

RAKHINE STATE – NUTRITION INFORMATION ANALYSIS

January 2015

INTRODUCTION

The nutrition sector in Rakhine State aims to improve the nutritional status of boys, girls, and women affected by conflict and disaster. The sector has agreed on the following four objectives for 2015:

1. People with acute malnutrition are identified and adequately treated
2. Nutritionally vulnerable groups access key preventive nutrition-specific services
3. Nutrition response is informed by timely situation monitoring and coordination mechanisms
4. Preparedness and resilience is strengthened

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

Indicators

- Number of children aged 6-59 months with severe acute malnutrition admitted to therapeutic care
- Percentage of exits from therapeutic care by children aged 6-59 months who have recovered
- Number of pregnant and lactating women who access infant and young child feeding counselling
- Number of children 6-59 months who receive micronutrient supplementation
- Number of pregnant and lactating women who receive micronutrient supplementation

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

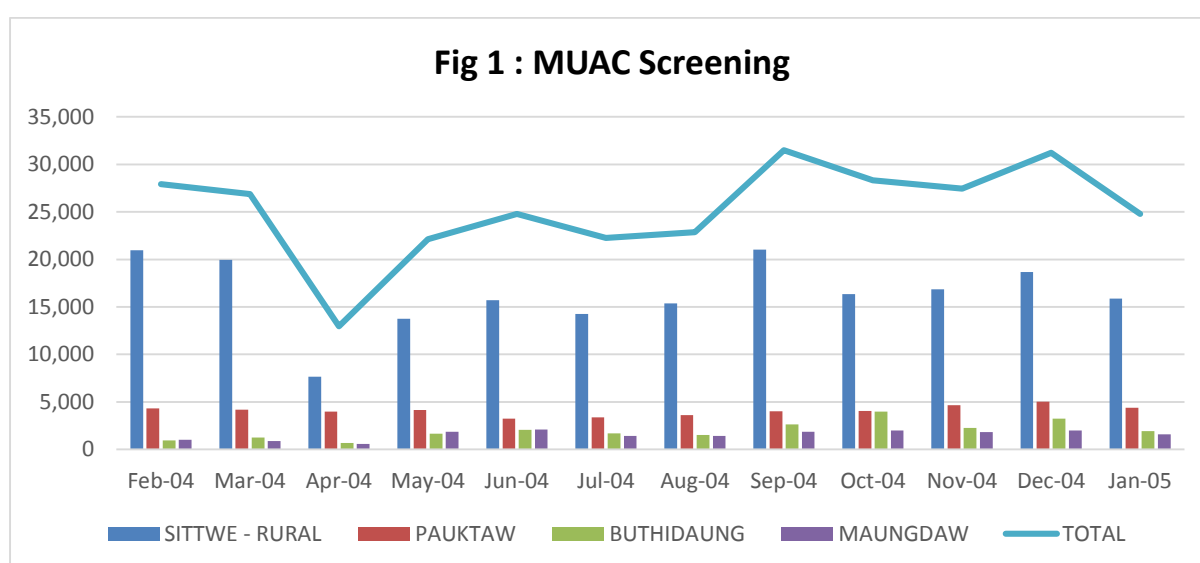
DoH, ACF, MHAA, SCI, UNICEF, WFP, MNMA

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).

A total of children 24,771 were screened in January. Numbers of screened children on a monthly basis are highest in Sittwe rural area and Pauktaw, making 82% of all screened children in January (Fig 1) with 15,871 children from Sittwe rural and 4,375 from Pauktaw. These two townships have a relatively large population size with joint active screening being conducted by ACF and SCI.

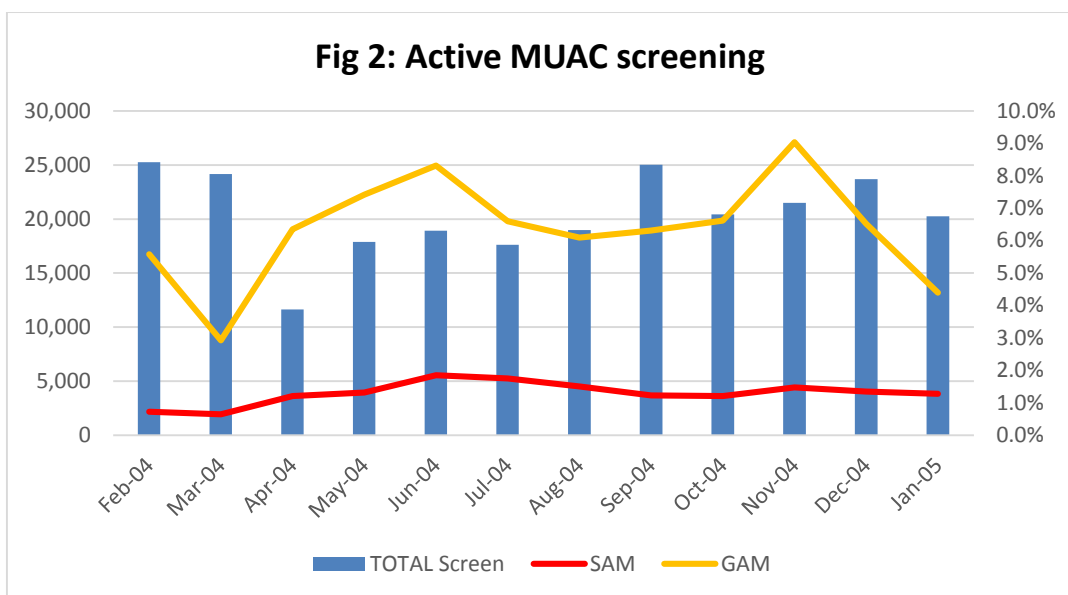


1.2. Screening by month:

In January, a total of **24,771** children (**12,257** boys and **12,514** 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).

	Male	Female	Total
SITTWE - URBAN	100	138	238
MINBYA	88	96	184
MRAUK-U	241	168	409
MYEBON	68	71	139
KYAUKTAW	36	0	36
BUTHIDAUNG	792	1128	1920
MAUNGDAW	704	895	1599

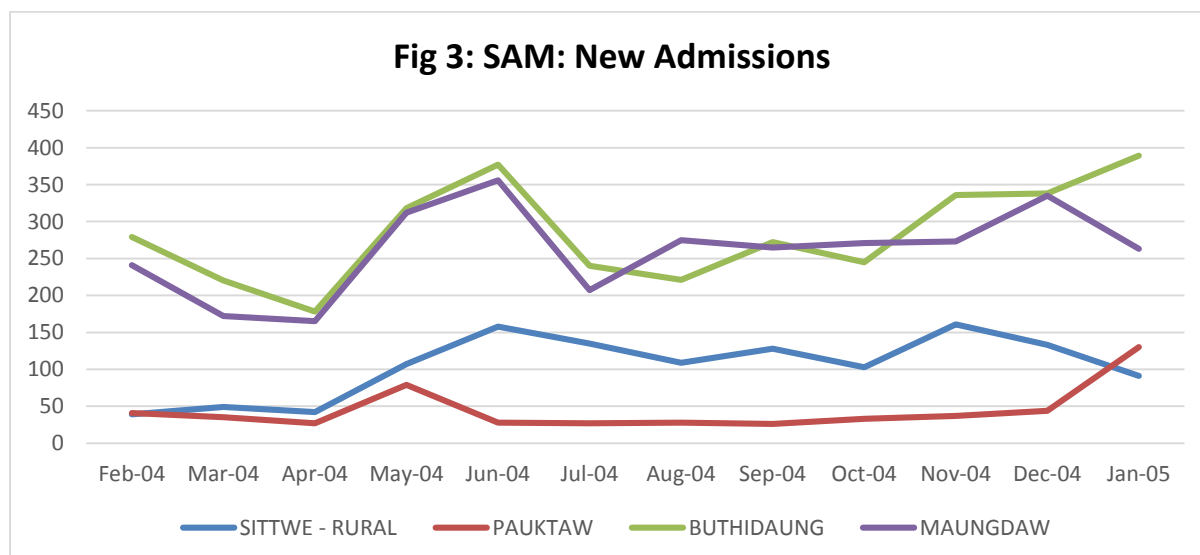
¹ ACF also uses weight for height as admission criteria during passive screening in Buthidaung and Maungdaw.



Active screening results in Pauktaw and Sittwe rural, reflect proxy rates of Global Acute Malnutrition (GAM) of 4.4% in January, a decreasing of about half GAM rate from November 2014 but Severe Acute Malnutrition (SAM) rate remained stable. (1.3% in January Fig.2). It needs to be taken into consideration that this data shows trends and not statistically significant changes.

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 January. 78% of SAM and 75% of MAM admissions were from northern townships of Rakhine state.

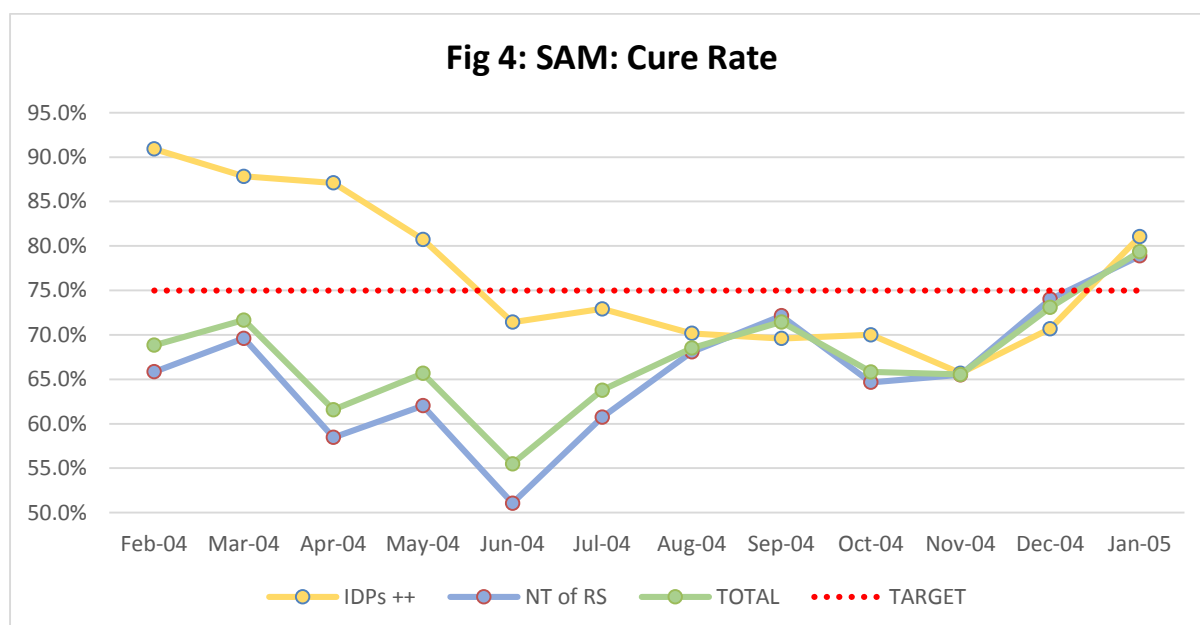


An upward trend of SAM admissions was observed in Buthidaung and Pauktaw but decreased in Maungdaw and Sittwe rural. (Fig 3). 5 SAM children were admitted from Mrauk U Township. No admission of SAM were noted in the other townships (Sittwe Urban, Minbya, Myaebon and Kyauktaw) in January 2015.

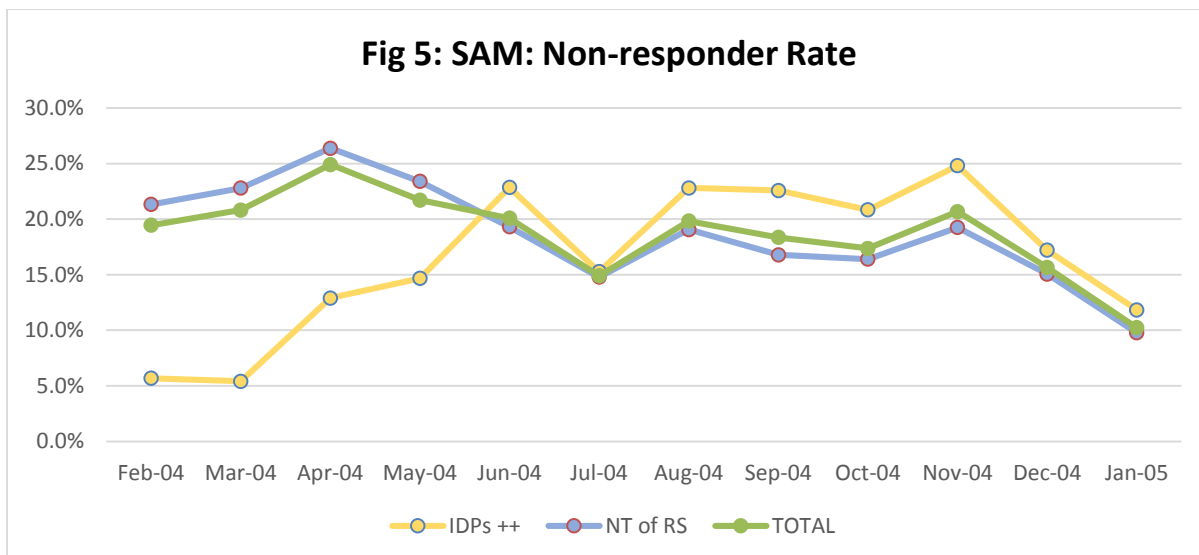
2. Programme performance

2.1. Management of SAM

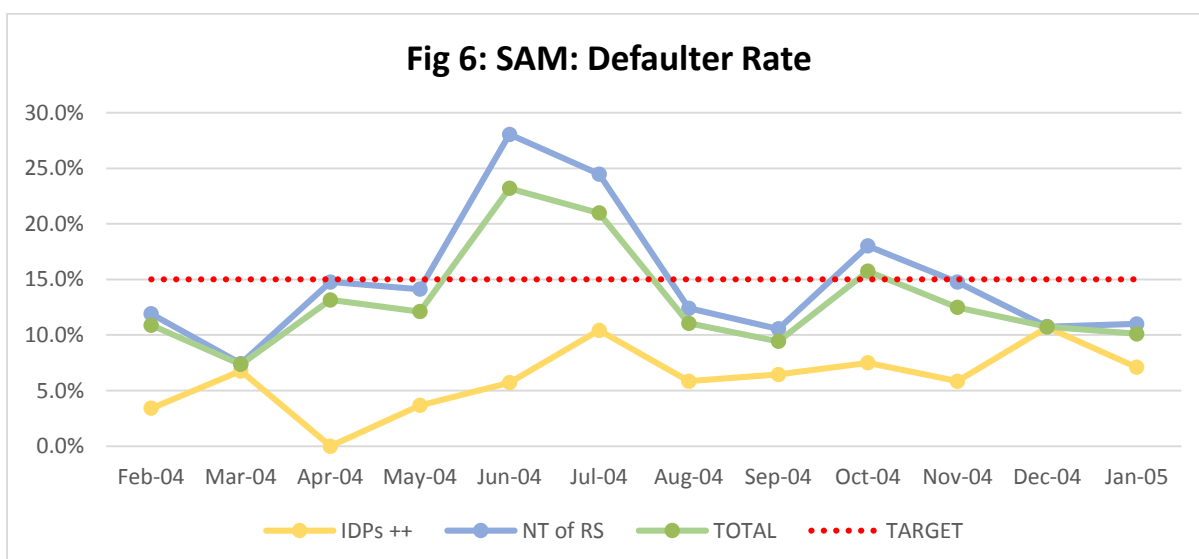
SAM cure rate: Improvement was seen in performance of therapeutic feeding program (TFP). Overall cure rate is 79.4% in January which is above the SPHERE standard (75%). Cure rate in Northern townships is 78.9%. The improved Cure Rate in northern townships can largely be attributed to the winter/crops season. It can be also attributed to the 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 81.1%.



SAM non-responder rate: Decreasing trend of non-responder rate has seen in last 2 months and only 10.2% for the month of January which is the best in last 12 months. (Fig 5) There were variations between townships; Sittwe rural, Maungdaw, Buthidaung and Pauktaw reported rates of 14.9%, 11%, 8.3% and 1.9% respectively. Other townships did not report any non-responders.

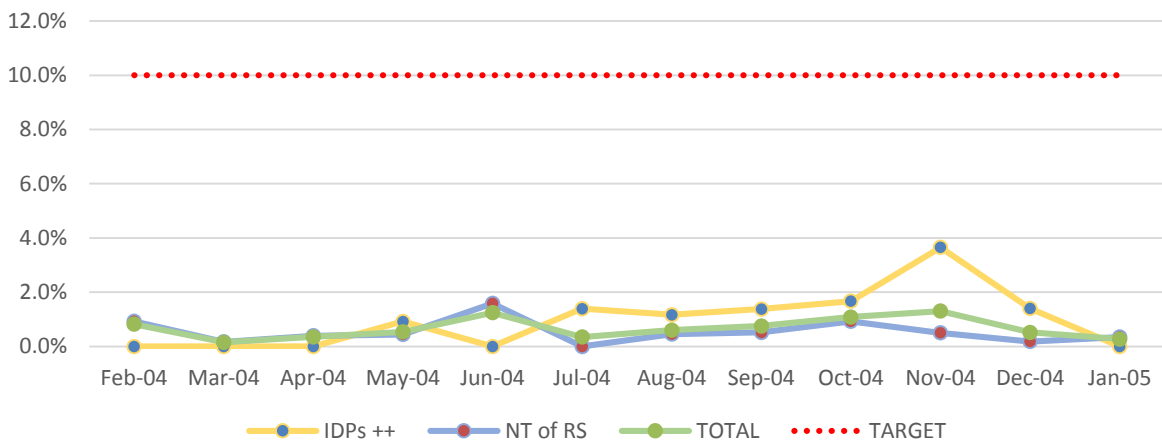


SAM defaulter rates: Overall defaulter rate was 14.9% for MgD and 6.4 for BgD and 7.1% for other townships (Fig: 6). A consistent decrease was noted in defaulter rates in the northern townships since October. The decrease could be attributed to the community involvement in nutrition activities as well as home visits and follow up by nutrition and mental health care practices teams.



Death rate: The death rates in TFPs were within the acceptable standards (< 10%, SPHERE) in January as shown in Fig. 7. 2 deaths were recorded in January, 1 each from Buthidaung and Maungdaw Townships. The causes of death relate to complications associated with SAM.

Fig 7: SAM: Death Rate



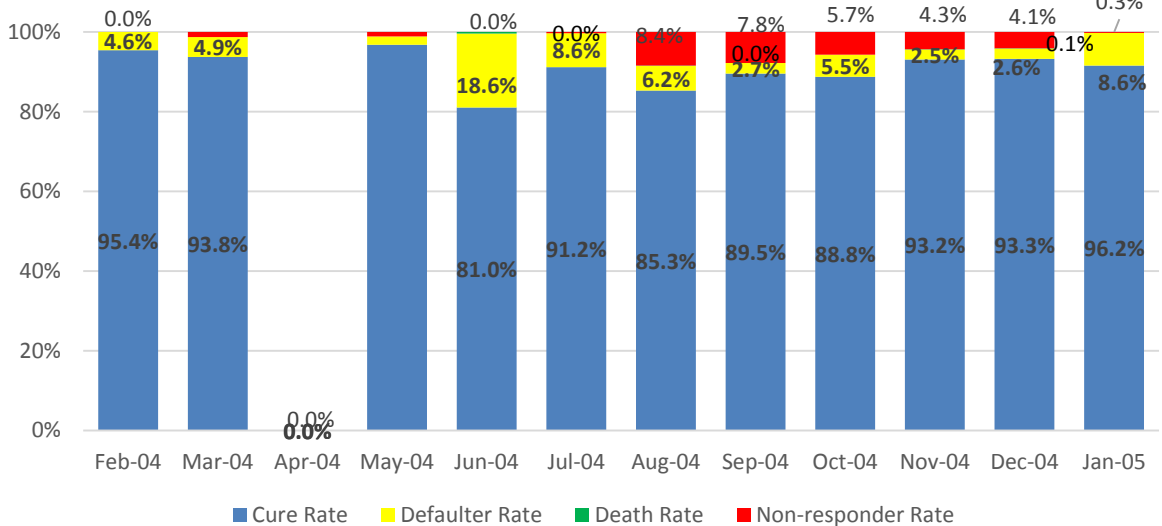
Discharge: Total 1059 children with SAM were discharged cured in January with majority (99.5%) of them (1054 cases) were from Buthidaung and Maungdaw.

2.2. Management of MAM

All program performance indicators: Only 11 admission for TSFP as admission of children under 5 were stopped at the end of January in Maungdaw and Buthidaung Townships. The program performed well above the minimum standards (> 75%, SPHERE standards) in terms of cure rate. In January, non-responder rate was at 4.4% and defaulter rate also 4.4%.

The majority of cured children, defaulters and non-responders were from northern townships as these programs have the most beneficiaries.

Fig 8: Outcome of MAM



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

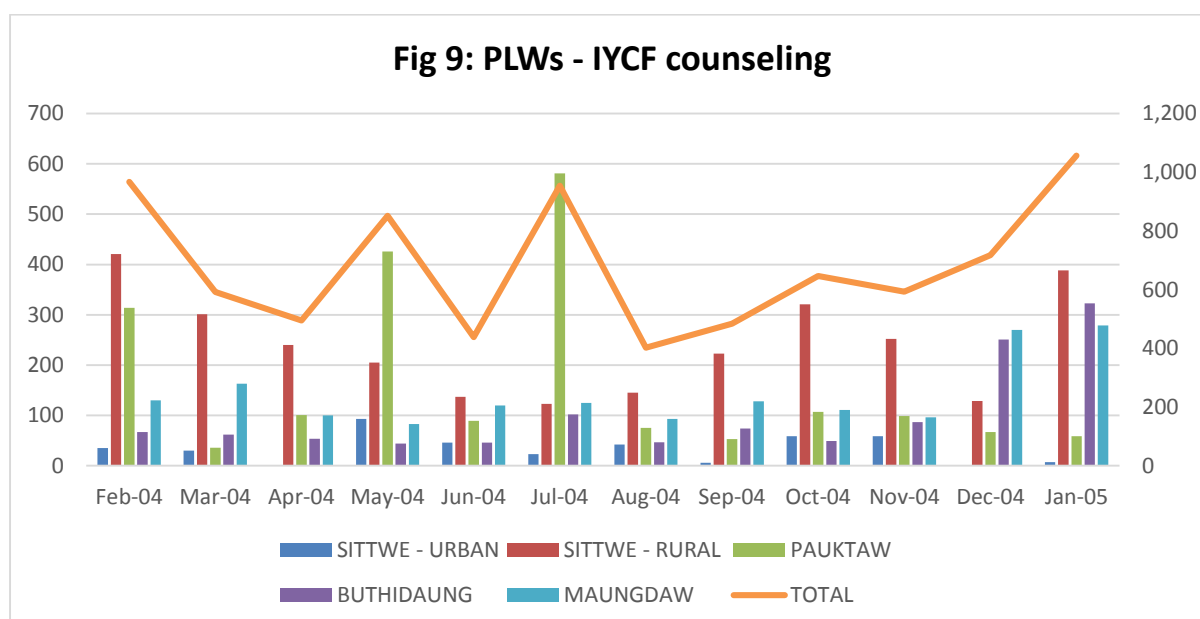
covers 587 villages and camps in 11 townships and reached 19,241 children aged 6-59 months and 7,587 pregnant and lactating women in January².

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. 1838 Pregnant and Lactating women received TSFP and 51.2% cure rate, 15.2% defaulter rate and 33.2% non-responder rate were reported for the month of January.

3. Access to preventive nutrition services

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

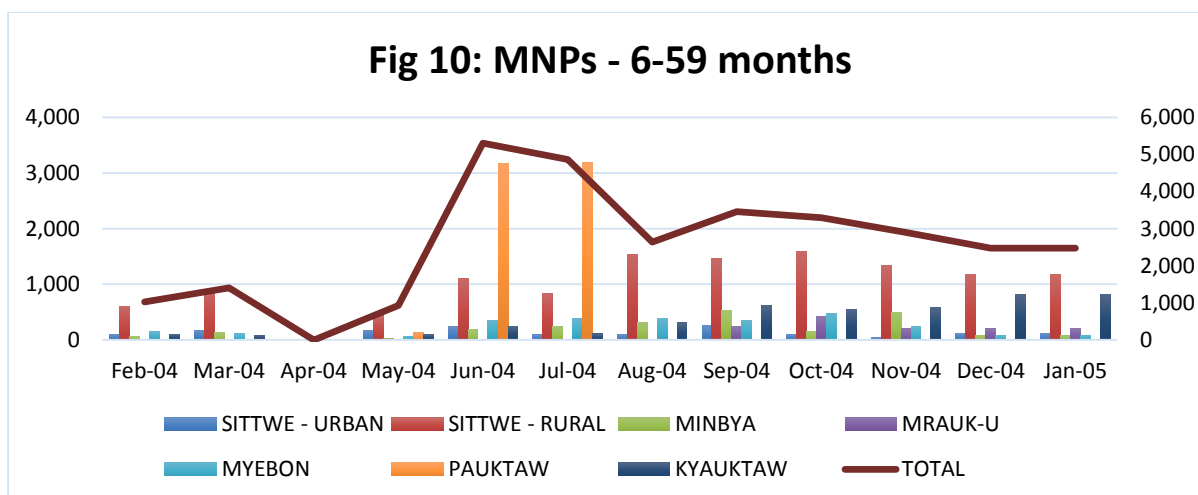
Skilled IYCF counselling is provided to PLW and to mothers /care givers of all children in Sittwe and Pauktaw townships as well as to pregnant and lactating mothers of acutely malnourished children in Buthidaung and Maungdaw. The total number of PLW accessing skilled IYCF and care practices support in January were 1056 (Fig: 9). 602 from Northern township and 454 from other affected townships.



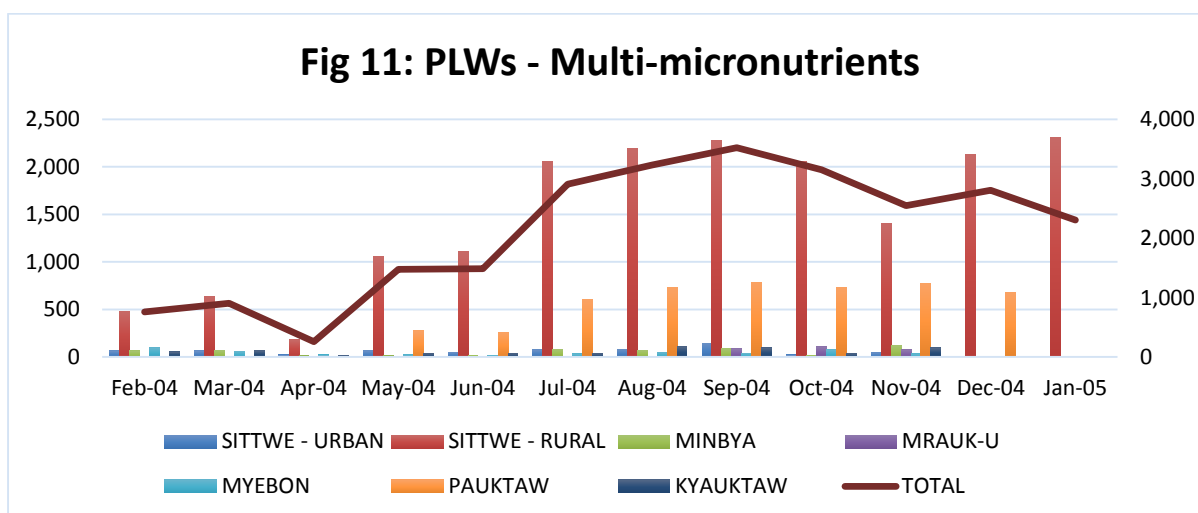
3.2. Provision of multiple micronutrients

Children 6-59 months (multiple micronutrient powders (MNPs)/sprinkles): The provision of multiple micronutrient supplementation reached 2,480 children (1069 boys and 1411 girls) of 6-59 months in January.

² This figure does not include Buthidaung and Maungdaw data



Pregnant and lactating women (multiple micronutrient tablets): A total of 2,306 PLW received multiple micronutrient supplementation (tablets) in January (Fig. 11). Only the PLW from Sittwe rural camps benefitted from supplementation in January.



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.
- Challenges with coordination of nutrition/health actors in northern Rakhine and for the sustainability, support and participation of local authorities is very important.
- Insufficient manpower also play a role in effective and timely programme implementation. Sometimes nutrition partners engage with other campaigns which may hinder the nutrition programme activities to some extent.

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 departments in the driving seat- Evaluate the possibility to do joint coordination meeting including UN (UNICEF-WHO) Health and nutrition partners and MoH (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 basic MoH health staff in screening will be a key in the scale up of the malnutrition detection.
- If possible, active screening should be conducted in other conflict affected townships for early case detection and prompt treatment.
- Skilled IYCF counselling should also be conducted by local NGOs in their project townships for better understanding of IYCF practices among PLW and caregivers of young children.