RAKHINE STATE – NUTRITION INFORMATION ANALYSIS

January – December 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)

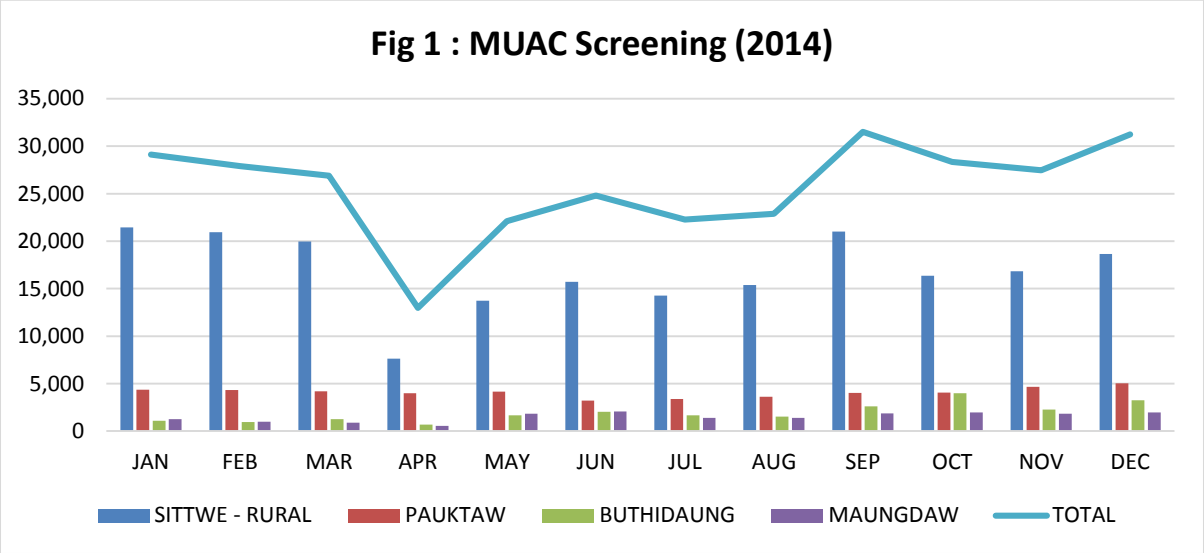
Organizations involved in response

DoH, ACF, MHAA, SCI, UNICEF, WFP, MNMA

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 9 townships (Sittwe, Pauktaw, Minbya, Myebon, Mrauk U, Kyauktaw, Buthidaung and Maungdaw, Rathedaung[1]). A total of children 31,237 were screened in December. Numbers of screened children on a monthly basis are highest in Sittwe rural area and Pauktaw, making 76% of all screened children in December (Fig 1) with 18,660 children from Sittwe rural and 5,035 from Pauktaw. These two townships have a relatively large population size with joint active screening being conducted by ACF and SCI.



1.2. Screening by month:

For the reporting period (January to December), a total of **307,424** children (**146,090** boys and **161,334 girls**) have been screened for acute malnutrition. Active screening is conducted in Sittwe rural and Pauktaw Township; Screening in other townships (Buthidaung, Maungdaw, Myebon, Mrauk U, Kyauktaw, Minbya and Sittwe (urban) townships) are majorly passive (Table 1).

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

	Male	Female	Total
SITTWE - URBAN	124	165	289
MINBYA	248	280	528
MRAUK-U	145	194	339
MYEBON	139	142	281
KYAUKTAW	381	495	876
BUTHIDAUNG	1232	2014	3246
MAUNGDAW	801	1182	1983

In 2014, 66% and 16% of total screening were from Sittwe rural and Pauktaw respectively (Fig 2).

[1] Nutrition screening was conducted alongside health activities and these have stopped since end of November 2014

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

Fig 2:Total SAM cases by township (2014)

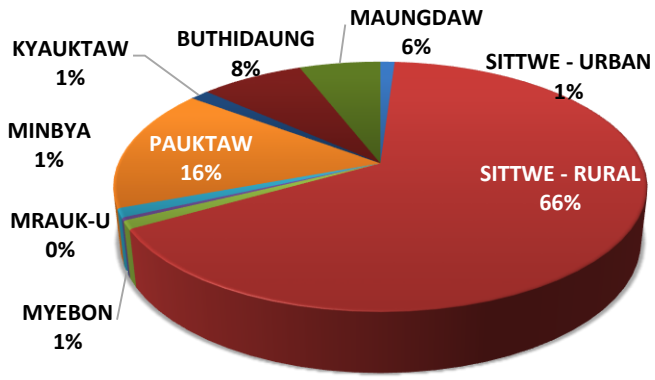
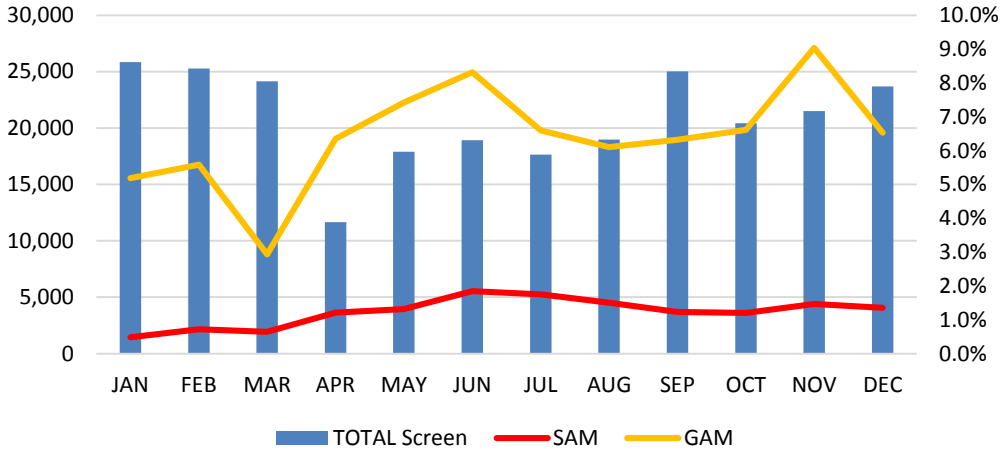


Fig 3: Active MUAC screening (2014)

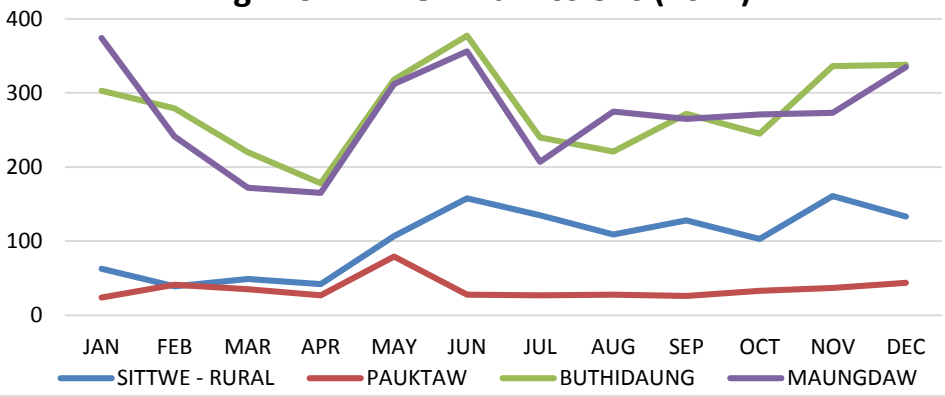


Active screening results in Pauktaw and Sittwe rural, reflect proxy rates of Global Acute Malnutrition (GAM) of 6.5% in December, a decrease from the 9% recorded in November.Severe Acute Malnutrition (SAM) rate was 1.4% in December. (Fig.3).

1.3. New admissions for treatment of acute malnutrition

Number of admission for SAM and MAM cases were 866 and 1,717 respectively for the month of December. 78% of SAM and 75% of MAM admissions were from northern townships of Rakhine state.

Fig 4: SAM: New Admissions (2014)



An upward trend of SAM admissions was observed in Maungdaw but admissions remained stable in Pauktaw and Buthidaung and reduced for Sittwe rural. (Fig 4). 14 SAM children were admitted from Mrauk U Township and 2 from Kyauktaw. No admission of SAM were noted in the other townships (Sittwe Urban, Minbya, Myaebon).

Throughout 2014, 79% of total SAM admission were from 2 northern townships (Buthidaung and Maundaw), whereas 14% were from Sittwe rural and the rest 7% were from Pauktaw, Kyauktaw and Mrauk U (Fig 5).

Two thirds of all SAM admissions in 2014 were girls (Fig 6). An anthropological study conducted in Sittwe Township in 2014 by ACF highlighted differences in the care of boys and girls in terms of time spent in care as well as differences in feeding practices that favour boys more than girls due to social value considerations; boys are believed to be the ones who reproduce family values. However according to the screening data, the GAM and SAM rate does not show specific discrepancy. It is hoped that further anthropological studies planned by ACF in Buthidaung and Maungdaw will shed more light regarding gender disparities in malnutrition.

Fig 5:Total SAM cases by township (2014)

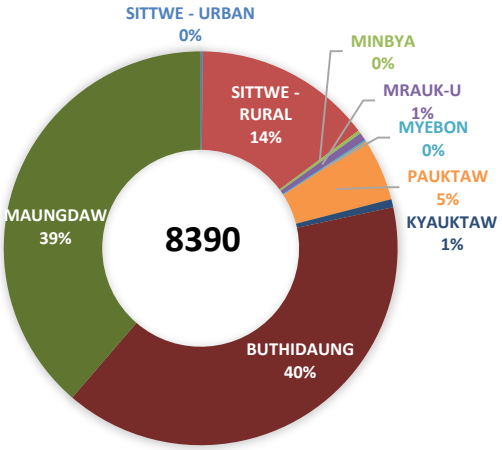
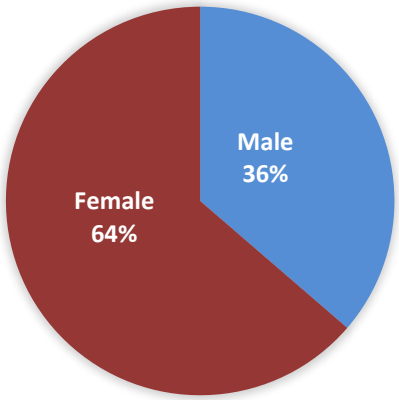


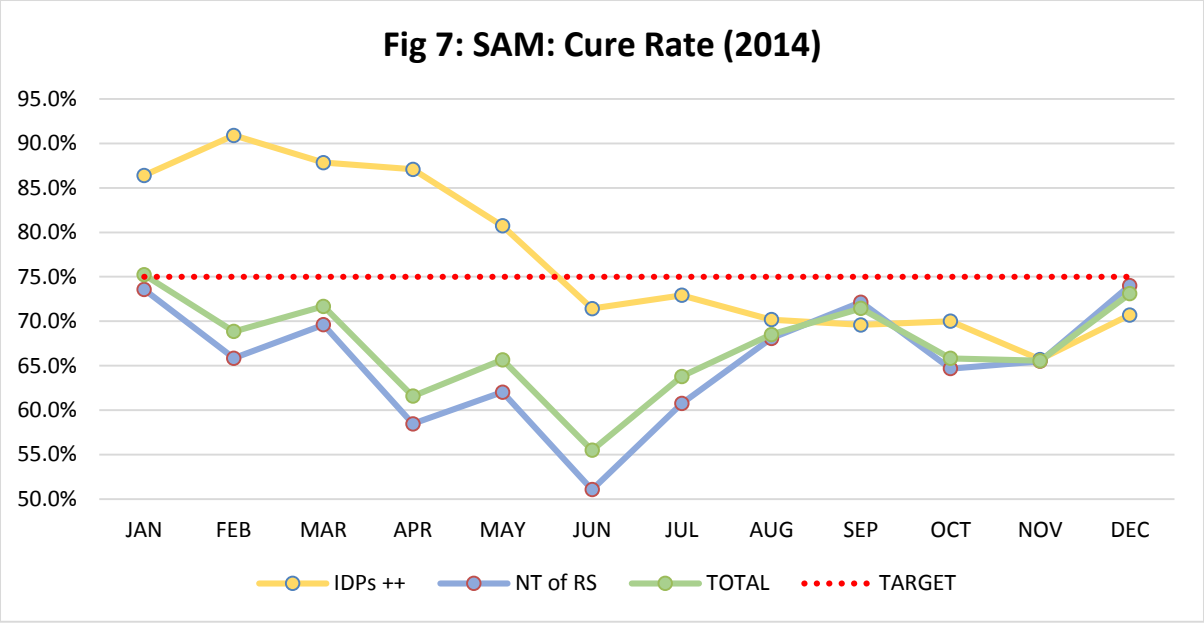
Fig 6:Total SAM admission by gender (2014)



2. Programme performance

2.1. Management of SAM

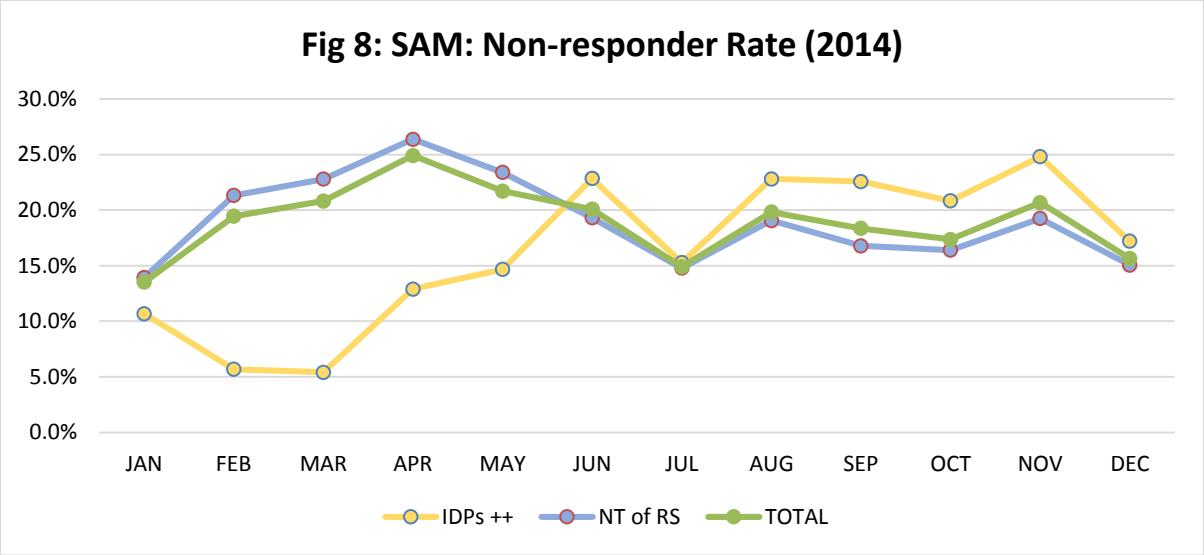
SAM cure rate: Unlike previous months, the Cure Rate in therapeutic feeding program (TFP) in Rakhine State is 73.1% in December which is close to the SPHERE standard (75%). Cure rate in Northern townships is 74%, which is the best for 2014, but still below the acceptable minimum standard. The improved Cure Rate in northern townships can largely be attributed to new malnutrition preventive approaches employed by programme implementers to engage communities in nutrition activities such as prevention, detection and treatment of malnutrition. Cure Rate in other affected townships is 70.7%.



Sittwe rural shows the lowest TFP program performance in December (61.7%) followed by Maungdaw (65.2%). There is no obvious gender difference in terms of cure rate seen in December. Table 2 provides a snapshot of TFP programme performance in December per township.

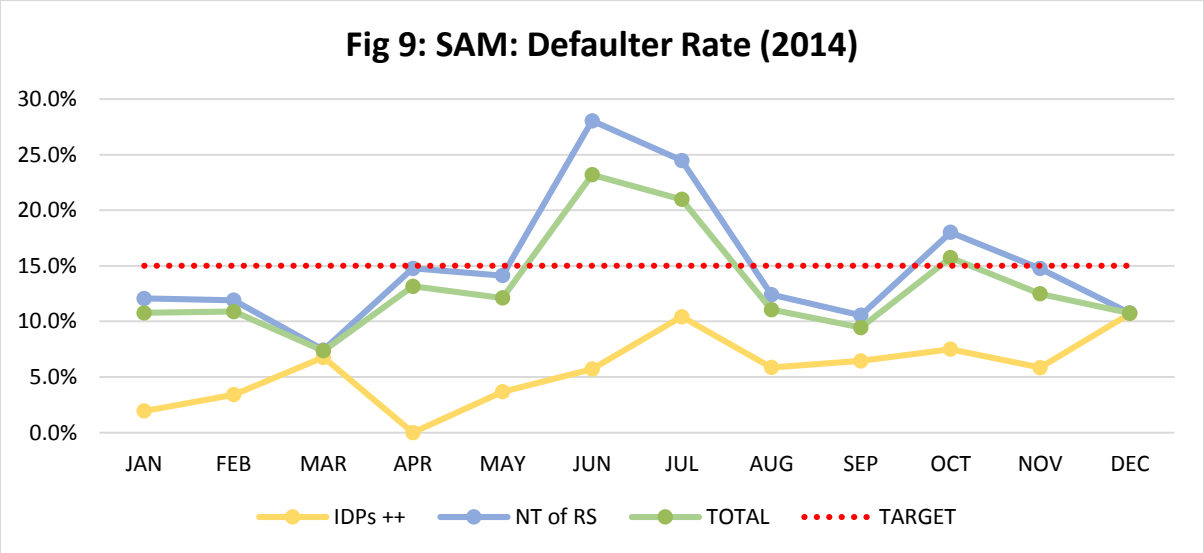
Table 3: SAM Cure Rate by Township- December 2014			
	Boy	Girl	TOTAL
SITTWE - URBAN	No Exits	100.0%	100%
SITTWE - RURAL	58.5%	64.9%	61.7%
MINBYA	100.0%	100.0%	100.0%
MRAUK-U	100.0%	100.0%	100.0%
MYEBON	100.0%	100.0%	100.0%
PAUKTAW	100.0%	95.2%	97.6%
KYAUKTAW	100.0%	66.7%	83.4%
BUTHIDAUNG	77.5%	88.6%	83.1%
MAUNGDAW	66.0%	64.3%	65.2%

SAM non-responder rate: Despite decreased non responder rate of 15% in December compared to that reported in November (19.1%), the overall rate remains still relatively high (Fig 8) with variations between townsips; Sittwe rural, Maungdaw and Buthidaung reported rates of 23.5%, 17.6% and 13% respectively.. Other townships did not report any non-responders.

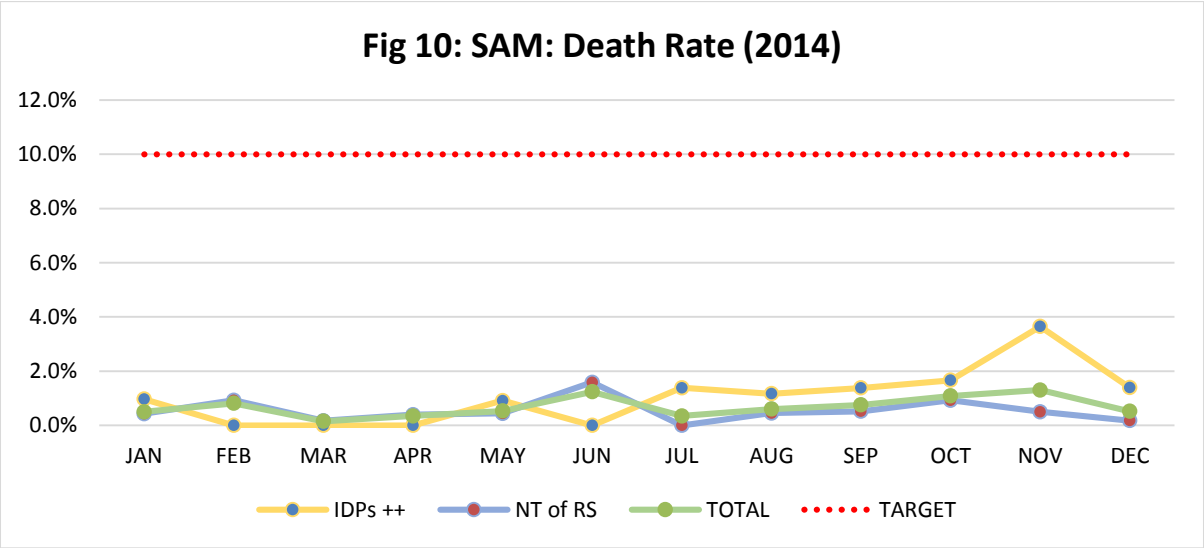


Lack of an adequately functioning referral system and primary health care services to complement nutrition services have partly contributed to the relatively high non-responder rates. Other factors that could be associated with high non-responder rates include high nutrition insecurity (especially in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

SAM defaulter rates: Overall defaulter rate decreased from 12.5% in November to 10.7% in December (Fig: 9). A consistent decrease was noted in defaulter rates in the northern townships since October. The decrease could be attributed to the communities' involvement in nutrition activities as well as home visits and follow up by nutrition and mental health care practice teams. An increase was noted in defaulter rates in December for all other affected townships; all defaulters were from Maungdaw (51 cases), Sittwe rural (22 cases), Buthidaung (9 cases) and 1 each from Pauktaw and Kyauktaw. Some reasons for high defaulter rates relate to far distances to cover by caregivers to get to nutrition treatment centres and the fear to pass through check points and other security issues.



Death rate: The death rates in TFPs were within the acceptable standards (< 10%, SPHERE) in December as shown in Fig. 10. 4 deaths were recorded in December, 2 from Sittwe rural and 1 each from Kyauktaw and Maungdaw Townships. The causes of death relate to complications associated with SAM.



Total 565 children with SAM were discharged cured in December with majority (73%) of them (262 cases) were from Buthidaung and Maungdaw.

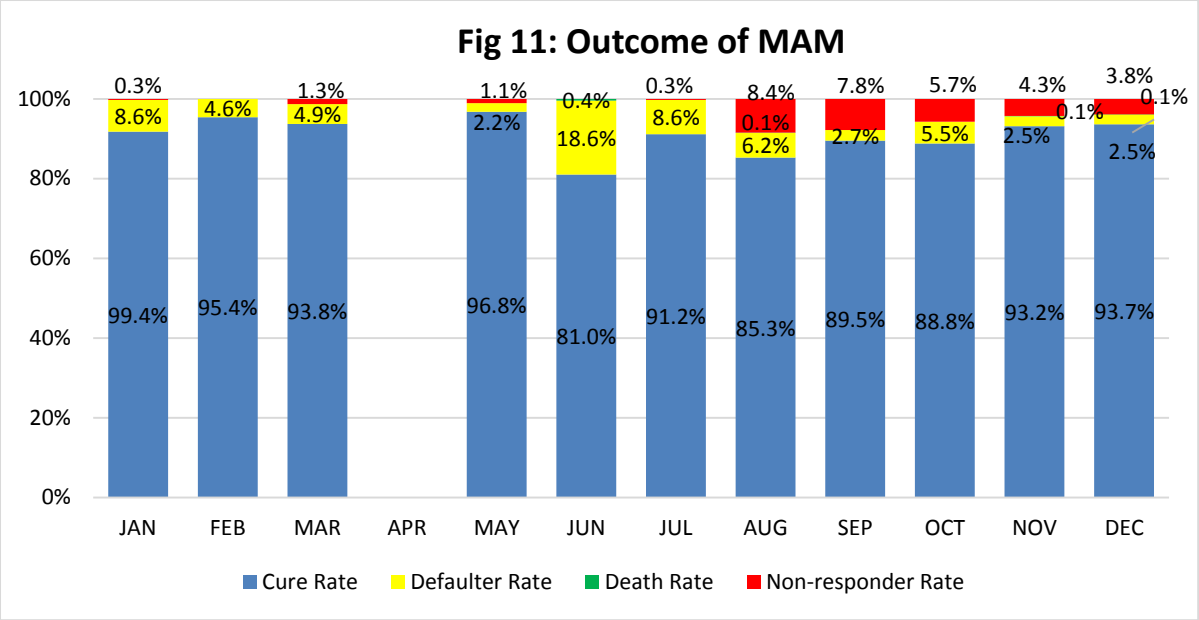
2.2. Management of MAM

All program performance indicators: The Targeted Supplementary feeding program for children 6- 59 months is being implemented in 8 townships[3] with 75% of total admission having been recorded in northern townships. The program performed well above the minimum standards (> 75%, SPHERE standards) in terms of cure rate. In December, non-responder rate was at 5.5% and defaulter rate was 3.4%.

The majority of defaulters were from Maungdaw (33 cases) and Buthidaung (5 cases) – as these programs have the most beneficiaries – as well as from 2 each from Kyauktaw and Sittwe rural. These were the same townships reporting high SAM defaulter rates. Among 67 non-responders, 50 cases were from Maungdaw. One death was also reported in Maungdaw. The cause of death is yet to be established.

Admission of children under 5 was stopped at the end of December in Maungdaw and Buthidaung Townships. The last beneficiaries should be discharged at the end of March.

[3] TSFP is implemented in Sittwe, Kyauktaw, Pauktaw, Minbya, Myaebon, Mrauk U Buthidaung and Maungdaw.



3.3 *Supplementary Feeding:*

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 587 villages and camps in 11 townships and reached 19,394 children aged 6-59 months and 6,234 pregnant and lactating women in December[4].

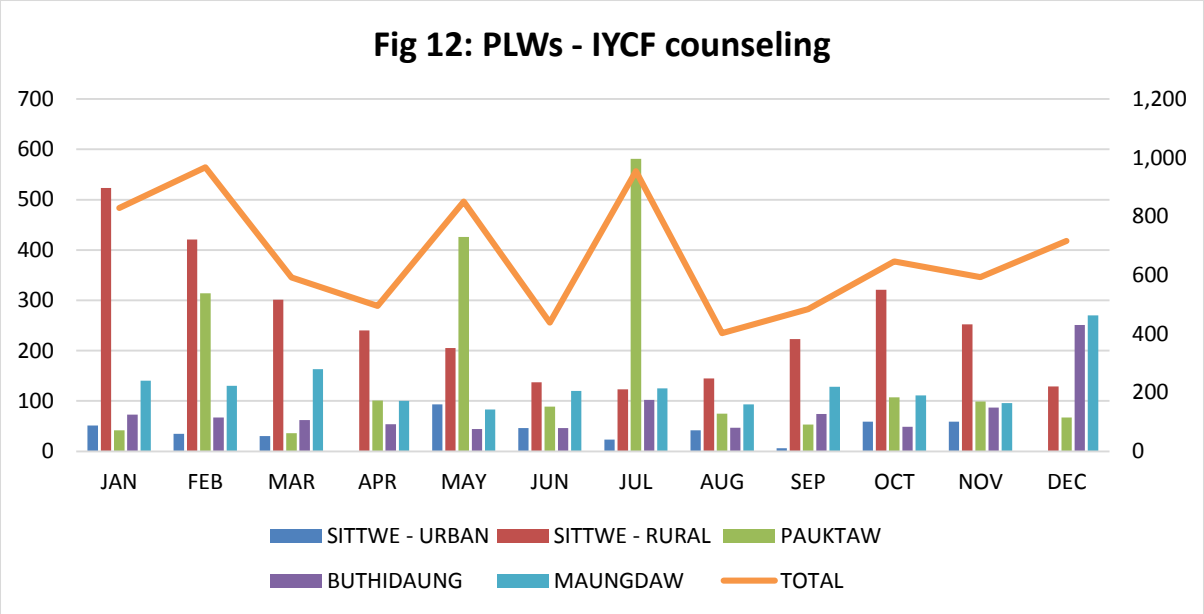
Targeted Supplementary Feeding: Additional to the TSFP provided to children 6-59 months reported in section 2.2, acutely malnourished pregnant women in Buthidaung and Maungdaw are being covered with targeted supplementary feeding. 783 Pregnant and Lactating women received TSFP and 27.5% cure rate, 10.0% defaulter rate and 62.5% non-responder rate were reported for the month of December

3. Access to preventive nutrition services

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

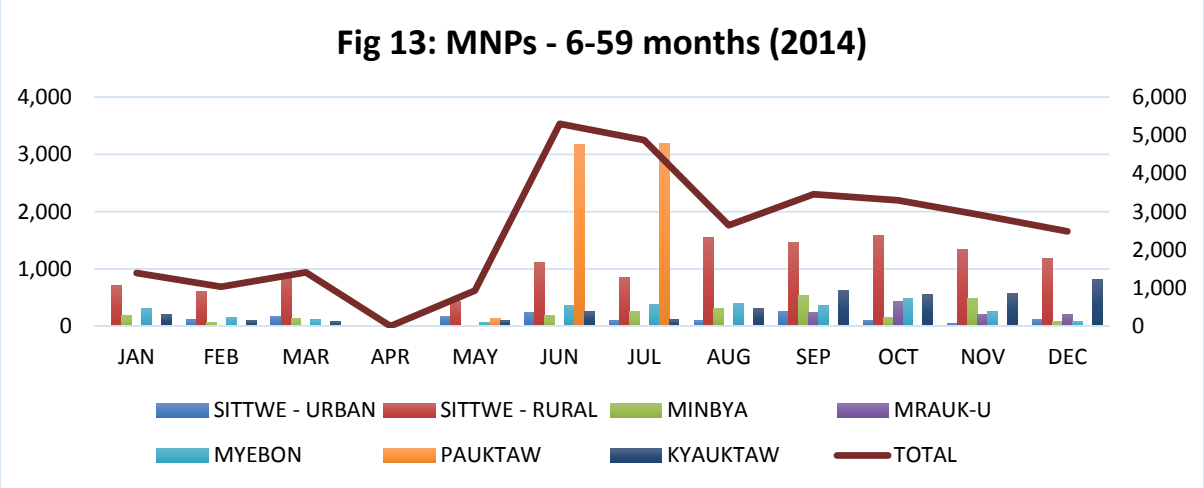
Skilled IYCF counselling is provided to PLW and to mothers /care givers of all children in Sittwe and Pauktaw townships as well as to pregnant and lactating mothers of acutely malnourished children in Buthidaung and Maungdaw. The total number of PLW accessing skilled IYCF and care practices support in December were 717 (Fig: 12). A total of 7,285 PLW are targeted in 2014 to receive breastfeeding counselling of which 7,969 (109% of all PLW) have been reached to date. 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, Rathedaung and Mrauk Oo townships.

[4] This figure does not include Buthidaung and Maungdaw data

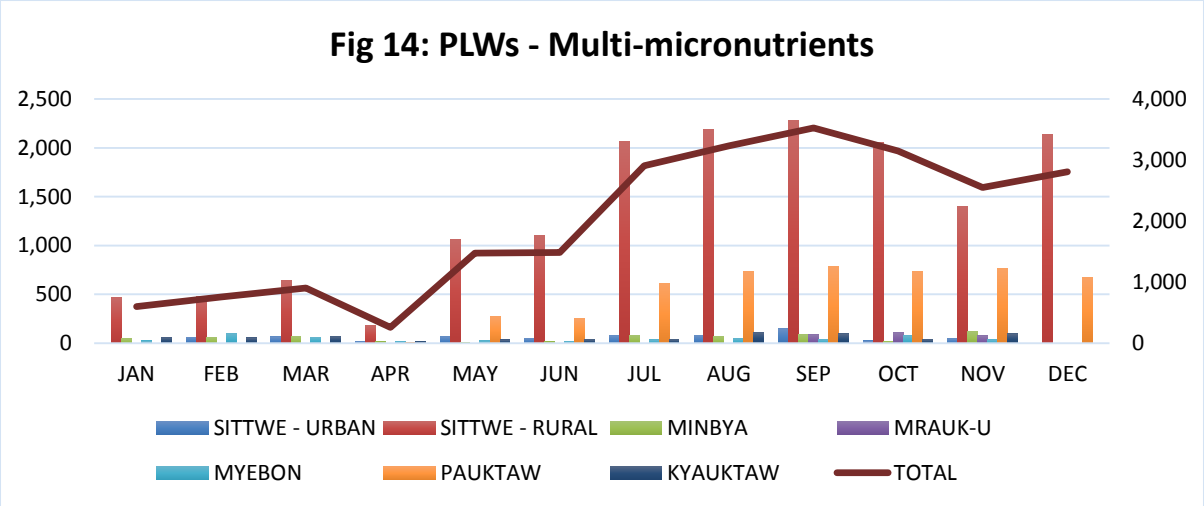


3.2. Provision of multiple micronutrients

Children 6-59 months (multiple micronutrient powders (MNPs)/sprinkles): The provision of multiple micronutrient supplementation reached 2,480 children 6-59 months in December. A total of 50,220 (90% of all children 6-59 months) are targeted by the service and to date, 29,709 (54%) have been reached (low coverage). That is partly due to the fact that about 30 % of targeted children (those in northern townships) are not reached by multiple micronutrient supplementation.



Pregnant and lactating women (multiple micronutrient tablets): A total of 2,807 PLW received multiple micronutrient supplementation (tablets) in December (Fig. 13). Of the total 13,113 (90% of all PLW) targeted with multiple micronutrient supplementation 23,656 (162%) have been reached to date. The overshooting of the target might be because of low target setting and double counting of beneficiaries over the months.



4. Main obstacles impacting on implementation of interventions

- Limited implementation capacity (number of partners) especially for IYCF services.
- Limited participation of local authorities in sector coordination restricting coordination efforts.
- Limited expansion of services in view of the perception by communities and local authorities on provision of equal aid.
- Delayed establishment of functional coordination mechanism of nutrition/health actors in northern Rakhine, supported by local authorities.

5. Recommendations

- Programmes to address underlying causes of malnutrition need to be put in place, especially in northern townships.
- Scaling up of innovative Communication for Development (C4D) initiatives to change harmful care Practices and address some of the underlying causes.
- Coordination of the nutrition sector, which has recently resumed in Maungdaw district needs to be sustained with the involvement of the Township Health Department in the driving seat. Explore the possibility of having joint coordination meetings of health and nutrition partners as well as TMOs.
- Continued lobbying needed at all levels for expansion of nutrition services, especially in northern Rakhine. National level support could be leveraged for this.
- Training of Basic Health staff will be key in the effective implementation of IYCF services where no active partner is providing these.
- Training of MoH Basic Health Staff in screening will be key in the scale up of detection of malnourished cases.