of programs at different levels. Inputs, processes and outputs are regularly monitored while outcomes and impact are periodically assessed either through surveys or evaluations. The M&E framework will demonstrate to stakeholders to what extent results have been achieved according to priorities in plans and establish a process through which information generated is reflected upon and intentionally used to continuously improve the implementation of the KNAP. Nutrition programs has adopted a basic M & E logical framework as illustrated in figure 8.

Figure 8: M&E Logical Framework



Inputs: Refer to all those resources that go into the nutrition programs at the onset or start-up phase or during the implementation to help the programs achieve their objectives as stipulated in KNAP and CNAPs. The inputs include human resources, financial resources for conducting various activities. Adequate inputs are critical for the attainment of the desired outputs.

Activities: These are actions taken, or the work performed as part of an intervention. Examples of activities include; technical advice and supervision for health workers involved in various activities, training/capacity development, coordination and review. Activities utilize inputs, such as funds, technical assistance and other types of resources to produce specific outputs. Essentially, activities or tasks are what the project will *'do'*.

Outputs: These refer to all goods and services produced after implementation of activities by those involved in nutrition programs at the national and county levels in line with the priorities of KNAP and CNAPs. These will include the number of training sessions, number of those trained, number of nutrition technical supervisions at county and field levels. Programme inputs must be transformed into outputs. The quantity and quality of the outputs is very important. For instance, if one activity was the training of M&E service providers, the outputs are the number of health service providers trained. The quality of the training should also be "adequate," so that the training results into *Enhanced capacity for the delivery of M&E services.* The availability of nutrition and nutrition-related policies to guide programme implementation for example, should result into *Improved implementation environment at both national and county levels.*

Outcomes: These are changes in behaviours/practices as a result of programme activities. The outputs, if of the right quantity and quality, should produce an outcome. For example, the knowledge and skills acquired by the health service providers should enable them to take accurate anthropometric measurements of children. The desired nutrition programme outcomes are clearly stipulated in KNAP for each Key Result Area.

Impacts: Refer to the achievement of higher level goals which a programme can contribute to, for example reduced malnutrition, improved financing of nutrition programmes, improved legislation for nutrition etc.

Processes: These are activities carried out to achieve the programme objectives. Monitoring of these activities will show what has been done and how well and timely they have been done based on the planned nutrition programme as stipulated in the national and county level M&E Frameworks.

Assumptions: Refers to the external factors, influences, situations or conditions which are necessary for programme but are largely or completely beyond the control of programme management. For example, the KNAP assumes that finances will be available for the implementation of the stipulated nutrition programmes and also for monitoring and evaluation of the programmes both at national and county levels. Accordingly, it is necessary to make assumptions explicit and list them as elements to be monitored or evaluated.

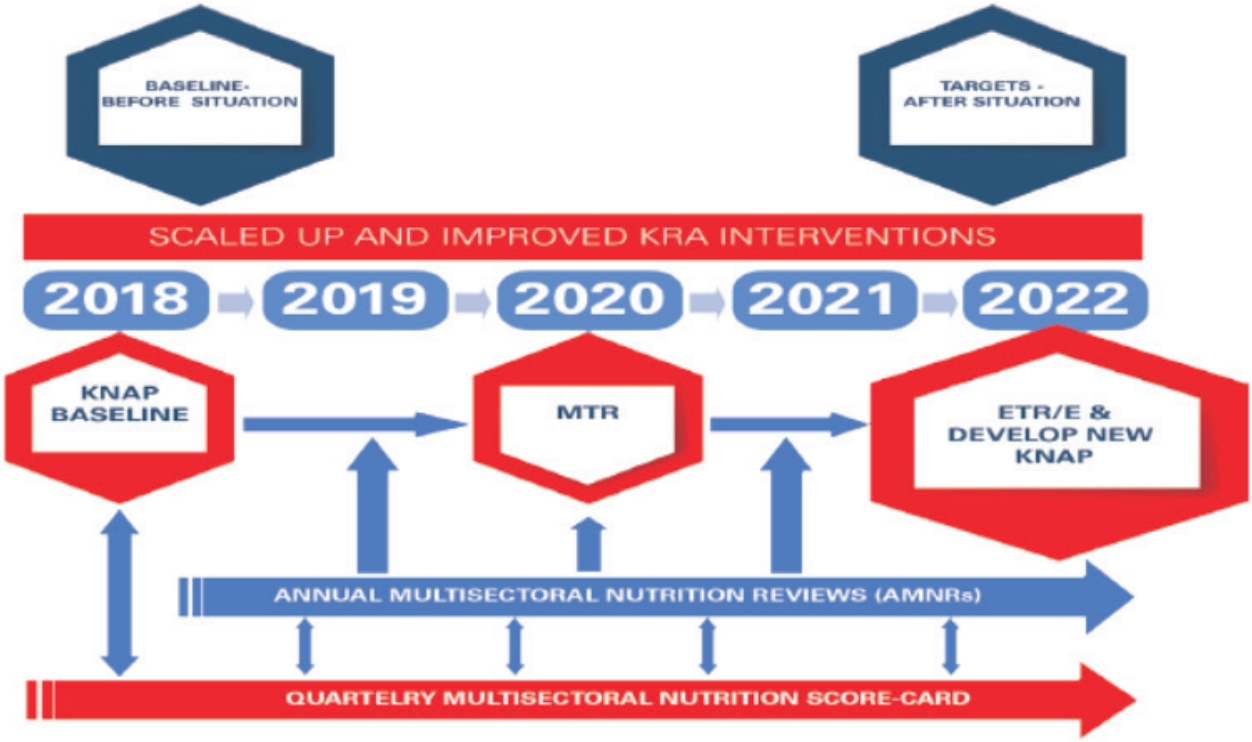
Indicator : A measure of change, progress or state. Programme indicators are at various levels; input, output, process, outcome and impact. **Input indicators** refer to the resources needed for the implementation of an activity or intervention. Availability of policies, human resources, materials, financial resources are examples of **input indicators.** An input indicator will measure the extent to which the planned for inputs were actually realized or achieved. **Output indicators** measure the quantity and sometimes the quality of the outputs as stipulated in the work plans for example number of training sessions and the content covered in the sessions. **Process indicators** measure the quantity, quality and timeliness of the products (goods or services) that are the result of an activity, as stipulated in the programme work plan. **Outcome indicators** measure the intermediate results generated by programme outputs and correspond to any change in people's behavior and practices as a result of project or programme activities. **Impact indicators** describe progress made towards higher-level goals. Examples of impact indicators derived from the KNAP include; reduced level of malnutrition and improved funding for nutrition programmes.

Monitoring: Monitoring is the process of collecting data on an on-going programme/project/activity analyzing, interpreting and using it to adjust the programme so that it proceeds according to plan. Monitoring of the activities in the in the national and county M&E frameworks will be done through routine collection, collation, analyzing, interpretation and dissemination of data using standardized tools. The frequency of monitoring the activities will be undertaken monthly, quarterly and annually.

Evaluation: Evaluation is the process of collecting data on on-going, completed or yet-to-start programme, analyzing and interpreting the data for purposes of determining the value of the programmes. It is the process to determine as systematically and objectively as possible, the relevance, effectiveness, efficiency and impact of programmes considering specified objectives. Evaluation typically includes measures both at the beginning, midway and at the end of a programme and when possible includes a control or comparison group to help determine whether change in outcome results is from programme activities themselves and not from other influences outside the programmes.

Figure 9 illustrates the timeframe for conducting the baseline, midterm and end line reviews of the KNAP.

Figure 9: KNAP evaluation timeframe



MTR= Midterm Review; ETR/E= End term review/Evaluation

Mid-term review

A Midterm review (MTR) will be conducted to evaluate the progress made at the mid-point of implementation and recommend adjustments in strategy or review of expected targets when deemed necessary. A midterm review is also undertaken to determine the extent to which the objectives are met. Trends may be assessed together using the results of the various assessments and surveys across the different indicator domains – inputs/processes; outputs; outcomes and expected results. A mid-term review will be conducted nationally and therefore will include a representation of the counties and various stakeholders. Each County will review the implementation of the CNAP in relation to the county M&E framework and document the findings in a MTR report. The reports will be shared at the national level for overall analysis and synthesis. National and county level MTR reports will be written on the overall implementation and performance of the KNAP 2018-2022 and CNAPs respectively.

End term evaluation

An end-term review (ETR) will be conducted at the end of the KNAP implementation period to evaluate the overall performance of the plan and use lessons learnt to develop the subsequent interventions of the sector against what had been planned. The ETR will involve a comprehensive analysis of progress and performance for the whole period of the KNAP. The ETR will be conducted in the same manner as the MTR; it will be national with a representation of counties. Counties will conduct reviews and share their findings with the national level. County and national reports will be written on the overall implementation and performance of the CNAPs and KNAPs respectively.

Accountability

This is the obligation to demonstrate by stakeholders to what extent results have been achieved according to established plans and resources allocated[10]. Accountability will be discussed at county and national review forums and documented in the county and national reports.

Learning

This is the process through which information generated from M&E is reflected upon and intentionally used to continuously improve the ability of an action plan/strategy to achieve results. This learning function enhances organizational and development knowledge to increase the understanding of why particular interventions have been successful. Additionally, this understanding informs decision making and potentially improves performance. National and County level review forums for all stakeholders will be held to facilitate learning and programme changes in terms of implementation.

Reporting

Reporting is the systematic and timely provision of essential information used as a basis for decision-making at appropriate management levels. It is an integral part of the monitoring function. Reporting shall be done at all levels that is community, facility, sub county, county and national levels by the relevant actors on the progress of achievement of the programme implementation as stipulated in KNAP and CNAPs. These review reports will outline the performance against the targets set for the stated period.

The mechanisms for providing M&E information, products, dissemination and provision of feedback to various audiences are shown in Annex 5. The annex details the what, when, where, how, and by whom of the feedback mechanisms for M&E.

10 International Federation of Red Cross and Red Crescent Societies. (2011). Project/Programmes monitoring and evaluation(M&E) guide. Geneva: IFRC.

CHAPTER 3

NUTRITION M&E FRAMEWORK IN KENYA

The goal of the Monitoring and Evaluation Framework is to ensure a systematic monitoring and evaluation of nutrition sector activities in Kenya in line with the Key Result Areas (KRAs) as derived from the Kenya Nutrition Action Plan 2018-2022 and serve as an accountability and learning framework for nutrition stakeholders. This chapter covers the Common Results and Accountability Framework (CRAF), Indicator matrix by Key Result Area, evaluation, learning and accountability mechanism.

3.1 Common Results Accountability Framework

A set of key indicators and targets referred to as "Common Results and Accountability Framework (CRAF)" were agreed upon during the development of KNAP 2018-2022 to measure progress of achievement of the strategies outlined in the plan. The CRAF uses a logical results framework process at three levels (impacts, outcome and output). 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.

Table 2: Common Results Accountability Framework: KNAP Adopted Nutrition Targets by 2022

S/N	KNAP 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 KDHS 2014	17	WHA target 1 NFNSP-IF
2	Reduce the prevalence of anaemia in women of reproductive age by 30%	Prevalence of anaemia in women 15-49 years (%)	27 KDHS 2014	17	WHA target 2 NFNSP-IF
3	Reduce the prevalence of low birthweight by 30%	Prevalence of low birth weight of 2.5 kg and below (%)	8 KDHS 2014	5	WHA target 3
4	No increase in childhood overweight/obesity	Prevalence of overweight/ obesity (W/A >2SD) of children 0-59 months (%)	4 KDHS 2014	<4	WHA target 4 & NFNSP-IF
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 KDHS 2014	75	WHA target 5 & NFNSP-IF
6	Maintain childhood wasting at less than 4%	Prevalence of wasting (W/H <2SD) in children 0-59 months (%)	4 KDHS 2014	<4	WHA target 6 & NFNSP-IF
7	Reduce childhood underweight by 30%	Prevalence of underweight (W/A <2SD) in children 0-59 months	11 KDHS 2014	7	NFNSP-IF
8	Maintain proportion of deaths at below 3% for MAM and 10% for SAM	Proportion (%) of discharges from treatment program who have died (among acutely malnourished children for MAM and SAM)	0.2% for MAM	<0.2% MAM	NFNSP-IF
			1.7% for SAM DHIS 2	<1.7 SAM	
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 KNMS	20	NFNSP-IF
11	Reduce anaemia in adolescent girls by 30%	Prevalence of anaemia in girls 15-19 years (%)	21 KNMS	15	KNAP
12	Reduce folic acid deficiency among non-pregnant women by 50%	Proportion of non-pregnant women with folic acid deficiency (%)	39 KNMS	20	NFNSP-IF

S/N	KNAP expected results (Global targets used where applicable)	Indicator	Baseline 2014	Target 2022	Framework for targets
13	Reduce vitamin A deficiency in children by 50%	Prevalence of VAD in children 0-59 months (%)	9 KNMS	4	NFNSP-IF
14	Reduce iodine deficiency among children <5 years by over 50%	Prevalence of iodine deficiency in children <5 years (%)	22 KNMS	<10	NFNSP-IF
15	Reduce iodine deficiency among non-pregnant women by over 50%	Prevalence of iodine deficiency in non-pregnant women (%)	26 KNMS	<10	NFNSP-IF
16	Reduce prevalence of zinc deficiency in pre-school children by 40%	Prevalence of zinc deficiency in children <5 years (%)	83 KNMS	50	NFNSP-IF
17	Reduce prevalence of zinc deficiency among pregnant women by 40%	Prevalence of zinc deficiency among pregnant women (%)	60 KNMS	36	NFNSP-IF
18	A 10% relative reduction in prevalence of insufficient physical activity	Prevalence of insufficient physical activity in adults 18–64 years of age (%)	6.5 Stepwise survey	5	NCD target 3
19	Reduce proportion of population with raised blood pressure or currently on medication by 25%	Proportion of population with raised blood pressure or currently on medication (%)	24 Stepwise survey	18	NCD target 6 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 Stepwise survey	1.5	NFNSP-IF
21	Increased proportion of men with normal waist: hip ratio	Proportion of men with normal waist: hip ratio (%)	73 Stepwise survey	78	NFNSP-IF
22	Increased proportion of women with normal waist: hip ratio	Proportion of women with normal waist: hip ratio (%)	64 Stepwise survey	75	NFNSP-IF
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

3.2 Indicators by Key Result Areas

The tables in this section highlight the outcomes, outputs to the outcome, expected results, indicators, baseline, mid-term and end line evaluation and means of verification, frequency of verification, the lead agency responsible for verification and the associated responsible actors. Each KRA has an outcome with several outputs (expected results) and their respective indicators.

For instance, **KRA 1** (Maternal Neonatal Infant and Young Child Nutrition)

- **Outcome 1:** Strengthened care practices and services for improved maternal, newborn, infant and youngchild nutrition
- **Output 1.1**: Increased proportion of mothers and care givers who practice optimal behaviors for improved nutrition of women of reproductive age (15-49 years).
- **Indicator:** Proportion of population with an acceptable household food consumption score.

The KRAs are organized according to the three focus thematic areas: outcomes 1-8 are nutrition specific outcomes, outcomes 9-13 are multi-sectorial nutrition sensitive outcomes and outcome 14-19 are enabling environment outcomes.

The frequency of monitoring is based on the indicator level (impact, outcome and output) and source of information. Some indicators may have more than one means of verification hence overlapping frequency and multiple sources of information. For instance, the means of verification (MOVs) for *Minimum Dietary Diversity for children 6-23 months old* can be in KDHS conducted every 5 years and MIYCN KABP surveys conducted every 2-3 years and therefore the frequency is indicated as 3-5 years.

Table 3: KRA 1 (Outcome 1) Indicators

Output	Expected Results	Indicator	Baseline	Mid Term	End term	Means of verification	Frequency	Lead	Associated
OUTCOME 1: KRA 1 – MATERNAL, NEONATAL INFANT AND YOUNG CHILD NUTRITION (MNIYCN)			**Strengthened care practices and services for improved maternal, newborn, infant and young child nutrition**						
Output 1.1	Increased proportion of mothers and care givers who practice optimal behaviors for improved nutrition of women of reproductive age (15-49 years)	Proportion of population with an acceptable household food consumption score (FCS).	88.8% (KDHS 2014)	92%	95% (KDHS 2014)	KDHS Report Nutrition SMART Surveys	3-5 years	MOH	Partners KNBS
Output 1.2	Increased proportion of care givers who practice optimal behaviors for improved nutrition of young children under five years	Percentage of children born in the last 24 months who were put to the breast within one hour of birth	62% (KDHS 2014)	68%	70% (KDHS 2014)	KDHS Report MIYCN KABP surveys	3-5 years	MOH	Partners KNBS
		Proportion of infants 0–5 months of age who are fed exclusively with breast milk	61.4% (KDHS 2014)	68%	75% (KDHS 2014)	KDHS Report MIYCN KABP surveys	3-5 years	MOH	Partners KNBS
		Proportion of children 18–23 months of age who are fed breast milk	53% (KDHS 2014)	57%	60% (KDHS 2014)	KDHS Report	3-5 years	MOH	Partners KNBS
		Proportion of infants 6–8 months of age who receive solid, semi-solid or soft foods.	80% (KDHS 2014)	83%	85% (KDHS 2014)	KDHS Report	3-5 years	MOH	Partners KNBS
		Proportion of children 6–23 months of age who receive foods from 4 or more food groups.	41% (KDHS 2014)	49%	55% (KDHS 2014)	KDHS Report	3-5 years	MOH	Partners KNBS
		Proportion of breastfed and non-breastfed children 6–23 months of age who receive solid, semi-solid, or soft foods (but also including milk feeds for non-breastfed children) the minimum number of times or more.	51% (KDHS 2014)	59%	65% (KDHS 2014)	KDHS Report	3-5 years	MOH	Partners KNBS
		Proportion of children 6–23 months of age who receive a minimum acceptable diet (WHO 2010 definition)	21%	25%	30% (KDHS 2014)	KDHS Report	3-5 years	MOH	Partners KNBS

Output	Expected Results	Indicator	Baseline	Mid Term	End term	Means of verification	Frequency	Lead	Associated
		Proportion of children 6–23 months of age who receive an iron-rich food or iron-fortified food that is specially designed for infants and young children, or that is fortified in the home.	33.3% (KDHS 2014)	36%	40% (KDHS 2014)	KDHS Report	3-5 years	MOH	Partners KNBS
		Proportion of children 0–23 months of age who are fed with a bottle.	22% (KDHS 2014)	17%	15% (KDHS 2014)	KDHS Report	3-5 years	MOH	Partners KNBS
		No of Human Milk Banks Established	1	2	3	DND Report	Annually	DND	Partners KNBS
Output 1.3.	MIYCN advocated for at global, national and county levels	Proportion of counties with initiatives for workplace support for breastfeeding at public and private work places	No Data	25%	50%	DND Report	Annually	DND	County
Output 1.4	Enhanced capacity for implementation of MIYCN activities at all levels	No. of national nutrition conferences/ symposium held	0	3	5	DND Report	Annually	DND	Partners and stakeholders
Output 1.5.	Improved MIYCN policy environment at national and county level	No. of MIYCN policies/ strategies reviewed	0	2	4	DND Report	DND	3 years	Partners and nutrition stakeholders

Table 4: KRA 2 (Outcome 2) Indicators

Output	Expected Results	Indicator	Baseline	Mid Term	End term	Means of verification	Frequency	Lead	Associated
KRA 2: NUTRITION OF OLDER CHILDREN AND ADOLESCENTS			**Increased nutrition awareness and uptake of nutrition services for improved nutrition status of older children (5-9 years) and adolescents (10-19 years)**						
Output 2.1	Increased awareness on healthy diets among caregivers, social influencers, older children and adolescents themselves.	No. of trainings of key stakeholders on nutrition for older children	3 (DND 2017)	7	10	Training reports	Annually	DND	Partners
Output 2.2	Reduction of marketing of unhealthy foods among older children and adolescents	Proportion of thin adolescents (falling below cutoff for BMI-for -age)	No Baseline Data	40%	30% (STEPS)	KDHS/ Stepwise survey Report	5 years	DND	Partners
		Proportion of adolescents falling below cut-off for height-for-age (Stunting)	No Baseline Data	50%	40% (STEPS)	KDHS/ Stepwise survey Report	5 years	DND	Partners
		Proportion of obese adolescents (falling above cut off for BMI-for-age)	No baseline Data	30%	15% (STEPS)	KDHS/ Stepwise survey Report	5 years	DND	Partners

Output	Expected Results	Indicator	Baseline	Mid Term	End term	Means of verification	Frequency	Lead	Associated
Output 2.3:	Enhanced linkages and collaboration with relevant sectors to promote the health and nutrition of the older child and adolescent	No of collaborations with relevant sectors on nutrition for older children and adolescents	No baseline data	7	10	Minutes on collaboration meetings	Annually	DND	Partners

Table 5: KRA 3 (Outcome 3) Indicators

Output	Expected Results	Indicator	Baseline	Mid term	End term	Means of verification	Frequency	Lead	Associated
OUTCOME 3: KRA 3 –ADULTS AND OLDER PERSONS					**Improved nutrition status of adults and older persons**				
Output 3.1	Promotion of nutrition support for older persons	Proportion of counties with strategies on management of nutrition of the older persons in their CNAP	0 (DND 2018)	32 percent	64 percent	County CNAP	Annually	County	Partners
Output 3.2	Strengthened food and nutrition security systems for older persons.	No. of mapping surveys on food and nutrition security conducted	0 (DND 2018)	0	1	Mapping Report	Quarterly/ Annually	MOH	Partners
Output 3.3	Advocacy, communication and social mobilization of nutrition of older persons strengthened and promoted	Proportion of population aware of geriatric nutrition	No data (2018)	10%	40% (MOH 2018)	KAP survey	3 years	MOH	Partners
	Strengthened financing and human resource capacity mechanisms for nutrition interventions for older persons	Proportion of nutrition budget allocated to the older persons	0 (MOH 2018)	2%	2% (MOH 2018)	Budget itemization	Annually	MOH	Partners
		No. of counties including older persons, in their budgetary development process	0 (MOH 2018)	20%	48% (MOH 2018)	Participant lists	Annually	County	Partners

Table 6: KRA 4 (Outcome 4) Indicators

OUTCOME 4: KRA 4 MICRONUTRIENTS			**Improved micronutrient status of Children, adolescents, women of reproductive age, men and older persons**						
Output	**Expected Results**	**Indicator**	**Baseline**	**Mid term**	**End term**	**Means of verification**	**Frequency**	**Lead**	**Associated**
Output 4.1	Strengthened routine micronutrient supplementation (vitamin A, iron and folate, and point of use fortification) for targeted groups	Proportion of children aged 6-59 months receiving Vitamin A supplements at least two doses annually.	46% (KHIS 2017)	56%	65% (KHIS 2017)	DHIS Report	Bi-annually / annually	MOH	UNICEF, NI, Map Intil, KRCS,
		Proportion of pregnant women who take Iron and Folate Supplements for at least 90 days	8% (KHIS 2017)	15% (KHIS 2017)	40% (KHIS 2017)	DHIS Report	Monthly	MOH	NI, UNICEF, WVK, KRCS, Save the Children, WFP
		Percentage of children aged 6-23 months provided with multiple micronutrient powders	No data (2018)	10%	25% (KHIS 2017)	DHIS Report	Monthly	MOH	NI, UNICEF, WFP, WVK, GAIN
Output 4.2	Increased dietary diversity and bio- fortification of food plants	Proportion of the population accessing adequate micro-nutrient intake	No data (2018)	>15%	>25%	Household Food consumption Survey, KIHBS, Annual food production reports, Annual food assessment reports.	Quarterly/ Annually	MoA & MoH	FAO, KEMRI
Output 4.3	Improved compliance to food fortification standards	Proportion of adequately fortified foods in the market (maize and wheat flour, salt, fats/oils)	No data (2018)	60%	80%	Periodic surveys	Annually	MOH	KEBS, NPHL, Istries
Output 4.4	Increased knowledge, improved practices and coverage of fortified foods	Proportion of households consuming fortified foods (maize and wheat flour, salt, fats/oils)	No Data (2018)	50%	70%	Survey Reports; KDHS; KIHBS	3 years	MOH	KEBS, NPHL, Istries
Output 4.5	Integrated public health measures with other micronutrient deficiencies prevention and control interventions.	Proportion of public health interventions integrating Micronutrients deficiency and control measures.	No data (2018)	2	4	Programmes reports, Annual Work Plan reports.	Annually	MOH	MOE

Table 7: KRA 5 (Outcome 5) Indicators

OUTCOME 5: KRA 5 – DRNCDS (Diet related Non-communicable diseases.			Reduced prevalence of diet related risk factors for NCDs in general population Improved management and control of the non-communicable diseases through nutrition therapy						
Output	**Expected Results**	**Indicator**	**Baseline**	**Mid term**	**End term**	**Means of verification**	**Frequency**	**Lead**	**Associated**
Output 5.1	Raised priority accorded to Nutrition in NCDs at national and county levels and to integrate their prevention and control into policies across all government and private sectors.	Number of NCD- ICC meeting with representation from NITWG	No data (2018)	2	4	ICC meetings minutes	Quarterly/ Annually	MOH-NCD	DND Civil Society Organizations CoG
		Proportion of counties with budgets for NCDs	10%	15%	30%	Counties AWPs and investment plans County Reports	Annually	COG	Treasury
		Proportion of National health budget allocated to NCDs	No data (2018)	1%	5%	Ministerial AWPs and investment plans	Annually	MOH-NCD	Treasury
Output 5.2	Strengthened national and county capacity, leadership, governance and partnerships to accelerate country response for prevention of NCDs	Number of policy makers and health care workers trained on Nutrition- NCD prevention and management	100	200	500	Training attendance list Trainingreports	Quarterly/ annually	DNCD DND	County Governments
Output 5.3	Increase visibility of NCDs within public & private media houses	Proportion of public & private media houses sensitized on nutrition and NCDs	No data (2018)	8%	25%	Minutes, Attendance list, reports	Annually	DNCD DND	Partners Civil Society
Output 5.4	Prevention and control of NCDs integrated into policies across relevant government sectors.	Number of NCDs prevention and control policies in sectors outside health (Agriculture, Trade, Education, Labor, Infrastructure, Finance, Planning and Environment	No data (2018)	4	8	Policies existing and developed	Annually	Ministry of Agriculture, Trade, Education, Labour, Infrastructure, Planning, Environment	Partners Civil Society DNCD H
Output 5.5	Healthy diets and lifestyles promoted to reduce the modifiable risk factors for NCDs	Proportion of population reading nutrient content in food products	No data (2018)	10%	30%	Acts of parliament, household survey reports	2 years	DNCD DND	Civil Society Partners
Output 5.6	Quality and timely treatment for NCDs is provided	Proportion of public hospitals with NCD and nutrition management centers	10%	30%	65%	M&E Reports DHIS reports	Monthly/ quarterly	MOH-DNCD	KNBS
Output 5.7	Improved monitoring and evaluation for diet related NCDs	Number of NCD indicators captured in DHIS and other data reporting platforms	4	12	20	Quarterly and annual reports in DHIS and other platforms	Quarterly/ annually	MOH-DNCD, HIS	H

Table 8: KRA 6 (Outcome 6) Indicators

OUTCOME 6: KRA 6 – (Integrated Management of Acute Malnutrition) IMAM			Increased coverage of integrated Management of Acute Malnutrition (IMAM)						
Output	**Expected Results**	**Indicator**	**Baseline**	**Mid term**	**End term**	**Means of verification**	**Frequency**	**Lead**	**Associated**
Output 6.1	IMAM services across all cohorts reviewed and scale up	No. of health facilities with capacity for IMAM Service delivery	1873	2100	2500	KHIS	Monthly	DND	CoG
		Proportion of children with acute malnutrition accessing IMAM services	No Baseline Data	75%	85% (KHIS)	KHIS (MOH713) Seasonal Assessment Reports	Monthly	DND	CoG
		No. of health facilities implementing IMAM services	1873	2100	2500	KHIS	Monthly	DND	CoG
Output 6.2	Quality of IMAM services improved	Number of counties meeting sphere standards for IMAM	No Baseline Data	20	47	KHIS	Monthly	DND	CoG

Table 9: KRA 7 (Outcome 7) Indicators

OUTCOME 7: KRA 7 - EMERGENCIES		Improved multi-level, and multi-sectoral capacity for risk preparedness, reduction and mitigation against impact of disasters							
Output	**Expected Results**	**Indicator**	**Baseline**	**Mid term**	**End term**	**Means of verification**	**Frequency**	**Lead**	**Associated**
Output 7.1	Functional Coordination committees in place and integrating preparedness and risk reduction agenda / actions	Functional national emergency preparedness coordination structures	No	Yes	Yes	Meeting minutes	Quarterly	DND	County
Output 7.2	Nutrition sector representation in multi sectoral coordination forums for preparedness and risk reduction	Proportion of multi sectoral coordination forums for emergency preparedness with nutrition sector representation annually	No Baseline Data	80%	100%	Meeting minutes	Quarterly	DND	County

OUTCOME 7: KRA 7 - EMERGENCIES		Improved multi-level, and multi-sectoral capacity for risk preparedness, reduction and mitigation against impact of disasters							
Output 7.3	Nutrition integrated in Disaster preparedness and response plan at County level	Number of counties implementing IMAM surge	8	12	15	IMAM surge reports	Monthly	DND	County
		Number of counties with integrated contingency, preparedness and response plans	23	47	47	Updated County contingency, preparedness and response plans	Bi annually.	DND	County
Output 7.4	Enhanced Nutrition sector participation in early warning system review processes	Proportion of review meetings on early warning system with Nutrition Sector presence	50%	80%	100%	Review meeting report and minutes	Quarterly	DND	County
Output 7.5	Improved nutrition needs assessments during emergencies	Proportion of emergency responses including nutrition needs assessments during emergencies	No data (2018)	75%	80%	Assessments Reports	Annually	DND	County
Output 7.6	Increased access to High impact Nutrition interventions as part of emergency response (MIYCN-E, IMAM, Micronutrient supplementation, Deworming, WASH interventions)	Proportion of emergency responses integrating comprehensive High Impact Nutrition interventions (IMAM, Micronutrient supplementation, Deworming, WASH interventions) during emergencies	No Baseline Data	75%	85%	Routine Programmes reports	Monthly	DND	County

Table 10: KRA 8 (Outcome 8) Indicators

OUTCOME 8: KRA 8 – NUTRITION IN HIV AND TB			Reduced impact of HIV related co-morbidities among People Living with HIV through targeted nutrition therapy						
Output	**Expected Results**	**Indicator**	**Baseline**	**Mid term**	**End term**	**Means of verification**	**Frequency**	**Lead**	**Associated**
Output 8.1	Improved routine screening for nutrition problems and referral for all TB and HIV patients	Proportion of patients screened and referred for nutrition problems	60.1%	75%	95%	KHIS	Quarterly	MOH – NASCOP Nutrition	County, Partners
Output 8.2	Increased coverage for nutrition integration for screening and referral of PLHIV and TB Patients in nutrition clinics	No of facilities conducting nutrition screening for HIV and TB in nutrition clinics for identification	12.7%	15%	30%	Annual reports, County reports	Annually	MOH -NASCOP	Counties Governments, Partners
		Proportion of health facilities equipped with nutrition screening and assessment equipment	No baseline data	50%	65%	Biannual Commodity support supervisor reports County reports Facility assessment reports	Quarterly	MoH, NASCOP Nutrition	County Governments
Output 8.3	Strengthened integration of nutrition interventions for home-based care at communitylevel for PLHIVs towards the 90.90.90	Proportion of health facilities undertaking nutrition integration activities	12.7%	30%	50%	Programmes reports	Monthly	MOH NASCOP Nutrition	Counties Partners
Output 8.4	Enhanced use of implementation research to generate evidence for cost effective nutrition TB and HIV programming	Proportion of in country research results in use in the country in HIV nutrition programming		One research report every 2 years	One research report every 2 years	In country Study reports available and in use	2 years	MOH NASCOP Nutrition	County Partners

Table 11: KRA 9 (Outcome 9) Indicators

OUTCOME 9: KRA 9 – CLINICAL NUTRITION AND DIETETICS			Improved and scaled up practices related to clinical nutrition and dietetics for disease prevention, control and management						
Output	**Expected Results**	**Indicator**	**Baseline**	**Mid term**	**End term**	**Means of verification**	**Frequency**	**Lead**	**Associated**
Output 9.1	Nutrition screening, assessment and triage to all individuals seeking health care promoted	Proportion of population accessing health care services at the facilities screened and assessed for nutrition status	No baseline data	10%	20%	KHIS	Monthly	MoH, DND	County Governments
Output 9.2	Enhanced nutrition screening and assessment at facility level	Proportion of health facilities implementingthe national SOPs on nutrition screening, assessment and triage	No baseline data	40%	60%	KHIS	Monthly	MoH, DND	County Governments
		Proportion of health facilities equipped with nutrition screening and assessment equipment	No baseline data	50%	65%	County reports Facility assessment reports	Quarterly	MoH, DND	County Governments
Output 9.3	Strengthened Inter-facility referral system for nutrition services	No. of counties sensitized on the use of standard inter-facility nutrition referral tool	No baseline data	25	47	Program Reports	Quarterly	MoH, DND	County Governments
Output 9.4	Improved qualityof careinthe nutrition management of diseases, co- morbidities and conditions	No. of counties sensitized on the use of national basic essential nutrition care package in management of diseases, co-morbidities and conditions	No baseline data	25	47	Program Reports	Monthly	MoH, DND	County Governments
Output 9.5	Strengthened management of malnutrition in disease and illness	Proportion of hospitals with disease-specific therapeutic feeds and supplements for management of malnutrition in illness and disease	No baseline data	50%	65%	County reports Facility assessment reports	MoH, DND	DND Quarterly	County Governments
Output 9.6	Clinical nutrition and disease management in the community	Proportion of counties sensitized on continuum of nutrition care in the community	No baseline	20%	40%	Training Report Attendance sheets	MoH, DND	DND Quarterly	County Governments
Output 9.7	Improved patient feeding inhealth care institutions	Proportion of hospitals offering inpatient feeding with standard therapeutic food production units	No baseline	5%	10%	County Reports Facility assessment reports	MoH, DND	DND Quarterly	County Governments
		No. of counties sensitized on the use of monitoring tool for inpatient feeding	No baseline	10	35	Training Report Attendance sheets	MoH, DND	DND Quarterly	County Governments
Output 9.8	Strengthened technical capacity for clinical nutrition and dietetics	Proportion of health care workers trained on clinical nutrition package	No baseline	20%	40%	County Report	MoH, DND	DND Annually	County Governments

Table 12: KRA 10 (Outcome 10) Indicators

	OUTCOME 10: KRA 10 10 - AGRICULTURE AND FOOD SECURITY			Linkages between Nutrition, Agriculture and Food Security strengthened					
Output	**Expected Results**	**Indicator**	**Baseline**	**Mid term**	**End term**	**Means of verification**	**Frequency**	**Lead**	**Associated**
Output 10.1	Strengthened sustainable and inclusive food systems that are diverse, productive and profitable for improved nutrition.	No. of joint strategic planning meeting held for nutrition sensitive agricultural production	1(2018)	6	8	Policy/strategy/ plan document	Quarterly	MoALC	MOH-DND, / MOE/COG/ Partners
	Inclusion of nutrition in the development of agriculture and food security sector policy documents	No. of agriculture policies that are nutrition-sensitive by 2022	1(2018)	6	8	Policy/strategy/ plan document	Annually	MoALC	MOH-DND, / MOE/COG/ Partners
Output 10.2	Improved access to nutritious and safe foods	Proportion of farm HH producing food items from five food groups for subsistence	35(2018)	40	60	Reports on food items/ Consumer info reports	Annually	MoALC	MOH, Culture Social protection, MODA, COG, MOE, Partners etc.
Output 10.3	Promotion of consumption of safe, diverse, and nutritious foods	No. of new and nutritious foods products availed in Kenyan market	1(2018)	3	5	Safety guidelines, new products briefs, Food safety reports, Food composition tables, Recipes	Annually	MoH	MoALC, MODA & partners
Output 10.4	Strengthened Agri- nutrition capacities and coordination at national and county levels	No. of counties where Agri-nutrition technologies have been disseminated	1(2018)	10	25	Curriculum, Technology, Attendance sheets Dissemination reports	Annually	MoH	MoALC & partners

Table 13: KRA 11 (Outcome 11) Indicators

OUTCOME 11: KRA 11 – HEALTH SECTOR				Nutrition in the Health Sector Strengthened					
Output	**Expected Results**	**Indicator**	**Baseline**	**Mid term**	**End term**	**Means of verification**	**Frequency**	**Lead**	**Associated**
Output 11.1	Nutrition integrated in health policy documents and represented in health sector policy development forums	Proportion of health sector policies with nutrition indicators included	5 percent	26 percent	40 percent	Health sector policies		MoH/ DND	MoH
Output 11.2	Nutrition integrated in health sector coordination mechanisms	Proportion of coordination forums where nutrition is integrated	20%	40%	60%	Annual reports		MoH/ DND	MoH
Output 11.3	Improved performance of nutrition within health sector	No. of nutrition indicators included in the Ministerial performance contracts	1	2	2	Health leadership Performance contracts at National		MoH/ DND	MoH

Table 14: KRA 12 (Outcome 12) Indicators

OUTCOME 12: KRA 12 – EDUCATION AND EARLY CHILDHOOD DEVELOPMENT (ECD)			Nutrition mainstreamed in Education sector policies, strategies and action plans						
Output	**Expected Results**	**Indicator**	**Baseline**	**Mid term**	**End term**	**Means of verification**	**Frequency**	**Lead**	**Associated**
Output 12.1	Policies, strategies, standards and guidelines on nutrition and physical activity in schools and other learning institutions developed and promoted	Number of Policies, strategies and guidelines on nutrition and physical activity developed for schools and other learning institutions	2					MoE	MoH
Output 12.2	Healthy and safe food environment promoted to ensure that food to learners is available, sufficient, nutritious, accessible and safe	Proportion of schools offering safe and nutritious foods	No Baseline Data	40%	60%	Assessment Reports	Quarterly	MOE	MoH
		Proportion of schools where nutrition assessment is done	No Baseline data	20%	35%	Assessment Reports	Quarterly	MOE	MoH

Table 15: KRA 13 (Outcome 13) Indicators

OUTCOME 13: KRA 13 - WATER, SANITATION AND HYGIENE (WASH)			Nutrition integrated into WASH policies, strategies, plans and programmes						
Output	**Expected Results**	**Indicator**	**Baseline**	**Mid term**	**End term**	**Means of verification**	**Frequency**	**Lead**	**Associated**
Output 13.1	Reduced morbidity and mortality due to consumption of water from unsafe water sources	Proportion of households using an improved sanitation facility	61.1 KDHS 2014	67	76	KDHS Report	Annually	MoH-WASH Hub	DND
		Proportion of deaths attributed to unsafe water sources	77.08 per 100,000 (GBD 2016)	65	60	https://vizhub.healthdata.org	Annually	MoH-WASH Hub	DND
		Proportion of households with access to an improved water source	71 KDHS 2014	77	86	KDHS Report	Annually	MoH-WASH Hub	DND
Output 13.2	Nutrition integrated in policies, strategies and plans on universal access to adequate WASH services	Proportion of WASH policies with nutrition component	No Baseline Data	77	86	Policy documents and strategies	Annually	MOH-WASH Hub	DND
Output 13.3	Reduction of morbidity and mortality due to poor access to handwashing facility	Proportion of households with handwashing station in compound	35 KDHS 2014	45	60	KDHS Report	Annually	MOH-WASH Hub	DND
		Proportion of deaths attributed to lack of access to hand washing facilities	53.6 per 100,000 (GBD 2016)	49.5	45	https://vizhub.healthdata.org	Annually	MOH-WASH Hub	DND

Table 16: KRA 14 (Outcome 14) Indicators

OUTCOME 14: KRA 14 -SOCIAL PROTECTION			Integration of Nutrition in Social Protection Programmess strengthened						
Output	**Expected Results**	**Indicator**	**Baseline**	**Mid term**	**End term**	**Means of verification**	**Frequency**	**Lead**	**Associated**
Output 14.1	Inclusion of nutrition component in social protection	Proportion of social protection programmes with a nutrition component	0 (2018)	30%	60%	NIMES and CPIMS reports	Annually	MOH/ ML&SP	Other line ministries -Development partners
Output 14.2	Enhanced monitoring of nutrition in social protection	Number of nutrition indicators integrated on the information system for social protection programmes	0 (2018)	1	2	NIMES and CPIMS report	Annually	MOH/ ML&SP	Other line ministries -Development partners

Table 17: KRA 15 (Outcome 15) Indicators

OUTCOME 15: KRA 15 –MULTISECTORAL NUTRITION GOVERNANCE				Efficient and Effective Nutrition Governance, Coordination and Legal Frameworks					
Output	Expected Results	Indicator	Baseline	Mid term	End term	Means of verification	Frequency	Lead	Associated
Output 15.1	Enhanced existing nutrition coordination and collaborating mechanisms and linkages between national and county Governments	Number of functional nutrition coordination committees' meetings held	14	54	90	Meeting minutes	Bi-annually	MOH/ COG	MOH
Output 15.2	Enhance coordination in development and implementation of regulatory frameworks	Annual nutrition standards and regulation summit with relevant nutrition actors	No data	3	5	Summit reports	Annually	MOH/ COG	MOH
Output 15.3	Strengthen partnerships for nutrition	Public Private Partnership strategy developed	0	1	1	Reports	Bi-annually	MOH/ COG	MOH
Output 15.4	Enhanced opportunities for collaboration and joint discourse for both levels of government and the sector in general	No of Annual Learning Meeting Held	No data	3	5	Reports – WHICH REPORTS?	Annually	MOH/line ministries/	MOH
		No. of research fund formed	0	1	1	Research fund report	5 years	DND	Partners
		No of Research findings validated	0	4	8	Results reports/ presentations	Annually	Partners	DND-RTWG
		Number of symposiums/ Conferences on nutrition	2	3	5	Symposiums	Annually	DND	Partners

Table 18: KRA 16 (Outcome 16) Indicators

OUTCOME 16: KRA 16 – MULTISECTORAL NUTRITION INFORMATION SYSTEMS				Sectoral and Multi-sectoral Nutrition Information Systems, Learning and Research strengthened					
Output	**Expected Results**	**Indicators**	**Baseline**	**Mid term**	**End term**	**Means of verification**	**Frequency**	**Lead**	**Associated**
Output 16.1	Enhanced nutrition planning and performance monitoring and evaluation	Nutrition sector plans progress reviewed every quarter	0	10	20	Nutrition M&E document Quarterly reports	Quarterly	DND	MOH
		Number of national nutrition annual Work plans developed by 2022/2023 FY	0	3	5	Nutrition Annual work Plan document	Annually	DND	MOH
		Number of Kenya Nutrition Action Plan evaluation conducted	0	1	2	KNAP Evaluation Reports	2-3 years	DND	MOH
Output 16.2	Strengthened Nutrition sector capacity in NIS and evidence-based decision making	Number of trainings conducted on Nutrition Information generation and use	21	40	74	Nutrition M&E document	Quarterly	DND	MOH
Output 16.3	Timely generation and dissemination of nutrition situation updates to inform programme planning and response	Number of nutrition situation reports (SRA/ LRA) generated	8	13	23	Nutrition M&E document	Annually	DND	MOH
		Number of updates of the population-based survey database	1	4	8	Nutrition survey database	Annually	DND	MOH
		Number of times Nutrition website updated	1	30	60	Nutrition website www.nutritionhealth.or.ke	Bi-annually	DND	MOH
Output 16.4	Standardized and harmonized nutrition data collection, management, and reporting at all levels	Number of nutrition information guidelines in place	7	8	12	Nutrition M&E document	Annually	DND	MOH
Output 16.5	Quality nutrition data generated for evidence-based programming	Number of Nutrition Assessments Validated	37	63	147	Assessment reports	Quarterly	DND	MOH
		No. of policy briefs generated to inform programming/policy change	5	10	15	Policy brief papers	Annually	DND	MOH

OUTCOME 16: KRA 16 – MULTISECTORAL NUTRITION INFORMATION SYSTEMS				Sectoral and Multi-sectoral Nutrition Information Systems, Learning and Research strengthened					
Output	**Expected Results**	**Indicators**	**Baseline**	**Mid term**	**End term**	**Means of verification**	**Frequency**	**Lead**	**Associated**
Output 16.6	Enhanced multi-sectoral linkages result in improved nutrition information efficiencies and cost-effectiveness	No. of nutrition- sensitive information linkages strengthened	0	1	2	Agric./Foodsec/ CHIS/ EWS	2-3 Years	DND	MOH
		No. of nutrition- specific information linkages strengthened	0	1	2	DHIS/ Surveillance/ DHS	2-3 years	DND	MOH
Output 16.7	Improved access to and use of nutrition information to inform programme quality improvement	Nutrition dashboard (within KHIS) developed	0	1	1	KHIS Nutrition board	5 years	DND	MOH
		Nutrition KHIS scorecard developed	0	1	1	Nutrition KHIS scorecard	5 years	DND	MOH
Output 16.8	Enhanced evidence-based decision making through research	No. of new strategic nutrition partnerships established including universities	1	3	5	MoU	2-3 years	DND	MoH Research Unit/ Partners
		No. of new research priorities identified annually	3	5	8	Research in Nutrition Technical Working Group (RTWG) minutes	2-3 years	DND	Partners
		No of counties undertaking nutrition research	0	5	8	County research findings	2-5 years	DND/ CNC	Counties/ Partners
		No. of operational / implementational researches Initiated	8 (2018)	10	12	Research proposals validated	2-3 years	DND-RTWG	KEMRI/ Partners

Table 19: KRA 17 (Outcome 17) Indicators

OUTCOME 17: KRA 1 – Advocacy, Communication and Social Mobilization (ACSM)				**Enhanced political commitment and continued prioritization of nutrition in national and county agenda**					
Output 17.1	**Expected Results**	**Indicators**	**Baseline**	**Mid term**	**End term**	**Means of verification**	**Frequency**	**Lead**	**Associated**
	Implementation of National advocacy strategy on nutrition	No. of high-level nutrition meetings held	0	3	5	Report	Annually	MOH/DND	CoG, Counties, Line Ministries, House committee on health
		No. of counties with nutrition advocacy plans	0	27	47	Report	Annually	MOH/DND	CoG, Counties, Line Ministries, House committee on health
		No. of nutrition champions identified	1 (2015)	6	10	Report	Annually	MOH/DND	Counties, National Govt, partners
Output 17.2	Increased and sustained multi-sectoral collaboration on advancing and integrating nutrition outcomes across relevant sectors at national and county	No. of functioning of Multi sectoral platforms	1 (2018)	3	3	Report	2-3 years	MOH/DND	CoG, Counties, Line Ministries, House committee on health
Output 17.3	Social accountability and financial tracking of nutrition resources at National and county Level	No. of relevant ministries and counties trained on nutrition financial tracking tool (47 counties and 13 Ministries)	16 (2018)	49	60	Report	Bi-Annually	MOH/DND	CoG, Counties, Line Ministries, House committee on health
		No. of National and County budgets tracked	16 (2017)	4	48	Report	Annually	MOH/DND	Line Ministries, Counties

OUTCOME 17: KRA 1 – Advocacy, Communication and Social Mobilization (ACSM)				Enhanced political commitment and continued prioritization of nutrition in national and county agenda					
Output 17.1	**Expected Results**	**Indicators**	**Baseline**	**Mid term**	**End term**	**Means of verification**	**Frequency**	**Lead**	**Associated**
Output 17.4	Adequate financial resources mobilized for sustained and quality nutrition services including domestic resource mobilization	No. of relevant MDAs with nutrition budget lines	No data	5	15	Budget line	Annually	MOH/DND	MDAs
		Nutrition mainstreamed in Ministerial and County performance contract	0	1	2	PC	Annually	MOH/DND	MDAs, Counties, CoG, Performance Management and Coordination office in Executive office of the President
Output 17.5	Increased and strengthened human capital and capacity for nutrition advocacy	Number of nutrition professionals and influencers trained on advocacy	0	180	300	Annually	Report/ certs	MOH/DND	Line ministries, CoG
		No. of nutritionists employed at national and county level	1200	1302	1360	Annually	Adverts/ contracts HR Report	MOH/ DND/ County governments	PSC, CoG, TNT, CPSB
Output 17.6	Evidence informed nutrition advocacy	No. of nutrition best practices documented and disseminated	0	15	25	Annually	Best practices/ newsletters	MOH/ DND/ County governments	Stakeholders, CoG, Partners, National government
		No. of sectors assisted in packaging their nutrition advocacy products	0	6	15	Annually	Reports	MOH/ DND	Stakeholders, MDAs
Output 17.7	Stronger relationships on nutrition with key media houses and journalists built and maintained	No. of media personnel trained (under influencers)	60 (2017)	120	120	Bi-annually	Training reports / certificates	MOH/DND	Partners, Media houses
		No. of nutrition documentaries held	0	12	20	Quarterly	Reports	MOH/DND	Media, Partners, CoG, National Government
Output 17.8	Community engagement, participation and feedback mechanisms in nutrition services and decision- making processes strengthened to enhance social accountability	No. of counties with feedback mechanisms on community engagement	0	30	47	Quarterly	Reports	MOH/DND/ County governments	Counties, Stakeholders, Partners, CoG,National Government

Table 20: KRA 18 (Outcome 18) Indicators

OUTCOME 18: KRA 18 – CAPACITY DEVELOPMENT				Capacity to deliver and demand nutrition services enhanced					
Output	**Expected Results**	**Indicators**	**Baseline**	**Mid term**	**End term**	**Frequency**	**Means of verification**	**Lead**	**Associated**
Output 18.1	Strengthened systemic and organizational capacity development on policy, governance, leadership, coordination and partnerships for nutrition at county and national level	No. of counties with comprehensive nutrition capacity assessments conducted	17	30	47	Annually	Capacity assessment reports and action plans	Capacity working group	DND and implementing partners
		No. of counties implementing the Kenya nutrition leadership and governance programme	0	3	4	Annually	Annual reports	Capacity working group	DND and implementing partners
Output 18.2	Enhanced systems for skills and competency development for nutrition workforce	No. of counties achieving at least 60% of the prescribed human resource norms and standards for nutritionists	13	24	35	Annually	HRH reports, Capacity assessment reports	Advocacy and communications, Capacity working group	DND and implementing partners
		No. of counties with improved score card performance on nutrition	0	20	40	Annually	Score card reports, DHIS	M & E working group, HRIOs	DND, Implementing partners
		No. of counties where the Nutrition Internship and placement guide is disseminated	0	25	47	Annually	Annual reports	Capacity working group, KNDI	DND and implementing partners,
Output 18.3	Strengthened capacity for community level demand generation and utilization of integrated nutrition services	Proportion of CHVs trained on nutrition packages (module 8)	10%	40%	80%	Annually	CHS reports and capacity assessment reports	CHS focal point, capacity working group	DND, Implementing partners

Table 21: KRA 19 (Outcome 19) Indicators

OUTCOME 19: KRA 19 – SUPPLY CHAIN MANAGEMENT				Strengthened integrated supply chain management system for nutrition commodities and allied tools.					
Output	**Expected Results**	**Indicator**	**Baseline**	**Mid term**	**End term**	**Frequency**	**Means of verification**	**Lead**	**Associated**
Output 19.1	Counties prioritizing procurement of nutrition commodities and equipment	Proportion of counties with a budget line for nutrition commodities and equipment	30%	40%	50%	Annually	County Budgets	DND	County
Output 19.2	Inclusion of nutrition commodities in the EML	No. of nutrition commodities included in the EML	17	20	24	2-3 years	EML List	DND	County
Output 19.3	Reduced cost for nutrition commodities and equipment	No. of new certified suppliers producing nutrition commodities and supplying equipment	5	8	12	Annually	List of prequalified suppliers	DND	County
Output 19.4	Public Financial Management (PFM) Act reviewed with inclusion of nutrition commodities	Proportion of counties with drawing rights at KEMSA for nutrition commodities and equipment	No data (2018)	24	35	Bi-annually	Procurement and distribution reports from KEMSA	DND	County KEMSA
Output 19.5	Expanded product base of locally produced nutrition commodities	No. of nutrition commodity coordination meetings held-Indicator does not reflect the expected result	1	10	20		Meeting Minutes	DND	County
Output 19.6	Timely Quantification for Nutrition Commodities and equipment	No. of nutrition commodities quantification and forecasting reports generated	1	2	5	Quarterly	Quantification Reports	DND	County
		Proportion of annual nutrition commodity needs met	50%	65%	80%	Annually	Distribution reports	DND	County
Output 19.7	Enhanced capacity for nutrition logistics and inventory management	Proportion of counties with Nutrition LMIS and Inventory Management training conducted	45%	55%	65%	Annually	Training reports	DND	County
Output 19.8	Safe and quality nutrition commodities and equipment at both national and county level	Proportion of Nutrition commodities and equipment meeting minimum quality and safety standards	70%	75%	80%	Annually	Certificates of Analysis	DND	County

3.3 Monitoring and Reporting

Monitoring of the KNAP activities and results will be done through routine collection, collation, analysis, interpretation and dissemination of data using standardized tools and procedures. The frequency of monitoring the activities will be undertaken monthly, quarterly and annually as outlined in the reporting frequency in the results framework. Monitoring of implementation of programmes will focus on inputs and activities, whereas results monitoring will focus on outputs and outcomes and finally situation monitoring will focus on the status of nutrition, for example undernutrition among under five-year children in Kenya. Each County will have developed CNAP that is context specific but aligned to the KNAP. It is expected that each county will have an M&E Framework within the CNAP to guide the monitoring and evaluation of the programmes in the CNAP and therefore the counties will also monitor activities monthly, quarterly and annually and document the findings. The monitoring will be conducted through the following steps[11]: reference to the results framework, planning for monitoring, selection of monitoring tools and approaches, data collection and analysis, communication and reporting of findings and taking of corrective action. The monitoring steps are elaborated below:

I. **Reference to the results framework:** The Common Results Framework, the 19 Key Result Areas and process indicators will be the main basis of monitoring. The monitoring activities and resources will hence ensure that data on priority indicators are available.

II. **Planning for monitoring:** This will include deciding on which data will be collected, by when and how. The monitoring plan should link to the monitoring and information system such as Kenya Health Information System, population-based surveys e.g. Nutrition SMART surveys, surveillance systems etc. Key stakeholders at national and county level for example the M&E will need to consult other programs in the Division of Nutrition and Dietetics and County Departments of Health during the planning stage. Resources should also be planned for including human and financial. At this point it is also important to consider how the collected data will be utilized.

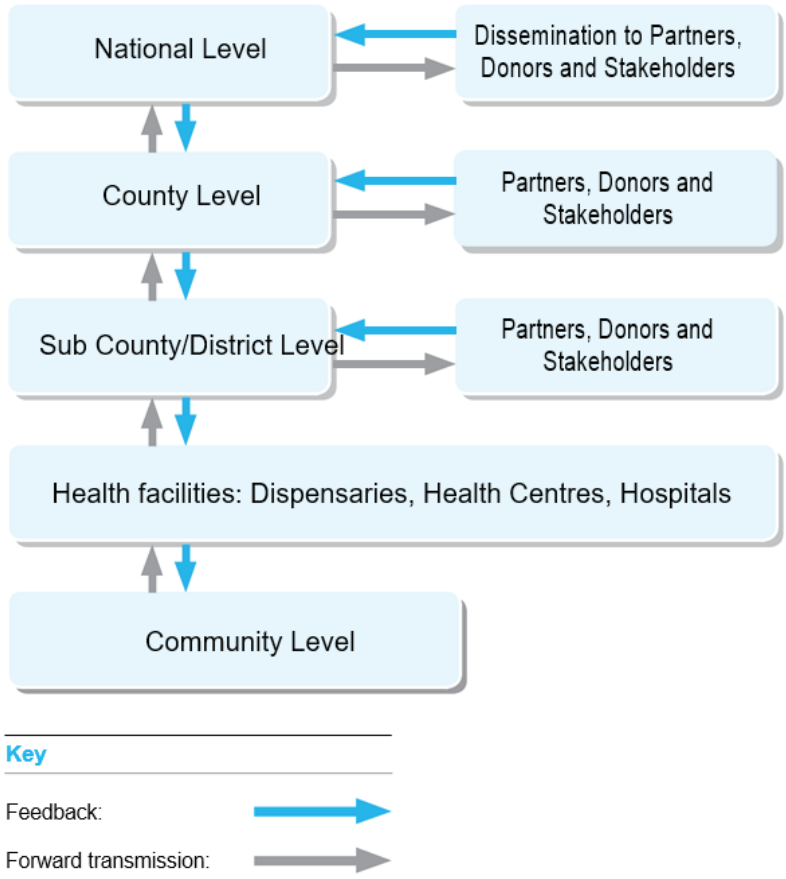
III. **Selection and development of monitoring tools and approaches:** Quality data on the indicators in the results framework should be collected using appropriate tools and methods. The NITWG will need to ensure various data collection tools e.g. for routine data and population-based surveys are up to date and relevant for the data collection methods. Development of guidelines and tools is critical and will be aligned to global standards e.g. DHS programmes, SMART methodology, IPC for Acute Malnutrition etc. Joint programme monitoring by government officials and implementing partners will also be useful in establishing progress and providing a mechanism for feedback.

IV. **Data collection and analysis:** In addition to what is covered in chapter 2, data collection will be based on the results framework indicators, cost, technical capacities and national/county level context. The data quality will be evaluated based on minimum criteria established in various national guidelines before performing analysis. The data analysis methods should be aligned to the guidance in the indicator compendium (Annex 2), technical manuals and thresholds. Data analysis should take into consideration gender disaggregation, equity, spatial distribution and disability in as far as this is possible. The findings should be validated by Nutrition Information Technical Working Group (NITWG) using agreed on standards.

V. **Reporting and communication of findings:** Timely reports should be produced upon validation of findings. The findings should first be validated at the county and finally at the national level. For example, Nutrition SMART survey reports should be finalized within 1 month of validating the findings. The reports should be submitted to the Ministry of Health/Division of Nutrition and Dietetics. The reports should be uploaded onto the nutrition website and disseminated to the target audience e.g. Nutrition Technical Forum members using other channels. To ensure improved uptake of findings, user friendly products such as short visual synopsis will be produced and disseminated using effective channels of communication. Figure 9 below illustrates the reporting cycle of routine data from Kenya Health Information System as well as from the community level to the national level and also the feedback mechanism from the national to the community level.

11 UNICEF (2017): Results Based Management Handbook – Working together for children.

Figure 9: Reporting cycle of routine data-KHIS



VI. Taking corrective action: The evidence generated will inform the kind of corrective action to be taken by various programmes and stakeholders to promote accountability and realization of results. Corrective actions may include the following:

- Making changes to what is being done and how it is being done e.g. scale up and scale down of activities.
- Allocating resources more appropriately to emerging needs.
- Building capacity on various technical areas.
- Re-orienting advocacy and policy influencing.

VII. Quarterly and Annual multisectoral and multi-stakeholder nutrition reviews (AMNRs): The focus will be on the progress of activities, processes and outputs in the annual work plans (Annex 6). The national level and counties are expected to conduct quarterly reviews using routine data from KHIS, Nutrition scorecard, field visits, implementation progress reports, technical working group coordination meetings feedback etc. The review meetings will have representation from various ministries and nutrition stakeholders such as NGOs, UN agencies, academia etc. Review meetings will take place at national and county levels as well as though regional meetings[12] for learning exchange. Review reports at national and county levels outlining progress will be produced and corresponding recommendations implemented and follow up made.

Detailed process monitoring indicator matrix for each KRA is presented in the M&E Process Monitoring Template uploaded at the MOH nutrition website http://nutritionhealth.or.ke.resources for easy access.

12 The regional clusters will include several counties coming together to learn and share best practices

3.4 Monitoring and Evaluation Implementation Matrix

The monitoring and evaluation implementation matrix for the key performance indicators is shown in Table 22.

Table 22: Monitoring and Evaluation Implementation Matrix

Key Performance Indicators	Activities	Sub Activities	Timeline (s)				
			2018/19	2019/20	2020/21	2021/22	2022/23
Expected Output: *Nutrition plans progress reviewed to inform planning and program adjustment*							
National annual Work plans developed by 2022/2023 FY	Develop annual work plans	Planning meetings within the programmes	**X**	**X**	**X**	**X**	**X**
		Joint planning meetings with Partners	X	X	X	X	X
		Sharing the tentative work plan with the partners for resource mobilization	X	X	X	X	X
A nutrition multiyear plan 2023-2027 (KNAP) developed	Develop a National Nutrition Action Plan for 2023-2027	Planning Meetings within the programmess					X
		Nutrition stakeholders' workshops					X
		Technical assistance during NNAP development					X
		Designing and printing the KNAP document					X
		Launching the developed KNAP					X
A Kenya Nutrition M&E Framework for the 2018/2022 KNAP in place by end of 2018/2019 FY	Develop a Kenya Nutrition M&E framework for the 2018-2022KNAP	Planning Meetings within the programmess	X				
		Holding Nutrition M&E framework development workshops	X				
		Technical Assistance during M&E framework development	X				
		Launch Nutrition M&E Framework	X				
A Kenya Nutrition M&E Framework for the 2023/2027 KNAP in place by end of 2022/2023 FY	Develop a Kenya Nutrition M&E framework for the 2023-2027 KNAP	Planning Meetings within the programmess					X
		Holding Nutrition M&E framework development workshops					X
		Technical Assistance during M&E framework development					X
		Launch Nutrition M&E Framework					X
National annual reports developed by 2022/2023	Develop national annual reports	Report writing workshops	X	X	X	X	X

Key Performance Indicators	Activities	Sub Activities	Timeline (s)				
			2018/19	2019/20	2020/21	2021/22	2022/23
An annual KNAP Review	Review KNAP implementation progress annually	Review meeting at national level to review progress and prepare for country wide review meeting	X	X		X	X
		Develop improvement plan based on progress, field experience and lessons learnt	X	X		X	X
		Develop a score card to ease tracking of KNAP implementation progress	X	X		X	X
		Regional (cluster) review workshops with counties and other stakeholders	X	X		X	X
A mid-term evaluation conducted by 2020/2021 FY	Mid-term Review of the KNAP implementation progress	Planning meetings for the mid-term review			X		
		Development of the mid-term review TOR			X		
		Technical assistance for mid-term review (consultancy)			X		
		Desk top reviews			X		
		Field visits to collect data/ conduct interviews			X		
		National level stakeholder consultative forum -validation of findings			X		
		Develop mid-term report with improvement plan			X		
		Generate a score card to track progress			X		
		Dissemination meeting for the KNAP mid-term review findings			X		
An end term evaluation for the 2018/2022 KNAP conducted by 2022/2023	An End-term Review of the KNAP implementation progress	Planning meetings for the end term review					X
		Development of the end term review TOR					X
		Technical assistance for end term review (consultancy)					X
		Desk top reviews					X
		Field visits to collect data/ conduct interviews					X
		National level stakeholder consultative forum -validation of findings					X
		Develop end term report with recommendations for the 2023-2027 KNAP					X
		Dissemination meeting for the KNAP End term review findings					X

Key Performance Indicators	Activities	Sub Activities	Timeline (s)				
			2018/19	2019/20	2020/21	2021/22	2022/23
Expected Output: *Strengthened Nutrition sector capacity in NIS and evidence-based decision making*							
200 health workers and managers trained/ sensitized on nutrition dashboards and scorecards	Sensitization and capacity development for national and counties on nutrition dashboards and scorecards	Planning meetings for the training			X	X	X
		Technical assistance / support	X	X	X	X	
		Prepare training Package			X		
		Training workshop for nutrition dashboards and score cards				X	X
		Update capacity development training template for updating of the IHRIS				X	X
15 officers trained on website maintenance and management by 2022	Train officers on website Maintenance and management	Planning meetings for the training		X			X
		Technical assistance / support		X			X
		Review of the training Package		X			X
		Training workshop for website maintenance		X			X
		Update capacity development training template for updating of the IHRIS		X			X
90 officers trained on qualitative research methodology by 2022	Train Officers on Qualitative Research Methodology, Data collection, Analysis and Report writing	Planning meetings for the training		X	X	X	
		Technical assistance / support		X	X	X	
		Review of the training Package		X	X	X	
		Training workshop for Qualitative Research Methodology		X	X	X	
		Update capacity development training template for updating of the IHRIS		X	X	X	
75 officers trained on SMART survey methodology by 2022	Train Officers on SMART Survey Methodology	Planning meetings for the training		X	X	X	
		Review of the training Package		X	X	X	
		Training workshop on SMART Methodology		X	X	X	
		Update capacity development training template for updating of the IHRIS		X	X	X	

Key Performance Indicators	Activities	Sub Activities	Timeline (s)				
			2018/19	2019/20	2020/21	2021/22	2022/23
350 officers trained on IPC for acute malnutrition by 2022	Train Officers on Integrated Phase Classification for Acute Malnutrition	Planning meetings for the training	X	X	X	X	X
		Review of the training Package	X	X	X	X	X
		Training workshop on IPC for Acute Malnutrition	X	X	X	X	X
		Update capacity development training template for updating of the IHRIS	X	X	X	X	X
60 officers trained on coverage methodology by 2022	Train on Coverage Methodology	Planning meetings for the training		X			X
		Technical assistance / support		X			X
		Review of the training Package		X			X
		Training workshop on Coverage Methodology		X			X
		Update capacity development training template for updating of the IHRIS		X			X
240 officers trained on nutrition data elements and indicators in the KHISKHIS	Train Officers on Nutrition data elements and indicators in the KHISKHIS	Planning meetings for the training	X	X	X	X	X
		Technical assistance / support	X	X	X	X	X
		Review of the training Package	X	X	X	X	X
		Training workshop on Nutrition data elements and indicators in the KHISkKHIS	X	X	X	X	X
		Update capacity development training template for updating of the IHRIS	X	X	X	X	X
70 officers trained on sentinel surveillance (EWS)	Train Officers on Sentinel Surveillance-Early Warning System	Planning meetings for the training	X		X		
		Review of the training Package	X		X		
		Training workshop on Sentinel Surveillance-Early Warning System	X		X		
		Update capacity development training template for updating of the IHRIS	X		X		
Semi-annual data review and feedback meetings held with counties	Routine Data review and feedback meetings with counties	Planning meetings with the stakeholders	X	X	X	X	X
		Data analysis and preparation of feedback package/slides	X	X	X	X	X
		Hold semi-annual review meeting - utilize ICT e.g. conference calls, skype etc.	X	X	X	X	X

Key Performance Indicators	Activities	Sub Activities	Timeline (s)				
			2018/19	2019/20	2020/21	2021/22	2022/23
An NIS/M&E needs assessment conducted by 2019/2020	Conduct M&E needs assessment	Assessment planning meetings		X			
		Questionnaire protocol development		X			
		Conduct online survey on NIS Gaps/needs		X			
		Generate a needs assessment report		X			
Technical assistance requirement report in place	Map NIS areas requiring additional technical assistance	Develop technical assistance requirement report		X	X	X	X
An NIS/M&E action plan developed by 2019/2020	develop action plan based on the assessment findings	Dissemination and development of the Action plans to address the needs		X			
		Develop a scorecard to track the key actions		X	X	X	X
Expected Output: *Standardized and harmonized nutrition data collection, management, and reporting at all levels*							
A Kenyan Nutrition Coverage Guideline in place	Finalize the Kenyan Nutrition Coverage Guideline	Input comments from internal and external reviewers	X				
		Present the Final document for approval and signing	X				
		Designing and printing	X				
		Dissemination/ sensitization/Launch meetings	X				
A National DQA guideline for Nutrition Indicators in the KHIS developed by 2020	Develop a DQA guideline for nutrition indicators in the KHIS	Guideline development working meetings		X			
		Pilot/pre-test the DQA guidelines		X			
		Finalize the guideline for use		X			
		Designing and printing		X			
		Dissemination/ sensitization/Launch meetings		X			
SOP for the Sentinel Sites DQA reviewed by 2018/2019	Review SOPs/ Sentinel sites DQA guidelines	SOPs/Sentinel sites DQA guidelines review meetings	X		X		
		Pilot/pre-test the SOPs/ Sentinel sites DQA Guidelines	X		X		
		Dissemination through existing structures	X		X		

Key Performance Indicators	Activities	Sub Activities	Timeline (s)				
			2018/19	2019/20	2020/21	2021/22	2022/23
An MIYCN KAP Field assessment manual in place by end of 2019/2020 FY	Finalization of the MIYCN KAP Field assessment manual	Manual Review workshop		X			X
		Share with the Internal and External reviewers for input		X			X
		Input comments from internal and external reviewers		X			X
		Present the Final document for approval and signing		X			X
		Designing and printing		X			X
		Dissemination/ sensitization/Launch meetings		X			X
HMIS Indicator manual review supported	Participate in the HMIS indicator manual review	Attend Review meetings		X			X
		Internal Working meetings on the nutrition indicators in the HMIS manual		X			X
A Guideline for County Nutrition Action Plan development in place	Develop a guideline for the CNAP development	Technical meetings for development of the guideline	X				
An IYCF-e Assessment tools and guidelines package reviewed by end of 2018/2019 FY	Review IYCF-e assessment tools and guidelines package	Technical Assistance in the review	X				
		Review and validation by the NITWG	X				
		Pilot the tools to make recommendations based on the field experience to feed into the assessment manual	X				
KKHIS Tools reviewed	Review KHISKHIS Tools	Planning meetings			X		
		Review workshops			X		
SMART Survey Questionnaire revised (MS word and ODK version)	Review SMART Survey Questionnaire	Review meetings	X	X	X	X	X
KAP Survey (MIYCN) Questionnaire reviewed (MS word and ODK version)	Review KAP survey Questionnaire	Review meetings		X			X
NIS/M&E tool and guideline packages printed	Print NIS/M&E tools and guidelines	Designing and printing			X		
	Pre-test NIS/ M&E tools and guidelines	Pre-test and feedback questionnaire based on the findings			X		

Key Performance Indicators	Activities	Sub Activities	Timeline (s)				
			2018/19	2019/20	2020/21	2021/22	2022/23
NIS/M&E tool and guideline packages distributed	Distribute NIS/ M&E tools and guidelines	Preparation of the distribution plan			X		
		Distribution of the tools			X		
NIS/M&E tool and guideline packages disseminated	Disseminate NIS/M&E tools and guidelines	Dissemination meetings			X		
Expected Output: *Timely generation and dissemination of nutrition situation updates to inform programme planning and response*							
Bi-annual nutrition situation reports developed during seasonal assessments by 2022/2023	Develop bi-annual nutrition situation reports	Data Collation and Analysis	X	X	X	X	X
		Develop situation maps	X	X	X	X	X
		Develop situation briefs and infographics	X	X	X	X	X
		Update caseload tracker	X	X	X	X	X
		Develop full situation report	X	X	X	X	X
		Disseminate findings at Kenya Food Security Meeting (KFSM), Emergency Nutrition Advisory Committee (ENAC) and other TWGs for response planning	X	X	X	X	X
Monthly nutrition situation update reports shared	Share monthly nutrition situation updates	Monthly routine nutrition data analysis	X	X	X	X	X
		Share feedback with the counties through emails, calls etc.	X	X	X	X	X
Nutrition website updated on a monthly basis	Update nutrition website on a monthly basis	Gather and Review/ approve the final products for uploading	X	X	X	X	X
		Uploading of the final product	X	X	X	X	X
Population based survey database updated semi-annually	Update population-based survey database monthly	Data mining from the reports	X	X	X	X	X
		Update the worksheets	X	X	X	X	X
		Upload the updated worksheet on the nutrition website	X	X	X	X	X
NIS/M&E Best practices annual report shared annually	Share best practices annual report	Form a best practice validation task force and TOR	X	X	X	X	X
		Prepare a best practice evaluation criteria	X	X	X	X	X
		Call for submission of Best practices	X	X	X	X	X
		Evaluate submitted Best practices	X	X	X	X	X
		Publish the scalable best practices for learning	X	X	X	X	X

Key Performance Indicators	Activities	Sub Activities	Timeline (s)				
			2018/19	2019/20	2020/21	2021/22	2022/23
Expected Output: *Quality nutrition data generated for evidence-based programming*							
Nutrition data clinic workshops held	Conduct nutrition data clinic and hold review meetings	Planning meeting	X	X	X	X	X
		Hold data clinic workshops	X	X	X	X	X
		Write data clinic report with action points and timelines	X	X	X	X	X
		Hold data clinic action point review meetings	X	X	X	X	X
Nutrition data quality audits conducted	Conduct KHISKHIS nutrition data quality audit	Conduct KHIS DQA Planning meetings	X	X	X	X	X
		Develop KHIS DQA protocol with budget	X	X	X	X	X
		Conduct KHIS DQA at field level	X	X	X	X	X
		Write KHIS DQA report	X	X	X	X	X
		Disseminate findings and develop improvement plan	X	X	X	X	X
		Monitor progress of improvement plan	X	X	X	X	X
	Conduct LMIS nutrition data quality audit	Conduct LMIS DQA Planning meetings	X	X	X	X	X
		Develop LMIS DQA protocol with budget	X	X	X	X	X
		Conduct LMIS DQA at field level	X	X	X	X	X
		Write LMIS DQA report	X	X	X	X	X
		Disseminate findings and develop improvement plan	X	X	X	X	X
		Monitor progress of improvement plan	X	X	X	X	X
	Conduct EWS/sentinel surveillance nutrition data quality audit	Conduct EWS DQA Planning meetings	X	X	X	X	X
		Develop EWS DQA protocol with budget	X	X	X	X	X
		Conduct EWS DQA at field level	X	X	X	X	X
		Write EWS DQA report	X	X	X	X	X
		Disseminate findings and develop improvement plan	X	X	X	X	X
		Monitor progress of improvement plan	X	X	X	X	X
Nutrition SMART, MIYCN KAP and Coverage Survey Methodologies reviewed	Review Nutrition SMART, MIYCN KAP and Coverage survey methodologies in monthly NITWG	Nutrition SMART, MIYCN KAP and Coverage Survey methodologies reviewed in NITWG meetings	X	X	X	X	X

Key Performance Indicators	Activities	Sub Activities	Timeline (s)				
			2018/19	2019/20	2020/21	2021/22	2022/23
Nutrition SMART, MIYCN KAP and Coverage Survey results validated	Review and validate Nutrition SMART, MIYCN KAP and Coverage Survey results in monthly NITWG	Nutrition SMART, MIYCN KAP and Coverage Survey results reviewed in monthly NITWG meetings	X	X	X	X	X
20 Quality Integrated Nutrition SMART Surveys conducted annually in the ASAL counties to inform nutrition situation	Conduct Integrated Nutrition SMART Surveys	Planning for the SMART Survey; Training of Data collectors; Field work; Data Analysis Reporting Validation and dissemination	X	X	X	X	X
15 Quality MIYCN KAP Surveys conducted every 3 years	Conduct MIYCN KAP Surveys	Planning for the KAP survey Training of Data collectors Field work Data Analysis Reporting Validation and dissemination			X		
15 Quality Coverage Surveys conducted every 3 years in the ASAL Counties in Kenya	Conduct Coverage Surveys	Planning for the Coverage Survey Training of Data collectors Field work Data Analysis Reporting Validation and dissemination			X		
Expected Output: *Improved multi-sectoral nutrition information efficiencies and cost-effectiveness through enhanced linkages*							
Number of nutrition-sensitive information linkages strengthened	Ensuring collaborations with nutrition sensitive sectors for nutrition sensitive information	Conduct initiation meetings and identify entry points for linkages/collaboration	X	X	X	X	X
		Regular participation of NITWG focal points in nutrition sensitive coordination fora/TWGs	X	X	X	X	X
		Annual review of effectiveness/achievements of enhanced multisectoral linkages	X	X	X	X	X
Number of nutrition-specific information linkages strengthened	Ensuring nutrition-specific information collaborations	Conduct initiation meetings and identify entry points for linkages/collaboration	X	X	X	X	X

Key Performance Indicators	Activities	Sub Activities	Timeline (s)				
			2018/19	2019/20	2020/21	2021/22	2022/23
		Regular participation of NITWG focal points in nutrition specific coordination fora/TWGs	X	X	X	X	X
		Annual review of effectiveness/achievements of enhanced nutrition specific linkages	X	X	X	X	X
NIS/M&E Terms of References reviewed annually	Review and update NITWG ToR	Review, update, and validation of ToR in NITWG	X	X	X	X	X
	Regular monitoring of NITWG Annual Plans	Quarterly review and presentation of NITWG Annual Plan progress	X	X	X	X	X
		Identification of solutions to key gaps and bottlenecks identified during review	X	X	X	X	X
Proportion of funds secured for NIS/M&E activities Annually	Securing resources for NITWG priorities	Resource mapping of current NITWG priorities	X	X	X	X	X
		Identification of key resource gaps and possible funding sources	X	X	X	X	X
		Inclusion of unfunded nutrition information priorities into ACSM	X	X	X	X	X
Number of multisectoral meetings conducted	Participate in multisectoral meetings	Participate in multisectoral meetings	X	X	X	X	X
Expected Output: *Improved access to and use of nutrition information for programme quality improvement*							
Number of national Data Protection Guidelines with nutrition sector inputs included	Ensure nutrition sector participation in development and updating of Data Protection Guidelines	Linkage with MoH on Data Protection guideline development process	X	X	X	X	X
		Regular participation of NITWG focal point in guideline development meetings and process			X	X	X
		Updated Data Protection Guideline progress and guidance disseminated through focal point					X
Nutrition included in KHO	Nutrition sector participation in KHO	NITWG and RNTWG focal points regularly participate in KHO TWG	X	X	X	X	X
		Continued advocacy for inclusion of nutrition dashboard in KHO	X	X	X	X	X
Nutrition dashboard (within KHIS) developed	Nutrition dashboard participation in Health and Demographic Surveillance Systems (HDSS) initiatives	Regular participation of NITWG focal points in HDSS meetings and TWG	X	X	X	X	X

Key Performance Indicators	Activities	Sub Activities	Timeline (s)				
			2018/19	2019/20	2020/21	2021/22	2022/23
		Ensure prioritization of support for development of nutrition dashboards	X	X			
	Develop and roll out of nutrition specific dashboards	Formation of Task Force for DHIS Nutrition Dashboards	X				
		Task Force to propose dashboards for different programme areas/ priorities		X			
		Validation of dashboard proposals by NITWG		X			
		Development of nutrition dashboards (IMAM, MIYCN, MN, Commodities, etc.) with HIS support			X	X	X
		Pilot of Nutrition Dashboard at national and county level				X	
Nutrition KHIS scorecard developed	Develop and roll out Nutrition KHIS scorecard	Formation of Task Force for KHIS scorecard	X				
		Task Force to propose scorecards for different programme areas/ priorities		X			
		Hold consultative meetings with nutrition programme officers		X			
		Validation of the DHIS nutrition scorecard by NITWG			X		
		Pilot of Nutrition Scorecard at national and county level			X		
Number of counties utilizing nutrition dashboard to improve programme quality	Implementation and roll out of nutrition dashboards and scorecards to inform programme performance	Sensitization and capacity development for counties on nutrition dashboards and scorecards		X	X	X	X
		Use of nutrition dashboards and scorecards in county level programme review meetings, including CNTF, CHMT, MCNP Regional Meetings, etc			X	X	X
		Development of county level action plans based on gaps and issues identified			X	X	X
		Regular review and monitoring of progress on resolution of bottlenecks and improvements in action plans			X	X	X
		Lessons learned/best practices review at national and county levels				X	X
		Update of nutrition dashboards and scorecards as informed by review meetings and feedback					X

3.5 Evaluation

The aim of an evaluation is to determine the relevance, impact, efficiency, effectiveness and sustainability of interventions and the contribution of the programme to results (UNICEF 2017). Evaluation provides credible evidence - based information to help nutrition sector continually improve its performance, learning and accountability. The main evaluations will be Mid Term Review (MTR), End Term Review (ETR), quarterly reviews and specific programme evaluations.

- **Mid -term review:** A midterm review (MTR) of the Kenya Nutrition Action Plan will be done in 2020 to review the progress made in the two years of implementation and recommend adjustments in strategy or review of expected targets if deemed necessary. It will also be aligned to the health sector strategic plan midterm review. It will cover all the targets mentioned in the plan, including targets for outcome and impact indicators. The results will be used to adjust the KNAP strategies, priorities and targets.

- **End term evaluation:** The end-term review (ETR) of the Kenya Nutrition Action Plan will be done in 2022 to evaluate the overall performance of the KNAP and use lessons learnt to develop the subsequent KNAP and review the final achievements of the sector against what had been planned. It will involve a comprehensive analysis of progress and performance for the whole period of the plan.

- **Specific programmes evaluations** – This will focus on specific interventions, policy, strategy etc.

To guide the evaluations in nutrition sector, a costed evaluation plan will be developed. The costed evaluation plan will provide the following details: proposed title of the evaluation, start and end dates, cost, source/s of funds, responsible programmes for conducting and tracking of progress. Evaluations are rigorous and hence a realistic plan is recommended.

Evaluation steps: During an evaluation process, the following seven steps will be followed:

I. Assess the utility, necessity and evaluability of the evaluation. This includes examining the design of the programmes, project, and strategy etc, availability of monitoring information, accountability and conduciveness of the context.

II. Plan and commission the evaluation – allocate responsibility and develop terms of reference (TORs). The TORs should include context of the evaluation, purpose of evaluation, scope, evaluation criteria, key evaluation questions, methodology, work plan and budget, products and reporting, management arrangements and dissemination plan. According to OECD-DAC[13], the key evaluation criteria are relevance, impact, efficiency, effectiveness and sustainability. Additional evaluation criteria depending on need include equity, gender and human rights. During humanitarian situations, it is also important to consider coverage of interventions, coordination and coherence.

III. Manage the inception phase – this should be implemented within 1 month. The evaluation team should provide a report outlining the revised work plan, understanding of the TOR and agreed evaluation methodology.

IV. Data collection, analysis and validation of findings.

V. Disseminate and use evaluation findings – packaging of evaluation findings and using of strategic dissemination forums relevant to target audience to increase uptake of evaluation findings.

VI. Prepare and track the implementation of evaluation recommendations.

VII. Use evaluation for learning and accountability.

13 Organisation for Economic Co-operation and Development's (OECD) Development Assistance Committee (DAC)

3.6 Accountability and Learning

Accountability: refers to the transparency of processes including planning, execution and reporting. This will:

- Ensure stakeholders are responsible for resources and results.
- Help decision makers to identify and track areas of greatest need to help achieve targets
- Serve as an advocacy tool for external partners and stakeholders
- Stimulates discussion among key players, benchmark and encourage cross learning among counties, aid to unmask disparities across counties and encourage social accountability and mutual dialogue with key players (multiagency, multi-sectoral and across all levels) to address malnutrition.

The M&E framework outlines the following strategies to ensure accountability:

1. Accountability on the side of the Division of Nutrition and Dietetics
    - Accountability for funds
    - Accountability for results
    - Social accountability

    How?
    - Annual review meetings through the Nutrition Technical Forum
    - Regular review meetings by the programme managers
    - Stakeholder engagement in every step of implementation of the KNAP inputs
    - Timely publication and wide dissemination of reports, guidelines and relevant documents
    - Kenya Nutrition Scorecard and the RMNCAH scorecard

2. Accountability by the county government Authorities (S/CHMT, S/CO-MOA, NDMA etc.)
    - Accountability for funds
    - Accountability for results

    Social accountability How?
    - Actions taken to improve nutrition indicators using the RMNCAH scorecard and Kenya nutrition scorecard
    - Financial tracking using the financial matrix
    - Data Quality Assurance activities like audits and review meetings
    - Joint supportive supervision and mentorship
    - Generation and dissemination of annual work plan reports
    - Kenya Nutrition Scorecard and the RMNCAH scorecard
    - Community feedback mechanisms and dialogues. Information sharing with the communities, using the relevant forums

3. Accountability by the partners
    - Accountability for funds
    - Accountability for results
    - Social accountability

    How?
    - Joint planning and execution of programme activities
    - Joint budget reviews and reporting with the relevant platforms
    - Information sharing with the communities, using the relevant forums
    - Information to be more user-friendly and accessible to the public and encourage public oversight through proactive engagement
    - Stakeholder engagement in every step of implementation of the KNAP inputs
    - Timely publication and wide dissemination of reports, guidelines and relevant documents

4. Accountability by Health Facilities (Health Workers, Health Facility committee etc.)
    - Accountability for allocated resources
    - Accountability for results
    - Social accountability
    - Hold regular monitoring and review of activities
    - Coordination meetings by the health facility committees
    - Community feedback mechanisms and dialogues. Information sharing with the communities, using the relevant forums

5. Accountability by the Community (Community Units, Community Leaders and Community Health Volunteers)
    - Hold regular monitoring and review of community led actions
    - Monitor effectiveness of the complaint and feedback mechanism
    - Communicate feedback to the community, encouraging them to respond in turn

Accountability Tools and Processes:
- Community score cards
- Participatory approaches: Community dialogues and Action days
- Joint monitoring
- Confidential Complaint and Feedback mechanism
- Kenya Nutrition Scorecard

Learning: Refers to the process through which information generated from M&E is reflected upon, and intentionally used to continuously improve a plan/strategy to achieve results. The learning process of the Kenya M&E Framework will adopt the adaptive management cycle approach stipulated in the KNAP, which involves improving outcomes through learning[14]. There will be implementation of the strategies and interventions to address the issues identified during the review of NNAP 2012-2017.

Learning will involve assessing what works well in a context or what does not work well, and which aspects have more influence on the achievement of results, which strategies can be replicated etc.

Approaches to guide in learning:

1. Compare results across time to determine which ones contribute to achieving the set tasks and expected results.

2. Facilitation of both levels of learning through formal or informal learning and reflection meetings of all stakeholders, by sharing learning experiences (positive and negative) with partners, communities, and other stakeholders, in response to their needs:

    - Organize workshops to reflect on lessons learned and to exchange good practices e.g. Regional meetings, which promote events for horizontal knowledge exchange by the counties.
    - Ride on community dialogue days to share lessons learned and reflect on best practices

3. Documentation of processes and reports, and appropriate storage of MEAL outputs to keep learning within the programmes and sectors even in absence of the key staffs.

    - Filing Paper based report
    - Majorly uploading soft copies (photos, videos) on the nutrition website

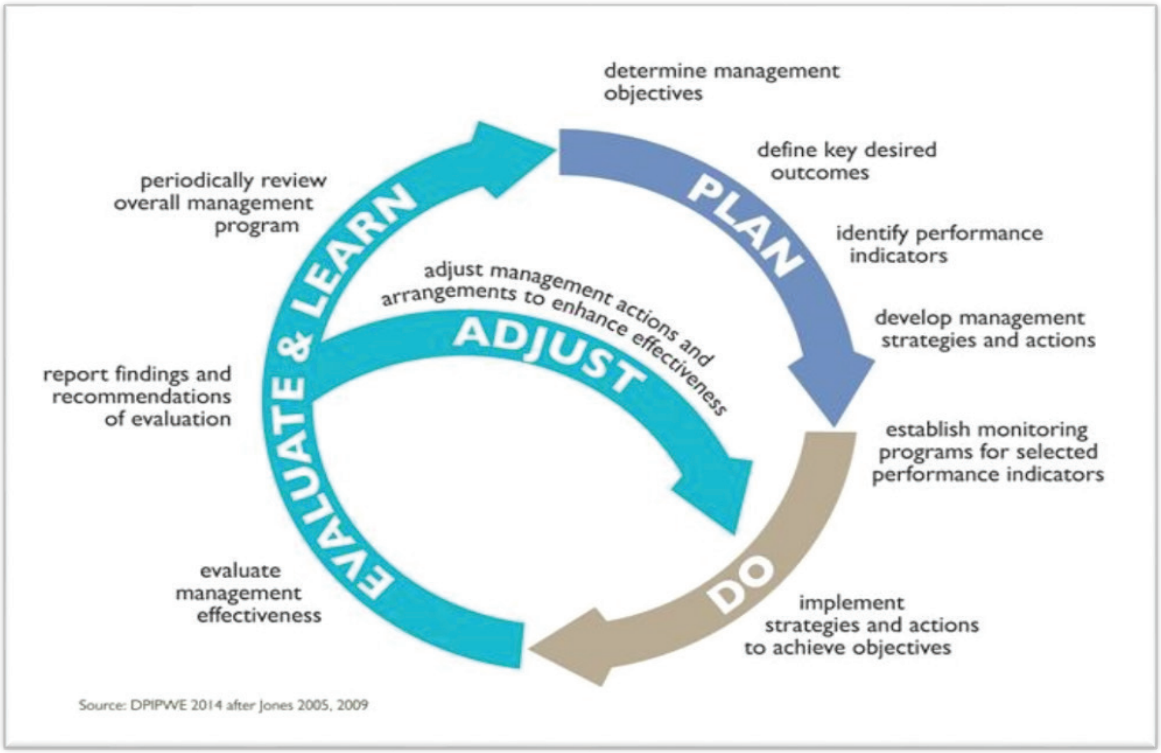
4. Learning needs assessment and support

    - Mentoring of staff with a focus on specific issues or identified needs and help individuals reflect and question existing practice.
    - Training courses in response to feedback.

14 The Kenya Monitoring and Learning Cycle

5. Development of innovative tools for MEAL
    - Online learning
6. Feedback mechanism

Figure 10 : Learning Cycle



3.7 Operational Research

Operational research is any research producing practically any usable knowledge (evidence, findings, information etc.) which can improve programme implementation (e.g. efficiency, effectiveness, quality, scale up, access and sustainability) regardless of type of research (design, methodology)[15]. Operations research typically tries to modulate inputs and processes in programmes and aims to measure desired changes in outputs, outcomes and impacts. For example, research in determining whether combining cash-based interventions and nutrition counselling can improve breast feeding and complementary feeding outcomes. Operational research is useful in providing context specific answers e.g. how does a proven intervention work in a different context? It helps to explain success and failure. Operations research uses mixed methods approaches that are often interlinked and can be broadly divided into two:

- Secondary data analysis
- Primary level research – this can take different forms:
    - Exploratory/diagnostic focusing on problem identification e.g. formative or needs assessment.
    - Field intervention – quasi experimental and randomized cluster trails.
    - Evaluative and cost effectiveness studies.

The nutrition research activities will be coordinated through the Research in Nutrition Technical Working Group (RNTWG) with linkages to relevant programmes and the relevant counties[16]. The working group will review, approve, facilitate and promote implementation of research of highest quality in nutrition to inform policy. Annex 4 is a guide for submitting research proposals to the technical working group. It is recommended that the technical working group validates research findings and disseminate effectively to target audience to increase uptake of research findings.

15 Sumit Malhotra (2010): Operations Research in Public Health
16 Relevant counties refer to the counties where the operational research will be carried out

3.8 Research and Learning Implementation Matrix

The research and learning implementation matrix is presented in Table 23.

Table 23: Research and Learning Implementation Matrix

Key Performance Indicators	Activities	Sub Activities	2018/19	2019/20	2020/21	2021/22	2022/23
Expected Output: *Strategic partnerships and linkages developed*							
Number of New Strategic research Partnerships established annually	Map out all the partners and networks including research institutions, universities, ethical research committees etc. that conduct research	Desk review to map partners and identify expertise	X	X	X	X	X
Expected Output: *Linkages on research in nutrition strengthened*							
Number of existing research partnerships strengthened by 2022/23	Identify expertise for research in nutrition from existing partnership	RNTWG meetings	X	X	X	X	X
Expected Output: *Research priorities identified through established Linkage between county and national government and other sectors;*							
Number of new research priorities identified annually	Desk reviews	RTWG meetings	X	X	X	X	X
Expected Output: *Research priority areas identified and mainstreamed/consolidated into national and county priority agenda;*							
Number of research priority mainstreamed in national Agenda	Needs assessment at national level to identify priorities	Consultative meetings	X	X	X	X	X
Expected Output: *Sub-committees for research established and strengthened*							
Number research priority mainstreamed in county agenda annually	Research Proposals presented and validated	RTWG	X	x	x	x	x
Expected Outcome: *Collaboration and partnerships with other TWGs involved in Research strengthened*							
Two subcommittees on research established annually	Develop concept noted on research prioritization and importance of evidence in decision making	Lobby counties to establish own research committees	X	x	x	x	x
Number of collaborations with Research TWG by 2022	Hold collaborative meetings	Collaborative RTWG Meetings	X	x	x	x	x
Expected Outcome: *Conduct of research improved and increased*							
Number of operational / implementation researches conducted by 2023	Review and validate research proposal submitted to the RTWG	RTWG Meetings	X	x	x	x	x

Key Performance Indicators	Activities	Sub Activities	2018/19	2019/20	2020/21	2021/22	2022/23
Expected Output: *Research skills and capacity developed*							
Number of people trained on Research skills in three research methodologies developed by 2022	Trainings on research skills		X		x		x
Expected Output: *Research fund is established*							
One research fund formed by 2022	Concept notes and grant applications		X	x	x	x	x
Expected Outputs: 1. *Quality and standards for conduct of research improved* 2. *Research studies, methodologies and results validated*							
Number of Standard Operating Procedures on conduct of research developed by 2022	Desk review and Mapping out existing SoPs/ guidelines, standards that support research in nutrition	RTWG meetings	X	x	x	x	x
Number of Research findings disseminated to county where research was undertaken by 2022	Review and validate and disseminate research findings submitted to the RTWG	RTWG meetings	X	x	x	x	x
Expected Output: *Research findings disseminated to decision/policy makers*							
Systematic review of nutrition research findings strengthened	Review and disseminate research findings	County meetings for dissemination by county teams	x	x	x		
Four systematic reviews of nutrition research findings (MIYCN, Capacity, SMART, coverage) conducted by 2022	Included in the M and E section	Included in the M and E section	x	x	x	x	x
Expected Output: *Symposiums and conferences organized*							
No. of symposiums/ Conferences on nutrition held by 2022	Organize for symposium/ conference	Conduct Research in Nutrition Symposium every 2 years		x		x	
Expected Output: *Knowledge platform designed and developed*							
One knowledge management platform on research on Nutrition established	Develop a knowledge platform work plan	Identify sources for knowledge platform content; Resource mobilize for design, set up and management of knowledge platform	x	x	x	x	x

Key Performance Indicators	Activities	Sub Activities	2018/19	2019/20	2020/21	2021/22	2022/23
Expected Output: *Nutrition and dietetics research data integrated into Nutrition and other allied portals*							
Research data integrated in two portals by 2022		Lobby for inclusion of nutrition and dietetics information into other allied portals	x	x	x	x	x
Expected Output: *Communities of practice / Best Practice forums in research in nutrition established*							
Number of community of practice forums established by 2022	Establish and maintain national committee for community of practice in an identified area	Consultative meetings; identification of possible communities of practice	x	x	x	x	x
Expected Output: *Linkages strengthened*							
Number of Linkages with universities to share research findings established by 2022			x	x	x	x	X
Expected Output: *Research repository platform designed and developed*							
Number of Research Repository developed by 2020	Design and develop the research repository platform;	Map researches available from different institutions;	x	x	x	x	X
		Desk Review quality of findings from the research to select most plausible;	x	x	x	x	X
		Meetings to discuss research findings for inclusion in research repository;	x	x	x	x	X
		Resource mobilize and Maintain and update research repository;	x	x	x	x	X
		Sensitize on the importance of common research repositories	x	x	x	x	X
Expected Output: *Increased access to research findings for decision making*							
Number of researches disseminated	Dissemination of research findings in conferences; meetings; workshops	Research dissemination workshops	x	x	x	x	X
Expected Output: *Open data access policies /guidelines developed*							
Open data access guideline/policy developed by 2022	Develop open data access guidelines		x	x	x	x	X

Key Performance Indicators	Activities	Sub Activities	2018/19	2019/20	2020/21	2021/22	2022/23
Expected Output: *Open data access systems put in place*							
One open data access portal established by 2022	Design and develop data access portal	RTWGs meetings	x	x	x	x	X
Expected Output: *Capacity on knowledge translation developed for increased capacity for translation*							
No. of Persons trainied/sensitized onon knowledge translation annually	Capacity building on knowledge translation	Develop policy brief as outputs of knowledge translation training	x	x	x	x	X
Expected Output: *Systematic review strengthened*							
Number of policy briefs/statements translated from research findings annually	Train on systematic review processes	Produce systematic reviews as outputs of the systematic review training	x	x	x	x	X
Expected Output: *Development of a nutrition journal initiated*							
A nutrition journal developed by 2022	Develop a nutrition journal development work plan	Identify key stakeholders for development of journal; Identify potential journal reviewers and editors; Plan for registration of journal		x	x	x	X
Expected Output: *Research finding published in various journals*							
Number of nutrition manuscripts published in various journals using sector data by 2022	Identify data/ findings for publication	Develop manuscripts for publishing in the nutrition journal		x	x	x	x
Expected Output: *Innovations in research in nutrition increased*							
One innovation in research in nutrition developed		Identify potential innovations in research in nutrition; Resource mobilize for innovations in research in nutrition	x	x	x	x	X

Best Practices: is "knowledge about what works in specific situations and contexts, without using inordinate resources to achieve the desired results, and which can be used to develop and implement solutions adapted to similar health problems in other situations and contexts".

Criteria for Selection of "Best Practices" are as follows:

- ***Effectiveness:*** This is a fundamental criterion: the practice must work and achieve measurable results.
- ***Efficiency:*** The proposed practice must produce results with a reasonable level of resources and time.
- ***Relevance:*** The proposed practice must address the priority health problems in the country
- ***Ethical soundness:*** The practice must respect the current rules of ethics for dealing with human populations.

- ***Sustainability:*** The proposed practice must be implementable over a long period without any massive injection of additional resources.
- ***Possibility of duplication:*** The proposed practice, as carried out, must be replicable elsewhere in the Country.
- ***Involvement of partnerships:*** The proposed practice must involve satisfactory collaboration between several stakeholders.
- ***Community involvement:*** The proposed practice must involve participation of the affected communities.
- ***Political commitment:*** The proposed practice must have support from the relevant national or local authorities.

Key components of documenting Best Practices (See ANNEX 3: Good Practice Template)

a) Title of the "Best Practice": This should be concise and reflect the practice being documented.

b) Introduction: This should provide the context and justification for the practice and address the following issues:
   a. What is the problem being addressed?
   b. Which population is being affected?
   c. How is the problem impacting on the population?
   d. What were the objectives being achieved?

c) Implementation of the Practice
   a. What are the main activities carried out?
   b. When and where were the activities carried out?
   c. Who were the key implementers and collaborators?
   d. What were the resource implications?

d) Results of the Practice – Outputs and Outcomes
   a. What were the concrete results achieved in terms of outputs and outcomes?
   b. Was an assessment of the practice carried out? If yes, what were the results?

e) Lessons Learnt
   a. What worked really well – what facilitated this?
   b. What did not work – why did it not work?

f) Conclusion
   a. How have the results benefited the population?
   b. Why that particular intervention should be considered a "Best Practice"?
   c. Recommendations for those intending to adopt the documented "Best Practice" or how can it help people working on the same issue(s).

g) Further Reading: Provide a list of references that give additional information on the "Best Practice" for those who may be interested in how the results have benefited the population.

Methods of disseminating and sharing Best Practices
- Publication to promote learning and sharing of experience
- Uploading on the nutrition website and providing the web link through email notification to the relevant stakeholders
- Presentation in conferences, symposia and forums
- Use other methods as appropriate

CHAPTER 4

IMPLEMENTATION STRATEGY FOR THE M&E FRAMEWORK

The implementation of the M&E framework will be spearheaded by the Ministry of Health – Division of Nutrition and Dietetics in collaboration with development partners and stakeholders at all levels. This will ensure successful implementation of M&E system in the Division of Nutrition and Dietetics. The implementation strategy shall be determined by the following:

Human Resource development:

1) Availability of relevant human resource for Monitoring, Evaluation, Accountability and Learning.
2) Clearly defined roles of various stakeholders that indicate the information generators, information managers, information custodians and information users.
3) Highlighting and remedying of M&E capacity-gaps required across information generators, information managers, information custodians and information users in order for the M&E system to be efficient and functional.
4) Capacity building of relevant stakeholders to utilize nutrition data and information.

Systems readiness for:

1) Appropriate information management infrastructure shall be in place to ensure compliance with data and information quality protocols, upwards and downwards flow of information and is easily accessible in an appropriate repository(ies).
2) Utilization of relevant emerging technologies that will accelerate information capture, aggregation, analysis and utilization. Pilot-tests of such technologies shall also provide learning experiences that shall be necessary for systems improvement.
3) Promotion of information quality management through frequent audits and checks.
4) Establishment of appropriate feedback and response mechanism with easy flow of information at different levels of nutrition programme implementation.
5) Forums for dissemination, learning and research.

Funding Mechanisms that will boost M&E human resource and M&E systems

Mechanisms should be put in place to ensure adequate funding for the NIS and M&E system activity cycle. The activity cycle includes data collection, transmission, aggregation, analysis and utilization. Such mechanisms include:

1) Integration of M&E activities and leveraging on resources for ongoing nutrition and nutrition-related programme activities for more efficient use of funds.
2) Use of and scale up of cost-effective strategies such as having online meetings, training and dissemination through teleconferencing instead of having physical meetings.
3) Mainstreaming nutrition information collection in other sector nonitoring and evaluation systems
4) Develop public/private partnerships to fund M&E system activities.

Coordination mechanism

1) Clearly defined multi-sectoral coordination structure with partners and other stakeholders at national and county levels for the planning, implementation and dissemination of M&E activities.
2) Presence of platform/technical forum that coordinates the technical review, validation and provides mentorship and sharing of M&E feedback at national and county levels (See Table 24).

4.1 Roles and Responsibilities of Stakeholders

The roles and responsibilities of stakeholders are shown in Table 24.

Table 24: Roles and Responsibilities of stakeholders in the M&E

Stakeholders	M&E roles and responsibilities
Division of Nutrition and Dietetics	• Develop standards, guidelines and tools for monitoring and evaluation of nutrition projects and programmes in the country • Standardization of nutrition data collection methodologies, management, and reporting. • Overall management and implementation of Kenya Nutrition M&E framework. • Development of M&E implementation plan and operational manuals. • Provide technical support to counties in data collection, reporting and analysis including review and validation of data, methodologies and results. Build capacity of national and county levels on nutrition information and M&E. • Mobilize resources to support implementation of M&E plans and framework. • Conduct periodic data quality audits, develop data quality improvement plans and monitor their implementation. • In collaboration with KNBS, partners and stakeholders provide technical expertise in conducting various evaluations and surveys including Kenya National Micronutrient Survey (KNMS), Kenya Demographic Health Survey (KDHS), Kenya Integrated Household Budget Survey (KIHBS), Multiple Indicator Cluster Surveys (MICS). • Ensure effective coordination of nutrition M&E and information at national and county levels. • Coordinate national level nutrition surveys, programme evaluations and statistical modeling and facilitate dissemination of findings to counties and stakeholders. • Strengthen multi-sectoral linkages and partnerships e.g. mainstreaming nutrition M&E in the relevant sector information systems and technical working groups, joint monitoring and assessments, etc. • Keep a common (central) nutrition data repository and manage the Kenya Nutrition Website for improved data access and utilization. Develop and disseminate national level nutrition M&E and information products. • Monitor implementation of national and county annual work plans in consultation with county governments. • Coordinate mid-term and end-term review of the KNAP and support counties to monitor implementation of CNAPs. • Document and disseminate best practices, case studies, research findings and success stories for evidence-based programming. • Promote/support accountability and feedback mechanisms.
Line Ministries/ Institution and Agencies including KNBS, KEMRI	• Mainstream M&E for Nutrition in their M&E systems. • Monitor and report on nutrition indicators and activities that fall in their dockets. • Participate and provide technical inputs in development of Nutrition Sector M&E plans, guidelines and frameworks. • KNBS and KEMRI provide technical support and expertise for national level nutrition surveys. • Participate in mid-term and end-term review of the KNAP. • In collaboration with DND participate in joint monitoring and supervision of implementation of nutrition sensitive activities in KNAP. • Undertake resource mobilization for implementation of KNAP MEAL framework.
Development Partners	• Provide technical and financial support to ensure Nutrition Sector M&E system is functional. • Conduct/support advocacy and resource mobilization to support implementation of M&E plans and framework. • Provide technical support in development, dissemination and implementation of nutrition M&E framework, Plans and guidelines . • In collaboration with DND and KNBS participate and provide technical expertise in conducting various researches, evaluations and surveys

Stakeholders	M&E roles and responsibilities
County Health Management Team	• Overall coordination of the implementation of nutrition M&E framework at the county level. • Ensure adherence to nutrition M&E standards and guidelines • Monitor implementation of county AWPs and develop annual performance reports. • Advocate for inclusion of nutrition indicators in county level plans such as the CIDP and CHSSP • Conduct mid-term and end-term review of the CNAPs • Domestication and dissemination of policies, guidelines, and reports. • Resource mobilization. • Provide technical and financial support for M&E activities. • Maintenance of the implementing partners' database at the county level. • Manage the nutrition database at the county level. • Dissemination of all reports and M&E products developed at both the county and national level. • Conduct regular data quality audit activities in the county. • Conduct quarterly health stakeholders' forum. • Operationalize the M&E TWG and CNTF. • Conduct data review at the county level. • Provide oversight on data collection and reporting. • Promote data demand and information use. • Conduct performance reviews at the county level. • Spearhead implementation of recommendations and improvement plans • Ensure proper information flow from various levels to inform decision-making. • Develop quarterly reports for the CECM, Chief Officer and County Director for Health. • Provide regular feedback on nutrition data quality to both sub counties and implementing partners. • Acquisition and distribution of HMIS tools to the sub counties. • Coordination of training, mentorship and OJTs. • Coordination of research and survey activities. • Development of quarterly and annual County Health Bulletin. • Provide technical, material and financial support for M&E to all sub-counties. • Carry out County M&E needs assessment and build capacity where applicable. • Keep a common (central) nutrition data repository at County level and update nutrition situation and reports in the relevant county websites. • With support from the national level, produce County specific tools for special studies and assessment based on need • Conduct Supportive supervision • Implementation of County feedback and accountability mechanism e.g. through community scorecards • Document and disseminate best practices, case studies, research findings and success stories for program adjustment and improvement

Stakeholders	M&E roles and responsibilities
Sub County Health Management Team	• Coordinate and manage M&E at the Sub County level. • Mobilization of resources for Sub-County level planned activities. • Supervise nutrition data collection in the facilities. • Receive and compile nutrition data from health facilities, community units and implementing partners and feed all reports on performance tracking into the KHIS or any other e-data capturing system linked to the county in a timely manner. • Provide regular feedback to the health facilities and community units. • Utilize data generated at the Sub County level for decision making. • Ensure proper information flow from and to the health facilities and community health units in the Sub Counties. • Develop Sub-County Health report and share it with the CHMT and County Director for Health. • Disseminate quarterly reports to Sub-County health facilities and community units. • Aggregate, analyze, disseminate and use health and health-related data on the performance of the health sector priorities outlined in the CHSSIP from all community health units, health facilities and provide feedback to all. • Analyze the quality of all reports received from health facilities and community health units and ensure follow-up in case of incompleteness, problems with validity, and delays and provide technical support to all sub-county level operational units and all tiers of health facilities in the sub-county for M&E. • Conduct Routine data quality audit - RDQA (quarterly). • Conduct quarterly data review. • Conduct monthly data validation before entry into the KHIS. • Conduct oversight to manage all health and health-related data from all service providers within the sub-county. • Maintain and update a common data repository • Distribution and redistribution of HMIS tools to health facilities. • Coordination of training, mentorships, and on job trainings OJTs to health facilities and community units. • Coordinate research and survey activities. • Implementation of community feedback and accountability mechanism e.g. through community scorecards • Document and disseminate best practices, case studies, research findings and success stories
Health facility	• Maintain and update the Health Information System, including records, filing system(s) and registry for primary data collection tools (such as registers, cards, file folders), and summary forms (such as reporting forms, CDs, electronic backups). Data collection, compilation, analysis and on ward transmission to the sub counties. • Conduct monthly facility data review before submission to the Sub County level. • Safeguard data and information system from any risks e.g., termites, fire, floods, access by unauthorized persons etc. • Prepare an analysis of the data for discussion during staff and board meetings for decision-making. • Provide regular feedback to the Community Units (CUs). • Implementation of policies and guidelines. • Provide platforms for data dissemination, accountability and community feedback e.g. community scorecards, community dialogues, suggestion boxes etc. • Document and share best practices, case studies, research findings and success stories

Stakeholders	M&E roles and responsibilities
Community Unit	• Collect data from the community. • Participate in community surveillance activities e.g. reporting of increased cases of children with malnutrition • Community involvement and consultation in nutrition data and information processes • Update and maintain community health information within the KHIS. • Compile and submit monthly reports to the health facility. • Conduct dialogue and action days. • Receive feedback from the facility, Sub County and County levels. • Use information collected and feedback received for decision making. • Develop quarterly and annual community health and nutrition reports for integration into facility reports. • Carry out M&E and regularly update household members in forums such as community dialogue days. • Maintain registers for documentation of household visits, activities and report regularly to supervising link-health facility. • Share best practices and success stories for documentation and scale up

4.2 Technical Coordination Mechanisms

The M&E technical coordination will align with Monitoring and Evaluation Framework of the Ministry of Health at the National and County levels. The technical M&E coordination structures will include Nutrition Information Technical Working Group (NITWG) and Research Technical Working Groups at the national level. The roles of these structures are outlined below.

4.2.1 Nutrition Information Technical Working Group

Nutrition Information Technical Working Group at the national level will play the following roles:

- Develop standards and guidelines for nutrition information.
- Contextualize relevant international guidelines for Kenya.
- Review and validate nutrition information collection, analysis and reporting.
- Centralize nutrition information, disseminate and advocate for action.
- Capacity strengthening/offer technical support on nutrition information when and as needed especially to the counties.
- Produce Nutrition Situation Reports.
- Strengthen multi-sectoral linkages on nutrition information through direct participation at various forums (education, social protection, agriculture, livestock, special programmes etc)
- Promote knowledge management among members of NITWG.
- Promote documentation of success stories/lessons by stakeholders.
- Strengthen continuity of NITWG partnership with stakeholders such as NDMA, KNBS, FEWSNET, MoH HIS and enhance linkages with other working groups within the sector.
- Establish linkage with and support county level M&E committees:
    - Build M&E capacity at the county.
    - Support the operationalization of M&E framework by guiding the development of county M&E Plans.

4.2.2 Research in Nutrition Technical Working Group (RNTWG)

Research in Nutrition Technical Working Group will play the following roles:

- Coordinate research in nutrition.
- Provide expert advice, technical guidance and leadership in nutrition research including networking.
- Identify priority areas for nutrition research in the country.
- Dissemination and sharing of research findings
- Support/advocate for uptake of research findings.
- Resource mobilization for priority research in nutrition.

- Establish a nutrition research repository database and create an access platform available to the public.
- Knowledge management.
- Coordination and linkage through setting up a community of practice by linking research finding to policy implementation.
- Promote nutrition research covering all areas in the field of nutrition.

4.3 Capacity Development for Nutrition Information and M&E

In order to improve system wide capacity in nutrition M&E, the four thematic areas (systemic, organizational, technical and community capacity) stipulated in the Kenya Nutrition Capacity Development Framework will guide capacity development for nutrition information and M&E. The following shall apply under this framework:

1. Nutrition M&E focal person is responsible for all aspects of capacity development in M&E and NIS including; systemic, organizational, technical and community capacity developments NIS/M&E initiatives.

2. Collection, analysis, validation and dissemination of capacity development assessment data on systemic, organizational, technical and community capacities for sound decision making on service delivery.

3. Capacity strengthening in nutrition M&E for all cadres of service delivery.

4. Link M&E systems to nutrition specific and nutrition sensitive sectors (e.g. agriculture, education, social protection, among others) to ensure adequate multi-sectorial data is available and used for decision making.

5. Monitor improved communication and linkages between regulatory organizations and partners.

4.3.1 Systemic capacity for M and E

There are several laws, guidelines and policies developed within the nutrition specific and nutrition sensitive programmes. For nutrition M&E component to be successfully implemented, this framework recommends:

- The nutrition workforce capacity to understand and implement these policies, laws, regulations and standards should be enhanced.
- The knowledge and understanding of policies among county government and other implementers should be promoted to increase the impact, coverage and monitoring of activities herein.
- Efforts should be made to ensure that county level governments allocate resources for NIS and M&E.
- The M&E guidelines will be disseminated at the national, county level and at stakeholder forums using innovative and non-resource intensive platforms.
- The implementers shall be equipped with resource mobilization, planning and budgeting skills, without which, efforts to successfully monitor nutrition activities will be undermined and frustrated.

4.3.2 Organizational capacity

The competencies required by nutrition professionals at organizational level and the areas of focus required for improved organizational capacity are key for successful monitoring and evaluation. Organizational capacity development should include the need for well-established infrastructure, tools and equipment in addition to skills enhancement. For instance, the skills for nutrition assessment can be compromised with the absence of relevant anthropometry equipment thereby negatively affecting the success of M&E activities. To ensure successful M&E competencies of implementers to coordinate M&E operations, staff and resources, as well as supervisory services, will need to be enhanced. In addition, technical oversight and capacity development for coordination within government line Ministries, NGOs, private sector, regulatory bodies and UN systems and other stakeholders addressing the various nutrition interventions will be required.

Nutrition issues of non-technical nature such as those related to the implementation process lack a visible database such as the KHIS. This means attaining information for programming or process related indicators require an un-systemized approach between individuals at national level and sub-national levels. Therefore, verifiable indicators such as: programme documents, working group coordination minutes and other relevant reports depicting activities undertaken will serve as verification. Qualitative and quantitative assessments and evaluations conducted by NGOs or other project-based activities will also depict capacity development issues in M&E and progress made. Other key capacities within the organizational pillar include: data collection and recording; how to use this data for decision making and advocacy, developing suitable indicators and capacity to conduct high quality research and utilization of the results for learning purposes.

4.3.3 Technical capacity

This refers to both the adequacy of workforce for M&E activities in all areas and also the proficiency in knowledge and skills necessary for effective M&E and NIS implementation. Human resources for NIS and nutrition M&E is one of the aspects where there is need for improvement. The findings from M&E system review[17] indicated 64.7 percent of the respondents reported that the human capacity is low, 29.5 percent indicated that it was moderate and only 5.9 percent said that it was high. To a large extent high staff turnover contributes to the inadequacy in capacity as this implies continuous training is necessary to build capacity of the new staff. At the national level, human capacity for M&E particularly at the DND and HIV and Nutrition, and TB programmes was relatively good but inadequate at the NCD programme. Most counties have employed nutritionists since devolution with disparity across counties. Likewise, capacity has improved with varying levels of intensity at the sub-county level; for many sub-counties the capacity is inadequate. Technical staff in the government and in partner organizations, both at national and county levels have contributed significantly to overall system strengthening.

Knowledge and skills for M&E varies across the data sources. For the population-based surveys (Integrated SMART surveys, MIYCN KABP, coverage, etc) the capacity to conduct these surveys is considered adequate because of the intense level of training received by those involved. Most of these surveys are funded by partners and therefore there are frequent trainings of personnel to conduct the frequently conducted surveys. However, only select highly vulnerable counties are covered and the system is heavily reliant on external funding therefore in the absence of this the system capacity would be negatively affected. For the routine data; human capacity is an issue influencing the M&E implementation, timely data collection and comprehensive reporting and quality of data right from the collection point. Funding is a major constraint limiting capacity development for M&E. Some of the inadequacies in capacity could be addressed through technical supervision, but again these are hampered by inadequate funding. More sustainable capacity development initiatives need to be further scaled up such as: on job training; mentorship programmes; and continuous professional development. A lot of effort has been geared towards capacity development for nutrition-specific interventions; capacity for nutrition-sensitive actions will require increased attention.

The M&E review findings also reported that efforts are in place to identify and utilize alternative strategies for capacity building. For example, it was reported that the Coordination Sector at the national level have conducted some capacity building for counties by teleconference. This was reported to be feasible and a cost-effective way of training because funds for per-diems is not required. The strategy has not had the same level of success at the sub-county level. Nutrition in HIV and Nutrition in TB programmes are also using this strategy for the training and dissemination of data. Nonetheless, full utilization of this strategy will depend on the change of people's mind-set, availability of computers and internet connectivity.

Since proficiencies and competencies attained by nutrition workforce through formal training is more sustainable, this framework suggests linkage with training institutions as follows:

- DND participation in curriculum reviews to ensure M&E for nutrition is informed by practice.
- Incorporation of trainers from learning institutions in review of guidelines, dissemination and roll out of M&E programmes where possible.

17 NIS/M&E system review report December 2019

4.3.4 Community capacity

Communities shall utilize data from Nutrition M&E to ensure the following:

1) Increased community awareness that results in demand for nutrition services through increased linkage with diverse community engagement strategies: (e.g. Community Strategy, of the Ministry of Health, School Health Programmes of the Ministry of Education and Junior Farmer Field and Life School (JFFLS) of the Ministry of Agriculture). In addition, the increased nutrition awareness will also result in better community participation practices that positively influence the overall service delivery at community level. When communities are aware of the nutrition services that they ought to receive, they will prompt the health facilities and local health authorities at national and sub-national levels to capacitate health staff and link them with community systems to provide required services.

2) A vibrant community linkage to the health system network evidenced by; increased service uptake, cohesive links between community and health systems and nutrition service delivery that is responsive to community needs.

3) Increased Nutrition Sector visibility through the use of champions who utilize data and evidence from MEAL to advocate for inclusion of nutrition into county government policies.

4.4 Data Quality Assurance

The data quality assurance (DQA) process will strive to ensure nutrition data is accurate, precise, reliable, timely, relevant and complete. DQA shall be conducted in data generation points, sub county level and county levels on a quarterly basis with support from national level. Tools and programmes for documenting DQA results will be used to ensure regular targeted support supervision for technical support at different levels. This shall be done to safeguard the minimum acceptable standards and ensure data produced is reliable and valid for decision making.

Routine Data Quality Audits (RDQA) tools will be used to verify the quality of reported data on key indicators.[18]. RDQA tools shall be used to conduct routine data quality checks as part of the on-going supervision, initial and follow up assessment of the data management and reporting systems, strengthening programmes staff capacity on data management and reporting as well as conducting formal data quality audits. Areas that will be considered for audit include the following:

- Reviewing availability, completeness and accuracy of all indicator source documents for the selected reporting period.
- Recounting results from source document and comparing the verified numbers to the site reported numbers and explaining discrepancies if any.
- Cross-checking reported results with other data sources, for example comparing routine data with survey data.
- Nutrition indicators definitions and reporting guidelines.
- Availability of nutrition data-collection and reporting forms and tools.
- Data management processes such as back up and confidentiality of source documents and registers.
- M&E system Structure, Functions and Capabilities.
- Compliance of reporting through the National Reporting System (KHIS).

As part of data quality audit, NITWG and Nutrition Programme teams shall conduct data clinics as well as conduct review and validation of methodology, tools and findings of all surveys and assessments in nutrition sector to inform planning and decision making for interventions.

18 https://www.measureevaluation.org/resources/publications/ms-17-117

4.5 Funding of the M&E system

The funding for the M&E system shall respond to the multi-sector Kenya National Nutrition Action Plan 2018-2022 and shall be advocated for and be sourced from various ministries namely; health, livestock, fisheries, water and agriculture. The key oversight ministry shall be the Ministry of Health. This model will similarly be adopted at the county level departments based on their local multi-sectoral relationships. Partnerships with Non-Governmental Organizations (NGOs) and business entities involved in support of the nutrition specific or nutrition sensitive actions will complement the funding for the system. Business entities including but not limited to those involved in food fortification shall be approached to invest in market surveys and compliance monitoring within the production industry.

According to the M&E system review, 65.6 percent of the respondents stated that funding for M&E activities is poor while one-third (31.3 percent) stated that it was moderate. The appropriate response to this would be to target investment and financial accountability for M&E activities that align to the nutrition activity investments for nutrition sensitive and specific activities.

To ensure successful monitoring and evaluation of activities, 5 to 10% of the total DND nutrition **activity budgets**, County departments budgets and partners' project budget with relevant nutrition activities should be allocated to the multi-sector monitoring and evaluation activities. This does not include funds allocated for human resource. National, county and partner funding commitments should demonstrate both allocation and disbursement of their funding quota as part of the sustainability model for the M&E system.

The funds generated will be used for production of data collection tools, M&E trainings, upgrade/maintenance of computer hardware and related networks, development/maintenance costs of software for nutrition database, costs related to data collection, cleaning and transmission, data analysis and meta-analysis, information dissemination, accountability and learning forums, communication and supportive supervision to give on-the-job technical assistance.

To ensure implementation of this requirement, a clause on this condition will be included in any agreement that the division signs with its partners with both parties demonstrating to co-share in allocation and eventual disbursement. The DND programmes will also take part in funds mobilization while taking advantage of the existing periodic surveys and systems e.g. MICS, KHIBS, DHS, Health facility Assessment survey to include specific programmes indicators as defined through the M&E framework.

4.5.1 Advocacy for nutrition information and M&E

Advocacy and resource mobilization for nutrition information and M&E shall be enhanced through the following:

1) Nutrition activities shall constantly require increased activity funding allocations. To demonstrate the funding gaps, information generated from county and national public accounts will be synthesized and shared as a point of advocacy to mobilize for more support from the County and National government funding mechanisms.

2) In order to increase the prominence of the NIS/M&E system, there will be need to constantly advocate for increased funding to MEAL activities as stipulated in the M&E framework to cover the M&E activity gaps. The agencies who are custodians of operationalization of the NIS/M&E Framework should build confidence of prospective funders/donors by increasing the level of accountability around how much was allocated/available and how much has been spent and what is the cost-benefit of the investment.

3) Advocacy efforts for funding of M&E/NIS activities must also include financial joint planning that limits duplication of funding efforts within the defined multi-sector context. This will broaden the base of funding opportunities for NIS/M&E activities.

4.5.2 Costing

The KNAP M&E implementation framework will cost a total of **Ksh1, 014,110,000 shown in Table 25.** Annex 7 presents detailed financial resource requirement by year.

Table 25: Cost of the M&E framework Implementation (figures captured are in millions)

Aspect/Year	1	2	3	4	5	Total
Monitoring	Ksh.32.86	Ksh. 30.01	Ksh 39.18	Ksh 30.35	Ksh 85.15	**Ksh.217.55**
Evaluation	Ksh 60.15	Ksh 60.15	Ksh. 165.15	Ksh. 60.15	Ksh. 60.15	**Ksh.405.75**
Accountability	X	X	X	X	X	**X**
Learning	Ksh.30.74	Ksh. 22.25	Ksh.28.97	Ksh. 26.11	Ksh. 25.87	**Ksh.133.94**
Capacity development	Ksh.31.37	Ksh. 83.33	Ksh. 36.99	Ksh. 36.58	Ksh. 68.6	**Ksh.256.87**
Total (in millions)	**Ksh.155.12**	**Ksh.195.74**	**Ksh.270.29**	**Ksh.153.19**	**Ksh.239.77**	**Ksh.1,014.11**

4.6 Accountability: Feedback and Response mechanisms

An effective feedback and response mechanism is critical for successful implementation of nutrition programmes. It promotes accountability in the programme by providing means to identify and respond to information requests, suggestions and complaints. Different channels will be used for giving feedback, complaints and response - these channels will include; community meetings and dialogues, community scorecards, suggestion boxes, hotlines, SMS platforms, monitoring visits focused on stakeholders' feedback, designated feedback days for the local office/ facilities to receive feedback as well as through emails.

Feedback will be provided at various levels of coordination and implementation to improve delivery of nutrition services. The processes for providing the feedback will be as follows:

1) Counties will provide feedback to implementers and service delivery points during support supervision and review visits. These visits will be informed by feedback issues identified in the reports.
2) Counties and sub-counties will interrogate the performance of nutrition indicators and provide feedback on the progress.
3) At the national and county levels, there will be regular generation of data on critical issues to be addressed.

At the national and county levels NTF and CNTF respectively, a task force will be formed that regularly receives and relays information to the stakeholders. This will enable the teams to be accountable at every level.

4.7 Updating of the Framework

The life of this framework is 5 years, in line with the KNAP 2018-2022. Regular update of the M&E plan will be done based on modification and/or inclusion of new interventions into the Division of Nutrition and Dietetics. M&E plan will be revised if new interventions to achieve any of the programme specific objectives are introduced based on the Kenya Nutrition Action Plan. A mid-term review of the framework will be done in 2020 to measure progress of its implementation and make necessary amendments.

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Annexes

Annex 1: Nutrition indicators thresholds

Indicators	Very Low	Low	Medium	High	Very High
Wasting	<2.5%	2.5%-<5%	5% to <10%	10% to <15%	≥ 15%
Overweight	<2.5%	2.5%-<5%	5% to <10%	10% to <15%	≥ 15%
Stunting	<2.5%	2.5%-<10%	10% to <20%	20% to <30%	≥ 30%
Indicators	**Acceptable**	**Alert**	**Serious**	**Critical**	**Very critical**
Mean weight for height (WHZ)	>-0.04	-0.40 to -0.69	-0.70 to -0.99; >usual / increasing	<-1.00; >usual /increasing	
GAM by MUAC children (%<12.5)	<5%	<5% with increase from seasonal trends	5.0 -9.9%	10.0–14.9%,orwhere there is significant increase from seasonal trends	>15%, or where there is significant increase from seasonal trends
Adult MUAC – Pregnant and Lactating (%<23.0cm, sphere 04)	<9.5%	9.5% - 14.9%	15 – 21.9%	22.0 – 27.9%	≥28%
Adult MUAC – Non- Pregnant and Non - Lactating (%<18.5cm, sphere 04)	<0.3%	0.3 - 0.49%	0.5 - 0.69%	0.7 – 1.99%	≥2.0%
Indicators	**Low**	**Medium**	**High Prevalence**	**Very High prevalence**	
Adult BMI<18.5	<10%	10.0 to 19.9%	20.0 to 39.9%	>40%	
Indicator	No Public health problem	Mild public health problem	Moderate public health problem	Severe public health problem	
Anemia[19] <110 g/l at sea level	<4.9	5.0-19.9	20.0-39.9	≥40.0	
Poor HH dietary Diversity (% consuming <4 fdgps))	<5%	5-9.9%	10-24.9%	25-49.9%	≥ 50%
Breastfeeding practices: (i)EBF, (ii) Continued BF at 1 yr. (iii)Continued BF at 2yr. reference	≥90%	50-89%	12-49%	0-11%	
Vitamin A supplementation coverage:1 dose in last 6 months	≥95%	80-94.9%	<80%		
Crude death rate/10000/day	<0.5	0.5 to <1	1 to <2 include information on the main causes	2 to ≤5 include information on the mancauses	>5 or doubling of rate from preceding phase. Include main causes
Under five years death rates/10000/day	<1	1-1.99	2-3.9/10000/ day include main cause	4 to 9.9 or doubling from previous phase, include main cause	≥10 or doubling rate from preceding phase. Include main cause

19 WHO (2010). Nutrition Landscape Information System (NLIS) county profile indicators. Geneva.

Annex 2 Indicator Compendium

Annex 2.1 Anthropometric measurements

Indicator	Description	Numerator	Denominator	Unit of Measure	Data Collection Method	Reporting	Comments
Percentage of children less than five (< 5) years who are stunted	Stunting Height for age <-2 z-score	Number of children aged 0-59 months that fall below minus two standard deviations from the median height-for-age of the WHO Child Growth Standards	Total number of children 0-59 months who are measured.	Percentage	Population based household surveys	Periodically (every 2-5 years)	Integrated SMART surveys provide data for children **6 to 59** months Disaggregation: Age, Sex, Location (urban/rural), Boundaries
Percentage of children less than five (< 5) years who are severely stunted	Severe stunting Height for age <- 3 z-score	Number of children aged 0-59 months that fall below minus three standard deviations from the median height-for-age of the WHO Child Growth Standards	Total number of children 0-59 months who are measured.	Percentage	Population based household surveys	Periodically (every 2-5 years)	Integrated SMART surveys provide data for children **6 to 59** months
Percentage of children under the age of five years, who are wasted (acute malnutrition). Weight for height Z-score	Wasting/ acute malnutrition (<-2 z-score and/or oedema)	Number of children aged 0-59 months that fall below minus two standard deviations from the median weight for height of the WHO Child Growth Standards	Total number of children 0-59 months who are measured.	Percentage	Population-based surveys. KDHS, SMART surveys	Periodically (every 2-5 years) Conducted annual or semi-annually in areas that are prone to shocks	Frequency should be increased during shocks or emergencies for early detection of deteriorating situation and to inform response
Percentage of children under the age of five years, who are severely wasted/severe acute malnutrition Weight for height Z-score	Wasting (<-3 z-score and/or oedema)	Number of children aged 0-59 months that fall below minus three standard deviations from the median weight for height of the WHO Child Growth Standards and/or oedema	Total number of children 0-59 months who are measured.	Percentage	Population-based surveys. KDHS, SMART surveys	Periodically (every 2-5 years Conducted annual or semi-annually in areas that are prone to shocks	
Prevalence of Acute Malnutrition by MUAC	GAM by MUAC	Number of children aged 0-59 months with MUAC < 125 mm and/or oedema)	Total number of children 0-59 months who are measured.	Percentage	Population based household surveys: SMART surveys, NDMA Early warning system, mass screening, MIYCN-E rapid assessments	Periodically (every 2-5 years Conducted annually or semi-annually in areas that are prone to shocks	

Indicator	Description	Numerator	Denominator	Unit of Measure	Data Collection Method	Reporting	Comments
Prevalence of severe acute malnutrition by MUAC	SAM by MUAC	Number of children aged 0-59 months with MUAC < 115 mm and/or oedema)	Total number of children 0-59 months who are measured.	Percentage	Population based household surveys: SMART surveys, NDMA Early warning system, mass screening, MIYCN-E rapid assessments	Periodically (every 2-5 years Conducted annual or semi-annually in areas that are prone to shocks	
Prevalence of underweight (<-2 z-score)	Underweight Weight for age <-2 z-score	Number of children aged 0-59 months that fall below minus two standard deviations from the median weight -for-age of the WHO Child Growth Standards	Total number of children 0-59 months who are measured	Percentage	Population based household surveys	Periodically (every 2-5 years	
Prevalence of severe underweight (<-3 z-score)	Severe underweight Weight for age <-3 z-score	Number of children aged 0-59 months that fall below minus three standard deviations from the median weight -for-age of the WHO Child Growth Standards	Total number of children 0-59 months who are measured	Percentage	Population based household surveys	Periodically (every 2-5 years	
Percentage of under-five Children attending CWC who are under-Weight	Routine measurement and the child welfare clinic	Number of children under the age of 5 years attending CWC with weight for age below -2 SD	Total number of children under 5 years weighed at the CWC	Percentage	KHIS aggregate (KHIS)	Monthly	Health facility data – may not be representative of the target population as only a proportion of the population may be attending CWC especially among children above one year
Percentage of children under 5 years who are attending MCH for growth monitoring for the first time.	Growth monitoring and promotion	Number of Children under 5 years who are attending MCH for growth monitoring for the first time	Total number of children under five years old in the catchment area	Percentage	KHIS aggregate	Monthly	

Indicator	Description	Numerator	Denominator	Unit of Measure	Data Collection Method	Reporting	Comments
Proportion of children 6-59 months with moderate acute malnutrition (MAM) receiving treatment	MAM indirect coverage	No. of new MAM cases who received treatment (outpatient or in-patient care) in the month preceding	No. of MAM cases in catchment area	Percentage	Numerator from routine data – KHIS aggregate Denominator: seasonal assessments - caseload calculation template	Monthly	Recommended not to calculate a percentage per HF but rather track admissions trends; calculating coverage is better done at higher level. Raw admissions trends can be used for surveillance; if admissions trends vary from previous years, this can be potentially used to interpret the severity of acute malnutrition situation in that area.
Proportion of children 6-59 months with moderate acute malnutrition discharged as: a) Cured, b) Died, c) Defaulted	MAM programmes treatment outcomes: cured defaulted, discharged	Number of children 6-59 months with moderate acute malnutrition discharged as: a) Cured, b) Died, c) Defaulted	Number of children 6-59 months with moderate acute malnutrition discharged from treatment	Percentage	KHIS aggregate		

Indicator	Description	Numerator	Denominator	Unit of Measure	Data Collection Method	Reporting	Comments
Proportion of children 6-59 months with severe acute malnutrition receiving treatment	SAM indirect coverage	No. of new SAM cases who received treatment (outpatient or in-patient care) in the month preceding	No. of SAM cases in catchment area	Percentage	Numerator from routine data – KHIS aggregate Denominator: seasonal assessments - caseload calculation template		Recommended not to calculate a percentage per HF but rather track admissions trends; calculating coverage is better done at higher level. Raw admissions trends can be used for surveillance; if admissions trends vary from previous years, this can be potentially used to interpret the severity of acute malnutrition situation in that area.
Proportion of children 6-59 months with severe acute malnutrition discharged as: a) Cured, b) Died, c) Defaulted		SAM programmes treatment outcomes: cured defaulted, discharged	Number of children 6-59 months with severe acute malnutrition discharged as: a) Cured, b) Died, c) Defaulted	Number of children 6-59 months with severe acute malnutrition discharged from treatment (excl. transfers)	KHIS aggregate		

Annex 2.2 Indicators to assess for MNPs programmes coverage in population-based surveys

Indicators to assess MNPs programmes performance and coverage should cover the following components: commodity availability, human resource, geographic coverage, utilization and community capacity to demand for MNPs services.

MNP Coverage Indicators

Indicator	Description	Numerator	Denominator	Unit of Measure	Data Collection Method	Reporting	Interpretation
Commodities availability							
Proportion of health facilities that do not have MNPs Stocks	Health facilities without MNPs stocks	Number of health facilities without MNPs stocks	Number of Health facilities in the County	Percentage	MoH 734 (LMIS Report)	Monthly	
Human Resource							
Proportion of health workers providing MNPs services	Health workers offering the MNPs services	Number of health workers providing MNPs services	Total number of health workers sampled/ interviewed	Percentage	KAP survey	Every 2 years	
Proportion of health workers providing MNPs who have been trained on MNPs guidelines	Health workers providing MNPs services trained on the guidelines	Number of health workers providing MNPs services who have been trained on the MNPs guidelines	Total Number of health workers in the Country/ County/Sampled	Percentage	Capacity assessment reports	Every 2 years	
Geographical coverage							
Proportion of health facilities offering MNPs services	Health facilities offering MNPS services	Number of health facilities offering MNPS services	Total number of health facilities in a County/ Region sampled	Percentage	LQAS Ad hoc assessments	Every 2 years	Health facilities offering MNPS should be equally distributed to ensure as many children as possible are reached
Proportion of health facilities with MNPs policy and IEC materials	Health facilities with MNPs policy and IEC materials	Number of health facilities with MNPs policy and IEC materials	Total number of health facilities in the country/ region or sampled in a survey	Percentage	SMART surveys KAP survey LQAS	Annually Every 2 years	

Indicator	Description	Numerator	Denominator	Unit of Measure	Data Collection Method	Reporting	Interpretation
Utilization							
Proportion of Children 6 to 23 months enrolled in MNPs programmes	Children 6 to 23 months who receive MNPs from health facilities	Number of children 6 to 23 months enrolled in MNPs Programmes	Total number of children 6 to 23 in the catchment area or sampled in case of surveys	Percentage	MoH 711 SMART Surveys KAP Surveys	Monthly Annually Once in 2 years	
Proportion of caregivers of children 6 to 23 months receiving counseling on use of MNPs	Caregivers of children 6 to 23 months receiving counseling on use of MNPs	Number of caregivers of children 6 to 23 months receiving counseling on use of MNPs	Total number of children 6 to 23 months sampled in the survey area	Percentage	SMART surveys KAP surveys	Annually once in 2 years	
Proportion of caregivers of children 6 to 23 months with correct knowledge on the frequency of giving MNPs	Caregivers of children 6 to 23 months with the correct knowledge on frequency of giving MNPs	Number of caregivers of children 6 to 23 months who give correct knowledge on MNPs frequency	Total number of caregivers of children 6 to 23 months in the country/county/sampled	Percentage	KAP surveys	Every 2 years	
Proportion of caregivers of children 6 to 23 months receiving MNPs for 6 continuous months	Caregivers of children 6 to 23 months receiving MNPs as per the schedule	Number of caregivers of children 6 to 23 months receiving MNPs for 6 continuous months	Total number of children 6 to 23 months in the catchment population or total number of children sampled in a survey	Percentage	SMART surveys KAP surveys 711	Annually Once in 2 years	
Proportion of caregivers of children 6 to 23 months reporting consumption of 80% of MNPs sachets in the last 6 months	Children 6 to 23 months who continuously receives MNPs and consumes at least 80% of MNPs	Number of children 6 to 23 months who consumed 80% of MNPs received in the past 6 months	Number of children 6 to 23 months in catchment population or sampled in a survey	Percentage	MoH 711 SMART Survey KABP Survey	Monthly Annually Once in two years	
Proportion of caregivers with children 6 to 23 months reporting non-consumption of MNPs due to any barrier	Caregivers of children 6 to 23 months who report non-consumption of MNPs by the children due to nay barrier	Number of caregivers of children 6 to 23 months reporting non-consumption of MNPs due to any reason	Number of children 6 to 23 months in the catchment population or sampled in the survey	Percentage	SMART survey KAP survey	Annually Once in two years	

Indicator	Description	Numerator	Denominator	Unit of Measure	Data Collection Method	Reporting	Interpretation
Community service							
Proportion of community units with CHVs sensitized on MNPs	Community units with CHVs sensitized on t MNPs	Number of community units with CHVs sensitized on the use and importance of MNPs	Total number of community units in the country/county or sampled community units in a survey	Percentage	KAP survey LQAS	Every 2 years Annually	
Percentage of caregivers of children 6 to 23 months who have been referred for MNPs services from the community	Caregivers of children 6 to 23 months being referred by CHVs for MNPs services	Number of caregivers of children 6 to 23 months referred by CHVs for MNPs services	Total number of children 6 to 23 months in the catchment population or sampled in a survey	Percentage	KAP survey	Every 2 years	

Annex 2.3 Indicators to assess IFAS programmes

In 2015, the Kenya nutrition sector adopted key indicators during a data clinic as tabulated below:

Indicator	Description	Numerator	Denominator	Unit of measure	Data collection methods	Reporting	Interpretation/ comments
Consumption							
Proportion of pregnant women consuming folic IFAS in the first trimester of pregnancy of their last birth	Percentage of pregnant women who consumed IFAS in the first trimester of pregnancy of their last birth	# of pregnant women reporting having consumed IFAS during the first trimester of pregnancy of their last birth	Number of women with a live birth sampled in the survey	Percentage	Caregivers with children under two years through KAP, LQAS surveys	Biannually or Every three years	IFAS is very critical in the first 28 days of pregnancy
Proportion of pregnant women received IFAS during pregnancy of their last birth	Percentage of pregnant women who received IFAS during pregnancy of their last birth	# of pregnant women reporting having received IFAS during pregnancy of their last birth	Number of women with a live birth sampled in the survey	Percentage	Caregivers with children under two years through KAP, nutrition SMART surveys	Biannually or Every three years	IFAS is very critical during pregnancy
Proportion of women taking IFAS during pregnancy	Percentage of women taking IFAS for less than 90, 90-180, 181-270, more than 270 days during pregnancy of their last birth	# of women taking IFAS for less than 90, 90-180, 181-270, more than 270 days during pregnancy of their last birth	Total number of women sampled/ interviewed	Percentage	Caregivers with children under two years through KAP, LQAS surveys		

Indicator	Description	Numerator	Denominator	Unit of measure	Data collection methods	Reporting	Interpretation/ comments
Knowledge							
Proportion of women who can cite at least 2 benefits of taking IFAS	Percentage of women who can cite two benefits of taking IFAS	Number of women (15-49 years) who can describe at least 2 benefits of taking IFAS during pregnancy	Number of women 15 to 49 years	Percentage	Caregivers with children under two years through KAP, LQAS surveys		
Proportion of women who report to have heard or seen IFAS messages	Percentage of women who report to have heard or seen messages on IFAS	Number of women who report to have heard or seen any information on IFAS	Number of women sampled	Percentage	Caregivers with children under two years through KAP, LQAS surveys		
Proportion of women who report of frontline workers that provide counselling on overcoming barriers to utilization of IFAS	Percentage of women reporting that frontline health workers provided them with counseling on how to overcome barriers to utilization of IFAS	Number of women who report of frontline workers that provide counselling on overcoming barriers to utilization of IFAS	Number of women sampled	Percentage	Caregivers with children under two years through KAP, LQAS surveys		
Commodity availability							
Proportion of Health facilities that do not have IFAS Stock outs	Percentage of Health facilities that do not have IFAS Stock outs	Number of health facilities that do not have IFAS stock outs	Total number of health facilities sampled	Percentage	Frontline health care providers through LQAS surveys		
Human resource							
Proportion of health workers providing IFAS Supplementation services	Percentage of health workers providing IFAS Supplementation services	# of health workers providing IFAS services	Total number of health workers sampled/interviewed	Percentage	Frontline health care providers through LQAS surveys		

Indicator	Description	Numerator	Denominator	Unit of measure	Data collection methods	Reporting	Interpretation/ comments
Proportion of health workers providing IFAS supplementation services who have ever been trained on IFAS supplementation guidelines	Percentage of health workers providing IFAS supplementation services who have ever been trained on IFAS supplementation guidelines	# of health workers trained on IFAS based on MOH curriculum	Total number of frontline health care workers sampled/ interviewed	Percentage	Frontline health care providers through LQAS surveys		
Proportion of health facility staff in place needed to deliver IFAS services		# of health facility staff delivering IFAS services	Total number of health facility staff	Percentage	Frontline health care providers through LQAS surveys		
Geographical Coverage							
Proportion of health facilities offering IFAS Supplementation	Percentage of health facilities offering IFAS Services	# of health facilities offering IFAS	Total number of health facilities sampled/visited	Percentage	Frontline health care providers through LQAS surveys		
Community Service							
Proportion of pregnant women who have been referred to the ANC from the community	Proportion of pregnant women who have been referred to the ANC from the community	# of pregnant women referred for ANC services by CHVs	Total number of women sampled	Percentage	Care providers with children less than 24 months through LQAS surveys, MIYCN KABP		This indicator is to assess contribution of CHS to ANC services
Proportion of pregnant women attending ANC early (1st trimester)	Percentage of pregnant women attending ANC early (1st trimester)	# of pregnant women attending ANC services in the first trimester	Total number of pregnant women attending ANC	Percentage	Care providers with children less than 24 months through LQAS surveys		

Indicator	Description	Numerator	Denominator	Unit of measure	Data collection methods	Reporting	Interpretation/ comments
Proportion of Community Volunteers that are trained on IFAS	Percentage of Community Volunteers that are trained on IFAS	# of community health volunteers trained on IFAS	Total number of community health volunteers	Percentage	Community health volunteers through LQAS surveys		
Proportion of PLW given family support	Percentage of PLW given family support	# of PLW reporting that they received support from any family member on ANC services	Total number of PLW sampled/ interviewed	Percentage	LQAS, KABP		

Vitamin A supplementation: Indicator calculation of routine data

The District Health Information Software (KHIS) is used monthly to report on routine vitamin A supplementation services (https://hiskenya.org). Vitamin A data of children 6-59 months is collected on immunization tally sheet (MOH 702) and reported on immunization summary report tool (MOH 710) in the DHIS aggregated by age and organizational unit.

This indicator is tracked on monthly basis by cumulating the numbers achieved against the set semester target. Coverage is computed on semester basis i.e. 6 months' interval (January to June and July to December as first and second semester respectively). To compute annual coverage, the lower coverage of the two semesters is considered. Calculation of coverage using routine data per semester

- Proportion of children 6-11 months who received one dose of vitamin A (100,000 IU) = (Number of children 6-11 months supplemented with one dose of Vitamin A) / (Total number of children aged 6-11 months) X 100
- Proportion of children 12-59 months who received one dose of vitamin A (200,000 IU) = (Number of children 12-59 months supplemented with one dose of Vitamin A) / (Total number of children aged 12-59 months) X 100
- Proportion of children 6-59 months who received one dose of vitamin A (age appropriate) = (Number of children 6-59 months supplemented with one dose of age appropriate Vitamin A) / (Total number of children aged 6-59 months) X 100

Indicators to assess for vitamin A supplementation in population-based surveys

Indicators to assess vitamin supplementation should cover the following components: availability of vitamin A supplements, availability of human resource e.g. whether there are adequately trained health workers/health workforce to administer vitamin A supplements, access, coverage and utilization of vitamin A services. *The* key indicators for vitamin A supplementation are presented in Table 25.

Annex 2.4 Key Indicators for VAS

Indicator	Description	Data collection methods	Numerator	Denominator	Unit of measure	Reporting	Interpretation/ comments
Utilization							
Proportion of children 6-59 months covered with age appropriate doses of Vitamin A supplementation within one year.	Percentage of Children aged 6-11 months who received one dose of vitamin A and those aged 12-59 months who received two doses of vitamin A supplement within one year.	DHIS	Number of children supplemented with age appropriate doses of Vitamin A within one year in the routine	Total number of children aged 6-11 and 12-59 months in the catchment area	Percentage	Data are reported monthly from the service delivery units to the sub-county for entry. Once entered, the data are available at all levels	All places i.e. Counties, Sub counties with a two dose coverage estimate of ≥80% will be considered as having achieved the target.
		SMART LQAS	Number of children supplemented with age appropriate doses of Vitamin A within one year in the survey	Total number of children aged 6-11, 12-59 and 6-59 months in the survey	Percentage	Data is Reported every time a survey is conducted.	
Proportion of Children aged 6-11 months who received one dose of 100,000 IU vitamin A	Percentage of Children aged 6-11 months who received one dose of 100,000 IU vitamin A	LQAS/ Integrated Nutrition SMART survey	Number of children aged 6-11 months supplemented within the survey	Total number of children aged 6-11 in the survey	Percentage	Data is Reported every time a survey is conducted	
Proportion of children 12-59 months who received two doses of VAS within n year	% of children aged 12-59 months who received two doses of vitamin A supplement within one year.	LQAS/ Integrated Nutrition SMART survey/MoH 216	# of children 12-59 months who received two doses of VAS within one year	Total number of children aged 12-59 months in the survey	Percentage	Data is Reported every time a survey is conducted	
Proportion of Children aged 6-59 months who received one dose of vitamin A	Percentage of Children aged 6-59 months who received one dose of vitamin A	LQAS/ Integrated Nutrition SMART survey	Number of children aged 6-59 months supplemented within the survey	Total number of children aged 6-59 in the survey	Percentage	Data is Reported every time a survey is conducted	

Indicator	Description	Data collection methods	Numerator	Denominator	Unit of measure	Reporting	Interpretation/ comments
Knowledge							
Proportion of caregivers who can give at least two benefits of VAS	% of caregivers (with children) who can cite at least two benefits of VAS at the time of survey	KPC/LQAS/ Integrated Nutrition SMART survey	# of caregivers who can cite at least two benefits of VAS at the time of survey	Total number of caregivers with children interviewed / sampled	Percentage	Data is Reported every time a survey is conducted	
Commodity availability							
Proportion of Health facilities that reports to have VAS stock outs	Number of Health facilities that reports to have stock outs for the past one year	LQAS/DHIS	# of HF that have reported stock outs in the past one year	All facilities that have reported	Percentage	Data is Reported every time a survey is conducted	
Human Resource							
Proportion of health workers providing VAS at service delivery points	Proportion of health workers providing VAS services	LQAS	# of health workers providing VAS services	Total number of health workers working at VAS service delivery points	Percentage	Data is Reported every time a survey is conducted	
Proportion of HW providing VAS services who have ever been trained on VAS guidelines	% of HW providing VAS services who have ever been trained on VAS guidelines	LQAS	# of HW providing VAS services who have ever been trained on VAS guidelines	Total number of HW providing VAS services	Percentage	Data is Reported every time a survey is conducted	
Proportion of health facilities staff in place to deliver VAS services	# of staff delivering VAS services	LQAS	# of staff in place delivering VAS services	Total number of health facilities' staff	Percentage	Data is Reported every time a survey is conducted	

Indicator	Description	Data collection methods	Numerator	Denominator	Unit of measure	Reporting	Interpretation/ comments
Geographical Coverage							
Proportion of Health Facilities offering VAS	# of HF offering VAS	LQAS	Total no. of health facilities offering VAS services	Total number of health facilities visited	percentage	Data is Reported every time a survey is conducted	
Proportion of children supplemented in ECD	Number of children supplemented in ECD		Number of children supplemented in ECD	Total number of children eligible for VAS in ECD	percentage	Programmes reports	

Annex 2. 5 Indicators for Mother Infant and Young child feeding practices (MIYCN)

Indicator	Description	Numerator	Denominator	Core or additional indicators	Unit of Measure	Data Collection Method	Reporting	Comments
Percentage of last-born children age 0–23 months who were put to the breast within 1 hour of delivery	Early initiation of breastfeeding Practice	Number of last-born children age 0–23 months who were put to the breast within 1 hour of delivery	Total number of last-born children age 0–23 months in the survey	Core	Percentage	Population level surveys	Every two years – MIYCN KAP surveys Every 5 years: KDHS Other integrated health and nurition surveys	Disaggregation: It is recommended that this indicator be further disaggregated and reported for (i) live births of children 0-11 months; and (ii) live births of children 12-23 months, if sample size permits
Proportion of caregivers of children 0-23 months who know at least two benefits of Early Initiation of breastfeeding	Knowledge	Number of caregivers who know at least 2 benefits of early initiation	Number of caregivers with children 0-23 months		Percentage	Population level surveys	Every two years – MIYCN KAP surveys	
Percentage of infants 0–5 months of age who are fed exclusively with breast milk	Exclusive breastfeeding under 6 months Practice	Infants 0–5 months of age who received only breast milk during the previous day	Infants 0–5 months of age	Core		Population level surveys	Every two years – MIYCN KAP surveys Every 5 years: KDHS Other integrated health and nutrition surveys	Exclusive breastfeeding means that the infant received breast milk (including milk expressed or from a wet nurse) and might have received oral rehydration solution (ORS), vitamins, minerals, and/or medicines, but did not receive any other food or liquid. The indicator is based on recall of the previous day for all living infants 0-5 months. Disaggregation: It is recommended that the indicator be further disaggregated and reported for the following age groups: 0-1 month, 2-3 months, 4-5 months and 0-3 months, if sample size permits.

Indicator	Description	Numerator	Denominator	Core or additional indicators	Unit of Measure	Data Collection Method	Reporting	Comments
Proportion of caregivers with children 0-23months who know at least two benefits of exclusive breastfeeding	Knowledge	Number of caregivers with children 0-23 months who know at least 2 benefits of exclusive breastfeeding	Number of caregivers with children 0-23months of age		Percentage	Population level surveys	Every two years – MIYCN KAP surveys	
Proportion of children born in the last 24 months who were ever breastfed	Children ever breastfed Practice	Children born in the last 24 months who were ever breastfed	Children born in the last 24 months assessed	Additional	Percentage	Population level surveys	Every two years – MIYCN KAP surveys Every 5 years: KDHS Other integrated health and nutrition surveys	Disaggregation: It is recommended that the indicator be further disaggregated and reported for (i) live births occurring in the last 12 months; and (ii) live births occurring between the last 12 and 24 months, if sample size permits
Percentage of children 12–15 months of age who are fed breast milk	Continued breastfeeding at 1 year Additional	Children 12–15 months of age who received breast milk during the previous day	Children 12–15 months of age			Population level surveys		The indicator has a relatively narrow age range of 4 months, estimates from surveys with small sample sizes are likely to have wide confidence intervals. This indicator includes breastfeeding by a wet nurse and feeding expressed milk. The infant can receive breastmilk either by breastfeeding or another means.
Percentage of children 20–23 months of age who are fed breast milk	Continued breastfeeding at 2 years (Core) Practice	Children 20–23 months of age who received breast milk during the previous day	Children 20–23 months of age	Core		Population level surveys	Every two years – MIYCN KAP surveys Every 5 years: KDHS Other integrated health and nutrition surveys	

Indicator	Description	Numerator	Denominator	Core or additional indicators	Unit of Measure	Data Collection Method	Reporting	Comments
Proportion of caregivers of children 0–23 months who are aware that a child should continue breastfeeding to two years and beyond	Knowledge	Number of caregivers who know at least two benefits of continued breastfeeding to two years and beyond	Number of caregivers with children 0-23 months of age			Population level surveys	Every two years – MIYCN KAP surveys	
Percentage of infants 6–8 months of age who receive solid, semi-solid, or soft foods	Introduction of solid, semi-solid, or soft foods—children (Core)	Infants 6–8 months of age who receive solid, semi-solid, or soft foods during the previous day	Infants 6–8 months of age			Population level surveys	Every two years – MIYCN KAP surveys Every 5 years: KDHS Other integrated health and nutrition surveys	
Proportion of caregivers with children 6-23 who know the appropriate time of introduction of solid, semi-solid, or soft foods		Number of caregivers with children 6-23 who know the appropriate time of introduction of solid, semi-solid, or soft foods	Number of mothers with children 6-23 months of age			Population level surveys	Every two years – MIYCN KAP surveys Every 5 years: KDHS Other integrated health and nutrition surveys	
Percentage of children 6–23 months of age who received an iron-rich food in the last 24 hours	Consumption of iron-rich foods Practice	Children 6–23 months of age who received an iron-rich food during the last 24 hours	Children 6–23 months of age	Core	Percentage	Population level surveys	Every two years – MIYCN KAP surveys Every 5 years: KDHS Other integrated health and nutrition surveys	Notes: Suitable iron-rich or iron-fortified foods include flesh foods, commercially fortified foods specially designed for infants and young children which contain iron, or foods fortified in the home with a micronutrient powder containing iron or a lipid-based nutrient supplement containing iron. Disaggregation: It is recommended that the indicator be further disaggregated and reported for the following age groups: 6-11 months, 12-17 months and 18-23 months, if sample size permits.

Indicator	Description	Numerator	Denominator	Core or additional indicators	Unit of Measure	Data Collection Method	Reporting	Comments
Proportion of caregivers with children 6-23 months who can name at least two food sources of iron	Knowledge	Proportion of caregivers with children 6-23 months who can name at least two food sources of iron	Number of caregivers with Children 6–23 months of age		Percentage	Population level surveys	Every two years – MIYCN KAP surveys	
Proportion of breastfed and non-breastfed children 6–23 months of age who received solid, semi-solid, or soft foods (but also including milk feeds for non-breastfed children) the minimum number of times or more	Minimum meal frequency—children Practice	Breastfed children 6-23 months who received solid, semi-solid or soft foods the minimum number of times or more during the previous day	Breastfed children 6-23 months old	Core	Percentage	Population level surveys	Every two years – MIYCN KAP surveys Every 5 years: KDHS Other integrated health and nutrition surveys	Note; 'Meals' include both meals and snacks (other than trivial amounts), and frequency is based on caregiver report Minimum is defined as: 2 times for breastfed infants 6–8 months 3 times for breastfed children 9–23 months 4 times for non-breastfed children 6–23 months Disaggregation: It is recommended that the indicator be further disaggregated and reported for the following age groups: 6-11 months, 12-17 months, and 18-23 months, if sample size permits. Results may also be reported separately for breastfed and non-breastfed children.

Indicator	Description	Numerator	Denominator	Core or additional indicators	Unit of Measure	Data Collection Method	Reporting	Comments
Percentage of children 6–23 months of age who receive foods from five or more food groups	Minimum dietary diversity—children (Core)	Children 6–23 months of age who received foods from ≥ five food groups during the previous day	Children 6–23 months of age		Percentage	Population level surveys	Every two years – MIYCN KAP surveys Every 5 years: KDHS Other integrated health and nutrition surveys	Minimum dietary diversity for breastfed children 6–23 months is defined as five or more foods from the following eight food groups When sample sizes allow, disaggregated data should be presented by sex, age and breastfeeding status. Recommended age groups for reporting are 6–11 months, 12–17 months and 18–23 months of age. It may also be useful to disaggregate by place of residence, socioeconomic status (e.g., wealth quintile), and maternal education 8 FOOD GROUPS IN MDD 1. Breast milk 2. Grains, white roots and tubers, and plantains 3. Legumes and Nuts 4. Dairy 5. Flesh foods (meat, fish, poultry and liver/organ meats) 6. Eggs 7. Vitamin A-rich fruits and vegetables 8. Other fruits and vegetables
Proportion of caregivers who can name at least four food groups for children 6-23 months of age		Number of caregivers who can name at least four food groups for children 6-23 months of age	Number of caregivers with children 6-23 months of age		Percentage	Population level surveys	Every two years – MIYCN KAP surveys Every 5 years: KDHS Other integrated health and nutrition surveys	

Indicator	Description	Numerator	Denominator	Core or additional indicators	Unit of Measure	Data Collection Method	Reporting	Comments
Proportion of children 6–23 months of age who received a minimum acceptable diet (apart from breast milk)	Minimum acceptable diet –children	Breastfed children 6–23 months of age who had at least the minimum dietary diversity and the minimum meal frequency during the previous day	Breastfed children 6–23 months of age	Core	Percentage	Population level surveys	Every two years – MIYCN KAP surveys Every 5 years: KDHS Other integrated health and nutrition surveys	Disaggregation: It is recommended that the indicator be further disaggregated and reported for the following age groups: 6-11 months, 12-17 months, and 18-23 months, if sample size permits.
		Non-breastfed children 6–23 months of age who had at least two milk feedings and have at least the minimum dietary diversity not including milk feeds and the minimum meal frequency during the previous day	Non-breastfed children 6–23 months of age		Percentage	Population level surveys	Every two years – MIYCN KAP surveys Every 5 years: KDHS Other integrated health and nutrition surveys	
Proportion of caregivers of children 6-23 months of age who know the minimum number of times their children should be given meals in a day		Number of caregivers of children 6-23 months of age who know the minimum number of times their children should be given meals in a day	Number of caregivers with children 6-23 months of age			Population level surveys	Every two years – MIYCN KAP surveys	

Indicator	Description	Numerator	Denominator	Core or additional indicators	Unit of Measure	Data Collection Method	Reporting	Comments
Percentage of last-born children age 0–23 months who were fed colostrum	Feeding colostrum (Additional)	Number of last-born children age 0–23 months who were fed colostrum	Total number of last-born children age 0–23 months in the survey	Additional		Population level surveys	Every two years – MIYCN KAP surveys Every 5 years: KDHS Other integrated health and nutrition surveys	
Percentage of mothers of children age 0–23 months who know at least one benefit of feeding baby on colostrum		Number of mothers of children 0–23 months who know at least one benefit of feeding baby on colostrum	Total number of mothers of children age 0–23 months in the survey			Population level surveys	Every two years – MIYCN KAP surveys	
Percentage of sick children ages 0-23 months in the 2 weeks preceding the survey who were offered more than usual to drink (including breast milk)	Appropriate Sick Child Care	Number of children ages 0–23 months who were offered more than usual to drink (including breast milk)	Number of children ages 0–23 months who were sick in the 2 weeks preceding the survey			Population level surveys	Every two years – MIYCN KAP surveys Every 5 years: KDHS Other integrated health and nutrition surveys	
Percentage of mothers of children age 0–23 months who while pregnant with their youngest child were counseled on nutrition during pregnancy	Nutrition counseling during pregnancy	Number of mothers of children age 0–23 months who while pregnant with their youngest child were counseled on nutrition during pregnancy	Total number of mothers of children age 0–23 months in the survey			Population level surveys	Every two years – MIYCN KAP surveys	

Indicator	Description	Numerator	Denominator	Core or additional indicators	Unit of Measure	Data Collection Method	Reporting	Comments
Proportion of women of reproductive age (15-49) who are consuming a minimum dietary diversity	Minimum Dietary Diversity—Women (core)	Women of reproductive age (15–49) consuming at least five of the ten MDD-W food groups	Women of reproductive age	Core		Population level surveys	Every two years – MIYCN KAP surveys Integrated SMART surveys	10 FOOD GROUPS IN MDD-W 1. Grains, white roots and tubers, and plantains 2. Pulses (beans, peas and lentils) 3. Nuts and seeds 4. Dairy 5. Meat, poultry and fish 6. Eggs 7. Dark green leafy vegetables 8. Vitamin A-rich fruits vegetables, roots and tubers 9. Other vegetables 10. Other fruits
Proportion of children 0-23 months old who were fed with a bottle during the previous day	Bottle feeding Practice	Children 0-23 months old who were fed with a bottle during the previous day	Children 0-23 months	Core		Population level surveys	Every two years – MIYCN KAP surveys Every 5 years: KDHS Other integrated health and nutrition surveys	Note: We include children less than 23 months who received any food or drink from a bottle with a nipple/teat Cup with spout or bottle with spoons during the previous day (including breast milk), regardless of whether or not the infant was breastfed. Disaggregation: It is recommended that the indicator be further disaggregated and reported for the following age groups: 0-5 months, 6-11 months, and 12-23 months, if sample size permits
Proportion of caregivers with children 0-23 months of age who know at least two consequences of bottle feeding		Proportion of caregivers who know at least two consequences of bottle feeding	Number of caregivers with children 0 to 23 months			Population level surveys	Every two years – MIYCN KAP surveys	

Annex 2.6 Nutrition commodities and supply chain management

Indicator	Numerator/ denominator	Measurement/ calculation	Source documents	Frequency of data collection
Proportion of CHVs trained on nutrition packages (module 8)	# of CHVs trained on nutrition packages Total # of CHVs	# of CHVs trained on nutrition packages dived by Total # of CHVs multiplied by 100	CHS reports and capacity assessment reports	Yearly
Proportion of counties with a budget line for nutrition commodities and equipment	# of counties with a budget line for nutrition commodities and equipment Total # of counties	# of counties with a budget line for nutrition commodities and equipment divided by total # of counties multiplied by 100	County Budgets	Yearly
Proportion of counties with drawing rights at KEMSA for nutrition commodities and equipment	Proportion of counties with drawing rights at KEMSA for nutrition commodities and equipment Total # of counties	# of counties with drawing rights at KEMSA for nutrition commodities and equipment divided by total # of counties multiplied by 100	Procurement and distribution reports from KEMSA	Quarterly/ Yearly
Proportion of annual nutrition commodity needs met	# of annual nutrition commodity needs met Total number commodity needs	# of annual nutrition commodity needs met dived by total number commodity needs multiplied by 100	Distribution reports	Monthly
Proportion of counties with Nutrition LMIS and inventory Management training conducted	# of counties with Nutrition LMIS and inventory Management training conducted Total number of counties	# of counties with Nutrition LMIS and inventory Management training conducted divided by Total number of counties multiplied by 100	Training reports	Yearly
Proportion of Nutrition commodities and equipment meeting minimum quality and safety standards	# of Nutrition commodities and equipment meeting minimum quality & safety standards Total of Nutrition commodities & equipment	# of Nutrition commodities and equipment meeting minimum quality & safety standards dived by Total of Nutrition commodities & equipment multiplied by 100	Certificates of Analysis	Yearly

Annex 3 Good Practice Template

Definition:
Good practices are well documented and assessed programming practices that provide evidence of success/impact and which are valuable for replication, scaling up and further study. The practice should have a formal evaluation and evidence of an adoption-diffusion process (piloting/scaling up). The practice should have been replicated in more than one site and generally in different contexts (economic, cultural, partners, etc).

Instructions for use:
Fill in the following fields with your information. Guidance is provided for the major sections *in Italic*. Either enter text directly or copy and paste from another document.

Category:	Good practice
Country:	*your text here*
Title:	*your text here*
Related links:	*Please provide links to related study, report, evaluation, website that may provide additional information on the good practice.*
Contact person:	*Please provide the name, title and e-mail address of a person who can be contacted for any questions regarding this good practice.*
Issue (Background):	*Briefly (1-2 paragraphs) describe the initial situation (context) and the problem/ issue which prompted the implementation of this good practice.*
Strategy and Implementation:	*Describe in 2-3 paragraphs the strategy and its implementation. This should link to the issue outlined above and highlight the main points of the strategy implemented. Strategies could be regarding to advocacy, participation, gender equity, ownership, capacity building, coordination and partnerships, monitoring and evaluation and replication/scaling up.*
Progress and Results:	*In summary (1-2 paragraphs), describe the progress and results validated through evaluations or formal review process. The results can be classified at output, outcome and impact level. Provide quantitative and or qualitative evidence for different aspects (e.g. relevance, effectiveness, efficacy, replicability, sustainability) that are the basis of the good practice. Please also describe factors that enabled or hindered progress (challenges).*
Good Practice:	*Please provide 1-2 short paragraphs to describe in summary good practice(s) in the field. This should leave the reader with an overall picture of the practices(s), why they are useful and evidence of value they add to programming.*
Potential application:	*Please describe briefly the potential application of this practice to programming beyond the original context. Are there potential applications nationally, regionally, in emergency situations, etc.? What are the issues that need to be considered?*
Next steps:	*Describe (1paragraphs) any planned next steps in implementation or any challenges in strategy as a result of this good practice to date.*

Annex 4 Research Proposal Guide Technical Working Group

Content	Guidance
Title page	• Research title: clear and concise, should reflect the focus of the study and number of words should not be too many.
	• Names and titles of principal investigators and affiliated institutions • Logos of institutions
Table of contents	Updated and include key contents of the chapters.
Introduction	• Background to the study problem, • Problem statement, • Justification of the study, • Research questions, • Hypothesis, • Broad and specific objectives
Literature review	Global, regional and specific aspects on existing evidence. Conceptual framework
Methodology	• Study area, • Study population, • Study design • Sample size determination • Sampling techniques, • Study variables, • Data collection techniques, • Data processing and analysis, • limitations and delimitations, • Operational definition of terms. • Ethical considerations.
Annex/additional	• Reference • Work plan • Budget

Annex 5 Monitoring and Evaluation products and Feedback mechanisms

Report	Purpose	Description of the M&E Product	Frequency of Production	Dissemination/ Feedback	Target	Audience	Responsible Institution
Quarterly report							
Bi-annual report							
Annual reports							
Mid-term reports							
End-Term reports							

Annex 6: Formats for presenting reports for Annual work Plans

RESULT AREA/ COHORT	OUTPUT	PROGRESS	COMMENTS

Annex 7: Detailed cost of Monitoring and Evaluation Framework

Sectoral and Multi-sectoral Nutrition Information Systems, Learning and Research Strengthened 2018-2022 KNAP, Key Result Area 16								
Outputs	**Activities**	**Budget in Ksh**						
		2018	**2019**	**2020**	**2021**	**2022**	**Total Ksh**	**Total USD**
Output 16.1 Nutrition sector plans progress reviewed		**18.49**	**16.12**	**23.76**	**2.89**	**58.25**	**119.50**	$ 1.18
	Activity 16.1.1: Review and update the Kenya Nutrition M&E framework	-	6.54	-	-	6.54	13.08	$ 0.13
	Activity 16.1.2: Support development and progress review of AWPs and other multi-year plans and policies	0.13	0.13	0.13	0.13	0.13	0.64	$ 0.01
	Activity 16.1.3: Conduct quarterly, annual, mid-term and end term reviews/evaluations of the KNAP and take corrective actions	15.83	6.92	21.10	0.23	49.05	93.11	$ 0.92
	Activity 16.1.4: Develop and disseminated annual reports	2.54	2.54	2.54	2.54	2.54	12.68	$ 0.13
Output 16.2 Strengthened Nutrition sector capacity in NIS and evidence based decision making		**7.08**	**27.55**	**15.98**	**27.60**	**33.79**	**112.00**	$ 1.11
	Activity 16.2.1: Develop and use a nutrition multi sectoral nutrition scored card to monitor key KNAP indicators quarterly	-	-	1.51	13.66	13.66	28.82	$ 0.29
	Activity 16.2.2: Train officers on website Maintenance and management; qualitative research methodology; SMART Survey methodology; Integrated Phase Classification for acute malnutrition; Nutrition data elements and indicators; Sentinel Surveillance-Early Warning System;	7.02	27.47	14.42	13.88	20.07	82.85	$ 0.82
	Activity 16.2.3: Routine Data review and feedback meetings with counties	0.06	0.06	0.06	0.06	0.06	0.30	$ 0.00
	Activity 16.2.4: Conduct M&E Capacity Needs Assessment and Action Plan for findings	-	0.02	-	-	-	0.02	$ 0.00
Output 16.3: Improved access to and use of nutrition information to inform programmes quality, adjustment and learning		**41.85**	**41.79**	**36.15**	**36.15**	**36.15**	**192.09**	$ 1.90

Sectoral and Multi-sectoral Nutrition Information Systems, Learning and Research Strengthened 2018-2022 KNAP, Key Result Area 16								
	Activity 16.3.1: Conduct nutrition situation analysis, generate information products, and disseminate to all levels for planning and response	17.82	17.82	17.82	17.82	17.82	89.10	$ 0.88
	Activity 16.3.2: Upload nutrition products reports and bulletins in the nutrition website and population survey database and document best practices and lessons learnt in M&E/NIS	0.09	0.09	0.09	0.09	0.09	0.45	$ 0.00
	Activity 16.3.2: Support development and review of data protection sharing guidelines.	17.82	17.82	17.82	17.82	17.82	89.10	$ 0.88
	Activity 16.3.2: Develop nutrition dashboards, scorecards, electronic data collection tools etc.	1.17	6.06	0.42	0.42	0.42	8.49	$ 0.08
	Activity 16.3.2: Systematic utilization of nutrition information to inform programmes quality improvement	4.95	-	-	-	-	4.95	$ 0.05
Output 16.4 Standardized and harmonized nutrition data collection methodologies, management, and reporting at all levels		**0.88**	**2.27**	**1.02**	**-**	**0.63**	**4.79**	$ 0.05
	Activity 16.4.1: Review/ Develop and disseminate guidelines on nutrition M&E based on field learning experience and emerging global guidance: Nutrition Coverage Guideline; DQA Guideline for nutrition indicators; Sentinel Sites DQA Guidelines reviewed; MIYCN KAP	0.50	0.38	-	-	-	0.88	$ 0.01
	Activity 16.4.2: Review/develop Field Assessment Manual; Guidelines on CNAP Development; IYCF-e assessment tools and guidelines; Nutrition KHIS tools review; SMART Survey Questionnaire review; KAP Survey Questionnaire review;	0.38	1.56	0.36	-	0.60	2.90	$ 0.03
	Activity 16.4.3: Participate in the HMIS indicator manual review	-	0.03	-	-	0.03	0.06	$ 0.00
	Activity 16.4.4: Print, distribute and disseminate MOH Nutrition M&E framework, tools, manuals, and guidelines.	-	0.30	0.66	-	-	0.96	$ 0.01
Output 16.5 Quality nutrition data generated for evidence-based programmesming		**62.47**	**62.47**	**167.47**	**62.47**	**61.92**	**416.80**	$ 4.13

Sectoral and Multi-sectoral Nutrition Information Systems, Learning and Research Strengthened 2018-2022 KNAP, Key Result Area 16								
	Activity 16.5.1: Conduct nutrition data clinics to reflect on NIS processes, key emerging issues, lessons learnt from field implementation and tap into national, regional and global experts to improve NIS	0.66	0.66	0.66	0.66	0.66	3.28	$ 0.03
	Activity 16.5.2: Conduct Data Quality Audits for DHIS, LMIS and sentinel surveillance	1.67	1.67	1.67	1.67	1.11	7.77	$ 0.08
	Activity 16.5.3 Review and validate methodologies and results and quality monitoring during nutrition surveys-SMART, MIYCN KAP and Coverage surveys	0.15	0.15	0.15	0.15	0.15	0.75	$ 0.01
	Activity 16.5.4: Conduct Integrated Nutrition SMART Surveys, MNIYCN KAP and coverage assessment	60.00	60.00	165.00	60.00	60.00	405.00	$ 4.01
Output 16.6 Enhanced multi-sectoral linkages result in improved nutrition information efficiencies and cost-effectiveness		**11.43**	**37.85**	**11.54**	**11.43**	**37.76**	**110.01**	$ 1.09
	Activity 16.6.1: Hold periodic Multi sectoral nutrition collaboration TWG meetings and monitoring of TWG Plan	0.64	0.64	0.64	0.64	0.64	3.19	$ 0.03
	Activity 16.6.2: Strengthen continuity of NITWG partnership with stakeholders such as NDMA, KNBS, FEWSNET, MOH HIS.	-	0.09	0.11	-	-	0.20	$ 0.00
	Activity 16.6.3: Enhance linkages between NITWG and other working groups within the sectors.	10.55	10.55	10.55	10.55	10.55	52.77	$ 0.52
	Activity 16.6.4: Plan/review TORs for M&E/NIS including monthly meetings and NITWG costed plan for resource mobilization.	-	26.33	-	-	26.33	52.65	$ 0.52
	Activity 16.6.5: Support the multi-sectoral Nutrition Information Platform (NIP) for improved multi-sectoral data analysis, dissemination and utilization.	0.24	0.24	0.24	0.24	0.24	1.20	$ 0.01
Output 16.8 Enhanced evidence-based decision making through research		**14.92**	**9.36**	**15.75**	**14.02**	**12.66**	**66.72**	$ 0.66
	Activity 16.7.1: Develop strategic partnerships and networks in addressing national research agenda	1.62	0.12	-	-	-	1.74	$ 0.02
	Activity 16.7.2: Advocate for research prioritization at both national and county levels	2.22	0.42	7.26	4.16	4.16	18.23	$ 0.18

Sectoral and Multi-sectoral Nutrition Information Systems, Learning and Research Strengthened 2018-2022 KNAP, Key Result Area 16								
	Activity 16.7.3: Advocate and strengthen formation and coordination of sub committees for research for all counties	-	-	-	-	-	-	$ -
	Activity 16.7.4: Develop capacity in research methodologies, knowledge translation and systemetic review processes	4.48	3.36	3.33	4.46	3.33	18.96	$ 0.19
	Activity 16.7.5: Dissemination of research findings	3.14	2.90	2.90	3.14	2.90	14.97	$ 0.15
	Activity 16.7.6: Strengthen systematic review of nutrition sensitive and nutrition specific research	-	0.30	-	-	-	0.30	$ 0.00
	Activity 16.7.7: Promote knowledge sharing forums such as Symposiums and conferences, workshops, meetings	1.32	1.32	1.32	1.32	1.32	6.60	$ 0.07
	Activity 16.7.8: Establish an effective mechanism for knowledge management and learning	0.48	-	-	-	-	0.48	$ 0.00
	Activity 16.7.9: Knowledge sharing trough publications	0.44	0.44	0.44	0.44	0.44	2.22	$ 0.02
	Activity 16.7.10: Establishment of research Repository	1.22	0.50	0.50	0.50	0.50	3.22	$ 0.03

Annex 8 List of contributors

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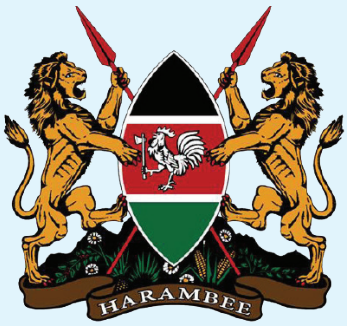

MINISTRY OF HEALTH

Kenya Nutrition Monitoring and Evaluation Framework 2018 to 2022