COMMUNICATION BRIEF: KENYA ASAL NUTRITION SITUATION OVERVIEW, FEBRUARY 2021

1.0. Key Facts and Messages

> ❖ Nutrition situation has remained similar across arid counties with an expected worsening situation during the projection period due to deteriorating food security situation including reduced milk production and consumption in arid areas.
>
> ❖ The total number of children requiring treatment of acute malnutrition is 541,662.

According to integrated phase classification for acute malnutrition (IPC-AMN) conducted in February 2021, the nutrition situation has remained similar across arid counties compared to the February and August 2020 analysis (Figure 1 and 2). Nutrition situation was critical in Garissa, Wajir, Mandera, Isiolo, Samburu, Turkana, North Horr & Laisamis sub-counties in Marsabit County and Tiaty in Baringo County. Tana River and West Pokot Counties were classified in serious phase (IPC Phase 3), Saku and Moyale sub-counties in Marsabit County were in alert phase (IPC Phase 2) while Kitui was in acceptable phase.

➕ Nutrition situation is expected to deteriorate within the same phase in most counties if the 2021 long rains perform poorly impacting negatively on food security situation with milk production and consumption in arid areas expected to worsen (Figure 3).

Number of children and Pregnant& Lactating Women (PLW) requiring treatment of acute malnutrition, February 2021	
Total caseload, acutely malnourished children	541,662
PLW caseload	98,759

➕ Several analysis areas were not classified due to lack of minimum evidence requirements for IPC classification. These included Kwale, Kilifi, Lamu, Taita Taveta, Meru North, Tharaka, Mbeere, Kieni, Laikipia, Makueni, Kajiado, and Narok.

➕ The main driver of acute malnutrition was poor dietary intake with reduced milk production and consumption which forms the main diet for children in arid areas reported across the arid areas. This was due to relatively poor performance of short rains resulting to deteriorating animal body condition. Other drivers included morbidity, poor childcare practices, poor sanitation and health environment.

➕ Recurrent and unusual shocks such as flooding reported due to backflow of Lake Turkana, interruption of regular operations and livelihood by the rising Turkwel Dam, current desert locust invasion in several counties, security incidences for example in Baringo County and COVID-19 related impacts especially in urban centers where livelihoods were most affected exacerbated the malnutrition problem. Disease outbreaks such as measles and Visceral leishmaniasis (kala-azar) were also reported in some areas.

➕ Basic causes such as low literacy levels, poor infrastructure and poverty that slow down recovery from the recurrent shocks increase exposure of the communities especially in arid areas to rapid deterioration of nutrition situation during the projection period.

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- The effects of COVID-19 pandemic continued to be felt across all the Counties where there was a disruption of normal health services e.g. slowdown of integrated health and nutrition outreaches and health campaigns due to the reallocation of resources to support the COVID-19 response.
- The pandemic affected continuity of essential health and nutrition services in far flung areas due to scale down of integrated health and nutrition outreach services. However, mechanisms to sustain access to health services including implementation of alternative strategies such as use of community health strategy in place of Malezi Bora weeks and use of family MUAC are being implemented to sustain and improve program coverage.
- Stock out of commodities to treat moderate acute malnutrition in supplementary feeding programs was a major contributing factor to poor access of IMAM services especially in Baringo, West Pokot and semi-arid areas exposing children to severe acute malnutrition.
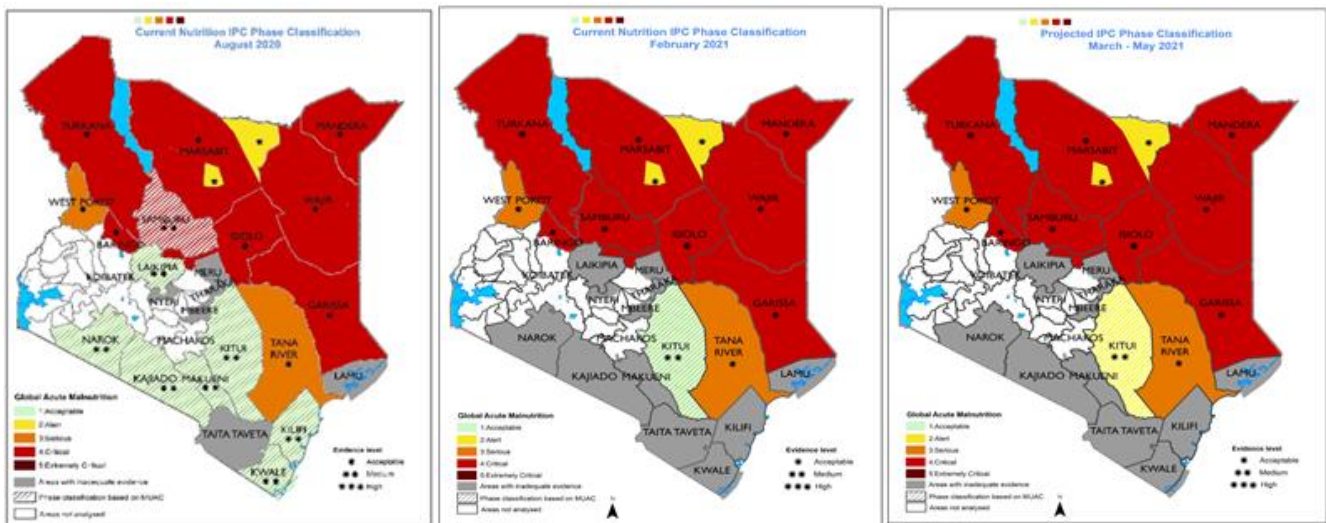

Figure 1: Nutrition Situation August 2020   *Figure 2: Nutrition Situation, February 2021*   *Figure 3: Projected Nutrition Situation*

- Overall, an estimated 541,662 children 6-59 months and 98,759 Pregnant and lactating women require treatment of acute malnutrition (Table 1). Due to the COVID-19 pandemic that is affecting all counties in the country, caseload for children 6 to 59 months requiring treatment were calculated for all counties in the country to inform planning in the context of the pandemic.

Table 1: Number of Children 6 to 59 months and Pregnant and Lactating Women (PLW) Requiring Treatment of Acute Malnutrition

| Area	Global acute malnutrition children 6-59 months		Severe acute malnutrition in children 6- 59 months		Moderate acute malnutrition Children 6-59 months		Pregnant and Lactating women	
	Total caseloads	Target	Total Caseloads	Target	Total Caseloads	Target	Total caseloads	Target
ASAL	352,842	198, 733	89,247	66,935	263,595	131,797	96, 971	96,971
Urban	59, 224	34, 616	20,018	15, 013	39,206	19,603	1,788	1,788
Non-ASAL	129,596	72,714	31,668	23,750	97,928	48,962		
Grand Total	**541,662**	**306,063**	**140,933**	**105,698**	**400,729**	**200,362**	**98,759**	**98,759**

2.0. Situation Summary and Key Drivers

According to acute malnutrition integrated phase classification analysis done in February 2021, the nutrition situation largely remained stable within the same phase when compared to the short rain and long rains analysis conducted in February and August 2020 respectively.

Most of the areas of analysis were classified in the critical phase (IPC AMN phase 4). They include Garissa, Wajir, Mandera, Isiolo, Samburu, Turkana counties, North Horr & Laisamis sub-counties in Marsabit County and Tiaty Sub County in Baringo County. Tana River and West Pokot Counties were classified at the serious phase (IPC AMN phase 3) while Moyale and Saku Sub Counties were at the alert phase (IPC AMN phase 2). Kitui County was classified at the acceptable phase (IPC AMN phase 1). Other areas namely, Kwale, Kilifi, Lamu, Taita Taveta, Meru North, Mbeere, Tharaka, Makueni, Kieni, Laikipia, Narok, and Kajiado did not meet the minimum evidence requirement for phase classification.

Although the situation is projected to remain in the same phase, it is projected to deteriorate in Turkana, Samburu, Mandera, Garissa, Wajir, Isiolo and North Horr and Laisamis sub-counties in Marsabit county. Tana River, Moyale and Saku are projected to remain similar while Kitui will deteriorate from acceptable to alert phase. Counties in agro-pastoral[1] cluster are projected to remain stable.

The main driver of acute malnutrition was poor dietary intake with reduced milk production and consumption which forms the main diet for children in arid areas reported across the arid areas. This was due to relatively poor performance of short rains resulting to deteriorating animal body condition. Food consumption was poor in several counties where counties like Lamu, Turkana, Tana River, Wajir and Marsabit reported 2, 31, 40 and 48.8 percent of households meeting the acceptable food consumption score respectively. In most areas, the current milk consumption was below the long-term average (Figure 4).

Figure 4: Milk Production and Consumption: North East Pastoral Cluster Livelihood
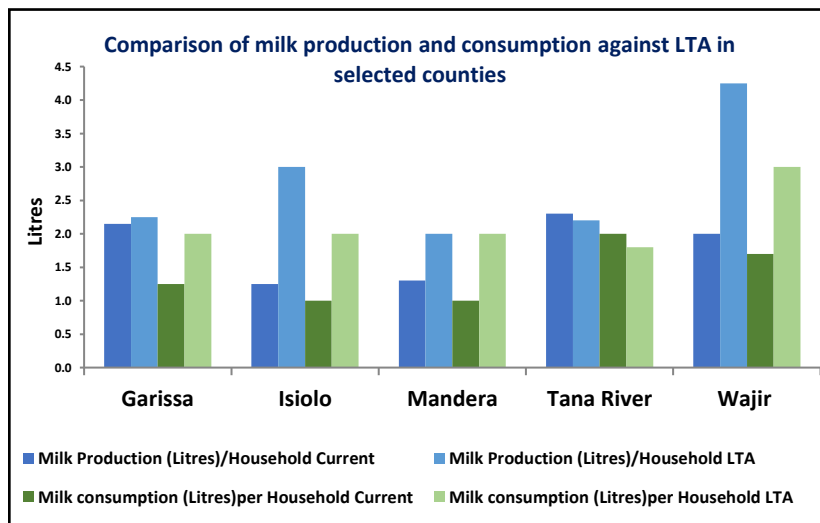
High morbidity which although seem to decline due to health workers strike was also a driver of malnutrition during the analysis period with the trends remaining high. Disease outbreaks were reported in some areas including measles in West Pokot, Tana River, Wajir, Garissa and Kilifi Counties. Visceral leishmaniasis was also reported in Marsabit, Garissa, Kitui, Baringo and West Pokot counties while Mandera and Isiolo Counties reported Rift valley fever during the analysis period. Other drivers included poor childcare practices, poor sanitation, health environment and suboptimal coverage of interventions. Stock out of

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[1] Coastal Marginal Agricultural Livelihood Cluster: Lamu, Taita Taveta, Kwale, Kilifi
North-West Livelihood Cluster: Turkana, Marsabit, Samburu
North-East Livelihood Cluster: Garissa, Mandera, Wajir, Isiolo, Tana River
South Eastern Marginal Agricultural Livelihood Cluster: Makueni, Kitui, Mbeere, Tharaka, Meru North
Agro-Pastoral Livelihood Cluster: East Pokot/Tiaty, West Pokot, Kieni, Kajiado, Narok, Laikipia

commodities to treat moderate acute malnutrition in supplementary feeding programs was a major contributing factor to poor access of IMAM services especially in Baringo, West Pokot and semi-arid areas exposing children to severe acute malnutrition.

Recurrent and unusual shocks such as flooding reported due to backflow of Lake Turkana, interruption of regular operations and livelihood by the rising Turkwel Dam, current desert locust invasion in several counties, security incidences for example in Baringo County and COVID-19 related impacts especially in urban centers where livelihoods were most affected exacerbated the malnutrition problem.

Basic causes such as low literacy levels, poor infrastructure and poverty that slow down recovery from the recurrent shocks increase exposure of the communities especially in arid areas to rapid deterioration of nutrition situation during the projection period.

COVID 19 Impacts on Food Security and Nutrition

Total COVID 19 cases: 102,792
Males: 65,072
Female: 37,720
Deaths: 1,795

MOH Daily COVID-19 SITREP, 13th Feb 2021

COVID-19 pandemic reported since March 2020 in Kenya rapidly interrupted regular operations across sectors with rapid reprioritization of activities through business continuity plans. Effects of containment measures such as movement restriction and temporary closure of public places continued to have effect on households especially in urban centers due to loss of incomes. Though markets were temporarily closed, traded volumes were below long-term average due to the impact of the pandemic on movement of people, livestock and goods. The pandemic interrupted learning and school meals programs which were a major source of nourishment for school going children in arid counties.

The pandemic affected continuity of essential health and nutrition services in far flung areas due to scale down of integrated health and nutrition outreach services - though some have been reinitiated. Mechanisms to sustain access to health services including implementation of alternative strategies such as use of community health strategy in place of Malezi Bora weeks and use of family MUAC are being implemented to sustain and improve program coverage. Community mobilization and messaging has been heightened including through mobile applications such as mHero and Rapidpro platforms.

Scale up of COVID-19 preventive measures such as provision of handwashing facilities in public places was observed across counties assessed. Coordination mechanisms were put in place across all the counties analyzed to respond to the COVID-19 pandemic though the role of nutrition in the management of cases especially in home isolation and care was generally not been discussed as a major intervention. Continuous training of health workers and community health volunteers to continue responding to the pandemic is ongoing. A key observation was general adjustment of populations assesses to the 'new normal'. General complacency and obvious non-adherence to containment measures such as not keeping physical distance and wearing masks inappropriately were observed.

3.0. Recommendation for Action

- Close monitoring of the projected worsening trends including safely resuming household level surveillance activities such as use of regular MUAC in the Early Warning System and integrated nutrition SMART surveys for improved detection and monitoring of the food and nutrition situation
- Continue to advocate for national and county governments to allocate resource aimed at addressing malnutrition including social safety net programs and procurement of commodities for management of acute malnutrition.

- Continued advocacy on the role of nutrition in disease management including in management of COVID-19 cases especially for cases under home-based isolation and care.
- Continue to monitor the effects of COVID-19 on continuity of essential services and livelihoods to mitigate its effect on food and nutrition situation.
- Engage other sectors such as agriculture to implement or scale up interventions that will improve access to complementary foods for infants and young children.
- Close monitoring of the effects of COVID-19 and the health care workers unrest on continuity of essential services to mitigate the potential impact on health and nutrition situation.
- Close monitoring of locust invasion and support risk communication and mitigation measures.

4.0. The Detailed number of children who are acutely malnourished and in need of treatment

The total number of children 6 to 59 months requiring treatment of acute malnutrition is 531,005 while 98,390 pregnant and lactating women require treatment (Table 2 and Figure 5).

Table 2: Detailed Number of Children 6 to 59 months and Pregnant and Lactating Women (PLW) Requiring Treatment of Acute Malnutrition

Area	Global Acute malnutrition		Severe Acute Malnutrition		Moderate acute malnutrition		Pregnant and lactating women	
	Total Caseloads	Target	Total Caseloads	Target	Total Caseloads	Target	Total Caseloads	Target
Baringo	15,509	8,804	4,198	3,149	11,311	5,655	2,185	2,185
Embu	1,283	663	86	64	1,197	599	229	229
Garissa	29,649	16,234	5,640	4,230	24,009	12,005	9,552	9,552
Isiolo	10,312	5,387	926	695	9,386	4,693	1,848	1,848
Kajiado	17,578	9,578	3,155	2,366	14,423	7,211	4,896	4,896
Kilifi	13,289	7,584	3,756	2,817	9,534	4,767	431	431
Kitui	9,807	6,265	5,448	4,086	4,359	2,179	808	808
Kwale	8,613	4,915	2,434	1,826	6,179	3,089	156	156
Laikipia	8,280	4,657	2,070	1,552	6,210	3,105	1,089	1,089
Lamu	1,878	1,067	512	384	1,366	683	277	277
Machakos	22,957	13,938	9,837	7,378	13,120	6,560	1,507	1,507
Makueni	6,272	3,763	2,509	1,882	3,763	1,882	283	283
Mandera	48,559	27,300	12,082	9,061	36,477	18,239	12,976	12,976
Marsabit	20,241	11,052	3,727	2,795	16,514	8,257	7,171	7,171
Meru	7,383	4,464	3,090	2,318	4,292	2,146	63	63
Narok	14,856	8,171	2,971	2,228	11,885	5,942	514	514
Nyeri	818	424	58	44	760	380	119	119
Samburu	11,509	6,191	1,748	1,311	9,761	4,880	6,864	6,864
Taita Taveta	3,132	1,887	1,286	965	1,846	923	143	143
Tana River	10,013	5,522	2,064	1,548	7,949	3,975	2,080	2,080
Tharaka Nithi	696	386	152	114	543	272	112	112
Turkana	43,627	23,863	8,198	6,149	35,428	17,714	25,709	25,709

Wajir	28,084	15,852	7,242	5,431	20,842	10,421	14,042	14,042
West Pokot	18,499	10,764	6,057	4,543	12,442	6,221	3,916	3,916
Total ASAL	**352,842**	**198,733**	**89,247**	**66,935**	**263,595**	**131,797**	**96,971**	**96,971**
Kisumu	4,723	2,842	1,920	1,440	2,803	1,402	336	336
Mombasa	10,264	6,680	6,194	4,645	4,070	2,035	84	84
Nairobi	44,237	25,094	11,904	8,928	32,333	16,166	1,368	1,368
Total Urban	**59,224**	**34,616**	**20,018**	**15,013**	**39,206**	**19,603**	**1,788**	**1,788**
Non-ASAL	129,596	72,714	31,668	23,750	97,928	48,962		
Grand Total	**541,662**	**306,063**	**140,933**	**105,698**	**400,729**	**200,363**	**98,759**	**98,759**

The automated standard Kenya Caseload Tracker was used to calculate the caseloads. The number of children requiring treatment was determined by analysis area using global acute malnutrition by weight for height (GAM WHZ) prevalence in the ASAL areas. The formula used to calculate the caseloads was Case load = N × P × K × C where N is the Population of children 6 to 59 month in the area, p is the estimated prevalence of SAM or MAM, K is a correction factor to account for new /incident cases over a given time period in this case K is 2.6, C is the mean coverage that is expected to be achieved by the program over the time period). Programmatic experience and considerations such as actual number of children admitted to the program in the previous years was also considered and the caseloads adjusted accordingly. Caseload calculation for the pregnant and lactating women was mainly based on programmatic experience coupled with technical discussion and consensus. Due to the COVID-19 pandemic that is affecting all counties in the country, caseload for children 6 to 59 months requiring treatment were calculated for all counties including urban and non-ASAL areas to inform planning in the context of the pandemic.
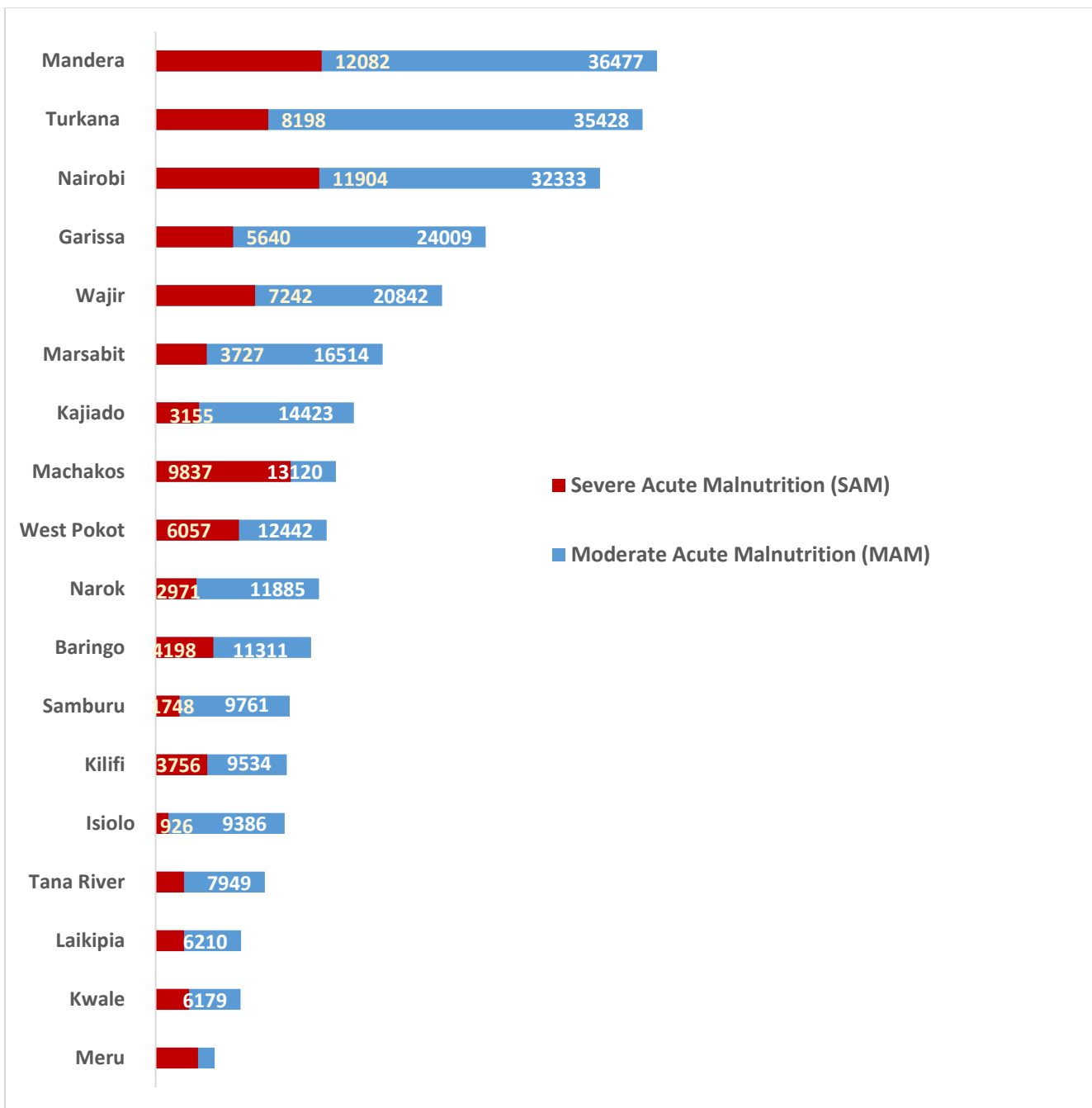
Figure 5: Detailed Number of Children 6 to 59 months Requiring Treatment of Acute Malnutrition by County

5.0. Process and Methodology

The analysis process strictly adhered to the IPC acute malnutrition protocols Version 3. IPC acute malnutrition guidelines on how to build assumptions for IPC acute malnutrition projections in the context of COVID-19 pandemic version 1 (April 2020), also guided the analysis process. The IPC AMN was conducted at the same time with IPC for acute food insecurity. A combination of physical and virtual meetings was applied considering the COVID-19 pandemic to ensure adherence to infection prevention control measures. A small team of analyst joined the physical short rains assessment (SRA) report writing workshop for complementarity and to ensure nutrition and

health was well integrated in the process. The nutrition analysis team worked over the overall leadership of the Ministry of Health with UNICEF as the co-lead technical agency.

Before the analysis, a three days virtual training on zoom platform was conducted with continued technical support throughout the analysis and report writing process. Cluster groups with a mix of analysts based on experience and current workstation were formed and facilitated with regular cluster meetings in zoom breakout rooms to plan/organize work, discuss progress and offer support as needed. Established analysts who are highly experienced in IPC protocols and nutrition situation analysis were assigned to each team to coach/mentor the groups during the analysis. In addition, a quality control team was formed to track progress and quality throughout the process. To enhance sustainability and ownership, the capacity building efforts ensured an intentional focus on national and county government staff and representatives from public universities.

IPC acute malnutrition analytical Framework (Figure 6) which is majorly adopted from UNICEF conceptual framework of acute malnutrition guided the analysis process whereas Acute malnutrition reference table guided in phase classification (Figure 7).
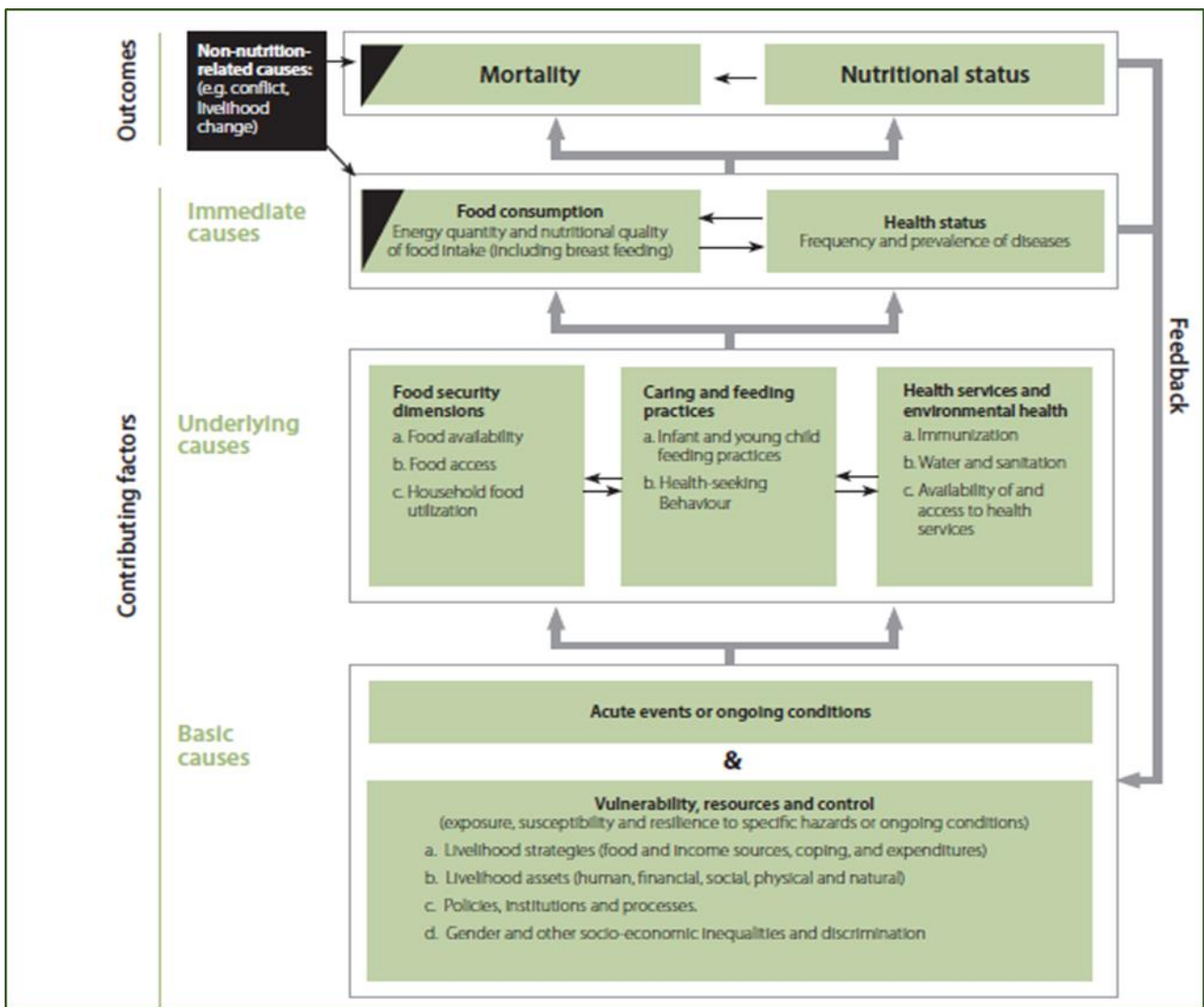

Figure 6: IPC acute malnutrition analytical Framework

Evidence was drawn from different sources namely; representative surveys, routine program data derived from KHIS aggregate[2]. Disease surveillance reports, the National Drought Management Surveillance data. Only evidence that met the minimum evidence requirement as guided by protocol 2.5 of IPC acute malnutrition was used for analysis purposes. The analysis resulted in a current situation and projection of the situation. The severity of acute malnutrition was referenced against international standards and key contributing factors both food security and non-food security-related factors were identified using the IPC for acute malnutrition conceptual framework as laid out in the analysis worksheet. Since both IPCs were conducted simultaneously, results from the IPC for acute malnutrition were included Food Security analysis, and results from Food Security IPC were also included in the IPC for acute malnutrition analysis. Finally, response actions and risk factors to monitor were identified.

Phase name and description	Phase 1 Acceptable	Phase 2 Alert	Phase 3 Serious	Phase 4 Critical	Phase 5 Extremely Critical
	Less than 5% of children are acutely malnourished.	5-9.9% of children are acutely malnourished.	10-14.9% of children are acutely malnourished.	15-29.9% of children are acutely malnourished. The mortality and morbidity levels are elevated or increasing. Individual food consumption is likely to be compromised.	30% or more children are acutely malnourished. Widespread morbidity and/or very large individual food consumption gaps are likely evident.
		The situation is progressively deteriorating, with increasing levels of acute malnutrition. Morbidity levels and/or individual food consumption gaps are likely to increase with increasing levels of acute malnutrition.			
Priority response objective to decrease acute malnutrition and to prevent related mortality.[2]	Maintain the low prevalence of acute malnutrition.	Strengthen existing response capacity and resilience. Address contributing factors to acute malnutrition. Monitor conditions and plan response as required.	Urgently reduce acute malnutrition levels through →		
			Scaling up of treatment and prevention of affected populations.	Significant scale-up and intensification of treatment and protection activities to reach additional population affected.	Addressing widespread acute malnutrition and disease epidemics by all means.
Global Acute Malnutrition (GAM) based on weight for height Z-score (WHZ)	<5%	5.0 to 9.9%	10.0 to 14.9%	15.0 to 29.9%	≥30%
Global Acute Malnutrition (GAM) based on mid-upper arm circumference (MUAC)	<5%	5-9.9%	10-14.9%		≥15%

*GAM based on MUAC must only be used in the absence of GAM based on WHZ; the final IPC Acute Malnutrition phase with GAM based on MUAC should be supported by the analysis of the relationship between WHZ and MUAC in the area of analysis and also by using convergence of evidence with contributing factors. In exceptional conditions where GAM based on MUAC is significantly higher than GAM based on WHZ (i.e. two or more phases), both GAM based on WHZ, and GAM based on MUAC should be considered, and the final phase should be determined with convergence of evidence.

Notes:
1. Refers to the increased risk of mortality with the increased levels of acute malnutrition.
2. Priority response objectives recommended by the IPC Acute Malnutrition Reference Table focus on decreasing acute malnutrition levels; specific actions should be informed through a response analysis based on the information provided by analyses of contributing factors to acute malnutrition as well as delivery-related issues, such as government and agencies' capacity, funding, insecurity in the area, etc.
3. GAM based on WHZ is defined as to WHZ<-2 or presence of oedema; GAM based on MUAC is defined as MUAC<125mm or presence of oedema

Figure 7: IPC acute malnutrition reference table

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[2] KHIS Aggregate is the Kenya Health Information System (KHIS) for aggregate reporting and analysis on DHIS2 platform

6.0.   Latest Acute Malnutrition Prevalence[3]

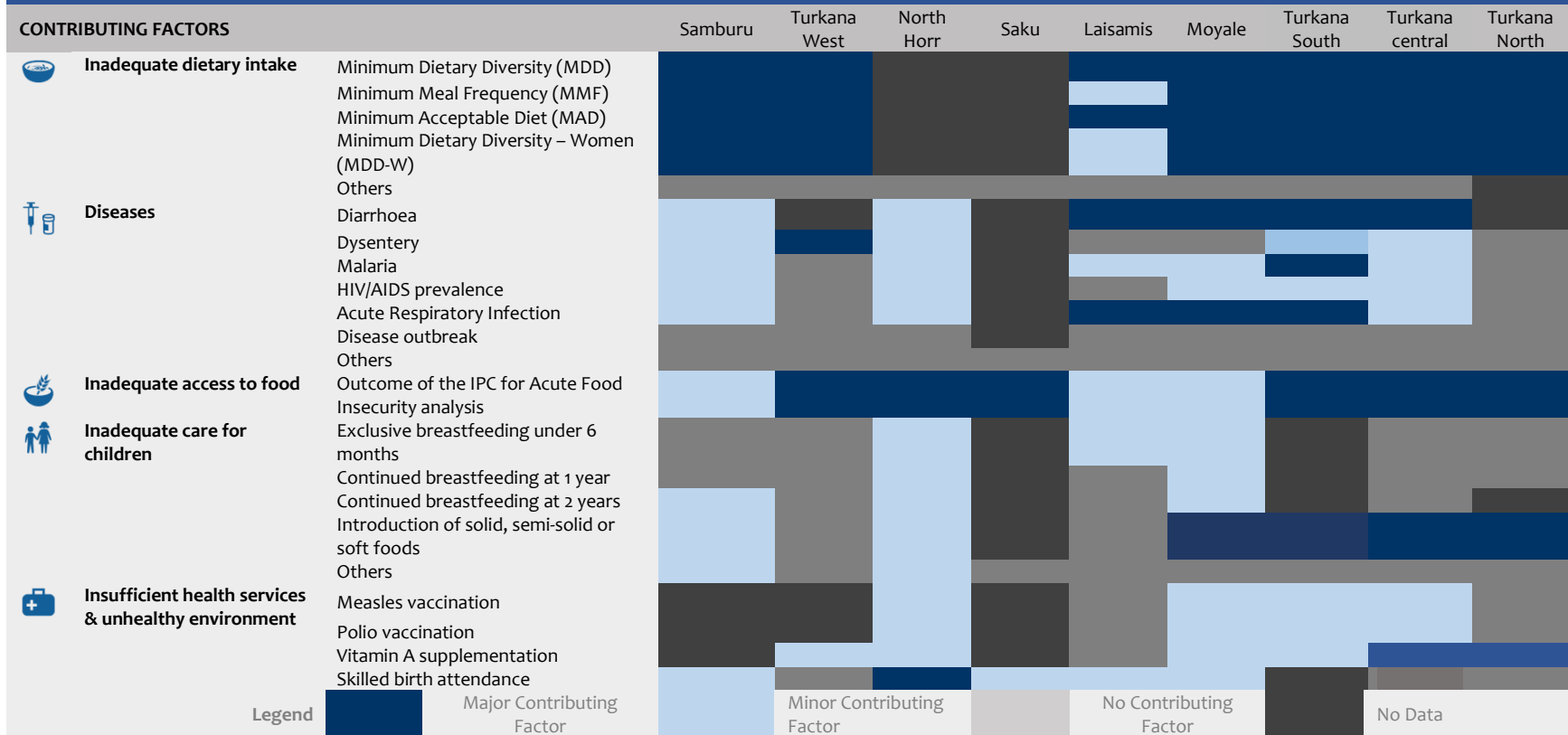*Table 3: Latest Prevalence of Acute malnutrition Prevalence*

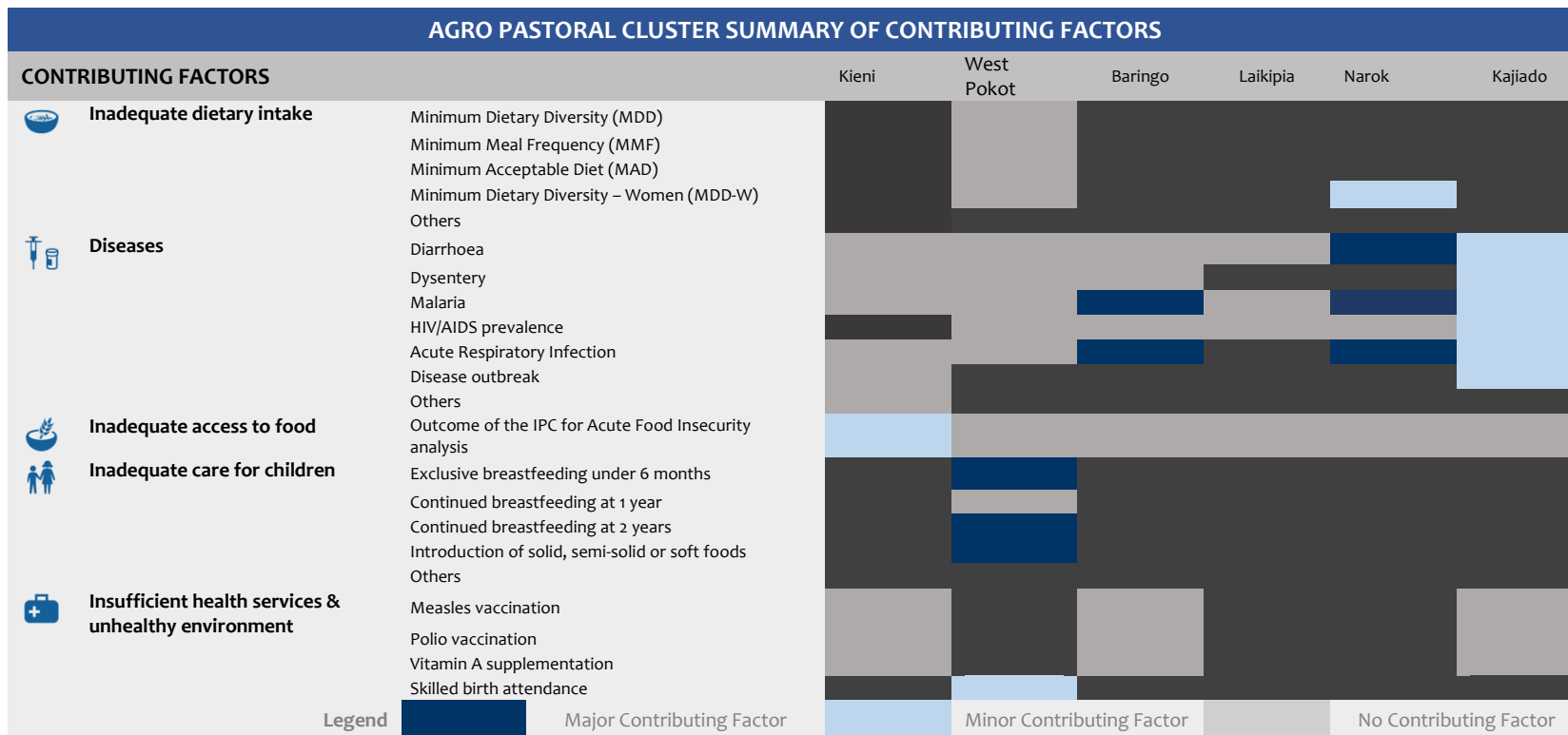| Areas	Survey timing	GAM WHZ children 6 to 59 months	SAM WHZ children 6 to 59 months	GAM MUAC children 6 to 59 months	SAM MUAC children 6 to 59 months	PLW (%)	Plausibility score
Isiolo	Feb-2020	16.7	1.5	4.2	0.7	6.8	5
Tana River	Feb-2020	13.1	2.7	2.2	0.3	3.9	5
Marsabit - Laisamis	Jul-19	30.7	6.4	6.4	1.2	21.7	1
Marsabit North Horr	Jul-19	25.1	3.1	4.5	0.5	14.6	4
Marsabit - Moyale	Jul-19	9	1.2	3.7	0.7	5.5	1
Marsabit - Saku	Jul-19	9.5	1	0.9	0.5	2	9
West Pokot County	Jun-19	11.7	1.9	3	0.2	3	2
Wajir County	Jun-19	16.4	2.7	4.8	1.5	4.2	4
Turkana Central	Jun-19	20.2	2.8	7.4	0.5	8.4	7
Turkana North	Jun-19	30.2	7.4	11.4	1.7	9.8	7
Turkana South	Jun-19	30.8	7.8	8.9	1.6	10.7	5
Turkana West	Jun-19	23	5.7	11.4	3	7.2	0
Baringo (East Pokot)	Jul-19	20.9	3.5	8.1	0.8	6.8	3
Baringo (Baringo North Marigat)	Jul-19	9.3	2.3	3.4	1.1	1.5	3
Samburu County	Jun-19	15.8	2.4	3.6	0.2	11.4	5
Garissa County	Jun-19	17.2	2.3	6.1	0.9	4.2	5
Mandera County	Jul-19	21.9	4	8.7	2.4	3.2	10

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[3] Population based integrated SMART surveys were not conducted as part of the 2020 Long Rains Assessment and 2020 Short Rains Assessments due to COVID-19 pandemic measures and guidelines. Routine data mainly from the DHIS2 and sentinel surveillance coupled with secondary data from previous surveys were used in the analysis.
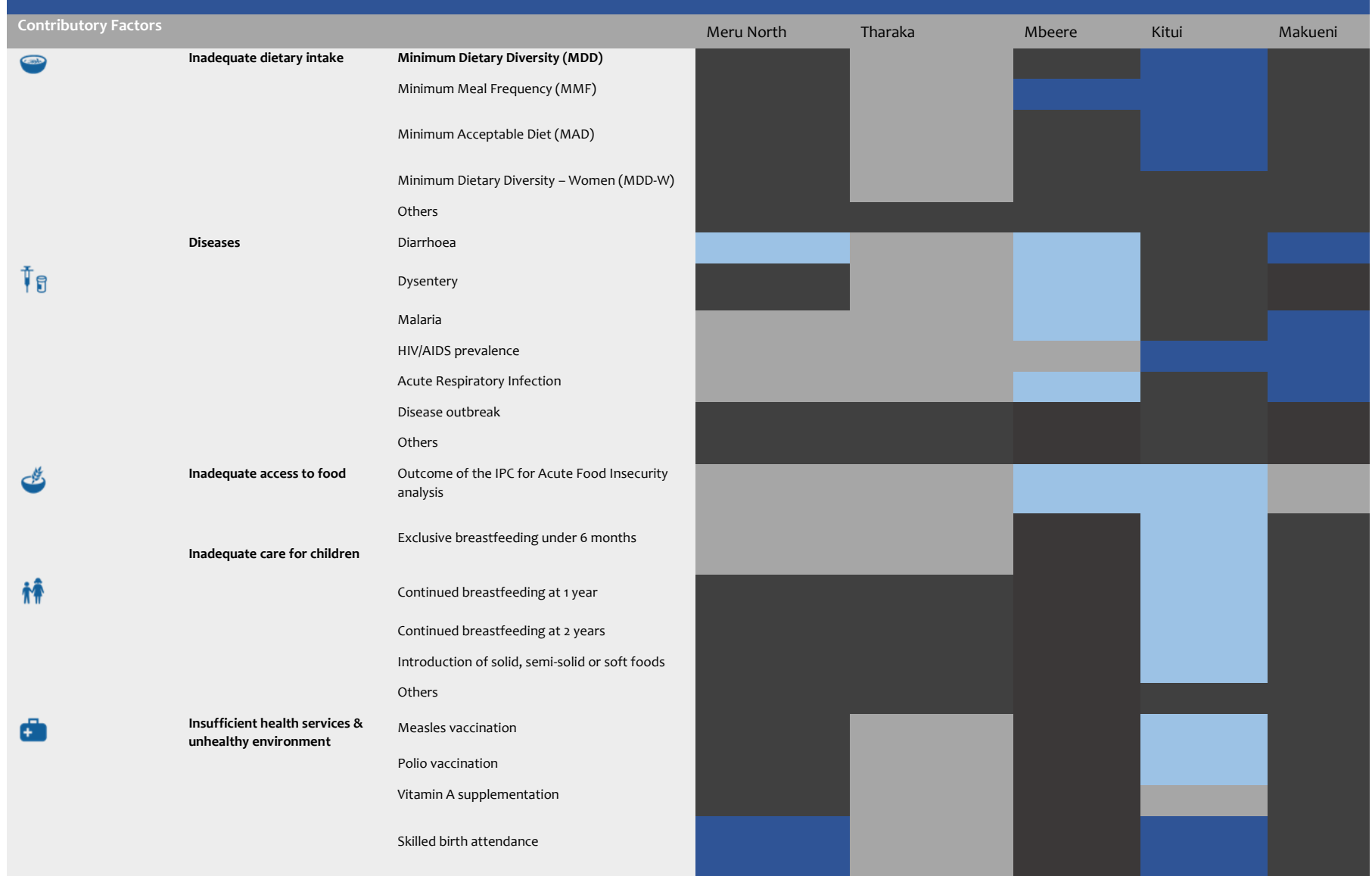
7.0. Summary of Key drivers

PASTORAL NORTHEAST CLUSTER SUMMARY OF CONTRIBUTING FACTORS

Contributing factor group	Indicator	Garissa	Isiolo	Mandera	Tana River	Wajir
Inadequate Dietary Intake	Minimum Dietary Diversity (MDD)					
	Minimum Meal Frequency (MMF)					
	Minimum Acceptable Diet (MAD)					
	Minimum Dietary Diversity – Women (MDD-W)					
	Others					
Diseases	Diarrhoea					
	Dysentery					
	Malaria/fever					
	Acute Respiratory Infection (ARI)					
	HIV/AIDS					
	Cholera or Acute Watery Diarrhoea (AWD)					
	Measles					
Inadequate access to food	Outcome of the IPC analysis					
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					
Insufficient health services & unhealthy environment	Measles vaccination					
	Polio vaccination					
	Vitamin A supplementation					
	Skilled birth attendance					
	Health seeking behaviour					
	Coverage of outreach programmes – CMAM programme coverage (SAM, MAM, or both)					
	Access to a sufficient quantity of water					
	Access to sanitation facilities					
	Access to an improved source of drinking water					

Legend:
- Major contributing Factor
- Minor contributing factor
- Not a contributing factor
- No Data

CONTRIBUTING FACTORS		Samburu	Turkana West	North Horr	Saku	Laisamis	Moyale	Turkana South	Turkana central	Turkana North
Inadequate dietary intake	Minimum Dietary Diversity (MDD)									
	Minimum Meal Frequency (MMF)									
	Minimum Acceptable Diet (MAD)									
	Minimum Dietary Diversity – Women (MDD-W)									
	Others									
Diseases	Diarrhoea									
	Dysentery									
	Malaria									
	HIV/AIDS prevalence									
	Acute Respiratory Infection									
	Disease outbreak									
	Others									
Inadequate access to food	Outcome of the IPC for Acute Food Insecurity analysis									
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									
Insufficient health services & unhealthy environment	Measles vaccination									
	Polio vaccination									
	Vitamin A supplementation									
	Skilled birth attendance									

Legend: Major Contributing Factor | Minor Contributing Factor | No Contributing Factor | No Data

AGRO PASTORAL CLUSTER SUMMARY OF CONTRIBUTING FACTORS

CONTRIBUTING FACTORS		Kieni	West Pokot	Baringo	Laikipia	Narok	Kajiado
Inadequate dietary intake	Minimum Dietary Diversity (MDD)						
	Minimum Meal Frequency (MMF)						
	Minimum Acceptable Diet (MAD)						
	Minimum Dietary Diversity – Women (MDD-W)						
	Others						
Diseases	Diarrhoea						
	Dysentery						
	Malaria						
	HIV/AIDS prevalence						
	Acute Respiratory Infection						
	Disease outbreak						
	Others						
Inadequate access to food	Outcome of the IPC for Acute Food Insecurity analysis						
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						
Insufficient health services & unhealthy environment	Measles vaccination						
	Polio vaccination						
	Vitamin A supplementation						
	Skilled birth attendance						

Legend: ■ Major Contributing Factor ■ Minor Contributing Factor ■ No Contributing Factor

SOUTH EASTERN MARGINAL AGRICULTURAL LIVELIHOOD CLUSTER

Contributory Factors			Meru North	Tharaka	Mbeere	Kitui	Makueni
	Inadequate dietary intake	Minimum Dietary Diversity (MDD)					
		Minimum Meal Frequency (MMF)					
		Minimum Acceptable Diet (MAD)					
		Minimum Dietary Diversity – Women (MDD-W)					
		Others					
	Diseases	Diarrhoea					
		Dysentery					
		Malaria					
		HIV/AIDS prevalence					
		Acute Respiratory Infection					
		Disease outbreak					
		Others					
	Inadequate access to food	Outcome of the IPC for Acute Food Insecurity analysis					
	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					
	Insufficient health services & unhealthy environment	Measles vaccination					
		Polio vaccination					
		Vitamin A supplementation					
		Skilled birth attendance					

COASTAL MARGINAL SUMMARY FACTORS CONTRIBUTING TO ACUTE MALNUTRITION

CONTRIBUTING FACTORS		LAMU	KILIFI	TAITA TAVETA	KWALE
Inadequate dietary intake	Minimum Dietary Diversity (MDD)				
	Minimum Meal Frequency (MMF)				
	Minimum Acceptable Diet (MAD)				
	Minimum Dietary Diversity – Women (MDD-W)				
	Others				
Diseases	Diarrhoea				
	Dysentery				
	Malaria				
	HIV/AIDS prevalence				
	Acute Respiratory Infection				
	Disease outbreak				
	Others				
Inadequate access to food	Outcome of the IPC for Acute Food Insecurity analysis				
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				
Insufficient health services & unhealthy environment	Measles vaccination				
	Polio vaccination				
	Vitamin A supplementation				
	Skilled birth attendance				

Legend: Major Contributing Factor — Minor Contributing Factor