TOOLKIT FOR CARE MAINSTREAMING IN PLANNING AND BUDGETING

NAIROBI CITY COUNTY

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NAIROBI CITY COUNTY GOVERNMENT

TOOLKIT FOR CARE MAINSTREAMING IN PLANNING AND BUDGETING

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List of Acronyms

ADPs	Annual Development Plans
CEC	County Excecutive Commitee
CECMs	County Excecutive Commitee Member
CIDP	County Integrated Development Plan
CFSP	County Fiscal Strategy Paper
CPD	Continuing Professional Development
ECD	Early Childhood Development
GBV	Gender-Based Violence
ICT	Information and Communication Technology
KDHS	Kenya Demographic and Health Survey
KHIS	Kenya Health Information System
KNBS	Kenya National Bureau of Statistics
KPIs	Key Performance Indicators
M&E	Monitoring & Evaluation
MOU	Memorandum of Understanding
MTEFs	Medium-Term Expenditure Frameworks
NCG	Nairobi City County
NCCG	Nairobi City County Government
NCD	Non-Communicable Diseases
PBB	Programme-Based Budget
PFMA	Public Finance Management Act
PPPs	Public-private partnerships
PWDs	Persons with Disabilities
SMART	Specific, Measurable, Achievable, Relevant, Time-bound
SWGs	Sector Working Groups
TVET	Technical and Vocational Education and Training

Foreword

Nairobi City County (NCG) is committed to building a city that upholds Order, Dignity, Hope and Opportunity for All. Central to this vision is the recognition that care both paid and unpaid is the invisible foundation upon which our households, communities, and economy stand. Yet, for far too long, care has remained insufficiently recognized, under-valued, and inadequately resourced within public policy and planning systems.

This Care Mainstreaming Toolkit marks a significant milestone in the County's journey towards inclusive and responsive governance. It provides a structured framework for integrating care considerations across all sectors of County planning, budgeting, and service delivery. By doing so, it ensures that our development investments respond to the lived realities of Nairobi residents particularly women, children, older persons, persons with disabilities, and vulnerable populations who disproportionately bear the burden of care.

The Toolkit is aligned with the constitutional values of equity, social justice, and human dignity, and gives practical effect to our obligations to deliver accessible, quality, and inclusive services. It also recognizes care as a driver of economic productivity and social cohesion, and positions Nairobi to harness its demographic dividend through strategic investment in human capital.

Importantly, this Toolkit introduces practical and measurable approaches to embedding care within our governance systems, including care-responsive planning tools, budget tagging frameworks, and performance indicators. These instruments will enable County departments to systematically identify care gaps, prioritize investments, and track outcomes in a manner that is transparent, evidence-based, and accountable to the people of Nairobi.

Equally, the success of this initiative will depend on strong partnerships and sustained engagement with communities, civil society, and the private sector. Care is inherently relational and cannot be delivered by government alone. This Toolkit therefore embraces a collaborative approach that values co-production, strengthens community systems, and leverages innovation to expand access to quality care services across all wards of the city.

I call upon all County departments, partners, and stakeholders to adopt and implement this Toolkit with commitment and accountability. Let us work together to transform care from an invisible burden into a visible and valued pillar of sustainable urban development.

Hon. Rosemary Kariuki

County Executive Committee Member
Inclusivity, Public Participation and Customer Service

Executive Summary

The Nairobi City County Care Mainstreaming Toolkit provides a comprehensive and practical framework for integrating care into the County's planning, budgeting, and service delivery systems. It responds to the findings of the State of Care Report and the City's evolving demographic profile, which underscores a high demand for childcare, adolescent support, social services, and community-based care systems.

The Toolkit is grounded in the constitutional and statutory framework governing County planning and public finance, and operationalizes care as a cross-cutting development priority within the County Integrated Development Plan (CIDP), Annual Development Plans (ADPs), Programme-Based Budgets, and departmental strategies. It introduces practical tools including care impact assessments, budget tagging systems, performance indicators, and monitoring frameworks to ensure that care considerations are systematically embedded in decision-making processes.

At its core, the Toolkit seeks to achieve three strategic outcomes. First, it institutionalizes care as a public good and a fundamental component of human development and social protection. Second, it promotes equitable access to care services across Nairobi's diverse communities, particularly in underserved and informal settlements. Third, it positions care as a driver of economic inclusion by reducing unpaid care burdens and enabling greater participation in productive activities.

The successful implementation of this Toolkit requires strong inter-departmental coordination, sustained political commitment, and robust monitoring and evaluation mechanisms. It also calls for active collaboration with non-state actors, development partners, and communities to co-create solutions that are responsive, scalable, and sustainable.

This Toolkit is therefore both a policy instrument and an operational guide—designed to transform how Nairobi plans, budgets, and delivers services in a manner that is inclusive, equitable, and anchored in dignity.

Mariam Dahir

County Chief Officer – Gender and Inclusivity

Acknowledgement

The development of the **Nairobi City County Care Mainstreaming Toolkit** has been a highly collaborative and inclusive process enabled by the collective contributions and sustained support of diverse institutions, partners and individuals.

First and foremost, the County wishes to extend its deepest appreciation to **Wow Mom Kenya**, whose technical leadership, strategic guidance and hands-on implementation support were central to the development of this Toolkit. Their expertise and sustained commitment to advancing the care agenda significantly shaped both the content and structure of this work.

We are profoundly grateful to **Metropolis** for funding the development of this Toolkit under the project "**Mainstreaming Care: Strengthening Nairobi City County Government's Capacity to Enhance Care Services through Increased Budgets and Policy Implementation**" as a key output of this initiative, advancing efforts to mainstream care within Nairobi City County.

The County also acknowledges the dedication of all sector representatives who participated in the **Nairobi County Care Sector Technical Working Group (TWG).** Their commitment, expertise and invaluable input ensured that the Toolkit reflects a truly multisectoral and practical approach to care mainstreaming.

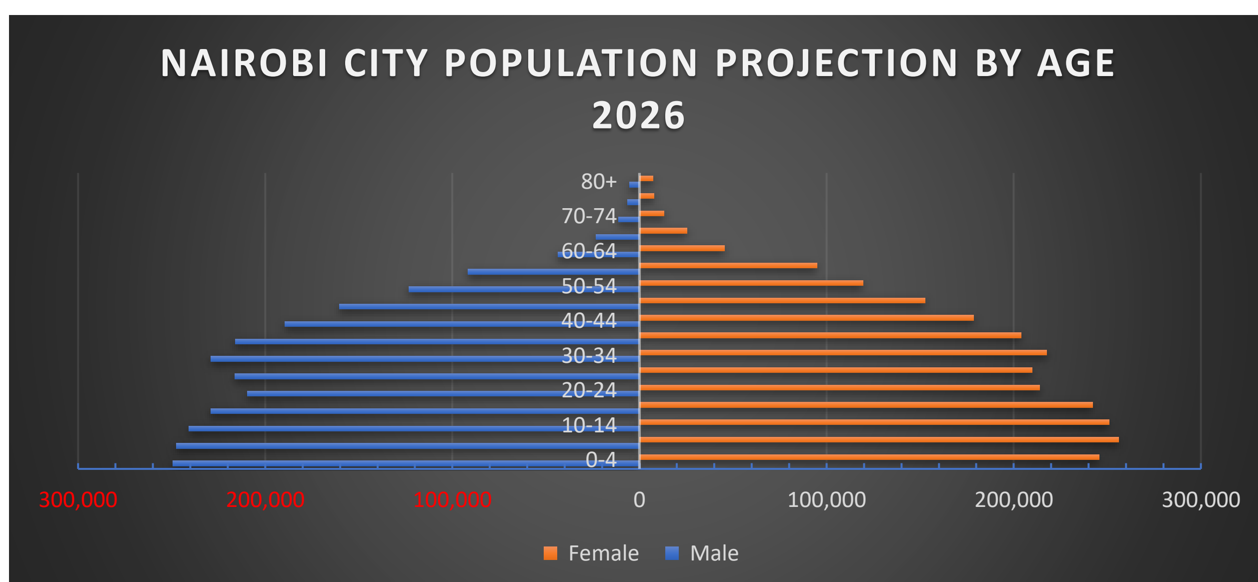
Finally, we extend our gratitude to all stakeholders who contributed through consultations, reviews and validation processes. Your collective efforts have laid a strong foundation for institutionalizing care within Nairobi City County's governance systems.

Jane Gichure
Director of Gender
Nairobi City County

Chapter One: Introduction and Scope of The Care Mainstreaming Toolkit

1.1 Introduction

Nairobi City stands at a defining demographic and social moment. With nearly 40 percent of its population below 20 years and a dominant working-age cohort, the City's growth trajectory is deeply shaped by the realities of care childcare, eldercare, disability support, community health, and unpaid household labor. The findings of the State of Care Report for Nairobi City underscore that care work, both paid and unpaid, remains largely invisible in planning and under-resourced in budgeting, despite being foundational to household stability, workforce productivity, and social cohesion. As the City advances its vision of **Order, Dignity, Hope and Opportunity for All**, embedding care into the architecture of public policy is no longer optional—it is strategic.



The County Toolkit for Mainstreaming Care in Planning and Budgeting responds to this imperative. It recognizes that Nairobi's youthful population structure increases demand for childcare, adolescent support services, maternal health, and community-based care systems, while gradual demographic transition calls for early preparation for healthy ageing. Care is therefore central to how the city designs housing, transport, markets, public spaces, water and sanitation systems, health services, and social protection programs. A care-responsive approach ensures that infrastructure and services reduce the unpaid care burden particularly on women while expanding economic participation and household resilience.

This Toolkit positions care not as a marginal social program, but as a cross-cutting development priority integrated into County Integrated Development Plans (CIDPs), Annual Development Plans (ADPs), Medium-Term Expenditure Frameworks (MTEFs), and departmental performance contracts. It provides practical instruments to embed care considerations into policy formulation, project appraisal, budget tagging, monitoring, and evaluation. By doing so, Nairobi affirms care as a public

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good that underpins human dignity; as a driver of economic inclusion that enables women, youth, and informal workers to participate productively in the economy; and as a social protection and human development priority essential to building an equitable, safe, and prosperous city.

1.2 Purpose

The purpose of this Toolkit is to institutionalize care as a core, cross-cutting principle within County planning and budgeting processes. It provides a structured framework to ensure that every department whether responsible for urban planning, transport, health, water, housing, education, markets, or social services integrates care considerations into program design, resource allocation, and performance measurement. By embedding care into planning instruments and fiscal decision-making, the County ensures that development investments respond to the lived realities of households and caregivers across Nairobi's wards.

The Toolkit further seeks to guarantee equitable access to quality care services across socio-economic and geographic divides, particularly for residents of informal settlements, low-income families, persons with disabilities, older persons, and vulnerable children. Through systematic planning, budget tagging, and monitoring mechanisms, it aligns care investments with the County's vision of Order, Dignity, Hope and Opportunity for All—ensuring that public services are not only efficient, but humane and inclusive.

Finally, the Toolkit strengthens the recognition of care as a public good that generates shared social and economic returns. It reframes care as a driver of economic inclusion—unlocking labor force participation, productivity, and entrepreneurship—while anchoring it firmly within Nairobi's social protection and human development agenda. In doing so, the County moves from fragmented care interventions toward a coherent, measurable, and sustainable care system that supports families, strengthens communities, and powers Nairobi's long-term prosperity.

- Integrate CARE as a cross-cutting development priority within county planning and budgeting.
- Ensure equitable access to care services aligned to the vision of a **City of Order, Dignity, Hope and Opportunity for All**.
- Strengthen recognition of care as:
    - a public good
    - a driver of economic inclusion
    - a social protection and human development priority.

1.3 Scope

The Toolkit applies across the full spectrum of Nairobi City County's planning, budgeting, and performance management architecture. It is grounded in the legal and institutional framework established under the **Constitution of Kenya**, the **County Governments Act**, and the **Public Finance Management Act**. It ensures that care is embedded from long-term visioning through to annual budgeting, implementation, and evaluation.

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1.3.1 The Proposed Nairobi Vision 2050

At the apex of County planning, the Toolkit informs the long-term development trajectory articulated in Nairobi Vision 2050. In line with Articles 10, 43, 174, 175 and 220 (2) of the Constitution which guarantee national values, socio-economic rights, and the objectives of devolution the Toolkit ensures that care is recognized as foundational to human dignity, equality, and inclusive growth.

Within this long-term vision framework, care is positioned as:

- A **public good** integral to social cohesion and dignity;
- A **driver of economic productivity and labor-force participation**; and
- A **pillar of human capital development** aligned with intergenerational equity.

The Toolkit guides the integration of care-sensitive infrastructure, social services, and inclusive urban systems into the City's long-range spatial, economic, and social transformation agenda.

1.3.2 County Sector Plans

Pursuant to Sections 107–112 of the County Governments Act, which require counties to prepare integrated development planning frameworks including sectoral plans, the Toolkit applies to all County sectors—health, transport, housing, water and sanitation, education, social services, trade, environment, and urban planning.

Within sector plans, the Toolkit seeks to ensure that each sector:

- Embeds care impact assessments in sector strategies;
- Ensures sector objectives reduce unpaid care burdens and expand access to care services;
- Aligns sector investments with Article 43 socio-economic rights (health, housing, sanitation, education, social security).

Sector departments are required to identify how their policies, infrastructure projects, and regulatory actions either support or constrain caregiving and human development outcomes.

1.3.3 County Integrated Development Plan (CIDP) Formulation and Review

Under Section 108 and 109 of the County Governments Act, every county must prepare a five-year County Integrated Development Plan (CIDP) as the primary planning instrument. The Toolkit integrates care as a cross-cutting development priority within the CIDP formulation and review process.

In alignment with Article 220(2) of the Constitution and Section 126 of the Public Finance Management Act (PFMA), which require plans to inform budgeting, the Toolkit ensures that:

- Situational analyses incorporate care indicators (childcare access, unpaid care burden, eldercare needs);
- Strategic objectives explicitly recognize care as central to economic inclusion and social protection;
- Resource allocation frameworks prioritize equitable access to care services across wards.

During CIDP reviews, the Toolkit mandates assessment of progress on care-related outcomes and re-alignment of strategies based on demographic shifts and service gaps.

1.3.4 Annual Development Plans (ADPs)

In accordance with Section 126 of the Public Finance Management Act, each County must prepare an Annual Development Plan (ADP) linked to the CIDP. The Toolkit operationalizes care mainstreaming within the ADP cycle by:

- Requiring departments to specify annual care-related outputs and targets;
- Aligning projects with measurable reductions in care burdens;
- Tagging development expenditures that directly or indirectly support care services.

This ensures that care priorities are not aspirational but translated into implementable annual commitments with clear fiscal implications.

1.3.5 Programme-Based Budgets (PBBs)

Programme-Based Budgeting, mandated under Sections 129 and 130 of the Public Finance Management Act, requires budgets to link resources to programmes, outputs, and outcomes. The Toolkit introduces care-responsive budgeting tools within this framework by:

- Establishing care budget tags across programmes;
- Linking programme indicators to care outcomes (e.g., childcare coverage, safe public spaces, time-saving water access);
- Strengthening accountability through performance-based reporting.

This ensures that public finance decisions reflect care as both a social investment and an economic enabler.

1.3.6 Departmental Strategic Plans

Departmental strategic plans, developed pursuant to the County Governments Act's planning obligations and aligned to the CIDP, must incorporate care-responsive objectives and performance indicators. The Toolkit guides departments to:

- Integrate care impact analysis in strategy formulation;
- Identify service delivery reforms that enhance dignity and equity;
- Align departmental Key Performance Indicators (KPIs) with care-sensitive targets.

This institutionalizes care within administrative systems rather than limiting it to social-sector departments alone.

1.3.7 Monitoring and Evaluation (M&E) Processes

Section 108(1)(c) of the County Governments Act requires Counties to establish performance management and monitoring systems. The Toolkit embeds care metrics into County M&E frameworks by:

- Developing standardized care indicators across departments;
- Incorporating care outcomes into quarterly and annual performance reports;
- Linking care performance to public participation and accountability mechanisms under Articles 10 and 196 of the Constitution.

Through these processes, care investments are systematically tracked, evaluated, and publicly reported.

1.4 Target Users

The Toolkit is designed as an operational instrument that strengthens institutional responsibility for integrating care into policy, planning, budgeting, and implementation across Nairobi City County. It clarifies accountability at political, executive, technical, and service-delivery levels, ensuring care is embedded as a cross-cutting development priority rather than treated as a stand-alone social programme.

Below is the specific role of each target user and the utility the Toolkit provides in advancing care-responsive governance.

1.4.1 County Executive Committee Members (CECMs)

Role in Governance: CECMs provide political and strategic leadership for County sectors under Article 179 of the Constitution and are responsible for policy direction, executive decisions, and presenting departmental priorities to Cabinet and the County Assembly.

Utility of the Toolkit: The Toolkit enables CECMs to:

- Integrate care as a policy priority within sector strategies and Cabinet memoranda;
- Justify care-related investments within the CIDP, ADP, and Programme-Based Budget;
- Align departmental programmes with constitutional socio-economic rights (Article 43);
- Champion care as an economic and human development investment at executive level.

In essence, the Toolkit strengthens CECMs' ability to position care within high-level policy and fiscal decision-making processes.

1.4.2 County Chief Officers (Accounting Officers)

Role in Governance: As Accounting Officers under the Public Finance Management framework, Chief Officers are responsible for financial management, programme execution, and ensuring value for money within their departments.

Utility of the Toolkit: The Toolkit supports Chief Officers to:

- Integrate care-sensitive indicators into programme-based budgets;
- Apply care budget tagging and expenditure tracking tools;
- Ensure departmental plans align with CIDP and ADP care commitments;
- Enhance compliance, performance reporting, and accountability on care outcomes.

For Accounting Officers, the Toolkit translates care from a policy concept into measurable financial and performance obligations.

1.4.3 Departmental Directors

Role in Governance: Departmental Directors oversee technical programme design, operational planning, and service delivery within sectors.

Utility of the Toolkit: The Toolkit assists Directors to:

- Conduct care impact assessments at project design stage;
- Integrate care-sensitive service standards into infrastructure and service delivery;
- Reduce unintended care burdens in sector projects (e.g., transport, housing, markets);
- Develop operational KPIs linked to care outcomes.

It provides practical tools to ensure daily programme implementation reflects the County's care commitments.

1.4.4 Sector Working Groups (Budgeting & Planning)

Role in Governance: Sector Working Groups (SWGs) coordinate interdepartmental planning and prepare sector submissions for the Medium-Term Expenditure Framework and annual budgets.

Utility of the Toolkit: The Toolkit enables SWGs to:

- Integrate care considerations into sector ceilings and prioritization processes;
- Harmonize cross-sector care interventions;
- Evaluate trade-offs using care impact criteria;
- Strengthen alignment between planning documents and fiscal allocations.

For SWGs, the Toolkit ensures care is systematically embedded in resource prioritization rather than appended after budgeting decisions are made.

1.4.5 Technical Working Group on Care (Multisectoral)

Role in Governance: The Technical Working Group (TWG) on Care serves as a multisectoral coordination platform bringing together departments, technical experts, and relevant stakeholders.

Utility of the Toolkit: The Toolkit provides the TWG with:

- A standardized framework for defining care priorities;

- Data and indicators for cross-sector tracking;
- Mechanisms to identify duplication or gaps;
- Evidence-based tools to recommend policy adjustments.

It strengthens horizontal coordination and ensures care mainstreaming remains coherent across sectors.

1.4.6 Monitoring & Evaluation (M&E) Officers

Role in Governance: M&E Officers are responsible for performance tracking, reporting, and evaluation under the County performance management framework.

Utility of the Toolkit: The Toolkit equips M&E Officers to:

- Incorporate care indicators into County performance dashboards;
- Track outputs, outcomes, and budget utilization related to care;
- Conduct care-focused evaluations of County programmes;
- Generate evidence for annual performance reports and CIDP reviews.

Through the Toolkit, M&E systems move beyond output counting to assessing impact on dignity, equity, and economic participation.

1.4.7 Borough Managers, Sub-County & Ward Administrators

Role in Governance: These officers represent the frontline of County administration and coordinate service delivery, public participation, and local implementation at devolved levels.

Utility of the Toolkit: The Toolkit enables them to:

- Identify ward-level care gaps and priorities;
- Facilitate community consultations with caregivers and vulnerable groups;
- Monitor localized service delivery standards;
- Feed grassroots data into County planning and budgeting processes.

For decentralized administrators, the Toolkit ensures that care mainstreaming is grounded in lived realities and that equity in access to services is achieved across geographic areas.

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Chapter Two: Guiding Principles and Core Care Domains in the County

2.1 Guiding Principles

The Nairobi City County Care Mainstreaming Toolkit is anchored in the 5R Framework for Decent Care Work; Recognize, Reduce, Redistribute, Reward and Represent while being firmly grounded in Kenya's constitutional and statutory architecture. The Constitution of Kenya, the County Governments Act, and the Public Finance Management Act collectively establish the legal obligation for counties to deliver inclusive, participatory, equitable, and accountable development.

The following principles interpret care mainstreaming within this binding legal and policy framework.

2.1.1 Human Rights and Dignity

Care mainstreaming is fundamentally a constitutional obligation grounded in Article 28 (Human Dignity) and Article 43 (Economic and Social Rights), which guarantee every person the right to the highest attainable standard of health, accessible housing, reasonable standards of sanitation, freedom from hunger, clean and safe water, social security, and education.

Article 21 further obligates the State and all public officers to observe, respect, protect, promote and fulfil these rights. At the County level, this obligation is operationalized through devolved functions under the Fourth Schedule, including county health services, pre-primary education, village polytechnics, water and sanitation services, and social welfare.

In policy terms, this principle positions care services—childcare, eldercare, disability services, maternal health, and community support—as instruments for realizing constitutional rights. County programmes must therefore be designed to uphold dignity, eliminate degrading conditions, and guarantee humane standards in public service delivery.

2.1.2 Equity and Inclusion

Article 10 enshrines national values of equity, social justice, inclusiveness, equality, and protection of the marginalized. Article 27 guarantees equality and freedom from discrimination, while Article 56 requires affirmative action for marginalized groups.

The County Governments Act reinforces these obligations through provisions on equitable service delivery and public participation. The Public Finance Management Act further requires equitable allocation of resources within planning and budgeting processes.

Applied to care, this principle mandates targeted resource allocation to underserved wards, informal settlements, vulnerable households, persons with disabilities, older persons, children, and marginalized communities. It requires disaggregated data, pro-poor budgeting, and spatial equity in

care infrastructure. Equity transforms care mainstreaming into a deliberate corrective measure against structural inequality.

2.1.3 Gender- and Age-Responsive Planning

Article 27(3) affirms equal rights for women and men, while Article 53 guarantees children's rights and Article 57 protect the rights of older persons. Article 21(3) requires public institutions to address the needs of vulnerable groups, including women, older members of society, persons with disabilities, youth, and children.

Statutorily, County planning processes under Sections 107–109 of the County Governments Act must integrate cross-cutting issues such as gender and youth. Gender-responsive budgeting practices are further supported under the Public Finance Management framework.

In practice, this principle requires Nairobi to integrate sex- and age-disaggregated data into the CIDP, ADP, and Programme-Based Budgets; to design transport, housing, and public spaces that account for caregiving responsibilities; and to provide age-appropriate services from early childhood to ageing populations. Care policy must recognize and address the disproportionate unpaid care burden borne by women and girls.

2.1.4 Evidence-Based Decision Making

Section 108 of the County Governments Act requires counties to establish planning and performance management systems. Section 126 of the Public Finance Management Act requires Annual Development Plans to be informed by strategic priorities and linked to measurable outputs and outcomes.

This principle ensures that care mainstreaming is supported by data—time-use statistics, service coverage indicators, fiscal analysis, and community feedback. Evidence-based planning strengthens accountability and aligns with Article 201 of the Constitution, which requires public finance to promote transparency, accountability, and responsible use of public resources.

Care investments must therefore be justified through measurable social and economic returns, and progress must be reported through structured monitoring and evaluation systems.

2.1.5 Prevention and Early Intervention

The constitutional commitment to progressive realization of socio-economic rights under Article 21(2) implies proactive policy design to prevent deprivation. The Fourth Schedule assigns counties responsibility for primary healthcare, pre-primary education, and social welfare—functions inherently preventive in nature.

Preventive care strategies—such as maternal and child health programmes, early childhood development, adolescent support initiatives, and violence prevention—reduce long-term fiscal burdens and social risks. Early intervention aligns with the Public Finance Management Act's emphasis on efficient and sustainable use of public resources.

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In Nairobi, this principle justifies prioritizing early childhood care, youth mental health, and community-based services as cost-effective human capital investments.

2.1.6 Community Participation

Article 10 identifies participation of the people as a national value, while Article 196 requires County Assemblies to facilitate public participation in legislative and policy processes. The County Governments Act (Part VIII) mandates public participation in planning and budgeting.

This principle requires structured engagement with caregivers, community groups, youth, older persons, and civil society during CIDP formulation, ADP preparation, and budget hearings. Participatory care mapping, community scorecards, and stakeholder consultations ensure that planning reflects lived experience and enhances legitimacy.

Care mainstreaming must therefore be co-created with residents rather than imposed administratively.

2.1.7 Inter-Departmental Coordination

Section 107 of the County Governments Act requires integrated development planning to ensure coherence across sectors. The Public Finance Management Act links planning and budgeting within a coordinated Medium-Term Expenditure Framework.

Because care intersects with health, housing, transport, water, markets, and education, coordination across departments is a legal and practical necessity. Sector Working Groups and Technical Working Groups on Care serve as institutional platforms for harmonization, preventing fragmentation and duplication.

Integrated governance ensures care is mainstreamed across all County functions rather than siloed within social services.

2.1.8 Fiscal Sustainability

Article 201 of the Constitution establishes principles of public finance, including openness, accountability, prudent use of public resources, and equitable sharing of burdens and benefits. The Public Finance Management Act provides the framework for fiscal discipline, medium-term planning, and programme-based budgeting.

Fiscal sustainability in care mainstreaming requires embedding care priorities within the Medium-Term Expenditure Framework, ensuring predictable funding streams, and conducting cost-benefit analysis to demonstrate economic returns. Sustainable care financing protects long-term service continuity and intergenerational equity.

Care must therefore be treated as strategic public investment rather than short-term expenditure.

2.1.9 Partnerships and Co-Creation with Non-State Actors

Article 1 of the Constitution vests sovereign power in the people, and Article 10 promotes inclusiveness and stakeholder engagement. The County Governments Act encourages collaboration with civil society and private actors in service delivery.

Care ecosystems in Nairobi include community-based organizations, faith-based institutions, private childcare providers, development partners, and social enterprises. This principle supports formalized partnerships, service-level agreements, regulatory oversight, and quality standards to expand coverage while ensuring accountability.

Co-production strengthens innovation, resource mobilization, and shared responsibility in achieving equitable care access.

Through these principles—anchored in constitutional mandates, statutory planning obligations, and public finance discipline—Nairobi City County institutionalizes care as a legally grounded, fiscally responsible, and development-oriented priority. Guided by the 5R Framework, the Toolkit transforms care from an invisible household function into a measurable public policy objective integral to achieving Order, Dignity, Hope, and Opportunity for all.

2.2 Classification of CARE within County Systems

2.2.1 Core Care Domains

The State of Care findings position care in Nairobi City as a structural urban governance issue that disproportionately affects specific population groups, particularly those already experiencing poverty, exclusion, or vulnerability. Across the city—and most acutely within informal settlements—the care ecosystem remains uneven, under-resourced, and heavily dependent on unpaid household Labor. The context of care for the identified groups is outlined below.

Domain	Characteristics	Prevalence in the City (Nairobi County)	Care Concerns
Children Below 5 Years	Early childhood (0–4 years); high dependency; concentrated in informal settlements; require nutrition, stimulation, safe childcare	**495,169 children (14% of county population)** – 2026 Census (KNBS)	Shortage of affordable & regulated childcare; overcrowded informal daycares; malnutrition; developmental delays; mothers forced out of workforce; lack of workplace childcare/lactation facilities
Persons with Disabilities (PWDs)	Physical, sensory, intellectual & psychosocial	Approx. **42,703 persons (~1.1%)** of county population (KNBS	Inaccessible public infrastructure; stigma & exclusion; limited assistive

Domain	Characteristics	Prevalence in the City (Nairobi County)	Care Concerns
	disabilities; require accessible infrastructure & assistive devices	disability data; KIPPRA county profile)	devices; inadequate specialized services; caregiver strain
Older Persons (60+ years)	Ageing population; chronic illness prevalence; social dependency; limited geriatric specialization	**~188,969 (~3.8%)** aged 60+ (KNBS, 2026)	Lack of geriatric health services; social isolation; poverty in informal settlements; absence of long-term care systems; dependency on family care
Chronically Ill Persons & NCD Patients	Adults with hypertension, diabetes, cardiovascular disease, cancer & other long-term conditions	2.16% of the **population)**; applying national urban NCD trends 105,899 (KHIS & national NCD reports and NCCG Health Records)	High treatment costs; interrupted care; catastrophic household expenditure; limited continuity of care; family caregiver burden
Persons with Psychosocial & Mental Health Needs	Depression, anxiety, trauma, substance use; includes adolescents, men, street-connected children	In the year 2025, a total of **41,304** cases were reported.; national facility data suggests mental health conditions account for **significant outpatient load (~20–25% in some urban facilities)**	Limited community mental health services; stigma; weak integration into primary health care; inadequate rehabilitation & psychosocial support
Gender-Based Violence (GBV) Survivors	Women & girls primarily affected; require medical, psychosocial, legal & shelter support	Nairobi female population approx. **2.2 million (50% of population)**; national surveys show high GBV prevalence (40%) among women (KDHS, 2022)	Limited safe houses; insufficient crisis centers; inadequate reintegration services; economic vulnerability post-violence
Immigrants, Refugees & Stateless Persons	Urban refugees & asylum seekers; documentation challenges; concentrated in informal settlements	Kenya hosts **869,000 refugees nationally** (Dept. of Refugee Services); Nairobi hosts **tens of thousands** in urban	Documentation barriers; exclusion from county services; limited access to health, housing & social protection; dependency on humanitarian actors

Domain	Characteristics	Prevalence in the City (Nairobi County)	Care Concerns
		settings (not fully enumerated in census)	
Unpaid & Informal Caregivers	Predominantly women; domestic workers; family caregivers balancing paid & unpaid labour	No census enumeration; given Nairobi's household structure (2.9 persons avg.), **majority of households rely on informal care arrangements**	Unpaid Labor; burnout; limited social protection; lack of training; reduced Labor force participation; gender inequality

2.2.2 Children Below the Age of Five Years

Children under five represent the population most affected by inadequate care services in Nairobi. The findings reveal a critical shortage of affordable, safe, and quality childcare, especially in low-income and informal settlements where many parents rely on informal or precarious employment. Informal daycare centers are frequently overcrowded, unregulated, and operated by untrained caregivers, exposing children to neglect, unsafe conditions, malnutrition, and delayed developmental milestones.

The absence of workplace childcare and lactation facilities further compounds the challenge, forcing many mothers either to withdraw from economic activity or to leave children in unsafe environments. Inadequate early childhood care not only undermines children's wellbeing and long-term human capital development but also restricts women's economic participation and reinforces intergenerational poverty.

2.2.3 Persons with Disabilities

For persons with disabilities, the care domain is shaped by systemic exclusion and physical inaccessibility. Public infrastructure, transport systems, health facilities, and social amenities are largely non-inclusive, limiting mobility and access to essential services. Caregivers often lack the training, resources, and assistive devices necessary to provide specialized support, resulting in neglect or confinement within homes.

Stigma and discrimination further marginalize persons with disabilities, restricting access to education, employment, and public life. Although some progress has been made through inclusive infrastructure initiatives and legislative reform, the overall care environment remains fragmented and insufficiently responsive to diverse disability needs.

2.2.4 Older Persons

Older persons experience a care environment characterized by neglect, social isolation, and limited access to age-appropriate healthcare. Nairobi lacks comprehensive geriatric services, and older

TELEPHONE: +254 725 624 489; +254 738 041 292 | EMAIL: INFO@NAIROBI.GO.KE | CITY HALL, CITY HALL WAY, P.O. BOX 30075 00100, NAIROBI, KENYA

persons—particularly those in informal settlements—face compounded challenges of poverty, chronic illness, and inadequate access to assistive devices such as walking aids and adult diapers.

Without structured long-term care systems or targeted policy frameworks, many older persons depend heavily on family or community support, which is often strained. Social stigma and invisibility in public programming further marginalize this group. While some facilities and respite centers have emerged, they remain limited relative to the scale of need.

2.2.5 Chronically Ill Persons and Patients with Non-Communicable Diseases (NCDs)

Chronically ill persons and patients with NCDs face care challenges rooted in the need for consistent, long-term medical engagement. High treatment costs, limited health coverage, and gaps in specialized services interrupt continuity of care, increasing the risk of disease progression and catastrophic household expenditure.

Families frequently absorb caregiving responsibilities, leading to lost productivity and financial instability. Although community-level health initiatives have expanded, the system continues to struggle in providing integrated, affordable, and sustained care for chronic conditions.

2.2.6 Persons with Psychosocial and Mental Health Needs

Persons with psychosocial and mental health needs occupy an emerging yet under-recognized care domain. Respondents highlighted mental health challenges among men, adolescents, young mothers, and street-connected children, noting limited availability of community-based mental health services and persistent stigma that discourages help-seeking.

Weak rehabilitation and psychosocial support systems leave many without appropriate intervention, contributing to untreated depression, anxiety, trauma, and increased vulnerability to substance abuse or violence. While awareness is growing and improvements in GBV-related psychosocial services have been noted, mental health care remains insufficiently integrated into primary healthcare and social services.

2.2.7 Gender-Based Violence (GBV) Survivors

GBV survivors require coordinated protection, health, psychosocial, legal, and housing support. However, safe houses, crisis centers, and long-term reintegration programs remain limited. Survivors often face economic vulnerability and may be forced to return to unsafe environments due to lack of alternatives.

The consequences extend beyond immediate trauma, affecting household stability and contributing to intergenerational harm. Although progress has been made in strengthening GBV protection services, the care ecosystem for survivors still lacks comprehensive coverage and sustainable reintegration pathways.

2.2.8 Immigrants, Refugees, and Stateless Persons

Immigrants, refugees, and stateless persons face care exclusion primarily through documentation barriers and administrative constraints. Without recognized documentation, many are excluded from county-level health, social protection, and housing programs. This exclusion is particularly acute in informal settlements, where poverty and overcrowding intensify vulnerability.

Chronic illness patients within migrant populations face additional barriers to consistent treatment. The absence of clear integration pathways into local service systems perpetuates marginalization and poor care outcomes.

2.2.9 Unpaid and Informal Caregivers

Unpaid and informal caregivers—predominantly women and domestic workers—form the invisible backbone of Nairobi's care economy. They shoulder long hours of unpaid or poorly paid labor, often without recognition, social protection, or psychosocial support. The dual burden of paid work and unpaid caregiving limits economic mobility and contributes to stress and burnout.

The absence of workplace childcare, flexible work arrangements, and structured self-care programs exacerbates these pressures. Although recent initiatives have increased training and recognition of childcare workers and domestic employees, the broader system continues to externalize care costs onto households, reinforcing gender inequality.

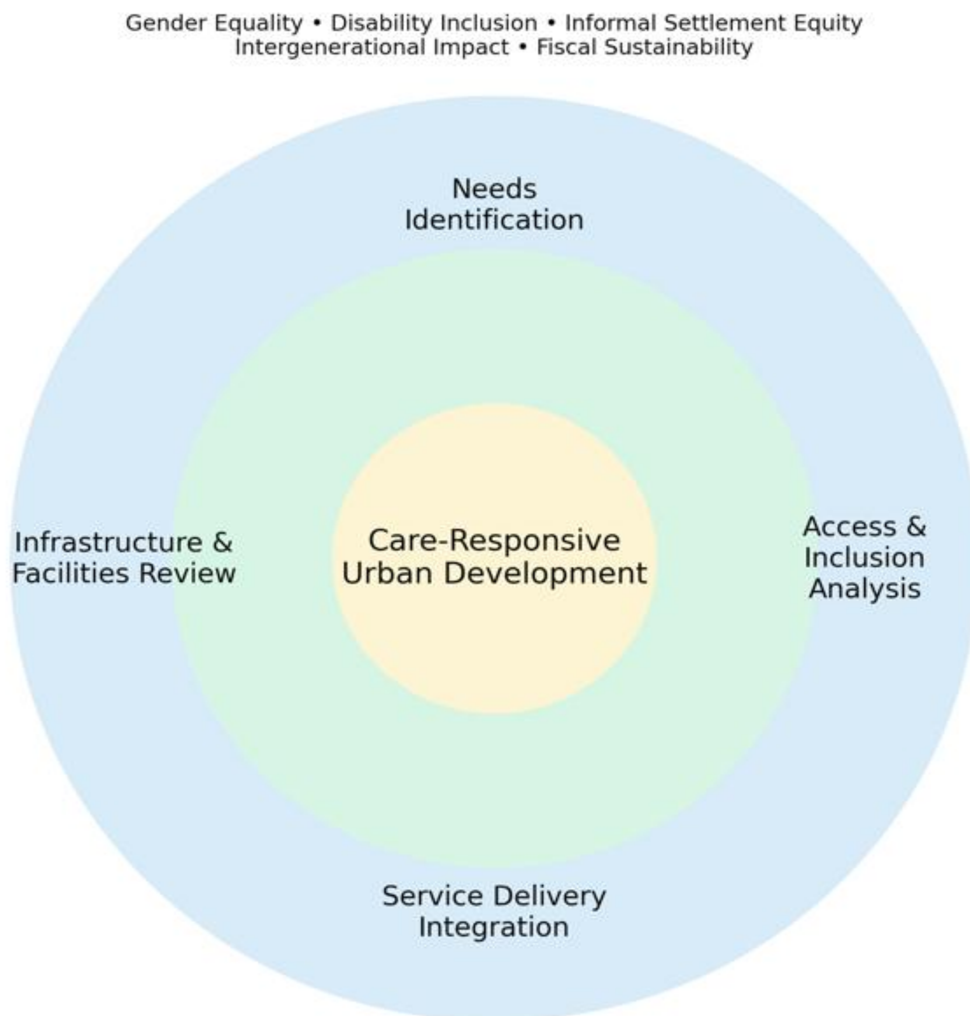
Across all these domains, inadequate care services generate systemic impacts including lost productivity, weakened social cohesion, overburdened public health systems, and intergenerational poverty. At the household level, families experience increased economic strain and emotional stress. At the individual level, vulnerable populations face neglect, exclusion, and diminished life opportunities, underscoring that care is a foundational pillar of inclusive urban development in Nairobi.

Chapter Three: Integrating Care into County Planning and Budgeting

3.1 Care Mainstreaming Framework

A CARE Mainstreaming Screening Framework strengthens planning by ensuring that care is not treated as a residual social issue but as a central component of inclusive urban development. Through systematic needs identification, rigorous access and inclusion analysis, integrated service delivery planning, and infrastructure review, county planning processes can shift from reactive care responses to proactive, equitable, and sustainable care systems.

The framework is summarised in Fig. Below.



3.1.1 Needs Identification

This section provides a structured framework for **CARE Mainstreaming Screening during City Planning**. The framework is designed to guide planners, sector departments, and project teams in systematically assessing whether policies, programs, budgets, and infrastructure proposals adequately respond to care needs.

Needs identification is the foundational step in care mainstreaming. It requires planners to systematically determine **who requires care, what type of care is needed, where gaps exist, and how needs differ across population groups and geographic areas**. This process must go beyond general service demand assessments and explicitly map care-dependent populations, including children under five, older persons, persons with disabilities, chronically ill persons, persons with psychosocial needs, GBV survivors, migrants, and unpaid caregivers.

A care-responsive needs assessment should combine demographic data (age distribution, disability prevalence, disease burden), spatial data (informal settlements, high-density areas, transport deserts), and socio-economic indicators (poverty levels, labor force participation, female-headed households). It must also identify intersectional vulnerabilities—for example, disability combined with poverty, or migrant status combined with chronic illness.

The screening process should answer key questions:

- Which populations in the target area are care-dependent or care-providing?
- What are the most pressing unmet care needs (childcare, eldercare, mental health support, chronic disease management, safe shelters, etc.)?
- What is the current level of service coverage and quality?
- What care burdens are being absorbed at the household level, particularly by women?

Needs identification must be evidence-based and participatory, incorporating community consultations, caregiver perspectives, and frontline service provider input. It should also consider projected demographic shifts, such as population growth or ageing, to ensure long-term responsiveness.

3.1.2 Access and Inclusion Analysis

Access and inclusion analysis evaluates whether existing or proposed services, infrastructure, and policies are **physically accessible, financially affordable, socially inclusive, and administratively reachable** to all care-dependent groups.

This screening step requires planners to examine structural barriers such as:

- Physical inaccessibility (lack of ramps, lifts, safe walkways, accessible toilets).
- Financial barriers (user fees, transport costs, informal payments).
- Documentation requirements excluding migrants or informal workers.
- Gender norms limiting women's mobility or access to services.
- Stigma and discrimination affecting persons with disabilities, mental health needs, or GBV survivors.

An inclusive care lens demands that services are designed with universal accessibility principles and that no group is inadvertently excluded through planning assumptions. For example, a childcare center may exist, but if it is too distant from informal markets or lacks flexible hours, it remains inaccessible to informal workers. Similarly, a health facility without mental health screening capacity excludes psychosocial needs by design.

The screening process should assess:

- Who can realistically access this service or facility?
- Are there gender, disability, age, or documentation-related barriers?
- Are services equitably distributed across wards?
- Does the proposal reduce or reinforce care-related inequality?

Access and inclusion analysis ensures that care mainstreaming addresses not only availability but also equitable reach.

- Which vulnerable populations interact with this programme?
- What care needs arise directly or indirectly?
- Are there unpaid care burdens created or reduced?

3.1.3 Service Delivery Integration

Service delivery integration examines whether care services are fragmented or coordinated across sectors and whether planning proposals strengthen an integrated care ecosystem.

Care needs are multi-dimensional. A GBV survivor may require medical treatment, psychosocial counselling, legal aid, safe housing, and economic reintegration support. A child under five may require nutrition services, early learning, health screening, and safe transport. Fragmented delivery systems increase the burden on families and caregivers, forcing them to navigate complex and disconnected systems.

The screening framework should therefore assess:

- Are care services linked across departments (health, social services,housing, education, urban planning)?
- Are referral pathways clearly defined?
- Are community-level services connected to higher-level facilities?
- Does the intervention reduce duplication and administrative burden?

Integrated care planning should encourage co-location of services where feasible (e.g., childcare within markets, health screening within social protection programs), strengthen community health systems, and establish data-sharing mechanisms while safeguarding privacy.

Effective service integration reduces household stress, enhances efficiency, and ensures that care recipients experience continuity rather than fragmentation.

3.1.4 Infrastructure and Facilities Review

Infrastructure and facilities review ensures that physical planning decisions reflect care needs and promote a care-supportive urban environment. Care is spatial: it depends on proximity, safety, transport connectivity, and design standards.

This screening step requires planners to assess whether:

- New infrastructure incorporates universal design standards.
- Public facilities include care-supportive elements (childcare spaces, lactation rooms, accessible toilets, safe waiting areas).
- Transport systems accommodate caregivers, older persons, and persons with disabilities.
- Public spaces are safe, well-lit, and conducive to caregiving activities.
- Health and social facilities are equitably distributed across high-need areas.

Infrastructure review should also evaluate maintenance and operational sustainability, not just capital investment. A childcare facility without trained staff, water, sanitation, or security fails to deliver meaningful care support.

In rapidly urbanizing areas, planners must anticipate care demands in new housing developments, markets, transport hubs, and regeneration projects. Embedding care considerations at the design stage is more cost-effective than retrofitting infrastructure later.

3.2 CARE Budget Integration Module

The CARE Budget Integration Module is designed to systematically embed care priorities into **program-based budgeting**, ensuring that county resources explicitly support vulnerable populations and strengthen care systems. By linking **strategic objectives, program outputs, and measurable outcomes** to resource allocation, the module enables transparent, equitable, and efficient budgeting for care services.

3.2.1 Strategic Objective Definition

At the outset, each care program must have a clearly articulated **strategic objective** that aligns with county development priorities, statutory obligations (e.g., Children Act 2022, Older Persons Bill, Disability Act), and national care policies. For example:

- **Strategic Objective Example:** "Enhance access to affordable, quality, and inclusive early childhood care and development services for children under five, with special focus on informal settlements."
- Objectives should be **SMART** (Specific, Measurable, Achievable, Relevant, Time-bound) and directly inform budget allocations.

3.2.2 Program Outputs and Targeted Outcomes

Outputs and outcomes should flow logically from the strategic objective and provide a clear **link between resources and results**.

- **Program Output:** Tangible deliverables or services produced by the program.
  - Example: "50 ECD centres upgraded or established in informal settlements by FY2026/27."
  - Example: "500 caregivers trained in inclusive childcare practices."
- **Targeted Outcome:** The measurable change or impact the program seeks to achieve.
  - Example: "Increase in the proportion of children under five accessing safe, quality care from 35% to 60%."
  - Example: "Reduction in caregiver burnout and improved workforce retention among domestic care workers."

Outputs and outcomes should include both **direct service delivery measures** and **system strengthening indicators** (e.g., infrastructure improvement, workforce capacity, data system functionality).

3.2.3 Activities

Each program should clearly identify activities necessary to produce the outputs. Activities should be actionable, time-bound, and linked to specific resources. **Examples include:**

3.2.3.1 Direct Care Services

- Provide free or subsidized ECD sessions for children under five.
- Offer community-based mental health screening and psychosocial counselling.
- Establish mobile clinics for NCD management in informal settlements.

3.2.3.2 Care-Enabling Infrastructure

- Renovate or construct care centers (ECD centres, respite homes for older persons).
- Install ramps, accessible toilets, and safe playgrounds.
- Upgrade health facilities with disability-inclusive equipment.

3.2.3.3 Care Workforce Development

- Conduct professional training for caregivers, community health workers, and domestic support staff.
- Offer mentorship and certification programs for early childhood educators.
- Implement caregiver wellness and psychosocial support programs.

3.2.3.4 Data and Monitoring Systems

- Develop digital registries for care beneficiaries (children, older persons, PWDs).
- Introduce routine reporting and monitoring tools for program performance.
- Conduct periodic surveys to assess service quality, reach, and satisfaction.

3.2.4 Costing for Each Activity

A critical component of CARE budget integration is **activity-based costing**, ensuring funds are allocated to achieve intended outputs efficiently. Practical considerations include:

- **Direct Care Costs:** Salaries or stipends for caregivers, purchase of medicines, nutrition supplies, therapy sessions.
- **Infrastructure Costs:** Construction, renovation, equipment, accessibility modifications, and facility maintenance.
- **Workforce Development Costs:** Training, certification, workshops, stipends for trainers, and recruitment.
- **Monitoring & Data Costs:** ICT systems, reporting tools, data collection surveys, and monitoring staff.

Each activity should have a **line-item budget**, with clarity on unit costs, total projected expenditure, and justification based on expected impact.

3.2.5 Delivery Unit Responsibilities

For effective program implementation, each activity must be assigned to a **responsible delivery unit** within the county structure. Examples:

- **Health Department:** Direct service provision for NCDs, mental health, and child health services.
- **Social Services / Department of Children & Older Persons:** Management of ECD centers, care homes, GBV support services.
- **Infrastructure & Urban Planning:** Construction, renovation, and retrofitting of care facilities.
- **Human Resource / Training Units:** Care workforce development and capacity-building programs.
- **Monitoring & Evaluation (M&E) Unit / County Planning Department:** Data systems, performance tracking, and program reporting.

Clearly defining delivery units promotes **accountability, performance monitoring, and integration across sectors**, avoiding duplication and ensuring coherent use of budgetary resources.

3.2.6 Practical Implementation Notes

- **Link Budgets to Outcomes:** PBB requires that each expenditure be directly traceable to a program output and outcome. Ensure care programs specify the **number of beneficiaries served**, **service quality standards**, and **performance indicators**.
- **Prioritize Vulnerable Populations:** Use data from the Nairobi City State of Care Report to allocate resources where unmet needs are highest (e.g., informal settlements, PWDs, older persons).
- **Integrate Across Sectors:** Care services often cut across health, education, social protection, and infrastructure; budgets must reflect these intersections.
- **Monitor Efficiency:** Establish periodic reviews to assess whether funds allocated are producing expected outputs, and adjust allocations as needed.
- **Sustainability:** Consider recurrent costs (staff salaries, facility maintenance) to ensure that care interventions remain functional beyond one fiscal cycle.

3.3 KEY CARE Budgeting Considerations

3.3.1 Whether the Programme has a Dedicated Care Component

When responding to this question, the first consideration is **substantive integration versus incidental benefit**.

A programme has a dedicated care component if:

- Care services, care infrastructure, or care workforce development are explicitly defined in the programme objective or sub-programme description.
- There are specific outputs and budget lines tied to care-related activities (e.g., ECD services, community health outreach, disability support services, elderly day-care centres).
- Care beneficiaries are clearly identified and quantified.

A programme does *not* have a dedicated care component if:

- Care benefits arise only indirectly (e.g., general road improvement that may ease access to facilities but does not explicitly target care).
- Care activities are embedded but **not costed separately or tracked**.
- No measurable care outputs exist.

Practically, reviewers should ask:

- Is there a sub-programme or activity titled or described as care-related?
- Are there specific indicators linked to care delivery?
- Is there a budget allocation traceable to care services?

If care activities exist but are not explicit, the recommendation should be to formalize them within programme documentation to enhance accountability and visibility.

3.3.2 Whether the Care Component is Development or Recurrent (Economic Classification)

This question requires analysing the **nature of expenditure** under government economic classifications.

3.3.2.1 Development expenditure

Typically includes:

- Construction or renovation of care centres.
- Procurement of equipment (hospital beds, assistive devices).
- ICT systems for beneficiary registration and monitoring.
- Capital investments in water, sanitation, and accessibility infrastructure.

3.3.2.2 Recurrent expenditure

Includes:

- Salaries and stipends for caregivers and social workers.
- Purchase of medicines, nutrition supplies, and consumables.
- Utilities, maintenance, and operational costs.
- Routine training and supervision.

In practice:

- Most care systems require a combination of development and recurrent funding.
- Infrastructure-heavy programmes may initially be development-focused but become recurrent-intensive once operational.
- Sustainability must be assessed: capital investment without provision for recurrent staffing and maintenance creates dysfunctional facilities.

The key consideration is whether the economic classification aligns with the **long-term sustainability of care delivery**.

3.3.3 Source of Funding

This requires identifying the **funding structure and fiscal risk exposure**.

Fully public funding implies:

- Budget allocations are sourced entirely from county equitable share, own-source revenue, or national transfers.
- The programme's continuity depends solely on public revenue streams.

Complemented funding may include:

- Donor grants.
- Public-private partnerships (PPP).
- Corporate social responsibility contributions.
- Community co-financing models.

Practical considerations include:

- Is donor funding time-bound?
- Are there signed agreements defining co-financing roles?
- Is the public sector expected to absorb costs once external funding ends?

A balanced financing model may enhance scale, but excessive reliance on external funds may threaten continuity. Reviewers should assess sustainability and fiscal resilience.

3.3.4 Whether the Funding is Ring-Fenced

Ring-fencing refers to **protecting allocated funds from diversion or reallocation.**

Funding is ring-fenced if:

- It is legally or administratively earmarked for specific care purposes.
- It appears as a distinct line item or conditional grant.
- Transfers cannot be reallocated without formal approval.

Without ring-fencing:

- Care budgets may be vulnerable to mid-year reallocations.
- Emergency reprioritization may erode care investments.
- Accountability becomes weaker.

However, rigid ring-fencing may also reduce flexibility in responding to emerging needs.

The practical approach is to assess:

- Whether safeguards exist to prevent diversion.
- Whether reporting mechanisms track expenditure strictly against care outputs.
- Whether legislative or executive directives protect the allocation.

3.3.5 Programme Impact on Unpaid Care Burdens

This question shifts focus from service provision to **redistribution of care responsibilities,** particularly those borne by women and girls.

Indicators that a programme reduces unpaid care burden include:

- Provision of affordable childcare services.
- Expansion of community health outreach reducing home-based caregiving strain.
- Access to water, sanitation, and energy infrastructure reducing time spent on domestic tasks.
- Respite care services for persons caring for elderly or disabled family members.

Reviewers should examine:

- Does the programme reduce time spent on unpaid domestic work?
- Does it substitute informal caregiving with formal services?
- Does it create dignified paid care employment?

Care-sensitive budgeting should explicitly analyse time-use impacts and labour redistribution effects.

3.3.6 Programme compliance to Gender-Responsive Budgeting (GRB)

Gender-responsive budgeting ensures that resource allocation addresses the different needs and constraints of women, men, girls, and boys.

A programme adopts GRB if it:

- Uses sex-disaggregated data in planning and targeting.
- Identifies gender gaps in care access or burden.
- Allocates resources intentionally to address gender inequalities.
- Includes gender-sensitive performance indicators.
- Conducts gender impact analysis before and after implementation.

In practice, reviewers should assess:

- Are beneficiaries disaggregated by gender?
- Does the programme acknowledge women's disproportionate unpaid care burden?
- Are budget allocations designed to correct existing inequities?
- Are monitoring reports gender-sensitive?

Importantly, gender-responsive budgeting is not merely allocating funds to women-focused activities; it involves **systematic integration of gender analysis across planning, allocation, and evaluation**.

3.4 Strategic Integration Note

When answering these six questions, the response should:

- Go beyond binary responses.
- Identify gaps and opportunities for strengthening care integration.
- Link financial allocations to measurable social impact.
- Consider sustainability, equity, and accountability.

Together, these considerations enable a structured CARE budget assessment that strengthens transparency, equity, and service effectiveness within program-based budgeting systems.

- Does the programme have a dedicated care component?
- Is funding ring-fenced?
- Does the programme reduce unpaid care burdens?
- Is there gender-responsive or inclusive budgeting applied?

3.5 Resource Mobilisation Lens

Effective budgeting for care at the County level requires a deliberate and diversified resource mobilization strategy to meet growing care demands sustainably. Sector Working Groups (SWGs) must begin by mapping all available **traditional revenue streams**, including equitable share

transfers, conditional grants, and own source revenue (OSR), and assessing the proportion currently allocated to care-related programmes. This analysis should identify fiscal space within existing ceilings and opportunities for reprioritization. Measurable indicators at this level may include: (i) percentage of total county budget allocated to care-related programmes, (ii) proportion of OSR dedicated to care services, and (iii) year-on-year growth in public financing for care as a share of total sector expenditure.

Beyond traditional financing, SWGs should actively pursue **innovative and complementary financing mechanisms** to expand the care envelope. These include development partner grants, intergovernmental transfers, Public Private Partnerships (PPPs), social enterprise collaborations, and philanthropic contributions. Resource mapping should categorize funding by type (public, donor, private, blended) and duration (short-term, medium-term, long-term) to assess sustainability and risk exposure. Performance indicators may include: (i) value of external funds mobilized for care annually, (ii) proportion of care projects co-financed through PPPs or donor agreements, (iii) number of active development partner agreements supporting care interventions, and (iv) leverage ratio of public funds to external contributions.

Finally, the Resource Mobilization Lens must assess the **effectiveness and predictability of financing flows** to ensure continuity of care services. The County should track the timeliness of disbursements, absorption rates of mobilized funds, and the extent to which alternative financing reduces fiscal pressure on recurrent budgets. SWGs should also monitor whether diversified financing contributes to scaling care infrastructure, strengthening the care workforce, and expanding direct services. Key indicators include: (i) budget absorption rate for care programmes, (ii) percentage of mobilized funds directed to capital versus recurrent care needs, (iii) reduction in funding gaps identified during planning, and (iv) sustainability index measuring continuation of programmes beyond initial grant cycles. Through structured resource mapping and performance tracking, counties can ensure that care budgeting is both adequately financed and fiscally resilient.

Chapter Four: Human Resource Planning and Capacity Development

4.1 Staffing Needs Assessment

Nairobi City County should undertake a structured **Care Workforce Needs Assessment** anchored in demographic data, disease burden trends, poverty indices, urban informality patterns, and migration flows. The assessment should be geographically disaggregated by sub-county and ward to identify care gaps in informal settlements, peri-urban zones, and high-density neighbourhoods.

The assessment should:

- Quantify current public, private and community-based care providers.
- Map service coverage across health facilities, early childhood development centres, social protection programmes, safe houses, rehabilitation centres, and elderly care services.
- Identify workload ratios (e.g., caregiver-to-child, social worker-to-household, counsellor-to-population).
- Analyse fiscal sustainability within the County Medium-Term Expenditure Framework (MTEF).

This process should align with Articles 43 and 53 of the Constitution of Kenya (social and child protection rights), the Fourth Schedule on devolved health and social services functions, and existing County sectoral plans.

4.2 Specialized Skills Mapping

Nairobi's care ecosystem requires deliberate mapping of specialized competencies to respond to complex urban vulnerabilities. The County should maintain a **Care Skills Registry** identifying practitioners and institutions across the following areas:

- **Child and Baby Care** – infant nutrition, safeguarding, stimulation, immunization follow-up, foster and alternative care systems.
- **Early Childhood Care and Education (ECCE)** – child development, inclusive learning, parental engagement, child protection compliance.
- **Counselling Services** – school-based counselling, family mediation, substance abuse intervention, crisis response.
- **Trauma and Psychological Care** – post-violence support, gender-based violence (GBV) response, disaster and displacement trauma management.
- **Disability Care** – inclusive education support, assistive device management, rehabilitation, sign language interpretation, occupational therapy.
- **Care for the Elderly** – geriatric health monitoring, dementia care, home-based support, social inclusion programming.

Skills mapping should include certification status, licensing requirements, language competencies (including Kenyan Sign Language), and availability for deployment during emergencies.

4.3 Training and Certification Standards

To professionalize the care sector, Nairobi City County should adopt minimum competency and certification standards consistent with national regulatory frameworks under the Ministry of Health, Ministry of Labour and Social Protection, and TVET regulatory bodies.

Key actions include:

- Establishing minimum qualifications for public and contracted caregivers.
- Requiring continuous professional development (CPD) credits for specialized care providers.
- Enforcing safeguarding and child protection compliance.
- Standardizing induction training for County-supported caregivers.

Certification standards should promote dignity of care workers, fair labour practices (Article 41 of the Constitution), and compliance with occupational safety standards.

4.4 Partnerships with Training Institutions

The County should formalize partnerships with accredited universities, TVET institutions, faith-based training colleges, and professional associations to expand care workforce supply and quality.

Partnerships may include:

- Structured internship and practicum placements in County facilities.
- Joint curriculum development aligned with urban care needs.
- Scholarship or bursary schemes for low-income youth entering care professions.
- Research collaboration for evidence-based care planning.

This approach supports workforce sustainability while reducing unemployment among trained youth within Nairobi.

4.5 Volunteer and Community Caregiver Frameworks

Given fiscal constraints and high demand, Nairobi should institutionalize a **Community Caregiver Framework** to support neighbourhood-level service delivery.

The framework should:

- Register and vet community caregivers.
- Provide structured orientation and safeguarding training.
- Offer modest stipends or non-monetary incentives where feasible.
- Integrate community caregivers into Ward-level coordination systems.
- Establish supervision and referral pathways to professional services.

This strengthens prevention and early intervention, especially in informal settlements where formal care infrastructure is limited.

4.6 Civic Awareness on Labour Rights

Care workforce planning must include civic education on labour protections and domestic worker rights. The County should collaborate with labour offices, civil society, and community organizations to raise awareness on:

- Fair wages and contracts for domestic workers.
- Protection against exploitation and abuse.
- Occupational health and safety standards.
- Access to dispute resolution mechanisms.

Public education campaigns should also target households employing domestic caregivers to promote ethical employment practices and compliance with national labour laws.

4.7 Care for Refugees and Stateless Persons

Nairobi hosts significant refugee and stateless populations requiring culturally sensitive and legally compliant care services. Workforce planning must integrate:

- Multilingual caregivers and interpreters.
- Trauma-informed support services for displaced persons.
- Referral pathways aligned with national refugee management frameworks.
- Collaboration with humanitarian agencies and community-based refugee organizations.

Care services should uphold non-discrimination principles under Article 27 of the Constitution and align with Kenya's international protection obligations.

4.8 Results Matrix for Care Capacity

Thematic Area	Baseline Situation (Typical Urban Context)	Proposed Interventions	Expected Outputs	Key Performance Indicators (KPIs)
1. Staffing Needs Assessment	Fragmented data on care providers; uneven distribution across sub-counties; high caregiver-to-client ratios in informal settlements; limited integration into MTEF planning.	Conduct countywide workforce audit; develop ward-level care staffing norms; integrate care workforce projections into sector budgets; establish Care Workforce Database.	Comprehensive Care Workforce Assessment Report; Ward-level staffing benchmarks; Operational workforce database.	• Careworkforce audit completed and approved • % of wards with defined staffing norms • Care workforce projections integrated into annual budget • Database operational and updated annually
2. Specialized Skills Mapping	Limited registry of specialized caregivers; inadequate trauma, disability, geriatric and psychological services; skills mismatched to emerging urban vulnerabilities.	Establish Care Skills Registry; map specialized competencies; identify shortages; develop targeted recruitment plan; maintain emergency deployment roster.	County Care Skills Registry; Skills gap analysis report; Deployment framework for specialized services.	• Functional skills registry established % of specialized roles mapped • Identified skills gaps reduced annually • Response time for emergency care deployment
3. Training and Certification Standards	Inconsistent qualifications among caregivers; limited CPD compliance; weak safeguarding and labour standards enforcement.	Develop minimum qualification framework; require CPD compliance; standardize induction training; align with national regulatory bodies; enforce safeguarding compliance.	Standardized certification guidelines; CPD tracking system; County-approved caregiver induction module.	% of caregivers meeting minimum qualification standards • % compliant with CPD requirements • Safeguarding compliance rate in County facilities • Reduction in care-related complaints

Thematic Area	Baseline Situation (Typical Urban Context)	Proposed Interventions	Expected Outputs	Key Performance Indicators (KPIs)
4. Partnerships with Training Institutions	Limited structured collaboration between County and training institutions; low practical placement opportunities; mismatch between training output and urban care needs.	Formalize MOUs with universities and TVETs; create internship pipelines; co-develop curricula; offer bursaries for care-related courses; commission joint research.	Signed MOUs; Internship placement programme; Updated care-oriented curricula; Research briefs informing policy.	• Number of active institutional partnerships • Annual number of interns placed in County facilities % of graduates absorbed into care services • Policy decisions informed by joint research
5. Volunteer & Community Caregiver Frameworks	Informal, unregulated community caregiving; limited supervision; inconsistent quality and safeguarding; weak referral systems.	Develop Community Caregiver Policy Framework; register and vet volunteers; provide structured orientation; establish supervision and referral linkages; consider stipends/incentives.	Registered Community Caregiver Network; Training modules delivered; Structured referral system operational.	• Number of registered community caregivers • % trained in safeguarding and referral protocols • Increase in early case identification and referrals • Community satisfaction ratings
6. Civic Awareness on Domestic & Labour Rights	Low awareness of domestic worker protections; informal employment arrangements; limited enforcement of labour standards.	Conduct civic education campaigns; develop simplified labour rights guides; partner with labour offices and civil society; establish reporting channels for abuse.	Public awareness materials; Community outreach sessions; Improved employer compliance.	• Number of civic awareness sessions conducted • Increase in registered domestic work contracts • Reduction in reported labour rights violations • Uptake of dispute resolution mechanisms

Thematic Area	Baseline Situation (Typical Urban Context)	Proposed Interventions	Expected Outputs	Key Performance Indicators (KPIs)
7. Care for Refugees & Stateless Persons	Limited culturally responsive services; language barriers; weak coordination with humanitarian actors; trauma support gaps.	Integrate refugee sensitive care planning; recruit multilingual caregivers; strengthen referral pathways; collaborate with humanitarian agencies; adopt trauma-informed care protocols.	Multilingual care roster; Refugee-inclusive service guidelines; Coordinated referral network.	• % of care facilities applying non-discrimination protocols • Number of multilingual caregivers engaged • Increase in refugee access to County care services • Beneficiary feedback on service accessibility

4.9 Strategic Outcome for Capacity Development

A well-planned care workforce enables Nairobi City County to shift from reactive crisis management to preventive, rights-based, and community-embedded care systems. By aligning staffing assessments, skills mapping, certification standards, partnerships, and inclusion frameworks, the County can build a resilient urban care economy that supports social stability, gender equity, and inclusive economic growth.

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Chapter Five: Institutional Coordination and Implementation Workflow

5.1 Situational Analysis Using the Care Screening Tool

At the commencement of the planning cycle, each Sector Working Group (SWG) shall apply the County Care Screening Tool to assess gaps in service coverage, workforce adequacy, infrastructure, financing, and unpaid care burden within their sector mandates. The screening shall utilize disaggregated administrative data, ward-level statistics, time-use insights, facility audits, and community consultations in compliance with participatory planning requirements under the County Governments Act.

The output of this stage shall be a documented Care Situational Analysis Report highlighting service deficits, inequities, fiscal implications, and priority interventions. The findings shall directly inform sector ceilings discussions and programme prioritization in preparation for the Annual Development Plan (ADP) process.

5.2 Programme Design with Care Integration

Following situational analysis, SWGs shall integrate care-responsive interventions into sector programmes using a results-based management approach. Each proposed programme shall clearly articulate care objectives, target populations, service delivery models, staffing implications, and measurable outputs and outcomes.

Programme design must ensure alignment with County Integrated Development Plan (CIDP) priorities and statutory timelines leading to the ADP (submitted by 30th September). Care integration should be explicit within programme descriptions, indicators, and implementation frameworks to enable traceability during budgeting and performance reporting.

5.3 Budget Tagging and Costing

All care-responsive interventions shall undergo structured costing, distinguishing between recurrent and development expenditures. Departments shall apply a Care Budget Tag within the Programme-Based Budget (PBB) framework to identify allocations directed toward childcare, elderly support, disability services, psychosocial care, workforce development, and related infrastructure.

Costing must align with indicative ceilings provided during the County Fiscal Strategy Paper (CFSP) stage and comply with fiscal responsibility principles under the PFMA. This step ensures care investments are visible, measurable, and defensible during budget scrutiny and appropriation.

5.4 Technical Review by Care Technical Working Group (TWG)

The Care TWG shall undertake a structured technical appraisal of proposed programmes and budgets to ensure policy coherence, fiscal realism, legal compliance, and alignment with County care standards. The review shall assess duplication risks, cross-sector linkages, workforce sufficiency, infrastructure feasibility, and monitoring indicators.

The TWG shall issue technical recommendations prior to final consolidation of the ADP and prior to submission of sector inputs into the CFSP and budget estimates. This process strengthens quality assurance and promotes whole-of-government coordination.

5.5 Inclusion in ADP and CFSP

Care-integrated programmes approved at sector level shall be consolidated into the Annual Development Plan (ADP) by 30th September in accordance with the PFMA and subsequently reflected in the County Fiscal Strategy Paper (CFSP) by 28th February. The CFSP shall articulate the policy rationale and fiscal prioritization for care investments within sector ceilings.

This ensures that care initiatives are embedded both in annual planning instruments and in medium-term fiscal strategy documents, providing a lawful basis for budget allocation and eventual appropriation by the County Assembly before 30th June.

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5.6 Implementation and Service Coordination

Upon approval of the Appropriation Act, implementing departments shall operationalize care programmes through coordinated service delivery plans. This includes workforce deployment, procurement of supplies and infrastructure, partnership activation, and establishment of referral pathways across health, social protection, education, and community systems.

Inter-departmental coordination mechanisms and ward-level structures shall be activated to prevent fragmentation. Implementation must adhere to procurement laws, financial management controls, and performance contracting frameworks to ensure accountability and efficiency.

5.7 Quarterly Monitoring and Annual Evaluation

Departments shall submit quarterly performance and financial reports detailing progress on care indicators, budget absorption, workforce ratios, service coverage, and beneficiary feedback. These reports shall feed into County Executive Committee (CEC) performance reviews and statutory reporting obligations.

An Annual Care Evaluation shall assess effectiveness, equity impact, fiscal sustainability, and progress in reducing unpaid care burdens. Lessons learned shall inform the next cycle's situational analysis, thereby completing a continuous, evidence-based planning, budgeting, implementation, and reporting loop consistent with County and national public

Chapter Six: Monitoring, Evaluation, Compliance and Accountability for Care

The Data, Monitoring and Evaluation (M&E) Framework of the County CARE Mainstreaming Toolkit establishes a structured, evidence-driven system for measuring progress, accountability and impact in the delivery of care services.

It provides a coherent approach for generating, analyzing and utilizing disaggregated data to inform planning, budgeting, policy refinement and performance management across all County sectors. It proposes indicators, reporting cycles, verification mechanisms and feedback loops to ensure that CARE integration moves beyond policy commitment to measurable outcomes improving service coverage, workforce adequacy, accessibility, financing, infrastructure, civic awareness and the reduction of unpaid care burdens.

This framework anchors care mainstreaming within the County's results-based management architecture, strengthening transparency, fiscal discipline and continuous learning in alignment with statutory planning and budgeting timelines.

6.1 Core Parameters

6.1.1 Service Coverage Rates

The County shall measure service coverage to determine the proportion of the target population accessing essential care services across health, early childhood development, disability services, elderly care, psychosocial support, and community-based care. Coverage rates should be disaggregated by ward, gender, age, disability status, refugee status, and income level to ensure equity tracking.

Administrative data from County departments, facility registers, and population-based surveys should be consolidated annually and reviewed quarterly to detect gaps and emerging vulnerabilities.

6.1.2 Accessibility Measures

Accessibility shall be assessed across four dimensions: physical accessibility, financial affordability, social inclusion, and information access. Monitoring should determine whether care facilities are equitably distributed, compliant with disability access standards, affordable to low-income households, and culturally responsive.

Accessibility monitoring should inform spatial planning, infrastructure investments, and targeted subsidies.

6.1.3 Care Workforce Ratios

The County shall establish standard workforce ratios to guide adequacy in staffing. Ratios may include caregiver-to-child, social worker-to-household, counsellor-to-population, and geriatric caregiver-to-elderly population benchmarks.

Workforce data should be updated annually and integrated into the County's human resource planning and budgeting cycle.

6.1.4 Budget Allocation to Care

Budget monitoring shall assess both absolute and proportional allocation of County resources toward care-related programmes. This includes tagging care-responsive expenditures within Programme-Based Budgets (PBB).

Quarterly budget execution reports and annual financial statements shall provide verification.

6.1.5 Beneficiary Satisfaction

Beneficiary satisfaction monitoring shall assess service quality, dignity, timeliness, and responsiveness. Feedback mechanisms should include structured surveys, digital feedback platforms, ward barazas, and suggestion systems at facilities.

Annual perception surveys and quarterly grievance redress reports should inform service improvements.

6.1.6 Reduction in Unpaid Care Burden

Reducing unpaid care burden particularly on women and girls is a strategic outcome of care mainstreaming. Measurement should focus on time-use data and shifts in household-level care responsibilities.

Periodic time-use surveys (every 2–3 years) and labour force data should be utilized to track progress.

6.2 Data Systems

- Standardised reporting templates
- Digital data collection tools
- Care service mapping dashboard
- Integration with County M&E system

6.3 Evaluation Questions

- Are care outcomes improving?
- Are underserved populations being reached?
- Are funds translating into measurable impact?

6.3.1 County CARE Monitoring and Evaluation Framework Matrix

Outcome Area	Expected Outcomes	Initiatives	Key Performance Indicators (KPIs)	Means of Verification & Reporting Regularity
1. Adequacy in Coverage of Care Services	Increased proportion of vulnerable populations accessing essential care services	Expand ECD centres; scale community caregiving; strengthen ward-level care mapping	• % increase in service coverage by ward • Reduction in service deserts	Administrative data; Annual coverage survey; Quarterly review
2. Adequacy of Policy Frameworks	Comprehensive, updated and harmonized care-related policies	Develop Care Policy Framework; integrate CARE in sector plans; review regulations	• Care Policy adopted • Number of sectors plans integrating CARE	Gazette notices; Policy documents; Annual policy review
3. Adequacy of Funding	Increased and predictable funding for care services	Budget tagging; advocate increased allocations; mobilize grants & PPPs	• % of County budget allocated to care • Growth in care funding year-on-year	Budget estimates; CFSP; Annual financial statements; Quarterly execution reports
4. Workforce Capacity for Care	Sufficient, skilled and equitably distributed care workforce	Workforce audit; CPD compliance; recruitment of specialists	• Workforce-to-population ratio compliance • % certified caregivers	HR records; Skills registry; Annual HR report
5. Reduction of Unpaid Care Burden	Decreased average unpaid care hours, especially for women	Expand childcare services; promote shared household responsibility campaigns	• % reduction in unpaid care hours • Increased female labour participation	Time-use surveys (biennial); Labour statistics; Annual gender report
6. Level of Civic Awareness on Availability of Care Services	Increased public knowledge of care rights and services	Civic campaigns; ward outreach forums; digital information portals	• % of residents aware of care services • Increase in service uptake	Survey data; Outreach reports; Annual awareness assessment

Outcome Area	Expected Outcomes	Initiatives	Key Performance Indicators (KPIs)	Means of Verification & Reporting Regularity
			following campaigns	
7. Adequacy of Infrastructure and Facilities	Sufficient and compliant care infrastructure	Upgrade facilities; ensure disability access; establish new care centres in underserved wards	• % facilities meeting standards • Number of new/rehabilitated facilities	Infrastructure audit; Annual facility inspection report
8. Accessibility and Affordability of Care Services	Improved physical and financial access	Fee regulation; targeted subsidies; spatial redistribution of facilities	• Reduction in average travel distance • % low-income beneficiaries supported	Household surveys; Administrative subsidy records; Annual review
9. Strength of Partnerships for Care	Functional multi-sectoral collaboration	Establish inter-sectoral coordination forum; formalize NGO & private sector MOUs	• Number of active partnerships • Joint initiatives implemented annually	Signed MOUs; Partnership reports; Annual coordination review
10. Collaboration with Training Centres	Improved supply of skilled care workers	Internship pipelines; curriculum alignment; bursaries	• Number of interns placed • % graduates absorbed into care services	Institutional reports; HR records; Annual workforce review
11. Formal Recognition of Care Skills and Work	Professionalization and dignity of care work	Certification standards; CPD system; recognition awards	• % caregivers certified • Reduction in informal/unregulated care services	Certification registry; Labour inspection reports; Annual skills audit

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6.4 Compliance & Accountability Mechanisms

- Mandatory care mainstreaming checklist before budget approval
- Annual Care Performance Scorecard
- Departmental care performance indicators
- Public participation and social accountability
- Care impact reporting to County Assembly

Implementation Toolkit Annexes

- CARE Mainstreaming Checklist Template
- CARE Budget Tagging Guide
- Inclusive Infrastructure Standards
- Care Workforce Competency Framework
- Standard Referral Pathway Map
- Care Programme Design Template
- CARE Indicators Menu
- Stakeholder Mapping Template

CARE Mainstreaming Checklist

(Aligned to CFSP & Annual Development Plan Preparation Templates)

SECTION A: PROGRAMME IDENTIFICATION & SITUATIONAL ANALYSIS

(CFSP Sector Review / ADP Situational Analysis Section)

Checklist Question	Yes/No	Evidence/Notes	Action Required
Has the programme identified vulnerable care-dependent populations affected?			
Are children under 5 considered where relevant?			
Are older persons considered?			
Are persons with disabilities included?			

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Are persons with chronic illnesses/NCDs considered?			
Are migrants, refugees or stateless persons included where relevant?			
Has the unpaid care burden been analysed?			
Are informal workers and indigents considered?			
Does data include gender, age and disability disaggregation?			
Are community consultations capturing caregiving needs?			

Output Requirement:

Care needs summary included in sector situational analysis.

SECTION B: PROGRAMME DESIGN & POLICY ALIGNMENT

(ADP Programme Narrative / CFSP Strategic Priorities)

Checklist Question	Yes/No	Evidence	Action
Does the programme explicitly address care needs?			
Is the National Care Policy domesticated in programme design?			
Are care services integrated (childcare, eldercare, disability support etc.)?			
Does the programme reduce unpaid care burdens?			
Are psychosocial and mental health supports considered?			
Are referral pathways incorporated?			
Does the programme address stigma or social barriers?			

Are community-based care approaches included?			
Are partnerships with NGOs/private care providers identified?			

Output Requirement:

Programme narrative must contain a CARE Integration Statement.

SECTION C: ACCESSIBILITY & INCLUSION SCREENING

(Infrastructure, Service Delivery and Equity Sections of ADP/CFSP)

Checklist Question	Yes/No	Evidence	Action
Are facilities disability-accessible?			
Are child-friendly spaces included where relevant?			
Are older-person friendly service designs applied?			
Is sign language/braille support planned?			
Are services affordable to indigent populations?			
Are language and cultural barriers addressed?			
Is gender-responsive design incorporated?			

Output Requirement:

Inclusion compliance statement in programme design.

SECTION D: BUDGET & RESOURCE ALLOCATION (CFSP CORE SECTION)

Checklist Question	Yes/No	Evidence	Action
Is there a dedicated CARE budget line?			
Has the programme been CARE-tagged in budgeting?			
Are funds ring-fenced for vulnerable groups?			
Are caregiver workforce costs included?			
Are training and certification costs included?			
Is gender-responsive budgeting applied?			
Are external resources identified			
Are partnerships leveraged to expand care coverage?			

Output Requirement:

CARE Budget Tag included in Programme Based Budget tables.

SECTION E: WORKFORCE & INSTITUTIONAL CAPACITY

(Human Resource Planning / Institutional Arrangements Sections)

Checklist Question	Yes/No	Evidence	Action
Is a departmental care focal person designated?			
Are staff trained in disability inclusion?			
Are counselling/trauma skills available?			

Are early childhood care skills included where relevant?			
Are psychosocial support competencies included?			
Are partnerships with training institutions identified?			
Is inter-departmental coordination planned?			

Output Requirement:

Departmental capacity strengthening plan.

SECTION F: IMPLEMENTATION & SERVICE DELIVERY

(ADP Implementation Matrix)

Checklist Question	Yes/No	Evidence	Action
Are integrated referral pathways established?			
Are community outreach services included?			
Are mobile or decentralised services planned?			
Are grievance and feedback systems accessible?			
Are care standards and protocols defined?			

Output Requirement:

CARE-sensitive implementation strategy.

SECTION G: MONITORING, EVALUATION & REPORTING

(M&E Framework Sections of CFSP and ADP)

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Checklist Question	Yes/No	Evidence	Action
Are care indicators included in programme results framework?			
Is data disaggregated by age, gender and disability?			
Are care service coverage indicators defined?			
Are caregiver outcomes tracked?			
Are beneficiary satisfaction measures included?			
Is there a digital or standardised reporting tool?			

Output Requirement:

CARE Indicators included in departmental performance frameworks.

SECTION H: APPROVAL & COMPLIANCE

(To be completed before CFSP/ADP submission)

Requirement	Completed (Yes/No)	Officer Responsible
CARE Mainstreaming Checklist Completed		
CARE Budget Tag Verified		
Care TWG Technical Review Done		
Inclusion Compliance Confirmed		
M&E Indicators Approved		

Nairobi City County
Nairobi City Hall,
City Hall Way,
Nairobi Kenya

Telephone

+254 725 624 489
+254 202 224 282
+254 730 047 047
+254 207 247 047

E-mail Address
info@nairobi.go.ke

metropolis
metropolis.org

wowmom.co.ke
info@wowmom.co.ke

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