RAKHINE STATE – NUTRITION INFORMATION ANALYSIS

January – November 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)

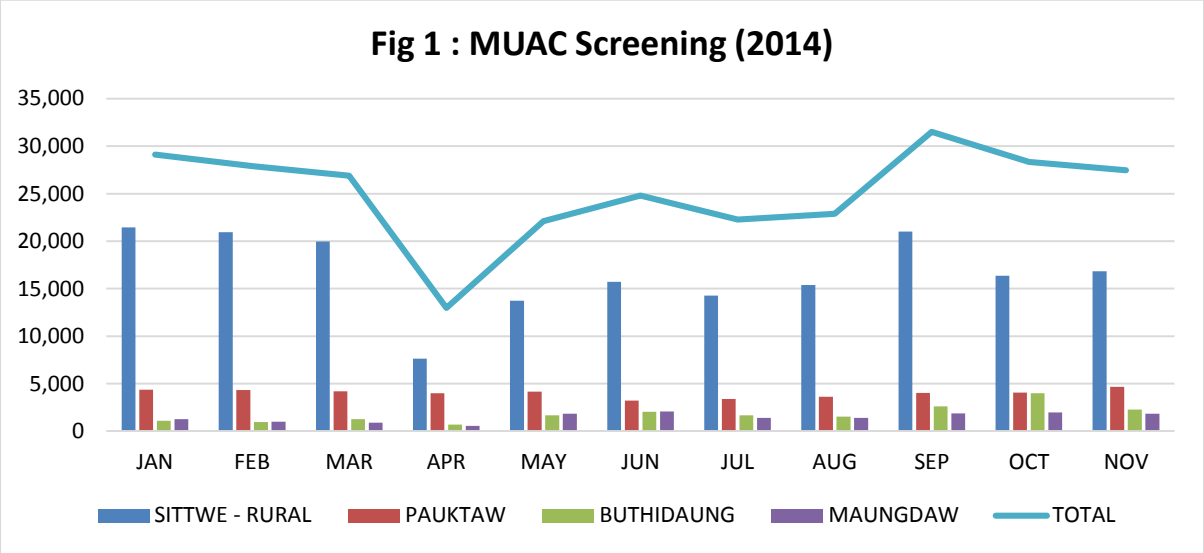
Organizations involved in response

DoH, ACF, MHAA, SCI, UNICEF, WFP

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 27,454 were screened in November. Numbers of screened children on a monthly basis are highest in Sittwe rural area and Pauktaw, making 78% of all screened children in November (fig 1) with 16,845 children from Sittwe and 4.649 from Pauktaw. The two townships have a relatively large population size wherejoint active screening is conducted by ACF and SCI in Sittwe rural.



1.2. Screening by month:

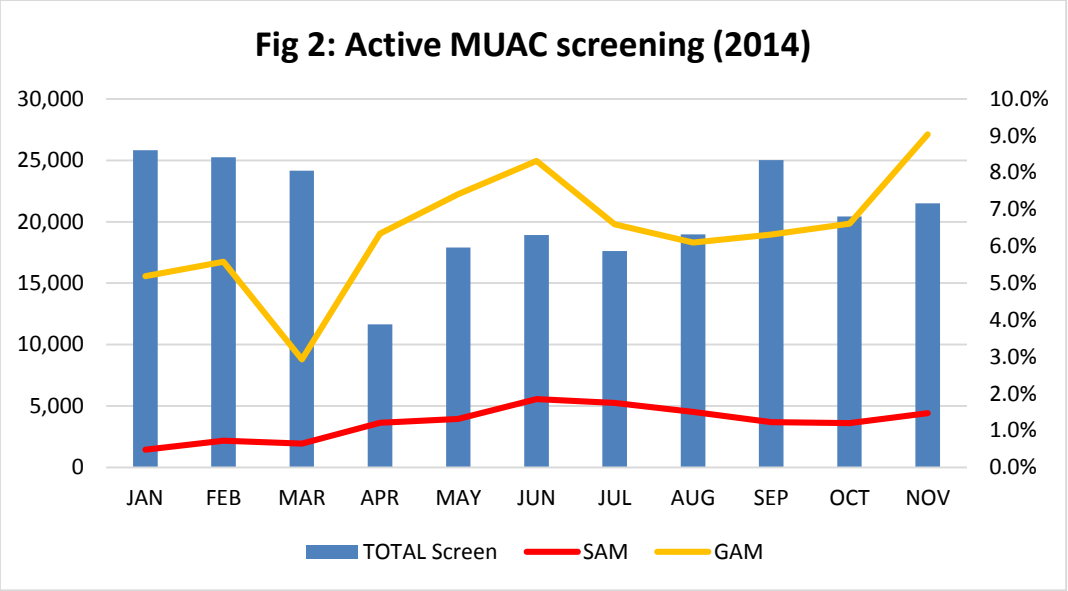
For the reporting period (January to November), a total of **276,187** children (**131,430** boys and **144,757 girls**) have been screened for acute malnutrition. Active screening was conducted in Sittwe rural and Pauktaw Township; Screening in other townships (Buthidaung, Maungdaw, Myebon, Mrauk U, Kyauktaw, Minbya and Sittwe (urban) townships) is majorly passive (Table 1).

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

	Male	Female	Total
SITTWE - URBAN	84	63	147
MINBYA	299	334	633
MRAUK-U	89	115	204
MYEBON	165	158	323
PAUKTAW	2350	2299	4649
KYAUKTAW	244	312	556
BUTHIDAUNG	943	1325	2268

[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.

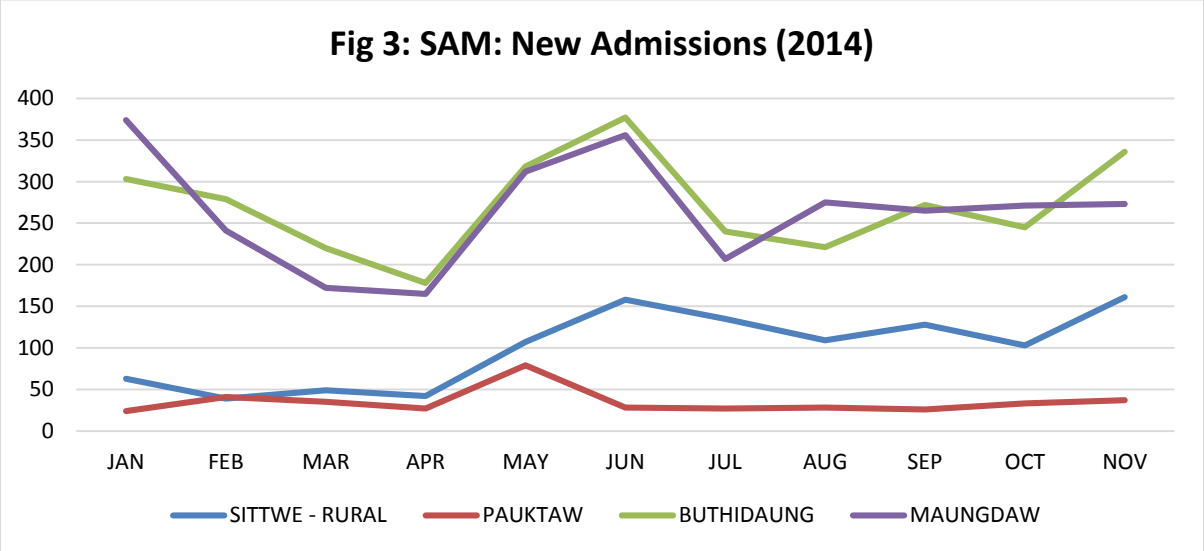
[2] ACF also uses weight for height as admission criteria during passive screening in Buthidaung and Maungdaw.



Active screening results in Pauktaw and Sittwe rural, reflect proxy rates of Global Acute Malnutrition (GAM) as having increased up to 9.0% in November which is the highest rate so far for 2014. Severe Acute Malnutrition (SAM) rate was 1.5% in November, a slight increase from the rate recorded in October (Fig.2).

1.3. New admissions for treatment of acute malnutrition

In November, number of admission for SAM and MAM cases were 848 and 1,925 respectively; 72% of SAM and 58% of MAM admissions were from northern townships of Rakhine state. More MAM cases (814 cases) were admitted from conflict affective townships in November compared to previous months (average 400 cases in previous months).



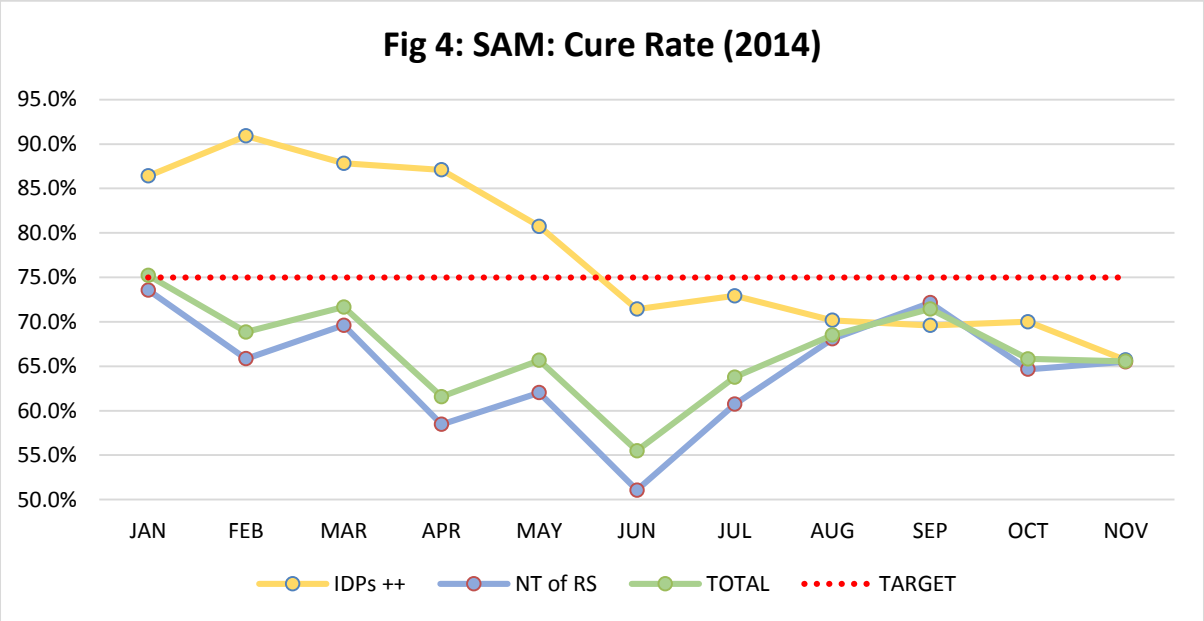
Similar to previous months, the number of new SAM admissions in November were higher in the northern townships than in other affected townships. Upward trend of SAM admissions were observed for Sittwe rural and Buthidaung but admissions remained stable in Pauktaw and Maungdaw. (Fig 3). 25 SAM children are also admitted from Mrauk U townships but low admission (6 cases each in Kyauktaw and Sittwe Urban and 2 case each from Minbya and

Myaebon) of SAM were noted in the other townships. These are the same townships where screening is passively conducted.

2. Programme performance

2.1. Management of SAM

SAM cure rate: The therapeutic feeding program (TFP) in Rakhine State has been consistently performing below the SPHERE standard (75%) from February to November and seems to worsen as per the SAM cure rate indicator and dropped to 65.5% of cure rate in November. (Cure rate in northern townships was 65.5% and 65.7% in other affected townships.)

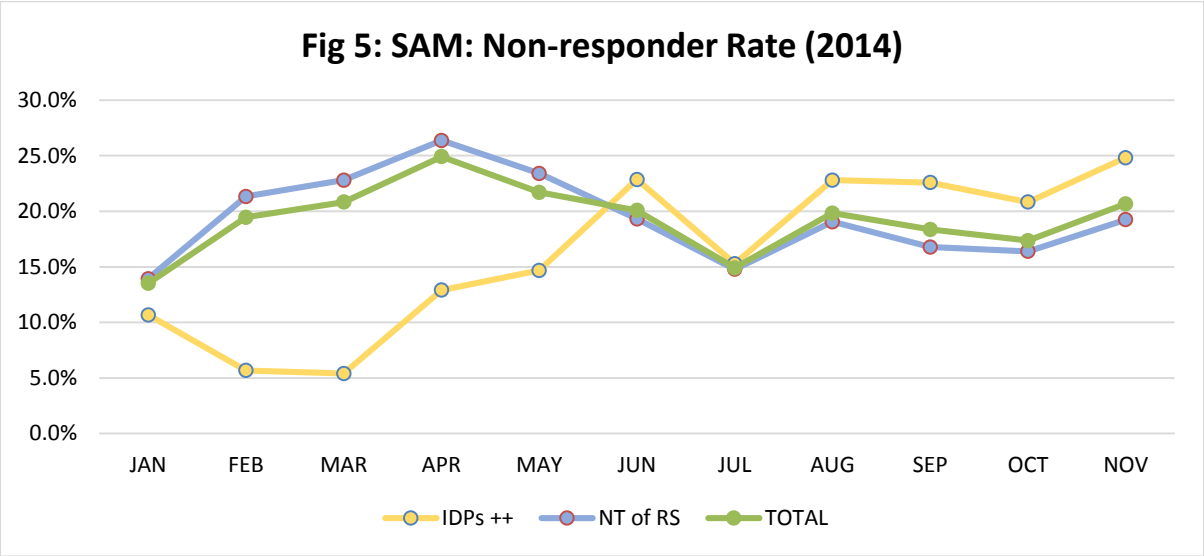


Maungdaw shows the lowest TFP program performance in November (61.4%) followed by Sittwe rural (62.8%) . Girls in SIttwe Rural and Maungdaw had lower cure rates than boys. Table 2 provides a snapshot of TFP programme performance in November per township.

Table 3: SAM Cure Rate by Township- November 2014			
	Boy	Girl	TOTAL
SITTWE - URBAN	No Exits	100.0%	100.0%
SITTWE - RURAL	72.7%	52.9%	62.8%
MINBYA	100.0%	No Exits	100.0%
MRAUK-U	100.0%	100.0%	100.0%
MYEBON	100.0%	100.0%	100.0%
PAUKTAW	86.7%	65.0%	75.9%
KYAUKTAW	No Exits	100.0%	100.0%
BUTHIDAUNG	75.8%	74.8%	75.3%
MAUNGDAW	72.4%	50.3%	61..4%

The low performance of the TFP program in some townships such as Sittwe Rural and Maungdaw were majorly due to the high non-responder rates (Fig: 5) as well as high defaulter rates (Fig: 6).

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 (19.1%) admitted to TFPs failed to respond to treatment between January to November. Although initially the northern townships reported higher non-responder rates than other parts of the State, from June more non- responder rates were observed in other affected townships compared to northern townships.



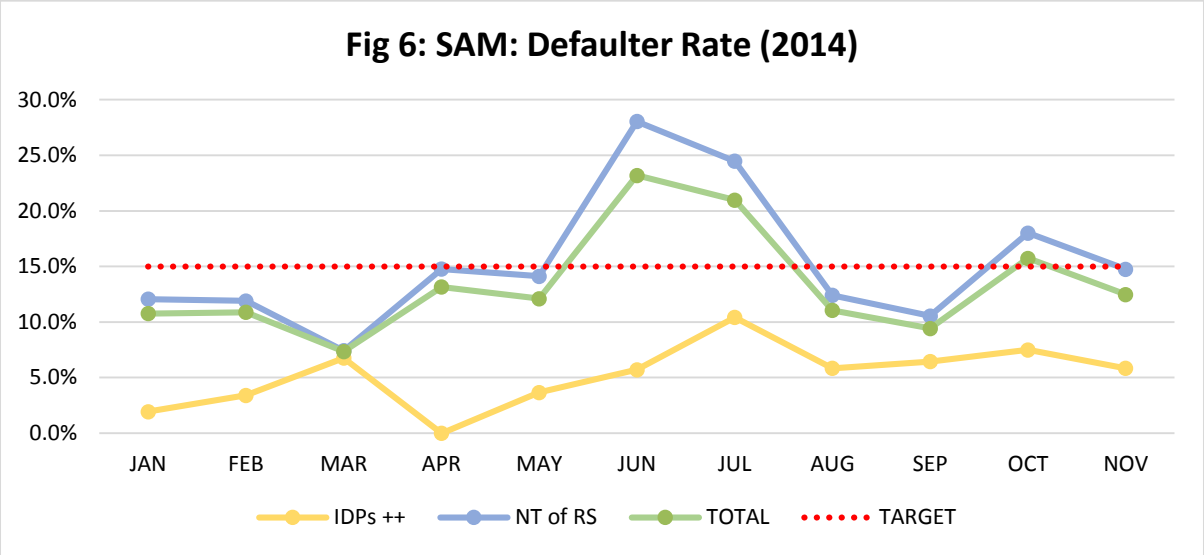
High non responder rate among girls in Sittwe rural, Pauktaw, BTD and MD are more than 20% with highest among Sittwe rural girls of 33.8% (Table 3).

Table 3: SAM Non responder Rate by Township- November 2014

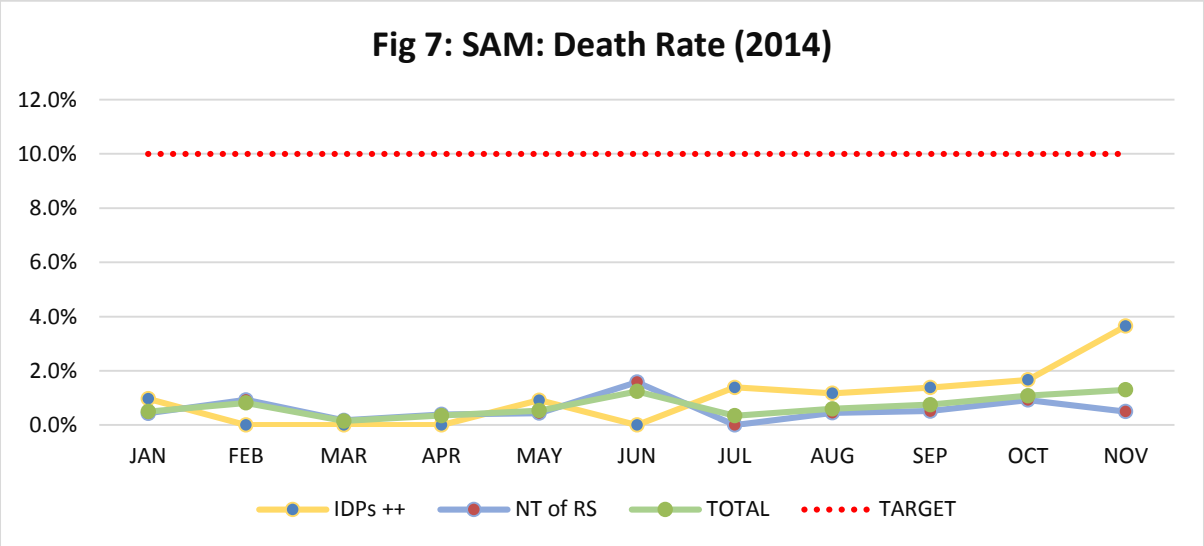
	Boy	Girl	TOTAL
SITTWE - URBAN	No Exits	0.0%	0.0%
SITTWE - RURAL	18.2%	33.8%	26.0%
MINBYA	0.0%	No Exits	0.0%
MRAUK-U	0.0%	0.0%	0.0%
MYEBON	0.0%	0.0%	0.0%
PAUKTAW	13.3%	25.0%	19.2%
KYAUKTAW	No Exits	0.0%	0.0%
BUTHIDAUNG	12.9%	20.0%	16.5%
MAUNGDAW	13.2%	24.5%	18.9%

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.

SAM defaulter rates: Overall defaulter rate is 12.5% for the month of November (Fig: 6) in which northern townships had 14.8% and 5.8% in other affected townships. In November, all the defaulters were from Maungdaw (48 cases), Buthidaung (11 cases) and Sittwe rural (6 cases). Some reasons provided by partners for high defaulter rates relate to far distances to cover by caregivers to get to nutrition treatment centres.



Death rate: The death rates in TFPs were within the acceptable standards (< 10%, SPHERE) in November as shown in Fig. 7. Seven deaths were recorded in November, 3 from Sittwe rural and 2 each from Pauktaw and Buthidaung Townships. The causes of death relate to complications associated with SAM.



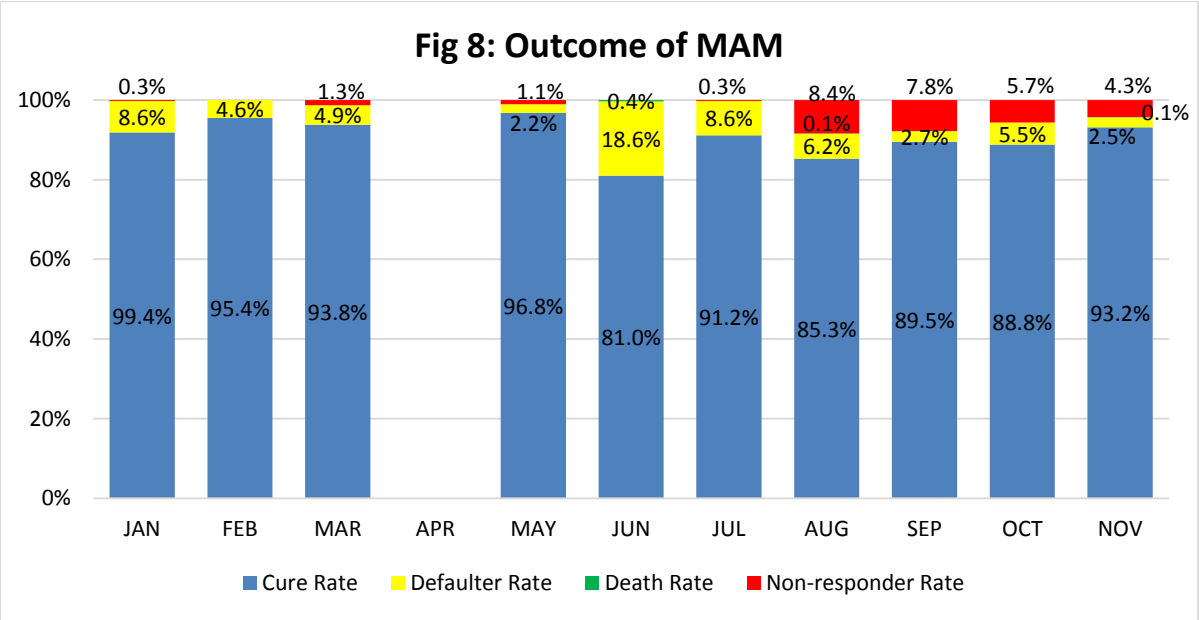
Total 352 children with SAM were discharged cured in November with majority of them 74% (262 cases) from Buthidaung and Maungdaw.

2.2. Management of MAM

All program performance indicators: The Targeted Supplementary Feeding program for children 5- 59 months is being implemented in 8 townships[3] with 58% 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 November, non-responder rate was at 4.3% and defaulter rate was 2.5%.

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

The majority of defaulters were from Maungdaw (23 cases) and Buthidaung (4 cases) – as these programs have the most beneficiaries – as well as from Sittwe rural (1 case). These were the same townships reporting high SAM defaulter rates. Among 50 non-responders, 44 cases were from Maungdaw. 1 death was also reported in 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 19,051 children aged 6-59 months and 7,817 pregnant and lactating women in November[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. Provisions will be made in subsequent months to capture this data in the nutrition information data base.

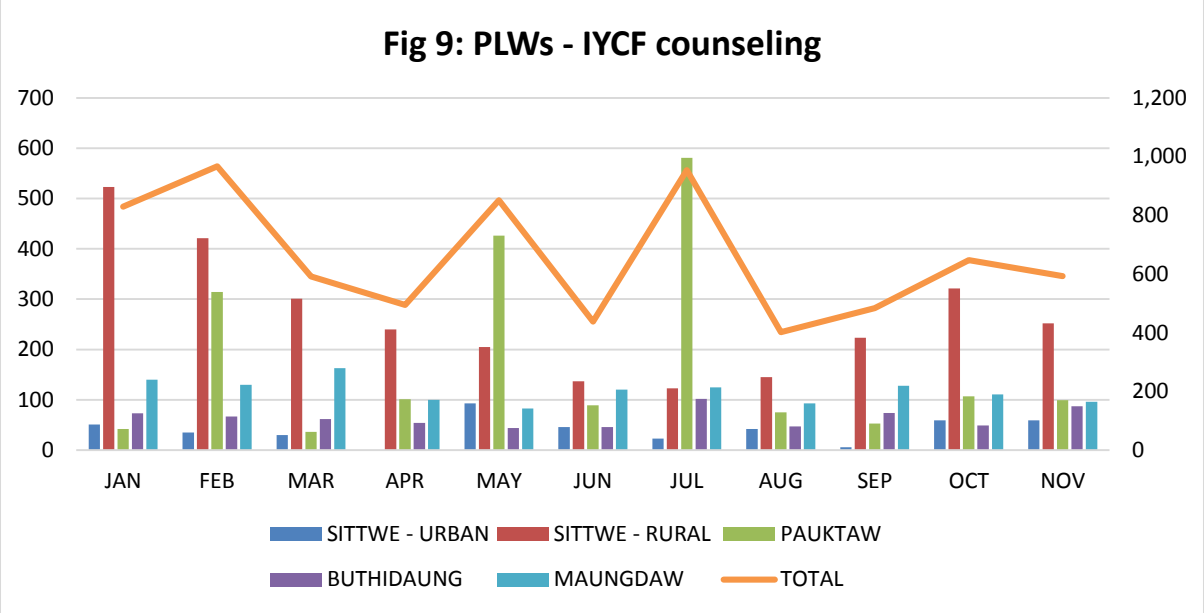
3. Access to preventive nutrition services

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 November were 593 (Fig: 9). A total of 7,285 PLW are targeted in 2014 to receive breastfeeding counselling of which 99.5% (7,252) have been reached to date. Integration of IYCF services in nutrition treatment services should be considered by all

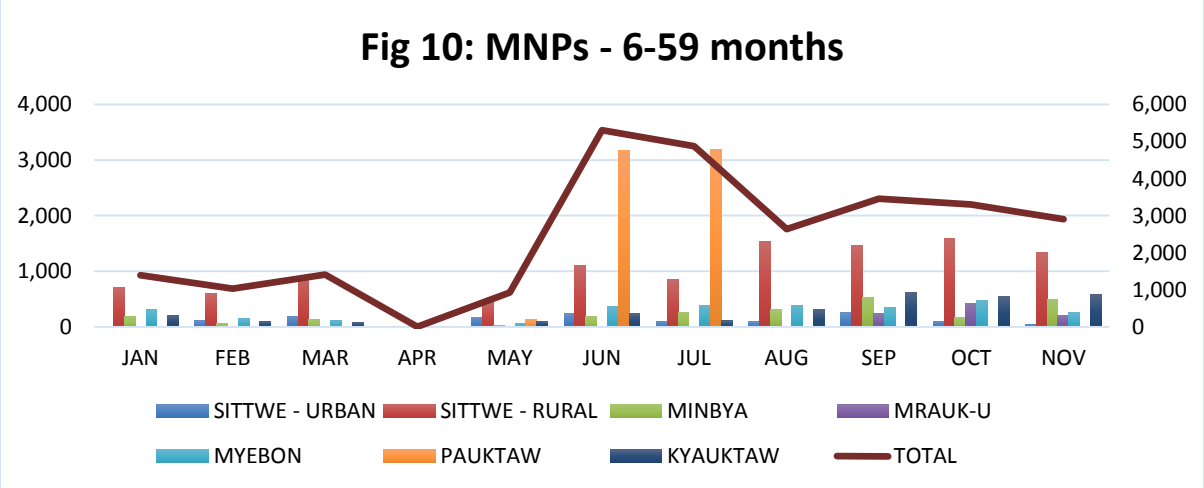
[4] This figure does not include Buthidaung and Maungdaw data

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.

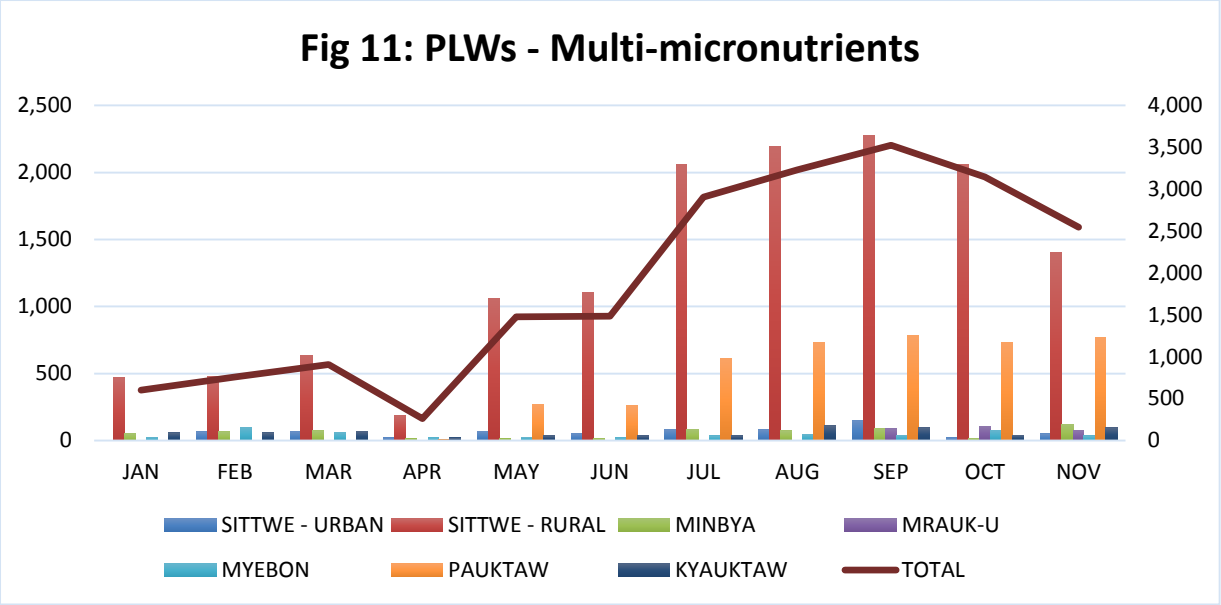


3.2. Provision of multiple micronutrients

Children 6-59 months (multiple micronutrient powders (MNPs)/sprinkles): The provision of multiple micronutrient supplementation reached 2,900 children 6-59 months in November. A total of 50,220 children 6-59 months are targeted by the service and to date, 27,229 (54%) have been reached (low coverage). That is partly due to 30 % of targeted children from northern townships are not reached by multiple micronutrient supplementation.



Pregnant and lactating women (multiple micronutrient tablets): A total of 1,722 PLW received multiple micronutrient supplementation (tablets) in November (Fig. 13). Of the total 13,113 PLW targeted with multiple micronutrient supplementation 20,849 (159%) 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.

5. Recommendations

- Provision to be made in the NIS system to capture data for PLWs in the supplementary feeding programme.
- 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 needs to be sustained.