SAVING LIVES
CHANGING LIVES

Nutrition in Numbers

An overview of WFP nutrition programming in 2017

WFP
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WFP Nutrition in 2017...

WFP

reached a total of **16.3 million** beneficiaries with **Nutrition-specific programming**

implemented **Nutrition-specific programming** in **55 countries** worldwide

52% beneficiaries reached through **treatment programming**

48% beneficiaries reached through **prevention programming**

Nutrition beneficiaries include

5.9 million
Children 6-23 months

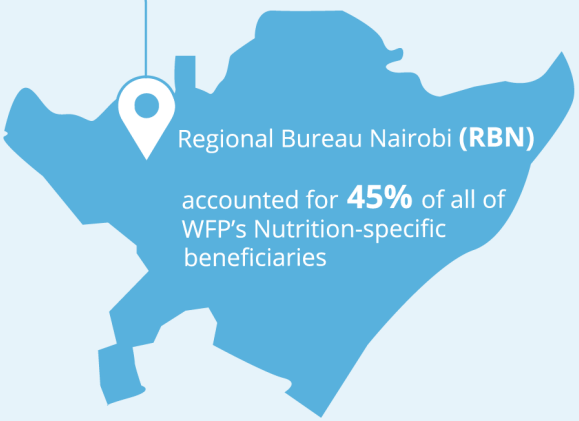
4.9 million
Children 24-59 months

5.0 million
Pregnant and Lactating Women

27% increase in beneficiaries reached with **Nutrition programming** (2016-2017)

Most of this growth was in **prevention programming (+45%)** compared to **treatment (+2%)**

67% of Nutrition-specific beneficiaries were in countries facing a humanitarian crisis



SBCC

WFP reached **4 million** people with nutrition messaging

MAM treatment performance indicators were generally **in line** with SPHERE standards

Coverage needs improvement. **Half** of nutrition programmes were well **below target or did not monitor coverage** at all

32 countries monitored **at least one** dietary outcome indicator (out of MAD, MDD-W, and/or FCS-N)

Specialised nutritious foods were included as part of the food transfer in

44% of countries for **General Distribution**

30% of countries for **School Meals programmes**

Introduction

This document draws on corporate reporting data to present an overview of WFP's nutrition programming worldwide in 2017. It includes figures related to WFP beneficiaries, outputs, outcomes and commodities, as well as historical data to present trends over the past five years.

Note that nutrition programming here refers only to direct assistance provided through nutrition-specific interventions, namely: treatment of moderate acute malnutrition (MAM), prevention of acute malnutrition, prevention of stunting, and prevention of micronutrient deficiencies. Activities related to capacity-strengthening and technical assistance are not presented, nor is programming related to HIV/TB.

This report only includes information documented in the 2017 Standard Project Reports (SPRs) and Annual Country Reports (ACRs), and therefore does not include data related to trust fund projects or operational grants.

Global Overview

In 2017 WFP directly assisted 89.8 million people across 82 countries. Of these, 55 countries implemented nutrition-specific programming, reaching a total of 16.3 million people worldwide – 71 percent of the total planned nutrition-specific beneficiaries for 2017.

By activity type

As shown in Figure 1, WFP reached 8.5 million beneficiaries through treatment of moderate acute malnutrition (MAM), accounting for 52 percent of all nutrition-specific beneficiaries. The remaining 48 percent were reached through prevention programming.

Figure 1: Actual versus planned nutrition-specific beneficiaries by activity

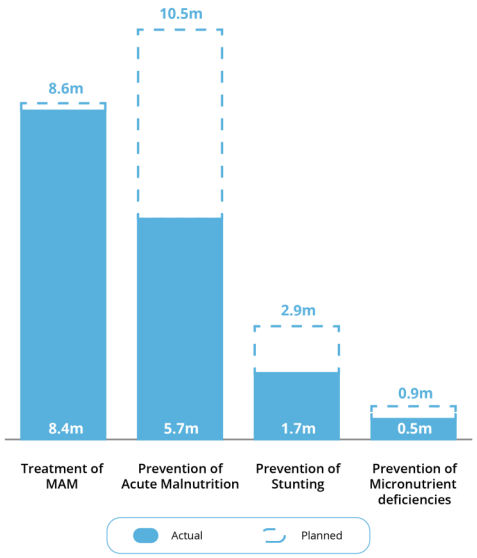


Figure 1 also compares the total number of beneficiaries reached to the total number planned. Overall, treatment programmes reached more than 97 percent of total planned beneficiaries, while this figure averages at 55 percent across prevention programmes. However, this is partly explained by large treatment programmes reaching many more beneficiaries than planned (such as in Ethiopia, South Sudan, and Malawi), which balances out under-achievements.

On average, both Treatment of MAM programmes and Prevention of Acute Malnutrition programmes reached about 86 percent of planned beneficiaries[1]. This figure is lower for Prevention of Stunting and Prevention of Micronutrient Deficiencies; these programmes reached an average of 75 percent and 63 percent of planned beneficiaries, respectively. This may be partly due to a prioritisation of immediate nutrition needs over longer term interventions when faced with resource constraints.

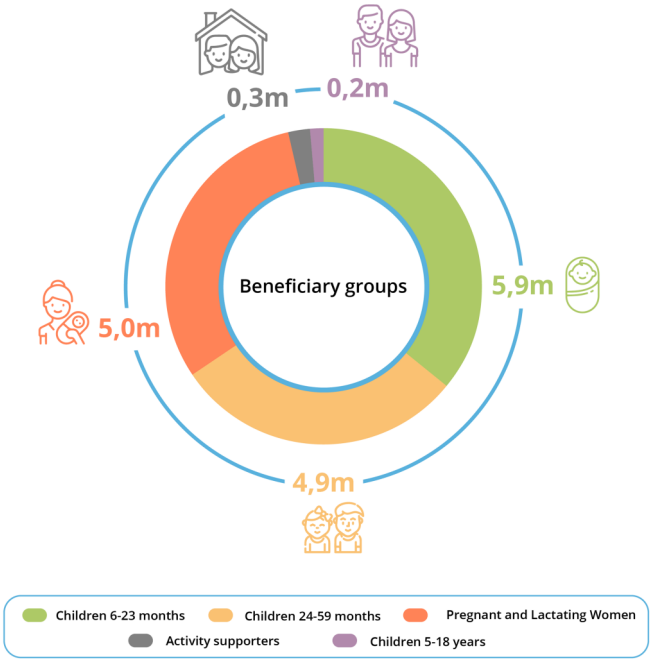
At the country level:

- 39 countries implemented MAM treatment (compared to 45 countries planned)
- 35 countries implemented prevention of acute malnutrition (compared to 37 planned)
- 25 countries implemented stunting prevention (compared to 31 planned)
- 5 countries implemented prevention of micronutrient deficiencies (compared to 10 planned)

By beneficiary type

In line with WFP's approach to target the most nutritionally-vulnerable household members, most nutrition beneficiaries were children 6-59 months (66 percent) and pregnant and lactating women (31 percent), as shown in Figure 2[2].

Figure 2: nutrition beneficiaries by beneficiaries group



[1] This is the median percentage of actual versus planned beneficiaries and refers only to programmes that were both planned and implemented

[2] WFP also reached 300,000 HIV/TB clients in 18 countries with MAM treatment through HIV/TB programming

A handful of countries also targeted children 5-18 years through nutrition programming, such as in the Democratic People's Republic of Korea (DPRK) where WFP provided nutrition support to children attending kindergartens (aged 5-6 years) and orphans at boarding schools (aged 11-16 years).

Half a million 'activity supporters' were also reported as nutrition beneficiaries, which largely consisted of either family household members who received food rations to prevent sharing of specialised nutritious foods, or of caregivers with children admitted to in-patient therapeutic feeding centres.

By region

Given the wide range of contexts in which WFP operates, the numbers of beneficiaries reached through nutrition programming varies greatly by region, as illustrated in Map 1. A full breakdown of nutrition beneficiaries by region and country can be found in Tables 2 and 5.

Due to the scale of humanitarian needs in East Africa in 2017, Regional Bureau Nairobi (RBN) accounted for 45 percent of WFP's nutrition beneficiaries. This was driven by large scale operations like Ethiopia (2.4 million nutrition beneficiaries), South Sudan (1.8 million) and Somalia (1.7 million).

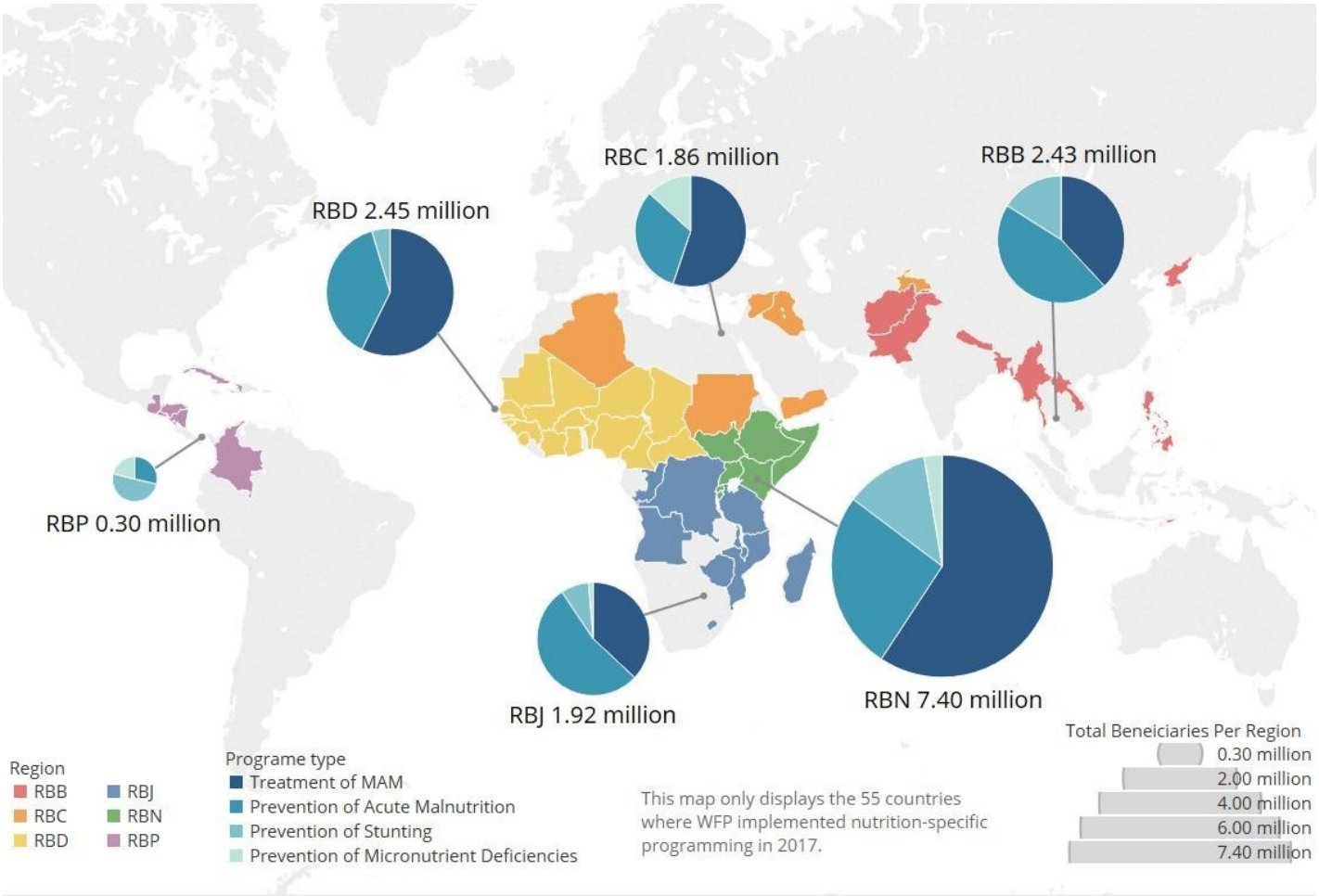
Regional Bureau Dakar (RBD) and Regional Bureau Bangkok (RBB) each accounted for 15 percent of WFP's nutrition beneficiaries, both reaching 2.5 million beneficiaries. Big contributors were Niger (850,000 beneficiaries) and Nigeria (400,000) in RBD, and Democratic People's Republic of Korea (740,000), Pakistan (660,000) and Afghanistan (400,000) in RBB.

Regional Bureau Cairo (RBC) and Regional Bureau Johannesburg both reached about 1.9 million beneficiaries through nutrition programming, each accounting for about 12 percent of WFP nutrition beneficiaries. For RBJ, this represents a growth of 170 percent in nutrition beneficiaries compared to 2016, driven particularly by large operations like Malawi (900,000 beneficiaries) and DRC (400,000). Almost all of RBC's nutrition beneficiaries were in Yemen (750,000 beneficiaries), Sudan (730,000) and Syria (330,000).

It is important to note that these are direct beneficiaries only; Map 1 does not take into account those that benefit from capacity-strengthening and technical assistance, which makes WFP's presence in regions like Latin America (RBP) appear comparatively small. The biggest operation in RBP was in Haiti, where WFP reached 175,000 nutrition beneficiaries.

RBP is also the only region where no treatment programming was implemented and all nutrition beneficiaries were reached through prevention programming. In RBB and RBJ, prevention programming accounted for more than 60 percent of nutrition beneficiaries. While in RBC, RBD and RBN, MAM treatment programmes were more dominant – accounting for at least 55 percent of nutrition beneficiaries in all three regions.

Map 1: Nutrition beneficiaries by region and activity type



Emergency contexts

In 2017, about 67 percent of WFP's nutrition-specific beneficiaries were reached in emergency contexts[3]. As shown in Figure 3, more than 60 percent of all beneficiaries reached through treatment programming were in emergency contexts. However, prevention programming was more likely to be implemented in stable contexts, particularly for stunting prevention and prevention of micronutrient deficiencies. Figure 4 gives an overview of actual versus planned figures for nutrition activities in emergency contexts, and shows that treatment programming reached overall more beneficiaries than planned.

Figure 3: Nutrition-specific beneficiaries reached in emergency and non-emergency contexts

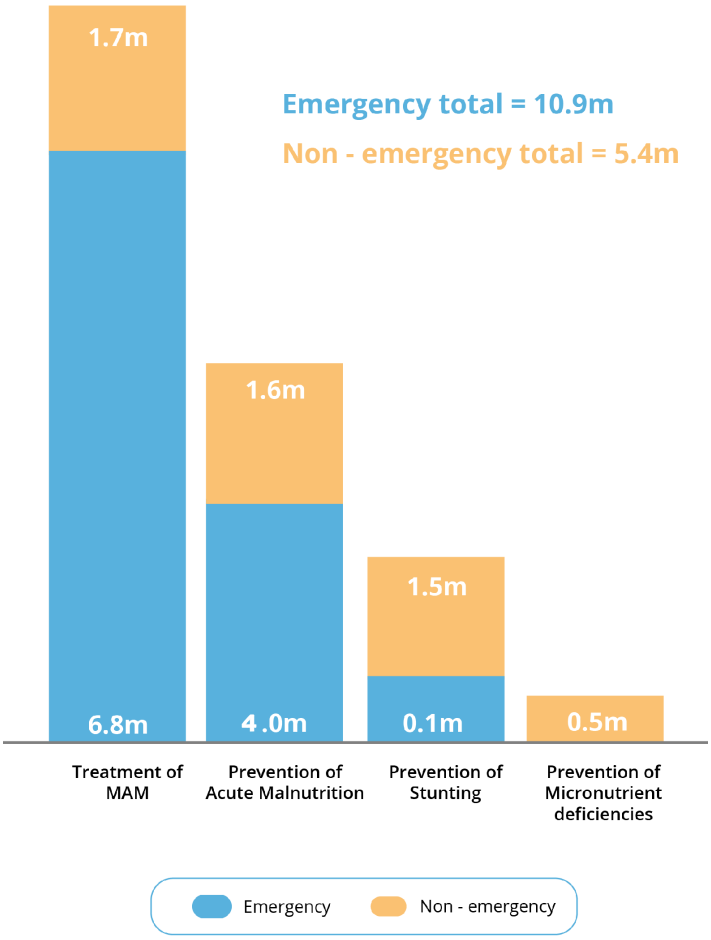


Figure 4: Actual versus planned nutrition-specific beneficiaries in emergency contexts

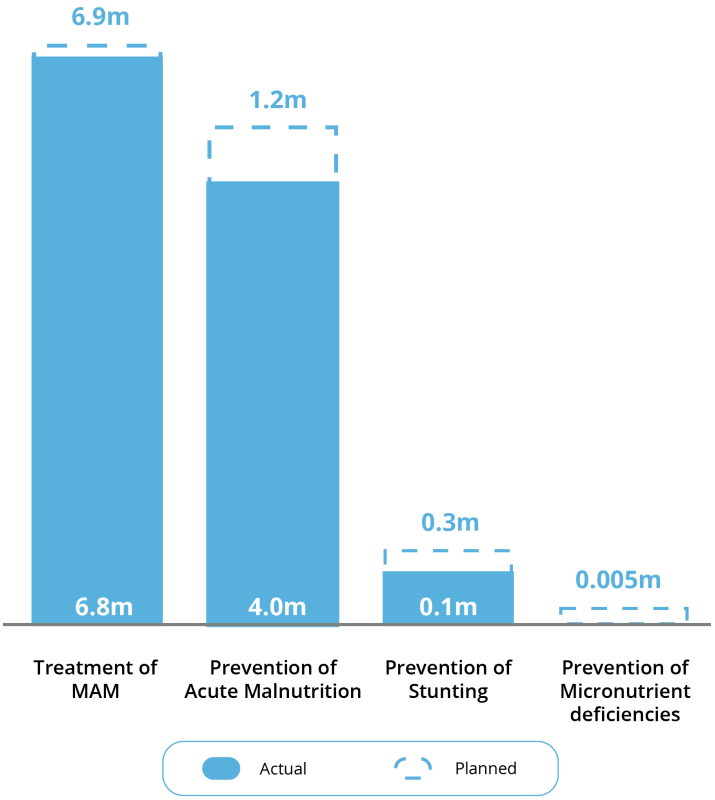


Photo: Nine-month-old child's mid-upper arm circumference shows he is malnourished at a food distribution site in Kenya

[3] Nutrition beneficiaries reached in an 'emergency context' are considered to include all nutrition beneficiaries in a WFP Emergency Operation (EMOP) as well as nutrition beneficiaries reached under Strategic Objective One in the following Protracted Relief and Recovery Operations (PRROs): Algeria 200301; Afghanistan 200447; Bangladesh 200673; Chad 200713, Democratic Republic of Congo 200832; Djibouti 200824; Ethiopia 200700; Ethiopia 200712; Haiti 200618; Kenya 200736; Kenya 200737; Madagascar 200735; Malawi 200460; Malawi 200692; Mali 200719; Mauritania 200640; Mozambique 200355; Niger 200961; Pakistan 200867; Rwanda 200744; Somalia 200844; South Sudan 200572; Sudan 200808; Syria 200988; Uganda 200852; Zimbabwe 200944

Trends in nutrition

In response to record levels of humanitarian needs, WFP's annual beneficiary reach has grown considerably over the last two years. In 2017 WFP reached its highest beneficiary count since 2012.

Relative to all of WFP beneficiaries, nutrition programming has seen an even sharper increase. Nutrition beneficiaries increased by 27 percent between 2016 and 2017, and now account for more than 18 percent of all WFP beneficiaries – up from 12 percent in 2013. This follows a steady increase in nutrition beneficiaries each year over the past five years (Figure 5).

At the activity level, beneficiaries across all nutrition activities increased between 2016 and 2017 (Figure 6). However, beneficiaries in treatment programming increased by just 2 percent, while much larger increases were seen for Prevention of Acute Malnutrition (40 percent increase), Prevention of Stunting (49 percent increase) and Prevention of Micronutrient Deficiencies (96 percent increase).

As shown in Figure 6, stunting prevention presents the clearest upward trend, with beneficiaries surging more than five-fold from 270,000 in 2013 to more than 1.7 million in 2017. The number of beneficiaries reached through the other nutrition activities have fluctuated more over the past five years. Complete figures for these trends can be seen in Tables 3 and 4.

Figure 5: WFP beneficiaries, 2013 - 2017

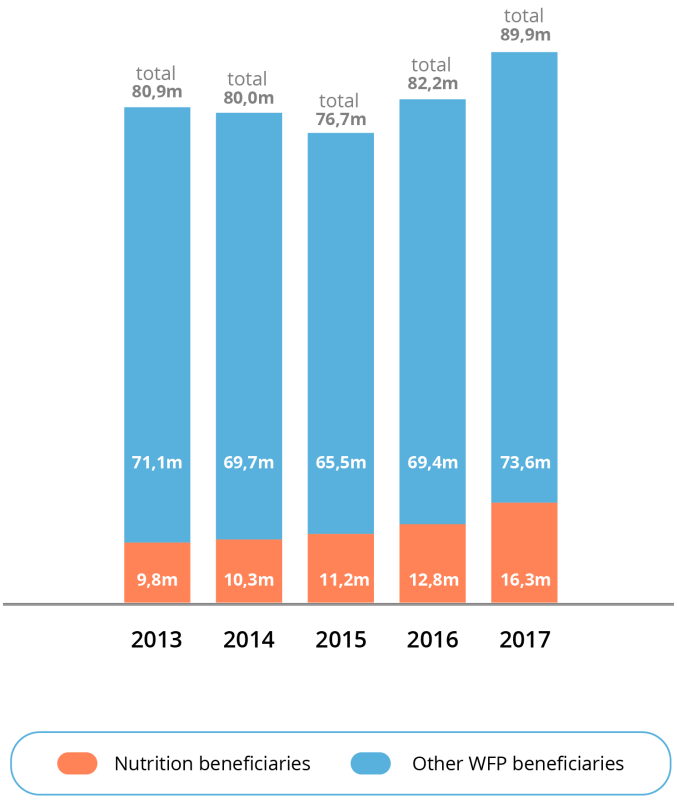
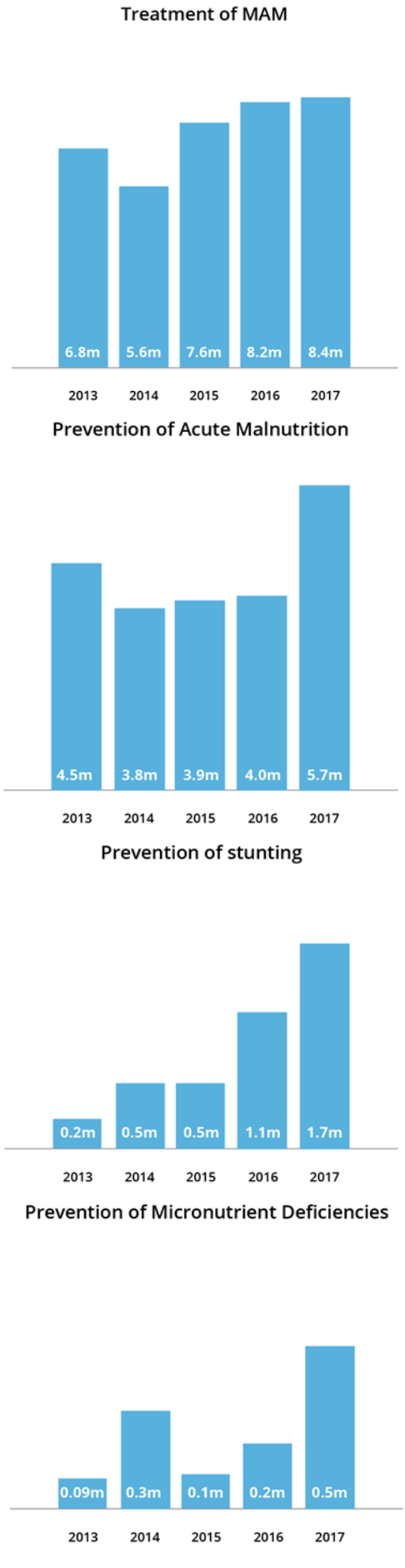


Figure 6: Nutrition beneficiaries by activity, 2013-2017



Specialised Nutritious Foods (SNFs)

With the support of partners, WFP has become a world leader in designing and delivering specialised nutritious foods[4] (SNFs) which meet the specific needs of vulnerable groups. Over the past four years, WFP's global procurement of SNFs has grown 40 percent to reach more than 290,000 metric tonnes in 2017 (Figure 7).

Figure 8 shows how these SNFs are used across WFP programming. About 65 percent of all SNFs were used in nutrition-specific programmes. 22 percent of WFP's SNFs were used in General Distribution and a further 10 percent were used in School Meals – most of which was Super Cereal in both cases. Asset Creation and HIV/TB programmes together accounted for less than 5 percent of WFP's SNFs.

Figure 7: Global procurement of specialised nutritious foods 2013 -2017

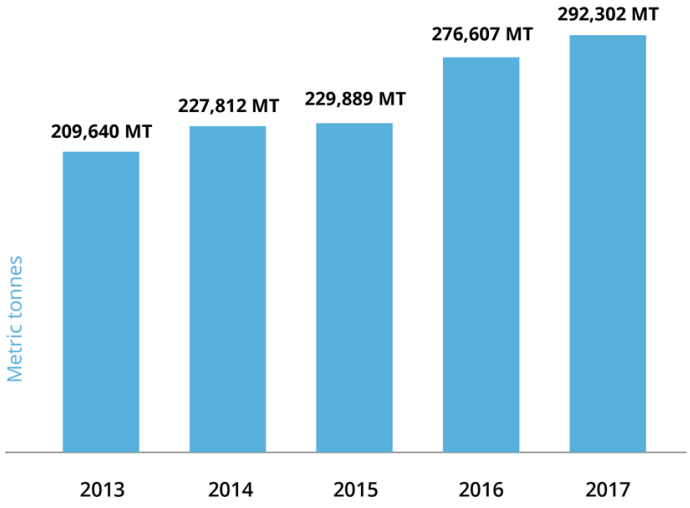


Figure 8: SNF distribution by programme type, 2017

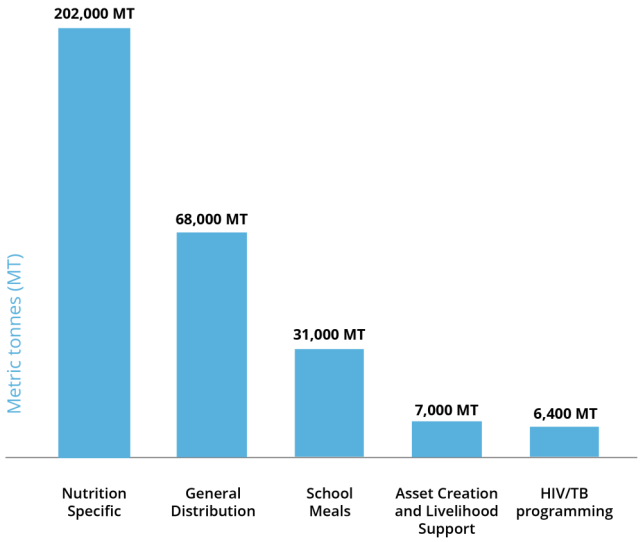


Photo: Child receives Super Cereal Plus as part of nutrition programming in Ethiopia

[4] Specialised nutritious foods (SNFs) refer here to Super Cereal, Super Cereal Plus, lipid-based nutrient supplements (LNS), and micronutrient powders (MNPs).

Foods used in nutrition-specific programming

This section provides an overview of the primary type of food transfer used by countries under different nutrition programmes[5], distinguishing between the two primary target groups: i) children 6-59 months and ii) pregnant and lactating women (PLW).

The results are illustrated in figure 9 for pregnant and lactating women and figure 10 for children 6-59 months. In Figure 10 we see that countries treating children with acute malnutrition primarily used large quantity lipid-based nutrient supplements (LNS-LQ), while Super Cereal Plus was the most common SNF used in Prevention of Acute Malnutrition and Prevention of Stunting. In figure 9, we can see that Super Cereal is by far the most common SNF used for pregnant and lactating women across all activity types.

Although most nutrition programmes provide an SNF as a direct transfer, in 2017 two countries (El Salvador and Ghana) used commodity vouchers, while countries like Syria and Somalia provided fresh food vouchers to improve dietary diversity[6].

These findings are generally consistent with WFP's programming guidance[7]. However, figure 9 shows some countries are still providing Super Cereal to children under five, which is not in line with Codex standards[8].

Figure 9: Use of SNFs by nutrition activity in countries targeting pregnant and lactating women

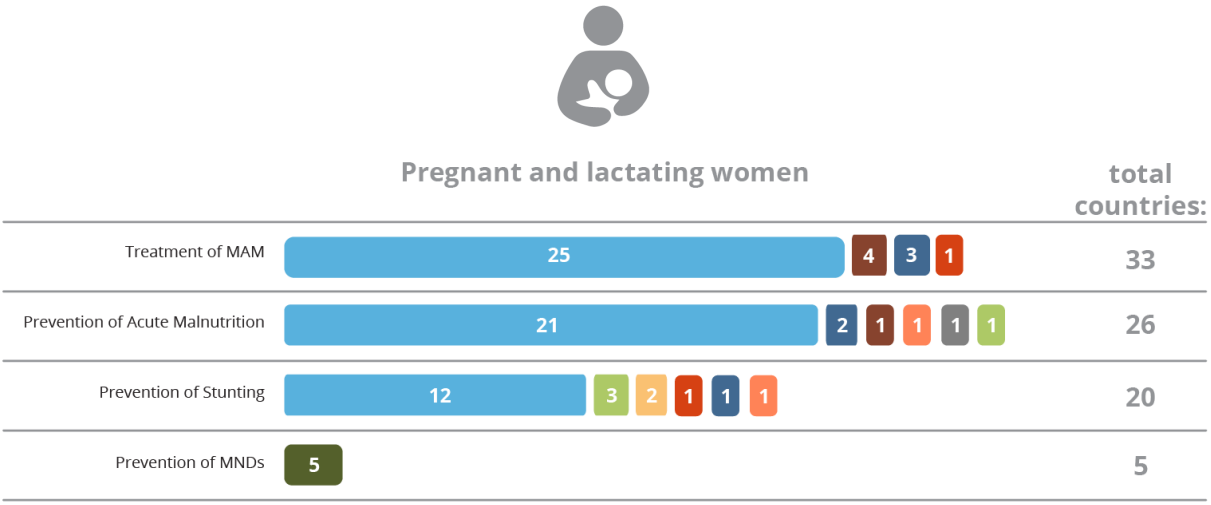
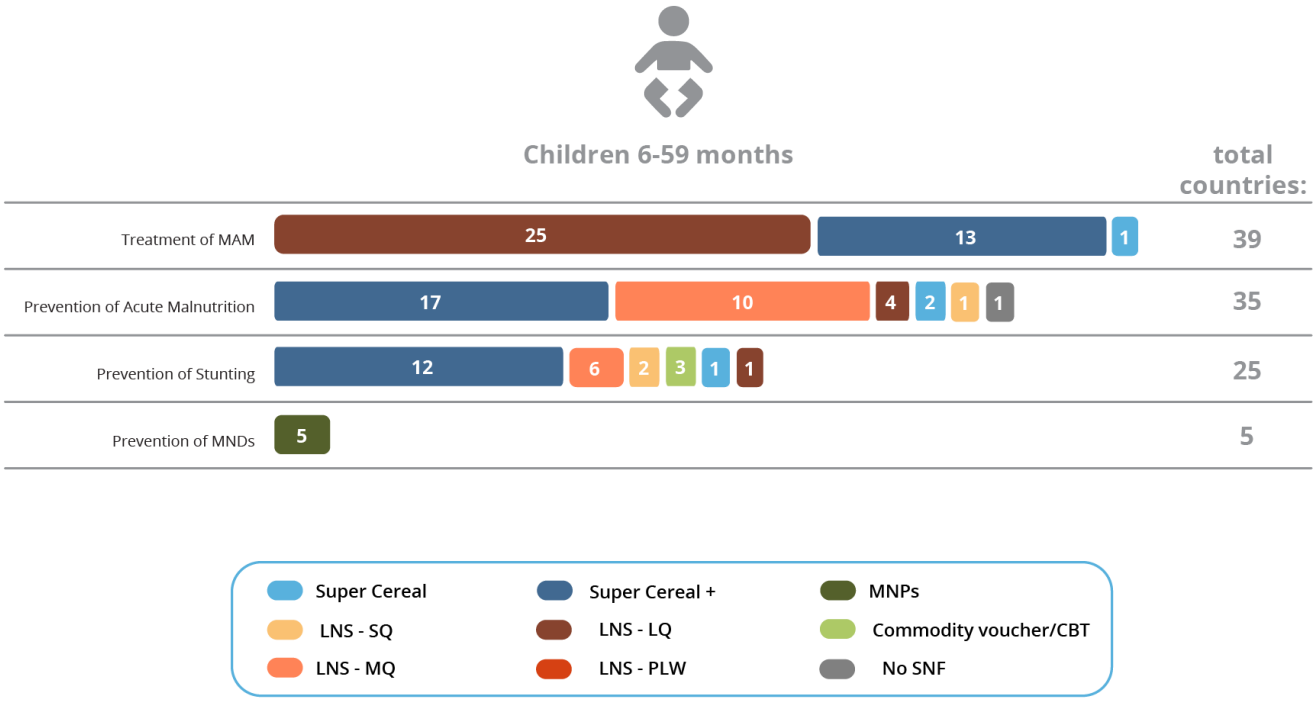


Figure 10: Use of SNFs by nutrition activity in countries targeting children 6-59 months



[5]Although a programme may distribute more than one commodity over the course of the year, the "primary" food transfer is calculated by considering both volume and frequency of distribution in 2017.
[6]Only one country (Democratic People's Republic of Korea) did not use any type of SNF or CBT in a nutrition programme.
[7] Target groups and programmatic recommendations for different specialised nutritious foods appear in WFP's Specialised Nutritious Food Sheet.
[8]In line with the Codex Alimentarius Commission guideline on deoxynivalenol (DON), WFP has been phasing out the use of Super Cereal for children under five years of age.

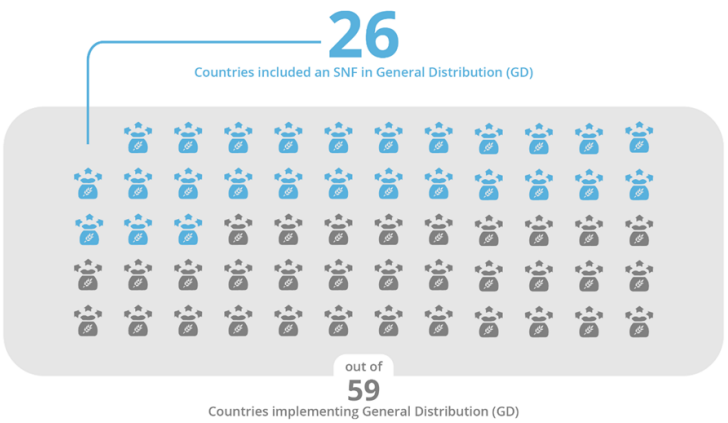
SNFs used in General Distribution and School Meals

Out of a total of 59 countries with General Distribution (GD) programmes in 2017, 26 countries (44 percent) included an SNF as part of the transfer[9]. This is illustrated in figure 11 below.

Although there is some overlap, we can break this down by commodity:

- 25 countries included Super Cereal in GD
- 8 countries included Super Cereal Plus in GD
- 4 countries included a large quantity lipid based nutrient supplement (LNS-LQ) in GD
- 1 country included a medium quantity lipid based nutrient supplement (LNS-MQ) in GD
- 2 countries included micronutrient powders in GD

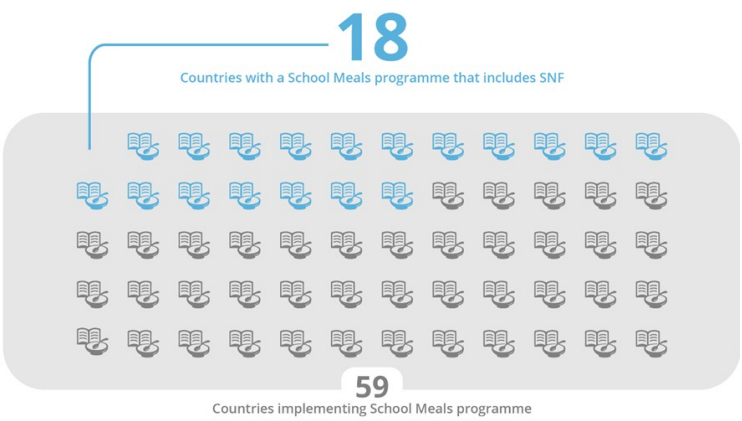
Figure 11: Countries using SNFs in General Distribution



Out of the 59 countries with School Meals programmes, 18 countries included an SNF (30 percent)[10], as shown in figure 12. Breaking this down by commodity, we find:

- 14 countries included Super Cereal in School Meals
- 3 countries included Super Cereal Plus in School Meals
- 3 countries included micronutrient powders in School Meals

Figure 12: Countries using SNFs in School Meals



[9] An SNF is considered to be part of the transfer in General Distribution (GD) if it is distributed for a minimum of two consecutive months within 2017.
[10] An SNF is considered to be part of the transfer in School Meals if it is distributed for a minimum of two consecutive months within 2017.

Food fortification

As detailed in the 2017-2021 Nutrition Policy, WFP is aiming to increase this percentage over the next five years as part of a broader effort to advance food fortification worldwide.

Out of 330,000 MT of rice distributed by WFP in 2017, about 11,000 MT (3 percent) of this was fortified (Figure 13). This is a modest increase from 2 percent in 2016. Figure 14 shows that more than half of WFP's fortified rice is distributed in the West Africa region (RBD), where 6 percent of WFP's rice is fortified. About 20 percent of WFP's fortified rice is distributed in RBB, where 3 percent of rice is fortified. The region with the highest percentage of rice that is fortified is RBP, where 8 percent of distributed rice was fortified.

It is difficult to track the distribution of fortified staple commodities other than rice. However, an analysis of procurement data from 2016 indicates that around 90 percent of the wheat flour and 58 percent of the maize meal procured by WFP is fortified. More than 99 percent of vegetable oil procured by WFP is fortified.

Figure 13: How much of WFP's rice is fortified?

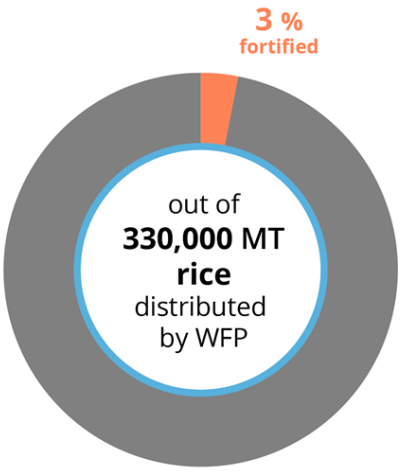
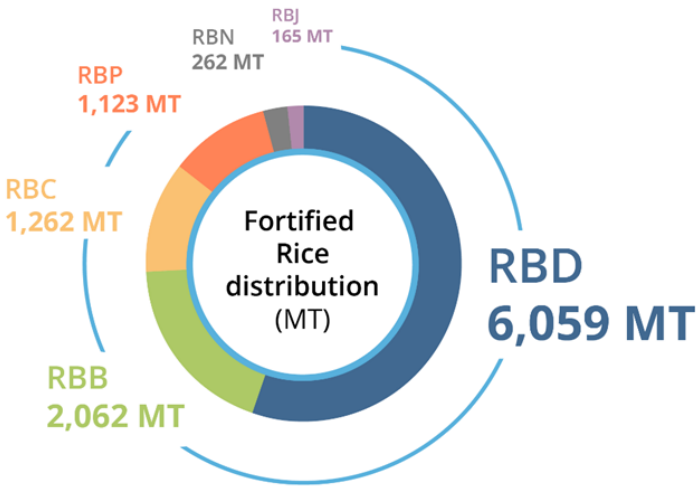


Figure 14: Where is WFP distributing fortified rice?



Social and Behaviour Change Communication (SBCC)

Social and Behaviour Change Communication (SBCC) is increasingly an important element to WFP's nutrition programming and a key strategy for improving nutrition. SBCC essentially includes a collection of communications-based approaches, activities, and tools used to positively influence people's behaviours. This section presents the extent to which SBCC is included as part of nutrition-specific programming.

In 2017 WFP helped reach approximately 4 million people with nutrition messaging[11]. Although some programmes such as School Meal and HIV/TB used nutrition messaging, most of these 4 million people were reached as part of nutrition-specific programming.

Figure 15 shows the share of different nutrition programmes that include at least one output indicator related to beneficiaries receiving nutrition messaging or counselling[12], which can be used as a proxy measure for SBCC. Stunting prevention programmes are the most likely to have SBCC-related activities, with 11 out of 25 countries including nutrition messaging and/or counselling as part of stunting prevention. Prevention of acute malnutrition are the least likely to include SBCC, with just 6 out of 35 countries including nutrition messaging or counselling.

Figure 15: Programmes that include nutrition messaging and/or counselling

[12] Nutrition messaging was included as part of HIV/TB programming in 2 countries, as part of General Distribution in 2 countries, and as part of School Meals in 2 countries.
[13] The full list of possible output indicators are: Number of targeted caregivers (male and female) receiving 3 key messages delivered through WFP supported messaging and counselling; Number of beneficiaries/caregivers who received messages/training on health and nutrition; Number of women exposed to nutrition messaging supported by WFP; Number of people exposed to nutrition messaging supported by WFP; Number of men exposed to nutrition messaging supported by WFP; Number of people receiving nutrition counselling supported by WFP; Number of men receiving nutrition counselling supported by WFP; Number of women receiving nutrition counselling supported by WFP.

Outcome Indicators

This section presents the performance of key outcome indicators used in nutrition-specific programming. Performance is assessed by comparing the latest outcome result with either a project milestone or end-of-project target, depending on whether the project is closed or ongoing.

Green results show good performance and reflect projects that achieve (or are on track to achieve) at least 90 percent of the indicator target value; yellow results show moderate performance and reflect projects that achieve between 50 percent and 90 percent of the target value; and red results show poor performance and reflect projects that achieve less than 50 percent of the target.

Grey results means there is insufficient data to assess performance. This often reflects cases where the indicator has not been monitored, or where data collection has been infrequent.

MAM Treatment Performance Indicators

All MAM treatment programmes are required to monitor the four MAM Treatment Performance Indicators: Mortality rate (beneficiaries dying during the programme); Default rate (beneficiaries not returning to the programme); Non-response rate (beneficiaries not recovering from acute malnutrition); and Recovery Rate (beneficiaries successfully recovering from acute malnutrition).
These are globally accepted standards for MAM Treatment programming endorsed by WHO, UNICEF and WFP. Indicator targets are based on the Sphere standards, whereby:

- Mortality Rate: <3%
- Default Rate: <15%
- Non-response Rate: <15%
- Recovery Rate: >75%

As shown in Figure 16, all four indicators generally performed well, with most results within 10 percent of the target. The default rate demonstrates the most potential for improvement, with 'green' results accounting for 68 percent of results – lower than the other three indicators.

Figure 16: MAM Treatment Performance Indicators

Coverage and Participation Indicators

Coverage (i.e. the proportion of eligible population who participate in the programme) is a required indicator for all nutrition programming; while participation (i.e. the proportion of target population participating in an adequate number of distributions) is required for all prevention programmes, but not for treatment.

For prevention programming, the indicator targets are:

- Participation: >66%
- Coverage: >70%

For treatment programming, the indicator targets for coverage vary depending on context, whereby:

- Rural areas: >50%
- Urban areas: >70%
- Camps: >90%

Figure 17 below shows the extent to which prevention programmes are able to reach the relevant participation indicator targets, and the extent to which all nutrition programmes (both treatment and prevention) are able to reach the relevant coverage indicator targets.

The graphs below suggest that data collection can be a challenge for both participation and coverage indicators, with 'insufficient data' accounting for 45 percent and 40 percent of results, respectively. Less than half of results show good performance in both cases; and for coverage, 14 percent of results are either moderate or poor.

Figure 17: Coverage and participation indicators

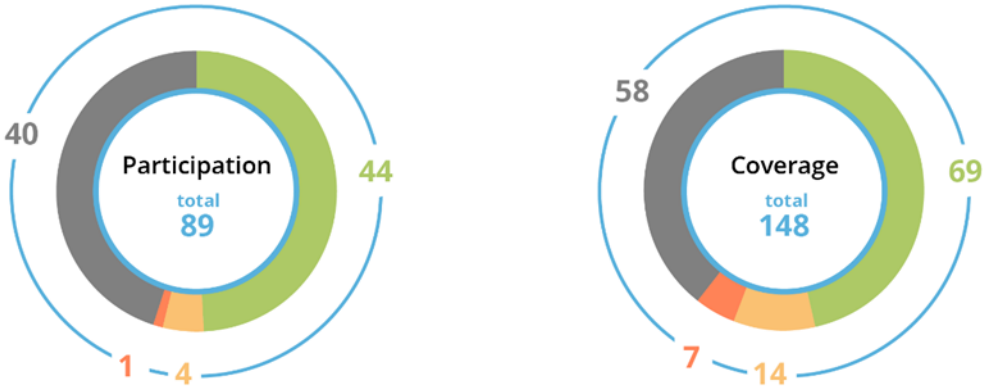


Photo: Family receives fortified rice through a government safety net programme in Bangladesh, with support from WFP

[12] It is not possible to separate the results of coverage indicators by treatment versus prevention programming, as outcomes are linked at the project level, not activity level.

Minimum Acceptable Diet (MAD)

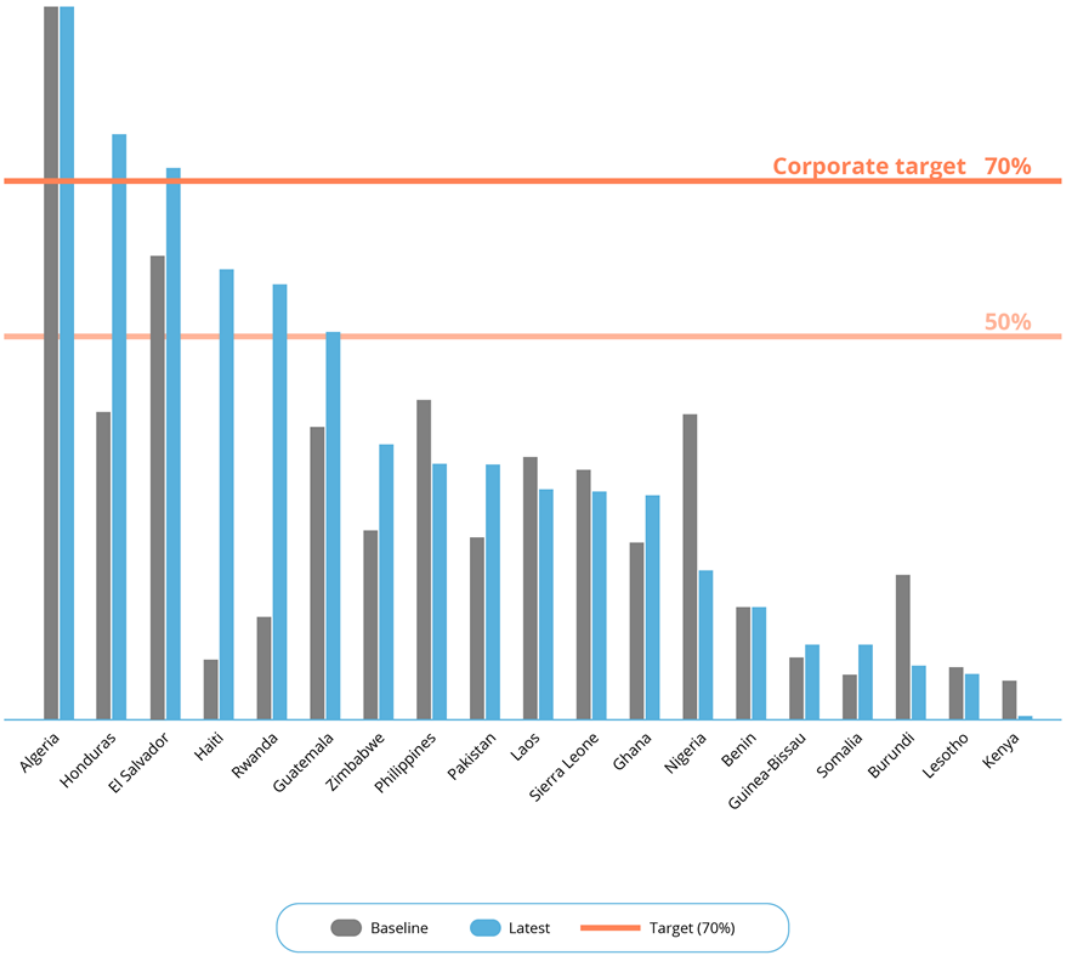
Minimum Acceptable Diet (MAD) is a required indicator for all of WFP's stunting prevention programming. MAD takes into account both the meal frequency and dietary diversity of young children, and is part of the compendium of indicators used internationally to measure Infant and Young Child Feeding (IYCF) practices. The corporate target is to have 70 percent of children consuming a minimum acceptable diet by the end of the project.

Of the 25 countries that implemented stunting prevention programming in 2017, 19 countries were able to monitor and report on MAD. The baseline and most recent follow-up values for MAD are presented for each country in figure 18 below.

We can see that few countries are able to reach the 70 percent target. Those that can meet the target generally start from high baselines, such as Honduras and El Salvador. Other countries saw large improvements in MAD since baseline survey, such as Haiti and Rwanda, even if the latest result was still below the 70 percent target.

It is important to note that the time period between the baseline survey and the latest follow-up are not the same across countries. Some are as short as one year, such as Ghana, while others are as long as three years, such as Honduras.

Figure 18: Proportion of children reaching Minimum Acceptable Diet (MAD)



Nutrition Sensitive Indicators

In line with the new Corporate Results Framework, some countries have started monitoring newly introduced nutrition-sensitive outcome indicators like Minimum Dietary Diversity for Women (MDD-W) and Food Consumption Score Nutrition (FCS-N).

In 2017 MDD-W was monitored in 6 countries: Tanzania, Myanmar, Cote d'Ivoire, Syria, Colombia and Bangladesh. MDD-W was mostly used to monitor Prevention of Stunting, but was also implemented to monitor unconditional resource transfers (URT) and resilience-building activities. FCS-N was monitored in 7 countries: Colombia, Democratic Republic of Congo, Ecuador, El Salvador, Mozambique, Sierra Leone, Sri Lanka and Zimbabwe. This was mostly to monitor unconditional resource transfers (URT), but was also used to monitor resilience-building and asset creation activities.

Starting in 2018, many more countries are expected to be monitoring these indicators. According to planning figures for 2018, a total of 34 countries have planned to monitor FCS-N, and 37 countries have planned to monitor MDD-W. As more countries begin reporting against the Corporate Results Framework, we can conduct a fuller analysis of the use of these new indicators and the performance of the programmes.

Raw Data Tables

Table 1: Planned versus actual beneficiaries by nutrition activity, 2017

Nutrition Activity	Planned	Actual
Treatment of MAM	8,645,406	8,448,785
Prevention of Acute Malnutrition	10,534,362	5,672,718
Prevention of Stunting	2,914,609	1,706,853
Prevention of Micronutrient Deficiencies	858,839	528,088
TOTAL	22,953,216	16,356,444

Table 2: Nutrition beneficiaries by region and activity, 2017

Region	MAM Treatment	Prevention of acute malnutrition	Prevention of stunting	Prevention of MNDs	Total
RBN	4385148	1924500	896845	192912	7,399,405
RBD	1403817	931997	113169	-	2,448,983
RBB	924148	1112664	389964	-	2,426,776
RBC	709185	1027650	153737	26582	1,917,154
RBJ	1026487	588685	-	244981	1,860,153
RBP	-	87222	153138	63613	303,973

Table 3: Nutrition and WFP beneficiaries 2013-2017

Year	Nutrition beneficiaries	WFP total beneficiaries
2013	9,800,000	80,900,000
2014	10,300,000	80,000,000
2015	11,200,000	76,700,000
2016	12,800,000	82,200,000
2017	16,300,000	89,900,000

Table 4: Nutrition beneficiaries by activity, 2013-2017

Year	MAM Treatment	Prevention of Acute Malnutrition	Prevention of stunting	Prevention of Micronutrient Deficiencies
2013	6,832,509	4,582,733	269,032	90,480
2014	5,633,192	3,839,934	508,103	336,401
2015	7,643,126	3,927,420	527,788	171,692
2016	8,297,969	4,035,323	1,147,970	269,597
2017	8,448,785	5,672,718	1,706,853	528,088

Table 5: Nutrition beneficiaries by region and country, 2017

Region/Country	Nutrition beneficiaries
RBB Regional Bureau Bangkok	**2,426,776**
Korea, Democratic Republic	744,389
Pakistan	658,464
Afghanistan	388,549
Nepal	233,947
Laos	143,420
Myanmar	139,930
Timor-Leste	57,793
Bangladesh	32,330
Philippines	27,954
RBC Regional Bureau Cairo	**1,860,153**
Yemen	753,492
Sudan	733,854
Syria	333,849
Algeria	21,924
Iraq	11,208
Tajikistan	5,826
RBD Regional Bureau Dakar	**2,448,983**
Niger	852,879
Nigeria	399,701
Chad	295,070
Mali	292,737
Cameroon	140,517
Burkina Faso	114,710
Sierra Leone	82,681
Central African Republic	63,815
Guinea	50,788
Mauritania	46,863
Gambia	45,239
Guinea-Bissau	26,355
Senegal	22,405
Cote d'Ivoire	9,376
Ghana	3,337
Benin	2,510
RBJ Regional Bureau Johannesburg	**1,917,154**
Malawi	
Congo, Democratic Republic of	
Madagascar	
Tanzania, United Republic of	
Zimbabwe	
Mozambique	
Lesotho	
Congo, Republic of	
Angola	
RBP Regional Bureau Panama City	
Haiti	
Cuba	
Guatemala	
Honduras	
Nicaragua	
El Salvador	
Colombia	
RBN Regional Bureau Nairobi	
Ethiopia	
South Sudan	
Somalia	
Kenya	
Uganda	
Burundi	
Rwanda	
Djibouti	
Grand Total	**16,356,444**

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