

Lesotho

Multi-sectoral Nutrition Overview

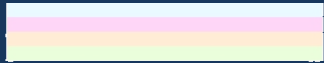
September 2017



REACH

ACCELERATING THE SCALE-UP OF FOOD AND NUTRITION ACTIONS

Nutrition Situation: Trends in malnutrition of the most affected population groups



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ACCELERATING THE SCALE-UP OF FOOD AND NUTRITION ACTIONS



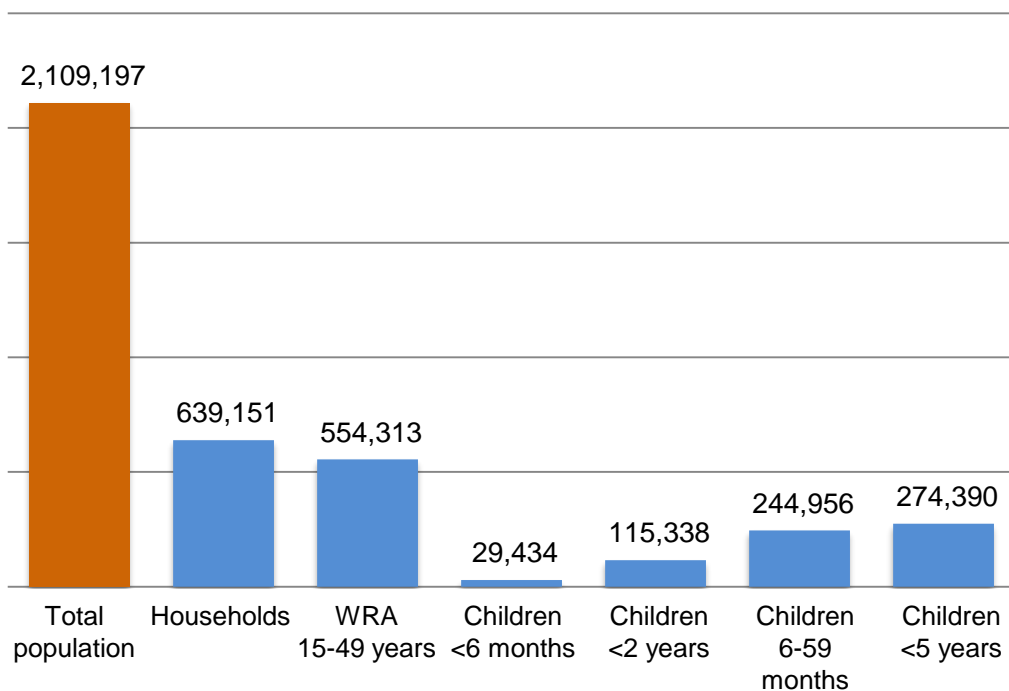
Key messages

- Chronic and acute malnutrition in children under five years have decreased since 2004, however stunting is high (33.2%) and remains above the WHO public health threshold
- Overweight in children under five years has remained around 7% since 2009, showing no increase
- While chronic and acute malnutrition have decreased since 2004, severe chronic malnutrition has shown the slowest decline (2.2 percentage points)
- Chronic malnutrition is high across all districts, especially in Butha-Buthe, Mokhotlong and Thaba-Tseka
- The districts with the highest number of stunted children do not always reflect the districts with the highest prevalence
- The districts with the largest number of stunted children are Maseru, Leribe and Mohale's Hoek
- Almost all districts recorded decreases in chronic malnutrition between 2009 and 2014, except Butha-Buthe, which recorded an increase of 7.8 percentage points
- Across all districts, the prevalence of wasting is low (under 5%)
- The districts with the largest number of children under five with acute malnutrition are Maseru, Leribe and Berea
- The majority of districts recorded a decrease in acute malnutrition between 2009 and 2014, except in Berea, Leribe and Qacha's Nek where there were slight increases
- The prevalence of anaemia in children under five years has remained a critical public health issue in the recent years
- Vitamin A deficiency among pre-school aged children is also a severe public health problem, although updated data is needed
- In 2002, one fifth of all school-aged children had iodine deficiency, although updated data is needed

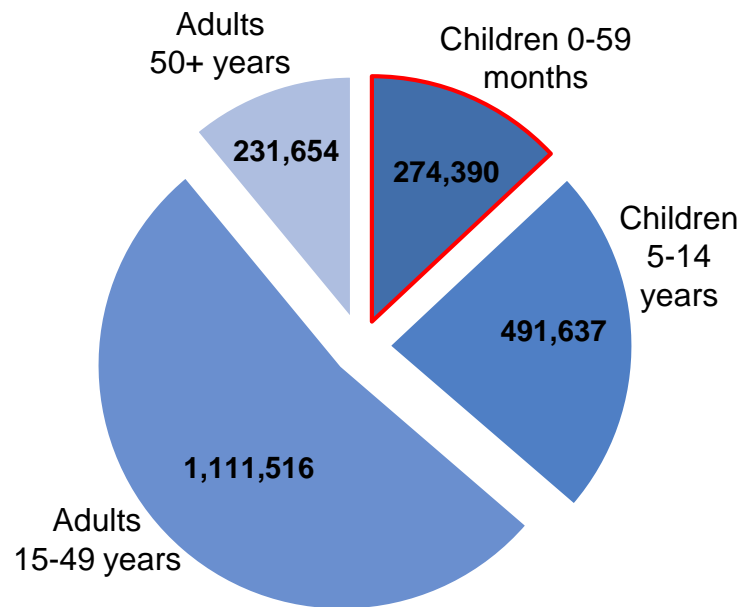
Demographic Statistics:
Key target population groups

Children under 5 years of age represent 13% of the total population

Composition of the main target groups in the fight against maternal and child malnutrition (2014)



Population, 2014



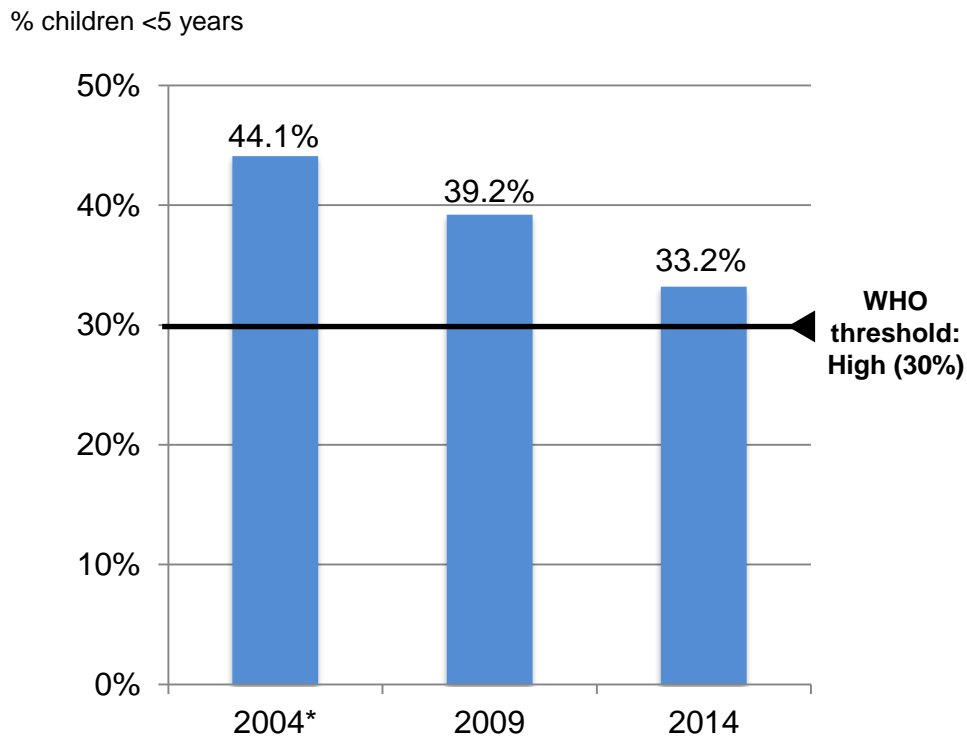
WRA=women of reproductive age

Sources: DHS 2014; United Nations, Department of Economic and Social Affairs, Population Division (2015). World Population Prospects: The 2015 Revision, DVD Edition.; Ministry of Finance and Development Planning: Bureau of Statistics 2006 Lesotho Population and Housing Census 5

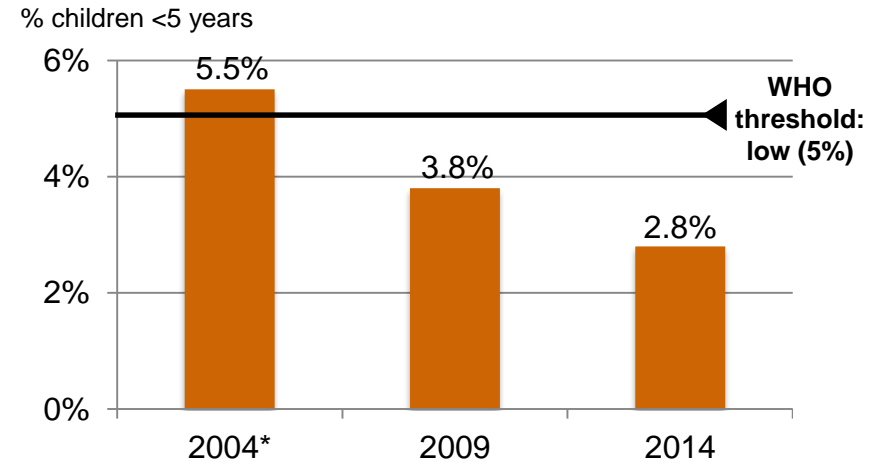
Anthropometric Indicators:
Chronic malnutrition, acute malnutrition and overweight

Chronic and acute malnutrition have decreased since 2004, however stunting remains high

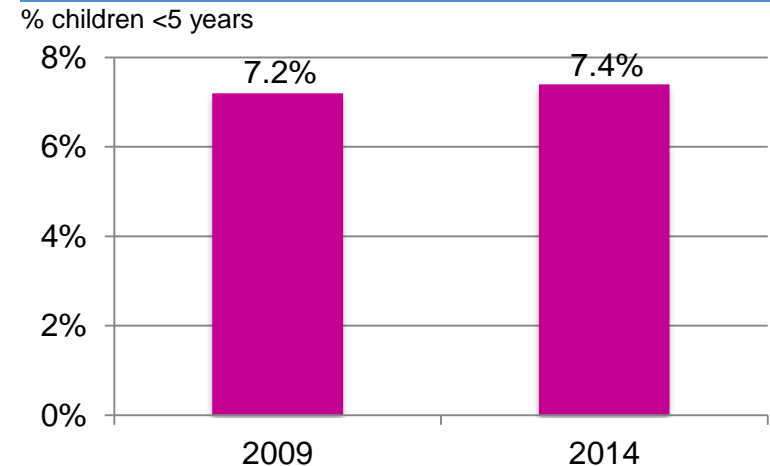
Chronic Malnutrition



Acute Malnutrition



Overweight

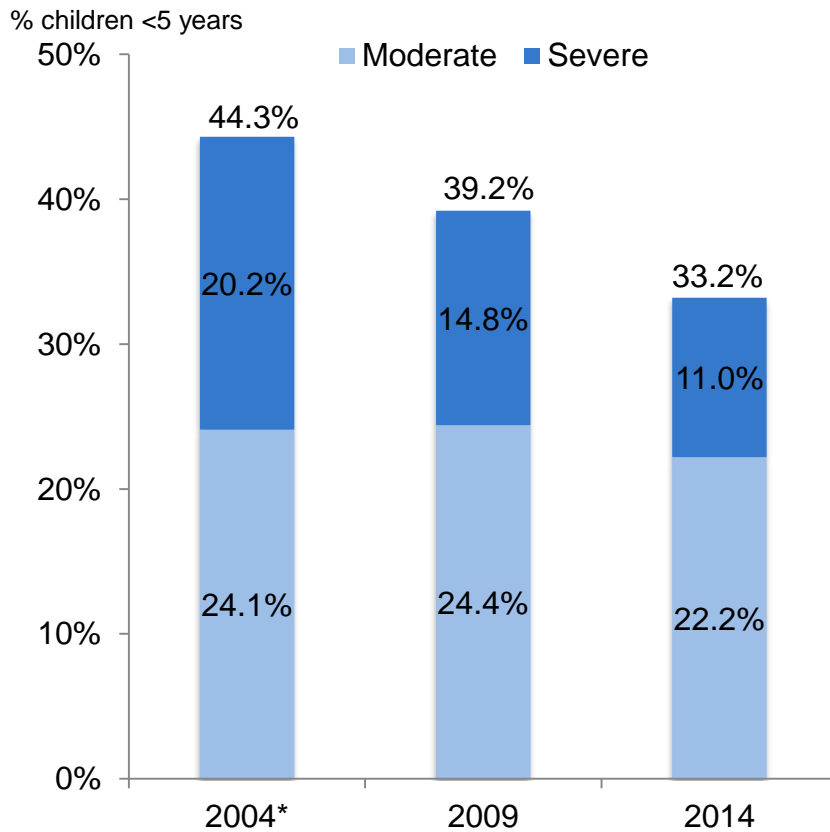


Note: The 2004 data was converted using the WHO Conversion tool on 2006 growth standards

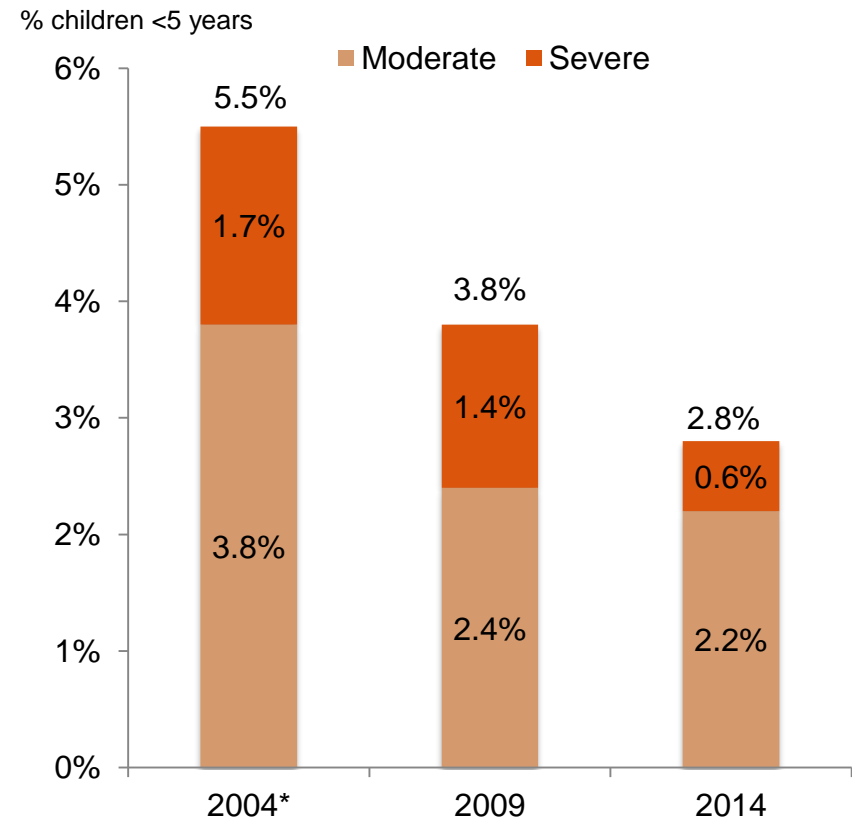
Sources: DHS 2004, 2009, 2014

While chronic and acute malnutrition have decreased since 2004, severe chronic malnutrition has shown the smallest decline

Chronic Malnutrition



Acute Malnutrition

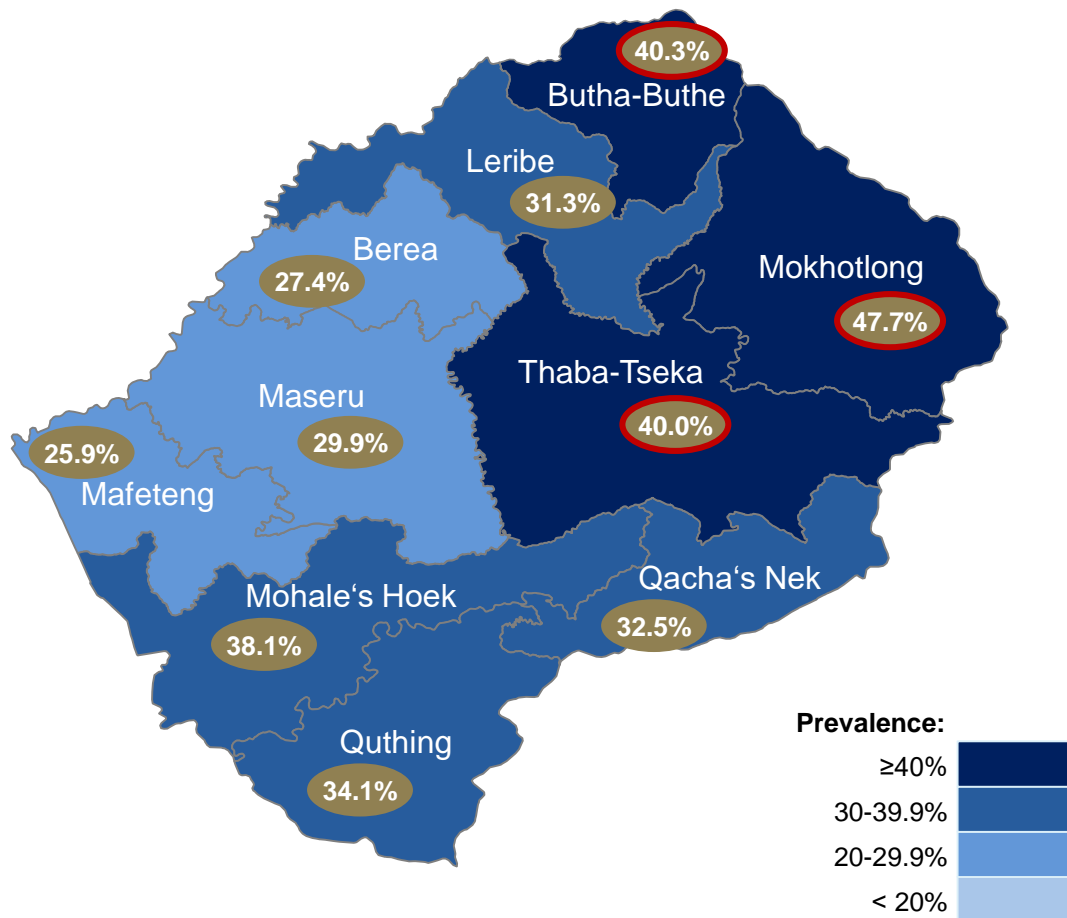


Note: The 2004 data was converted using the WHO Conversion tool on 2006 growth standards

Sources: DHS 2004, 2009, 2014

All districts have high rates of chronic malnutrition, especially the three districts in the northeast, located in the mountains

Prevalence of Chronic Malnutrition



- The prevalence of stunting in the north-eastern districts of Butha-Buthe, Mokhotlong and Thaba-Tseka is above the critical 40% threshold for chronic malnutrition set by WHO
- In 4 of the 10 districts, prevalence is just below the highest critical threshold (between 30 and 40%)
- The western districts of Maseru, Berea and Mafeteng have the lowest rates of chronic malnutrition, however are still above the lowest critical threshold of 20% for chronic malnutrition

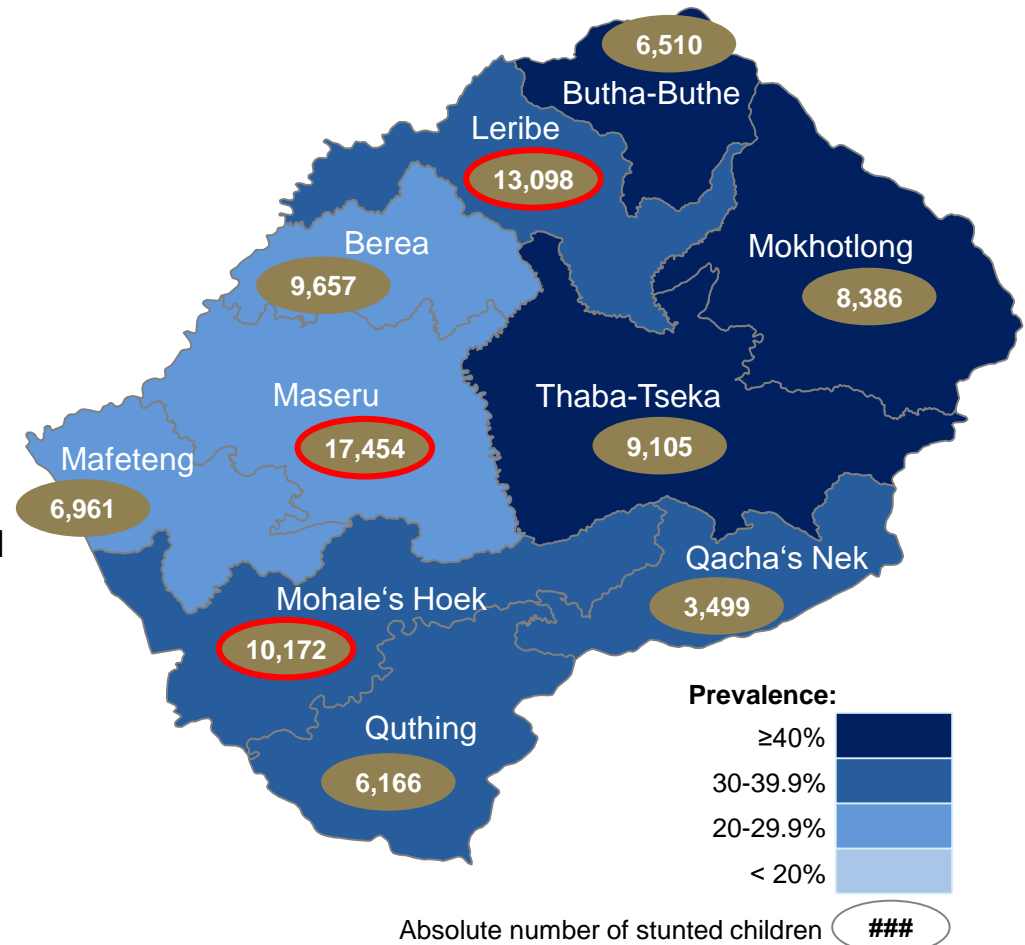
High stunting prevalence does not necessarily equate to large numbers of stunted children, as best exhibited in Butha-Buthe

Chronic Malnutrition: absolute numbers and prevalence

Population density variances can explain discrepancies btwn. prevalence & absolute numbers of stunting at the district level

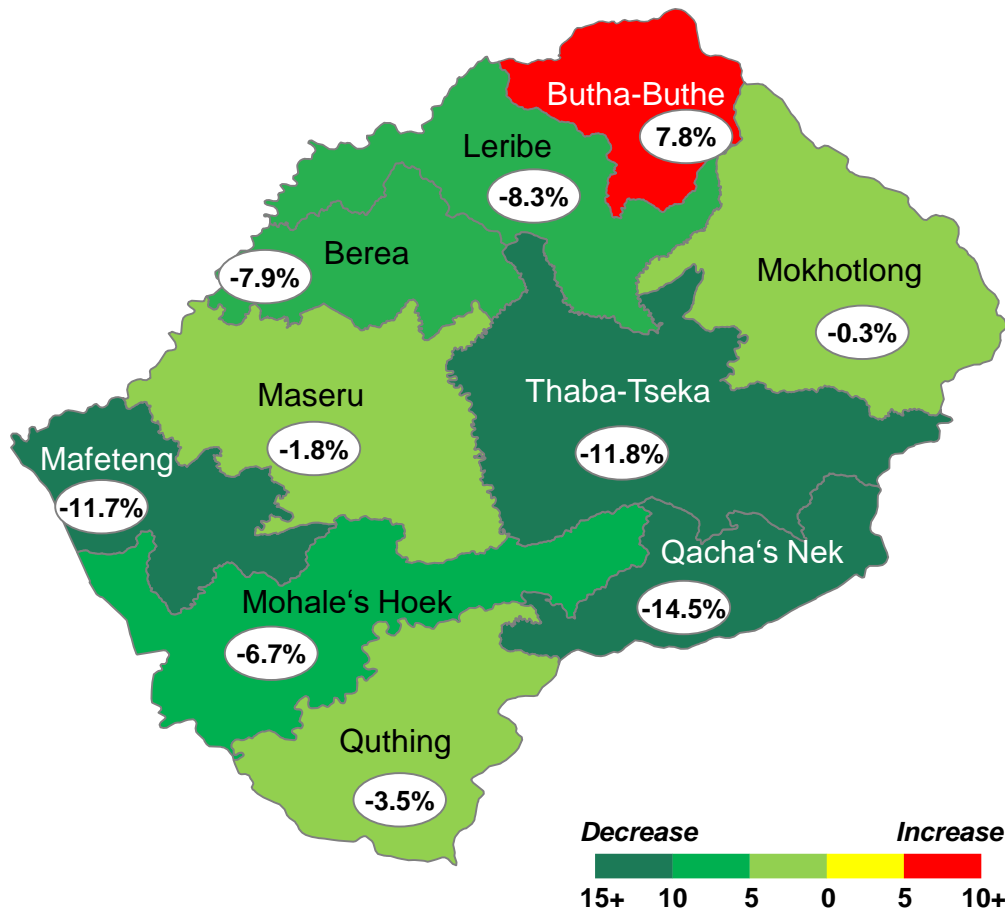
The Maseru district has the highest number of stunted children, yet a relatively low prevalence of stunting

Of the 3 regions with the highest stunting prevalence, 2 (Mokhotlong & Thaba-Tseka) also have somewhat high numbers of stunted children



Chronic malnutrition decreased in almost all districts between 2009 and 2014, except in Butha-Buthe

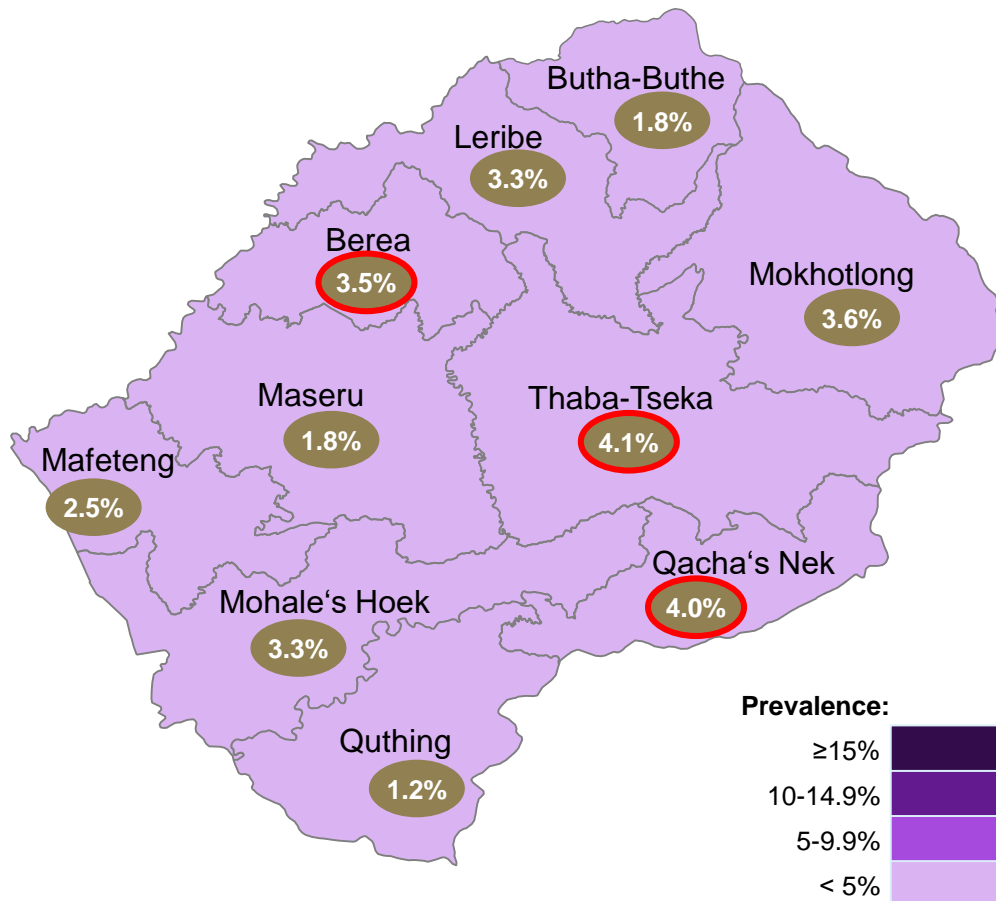
The change in chronic malnutrition prevalence (in % points) between 2009 and 2014



- 3 of 10 districts showed a strong decrease (>10 percentage points) in overall prevalence of chronic malnutrition between 2009 and 2014
- 3 districts recorded a smaller decrease (5-10 percentage points) in the overall prevalence of chronic malnutrition
- 1 district (Butha-Buthe) recorded a significant increase of 7.8 percentage points in the overall prevalence of chronic malnutrition

The prevalence of wasting remains low (under 5%) across all 10 districts

Prevalence of acute malnutrition

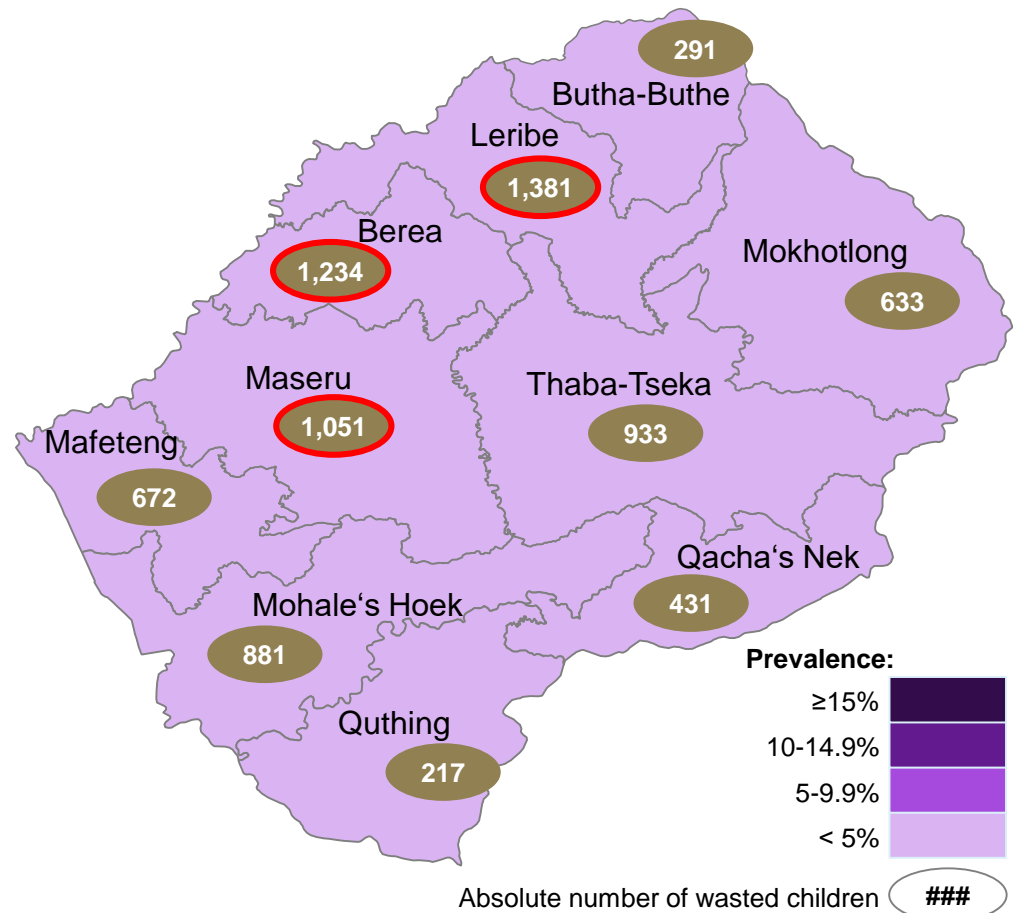


- The prevalence of wasting remains below 5% across all 10 districts
- Thaba-Tseka has the highest rate of wasting (4.1%), while Quthing has the lowest rate (1.2%)

The district with the largest number of children under five with acute malnutrition is Leribe, followed by Berea and Maseru

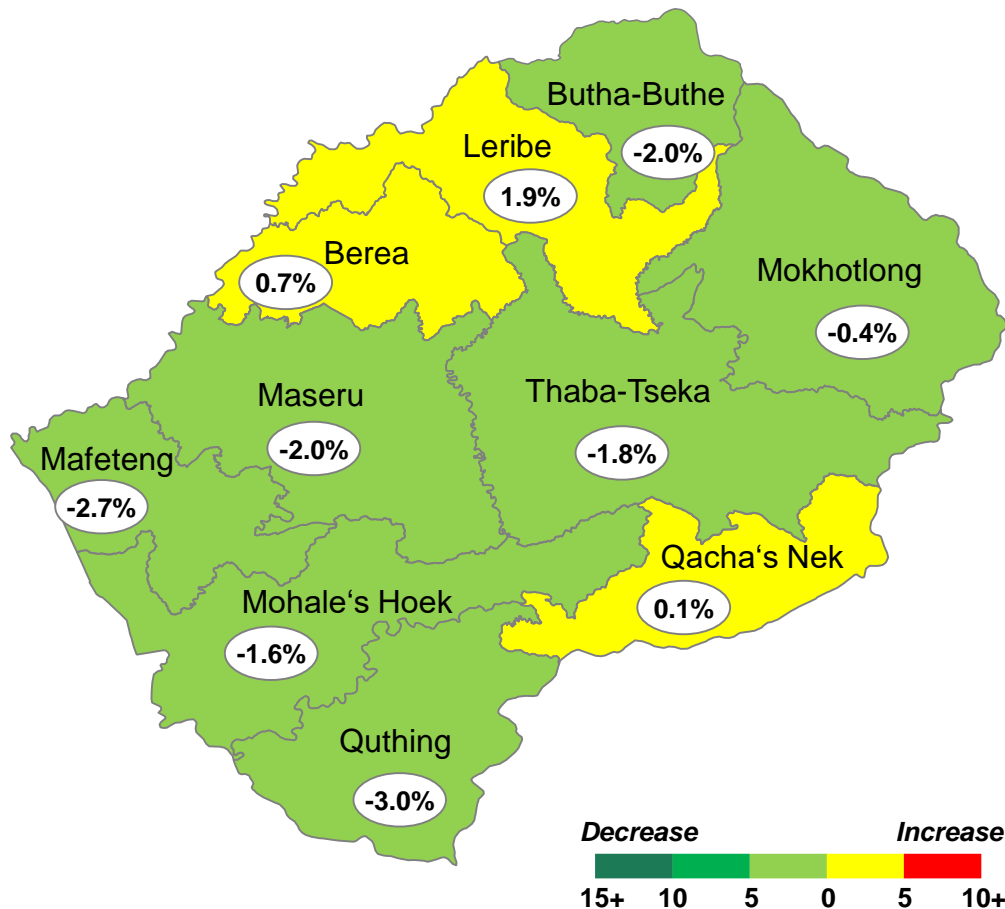
Acute Malnutrition: absolute numbers and prevalence

- The districts with the highest number of children with wasting do not always reflect the districts with the highest prevalence due to disparities in population density
- The northwestern districts of Leribe, Berea and Maseru have the largest number of acutely malnourished children under five years of age
- Of the districts with the largest number of acutely malnourished children, Leribe and Berea also have relatively high prevalence of wasting



The majority of districts recorded decreases in acute malnutrition between 2009 and 2014

The change in acute malnutrition prevalence (in % points) between 2009 and 2014



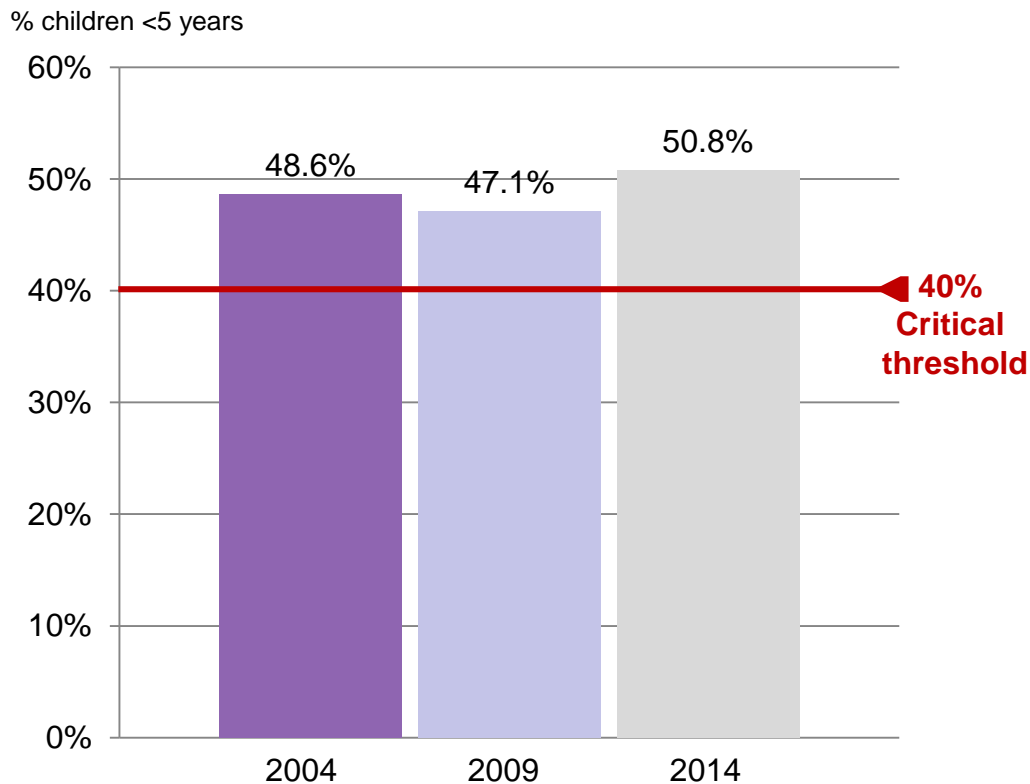
- 7 of 10 districts showed a slight decrease (<5 percentage points) in prevalence of acute malnutrition between 2009 and 2014
- 3 districts showed a slight increase (<2 percentage points) in prevalence of acute malnutrition between 2009 and 2014

Micronutrient Deficiencies:

Anaemia, Vitamin A deficiency and iodine deficiency

The prevalence of anaemia in children has remained a critical public health issue over time, showing a slight increase in recent years

Half of all children have some form of anaemia



Consequences:

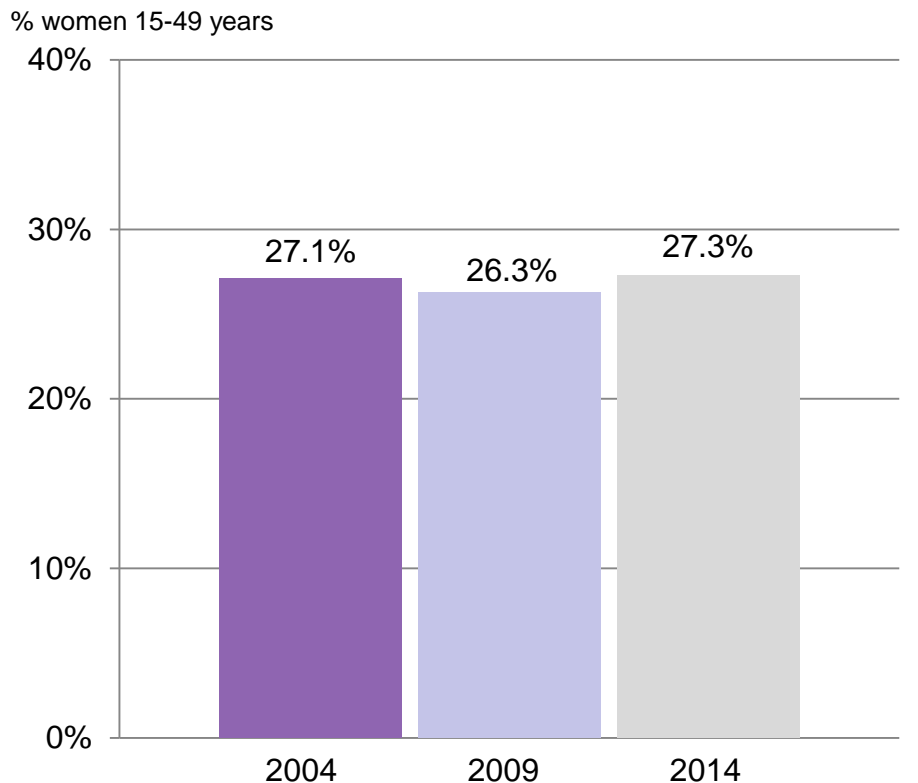
- Reduced immunity
- Increased risk of maternal and perinatal mortality
- Intrauterine growth retardation
- Premature birth
- Reduced cognitive and psychomotor development
- Reduced ability to concentrate and scholastic performance
- Fatigue and reduced physical activity

Measure:

- Anaemia is a proxy for iron deficiency
- Measurement of haemoglobin levels in blood is the most common measure

The prevalence of anaemia in women 15-49 years has remained stagnant since 2004

Over a quarter of women have some level of anaemia



Consequences:

- Reduced immunity
- Increased risk of maternal and perinatal mortality
- Intrauterine growth retardation
- Premature birth
- Reduced cognitive and psychomotor development
- Reduced ability to concentrate and scholastic performance
- Fatigue and reduced physical activity

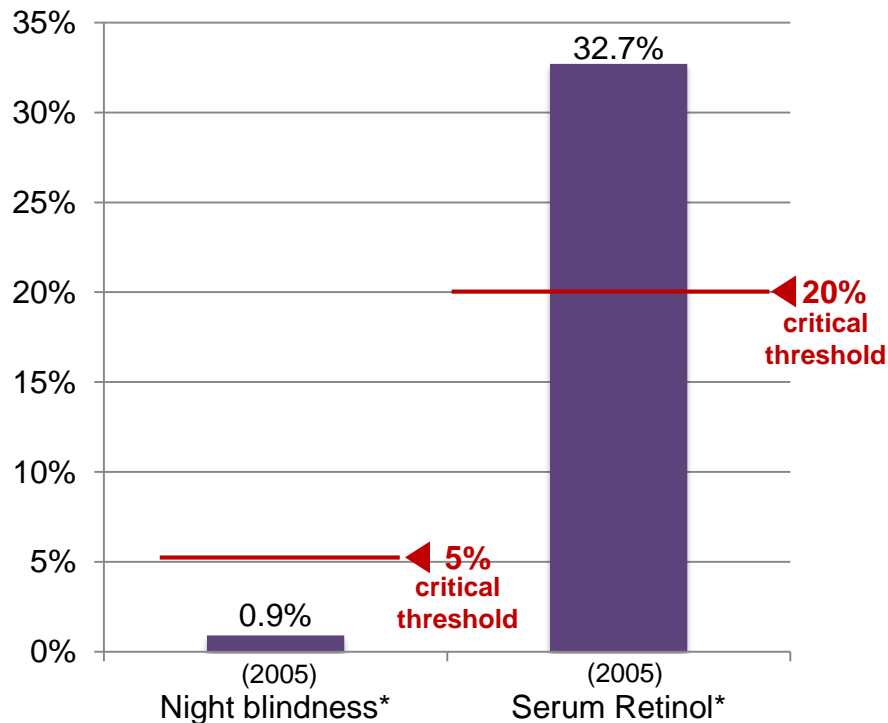
Measure:

- Anaemia is a proxy for iron deficiency
- Measurement of haemoglobin levels in blood is the most common measure

Vitamin A deficiency among pre-school aged children is a severe public health problem, although updated data is needed

Vitamin A deficiency in pre-school age children

% pre-school aged children



* = regression-based estimate made by WHO

Sources: WHO Global Database on Vitamin A Deficiency (2009) *Global prevalence of vitamin A deficiency in populations at risk 1995-2005.*; Calverton, MD, ORC Macro, 2005. Ref 5356; Micronutrient Initiative Global Report (2009); CDC and WFP (2007). *A Manual: Measuring and Interpreting Malnutrition and Mortality.*; Black RE et al. (2008). 'Paper 1 Maternal and child undernutrition: global and regional exposures and health consequences.' *The Lancet Maternal and Child Undernutrition Series*. Page 243-260.

Consequences:

- Can compromise immunity and lead to preventable blindness
- Increased risk of mortality
- Reciprocal relationship with measles, a leading cause of death among young children

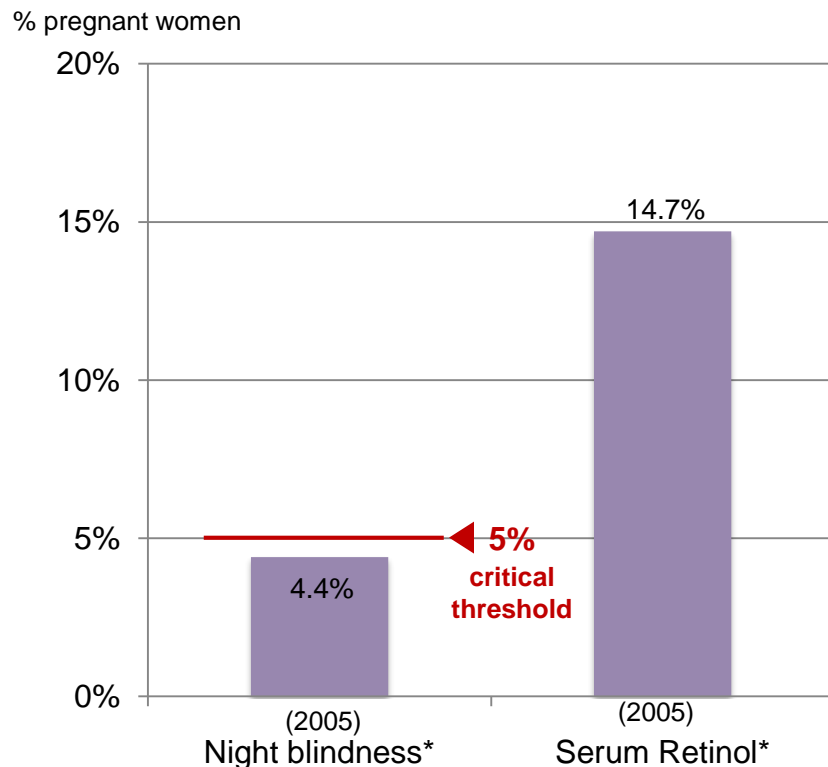
Assessment:

- *Night blindness* is a subclinical sign and proxy for Vitamin A deficiency, though measurement is subjective
- Measuring *retinol levels in blood* is a biochemical indicator whereby levels $<0.70\mu\text{mol/l}$ constitutes Vitamin A deficiency

Updated data on Vitamin A deficiency is needed

The prevalence of vitamin A deficiency in pregnant women is just below the critical threshold, although updated data is needed

Vitamin A deficiency in pregnant women



Consequences:

- Can compromise immunity and lead to preventable blindness
- Increased risk of mortality
- Reciprocal relationship with measles, a leading cause of death among young children

Assessment:

- *Night blindness* is a subclinical sign and proxy for Vitamin A deficiency, though measurement is subjective
- Measuring *retinol levels in blood* is a biochemical indicator whereby levels $<0.70\mu\text{mol/l}$ constitutes Vitamin A deficiency

Updated data on Vitamin A deficiency is needed

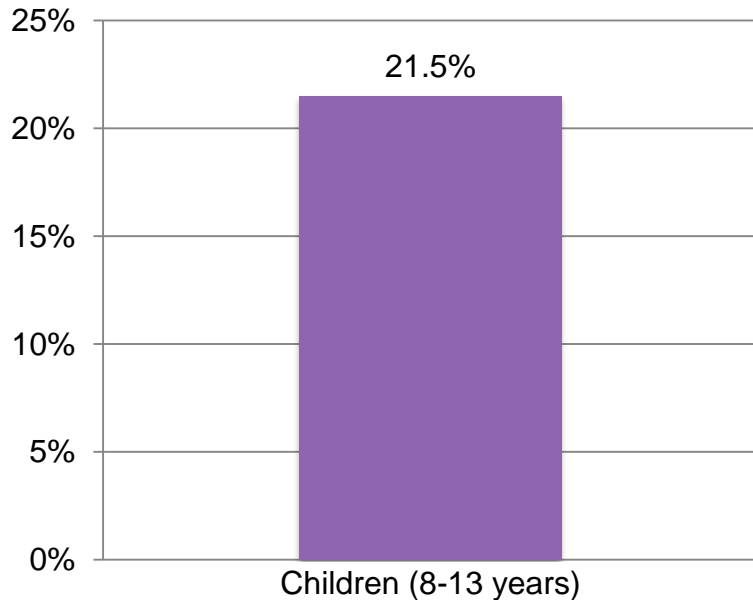
* = regression-based estimate made by WHO

Sources: WHO Global Database on Vitamin A Deficiency (2009) *Global prevalence of vitamin A deficiency in populations at risk 1995-2005.*; Calverton, MD, ORC Macro, 2005. Ref 5356; Micronutrient Initiative Global Report (2009); CDC and WFP (2007). *A Manual: Measuring and Interpreting Malnutrition and Mortality.*; Black RE et al. (2008). 'Paper 1 Maternal and child undernutrition: global and regional exposures and health consequences.' *The Lancet Maternal and Child Undernutrition Series*. Page 243-260.

In 2002, about one fifth of all school-aged children had iodine deficiency, although updated data is needed

Prevalence of iodine deficiency in children 8-13 years of age (2002)

% children 8-13 years



Consequences:

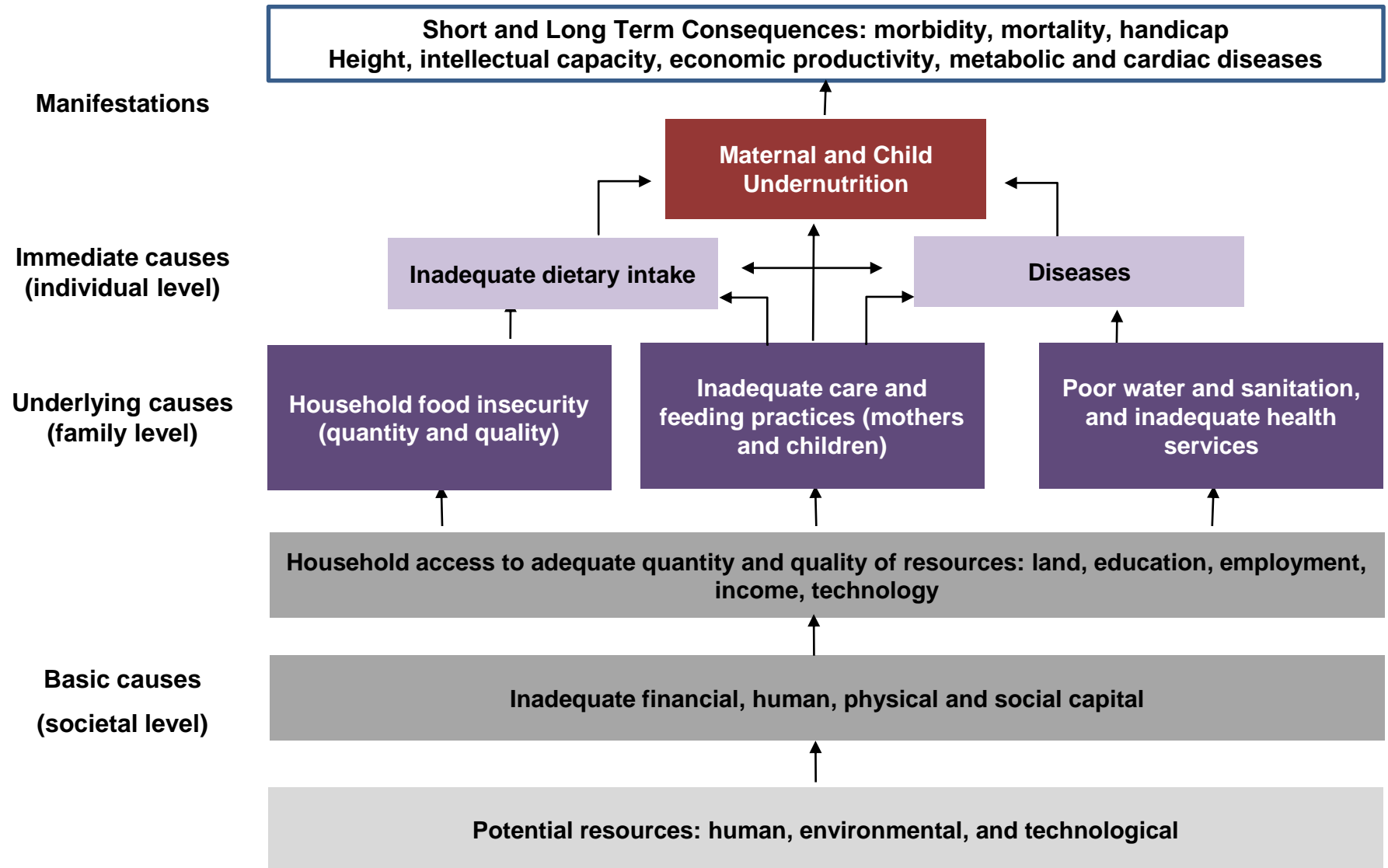
- Goitre (swelling of thyroid gland)
- Stillbirth or miscarriages
- Impaired cognitive development/capacity, leading to mental retardation in severe cases, including Cretinism
- Deaf-mutism

Assessment:

- Measuring *urinary iodine levels* is a biochemical indicator whereby low median urinary levels ($<100 \mu\text{g/L}$) indicate deficiency

Updated data on iodine deficiency disorders is needed

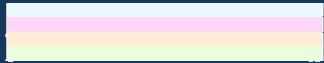
Only a multisectoral approach can solve the problem of undernutrition: a conceptual framework of the causes of malnutrition



Underlying factors:

Care Practices

Figures, trends, causes



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ACCELERATING THE SCALE-UP OF FOOD AND NUTRITION ACTIONS

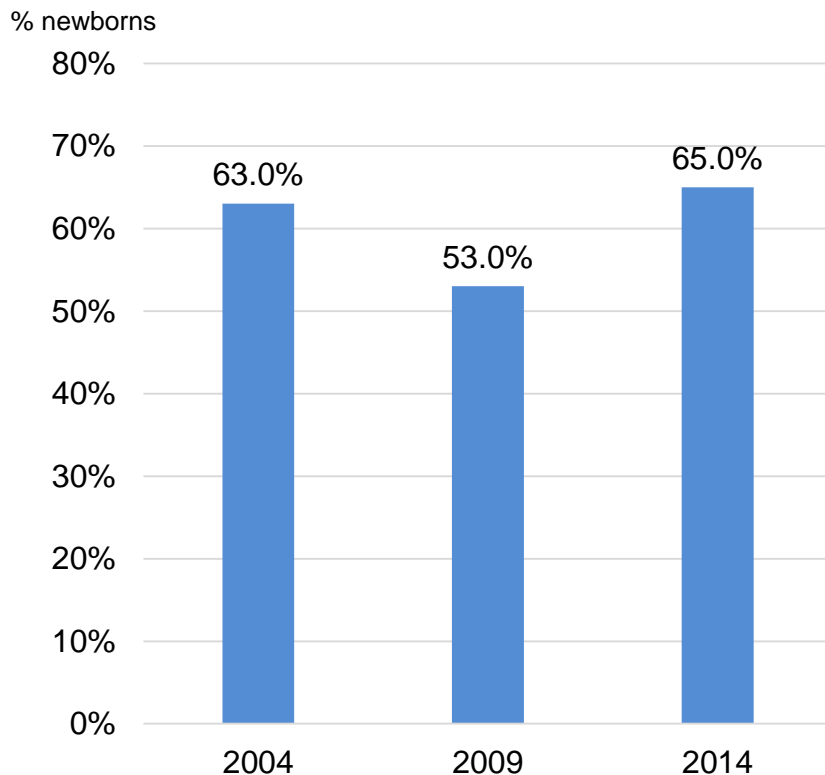


Key Messages

- Nationally, approximately two thirds of newborns (65%) are breastfed within the first hour of birth
- Early initiation of breastfeeding varies between districts, where it is lowest in Leribe (59%) and highest in Thaba-Tseka (79%). There is also variation by ecological zones, where the lowest rate is in the lowlands (61.6%) and the highest is in the mountains (73%)
- Overall, one third of children (33.1%) under 6 months age is not exclusively breastfed, despite global recommendations from WHO and UNICEF
- After 3 months of age, the rate of exclusive breastfeeding declines rapidly as the introduction of complementary foods increases, despite WHO recommendation that complementary foods be introduced only after 6 months
- At 6-8 months of age, the majority of breastfed children (92.8%) receive complementary foods
- Few children 6-23 months (11.3%) are fed according to the appropriate infant and young child feeding (IYCF) practices, though children living in urban households are more likely to receive appropriate IYCF practices than children in rural households
- The percentage of children 6-23 months receiving a minimum acceptable diet varies greatly by district and ecological zones, and it is particularly rare in three districts (Mohale's Hoke, Qacha's Nek and Mokhotlong)
- Fewer than half of all children 6-23 months (40.5%) consume iron rich foods, across all age groups and household settings
- Three fifths of children 6-23 months (60.5%) consume foods rich in vitamin A, however the closer to 23 months a child is the more likely they are to consume vitamin A rich foods
- Of the households that have a place for hand washing, only half have both soap and water (46%)
- More than one third of households in rural areas (36.6%) spend 30 minutes or more obtaining drinking water

Two thirds (65%) of newborns are breastfed within the first hour of birth

Early initiation of breastfeeding decreased between 2004 and 2009, but increased again in 2014



Colostrum is contained in the mother's first milk, just after birth

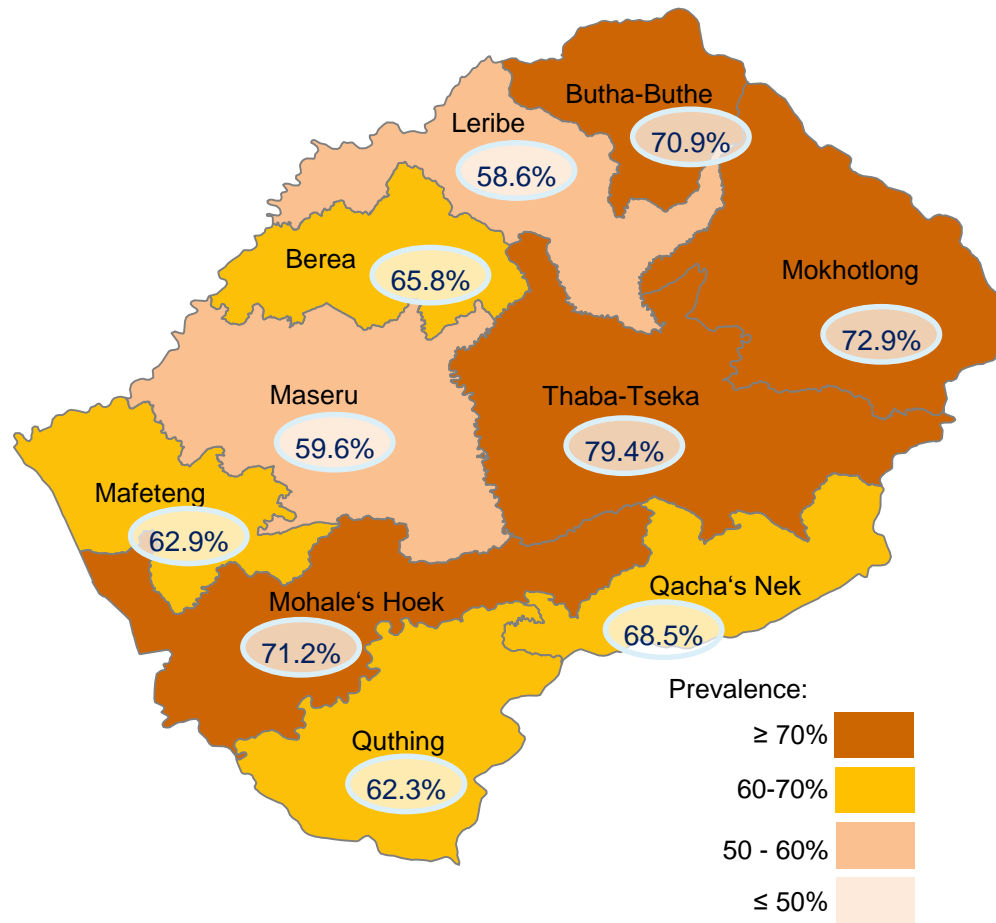
It contributes to the prevention of infections and is extremely rich in nutrients

Early initiation to breastfeeding promotes good lactation; it also presents a series of benefits for post-partum mothers

- Only two thirds (65%) of newborns are breastfed within the first hour of birth, despite the WHO recommendations that mothers initiate breastfeeding within one hour of birth
- There was a significant drop in early initiation of breastfeeding between 2004 and 2009 (10 percentage points)

In the four districts with the highest rates of early breastfeeding, at least 70% of children are breastfed within the first hour of birth

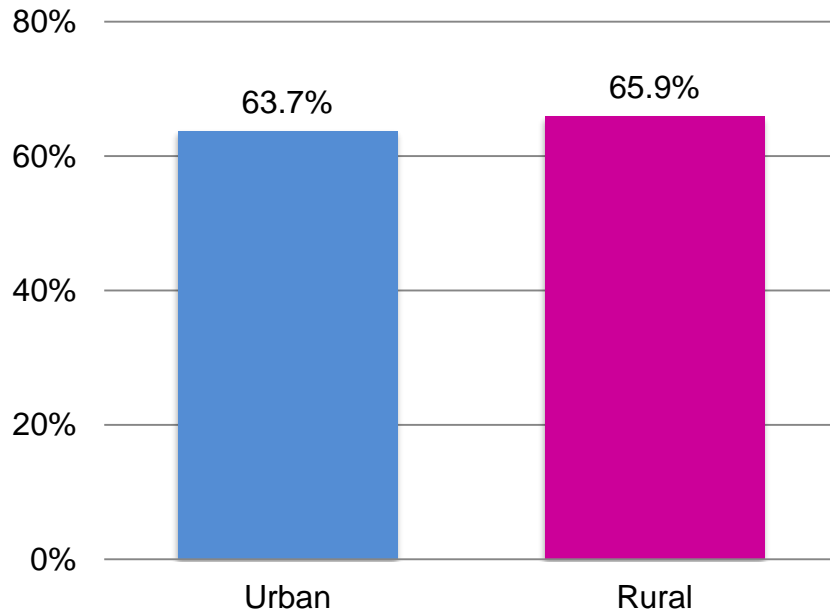
Early breastfeeding varies by district, ranging from a low of 58.6% in Leribe to a high of 79.4% in Thaba-Tseka



Breastfeeding within the first hour of birth varies between ecological zones, and is highest in the mountain zone (73.0%)

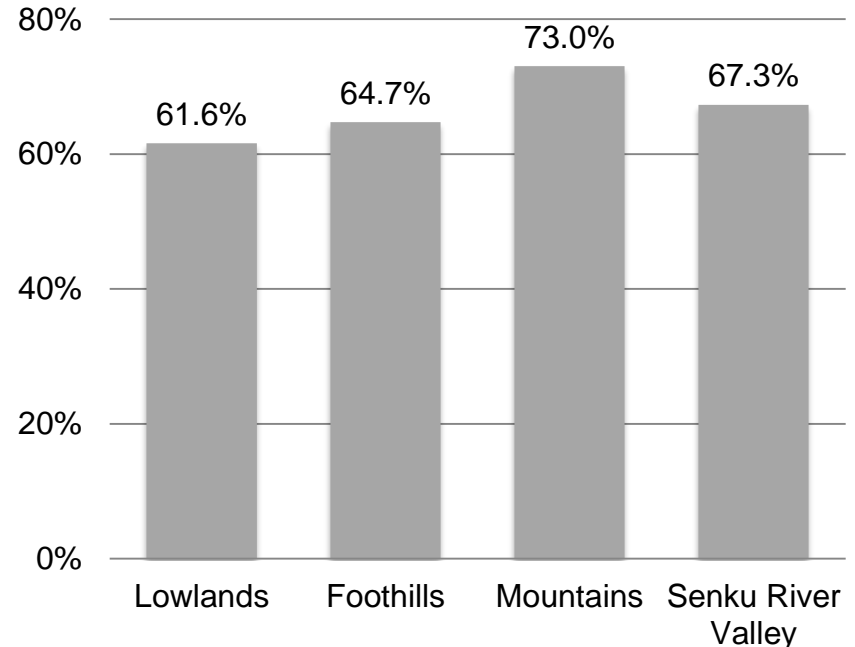
The prevalence of early initiation of breastfeeding varies only slightly between rural and urban settings

% of newborns breastfed within 1 hour of birth



- Breastfeeding within the first hour is slightly more prominent in the rural areas (65.9%) than in the urban areas (63.7%)

% of newborns breastfed within 1 hour of birth

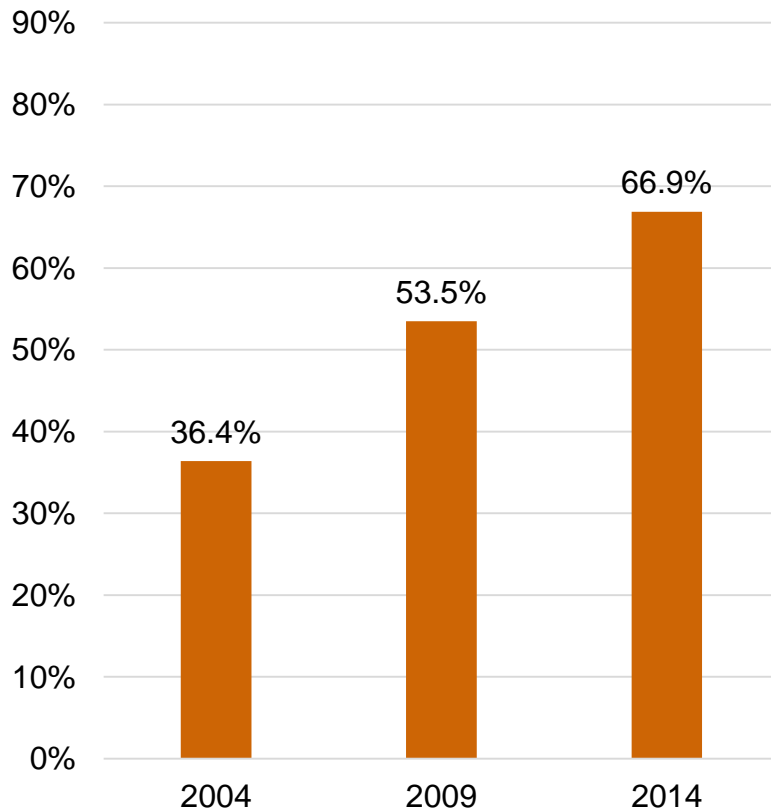


- Early initiation of breastfeeding is practiced more in the mountain zone (73.0%) than in the lowlands (61.6%)

Two thirds (66.9%) of children under 6 months are exclusively breastfed

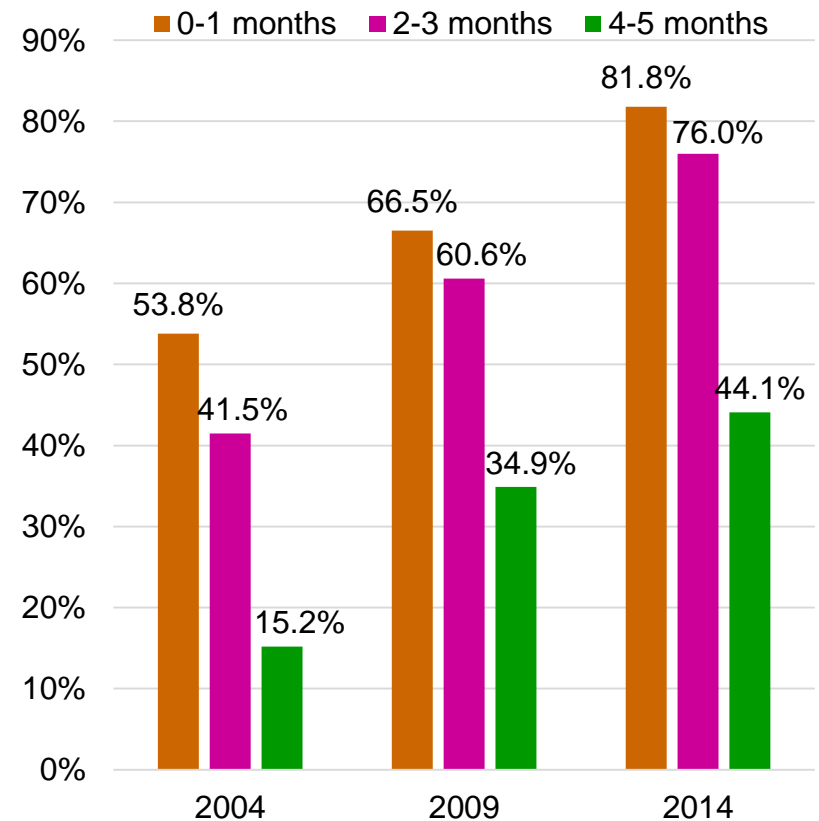
The prevalence of exclusive breastfeeding for infants 0-5 months of age has almost doubled since 2004

% of children 0-5 months exclusively breastfed



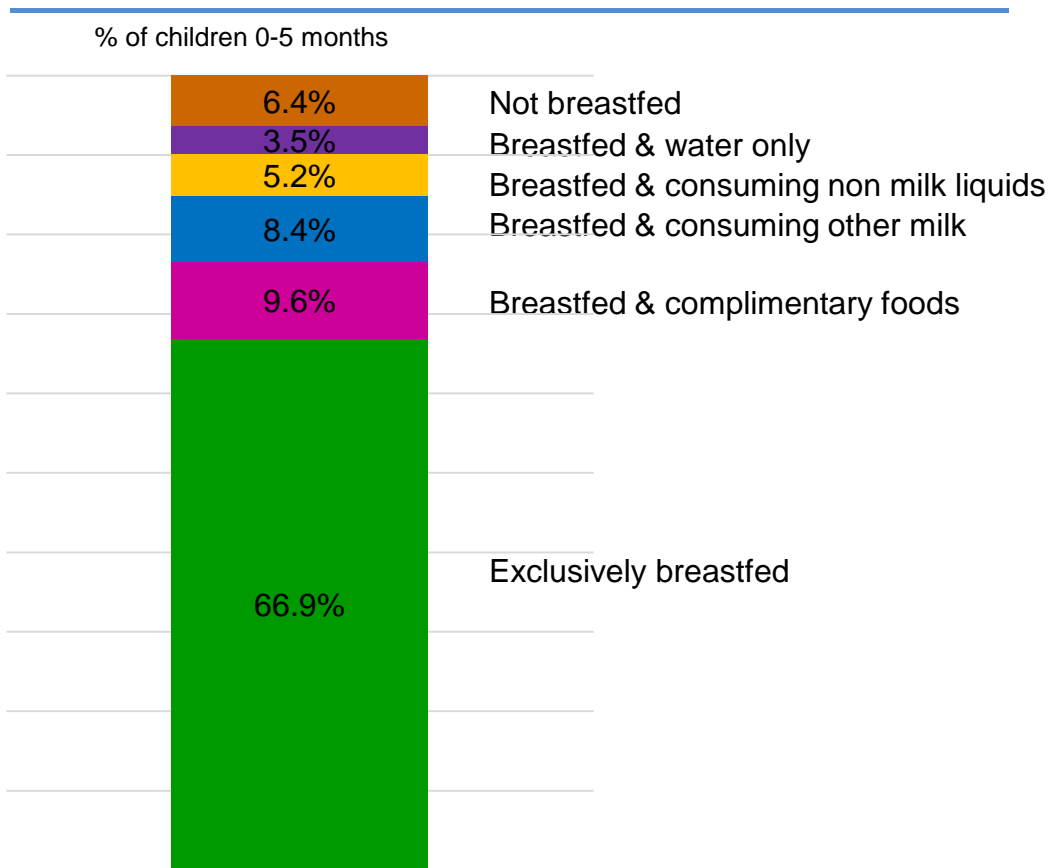
Despite improvements, the prevalence of exclusive breastfeeding drops to under 50% after children reach three months of age

% of children 0-5 months exclusively breastfed



One third of children 0-5 months (33.1%) of age is not exclusively breastfed, despite recommendations from WHO and UNICEF

Two thirds of children 0-5 months of age are exclusively breastfed



Recommendations:

- According to UNICEF and WHO recommendations, all children should be exclusively breastfed from birth to six months of age

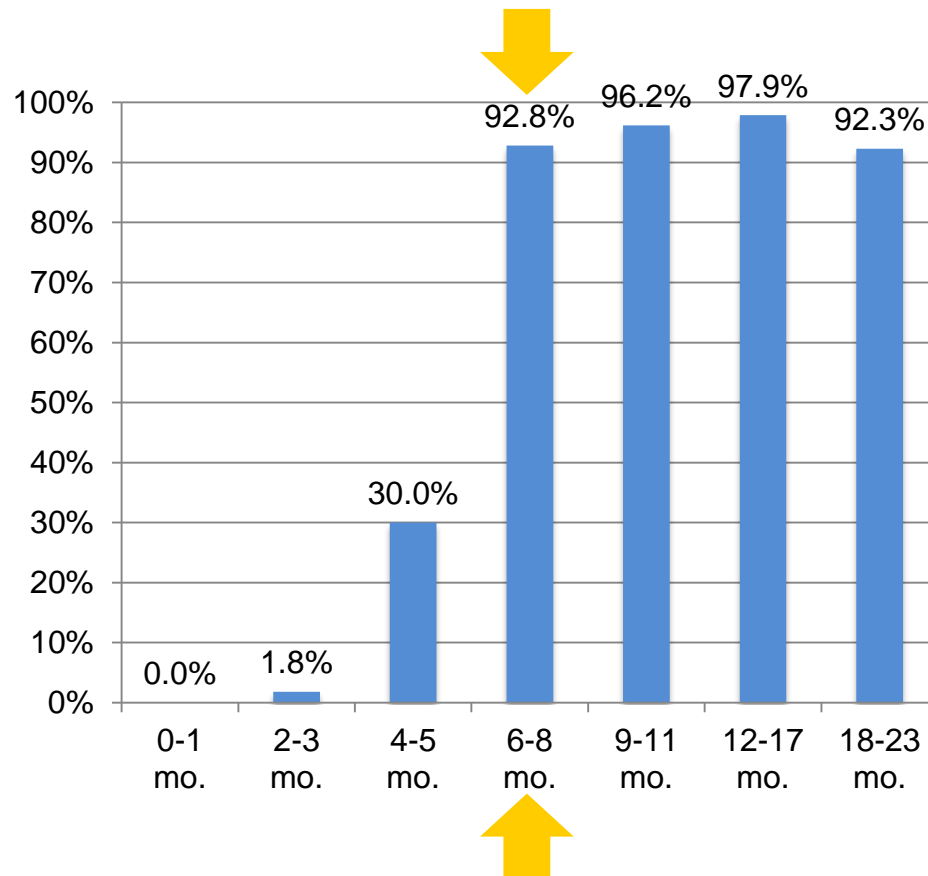
Consequences:

- Early introduction to complementary foods exposes children to pathogens and increases their risk of disease, especially diarrhoea
- Complementary foods often have low nutritional value

The majority (92.8%) of breastfed children receives complementary feeding at 6-8 months of age

Most breastfed children receive complementary feeding at 6-8 months of age

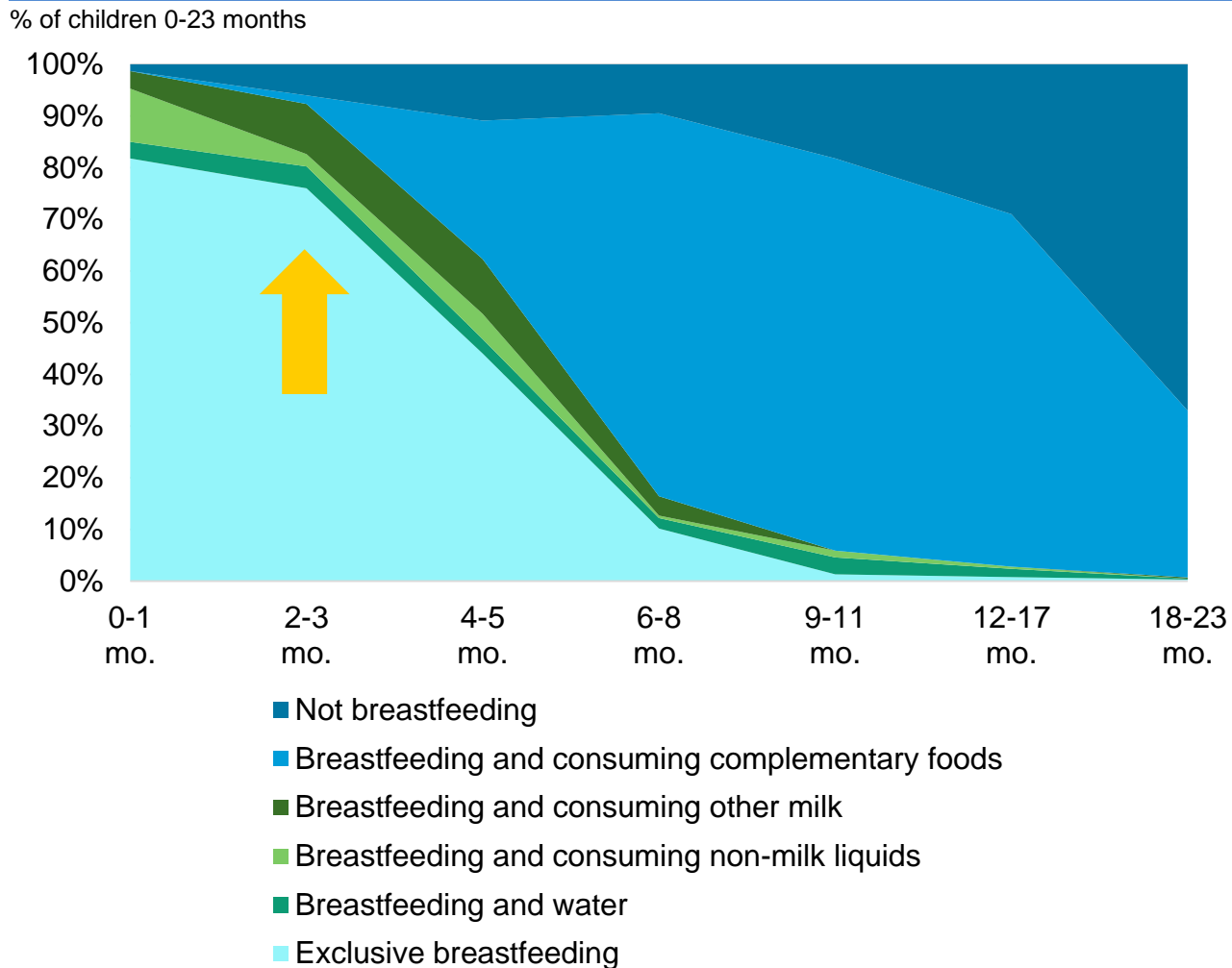
% of breastfed children 0-23 months who consumed any solid or semi-solid food



- Most breastfed children (92.8%) consume solid or semi-solid foods at 6-8 months of age
- It is recommended to reduce early complementary feeding, as 30.0% of 4-5 month olds are receiving complementary foods too young

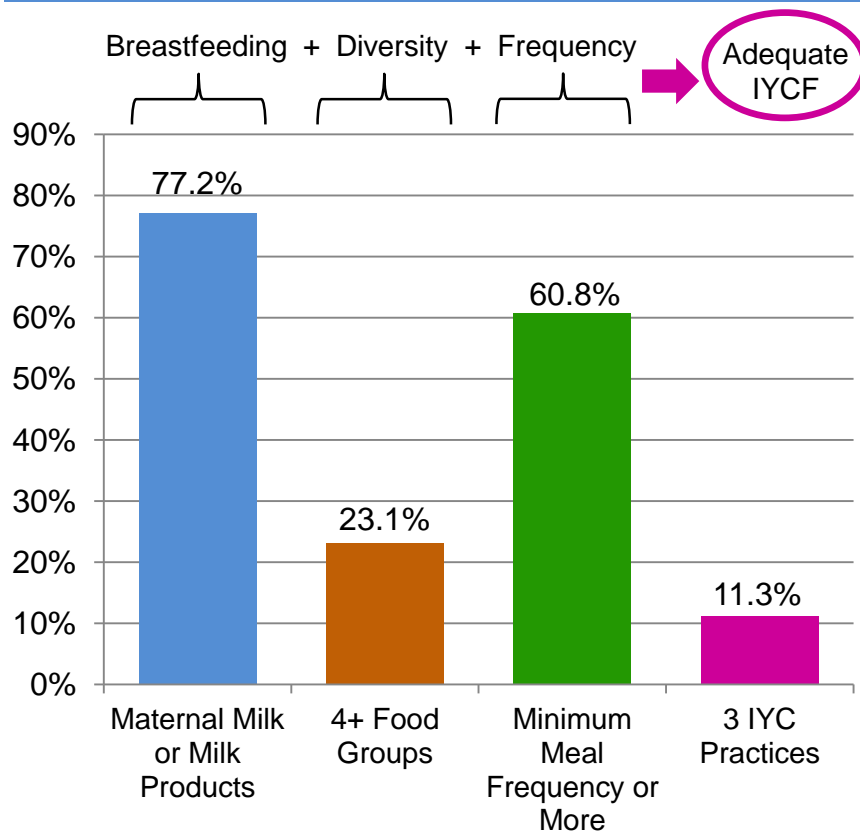
After 3 months of age, the rate of exclusive breastfeeding declines rapidly as introduction of complementary foods increases

Breastfeeding practices by age group



Few children 6-23 months (11.3%) are fed according to appropriate Infant and Young Child Feeding (IYCF) practices

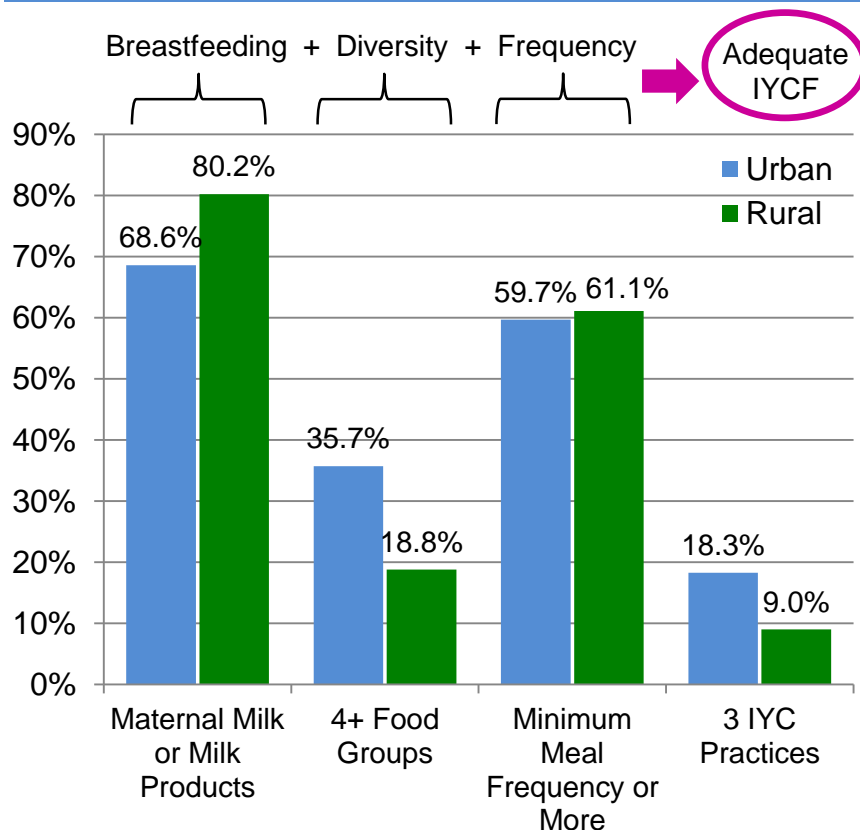
Less than a quarter of all children 6-23 months are fed at least 4 food groups



- The vast majority (77.2%) of all children 6-23 months of age receive breastmilk, breastmilk substitutes or milk products at least twice per day
- Less than a quarter (23.1%) of children 6-23 months of age received a diverse diet of 4 or more different food groups
- Over half (60.8%) of children 6-23 months of age were fed the recommended minimum number of times per day according to their age
- As a result, only 11.3% of children 6-23 months of age received a minimum acceptable diet according to the three IYCF feeding practices

More children in urban households are fed according to appropriate IYCF practices than those in rural households

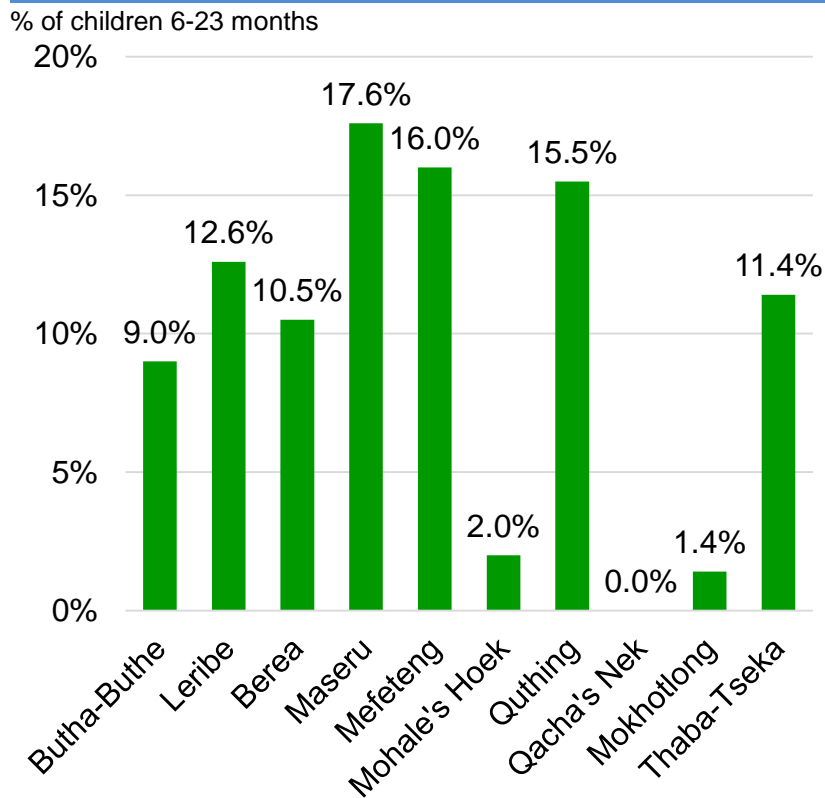
Of the IYCF feeding practices, diet diversity differs the most between rural and urban settings



- The vast majority of all children 6-23 months of age is breastfed, though there are differences between urban (68.6%) and rural (80.2%) areas
- Children 6-23 months in urban areas received a more diverse diet of 4 or more food groups than children in rural areas
- The frequency of meals does not differ much between rural and urban settings
- As a result, children 6-23 months in urban areas are more likely to receive a minimum acceptable diet than children 6-23 months in rural areas

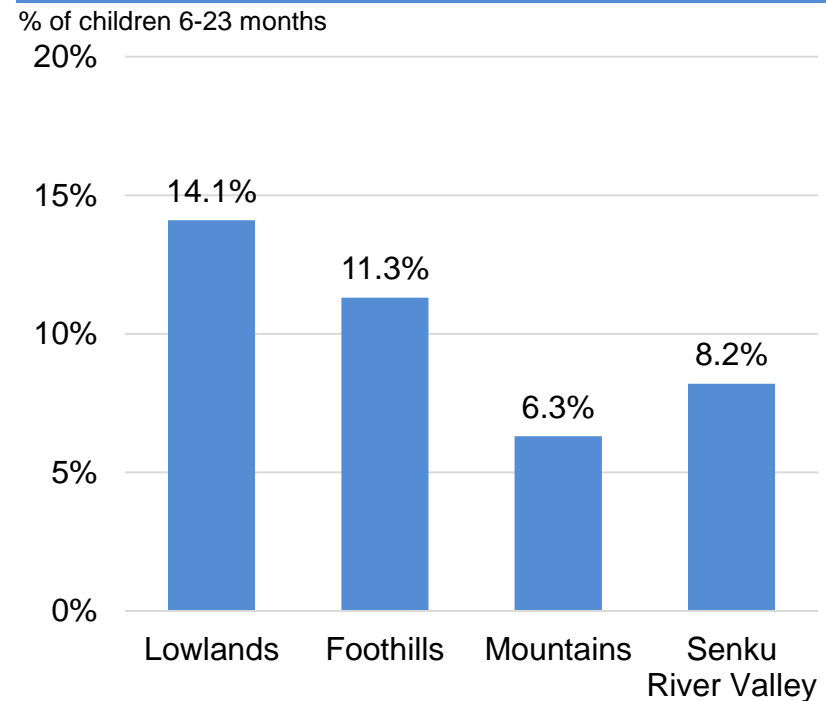
Children 6-23 months receiving a minimum acceptable diet varies greatly by district and ecological zones

Children 6-23 months that are fed with 3 IYCF feeding practices varies from a high in Maseru to a low in Qacha's Nek



- In three districts (Mohale's Hoke, Qacha's Nek and Mokhotlong), children 6-23 months are unlikely to receive a minimum acceptable diet

The highest percentage of children 6-23 months that are fed with 3 IYCF feeding practices live in the lowlands and foothills

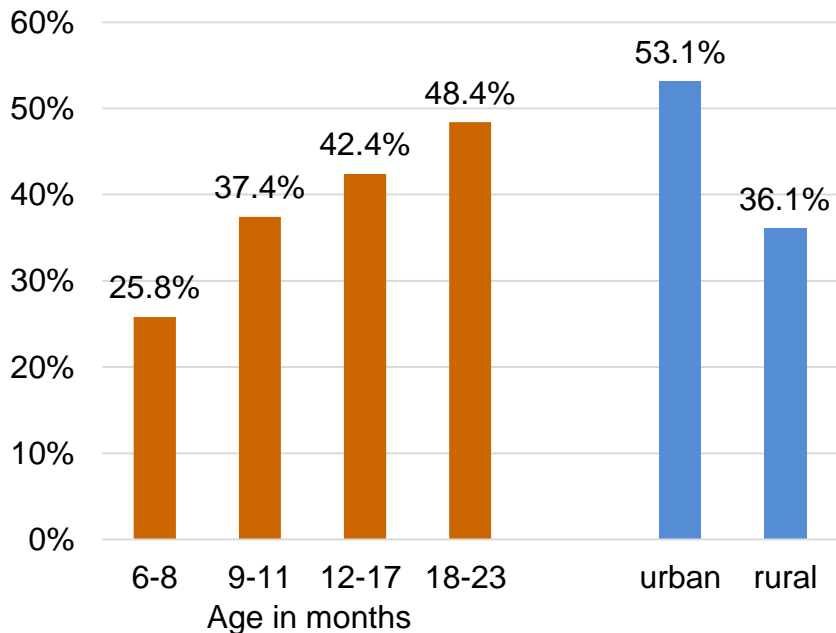


- While children in the mountain zone are less likely to receive all 3 IYCF practices, they are more likely to be breastfed within one hour of birth

At the national level, less than half of children 6-23 months consume food rich in iron, however this varies between districts and household settings

The consumption of iron rich foods increases with age group

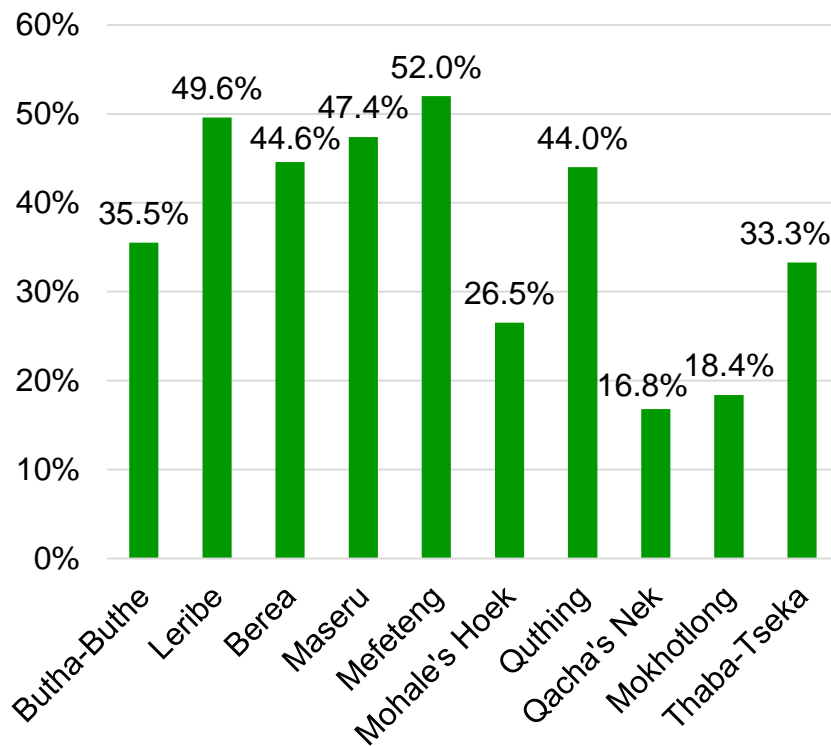
% of children who consumed food rich in iron in the last 24 hours



- The consumption of iron rich foods varies between urban and rural households

The consumption of iron rich foods varies across districts

% of children who consumed food rich in iron in the last 24 hours

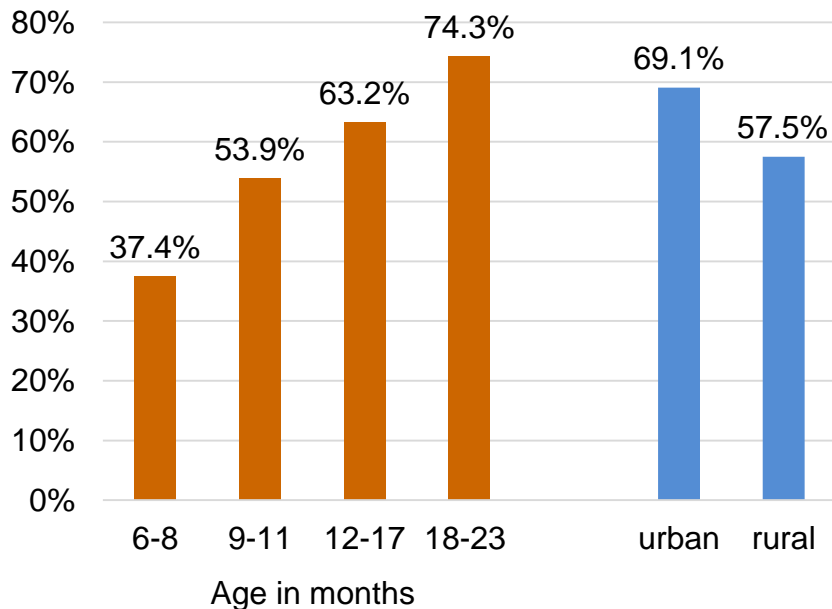


- Children in Qacha's Nek (16.8%) and Mokhotlong (18.4%) have the lowest prevalence of consumption of iron rich foods

As children 6-23 months age, they are more likely to consume foods rich in vitamin A than foods rich in iron

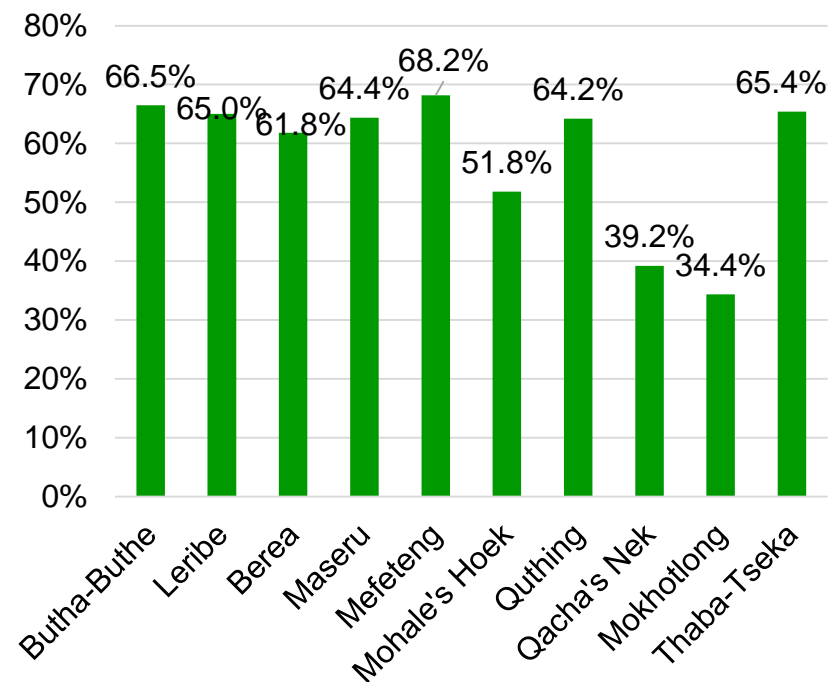
By 18-23 months, the two thirds of children are consuming foods rich in vitamin A

% of children who consumed food rich in Vitamin A in the last 24 hours



The prevalence of children who consume foods rich in vitamin A varies across districts

% of children who consumed food rich in Vitamin A in the last 24 hours



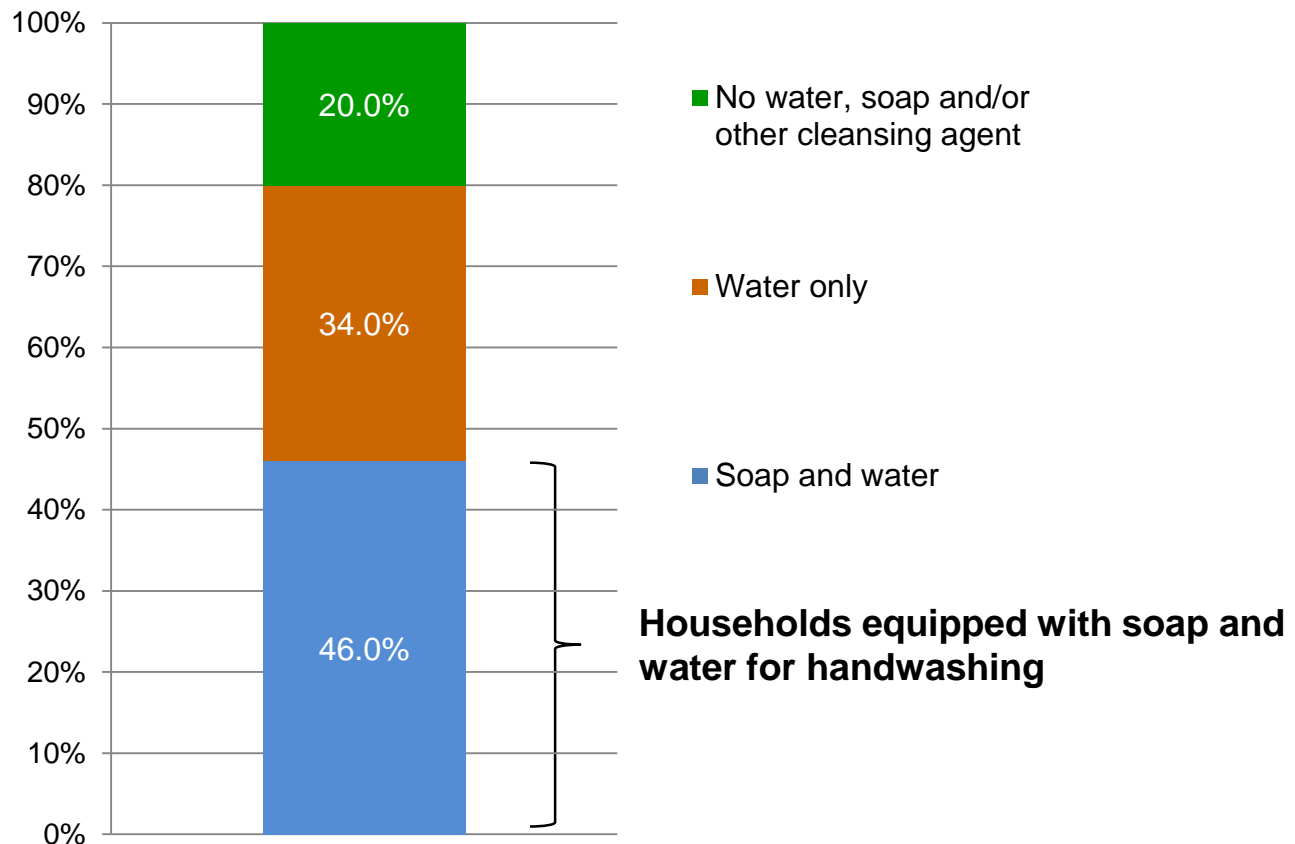
- Consumption of foods rich in vitamin A increases with age group and is higher in urban areas than rural areas

- Children in Qacha's Nek (39.2%) and Mokhotlong (34.4%) have the lowest consumption of vitamin A rich foods

The majority of households do not have a place for hand washing and only half of those have both soap and water

Of households with hand washing stations, less than half do not have soap and water

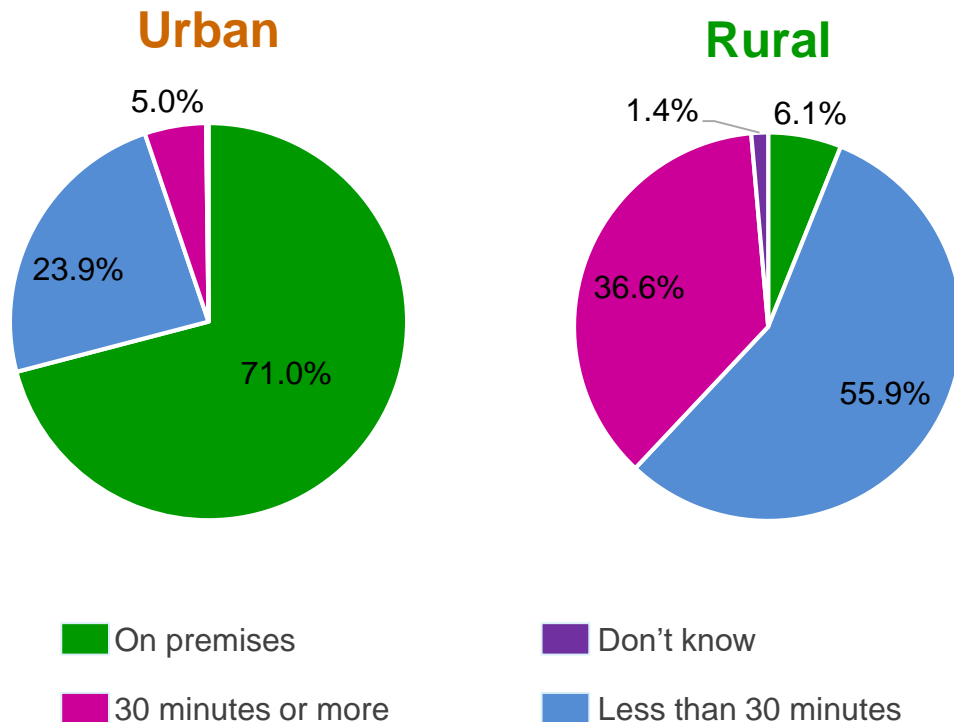
% of households with handwashing facilities



More than one third of households in rural areas spend 30 minutes or more obtaining drinking water

While the majority of urban households have access to water on their premises, very few rural households do

% of households

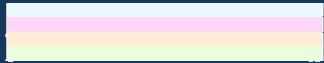


- In urban areas, 71% of households have access to drinking water on their premises
- Approximately one third (36.6%) of rural households are 30 minutes or more from water
- On average, only 27% of all households in Lesotho have access to water supply on premise, 46% have access to drinking water within 30 minutes and 26% need to travel more than 30 minutes to access drinking water

Underlying factors:

Health Services and the Environment

Figures, trends, causes



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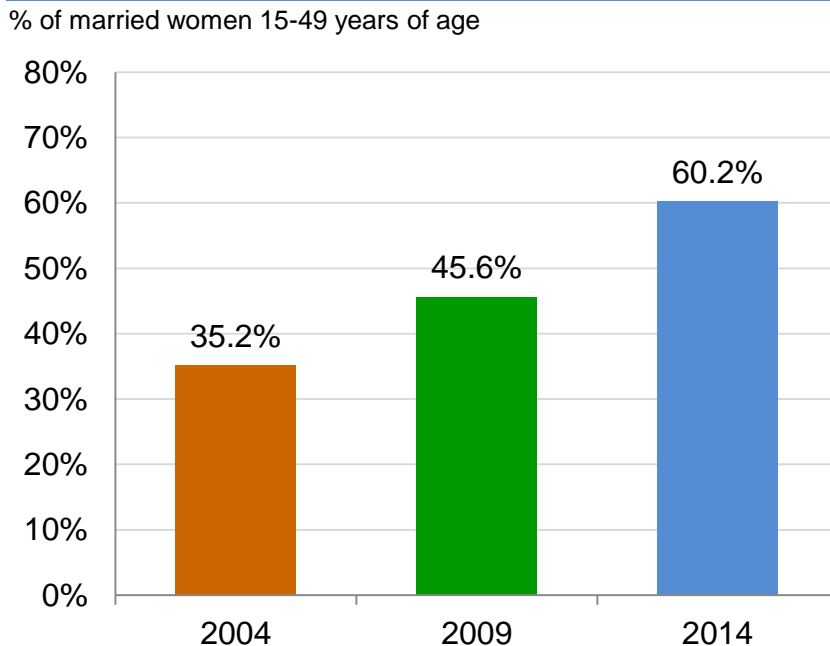


Key Messages

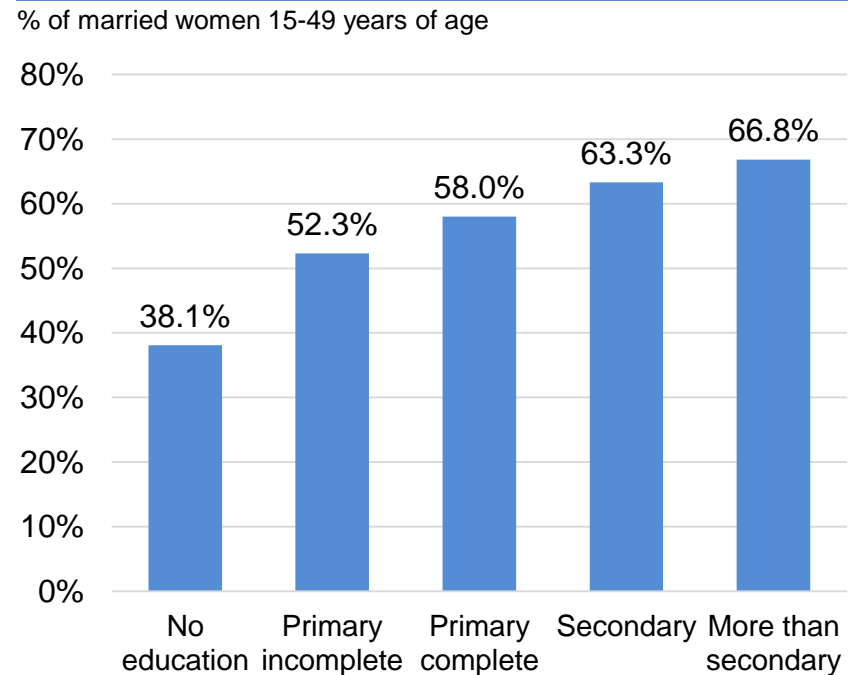
- The use of contraception has almost doubled nationally (from 35.2% in 2004 to 60.2% in 2014) and is notably higher in areas where women are more educated
- Nonetheless, one in five women do not have their contraceptive needs met and this demand is higher for women living in urban areas
- In 2014, the majority of women 15-49 years of age (95.2%) benefited from at least one antenatal care (ANC) visit, while three fourths of women (74.4%) received four or more ANC visits
- Over half of women (53.9%) do not receive their first ANC visit until 4 months into their pregnancy and the recommended prenatal care services are not always performed
- Though the majority of women give birth in facilities, the rate fluctuates by district. The increase in assisted deliveries at the national level since 2004 is mainly due to an increase in the rate in rural areas (23.1 percentage points)
- A large proportion of women (77.3%) do not receive postnatal care or receive it too late after childbirth
- The prevalence of HIV is high in all ten districts, averaging 24.6% nationally, with the highest prevalence found in Maseru, where almost a third of the population HIV positive (28.0%)
- Knowledge around the prevention of mother-to-child transmission (PMTCT) has increased for both men and women since 2004
- One third of children do not receive all the recommended vaccinations, in both urban and rural areas
- The prevalence of diarrhoea among children has decreased since 2004
- Only half of caregivers (50.9%) seek medical advice or treatment when a child has diarrhoea, and zinc supplements are very rarely administered (0.7%)
- Approximately 3 out of 5 children who recently had a fever sought medical attention
- About two thirds of children receive vitamin A supplementation (61.3%), however there are some disparities between districts
- Coverage of households using an improved water source has increased since 2004 (from 50.9% to 82.2%), however households in rural areas have less access (77.2%) than households in urban areas (96.9%)
- Despite almost a quarter (22.8%) of rural households not having access to an improved water source, very few treat household water supply properly (11.8%)

The use of contraceptives has increased over time, however is higher for women who are more educated

The use of contraceptives for married women has increased since 2004



The use of modern contraception increases with the education level of women

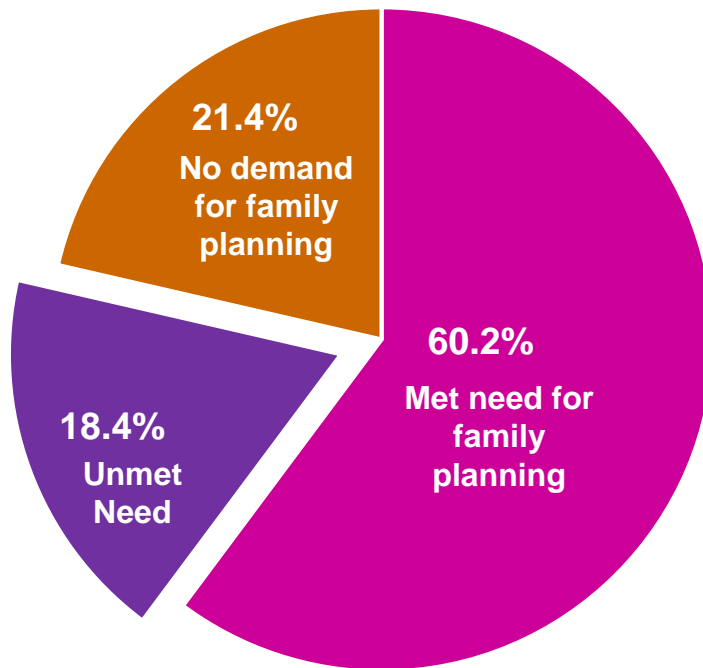


- Women with higher education use more modern methods of contraception (66.8%) than women who have no education (38.1%)
- Berea (63.9%), followed by Quthing (63.6%) and Leribe (63.4%), have the highest use of modern contraception. Mokhotlong has the lowest use of modern contraception (48.4%)

Almost one in five women do not have their family planning needs met

Two thirds of women have their family planning needs met

% of married women 15-49 years of age

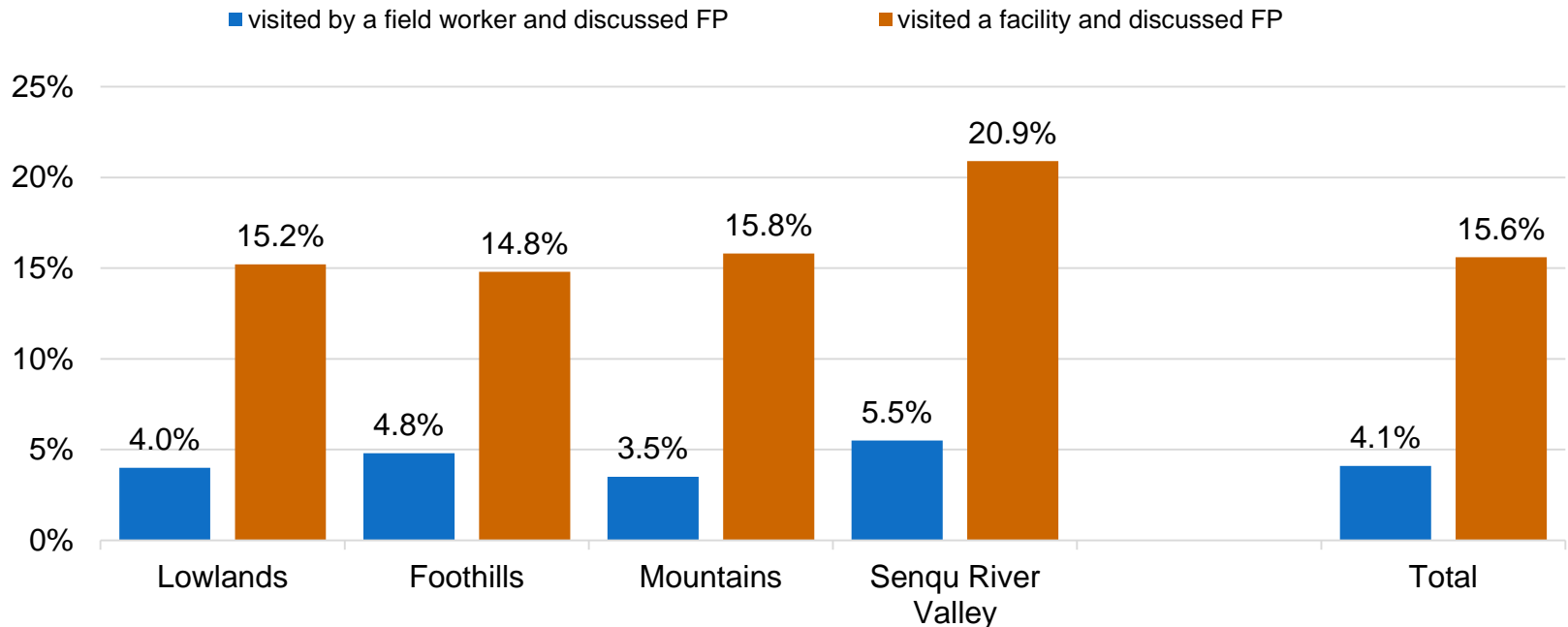


- Married women expressed a need for contraception because they:
 - want to wait at least 2 years before having another child (24%)
 - want no more children at all (56%)
- The demand for birth spacing is lower in urban areas (30.4%) than in rural areas (31.3%)
- The demand for birth limiting is higher in rural areas (48.7%) than in urban areas (47.0%)

The majority of women who are not using a contraceptive method have not discussed family planning with a health worker (82.0%)

Less than 1 in 6 women not using contraception have discussed family planning with a facility-based health worker or field worker

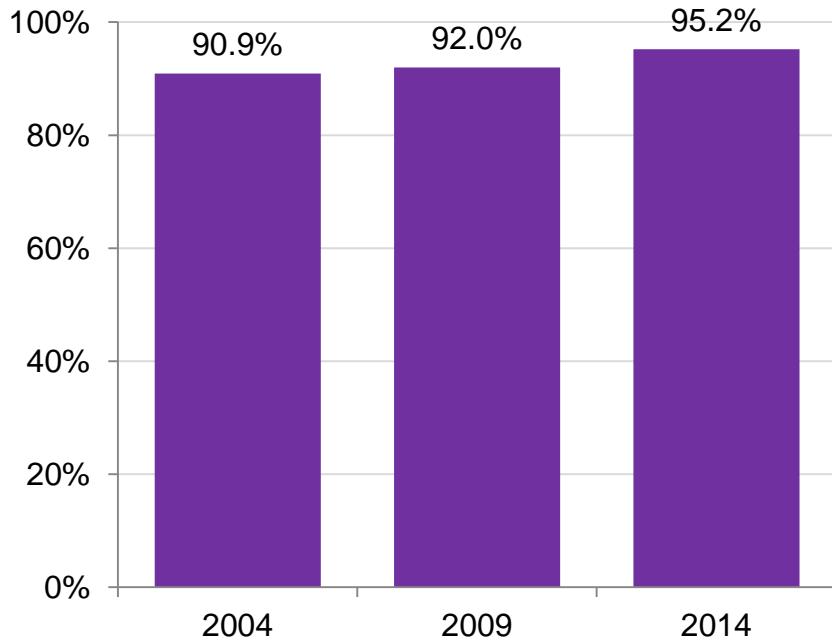
% of women age 15-49 who are not using contraception



In 2014, the majority (95.2%) of women 15-49 years of age have benefited from at least one antenatal care visit

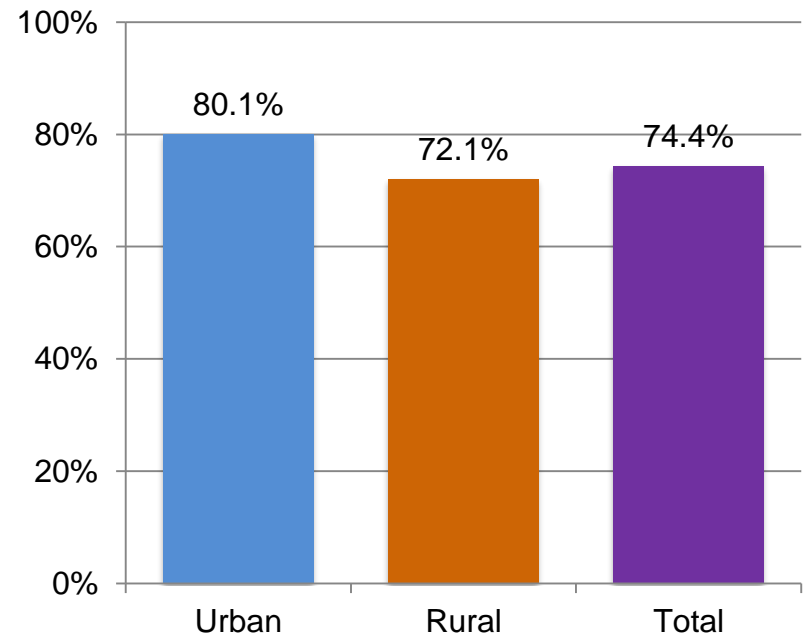
The proportion of women who benefit from antenatal care has increased since 2004

% of women 15-49 years of age having given birth in the past 5 years



The majority of women have at least four antenatal care visits during their pregnancy

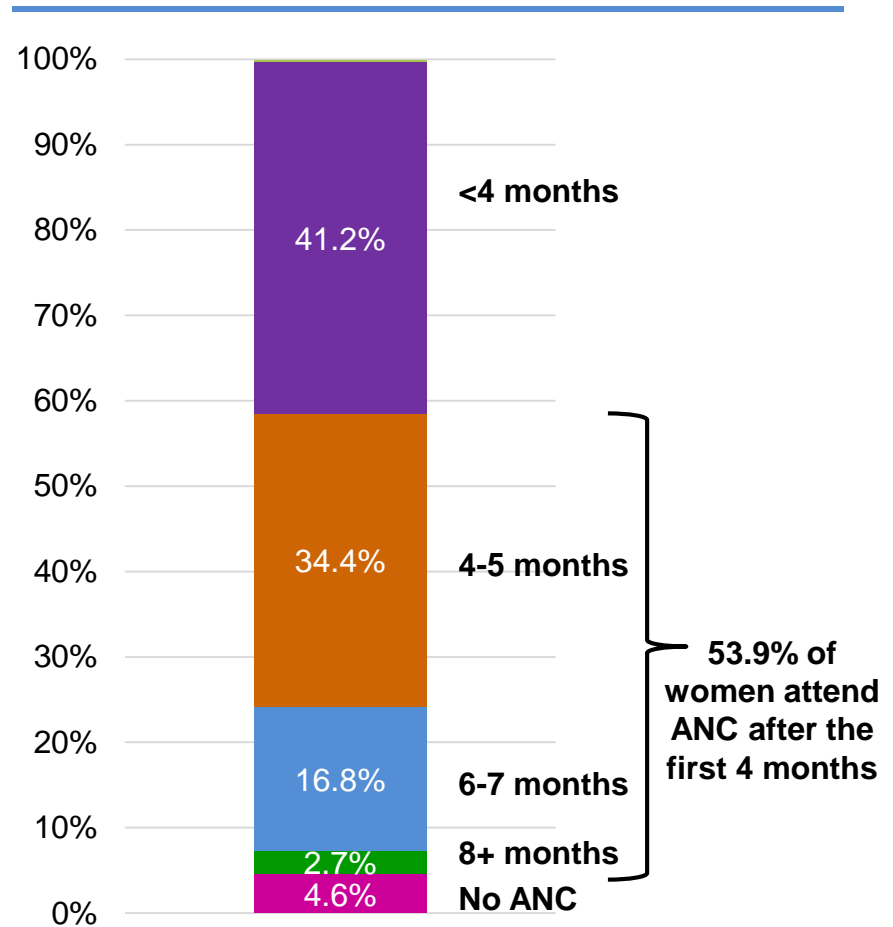
% of women 15-49 years of age having given birth in the past 5 years and having had at least 4 antenatal care visits



Three fourths of women have had four or more antenatal care visits, but over half (53.9%) do not receive their first visit until they are four months of into pregnancy

- Antenatal care increases the likelihood of an institutional delivery. If mothers have at least one ANC visit, births are more than three times as likely to take place in a facility
- On average, pregnant women attend their first ANC visit at 4.3 months
- WHO recommends the first ANC visit to take place within the first 12 weeks of gestation

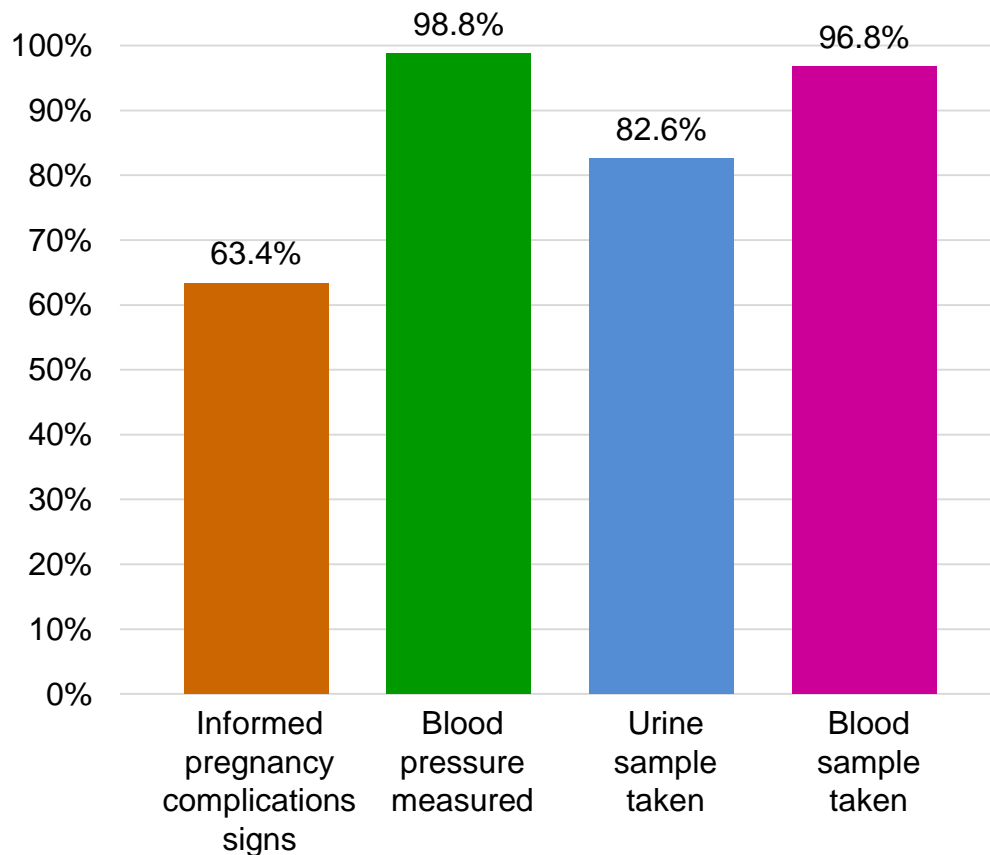
Less than half of women attended their first antenatal care visit within the first 4 months of pregnancy



The four recommended prenatal care services are not always performed during ANC visits

Not all women who attend antenatal care visits received the same level of care

% of women who received ANC for their most recent birth in the past 5 years

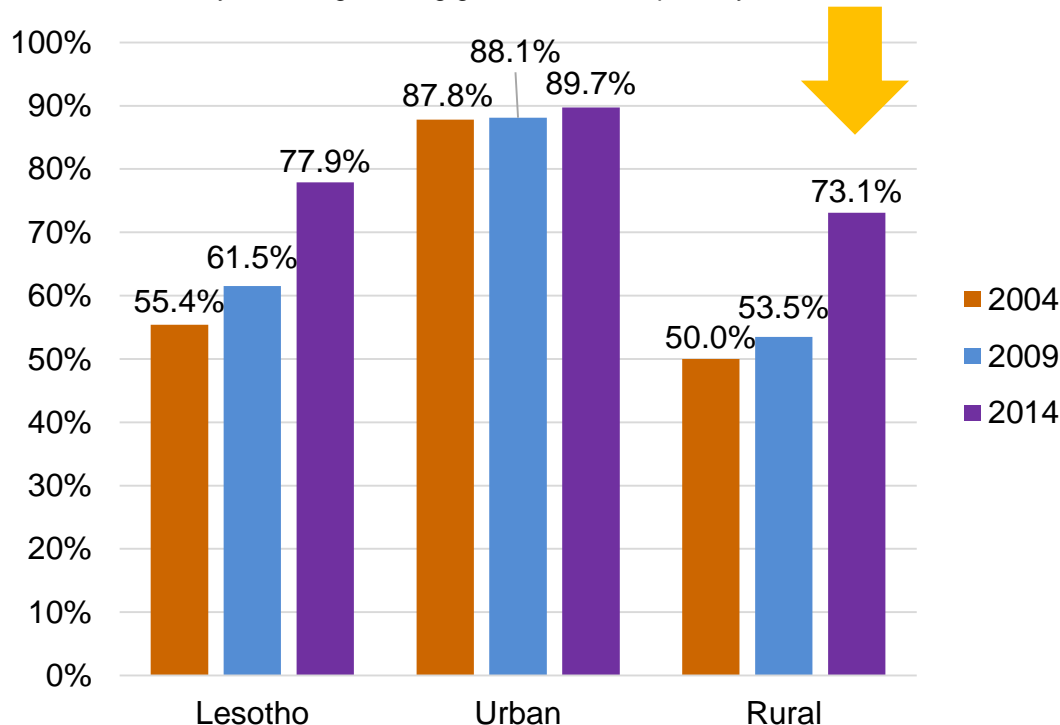


- The effectiveness of antenatal care depends on the type of examinations conducted during consultations as well as the advice given to women
- Undernutrition in pregnant women can lead to complications during childbirth and problems for their child's weight, such as underweight
- Prenatal visits are therefore essential to ensure the good nutrition of pregnant women, as well as the health of their children
- For example, blood tests can detect anaemia in pregnant women, who should then receive iron supplements

The increase in assisted deliveries at the national level since 2004 is mainly due to an increase in rural areas

As of 2014, the vast majority of women are assisted by a skilled healthcare personnel during childbirth

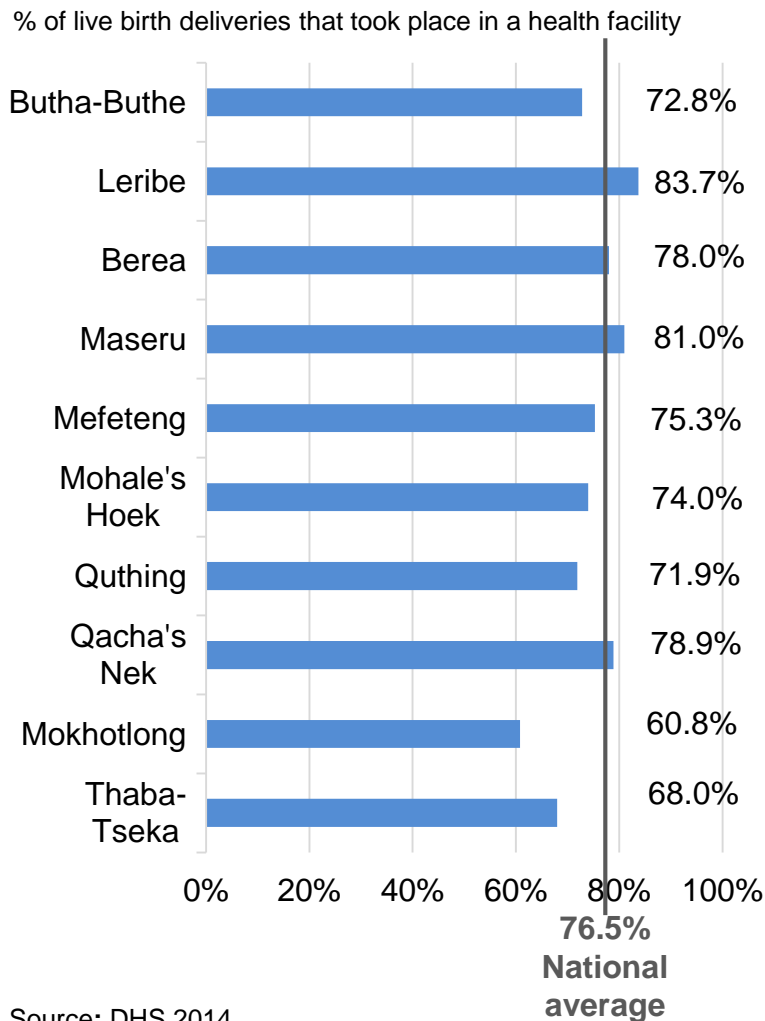
% of women 15-49 years of age having given birth in the past 5 years



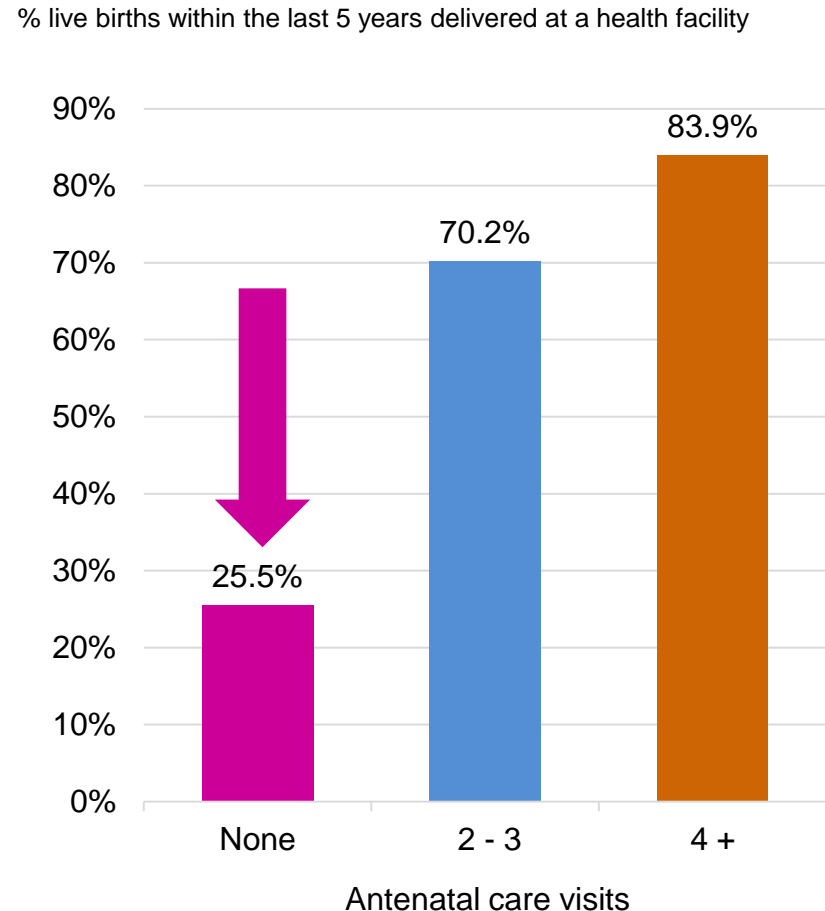
- The majority (77.9%) of deliveries are assisted by skilled birth attendants (doctor, midwife, nurse, or nurse assistant)
- There has been a steady increase in assisted deliveries by skilled personnel since 2004
- The most notable increase has been in the rural areas, where rates have jumped from half (50.0%) in 2004 to three quarters (73.1%) in 2014

Though the majority of women give birth in health facilities, the rate fluctuates by districts

The rate of delivery in health structures varies by districts



Women who do not attend ANC visits are least likely to give birth in a health facility

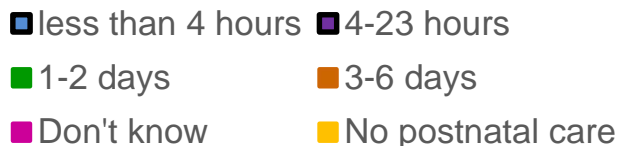
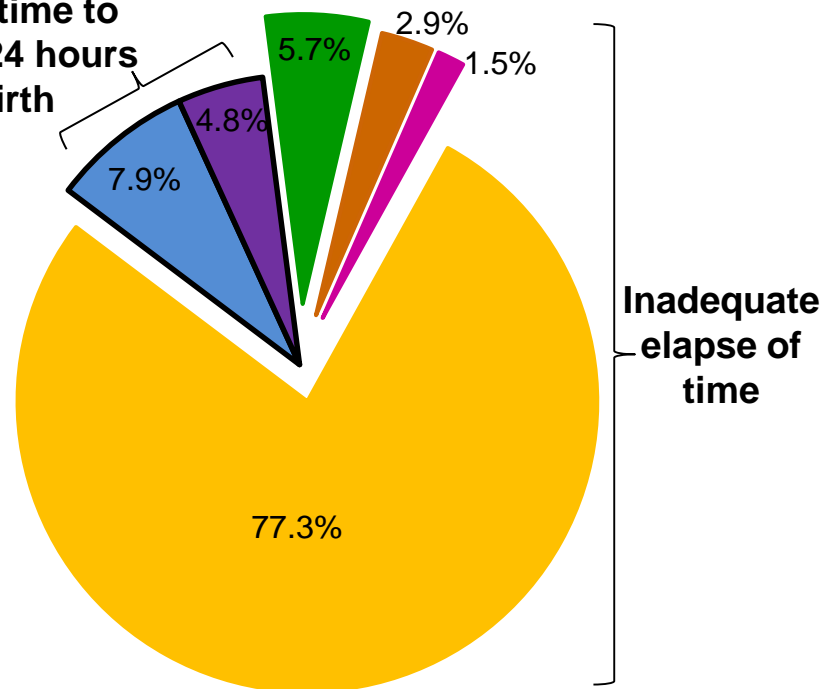


Most women (77.3%) do not receive postnatal care or receive it too late after childbirth

Duration from delivery to when the mother received her first postnatal care

% women who gave birth in the 2 years preceding the survey

Adequate time to complete: 24 hours after birth

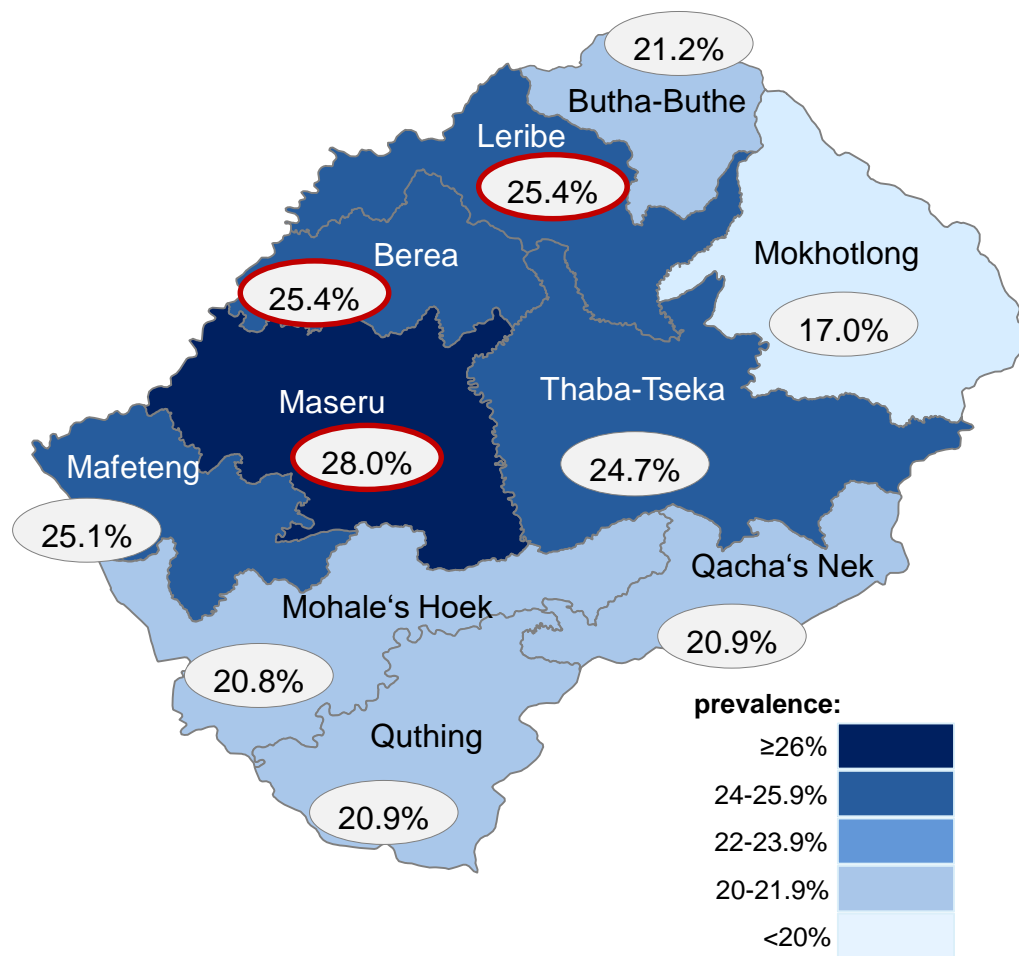


- It is recommended that all women and newborns receive postnatal care
- Women can receive counseling on breastfeeding and nutrition education, and children can be screened for acute malnutrition and referred to a food supplementation program, among other care
- The majority of women and newborn deaths occur within the first day after childbirth
- On average, 12.7% of women in Lesotho receive postnatal care within 24 hours of birth

The prevalence of HIV is high in all ten districts, averaging 24.6% nationally, with the highest prevalence found in Maseru, where almost a third of the population (28.0%) is HIV positive

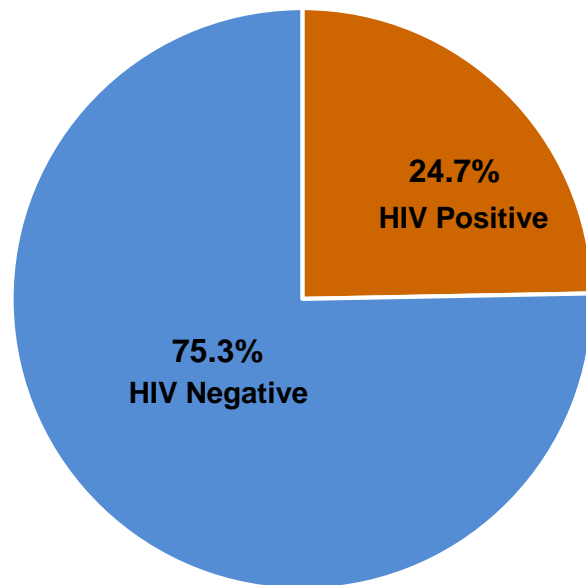
- Lesotho has high rates of female adult mortality, which is in part due to the HIV epidemic
- On average, more than a quarter (29.7%) of women and one fifth (19.7%) of men are HIV positive
- The undiagnosed infection remains a significant factor fueling the HIV epidemic
- HIV prevalence among adults age 15-49 varies by district, ranging from a low of 17.0% in Mokhotlong to a high of 28.0% in Maseru
- HIV prevalence varies by marital status and is highest among those who are widowed, followed by women and men who are divorced or separated

At least a quarter of all adults are infected with HIV in five out of ten districts in Lesotho

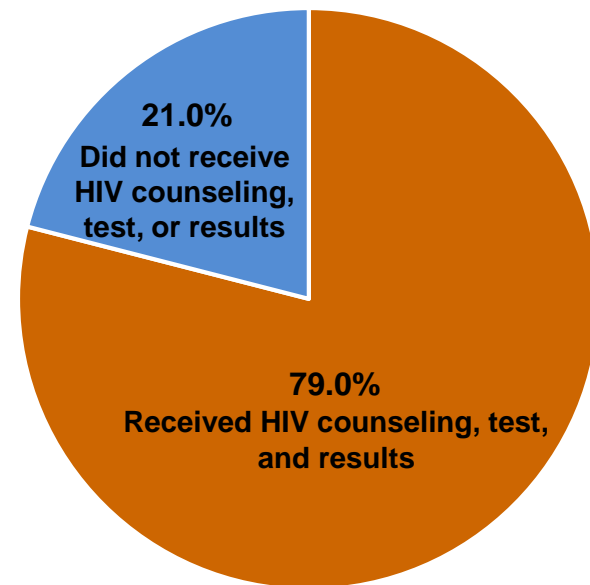


On average, three quarters (79.0%) of pregnant women receive HIV testing and counseling, and a quarter (24.7%) of them are HIV positive

Percentage of pregnant women who are HIV positive



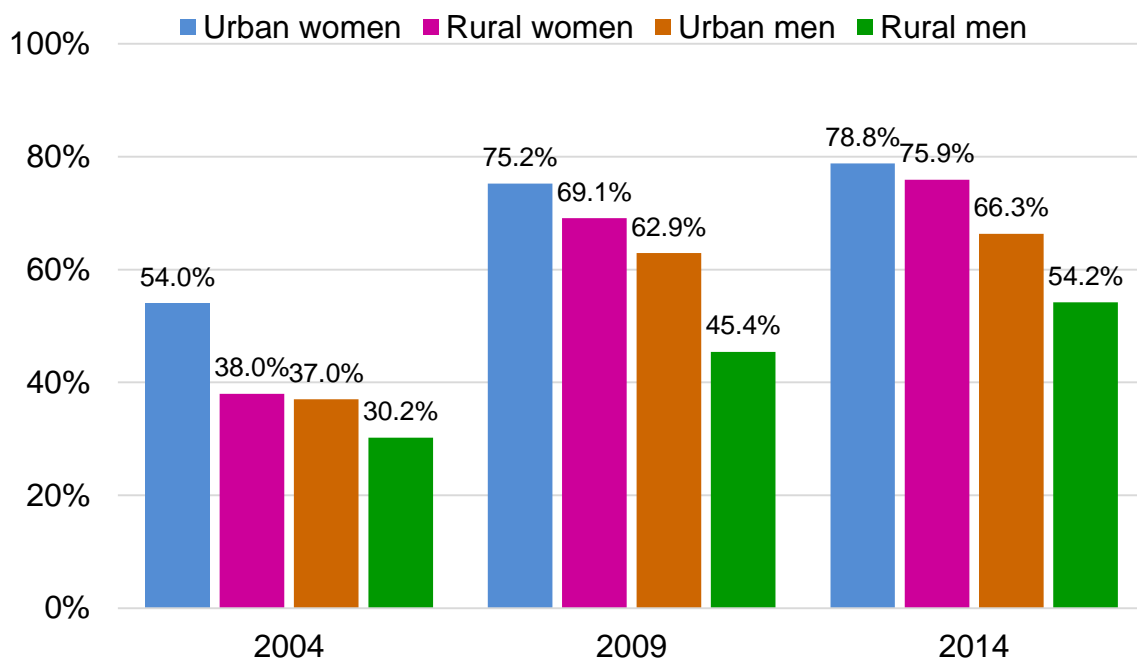
Percentage of pregnant women who received HIV counseling, testing and results during ANC appointments



- HIV can be transmitted through pregnancy, childbirth and breastfeeding, and a child infected with HIV is vulnerable to acute malnutrition
- An HIV-infected child with acute malnutrition will have an increased risk of infection, which reduces the effectiveness of anti-retroviral treatment

Knowledge on prevention of mother to child transmission (PMTCT) has increased for both men and women since 2004

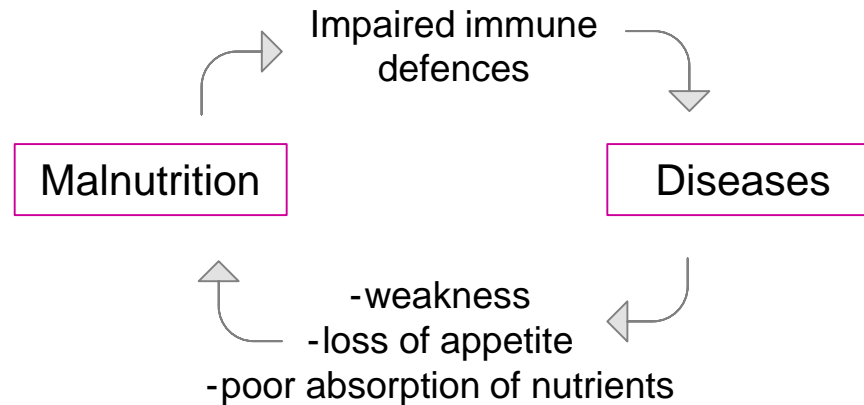
Knowledge around preventing mother-to-child transmission of HIV is higher among women than men, both in urban and rural areas



- Knowledge that the transmission of HIV from mother to children can be prevented, with drugs and by avoiding breastfeeding, has increased between 2004 and 2014:
 - By 35.1 percentage points for women between 2004 and 2014
 - By 26.7 percentage points for men
- In rural areas, men's knowledge increased from 30.2% in 2004 to 54.2% in 2014, while women's knowledge increased from 38.0% in 2004 to 75.9% in 2014
- In urban areas, men's knowledge increased 29.3 percentage points, while women's knowledge increased 24.8 percentage points between 2004 and 2014

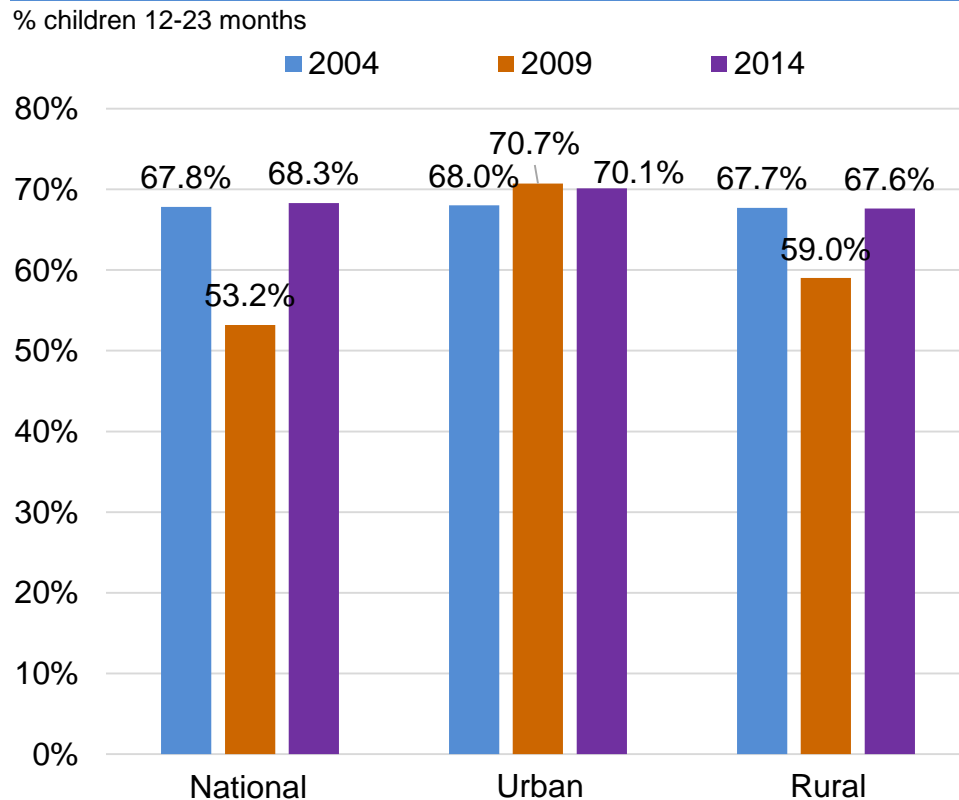
Infectious diseases increase the risk of malnutrition, and vice versa

The vicious circle of malnutrition-infection



Over two thirds of children receive all recommended vaccinations, in both urban (70.1%) and rural (67.6%) areas

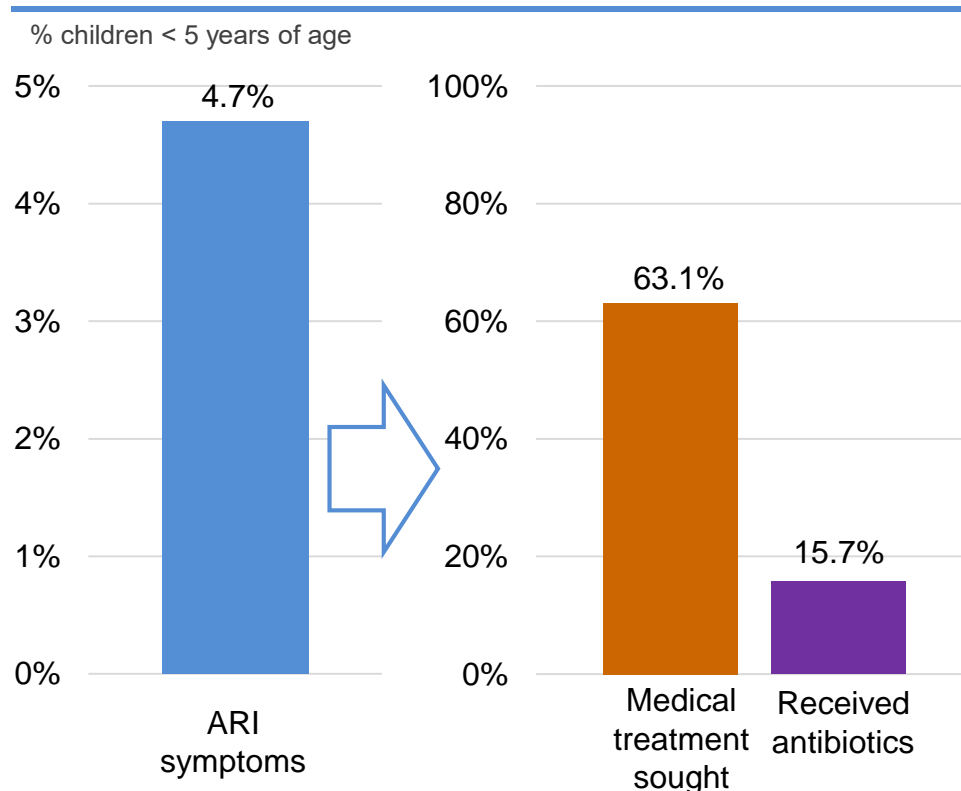
The rate of vaccination between 2004 and 2014 has not increased significantly



- Over two thirds (68.3%) of children ages 12-23 months received all recommended vaccinations at the national level
- Vaccination rates decreased between 2004 and 2009, and increased again in 2014
- The vaccination rates remain slightly lower in the rural areas compared to the urban areas

Infectious diseases such as acute respiratory infections expose children to acute malnutrition

Children under five years of age with symptoms of Acute Respiratory Infection

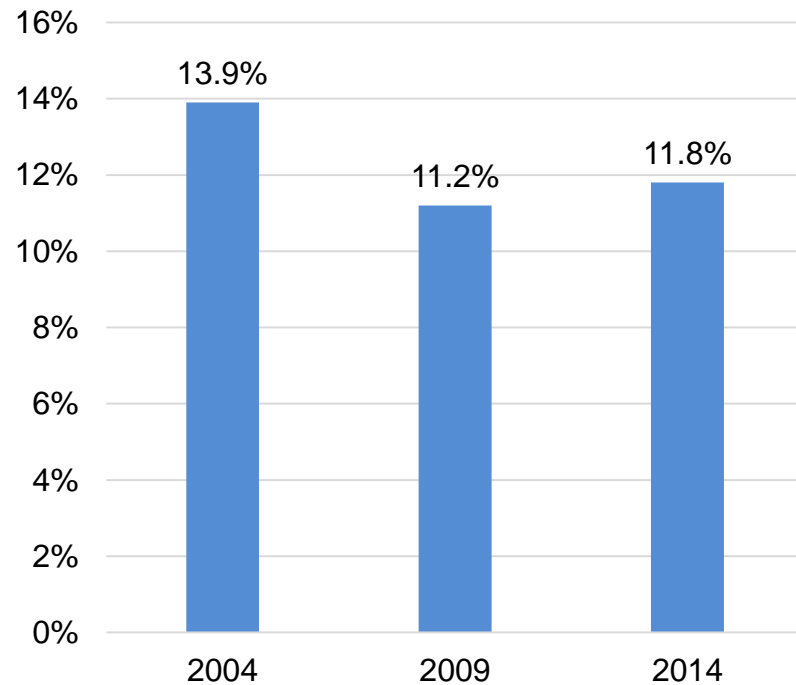


- Acute respiratory infections (ARI), particularly pneumonia, are one of the leading causes of child mortality in developing countries
- Infectious diseases in young children can lead to moderate acute malnutrition in the short term and contribute to long-term growth retardation due to the additional nutritional requirements needed to fight infections or reduced nutrient uptake
- Chronic malnutrition, acute malnutrition and underweight contribute to a high risk of infant mortality by infectious diseases

The prevalence of diarrhoea among children has decreased since 2004, however it is most common in the foothills (13.2%) and lowlands (12.3%)

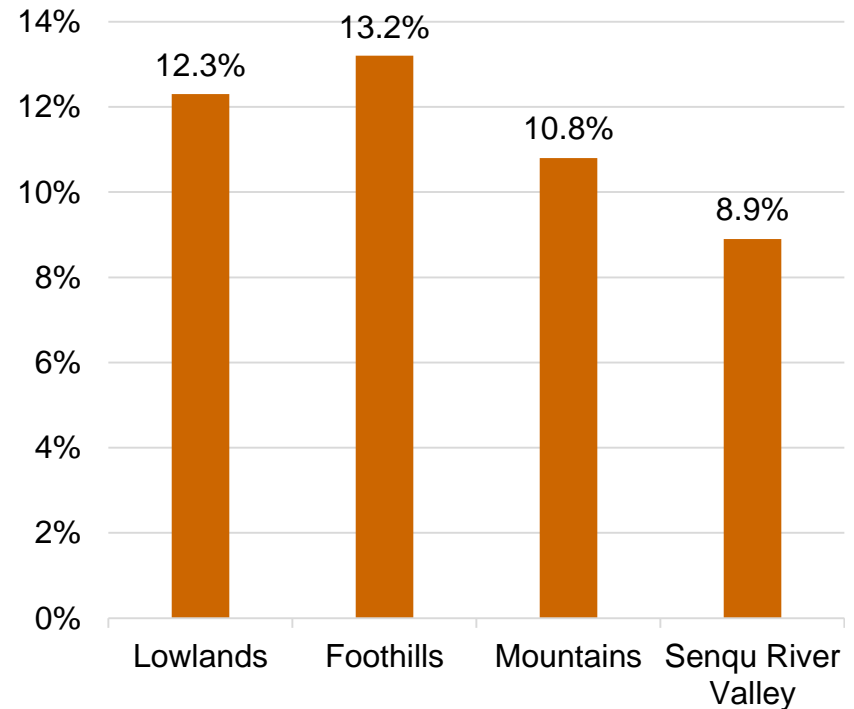
The prevalence of diarrhoea has slightly decreased since 2004

% of children <5 years having had diarrhoea in the past two weeks



Diarrhoea prevalence is higher in the foothills than the other ecological zones (2014)

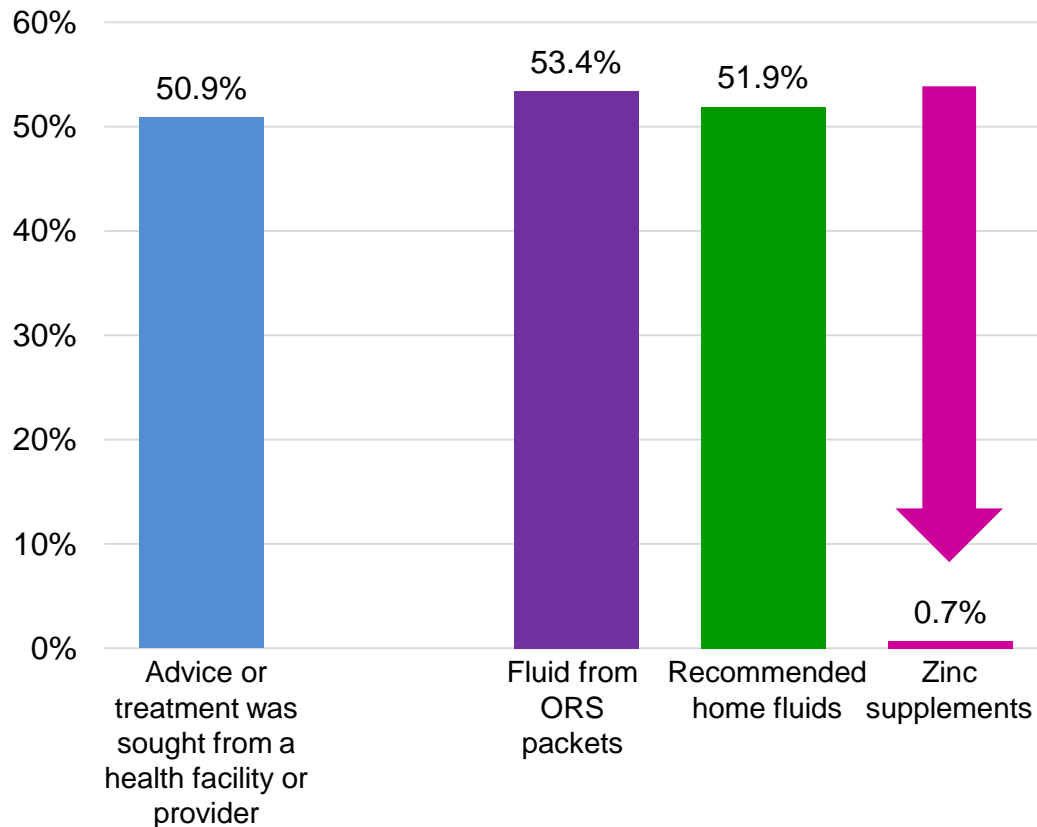
% of children <5 years having had diarrhoea in the past two weeks



Only half of caregivers (50.9%) seek medical advice or treatment when a child has diarrhoea, and zinc supplements are very rarely administered (0.7%)

Diarrhoea treatment practices for children under 5 years of age

% children <5 years of age with diarrhoea



- Children in rural areas are more likely than children in urban areas to be taken to a health facility or provider when they have diarrhoea (54% versus 42%)
- However, a greater proportion of diarrhoea cases among children in rural areas go untreated than among children in urban areas (21% versus 11%)
- Diarrhoea can interfere with the absorption of nutrients by the body, making one more vulnerable to undernutrition
- Zinc supplementation is essential because it helps decrease the number and duration of diarrhoeal episodes
- Almost no children receive zinc supplements for diarrhoea in Lesotho (0.7%)

The multiple causes of anaemia require a multidimensional response

Causes of anaemia

Iron deficiency

- Insufficient consumption of iron-rich foods
- Presence of iron inhibitors in the diet and insufficient spacing between consumption of these foods and iron sources

Parasitic Infections and malaria

- helminths and for schistosomiasis.

Multiple responses

Food diversification

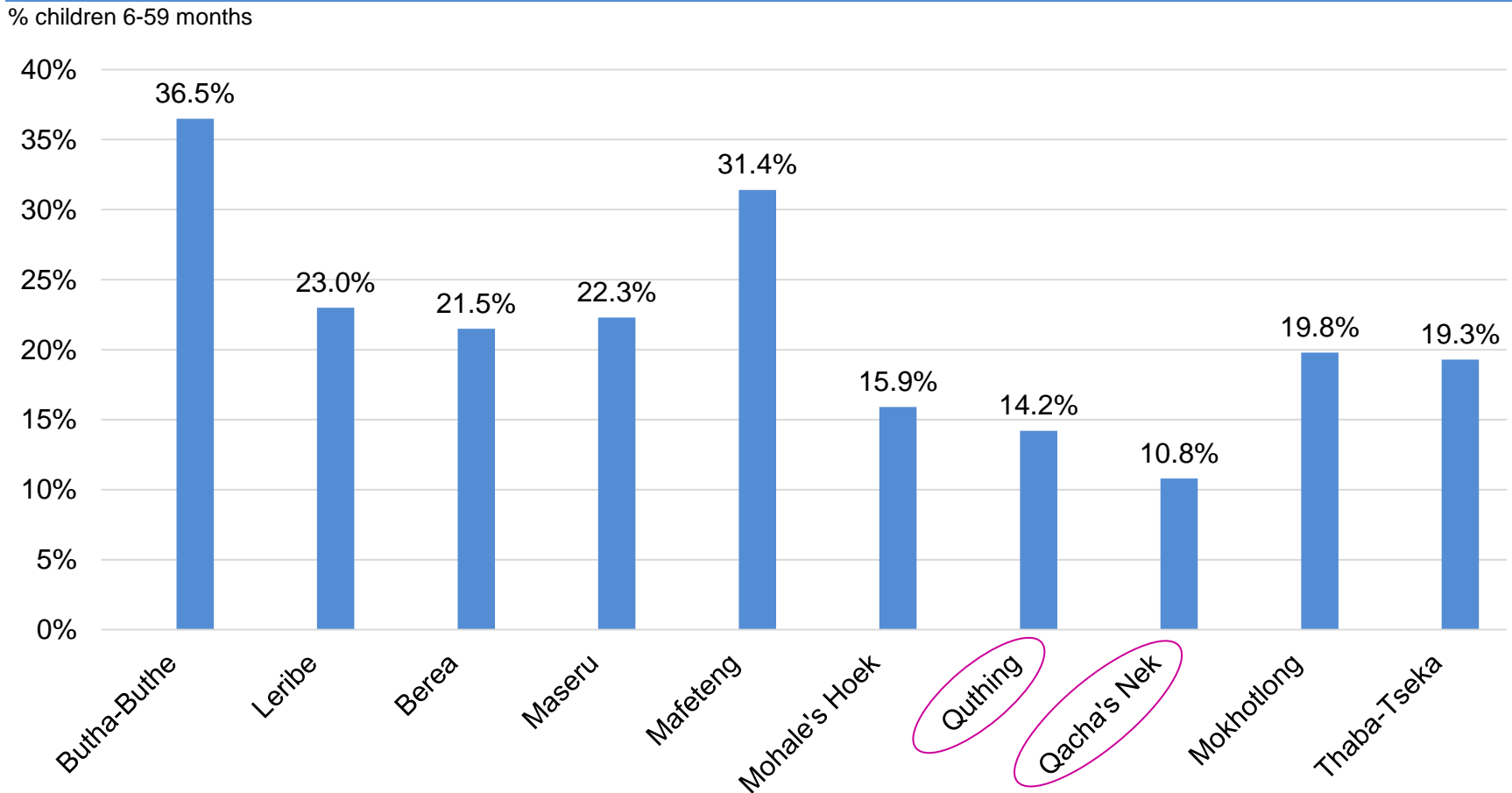
Iron supplementation

Deworming

Malaria prevention

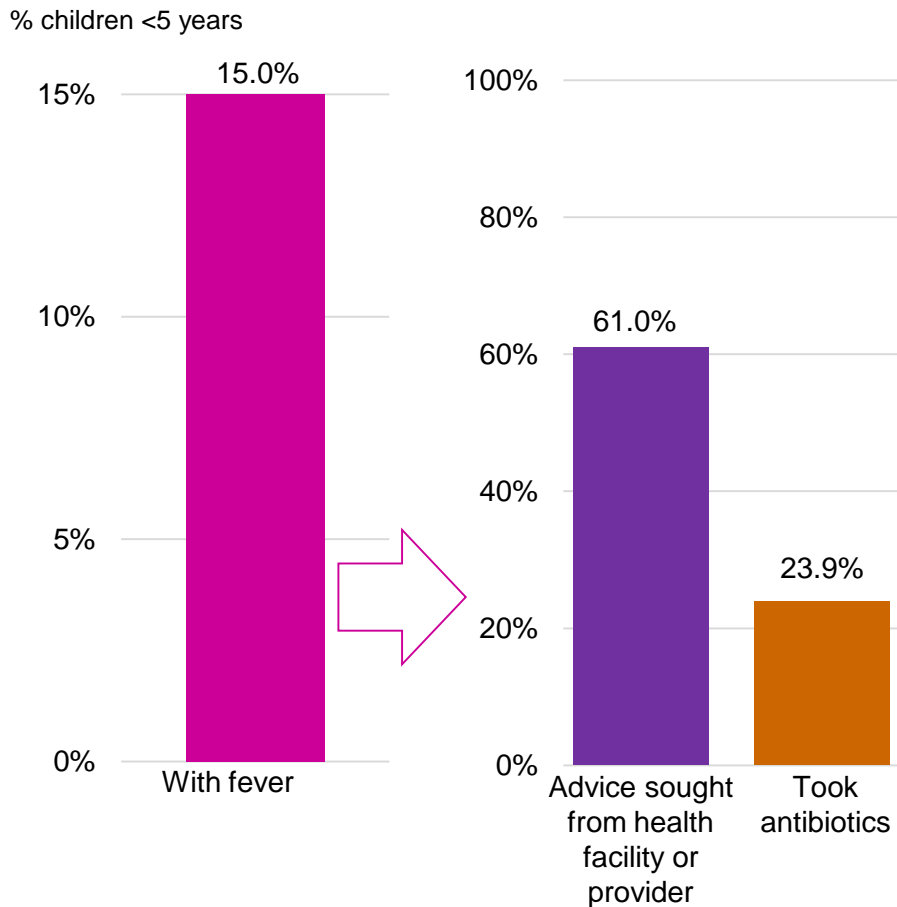
Deworming of children is one of the interventions to combat anaemia

On average, one in five children in Lesotho receive deworming medication, though rates are lower in the Quthing and Qacha's Nek districts



Approximately 3 out of 5 children under five years who have recently had a fever sought medical attention

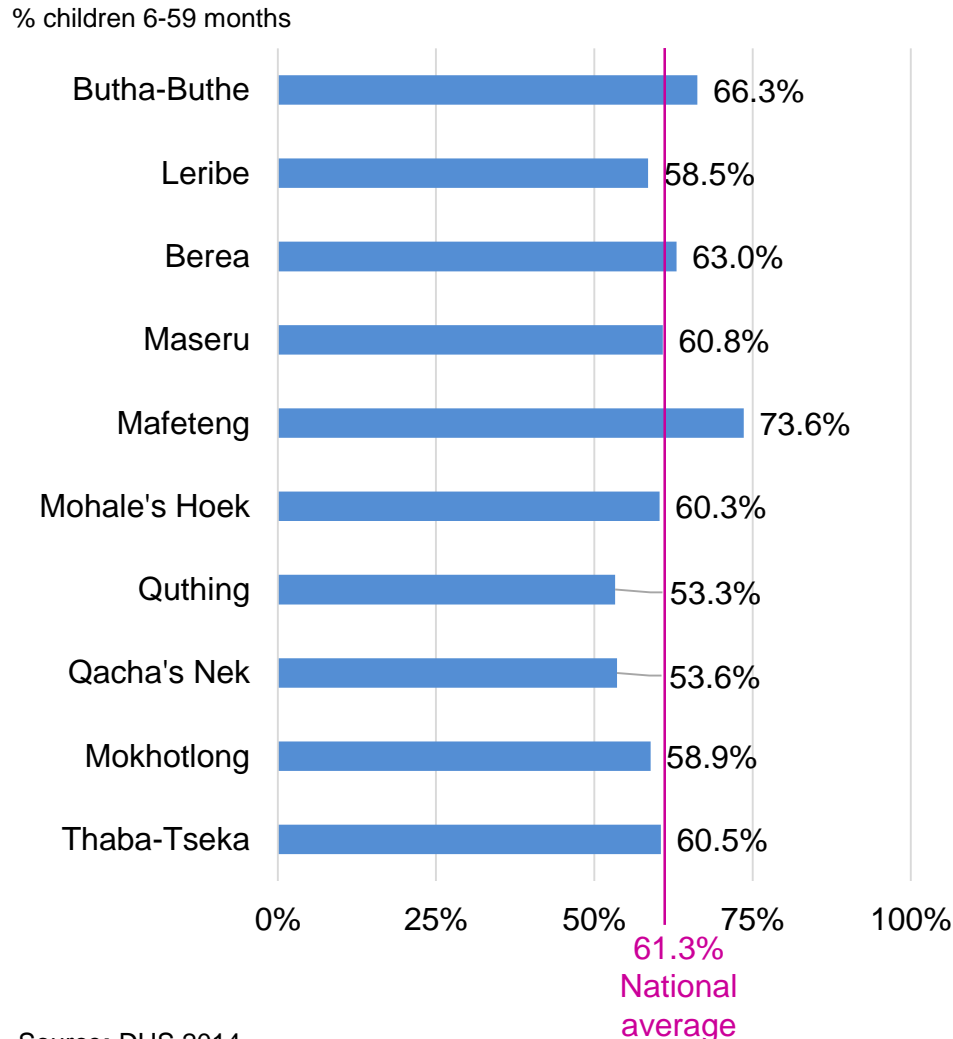
Most mothers with children under 5 years of age who have a fever seek medical advice



- Fever is a symptom of numerous illnesses including pneumonia, common cold and influenza
- Over half of the children under 5 years with a fever are taken to a health facility or healthcare provider for medical advice
- Approximately a quarter of children with a fever are given antibiotics

About two thirds of children receive vitamin A supplementation (61.3%), however there are some disparities between districts

Vitamin A supplementation for children 6-59 months

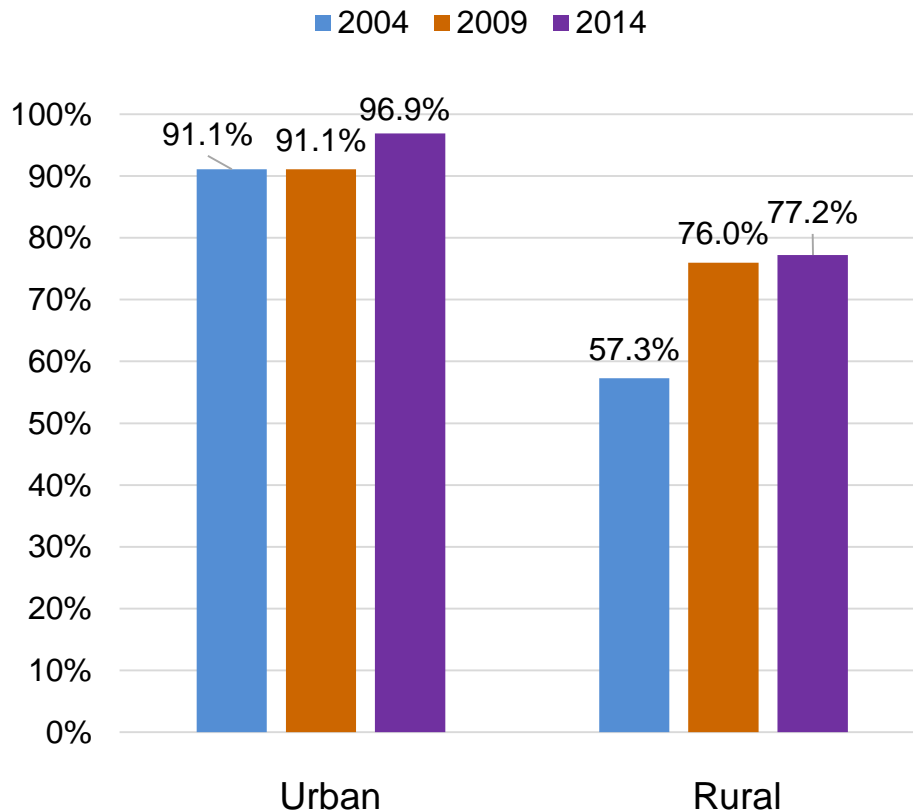


- Vitamin A deficiency affects the immune systems of children and pregnant & lactating women, as well as contributing to other health problems
- Supplements can help children, who do not have a balanced diet, receive the vitamins they need

Coverage of households using an improved water source has increased since 2004, but is still lacking in rural areas

The majority of urban households have access to improved water sources in 2014

% of households who have access to improved drinking water source

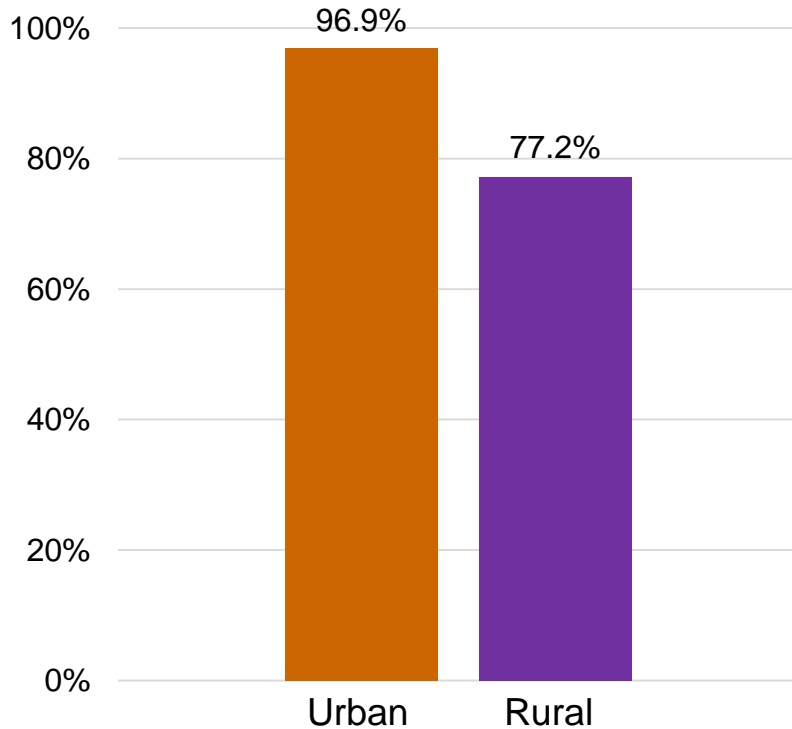


- Consumption of unclean water can lead to water-borne diseases and affect the body's ability to absorb nutrients
- The proportion of households with access to a source of drinking water in rural areas increased significantly between 2004 and 2014 (19.9 percentage points)
- In 2014, coverage of improved water sources was higher in urban areas than in rural areas (19.7 percentage points)

Almost a quarter of rural households do not have access to an improved water source, yet very few treat their water properly

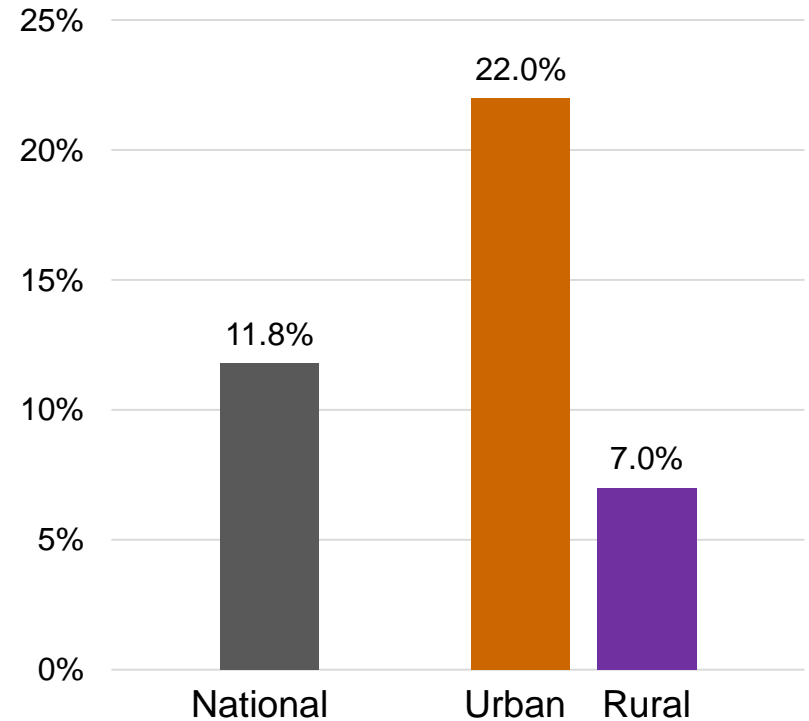
In 2014, the majority of urban households had access to improved water sources

% households using an improved drinking water source



The household treatment of water varies significantly between living environment

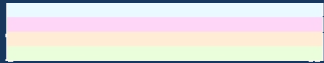
% households using an appropriate water treatment technique before drinking



Underlying factors:

Food Security and Livelihoods

Figures, trends, causes



REACH

ACCELERATING THE SCALE-UP OF FOOD AND NUTRITION ACTIONS

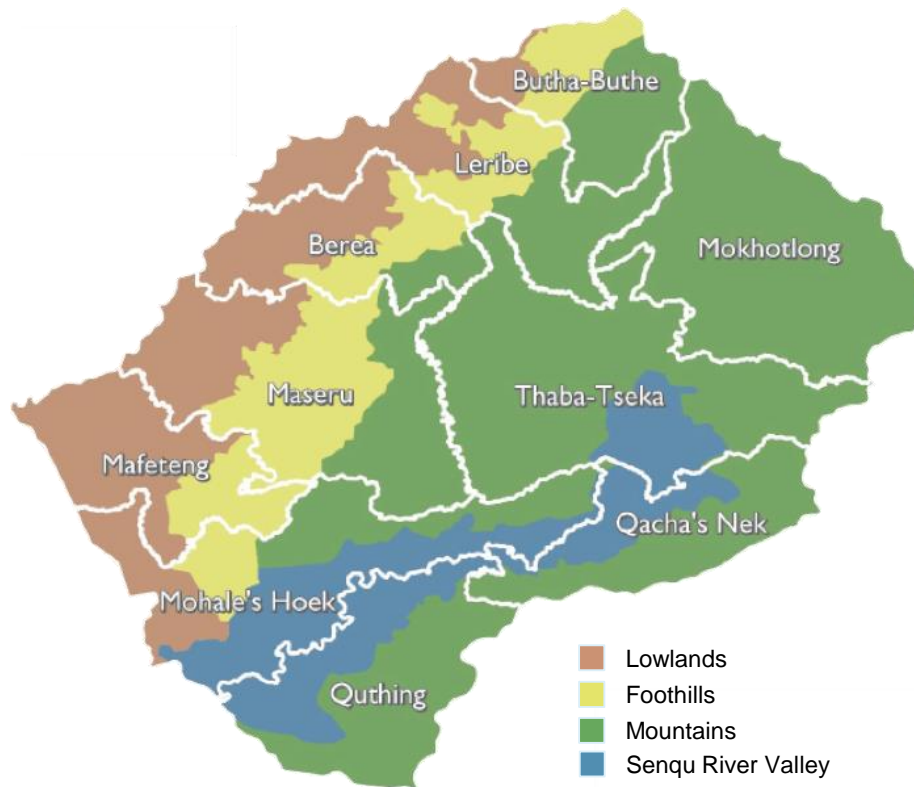


Key Messages

- The major occupations are unskilled labour (34.5%), service & sales jobs (20.9%), crafts & related trade workers (15.0%), followed by skilled agricultural, forestry and fishery occupations (11.7%)
- While only 10% of land is arable, the majority of farming households produce crops for household consumption
- Lesotho is vulnerable to the impact of climate change, with droughts the most likely to affect harvest yields
- Since 2013, there has been an increase in the population that is at risk of food insecurity
- Rural populations are the most vulnerable group in Lesotho; on average, half of the population faces food deficits
- In 2016, low agricultural production was reported across all districts and the cost of crops increased as a result of the low production, leading to approximately two thirds (63.6%) of the country being food insecure
- Households headed by those with high education have higher dietary diversity than households whose heads have no or low education
- Some very poor and poor households face food deficits in the presence of shocks, even when they have safety nets

Climatic changes affect farmers across Lesotho and all its agro-ecological zones

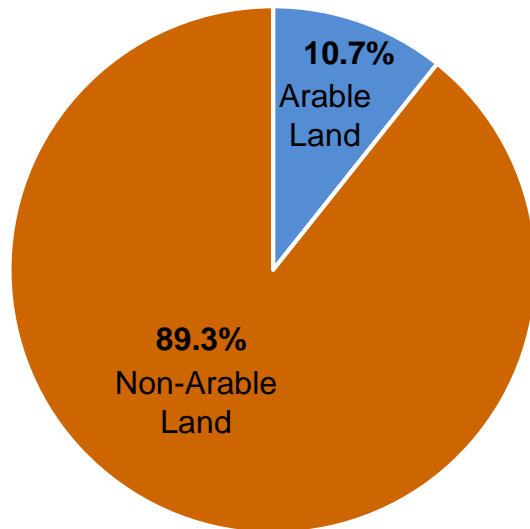
There are four main agro-ecological zones



- The lowland zone is the most densely populated area and is the most intensively cultivated zone with relatively high chances of rainfall
- The foothill zone, as compared to lowland is less populated and receives less rainfall
- The mountain zone is the largest zone in the country and is characterized by having very cold winters
- Senqu River Valley is the smallest zone, which runs from the east to the west across some districts

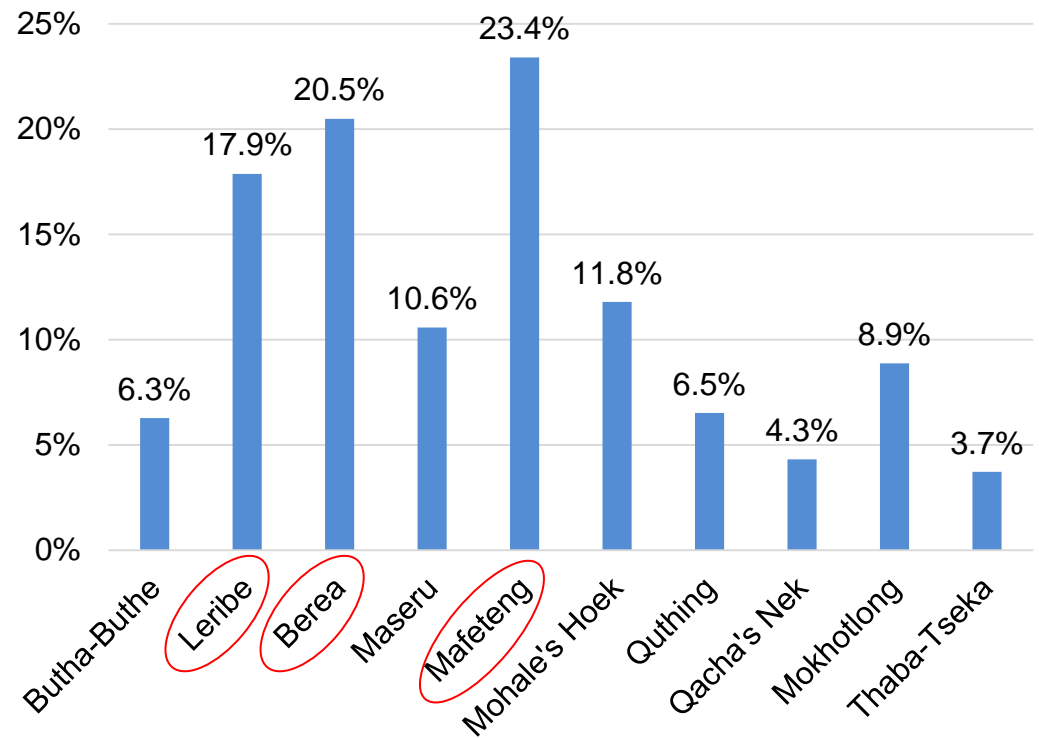
Only 10.7% of the land in Lesotho is arable – Mafeteng, Berea and Leribe districts have the highest percentage of arable land

Percentage of arable and non-arable land



The scarcity of arable land has led to over-cultivation and further degradation of the available land

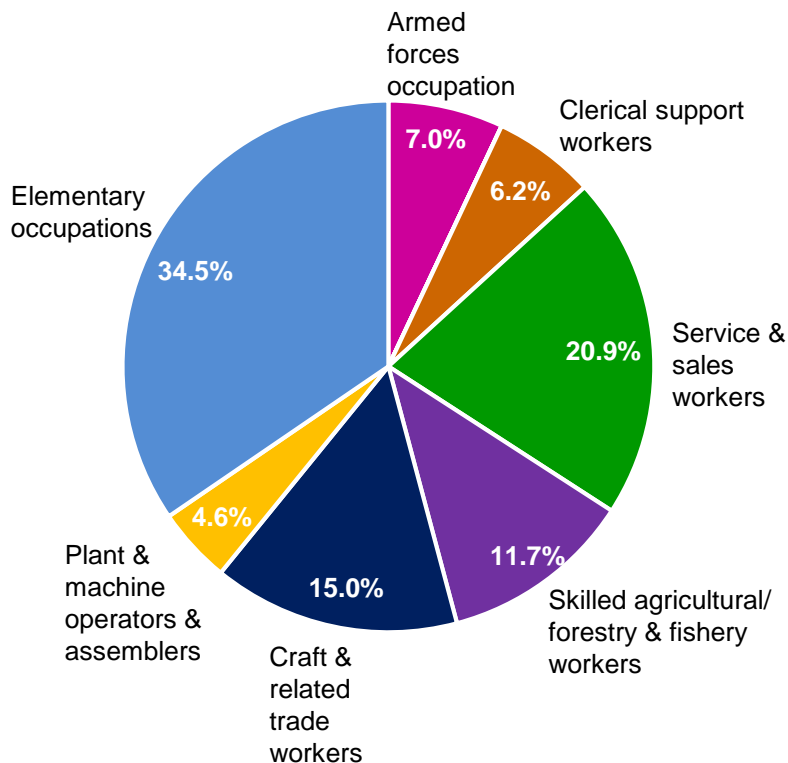
Percentage of arable land in each district



The major occupations are unskilled labour (34.5%), service & sales jobs (20.9%), crafts & related trade workers (15.0%), followed by skilled agricultural, forestry and fishery occupations (11.7%)

The percentage of household members per major occupations (of the employed population)

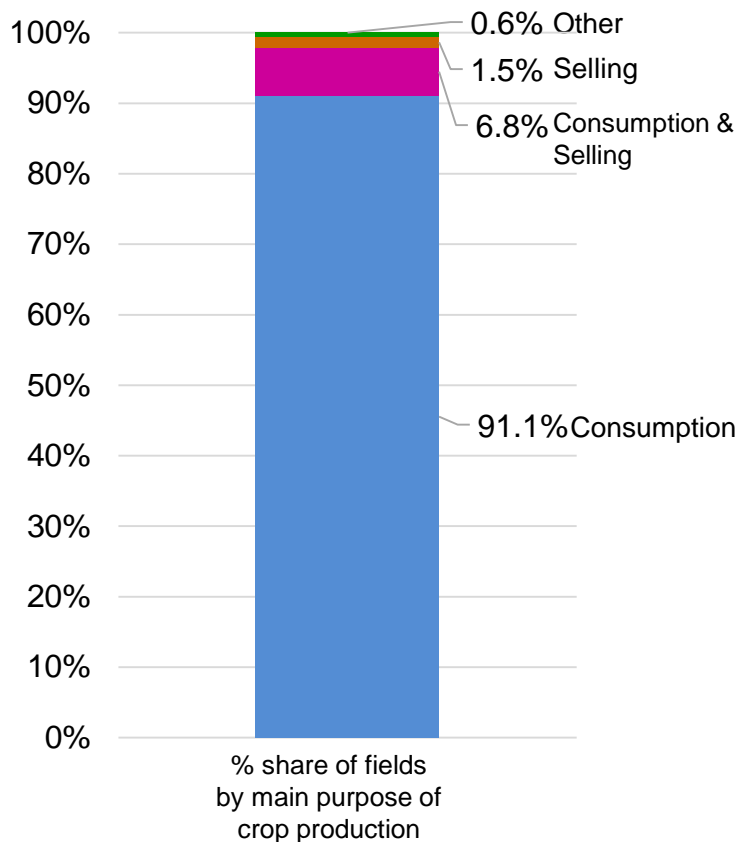
% of employed population



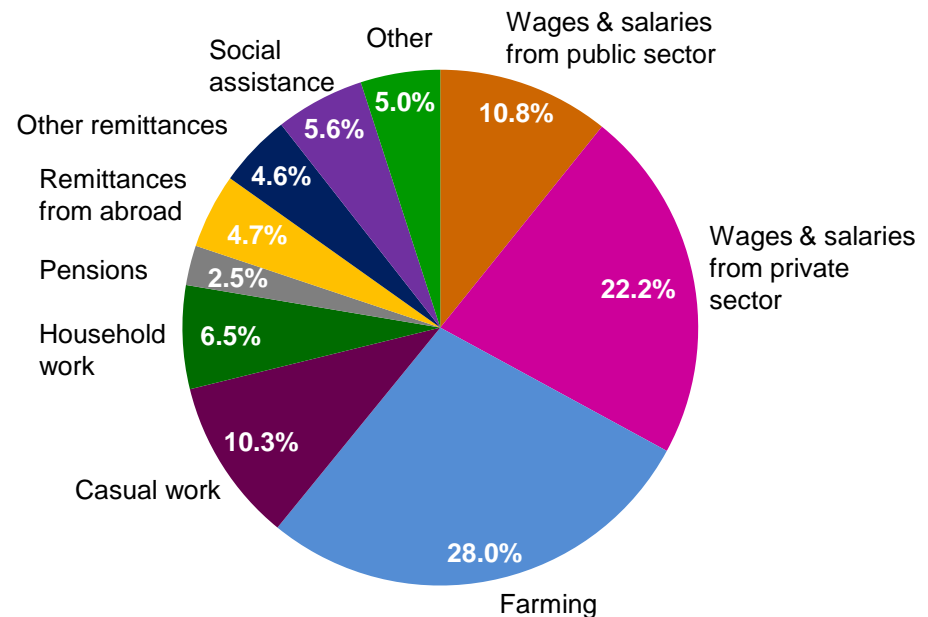
- On average, one third (34.5%) of household members hold unskilled labour occupations, which include unskilled labour in agricultural, forestry and fishery, mining, construction, cleaning, etc.
- Approximately one in ten (11.7%) household members are skilled labourers in the agricultural, forestry or fishery sector

With only 10% of arable land, the majority of farming households produce crops for household consumption

Main purpose of crop production



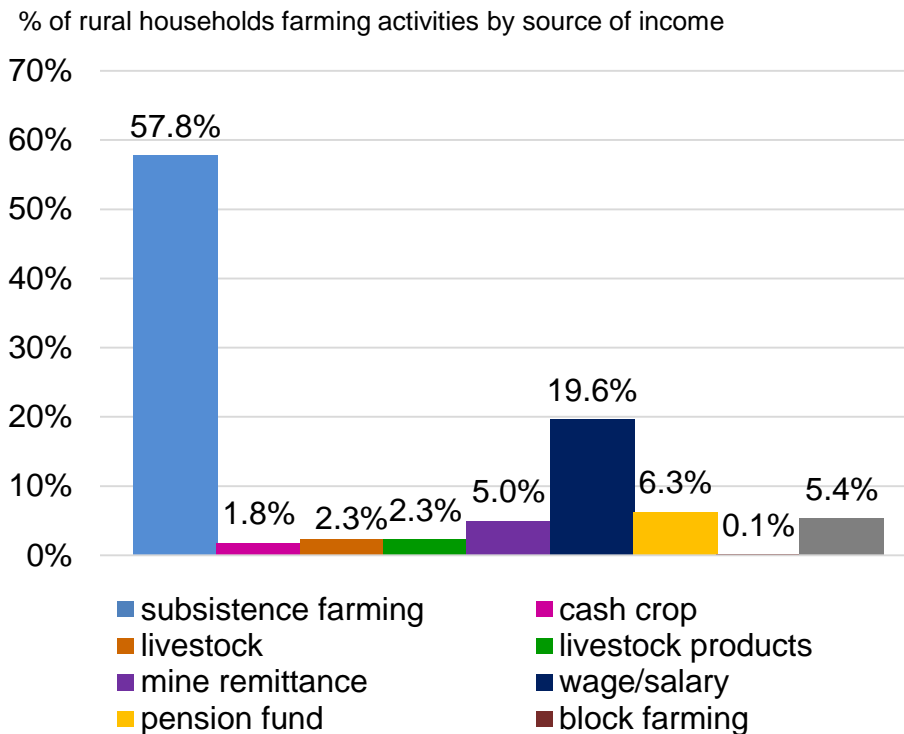
Distribution of households by main sources of income



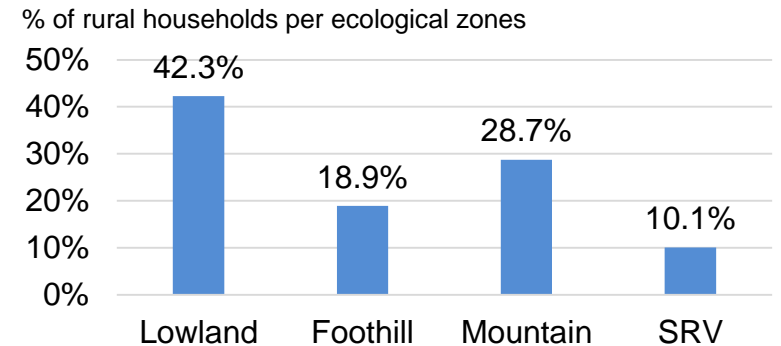
- Approximately one third of households (28.0%) depend primarily on farming for income

Subsistence farming accounts for the majority of the income for agricultural households

Percentage of rural agricultural households' farming activity by source of income (2009/2010)



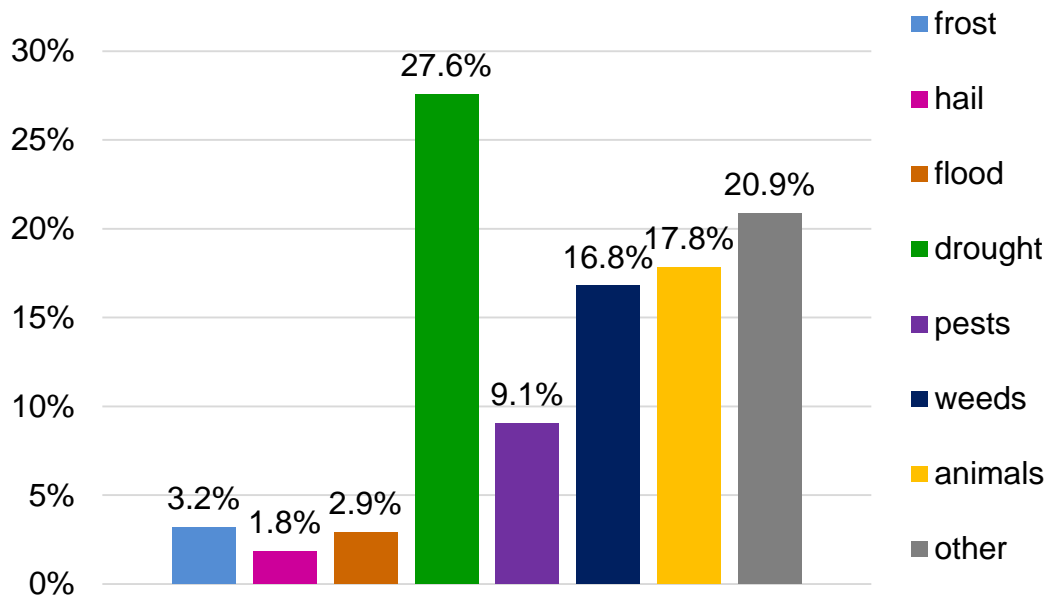
Percentage of rural households per zone



- 42.3% of rural household reside in the lowlands, of which 51.1% depend on subsistence farming and 2.6% on cash crops for income
- For rural households residing in the foothills, 68.5% depend on subsistence farming and 1.1% on cash crops
- For rural households residing in the mountains, 57.7% depend on subsistence farming and 6.1% on livestock
- For rural households residing in the SRV, 66.3% depend on subsistence farming and 1.7% on cash crops and livestock

Lesotho is vulnerable to the impact of climate change, with droughts the most likely to impact harvest yields

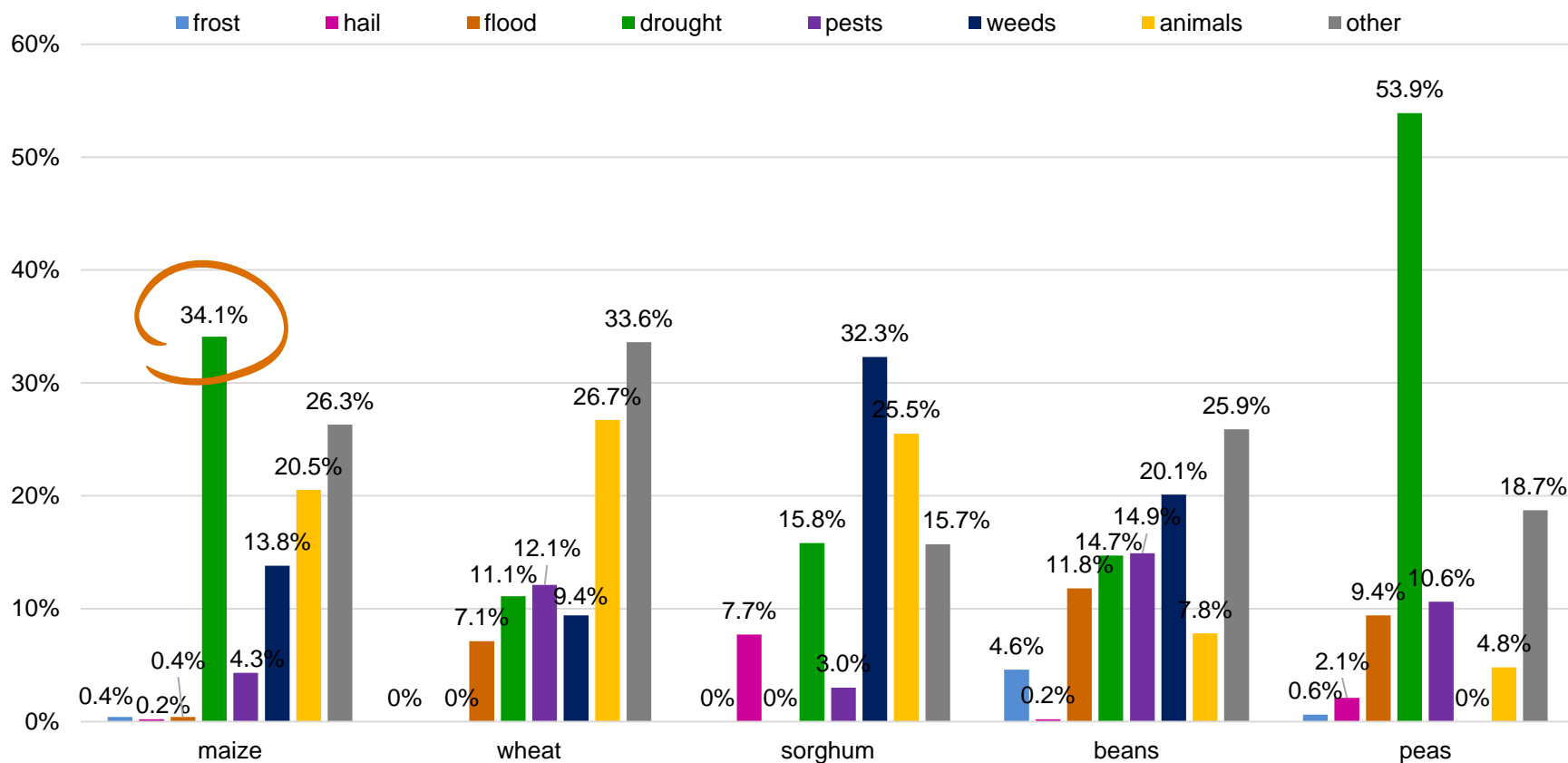
Drought accounts for over a quarter of total crop failure



- Of the estimated 324,767 hectares of cultivated land, 23,557 hectares failed in 2009-2010, which is approximately 7.3% of the land area
- In 2009-2010, a substantial amount of rain was recorded, the main reason for crop failure was drought due to late rains
- Drought affected 6,491 hectares, of which 2,223 hectares were in Mafeteng
- Berea was the most affected district (6,819 hectares of failed crop) where 29.1% were destroyed by animals and 23.3% failed due to weeds

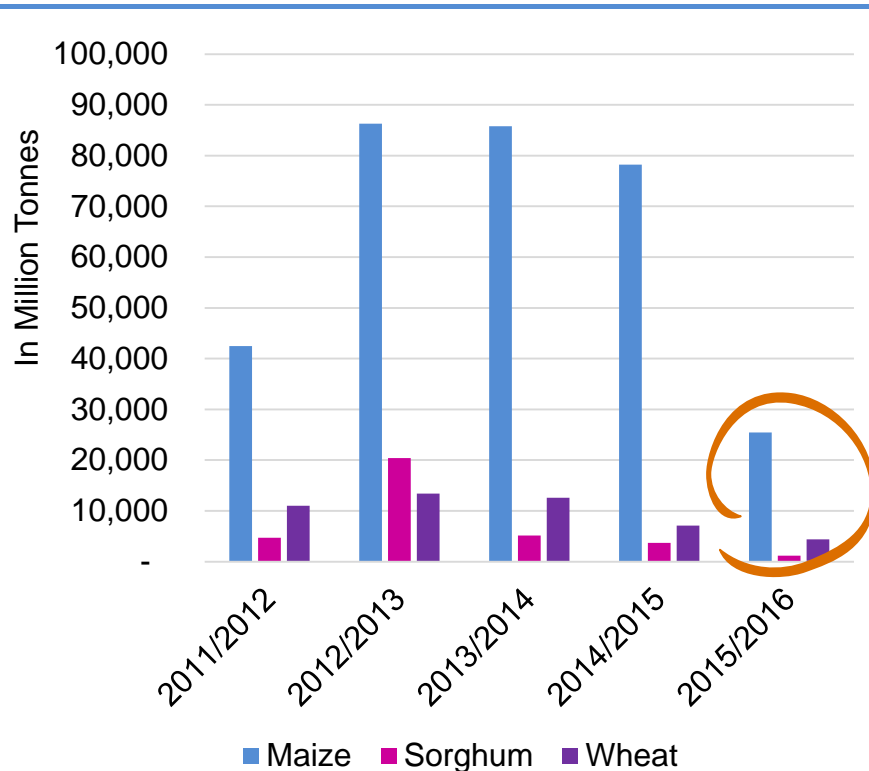
Among the reasons for crop failure in 2010, drought affected one third of all maize, the most prominent crop grown in Lesotho

Crop failure by crop and cause



In 2016, low agricultural production was again noted across all districts

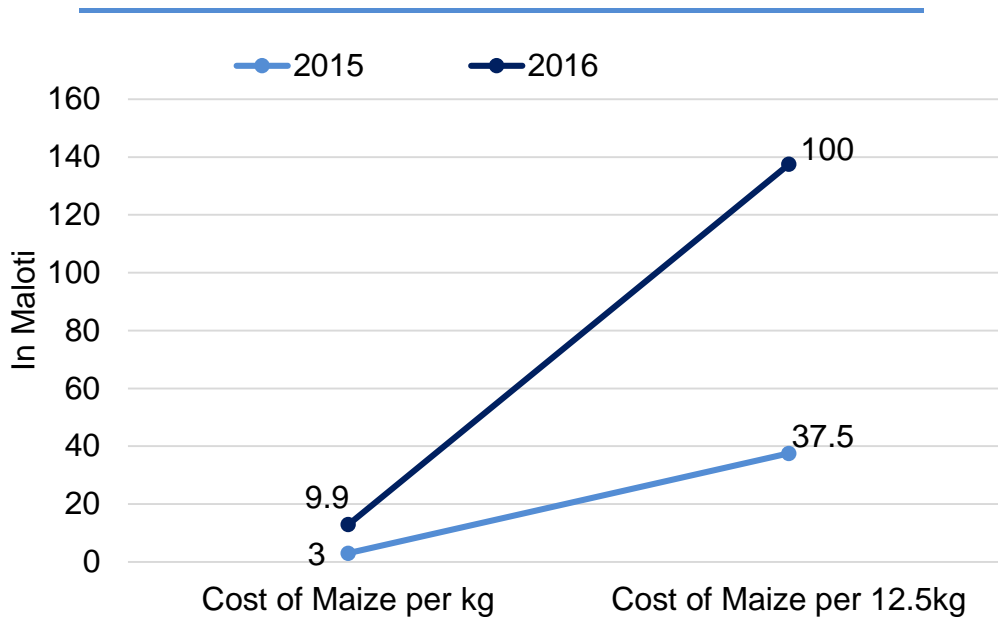
Crop production trends



- Lesotho experienced one of the strongest El Niño episodes in 35 years, which resulted in below average rainfall in the 2015/16 agriculture season and poor rainfall distribution across districts
- All districts faced low cereal production, with some having cereal production decrease by half
- Leribe recorded a decline of 78% in maize production, while Thaba-Tseka recorded the lowest decline of 21%
- In the face of low crop production, the majority of households had to access staple food through purchases rather than their own crop production

The cost of crops increased due to low production in 2016

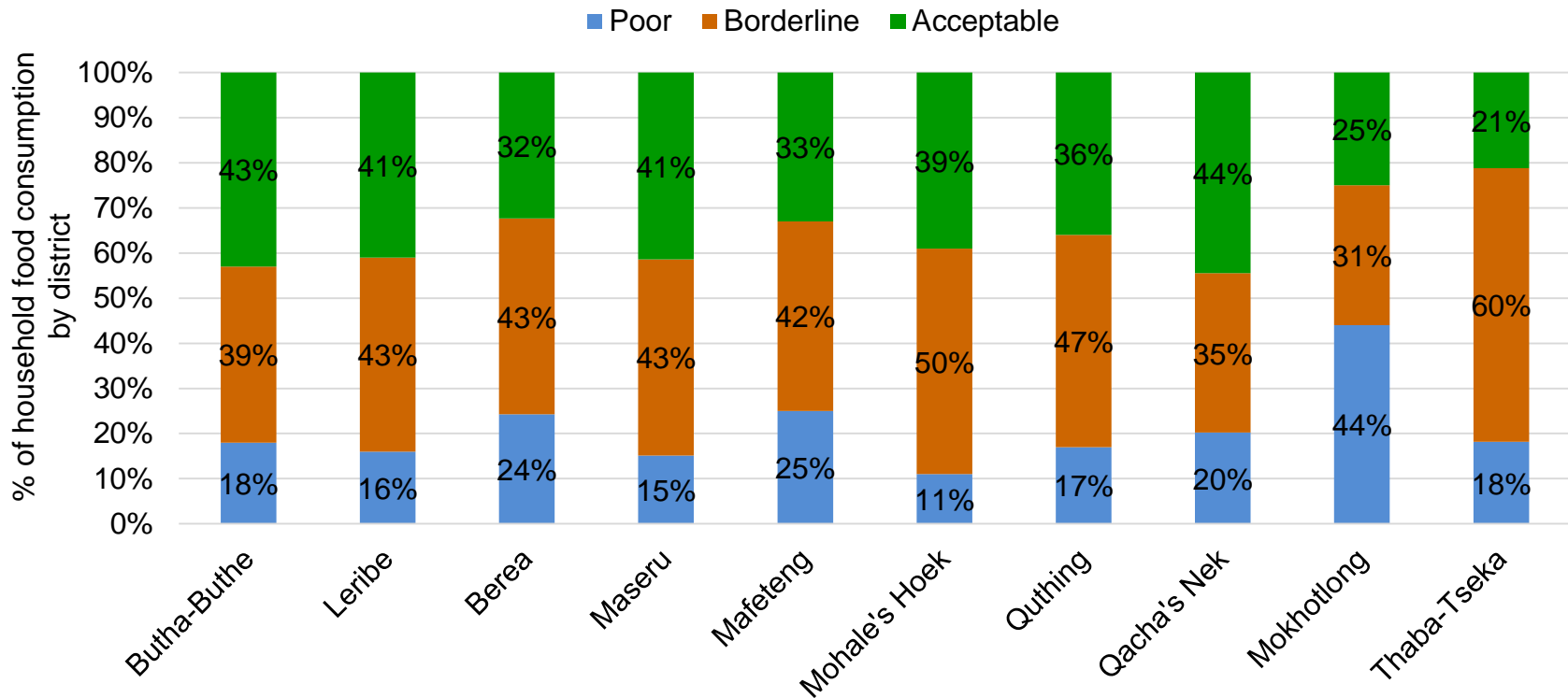
The cost of maize increased by 230% per kg between 2015 and 2016



- The 2016 cereal production was two thirds lower than the previous five-year average
- The decline in cereal production has contributed to increased prices and the need to import to ensure food availability

In 2016, approximately two thirds (63.6%) of the country remained food insecure (having borderline and poor food consumption)

Almost half of the population (44.6%) experienced borderline food consumption and a fifth (19%) experienced poor food consumption

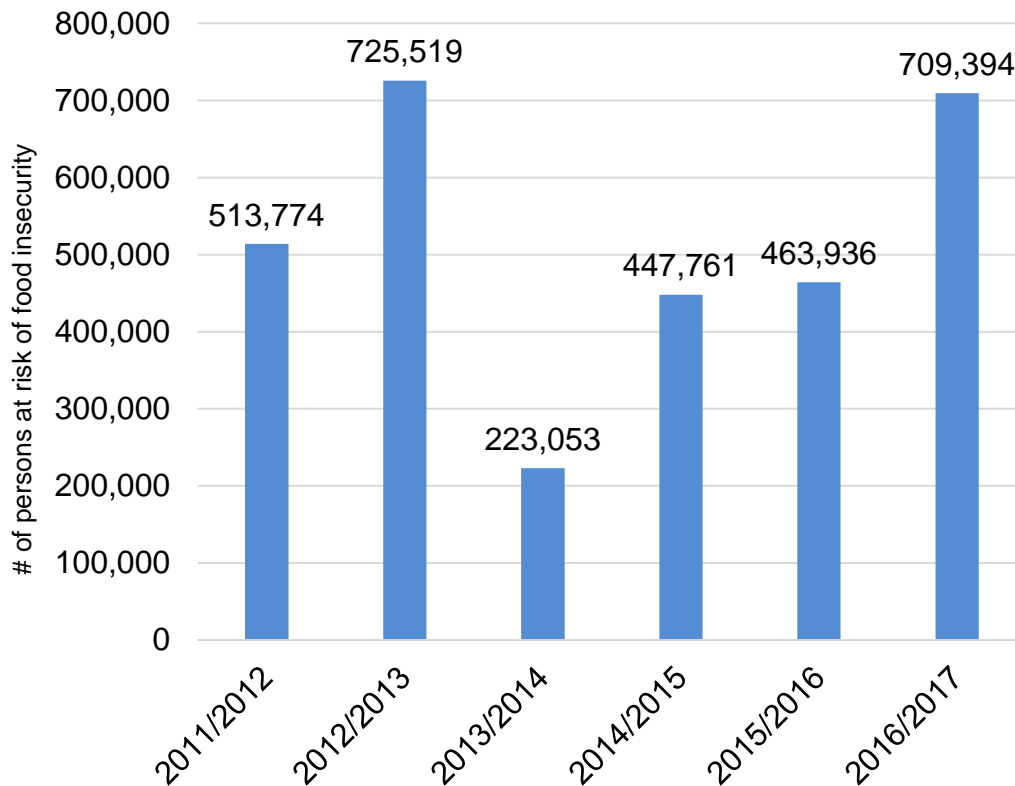


- At the national level, one third (36.4%) of households had acceptable food consumption
- Of the ten districts, Mokhotlong had the highest proportion of households with poor food consumption (44%), and Mohale's Hoek had the lowest proportion (11%)

Since 2013, there has been an increase in the population at risk of food insecurity

Estimated population at risk of food insecurity since 2011

of persons at risk of food insecurity by year

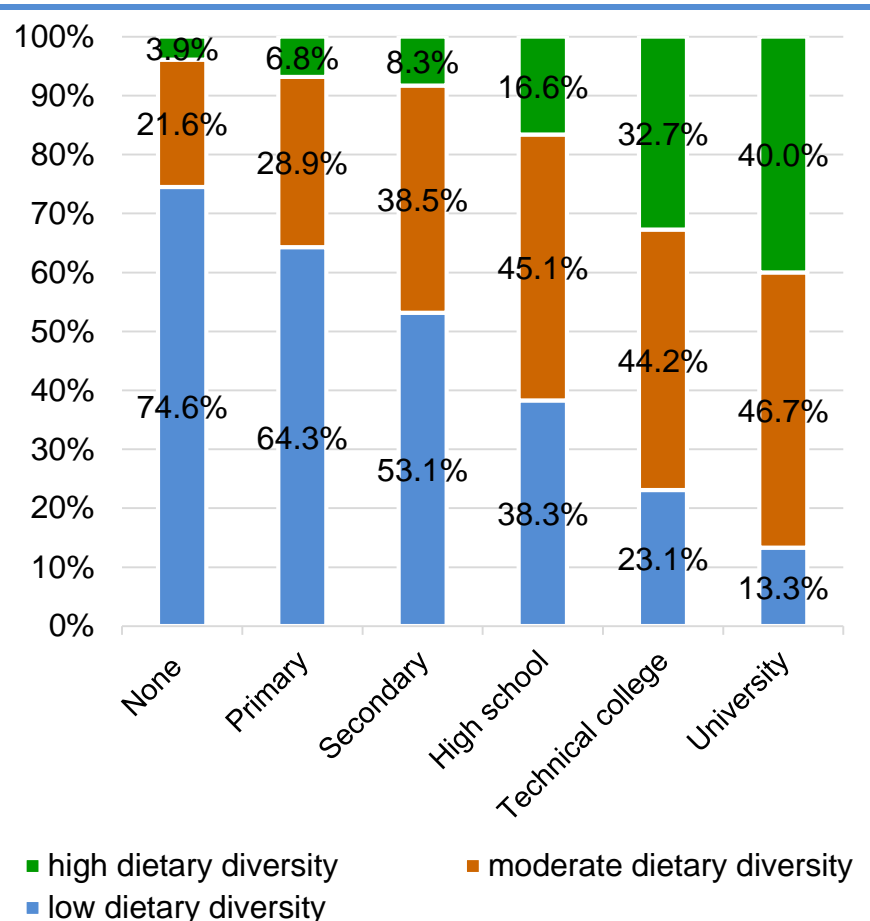


- Food insecurity is one of the leading causes of poverty in Lesotho
- The underlying roots are linked to low level agricultural productivity and crop failures
- Lesotho's agricultural activities are susceptible to climate change, particularly the effects of drought
- In 2016, Lesotho experienced one of the strongest El Niño episodes in years, resulting in very low rainfall during the agriculture season and poor distribution of rainfall. Its impacts were estimated to be more significant than the impacts of El Niño in 2012 and in 2006

Households headed by those with higher education are more likely to have a diverse diet

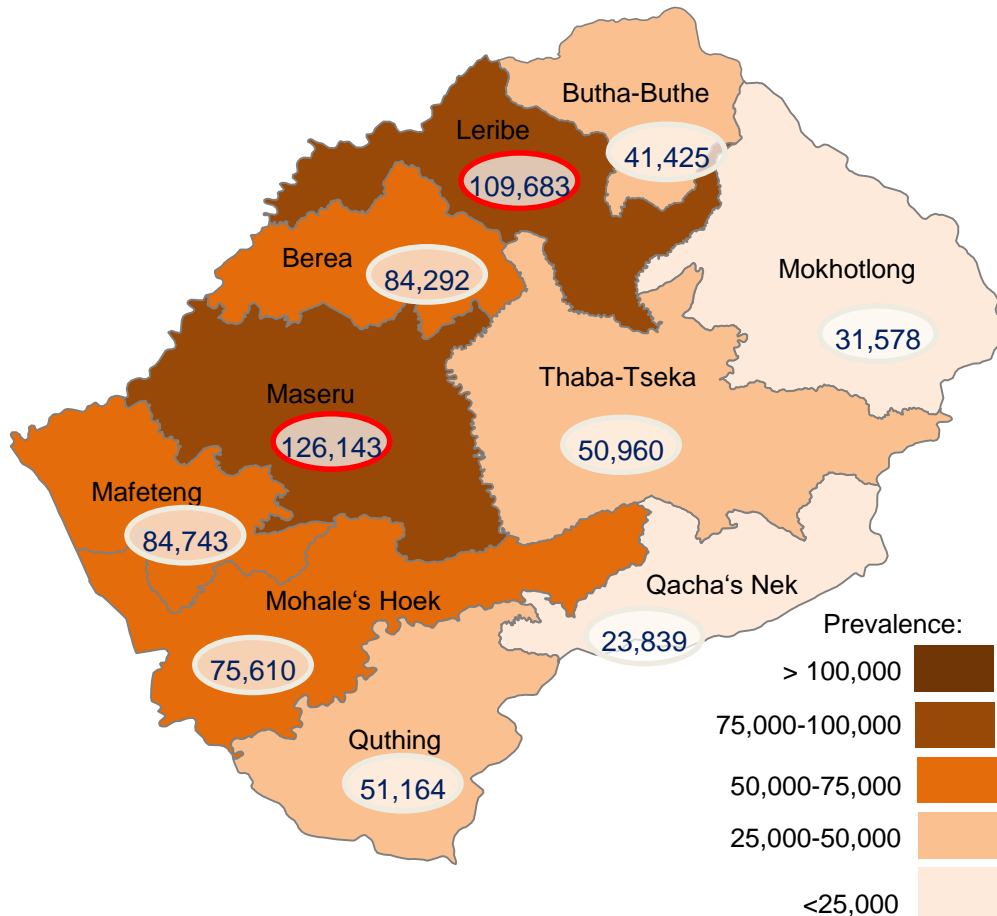
- In 2016, low dietary diversity impacted 61.8% of the rural population
- The very poor and poor households spent more than 50% of their income on food in 2016
- The level of education in a household influences the level of dietary diversity - the more educated the household, the higher dietary diversity
- The majority of households whose heads have no education have low dietary diversity (74.6%), compared to household whose heads have high school education (38.3%) and those with university education (13.3%)
- Few households whose heads have no education have high dietary diversity (3.9%), compared to those whose household heads have high school education (16.6%) and university education (40.0%)

Dietary diversity by education levels of household heads (2016)



However, even in the presence of safety nets, some of the very poor and poor households are in need of immediate assistance in the face of recent production deficits

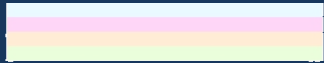
After factoring in existing safety nets, the absolute number of livelihoods protection deficits are highest in Maseru and Leribe



- The lack of safety nets in 2016/2017 resulted in a total of 709,394 people being food insecure
- On average, 22.1% of the population has a survival deficit, needing immediate assistance

Fundamental Causes

Figures, trends, causes



REACH

ACCELERATING THE SCALE-UP OF FOOD AND NUTRITION ACTIONS



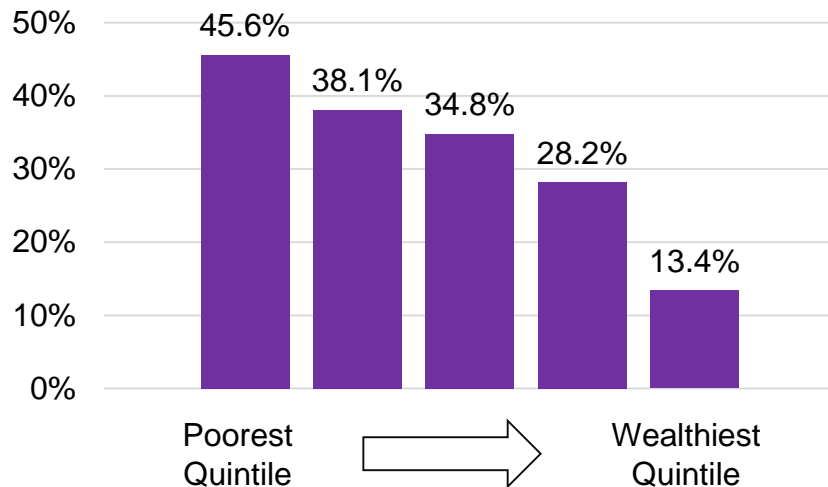
Key Messages

- Household poverty is a determining factor in the nutritional status of the child
- In 2014, Lesotho had the highest global incidence of TB and three quarters (74.0%) of TB cases were also HIV positive, both contributing factors to the burden of malnutrition
- Among children under age 18, more than one-quarter are orphans and over one-third do not live with either parent
- A mother's level of education is correlated with of her child's nutritional status
- The rate of stunting is more than 2 times higher among children whose mothers have only attained primary education compared to children whose mothers have attained higher levels of education
- Though decision making about health care is conducted primarily by women or jointly between partners, wife-beating remains prevalent and an indicator of gender inequality
- Four in ten women (41.8%) in Lesotho reported at least one problem in accessing health care for themselves
- A higher level of education delays the age at which a woman will give birth to her first child
- The adolescent fertility rate has not varied significantly since 2004; about one fifth of women 15-19 years have had a child and over a third of women have begun childbearing by age 19
- Though the fertility rate has not changed much over time, the fertility rate does vary significantly between wealth quintiles and living situations

Household poverty is a determining factor in the nutritional status of the child

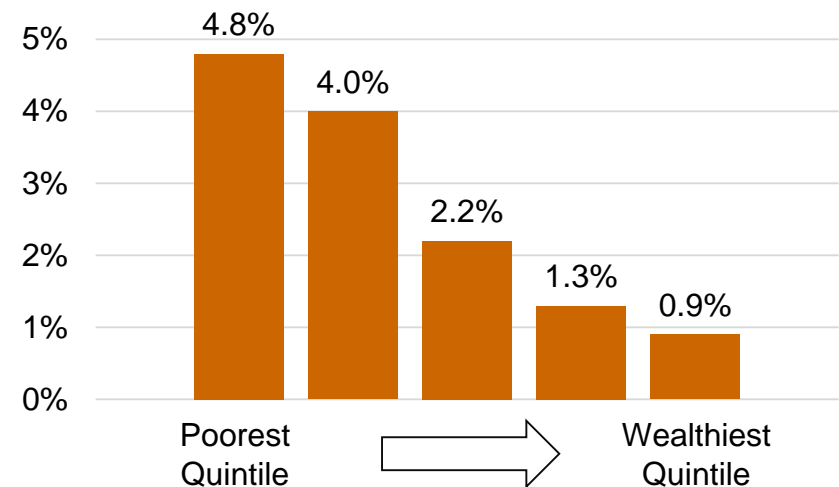
Chronic malnutrition is less common in wealthier households

% children <5 years



Acute malnutrition is less common in wealthier households

% children <5 years

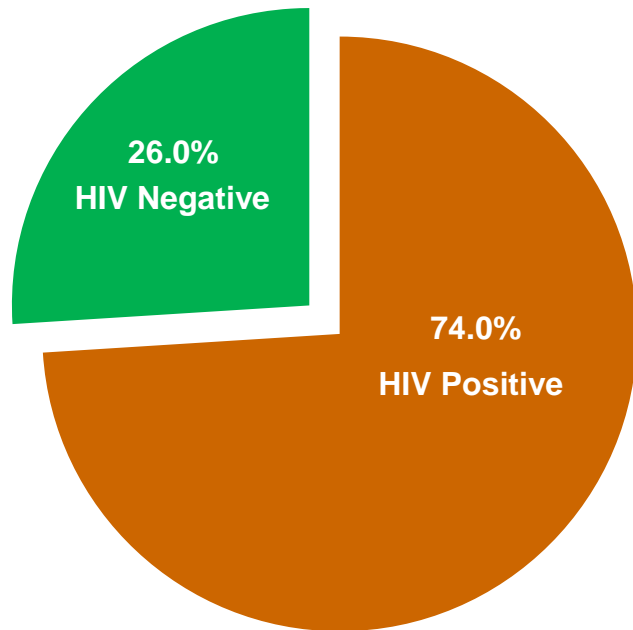


- There is a correlation between wealth and malnutrition: on average, children in households with higher income are less likely to be stunted or wasted
- However, child malnutrition is present even in the richest households and addressing poverty is therefore not sufficient to eliminate undernutrition

In 2014, Lesotho had the highest global incidence of TB and three quarters (74.0%) of TB cases were also HIV positive, both contributing factors to the burden of malnutrition

Percentage of TB cases estimated to be HIV-positive

% TB cases



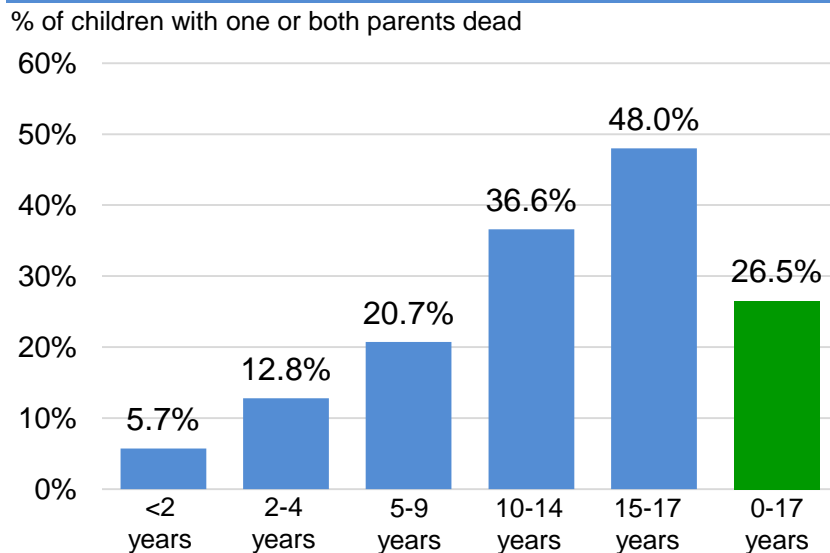
- Tuberculosis (TB) is one of the top ten causes of morbidity and mortality in Lesotho
- Those who are malnourished and food insecure are more prone to TB infection, and conversely, TB is an underlying cause of wasting: those living with TB have less appetite and their bodies cannot absorb as many nutrients

TB=Tuberculosis

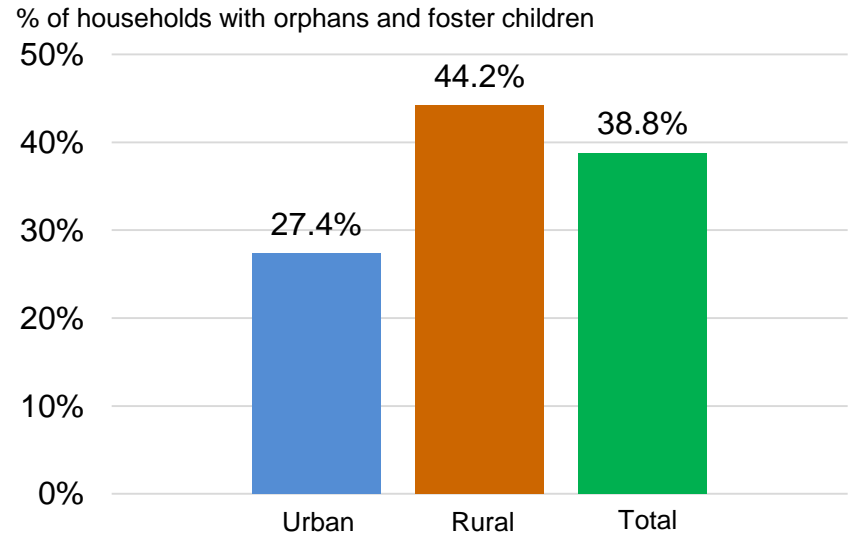
Source: Lesotho Ministry of Health. 2015. Country AIDS Progress Report; Gupta et al. 2009. Tuberculosis and Nutrition; WFP: Tuberculosis and Nutrition, accessible at <https://www.wfp.org/hiv-aids/tuberculosis-nutrition>

Among children under age 18, more than one-quarter (26.5%) are orphans

Percentage of children under 18 with one or both parents deceased (2014)



Percentage of households with orphans and foster children* under 18 (2014)



- The proportion of orphaned children increases rapidly with age group
- Of the total orphan population in Lesotho, an estimated 51.4% of them are as a result of AIDS
- There is a higher percentage of households in rural areas with orphans and foster children than households in urban areas
- Four out of ten households (38.8%) have orphans and foster children under 18 years

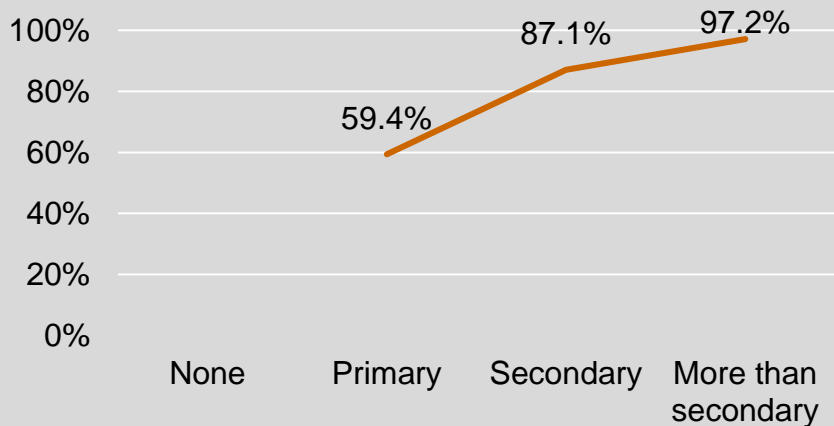
*Note: Foster children are those under age 18 living in households with neither their mother nor their father present. Orphans include both children categorized as single or double orphans. Single orphans includes children with one dead parent and an unknown survival status of the other parent. Double orphans are children that have lost both parents.

Source: DHS 2014; USAID 2016 Report: Enhancing Care for Orphans and Vulnerable Children in Lesotho

The mother's level of education is a factor that affects many aspects of her health and nutrition, including that of her child

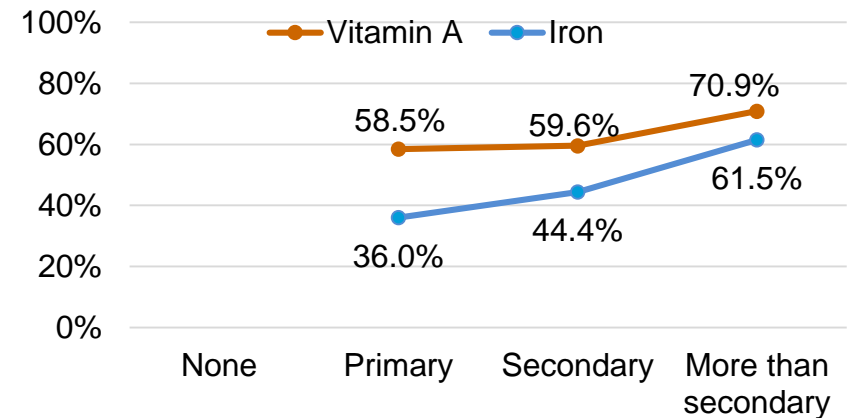
Births attended by a skilled provider increase with the mother's education level

% of births attended by skilled provider



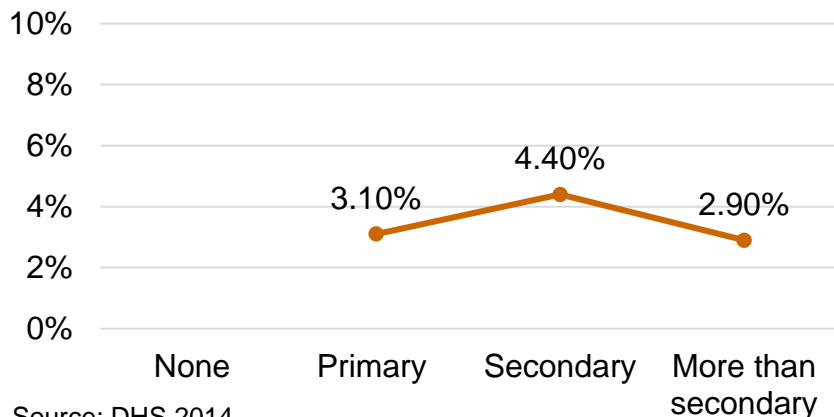
Children's consumption of vitamin A and iron-rich foods increases with mother's education level

% of 6-23 month olds having received micronutrient rich foods



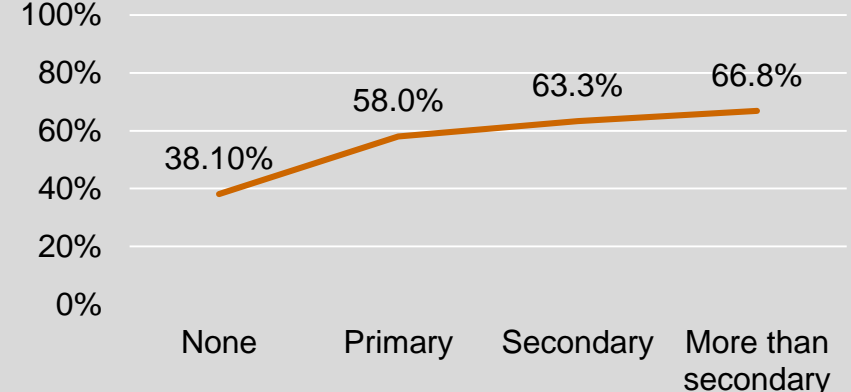
Thinness in women (low BMI) is not correlated with the mother's education level

% of women with low BMI



Contraceptive use increases significantly with mother's educational attainment

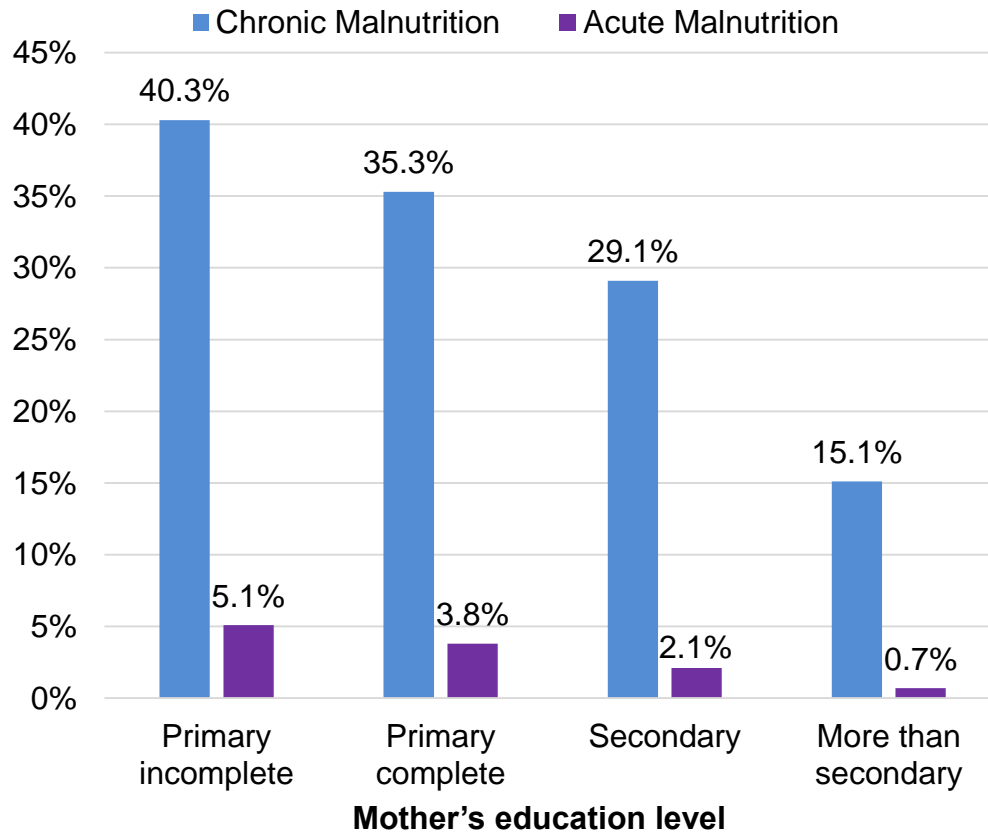
% of married women age 15-49 who use contraceptive method



A mother's level of education is correlated with of her child's nutritional status

Mothers with higher educational completion have children with better nutritional status

% children <5 years

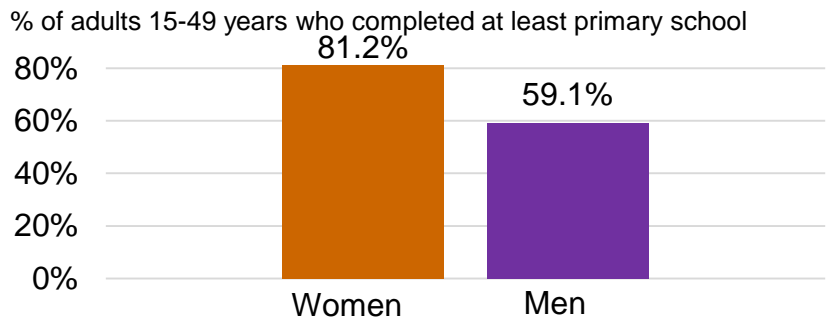


- The rate of stunting is more than 2 times higher among children whose mothers have only attained primary education compared to children whose mothers have attained higher levels of education

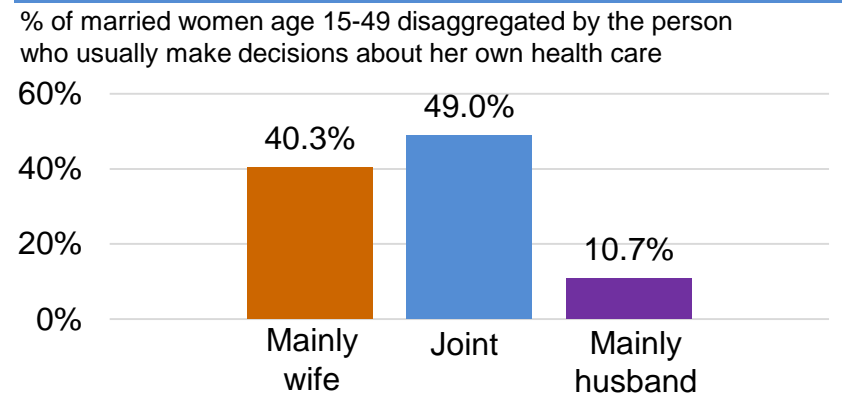
Though decision making about health care is conducted primarily by women or jointly between partners, wife-beating remains prevalent and an indicator of gender inequality

Lesotho was ranked 38th out of 144 countries on the Global Gender Gap Index in 2014 and has dropped to 57th in 2016, indicating a deterioration of gender equality

Women are more likely to complete at least primary school than men

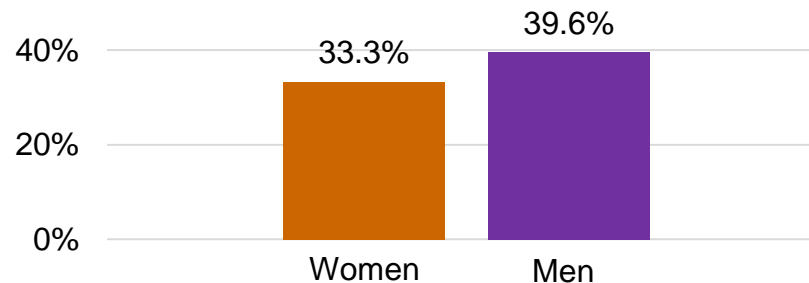


Most women make independent or joint decisions about their own health care



One third of adults agree that wife beating is justified in certain instances

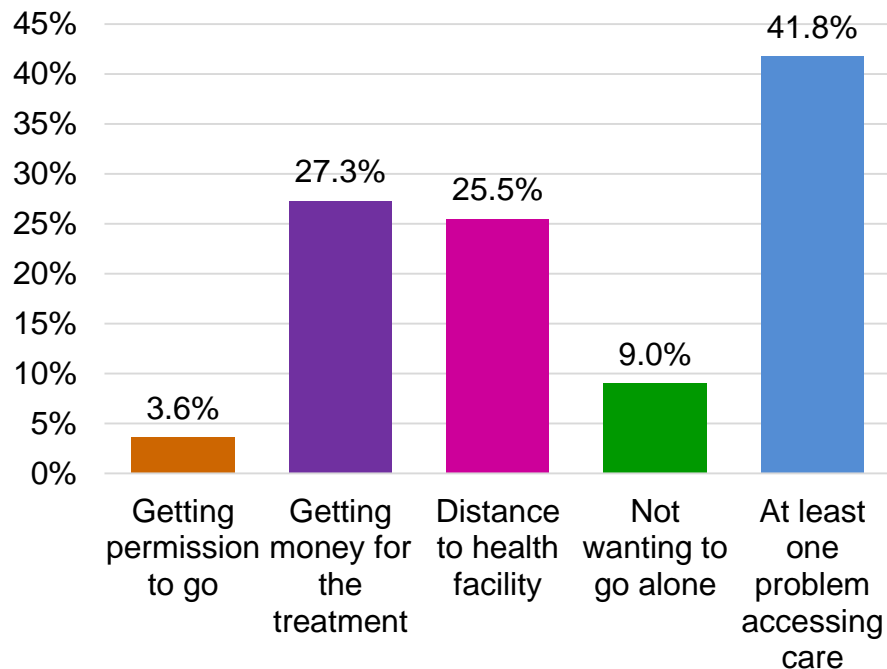
% of 15-49 year olds who agree that a husband is justified in hitting or beating his wife for specific reasons



Four in ten women (41.8%) in Lesotho reported at least one problem in accessing health care for themselves

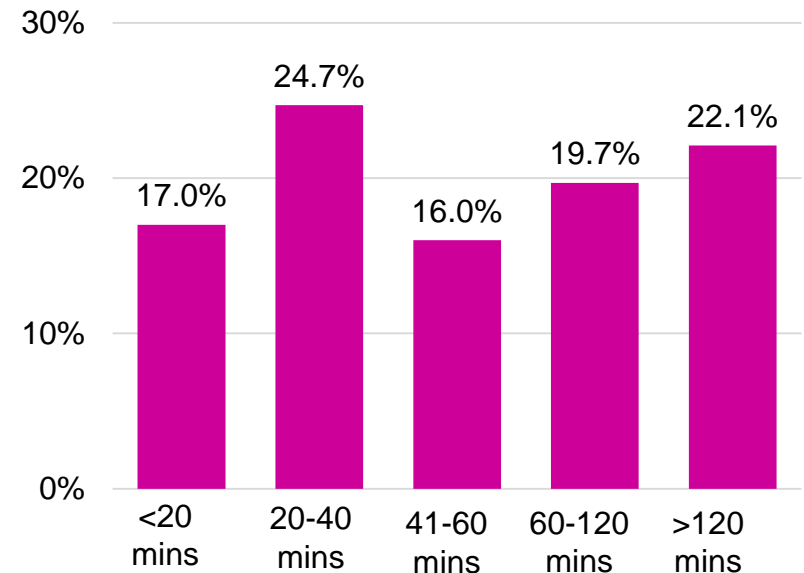
Women are most likely to have problems getting money for treatment or getting to a health facility

% of women 15-49 year who reported that they have serious problems in accessing health care



On average, households are likely to spend more than 20 minutes traveling to a health facility

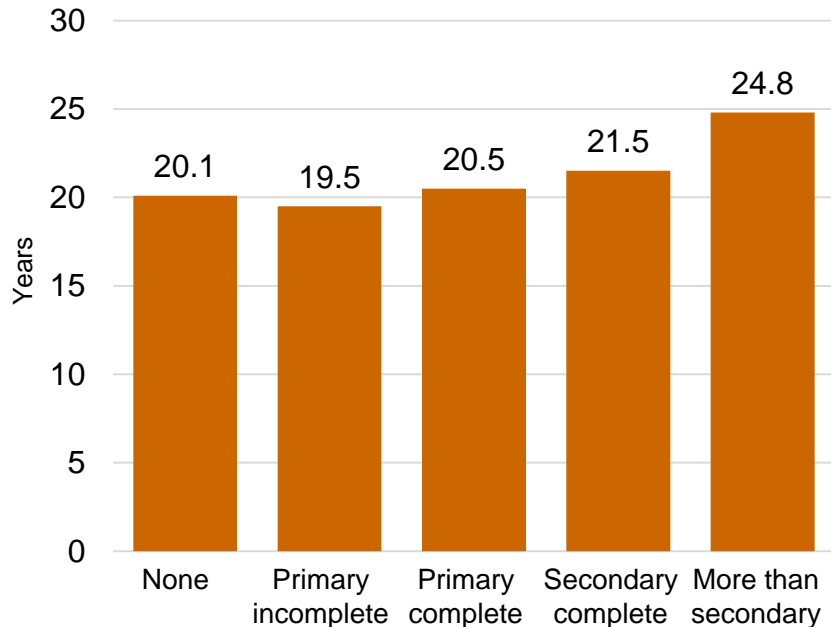
% of households by transportation time to nearest health facility



A higher level of education delays the age at which a woman will give birth to her first child

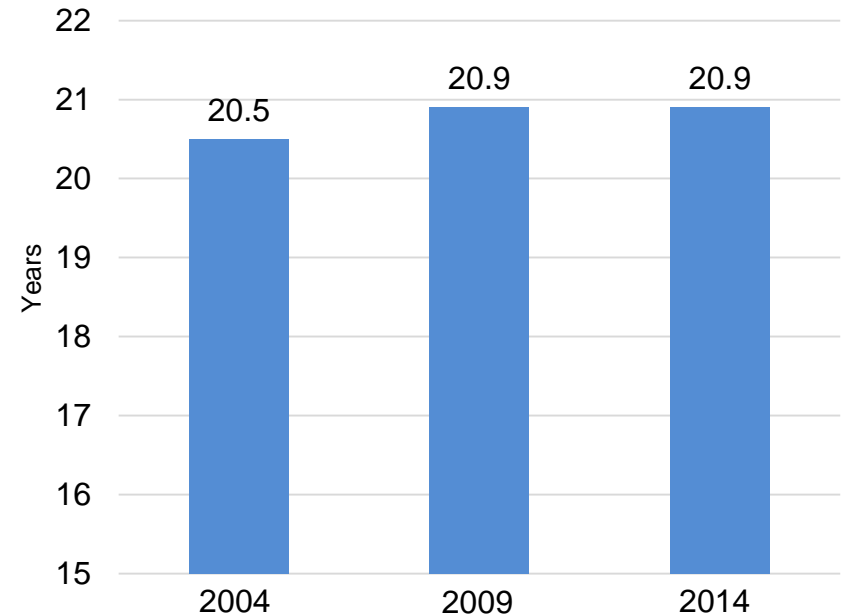
The median age at which a women gives birth to her first child increases as she completes higher levels of education

Median age at first birth among women age 25-49 by education level



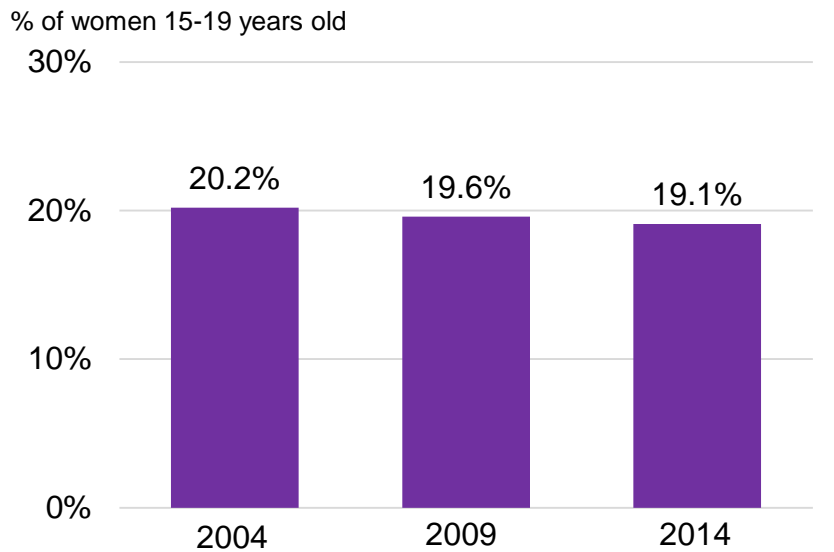
The median age which a women gives birth to her first child has not changed significantly since 2004

Median age at first birth among women age 25-49

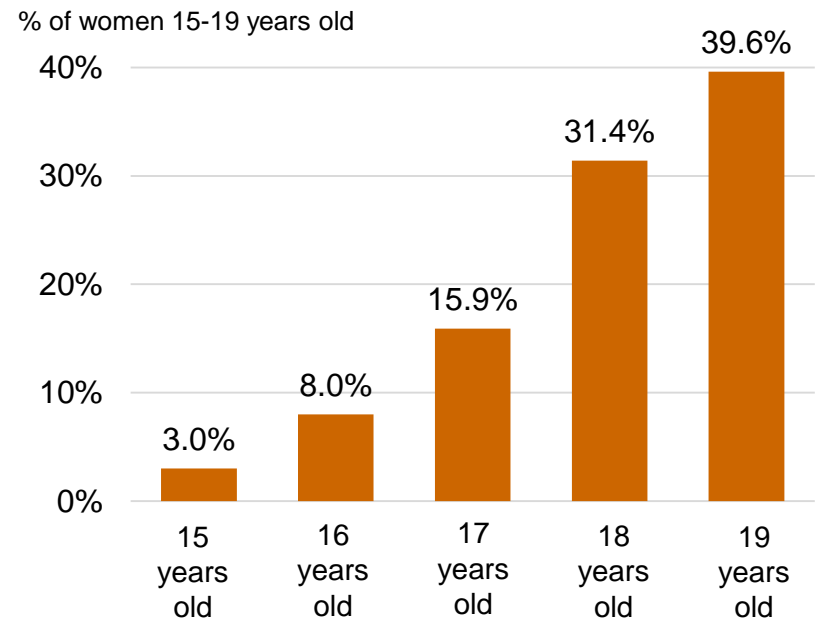


The adolescent fertility rate has not varied significantly since 2004

About one fifth of women 15-19 years have had a child



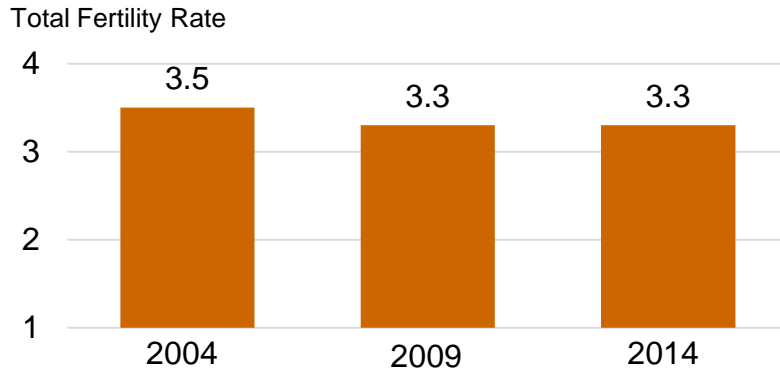
Over a third of women have begun childbearing by age 19



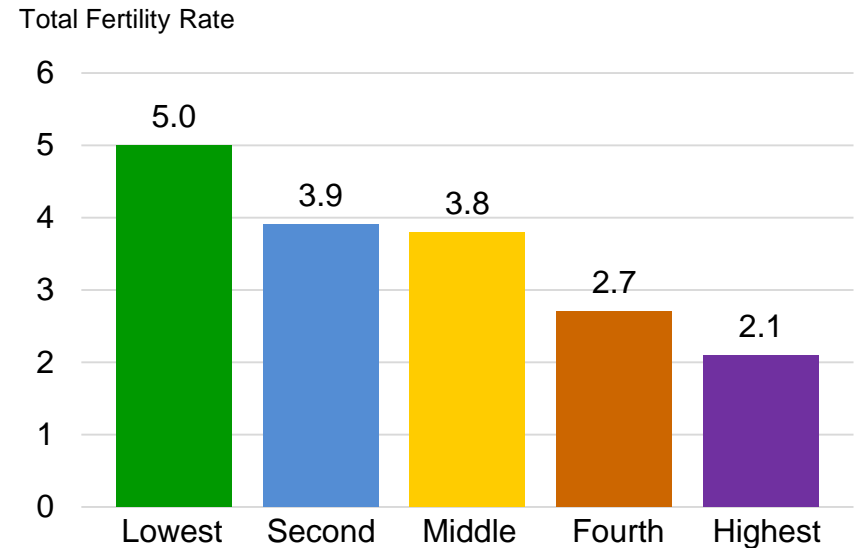
Adolescent girls who give birth before completing their own growth are at risk of complications at the time of childbirth and their children are more likely to suffer from chronic malnutrition

The total fertility rate has not changed much over time, although this rate does vary significantly between wealth quintiles and settings

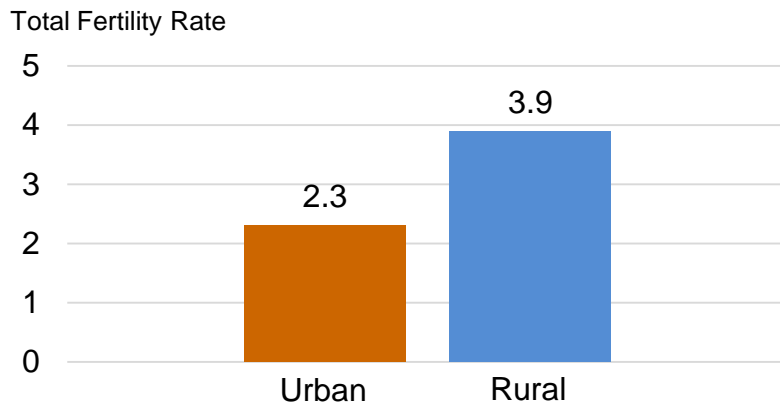
The total fertility rate has only slightly decreased since 2004



Households in higher wealth quintiles have lower total fertility rates

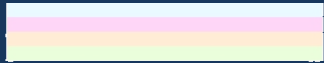


The total fertility rate is higher in rural areas than in urban areas



Situation Analysis Dashboard

National Level



REACH

ACCELERATING THE SCALE-UP OF FOOD AND NUTRITION ACTIONS



Situation Analysis Dashboard

National level

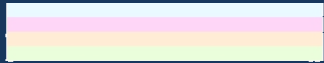
- Not currently a serious problem
- Requiring action
- Serious problem requiring urgent action
- Threshold not determined

- Improving; positive trends
- ➡ No change
- Getting worse; negative trend
- n.a.** Data not available

	Indicator	Status	Source	Year	Severity	Trend	
Nutritional Impact	Stunting	Prevalence of stunting among children <5 years old	33.2%	DHS	2014	●	➤
	Wasting	GAM prevalence among children <5 years old	2.8%	DHS	2014	●	➤
		SAM prevalence among children <5 years old	0.6%	DHS	2014	●	➤
	VAD	Children <5 years old with vitamin A deficiency	32.7%	DHS	2014	●	n.a.
	Iron deficiency	Children 6-59 months old with anaemia	50.8%	DHS	2016	●	➤
		Women ages 15-49 years old with anaemia	46.5%	DHS	2014	●	➡
IDD	Children 6-11 years old with iodine deficiency (median UI)	214.7 µg/L	Urinary Iodine Excretion Survey	2002	●	➤	
Underlying Causes	Food Security	Households with poor or borderline food consumption	63.6%	LVAC	2016	○	n.a.
		Prevalence of undernourishment	11.2%	FAO STAT/IFPRI	2016	●	➡
	Health & Sanitation	Under 5 mortality rate (deaths per 1000 live births)	90.2	UNICEF	2015	●	➤
		Low birthweight	10.4%	DHS	2014	○	➤
		HIV Prevalence	24.6%	DHS	2014	○	➤
		Women 15-49 years old with problems accessing health care	41.8%	DHS	2014	●	➤
		Household access to improved water source	54.0%	DHS	2014	●	n.a.
		Household access to improved sanitation facilities	47.1%	DHS	2014	○	➤
	Care	Timely initiation of breastfeeding	65.0%	DHS	2014	○	➤
		Infants 0-5 months old exclusively breastfed	66.9%	DHS	2014	○	➤
		Children 6-23 months old with adequate complementary feeding	11.3%	DHS	2016	○	➤
		Time to fetch water (households that take ≥30 min)	46.0%	DHS	2014	○	n.a.
Basic Causes	Education	Females that completed at least primary school	81.2%	DHS	2014	○	n.a.
		Female literacy rate	97.0%	DHS	2014	○	➡
	Population	Total fertility rate per woman	3.3	DHS	2014	○	n.a.
	Gender	Women ages 20-49 years old, with first birth at 15 years	15%	DHS	2014	○	n.a.
		Women's intra-household decision-making power	65.4%	DHS	2014	○	n.a.
	Poverty	Population living under national poverty line	57.1%	HDR	2016	○	➤

Situation Analysis Dashboard

District Level



REACH

ACCELERATING THE SCALE-UP OF FOOD AND NUTRITION ACTIONS



Situation Analysis Dashboard

Berea District

- Not currently a serious problem
- Requiring action
- Serious problem requiring urgent action
- Threshold not determined

		Indicator	Berea	Severity	National	Source	Year
Nutritional Impact	Stunting	Prevalence of stunting among children <5 years old	27.4%	●	33.2%	DHS	2014
	Wasting	GAM prevalence among children <5 years old	3.5%	●	2.8%	DHS	2014
		SAM prevalence among children <5 years old	0.0%	●	0.6%	DHS	2014
	VAD	Children <5 years old with vitamin A deficiency	n/a		32.7%	DHS	2014
	Iron deficiency	Children 6-59 months old with anaemia	40.9%	●	50.8%	DHS	2016
		Women ages 15-49 years old with anaemia	22.9%	●	46.5%	DHS	2014
IDD	Children 6-11 years old with iodine deficiency (median UI)	n/a		214.7 µg/L	UIES	2002	
Underlying Causes	Food Security	Households with poor or borderline food consumption	67.0%		63.6%	LVAC	2016
		Prevalence of undernourishment	n/a		11.2%	FAO STAT	2016
	Health & Sanitation	Under 5 mortality rate (deaths per 1000 live births)	n/a		90.2	UNICEF	2015
		Low birthweight	8.3%		10.4%	DHS	2014
		HIV Prevalence	25.4%		24.6%	DHS	2014
		Women 15-49 years old with problems accessing health care	42.1%		41.8%	DHS	2014
		Household access to improved water source	n/a		54.0%	DHS	2014
		Household access to improved sanitation facilities	n/a		47.1%	DHS	2014
	Care	Timely initiation of breastfeeding	65.8%		65.0%	DHS	2014
		Infants 0-5 months old exclusively breastfed	n/a		66.9%	DHS	2014
		Children 6-23 months old with adequate complementary feeding	10.5%		11.3%	DHS	2016
		Time to fetch water (households that take ≥30 min)	n/a		46.0%	DHS	2014
Basic Causes	Education	Females that completed at least primary school	69.8%		81.2%	DHS	2014
		Female literacy rate	98.1%		97.0%	DHS	2014
	Population	Total fertility rate per woman	3.1		3.3	DHS	2014
	Gender	Women ages 20-49 years old, with first birth at 15 years	17.1%		15.0%	DHS	2014
		Women's intra-household decision-making power	63.9%		65.4%	DHS	2014
	Poverty	Population living under national poverty line	n/a		57.1%	HDR	2016

Situation Analysis Dashboard

Leribe District

- Not currently a serious problem
- Requiring action
- Serious problem requiring urgent action
- Threshold not determined

		Indicator	Leribe	Severity	National	Source	Year
Nutritional Impact	Stunting	Prevalence of stunting among children <5 years old	31.3%	●	33.2%	DHS	2014
	Wasting	GAM prevalence among children <5 years old	3.3%	●	2.8%	DHS	2014
		SAM prevalence among children <5 years old	0%	●	0.6%	DHS	2014
	VAD	Children <5 years old with vitamin A deficiency	n/a		32.7%	DHS	2014
	Iron deficiency	Children 6-59 months old with anaemia	55.7%	●	50.8%	DHS	2016
		Women ages 15-49 years old with anaemia	25.4%	●	46.5%	DHS	2014
IDD	Children 6-11 years old with iodine deficiency (median UI)	n/a		214.7 µg/L	UIES	2002	
Underlying Causes	Food Security	Households with poor or borderline food consumption	59.0%		63.6%	LVAC	2016
		Prevalence of undernourishment	n/a		11.2%	FAO STAT	2016
	Health & Sanitation	Under 5 mortality rate (deaths per 1000 live births)	n/a		90.2	UNICEF	2015
		Low birthweight	7.6%		10.4%	DHS	2014
		HIV Prevalence	25.4%		24.6%	DHS	2014
		Women 15-49 years old with problems accessing health care	44.2%		41.8%	DHS	2014
		Household access to improved water source	n/a		54.0%	DHS	2014
		Household access to improved sanitation facilities	n/a		47.1%	DHS	2014
	Care	Timely initiation of breastfeeding	58.6%		65.0%	DHS	2014
		Infants 0-5 months old exclusively breastfed	n/a		66.9%	DHS	2014
		Children 6-23 months old with adequate complementary feeding	12.6%		11.3%	DHS	2016
		Time to fetch water (households that take ≥30 min)	n/a		46.0%	DHS	2014
Basic Causes	Education	Females that completed at least primary school	75.9%		81.2%	DHS	2014
		Female literacy rate	96.9%		97.0%	DHS	2014
	Population	Total fertility rate per woman	3.5		3.3	DHS	2014
	Gender	Women ages 20-49 years old, with first birth at 15 years	16.0%		15.0%	DHS	2014
		Women's intra-household decision-making power	67.4%		65.4%	DHS	2014
	Poverty	Population living under national poverty line	n/a		57.1%	HDR	2016

Situation Analysis Dashboard

Mokhotlong District

- Not currently a serious problem
- Requiring action
- Serious problem requiring urgent action
- Threshold not determined

		Indicator	Mokhotlong	Severity	National	Source	Year
Nutritional Impact	Stunting	Prevalence of stunting among children <5 years old	47.7%	●	33.2%	DHS	2014
	Wasting	GAM prevalence among children <5 years old	3.6%	●	2.8%	DHS	2014
		SAM prevalence among children <5 years old	0.3%	●	0.6%	DHS	2014
	VAD	Children <5 years old with vitamin A deficiency	n/a		32.7%	DHS	2014
	Iron deficiency	Children 6-59 months old with anaemia	58.5%	●	50.8%	DHS	2016
		Women ages 15-49 years old with anaemia	24.4%	●	46.5%	DHS	2014
IDD	Children 6-11 years old with iodine deficiency (median UI)	n/a		214.7 µg/L	UIES	2002	
Underlying Causes	Food Security	Households with poor or borderline food consumption	75.0%		63.6%	LVAC	2016
		Prevalence of undernourishment	n/a		11.2%	FAO STAT	2016
	Health & Sanitation	Under 5 mortality rate (deaths per 1000 live births)	n/a		90.2	UNICEF	2015
		Low birthweight	15.0%		10.4%	DHS	2014
		HIV Prevalence	17.0%		24.6%	DHS	2014
		Women 15-49 years old with problems accessing health care	45.8%		41.8%	DHS	2014
		Household access to improved water source	n/a		54.0%	DHS	2014
		Household access to improved sanitation facilities	n/a		47.1%	DHS	2014
	Care	Timely initiation of breastfeeding	72.9%		65.0%	DHS	2014
		Infants 0-5 months old exclusively breastfed	n/a		66.9%	DHS	2014
		Children 6-23 months old with adequate complementary feeding	1.4%		11.3%	DHS	2016
		Time to fetch water (households that take ≥30 min)	n/a		46.0%	DHS	2014
Basic Causes	Education	Females that completed at least primary school	83.9%		81.2%	DHS	2014
		Female literacy rate	95.3%		97.0%	DHS	2014
	Population	Total fertility rate per woman	4.4		3.3	DHS	2014
	Gender	Women ages 20-49 years old, with first birth at 15 years	18.4%		15.0%	DHS	2014
		Women's intra-household decision-making power	56.9%		65.4%	DHS	2014
	Poverty	Population living under national poverty line	n/a		57.1%	HDR	2016

Situation Analysis Dashboard

Mafeteng District

- Not currently a serious problem
- Requiring action
- Serious problem requiring urgent action
- Threshold not determined

		Indicator	Mafeteng	Severity	National	Source	Year
Nutritional Impact	Stunting	Prevalence of stunting among children <5 years old	25.9%	●	33.2%	DHS	2014
	Wasting	GAM prevalence among children <5 years old	2.5%	●	2.8%	DHS	2014
		SAM prevalence among children <5 years old	1.3%	●	0.6%	DHS	2014
	VAD	Children <5 years old with vitamin A deficiency	n/a		32.7%	DHS	2014
	Iron deficiency	Children 6-59 months old with anaemia	44.5%	●	50.8%	DHS	2016
		Women ages 15-49 years old with anaemia	27.7%	●	46.5%	DHS	2014
IDD	Children 6-11 years old with iodine deficiency (median UI)	n/a		214.7 µg/L	UIES	2002	
Underlying Causes	Food Security	Households with poor or borderline food consumption	67%		63.6%	LVAC	2016
		Prevalence of undernourishment	n/a		11.2%	FAO STAT	2016
	Health & Sanitation	Under 5 mortality rate (deaths per 1000 live births)	n/a		90.2	UNICEF	2015
		Low birthweight	13.0%		10.4%	DHS	2014
		HIV Prevalence	25.1%		24.6%	DHS	2014
		Women 15-49 years old with problems accessing health care	40.0%		41.8%	DHS	2014
		Household access to improved water source	n/a		54.0%	DHS	2014
		Household access to improved sanitation facilities	n/a		47.1%	DHS	2014
	Care	Timely initiation of breastfeeding	62.9%		65.0%	DHS	2014
		Infants 0-5 months old exclusively breastfed	n/a		66.9%	DHS	2014
		Children 6-23 months old with adequate complementary feeding	16.0%		11.3%	DHS	2016
		Time to fetch water (households that take ≥30 min)	n/a		46.0%	DHS	2014
Basic Causes	Education	Females that completed at least primary school	76.9%		81.2%	DHS	2014
		Female literacy rate	97.3%		97.0%	DHS	2014
	Population	Total fertility rate per woman	2.8		3.3	DHS	2014
	Gender	Women ages 20-49 years old, with first birth at 15 years	8.9%		15.0%	DHS	2014
		Women's intra-household decision-making power	57.1%		65.4%	DHS	2014
Poverty	Population living under national poverty line	n/a		57.1%	HDR	2016	

Situation Analysis Dashboard

Mohale's Hoek District

- Not currently a serious problem
- Requiring action
- Serious problem requiring urgent action
- Threshold not determined

		Indicator	Mohale's Hoek	Severity	National	Source	Year
Nutritional Impact	Stunting	Prevalence of stunting among children <5 years old	38.1%	●	33.2%	DHS	2014
		Wasting	GAM prevalence among children <5 years old	3.3%	●	2.8%	DHS
	SAM prevalence among children <5 years old		1.7%	●	0.6%	DHS	2014
	VAD	Children <5 years old with vitamin A deficiency	n/a		32.7%	DHS	2014
	Iron deficiency	Children 6-59 months old with anaemia	56.1%	●	50.8%	DHS	2016
		Women ages 15-49 years old with anaemia	25.8%	●	46.5%	DHS	2014
IDD	Children 6-11 years old with iodine deficiency (median UI)	n/a		214.7 µg/L	UIES	2002	
Underlying Causes	Food Security	Households with poor or borderline food consumption	61%		63.6%	LVAC	2016
		Prevalence of undernourishment	n/a		11.2%	FAO STAT	2016
	Health & Sanitation	Under 5 mortality rate (deaths per 1000 live births)	n/a		90.2	UNICEF	2015
		Low birthweight	11.2%		10.4%	DHS	2014
		HIV Prevalence	20.1%		24.6%	DHS	2014
		Women 15-49 years old with problems accessing health care	42.8%		41.8%	DHS	2014
		Household access to improved water source	n/a		54.0%	DHS	2014
		Household access to improved sanitation facilities	n/a		47.1%	DHS	2014
	Care	Timely initiation of breastfeeding	71.2%		65.0%	DHS	2014
		Infants 0-5 months old exclusively breastfed	n/a		66.9%	DHS	2014
		Children 6-23 months old with adequate complementary feeding	2.0%		11.3%	DHS	2016
		Time to fetch water (households that take ≥30 min)	n/a		46.0%	DHS	2014
Basic Causes	Education	Females that completed at least primary school	79.1%		81.2%	DHS	2014
		Female literacy rate	96.5%		97.0%	DHS	2014
	Population	Total fertility rate per woman	3.8		3.3	DHS	2014
	Gender	Women ages 20-49 years old, with first birth at 15 years	18.2%		15.0%	DHS	2014
		Women's intra-household decision-making power	63.1%		65.4%	DHS	2014
Poverty	Population living under national poverty line	n/a		57.1%	HDR	2016	

Situation Analysis Dashboard

Thaba-Tseka District

- Not currently a serious problem
- Requiring action
- Serious problem requiring urgent action
- Threshold not determined

		Indicator	Thaba-Tseka	Severity	National	Source	Year
Nutritional Impact	Stunting	Prevalence of stunting among children <5 years old	40.0%	●	33.2%	DHS	2014
	Wasting	GAM prevalence among children <5 years old	4.1%	●	2.8%	DHS	2014
		SAM prevalence among children <5 years old	0.4%	●	0.6%	DHS	2014
	VAD	Children <5 years old with vitamin A deficiency	n/a		32.7%	DHS	2014
	Iron deficiency	Children 6-59 months old with anaemia	53.5%	●	50.8%	DHS	2016
		Women ages 15-49 years old with anaemia	16.9%	●	46.5%	DHS	2014
IDD	Children 6-11 years old with iodine deficiency (median UI)	n/a		214.7 µg/L	UIES	2002	
Underlying Causes	Food Security	Households with poor or borderline food consumption	78.0%		63.6%	LVAC	2016
		Prevalence of undernourishment	n/a		11.2%	FAO STAT	2016
	Health & Sanitation	Under 5 mortality rate (deaths per 1000 live births)	n/a		90.2	UNICEF	2015
		Low birthweight	13.7%		10.4%	DHS	2014
		HIV Prevalence	24.7%		24.6%	DHS	2014
		Women 15-49 years old with problems accessing health care	56.0%		41.8%	DHS	2014
		Household access to improved water source	n/a		54.0%	DHS	2014
		Household access to improved sanitation facilities	n/a		47.1%	DHS	2014
	Care	Timely initiation of breastfeeding	79.4%		65.0%	DHS	2014
		Infants 0-5 months old exclusively breastfed	n/a		66.9%	DHS	2014
		Children 6-23 months old with adequate complementary feeding	11.4%		11.3%	DHS	2016
		Time to fetch water (households that take ≥30 min)	n/a		46.0%	DHS	2014
Basic Causes	Education	Females that completed at least primary school	79.9%		81.2%	DHS	2014
		Female literacy rate	95.0%		97.0%	DHS	2014
	Population	Total fertility rate per woman	4.0		3.3	DHS	2014
	Gender	Women ages 20-49 years old, with first birth at 15 years	16.5%		15.0%	DHS	2014
		Women's intra-household decision-making power	54.2%		65.4%	DHS	2014
	Poverty	Population living under national poverty line	n/a		57.1%	HDR	2016

Situation Analysis Dashboard

Butha-Buthe District

- Not currently a serious problem
- Requiring action
- Serious problem requiring urgent action
- Threshold not determined

		Indicator	Butha-Buthe	Severity	National	Source	Year
Nutritional Impact	Stunting	Prevalence of stunting among children <5 years old	40.3%	●	33.2%	DHS	2014
	Wasting	GAM prevalence among children <5 years old	1.8%	●	2.8%	DHS	2014
		SAM prevalence among children <5 years old	1.2%	●	0.6%	DHS	2014
	VAD	Children <5 years old with vitamin A deficiency	n/a		32.7%	DHS	2014
	Iron deficiency	Children 6-59 months old with anaemia	59.2%	●	50.8%	DHS	2016
		Women ages 15-49 years old with anaemia	29.4%	●	46.5%	DHS	2014
IDD	Children 6-11 years old with iodine deficiency (median UI)	n/a		214.7 µg/L	UIES	2002	
Underlying Causes	Food Security	Households with poor or borderline food consumption	57%		63.6%	LVAC	2016
		Prevalence of undernourishment	n/a		11.2%	FAO STAT	2016
	Health & Sanitation	Under 5 mortality rate (deaths per 1000 live births)	n/a		90.2	UNICEF	2015
		Low birthweight	9.5%		10.4%	DHS	2014
		HIV Prevalence	21.2%		24.6%	DHS	2014
		Women 15-49 years old with problems accessing health care	42.4%		41.8%	DHS	2014
		Household access to improved water source	n/a		54.0%	DHS	2014
		Household access to improved sanitation facilities	n/a		47.1%	DHS	2014
	Care	Timely initiation of breastfeeding	70.9%		65.0%	DHS	2014
		Infants 0-5 months old exclusively breastfed	n/a		66.9%	DHS	2014
		Children 6-23 months old with adequate complementary feeding	9.0%		11.3%	DHS	2016
		Time to fetch water (households that take ≥30 min)	n/a		46.0%	DHS	2014
	Basic Causes	Education	Females that completed at least primary school	77.8%		81.2%	DHS
Female literacy rate			96.8%		97.0%	DHS	2014
Population		Total fertility rate per woman	3.7		3.3	DHS	2014
Gender		Women ages 20-49 years old, with first birth at 15 years	21.5%		15.0%	DHS	2014
		Women's intra-household decision-making power	72.0%		65.4%	DHS	2014
Poverty	Population living under national poverty line	n/a		57.1%	HDR	2016	

Situation Analysis Dashboard

Maseru District

- Not currently a serious problem
- Requiring action
- Serious problem requiring urgent action
- Threshold not determined

		Indicator	Maseru	Severity	National	Source	Year
Nutritional Impact	Stunting	Prevalence of stunting among children <5 years old	29.9%	●	33.2%	DHS	2014
	Wasting	GAM prevalence among children <5 years old	1.8%	●	2.8%	DHS	2014
		SAM prevalence among children <5 years old	0.5%	●	0.6%	DHS	2014
	VAD	Children <5 years old with vitamin A deficiency	n/a		32.7%	DHS	2014
	Iron deficiency	Children 6-59 months old with anaemia	48.5%	●	50.8%	DHS	2016
		Women ages 15-49 years old with anaemia	34.2%	●	46.5%	DHS	2014
IDD	Children 6-11 years old with iodine deficiency (median UI)	n/a		214.7 µg/L	UIES	2002	
Underlying Causes	Food Security	Households with poor or borderline food consumption	58.0%		63.6%	LVAC	2016
		Prevalence of undernourishment	n/a		11.2%	FAO STAT	2016
	Health & Sanitation	Under 5 mortality rate (deaths per 1000 live births)	n/a		90.2	UNICEF	2015
		Low birthweight	10.0%		10.4%	DHS	2014
		HIV Prevalence	28.0%		24.6%	DHS	2014
		Women 15-49 years old with problems accessing health care	36.2%		41.8%	DHS	2014
		Household access to improved water source	n/a		54.0%	DHS	2014
		Household access to improved sanitation facilities	n/a		47.1%	DHS	2014
	Care	Timely initiation of breastfeeding	59.6%		65.0%	DHS	2014
		Infants 0-5 months old exclusively breastfed	n/a		66.9%	DHS	2014
		Children 6-23 months old with adequate complementary feeding	17.6%		11.3%	DHS	2016
		Time to fetch water (households that take ≥30 min)	n/a		46.0%	DHS	2014
Basic Causes	Education	Females that completed at least primary school	69.8%		81.2%	DHS	2014
		Female literacy rate	97.9%		97.0%	DHS	2014
	Population	Total fertility rate per woman	2.6		3.3	DHS	2014
	Gender	Women ages 20-49 years old, with first birth at 15 years	11.6%		15.0%	DHS	2014
		Women's intra-household decision-making power	73.0%		65.4%	DHS	2014
	Poverty	Population living under national poverty line	n/a		57.1%	HDR	2016

Situation Analysis Dashboard

Quthing District

- Not currently a serious problem
- Requiring action
- Serious problem requiring urgent action
- Threshold not determined

		Indicator	Quthing	Severity	National	Source	Year
Nutritional Impact	Stunting	Prevalence of stunting among children <5 years old	36.1%	●	33.2%	DHS	2014
		Wasting	GAM prevalence among children <5 years old	1.2%	●	2.8%	DHS
	SAM prevalence among children <5 years old		0.0%	●	0.6%	DHS	2014
	VAD	Children <5 years old with vitamin A deficiency	n/a		32.7%	DHS	2014
	Iron deficiency	Children 6-59 months old with anaemia	47.4%	●	50.8%	DHS	2016
		Women ages 15-49 years old with anaemia	23.6%	●	46.5%	DHS	2014
IDD	Children 6-11 years old with iodine deficiency (median UI)	n/a		214.7 µg/L	UIES	2002	
Underlying Causes	Food Security	Households with poor or borderline food consumption	64.0%		63.6%	LVAC	2016
		Prevalence of undernourishment	n/a		11.2%	FAO STAT	2016
	Health & Sanitation	Under 5 mortality rate (deaths per 1000 live births)	n/a		90.2	UNICEF	2015
		Low birthweight	13.7%		10.4%	DHS	2014
		HIV Prevalence	20.8%		24.6%	DHS	2014
		Women 15-49 years old with problems accessing health care	41.1%		41.8%	DHS	2014
		Household access to improved water source	n/a		54.0%	DHS	2014
		Household access to improved sanitation facilities	n/a		47.1%	DHS	2014
	Care	Timely initiation of breastfeeding	62.3%		65.0%	DHS	2014
		Infants 0-5 months old exclusively breastfed	n/a		66.9%	DHS	2014
		Children 6-23 months old with adequate complementary feeding	15.5%		11.3%	DHS	2016
		Time to fetch water (households that take ≥30 min)	n/a		46.0%	DHS	2014
	Basic Causes	Education	Females that completed at least primary school	83.0%		81.2%	DHS
Female literacy rate			96.1%		97.0%	DHS	2014
Population		Total fertility rate per woman	3.9		3.3	DHS	2014
Gender		Women ages 20-49 years old, with first birth at 15 years	18.7%		15.0%	DHS	2014
		Women's intra-household decision-making power	66.3%		65.4%	DHS	2014
Poverty		Population living under national poverty line	n/a		57.1%	HDR	2016

Situation Analysis Dashboard

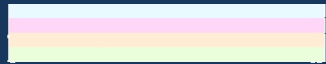
Qacha's Nek District

- Not currently a serious problem
- Requiring action
- Serious problem requiring urgent action
- Threshold not determined

	Indicator	Qacha's Nek	Severity	National	Source	Year	
Nutritional Impact	Stunting	Prevalence of stunting among children <5 years old	32.5%	●	33.2%	DHS	2014
	Wasting	GAM prevalence among children <5 years old	4.0%	●	2.8%	DHS	2014
		SAM prevalence among children <5 years old	1.7%	●	0.6%	DHS	2014
	VAD	Children <5 years old with vitamin A deficiency	n/a		32.7%	DHS	2014
	Iron deficiency	Children 6-59 months old with anaemia	47.3%	●	50.8%	DHS	2016
		Women ages 15-49 years old with anaemia	27.5%	●	46.5%	DHS	2014
IDD	Children 6-11 years old with iodine deficiency (median UI)	n/a		214.7 µg/L	UIES	2002	
Underlying Causes	Food Security	Households with poor or borderline food consumption	55.0%		63.6%	LVAC	2016
		Prevalence of undernourishment	n/a		11.2%	FAO STAT	2016
	Health & Sanitation	Under 5 mortality rate (deaths per 1000 live births)	n/a		90.2	UNICEF	2015
		Low birthweight	7.9%		10.4%	DHS	2014
		HIV Prevalence	20.9%		24.6%	DHS	2014
		Women 15-49 years old with problems accessing health care	42.5%		41.8%	DHS	2014
		Household access to improved water source	n/a		54.0%	DHS	2014
		Household access to improved sanitation facilities	n/a		47.1%	DHS	2014
	Care	Timely initiation of breastfeeding	68.5%		65.0%	DHS	2014
		Infants 0-5 months old exclusively breastfed	n/a		66.9%	DHS	2014
		Children 6-23 months old with adequate complementary feeding	0.0%		11.3%	DHS	2016
		Time to fetch water (households that take ≥30 min)	n/a		46.0%	DHS	2014
Basic Causes	Education	Females that completed at least primary school	80.6%		81.2%	DHS	2014
		Female literacy rate	95.3%		97.0%	DHS	2014
	Population	Total fertility rate per woman	2.9		3.3	DHS	2014
	Gender	Women ages 20-49 years old, with first birth at 15 years	9.9%		15.0%	DHS	2014
		Women's intra-household decision-making power	56.3%		65.4%	DHS	2014
	Poverty	Population living under national poverty line	n/a		57.1%	HDR	2016

Situation Analysis Dashboard

Back-up slides



REACH

ACCELERATING THE SCALE-UP OF FOOD AND NUTRITION ACTIONS



Indicator definitions (1 of 2)

		Indicator	Definition
Nutritional Impact	Stunting	Prevalence of stunting among children <5 years old	Prevalence of stunting among children ages 0-59 months old (HAZ <-2SD)
	Wasting	GAM prevalence among children <5 years old	Prevalence of wasting among children ages 0-59 months old (WHZ <-2 SD) and/or bilateral oedema
		SAM prevalence among children <5 years old	Prevalence of severe acute malnutrition (severe wasting) among children ages 0-59 months old (WHZ <-3SD) and/or bilateral oedema.
	Overweight	Prevalence of overweight among children <5 years old	Prevalence of overweight among children ages 0-59 months old (WHZ >+ 2 SD)
	VAD	Children <5 years old with vitamin A deficiency	% children 6-59 months old with serum retinol values of vitamin A $\leq 0.7 \mu\text{mol/L}$ ($\leq 20 \mu\text{g/L}$)
	Iron deficiency	Children 6-59 months old with anaemia	% children 6-59 months old with mild, moderate or severe anaemia (haemoglobin <11 g/dL)
		Women ages 15-49 years old with anaemia	% women 15-49 years old with mild, moderate or severe anaemia (haemoglobin <12 g/dL in nonpregnant women, <11 g/dL in pregnant women)
	IDD	Children 6-11 years old with iodine deficiency (median UI)	Median urinary iodine (UI) level $\mu\text{g/l}$ among school-age children (6-11 years old)
Underlying Causes	Food Security	Households with poor or borderline food consumption	% households with poor or borderline food consumption as measured by the WFP VAM Food Consumption Score (FCS), whereby FCS is ≤ 35
		Prevalence of undernourishment (inadequate caloric intake)	% population with caloric intake < minimum dietary energy requirement (average 1800 kcal per person per day)
	Health & Sanitation	Under 5 mortality rate (deaths per 1000 live births)	Under 5 mortality rate (deaths per 1,000 live births)
		Low birthweight	% newborns weighing less than < 2.5 kg
		Women 15-49 years old with problems accessing health care	% women 15-49 years old who reported at least one serious problem accessing health care for themselves when sick
		Household access to improved water source	% households with an improved water sources (e.g. household pipe, borehole, protected dug well, protected spring or rainwater collection)
		Household access to improved sanitation facilities	% households with access to improved sanitation facilities (e.g. traditional pit latrines, VIP latrines, flush latrines or toilet with water)

Indicator definitions (2 of 2)

		Indicator	Definition
Underlying Causes (cont.)	Care	Timely initiation of breastfeeding	% children born in last 24 months who were put to the breast within one hour of birth
		Infants 0-5 months old exclusively breastfed	% infants age 0–5 months old who were fed exclusively with breast milk during the 24 hours preceding the survey
		Children 6-23 months old with adequate complementary feeding	% children 6–23 months old who receive a minimum acceptable diet (apart from breast milk)
		Time to fetch water (households that take ≥30 min)	% households for which it takes 30 minutes or longer to go to the water source, get the water and return
		Handwashing with soap and water	% households with a handwashing facility with soap and water
Basic Causes	Education	Females that completed at least primary school	Combined % of females age 15-49 years old that: (a) completed primary; (b) attended some secondary; (c) completed secondary; (d) more than secondary schooling
		Female literacy rate	% females age 15- 59 years who attended secondary school or higher and women who can read a whole sentence or part of a sentence
	Population	Total fertility rate per woman	Total fertility rate, expressed per woman
	Gender	Women ages 20-49 years old, with first birth at 15 years	% women age 20-49 years old who gave birth for the first time at 15 years
		Women’s intra-household decision-making power	% currently married women age 15-49 years old who usually participate in all 3 types of decisions: (a) own health care; (b) making major household purchases; and (c) visits to her family or relatives
	Poverty	Population living under national poverty line	% population living under national poverty line

- Not currently a serious problem
- Requiring action
- Serious problem requiring urgent action
- Threshold not determined

Threshold definitions (1 of 2)

		Indicator	● Red	● Yellow	● Green	○ White
Nutritional Impact	Stunting	Prevalence of stunting among children <5 years old	Critical: ≥ 40% stunting Serious: 30-39% stunting	Poor: 20-29% stunting	Acceptable: < 20% stunting	n/a
	Wasting	GAM prevalence among children <5 years old	Critical: ≥ 15% GAM Serious: 10-14% GAM	Poor: 5-9% GAM	Acceptable: < 5% GAM	n/a
		SAM prevalence among children <5 years old	Emergency: ≥ 2% SAM	0.1-1.9% SAM	n/a	n/a
	Overweight	Prevalence of overweight among children <5 years old	n/a	n/a	n/a	All values
	VAD	Children <5 years old with vitamin A deficiency	Severe: ≥ 20% vitamin A deficient	Moderate: >10 to <20% vitamin A deficient Mild: ≥ 2-10% vitamin A deficient	Normal: <2% vitamin A deficient	n/a
	Iron deficiency	Children 6-59 months old with anaemia	Severe: ≥ 40% anaemic	Moderate: 20.0-39.9% anaemic Mild: 5.0-19.9% anaemic	Normal: ≤ 4.9% anaemic	n/a
		Women ages 15-49 years old with anaemia				
IDD	Children 6-11 years old with iodine deficiency (median UI)	Severe: <20 median UI	Moderate: 20.0-49.9 median UI Mild: 50.0-99.9 median UI	Normal: ≥ 100 median UI	n/a	
Underlying Causes	Food Security	Prevalence of undernourishment (inadequate caloric intake)	Very high: ≥ 35% undernourished High: 20-34% undernourished	Moderately high: 10-19% undernourished Moderately low: 5-9% undernourished	Very low: < 5% undernourished	n/a
		Global hunger index rating	Extremely alarming: ≥ 30 GHI score Alarming: 20.0-29.9 GHI score	Serious: 10.0-19.0 GHI score Moderate: 5.0 -9.9 GHI score	Low: < 4.9 GHI score	n/a
	Health & Sanitation	Under 5 mortality rate (deaths per 1000 live births)	Emergency U5MR: ≥ 2.3	Emergency U5MR: > 1.14 to < 2.3	Emergency U5MR: ≤ 1.14	n/a
		Low birthweight	n/a	n/a	n/a	All values
		Women 15-49 years old with problems accessing health care	n/a	n/a	n/a	All values
		Household access to improved water source	<50% use of improved drinking-water sources	50-75% use of improved drinking-water sources 76-90% use of improved drinking-water sources	97-100% use of improved drinking-water sources	n/a
		Household access to improved sanitation facilities	n/a	n/a	n/a	All values

Note: for further information on the indicators, rationale for inclusion and trend data, please see the full Nutrition Situation Analysis Dashboard Excel file

- Not currently a serious problem
- Requiring action
- Serious problem requiring urgent action
- Threshold not determined

Threshold definitions (2 of 2)

		Indicator	● Red	● Yellow	● Green	○ White
Underlying Causes (cont.)	Care	Timely initiation of breastfeeding	n/a	n/a	n/a	All values
		Infants 0-5 months old exclusively breastfed	n/a	n/a	n/a	All values
		Children 6-23 months old with adequate complementary feeding	n/a	n/a	n/a	All values
		Time to fetch water (households that take ≥30 min)	n/a	n/a	n/a	All values
		Handwashing with soap and water	n/a	n/a	n/a	All values
Basic Causes	Education	Females that completed at least primary school	n/a	n/a	n/a	All values
		Female literacy rate	n/a	n/a	n/a	All values
	Population	Total fertility rate per woman	n/a	n/a	n/a	All values
	Gender	Women ages 20-49 years old, with first birth at 15 years	n/a	n/a	n/a	All values
		Women's intra-household decision-making power	n/a	n/a	n/a	All values
	Poverty	Population living under national poverty line	n/a	n/a	n/a	All values

Note: for further information on the indicators, rationale for inclusion and trend data, please see the full Nutrition Situation Analysis Dashboard Excel file

- Not currently a serious problem
- Requiring action
- Serious problem requiring urgent action
- Threshold not determined

Threshold definition notes (1 of 2)

	Indicator	Notes
Nutritional Impact	Stunting	Prevalence of stunting among children <5 years old The WHO standard classification for stunting on public health significance was condensed into the REACH 3-point, stoplight system to indicate public health severity.
	Wasting	GAM prevalence among children <5 years old WHO's public health thresholds for global acute malnutrition (GAM) informed the REACH 3-point, stoplight system in an effort to build upon the global consensus.
		SAM prevalence among children <5 years old An emergency threshold exists only. Due to the very low percentage of the emergency threshold (2%), it is difficult to establish thresholds for less severe public health significance with statistical robustness. The REACH Secretariat therefore recommends classifying levels of 0.1 to 1.9% as requiring action (yellow light).
	Overweight	Prevalence of overweight among children <5 years old To our knowledge, there are no established public health significance categories for the overweight indicator.
	VAD	Children <5 years old with vitamin A deficiency The existing public health thresholds were applied to the REACH 3-point, stoplight system.
	Iron deficiency	Children 6-59 months old with anaemia The REACH stoplight system for these anaemia indicators uses the current global consensus regarding public health thresholds for anaemia, whereby the existing four public health significance categories are consolidated into the REACH 3-point rating system.
		Women ages 15-49 years old with anaemia
IDD	Children 6-11 years old with iodine deficiency (median UI) There are established public health significance categories for median urinary iodine level in school children µg/L (%), which have been incorporated into the REACH stoplight system.	
Underlying Causes	Food Security	Prevalence of undernourishment (inadequate caloric intake) The REACH stoplight classification utilises the five established categories for 'Prevalence of Undernourishment', condensing them into the three-point rating system. The ranges of the % population undernourished which define these five categories were taken from the joint-FAO and WFP 'The State of Food Insecurity in the World.'
		Global hunger index rating The GHI's five categories to indicate the severity of the situation were folded into the REACH three-point stoplight system as indicated here.
	Health & Sanitation	Under 5 mortality rate (deaths per 1000 live births) In absence of evident public health significance categories for U5MR reported in terms of deaths per 1,000 live births, the applicable guidelines for U5MR per 10,000 per day were tentatively used to inform the REACH stoplight system.
		Low birthweight To our knowledge, there are no established public health significance categories for the low birthweight indicator.
		Women 15-49 years old with problems accessing health care To our knowledge, there are no established public health significance categories for the problems accessing health care indicator.

- Not currently a serious problem
- Requiring action
- Serious problem requiring urgent action
- Threshold not determined

Threshold definition notes (2 of 2)

		Indicator	Notes
Underlying Causes (cont.)	Health & Sanitation (cont.)	Household access to improved water source	REACH Secretariat consulted a Water Specialist from FAO regarding the existence of public health significance categories for 'household access to an improved water source'. While there are no known categories for this indicator, the WHO/UNICEF Joint Monitoring Programme for Water Supply and Sanitation presented intervals for 'Use of improved drinking-water sources.' These categories have been used to inform the REACH spotlight classification system despite the subtle distinction between the two indicators.
		Household access to improved sanitation facilities	To our knowledge, there are no established public health significance categories for this indicator.
	Care	Timely initiation of breastfeeding	There have been extensive efforts to review infant and young child feeding indicators in recent years which have culminated in a joint-publication (by USAID, WHO, AED Fanta, University of California at Davis, IFPRI, UNICEF and WHO) on core and recommended indicators for infant and young child feeding. These have addressed the selection/use of specific indicators, though they have not encompassed the formulation of population thresholds/public health significance categories.
		Infants 0-5 months old exclusively breastfed	To our knowledge, there are no established public health significance categories for this indicator.
		Children 6-23 months old with adequate complementary feeding	
		Time to fetch water (households that take ≥30 min)	
Handwashing with soap and water			
Basic Causes	Education	Females that completed at least primary school	To our knowledge, there are no established public health significance categories for this indicator.
		Female literacy rate	
	Population	Total fertility rate per woman	
	Gender	Women ages 20-49 years old, with first birth at 15 years	
		Women's intra-household decision-making power	
Poverty	Population living under national poverty line		