PREVALENCE OF ACUTE UNDERNUTRITION (MUAC, OEDEMA)

Impact indicator, Outcome indicator, Global Cluster indicator

Indicator Phrasing

**English:** % of children aged 6-59 months with a MUAC < 125mm (and/or bilateral oedema)

**French:** % d’enfants âgés de 6 à 59 mois avec un PB <125 mm (et / ou un œdème bilatéral)

**Portuguese:** % de crianças com idade entre 6-59 meses com um PB (perímetro braquial) < 125mm (e/ou edema bilateral)

**Czech:** % dětí ve věku 6-59 měsíců s obvodem horní části paže < 125mm (anebo oboustranným edémem)

What is its purpose?

The indicator measures the prevalence of children with mid-upper arm circumference (MUAC) between 115mm and <125mm (moderate acute malnutrition) and <115mm (severe acute malnutrition) and/or bilateral oedema.

How to Collect and Analyse the Required Data

Data can be collected either as a part of [SMART survey](#) collecting for also other anthropometric data or in a separate survey collecting MUAC-only data. The second option is much faster and is used when a lack of time or funding does not allow the conducting of a full-scale SMART survey.

Disaggregate by

1) This indicator relies on accurate age assessment. Since people often do not remember the exact dates of their children’s birth, the data collectors should **never rely only on the information provided by caregivers and always verify the child’s age**. This can be done by reviewing the child’s birth certificate or other documents; however, since many caregivers do not have such documents, it is essential that your data collectors are able to **determine the child’s age by using local events calendars**. Read FAO’s Guidelines (see below) to learn how to prepare local events calendars and how to train data collectors in their correct use.

2) Some countries (e.g. Ethiopia) use **older 120/ 110mm cut off points** as opposed to the WHO currently recommended 125/ 115mm. If you work in a country using older standards, report the results according to the older as well as the more recent standards. **Always record the exact circumference** (in mm), not just whether it is below or above the cut off point.
3) Prevention-oriented projects should use this indicator only if their strategy is likely to have an impact on the **nutritional status** of the target population. If your project is too short or focuses, for example, primarily on improving agricultural production, use less ambitious indicators measuring, for example, **nutritional intake** (such as Individual Dietary Diversity Score) or specific **nutritional practices**.

4) In many countries, acute undernutrition is prone to **significant seasonal differences** (e.g. ranging from 5% in the months following the harvest to 11% before the harvest). Therefore, if you need to compare your baseline and endline data to assess the result of your work, **ensure that the data is collected at the same time of a year**, otherwise you will receive two sets of data which say very little about the change your project has (not) achieved.

5) Since the differences in the prevalence of acute malnutrition are often very small (e.g. from 7% to 5%), MUAC-based surveys need to **use a very small margin of error** (2-3%), using a large sample of children. With a larger team of measurers, MUAC data for a survey can be **collected within 6 - 8 working days** (training incl. piloting can be done in 1-2 days). To ensure maximum quality, **use the guidance recommended below**; if required, contract an in-country or headquarters-based advisor to design methodology, train your team and supervise the survey quality.

### Important Comments

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