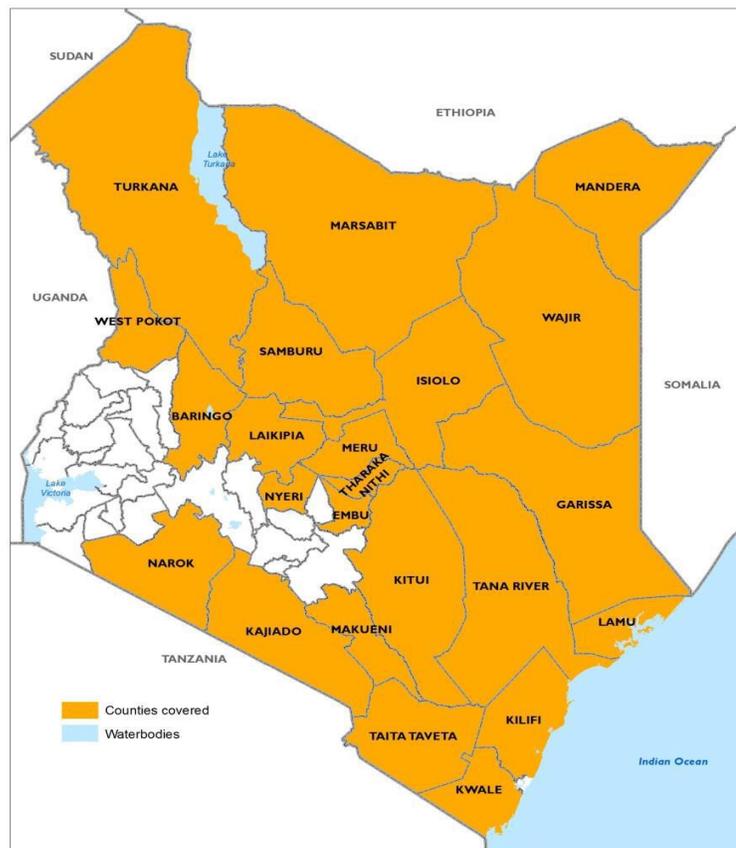


REPUBLIC OF KENYA



MINISTRY OF HEALTH

NUTRITION SITUATION REPORT FOR ARID AND SEMI ARID AREAS FEBRUARY 2017



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1.0 INTRODUCTION

The Kenya Food Security Steering Group (KFSSG) undertakes biannual seasonal assessments i.e. Long Rains Assessment (LRA) and Short Rains Assessment (SRA). Nutrition team through the Nutrition Information Technical Working Group (NITWG) supports in the health and nutrition analysis. The objective of the bi-annual the assessments conducted after the long and short rains is to determine how each season has affected food and nutrition security. Specifically, IPC for acute malnutrition helps to determine the severity of acute malnutrition, geographical areas that are most affected and the contributing factors to acute malnutrition. These in turn help in identification of the required immediate, intermediate and long term response actions.

The resulting food and nutrition security situation updates including the number of children and PLW requiring nutritional support informs the nutrition response plan and the integrated contingency plan in the National Drought Management Authority.

1.1 Scope and Unit of Analysis

Integrated Phase Classification (IPC) for Acute Malnutrition was conducted from 30th January to 8th February 2017 alongside Food Security Integrated Phase Classification during the 2017 Short Rains Assessment Report Writing Workshop. The assessment covered 23 counties classified as arid and semi-arid. These counties are also considered to be most vulnerable to acute malnutrition. They include: Mandera, Garissa, Tana River, Wajir, Isiolo, Turkana, Samburu, Marsabit, Baringo, Laikipia, West Pokot, Kajiado, Narok, Kitui, Makueni, Nyeri (Kieni), Meru (Meru North), Embu (Mbeere), Tharaka Nithi (Tharaka), Kwale, Taita Taveta, Kilifi and Lamu. The unit of analysis was dependent on homogeneity/heterogeneity of the prevalence of acute malnutrition in a county. As such Turkana and Marsabit Counties had four units of analysis each while Wajir and Baringo County had 2 units of analysis each.

Urban areas usually report low prevalence of acute malnutrition but high case loads of acute malnutrition. This is due to higher populations living in these areas especially in the informal settlements. As such to ensure urban needs are met and ensure coordinated resource mobilization, caseload for urban areas have been included in this report.

2. METHODS

The analysis applied the global protocols for Integrated Phase Classification for Acute Malnutrition released in November 2016. The IPC for Acute Malnutrition classified the severity of acute malnutrition into five Phases which was done based on the prevalence of GAM. A higher prevalence of acute malnutrition characterized the most severe phases as shown in Figure 2.1.

Phase Name and Description	PHASE 1 Acceptable	PHASE 2 Alert	PHASE 3 Serious	PHASE 4 Critical	PHASE 5 Extreme critical
	Less than 5% of children are acutely malnourished by GAM by WHZ measure or Less than 6% of children are acutely malnourished by GAM by MUAC measure	Even with any humanitarian assistance, about 5-10% of children are acutely malnourished by GAM by WHZ measure or about 6-11% of children are acutely malnourished by GAM by MUAC measure.	Even with any humanitarian assistance, about 10-15% of children are acutely malnourished by GAM by WHZ measure or about 6-11% of children are acutely malnourished by GAM by MUAC measure.	Even with any humanitarian assistance, 15-30% of children are acutely malnourished by GAM by WHZ measure or 11-17% of children are acutely malnourished by GAM by MUAC measure, showing conditions for excess mortality ³ .	Even with any humanitarian assistance, >30% of children are acutely malnourished by GAM by WHZ measure or >17% of children are acutely malnourished by GAM by MUAC measure, showing conditions for widespread death ³ .
Priority Response Objective to decrease Acute Malnutrition ⁴	Maintain the low prevalence of acute malnutrition	Strengthen existing response capacity and resilience. Address contributing factors to malnutrition. Monitor conditions and plan response as required.	Urgently reduce acute malnutrition levels through →		
			Scaling up of existing capacity and response as well as addressing contributing factors to malnutrition	Significant scale up with external help, if needed, of nutrition response and addressing of contributing factors to malnutrition in close co-ordination with other sectors	Addressing widespread acute malnutrition and death by all means. Also address all causes of malnutrition through greater scaling up of all public health programme interventions in close co-ordination with all other sectors.
GAM by WHZ) <-2 standard deviation and/or Oedema	< 5%	5.0 to 9.9%	10.0 to 14.9%	15.0 to 29.9%	≥30%
GAM by MUAC < 125 mm and/or Oedema	<6%	6.0 to 10.9%		11.0 to 16.9%	≥17%

Figure 2.1: IPC for Acute Malnutrition Reference Table

The analysis resulted to a current situation update and projection of the situation in the next three months i.e. February to April 2017. Key contributing factors both food security and non food security related factors were identified using the UNICEF conceptual framework (Figure 2.2) as laid out in the analysis work sheet (Appendix 4.5). Since both IPCs were conducted simultaneously, results from the IPC for acute malnutrition were input into the Food Security IPC and results from Food Security IPC were also input in the IPC from acute malnutrition. Finally response actions were identified. A one page summary of the situation including maps was developed.

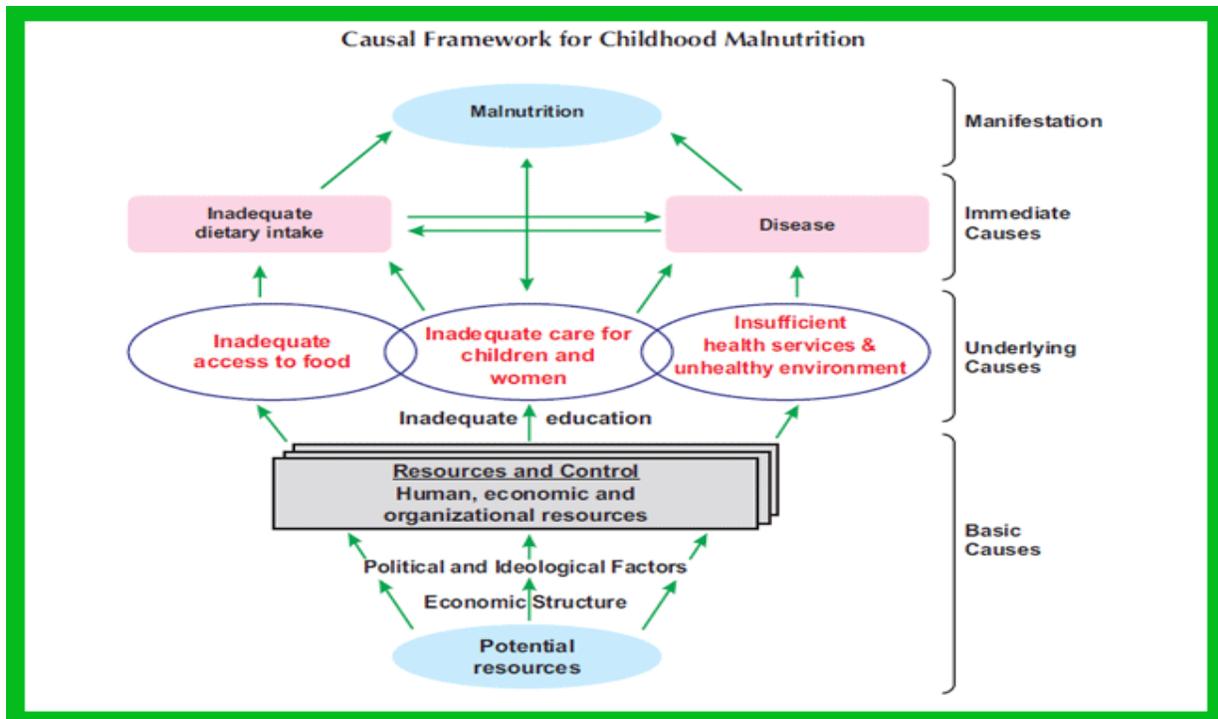


Figure 2.2: UNICEF Conceptual Framework

Data sources and quality: Data on Global Acute Malnutrition (GAM) used in the IPC for Acute Malnutrition were from representative surveys (GAM by WHZ) and the National Drought Management Authority sentinel sites (GAM by MUAC). Only data of acceptable quality was used in the analysis. Reliability scores were also assigned. Only areas with reliable information from the same season of analysis were classified for current classification while secondary information was used for the projection. Secondary data was gathered from multiple sources including the DHIS, small and large scale survey reports, sentinel surveillance, rapid assessments etc.

3. NUTRITION SITUATION

3.1 National Nutrition Situation Overview

According to the Integrated Phase Classification (IPC) for Acute Malnutrition conducted in February 2017, Turkana North, North Horr in Marsabit and Mandera counties **reported a Very Critical Nutrition situation** (phase 5; Global Acute Malnutrition ≥ 30 percent). A **Critical Nutrition Situation** (Phase 4; GAM WHZ 15.0 - 29.9 percent) was reported in East Pokot in Baringo county, Isiolo and Turkana South, West and Central. Tana River county reported a **Serious Nutrition Situation** (GAM WHZ 10.0 - 14.9 percent) while Tharaka Nithi was in phase 2 (alert GAM WHZ ≥ 5 to 9.9 percent). Finally Kitui, Kilifi, Meru north, Mbeere, Kajiado and Kwale reported rates in Phase 1 (acceptable GAM WHZ < 5 percent and GAM by MUAC < 6 percent). Compared with August 2016, improvement in the nutrition situation was noted in Turkana south while deterioration was noted in Turkana North, Isiolo Mandera and Marsabit Counties (Figures 3.1, 3.2 and 3.3; Appendix 4.1). The nutrition situation is expected to deteriorate across all ASAL counties in the coming months if the dry spell persists.

The analysis indicates that the poor nutrition status reported across the ASAL Counties is majorly due to poor dietary intake and household level food insecurity, coupled with high disease burden (Appendix 4.3). These factors compounded with the chronic issues prevalent in these areas like limited access to quality health services and inappropriate child care and feeding practices increase the vulnerability of the population, and aggravate the high malnutrition rates.

The total number of children requiring treatment of acute malnutrition in the ASAL areas is 343,559 (MAM - 268,549 and SAM – 75,010) and 37,223 pregnant and lactating women (Table 3.1). This is an increase compared to August 2016 where total number of children requiring treatment were 294,330 (MAM- 233,700 and SAM 60,600) and 29,500 pregnant and lactating women. The increase is mainly due to increase in GAM and SAM prevalence and calculation of caseloads using the revised projected population for 2016. Figure 3.4 presents caseloads by county while Appendix 4.2 presents caseloads in greater detail. A decline is observed in the months of November and December which can be attributed to the ongoing health workers strike.

Figure 3.1: Nutrition Situation May to August 2016

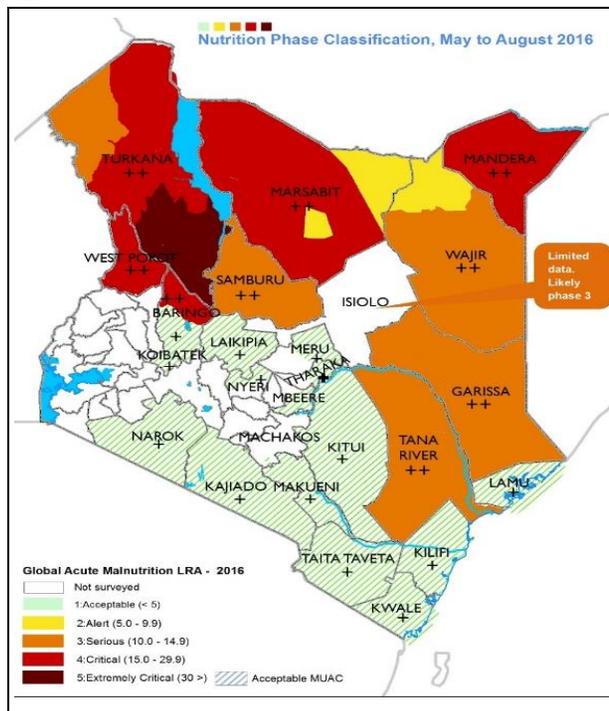


Figure 3.2: Nutrition Situation October 2016 to January 2017

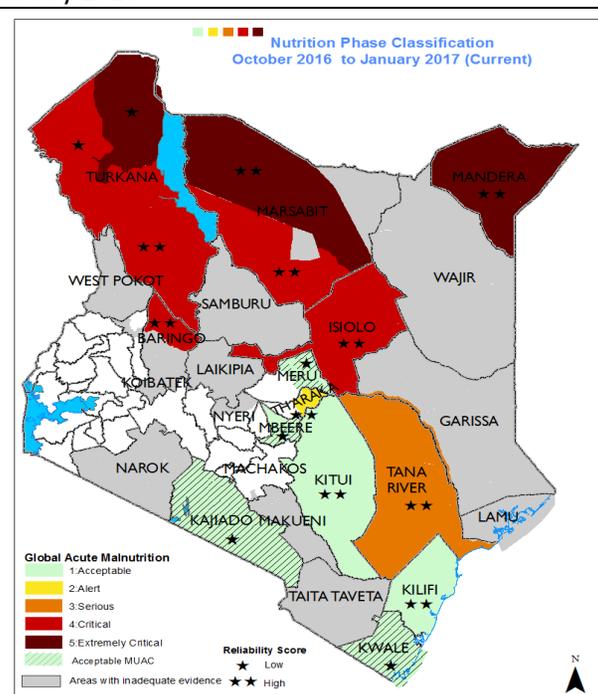


Figure 3.3: Projected Nutrition Situation February to April 2017

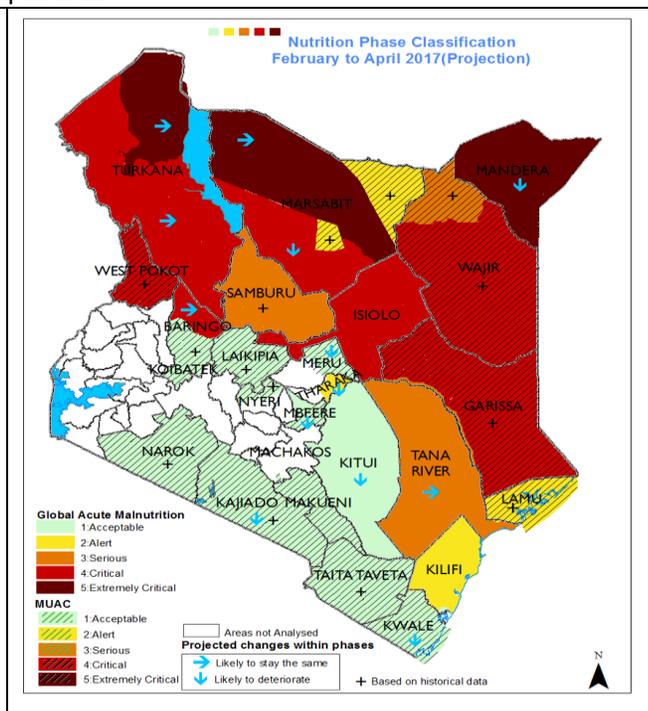
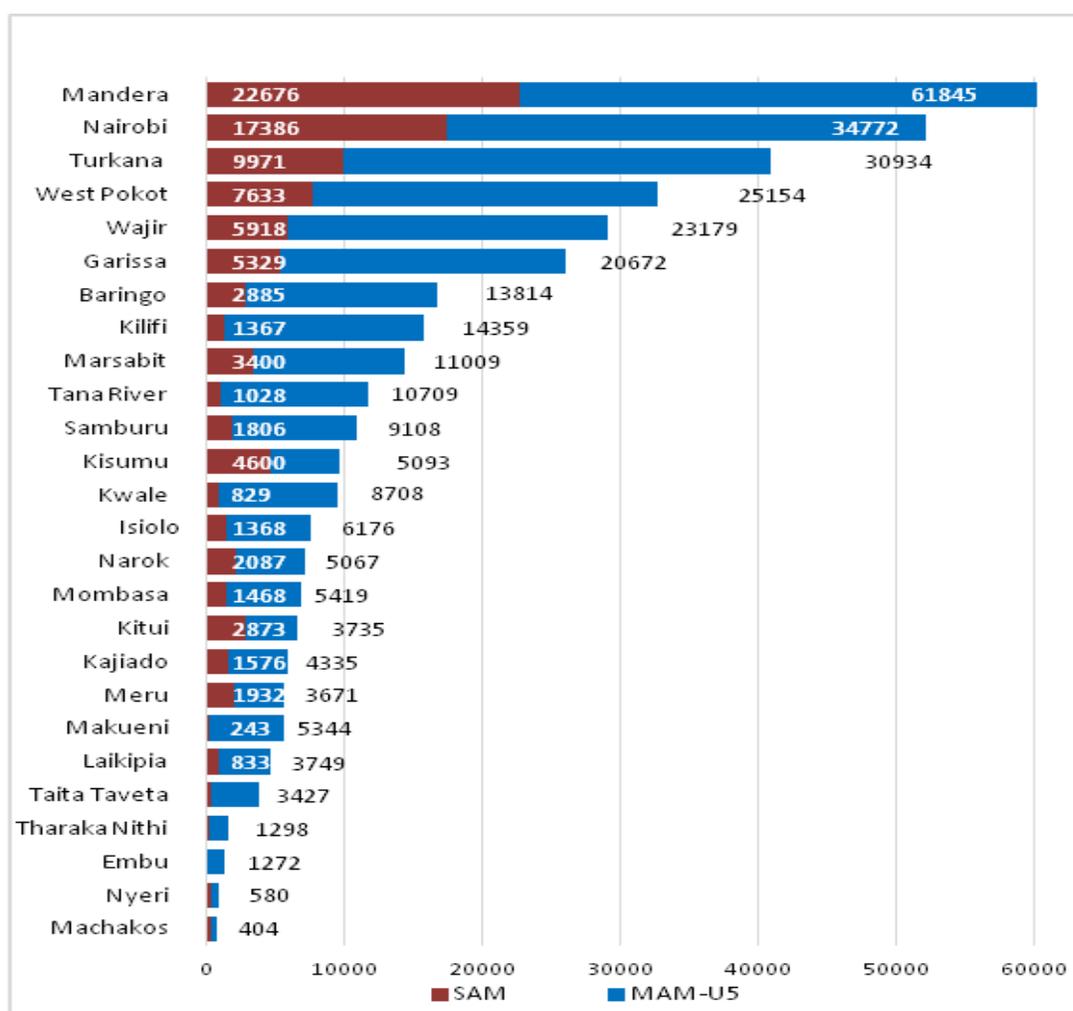


Table 3.1: Estimated Caseloads for Children and PLW Requiring Treatment for Acute Malnutrition

Area	SAM Children 6- 59	MAM Children 6-59	Total caseload 6-59 months	Pregnant and Lactating Women
ASAL	75,010	268,549	343,559	37,223
Urban	23,454	45,284	68,738	6,229
Total caseloads	98,464	313,833	412,297	43,452

Figure 3.4: Estimated Caseloads for Children 6-59 Months Requiring Treatment for Acute Malnutrition by County, February 2017



Currently, there are various nutrition interventions targeting acute and chronic malnutrition going on in all counties which should be continued at scale. However, the ongoing health workers strike has affected health care services. Figure 3.5, 3.6 and 3.7 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.

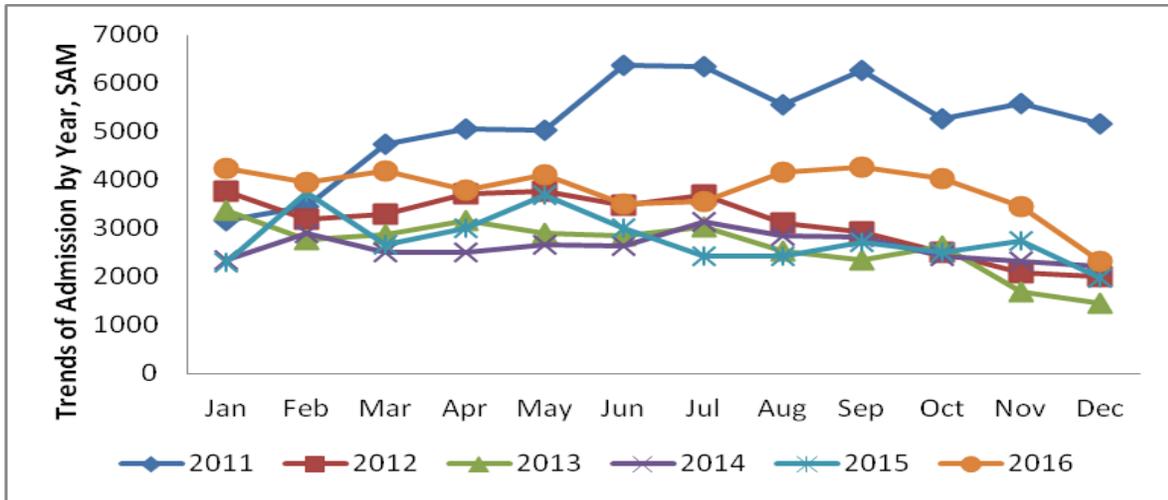


Figure 3.5: Total Admission Trends, Severe Acute Malnutrition for Children 6 to 59 Months, ASAL Counties 2011 to 2016

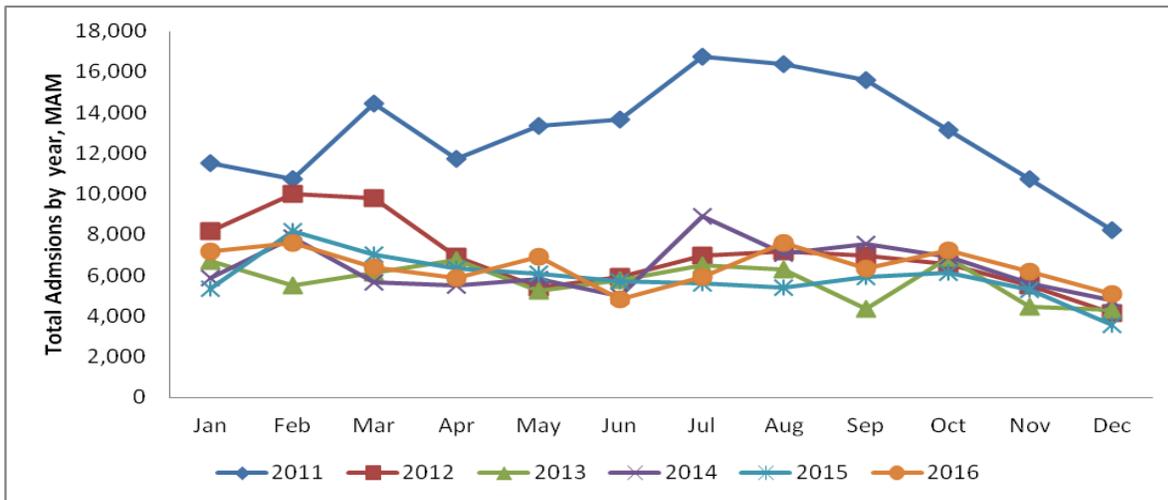


Figure 3.6: Total Admission Trends, Moderate Acute Malnutrition for Children 6 to 59 Months, ASAL Counties 2011 to 2016

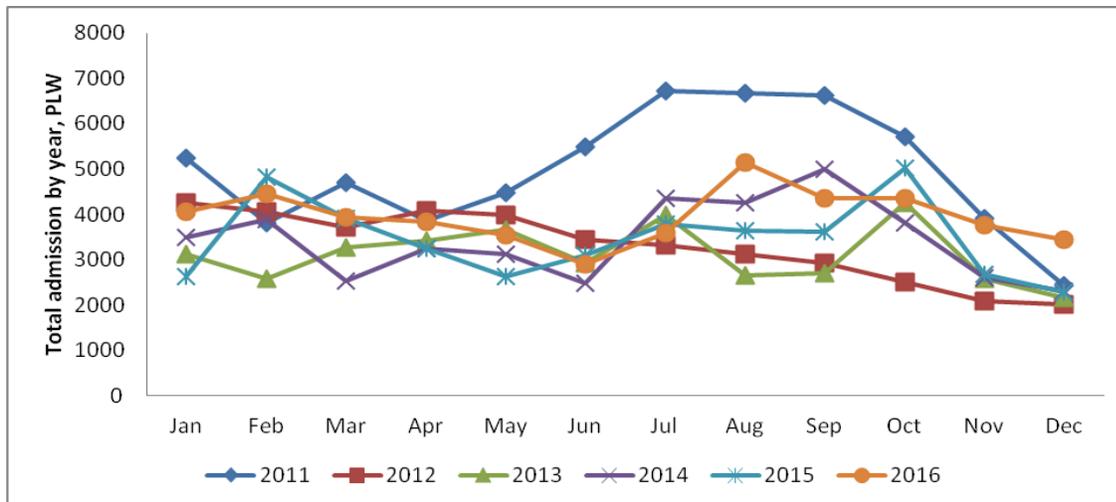


Figure 3.7: Total Admission Trends, Moderate Acute Malnutrition for Pregnant and Lactating Women, ASAL Counties 2011 to 2016

Noting that nutrition situation is expected to deteriorate if the dry spell persist immediate response actions proposed include:

- Scale up mass screening and referral in order to identify and treat children and PLW with acute malnutrition
- Engage community health services to ensure close follow up of identified cases especially referrals and defaulters
- Scale up integrated outreach services in hard to reach areas
- Link acutely malnourished children and women to existing social safety net programs
- Scale up of WASH services in areas that are most affected by drought
- Increased surveillance including regular situation updates and feedback at national and county levels with strong linkages to response
- Capacity strengthening on Integrated Management of Acute Malnutrition (IMAM) and IMAM surge
- Manage and strengthen supply chain to ensure appropriate nutrition commodities are consistently available at health facility level
- Promote multi-sectoral engagement and collaboration to ensure coordinated efforts and synergy to address acute malnutrition
- Ensure active follow up of implementation of emergency response plans and adjust based on evidence and learning

3.2 Nutrition Situation by Livelihood Zone Clusters

3.2.1 Pastoral Northeast Cluster

(Wajir, Mandera, Garissa, Isiolo, Tana River)

Analysis of nutrition information from Counties under Pastoral North East cluster shows deteriorating nutrition situation. Mandera County reported very critical nutrition situation with prevalence of GAM by WHZ at 32.8 percent (CI 26.3 - 40.0) and severe acute malnutrition at 8.7 percent (CI 5.3 - 14.1). Isiolo reported a critical situation with GAM BY WHZ of 18.2 percent (14.6- 22.5) an increase from 12.3 percent (9.6- 15.8) reported in Feb. 2016. The situation was serious in Tana River with GAM by WHZ of 13.7 percent (10.1- 18.2). Surveillance data from NDMA sentinel sites showed higher proportion of children with MUAC less than 135 mm compared to the long term average in Wajir, Isiolo and Mandera Counties (Figure 3.8).

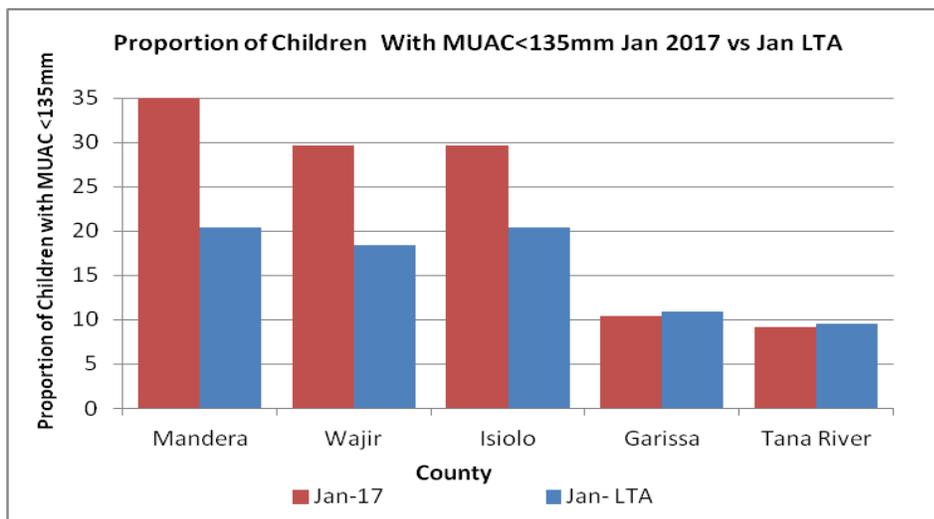


Figure 3.8: Proportion of Children With MUAC less than 135 mm January 2016 compared to January LTA, Pastoral North East Cluster

The most common diseases for both the under-fives and the general population across the cluster were diarrhea, upper respiratory infection, diseases of the skin and pneumonia. Others were malaria and dysentery in Mandera. These diseases are common during the dry spell across the cluster as a result of dust and poor water hygiene and sanitation. According to a rapid SMART survey carried out in Mandera County in February, morbidity among children 6 to 59 months was high as 52.9 percent of these children were ill in the two weeks preceding the survey. Of these 66.8 percent, 65.5 percent, 23.2 percent had fever, ARI/cough and diarrhea respectively.

The percentage of fully immunized child (FIC) for Wajir, Mandera and Isiolo Counties in the months of July to December 2016, decreased compared to the same period last year while Tana River and Garissa showed improvement. Coverage was below the national target of 80 percent. This was attributed to high staff turnover and limited outreach services. Disruption of health services due to health workers strike in the months of November and December 2016 may have affected the coverage even further.

Routine Vitamin A supplementation coverage for children under five ranged from 14.3 -59 percent across the cluster (Figure 3.9). The coverage for Isiolo, Garissa, Tana River and Wajir Counties shows improvement compared to the same period last year although way below national targets of 80 percent.

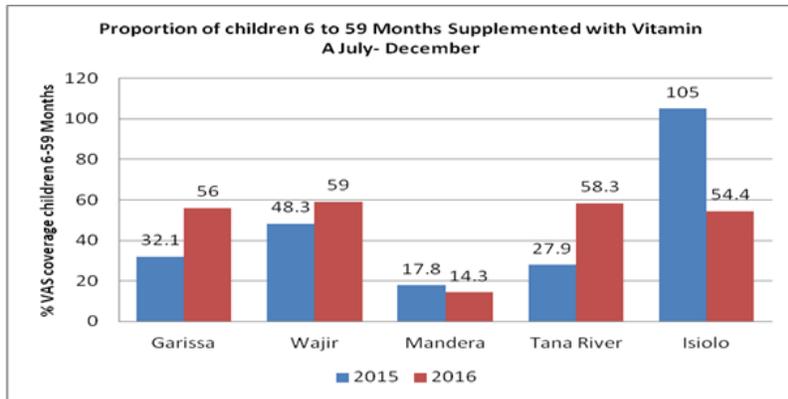


Figure 3.9: Proportion of Children 6 to 59 Months Supplemented with Vitamin A July to December 2016

The main contributors of acute malnutrition included; low dietary intake especially in pastoral livelihood zones where pasture was reported to be depleted resulting to reduced milk production and consumption, livestock migration, insecurity in some areas and high food prices as well as diseases emanating from poor hygiene and sanitation. Other factors included; underlying issues like poor access to basic health services, inadequate maternal and child care practices.

Summary of Recommendations:

Short term Recommendations:

- Mass Screening of malnourished children at community level and treatment through existing health facilities
- Scale up integrated outreach services to improve access to health and nutrition services
- Supply chain management to ensure availability of commodity at health facility level at all times
- Water tracking in the most affected areas

- Increased nutrition surveillance and response
- Ensure linkage of the vulnerable households to existing social safety nets
- Enhanced management of diseases, diarrhea, dysentery, malaria and ARI ,including use of Mosquito nets
- Strengthen and scale-up of surge model
- Strengthen School feeding program especially for the ECDs across the cluster
- Ensure response plans are updated and close monitoring and follow up of response actions
- Promote multi-sectoral engagement and collaboration to ensure coordinated efforts and synergy in response

Long term recommendations

- Advocacy to help improve nutrition integration in County planning and resource allocation
- Implement communication for development (C4D) and nutrition education addressing improved maternal, infant and young child nutrition
- Implement resilience programs to curb food and nutrition insecurity in households
- Improve water infrastructure Implement WASH projects such as CLTS

3.2.2 Pastoral Northwest Cluster

(Marsabit, Turkana And Samburu Counties)

According to SMART surveys conducted in Turkana County, Turkana North reported Extremely Critical nutrition situation (phase 5) with GAM prevalence of 30.7 percent while Turkana West, Central and South reported Critical nutrition situation (Phase 4) with reported GAM prevalence of 15.3 percent, 25.9 percent and 22.9 percent respectively. Analysis for Marsabit County has shown deterioration in North Horr which is classified as Extremely Critical (Phase 5) with GAM prevalence of 31.5 percent and slight deterioration in Laisamis (GAM 24.7 percent) which indicates Critical nutrition situation (Phase 4).

Analysis of secondary data projected that nutrition situation is likely to be in Phase 2 (Alert) in Moyale and Saku Sub Counties in the next three months (February to April) while Samburu is projected to have serious nutrition situation (Phase 3). According to sentinel surveillance data from NDMA, the percentage of children under five with MUAC <135 mm was higher January compared to the Long Term Average (LTA) in Samburu County (Figure 3.10).

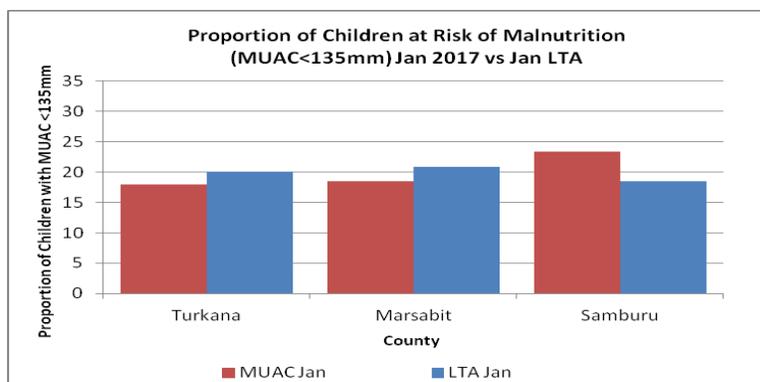


Figure 3.10: Proportion of Children With MUAC less than 135 mm January 2016 compared to January LTA, Pastoral North West Cluster

IMAM admission trends in the cluster from September 2016 to January 2017 indicate a stable situation with high admissions recorded in Marsabit and Turkana in the month of September and November respectively. A sharp decline was recorded from November 2016 through to January 2017. This could be attributed to poor access to health services across the cluster owing to the health workers strike. The major drivers of high acute malnutrition in the cluster are: poor dietary intake and morbidity. Routine Vitamin A and immunization coverage as per DHIS was generally poor across the cluster, with none of the county achieving the national target of 80 percent. This poor coverage was attributed to poor health seeking behavior and inadequate support for integrated outreaches activities in the hard to reach areas. Other underlying factors that affect malnutrition within the cluster include inadequate maternal and child care practices, low access to safe drinking water and poor hygiene and sanitation practices.

Short term recommendations for the Cluster

- Continue mass screening of children and women and treatment through existing health facilities and mapped outreaches.
- Scale up integrated outreach services to improve access to health and nutrition services in hard to reach areas.
- Ensure nutrition commodities are prepositioned
- Emergency food support/distribution need to target the ECDs
- Short term Emergency safety nets to consider using a food voucher instead of Cash to cushion populations from the increased food prices and also control the proportion of the allocations that goes directly to food purchase.
- Enhance surveillance through the IDSR especially Diarrhea and ARI

- Scale up IMAM surge approach.
- Due to the increased SAM, the county departments of health need to procure additional routine antibiotics used in treatment and management of malnourished children.
- Distribution of Water treatment chemicals and Jerricans in areas where unprotected water sources are used.

Short term recommendations for the Cluster

- Investment in water infrastructure and WASH interventions including Community Led Total Sanitation
- Develop intervention to promote behavior change to improve health seeking behavior
- Social behavior change communication and nutrition education addressing improved maternal, infant and young child nutrition

3.2.3 South East Marginal Cluster

(Meru North, Tharaka, Mbeere, Kitui, Makueni)

The nutrition situation in the south eastern marginal agriculture cluster based on surveillance data, showed a stable nutrition situation. The percentage of children under five with MUAC less than 135mm remained stable. In January 2017, lower rates were reported against LTA in three counties with exception of Tharaka and Kitui which remained stable. According to SMART surveys conducted in Kitui and Tharaka within this season, the Global Acute Malnutrition (GAM) was reported to be 2.6 percent and 5 percent respectively. According to IPC for acute malnutrition, Kitui is classified in Phase I (Acceptable; GAM less than 5 percent) while Tharaka is in phase 2 (Alert; GAM 5 to 9.9 percent).

Across the counties in this cluster, the diseases most prevalent among children under five years were Upper Respiratory Tract Infections (URTIs), Diarrhea, Intestinal worms, pneumonia and skin diseases. The major diseases among general population included; URTI, hypertension arthritis, skin diseases, and Urinary Tract Infection (UTI). Diarrhea cases among children under five years declined in 2016 compared to 2015 with Tharaka reporting the highest decrease of 23 percent. This decline should however be interpreted with caution as health services were disrupted on several occasions by health workers strike.

Coverage for Fully Immunized Children (FIC) under one year old varied from 54 to 83 percent (Figure 3.11), with Makueni being the only County reporting coverage of above 80 percent. Tharaka, Kitui and Mbeere had lower coverage compared to the same period last year.

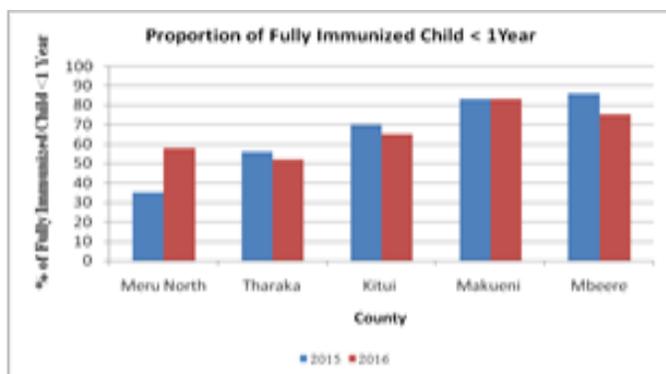


Figure 3.11: Proportion of Fully Immunized Child < 1 year

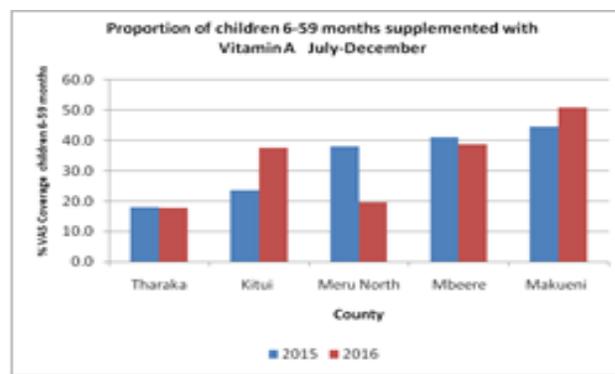


Figure 3.12: Proportion of Children 6 to 59 Months Supplemented with Vitamin A July to December 2016

Routine Vitamin A supplementation coverage for children six to 59 months remained below national target of 80 percent across the cluster (Figure 3.12). The decline in coverage was attributed to documentation gaps across the counties. Disruption of health services and change of the schools calendar which are used as avenue to reach more children during “malezi bora” also contributed to low coverage.

Current meal frequency is two to three meals per day as compared to the normal of three to four meals per day. This can be attributed to diminishing food stocks and limited sources of income. The meals have low dietary diversity of 3-5 food groups consisting mainly of cereals, pulses, vegetables, daily and fruits. Across the cluster, good hygiene practices such hand washing at the critical times remains a challenge as not more than 20 percent are practicing it. Latrine coverage ranges between 80 to 90 percent while water treatment remains poor at 60 percent. This puts the population at risk of getting water borne diseases especially due to the ongoing water stress in the cluster.

Recommendations

A) Immediate/short-term response objectives:

- Strengthening of therapeutic and supplementary feeding programs
- Ongoing school feeding programs need to be sustained
- General food distribution is recommended in most affected households
- Continue implementing IMAM program
- Ensure IMAM supplies are consistently available at health facility level
- Increased nutrition surveillance

B) Medium to Long term response objectives:

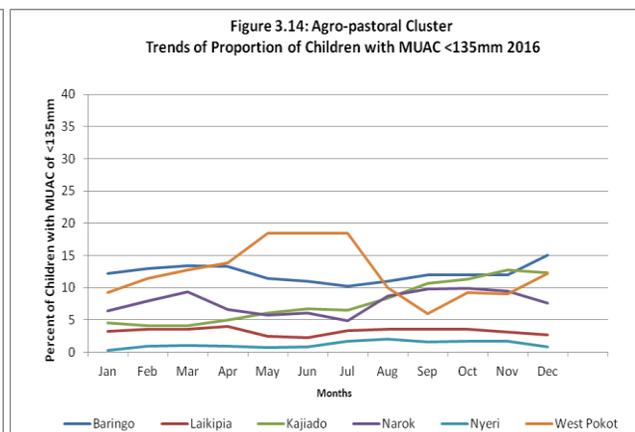
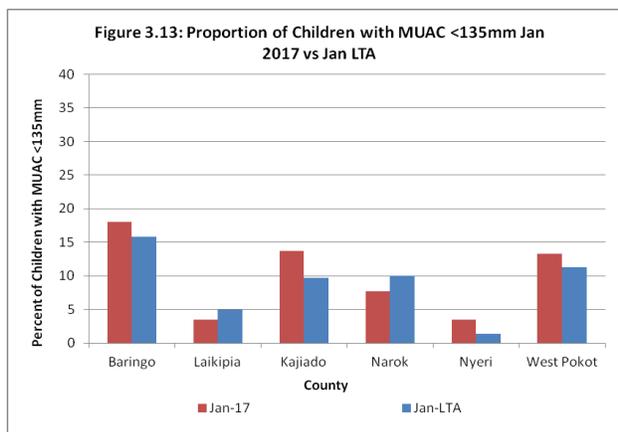
- Enhance social and behaviour change strategies
- Diversification of income generating activities
- Digging of water pans and drilling of boreholes to increase access to safe and adequate amount of water
- Increase land under irrigation in the Counties

3.2.4 Agro-Pastoral Cluster

(Nyeri North - Kieni, Laikipia, Baringo, West Pokot, Kajiado, Narok)

According to SMART a survey conducted in East Pokot in Baringo County, the prevalence of GAM by WHZ was 23.3 percent (CI 19.2 - 28.1 percent) showing critical nutrition situation (phase 4) in the area. Kajiado County was in Phase I (acceptable) based on GAM by MUAC. Other counties in the cluster did not have sufficient data for current classification. However, based on analysis of previous trends of acute malnutrition and contributory factors, it is projected that West Pokot County will be in Phase 4 (critical) while Laikipia, Kieni, and Narok will be in phase I and are likely to deteriorate within this phase in the next three months (February to April).

Further analysis based on MUAC from sentinel sites showed that the proportion of children with MUAC less than 135 mm was above the long term average in except for Laikipia and Narok Counties. The MUAC trends showed stable trends of proportion of children less than 135 mm.



Poor nutrition situation in Baringo and West Pokot counties is attributed to poor food consumption at household with most households in Baringo consuming an average of one to two meals in a day

comprising of mainly tea, ugali, wild vegetables and porridge in the Pastoral. In West Pokot County, most mothers in the Mixed and agro-pastoral zones spend most of their time in the farms, leaving children under the care of other children hence poor infant and young child feeding practices. All the counties in the cluster reported reduced cases of morbidity compared with the same period last year. These statistics however should be interpreted with caution as health services were interrupted due to the health workers strike in the months of November and December. There were no reported cases of outbreak within the period under review.

Immunization coverage across the cluster was comparable with the previous season in 2015 except in Narok County which had an improvement from 31 percent in 2015 to 55 percent in 2016 (Figure 3.14). The coverage for Fully Immunized children was below the national target of 80 percent for all except for Kieni. This could be attributed to health workers' strike, poor documentation coupled with changes made in the school calendar as schools closed early noting that early child development centers (ECDs) are normally used as avenues for boosting vitamin A supplementation coverage during malezi bora week. In West Pokot County, the immunization coverage was highest in mixed farming zone >80 percent and lowest in pastoral zones at 30 percent. Vitamin A coverage across the cluster was below the national threshold of 80 percent (Figure 3.15). However, improvement was noted in West pokot, Kajiado, Narok and Baringo counties while Nyeri and Laikipia recorded a decrease in coverage.

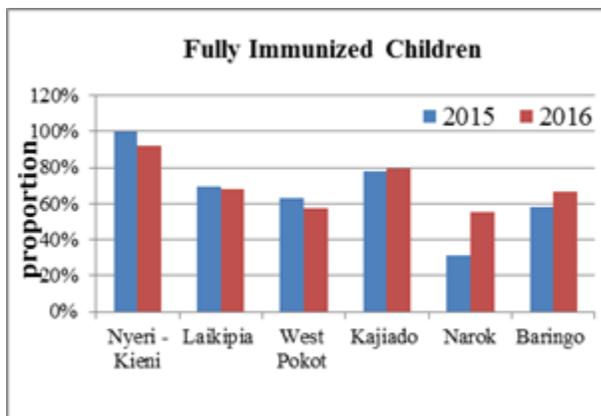


Figure 3.14: Proportion of Children Fully Immunized

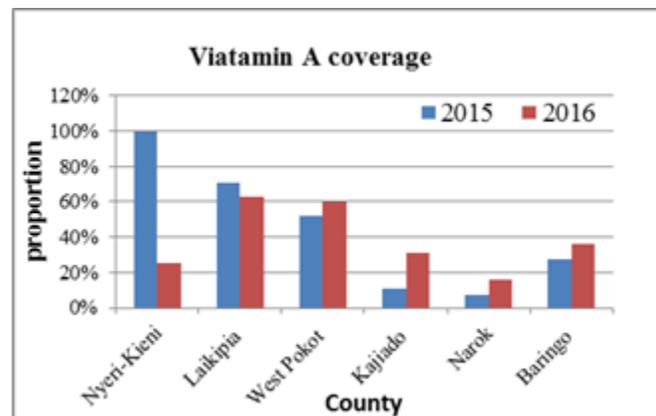


Figure 3.15: Proportion of Children 6 to 59 Months Supplemented with Vitamin A

The latrine coverage across the cluster was low ranging from 10 - 88 percent with variations across the livelihood zones. In Baringo the coverage was 10 and 55 percent in pastoral and agro-pastoral

livelihood respectively. However, East Pokot SMART reported that only 2 percent of the surveyed households were accessing improved sanitation facilities. Laikipia had the highest latrine coverage at 88 percent attributed to the creation of more community units supported by the Anglican Church of Kenya. Water treatment and hand washing practices at four critical times are poor in the cluster.

Recommendations for the Cluster

- ✓ Mass screening of children and pregnant and lactating women at community level and treatment through existing health facilities including reactivation of stabilization centre in West Pokot and East Pokot.
- ✓ Scale up integrated outreach services to improve access to health and nutrition services in hard to reach areas in West pokot, East pokot ,Kajiado and Narok
- ✓ Investment in water infrastructure and WASH interventions including Community Led Total Sanitation in Narok, Kajiado, West Pokot,
- ✓ Water tracking in West Pokot and East Pokot
- ✓ Enhanced disease surveillance and management of diseases like ARI, diarrhoea, dysentery
- ✓ Develop intervention to promote behaviour change to improve health seeking behaviour
- ✓ Social behaviour change communication and nutrition education addressing maternal, infant and young child nutrition
- ✓ Carry out MIYCN and SMART surveys in order to generate county specific nutrition indicators in Counties that have no surveys. Narok, Nyeri North, Laikipia and Kajiado.

3.2.5 Coastal Marginal Cluster

(Kwale, Taita Taveta, Kilifi, Lamu)

Analysis of the nutrition situation show stable trend of the proportion of children with MUAC less than 135mm across the cluster (Figure 3.16). The January 2017 prevalence when compared to the long term average in the cluster is stable, with Taita Taveta County recording the lowest (Figure 3.17). A SMART survey conducted in Kilifi County in November 2016 reported a GAM by WHZ of 4.6 percent and thus the county is classified in phase I (acceptable). Kwale was classified Phase I (Acceptable) based on GAM by MUAC.

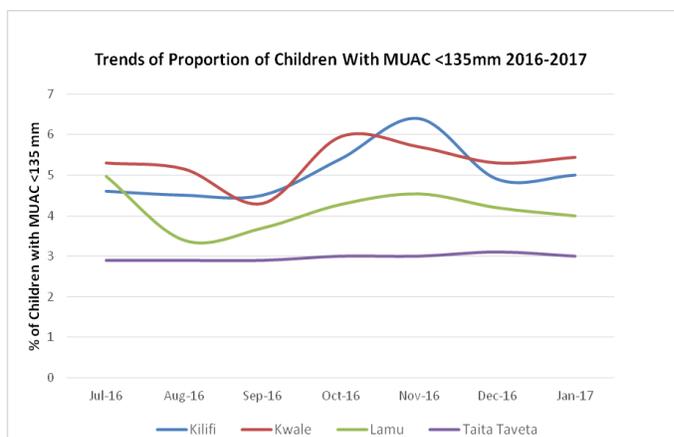


Figure 3.16: Trends of Proportion of Children with MUAC <135mm

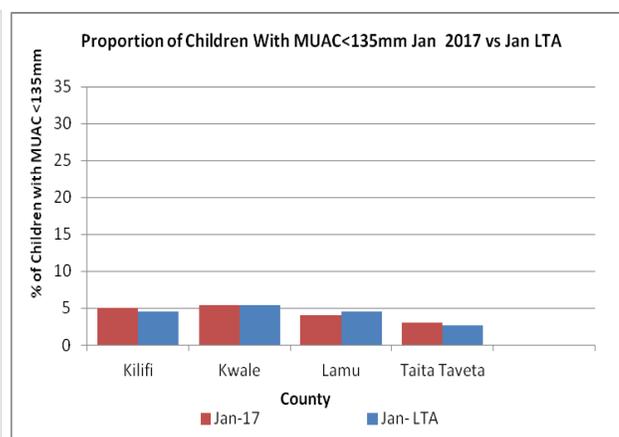


Figure 3.17: Proportion of Children with MUAC <135mm January 2017 vs January LTA

The food consumption score (FCS) revealed 67 and 6 percent of the households were within acceptable and poor consumption score respectively. This was an improvement compared to both May 2015, and 2014 and could be attributed to stable markets and adequate food stocks at households in the cluster. Meal frequency is two to three meals per day as compared to the normal of three to four meals per day with exception of marginal mixed livelihood zones of Kilifi where the meal frequency is one to two meals per day. This can be attributed to crop failure and limited sources of income.

The five most common diseases reported across the cluster for children below five years were: Upper respiratory tract infections (URTI), diarrhoea, skin infection, pneumonia, and malaria. However, Lamu County reported 22 percent increase in diarrheal diseases among the children below five years in 2016 compared to similar period in 2015. This could be attributed to water shortage resulting to poor hygiene practices.

The general population had similar top five diseases reported in children under five years. Except Kwale which reported rheumatism and hypertension among the top five diseases in the general population. Overall, there was an increase in URTI, malaria and diarrhoea respectively in the cluster. However, there were no recorded cases of cholera in the cluster as seen in the neighboring North East Pastoral cluster (Tana River County).

Hand washing at critical times at households across the cluster ranges from 60 to 80 percent. Water treatment at household level ranged from 50 to 60 percent. Access to safe drinking water was good in areas which are not dependent on water from earth surface, with exception of Kishenyi in Taita Sub-

County where the community has been advised not to use water from Kishenyi dam due to suspected poisoning after fish started dying. The samples have been taken for analysis, and water trucking is meanwhile being carried out in the area. Latrine coverage in the cluster averages 53 percent.

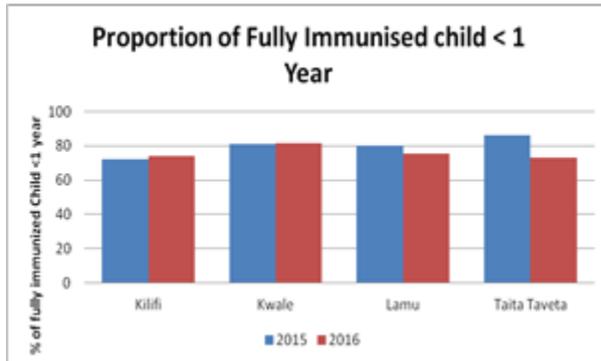


Figure 3.18: Proportion of fully Immunized Children <1 year

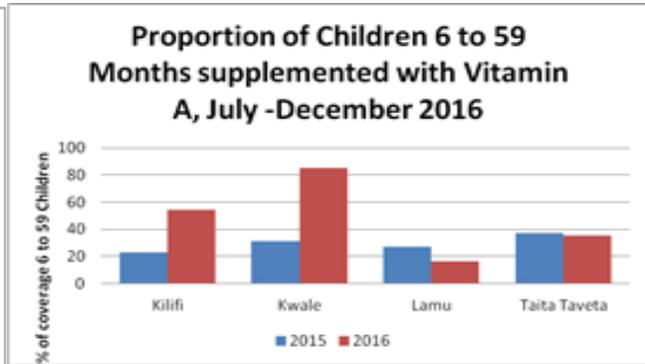


Figure 3.19: Proportion of Children 6 to 59 Months supplemented with Vitamin July to December 2016

The proportion of fully immunized children vaccinated during the period between June and Dec 2016 compared with same period in 2015 remained relatively stable (Figure 3.18). Vitamin A coverage as per District Health Information Services (DHIS) is below the national target of 80 percent across the cluster, with exception of Kwale County (Figure 3.19). Low vitamin A coverage in the counties is attributed to poor health seeking behaviour and inadequate support for integrated outreach activities in the hard to reach areas.

Latrine coverage across the county is at an average of 53 percent. However in Kilifi open defecation ranges from 50 to less than 10 percent. Household water treatment practices were generally low across the cluster with approximately 5 to 10 percent of households boiling water before drinking.

Recommendations for the Cluster

1. Monitoring DHIS facility data for any surge of malnutrition cases and any disease outbreak.
2. Continue Supplementary/ Therapeutic feeding program in health facilities
3. Scale-up vitamin A supplementation for children 6-59 months through ECDs
4. Advocate for safety nets such as cash transfers to the elderly, orphaned and vulnerable children, people with severe disability and general food distribution to the most affected households
5. Enhance Promotion of maternal and child health in the four counties.
6. Mass screening and active case finding (under-five years old, pregnant and lactating women) and strengthen outreaches
7. Scale-up vitamin A supplementation for children 6-59 months through ECDs

8. Ensure availability of adequate nutrition commodities/supplies and medical supplies

4. APPENDIX

Appendix 4.1: Summary of Global Acute Malnutrition and Severe Acute Malnutrition Prevalence from Smart Surveys

Analysis Area (County or Sub County)	GAM ¹		SAM ²		MUAC ³ < 12.5cm	
	Feb. 2016	Feb. 2017	Feb. 2016	Feb. 2017	Feb 2016	Feb 2017
Mandera		32.8 % (26.3-40.0)		8.7% (5.3-14.1)		11.3 % (7.4 - 16.9)
Turkana Central		25.9% (21.7- 30.6)		6.4% (4.4-9.2)		7.1% (4.6-10.8)
Turkana North		30.7% (26.6-35.1)		8.1% (6.0-10.7)		10.3% (7.2-14.6)
Turkana South		22.9% (18.4-28.0)		5.7 % (3.7-8.7)		8.8% (5.9-13.1)
Turkana West		15.3% (11.5-20.2)		3.1% (1.6-5.9)		5.5% (3.4-8.7)
Baringo (East Pokot)		23.3%(19.2- 28.1)		4.0%(2.4- 6.5)		
Isiolo	12.3% (9.6- 15.8)	18.2(14.6- 22.5)	1.2% (0.4-3.4)	3.3% (2.1- 5.3)	3.8% 2.8- 6.4)	7.7% (5.6- 10.6)
Tana River		13.7% (10.1- 18.2)		3.0% (1.3 – 6.4)		4.0%(2.3- 7.1)
Marsabit (Loiyangalani/ Laisamis		24.7%(19.3- 31.0)		5.5%(3.5- 8.5)		7.1% (3.8- 12.9)
Marsabit North Horr		31.5% (25.3- 38.5)		9.8%(6.6- 14.3)		10.1% (6.7- 14.9)
Kilifi		4.6% (3.3- 6.6)		0.4%(0.1- 1.3)		2.8% (1.5- 4.9)
Kitui		2.6%(1.5- 4.5)		0.2%(0.0- 1.8)		2.6%(1.5- 4.6)
Tharaka Nithi		5.0%(2.6- 9.5)		0.7%(0.2- 3.0)		2.1%(0.9- 5.0)

¹ Global acute malnutrition <-2 SD or oedema

² Severe Acute malnutrition <- 3 SD or oedema

³ Mid Upper arm circumference

Appendix 4.2: Estimated Caseloads

County/Sub County	GAM caseloads by area surveyed	SAM caseloads by area surveyed	MAM caseloads by County	Pregnant and lactating women caseloads- County/ area surveyed
	Children 6- 59 months	Children 6- 59 months	Children 6- 59 months	
Samburu	10,914	1,806	9,108	1,492
Mbeere	1,363	91	1,272	162
West Pokot	37,787	7,633	25,154	1,790
Isiolo	7,544	1,368	6,176	827
Tana River	11,737	1,028	10,709	819
Garissa	26,001	5,329	20,672	3,665
Mandera	84,521	22,676	61,845	5412
Wajir County	29,097	5,918	23,179	3,893
Meru North	5,603	1,932	3,671	779
Turkana Central	9,583	2,368	7,215	1,106
Turkana East/South	8,551	2,128	6,422	931
Turkana West	8,704	1,764	6,941	1,107
Turkana North	14,067	3,712	10,356	1,532
Marsabit-Moyale/Sololo	2,244	150	2,095	801
Marsabit-Laisamis/Loiyangalani	4,676	1,041	3,635	1,099
Marsabit North Horr/Chalbi	6,497	2,021	4,476	558
Marsabit Saku	992	188	804	153
Baringo- Mixed farming LHZ	8,161	1,415	6,746	304
Baringo- East	8,557	1,469	7088	612

County/Sub County	GAM caseloads by area surveyed	SAM caseloads by area surveyed	MAM caseloads by County	Pregnant and lactating women caseloads- County/ area surveyed
	Children 6- 59 months	Children 6- 59 months	Children 6- 59 months	
Pokot				
Kitui	6,608	2,873	3,735	566
Taita Taveta	3,764	336	3,427	285
Narok	7,154	2,087	5,067	1,987
Kajiado	5,911	1,576	4,335	1,572
Laikipia	4,582	833	3,749	2,442
Kilifi	15,726	1,367	14,359	1,651
Kinango	9,537	829	8,708	954
Machakos (Yatta	717	311	404	80
Makueni	5,587	243	5,344	515
Nairobi	52,158	17,386	34,772	3,991
Nyeri North	885	305	580	11
Tharaka Nithi	1,509	211	1,298	134
Total Caseloads (ASAL)	412,297	98,464	313,833	43,452

Appendix 4.3: Summary of Contributing Factors

I. Pastoral North East (Wajir, Mandera, Garissa, Isiolo, Tana River)

SUMMARY CONTRIBUTING FACTORS BY AREA		WAJIR EAST	WAJIR NORTH	MANDERA	GARISSA	ISIOLO	T/RIVER
	Major contributing factor		Minor contributing factor		Not a contributing factor		
Inadequate dietary intake	Minimum Dietary Diversity (MDD)	Major	Major	Major	Major	Major	Major
	Minimum Meal Frequency (MMF)	Major	Major	Major	Major	Minor	Major
	Minimum Acceptable Diet (MAD)	Major	Major	Major	Major	Major	Major
	Minimum Dietary Diversity – Women (MDD-W)	Major	Minor	Major	Minor	Minor	Major
	Others	Minor	Minor	Minor	Minor	Minor	Minor
Diseases	Diarrhoea	Major	Minor	Minor	Minor	Major	Major
	Dysentery	Minor	Minor	Minor	Minor	Minor	Minor
	Malaria	Minor	Minor	Minor	Minor	Major	Minor
	HIV/AIDS prevalence	Minor	Minor	Minor	Minor	Minor	Minor
	Acute Respiratory Infection	Major	Minor	Major	Minor	Major	Major
	Disease outbreak	Minor	Minor	Major	Minor	Major	Minor
	Others	Minor	Minor	Minor	Minor	Minor	Minor
Inadequate access to food	Outcome of the IPC for Acute Food Insecurity analysis	Major	Major	Minor	Minor	Minor	Major
Inadequate care for children	Exclusive breastfeeding under 6 months	Minor	Minor	Major	Major	Minor	Minor
	Continued breastfeeding at 1 year	Minor	Minor	Major	Minor	Minor	Minor
	Continued breastfeeding at 2 years	Major	Minor	Minor	Minor	Minor	Minor
	Introduction of solid, semi-solid or soft foods	Minor	Minor	Major	Major	Major	Minor
	Others	Minor	Minor	Minor	Minor	Minor	Minor
Insufficient health services & unhealthy environment	Measles vaccination	Minor	Minor	Minor	Minor	Minor	Minor
	Polio vaccination	Minor	Minor	Minor	Minor	Minor	Minor
	Vitamin A supplementation	Minor	Minor	Minor	Minor	Minor	Minor
	Skilled birth attendance	Minor	Minor	Minor	Minor	Minor	Minor
	Health seeking behavior	Minor	Minor	Minor	Minor	Minor	Minor
	Coverage of outreach programmes – CMAM programme coverage (SAM, MAM, or both)	Minor	Minor	Minor	Minor	Minor	Minor

	Access to a sufficient quantity of water	Red			Red		Yellow
	Access to sanitation facilities	Red			Red	Red	Yellow
	Access to a source of safe drinking water	Red			Red	Red	Red
	Others						
Basic causes	Human capital	Red	Yellow	Red	Red	Red	Red
	Physical capital	Red	Yellow	Red	Red	Red	Yellow
	Financial capital	Yellow	Yellow	Red	Red	Red	Yellow
	Natural capital	Red	Yellow	Red	Red	Red	Yellow
	Social capital	Red	Yellow	Red		Red	Yellow
	Policies, Institutions and Processes	Yellow	Yellow		Red		Yellow
	Usual/Normal Shocks	Yellow	Red	Red	Red	Red	Red
	Recurrent Crises due to Unusual Shocks	Yellow	Yellow	Red			Yellow
	Other basic causes						
Other nutrition issues	Anaemia among children 6-59 months	Yellow		Yellow			
	Anaemia among pregnant women						
	Anaemia among non-pregnant women						
	Vitamin A deficiency among children 6-59 months						
	Low birth weight	Red	Yellow	Red	Red	Red	
	Fertility rate	Yellow	Yellow	Yellow	Red		
	Others						

2. Summary Contributing Factors Pastoral North West (Marsabit, Turkana, Samburu)

SUMMARY CONTRIBUTING FACTORS BY AREA		LAISAMIS	NORTH HERR	SAKU	TURKANA CENTRAL	TURKANA NORTH	TURKANA SOUTH	TURKANA WEST	SAMBURU
									
Inadequate dietary intake	Minimum Dietary Diversity (MDD)	Major	Major	Major	Major	Major	Major	Major	Major
	Minimum Meal Frequency (MMF)	Major	Major	Major	Minor	Minor	Major	Minor	Major
	Minimum Acceptable Diet (MAD)	Major	Major	Major	Major	Major	Major	Major	Major
	Minimum Dietary Diversity – Women (MDD-W)	Major	Major	Major	Not a	Not a	Major	Not a	Major
	Others – Food Consumption	Not a	Not a	Not a	Major	Not a	Not a	Major	Not a
Diseases	Diarrhoea	Major	Major	Major	Not a	Major	Major	Major	Major
	Dysentery	Not a	Not a	Major	Major	Not a	Not a	Not a	Minor
	Malaria	Minor	Major	Major	Not a	Major	Major	Major	Minor
	HIV/AIDS prevalence	Minor	Not a	Minor	Major	Major	Major	Minor	Minor
	Acute Respiratory Infection	Minor	Major	Major	Major	Major	Major	Major	Major
	Disease outbreak	Not a	Not a	Minor	Major	Not a	Not a	Not a	Minor
	Others	Not a	Not a	Not a	Not a	Not a	Not a	Not a	Minor
Inadequate access to food	Major	Not a	Not a	Not a	Not a	Not a	Major	Major	
Inadequate care for children	Exclusive breastfeeding under 6 months	Not a	Minor	Minor	Major	Major	Major	Minor	Minor
	Continued breastfeeding at 1 year	Not a	Minor	Minor	Not a	Not a	Major	Minor	Minor
	Continued breastfeeding at 2 years	Minor	Minor	Minor	Minor	Major	Not a	Minor	Minor

	Introduction of solid, semi-solid or soft foods	Yellow	White	Yellow	Red	White	Red	Red	Yellow
	Others	White	White	White	White	White	White	White	White
Insufficient health services & unhealthy environment	Measles vaccination	White	Yellow	White	Yellow	Yellow	Yellow	Yellow	Yellow
	Polo vaccination	White	White	White	Yellow	Yellow	Yellow	Yellow	Yellow
	Vitamin A supplementation	Yellow	Yellow	White	Red	Red	Red	Yellow	Yellow
	Skilled birth attendance	White	Yellow	White	Yellow	Yellow	Yellow	Yellow	White
	Health seeking behaviour	White	Red	White	Red	Red	White	Red	White
	Coverage of outreach programmes – CMAM programme coverage (SAM, MAM, or both)	Yellow	Red	Yellow	Red	Red	Red	Yellow	Red
	Access to a sufficient quantity of water	White	White	Yellow	Red	Red	Red	Red	Red
	Access to sanitation facilities	White	Red	Yellow	Red	Red	Red	Red	Yellow
	Access to a source of safe drinking water	White	Yellow	Yellow	Red	Red	Red	Red	Yellow
	Others	White	White	White	White	White	White	White	White
	Basic causes	Human capital	Red	Red	Yellow	Red	Red	Red	Red
Physical capital		Red	Red	Yellow	Red	Red	Red	Red	Red
Financial capital		Yellow	Red	Red	Yellow	Yellow	Yellow	Yellow	Red
Natural capital		Yellow	Red	Red	Yellow	Yellow	Yellow	Yellow	Yellow
Social capital		Red	White	Yellow	Red	Red	Red	Red	Red
Policies, Institutions and Processes		Yellow	White	Yellow	Red	Red	Red	Red	Red
Usual/Normal Shocks		White	Red	Red	Yellow	Yellow	Yellow	Yellow	Red
Recurrent Crises due to Unusual Shocks		White	White	Red	Yellow	Yellow	Yellow	Yellow	White
Other basic causes		White	White	White	White	White	White	White	White
Other nutrition issues	Anaemia among children 6-59 months	Yellow	White						
	Anaemia among pregnant women	White	White	White	Yellow	White	White	White	White

Anaemia among non-pregnant women									
Vitamin A deficiency among children 6-59 months									
Low birth weight									
Fertility rate									
Others									

3. Summary Contributing Factors Coastal Marginal (Kilifi, Taita Taveta, Kwale, Lamu)

SUMMARY CONTRIBUTING FACTORS BY AREA		KILIFI	T/TAVETA	KWALE	LAMU
	Major contributing factor		Minor contributing factor		Not a contributing factor
Inadequate dietary intake	Minimum Dietary Diversity (MDD)	Major	Minor	Minor	Major
	Minimum Meal Frequency (MMF)	Major	Minor	Minor	Major
	Minimum Acceptable Diet (MAD)	Major	Not	Minor	Major
	Minimum Dietary Diversity – Women (MDD-W)	Major	Not	Not	Not
	Others	Not	Not	Not	Not
Diseases	Diarrhoea	Not	Minor	Major	Major
	Dysentery	Not	Not	Minor	Minor
	Malaria	Minor	Minor	Major	Major
	HIV/AIDS prevalence	Not	Not	Not	Minor
	Acute Respiratory Infection	Major	Minor	Minor	Not
	Disease outbreak	Not	Not	Not	Not
Others	Not	Not	Not	Not	
Inadequate access to food	Outcome of the IPC for Acute Food Insecurity analysis	Major	Not	Not	Major
Inadequate care for children	Exclusive breastfeeding under 6 months	Not	Not	Not	Not
	Continued breastfeeding at 1 year	Not	Not	Not	Not
	Continued breastfeeding at 2 years	Not	Not	Not	Not
	Introduction of solid, semi-solid or soft foods	Not	Not	Not	Not
	Others	Not	Not	Not	Not
Insufficient health services & unhealthy environment	Measles vaccination	Not	Not	Not	Not
	Polo vaccination	Not	Not	Not	Not
	Vitamin A supplementation	Minor	Minor	Minor	Not
	Skilled birth attendance	Not	Not	Not	Not
	Health seeking behaviour	Not	Not	Not	Not
	Coverage of outreach programmes – CMAM programme coverage (SAM, MAM, or both)	Not	Not	Not	Not
	Access to a sufficient quantity of water	Major	Minor	Not	Not

	Access to sanitation facilities		Yellow		
	Access to a source of safe drinking water	Red	Yellow		Red
	Others				
Basic causes	Human capital	Yellow	Yellow	Yellow	Yellow
	Physical capital	Yellow	Yellow		Red
	Financial capital	Red	Yellow		Yellow
	Natural capital	Yellow	Yellow		Red
	Social capital	Red	Yellow		Yellow
	Policies, Institutions and Processes				Red
	Usual/Normal Shocks	Yellow		Yellow	Red
	Recurrent Crises due to Unusual Shocks	Yellow			Red
	Other basic causes				
Other nutrition issues	Anaemia among children 6-59 months		Yellow		
	Anaemia among pregnant women				
	Anaemia among non-pregnant women				
	Vitamin A deficiency among children 6-59 months				
	Low birth weight				
	Fertility rate				
	Others				

4. Summary Contributing Factors South East Marginal (Mbeere, Tharaka, Kitui, Makeni, Meru North)

SUMMARY CONTRIBUTING FACTORS BY AREA		MBEER	THARAKA	KITUI	MAKUENI	MERU/N
	Major contributing factor		Minor contributing factor		Not a contributing factor	
Inadequate dietary intake	Minimum Dietary Diversity (MDD)	Minor	Minor	Major	Major	Major
	Minimum Meal Frequency (MMF)	Not	Minor	Minor	Minor	Major
	Minimum Acceptable Diet (MAD)	Minor	Minor	Major	Major	Major
	Minimum Dietary Diversity – Women (MDD-W)	Not	Not	Not	Not	Not
	Others	Not	Not	Not	Not	Not
Diseases	Diarrhoea	Minor	Minor	Major	Major	Minor
	Dysentery	Not	Minor	Not	Minor	Minor
	Malaria	Minor	Minor	Minor	Not	Minor
	HIV/AIDS prevalence	Not	Minor	Minor	Not	Minor
	Acute Respiratory Infection	Minor	Minor	Major	Major	Minor
	Disease outbreak	Not	Minor	Minor	Not	Not
	Others	Not	Not	Not	Not	Not
Inadequate access to food	Outcome of the IPC for Acute Food Insecurity analysis	Minor	Major	Major	Minor	Not
Inadequate care for children	Exclusive breastfeeding under 6 months	Minor	Minor	Minor	Minor	Minor
	Continued breastfeeding at 1 year	Minor	Minor	Minor	Not	Minor
	Continued breastfeeding at 2 years	Minor	Minor	Minor	Not	Minor
	Introduction of solid, semi-solid or soft foods	Minor	Major	Minor	Not	Minor
	Others	Not	Not	Not	Not	Not
Insufficient health services & unhealthy environment	Measles vaccination	Not	Minor	Minor	Minor	Minor
	Polo vaccination	Not	Minor	Not	Minor	Minor
	Vitamin A supplementation	Not	Minor	Major	Minor	Minor
	Skilled birth attendance	Not	Minor	Major	Minor	Minor
	Health seeking behaviour	Not	Minor	Minor	Not	Minor
	Coverage of outreach programmes – CMAM programme coverage (SAM, MAM, or both)	Not	Not	Not	Not	Not
	Access to a sufficient quantity of water	Not	Minor	Minor	Major	Not

	Access to sanitation facilities							
	Access to a source of safe drinking water							
	Others							
Basic causes	Human capital							
	Physical capital							
	Financial capital							
	Natural capital							
	Social capital							
	Policies, Institutions and Processes							
	Usual/Normal Shocks							
	Recurrent Crises due to Unusual Shocks							
	Other basic causes							
Other nutrition issues	Anaemia among children 6-59 months							
	Anaemia among pregnant women							
	Anaemia among non-pregnant women							
	Vitamin A deficiency among children 6-59 months							
	Low birth weight							
	Fertility rate							
	Others							

5. Summary Contributing Factors Agro- pastoral (Nyeri North, Laikipia, Baringo, West Pokot, Kajiado, Narok)

SUMMARY CONTRIBUTING FACTORS BY AREA		NYERI /N	LAIKIPIA	BARINGO (EAST)	W/POKOT	AKAJIADO	NAROK
	Major contributing factor		Minor contributing factor		Not a contributing factor		
Inadequate dietary intake	Minimum Dietary Diversity (MDD)	Major	Major	Major	Major	Major	Major
	Minimum Meal Frequency (MMF)	Major	Major	Major	Major	Major	Major
	Minimum Acceptable Diet (MAD)	Major	Major	Major	Major	Major	Major
	Minimum Dietary Diversity – Women (MDD-W)	Major	Major	Minor	Major	Major	Major
	Others	Major	Major	Major	Major	Major	Major
Diseases	Diarrhoea	Major	Minor	Major	Major	Major	Major
	Dysentery	Major	Major	Major	Major	Major	Major
	Malaria	Major	Major	Major	Major	Major	Major
	HIV/AIDS prevalence	Major	Major	Major	Major	Major	Major
	Acute Respiratory Infection	Major	Major	Major	Major	Major	Major
	Disease outbreak	Major	Major	Major	Major	Major	Major
	Others	Major	Major	Major	Major	Major	Major
Inadequate access to food	Outcome of the IPC for Acute Food Insecurity analysis	Major	Major	Major	Major	Major	Major
Inadequate care for children	Exclusive breastfeeding under 6 months	Major	Major	Major	Major	Major	Major
	Continued breastfeeding at 1 year	Major	Major	Major	Major	Major	Major
	Continued breastfeeding at 2 years	Major	Major	Major	Major	Major	Major
	Introduction of solid, semi-solid or soft foods	Major	Major	Major	Major	Major	Major
	Others	Major	Major	Major	Major	Major	Major
Insufficient health services & unhealthy environment	Measles vaccination	Major	Major	Major	Major	Major	Major
	Polo vaccination	Major	Major	Major	Major	Major	Major
	Vitamin A supplementation	Major	Major	Major	Major	Major	Major
	Skilled birth attendance	Major	Major	Major	Major	Major	Major
	Health seeking behavior	Major	Major	Major	Major	Major	Major
	Coverage of outreach programmes – CMAM programme coverage (SAM, MAM, or both)	Major	Major	Major	Major	Major	Major
	Access to a sufficient quantity of water	Major	Major	Major	Major	Major	Major

Appendix 4.5: Analysis Worksheet

IPC FOR ACUTE MALNUTRITION							
ANALYSIS WORKSHEET							
SECTION A: GENERAL ANALYSIS INFORMATION							
STEP 1: DEFINE ANALYSIS AREA							
A1. GENERAL INFORMATION	AREA OF ANALYSIS:	<i>[Write the name of area for which analysis is carried out]</i>					
	DATE OF ANALYSIS	<i>[Write the date on which you are filling out this worksheet - (DD/MM/YYYY)]</i>					
A2. CURRENT ANALYSIS	SEASON OF CURRENT ANALYSIS	<i>[Write the agricultural season for which the analysis is carried out – e.g. pre-harvest, post-harvest, lean, etc.]</i>					
	VALIDITY OF CURRENT ANALYSIS	<i>[Specify months for which the current analysis is expected to be valid (e.g. from Jun. to Aug. 2016)]</i>					
A3. PROJECTION ANALYSIS	SEASON OF PROJECTION ANALYSIS	<i>[Write the agricultural season for which the projection is carried out – e.g. pre-harvest, post-harvest, lean, etc.]</i>					
	VALIDITY OF PROJECTION	<i>[Specify months for which the projection is expected to be valid (e.g. Sept. to Nov. 2016)]</i>					
STEP 2: DOCUMENT EVIDENCE IN REPOSITORY <i>[Fill out the document repository]</i>							
SECTION B: IPC FOR ACUTE MALNUTRITION PHASE CLASSIFICATION							
STEP 3: ANALYSE EVIDENCE ON ACUTE MALNUTRITION OUTCOME INDICATORS				STEP 8: IDENTIFY POTENTIAL CHANGES IN THE OUTCOME INDICATORS			
ACUTE MALNUTRITION OUTCOME INDICATORS [For definition and sources of these indicators, see annex 6]	CURRENT SITUATION			PROJECTED SITUATION [To be completed after filling out summary contributing factors table below]			
	DC⁴	PREVALENCE⁵	PHASE⁶	TECHNICAL REMARKS⁷	POTENTIAL CHANGE⁸	EXPLANATION FOR THE PROJECTED CHANGE⁹	PROJECTED PHASE

⁴ Documentation Code (DC): Write the document code given to this information in the document repository

⁵ Write the prevalence estimate, without confidence intervals

B. 1	GAM by WHZ from Representative Survey (Reliability Score 2, Preference Ranking 1)						
B. 2	GAM by WHZ from Sentinel Sites (Reliability Score 1, Preference Ranking 2)						
B. 3	GAM by MUAC from Representative Survey (Reliability Score 2, Preference Ranking 3)						
B. 4	GAM by MUAC from Exhaustive Screening (Reliability Score 2, Preference Ranking 4)						
B. 5	GAM by MUAC from Sentinel Sites (Reliability Score 1, Preference Ranking 5)						
B. 6	GAM by MUAC from Screening (Reliability Score 1, Preference Ranking 6)						

SUMMARY OF IPC FOR ACUTE MALNUTRITION			
STEP	SITUATION	(B.7)	(B.8) INDICATOR, RELIABILITY SCORE, AND PREFERENCE

⁶ Indicate the Phase, in number (between 1 and 5). Refer to IPC for Acute Malnutrition Reference Table for details.

⁷ Indicate issues with data quality, representativeness, etc.

⁸ Using arrows, indicate how likely these indicators are to change in the projection period; use ↑: to indicate improvement, ↓: to indicate deterioration, and →: to indicate it is likely to stay the same

⁹ Describe the reasons why there is likely improvement, deterioration, or no change in each of these indicators in the projection period

		PHASE ¹⁰	RANKING
STEP 4: MAKE PHASE CLASSIFICATION (CURRENT)	Current Situation		<i>Specify Indicator, Reliability Score, and Preference Ranking – e.g. GAM by WHZ from Representative Survey (Reliability Score 2, Preference Ranking 1)</i>
STEP 9: MAKE PHASE CLASSIFICATION (PROJECTION)	Projected Situation ¹¹		<i>Specify Indicator, Reliability Score, and Preference Ranking – e.g. GAM by WHZ from Representative Survey (Reliability Score 2, Preference Ranking 1)</i>

SECTION C: ANALYSIS OF CONTRIBUTING FACTORS BASED ON THE UNICEF CONCEPTUAL FRAMEWORK ON MALNUTRITION							
[ANALYSIS OF THESE INDICATORS WILL INFORM ON POTENTIAL CONTRIBUTING FACTORS TO ACUTE MALNUTRITION IN THE AREA OF ANALYSIS]							
C1. IMMEDIATE CAUSES: INADEQUATE DIETARY INTAKE							
STEP 5: ANALYSE EVIDENCE ON CONTRIBUTING FACTORS AND OTHER ISSUES – IMMEDIATE CAUSES				STEP 7: IDENTIFY POTENTIAL CHANGES IN THE CONTRIBUTING FACTORS AND OTHER ISSUES			
INDICATORS [For definition and sources of these indicators, see annex 6]		CURRENT SITUATION			PROJECTED SITUATION [To be completed after filling out summary contributing factors table below]		
		DC¹²	PREVA-LENCE¹³	TECHNICAL REMARKS¹⁴	POTENTIAL CHANGE¹⁵	EXPLANATION FOR THE POTENTIAL CHANGE¹⁶	REMARKS¹⁷
C1.1	Minimum Dietary Diversity (MDD)						

¹⁰ Indicate the Phase, in number (between 1 and 5)

¹¹ To be completed after filling out summary contributing factors table below

¹² Documentation Code (DC): Write the document code given to this information in the document repository

¹³ Write the prevalence estimate, without confidence intervals

¹⁴ Indicate issues with data quality, representativeness, etc.

¹⁵ Using arrows, indicate how likely these indicators are to change in the projection period; use ↑: to indicate improvement, ↓: to indicate deterioration, and →: to indicate it is likely to stay the same

¹⁶ Describe the reasons why there is likely improvement, deterioration, or no change in each of these indicators in the projection period

¹⁷ Include any other information that should be considered in the projection

C1.2	Minimum Meal Frequency (MMF)						
C1.3	Minimum Acceptable Diet (MAD)						
C1.4	Minimum Dietary Diversity – Women (MDD-W)						
Other indicators (include any other indicator that may also be considered under inadequate dietary intake; add additional rows if necessary):							
C1.5							

C2. IMMEDIATE CAUSES: DISEASES						
STEP 5: ANALYSE EVIDENCE ON CONTRIBUTING FACTORS AND OTHER ISSUES – IMMEDIATE CAUSES (CONT.)				STEP 7: IDENTIFY POTENTIAL CHANGES IN THE CONTRIBUTING FACTORS AND OTHER ISSUES (CONT.)		
INDICATORS [For definition and sources of these indicators, see annex 6]	CURRENT SITUATION			PROJECTED SITUATION [To be completed after filling out summary contributing factors table below]		
	DC¹⁸	PREVA- LENCE¹⁹	TECHNICAL REMARKS²⁰	POTENTIAL CHANGE²¹	EXPLANATION FOR THE POTENTIAL CHANGE²²	REMARKS²³
C2.1	Diarrhoea					
C2.2	Dysentery					
C2.3	Malaria/fever					

¹⁸ Documentation Code (DC): Write the document code given to this information in the document repository

¹⁹ Write the prevalence estimate, without confidence intervals

²⁰ Indicate issues with data quality, representativeness, etc.

²¹ Using arrows, indicate how likely these indicators are to change in the projection period; use ↑: to indicate improvement, ↓: to indicate deterioration, and →: to indicate it is likely to stay the same

²² Describe the reasons why there is likely improvement, deterioration, or no change in each of these indicators in the projection period

²³ Include any other information that should be considered in the projection

C2.4	Acute Respiratory Infection (ARI)						
C2.5	HIV/AIDS prevalence						
<i>Disease outbreaks (are there disease outbreaks? If yes, include the following)</i>							
C2.6	Cholera or Acute Watery Diarrhoea (AWD) ²⁴						
C2.7	Measles						
<i>Other outbreaks (are there any other disease outbreak? If yes, include it in the row below ; add additional rows if necessary)</i>							
C2.8							
<i>Other indicators (include any other diseases that may also be relevant in the context of analysis; add additional rows if necessary)</i>							
C2.9							

C3. UNDERLYING CAUSES: INADEQUATE ACCESS TO FOOD						
STEP 5: ANALYSE EVIDENCE ON CONTRIBUTING FACTORS AND OTHER ISSUES – UNDERLYING CAUSES				STEP 7: IDENTIFY POTENTIAL CHANGES IN THE CONTRIBUTING FACTORS AND OTHER ISSUES (CONT.)		
OUTCOME OF THE IPC FOR ACUTE FOOD INSECURITY ANALYSIS	CURRENT SITUATION			PROJECTED SITUATION		
				[To be completed after filling out summary contributing factors table below]		
	DC²⁵	OUTCOME²⁶	TECHNICAL REMARKS²⁷	POTENTIAL CHANGE²⁸	EXPLANATION FOR THE POTENTIAL CHANGE²⁹	PROJECTED PHASE³⁰

²⁴ If there is cholera/AWD, additional include information on the scale (i.e. number. of people affected) and any available response under remarks

²⁵ Documentation Code (DC): Write the document code given to this information in the document repository

²⁶ Indicate the overall Phase of the IPC for Acute Food Insecurity Analysis

²⁷ Indicate specific food security issues most relevant to acute malnutrition, issues with data quality, representativeness, age of data, etc.

²⁸ Using arrows, indicate how likely these indicators are to change in the projection period; use ↑: to indicate improvement, ↓: to indicate deterioration, and →: to indicate it is likely to stay the same

²⁹ Describe the reasons why there is likely improvement, deterioration, or no change in each of these indicators in the projection period

C3.1	Outcome of the IPC for Acute Food Insecurity analysis – IPC Product or IPC Compatible, when IPC Product is unavailable						
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C4. UNDERLYING CAUSES: INADEQUATE CARE FOR CHILDREN AND WOMEN							
STEP 5: ANALYSE EVIDENCE ON CONTRIBUTING FACTORS AND OTHER ISSUES – UNDERLYING CAUSES (CONT.)				STEP 7: IDENTIFY POTENTIAL CHANGES IN THE CONTRIBUTING FACTORS AND OTHER ISSUES (CONT.)			
INDICATORS [For definition and sources of these indicators, see annex 6]		CURRENT SITUATION			PROJECTED SITUATION [To be completed after filling out summary contributing factors table below]		
		DC²²	PREVA- LENCE³¹	TECHNICAL REMARKS³²	POTENTIAL CHANGE²⁴	EXPLANATION FOR THE POTENTIAL CHANGE²⁵	REMARKS³³
C4.1	Exclusive breastfeeding under 6 months						
C4.2	Continued breastfeeding at 1 year						
C4.3	Continued breastfeeding at 2 years						
C4.4	Introduction of solid, semi-solid or soft foods						
<i>Other indicators (include other indicators relevant for analysis of inadequate care for children and women; add additional rows if necessary)</i>							

³⁰ If the IPC for Acute Food Insecurity analysis did not include projection analysis, determine the food security outlook for the projection period with the help of food security specialists.

³¹ Write the prevalence estimate, without confidence intervals

³² Indicate issues with data quality, representativeness, etc.

³³ Include any other information that should be considered in the projection

C4.5						
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C5. UNDERLYING CAUSES: INADEQUATE CARE FOR CHILDREN AND WOMEN						
STEP 5: ANALYSE EVIDENCE ON CONTRIBUTING FACTORS AND OTHER ISSUES – UNDERLYING CAUSES (CONT.)				STEP 7: IDENTIFY POTENTIAL CHANGES IN THE CONTRIBUTING FACTORS AND OTHER ISSUES (CONT.)		
INDICATORS [For definition and sources of these indicators, see annex 6]	CURRENT SITUATION			PROJECTED SITUATION [To be completed after filling out summary contributing factors table below]		
	DC ³⁴	PREVA- LENCE ³⁵	TECHNICAL REMARKS ³⁶	POTENTIAL CHANGE ³⁷	EXPLANATION FOR THE POTENTIAL CHANGE ³⁸	REMARKS ³⁹
<i>Access to health and nutrition services</i>						
C5.1	Routine measles vaccination coverage					
C5.2	Routine polio vaccination coverage					
C5.3	Routine vitamin A supplementation coverage					
C5.4	Campaign measles vaccination coverage					
C5.5	Campaign polio vaccination coverage					
C5.6	Campaign vitamin A supplementation					

³⁴ Documentation Code (DC): Write the document code given to this information in the document repository

³⁵ Write the prevalence estimate, without confidence intervals

³⁶ Indicate issues with data quality, representativeness, etc.

³⁷ Using arrows, indicate how likely these indicators are to change in the projection period; use ↑: to indicate improvement, ↓: to indicate deterioration, and →: to indicate it is likely to stay the same

³⁸ [Describe the reasons why there is likely improvement, deterioration, or no change in each of these indicators in the projection period]

³⁹ Include any other information that should be considered in the projection

C5.7	Measles vaccination coverage from surveys						
C5.8	Polio vaccination coverage from surveys						
C5.9	Vitamin A supplementation coverage from surveys						
C5.10	Coverage of all basic vaccinations from surveys						
C5.11	Skilled attendant at delivery						
C5.12	Health seeking behaviour ⁴⁰						
C5.13	Coverage of outreach programmes – CMAM programme coverage (SAM, MAM, or both)						
Access to safe WASH							
C5.14	Access to a sufficient quantity of water						
C5.15	Access to improved sanitation facilities						
C5.16	Access to safe/improved drinking water						
Other indicators (include other indicators relevant under insufficient health services & unhealthy health environment; add additional rows if necessary):							
C5.17							

C6. BASIC CAUSES	
STEP 5: ANALYSE EVIDENCE ON CONTRIBUTING FACTORS AND	STEP 7: IDENTIFY POTENTIAL CHANGES IN

⁴⁰ It may be reported for every single disease or in total; if it is reported by individual diseases, include each disease by adding additional rows

OTHER ISSUES – BASIC CAUSES			THE CONTRIBUTING FACTORS AND OTHER ISSUES (CONT.)			
BASIC CAUSES ⁴¹	CURRENT SITUATION			PROJECTED SITUATION [To be completed after filling out summary contributing factors table below]		
	DC ⁴²	COLOUR/S HADE THE CELL AS 	SUMMAR Y CONCLUS IONS ⁴⁴	POTENTI AL CHANGE ⁴⁵	EXPLANAT ION FOR THE POTENTIA L CHANGE ⁴⁶	REMARKS ⁴⁷
C 6. 1 Human Capital <i>[Consider aspects of education and literacy rate, inter-generational knowledge transfer, presence of healthy working members and dependency ratio, limited human resources due to disease burden and lack of access to health care etc., and how these aspects contribute to acute malnutrition in your area of analysis; for e.g., if maternal education is poor, it's likely to be a cause of concern for acute malnutrition as there is a clear link</i>						

⁴¹ Consider how each of these capitals contributes to acute malnutrition in your area of analysis; there are specific issues listed below under each capital for consideration. Some of these aspects may be poor while others maybe in a better situation in the area of your analysis. Consider all aspects when determining whether a particular capital may be a major, minor, or not a contributing factor. Specify the aspects that indicates the worst situation under remarks

⁴² Documentation Code (DC): Write the document code given to this information in the document repository

⁴³ Based on available data and your discussion in the group decide if a given capital is a major, minor, or not a contributing factor; shade the corresponding cell accordingly; where data is available, include the prevalence estimates for the indicators you considered

⁴⁴ Based on the available data, describe how a given capital is likely to impact on acute malnutrition

⁴⁵ Using arrows, indicate how likely these indicators are to change in the projection period; use ↑: to indicate improvement, ↓: to indicate deterioration, and →: to indicate it is likely to stay the same

⁴⁶ Describe the reasons why there is likely improvement, deterioration, or no change in each of these indicators in the projection period

⁴⁷ Include any other information that should be considered in the projection

	<i>between maternal education and child acute malnutrition]</i>						
C 6.2	Physical Capital <i>[Consider constraints in terms of housing, water and sanitation facilities, roads, markets, basic services such as health and education facilities etc., and how they may impact on acute malnutrition in your area of analysis; for e.g., poor sanitation facilities may lead to improper disposal of human waste, which in turn may cause diseases and acute malnutrition]</i>						
C 6.3	Financial Capital <i>[Consider what income and cash resources the group has access to, including diversity and stability of income sources, resilience of sources to common shocks, access to loans, and savings among others; for e.g., there is an established link between poverty and acute malnutrition and cash transfers have positive impact on the reduction of acute malnutrition]</i>						
C 6.4	Natural Capital <i>[Consider assets related to bio-physical environment, such as proximity to water bodies, soil and climatic condition, access to forests, existence of minerals and other resources, etc. in your area of analysis and their impact on acute malnutrition; for e.g., while being close to water improves access to water it also reduces the time spent on collecting water, which in turn will increase the time available to care for children]</i>						
C 6.5	Social Capital <i>[Consider social cohesion and the connectedness, discrimination of</i>						

	<p>groups, such as women and ethnic minorities. Consider cultural practices that have an impact on acute malnutrition; for e.g., women not being allowed to go outside home within the 30 days of delivery in some communities would likely result in better caring and improved nutrition of the children]</p>						
C 6. 6	<p>Policies, Institutions and Processes (PIPs)</p> <p>[Consider macro and micro-level policies and processes such as safety nets, school feeding, cash vouchers, food aid and other social safety nets and their possible impact on acute malnutrition; for e.g., universal healthcare for children under 5 would likely lead to increased health seeking while children are sick and improved nutrition]</p>						
C 6. 7	<p>Usual/Normal Shocks</p> <p>[Consider common and usual shocks that do not result in crises but negatively impact on acute malnutrition – e.g. dry spells, lack of rainfall, human, livestock and plant diseases; for e.g., dry spells that may be cyclical (but not at crisis level) may still increase the incidence of diseases and acute malnutrition during that time period]</p>						
C 6. 8	<p>Unusual Shocks</p> <p>[Consider how much of a negative impact unusual crises have had on acute malnutrition; for e.g., unusual flooding may lead to increase of diseases and acute malnutrition]</p>						
Other Basic Causes (include other relevant basic causes)							
C 6. 9							

SECTION D: OTHER ISSUES							
D1. OTHER ISSUES: OTHER OUTCOMES							
STEP 5: ANALYSE EVIDENCE ON CONTRIBUTING FACTORS AND OTHER ISSUES – OTHER OUTCOMES				STEP 7: IDENTIFY POTENTIAL CHANGES IN THE CONTRIBUTING FACTORS AND OTHER ISSUES (CONT.)			
OTHER OUTCOMES [For definition and sources of these indicators, see annex 6]		CURRENT SITUATION			PROJECTED SITUATION [To be completed after filling out summary contributing factors table below]		
		DC ⁴⁸	PREVA- LENCE ⁴⁹	TECHNICAL REMARKS ⁵⁰	POTENTIAL CHANGE ⁵¹	EXPLANATION FOR THE POTENTIAL CHANGE ⁵²	REMARKS ⁵³
D1.1	Anaemia among children 6-59 months						
D1.2	Anaemia among pregnant women						
D1.3	Anaemia among non-pregnant women						
D1.4	Vitamin A deficiency among pre-school children (6 – 71 months)						
D1.5	Vitamin A deficiency among non-pregnant women (15 – 49 years)						
D1.6	Low birth weight						

⁴⁸ Documentation Code (DC): Write the document code given to this information in the document repository

⁴⁹ Write the prevalence estimate, without confidence intervals

⁵⁰ Indicate issues with data quality, representativeness, etc.

⁵¹ Using arrows, indicate how likely these indicators are to change in the projection period; use ↑: to indicate improvement, ↓: to indicate deterioration, and →: to indicate it is likely to stay the same

⁵² Describe the reasons why there is likely improvement, deterioration, or no change in each of these indicators in the projection period

⁵³ Include any other information that should be considered in the projection

D1.7	Fertility rate						
<i>Other indicators (include other nutrition related issues that may also be of concern; add additional rows if necessary)</i>							
D1.8							

D2. OTHER ISSUES: MORTALITY							
STEP 5: ANALYSE EVIDENCE ON CONTRIBUTING FACTORS AND OTHER ISSUES - MORTALITY					STEP 7: IDENTIFY POTENTIAL CHANGES IN THE CONTRIBUTING FACTORS AND OTHER ISSUES (CONT.)		
MORTALITY [For definition and sources of these indicators, see annex 6]	CURRENT SITUATION			PROJECTED SITUATION [To be completed after filling out summary contributing factors table below]			
	DC ⁴²	DEATH RATE ⁵⁴	TECHNICAL REMARKS ⁵⁵	POTENTIAL CHANGE ⁴⁵	EXPLANATION FOR THE POTENTIAL CHANGE ⁴⁶	REMARKS ⁴⁷	
D2.1	Crude Death Rate (CDR)						
D2.2	Under Five Death Rate (U5DR)						

D. OTHER ISSUES: FEEDING PROGRAMMES							
STEP 5: ANALYSE EVIDENCE ON CONTRIBUTING FACTORS AND OTHER ISSUES – FEEDING PROGRAMMES					STEP 7: IDENTIFY POTENTIAL CHANGES IN THE CONTRIBUTING FACTORS AND OTHER ISSUES (CONT.)		
FEEDING PROGRAMMES [For definition and sources of these indicators, see annex 6]	CURRENT SITUATION			PROJECTED SITUATION [To be completed after filling out summary contributing factors table below]			
	DC ⁵⁶	STATUS ⁵⁷	TECHNICAL	POTENTIAL	EXPLANATION	REMARKS ⁶¹	

⁵⁴ Write the death rate, without confidence intervals

⁵⁵ Indicate severity, issues with data quality, representativeness, etc.

⁵⁶ Documentation Code (DC): Write the document code given to this information in the document repository

			REMARKS ⁵⁸	CHANGE ⁵⁹	FOR THE POTENTIAL CHANGE ⁶⁰	
D3.1	Feeding programme admission trends					

SECTION E: PROTECTIVE FACTORS							
STEP 5: ANALYSE EVIDENCE ON CONTRIBUTING FACTORS AND OTHER ISSUES – PROTECTIVE FACTORS				STEP 7: IDENTIFY POTENTIAL CHANGES IN THE CONTRIBUTING FACTORS AND OTHER ISSUES (CONT.)			
INDICATOR [For definition and sources of these indicators, see annex 6]		CURRENT SITUATION			PROJECTED SITUATION [To be completed after filling out summary contributing factors table below]		
		DC ⁵⁰	YES/NO ⁶²	TECHNICAL REMARKS ⁶³	POTENTIAL CHANGE ⁵³	EXPLANATION FOR THE POTENTIAL CHANGE ⁶⁴	REMARKS ⁶⁵
E1.1	Social safety net programmes						
E1.2	Micronutrient supplementation programmes						
E1.3	Dietary supplementation programmes						

⁵⁷ Increasing/decreasing/stable compared to the same season the previous year

⁶¹ Include any other information that should be considered in the projection

⁵⁸ Describe the main reasons for the increase/decrease/stable admission trends

⁵⁹ Using arrows, indicate how likely these indicators are to change in the projection period; use ↑: to indicate improvement, ↓: to indicate deterioration, and →: to indicate it is likely to stay the same

⁶⁰ Describe the reasons why there is likely improvement, deterioration, or no change in each of these indicators in the projection period

⁶² Indicate whether these exist in your area of analysis

⁶³ Describe the coverage, target group, etc. of these programmes

⁶⁴ Describe the reasons why there is likely improvement, deterioration, or no change in each of these indicators in the projection period

⁶⁵ Include any other information that should be considered in the projection

STEP 6: IDENTIFY MAJOR CONTRIBUTING FACTORS AND OTHER ISSUES			
SUMMARY CONTRIBUTING FACTORS		COLOUR/SHADE THE CELL AS	SUMMARY CONCLUSIONS
<p>[Based on the analysis above, indicate if each of the contributing factors is a major, minor, or not a contributing factor in the analysis area; note that, e.g. of all the indicators listed under inadequate dietary intake, some of them may be major while others may be minor or not contributing factors; justify your reasons under summary conclusions]</p>		 <p>Major Minor Not a Contributing Factor⁶⁶</p>	
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		

⁶⁶ Based on available data and your discussion in the group decide each of the indicator is a major, minor, or not a contributing factor; shade the corresponding cell accordingly; where data is available, include the prevalence estimates for the indicators you considered

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		
	Polo 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 a source of safe drinking water		
	Others		
Basic causes	Human capital		
	Physical capital		
	Financial capital		
	Natural capital		
	Social capital		
	Policies, Institutions and Processes		
	Usual/Normal Shocks		
	Recurrent Crises due to Unusual Shocks		
	Other basic causes		

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

STEP 10: IDENTIFY LIMITATIONS OF THE ANALYSIS
Limitations of the analysis
[What are the main limitations in the analysis?]:

STEP 11: SUGGEST PRIORITY RESPONSE
Priority response objectives:
[Based on the above analysis, suggest appropriate response objectives to the current situation; separate the objectives as immediate/short term and medium to long term categories]:

C) Immediate/short-term response objectives:

-

D) Medium to Long term response objectives

IPC FOR ACUTE MALNUTRITION

DOCUMENT REPOSITORY

DOCUMENT CODE [Extend the table as needed]	REFERENCE				REMARKS AND RAW DATA EVIDANCE [Indicate representativeness, quality, etc. of the report; where possible, also include the raw evidence such as graph, image, table, etc.]
	NAME OF REPORT [Write the exact name of the report]	SOURCE OF REPORT [Write the name(s) of agency(ies) that published the report]	DATA COLLECTION PERIOD [Write the dates during which the data was collected]	DATE OF PUBLICATION [Write the date in which the report was published]	
1					
2					
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