

# RAKHINE STATE – NUTRITION INFORMATION ANALYSIS

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January – September 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 through 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)

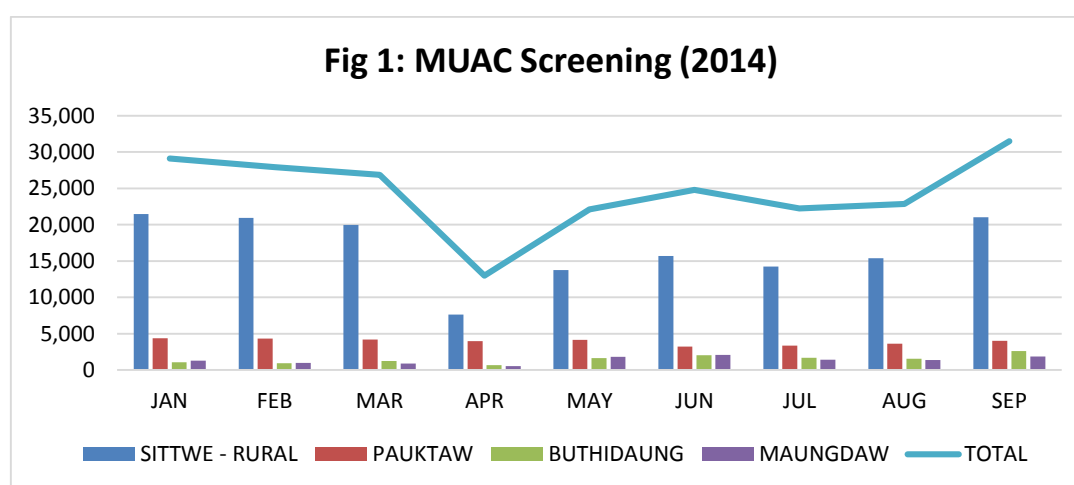
### Organizations involved in response

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<sup>1</sup>). Total number of children (31,490) were screened in September which is highest for the 2014. Numbers screened on a monthly basis are highest in Sittwe rural area (67% of all screening in September) followed by Pauktaw (fig 1). This was the same trend observed for the period January- August. The higher numbers recorded for these two townships are 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.



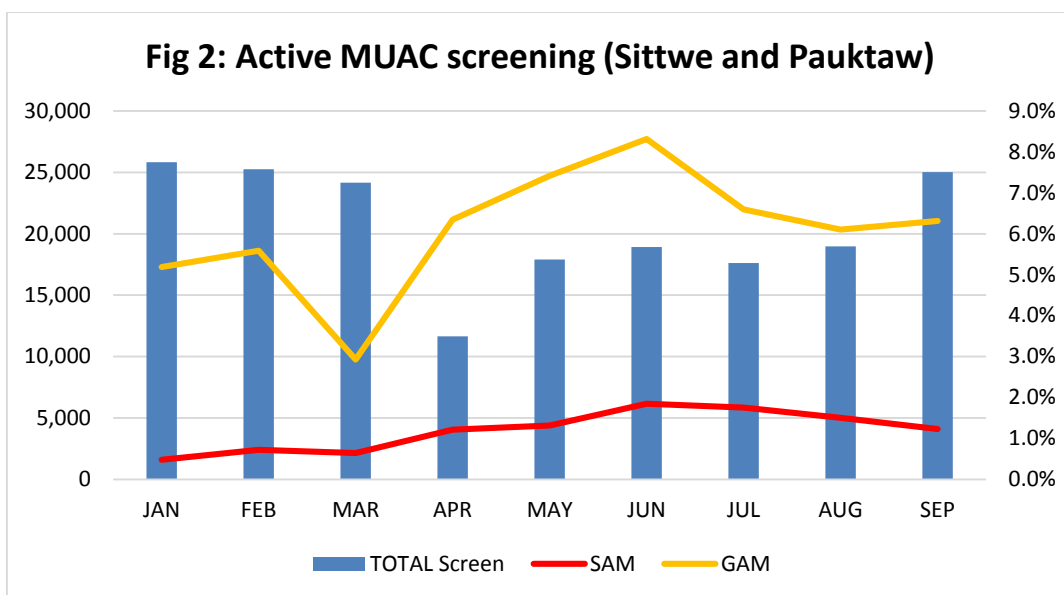
### 1.2. Screening by month:

For the reporting period (January to September), a total of **220,406** children (**105,076** boys and **115,330** girls) have been screened for acute malnutrition. More girls than boys were screened; 59 % of identified acute malnutrition cases (total of 21,626) were girls. Screening was conducted in Buthidaung, Maungdaw, Myebon, Mrauk U, Kyauktaw, Minbya and Sittwe (urban) townships in September (Table 1).

	Male	Female	Total
MINBYA	261	265	526
MRAUK-U	111	125	236
MYEBON	147	164	311
KYAUKTAW	254	371	625
SITTWE - URBAN	119	164	283
BUTHIDAUNG	1087	1538	2625
MAUNGDAW	1081	774	1855

<sup>1</sup> 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.

<sup>2</sup> ACF also uses weight for height as admission criteria during passive screening in Buthidaung and Maungdaw.

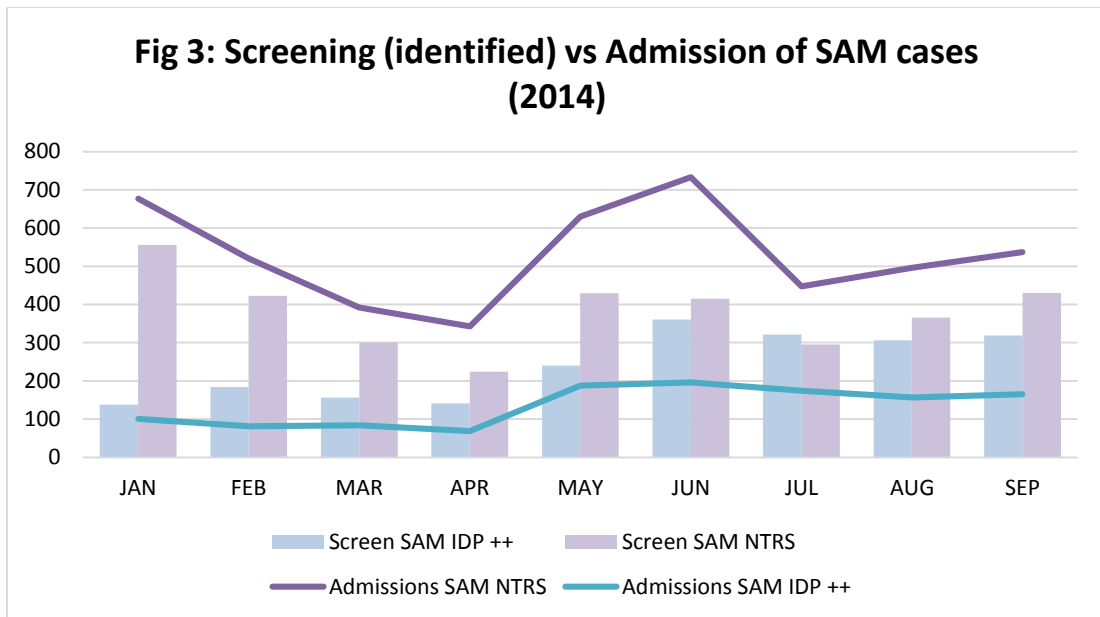


According to active screening results, proxy rates of GAM were 6.3% in September (Fig.2); Proxy rates of Severe Acute Malnutrition (SAM) were lower at 1.2% in September<sup>3</sup> compared to the previous three months (June- August).

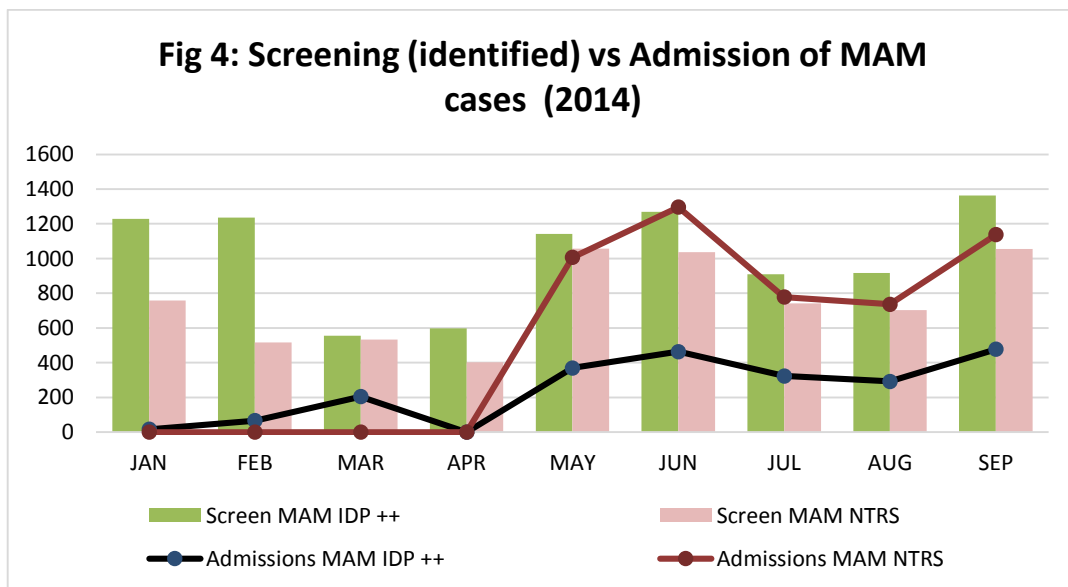
## 2. Treatment of acute malnutrition

### 2.1. New admissions for treatment of acute malnutrition

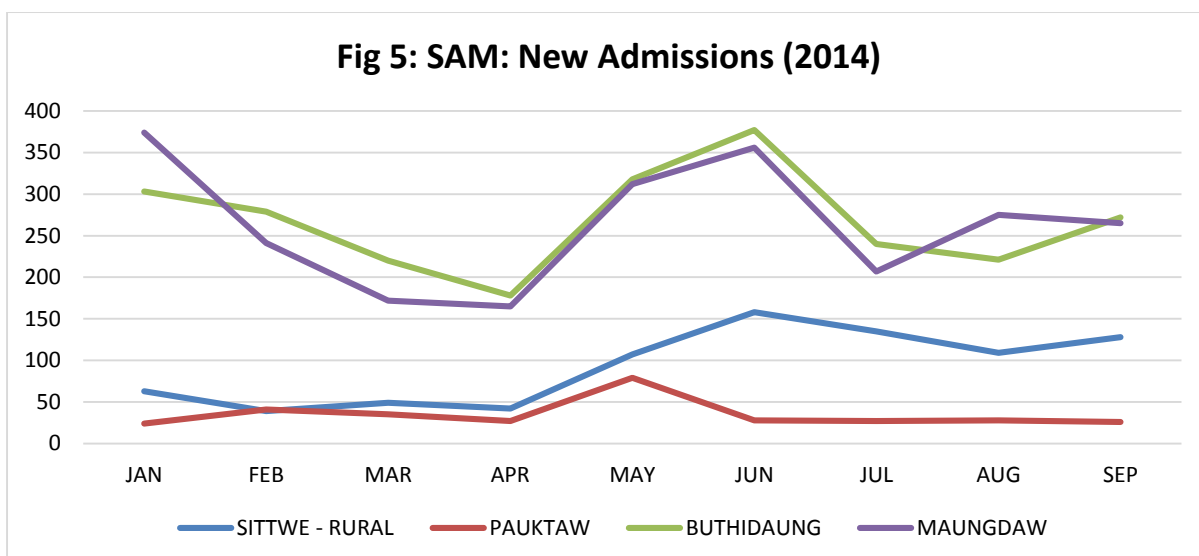
In September, number of admission for SAM and MAM cases were 702 and 1616 respectively; 76% of SAM and 70% of MAM admission were from northern townships of Rakhine state. More SAM cases than identified were admitted to the program in northern townships but only about half of the identified SAM cases in other townships were enrolled to the program. (Fig 3). Reasons for disproportionate admissions against numbers identified relate to probable high numbers of self-referrals following mobilization who were not initially picked during active screening or lack of access by beneficiaries.



This is also similar for the MAM cases where more enrollment of cases in northern townships but only about one third of identified cases were admitted to the nutrition treatment programs in other townships in September (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.

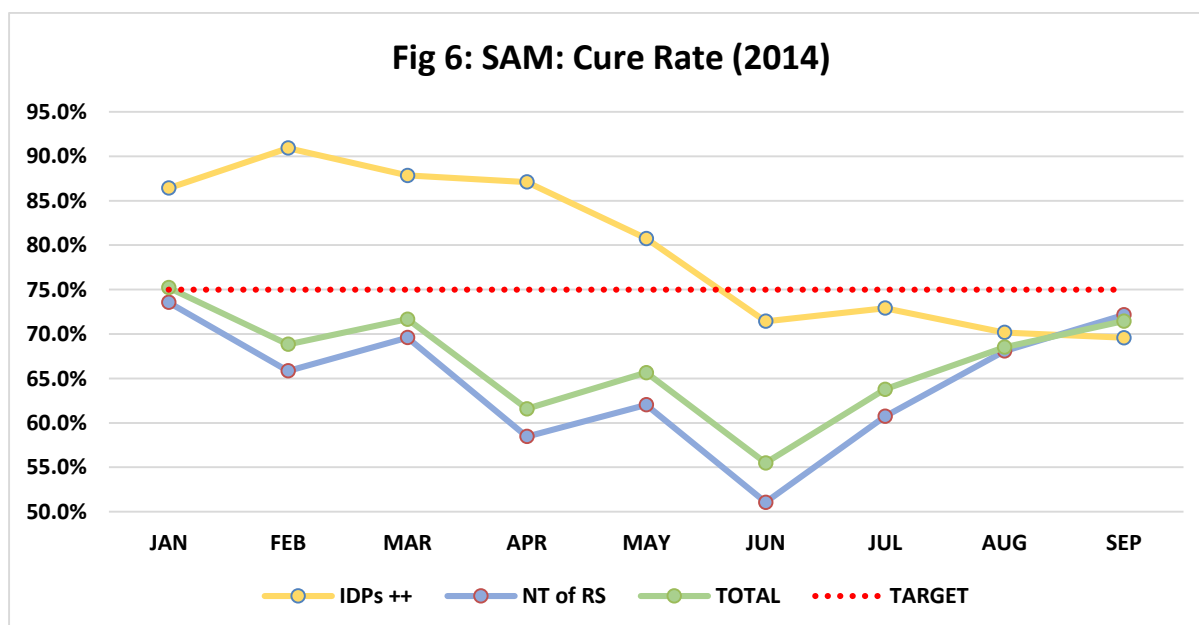


Similar to previous months, the number of new SAM admissions in September were higher in the northern townships than in other conflict affected townships. An increase in SAM admissions was observed for Sittwe rural and Buthidaung; admissions remained stable in Pauktaw and Maungdaw. (Fig 5). Low admission (5 cases in Kyauktaw and 3 cases each from Minbya and Mrauk U) of SAM were noted and no new admission for the other townships in September. These are the same townships where screening is passively conducted.

### 3. Programme performance

#### 3.1. 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 September as per the SAM cure rate indicator; improvement was observed between August (68.5%) to September (71.4%). Unlike in the previous months, performance by cure rate was lower in other conflict affected townships than in northern townships in September (Fig. 6).

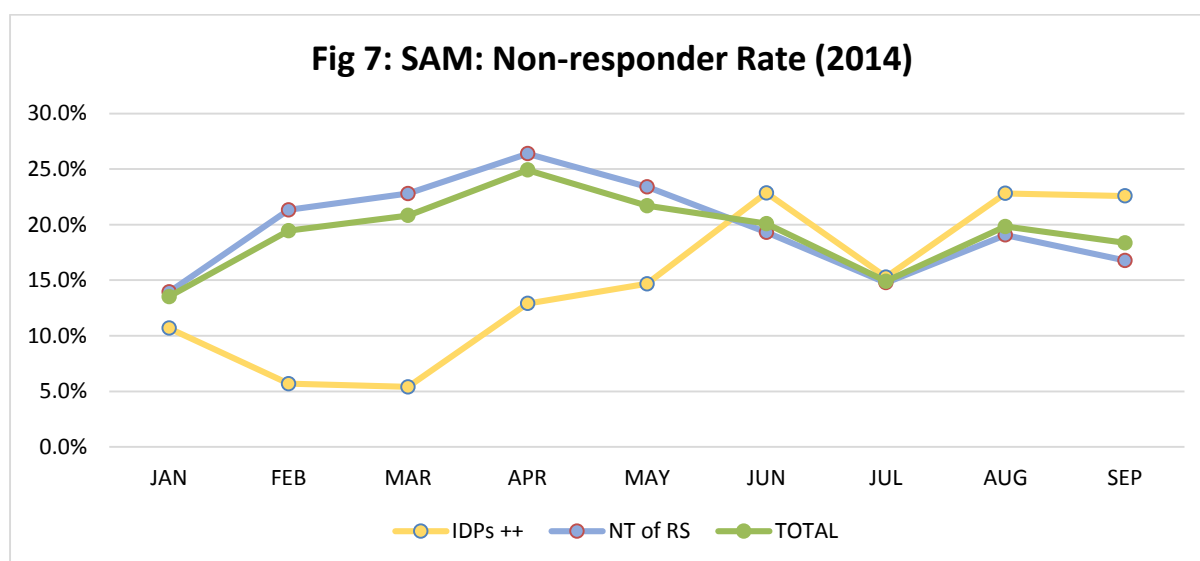


Maungdaw shows the lowest TFP program performance in September (66.5%) followed by Sittwe rural (66.9%) and Minbya (70.9%). Table 2 provides a snapshot of TFP programme performance in September per township.

	Male	Female	TOTAL
SITTWE - URBAN	No Exits	No Exits	No Exits
SITTWE - RURAL	64.9%	68.8%	66.9%
MINBYA	66.7%	75.0%	70.9%
MRAUK-U	No Exits	No Exits	No Exits
MYEBON	No Exits	No Exits	No Exits
PAUKTAW	88.9%	70.4%	79.7%
BUTHIDAUNG	86.0%	77.5%	81.8%
MAUNGDAW	70.5%	62.0%	66.5%

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).

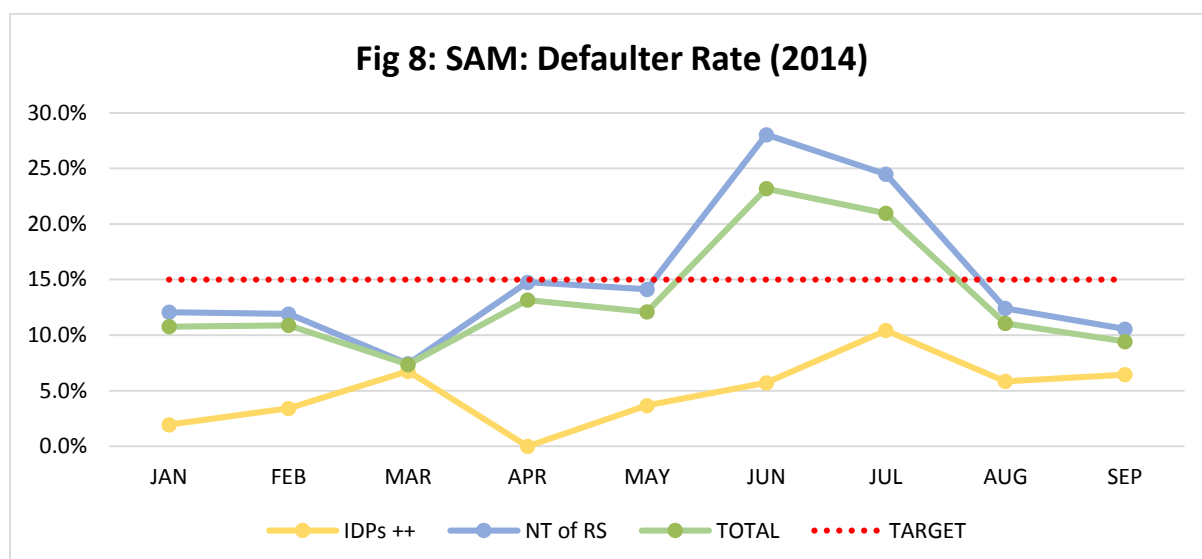
**SAM non-responder rate:** Although there is no cut-off to gauge programme performance in relation to non-responder rates, a relatively high proportion of SAM children (average 19.1%) admitted to TFPs failed to respond to treatment between January to September. Since June, higher non-responder rates were observed in other conflict affected townships compared to northern Townships.



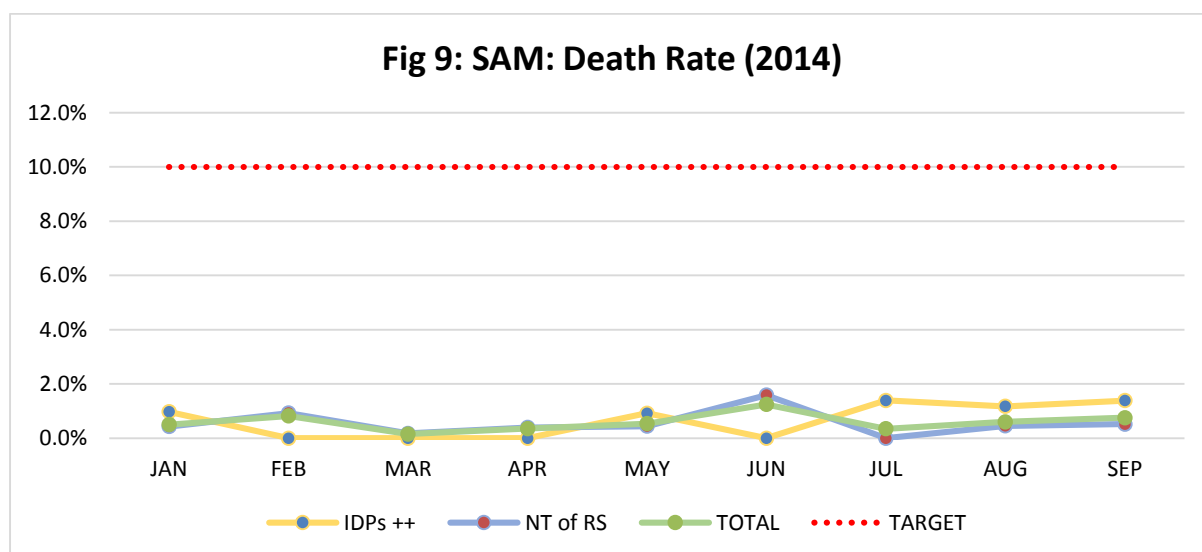
Lack of an adequately functioning referral system and primary health care services to complement nutrition services have partly contributed to the relatively high non-responder rates. Other factors that could be associated with high non-responder rates include high nutrition insecurity (especially in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

**SAM defaulter rates:** A downward trend in the overall proportion of defaulters is observed and within acceptable levels (9.4%) for the month of September (Fig: 8). Defaulter rates also decreased in Northern townships in September compared to the previous three months. In

September, all the defaulters were from Maungdaw (41 cases), Buthidaung (20 cases), Sittwe rural (10 cases) and Pauktaw (4 cases) Townships.



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

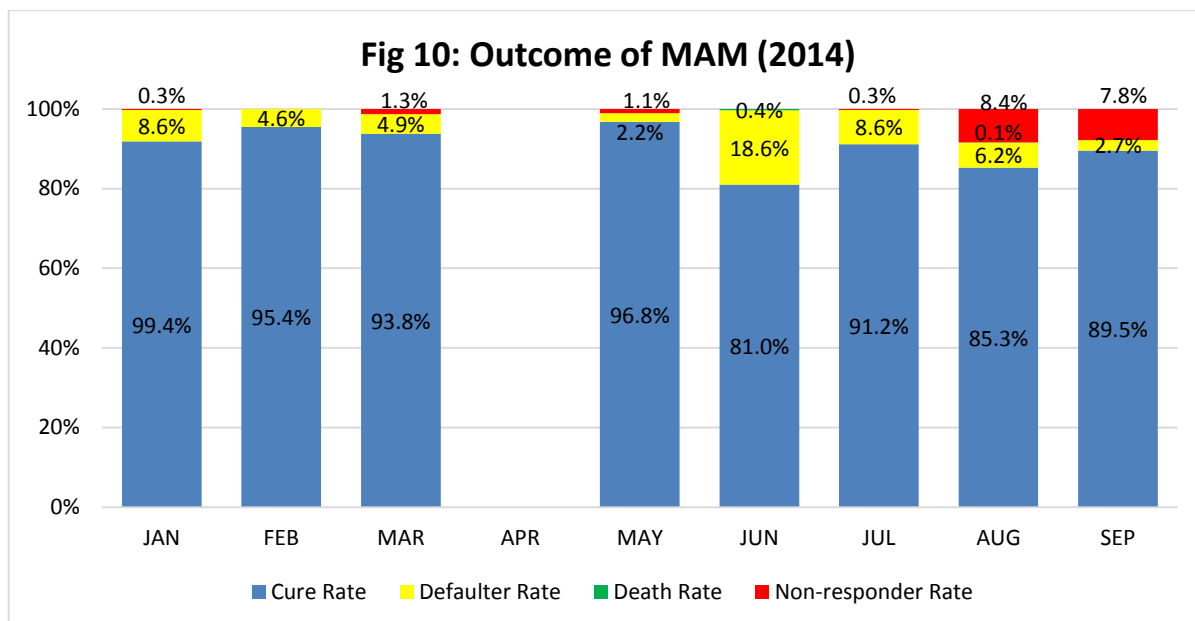


### 3.2. Management of MAM

**All program performance indicators:** The Targeted Supplementary Feeding program is being implemented in 7 townships<sup>4</sup> with 70% of total admission recorded in northern Townships. The program performed well above the minimum standards (> 75%, SPHERE standards) in terms of cure rate. In September, non-responder rate was at 7.8% whereas defaulter rate was within acceptable levels at 2.7%.

<sup>4</sup> TSFP is implemented in Sittwe, Kyauktaw, Pauktaw, Minbya, Buthidaung and Maungdaw.

The majority of defaulters were from Maungdaw (14 cases) and Buthidaung (9 cases) – as these programs have the most beneficiaries – as well as from Sittwe rural (8 cases). Among 91 non-responders, 85 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 19,044 children aged 6-59 months and 6,644 pregnant and lactating women in September<sup>5</sup>.

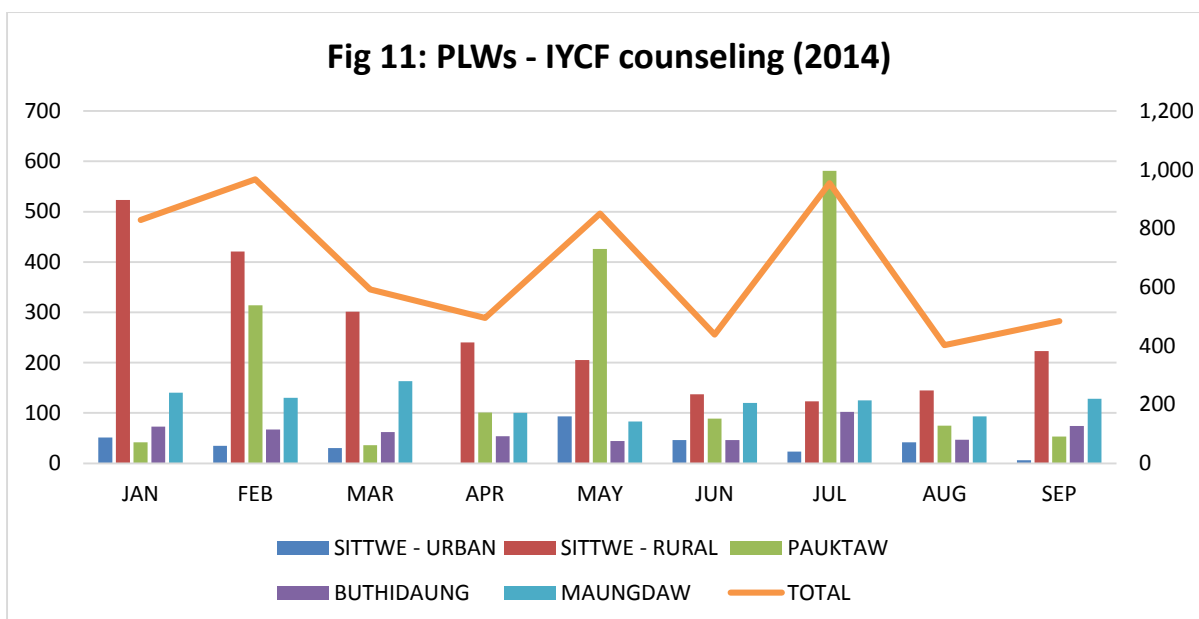
## 4. Access to preventive nutrition services

### 4.1. 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 September were 484 (Fig: 11). Reduced numbers of counselling sessions were reported in Pauktaw Township. A total of 7,285 PLW are targeted in 2014 to receive breastfeeding counselling of which 83% (6,012) 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.

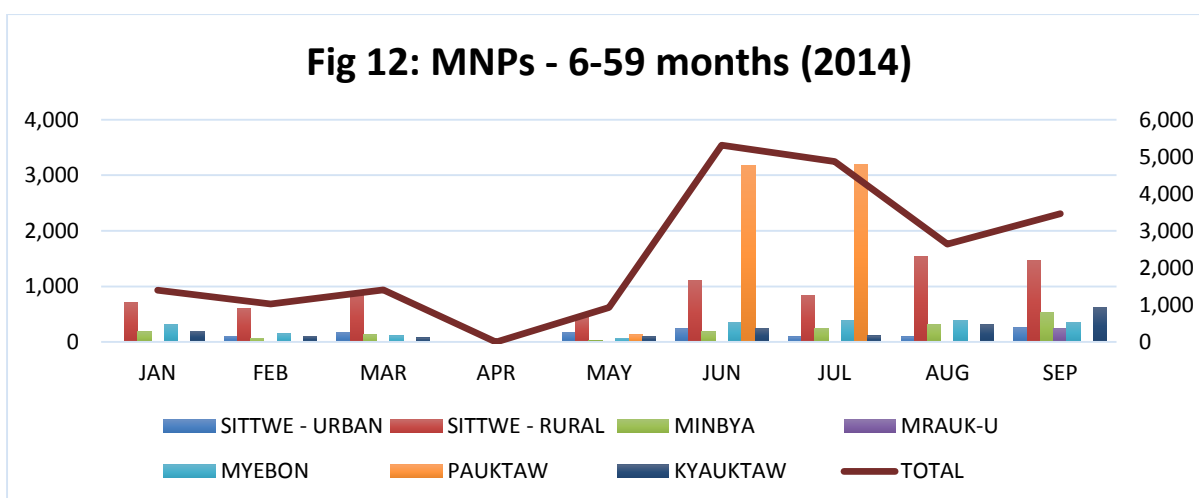
<sup>5</sup> Northern townships BSFP data is not included





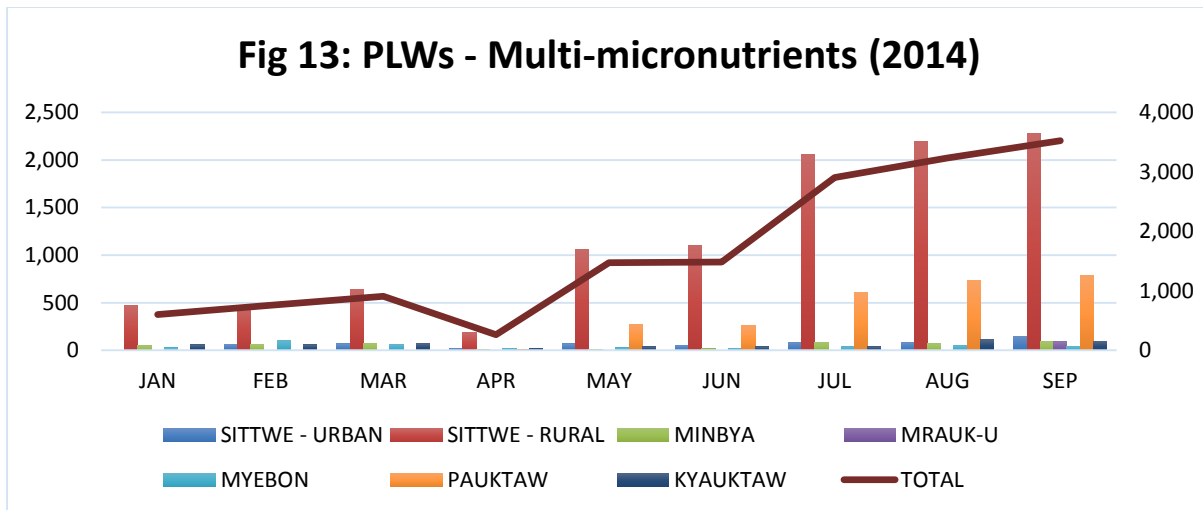
#### 4.2. Provision of multiple micronutrients

**Children 6-59 months (multiple micronutrient powders (MNPs)/sprinkles):** The provision of multiple micronutrient supplementation reached 3,459 children 6-59 months in September. A total of 50,220 children 6-59 months are targeted by the service and to date, 21,031 (42%) have been reached (low coverage). That is because 30 % of targeted children from northern townships are not reached by multiple micronutrient supplementation.



**Pregnant and lactating women (multiple micronutrient tablets):** A total of 3,524 PLW received multiple micronutrient supplementation (tablets) in September which is the highest number recorded for 2014 (Fig. 13). Of the total 13,113 PLW targeted with multiple micronutrient supplementation 15,152 (116%) 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.

**Fig 13: PLWs - Multi-micronutrients (2014)**



## 5. 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, food insecurity, poor sanitation, and sharing and selling of therapeutic and supplementary food.
- High rate of defaulter rates partly due to security reasons (including check points) and high transportation cost.
- In some areas, mothers/carers prefer 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. The lack of firewood mostly affects IDP camps.
- Sub-optimal caring practices among mothers impacting negatively on programme outcomes.

## 6. 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 (every 2 months).

- 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.