



KENYA NUTRITION BULLETIN AUGUST 2017

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THEME : FOOD AND NUTRITION SECURITY FOR ALL

Food and nutrition security exist when all people at all times have access to physical economic and social access to sufficient safe and nutritious foods. **Nutrition security** means access by all people at all times to adequate utilization and absorption of nutrients in food ,in order to be able to live a healthy and active life. To achieve the constitutional right by all Kenyans to access to food of acceptable quality at all times, the country’s food and nutrition sectors have organised and implemented various actions and activities through government and other stakeholders. The programs and projects range from evidence generation through research , provision of food and nutrition commodities and supplies to the less vulnerable including therapeutic supplements for those with under -nutrition , cash transfers to cushion households from effects of food and nutrition insecurity ,capacity building communities for resilience to cushion households from deteriorating during drought and emergency while adopting positive behaviours that influence good health and nutrition status.

NUTRITION SITUATION OVERVIEW IN ARID AND SEMI-ARID AREAS, JULY 2017

The IPC for Acute Malnutrition conducted in July 2017 has reported a Very Critical nutrition situation (Phase 5; GAM WHZ ≥ 30 percent) in Turkana Central, Turkana North, Turkana South, and North Horr in Marsabit. The rates of acute malnutrition in Turkana are very alarming and are comparable with the rates recorded in 2011 Horn of Africa Crisis with the highest Global Acute Malnutrition (GAM) of 37% recorded in Turkana South. A Critical nutrition situation (Phase 4; GAM WHZ 15.0 - 29.9 percent) was reported in East Pokot (Baringo), Samburu, West Pokot, Turkana West, Garissa, Wajir, and Mandera, while Laikipia reported a Serious nutrition situation (Phase 3; GAM WHZ 10.0 -14.9 percent). Moyale and Saku were classified as Alert (Phase 2; GAM WHZ ≥ 5 to 9.9 percent), while Narok, Kajiado, Makueni, Mbeere, Kwale, and Kilifi were Acceptable (Phase 1; GAM WHZ <5%) (Figure 1).

Continued and deepening crisis across most ASAL counties, with an overall increase in numbers of moderately malnourished children

420,674
Total caseload of acutely malnourished children

83,110
SAM 6-59m case load

337,564
MAM 6-59m case load

39,068
PLW caseload

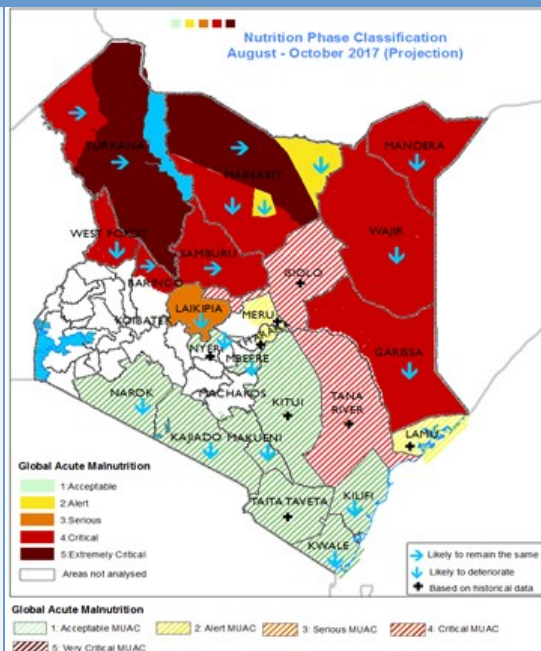
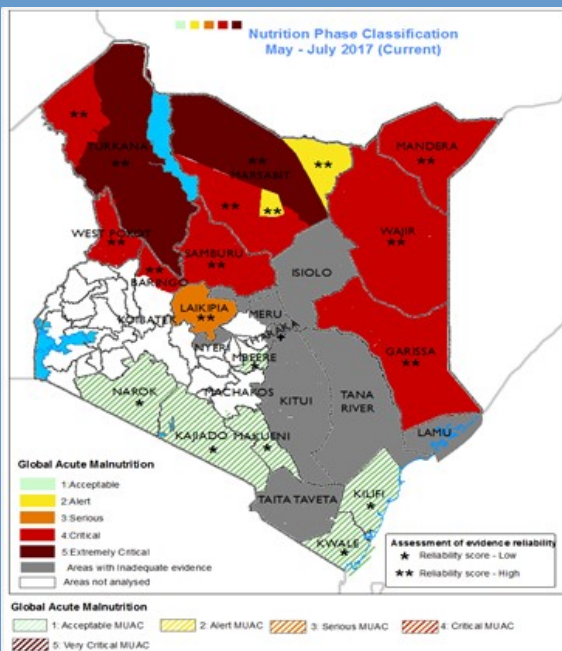


Figure 1: Nutrition situation - Current map

Figure 2: Nutrition situation - Projected

Compared to February 2017, the overall nutrition situation continues to remain of great concern (Figure 1), including deterioration recorded in some counties. Furthermore, the situation is at risk of further deterioration in most counties in the coming months (Figure 2) due to the anticipated worsening of the food security situation (Figure 3 and 4). Currently, 420,674 children 6 to 59 months and 39,068 pregnant and lactating women require treatment for acute malnutrition across the ASAL and Urban counties (Tables 1). Figure 5 presents caseloads by county.

The main contributing factor to the increased malnutrition is household food insecurity resulting from reduced milk availability at household level, reduced household food stocks and increased food prices. Other contributing factors include: common illnesses such as diarrhea, disease outbreaks, low coverage of supplementation programs, poor child feeding practices and poor water and hygiene practices. Pre-existing factors such as high poverty rates, low literacy, poor access to health facilities and frequent shocks aggravate the situation. Comprehensive County Food and Nutrition Security LRA 2017 reports can be found at the National Drought Management Authority website at ndma.go.ke and the nutrition website at www.nutritionhealth.or.ke

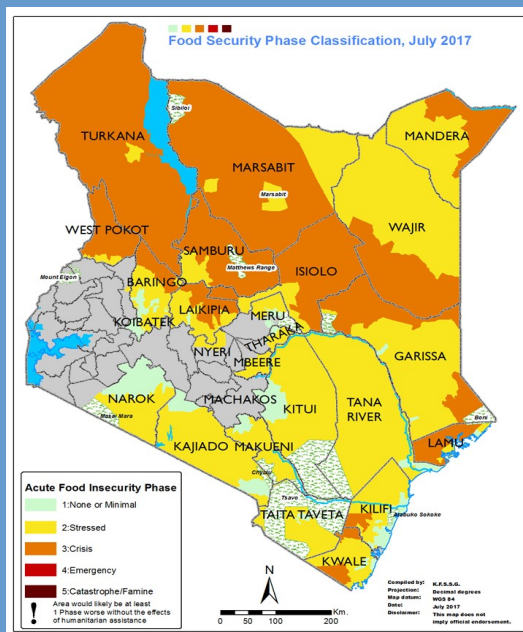


Figure 3: Food security situation – current map

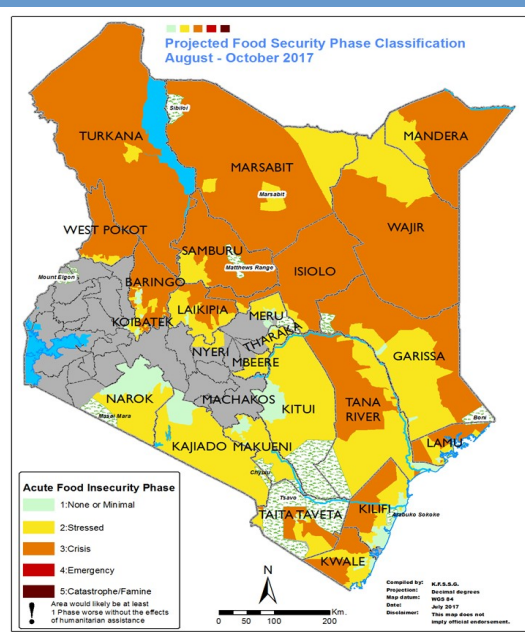


Figure 4: Food security situation – projected map

Table 1. Estimated Caseloads of Children and PLW Requiring Treatment for Acute Malnutrition, July 2017

Area	Global Acute Malnutrition Children 6 to 59 months		Severe Acute Malnutrition Children 6 to 59 months		Moderate Acute Malnutrition Children 6 to 59 months		Pregnant and lactating women	
	Total Caseload	Program Target	Total Caseload	Program Target	Total Caseload	Program Target	Total Caseload	Program Target
ASAL	369,277	202,796	72,632	54,474	296,645	148,322	36,988	36,988
Urban	51,397	29,217	10,478	8,323	40,919	20,894	2,081	2,081
Grand Total	420,674	232,013	83,110	62,797	337,564	169,216	39,068	39,068

Ongoing interventions

Various interventions have been targeting children below five years and pregnant and lactating women to address health and nutrition issues. Some of the nutrition specific interventions include: vitamin A supplementation, zinc supplementation in diarrhea management, promotion of exclusive breastfeeding and appropriate complementary feeding and iron and folic acid supplementation for pregnant women. Integrated Management of Acute Malnutrition (IMAM) Program has been targeting children with severe acute malnutrition and moderate acute malnutrition and, pregnant and lactating with acute malnutrition. Figure 6, 7 and 8 presents total admission trends for the Integrated Management of Acute Malnutrition in the arid and semi-arid areas for children 6 to 59 months and pregnant and lactating women. Health services have been hampered by the ongoing health worker strike resulting to reduced admissions and reporting. Other sectors are also implementing multiple programs such as cash transfer, water trucking in the most affected areas, school meals programs among others.

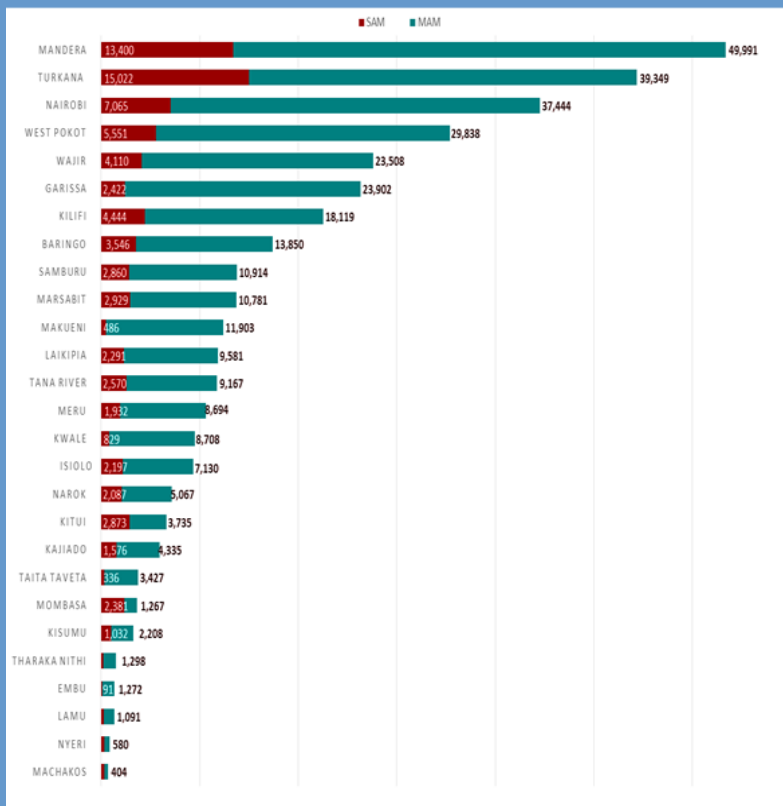


Figure 5: Estimated Caseloads of Children 6-59 Months Requiring Treatment for Acute Malnutrition by County/Sub-county

Key recommendations - immediate response

- ◆ Further scale up of screening and treatment of acutely malnourished children and women through integrated outreaches in the most affected areas
- ◆ Enhanced mobilization and community engagement to further improve demand and coverage of integrated health and nutrition programs
- ◆ Scale up of WASH services in most affected areas
- ◆ Scale up blanket supplementary feeding in the most affected counties
- ◆ Ensure nutrition commodities are prepositioned and supply chain monitoring is routinely done to avoid stock outs
- ◆ Urgent increase in household food access interventions including cash tops up and in kind to meet HH food needs in the most affected areas
- ◆ Specific focus on increasing HH food access in Turkana county to reduce risk of malnutrition related mortality
- ◆ Advocate for resolution of nurses strike to ensure lives are not lost due to impaired service delivery at facility level.
- ◆ Increased surveillance with real time reporting and action at national and county levels
- ◆ Continued support to effective coordination for monitoring of the emergency response plan

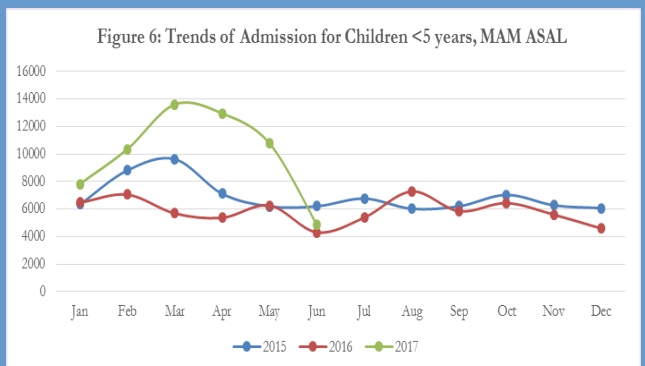


Figure 6: Trends of Admission for Children <5 years, MAM ASAL

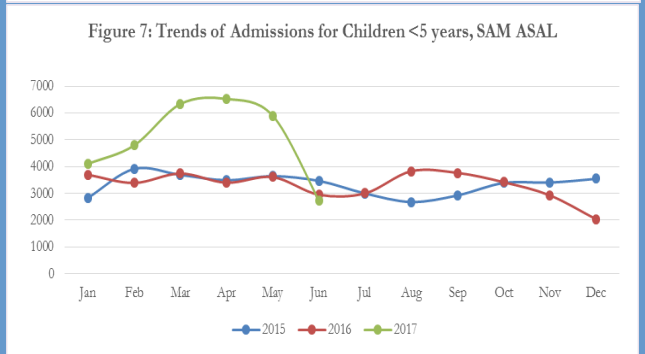


Figure 7: Trends of Admissions for Children <5 years, SAM ASAL

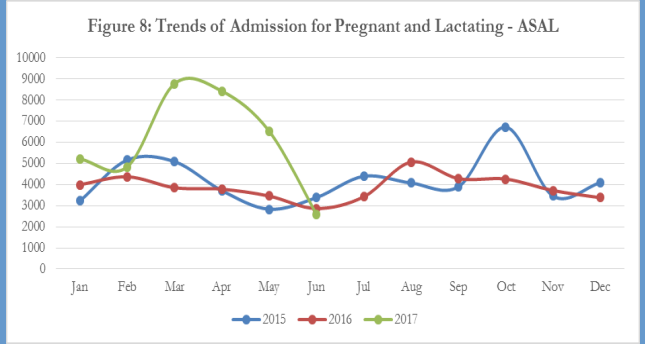


Figure 8: Trends of Admission for Pregnant and Lactating - ASAL

Factors to monitor:

- ◆ Food security situation
- ◆ Staple food prices which have implications on household food access
- ◆ Livestock health and mortality: this is likely to impact negatively on milk availability and sources of income
- ◆ Resource based conflicts and insecurity
- ◆ Household food stocks: the effects of failed season and army worm
- ◆ 2017 elections:
 - * Can result to displacement in case of violence.
 - * Can lead to delay in implementation of programs during the transition period to the next government cycle
- ◆ Impacts of programs and interventions
- ◆ The performance of the upcoming 2017 short rains

THE BABY FRIENDLY COMMUNITY INITIATIVE, A PILOT STUDY IN KOIBATEK, BARINGO COUNTY, KENYA

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Introduction

Interventions promoting optimal infant and young child nutrition could prevent a fifth of under five deaths in countries with high mortality. Effective strategies to improve infant and young child feeding practices are needed. Baby friendly community initiative is one such strategies, which is a global initiative recommended by the World Health Organization (WHO) to promote optimal infant and young child feeding practices. The study set out to primarily determine feasibility and effectiveness of BFCI as outlined in the Kenya implementation guidelines, with regards to exclusive breastfeeding in the first six months after delivery, within a rural setting in Kenya.

Methods

The study, employing a cluster-randomized trial design, was conducted in Koibatek, Baringo County between 2014 and 2016. A total of 13 clusters, which each constitute a community unit within the Kenyan government's community health strategy, were randomized. Six clusters were allocated to the intervention and seven to the control arm. A total of ~800 pregnant women and their respective children were recruited into the study. The mother-child pairs were followed up until the child was about six months.

The intervention involved regular counselling and support of mothers by trained community health volunteers (CHVs) and health professionals on maternal, infant and young child nutrition as well as provision of support to mothers through community mother support groups (CMMSGs) and mother to mother support groups (M2MMSGs). Regular quantitative assessment of knowledge, attitudes and practices on maternal, infant and young child nutrition was done. Qualitative exploration on the effects of the intervention was also done.

Results

With regards to the primary objective, significantly higher exclusive breastfeeding rates were documented in the

intervention compared to the control group. For children aged less than two months, 95% were on exclusive breastfeeding compared to 86% in the control group ($p<0.05$). 88% of children in the intervention group were reported to be exclusively breastfed for six months, 44% were reported as so in the control group ($p<0.05$). Narratives indicated that the counselling of women by community health volunteers, and the support received through the support groups (CMMSGs and M2MMSGs) enhanced their skills and competencies in breastfeeding and infant feeding which led to better practices of the same.

Conclusion

In conclusion, projects with the objective of enhancing maternal and child health can leverage on the community health strategy framework through CHVs who are easily accessible. Support groups (CMMSGs and M2MMSGs) are an innovative and sustainable way of leveraging peer support for mothers. This pilot study recommends implementing the BFCI model within other settings in Kenya, and with further research on the feasibility.

INFANT AND YOUNG CHILD NUTRITION (IYCN); ASSESSMENT PROTOCOLS DEVELOPMENT STATUS & LESSONS LEARNT, 2013-2017

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The views of Lucy Maina-Gathigi incorporated in this article are their own and do not necessarily represent the views of UNICEF

Introduction

Poor nutrition is an underlying cause of at least one third of all child deaths in developing countries (Black et al, 2008). This represents a major risk factor to child survival and development. According to the most recent KDHS survey, 26 percent of children are stunted, only 22 percent received adequate complementary diets, and exclusive breastfeeding before six months of age was at 61 percent. More needs to be done to optimize on child feeding in order to boost nutrition status of children. Given that Demographic Health Surveys are conducted every five years, the need to ensure regular assessment as part of monitoring of on-going intervention programs remains important to track progress and allow for timely program adjustment and improvement.

IYCN data is collected from household based surveys that cover outcome indicators as well as behavioral aspects that influence attitudes and practices of care-givers.

Before 2014 Infant and Young Children Feeding (IYCF) questions were integrated in SMART surveys. However, in SMART surveys, sample sizes are calculated using the prevalence of global acute malnutrition among children 6 to 59 months. On the other hand, IYCF practices are mainly assessed among children 0 to 23 months. Disaggregation by age group is also required for a number of the IYCF indicators resulting to narrow age ranges. Findings from integrated SMART surveys therefore had inadequate sample sizes for most IYCF indicators and were very erratic making comparison over time difficult. IYCF also requires additional and comprehensive data on the 'whys' which was hard to achieve in integrated SMART surveys given the need to sustain timely, high data quality in SMART surveys.

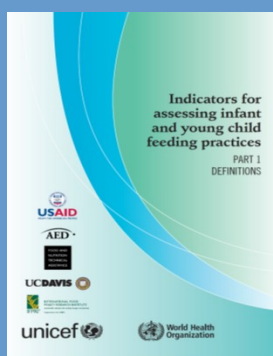
The National Nutrition Information Technical Working Group in consultation with the Maternal Infant and Child Nutrition Working Group made a decision to conduct SMART and IYCF surveys separately. MIYCN knowledge, attitude and practice (MIYCN KAP) surveys were therefore initiated as the standard surveys for IYCF and maternal nutrition in Kenya with a comprehensive qualitative component. The working groups also agreed to continue standardizing the MIYCN KAP surveys while ensuring piloting at different stages to ensure field learning was considered before scale up.

One of the key gaps was the lack of a common standardized tool for use in Maternal Infant and Young Child (MIYCN) household surveys. Standardization ensures comparison of data across regions and programs, and also better quality data is collected as the indicators are based on internationally validated tools and protocols.

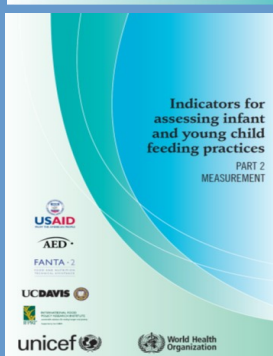
Development of the IYCN Assessment protocol

The Nutrition Unit at the Ministry of Health, through the Nutrition Information Technical Working Group (NITWG) and the MIYCN working group developed a standard Knowledge Attitudes and Practices (KAP) household questionnaire for maternal and child nutrition assessment in 2013. The tool was piloted across several areas in Kenya (West Pokot, Turkana, Laisamis, Wajir East and South, Mandera Central and Samburu Central) in 2014.

The KAP surveys protocol relies on a multi-stage cluster sampling approach. This is the most recommended sampling for KAP surveys as it guarantees the greatest representativeness within the selected sampling frame. The tool is based on core WHO IYCN indicators



(WHO, 2008), as well maternal factors such as; Women birth history, ANC and PNC maternal practices, Maternal dietary diversity, Maternal nutrition status based on MUAC results. Demographic surveys, multiple indicator cluster surveys, WHO IYCF indicator definitions and measurements, and the FAO guideline on dietary diversity formed the main references in this process.



Sample Size determination for some of the IYCF indicators such as meal frequency and continued breastfeeding is challenging given the narrow age ranges in the numerator and denominators, this has the potential to lead to small sample sizes which would make it imprecise and low in statistical validity to be of use in assessment and monitoring. To overcome this dilemma the surveys adopted the CARE IYCF sample size determination guidelines which require that the calculated sample size based on the indicator with the highest prevalence is multiplied by 4 to cater for the 4 age groups within 0-23months (0-5months, 6-11months, 12-17 months, and 18-23months) (CARE, 2010).

Data collection has traditionally been done using paper questionnaires, with availability of free software such as Open Data Kit (ODK), the data collection has also been successfully undertaken using ODK in 2017. This has the advantage of shortening the data collection period as skip patterns are in-built, the cost of reproducing many hard copies is reduced, and through restriction of questions missing data is eliminated, while taking of GPS helps in mapping out representativeness and validating data from selected clusters.

Status and lessons learnt

Between the years 2014-2017 the MIYCN KAP has become the standard data collection tool on IYCN. Development of a field manual is underway. The manual defines field procedures, explains each question to ensure questions are consistently understood and asked over time and also gives indicator definitions and guides on qualitative data collection procedures.

With a recommended repeat cycle of every 2 years, the 2017 KAP surveys are now providing data that can be compared over time. The surveys also provides estimates for County governments to benchmark IYCN indicators and progress made both at mid term and at the end of their administrations. This provides a score card for advocacy on infant feeding.

Within the second cycle of KAP assessments the following are emerging; IYCN knowledge among care-givers on optimal practices is high, however this has not translated into improved practices hence low levels of achievement on IYCN indicators. Socio-cultural beliefs and taboos remain entrenched among communities, this include the use of pre-lacteal feeds as a cultural rite of passage, cultural restrictions of certain foods among pregnant women and certain foods being considered as harmful for children. Poor health seeking practices among pregnant and lactating women due to cultural barriers as well as distance to health facilities remains a challenge and has negative impact on nutritional status of children and women. Food insecurity resulting from decline in own production, intra-household food distribution and high food prices also compromises the quality of diets.

Conclusion and Way forward

The MIYCN household questionnaire has been adopted

successfully. However, there is need for continuous improvement of the questionnaire based on field learning and emerging global guidance. Finalization of the field manual and dissemination is of priority in ensuring standardization of field procedures, analysis and reporting.

References IYCN Assessment protocols

- ◆ Black R.E., et al (2008) Maternal and child nutrition: global and regional exposures and health consequences. *The Lancet* 2008.
- ◆ CARE (2010) Infant and Young Child Feeding Practices: Collecting and assessing data, a step by step guide.
- ◆ KNBS (2014) Kenya demographic and health survey 2014-15. ICF Macro, USA.
- ◆ WHO (2007) Indicators for Assessing IYCF practices; Part1 definitions.
- ◆ WHO (2010) Indicators for assessing infant and young child feeding practices; Part 2 Measurement.

Policy change:

The Policy Guideline for Vitamin A supplementation has been revised based on emerging evidence as shown below.

MINISTRY OF HEALTH

Policy Guideline for Preventive Vitamin A Supplementation for Children 6-59 Months

Purpose of Vitamin A Supplementation

Vitamin A supplementation (VAS) prevents morbidity and mortality in children from 6 to 59 months of age. It is essential for growth and development of children and helps to prevent and decrease the severity of many infections.

Target group	Infants 6 -11 Months of age	Children 12-59 Months of age
Dosage	100,000 I.U (30mg Retinol Equivalent) Vitamin A	200,000 I.U (60mg Retinol Equivalent) Vitamin A
Frequency	Once	Twice a year (After Every six months)
Type of supplement	Oil based preparation capsule of Retinyl palmitate or retinyl acetate	
Administration	Oral, at any time (does not have to be taken with meals)	
Delivery approaches	I. Routine contact points at Health Facility II. Integration in Campaigns and Malezi Bora III. Community Health Unit – Outreaches and Early Childhood Centres	

After administering Vitamin A, it should be recorded in the Mother-Child Health Handbook and tally sheet

It is recommended that Vitamin A intake through diversified diets to meet recommended dietary intake remains as the key intervention to prevent deficiencies. Advice should be given to caregivers as follows:

- Children should be exclusively breastfed from birth up to six months and continue to be breastfed with appropriate complementary foods for at least 2 years
- Other foods rich in micronutrients should be introduced from 6 months to complement breastmilk
- Include vitamin A rich foods from both animal and plant sources (dark green leafy vegetables, orange and yellow coloured foods) for the whole family in all meals
- Use some oil in preparation of foods – fortified oils and fats are recommended

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Director of Medical Services
27th April 2017

ISO 9001:2008
Certified

The Kenya National Micronutrient Survey (KNMS) was conducted in 2011. Below is an extract of key findings from the KNMS report

The Kenya National Micronutrient Survey 2011

SUMMARY OF KEY FINDINGS IN KENYA NATIONAL MICRONUTRIENT SURVEY 2011

Indicators	National Prevalence			
	n	%	95% CI	
Nutritional status				
Pre-School Children {(children 6-59 months, Height-for-age <2 SD (Stunting))}	1130	26.3	23.7	28.9
Pregnant Women (MUAC <23 cm)	117	11.7	5.9	17.5
Anaemia (based on Hb cut-offs that are age specific and adjusted for altitude)				
Pre-School Children	827	26.3	23.3	29.3
School Age Children (Children 5-14 years)	872	16.5	14.0	19.0
Pregnant Women	104	41.6	32.1	51.1
Non-pregnant Women	592	21.9	18.6	25.2
Men	240	9.3	5.87	13.3
Iron Deficiency (based on age specific serum ferritin cut-offs which is corrected for inflammation)				
Pre-School Children	918	21.8	19.1	24.5
School Age Children	942	9.4	7.5	11.3
Pregnant Women	111	36.1	27.2	45.0
Non-pregnant Women	633	21.3	18.1	24.5
Men	247	3.6	1.3	5.9
Iron Deficiency Anaemia (based Hb and serum ferritin cut-offs)				
Pre-School Children	827	13.3	11.0	15.6
School Age Children	942	4.9	3.5	6.3
Pregnant Women	104	26.0	17.6	34.4
Non-pregnant Women	592	14.0	11.2	16.8
Men	243	2.9	0.8	5.0
Vitamin A Deficiency (based on RBP cut-offs)				
Pre-School Children	918	9.2	7.3	11.1
School Age Children	942	4.7	3.4	6.1
Pregnant Women	111	5.4	1.2	9.6
Non-pregnant Women	632	2.0	0.9	3.1
Men	111	0.0	0	0
Folate Deficiency				
Pregnant Women	78	32.1	21.7	42.5
Non-pregnant Women	445	30.9	26.6	35.2
Vitamin B₁₂ Deficiency				
Pregnant Women	78	7.7	1.8	13.6
Non-pregnant Women	445	34.7	30.3	39.1
Zinc Deficiency (Based on serum zinc that is corrected for inflammation)				
Pre-School Children	711	81.6	78.8	84.5
School Age Children	901	79.0	76.3	81.7
Pregnant Women	109	67.9	59.1	76.7
Non-pregnant Women	617	79.9	76.7	83.1
Men	239	77.4	72.1	82.7
Iodine Deficiency				
School age Children	951	22.1	19.5	24.7
Non-pregnant Women	623	25.6	22.2	29.0



SUN MOVEMENT PROGRESS ASSESSMENT

In August 2012, the Republic of Kenya joined the SUN Movement with a letter of commitment from HE Beth Mugo, the Minister for Public Health and Sanitation. Every year Kenya joins the rest of the countries that have signed up to SUN movement to carry out a self-assessment aimed at establishing the progress



made within the country in the four SUN processes. May 2017 was not different, an event bringing together all six SUN Networks in Kenya was held to assess the progress of the country on the four SUN processes namely: Bringing people together into a shared space for action, ensuring a coherent policy and legal framework, aligning actions around a Common Results Framework and financing tracking and resource mobilisation. The assessment was well attended with all the SUN Networks in Kenya being well represented. The decision on rating was through consensus. The networks secretariat took a lead role in guiding discussions and contributing to consensus building.

The assessment found that overall Kenya had made remarkable progress in the four processes.

Bringing people together into a shared space for action

Despite facing severe drought over the past year, progress had been made towards establishment of high-level nutrition multi-stakeholder platforms (MSPs) at both national and county level. The engagement of specialized groups such as human rights groups and private sector alliances had increased, especially at county level.

Ensuring a coherent policy and legal framework

Several nutrition specific and sensitive policies and guidelines have been developed/ reviewed through consultative processes. For example, the National Nutrition Action Plan

(NNAP) 2012 -2017 is under review and will inform development of the 2018-2022 NNAP. Besides ongoing advocacy and support to the Food and Nutrition Security Bill, the Food and Nutrition Security Policy Implementation Framework and the 2016 Health Bill, a revised Agriculture Sector Development Strategy is underway. Regulations for the Breast-milk Substitutes Act 2012 have been developed and will go through parliament.

Aligning actions around a Common Results Framework

The NNAP 2012-2017 continues to be the Common Results Framework (CRF) for the government and partners. However, the FNISP Implementation Framework being developed will become the new CRF. Good progress was made in assessing the capacity to implement and achieve goals laid out in the current NNAP.

Financing tracking and resource mobilisation

Progress has been made in ensuring that a nutrition costing tool is in place which is used to provide cost estimates for nutrition related actions, e.g. those included in the FNISP Implementation Framework. As part of the efforts to enhance nutrition financial tracking, a financial tracking tool has been developed, a cost-benefit analysis (CBA) completed, and nutrition financial tracking analysis undertaken at national level and in six counties. The financial tracking tool will be especially useful to assess and monitor allocations for nutrition sensitive interventions. There has been a general reduction in funding available for nutrition, though emergency response funding has been better.

Next steps for Kenya and the priorities for the next year:

- ◆ Continue efforts towards establishment of nutrition MSPs at national and county levels
- ◆ Finalization of the FNISP Implementation Framework with subsequent roll-out in counties
- ◆ Advocate and support for the finalization and dissemination of key bills in parliament, e.g. Food and Nutrition Security Bill and the Breastfeeding Bill
- ◆ Support the dissemination and implementation of the Health Act of 2017
- ◆ Reviewing progress of NNAP 2012-2017 to inform the new NNAP 2017-2022

- ◆ Development of strategies and guidelines geared towards enhancing nutrition sensitive programming including development of an Agriculture-Nutrition Strategy

Announcements

- ◆ Progress review of the 2012-2017 National Nutrition Plan (NNAP) is ongoing . The review will inform the development of the 2018-2022 National Plan of Action

For feedback please contact Gladys Mugambi, Head Nutrition and Dietetics Unit at headnutrition.moh@gmail.com;
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For further information, visit us on www.nutritionhealth.or.ke

Access and download maps, tables and graphs from our interactive population based survey database on
stat planet at:

<http://www.nutritionhealth.or.ke/nutrition-reports-on-maps/>