RAKHINE STATE – NUTRITION INFORMATION ANALYSIS

January – August 2014

INTRODUCTION

The Rakhine state nutrition response aims to achieve 4 key objectives:

Sector objectives

1. To reduce malnutrition-related deaths in girls and boys under-5 by ensuring access to quality life-saving interventions for management of acute malnutrition, guided by global standards;
2. Ensure access to key preventive nutrition services routinely provided by Government;
3. Ensure enhanced monitoring and analysis of nutrition situation, needs, and evolving vulnerabilities;
4. Improve cross sector and actor collaboration to address underlying factors of malnutrition.

This report addresses the first and second objectives for which the sector is able to obtain information regularly though the Nutrition Information Systems (NIS) and monitor indicators on a monthly basis;

Outcome level indicators

1. Percentage of girls and boys CURED of acute malnutrition
2. Percentage of girls and boys with acute malnutrition who DIED
3. Percentage of children under 5 years provided with vitamin A and deworming treatment routinely provided by government
4. Percentage of affected women provided with skilled breastfeeding counselling

Activities

- Active and passive screening of children 6-59 months for acute malnutrition
- Treatment of severe and moderate acute malnutrition in children 6-59 months through provision of ready-to-use therapeutic or supplementary food, routine medicines, medical consultation and counselling for cases of severe acute malnutrition with infant and young child feeding support
- Micronutrient prevention and control (children/ PLW)
- Vitamin A supplementation and deworming
- Blanket supplementary feeding (children/ PLW)

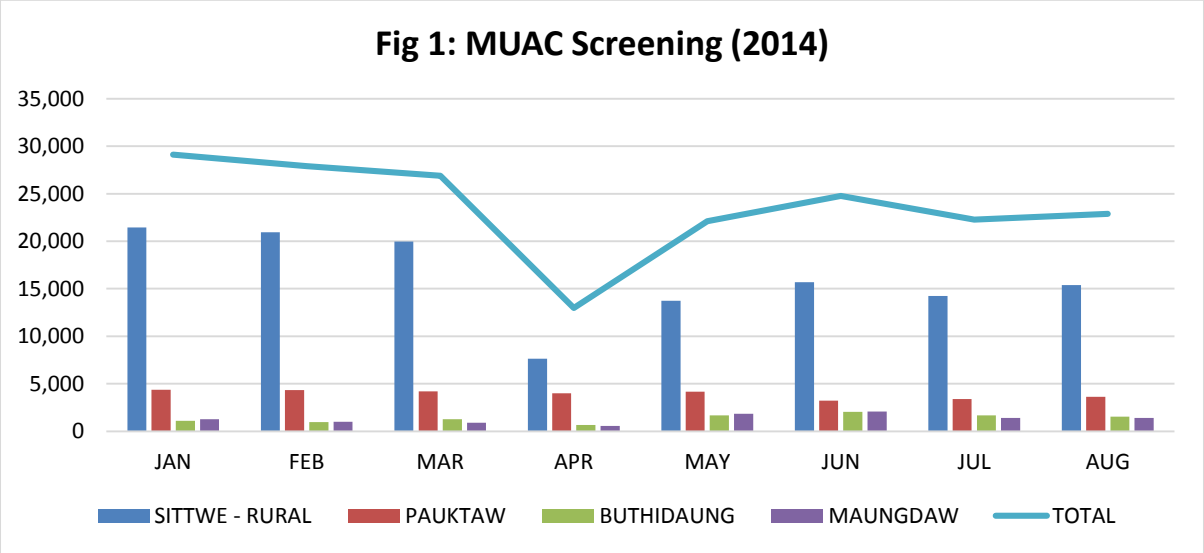
Organizations involved in response

ACF, MHAA, SCI, UNCIEF, WFP

1. Monthly screening of children 6-59 months for acute malnutrition

1.1. Screening by Township:

Out of the 11 townships targeted for emergency nutrition response, active/passive screening activities to identify children with acute malnutrition are conducted in villages and camps in 8 townships (Sittwe, Pauktaw, Minbya, Myebon, Kyauktaw, Buthidaung and Maungdaw, Rathedaung[1]). About 23,000 under 5 children per month were screened with MUAC during the last 4 months. Numbers screened on a monthly basis are highest in Sittwe rural area followed by Pauktaw (fig 1). This was the same trend observed for the period January- August. The higher numbers recorded for these two townships are partly due to the relatively large population size as well as to the fact that joint active screening is conducted by ACF and SCI in Sittwe rural.



1.2. Screening by month:

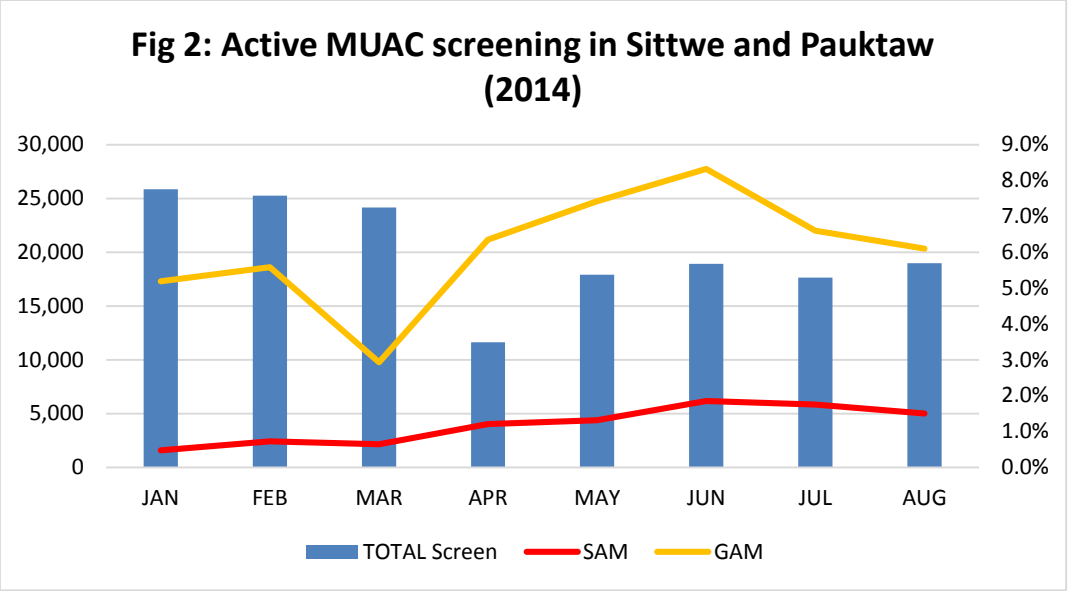
For the reporting period (January to August), a total of **188,916** children (**89,862** boys and **99,054** girls) have been screened for acute malnutrition. More girls were screened than boys (about 10,000), and 58 % of identified acute malnutrition cases (total of 18,458) were girls. Passive screening was conducted in Buthidaung, Maungdaw, Myebon, Kyauktaw, Minbya and Sittwe (urban) townships in August. The number of children screened varied from around 100 to 400 in conflict affected areas and around 1,500 in the northern townships. (Table 1).

Table 1: Passive MUAC[2] screening-August 2014

	Male	Female	Total
MINBYA	46	51	97
MYEBON	180	217	397
KYAUKTAW	131	177	308
SITTWE - URBAN	81	70	151
BUTHIDAUNG	707	828	1555
MAUNGDAW	607	794	1401

[1] In Rathedaung, only screening is conducted but not consistently; there is no partner yet implementing nutrition treatment activities here. Cases identified in Rathedaung as acutely malnourished are referred to nutrition treatment programs in neighboring Buthidaung or Maungdaw but face difficulties in accessing the services due to movement restriction. Other townships such as Ramree, and Kyaukphyu also do not have nutrition treatment services. Mrauk U has now started nutrition services but will need to operate to scale.

[2] ACF also uses weight for height as admission criteria during passive screening in Buthidaung and Maungdaw.

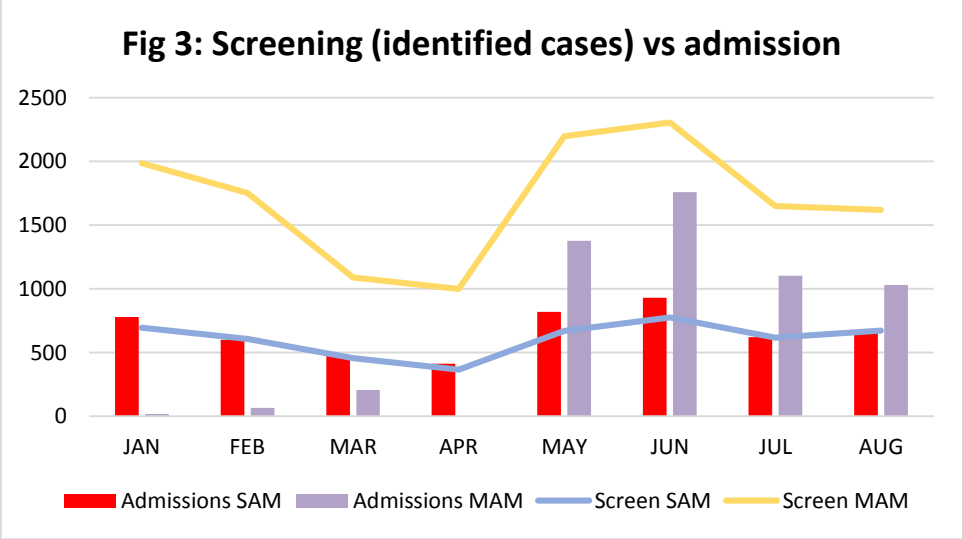


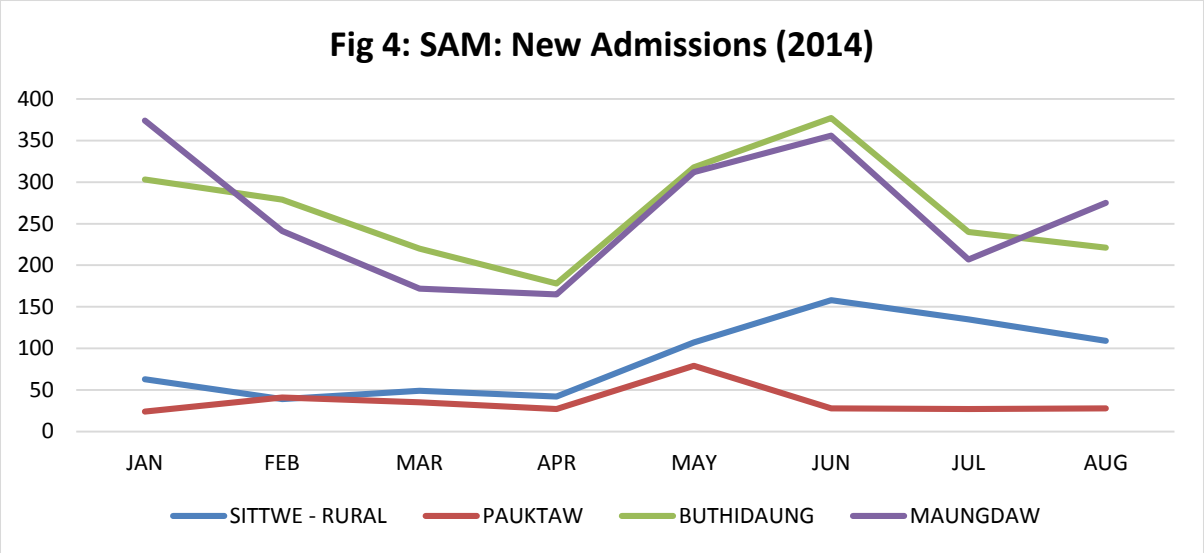
Proxy rates of acute malnutrition are based on screening data obtained in Sittwe and Pauktaw. According to active screening results, proxy rates of GAM showed a downward trend from June (8.3%) to 6.1% in August (Fig.2); Proxy rates of Severe Acute Malnutrition (SAM) were stable around 1.5% over the last 4 months.

2. Treatment of acute malnutrition

2.1. New admissions for treatment of acute malnutrition

Overall, a reduction of new SAM and MAM admissions is observed in July and August. Thus, 653 SAM cases (out of 672 identified) and 1,029 MAM cases (out of 1,619 identified) were admitted in August across 7 townships. Sometimes long distance to nutrition centres for MAM treatment prohibit access to services. This results in a large and consistent discrepancy in numbers identified as MAM versus numbers admitted for treatment. A mobile nutrition clinic providing Targeted Supplementary Feeding has been initiated to address this issue, but it only operates in Sittwe.





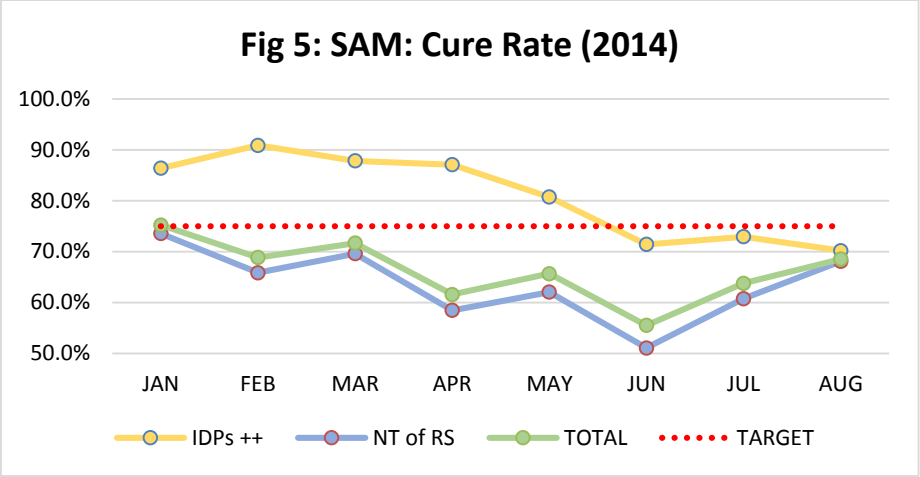
Similar to previous months, the number of new SAM admissions in August were higher in the northern townships than in other conflict affected townships. Nearly 76% (496 out of 653) of all total SAM admissions recorded in August were from northern Rakhine townships. A decrease in SAM admissions was observed for Sittwe rural and Buthidaung. However, an increase was observed in Maungdaw in August compared to July. There has been an ongoing seasonal SFP programme in the two townships through ACF from middle of April which could possibly explain part of the reduction in SAM new admissions. Other reasons for decreased admissions may be linked to the beginning of work in paddy fields, as well as poor access to centers due to heavy rains and poor road conditions. Security concerns related to the population counting exercise could also explain reduced admissions. Increasing levels of admission in Maungdaw could be due to better access brought about by improved road conditions and less heavy rain.

Low admission (8 cases in Kyauktaw and 2 cases each from Sittwe urban and Myaebon) of SAM were noted and no new admission for the other townships in August. These are the same townships where screening is passively conducted.

3. Programme performance

3.1. Management of SAM

SAM cure rate: Overall, the Therapeutic feeding program (TFP) in Rakhine State has been consistently performing below the SPHERE standard (75%) from February to August as per the SAM cure rate indicator but improvement was observed between June (55.5%) to August (68.5%). Program performance in the northern townships of Buthidaung and Maungdaw was below the SPHERE standard throughout 2014. Some of the reasons affecting program performance as cited by implementing agencies include protracted poor coverage with health services that worsened with the departure of MSF, food and nutrition insecurity and well as the insecurity experienced by beneficiaries and at times by service providers in the area. For the rest of the townships, program performance was well above the SPHERE standards, except in June to August where it dropped below 75% (Fig. 5).



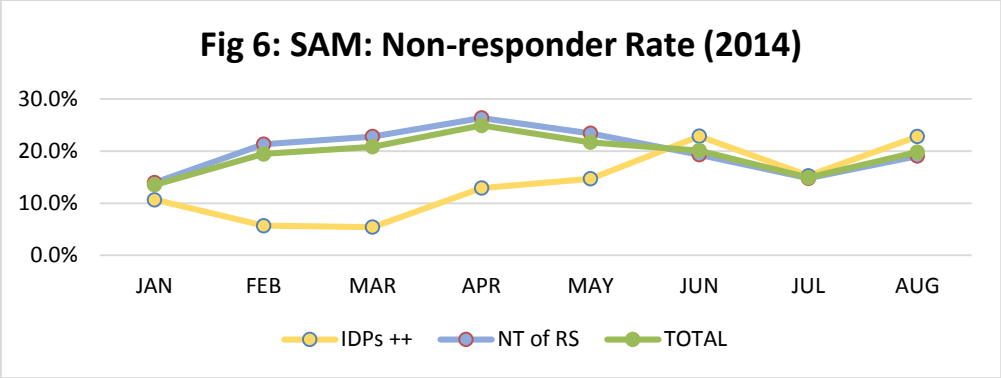
Maungdaw shows the lowest TFP program performance in August (62.5%) followed by Sittwe rural (68.1%) with Buthidaung being close to acceptable levels (74.3%). Apart from these three townships, the rest are equal or above the standard. Table 2 provides a snapshot of TFP programme performance in August per township.

Table 3: SAM Cure Rate by Township- August 2014

	Male	Female	TOTAL
SITTWE - URBAN	100.0%	100.0%	100%
SITTWE - RURAL	70.9%	65.3%	68.1%
MINBYA	100.0%	50.0%	75%
MYEBON	100.0%	100.0%	100%
PAUKTAW	81.8%	69.6%	75.7%
KYAUKTAW	No Exit	100.0%	100%
BUTHIDAUNG	79.0%	69.5%	74.3%
MAUNGDAW	61.7%	63.3%	62.5%

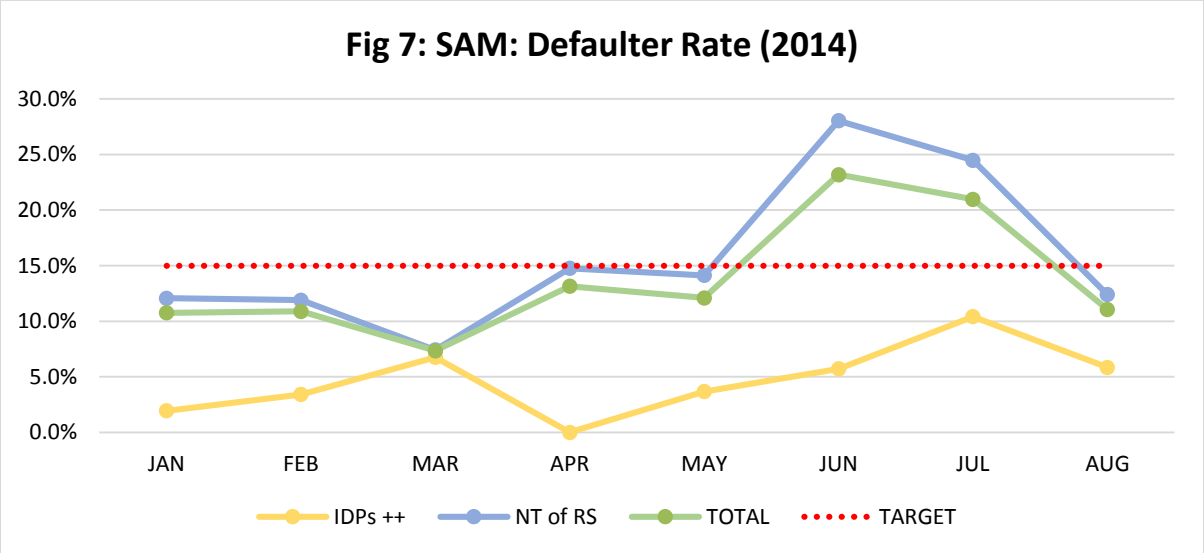
The poor performance of the TFP program in some townships may be due to the high non-responder rates consistently reported (Fig. 6) as well as high defaulter rates for northern townships during some months (June and July, Fig. 7).

SAM non-responder rate: Although there is no cut-off to gauge programme performance in relation to non-responder rates, a relatively high proportion of SAM children (average 20.1%) admitted to TFPs failed to respond to treatment between January and August. The higher non-responder rates reported in TFPs of both locations (IDP++ and NRS) were reported in August compared with July with the rate of 19.8% for all townships.

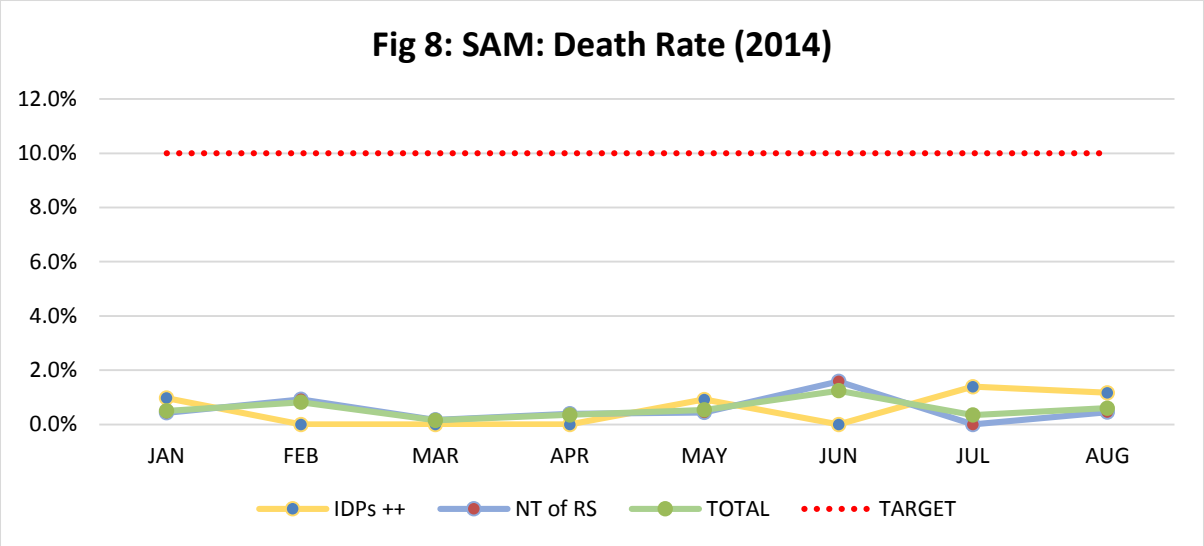


Lack of an adequately functioning referral system and primary health care services to complement nutrition services have partly contributed to the relatively high non-responder rate. Other factors that could be associated with high non-responder rates include high nutrition insecurity (especially in NRS) as well as social, nutritional, psychiatric and medical problems.

SAM defaulter rates: A downward trend in the proportion of defaulters is observed and is within acceptable levels (11.1%) for the month of August (Fig.7). Defaulter rates also decreased in Buthidaung and Maungdaw in August compared with the previous two months. In August, all the defaulters were from Sittwe rural (8 cases), Rathedaung (28 cases) and Buthidaung (54 cases).



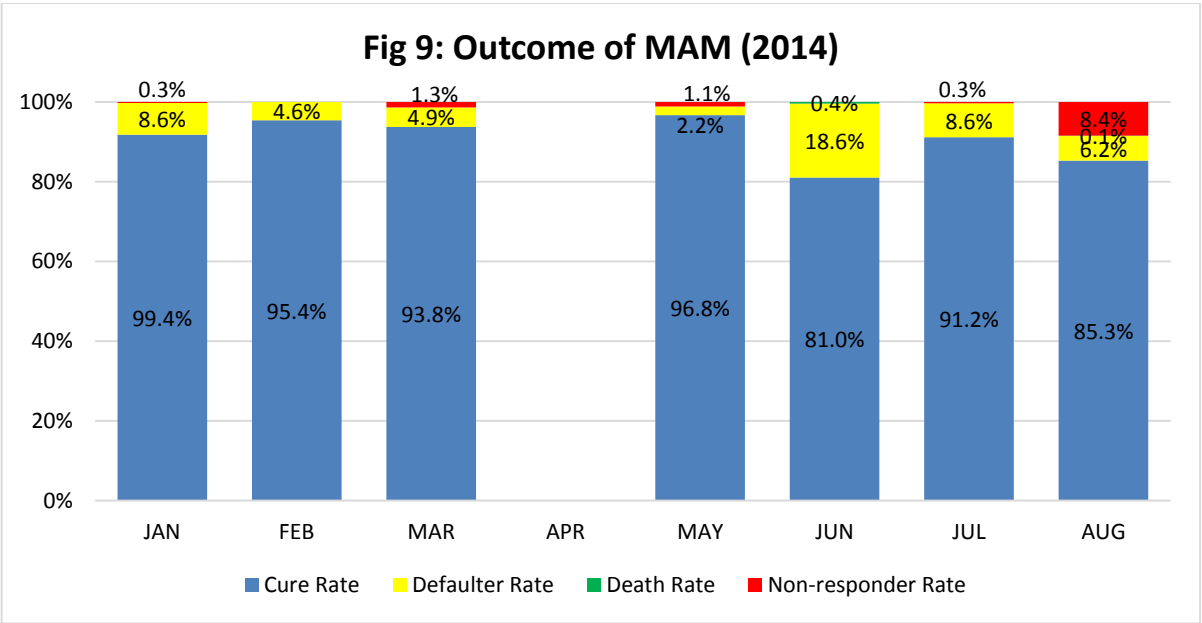
Death rate: The death rates in TFPs were within the acceptable minimum standard (<10%, SPHERE) as shown in Fig. 8. Four children's deaths were recorded in August, one each from Sittwe rural, Minbya, Buthidaung and Maungdaw.



3.2. Management of MAM

All program performance indicators: The Targeted Supplementary Feeding program is being implemented in 7 townships[3] with 72% of new cases being admitted in NRS. The program performed well above the minimum standards (> 75%, SPHERE standards) in terms of cure rate but lower performance was observed in August (85%) compared to July. In August, non-responder and defaulter rates were 8.4% and 6.2% respectively.

The majority of defaulters were from Maungdaw (31 cases) and Buthidaung (22 cases) – as these programs have the most beneficiaries – as well as Sittwe rural (17 cases) and 5 from other townships. Among 101 non-responders, 88 cases were from Maungdaw.



[3] TSFP is implemented in Sittwe, Kyauktaw, Pauktaw, Minbya and Myebon while seasonal TSFP (mid-April to September 2014) is implemented in Buthidaung and Maungdaw.

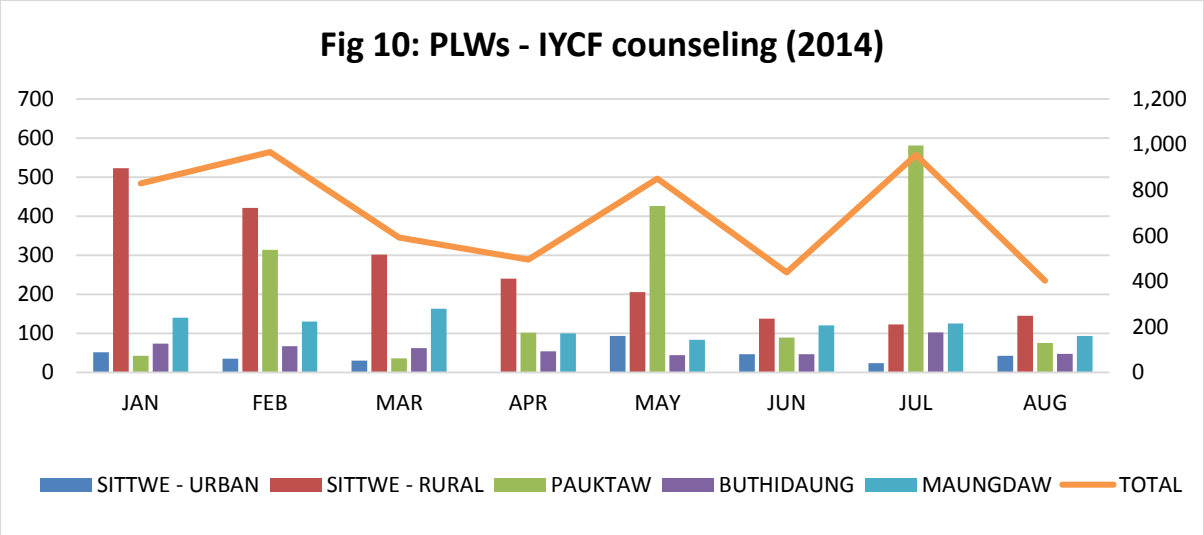
3.3 *Blanket Supplementary Feeding (BSFP):*

Through the BSF Program, children 6-59 months and pregnant and lactating women (PLW) are provided with fortified blended food. The program covers 48 villages and camps in 8 townships and reached 19,044 children aged 6-59 months and 6,467 pregnant and lactating women in August.

4. Access to preventive nutrition services

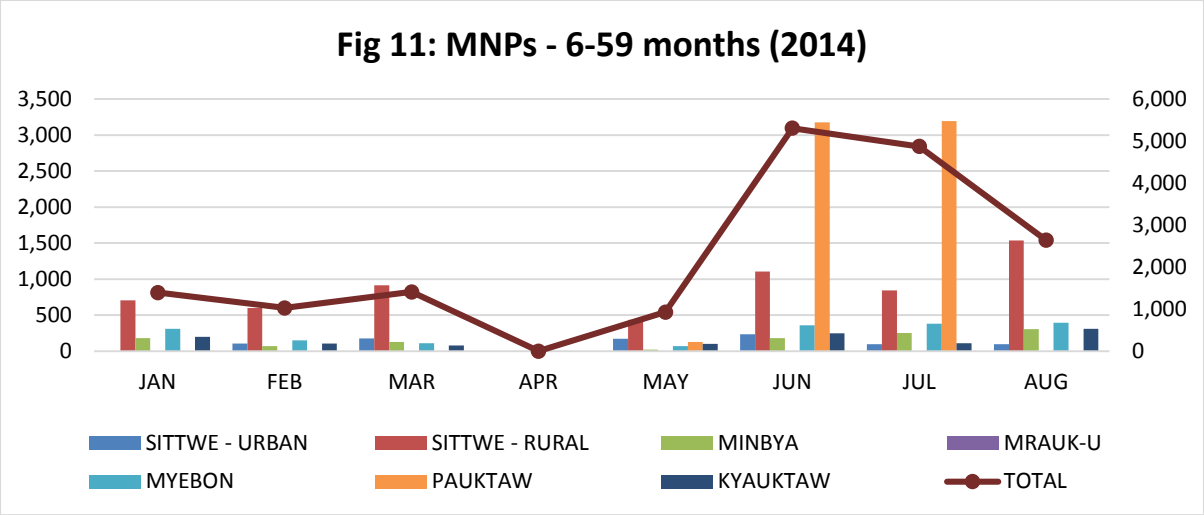
4.1. Provision of skilled Infant and Young Child Feeding (IYCF) counselling and care support

Skilled IYCF counselling is provided to PLW and to mothers /care givers of all children in Sittwe and Pauktaw townships as well as to pregnant and lactating mothers of acutely malnourished children in Buthidaung and Maungdaw. The total number of PLW accessing skilled IYCF and care practices support sharply decreased to 402 in August compared to 954 in July (Fig.10). This is the result of low numbers of counselling sessions in Pauktaw and Buthidaung. A total of 7,285 PLW are targeted in 2014 to receive breastfeeding counselling and 76% (5,528) have been reached until now. Integration of IYCF services in nutrition treatment services should be considered by all partners where capacity allows so as to maximize program impact. Currently, no counselling services are provided in Myebon, Minbya, Kyauktaw and Mrauk Oo townships.

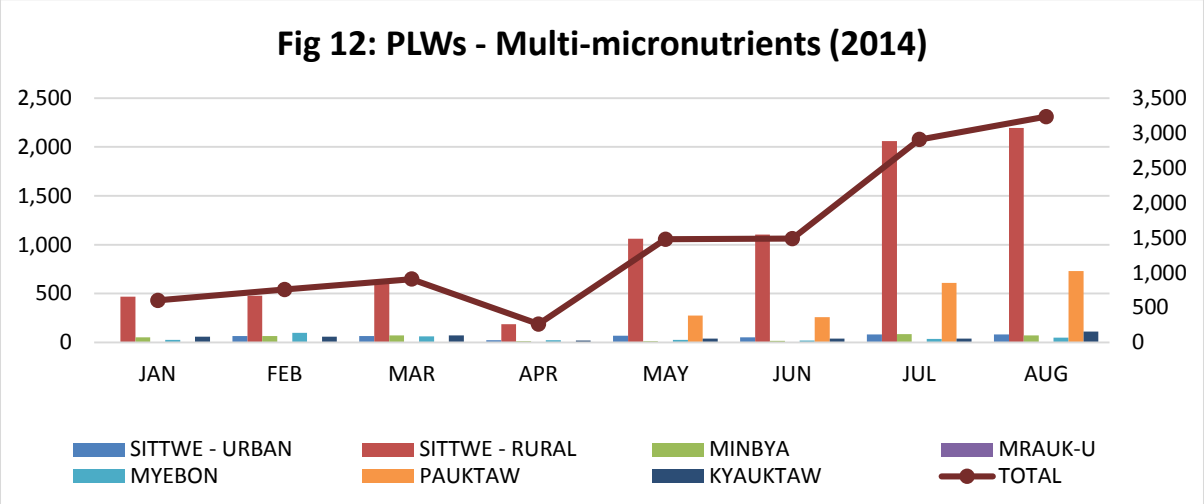


4.2. Provision of multiple micronutrients

Children 6-59 months (multiple micronutrient powders (MNPs)/sprinkles): The provision of multiple micronutrient supplementation reached 2,640 children 6-59 months in August. About 60% of the children receiving supplementation in August from Sittwe rural (1,538 children). A total of 50,220 children 6-59 months are targeted by the service for 2014 and to date, 17,572 (35%) have been reached (low coverage).



Pregnant and lactating women (multiple micronutrient tablets): A total of 3,233 PLW received multiple micronutrient supplementation (tablets) in August which is the highest number recorded for 2014 (fig. 12). Of the total 13,113 PLW targeted with multiple micronutrient supplementation, to date 11,628 (89%) have been reached (good progress towards target)**.** There were monthly variations in numbers reached; Sittwe rural and Pauktaw recorded the highest numbers of both children and PLWs reached with multiple micronutrient supplementation due to high number of beneficiaries.



5. Main obstacles impacting on implementation of interventions

- Lack of adequate health services and referral system to complement nutrition services after MSF activities cessation.
- Transportation of referral cases is another challenge due to distance to nearest hospitals as well as transportation cost, except for Sittwe.
- Impact of rumours and social media propaganda on uptake of inpatient health services for referral cases.
- Relatively high non-responder rates related to issues such as inadequate health services, sharing and selling of therapeutic and supplementary food.
- High rate of defaulter rates partly due to security reasons and high transportation cost.

6. Recommendations

- Start more mobile nutrition clinics to bring services closer to villages and camps so as to lower gaps between numbers identified as MAM during screening and those admitted especially in Sittwe.
- Explore how to best expand to all conflict affected townships the coverage with multiple micronutrient supplementation, especially for children 6-59 months.
- Access: Advocacy for access to services by beneficiaries where there is restriction of movement, especially in NRS to be heightened at all levels.
- Advocate for an increase of the number of nutrition centres in NRS.
- UNICEF to visit NRS and try to organize a nutrition sector meeting.