RAKHINE STATE – NUTRITION INFORMATION ANALYSIS

March 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 though 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)

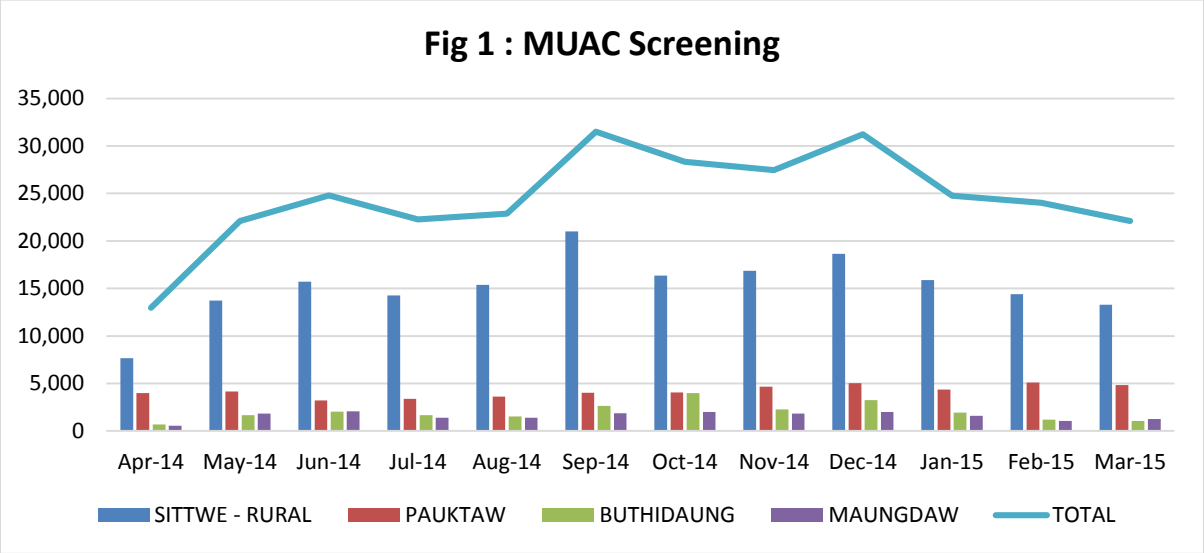
Organizations involved in response

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 8 townships (Sittwe, Pauktaw, Minbya, Myebon, Mrauk U, Kyauktaw, Buthidaung and Maungdaw). A total of 22,117 children were screened in March. Due to a relatively large population size with joint active screening being conducted by ACF and SCI, numbers of screened children on a monthly basis are highest in Sittwe rural area and Pauktaw, accounting for 82% of all screened children in March (Fig 1) with 13,289 children from Sittwe rural and 4,814 from Pauktaw.



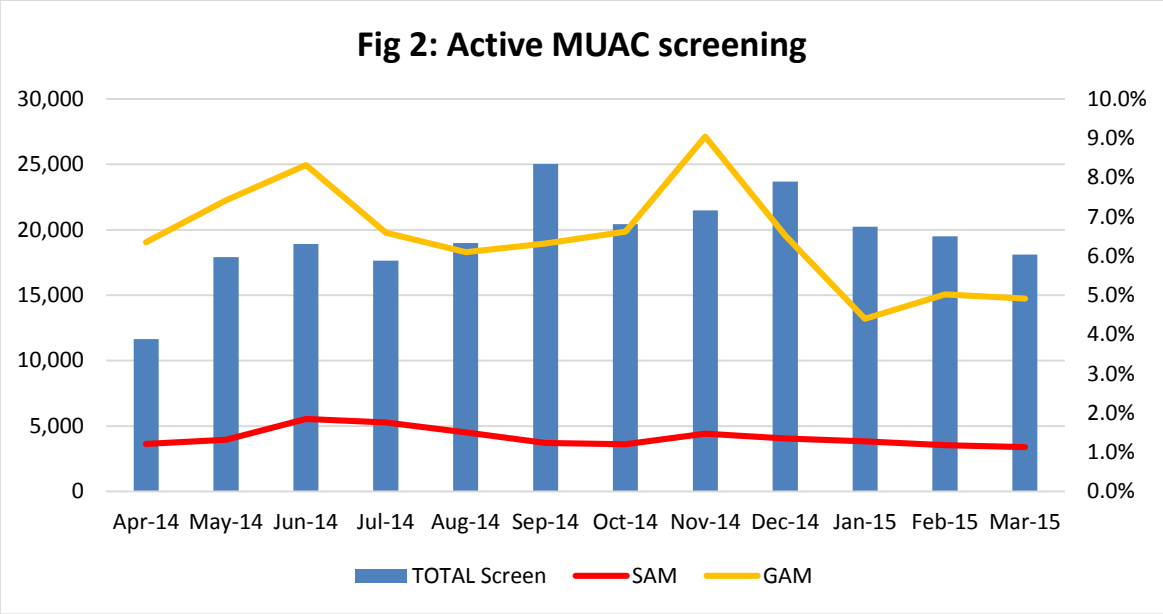
1.2. Screening by month:

In March, a total of **22,117** children (**10,631** boys and **11,486** girls) have been screened for acute malnutrition. Active screening is conducted in Sittwe rural and Pauktaw Townships; Screening in other townships (Buthidaung, Maungdaw, Myebon, Mrauk U, Kyauktaw, Minbya and Sittwe (urban) townships) is mostly passive (Table 1).

Table 1: Passive MUAC[1] screening- March 2015

	Male	Female	Total
SITTWE - URBAN	47	67	114
MINBYA	161	193	354
MRAUK-U	180	205	385
MYEBON	309	285	594
KYAUKTAW	96	159	255
BUTHIDAUNG	463	582	1045
MAUNGDAW	540	727	1267

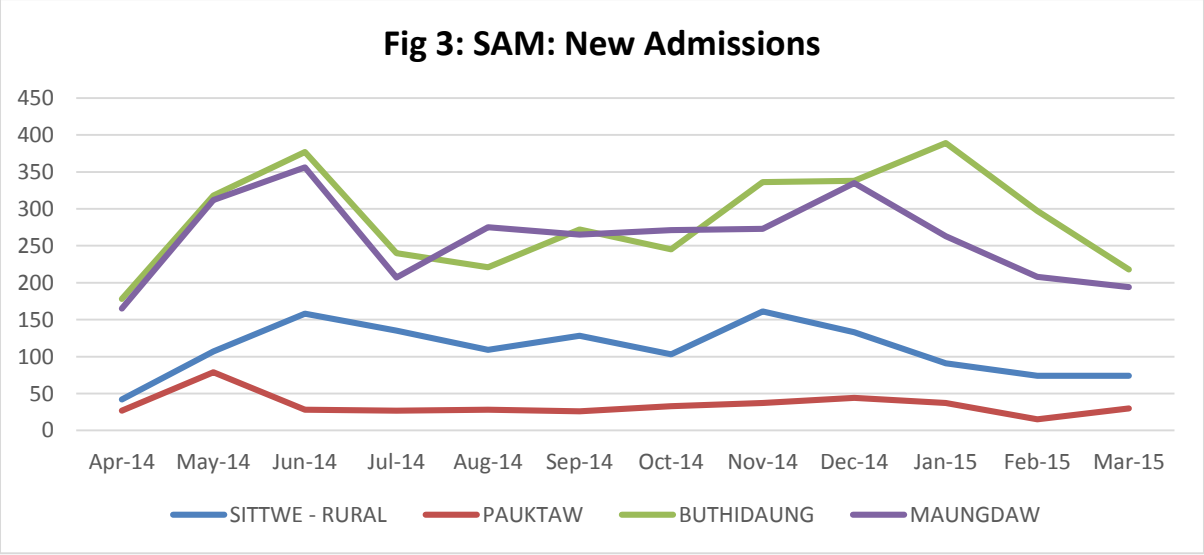
[1] ACF also uses weight for height as admission criteria during passive screening in Buthidaung and Maungdaw.



Active screening results from Pauktaw and Sittwe rural reflect proxy rates of Global Acute Malnutrition (GAM) of 4.9% in March. The rate of acute malnutrition was also low in first quarter of 2014. Severe Acute Malnutrition (SAM) rate remains stable (1.1% in March, Fig.2).

1.3. New admissions for treatment of acute malnutrition

The number of admissions for SAM and MAM were 5,165 and 157 respectively for the month of March. 80% of SAM admissions were from northern townships of Rakhine state. All MAM admissions were from conflict affected townships because there is no new MAM admission for U5 children in northern townships starting from early 2015.

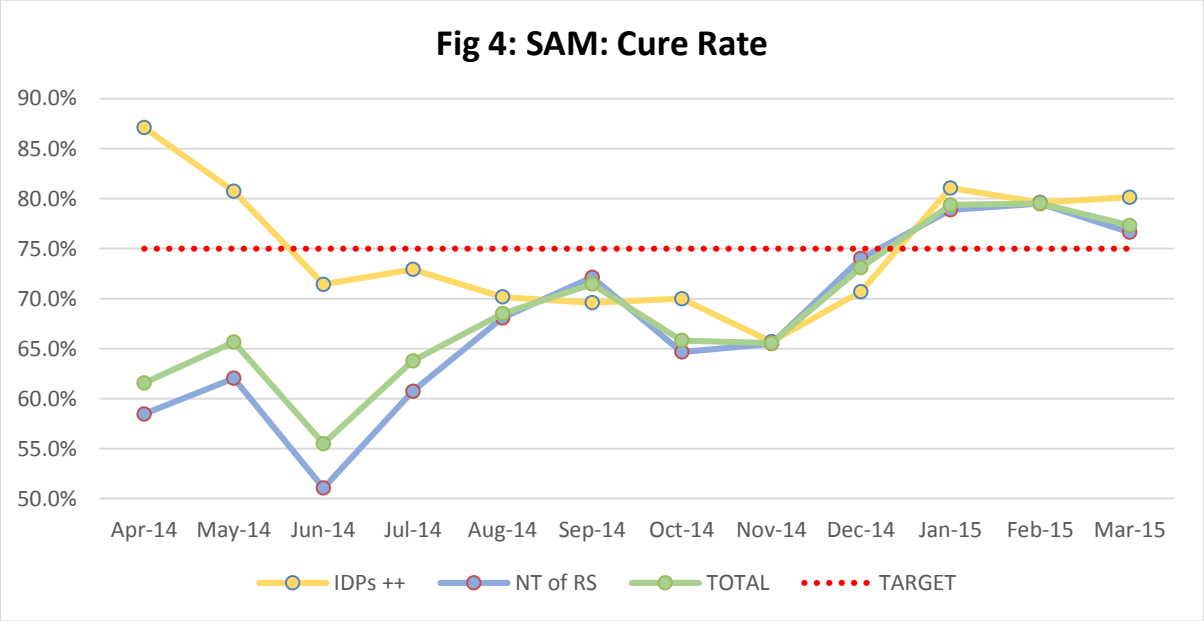


A downward trend of SAM admissions is observed in Buthidaung and Maungdaw townships but a slight increase is observed in Pauktaw, and there is no change in Sittwe rural (Fig 3). No SAM cases have been admitted in other townships.

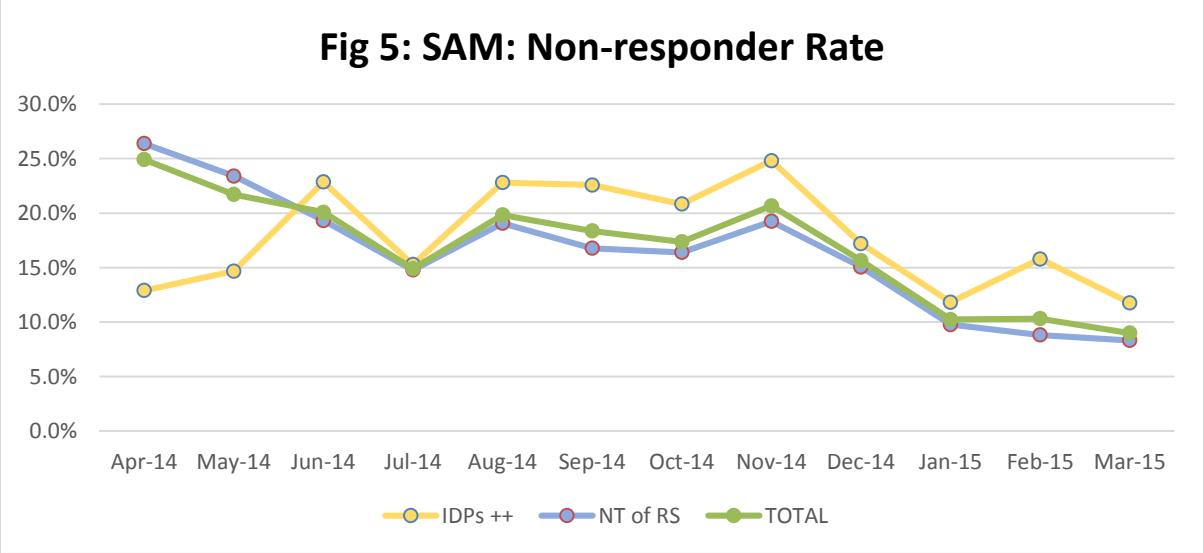
2. Programme performance

2.1. Management of SAM

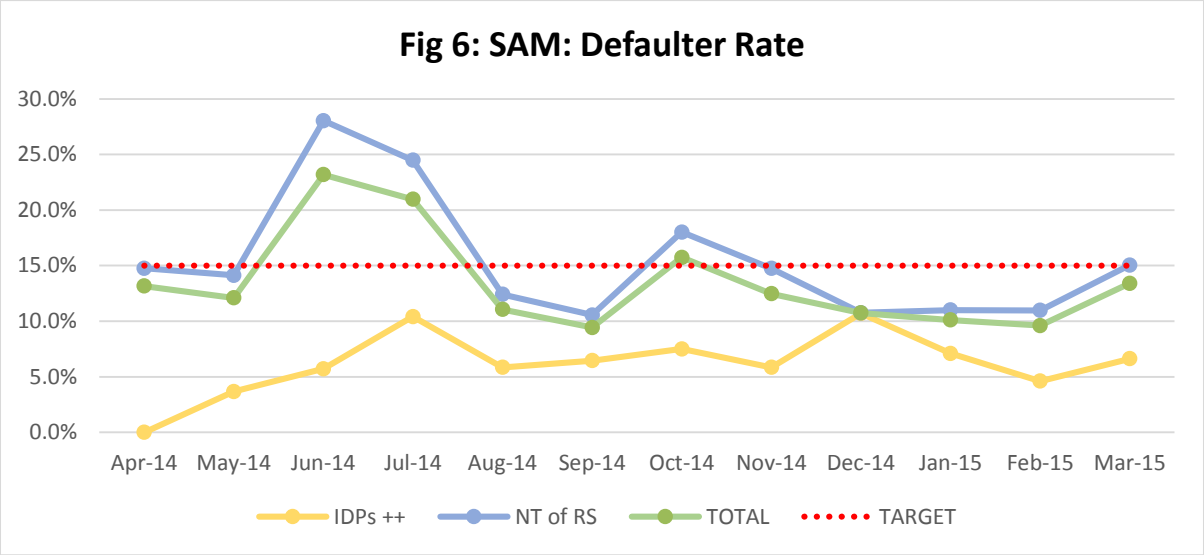
SAM cure rate: Improvement was seen in performance of therapeutic feeding program (TFP) starting from January. The overall cure rate is 77.3% in March which is above the SPHERE standard (75%). The cure rate in the northern townships is 76.6% and the improvement can partially be attributed to new malnutrition preventive approaches employed by programme implementers to engage communities in nutrition activities such as prevention, detection and treatment of malnutrition. This improvement is related to the seasonal calendar (harvest period). The cure rate in other affected townships is 80.1%. A total of 542 children with SAM were discharged cured in March.



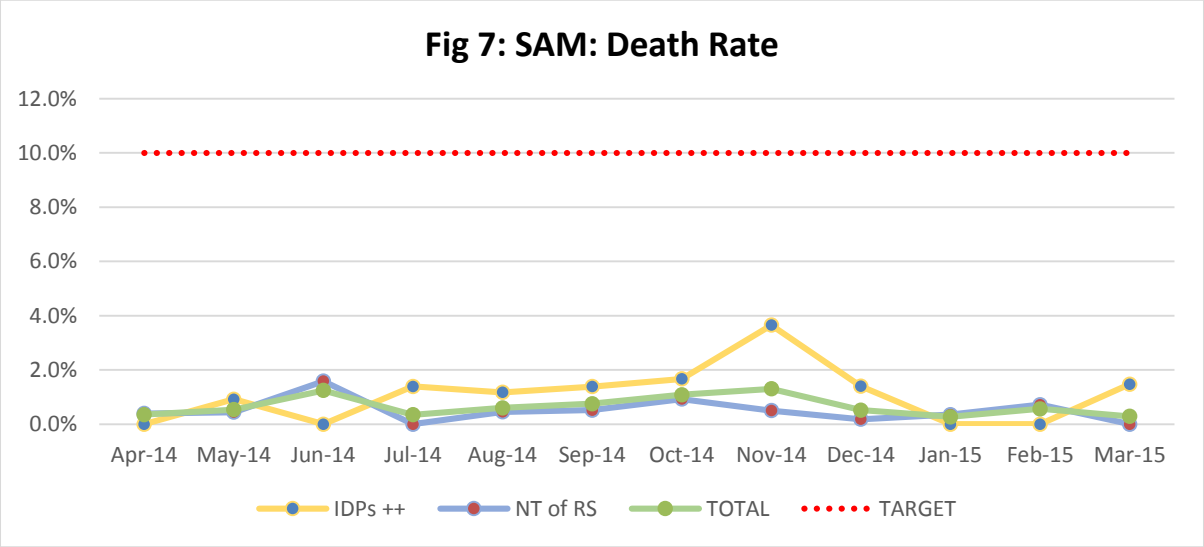
SAM non-responder rate: A decreasing trend of non-responders is observed since November 2014 and only 9.0% for the month of March which is the lowest over the past 12 months. There were variations between townships; Sittwe rural, Maungdaw, Buthidaung and Pauktaw reported rates of 12.8%, 10.3%, 7.3% and 9.7% respectively. Obvious improvement was observed for the northern townships (Fig 5).



SAM defaulter rates: The overall defaulter rate was 13.4% in March – 15.0% for northern townships and 6.6% for other townships (Fig: 6). The defaulter rate increased in March but is still below SPHERE standard.



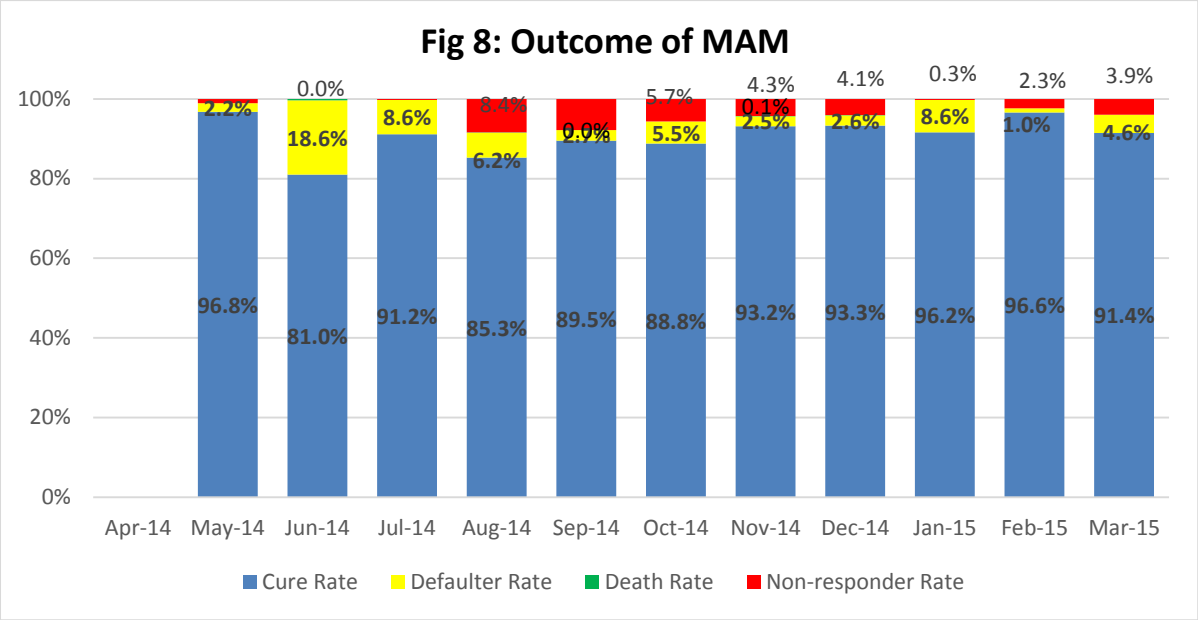
Death rate: The death rates in TFPs were within the acceptable standards (< 10%, SPHERE) in March as shown in Fig. 7. 2. Deaths recorded in March – one each from Sittwe rural and Pauktaw Townships. The causes of death relate to complications associated with SAM.



2.2. Management of MAM

All program performance indicators: Only 157 children were admitted to TSFP in March because new admission were stopped in Maungdaw and Buthidaung townships at the end of December 2014. This data is only for 3 weeks in March 2015 (PCA was up to 21.03.2015) and the fact that MHAA staff spent one week on VAS and deworming campaign in Sittwe in March can explain the lower number of MAM admissions this month.

The program performed well above the minimum standards (> 75%, SPHERE standards) in terms of cure rate. In March, the non-responder rate was 3.9% and the defaulter rate was 4.6%.



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 19,421 children aged 6-59 months and 6,931 pregnant and lactating women in March[2].

Targeted Supplementary Feeding: In addition to the TSFP provided to children 6-59 months reported in section 2.2, acutely malnourished PLW in Buthidaung and Maungdaw are being covered with targeted supplementary feeding. A total of 257 PLW received TSFP with a cure rate at 55.9%, defaulter rate at 30.8%, non-responder rate at 12.3% and a death rate at 1.0% reported for the month of March.

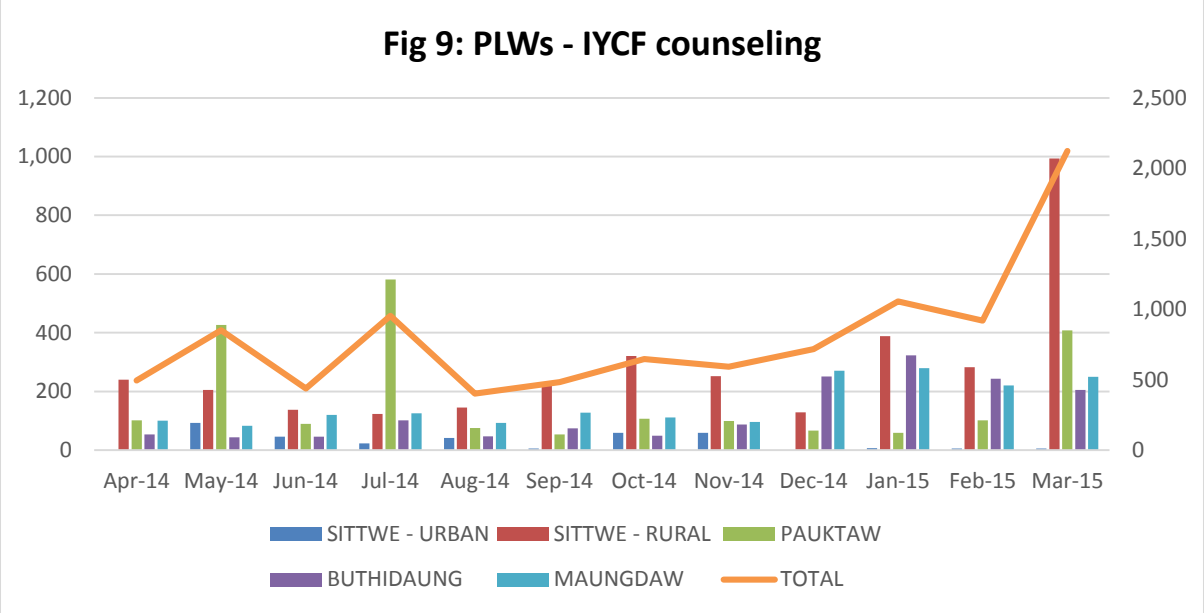
3. Access to preventive nutrition services

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 PLW of acutely malnourished children and acutely malnourished PLW in Buthidaung and Maungdaw. The total number of PLW accessing skilled IYCF and care practices support in March were 2,122 (Fig: 9) (455 from northern township and 1,667 from other affected townships). The number of PLW who received counselling has

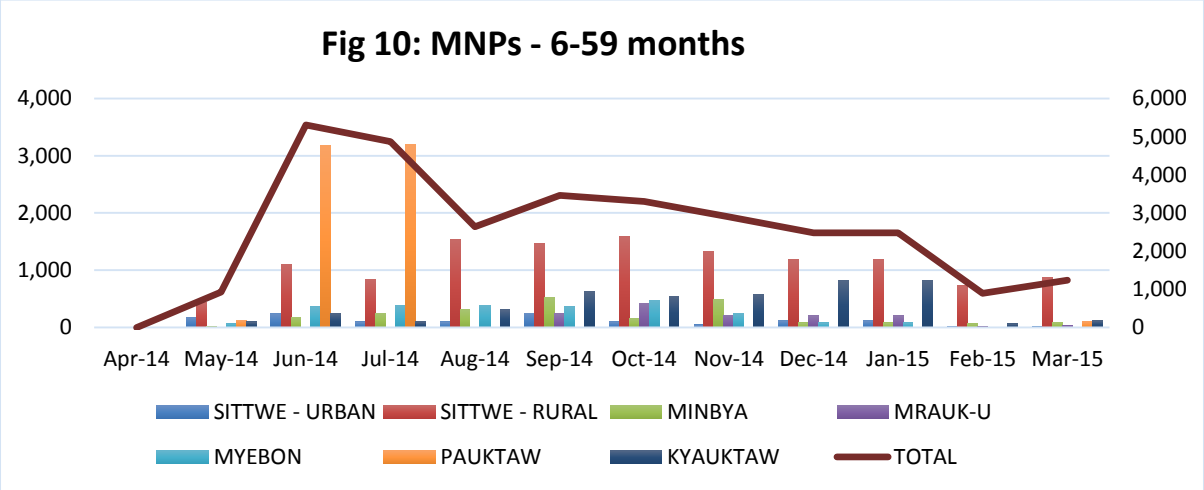
[2] This figure does not include Buthidaung and Maungdaw data

increased in other affected townships due to the fact that MNMA conducted a lot of counselling sessions.

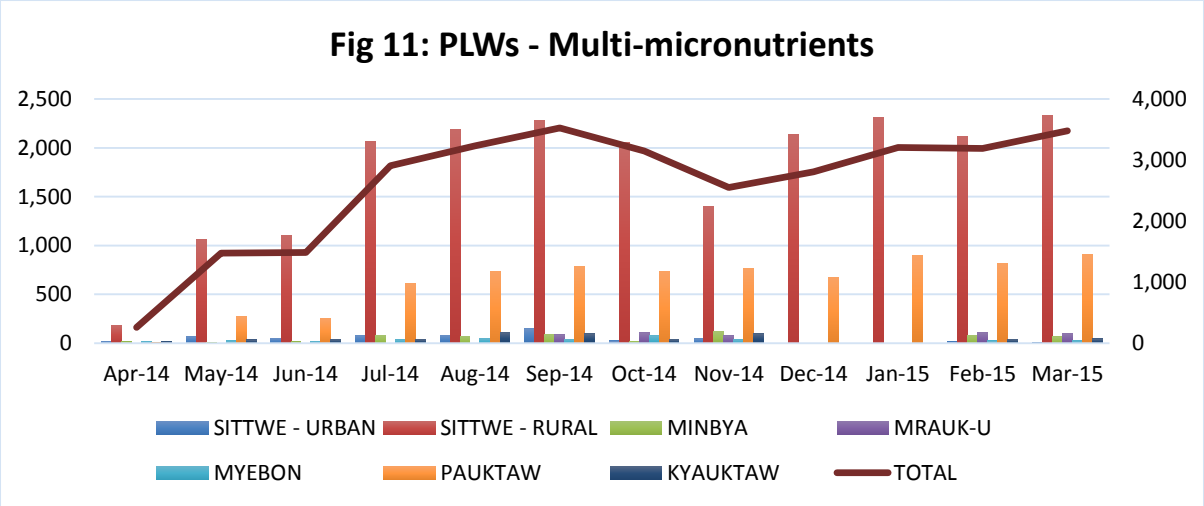


3.2. Provision of multiple micronutrients

Children 6-59 months (multiple micronutrient powders (MNPs)/sprinkles): The provision of multiple micronutrient supplementation reached 1,241 children (559 boys and 682 girls) aged 6-59 months in March.



Pregnant and lactating women (multiple micronutrient tablets): A total of 3,478 PLW received multiple micronutrient supplementation (tablets) in March (Fig. 11).



4. Main obstacles impacting on implementation of interventions

- Delayed implementation of activities including micronutrient supplementation by some of the new nutrition partners compromised programme coverage.
- One of the key national NGOs providing health and nutrition services had only 3 working weeks in March 2015 before running out of funding support; Although contingent measures were taken to distribute fortified blended food to cover the month of April, treatment and referral for impending MAM cases in six townships was not assured.
- Lack of capacity on infant and young child feeding including supplementary feeding in the State is compromising service provision in terms of taking appropriate actions especially for non-breastfed children aged 0 to 6 months with severe acute malnutrition.
- Communities are unaware of nutrition services available and where these can be accessed as well as the importance and appropriate use of specialized nutrition products and thus resulting to abuse of these through selling.
- Cultural and gender barriers hinder access to services by care givers.

5. Recommendations

- Consider putting contingent plans in place by all partners to enable continuity of services between funding phases.
- Training needed on feeding of non-breast fed infants and management of SAM in the same group of children. Since this will involve government health staff, the NNC needs to be involved.
- Community mobilization and sensitization should be strengthened to help raise communities' awareness on the services provided by nutrition partners for community acceptance, maximise coverage and reduce abuse of specialized nutrition products.
- Sector plans and project documents should factor in strategies to address cultural and gender issues impacting on access to services.