Overall Nutrition Situation in Kenya

Figure 1: Nutrition Situation February 2014
Figure 2: Nutrition Situation August to October

Nutrition situation analysis conducted in March 2014, as part of the 2013 short rains seasonal assessments, based on non-representative data indicated a likelihood of a deterioration in the overall nutrition situation especially in Turkana, Marsabit and Mandera; and warned of further, rapid deterioration in the event the performance of the long rains season of 2014 was below average. In June/July 2014, a series of nutrition surveys were conducted across the most vulnerable arid and semi-arid counties to monitor the nutrition situation.
The results of the surveys indicate that the overall nutrition situation in Turkana, Baringo (East Pokot), Mandera, Wajir West and Marsabit (Chalbi and North Horr Loyangalani) has deteriorated significantly from last year to Very Critical levels (>20% GAM); and to Critical levels (<20%). These results indicate on average 1 out of 4 children is acutely malnourished. Review of nutrition survey methodology, data and results is conducted at national level by the Nutrition Information Technical Working Group (NITWG), the group conducts a technical objective review of all datasets quality; all surveys published here have passed those quality checks.

The deterioration is likely due to the negative impacts of the current 2014 long rains season, the underperforming 2013 short rains, coupled with extremely high levels of chronic vulnerability. The long rains seasonal assessment led by the KFSSG, estimate the total population requiring immediate humanitarian assistance at 1,500,000 million, an increase compared to the 1,200,000 reported after the short rains seasonal assessment. The current total caseloads of children requiring treatment in the ASAL and urban areas for acute malnutrition has increased from 292,356 to 352,508. This calls for immediate and urgent scaling up of nutrition service delivery and drought response structures led at the County Steering Group (CSG) and the Kenya Food Security Steering Group KFSSG.

The total number of children in the ASAL areas admitted to programmes managing severe acute malnutrition (OTP) increased from 2,462 in June 2014 to 3,136 in July 204. The number also increased for the children in the MAM programme from 4,995 (Jun’14) to 8,902 (Jul’14). The highest increase in numbers was noted in Turkana, Marsabit, and Mandera. The number of women in the SFP programme also increased from 2,479 (Jun’14) to 4,346 (Jul’14), the highest numbers and increase was noted in Turkana, Marsabit, Wajir, Samburu and Baringo. This is due to increased active case finding and surveillance., amidst the declining nutrition situation. Currently there are sufficient resources and capacity to scale-up the nutrition response in the most affected counties through the established county and national coordination mechanisms for the coming 2-3 months with support from partners, however should the situation continue to deteriorate there will be need for increased resources. Activation of contingency and

**Nutrition situation by livelihood zone clusters**

**Northwest Pastoral Livelihood Zone**

The nutrition situation in the Northwest Pastoral Livelihood Zone has deteriorated, in February 2014, the nutrition situational analysis indicated a deteriorating nutrition situation, and warned of further deterioration if the long rains season performed below average. In June 2014, comprehensive nutrition surveys were conducted in Turkana, Marsabit and Samburu. The result of the surveys confirmed a worsening nutrition situation, with Turkana North, East/South and Central, Marsabit (North Horr/ Loyangalani) reporting GAM rates above emergency thresholds, ranging between 20.5-29.2%. Significant deterioration of GAM rates has been observed in Turkana and Samburu counties. In Turkana West, and Samburu the nutrition situation declined from Serious to Critical levels of 17.3%-18.2%). The worst deterioration was noted in Turkana West with GAM rates deteriorating from 9.7 percent (poor levels) in July, 2013 to 17.4 percent (Critical levels) to 2014 same period.

NDMA sentinel site data indicated that the proportion of under-five children at risk of malnutrition by mid upper arm circumference (MUAC< 135mm) in Turkana County increased from 23 percent in June, 2013 to 26 percent in 2014 same period above the long term average. MUAC (<135mm) rates are 14.7 percent and 25.5 percent for Moyale (Sololo) and Marsabit (Saku, Laisamis and North Horr), which was below LTA of 22.3 percent. In Samburu the current MUAC rates (<135mm) are stable at 20 percent for Samburu County with exception of pocket areas in Kawop, South Horr and Tuum which had 42.1 percent, 36.9 percent and 36.3 percent respectively. The percentage of households with poor and borderline Food Consumption Score increased from 29 percent and 24 percent in May, 2013 to 42 percent and 34 percent respectively in May 2014 across the livelihood cluster. (WFP FSOM Report, May 2014)

Meal frequency is currently at one to two meals in a day across the livelihood cluster. Milk availability ranges between 1/4 to 1 liter.
The current food security phase classification for the cluster is mainly “Stressed (IPC Phase 2)” except for pockets in Marsabit (North Horr and Loyangalani), Turkana (Kakuma, Turkwel and Kerio) and Samburu (Nyiro, Baragoi and Wamba) which are in the “Crisis” (IPC Phase 3). The situation is likely to deteriorate between August and October 2014, ahead of the start of the short rains seasons. Counties in this cluster have activated their contingency plans, and increased nutrition monitoring and surveillance, coupled with increased active case finding.

**Northeast Pastoral Livelihood Zone**

The nutrition situation in the northeast pastoral livelihood zone that consists of Mandera, Wajir, Garissa, Tana River and Isiolo counties has generally shown a deterioration in the nutrition survey, apart from Tana River and Wajir North. Results from SMART surveys conducted in Wajir reported increased prevalence of global acute malnutrition (GAM) at 20.7% (17.6-24.3) and 16.8% (13.9-20.2) in Wajir West and Wajir East/South respectively. There was also an increase in GAM in Mandera County at 22.3% (17.8-27.6), 23.6% (19.0-29.0) and 27.3(32.1-32.0) in Mandera Central, Mandera East and Mandera North respectively. The results indicate a **Very Critical** situation in Wajir West and Mandera and a **Critical** situation in Wajir East/South according to WHO classification. The main factors affecting the nutritional situation of the population include reduced household food security and morbidity, coupled with the chronic underlying factors affecting the nutritional status of the children such as poor infant and young child feeding and care practices, lack of appropriate access to water and sanitation facilities and health services. There was also a slight increase in prevalence of GAM in Garissa county at 14.6% (11.8-17.8) in 2014 compared to 12.0% (9.3-15.5) in 2013. However the nutrition situation in Tana River improved with GAM at 7.5% (5.3-10.4) in May 2014 compared to 13.8% (10.4-18.0) reported in February 2013. In Isiolo County, the nutrition survey conducted in February 2014 reported a **Serious** nutrition situation. Analysis of the NDMA sentinel site data for Isiolo county indicated the proportion of children with MUAC at risk (<135mm) is currently at 18% as of July 2014, this is below the Long Term Average (LTA) of 23.2 percent. However, the trend has increased from April 2014, showing a likely deterioration in the nutrition situation.

The food consumption score (FCS) across the cluster livelihood was 43, 6 and 51 percent for poor, borderline and acceptable level respectively as of May 2014. The households under poor FCS classification increased from 24 percent to 43 percent in 2013 and 2014 respectively. Milk availability in the cluster has also significantly reduced, abnormal migrations have also been noted in parts of Mandera and Wajir. The nutrition situation in the county is likely to deteriorate between August and October 2014, especially in Mandera, parts of Wajir, Garissa and Isiolo. In Mandera county, there is a further risk of deterioration because of the current insecurity in the county, that may interrupt delivery of services. The current food insecurity phase classification for the cluster is “Stressed” (IPC Phase 2). However, few pockets in Wajir (Griftu, Hadado) and Mandera (Harari) are in **Crisis** (IPC Phase 3). According to the projected analysis, there is a likelihood of the food security situation deteriorating further ahead of the short rains season scheduled to start in October 2014. More areas in parts of Mandera, Garissa, Wajir and Isiolo will deteriorate to IPC Phase 3, **Crisis**.

**Agropastoral Livelihood Zone**

The nutrition situation is stable across the agro-pastoral cluster except for East Pokot where the situation has deteriorated rapidly from Serious to **Very Critical** with a GAM rate of 21.1% (21.1% (17.2-25.7), which may be attributed to the declining food security situation, escalating prices of basic food commodities and insecurity. In Baringo County, households are currently consuming one to two meals in the pastoral and agro pastoral livelihood zone and two to three in mixed and marginal mixed farming livelihood zone compared to the normal two to three meals per day. In Narok and Kajiado counties, meal frequency is stable at three meals per day across the livelihood zones. Meal frequency in Nyeri is currently at two to three meals compared to normal of three to four meals per day. The nutrition situation in West Pokot re-
mained stable with GAM and SAM prevalence at 11.8% (8.8-15.7) and 1.7% (0.8-3.4) respectively in June 2014.

The percentage of children at risk of malnutrition as measured by Mid Upper Arm Circumference (MUAC <135mm) is stable across the cluster except in some areas such as Pserem, Ptokou, Sasak, Poole in West Pokot and Naromoru area in Nyeri County where an increasing trend has been noted. An increasing trend was also noted in Kajiado County from the month of March. In West Pokot, meal frequency has reduced from three to four meals per day to two to three meals per day in the Agro Pastoral Livelihood zone and from two to three meals per day to one to two meals per day in the Pastoral Livelihood zone. The percentage of households with poor food consumption increased from 10 percent in May 2013 to 34 percent in May 2013 in West Pokot, Laikipia and Baringo and from 0 to 77 percent in Narok and Kajiado counties. The current food security phase classification for the cluster is None/minimal phase (IPC Phase 1) except for pastoral and agro pastoral Livelihood zones in West Pokot, marginal mixed farming zone in Kieni and pastoral and marginal mixed farming livelihood zones in Laikipia which are in Stressed Phase (IPC Phase 2). Parts of Baringo and West Pokot counties are in Crisis Phase (IPC Phase 3).

South Eastern Marginal Cluster Livelihood Zone

The south eastern marginal cluster comprises of Makueni, Kitu, Mbeere, Tharaka and Meru North. The current food insecurity phase classification for the cluster is “Stressed” except for Makueni and Mbeere which are in the minimal phase. The nutrition situation across the cluster is stable. The proportion of children at risk of malnutrition measured by Mid Upper Arm Circumference (MUAC <135mm) was stable across the cluster with exception of Tharaka Nithi and Meru North where MUAC rates were above the long term average (LTA) as illustrated in the figure below. Surveys conducted in Meru North previously indicate high chronic malnutrition rates, attributed to poor feeding and care practices. The food consumption scores (FCS) across the livelihood cluster was 45 percent, one percent and 54 percent for poor, borderline and acceptable levels.

Coast Marginal Livelihood Zone

The nutrition situation in the cluster is generally stable, with low levels of acute malnutrition. The coast marginal cluster comprises of Kwale, Kilifi, Taita Taveta and Lamu. No representative nutrition survey conducted for the current season in the livelihood zone. Sentinel site data on percentage of children under five years at risk of malnutrition as measured by mid upper arm circumference (MUAC < 135 mm) has been on a downward trend from February to June 2014 and also below the LTA.
Urban Nutrition Situation
A baseline nutrition survey conducted by Concern and the Nairobi county nutrition team, in the informal settlements of Kawangware and Korogocho/Mathare indicate a global acute malnutrition rate of 5.7% (4.2-7.6), and a severe acute malnutrition rate of 1.9% (1.1-3.2). Although the nutrition situation is classified as Poor, the population of children residing in the informal settlements is very high, this translates to a large caseload of children who are acutely malnourished and require treatment. The caseloads for the number of children in Mombasa and Kisumu requiring treatment currently remains unchanged. The total caseloads of children requiring treatment for acute malnutrition in the informal urban settlements is 42,961 children and 4,445 pregnant and lactating women.

Integrated Management of Acute Malnutrition programme Admissions and Performance
As of July 2014, admissions into the IMAM program showed an increasing trend in both the supplementary feeding and therapeutic feeding programs. IMAM program outcomes are within the sphere standards of >75% for recovery, <10% for death rate and < 15% for defaulter rate and >75% for recovery, <3% for death rate and < 15% for defaulter rate for the Severe Acute Malnutrition and Moderate Acute Malnutrition programs respectively. The sharp increase in the admissions noted in the month of July 2014 was also due to the increased active case finding and surveillance due to the survey results that reported a declining nutrition situation in most of the northern pastoral counties of the country.

The trends indicate a declining trend in the nutrition situation, for all programmes, OTP, SFP and for pregnant and lactating women.

The highest increase in noted in Turkana, Marasbit, Baringo and Mandera counties. There is also an increase in the active case finding and surveillance in these counties. However, the food security situation in these counties has also deteriorated significantly, mainly due to the negative impacts of the poor performance of the long rains season.

Effective Interventions to Reduce Stunting: The Lancet Series
The Lancet published a series of papers on maternal and child under-nutrition. This series shows there are proven effective interventions to reduce stunting and micronutrient deficiencies. However, these interventions need additional programmatic experience on how best to achieve full coverage.
Key messages from the Lancet:-

• Effective interventions are available to reduce stunting, micronutrient deficiencies, and child deaths. If implemented at sufficient scale, they would reduce all child deaths by about a quarter in the short term.

• Of these interventions, counselling about breastfeeding and fortification or supplementation with vitamin A and zinc has the greatest potential to reduce the burden of child morbidity and mortality.

• Improvement of complementary feeding could substantially reduce stunting and related burden of disease, organizational profiles, needs.

• Interventions for maternal nutrition (supplements of iron folate, multiple micronutrients, calcium, and balanced energy and protein) can improve outcomes for maternal health and births, but few have been assessed at sufficient scale.

• Although available interventions can make a difference in the short term, elimination of stunting also requires long-term investments to improve education, economic status, and empowerment of women.

The Scaling Up Nutrition movement therefore builds on the proven highly cost effective interventions that have been shown to contribute to reduction in morbidity and mortality using the 1000 days; window of opportunity from pregnancy to two years of a child life to reduce under-nutrition.

The movement is an approach that transforms implementation of nutrition from one sector into multi-sector platforms and recognizes the need to link nutrition specific and nutrition sensitive interventions. Kenya signed up to the Scaling up Nutrition Movement in November 2012. The high impact nutrition interventions include both nutrition specific and nutrition sensitive interventions.

Nutrition Specific Interventions include:

• Support for Exclusive Breastfeeding up to 6 months of age and Continued Breastfeeding, together with appropriate and nutritious food, up to 2 years of age;
• Fortification of Foods;
• Micronutrient Supplementation
• Treatment of Severe Malnutrition

Nutrition Sensitive Interventions include:

• Agriculture: Making nutritious food more accessible to everyone
• Clean Water and Sanitation: Improving access in order to reduce infection and disease
• Education and Employment: Making sure children have the energy that they need to learn and earn sufficient income as adults
• Health Care: Improving access to services to ensure that women and children stay healthy
• Support for Resilience: Establishing a stronger, healthier population and sustained prosperity to better endure emergencies and conflicts
• Women Empowerment

LAUNCH OF THE LANCET SERIES IN KENYA

The launch took place on 1st February, 2014 at the Windsor Hotel Nairobi. About 120 Participants attended from Government, Development Partners, Civil Society Organizations, UN agencies, Academic Institutions and the Kenya Paediatrics Association. Two Lancet Series Authors – Professors Robert Black and Zulfiqar Bhutta were the main speakers.

The launch covered two thematic areas:-

1) Maternal and Child Nutrition
MENTOR MOTHERS IMPROVING ACCESS TO MATERNAL INFANT AND YOUNG CHILD NUTRITION PRACTICES AT THE COMMUNITY SUCCESS STORY IN GARISSE COUNTY, KENYA

Since May 2012 Mercy-USA through the Ministry of Health (MOH) has been implementing Mother to Mother Support Groups (MTMSGs) in Garissa County, Kenya. In June 2012, a new strategy was introduced for enhancing the sustainability and improving the community ownership of the MTMSG. This involved engaging elderly and experienced mothers in the community to act as mentor mothers of the support groups. This strategy aimed at improving the participation of mothers, improving the low trends in maternal and child nutrition and health, and improving access and demand for services especially maternal, infant, and young child feeding practices. This success story details the experience of one woman, Farhiya Abdi, who was selected by her community as a Mentor Mother of a MTMSG in Danyere Division.

Background: Danyere Health Centre is located 70 km from Balambala Sub-District Hospital, the area has poor maternal and child nutrition and health practices. Therefore, 2 MTMSGs were formed at the health facility in the area in May 2012. Mercy-USA, through support to the MOH, promotes initiatives to enhance and expand community engagement on maternal and child nutrition, one of these initiatives is through mentor mothers to support MTMSGs. Enthusiastic Mentor Mothers (MMs), like Farhiya Abdi, have great hope that the poor health and nutrition practices in the villages will be reversed. The MMs work tirelessly to advocate for behaviour change that will positively impact on the nutrition and health of the mothers and children of Danyere division, Balambala district. Farhiya was trained on maternal and child health and nutrition services, as a MTMSG Mentor, she learned about Infant and Young Child Nutrition (IYCN) that entailed postnatal care, infant positioning and attachment, exclusive breastfeeding, weaning, feeds preparation, danger signs for new born babies, maternal nutrition and personal facilitation skills. The 4 day training was conducted by the MOH staff with technical and financial support from MERCY USA. Farhiya was expected to orient the young “new” mothers on issues of MCH services during monthly meetings, with the aim of advocating to them to increase their uptake of services supported by Mercy-USA through the MOH.

Success: So far, Farhiya has oriented 30 MTMSG members with the support of Mercy-USA project and MOH staff. She really enjoys and appreciates the support given to her by Mercy-USA and MOH. In her opinion, these initiatives have resulted in increased uptake of services and referrals to health facilities. Most mothers in the groups appreciate the skills learnt on exclusive breastfeeding (infants0-6 months) and are reaching out to more community members, creating a multiplier effect among mothers.

Article by: Hassan Ali Ahmed, M&E Officer, Mercy USA

SUSTAINABILITY OF MOTHER TO MOTHER SUPPORT GROUPS IN NOMADIC COMMUNITIES LESSONS LEARNT FROM GARISSE COUNTY

A MTMSG’s goal is to encourage and support pregnant and lactating women on optimal MIYCN practices. This support is provided by fellow mothers who are currently breastfeeding and those who have done so in the past (mentors). It is done through individual or group counseling facilitated by an experienced health worker. MTM support includes psycho-emotional support, encouragement and education about breast-feeding and solving infant and young child feeding problems. Mentors who provide this support undergo specific training; they work in informal groups or through one-on-one visits in the home, clinic, or hospital.

Situation before MTMSG: In Garissa county, the MIYCN practices were suboptimal (April 2011 Garissa
Nutrition Survey). In the county, children under five years were especially pre-disposed to malnutrition. In particular, there was a big gap in terms of IYCF practices especially on the benefits of breastfeeding.

The 2011 survey showed that 6.3% of the children had never been breastfed and 11.1% of the caregivers gave other fluid/liquid apart from breast milk within the first three days of life to infants. Additionally, only 40.6% of the children were breastfed immediately after birth and low levels of breastfeeding were reported in the first hour after delivery. Complementary feeding practices were also poor with oils, fats and seasonings being the most consumed food group by children in the county. Combined, these practices negatively impacted the nutritional status and development of children.

Interventions: As a result of the poor IYCN practices, Mercy USA proposed a strategy to support the MOH to form MTMSGs in all the facilities under the support of Mercy USA. This process involved the capacity building of the District Health Management Teams (DHMT), Health workers and Mercy USA staff on MIYCN.

After the training, each health worker was tasked to initiate at least two MTMSGs in their respective facilities. Each group had 15 members composed of lactating mothers, pregnant women, mothers in law, Traditional Birth Attendants (TBA), and mentor mothers. A mentor for each group was trained in a four-day workshop on group leadership skills, the choice of the topic to teach and the content of what to cover with the mothers. These groups were expected to have monthly meetings at the facilities where they would discuss the issues surrounding breastfeeding and timely introduction of complementary foods, as well as issues concerning women’s reproductive health. The topics were facilitated by the health workers and technical people in different fields. Mothers in the group were encouraged to share what they had learnt to others who never attended and were not part of the groups due to their nomadic culture.

Rationale: Knowing the fact that women’s social networks are highly influential in their decision-making processes, they can either be barriers or points of encouragement for breastfeeding. It was noted that “new mothers” preferred other mothers who are experienced as a resource for concerns about child rearing and feeding. communities. MTMSGs were expected to foster such support.

For example, advice from grandmothers and elderly female relatives are commonly cited as a reason for decisions about infant feeding in nomadic communities. MTMSGs were expected to foster such support. MTMSGs were also viewed as a cost-effective approach and culturally competent way to promote and support breastfeeding for women of varying socio-economic backgrounds. This is especially the case in Garissa county, as it primarily consists of nomadic communities where mothers are always moving around with their animals. This was put into consideration, since members of these MTMSGs could be used as messengers and ambassadors of breastfeeding and appropriate complementary feeding to their respective communities.

Evidence of effectiveness As a result of the formation of the MTMSGs in each Mercy-USA supported health facility in Garissa County, it was found that Mother to Mother support programs can be effective by themselves in increasing the initiation and duration of breastfeeding. This is evidenced by the increase in the rate of early initiation of breastfeeding from 40.6% in 2011 and 2013 which was highly contributed by these MTMSG’s among other IYCN interventions in the county. These improvements in feeding were observed among women who are always migrating. Support from MTMSG mentors who are easily accessible was important. Considering the nomadic nature of the communities having these mentor mothers from the community ensured consistency of IYCN messaging at community level, since the mentor mothers are part of the community and also move with the community, they provided constant support which was not always feasible with facility based technical support.

Continued page 9......
Lessons learnt from mother to mother support in Garissa County

- Full involvement of the health worker in the formation and sensitization of the MTMMSG leads to sustainability and ownership of the group.
- Integrating MTM support within the overall health system to contribute to the ongoing maintenance of the program.
- It may help to provide additional training to MTMMSG members on suitable alternative livelihood activities e.g. poultry rearing, kitchen gardening, entrepreneurship and goat farming, etc. This helps to ensure the sustainability of the groups and also compliments nutrition messages.
- MTMMSGs have allowed mothers to make informed decisions about infant feeding practices. To many health workers, who are accustomed to making decisions for their patients, handing over decision-making to mothers with confidence of their capacity to practice good infant feeding practices has been a great achievement and a moment of pride.
- Although many MTMMSGs are trying to adapt services to involve male partners, large gaps still exist. Current MTM services are, for the most part, not designed to welcome men. Frequently, staff and women clients at the MTMMSG consider men as intruders.
- MTMMSGs usually have their meetings at the times when working men cannot most easily attend. To increase impact, ways to reach these individuals, should be considered.

UPCOMING EVENTS AND ACTIVITIES AUGUST TO SEPTEMBER 2014

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<tr>
<th>Event/Activity</th>
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<tr>
<td>Kenya Demographic Health Survey</td>
<td>May to October 2014</td>
<td>Lucy Gathigi- <a href="mailto:lgathigi_don@dfh.or.ke">lgathigi_don@dfh.or.ke</a></td>
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<td>Technical Support to DHIS at</td>
<td>August to September 2014</td>
<td>Kibet Chirchir– <a href="mailto:chirchir@unops.org">chirchir@unops.org</a></td>
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<td>Mahinda Murage- <a href="mailto:smurage_don@dfh.or.ke">smurage_don@dfh.or.ke</a></td>
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**Invitation to submit publication materials to the Kenya Nutrition Bulletin:**

The nutrition bulletin is a quarterly publication of the Human Nutrition and Dietetics Unit, Ministry of Health.

The deadline for submissions for next the bulletin is 30th September 2014

**The theme for the next bulletin:** Nutrition Information Management

To send contributions, contact: Lucy Gathigi email address lgathigi_don@dfh.or.ke or Samuel Murage smurage_don@dfh.or.ke