NUTRITION SITUATION REPORT
AUGUST 2016

National Summary

As part of the long rains seasonal assessment analysis and report writing, the KFSSG and NIWG conducted an IPC (Integrated Phase Classification (IPC)) for both food security and nutrition. The analysis was conducted across the most vulnerable arid and semi-arid counties to monitor the food security and nutrition situation. A detailed IPC nutrition situation analysis shows the nutrition situation in Turkana South is Extremely Critical (Phase 5), while Turkana Central and North is Critical (Phase 4), and Serious (Phase 3) in Turkana West, a slight deterioration compared to the same time last year. Analysis from neighbouring areas, East Pokot and West Pokot, has also shown deterioration and are currently classified as Critical (Phase 4) and Serious (Phase 3) respectively. Deterioration has also been noted in Tana River County, currently classified as Serious (Phase 3). The nutrition situation in Marsabit (Laisamis and North Horr sub-counties) although showing slight
improvements still has elevated levels of acute malnutrition and is classified as **Critical** (Phase 4). Saku and Moyale sub counties show lower rates of acute malnutrition and are classified as **Alert** (Phase 2). The situation in Mandera is classified as **Critical** (Phase 4), although the rates remain high, the situation has remained stable. Detailed analysis indicates low dietary intake and household level food insecurity, coupled with high disease burden and localised outbreaks of cholera (Mandera, Marsabit, Wajir and Tana River), measles (Moyale and Mandera), chikungunya (Mandera) as the key factors affecting the nutrition situation this season. These factors in addition to the chronic issues among these vulnerable populations namely, limited access to quality health services and inappropriate child care and feeding practices increase the vulnerability of the population, and aggravate the high malnutrition rates.

The nutrition situation is **Serious** (Phase 3) but stable in Samburu, Garissa and Isiolo Counties, with improvements noted in Wajir County, now classified as **Serious** (Phase 3 in Wajir East, South) and **Alert** (Phase 2) in Wajir North. The improvements are linked to the positive impacts of the season on food security in the area, including increased access to milk consumption. Analysis of the situation in the south eastern and coastal counties indicates low and stable levels of acute malnutrition, according to analysis using IPC nutrition protocols, these areas are classified as **Acceptable** (Phase 1). However it was noted that access to quality health services and improved child care and feeding practices are still of concern in these areas and should be improved to achieve optimal nutrition.

The total number of children requiring treatment in February 2016 in the ASAL areas was 177,000 (MAM-177,000 and SAM-46,000) and 34,400 pregnant and lactating women. Currently, the total estimated number of children requiring treatment in the ASAL areas is **294,330** (MAM- 233,700 and SAM 60,600) and 29,500 pregnant and lactating women. The increase is mainly due to the increase in the GAM and SAM cases in Turkana, West Pokot, East Pokot and Tana River and calculation of the caseloads using the revised population projections (2016) for the population under five. Nutrition interventions targeting acute and chronic malnutrition are ongoing in all counties, and should continue. These include continued advocacy, joint contingency planning and response across sectors at county level, promotion of community awareness on acute malnutrition for early case management, mass screening and active case finding of acutely malnourished children. In addition to continued implementation of high impact nutrition interventions (HINI), enhancing the supply chain management of nutrition commodities, identifying households with acutely malnourished
children to be referred to programmes linked to supportive safety net programs and continued nutrition and disease surveillance and monitoring at county and national levels.

**NUTRITION SITUATION BY LIVELIHOOD ZONE CLUSTERS**

**Northwest Pastoral Cluster - Turkana, Marsabit and Samburu**

Analysis of nutrition information\(^1\) for North West Pastoral indicates a deteriorating situation in Turkana, a stable situation in Marsabit and improvement in Samburu County. GAM rates remained above 20 percent in Turkana Central South/East, North, Marsabit, North Horr, Laisamis/Loyanganlani, these are the main areas on concern in the cluster. In Turkana, the county weighted GAM\(^2\) increased from 21.2% (19.7-22.9) in 2015 to 23.3% (21.1-25.5) with high disparities within the sub counties. Turkana Central, North GAM rates were categorized are critical with Turkana South categorized as very critical while Turkana West was at serious phase with GAM rates of 24.5% (20.2-29.4), 30.3% (26.7-34.1), 23.4% (19.4-28.1) and 14.4% (11.1-18.5) respectively. The nutrition situation in Marsabit indicates high levels of GAM in North Horr and Laisamis, however showing improvement compared with previous season with GAM rates of 22.8% (17.8-28.7) and 22.5% (18.2-27.4) compared with 29.2% (23.3-36) and 23.7% (18.6-29.6) for the previous season respectively. Moyale and Saku recorded a GAM rates of 7.5% (5.2-10.7) and 7.4% (4.8-11.3), classified as Alert (IPC Phase 2). The nutrition results for Samburu County indicate an improvement though not statistically significant with global acute malnutrition (GAM) rates declining from 17.3% (Critical-IPC Phase 4) in 2014 to 14.5% (Serious-IPC Phase 3) in 2016.

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\(^1\) From 2016 June SMART surveys
\(^2\) Global Acute Malnutrition
IMAM admission trends in the cluster from January to June 2016 indicate as stable situation with a high admissions recorded in Turkana and Marsabit in the month of April and May with Samburu admission being stable.

The major drivers of high acute malnutrition rates in the cluster are: poor dietary intake and morbidity. The IPC food security analysis, classified the food security situation in the cluster as Stressed (IPC Phase 2), with a few pockets in Turkana, Marsabit and Samburu agro pastoral with minimal food insecurity (IPC Phase1).

Though there was an improvement in proportion of households with poor and borderline food consumption across the cluster, there still remains households with poor food consumption, especially in Turkana, where 30% of the households had poor or borderline food consumption score. The results of June 2016 SMART survey revealed that the proportion of households having acceptable food consumption scores increased across especially in Samburu by 16.3 percent. Households are consuming 1-2 meals across the cluster except in Marsabit where households are consuming 2 – 3 meals in a day. Dietary intake was low, across the cluster with low proportions of individuals and children meeting a minimum acceptable diet. In Turkana, the proportion of children meting the minimum acceptable diet was only 6.5%. This indicates a wanting situation in regards to dietary quantity and quality especially for young children.

There was an increase in morbidity in Turkana County with cases of with malaria and acute respiratory tract infection and watery diarrhoea reported. In Marsabit County 39.4%, (19.1%) 42.4% and 30% of children in Moyale, North Horr, Laisamis and Saku respectively were reported to have been ill two weeks prior to survey (SMART Surveys 2016). There were reported cases of measles.
Cholera and dysentery reported with Marsabit reporting the highest number of dysentery cases at 6389 (Disease surveillance). Other underlying causes affecting nutrition in the cluster include low vitamin A supplementation coverage, poor WASH practices, low latrine coverage, consumption of unsafe drinking water and poor health seeking behaviour. A response plan has already been developed at the counties to address the high GAM rates in the especially Turkana and Marsabit with Pockets in Samburu.

**Key Recommendations:**

**Immediate**
- Conduct mass screening
- Ensure nutrition commodities and supplies are positioned
- Integrated outreach services to improve access to health and nutrition services.
- Increase access to food by the poor and vulnerable households targeted by the existing social safety nets

**Medium/Long term**
- Improve Vitamin A coverage
- Improved investment in WASH including Community Led Total Sanitation
- Strengthen Inter sector linkages and focus on resilience programs

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**Northeast Pastoral Cluster (Mandera, Wajir, Garissa, Isiolo, Tana River)**

The nutrition situation in the North East cluster ranged from Alert (IPC Phase 2) to Critical (IPC Phase 4). The highest level of GAM was recorded in in Mandera (22.6%) while the lowest was recorded in Wajir North (9.4%). Wajir East recorded 13.4% while Tana River and Garissa had 14.0% and 14.7% respectively. 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 showed a varied trend among the counties trend. The proportion ranged between 4.85 – 21.6 percent. The trend across the counties was stable or increasing. In
Garissa and Mandera, it was in increasing trend while in Wajir and Isiolo it was stable. In Tana River, it was stable in the first five months after which it took an upward trend.

The meal frequency was below normal in the pastoral livelihood zones where the household consumption was 1-2 meals compared to normal 2 to 3 meals. In agro pastoral zones the household meal consumption was normal at 2 to 3 meals per day. The food groups mainly consumed included; cereals, milk, pulses and sometimes vegetables. The main contributors of malnutrition included; depletion of pastures in pastoral livelihood zones as well as migration of livestock reducing milk production and consumption. In Garissa, there was heavy flooding of river Tana which washed away crops and delayed planting was also a cause of poor food production leading to reduced household level food security and dietary intake. Other factors included; poor child care and feeding practices and dietary diversity. Although the situation was stable, there are underlying factors that affect malnutrition like poor access to basic health services, inadequate maternal and child care practices and poor hygiene and sanitation practices. Poor adherence to water safety, hygiene and sanitation practices largely contributed to the widespread of cholera outbreak in Isiolo, Tana River and Mandera Counties.

The admission trends for IMAM programs for Tana River and Isiolo Counties remained low and stable between January and June 2016, however, in July Tana River admission drastically increased. Garissa County trends remained stable though there was notable reduction in July. For Wajir and Mandera Counties, admissions remained high and unstable. A drastic reduction was noted in July 2016. Drastic increase in IMAM admission in Tana River County was attributed to worsening of
situation attributed to poor long and short rain performance leading to water stress at the household level and livestock migration. Across the county the Terms of Trade (TOT) has deteriorated from about 99 kg of maize in February, 2016 to the current 70 kg from the sale of a goat, a possible indication of reduced household level food security. The outbreak of diseases e.g. cholera can also be attributed to this drastic change. In earlier months, the situation in Wajir was in alert phase of drought cycle, however as the time progressed, the situation turned out to be normal. In February the situation was at alert and worsening phase while in June 2016 the overall situation across the livelihood zones was normal and stable, an explanation of drastic reduction in admission trends in July. In Mandera County, outbreak of diseases such as cholera and Chikungunya as well as the drought situation in earlier months of the year was attributed to high admission rates in the County. In the later months, the situation normalized and this explains reduction of IMAM admissions in July 2016.

Summary of Recommendations:

Short term Recommendations:

1. Screening of malnourished children and treatment through existing health facilities, and
   Increases Nutrition surveillance
2. Integrated outreach services to improve access to health and nutrition services.
3. Increase access to food by the poor and vulnerable households that are not currently targeted by the existing social safety nets and improvement of dietary diversity for children
and mothers
4. Enhanced management of diseases, diarrhoea, dysentery, malaria and ARI, including use of Mosquito nets
5. Strengthen and scale-up of surge model

**Long term recommendations**

1. Integrate nutrition interventions into development strategies across all sectors and including nutrition outcomes for under-fives as a core indicator in programs on agriculture, water and sanitation, education and food security and social protection
2. Advocate for improve on health seeking behaviour
3. Social behaviour change communication and nutrition education addressing improved maternal, infant and young child nutrition
4. Focus on Resilience programs, including women empowerment in response to food/nutrition insecurity in a household
5. County Government to have emergency kitty to mitigate unusual shocks
6. Mobilize funds to Improve water infrastructure and continued water infrastructure

**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 proportion of children with MUAC measurements of less than 135mm showed a stable trend across the cluster. In July 2016, lower rates were reported against LTA in all the five counties. It was noted that Meru North had higher but stable trends of MUAC data throughout the review period and the agro pastoral zone in the same area was stressed in reference to food insecurity; in addition most counties had shown slight increase in number of children with low MUAC from June 2016.
The nutrition status of children has remained stable mostly due to improved dietary intake reflected by food consumption score of 91 and percent of households which had acceptable consumption score compared to 2015. The main factors affecting malnutrition include minimal use of treated water which has remained at 20-30 percent across the cluster coupled with low latrine coverage at 60% in some areas; this situation may have impacted nutrition status negatively by increasing diarrheal diseases. In addition food security, poor child feeding and care practices have an impact on malnutrition.

**Response action in the cluster**

**Meru North:**
- Screening of malnourished children and treatment through existing health facilities, and
  - Increases Nutrition surveillance
- Strengthening of MIYCN interventions including training of caregivers on appropriate children care practice

**Makueni:**
- Integrated outreach services to improve access to health and nutrition services
- Advocate for improve on health seeking behavior

**Mbeere:**
- Improve or initiate micronutrient supplementation including Vitamin A supplementation
- Strengthening MIYCN interventions
- Strengthening MIYCN interventions

**Tharaka**
- Focus on Resilience programs, including women empowerment in response to food/nutrition insecurity in a household

**Kitui**
- Improve water infrastructure
- Strengthening MIYCN interventions
Agro-Pastoral (West Pokot, Baringo, Nyeri- Kieni, Laikipia, Narok, Kajiado)

The nutrition situation according to Integrated Phase Classification (IPC) for acute malnutrition was acceptable (Phase 1) for Nyeri, Laikipia, Narok, Kajiado and Baringo (in mixed farming and agro-pastoral zones) Counties. However in West Pokot and Baringo (pastoral areas – East Pokot) Counties the nutrition phase was classified as critical (Phase 4). 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 stable except for West Pokot that was 10.9 against LTA of 9. SMART survey done in West Pokot and East Pokot (Baringo) showed that Global Acute Malnutrition (GAM) rates in West Pokot increased to 15.3% from 12.4% percent recorded in 2015 while in East Pokot the GAM levels increased from 18.4% (2015) to 23% (2016). This increase was attributed to increase in disease prevalence and poor child feeding and care practices.

Meal frequency and dietary diversity had improved in all the counties within the cluster compared to the same period last year. The number of meals taken per day was one to two in pastoral livelihood zones and two to three meals in mixed farming areas. The composition of meals included five groups namely cereals, vegetables, pulses, fruits, milk and meat. 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 behaviour 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.
Coastal Marginal Cluster (Kwale, Taita Taveta, Kilifi, Lamu)

The percentage of children under five at risk of malnutrition based on MUAC less than 135mm remained stable with exception of Kilifi County reporting higher rates March and April 2016. In July 2016, lower rates were reported against LTA in all counties
The food consumption score (FCS) revealed 67 and 6 percent of the households were within acceptable and poor consumption score respectively (Figure). 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. Currently 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 poor yield and limited sources of income.

Hand washing at critical times at households across the county is practiced and averages from 60 to 80 percent. Water treatment at household ranges between 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 this area. Latrine coverage in the cluster averaged 70 percent.
# Matrix Summarizing Contributing Factors for Acute Malnutrition for IPC Nutrition Analysis

## 1. Summary Contributing Factors - Pastoral North East

<table>
<thead>
<tr>
<th>SUMMARY CONTRIBUTING FACTORS BY AREA</th>
<th>GARISSE</th>
<th>TANA RIVER</th>
<th>WAJR NORTH</th>
<th>WAJR EAST</th>
<th>ISIOLO</th>
<th>MANDERA</th>
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### Summary Contributing Factors by Area

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<th>Major contributing factor</th>
<th>Minor contributing factor</th>
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<td>Access to sanitation facilities</td>
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**Basic causes**

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<th>Human capital</th>
<th>Physical capital</th>
<th>Financial capital</th>
<th>Natural capital</th>
<th>Social capital</th>
<th>Policies, Institutions and Processes</th>
<th>Usual/Normal Shocks</th>
<th>Recurrent Crises due to Unusual Shocks</th>
<th>Other basic causes</th>
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**Other nutrition issues**

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<th>Anaemia among children 6-59 months</th>
<th>Anaemia among pregnant women</th>
<th>Anaemia among non-pregnant women</th>
<th>Vitamin A deficiency among children 6-59 months</th>
<th>Low birth weight</th>
<th>Fertility rate</th>
<th>Others</th>
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### 2. Summary Contributing Factors - Pastoral North West

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### 3. Summary Contributing Factors - Coastal marginal

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### Summary Contributing Factors by Area

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#### Kilifi
- Recurrent Crises due to Unusual Shocks

#### Kwale
- Other basic causes

#### Taita Taveta
- Other nutrition issues
  - Anaemia among children 6-59 months
  - Anaemia among pregnant women
  - Anaemia among non-pregnant women
  - Vitamin A deficiency among children 6-59 months
- Low birth weight
- Fertility rate
- Others

#### Lamu
- Other nutrition issues
  - Anaemia among children 6-59 months

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### 4. Summary Contributing Factors - Agro-Pastoral (West Pokot, Baringo, Nyeri- Kieni, Laikipia, Narok, Kajiado)

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<th>Kajiado</th>
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#### Narok
- Inadequate dietary intake
  - Minimum Dietary Diversity (MDD)
  - Minimum Meal Frequency (MMF)
  - Minimum Acceptable Diet (MAD)
  - Minimum Dietary Diversity – Women (MDD-W)
- Others

#### Laikipia
- Diseases
  - Diarrhoea
  - Dysentery
  - Malaria
  - HIV/AIDS prevalence
  - Acute Respiratory Infection
  - Disease outbreak
- Others

#### Kajiado
- Inadequate access to food
  - Outcome of the IPC for Acute Food Insecurity analysis

#### Baringo
- Inadequate care for children
  - Exclusive breastfeeding under 6 months
  - Continued breastfeeding at 1 year
  - Continued breastfeeding at 2 years
  - Introduction of solid, semi-solid or soft foods
- Others
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<td>Turkana Central</td>
<td>20.9 (17.9-24.4)</td>
<td>24.5% (20.2-29.4)</td>
<td>4.8% (3.4-6.6)</td>
</tr>
<tr>
<td>Turkana south</td>
<td>24.4 (20.8-28.6)</td>
<td>30.3% (26.7-34.1)</td>
<td>6.1% (4.3-8.5)</td>
</tr>
<tr>
<td>Turkana North</td>
<td>22.9 (19.6-26.6)</td>
<td>23.4% (19.4-28.1)</td>
<td>3.8% (2.4-6.1)</td>
</tr>
<tr>
<td>Turkana West</td>
<td>16.7 (13.8-23.2)</td>
<td>14.4% (11.1-18.5)</td>
<td>4.8% (3.3-6.9)</td>
</tr>
<tr>
<td>West Pokot</td>
<td>12.4% (9.7-15.6)</td>
<td>15.3% (12.3-8.9)</td>
<td>1.3% (0.6-3.0)</td>
</tr>
<tr>
<td>Samburu</td>
<td>17.3%&lt;sup&gt;6&lt;/sup&gt;</td>
<td>14.5% (12.0-7.4)</td>
<td>3.3% (1.9-5.4)</td>
</tr>
<tr>
<td>Baringo (East Pokot)</td>
<td>18.8 % (15.3 - 22.9)</td>
<td>23.0% (18.6-28.0)</td>
<td>3.8% (2.4 - 5.9)</td>
</tr>
<tr>
<td>Wajir North (Agro)</td>
<td>14.3 (11.4-17.8)</td>
<td>9.4 % (7.4 - 11.9)</td>
<td>2.2% (1.3-3.6)</td>
</tr>
<tr>
<td>Wajir (Pastoral )</td>
<td>17.8 (14.8-21.2)</td>
<td>13.4 % (10.0 - 17.7)</td>
<td>2.1% (1.2-3.7)</td>
</tr>
<tr>
<td>Garissa</td>
<td>11.9%&lt;sup&gt;7&lt;/sup&gt;</td>
<td>14.7 (11.5-18.2)</td>
<td>1.8% (0.8-4.1)</td>
</tr>
<tr>
<td>Tana River</td>
<td>9.9% (6.8-14.2)</td>
<td>14.0% (10.5-18.5)</td>
<td>1.0% (0.4-2.5)</td>
</tr>
<tr>
<td>Mandera</td>
<td>24.5% (19.7-30.1)</td>
<td>22.6% (18.6-27.2)</td>
<td>3.7% (2.3-6.1)</td>
</tr>
<tr>
<td>Marsabit Laisamis/Loyangalani</td>
<td>23.7%&lt;sup&gt;8&lt;/sup&gt;</td>
<td>21.8% (17.7-26.7)</td>
<td>6.5% (4.4-9.5)</td>
</tr>
<tr>
<td>Marsabit North Horr</td>
<td>22.8% (17.8-28.7)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Marsabit Moyale</td>
<td>7.5% (5.2-10.7)</td>
<td></td>
<td>0.5% (0.1-2)</td>
</tr>
</tbody>
</table>

<sup>3</sup> Global Acute Malnutrition <2 or oedema
<sup>4</sup> Severe Acute Malnutrition <3 or oedema
<sup>5</sup> Mid Upper Arm Circumference
<sup>6</sup> Survey conducted May 2014
<sup>7</sup> June 2014
<sup>8</sup> September 2015
## Caseloads

<table>
<thead>
<tr>
<th>County or sub county</th>
<th>GAM Caseloads by Areas Surveyed - children 6 to 59 months</th>
<th>SAM Caseloads by Area Surveyed - children 6 to 59 months</th>
<th>GAM case loads by County - children 6 to 59 months</th>
<th>SAM cases loads by County - children 6 to 59 months</th>
<th>MAM case loads by County - children 6 to 59 months</th>
<th>Pregnant and Lactating Women caseloads - county</th>
</tr>
</thead>
<tbody>
<tr>
<td>Samburu</td>
<td>10,877</td>
<td>1,800</td>
<td>10,877</td>
<td>1,800</td>
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<td>West Pokot</td>
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<td>26,453</td>
<td>5,014</td>
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<td>5,082</td>
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<td>58,041</td>
<td>11,043</td>
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<tr>
<td>County or sub-county</td>
<td>GAM Caseloads by Areas Surveyed - children 6 to 59 months</td>
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<td>Pregnant and Lactating Women caseloads - county</td>
</tr>
<tr>
<td>------------------------------------------</td>
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<td>Marsabit Moyale/Sololo</td>
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<td>Baringo - Pastoral/Agro pastoral/Marginal mixed Farming LHZ(East pokot)</td>
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<td>County or sub county</td>
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</tr>
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<td>TOTAL CASELOADS ASAL</td>
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</tbody>
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