



SMART SURVEY FINAL REPORT
EAST POKOT SUB COUNTY
BARINGO COUNTY
JULY, 2016



ACKNOWLEDGEMENT

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ACCROYNM AND ABBREVIATIONS

BPHS:	Basic Package of Health Services
CI:	Confidence Interval
CNO:	County Nutrition Officer
CSI:	Coping Strategy Index
DEFF:	Design Effect
ENA:	Emergency Nutrition Assessment
FGD:	Focus Group Discussion
GAM:	Global Acute Malnutrition
HAZ:	Weight-for-Age Z score
HH:	Household
HiNi:	High Impact Nutrition Intervention
KII:	Key Informant Interview
MAM:	Moderate Acute Malnutrition
MoH:	Ministry of Health
MUAC:	Mid Upper Arm Circumference
NDMA:	National Draught Management Authority
NGO:	Non-Governmental Organization
NSO:	Nutrition Support Officer
PPS:	Probability Proportional to Population Size
SAM:	Severe Acute Malnutrition
SCHMT:	Sub-County Health Management Team
SMART:	Standardized Monitoring and Assessment in Relief and Transition
UN:	United Nations
UNICEF:	United Nation Children Fund
WHO:	World Health Organization
WAZ:	Weight-for-Age Z score
WASH:	Water, Sanitation and Hygiene
WFA:	Weight-for-Age
WHZ:	Weight-for-Height Z score

EXECUTIVE SUMMARY

East Pokot is one of the six Sub-Counties (Baringo South (Marigat), Mogotio, Koibatek, Baringo North and Baringo Central) in Baringo County. It borders Turkana East to the North, Marakwet to the West, Laikipia and Samburu Districts to the East, and Marigat to the South. It has an average area of 4524.8 square kilometres with estimated population of 159,404 people and about 28,693 children under five years (projection from 2009 population census).

The area has two livelihood zones, Pastoral (Kolowa, Tangelbei, Akoret, Mond, Ngoron, Nginyang divisions) and Agro-Pastoral (Churo division)

Over the years, East Pokot experiences poor health and nutrition outcomes which are mainly related to household food insecurity as a result of recurrent drought. This survey was done as part of surveillance in order to establish the current nutrition status in East Pokot. The results were also meant to feed in to the Long Rain Assessment report conducted by Kenya Food Security Steering Group.

The general objective of the survey was to determine the prevalence of malnutrition among the children aged 6- 59 months old, pregnant and lactating mothers in East Pokot Sub County with the following specific objectives:

- To estimate the current prevalence of acute malnutrition in children aged 6 – 59 months
- To compare the overall nutritional changes with the previous GAM and SAM
- To determine the morbidity rates amongst children aged 0-59 months over a two week recall period
- To estimate the coverage of Measles, BCG vaccination and deworming for children 9-59 months, 6-59 months and 12-59 months respectively
- To determine the coverage for zinc supplementation and vitamin A supplementation among the children 6-59 months
- To estimate the nutritional status of female caregivers aged 15-49 years using MUAC measurements
- To assess household food security and livelihoods
- To assess water sanitation and hygiene practices

The survey applied a two stage stratified cluster sampling using the SMART methodology with the clusters being selected using the probability proportional to population size (PPS). Stage one sampling involved the sampling of the clusters which were included in the survey while the second stage sampling involved the selection of the households from the sampled clusters. The total sample size was 491 children aged between 6 and 59 months from 521 households. Data was collected by 10 Teams. The data collection team was given a four days training in Marigat Town and facilitated by Ministry of Health, World Vision and UNICEF as part of County Nutrition Information Working Group. The training included the review of the survey tools, survey methodology and using anthropometric measurements. In addition, a standardization

test was done on the third day of the training while also a pilot survey was conducted on the fourth day of the survey. As the data was being collected using Open Data Kit (ODK) platform, a module on use of mobile phone in data collection was included in the training agenda. The data collected during the survey included: anthropometry, morbidity, vaccination and deworming status, Vitamin A supplementation, hygiene and sanitation practices, other indicators assessed were household food security and livelihood. The standard data collection tool recommended by the National Nutrition Information Working Group was used.

All 35 sampled clusters were visited. In total 516 households were visited out of which 664 children aged 6 to 59 months and 319 women of reproductive age were reached.

Anthropometric data was analyzed using the ENA for SMART 2011 software version July, 9th 2015 while other indicators were analyzed using Microsoft excel and SPSS Version 20.0

Table 1: Summary of Survey Findings

Indicators	Coverage
HHs covered	516
Children assessed	664
Global Acute Malnutrition (<-2 Z-score)	(149) 23.0 % (18.6 - 28.0 95% C.I.)
Severe Acute malnutrition (<-3 Z-score)	(23) 3.5 % (2.2 - 5.7 95% C.I.)
Prevalence of Global Underweight (<-2 Z-score)	(254) 38.8 % (33.9 - 43.9 95% C.I.)
Prevalence of Global Stunting (<-2 Z-score)	(228) 36.5 % (32.0 - 41.2 95% C.I.)
Measles Coverage at 9 Months	71.4%
Measles Coverage at 18 Months	32.1%
BCG by scar	89.9%
OPV 1	91.1%
OPV 3	80.8%
Zinc Supplementation	11%
Vitamin A (6 – 11 months- once)	22.6%
Vitamin A (12 – 59 months) –more than twice	30.7%
Vitamin A (12 – 59 months- once)	13.3%
Deworming (12-59 months)	14.9%
Sickness two weeks prior to survey	59%
Acute Respiratory Infection	73.0%
Fever	53.6%
Watery diarrhoea	40.8%
Bloody diarrhoea	35.5%
Seek assistance	42.8%
Maternal MUAC <21cm	9.7%
Maternal MUAC <21cm for PLW	9.4%
Iron Folate Supplementation < 90 days	50.2%
Iron Folate Supplementation 90 days and above	8.3%
Food Consumption Score (FCS)	

Poor FCS	2.71%
Border FCS	9.88%
Good FCS	87.4%
House hold consuming >4 food groups	63.2%
Minimum Women's Dietary Diversity	22.5%
CSI	27.59%
Water sources	
Protected source(safe sources)	5.4%
Unprotected source(unsafe sources)	94.6%
Water treatment	2.9%
Hand washing at 4 critical times	2%
Hand washing at 3 critical times	8%
Methods of relieving	
Open defecation	96%
Own latrine	3%

The survey results show that the nutrition situation in East Pokot has deteriorated though not significantly compared to 2015 SMART survey results. The probable causes of malnutrition include; poor infant and young child care practices, poor household dietary diversity, and morbidity as well as poor water sanitation and hygiene practices including open defecation.

From the survey results a number of recommendations were done which include: Carrying out mass screening and scaling up of IMAM and outreach services, Implement surge model in every health facilities, Integrate Vitamin A supplementation and Deworming to ECDs, Train CHVs on nutrition technical module and implement the existing SBCC Strategy.

CHAPTER ONE

1.0 INTRODUCTION

1.1 BACKGROUND INFORMATION

East Pokot is one of the 6 sub counties of Baringo County and it borders Turkana East to the North, Marakwet and Baringo North to the West, Laikipia and Samburu county to the East, and Marigat to the South. It has an average area of 4524.8Km and is sub-divided into seven (7) administrative divisions with an official estimated population of around 159,404 people which is a projection from 2009 population census. The area has two livelihood zones, Pastoral (Kolowa, Tangelbei, Akoret, Mondri, Ngoron, Nginyang divisions) and Agro-Pastoral (Churo division).

The sub county experiences poor health and nutrition outcomes which are mainly attributed to poor access to critical health services. Additionally, other major factors contributing to high malnutrition rates include chronic and acute food insecurity due to poor rainfall, low purchasing power due to eroded capacity as a result of seasons of successive droughts, suboptimal child care and feeding practices and poor hygiene and sanitation practices and retrogressive cultural beliefs.

To try to improve the health and nutrition status in the county, various partners have been working with the Ministry of Health in the implementation and up scaling the High Impact Nutrition Intervention (HiNi) in the County. For instance World Vision has been supporting the Ministry of Health (MoH) in the implementation of the HiNi services in Baringo County. Other partners supporting other nutrition interventions include Maternal and Child Survival Project (MCSP) and Kenya Red Cross during response. World Vision is also supporting Food for asset (FFA) projects in the area.

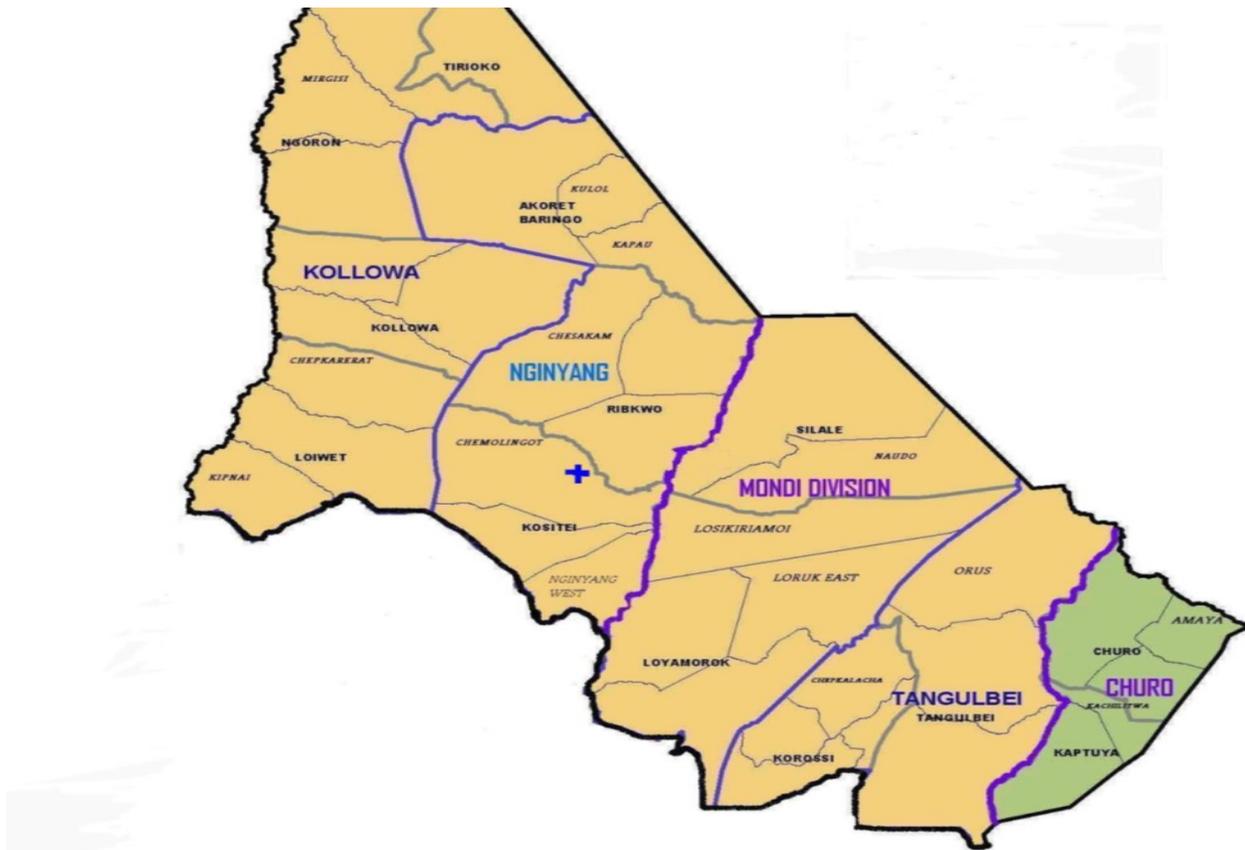


Figure 1: Map of East Pokot Sub County with Livelihood zones

1.1.1 Justification

The results of 2015 showed a critical GAM level of 18.8 % (15.3 to 22.9% 95% CI). There has been several aggravating factors like conflict and floods in the sub county. The sub county has been ranked as the second poorest in rains performance in the last two rains assessments by KFSSG.

1.2 Survey Objectives

1.2.1 General Objective

The overall objective: To determine the prevalence of malnutrition among the children aged 6- 59 months old, pregnant and lactating mothers.

1.2.2 The specific objectives:

- To determine the prevalence of acute malnutrition among children aged 6-59 months.
- Estimate prevalence of maternal malnutrition using MUAC measurements
- To determine the immunization coverage for measles, BCG, Oral Polio Vaccines (OPV 1 and 3) and vitamin A supplementation in children aged 6-59 months
- To determine de-worming coverage for children aged 12 to 59 months

- To estimate the use of zinc in diarrheal treatment in children;
- To determine the morbidity rates amongst children U5 years over a two week recall period.
- To collect information on possible underlying causes of malnutrition such as household food security, water, sanitation, and hygiene practices.

1.3 Timing of the Survey

The survey was undertaken during a dry spell as from 4th to 13th July 2016. Training and piloting of the survey materials and standardization test was conducted from 4th to 8th July 2016 and thereafter data collection for five days from 9th to 13th 2016.

CHAPTER TWO

2.0 SURVEY METHODOLOGY

2.1 Geographic Target Area and Population Group

The survey was conducted in Baringo County, East Pokot Sub County. The primary respondent for the survey was the mother/care taker of the child for both household and child questionnaire.

Data was collected on the following variables; anthropometry, morbidity, vaccination and deworming status, Vitamin A supplementation, hygiene, sanitation practices, household food security and livelihood. In addition, the nutritional status of children aged 6 – 59 months and women aged 15 – 49 years were also determined.

2.2 Survey Design

The survey applied a two stage cluster sampling with the clusters were selected using the probability proportional to population size (PPS).The villages constituted the sampling frame.

2.3 Study Population

The target population for the survey was children aged 6 – 59 months for the anthropometric measurements and women of reproductive age between 15 – 49 years for the maternal health component.

2.4 Anthropometric Sample Size

The anthropometric survey sample size was calculated using the SMART survey calculator. The parameters of interest were captured in the ENA July 9th 2015 software and the respective number of children and households required for the survey computed. The sampling frame for this survey was the updated list of villages (with current projected population) from the survey area.

Table 2: Anthropometric Sample Size calculation and rationale for the East Pokot County survey

Data entered on ENA software	Anthropometric Survey	Rationale
Estimated prevalence of GAM	15.3%	Due to improving situation based on NDMA monthly bulletins (May 2016). SMART survey 2015 GAM: 18.8 % (15.3 – 22.9 95% C.I.)
±Desired precision	4%	Based on nutrition survey guidelines
Design effect	1.45	Based on the previous 2015 survey to cater for heterogeneity.
Average household size	6	2015 SMART survey
Percent of <5	18%	2015 SMART survey
Percent of non-	3%	Due to the frequent movements in most parts

respondent		of the county hence non-response anticipated
Households to be included	521	As calculated using the ENA for SMART software
Children to be included	491	As calculated using the ENA for SMART software

2.5 Cluster and Household Selection

All accessible villages were included in the initial sample selection with each village considered a cluster which was sampled with probability proportional to size. At stage two each team used the simple random sampling method in household selection. Within the selected households all children 6-59 months fitting the inclusion criteria were measured.

A household was defined as a group of people who lived together and shared a common cooking pot. In polygamous families with several structures within the same compound but with different wives having their own cooking pots, the structures were considered as separate households and assessed separately.

In cases where there was no eligible child, a household was still considered part of the sample. If a respondent was absent during the time of household visit, the teams left a message and re-visited later to collect data for the missing person, with no substitution of households allowed.

2.6 Variables Collected

Age: the age of the child was recorded based on a combination of child health cards, the mothers'/caretakers' knowledge of the birth date and use of a calendar of events for the district developed in collaboration with the survey team.

Sex: it was recorded whether a child was male or female.

Bilateral Oedema: normal thumb pressure was applied on the top part of both feet for 3 seconds. If pitting occurred on both feet upon release of the fingers, nutritional oedema was indicated.

Weight: the weights of children were taken with minimal or light clothing on, using Bathroom scale (SECA digital model with a threshold of 150kgs and recorded to the nearest 0.1kg).

Length/Height: children were measured bareheaded and barefooted using wooden UNICEF height boards with a precision of 0.1cm. Children under the age of two years were measured while lying down (length) and those over two years while standing upright (height). If child age could not be accurately determined, proxy heights were used to determine cases where height would be taken in a supine position (<87cm) or in an upright position (≥87cm).

Mid Upper Arm Circumference (MUAC): the MUAC of children were taken at the midpoint of the upper left arm using a MUAC tape and recorded to the nearest 0.1cm.

Retrospective Morbidity of Children: A 2-week morbidity recall was conducted for all children (6-59 months) to assess the prevalence of common diseases (e.g. malaria, diarrhoea).

Vaccination Status and Coverage:

For all children 6-59 months, information on BCG, Oral polio Vaccine (OPV) 1, OPV 3 and measles vaccination was collected using health cards and recall from caregivers. The vaccination coverage was calculated as the proportion of children immunized based on card and recall.

Vitamin A Supplementation Status: For all children 6-59 months of age, information on Vitamin A supplementation was collected using the child welfare cards and recall from caregivers. Information on whether the child had received supplementation in the last 6 months was collected. Vitamin A capsules were also shown to the mothers to aid in recall.

De-worming Status: Information was solicited from the care takers as to whether their child/children 6-59 months had been de-wormed in the last 6 months.

Household Food Diversity: Dietary diversity is a qualitative measure of food consumption that reflects household access to a wide variety of foods, and is also a proxy of the nutrient intake adequacy of the diet for individuals. Dietary diversity scores were created by summing the number of food groups consumed over a 7- days period to aid in understanding if and how the diets are diversified. Household dietary diversity score (HDDS) is meant to reflect, in a snap shot the economic ability of a household to consume a variety of foods. A score of 1 was allocated to each food group that was consumed by the household per day and a score of 0 for each of the food groups not consumed by the household, and thus the highest possible score per day was 16.

Household Water Consumption and Utilization: The indicators used were main source of drinking and household water, time taken to water source and back, cost of water per 20-litre jerry-can and treatment given to drinking water.

Sanitation: Information on household accessibility to a toilet/latrine, disposal of children's faeces and occasions when the respondents wash their hands was obtained.

2.7 Organization of the Survey

- **Coordination/Collaboration:** before the survey was conducted meetings were held with the respective county authorities and key stakeholders briefed them about the purpose, objectives and methods for the survey. The survey details were discussed with the County Steering Group, County Nutrition Technical Forum, County Information Working Group and conducted in collaboration with the County and Sub-Counties Health Offices and UNICEF. The authorities were requested to officially inform the communities (villages) that were involved in the assessment.
- **Recruiting the Survey Team:** recruitment was done in collaboration with the Ministry of Health office at the sub-county level in order to give ownership and participation in the assessment.
- **Training of the Survey Team:** the teams were given 4-days training prior to field work, including a standardization test to ensure standardization of measurement and recording
- **Quality assurance**
- Daily Plausibility check for data quality

- Giving daily feedback and updates to teams based on quality checks
- Teams supervision/ follow up while in the field
- Use of ODK and recording of Geo points

2.8 Case Definition

The Global Acute Malnutrition (GAM) is the index which is used to measure the level of wasting in any given population. In this survey, GAM was defined as the proportion of children with a z-score of less than -2 z-scores weight-for-height and/or presence of bilateral oedema. Severe Acute Malnutrition (SAM) was defined as the proportion of children with a z-score of less than -3 z-score and/or presence of oedema. Further, using the mid-upper arm circumference (MUAC), GAM was defined as the proportion of children with a MUAC of less than 125 mm and/or presence of oedema while SAM was defined as the proportion of children with a MUAC of less than 115 mm and/or presence of oedema.

2.8.1 Malnutrition by Z-Score: WHO (2006) Standard.

- Severe acute malnutrition is defined by WFH < -3 SD and/or existing bilateral oedema on the lower limbs.
- Moderate acute malnutrition is defined by WFH < -2 SD and >-3 SD and no oedema
- Global acute malnutrition is defined by WFH < -2 SD and/or existing bilateral oedema

2.8.2 Malnutrition by MUAC

- Severe malnutrition is defined by MUAC < 115 mm and/or presence of bilateral oedema
- Moderate malnutrition is defined by MUAC < 125 mm and \geq 115 mm and no oedema
- Global acute malnutrition is defined by MUAC < 125 mm and/or existing bilateral oedema.

2.9. Questionnaire

The survey adopted the data collection tools recommended in the Nutrition Information Working Group but converted to Open Data Kit (ODK) format to enable data collection using android smart phones.

2.10 Data uploading, Analysis and Report Writing

- Data was uploaded on daily basis, downloaded on excel format and analyzed using Excel, ENA for SMART and SPSS version 20 Statistical software. Results were presented using the new WHO reference levels.
- **Preliminary Results and Final Report:** Preliminary findings were submitted to County Nutrition Technical Forum (CNTF) and County Steering Group (CSG) at the County and (NIWG) at the National levels after completion of the survey fieldwork. The information shared in the preliminary report included the prevalence of global acute malnutrition as well as the prevalence of moderate and severe acute malnutrition, vaccination and other relevant information. The survey results were validated by both the County and National NITWG level.

CHAPTER THREE

3.0 SURVEY RESULTS AND DISCUSSION

3.1 House hold demographics

The survey reached a total of 516 households where 664 children under five years and 319 women 15-49years were reached.

3.2 Residency and marital Status of the Respondents:

Majority of the households visited were residents 99.4% while 0.6% were internally displaced persons (IDPs). 95.3% of the respondents were married.

3.3 Education Level of the respondents

The Illiteracy levels in East Pokot were found to have reduced from 88.7% in Aug. 2015 to 65.7% in July 2016 with few (4.3%) of the respondents interviewed reporting that the household head had acquired secondary level as shown in the table below

Table 3: Education levels of the respondents

Level of Education	Aug. 2015	July 2016
	%	%
None	88.7	65.7
pre primary	2.1	20.7
Primary	6.4	7.8
Secondary		4.3
Tertiary		1.4

3.4 Nutritional Status of Under-Five Children

3.4.1 Age distribution and anthropometric data quality check

Among 664 children under five years reached 50.0% were boys and 50.0% girls. The overall sex ratio of boys to girls' was 1.0 and was within the recommended range of 0.8-1.2 showing unbiased selection of the sample. The ratio for Skewness and Kurtosis of WHZ also showed unbiased distribution of the sampled children.

Table 4: Distribution of sex and age of sample

AGE (mo)	Boys		Girls		Total		Ratio
	no.	%	no.	%	no.	%	Boy: girl
6-17	87	49.7	88	50.3	175	26.4	1.0

18-29	86	49.7	87	50.3	173	26.1	1.0
30-41	78	51.3	74	48.7	152	22.9	1.1
42-53	70	55.1	57	44.9	127	19.1	1.2
54-59	11	29.7	26	70.3	37	5.6	0.4
Total	332	50.0	332	50.0	664	100.0	1.0

3.4.2 Prevalence of acute malnutrition (weight-for-height z-score –WHO Standards 2006)

The weight for height index measures body mass in relation to height or length and describes the current nutritional status. Children below standard deviations of below the mean indicate wasting and represent failure to receive adequate nutrition in a period immediately preceding the survey.

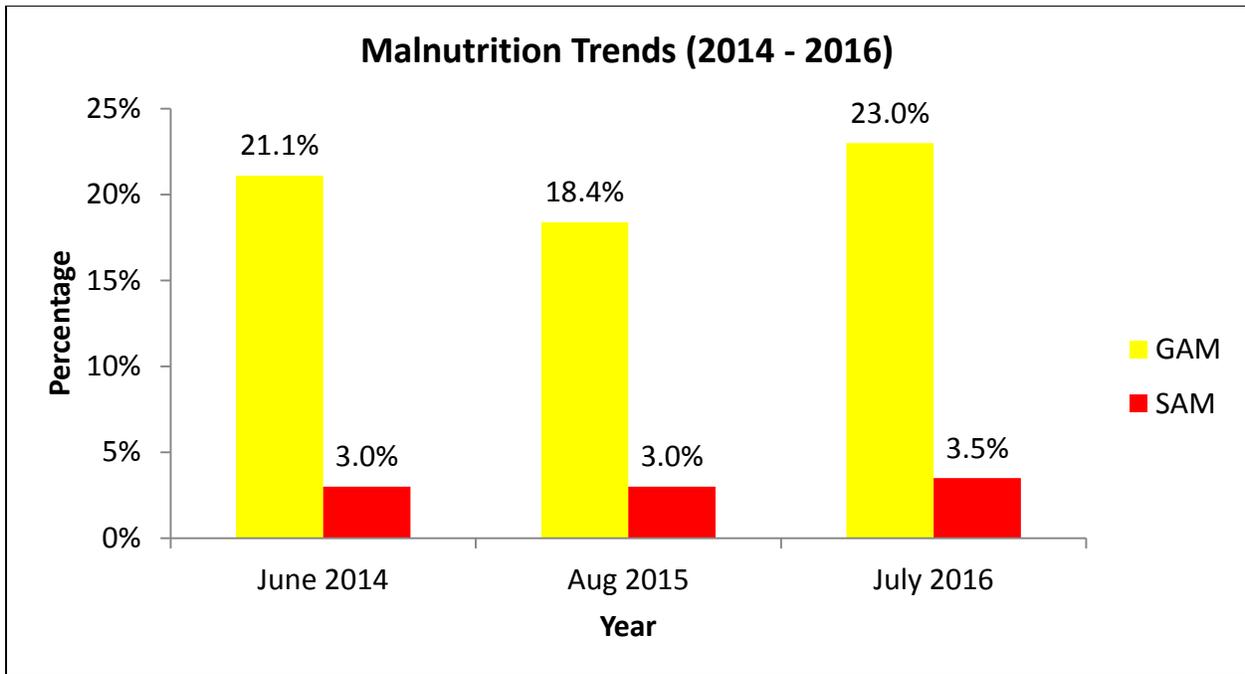
The information presented here is based on the analyzable sample of eligible children whose plausible anthropometric data were collected, excluding those that were SMART flagged.

The Global acute malnutrition (GAM) levels increased from 18.4% (Aug. 2015) to 23.0% (July 2016) with no significant change ($P= 0.111$). This was above the emergency GAM thresholds (15.0%) indicating a critical situation.

Table 5: Overall prevalence of GAM compared to previous year's survey findings.

	July 2016 n = 649	June 2015 n = 321
Prevalence of global malnutrition (<-2 z-score and/or oedema)	(149) 23.0 % (18.6 - 28.0 95% C.I.)	(125) 18.4 % (15.3 - 22.9 95% C.I.)
Prevalence of moderate malnutrition (<-2 z-score and >=-3 z-score, no oedema)	(126) 19.4 % (16.0 - 23.4 95% C.I.)	(100) 15.0 % (12.0 - 18.6 95% C.I.)
Prevalence of severe malnutrition (<-3 z-score and/or oedema)	(23) 3.5 % (2.2 - 5.7 95% C.I.)	(25) 3.8 % (2.4 - 5.9 95% C.I.)

Figure 2: Shows the trend of Malnutrition from 2014 to 2016



3.4.3 Prevalence of Acute malnutrition by sex

The table below shows that almost equal numbers of boys to girls were malnourished. However, the number of girls reported to be malnourished was slightly more than boys as shown in table 5 below

Table 6: Prevalence of acute malnutrition based on weight-for-height z-scores (and/or oedema) and by sex

	All n = 649	Boys n = 321	Girls n = 328
Prevalence of global malnutrition (<-2 z-score and/or oedema)	(149) 23.0 % (18.6 - 28.0 95% C.I.)	(73) 22.7 % (18.4 - 27.7 95% C.I.)	(76) 23.2 % (17.9 - 29.4 95% C.I.)
Prevalence of moderate malnutrition (<-2 z-score and >=-3 z-score, no oedema)	(126) 19.4 % (16.0 - 23.4 95% C.I.)	(62) 19.3 % (15.4 - 23.9 95% C.I.)	(64) 19.5 % (14.8 - 25.2 95% C.I.)
Prevalence of severe malnutrition (<-3 z-score and/or oedema)	(23) 3.5 % (2.2 - 5.7 95% C.I.)	(11) 3.4 % (1.8 - 6.4 95% C.I.)	(12) 3.7 % (2.1 - 6.4 95% C.I.)

3.4.4 Prevalence of acute malnutrition by age

Table 6 shows that all age groups were affected by both severe and moderate acute malnutrition. However, age groups 6-17 and 18-29 months seem to be more affected by severe malnutrition. This can be attributed to untimely complementary feeding practices in the

community while age groups 6-17 and 42-53 seem to be more affected by moderate acute malnutrition. There was no oedema recorded in this survey

Table 7: Prevalence of acute malnutrition by age, based on weight-for-height z-scores and/or oedema

Age (mo)	Total no.	Severe wasting (<-3 z-score)		Moderate wasting (>= -3 and <-2 z-score)		Normal (> = -2 z score)		Oedema	
		No.	%	No.	%	No.	%	No.	%
6-17	168	8	4.8	29	17.3	131	78.0	0	0.0
18-29	171	8	4.7	22	12.9	141	82.5	0	0.0
30-41	148	0	0.0	26	17.6	122	82.4	0	0.0
42-53	125	4	3.2	35	28.0	86	68.8	0	0.0
54-59	37	3	8.1	14	37.8	20	54.1	0	0.0
Total	649	23	3.5	126	19.4	500	77.0	0	0.0

3.4.5 Distribution of acute malnutrition and oedema based on weight-for-height z-scores

There was no oedema cases observed. However, twenty six children (3.9%) were severely wasted (Marasmic) while 96.1% were reported not to be severely malnourished. Those severely malnourished were referred to the nearest health facilities.

Table 8: Distribution of acute malnutrition and oedema based on weight-for-height z-scores

	<-3 z-score	>=-3 z-score
Oedema present	Marasmic kwashiorkor No. 0 (0.0 %)	Kwashiorkor No. 0 (0.0 %)
Oedema absent	Marasmic No. 26 (3.9 %)	Not severely malnourished No. 638 (96.1 %)

3.4.6 Prevalence of acute malnutrition based on MUAC cut off's (and/or oedema) and by sex.

Table 8 below shows the prevalence of global malnutrition based on MUAC at 9.0% compared to 4.8% reported in Aug. 2015 SMART Survey. The prevalence of moderate acute malnutrition based on MUAC was 8.35% and severe acute malnutrition prevalence was 0.6%.

From the GAM prevalence by MUAC, girls seemed to be more malnourished than boys; this trend is in harmony with what was reported in the GAM prevalence by W/H.

Table 9: Prevalence of acute malnutrition based on MUAC cut off's (and/or oedema) and by sex

	All n = 664	Boys n = 332	Girls n = 332
Prevalence of global malnutrition (< 125 mm and/or oedema)	(60) 9.0 % (6.8 - 12.0 95% C.I.)	(21) 6.3 % (4.4 - 9.0 95% C.I.)	(39) 11.7 % (8.4 - 16.3 95% C.I.)
Prevalence of moderate malnutrition (< 125 mm and >= 115 mm, no oedema)	(55) 8.3 % (6.0 - 11.3 95% C.I.)	(19) 5.7 % (3.9 - 8.4 95% C.I.)	(36) 10.8 % (7.5 - 15.4 95% C.I.)
Prevalence of severe malnutrition (< 115 mm and/or oedema)	(5) 0.8 % (0.3 - 1.8 95% C.I.)	(2) 0.6 % (0.1 - 2.5 95% C.I.)	(3) 0.9 % (0.3 - 2.8 95% C.I.)

3.4.7 Prevalence of acute malnutrition by age, based on MUAC cut off's and/or oedema

Severe wasting by MUAC was found to be more prevalent among children of age group 6-17 months. There were no cases of severe wasting by MUAC from all other age groups while the prevalence of moderate malnutrition was more among children aged 6-17 followed by 18-29 months. There were no cases of oedema.

Table 10: Prevalence of acute malnutrition by age, based on MUAC cut off's and/or oedema

Age (mo)	Total no.	Severe wasting (< 115 mm)		Moderate wasting (>= 115 mm and < 125 mm)		Normal (>= 125 mm)		Oedema	
		No.	%	No.	%	No.	%	No.	%
6-17	175	5	2.9	32	18.3	138	78.9	0	0.0
18-29	173	0	0.0	12	6.9	161	93.1	0	0.0
30-41	152	0	0.0	5	3.3	147	96.7	0	0.0
42-53	127	0	0.0	5	3.9	122	96.1	0	0.0
54-59	37	0	0.0	1	2.7	36	97.3	0	0.0
Total	664	5	0.8	55	8.3	604	91.0	0	0.0

3.4.8 Prevalence of underweight based on weight-for-age z-scores by sex

Table 10 below show the global underweight rates for East Pokot Sub County is at 38.8% which is an increase from 32.2% reported in Aug. 2015. This is significantly higher (P= 0.040) Girls seem to be more underweight than boys and this is a turnaround from other surveys conducted in East Pokot that showed that more boys than girls were underweight

Table 11: Prevalence of underweight based on weight-for-age z-scores by sex

	All n = 655	Boys n = 328	Girls n = 327	2015
Prevalence of underweight (<-2 z-score)	(254) 38.8 % (33.9 - 43.9 95% C.I.)	(126) 38.4 % (31.9 - 45.3 95% C.I.)	(128) 39.1 % (33.4 - 45.2 95% C.I.)	(215) 32.2 % (28.3 - 36.5 95% C.I.)
Prevalence of moderate underweight (<-2 z-score and >=-3 z-score)	(172) 26.3 % (22.6 - 30.3 95% C.I.)	(83) 25.3 % (20.9 - 30.3 95% C.I.)	(89) 27.2 % (22.4 - 32.7 95% C.I.)	(148) 22.2 % (19.0 - 25.8 95% C.I.)
Prevalence of severe underweight (<-3 z-score)	(82) 12.5 % (10.0 - 15.5 95% C.I.)	(43) 13.1 % (10.1 - 16.8 95% C.I.)	(39) 11.9 % (8.5 - 16.5 95% C.I.)	(67) 10.0 % (7.3 - 13.6 95% C.I.)

3.4.9 Prevalence of underweight by age, based on weight-for-age z-scores

The prevalence of severe and moderate underweight is higher in children of age groups 6-17 and 18-29 months. Children of age group 54-59 are the least affected by severe underweight.

Table 12: Prevalence of underweight by age, based on weight-for-age z-scores

Age (mo)	Total no.	Severe underweight (<-3 z-score)		Moderate underweight (>= -3 and <-2 z-score)		Normal (> = -2 z score)		Oedema	
		No.	%	No.	%	No.	%	No.	%
6-17	172	22	12.8	42	24.4	108	62.8	0	0.0
18-29	168	22	13.1	49	29.2	97	57.7	0	0.0
30-41	152	14	9.2	38	25.0	100	65.8	0	0.0
42-53	126	15	11.9	34	27.0	77	61.1	0	0.0
54-59	37	9	24.3	9	24.3	19	51.4	0	0.0
Total	655	82	12.5	172	26.3	401	61.2	0	0.0

3.4.10 Prevalence of stunting based on height-for-age z-scores and by sex

Stunting is measured by the index of height for age and reflects failure to receive adequate micro and macro nutrients over a long period of time and is also affected by recurrent and chronic illness. Stunting levels in East Pokot Sub County increased from 34% (Aug. 2015) to 36.5% but with no significant change. This is higher than the national levels of 26% and the Baringo county levels of 29% (KDHS 2014). Further the results showed that boys were more

stunted 39.6% as compared to girls at 33.3% and this trend was similar from the previous nutrition surveys.

Table 13: Prevalence of stunting based on height-for-age z-scores and by sex

	All n = 625	Boys n = 313	Girls n = 312
Prevalence of stunting (<-2 z-score)	(228) 36.5 % (32.0 - 41.2 95% C.I.)	(124) 39.6 % (33.1 - 46.5 95% C.I.)	(104) 33.3 % (27.7 - 39.5 95% C.I.)
Prevalence of moderate stunting (<-2 z-score and >=-3 z-score)	(137) 21.9 % (18.8 - 25.4 95% C.I.)	(73) 23.3 % (19.0 - 28.3 95% C.I.)	(64) 20.5 % (17.1 - 24.4 95% C.I.)
Prevalence of severe stunting (<-3 z-score)	(91) 14.6 % (11.6 - 18.1 95% C.I.)	(51) 16.3 % (12.3 - 21.3 95% C.I.)	(40) 12.8 % (9.0 - 18.0 95% C.I.)

3.4.11 Prevalence of stunting by age based on height-for-age z-scores

Table 13 below shows that the prevalence of severe stunting is higher in children aged 18-29 and 30-41 months respectively. Children of age 54-59 months seem to be least affected by stunting. The prevalence of moderate stunting seems to be evenly distributed among all age groups.

Table 14: Prevalence of stunting by age based on height-for-age z-scores

Age (mo)	Total no.	Severe stunting (<-3 z-score)		Moderate stunting (>= -3 and <-2 z-score)		Normal (> = -2 z score)	
		No.	%	No.	%	No.	%
6-17	167	23	13.8	30	18.0	114	68.3
18-29	159	32	20.1	43	27.0	84	52.8
30-41	141	25	17.7	28	19.9	88	62.4
42-53	123	9	7.3	27	22.0	87	70.7
54-59	35	2	5.7	9	25.7	24	68.6
Total	625	91	14.6	137	21.9	397	63.5

3.4.12 Prevalence of overweight based on weight for height cut offs and by sex (no oedema)

The overall prevalence of overweight is 0.0%.

3.5 MATERNAL NUTRITION STATUS

MUAC was used to determine the level of under nutrition among pregnant and lactating women using a cutoff point of < 21cm. The maternal malnutrition was defined as women whose MUAC measurements were < 21.0cm while women whose MUAC measurements were between 21.0 <23.0cm were classified as at risk of malnutrition.

The survey reached a total of 318 women of reproductive age (15-49years). Among the mothers sampled 67.0% of them were lactating, 16.4% were pregnant and 1.3% were both pregnant and lactating. Out of these, 31 (9.7%) were undernourished as shown in table 17 below

Figure 3: Physiological status of the mother

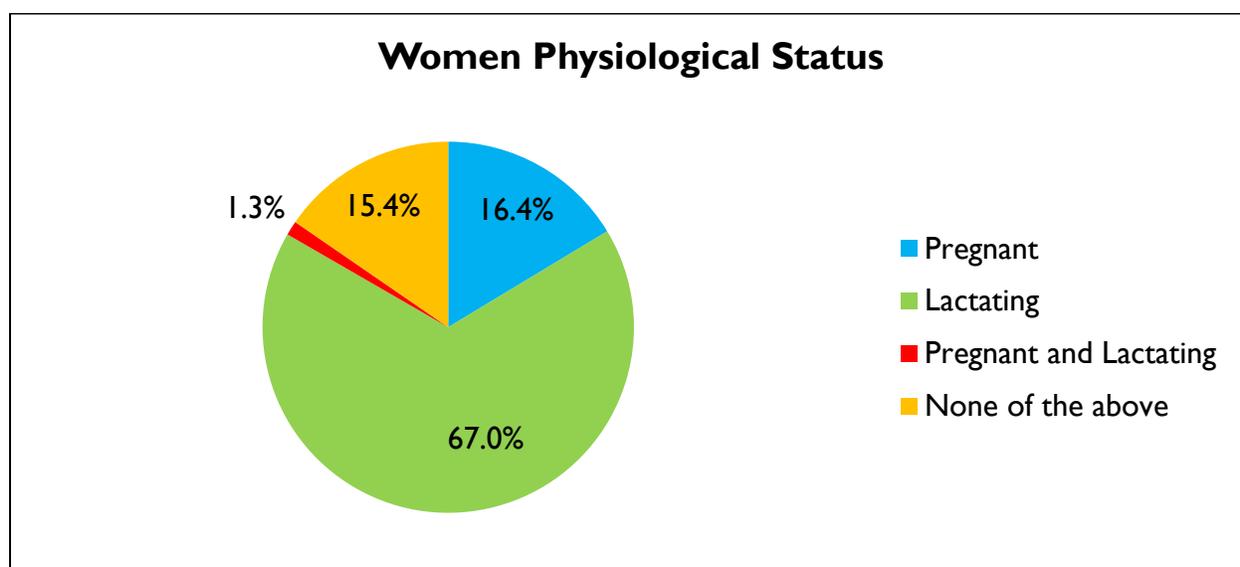


Table 15: Prevalence of Malnutrition of mothers by MUAC

Indicator	N	%
MUAC <21.0 cm for all women	31	9.7%
MUAC <21.0 cm for PLW	30	9.4%

Iron folate supplementation was poor among pregnant mothers in East Pokot. No mother was found to have taken IFAs for more than 180 days. Only 18 mothers (8.3%) had received the supplement for 90 days and above. Generally the average number of day's mothers was supplemented with IFAS was 50 days.

Table 16: Iron Folate intake by pregnant mothers

Categories of IFA Consumption (In Days)	No of women	Proportion (%)
< 90 Days	109	50.2%
90≥180 Days	18	8.3%
> 180 Days	0	0%

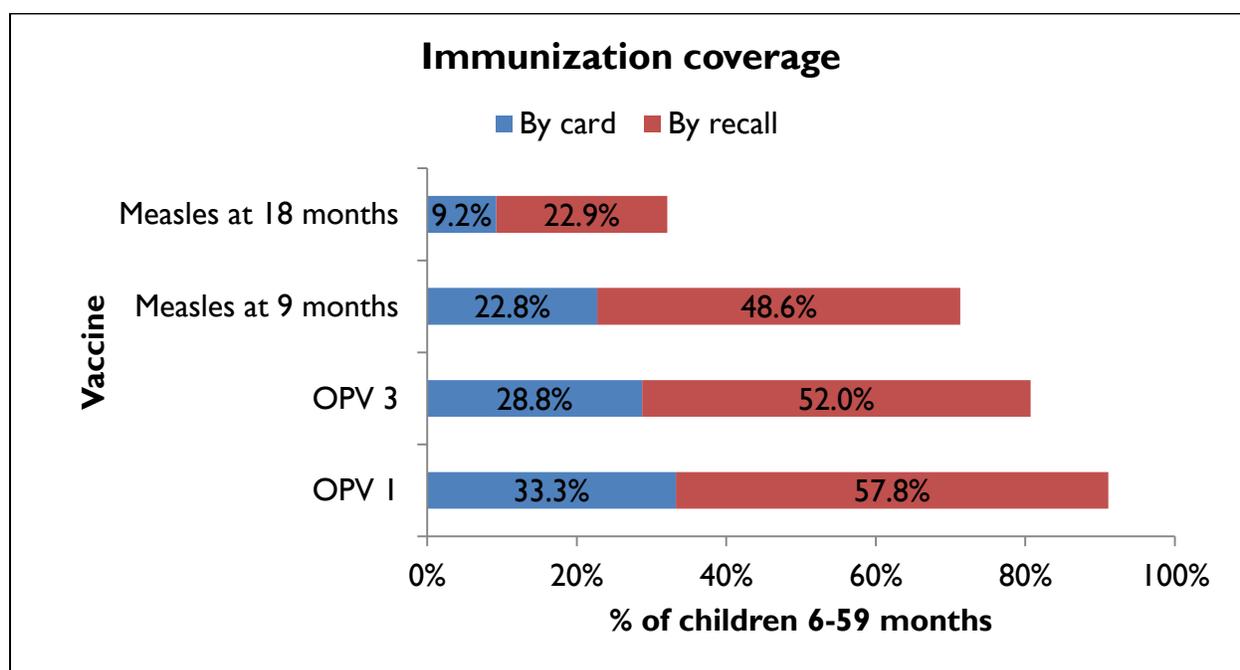
3.6 ACCESS AND UTILIZATION OF HEALTH AND NUTRITION SERVICES

3.6.1 Immunization Coverage

The survey used three antigens as a proxy for immunization coverage. These were; BCG, Oral Polio vaccination (1 and 3) and measles vaccine (1 and 2). The second measles vaccine given at 18 months was recently introduced by the Ministry of Health in the country.

Immunization was confirmed either by card (mother-child booklet) or by recall. BCG was confirmed by observing the scar at the child's arm. BCG, OPV 1 and OPV 3 immunization coverage were at 89.9%, 91.1% and 80.8% respectively which was above the national target of 80%. However Measles at 9 months and 18 months was at 71.4% and 32.1% respectively.

Figure 4: Immunization coverage



3.6.2 Vitamin A, Zinc supplementation and Deworming.

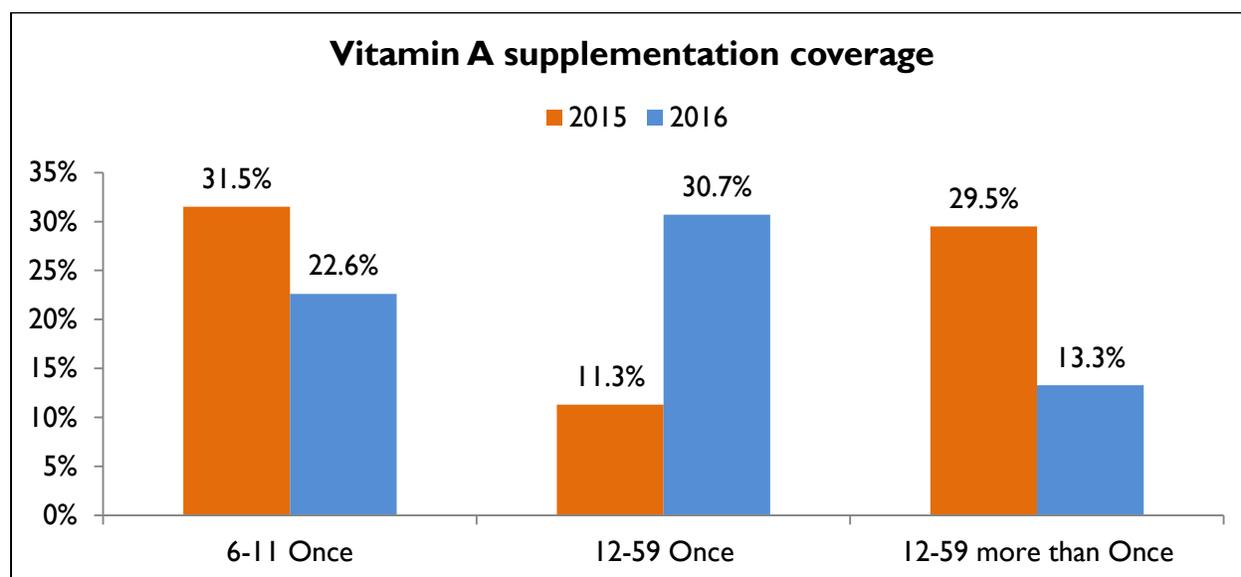
The survey findings showed low coverage of Vitamin A. Children aged 6-11 months who had received Vitamin A was 22.6% a drop from last year that was at 31.5% and children 12-59

months who had received Vitamin A twice or more was at 13.3% a slight increase from last year's coverage of 11.3% which is far much below the national target recommendation of 80%.

Zinc supplementation during diarrheal episodes is highly recommended to reduce severity of the disease and reduce child mortality related to diarrheal diseases. Zinc coverage was found to be 42.9% of the 42 children that had reported to have diarrhoea in the last two weeks prior to survey date.

The survey showed that only 14.9% received dewormers in the last one year. Though slightly improved from last year's coverage of 13.3% it is still low from the national target of 80%.

Figure 5: Vitamin A supplementation coverage



3.6.3 Child Morbidity and Health Seeking Behavior

The survey results showed that 59% of children were reported to be ill within the last two weeks before the survey. This was an increase from 28.4% reported in Aug. 2015 survey. Most cases reported to have suffered from Acute Respiratory Infection (ARI) 73.0% followed with fever at 53.6%. Bloody diarrhea was at 35.5% an increase from 0.5% last year as shown in the below

Table 17: Child Morbidity rates

Disease	Prevalence (%)		
	Aug. 2015	July 2016	
	%	N	%
Total Illness	28.4%	392	59%
Fever with chills	26.3%	210	53.6%

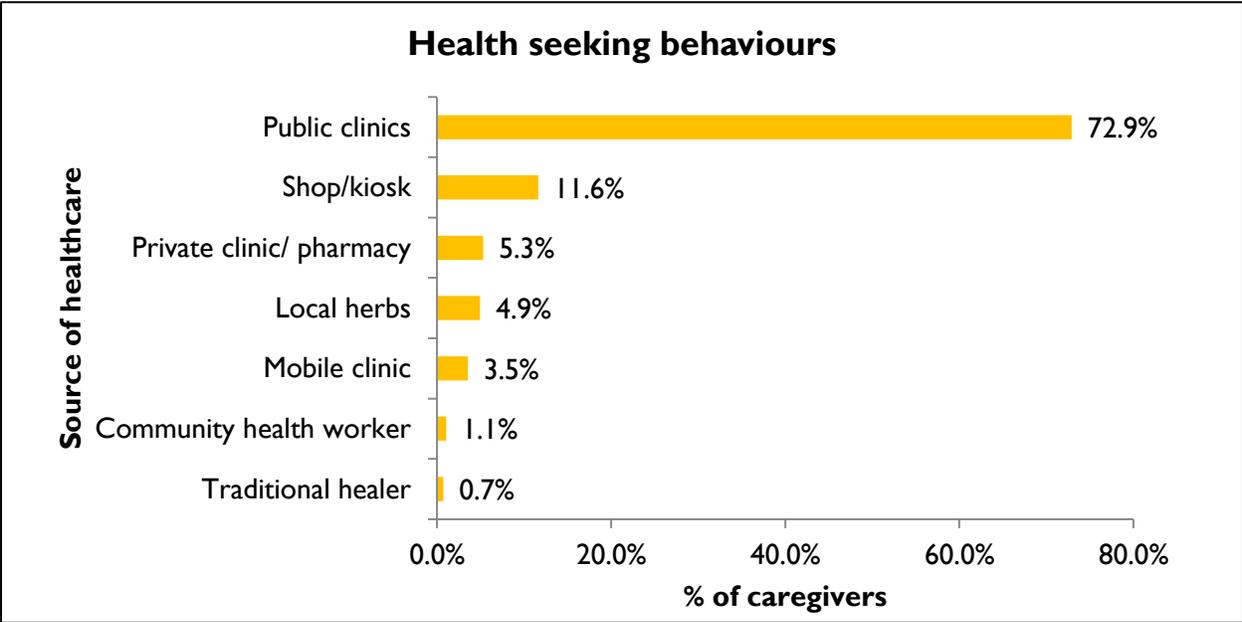
ARI	50%	286	73.0%
Watery diarrhoea	22.1%	160	40.8%
Bloody Diarrhoea	0.5%	139	35.5%
Others (pneumonia, Skin infection, Eyes and ear infections)	5.4%	32	8.2%

The high diarrhoea rates could be as a result of poor hygiene and sanitation practices where by the latrine coverage is at 3% and only 2% of the respondents washed hands at the 4 critical times. Over 90% of households in East Pokot did not treat their drinking water thus exposing themselves to risk of getting water waterborne diseases. The high prevalence for acute respiratory infections could be attributed to the cold season which accompanies the long rains and hence most of the children under five years are prone to these diseases.

3.6.4 Health seeking behaviors

Most of the caregivers (81.7%) reported to seek medical attention from public and private clinics hence this show that most care givers are aware of the formal treatment regime apart from few who used local herbs (4.9%).

Figure 6: Health seeking behaviors



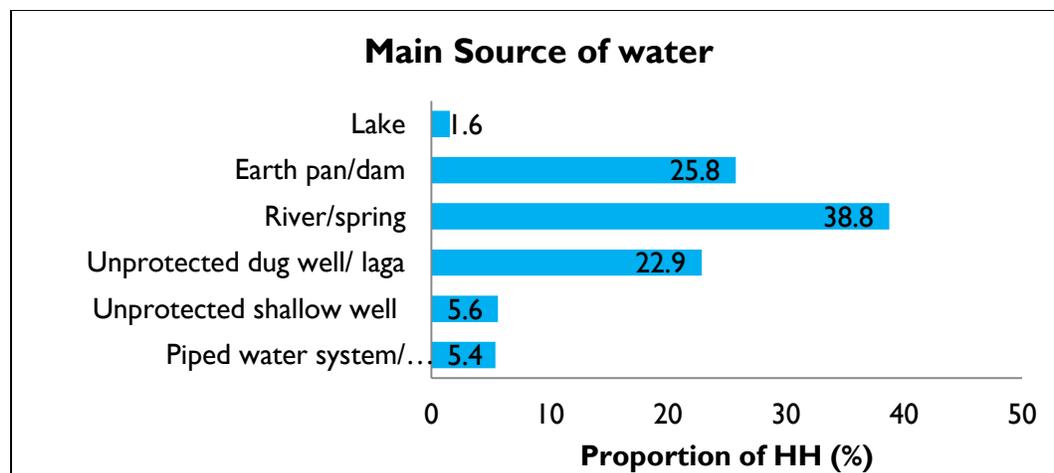
3.7 Household Water Access, Hygiene and Sanitation

3.7.1 Main source of drinking water for the residents

Majority of the residents of East Pokot Sub County (94.7%) obtain their drinking water from unsafe sources mainly unprotected shallow well, unprotected dug wells, lakes, rivers and water

pans. Only 5.4% of the residents are able to access safe drinking water from protected shallow wells, protected springs and taps as indicated in the graph below.

Figure 7: Main water sources



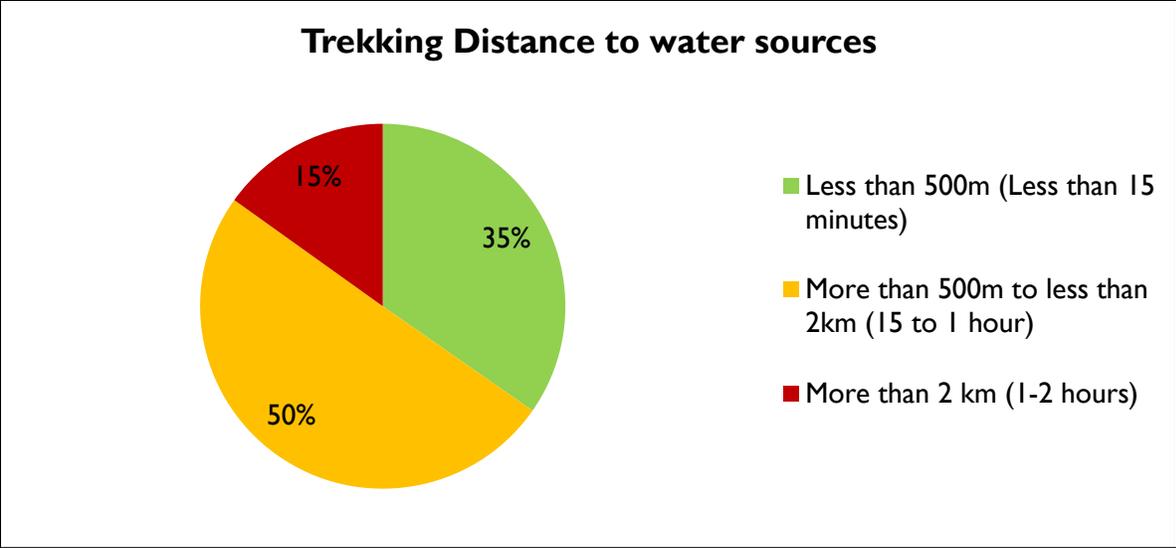
3.7.2 Methods of Treating and Storing Drinking Water

98.1% did not treat water before drinking and 51% stored their drinking water in closed containers. Despite many households fetching water from unprotected sources, water treatment before drinking was rarely done. Only 2.9 % of the households treated water while one percent used filtering pots and less than one percent used chemicals.

3.7.3 Distance To/ from Water Source

SPHERE standards for WASH recommends that the maximum distance from any household to the nearest water point should be 500 meters. Half of the respondents (50%) reported to trek for more than 500meters and less than 2 kilometres to get water while 35% reported to trek for less than 500meters and 15% reported to trek for more than 2 kilometres.

Figure 8: Trekking distance to water sources



3.7.4 Hygiene and Sanitation

Most of the respondents (91%) washed their hands before eating and 58% washed their hands before cooking. Only 11% washed hands after visiting toilet/latrine, while 7% washed hands after taking children to the toilet/latrine. However, those who practiced hand washing at the four critical times were only 2%.

Those who owned toilets or latrines were only 3% and 96% of the respondents practiced open defecation.

Table 18: Hand washing practices

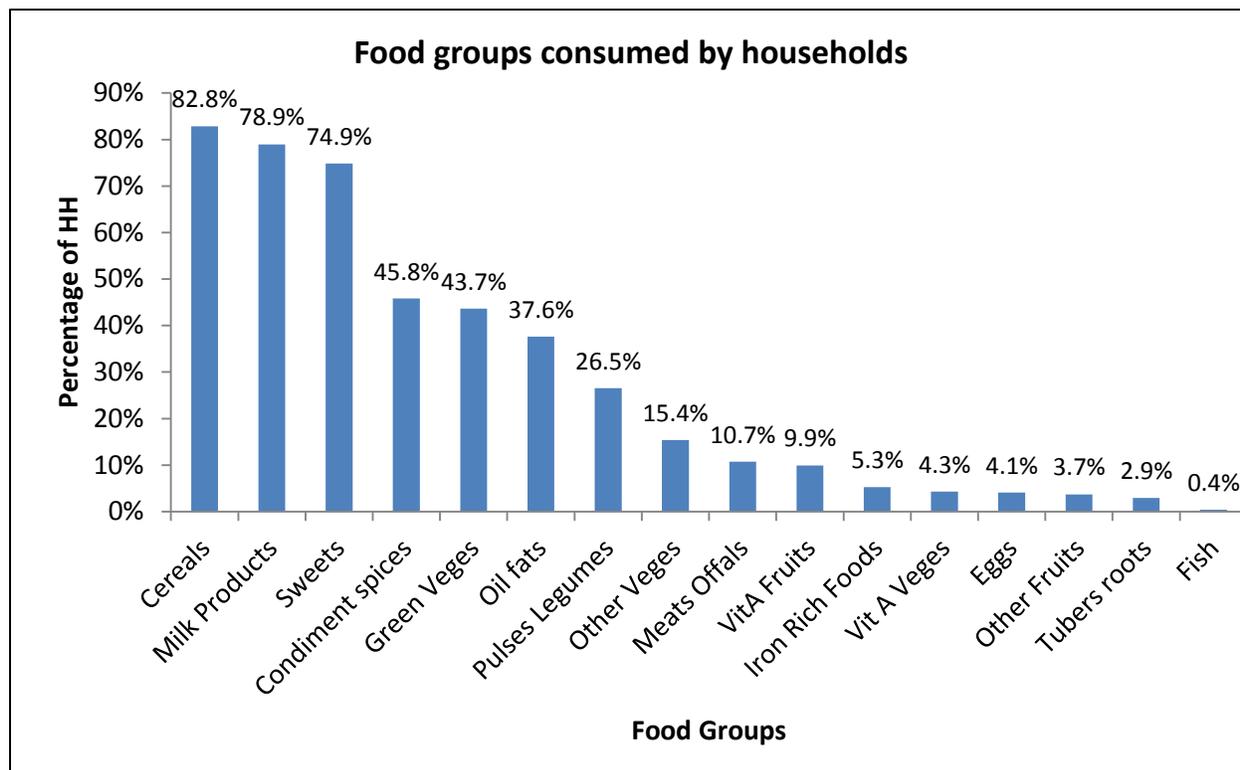
HYGIENE	N	%
HH Aware of hygiene practices	467	
After toilet	53	11%
Before cooking	272	58%
Before eating	424	91%
After taking children to the toilet	31	7%
Before Milking	71	15%
Hand washing in all 4 critical times	9	2%
Hand washing >3 times	38	8%
Hand washing by soap and water	84	18%
SANITATION		
Open defecation(bushes)	497	96%
Own traditional/improved latrine	16	3%

3.8 Household Dietary Diversity and Food Consumption Score

3.8.1 Household Dietary Diversity

In assessing the nutritional quality and quantity of the food consumed by the respondents, a week retrospective household dietary diversity questionnaire was administered. Only one main food groups (cereals) was consistently consumed within 7 days by more than 80% of the sampled households. Milk products and sweets were also highly consumed at over 70%. Fruits and other proteins other than milk were consumed by less than 50% of the respondents.

Figure 9: Food groups consumed by households



3.8.2 Household Dietary Diversity Score based on 24 hours recall

63.2 % of the respondents were able to take more than 4 food groups per day, this has declined from the last year’s survey where 77.7% were able to consume 4 food groups per day. This could be attributed to lack of food varieties available to households due to high prices in the market and inaccessibility of markets due to poor road networks.

Table 19: Household Dietary Diversity Score based on 24 hours recall

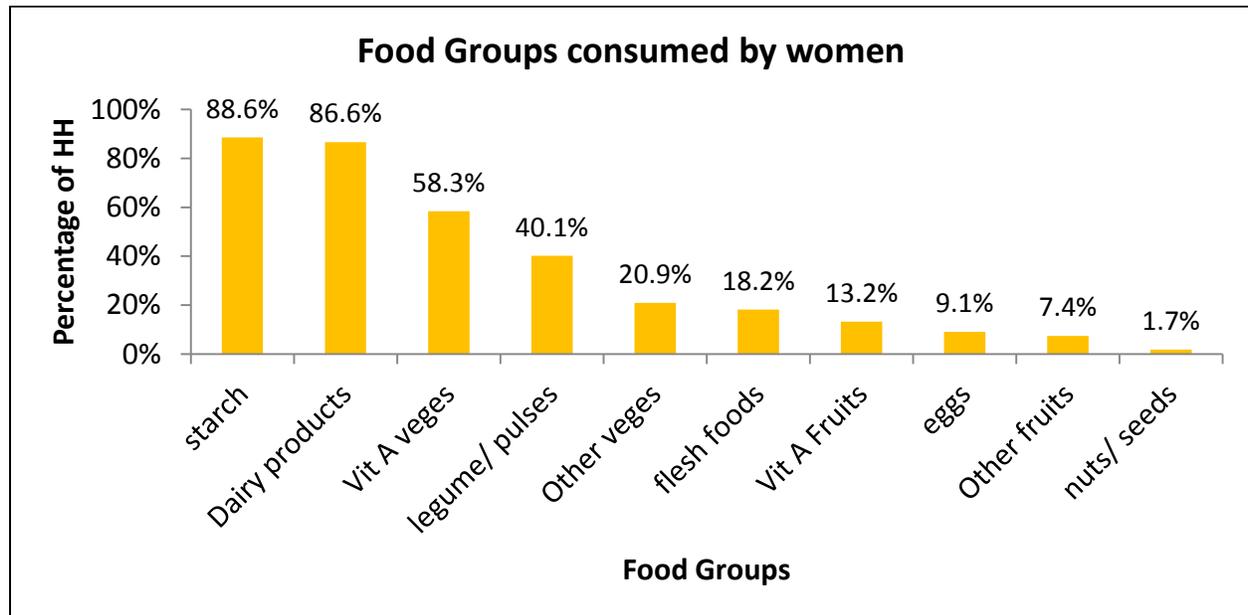
Indicator	Aug. 2015	July 2016
Households Consuming <4 Food Groups	22.3%	36.8%

Households Consuming >4 Food Groups	77.7%	63.2%
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3.8.3 Women Minimum Dietary Diversity

In assessing the nutritional quality and quantity of the food consumed by the surveyed women of reproductive age, a 24 hour recall period household dietary diversity questionnaire was administered. The consumption of 10 food groups is as shown in the graph below

Figure 10: Food groups by women



3.8.4 Women Minimum Dietary Diversity

Women Minimum Dietary Diversity indicator tells whether or not women 15-49 years of age have consumed at least five out of ten defined food groups the previous day or night.

In East Pokot 22.5% of the women surveyed had consumed more than 5 food groups.

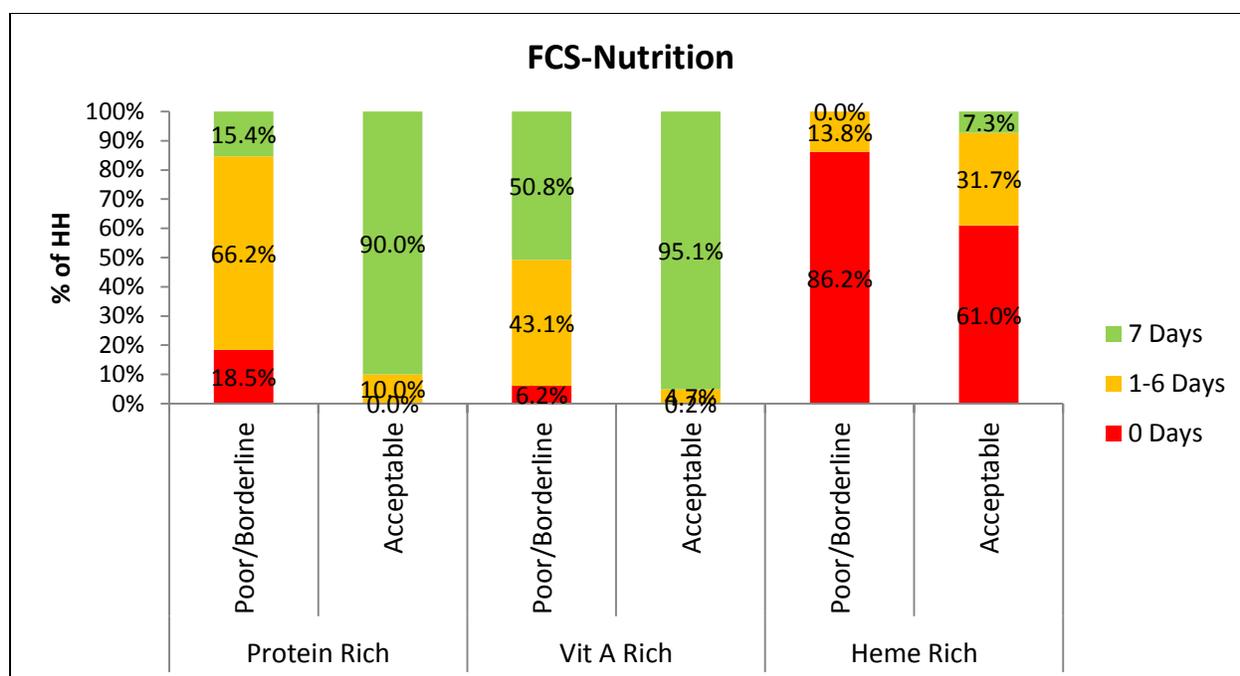
3.8.5 FCS- Nutrition

The purpose of FCS - Nutrition is to assess nutrient inadequacy by looking at the frequencies of consumption of food groups rich in the nutrients of interest like Vitamin A and Iron.

Deficiencies in micronutrients, such as vitamin A and iron, over a long period of time, lead to chronic undernutrition. Iron deficiency leads to anaemia and Vitamin A deficiency leads to blindness and interferes with the normal functioning of the immune system, growth and development as well as reproduction.

In East Pokot the HHs classified as food insecure (both poor and borderline) as well as those considered with adequate food consumption are at important risk of deficiency of Heme iron as shown in the graph below

Figure 11: FCS-Nutrition



3.8.6 Food Consumption Score and Coping Strategy Index.

The food consumption score is an acceptable proxy indicator to measure caloric intake and diet quality at household level, giving an indication of food security status of the household. It's a composite score based on dietary diversity, food frequency and relative nutritional importance of different food groups. 87.4% of the sampled households had acceptable FCS, 9.88% were in the borderline and only 2.71% had poor score.

Table 20: Food Consumption Score and Coping Strategy Index.

Main Threshold	Nomenclature	Proportion of Households	
		Aug. 2015	July 2016
0-21	Poor food consumption...manly cereal and sugar	3.3%	2.71%
21.5-35	Borderline food consumption Cereal, legumes, milk, oil, sugar	6.2%	9.88%
>35.5	Good food consumption Cereal, legumes, milk, condiment, flesh meat, vegetable, oil, sugar	90.5%	87.4%

The Coping strategy index (CSI) is considered an outcome of household food insecurity. The collection is per the number of days a household had to rely on the various coping strategies in the past seven days. The average CSI for East Pokot was 27.59% higher from last year's index which was 14.66% meaning the sampled population is engaging more in different survival tactics due to inadequate food availability at household level.

Table 21: Coping strategy Index

Coping strategy	Proportion of HHs (N=)	Frequency score (0-7)	Severity score (1-3)	Weighted score=Frequency*weight	
				Aug. 2015	July 2016
Rely on less preferred & less expensive food	60.5 (n= 312)	3.17	1		3.17
Borrow food	62.2% (n= 321)	2.93	2		5.86
Limit portion sizes	66.1% (n= 321)	3.71	1		3.71
Restrict consumption of food by adults for young children to eat	67.6% (n= 349)	3.64	3		10.92
Reduced number of meals	65.3% (337)	3.93	1		3.93
Total weighted Coping Strategy Score				14.66	27.59

CHAPTER FOUR

CONCLUSION AND RECOMMENDATIONS

The survey team took time to look at the recommendations that were done in the 2015 SMART and their progress of implementation so far. This is as shown in the table below

Table 22: Recommendations from Aug. 2015 survey and progress of implementation

Recommendations from 2015 SMART Survey	Progress on Implementation
Review of nutrition response plan for East Pokot.	Was done and the Maternal and Child Health Program is now being implemented in East Pokot.
Integrated outreach services	6 integrated outreaches done bi monthly
Quarterly mass screening	It's done quarterly in East Pokot
Train health workers on MIYCN and IMAM	79 health workers trained on MIYCN and IMAM
Train MTMSG on detection of malnutrition and referrals , and MIYCN	Two MTMSGs have been capacity build on MIYN
Train health workers on nutrition supply chain system and management.	30 Members of County health management team trained.
Train CHVs in the 8 CUs on community strategy nutrition technical module.	Seven community Units trained and strengthened.
Enhance linkage of nutrition specific with nutrition sensitive interventions in other sectors, livestock, agriculture, education,	Involving other sectors in planning nutrition activities and implementing them in ECDs
Train MTMSG and CHVs on proper WASH practices.	Two mother support groups trained on WASH practices
Triggering community led total sanitation.	4 community units trained on CLTS in East Pokot.
Conduct health education on WASH in schools	Not done in East Pokot

Training ECD teachers on VAS, deworming, growth monitoring and linkage to health facilities.	Planned to be done Before August
Training health workers on micronutrient supplementation.	43 health workers trained
Support preposition of nutrition therapeutic supplies.	30 members of the CHMT and SCHMT have been trained on supply chain.
Equip the Chemolingot Sub County, Kollowa and Tangulbei stabilization centers and train health workers on SC	Ongoing at procurement stage

Table 23: July 2016 Smart Survey Recommendation And Implementation Timeline

FINDINGS	RECOMMENDATION	ACTOR (BY WHO?)	IMPLEMENTATION TIME LINE
GAM - 23.0% SAM- 3.5% PLWVs -9.4%	<ul style="list-style-type: none"> ➤ Carryout mass screening in East Pokot Sub County. ➤ Reactivate stabilization centres. ➤ Scale up IMAM to all East Pokot Health facilities. ➤ Implement surge model in every health facilities. ➤ Scale up Outreaches. 	MOH, WVK KRCS UNICEF	October 2016. Sept 2016. Dec 2016 Dec 2016 Sept 2016
Low coverage of Vit A and Deworming. Poor hygiene Practices.	<ul style="list-style-type: none"> ➤ Integrate Vit A supplementation and Deworming to ECDs. ➤ Train CHVs on nutrition technical module. ➤ Implement the existing SBCC Strategy. ➤ Implement the complementary feeding action plan. ➤ Reactivate the SCNTF ➤ Conduct health education on WASH in schools. 	MoH, WVK KRCS UNICEF	On-going On-going Sept 2016 Sept 2016 Aug 2016 Dec 2016