# RAKHINE STATE – NUTRITION INFORMATION ANALYSIS

## January – October 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)

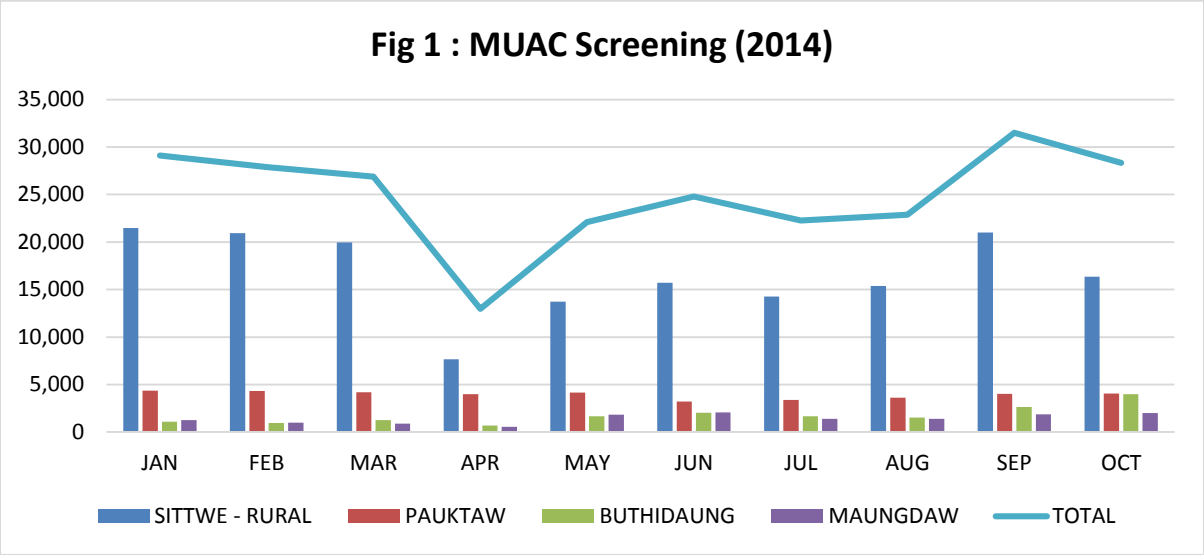
**Organizations involved in response**

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]). Total number of children (28,327) were screened in October Numbers screened on a monthly basis are highest in Sittwe rural area (58% of all screening in October) (fig 1). This is 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:*

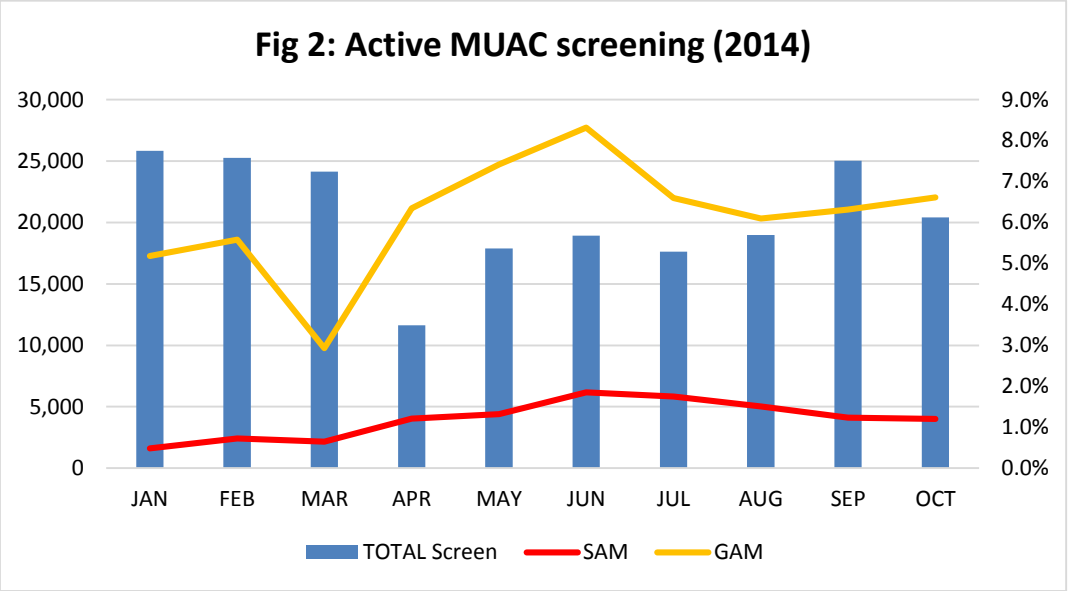
For the reporting period (January to October), a total of **248,733** children (**118,268** boys and **130,465 girls**) have been screened for acute malnutrition. More girls than boys were screened and 59 % of identified acute malnutrition cases (total of 24,472) were girls. Active screening was conducted in Sittwe rural and Pauktaw and the rest area were screened by passively (Buthidaung, Maungdaw, Myebon, Mrauk U, Kyauktaw, Minbya and Sittwe (urban) townships) in October (Table 1)

**Table 1: Passive MUAC[2] screening- October 2014**

| | Male | Female | Total |
|---|---|---|---|
| **SITTWE - URBAN** | 79 | 124 | 203 |
| **MINBYA** | 164 | 169 | 333 |
| **MRAUK-U** | 176 | 198 | 374 |
| **MYEBON** | 234 | 244 | 478 |
| **KYAUKTAW** | 247 | 304 | 551 |
| **BUTHIDAUNG** | 1294 | 2685 | 3979 |
| **MAUNGDAW** | 869 | 1117 | 1986 |

[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.

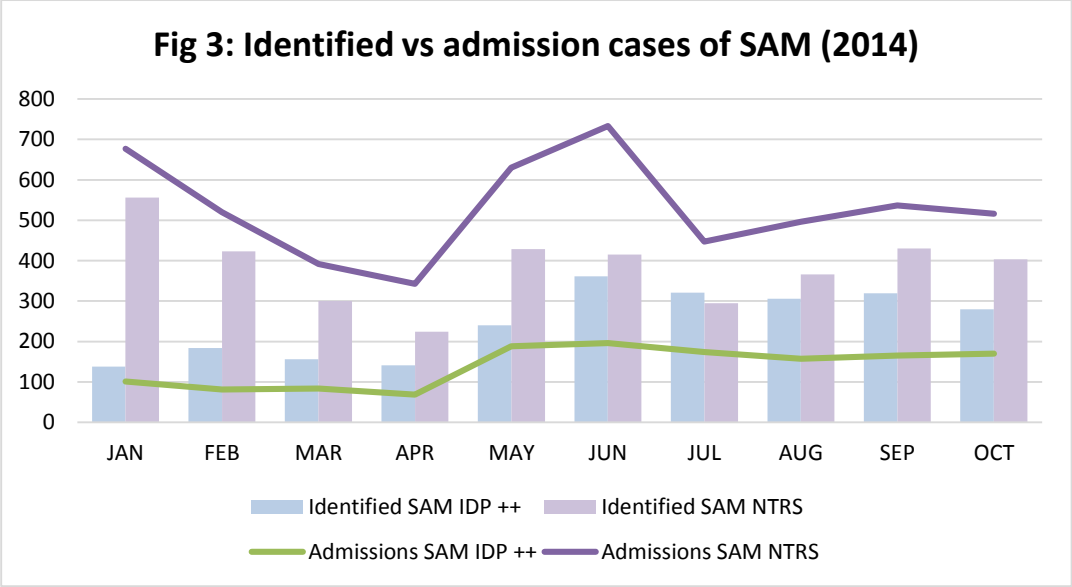
[2] ACF also uses weight for height as admission criteria during passive screening in Buthidaung and Maungdaw.



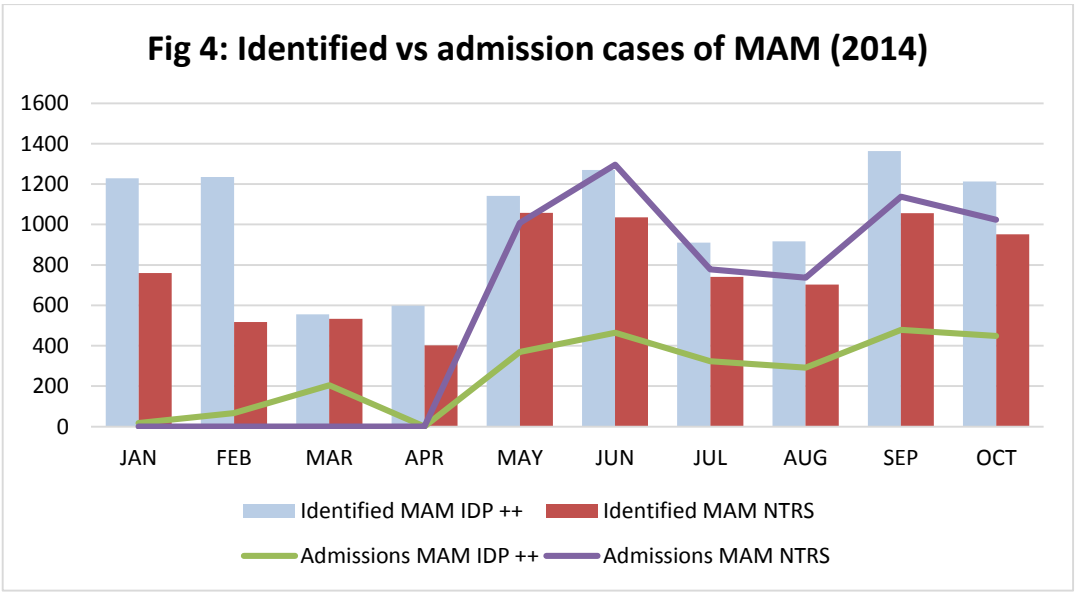

According to active screening results in Pauktaw and Sittwe rural, proxy rates of Global Acute Malnutrition (GAM) was 7.8% and rates of Severe Acute Malnutrition (SAM) was 1.2% in October (Fig.2).

### *1.3. New admissions for treatment of acute malnutrition*

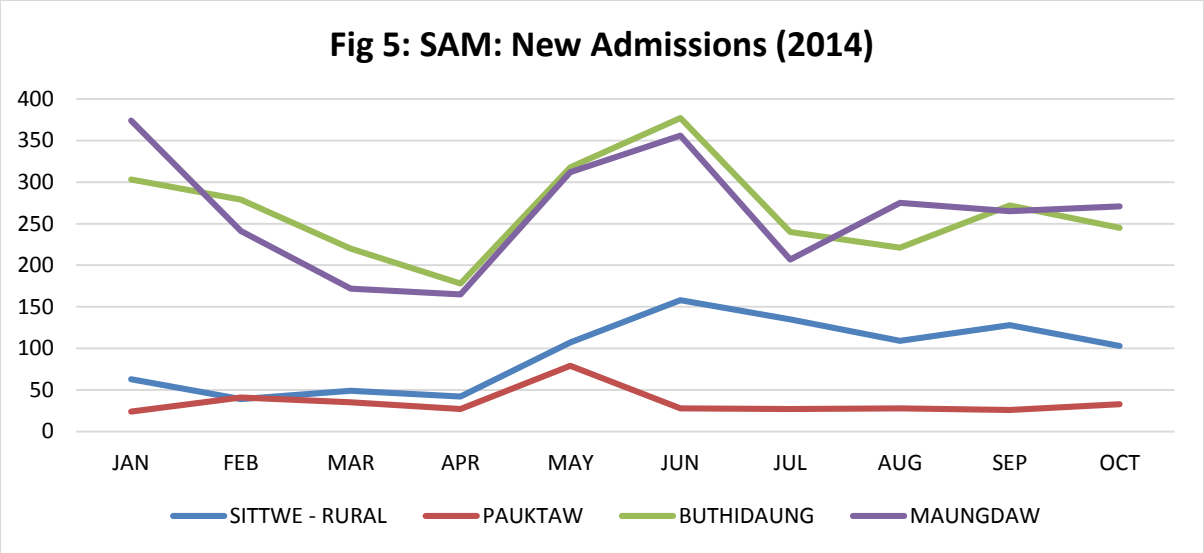
In October, number of admission for SAM and MAM cases were 686 and 1472 respectively; 75% of SAM and 70% of MAM admission were from northern townships of Rakhine state. More SAM cases than identified were admitted to the nutrition treatment program in northern townships but less identified SAM cases in other townships were admitted to the programs. (Fig 3). Active screening in NRS are done by volunteer and collect data every 3 months. So it is not reflect in the screening figure that we provide to you on a monthly base. (as ACF do not count them in passive screening). This is the reason why more admission than screening.




This is also similar for the MAM cases, where more admission of cases in northern townships but only about half of identified cases were admitted to the nutrition treatment programs in other townships for October (Fig 4). Long distance to nutrition centres for MAM treatment prohibit access to services in some cases. 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 in Sittwe.




Strengthening timely referral mechanism of identified malnourished children to the therapeutic and supplementary feeding program is needed especially in Sittwe rural area where active screening takes place.

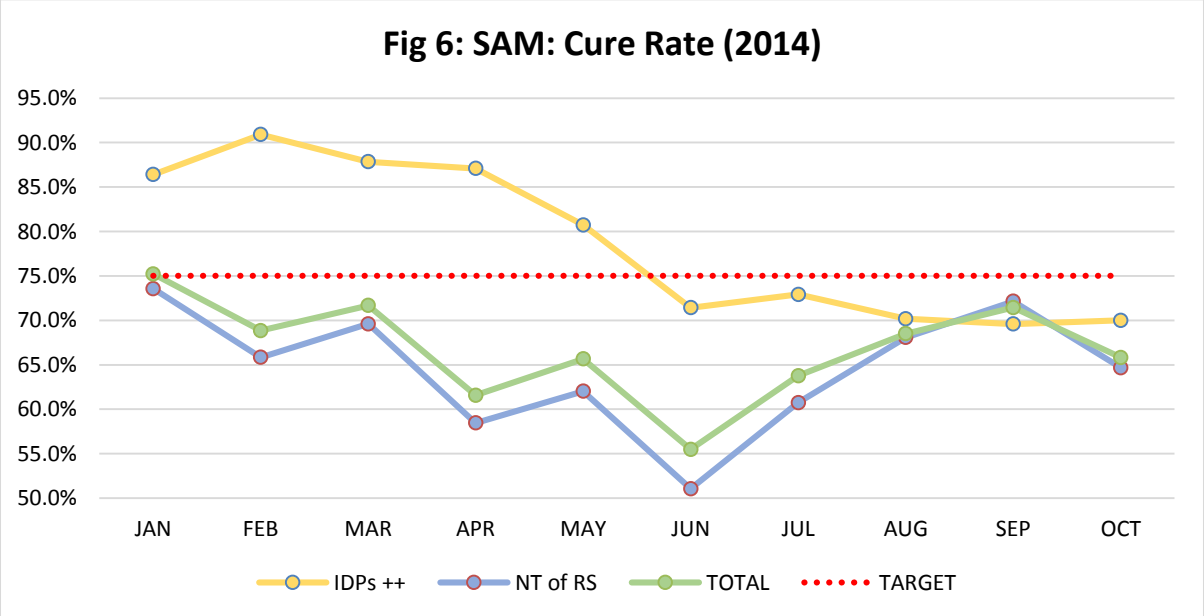



Similar to previous months, the number of new SAM admissions in October were higher in the northern townships than in other affected townships. A slight decrease in SAM admissions was observed for Sittwe rural and Buthidaung but admissions remained stable in Pauktaw and Maungdaw. (Fig 5). Low admission (17 cases in Kyauktaw, 2 cases in Sittwe Urban and 1 case each from Minbya and Myaebon) of SAM were noted and no new admission for the other townships in October. These are the same townships where screening is passively conducted.

## 2. Programme performance

### *2.1. 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 October as per the SAM cure rate indicator; dropped to 65.8% was observed in October. Cure rate in northern townships was 64.7% and 70% in other affected townships.

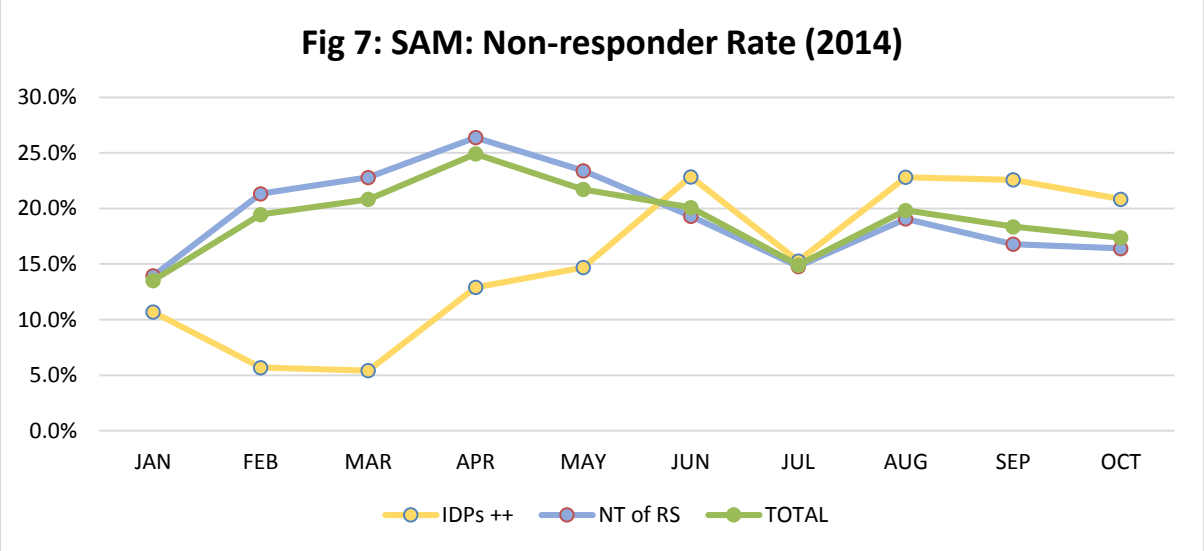


Maungdaw shows the lowest TFP program performance in October (57.7%) followed by Sittwe rural (63.5%) and Buthidaung (72.5%). Table 2 provides a snapshot of TFP programme performance in October per township. (Table 2)

| Table 2: SAM Cure Rate by Township- September 2014 | | | |
|---|---|---|---|
| | Male | Female | TOTAL |
| SITTWE - URBAN | No Exits | 100.0% | 100.0% |
| SITTWE - RURAL | 68.6% | 58.3% | 63.5% |
| MINBYA | No Exits | No Exits | No Exits |
| MRAUK-U | No Exits | No Exits | No Exits |
| MYEBON | No Exits | No Exits | No Exits |
| PAUKTAW | 92.9% | 80.0% | 86.4% |
| KYAUKTAW | No Exits | 100.0% | 100.0% |
| BUTHIDAUNG | 77.5% | 67.5% | 72.5% |
| MAUNGDAW | 58.1% | 57.3% | 57.7% |

The low performance of the TFP program in some townships were due to the high non-responder rates (Fig: 7) as well as high defaulter rates (Fig: 8).

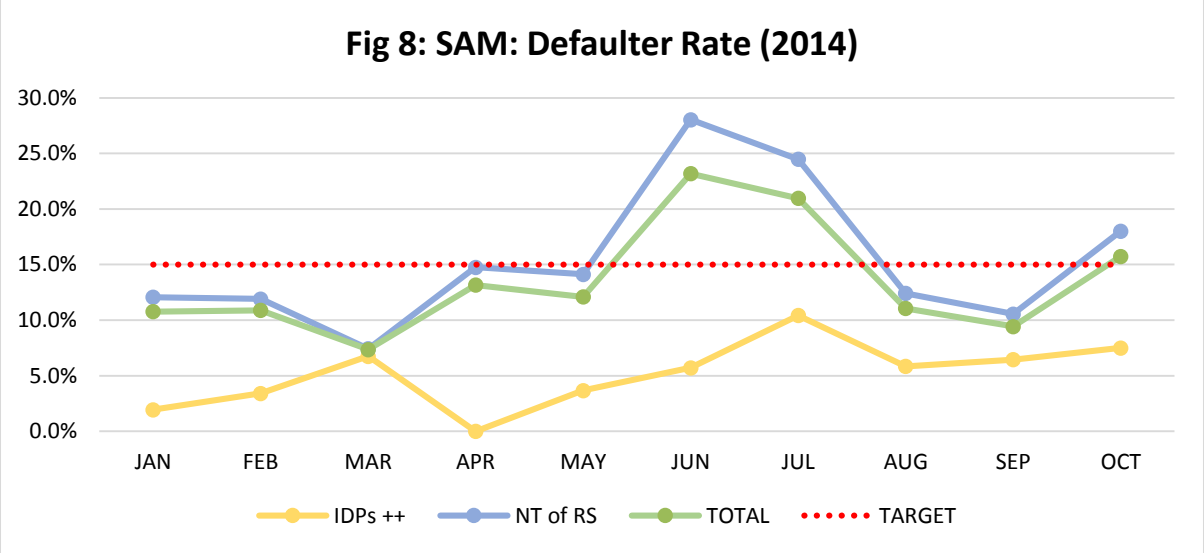
**SAM non-responder rate:** Although there is no cut-off to gauge programme performance in relation to non-responder rates, a relatively high proportion of SAM children (18.9%) admitted to TFPs failed to respond to treatment between January to October. Since June, higher non- responder rates were observed in other affected townships in compared to northern townships.



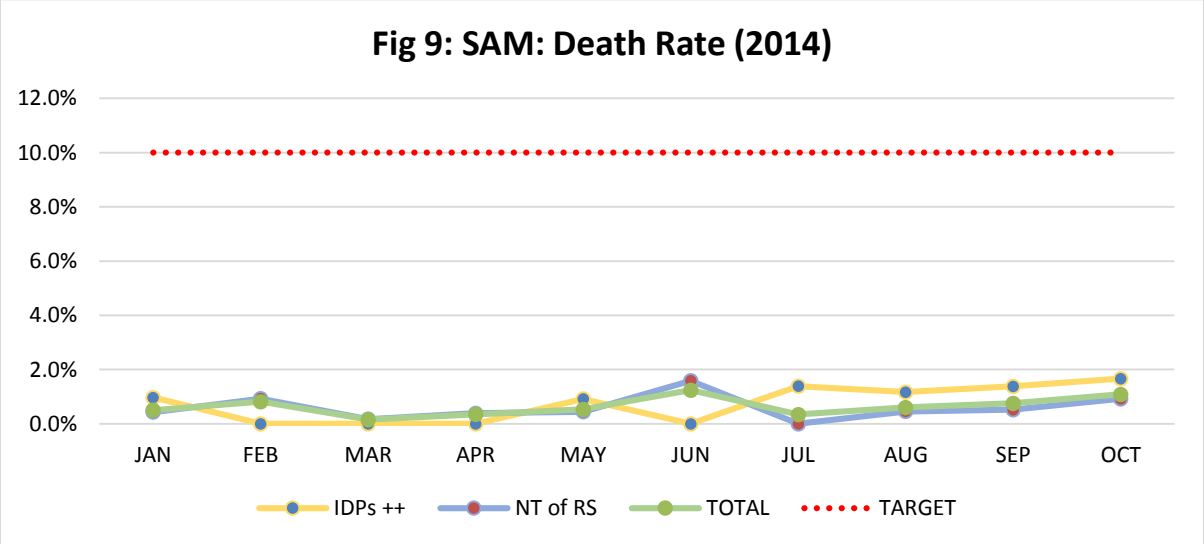

Lack of an adequately functioning referral system and primary health care services to complement nutrition services have partly contributed to the relatively high non-responder rates. Other factors that could be associated with high non-responder rates include high nutrition insecurity (especially in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

**SAM defaulter rates**: Unlike previous 2 months, defaulters rate is increased to 15.7% which is higher than acceptable levels (15%) for the month of October (Fig: 8) especially in Northern

townships. In october, all the defaulters were from Maungdaw (49 cases), Buthidaung (29 cases), Sittwe rural (8 cases) and Pauktaw (1 case) Townships.




**Death rate:** The death rates in TFPs were within the acceptable standards (< 10%, SPHERE) as shown in Fig. 9. Six deaths were recorded in October, 2 each from Maungdaw, Sittwe rural and Buthidaung Townships. The causes of death relate to complications associated with SAM.




Total 364 children with SAM were discharged with cure in October where 77% (280 cases) where from BTD and MD.

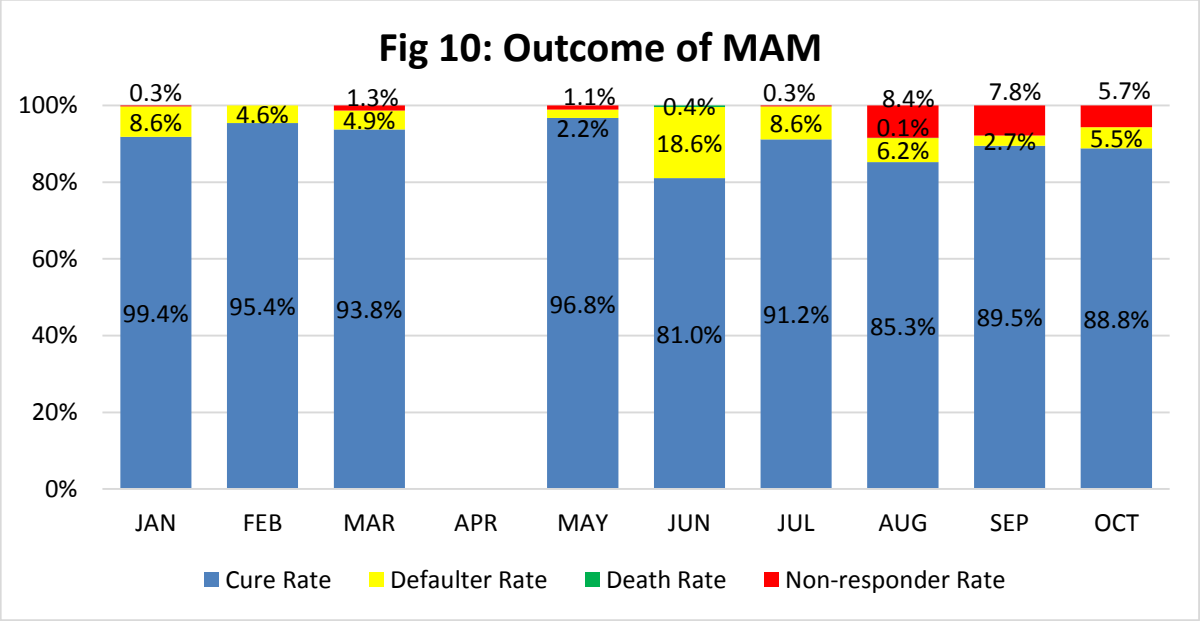
### *2.2. Management of MAM*

**All program performance indicators**: The Targeted Supplementary Feeding program is being implemented in 7 townships[3] with 70% of total admission were recorded in northern townships. The program performed well above the minimum standards (> 75%, SPHERE

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

standards) in terms of cure rate. In October, non-responder rate was at 5.7% whereas defaulter rate was within acceptable levels at 5.5%.

The majority of defaulters were from Maungdaw (30 cases) and Buthidaung (24 cases) – as these programs have the most beneficiaries – as well as from Sittwe rural (01 cases). Among 69 non-responders, 55 cases were from Maungdaw.



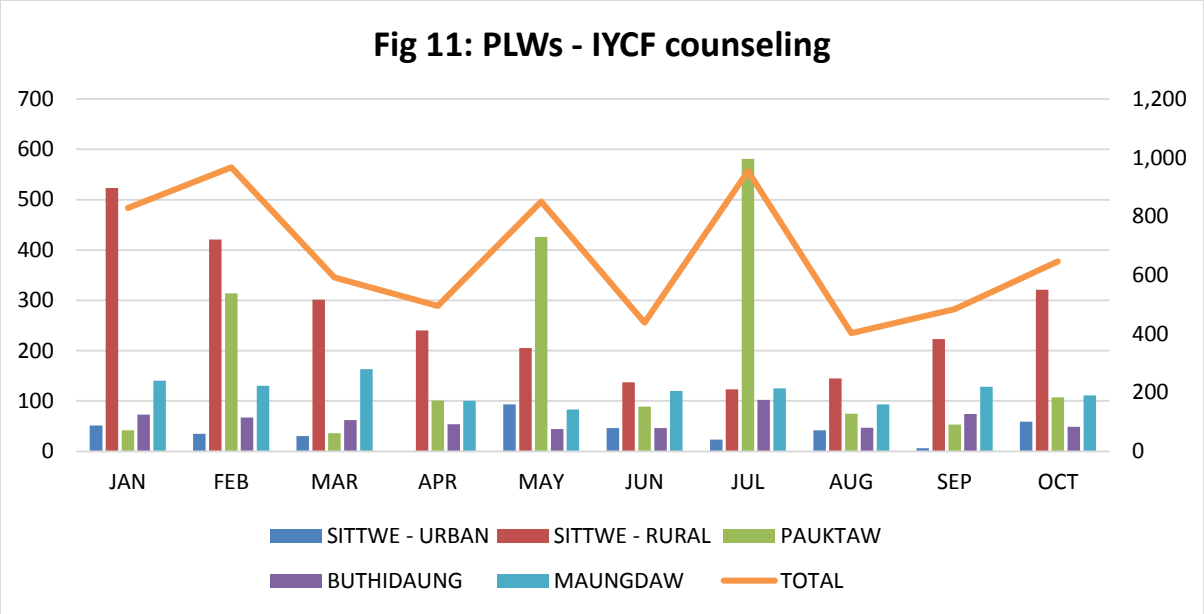

3.3 *Blanket Supplementary Feeding (BSFP):*

Through the BSF Program, children 6-59 months and pregnant and lactating women (PLW) are provided with fortified blended food. The program covers 587 villages and camps in 11 townships and reached 32,589 children aged 6-59 months and 9,672 pregnant and lactating women in October.

## 3. Access to preventive nutrition services

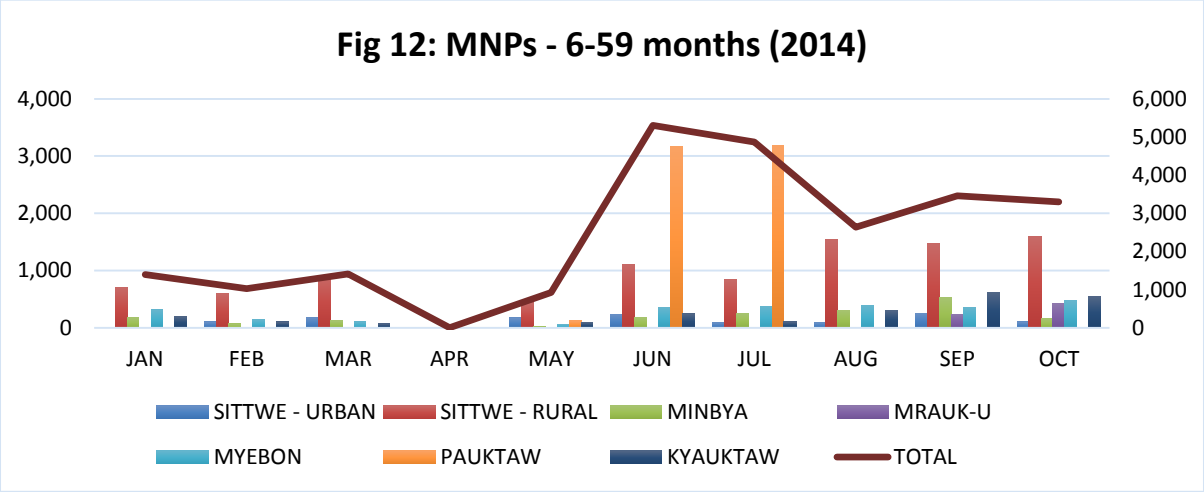
*3.1. Provision of skilled Infant and Young Child Feeding (IYCF) counselling and care support*

**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 October were 362 (Fig: 11). Reduced numbers of counselling sessions were reported in Pauktaw Township and no information from northern townships. A total of 7,285 PLW are targeted in 2014 to receive breastfeeding counselling of which 87% (6,374) 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.

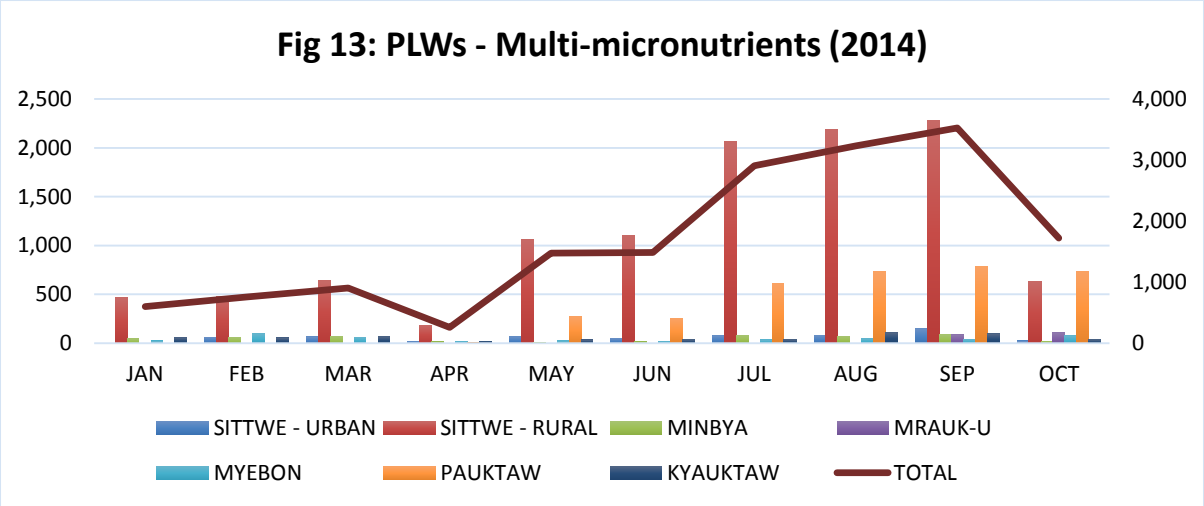



### *3.2. Provision of multiple micronutrients*

**Children 6-59 months (multiple micronutrient powders (MNPs)/sprinkles):** The provision of multiple micronutrient supplementation reached 3,298 children 6-59 months in October. A total of 50,220 children 6-59 months are targeted by the service and to date, 24,329 (48%) 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 October (Fig. 13). Of the total 13,113 PLW targeted with multiple micronutrient supplementation 16,874 (129%) 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

- 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.
- Mothers/carers' from camps preference of RUSF (Ready to Use Supplementary Food e.g. NRG 5) to BF (Blended food) since they need time and fuel/fire woods to prepare BF which may result to selling of the food.
- Sub-optimal caring practices among mothers impacting negatively on programme outcomes.
- Higher caseload due to fewer frequency of visit by nutrition partners lead to poor programme quality. Insufficient manpower including qualified ones also play a role in effective programme implementation. This is still an important challenge to find and retain medical staff especially in NRS.

## 5. Recommendations

- Initiate additional 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 and to promote better utilization of the services and to lessen the opportunity costs to the carers.
- 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 continue with visits to NRS to conduct periodic nutrition sector meetings.
- Provision of standardized guidelines on Integrated Management of Acute Malnutrition to all partners once the former is finalized to facilitate better adherence to protocols on management of acute malnutrition.
- To conduct the Refresher trainings/on-site trainings for the staff in SC, OTP, TSFP and programmes and hospital (where SAM cases with complication are referred) to keep abreast of the latest guidelines on Integrated Management of Acute Malnutrition and IYCF once the guideline is finalized.