NUTRITION SECTOR SITUATION UPDATE AND RESPONSE PLAN

FEBURARY –JULY 2017

NUTRITION AND DIETETICS UNIT

DEPARTMENT OF FAMILY HEALTH, MINISTRY OF HEALTH

16TH FEBRUARY 2017

1.0 INTRODUCTION

The Nutrition sector led by Ministry of Health through Human, Nutrition and Dietetics Unit (HNDU) anchors this Situation report, preparedness and response plan on strategic objective 4 of the National Nutrition Action Plan that guides and coordinates the sectors efforts in emergency preparedness and response at National and County level through the county health and nutrition teams in collaboration with National Drought Management Authority (NDMA) and other partners. The plan is in response to the 2017 January Short Rains seasonal Food and Nutrition Security assessment. It is an update of the August 2016-January 2017 Response plan which realized financial support from the GOK to the tune of Kshs 734 Million against a gap of Kshs 1.2 Billion (65%) realization. **The sector response plan complies to the principle of devolution and attempts to be as context specific as possible. The response plan seeks to ensure that acute nutrition vulnerabilities identified are responded in a timely, coordinated and comprehensive manner that minimizes their impacts specifically on morbidity and mortality for children under five years (boys and girls) and pregnant and lactating women. The plan takes into consideration the urban poor who are equally affected by season fluctuation in food prices and general food availability in the markets.Lessons learnt and responses that were initiated based on the previous plan (August 2016 – January 2017) also inform this current update.**

2.0 NUTRITION SITUATION UPDATE

In January, February 2017, a detailed nutrition situation analysis was conducted in the arid and semi-arid counties to monitor the situation following the short rains season. Fifteen SMART surveys were undertaken from October to February 2017 further informing the situation analysis. According to the Integrated Phase Classification (IPC) for Acute Malnutrition conducted in February 2017, Turkana North, North Horr in Marsabit and Mandera counties **reported a Very Critical Nutrition situation** (phase 5; Global Acute Malnutrition ≥30 percent). A **Critical Nutrition Situation** (Phase 4; GAM WHZ 15.0 - 29.9 percent) was reported in East Pokot in Baringo County, Isiolo and Turkana South, West and Central. Tana River county reported a **Serious Nutrition Situation** GAM WHZ 10.0 -14.9 percent) while Tharaka Nithi was in phase 2 (alert GAM WHZ ≥ 5 to 9.9 percent). Finally Kitui, Kilifi, Meru north, Mbeere, Kajiado and Kwale reported rates in Phase 1 (acceptable GAM WHZ <5% and GAM by MUAC <6%). Compared with August 2016, improvement in the nutrition situation was noted in Turkana south while deterioration was noted in Turkana North, Isiolo Mandera and Marsabit Counties (Figures 1, 2 and 3). The nutrition situation is expected to deteriorate across all ASAL counties in the coming months if the dry spell persists.

Figure 1: Nutrition Situation May to August 2016

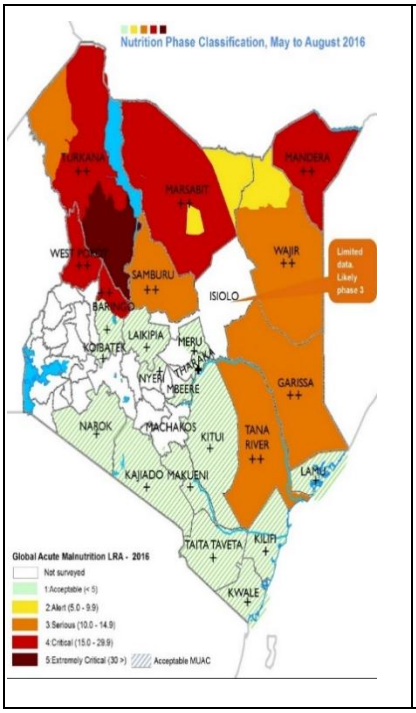


Figure 2: Nutrition Situation October 2016 to January 2017

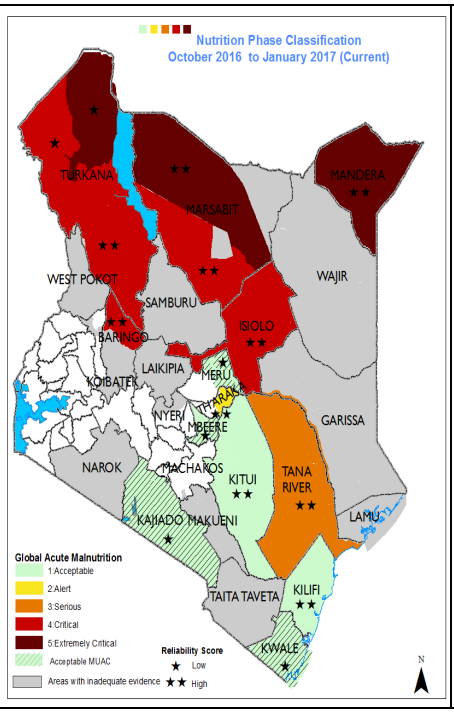
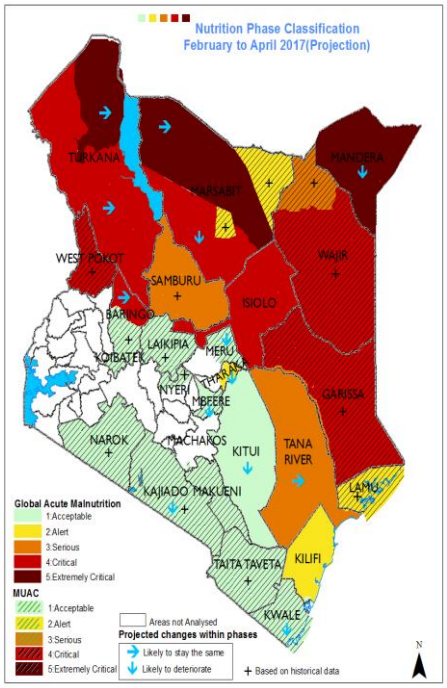
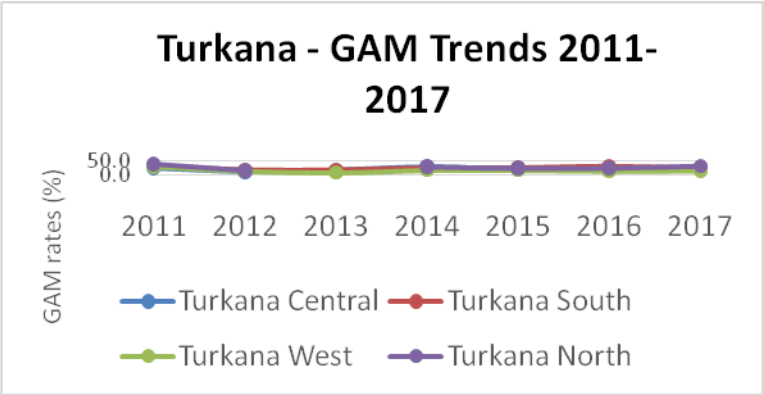


Figure 3: Projected Nutrition Situation February to April 2017



The analysis indicates that the poor nutrition status reported across the ASAL Counties is majorly due to poor reduced dietary intake as a direct result of household level food insecurity, coupled with high disease burden. These factors compounded with the chronic issues prevalent in these areas like high poverty rates, diminished livelihood capacities, limited access to quality health services and inappropriate child care and feeding practices increase the vulnerability of the population, and aggravate the situation. Most of the arid counties especially, have over the years, endemic levels of acute malnutrition, as seen from the Turkana GAM trends.***Figure 1: Turkana County – GAM Trends***



The total number of children requiring treatment has increased significantly compared to a similar time in 2016. In February2016, the caseloads in the ASAL areas was **223,000**(MAM-177,000 and SAM-46,000) and **34,400** pregnant and lactating women. In August 2016, the total estimated number of children requiring treatment in the ASAL areas was **294,330**(MAM-233,700 and SAM 60,600) and **29,500** pregnant and lactating women. Currently, the caseload in ASAL areas is **343,559 (268,549 MAM and 75,010 SAM**) which after adjusting for population level changes accounts for a **32% increase** in total numbers of boys and girls. The increase is mainly due to the extremely high levels of GAM and SAM in Turkana, Marsabit, Mandera and

Arid and Semi-Arid counties:
Children < 5: **343,559** (75,010 SAM cases and 268,549 MAM cases) PLW: **37,223**

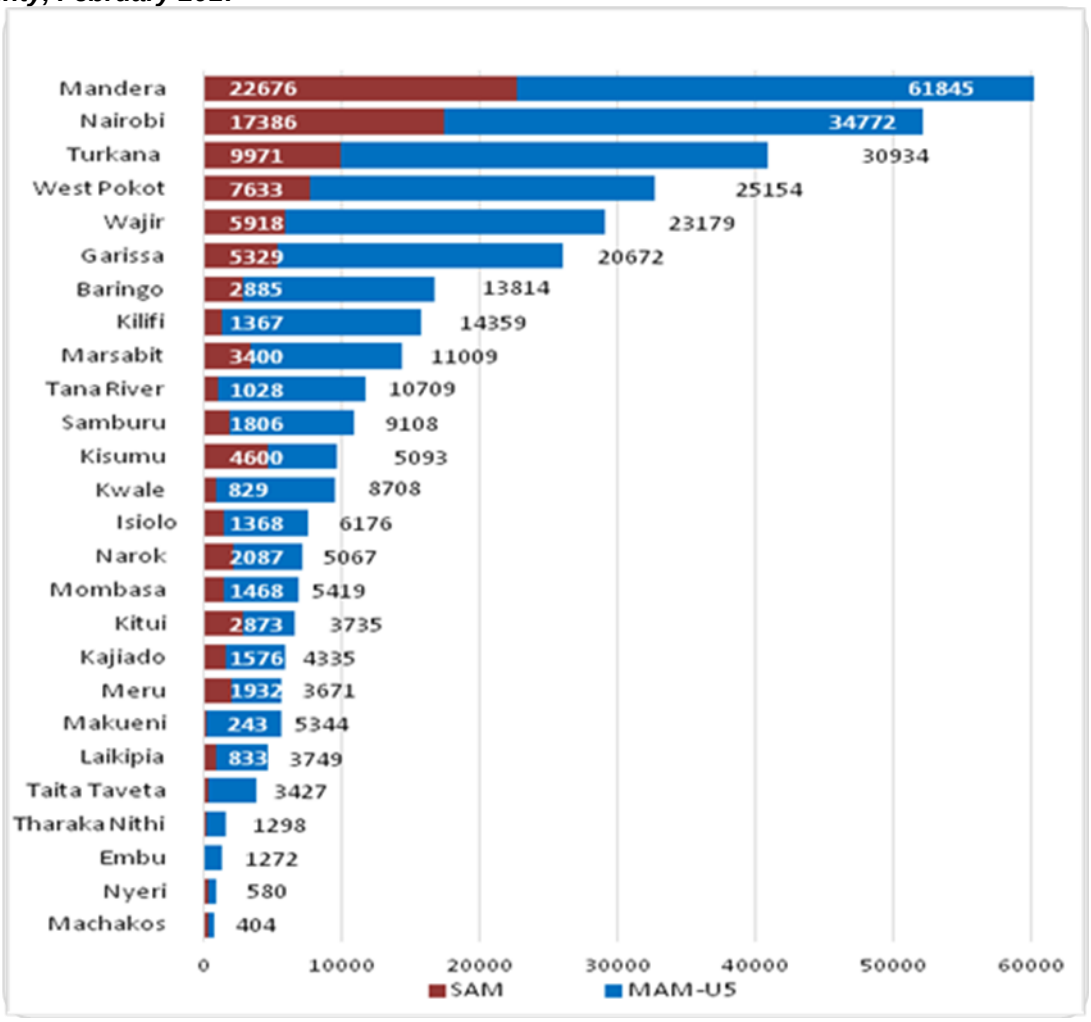
Urban Areas: (Nairobi, Mombasa, Kisumu)
Children < 5: **68,738**(23,454 SAM cases and 45,284 MAM cases)PLW:**6,229**

IN SUMMARY

- Very critical nutrition situation in Turkana North, North Horr – Marsabit and Mandera
- Critical nutrition situation in East Pokot – Baringo; Isiolo, Turkana South, Central and West.
- Nutrition situation expected to deteriorate across all ASAL counties in the coming months if dry spell exists

Baringo – East Pokot counties. Nairobi County has the second highest number of children with malnutrition largely as a factor of its population despite a lower GAM rate.

Figure 2: Estimated Caseloads for Children 6-59 Months Requiring Treatment for Acute Malnutrition by County, February 2017



The short rains seasonal assessment February 2017 led by the KFFSG[1], estimates the total population requiring immediate humanitarian assistance at **2,700,000 million**, an increasecompared to **1,300,000 million** reported after the 2016 Long rains seasonal assessment. 15 nutrition surveys were conducted in the short rains assessment period and cleabrly indicated a nutrition emergency in parts of the Arid and Semi-Arid Counties. Important to note is that the Nutrition sector had already indicated a crisis situation in the 2016 assessment. **Above emergency thresholds (global acute malnutrition above 20 %) was realized in Turkana, Mandera, East Pokot (Baringo county) and Laisamis (Marsabit county**) and there was projected **deterioration in Turkana, East Pokot, West Pokot, Tana River, Garissa, parts of Kilifi and Kwale Counties**- mainly attributed to household level food insecurity. The poor performing short rain season is seen to have further aggravated the food security situation and pushed the rates of acute malnutrition even higher in already affected counties. The urban dimension is exemplified in counties like Nairobi that has the

[1]Kenya Food Security Steering Group

2nd highest caseload of children affected due to its population density but as well, due to the challenges associated with informal settlements.

The Nutrition sector in August 2016 initiated and scaled up actions guided by the response plan targeting most affected Arid and Semi around counties. There was enhanced and adopted programming to support timely access to services in the most affected areas through integrated health and nutrition outreaches. Similarly, the sector scaled up response coordination that effectively supported advocacy and resource mobilization for the moderate acute malnutrition resulting in a **USD 5 Million** realization funding by Government to the Ministry of Health for procurement of supplementary feeding programme commodities. As at December 2016, the sector had reached 122,143 children acutely malnourished children under five years of age in the ASAL and urban (45,468 SAM and 76,675 MAM) an additional 33,076 children (11,867 SAM and 21,209 MAM) were also treated in Kakuma and Dadaab refugee camps from January through December 2016. The recovery rates are above SPHERE standards of 75% in most ASAL counties and refugee camps. The **57,335 SAM cases** treated **reached 92% of the 2016 nutrition sector target (inclusive of refugee target)** however reducing admissions in November were noted and linked to the health worker strike and migrations in pastoral counties. For MAM 98,884 moderately malnourished children were reached **67% of the 2016 nutrition sector target**, with lower numbers reached likely due to the RUSF pipeline breaks for treatment in many of the counties as well as the health worker strike. **To note is that** the **use of the outreach screening and referral mechanisms remain vital** to identify and treat these vulnerable children.

The interventions, implemented by various actors in the Counties and at National level are on-going amidst challenges of chronic food insecurity, morbidity, access to health services, sub optimal care practices for children and women, including social patterns like increased alcohol consumptionthat are impairing abilities of care givers to live healthy productive lifestyles. Water un-availability in the ASALs and resulting challenges in hygiene and sanitation are an additional risk factor for morbidity as well as livelihood viability. There is need to enhance dialogue and coordination across sectors to ensure that all social determinants of health are addressed sustainably. This ultimately will yield positive results across various health and nutrition indicators that not only rely on immediate factors but longer term development factors, to improve. ,

3.0 NUTRITION SITUATION BY LIVELIHOOD ZONE CLUSTERS

Northwest Pastoral Cluster- Turkana, Marsabit and Samburu

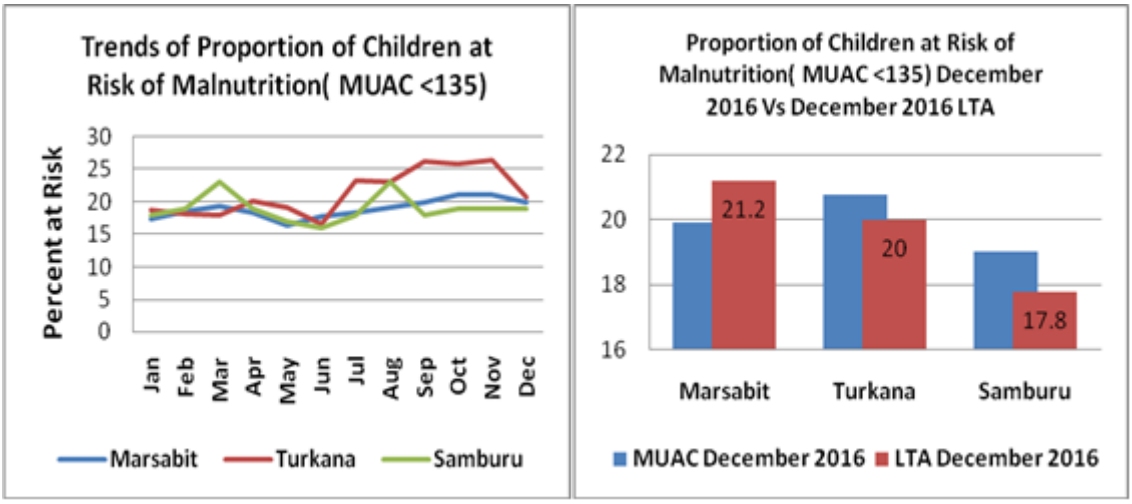
The nutrition situation according to Integrated Phase Classification (IPC) for acute malnutrition analysis shows that the Nutrition situation in Turkana North **is *Extremely Critical* (phase 5) with GAM rates of 30. 7%** while Turkana West, Central and South is ***Critical* (Phase 4) with reported GAM rates of 15.3%, 25.9% and 22.9% respectively.** Turkana South showed improved nutrition situation compared to August 2016 where it was classified as very critical. This improvement was attributed to the existing peace prevailing in the area hence low disruption of livelihood activities. Analysis for Marsabit County has shown high deterioration in **North Horr which is classified as *Extremely Critical* (Phase 5) with GAM rates of 31.5%** and slight deterioration in Laisamis (GAM 24.7%) which indicates *Critical* (Phase 4). The nutrition situation is likely to be Alert (Phase 2) in Moyale and Saku Sub – Counties of Marsabit and **Serious (Phase 3) in Samburu County where nutrition survey was not done this season**. The percentage of children under five at risk of malnutrition based on analysis of mid-upper-arm circumference (MUAC <135 mm) surveillance data from sentinel sites within the cluster was high compared to the LTA except Marsabit County which overall reported 19.9 % compared to the LTA(21.2%).

IMAM admission trends in the cluster from September 2016 to January 2017 indicate as stable situation with **a high admissions recorded in Marsabit and Turkana in the month of September and November** respectively. A sharp decline was recorded from November 2016 through to January 2017; this could be attributed to poor access to health services across the cluster owing to the health workers strike.

Routine Vitamin A and immunization coverage as per DHIS was generally poor across the cluster, with none of the county achieving the national target of 80%. This poor coverage was attributed to poor health seeking behavior and inadequate support for integrated outreaches activities in the hard to reach areas. Other underlying factors that affect malnutrition within the cluster include inadequate maternal and

child care practices, low access to safe drinking water and poor hygiene and sanitation practices.

Fig . Trend of proportion of children at risk of malnutrition (MUAC < 135mm)

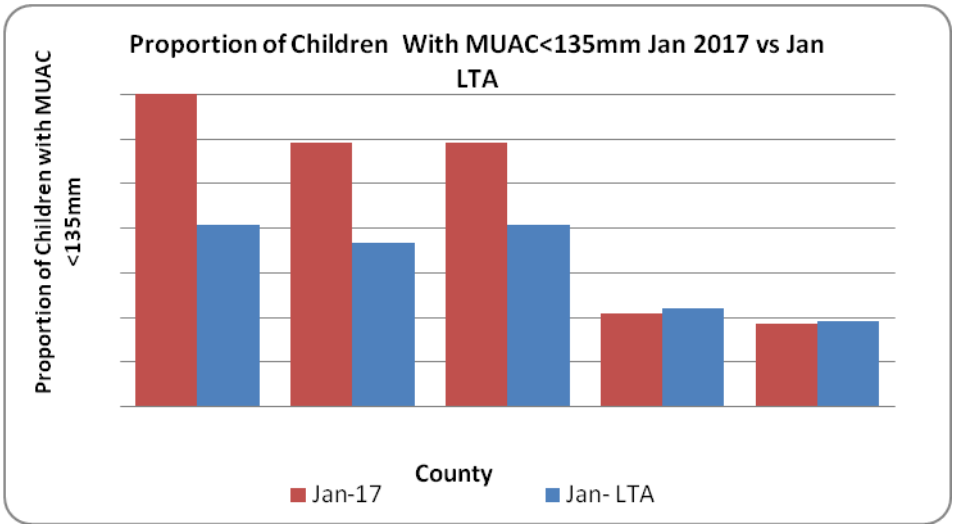


Major drivers of acute malnutrition

The major drivers of high acute malnutrition rates in the cluster are: poor dietary intake and morbidity.

Northeast Pastoral Cluster - Mandera, Wajir, Garissa, Isiolo, Tana River

Analysis of nutrition information from Counties under Pastoral North East cluster shows deteriorating nutrition situation. Mandera County reported very critical nutrition situation with prevalence of GAM by WHZ at 32.8 percent (CI 26.3 - 40.0) and severe acute malnutrition at 8.7 percent (CI 5.3 - 14.1).Isiolo reported a critical situation with GAM BY WHZ of 18.2 percent (14.6- 22.5) an increase from 12.3 percent (9.6- 15.8) reported in Feb. 2016. The situation was serious in Tana River with GAM by WHZ of 13.7 percent (10.1-18.2). Surveillance data from NDMA sentinel sites showed a deteriorating trend. The proportion of children under five with MUAC less than 135 mm ranged from 12.6 to 26.3 percent within the cluster.

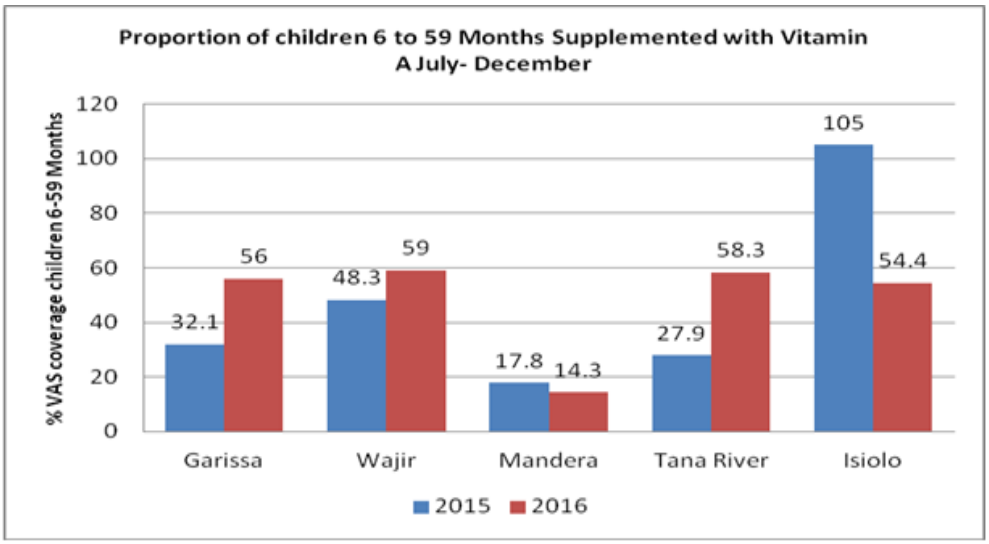


The most common diseases for both the under-fives and the general population across the cluster were diarrhea, upper respiratory infection, diseases of the skin and pneumonia. Others were malaria and dysentery in Mandera. These diseases are common during the dry spell across the cluster as a result of dust and poor water hygiene and sanitation.

The percentage of fully immunized child (FIC) for Wajir, Mandera and Isiolo Counties in the months of July to December 2016, decreased compared to the same period last year while Tana River and Garissa showed improvement. Coverage was below the national target of 80 percent. This was attributed to

high staff turnover and limited outreach services. Disruption of health services due to health workers strike in the months of November and December 2016 may have affected the coverage even further.

Routine Vitamin A supplementation coverage for children under five ranged from 14.3 -59 percent across the cluster. The coverage for Isiolo, Garissa, Tana River and Wajir Counties shows improvement compared to the same period last year although way below national targets of 80 percent.



Major drivers of acute malnutrition

The main contributors of acute malnutrition included; low dietary intake especially in pastoral livelihood zones where pasture was reported to be depleted resulting to reduced milk production and consumption, livestock migration, insecurity in some areas and high food prices as well as diseases emanating from poor hygiene and sanitation. Other factors included; underlying issues like poor access to basic health services, inadequate maternal and child care practices.

Agro-pastoral Cluster -Baringo, Laikipia, Kajiado, Narok, Nyeri (Kieni), West Pokot

According to SMART a survey conducted in **East Pokot in Baringo County, the prevalence of GAM by WHZ was 23.3 percent (CI 19.2 - 28.1 percent) showing critical nutrition** situation (phase 4) in the area. Kajiado County was in Phase 1 (acceptable) based on GAM by MUAC. Other counties in the cluster did not have sufficient data for current classification. However, based on analysis of previous trends of acute malnutrition and contributory factors **it is projected that West Pokot County will be in Phase 4 (critical) in the next three months (February to April). Poor nutrition situation in Baringo and West Pokot counties is attributed to poor food consumption at household with most households in Baringo consuming an average of one to two meals in a day comprising of mainly tea, ugali, wild vegetables and porridge in the Pastoral**. In West Pokot County, most mothers in the Mixed and agro-pastoral zones spend most of their time in the farms, leaving children under the care of other children hence poor infant and young child feeding practices.

Further analysis based on MUAC from sentinel sites showed that the proportion of children with MUAC less than 135 mm in the cluster was below the long term average except for West Pokot and Baringo Counties. The MUAC trends from August 2016 to January 2017 showed stable and low proportions of children less than 135 mm for Nyeri and Laikipia Counties, while Kajiado and Narok showed a stable but high proportion of children with MUAC less than 135 mm. West Pokot and Baringo Counties showed an deteriorating trend.

All the counties in the cluster reported reduced cases of morbidity compared with the same period last year. These statistics however should be interpreted with caution as health services were interrupted due to the health workers strike in the months of November and December. There were no reported cases of outbreak within the period under review.

Immunization coverage across the cluster was comparable with the previous season in 2015 except in Narok County which had an improvement from 31 percent in 2015 to 55 percent in 2016. **The coverage for**

Fully Immunized children was below the national target of 80 percent for all except for Kieni. This could be attributed to health workers' strike, poor documentation coupled with changes made in the school calendar as schools closed early noting that early child development centers (ECDs) are normally used as avenues for boosting vitamin A supplementation coverage during malezi bora week. In West Pokot County, the immunization coverage was highest in mixed farming zone >80 percent and lowest in pastoral zones at 30 percent. Vitamin A coverage across the cluster was below the national threshold of 80 percent. However, improvement was noted in West pokot, Kajiado, Narok and Baringo counties while Nyeri and Laikipia recorded a decrease in coverage. This cluster has reported an upsurge in Conflict especially Laikipia, Baringo and West Pokot as a factor of increased migration of livestock and encroachment into private ranches as seen in Laikipia County. Human wildlife conflict has also escalated in Laikipia as factor of the drought.

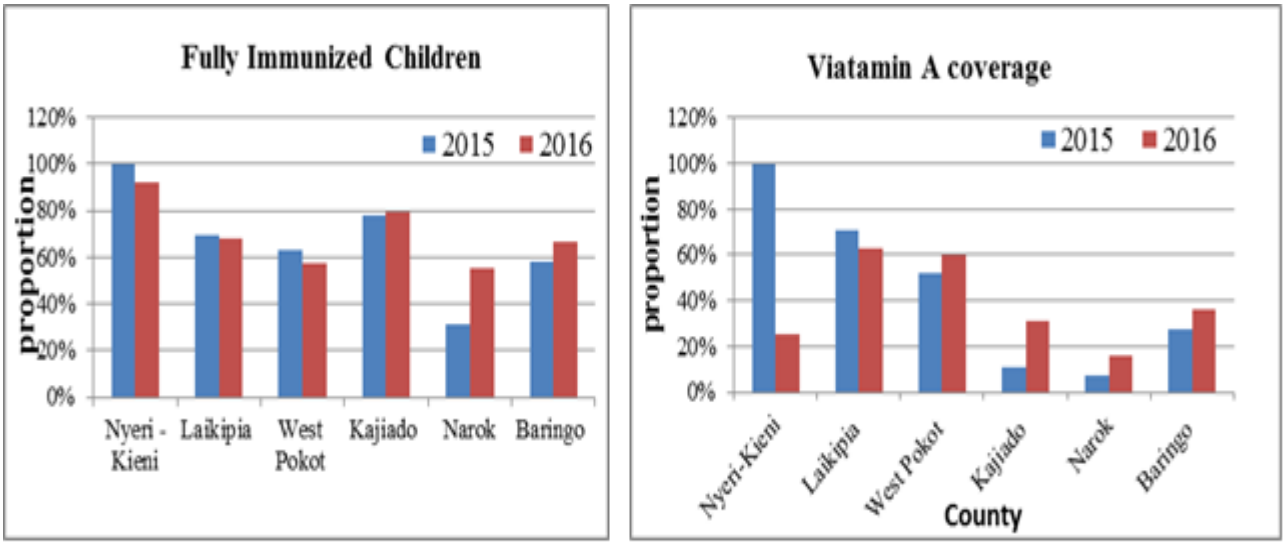


Figure 1: Proportion of children Fully Immunized and Vitamin A coverage Agropastoral Cluster

The latrine coverage across the cluster was low ranging from 10 - 88 percent with variations across the livelihood zones. In Baringo the coverage was 10 and 55 percent in pastoral and agro-pastoral livelihood respectively. However, East Pokot SMART reported that only 2 percent of the surveyed households were accessing improved sanitation facilities. Laikipia had the highest latrine coverage at 88 percent attributed to the creation of more community units supported by the Anglican Church of Kenya. Water treatment and hand washing practices at four critical times are poor in the cluster.

South Eastern Marginal Agriculture Cluster (Meru North, Tharaka, Mbeere, Kitui, Makueni)

The nutrition situation in the south eastern marginal agriculture cluster based on surveillance data, showed a stable nutrition situation. The percentage of children under five with MUAC less than 135mm remained stable. In January 2017, lower rates were reported against LTA in three counties with exception of Tharaka and Kitui which remained stable. According to SMART surveys conducted in Kitui and Tharaka within this season, the Global Acute Malnutrition (GAM) was reported to be 2.6 percent and 5 percent respectively. According to IPC for acute malnutrition, Kitui is classified in Phase 1 (Acceptable; GAM less than 5 percent) while Tharaka is in phase 2 (Alert; GAM 5 to 9.9 percent).

Across the counties in this cluster, the diseases most prevalent among children under five years were Upper Respiratory Tract Infections (URTIs), Diarrhea, Intestinal worms, pneumonia and skin diseases. The major diseases among general population included; URTI, hypertension arthritis, skin diseases, and Urinary Tract Infection (UTI). Diarrhea cases among children under five years declined in 2016 compared to 2015 with Tharaka reporting the highest decrease of 23 percent. This decline should however be interpreted with caution as health services were disrupted on several occasions by health workers strike.

Coverage for Fully Immunized Children (FIC) under one year old varied from 54 to 83 percent, with Makueni being the only County reporting coverage of above 80 percent as per recommended national target. Tharaka, Kitui and Mbeere had lower coverages compared to the same period last year.

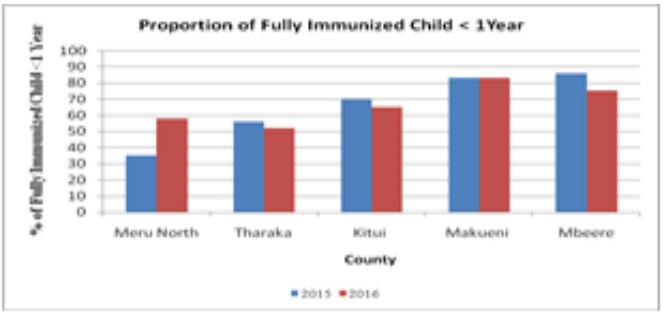


Figure : Proportion of Fully Immunized Child<1 year

Routine Vitamin A supplementation coverage for children six to 59 months remained below national target of 80 percent across the cluster. The decline in coverage was attributed to documentation gaps across the counties. Disruption of health services and change of the schools calendar which are used as avenue to reach more children during “Malezi bora” also contributed to low coverage.

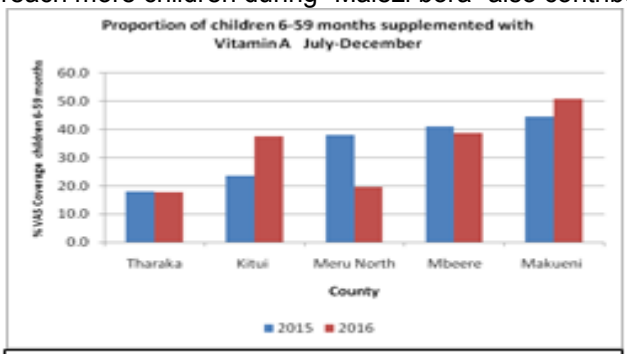


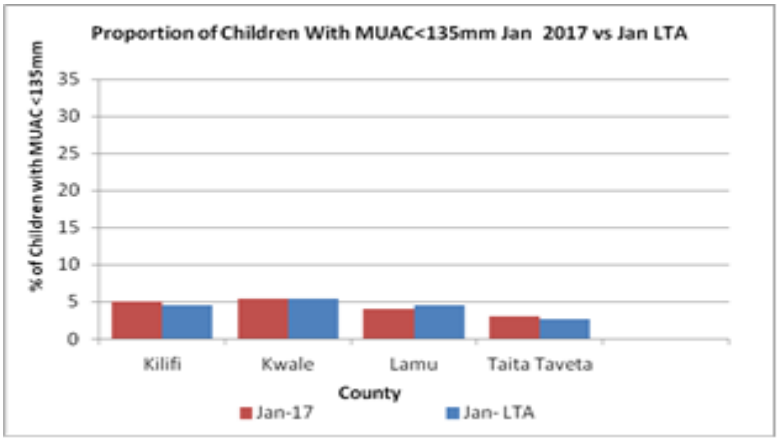
Figure: Vitamin A Supplementation

Current meal frequency is two to three meals per day as compared to the normal of three to four meals per day. This can be attributed to diminishing food stocks and limited sources of income. The meals have low dietary diversity of 3-5 food groups consisting mainly of cereals, pulses, vegetables, daily and fruits.

Across the cluster good hygiene practices such hand washing at the critical times remains a challenge as not more than 20 percent are practicing it. Latrine coverage ranges between 80 to 90 percent while water treatment remains poor at 60 percent. This puts the population at risk of getting water borne diseases especially due to the ongoing water stress in the cluster

Coastal Marginal Agriculture (Taita Taveta, Kwale, Kilifi and Lamu)

Analysis of the nutrition situation show stable trend of the proportion of children with MUAC less than 135mm across the cluster. The January 2017 prevalence when compared to the long term average in the cluster is stable, with Taita Taveta County recording the lowest. A SMART survey conducted in Kilifi County in November 2016 reported a GAM by WHZ of 4.6 percent and thus the county is classified in phase 1 (acceptable). Kwale was classified Phase 1 (Acceptable) based on GAM by MUAC. In Lamu, survey conducted in February 2017 reported a GAM of 4.8 percent hence classified in phase 1. The most affected areas were in island of Faza (Kiangwe & Kizingitini) and Pandanguo in Lamu West.

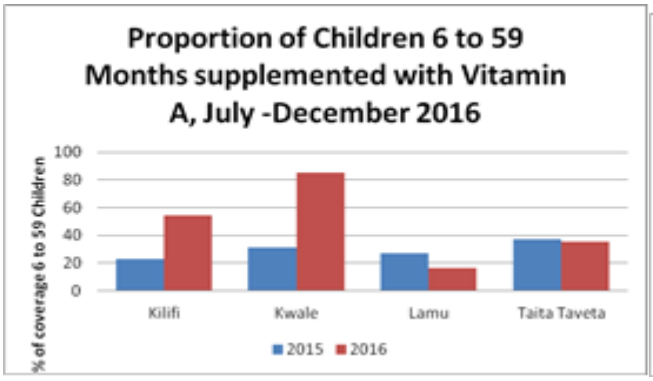


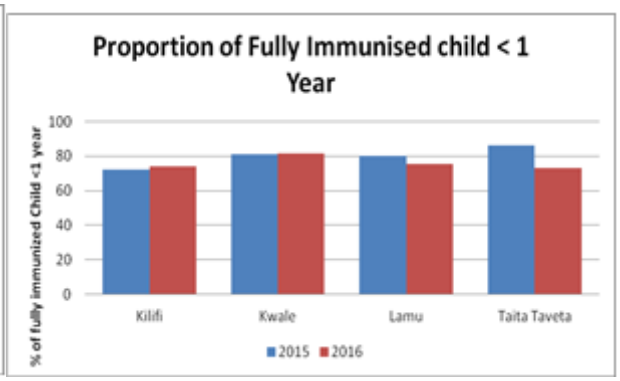
The food consumption score (FCS) revealed 67 and 6 percent of the households were within acceptable and poor consumption score respectively. This was an improvement compared to both May 2015, and 2014 and could be attributed to stable markets and adequate food stocks at households in the cluster. Meal frequency is two to three meals per day as compared to the normal of three to four meals per day with exception of marginal mixed livelihood zones of Kilifi where the meal frequency is one to two meals per day.

This can be attributed to crop failure and limited sources of income.

The five most common diseases reported across the cluster for children below five years were: Upper respiratory tract infections (URTI), diarrhoea, skin infection, pneumonia, and malaria. However, Lamu County reported 22 percent increase in diarrheal diseases among the children below five years in 2016 compared to similar period in 2015. This could be attributed to water shortage resulting to poor hygiene practices.
The general population had similar top five diseases reported in children under five years. Except Kwale which reported rheumatism and hypertension among the top five diseases in the general population. Overall, there was an increase in URTI, malaria and diarrhoea respectively in the cluster. However, there were no recorded cases of cholera in the cluster as seen in the neighboring North East Pastoral cluster (Tana River County).

Hand washing at critical times at households across the cluster ranges from 60 to 80 percent. Water treatment at household level ranged from 50 to 60 percent. Access to safe drinking water was good in areas which are not dependent on water from earth surface, with exception of Kishenyi in Taita Sub-County where the community has been advised not to use water from Kishenyi dam due to suspected poisoning after fish started dying. The samples have been taken for analysis, and water trucking is meanwhile being carried out in the area. Latrine coverage in the cluster averages 53 percent.
The proportion of fully immunized children vaccinated during the period between June and Dec 2016 compared with same period in 2015 remained relatively stable. Vitamin A coverage as per District Health Information Services (DHIS) is below the national target of 80 percent across the cluster, with exception of Kwale County. Low vitamin A coverage in the counties is attributed to poor health seeking behaviour and inadequate support for integrated outreach activities in the hard to reach areas.





Latrine coverage across the county is at an average of 53 percent. However in Kilifi open defecation ranges from 50 to less than 10 percent. Household water treatment practices were generally low across the cluster with approximately 5 to 10 percent of households boiling water before drinking.

4.0 RESPONSE PLAN

The Ministry of Health through Human, Nutrition and Dietetics Unit (HNDU) in collaboration with partners in the nutrition sector, anchors the preparedness and response plan on strategic objective 4 of the National Nutrition Action Plan which deals with emergency preparedness and response. The Strategic objective guides the nutrition sector in undertaking risk informed strategies in programming and lists out activities as well as monitoring framework for emergency preparedness and response. The Sector response plan (SRP) is developed twice annually as well for specific events such as the elections to guide response actions at National and County level. The sole purpose of the SRP is ensuring that that nutrition vulnerabilities identified are responded in a timely, coordinated and comprehensive manner that minimizes their impacts specifically morbidity and mortality for children under five years (boys and girls) and pregnant and lactating women. The plan takes into consideration the urban poor and the projection for the Long rains of 2017 to guide implementation for the next 6 months.

REVIEW OF RESPONSE ACTIONS (FEB TO AUGUST 2016)

The second SRP of 2016 was produced following the long rains assessment of August 2016. The Nutrition outlook was not good for four counties where Global acute malnutrition levels were at crisis levels. **Above emergency thresholds (global acute malnutrition above 20 %) in Turkana, Mandera, East Pokot (Baringo county) and Laisamis (Marsabit county**) and **deterioration in Turkana, East Pokot, West Pokot, Tana River, Garissa, parts of Kilifi and Kwale Counties**- mainly attributed to household level food insecurity. Contrary to the poor nutrition situation, food security was considered relatively stable with 1.3 Million Kenyans being categorized as being in need of assistance. Projections issued by FEWSNET over the similar period and the Kenya Meteorological department forecast for the short rains 2016 indicated a relatively poor and underperforming season due to delayed and poor rains. It is with this premise that the Sector immediately initiated its response from August 2016 in the most affected counties. Response actions were initiated and **formed the basis by which the sector benefited from Kshs 22M (USD 220,000) from the National drought management authority through its drought contingency fund**. The sector was also able to realize funding through Government to the tune of Kshs 5 Million for procurement of supplementary feeding programme commodities which was a major gap noted in the costed response plan. Suffice to note is that the sector was also supported by the Ministry of Devolution through State department of Special programmes to procure an additional 376 Mt of Corn soya blend that was used for the MAM programme targeting the pregnant and lactating women.

The Nutrition sector response plan was instrumental in directing and coordinating actions amongst all the actors at National and County level and was especially crucial in enabling advocacy, resource mobilization and most importantly coordination of all response efforts. A total of 15 surveys were funded by UNICEF in the period as a response measure to update on the situation and inform the IPC Nutrition for the ASAL counties. From August 2016, the sector has reached over 120,000 children –boys and girls with acute malnutrition and done so by enhancing access through integrated outreaches. The sector has relied on the response efficiency and capacity of the Kenya Red Cross to scale up actions in a timely manner in concert with the other implementing agencies which has been especially critical in mitigating and reducing mortality risk in the high burden malnutrition counties. Close collaboration between Government both at National and County level has been instrumental

PRIORITY IMMEDIATE RESPONSE ACTIONS FOR THE SECTOR

The immediate response actions for the sector are highlighted based on the findings of the Short rains assessments as well as the October – December 2016 short food security ooutlook issued by the Famine Early Warning Systems Network (FEWSNET). Counties will be supported to plan for, prepare and respond to both scenarios through the below identified actions.

	Counties **Priority Response Actions**
National level priorities	• Capacity and resource mapping (HR, technical knowledge/ need for training, supplies, funding) • Resource mobilization for nutrition response gaps, and advocacy • Technical support to counties for response activation and monitoring of response (review and consolidation of county response plans) • Procurement of supplies for management of acute malnutrition and delivery to counties through KEMSA • Surveillance and weekly reporting through MOH EOC • Representation at National level coordination inter-governmental drought coordination fora • National cross sectoral policy dialogue
RESPONSE ACTIONS	

Very Critical Nutrition situation (phase 5; Global Acute Malnutrition ≥30 percent) Aggravating factors – Food insecurity, livestock migration, High burden of diseases	Turkana- ***Turkana North***, Mandera, Marsabit – ***North Horr***	**Immediate : March – May 2017** • Finalize mapping for integrated outreach services to increase geographical coverage and develop outreach sustainability plan • Resource mapping for cost efficiencies, including clear allocations and sites for Drought contingency funds, Emergency KRCS support and partner additional resource mobilization • Maintain active case finding of acutely malnourished cases for early and accurate identification and referral of cases in areas near facilities • Support and strengthen systems for community mobilization to support outreach as well as for the identification and referral of acute malnutrition. • Scale up provision of **integrated health and nutrition services** during outreach. • Blanket supplementary feeding for all under-fives, Pregnant and lactating women • Ensure inclusion of vitamin A supplementation , vaccination and deworming in health outreach services for children 6–59 months old, and (12–59 months old) respectively • Advise county emergency teams on food options for procurement as relief food. Ensure at minimum that cereals (milled) ; pulses, fortified commodities including iodized salt, vegetable oil are included • Ensure provision of multiple micronutrient preparations for children 6–59 and Iron, folic acid supplements to all pregnant women as per the National policy • Protect, support and promote early initiation and exclusive breastfeeding of infants, with counselling for pregnant and lactating women; support safe and adequate feeding for non-breastfed infants less than 6 months old, while minimizing the risks of artificial feeding; ensure appropriate counselling regarding infantffeeding options and follow-up and support for HIV-positive mothers; • Hold coordination forums at county and sub county level to review response actions and expand programming – to include attending NDMA led County steering group forums -CNO • Map out and train any new health workers on IMAM and other essential nutrition services • Produce and submit Weekly situational updates to Emergency nutrition advisory committee • Supply chain redistribution across facilities based on requirements • Support supervision to assess service delivery across the various facilities and monitoring of situation • Scale up community dialogues for effective engagement of communities in response actions • IMAM surge roll out to focus on critical areas and after initial emergency is stabilized • Continued lobbying with County government for resources **June – August 2017** • Participation in County steering groups meetings • Undertake Comprehensive Capacity assessment for County nutrition sector • Hold regular CNTFs and review early warning bulletins, review programme data and where necessary, initiate enhanced active case finding e.g. Mass screening using both WFH and MUAC, review contingency plans • Participate in Long rains assessment • Participate in dialogue with other resilience actors for inclusion of nutrition outcomes in programmes that will be rolled out during recovery phase of drought • Sustain community dialogue especially in the most affected areas based on NDMA and programme data

		• Sustain community surveillance through existing community units • Capacity strengthening for sub county teams on coordination
Critical Situation and Serious IPC Phase 4 and 3 .	Tana river Baringo West pokot Samburu Isiolo	• Mount KIRA in the conflict affected areas / IDP sites in Baringo county and neighbouring counties – Elgeyo Marakwet, West Pokot • Blanket supplementary feeding for Baringo and Isiolo where GAM is > 20% • Mapping of all areas that require additional scale up and resources for response • Increase active case finding of acutely malnourished cases for early and accurate identification and referral of cases. • Scale up integrated health and nutrition outreaches in the most affected areas of the Counties for a minimum period of 3 months • Ensure household with acutely malnourished and at risk children at are linked and referred to supportive safety nets programs • Map out and train any new health workers on IMAM and other essential nutrition services • Support supervision to assess service delivery across the various facilities and monitoring of situation • Monthly situation updates prepared and shared with the County and National emergency response teams • Promote maternal, infant and young child nutrition services, including routine provision of micronutrient supplementation to children 6-59months, pregnant and lactating women • Weekly reporting of the programme activities to support monitoring (Monthly through DHIS) • Supply chain redistribution across facilities based on requirements • Bi monthly response coordination • Scale up community dialogues for effective engagement of communities in response actions • Capacity strengthening for sub county teams on coordination
Acceptable – with aggravating factors and pockets of Malnutrition	Kwale, Kilifi, Narok, Makueni, Laikipia, Mbeere, Meru North Tharaka Nithi, Kajiado	• Map out hot spots and determine capacity to mount response. Counties can seek support from National level (see communication tree) • Map out urgent training needs to support response in the hot spot areas • Initiate response actions in the hot spots including mass screening and referral for cases of acute malnutrition • Protect, support and promote early initiation and exclusive breastfeeding of infants, with counselling for pregnant and lactating women; support safe and adequate feeding for non-breastfed infants less than 6 months old,7 while minimizing the risks of artificial feeding; ensure appropriate counselling regarding infant • feeding options and follow-up and support for HIV-positive mothers; • Hold regular coordination forums, and review early warning bulletins by NDMA, programme data • Attend NDMA CSG and other forums to understand and map out

		linkages for households with children below 5, map out opportunities for enhancing capacity of the community health system e.g. training of CHVs • Monthly review and update of contingency plans, including taking stock of the implementation • Continue monitoring of the nutrition situation both at the county and national level. • Develop and finalize costed nutrition sector annual work plans • Update and revise the nutrition sector contingency preparedness and response plans in the county NDMA contingency plans. • Lobbying for multi-sectorial response to address the household nutrition vulnerabilities through existing coordination mechanisms with other sectors
		•

MONITORING TARGETS AND RESULTS

Sector Objective: ***To prevent deterioration of nutritional status and save the lives of the most vulnerable in emergencies***

Outputs	Indicators	Targets	Frequency of reporting
Output 1: ***Timely identification, referral and management of children [boys and girls] women with acute malnutrition***	Proportion of health facilities offering the essential nutrition services package	85%	Monthly
	Proportion of planned outreaches conducted	Above 75% of the planned	Weekly and Monthly
	Proportion of discharged children who have died (death rate)	Below 3% for MAM Below 10% for SAM	Monthly
	Proportion of discharged children recovered (cure rate)	Above 75%	Monthly
	Proportion of discharged children defaulted (defaulter rate)	<15% for MAM and SAM	
Output 2: Increased coverage of facilities offering the essential HINI package and other health components including vaccination			
	Number of countiesreporting on a timely basis	80%	Weekly and Monthly
	Number of countiesexperiencing no stock outsof essential nutrition Commodities	80%	Monthly
Output 3: Improved Maternal, infant and young child feeding programmes	Proportion of children [boys and girls] 6-59 months receiving Vitamin A within 6 months	80%	Monthly
	Proportion of pregnant women receiving IFAS	80%	Monthly
Output 4: ***Increased nutrition surveillance and monitoring***	Proportion of ASAL counties providing weekly and monthly situation reports including program admissions	Above 90% Updated weekly/monthly reports	Weekly and Monthly
	Proportion of planned surveys that are implemented	Above 90%	Weekly and Monthly
	Participation of nutrition sector in the 2017 LRA	LRA reports reviewed Filled nutrition templates Food and Nutrition Security report – LRA 2017	Once in the period under review

Output5:*Enhanced Coordination, advocacy, partnerships and resource mobilization for response*	% realization of funding for the response against the National response plan	80%	Weekly and Monthly
	Proportion of planned emergency response and information management coordination meetings held/attended with ENAC, NITWG, KFSSG, NTF	Above 95%	Monthly
	Proportion of counties with up to date response plans	>95%	Weekly and Monthly
	Policy round table between Nutrition and other sectors for collaborative programming for resilience building of the ASAL	2	Bi annual
	Monthly Nutrition Sector Briefs developed and disseminated	Nutrition Sector Brief	Monthly
Output 6: Preventing acute malnutrition among children, pregnant and lactating women in counties with critical or very critical GAM levels through Blanket Supplementary Feeding	Coverage - Attendance vs planned per cycle	90%	Monthly
	Proportion and number screened for acute malnutrition	90%	Monthly
	Proportion and number screened and referred for acute malnutrition services	N/A[2]	Monthly
	Proportion and number referred for signs of illness	N/A	Monthly
	Proportion and number receiving systematic treatment (vitamin A and/or immunization and/or deworming)	N/A	Monthly
	Commodity distribution details (stock movement)	90%	Monthly
Output 7: Enhanced capacity on emergency response and accountability to affected populations	Proportion of field support visit conducted (technical support visits)	>80%	Weekly and Monthly
	Proportion of counties where targeted trainings for IMAM, Coordination etc. are undertaken	80%	Quarterly
	Proportion of counties with existing and functional community feedback mechanisms	90%	Monthly

[22]Cannot be estimated prior to intervention or other factors contribute to this indicator

	Proportion of submitted reports reviewed and feedback given on areas of improvement (through mails/calls)	100%	Based on need
	High level sensitization on nutrition IPC	One meeting held	Once

COMMUNICATION TREE

For ease of communication and coordination, the planed communication tree will take the following dynamic.

- **County level**: weekly response update prepared by response team that will be comprised of CNO, NSO, KRCS RNO and UNICEF, WFP Zonal office focal programme officer. THE CORE Team will coordinate with other implementing partners on ground for the response coordination and implementation
- **County level weekly response update** will be shared by CNO or any of the other members in the response team at county level should CNO not be in a position to send the communication – the update will be weekly in the first 2 months and will move to twice weekly then monthly as the situation dictates
- **National level:** The core response coordination team that will interact with the Core county team will be comprised of the: Head of unit (Gladys mugambi) programme manager emergency(Grace Gichohi) M and E (Lucy Kinyua, Samuel Murage and Lucy Maina – Gathigi) and Sector coordinator (Victoria Mwenda)
    - Gladys Mugambi: Head Nutrition MOH headnutrition.moh@gmail.com
    - Grace Gichohi: Programme officer food security: grace gichohi gichohigrace@gmail.com
    - Lucy Kinyua: Research, Monitoring and Evaluation Manager luroy13@gmail.com
    - Victoria Mwenda: Sector Coordinator: vmwenda@unicef.org

1. RESOURCES: NEEDS AND GAPS FUNDING

INTEGRATED MANAGEMENT OF ACUTE MALNUTRITION SUPPLIES IN THE ARID, SEMI ARID AND URBAN AREAS

A. PLANNING ESTIMATES FOR CASELOADS

Estimated Caseload including incidence rate of 1.6	Urban Caseload	ASAL Caseload	Total	Sector target (75% for SAM and 50% for MAM)
SAM in-patient	2,345	7,501	**9,846**	**7,385**
SAM out-patient	23,454	75,010	**98,464**	**73,848**
MAM (<5 years)	45,284	268,549	**313,833**	**156,916.50**
MAM (PLW)	6,229	37,223	**43,452**	**21,726**
Total	**77,312**	**388,283**	**465,595**	**259,875**

B. SUPPLY CHAIN PLANNING ESTIMATES

SUPPLY REQUIREMENTS								
Items	**Unit**	**No of unit per treatment/person**	**Number of units required (100% of sector target)**	**Number of units required plus 15% contingency**	**Number of Boxes /MT required**	**cost per unit (USD)**	**Total cost (USD)**	**Total cost (KES)**
Resomal	sachet 42g	0.4	2,954	3,397	34	18.17	617	64,094
F-75	sachet 102.5g	12	88,618	101,910	849	42.8	36,348	3,758,382
F-100	sachet 114g	4	29,539	33,970	377	41.55	15,683	1,621,607
RUTF	sachet 92g	150	11,077,200	12,738,780	84,925	52	4,416,110	456,625,815
RUSF	Sachets 92g	120	18,829,980.00	21,654,477	1,992.21	3428	6,829,302.34	706,149,862
Corn Soy Blend(CSB)	kg	30	1,116,690	1,284,194	1,284.19	500	642,096.75	66,392,804
Veg Oil	kg	3	111,669.00	128,419	128.419	1090	139,976.71	14,473,592

C. SUPPLY CHAIN GAPS

Items	Total requirement (March - December 2017)	In stock /Pipeline MOH-2017	In stock /Pipeline UNICEF-2017	In stock /Pipeline WFP (Plumpy sup in Cartons, CSB and veg oil in mts)	In stock/ Pipeline NHP Plus - 2017	Total in Stock/pipeline	Gaps (supplies)	Cost (USD)	Cost Kshs
ReSoMal (CTNS)	28	0	300	0	0	300	(272)	(4,937)	(510,448.20)
F-75 (CTNS)	708	0	685	0	0	685	23	972	100,503.56
F-100 (CTNS)	315	0	652	0	0	652	(337)	(14,022)	(1,449,828.82)
RUTF (CTNS)	70,771	6,095.00	46,067	0	7000	59,162.00	11,609	603,668	62,419,271.20
RUSF (CTNS)	1,660	400	0	0	0	400.2	1,260	4,319,199.68	446,605,247.11
Corn Soy Blend (CSB) (MT)	1,070.16	1,250	0	0	0	1250	(180)	(89,919)	(9,297,663.37)
Vegetable Oil (MT)		0	0	0	0	0	-	-	-
TB: 19,792 Kg in 24kg bags ; HIV: 1,125,000 satchets (7500 boxes) RUTF: 553 TARGETING ADULTS LIVING WITH TB and HIV/AIDS									

BLANKET SUPPLEMENTARY FEEDING ESTIMATES

Counties	Under 5s	PLWs	Assitance Period in Months - PLWs	Assitance Period in Months - Under 5s	Feeding Days	*U5s*	*PLWs*	
						CSB++	***CSB++***	***TOTAL***
					Rations in g/p/d	***200***	***200***	***400***
Marsabit, Turkana, Mandera, Isiolo and East Pokot	452,324	100,934	6	6	30	16,283.66	3,633.62	***19,917***
Grand Total	**452,324**	**100,934**				**16,284**	**3,634**	**19,917**

Cost Category	US$/MT	MT	US$
1. Commodity			
Super Cereal Plus (CSB++)	900	19,917	17,925,559
Commodity Costs Total	**19,917**		**17,925,559**
2. Ext. Transport	60	19,917	1,195,037
3.LTSH	190	19,917	3,790,061
4. ODOC	36	19,917	721,603
DOC = Comm + ExTr + LTSH + ODOC	→		23,632,261
5. DSC (% of DOC)	20%		4,773,717
Total Direct Costs (TDC) = DOC + DSC	→		28,405,977
6. ISC = 7% of TDC	7%		1,988,418
Associated CostsTotal			**12,468,836**
Overall Total Costs		**30,394,396**	

D. FINANICAL REQUIREMENTS AND RELATED GAPS (SUMMARY POPULATED FROM D 2)

		2017 Sector response budget		Gap		
Objective	**Activity**	**USD**	**KES**	**USD**	**KES**	**Comments**
To prevent deterioration in nutritional status of populations affected by emergencies	Scale up delivery of essential nutrition services (High Impact Nutrition Interventions) including IMAM Surge	7,289,650	753,749,852	6,995,530	723,337,802	Includes Drought Contingency funds received , KRCS PCA
	Supplies – MAM and SAM	11,298,061	1,168,219,760	4,904,881	507,164,744.85	Includes gaps from WFP pipeline
	Supplies -BSFP	30,434,501	3,146,927,403.40	30,434,501	3,146,927,403.40	
	Surveillance and Monitoring	898,664	92,921,857.60	898,664	92,921,857.60	Includes nutrition surveys
TOTAL		**49,920,876**	**5,161,818,873**	**43,233,576**	**4,470,351,807.8**	

D 2: FINANCIAL MATRIX WITH PARTNER CONTRIBUTION

County	**Response budget in Kshs(based on County Contingency plans and activities that align with the response plan**	**County Government Allocation**	**Response Budget from NDMA**	**Fund received in Kshs(by IP)**	**Start date**	**End date**	**Funding source**	**Funding Gap**
Turkana	Intensify outreaches, mass screening, IMAM training, coordination (104,500,000)		1,125,800	5,000,000 – SCI 6,325,000 KRC 3,000,000 IRC	Feb 2017 March 2017 March 2017	April 2017 May 2017	SCI UNICEF IRC	89,049,200
Mandera	Integrated outreaches, mass screening, MN supplementation and deworming		416,000	3,469,800SCI 5,565,000 KRC	Feb 2017 March 2017	May 2017	SCI UNICEF	82,549,200

	(92,000,000)							
Wajir	Scale up outreaches, mass screening, coordination (66,700,000)		1,816,200	1,208,000 KRC	March 2017	May 2017	UNICEF	63,675,800
Baringo	MN supplementation, IMAM, Deworming (55,760,000)		1,226,200	800,000 KRC	March 2017	May 2017	UNICEF	53,733,800
Samburu	Scale up outreach services and mass screening. (54,630,000)	600,000			January 2017			54,030,000
Isiolo	Outreaches, mass screening, MN supplementation, IMAM **(43,827,000)**		615,750	1,200,000 KRC	March 2017		UNICEF	42,011,250
West Pokot	Community mobilization, outreaches, mass screening, supervision 45,740,000)	1,000,000	2,696,000	800,000 KRC	March 2017		UNICEF	40,244,000
Kilifi	Outreaches, mass screening, surveys, MN supplementation (40,500,000)		2,963,900					37,536,100
Kitui	Mass screening, outreaches, IMAM training – no budget (27,000,000)							27,000,000
Kwale	MN supplementation, outreaches, mass screening, IMAM, supplementation (30,200,000)		1,835,200.00					28,364,800
Marsabit	Scaling up outreaches and mass screening. (103,000,000)		4,420,600	2,000,000 Concern 3,000,000 FHK 2,350,000 KRC	Jan 2017 Jan 2017 March 2017	April 2017 April 2017 May 2017	CWW HQ FHK HQ UNICEF	91,229,400

Narok	MN supplementation, IMAM (12,100,000)							12,100,000
Machakos	Not assessed							
Tharaka Nithi	Outreaches, mass screening and IMAM implementation (13,200,000)		1,440,000					11,760,000
Taita Taveta	Conduct survey, coordination, surveillance, outreaches (14,300,000)		664,000					13,636,000
Embu	Outreaches and mass screening (6,000,802)							6,000,802
Meru	Vitamin A supplementation, mass screening & outreaches (10,000,000)							10,000,000
Tana River	Scale up outreaches, mass screening, MN supplementation (50,000,000)		786,800	654,000 KRC	March 2017		UNICEF	48,559,200
Garissa	Survey, outreaches, mass screening, support supervision (57,265,000)		4,084,800.00	850,000 KRC	March 2017		UNICEF	52,330,200
Makueni	Outreaches, mass screening, MN supplementation and IMAM implementation (13,000,000)							13,000,0000
Lamu	Outreaches and mass screening, MN supplementation (21,500,000)		-	500,000 KRC	March 2017		UNICEF	21,000,000
Nairobi	Outreach, screening and referral (15,337 000)							15,337,000

Laikipia	Smart survey, outreaches, mass screening, support supervision, IMAM training (31,500,000)		-					31,500,000
Kajiado	IMAM training, outreaches, mass screening & MN supplementation (5,600,000)		-					5,600,000
Narok	MN supplementation, IMAM, (11,700,000)		-					11,700,000
	753,749,852							**723,337,802**

Annexes

Annex 1: Summary of Nutrition Survey Results for January 2017

Analysis Area (County or Sub County)	GAM[3]		SAM[4]		MUAC[5]< 12.5cm	
	Feb. 2016	Feb. 2017	Feb. 2016	Feb. 2017	Feb 2016	Feb 2017
Mandera		32.8 %(26.3-40.0)		8.7% (5.3-14.1)		11.3 % (7.4 - 16.9)
Turkana Central		25.9% (21.7- 30.6)		6.4% (4.4-9.2)		7.1% (4.6-10.8)
Turkana North		30.7% (26.6-35.1)		8.1% (6.0-10.7)		10.3% (7.2-14.6)
Turkana South		22.9% (18.4-28.0)		5.7 % (3.7-8.7)		8.8% (5.9-13.1)
Turkana West		15.3% (11.5-20.2		3.1% (1.6-5.9)		5.5% (3.4-8.7)
Baringo (East Pokot)		23.3%(19.2- 28.1)		4.0%(2.4- 6.5)		
Isiolo	12.3% (9.6-15.8)	18.2(14.6- 22.5)	1.2% (0.4-3.4)	3.3% (2.1- 5.3)	3.8% 2.8- 6.4)	7.7% (5.6- 10.6)
Tana River		13.7% (10.1- 18.2)		3.0% (1.3 – 6.4)		4.0%(2.3- 7.1)
Marsabit (Loiyangalani/ Laisamis		24.7%(19.3- 31.0)		5.5%(3.5- 8.5)		7.1% (3.8- 12.9)
Marsabit North Horr		31.5% (25.3- 38.5)		9.8%(6.6- 14.3)		10.1% (6.7- 14.9)
Kilifi		4.6% (3.3- 6.6)		0.4%(0.1- 1.3)		2.8% (1.5- 4.9)

[3] Global acute malnutrition <-2 SD or oedema

[4] Severe Acute malnutrition <- 3 SD or oedema

[5] Mid Upper arm circumference

Kitui		2.6%(1.5- 4.5)		0.2%(0.0- 1.8)		2.6%(1.5- 4.6)
Tharaka Nithi		5.0%(2.6- 9.5)		0.7%(0.2- 3.0)		2.1%(0.9- 5.0)
Lamu		4.8% (3.1 – 7.3)		0.9% (0.3 – 2.4)		2.8% (1.6 – 4.8)