

NUTRITION IN MYANMAR: FOCUS ON RAKHINE STATE

REVIEW

A review by the HARP Facility

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March, 2021.



Supported by:



This material has been funded by UK aid from the UK government; however the views expressed do not necessarily reflect the UK government's official policies.

EXECUTIVE SUMMARY

Myanmar has made significant progress in improving undernutrition in children under five years of age in the past decade, reducing wasting and stunting by almost half. However, Myanmar remains fragile and ranks 147 out of 189 in the 2019 Human Development Index, one of the lowest countries in the region. Additionally, Myanmar has a high risk of shocks, with the INFORM Index for Risk Management ranking Myanmar 20th most at risk out of 191 countries in 2021. The COVID-19 pandemic and the recent coup d'état resulting in military control poses a significant threat to the developments already achieved and complicates the already difficult operating environment.

The long running civil unrest between the Myanmar Armed Forces and Arakan Army has left large humanitarian needs in the country. Nutrition and the prevalence of malnutrition is a sensitive subject in Myanmar and in Rakhine State, and the persecution of the Rohingya and a large number of internally displaced persons (IDPs) are a constant humanitarian concern. Gaining humanitarian access requires multiple administrative procedures and as a result, restrictions on NGO staff mean access to vulnerable populations is severely hampered, especially in Northern Rakhine State (NRS) and internal displaced persons (IDP) camps.

To assess the impact of these challenges on nutrition, HARP-F commissioned this review to provide recommendations to better address malnutrition in Rakhine State and Myanmar at large. The following findings were based on desk-reviews and interviews with key stakeholders.

Key Findings:

The Nutrition Situation

- Myanmar has made progress in reducing under-5 child wasting and stunting in the past decade. As of the latest national survey (DHS 2015) wasting is 7% and stunting is 29%. However the current nutrition situation as shown by available data, including the burden of undernutrition and quality of infant and young child feeding practices, is likely worse than indicated as there have been multiple crises since the most recent nutrition surveys were implemented, such as the COVID-19 pandemic and the Rohingya displacement in Rakhine in 2017. Further deterioration to livelihoods, food security and to the nutrition situation is anticipated given increased political insecurity since February 2021.

Coordination

- There are two main nutrition coordination mechanisms at the national level: The Nutrition in Emergencies Technical Working Group (NIE TWG) under the Myanmar Nutrition Technical Network (MNTN) and the Scaling up Nutrition (SUN) Network. The NIE TWG is active but lacks capacity in humanitarian response, although new personnel are being recruited and an Emergency Response Plan (ERP) process is being undertaken. The SUN Network is also active but its work has focused on the development of the Multi-Sectoral National Plan of Action on Nutrition (MS-NPAN) to date, the future of which is uncertain given this is a government owned and led plan.
- Given the recent political insecurity and likely deterioration in the nutrition situation, there is a need to switch from a solely developmental approach to one with an emergency focus, not only with regard to programming but also coordination and funding. The current NIE TWG lacks emergency experience to drive the shift, however an interim Nutrition Cluster Coordinator (NCC) will deploy from the Global Nutrition Cluster (GNC) in April 2021 which is a good opportunity to drive appropriate progress in nutrition given the changing context. Donors will also need to be ready to rapidly mobilise funding for the emergency nutrition response activities identified under the ERP.
- Even though efforts have been made to set up early warning systems in Myanmar, current nutrition data is inadequate in providing timely information to raise warning for an increase in nutrition needs. Historically, it has been very difficult to obtain government approvals to conduct surveys and assessments, particularly in Rakhine state where they have been banned since 2017. However, partners have been able to conduct informal assessments to

guide implementation. A national nutrition surveillance system is urgently needed to support monitoring efforts for nutrition.

- While there is a strong membership of coordination mechanisms at the national level, the nutrition subsector in Rakhine is under-capacitated without a dedicated nutrition sector lead to effectively lead on coordination and capacity-building, leaving gaps in nutrition services. As a result, nutrition is not prioritised in multi-sectoral responses. To effectively respond to increased nutrition needs, the coordination in Rakhine needs to be urgently improved through the recruitment of a Rakhine nutrition sector lead.

Nutrition Programming

- Nutrition-specific and nutrition-sensitive service provision in Rakhine has been decreasing since 2017, prior to the COVID-19 pandemic, leaving many children untreated and thus increasing the risk of malnutrition, morbidity and mortality. Nutrition services, including active wasting case detection, referral and treatment, have been severely disrupted by insecurity and increased access restrictions since 2017. Service provision, including outside of Rakhine state, has been further reduced by COVID-19 and the recent political instability. There is a lack of cohesion between and within malnutrition treatment and prevention services, increasing the risk of children missing lifesaving treatment. In addition wasting and stunting are seen as separate manifestations of malnutrition, with no programmes to jointly address both and their shared risk factors.
- Scaling-up coverage of wasting treatment in Myanmar and Rakhine in particular requires innovative approaches such as using Mother Mid-Upper Circumference (MUAC), which has been shown to be feasible, and piloting simplified approaches to wasting treatment for low-literacy health workers. Other opportunities also include integration of nutrition services into mobile health clinics. The barriers to seeking maternal and child health services are multi-factorial, with Muslim households facing additional obstacles, and these will need to be addressed to achieve increased coverage. Other major gaps in nutrition service provision include identification and management of at-risk infants under six months and their mothers [MAMI] and better management of children with severe wasting with medical complications.
- While the operating environment limits programme implementation, there are also challenges identified in the recently funded Action Against Hunger (ACF) programme that are not unique to ACF and that others can learn from. These include a lack of advocacy and engagement with key decision-makers at the start of programme design, slow recruitment processes, inefficient coordination between multiple funders perpetuated by a lack of nutrition expertise within HARP-F, and an excessively large geographic coverage for a pilot project.
- Given the precarious food security situation currently in Myanmar as a result of the coup and its resulting impacts, such as on cash availability, it is also important to ensure children over six months, adolescent girls and women receive adequate macro- and micronutrients in their diets. There have been efforts to link and mainstream nutrition within other sectors in the context of COVID-19, however, there have been disruptions and delays to food and cash distributions which increases the risk of malnutrition, especially in vulnerable populations dependent on aid.
- Adequate provision of nutrition-specific and nutrition-sensitive services continue to be under threat. As a result, there is a need to move towards establishing remote monitoring systems and increasing the capacity of national partners to directly implement and lead on nutrition service provision.

Recommendations and immediate priorities:

The following are the recommendations and immediate priorities to address the above key findings. For next steps and longer-term future recommendations, see the full report for details.

Recommendations	Immediate Priorities
<p>1. Invest in coordination to facilitate an adequate nutrition emergency response considering the changing environment, building on existing development frameworks e.g. MS-NPAN</p>	<ul style="list-style-type: none"> ● Ensure the approach taken by the nutrition sector in Myanmar builds on existing long-term development plans and frameworks, to ensure an adequate emergency response centred on critical lifesaving nutrition services is in place where needed ● With the support of the GNC, develop a comprehensive multi-sectoral emergency response plan (ERP) for nutrition which includes specific priority activities and geographic areas for nutrition ● Ensure that all nutrition actors (INGOs, NGOs, UN agencies and national organisations) consult the central nutrition coordination body prior to designing and implementing activities in order to coordinate and prioritise geographic areas and programmes for nutrition support ● UNICEF, as the cluster lead agency for nutrition, should continue to ensure nutrition coordination is prioritised in Myanmar and identify a dedicated sector leadership position for Rakhine ● Ensure nutrition is prioritised in Myanmar and Rakhine state (and other priority states and regions)
<p>2. Ensure funding is increased and coordinated optimally, to allow for flexibility given the changing operational environment</p>	<ul style="list-style-type: none"> ● Improve collaboration between FCD0-funded mechanisms which can be better utilised together to optimally address malnutrition (HARP-F, LIFT, Access to Health) ● Donors to provide increased and flexible funding to allow for adaptability given the changing operational environment ● Identify solutions to the cash flow and liquidity challenges and plan for disruptions to bank services, to prevent disruptions to nutrition and nutrition-related services
<p>3. Increase the capacity of national organisations to lead the nutrition response</p>	<ul style="list-style-type: none"> ● Conduct a partner mapping and capacity assessment to identify which national partners (non-governmental organisations, community-based organisations, civil society organisations) are able to immediately scale-up their nutrition response and which national partners can redirect attention to lifesaving activities ● Develop a capacity-building strategy and establish a mechanism for high-capacity nutrition partners to provide mentorship to national organisations ● Consider a central funding mechanism to channel funding through a high-capacity nutrition partner who then subgrants to lower capacity nutrition partners and provides nutrition technical support
<p>4. Improve collection, analysis and use of data for decision-making, to enable a greater understanding of the evolving nutrition situation and trends and to inform the nutrition emergency response</p>	<ul style="list-style-type: none"> ● Conduct an information needs assessment of available data and gaps to improve data availability ● Establish a nutrition surveillance system to ensure trends are monitored as the situation evolves, to facilitate decision-making on appropriate lifesaving activities ● Use available MUAC screening data from all partners and all relevant services (including non-nutrition-specific) to continually analyse the nutrition situation ● Fund information management capacity to increase ability to coordinate and conduct emergency assessments and data monitoring

Recommendations	Immediate Priorities
<p>5. Protect the collapse of basic maternal and child health and nutrition services and scale-up lifesaving nutrition services in priority locations in anticipation of increased nutrition needs</p>	<ul style="list-style-type: none"> ● Ensure nutrition is funded and mainstreamed in multi-sectoral response plans and in non-nutrition programming to increase access to nutrition services, especially for vulnerable groups ● Ensure scale-up of lifesaving nutrition services is aligned with the new ERP] (priority locations, services and scenario planning) and builds on the MS-NPAN framework already in place ● Plan for delivery mechanisms in the absence of a functioning government ● Plan for potential interruptions in the supply chain to prevent gaps in nutrition service provision ● Address the fear and administrative barriers limiting access to health centres
<p>6. In particular, increase coverage of wasting treatment services, including screening and referral, with a focus on severe wasting treatment of children 6-59 months and management of at-risk infants under 6 months and their mothers [MAMI]¹</p>	<ul style="list-style-type: none"> ● Intensify active nutrition screening using MUAC and home visits to increase referrals of cases of severe wasting (including with medical complications) and moderate wasting ● Strengthen referral mechanisms between nutrition services to ensure continuation of care and that cases of wasting do not miss out on treatment ● Prioritise and fund the scale-up of severe wasting treatment through OTPs (as opposed to TSFP or inpatient care) given funding constraints ● Use the shift to lifesaving activities as an opportunity to pilot MAMI services, building on the learning from the Rohingya refugee response in Bangladesh in 2017
<p>7. Increase coverage and quality of infant and young child feeding [IYCF] services, including support for exclusive breastfeeding <6 months and continued breastfeeding up to 2 years of age, timely introduction of complementary feeding, and monitoring of breastmilk substitutes [BMS] and violations of The Code</p>	<ul style="list-style-type: none"> ● Support the identification of any violations of the Code of Marketing of BMS, including untargeted distributions/ donations of infant formula ● Extend the coverage of one-to-one breastfeeding counselling and mother support groups to ensure exclusive breastfeeding in infants <6 months and continued breastfeeding for children up to two years, in both camps and villages ● Explore opportunities for new entry points in existing programming to increase support for optimal and timely introduction of complementary foods for children at 6 months of age ● Where possible, conduct an IYCF rapid assessment to assess the evolving IYCF situation
<p>8. Ensure specific nutrition vulnerabilities faced by women and adolescent girls are considered and their nutrition needs, including micronutrient needs, are comprehensively addressed</p>	<ul style="list-style-type: none"> ● Ensure the continuation of social safety net programmes (food and cash distributions) to reduce the risk of food insecurity for women and children ● Prioritise women with young children for social safety net programmes ● Prevent service disruption to antenatal care, postnatal care and other sexual and reproductive health services, with specific attention to women and adolescent girls of ethnic minorities ● Ensure communication, education and information is accessible, taking into consideration barriers for women in accessing services

¹ MAMI is the management of small and nutritionally at-risk infants under six months and their mothers

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Abbreviations

4W	Who, what, where, when
A2H	Access to Health
AA	Arakan Army
ACF/AAH	Action Contre le Faim/ Action Against Hunger
ANC	Antenatal care
BHA	Bureau for Humanitarian Assistance
BMI	Body mass index
BMS	Breastmilk substitute
BSFP	Blanket supplementary feeding programme
CBO	Community-based organisation
CBT	Cash-based transfers
CDM	Civil disobedience movement
CHW	Community health worker
CMAM	Community-based management of acute malnutrition
CRP	Contingency response plan
CSI	Centre for Social Integrity
CSO	Civil society organisation
DHS	Demographic and Health Survey
ECHO	European Civil Protection and Humanitarian Aid Operations
EPHS	Essential Package of Health Services
ERP	Emergency response plan
FCDO	Foreign, Commonwealth and Development Office
FFP	Food for Peace
GAM	Global acute malnutrition/ global wasting
GDP	Gross domestic product
GNC	Global Nutrition Cluster
HARP-F	Humanitarian Assistance and Resilience Programme Facility
HFA	Height-for-age
HNO	Humanitarian Needs Overview
HPF	Humanitarian Pooled Fund
HRP	Humanitarian Response Plan
IDP	Internally displaced person
IMO	Information management officer
INGOs	International non-governmental organisation
IRC	International Rescue Committee
IYCF	Infant and young child feeding
LIFT	Livelihoods and Food Security Fund
LQAS	Lot quality assurance sampling
MAF	Myanmar Armed Forces
MAM	Moderate acute malnutrition/ moderate wasting
MAMI	Management of at-risk infants under six months and their mothers
MCCT	Maternal and child cash transfers
MICS	Multiple Indicator Cluster Surveys
MHAA	Myanmar Health Assistant Association (MHAA)
MMFCS	Myanmar Micronutrient and Food Consumption Survey
MNTN	Myanmar Nutrition Technical Network
MoE	Ministry of Education
MoSWRR	Ministry of Social Welfare, Relief and Reconstruction
MoHS	Ministry of Health and Sports
MMS	Multiple micronutrient supplementation
MNP	Micronutrient powders

MQSUN+	Maximising the Quality of Scaling Up Nutrition Plus
MS-NPAN	Multi-Sectoral National Plan of Action on Nutrition
MUAC	Mid-upper arm circumference
NCC	National Cluster Coordinator
NGO	Non-governmental organisation
NRS	Northern Rakhine State
NIE	Nutrition in emergencies
OCHA	United Nations Office for the Coordination of Humanitarian Affairs
OTP	Outpatient therapeutic programme
PLW	Pregnant and lactating women
PNC	Postnatal care
RUSF	Ready-to-use Supplementary Food
RUTF	Ready-to-use Therapeutic Food
SAG	Strategic advisory group
SAM	Severe acute malnutrition/ severe wasting
SBCC	Social and behaviour change communication
SCI	Save the Children International (SCI)
SMART	Standardised Monitoring and Assessment of Relief and Transition
SQUEAC	Semi-Quantitative Evaluation of Access and Coverage
SUN	Scaling Up Nutrition
TA	Travel authorisation
TOR	Terms of reference
TRRT	Technical Rapid Response Team
TSFP	Targeted supplementary feeding programme
TWG	Technical working group
UN	United Nations
UNDRR	United Nations Office for Disaster Risk Reduction
UNICEF	United Nations Children's Emergency Fund
WASH	Water, sanitation, and hygiene
WFA	Weight-for-age
WFH	Weight-for-height
WFP	World Food Programme
WHO	World Health Organisation
WSB+	Wheat Soy Blend +
WSB++	Wheat Soy Blend ++

INTRODUCTION

Myanmar is a complicated context within which to operate and the prevalence of malnutrition is a sensitive subject. There are several protracted crises related to internal conflicts in existence, with one of the most complex locations being Rakhine State. The persecution of the Rohingya is a constant humanitarian concern, as is the persecution of other internally displaced persons (IDPs) in Myanmar, all of whom are particularly vulnerable. The arrival of the COVID-19 pandemic in 2020 posed additional challenges in a context with an already inadequate health system, and repeated lockdowns increased the vulnerability of those living hand to mouth as livelihoods were disrupted. Finally the coup d'état in February 2021 has meant uncertainty regarding how best to ensure service provision is continued and scaled up, with disruption to banking and availability of cash likely to affect operation of all services. The military is likely to continue to maintain control nationally which means a complete shift in approach to ensuring the basic human rights of all those living in Myanmar is needed, including how to ensure lifesaving services are provided as a priority in the absence of government leadership. The operational challenges in Myanmar, and more specifically in Rakhine, are highlighted below.

Operating Environment

Myanmar as a whole is a unique context to programme in but the situation is made all the more complicated by the recent coup d'état given the unknowns and uncertainties this brings, particularly around government engagement. There were challenges prior to the coup which are now further exacerbated by recent events and under the new military control, regulations are constantly changing.

- **New barriers to freedom of movement have been imposed since the coup.** For example, even though the Tatmadaw promised Rohingya leaders freedom of movement for COVID-19 vaccinations, there were reports of Rohingya adults sent to prison for unauthorised travel ([People Media 2021](#)). Additionally village administrators indicated they must now report any overnight visitors to their jurisdiction. This restriction may make it more difficult for health workers to stay overnight when travelling to provide health services.
- **Due to the recent political instability organisations are struggling to get money into the country and if they do manage to, it is increasingly difficult to transfer it round the country.** The civil disobedience movement [CDM] has taken hold and is increasing in scale, and there have been social media movements calling for and resulting in nationwide strikes. Most bank staff are not currently working and most banks are closed, resulting in most transfers largely coming to a halt. At the beginning of March 2021 the central bank published new instructions capping the amount of money that can be withdrawn, which leaves organisations facing major problems in obtaining enough money for suppliers and salaries. Where mobile financial services were proving a possibility, there are also new financial regulations for this service as well (interviews).
- **Health service provision is currently disrupted with minimal health services operating to provide care, as health workers themselves are joining the strikes and protests and hospitals are now a target of the military** ([The Guardian, March 2021](#)). Prior to the coup there were around 20,000 COVID-19 tests being conducted per day but currently this has been vastly reduced to around 1,000 per day ([HARP-F, 1 March 2021](#)). Even where a COVID-19 case requiring hospitalisation is identified, provision of care is now unavailable. The risks of the COVID-19 pandemic becoming further out of control are huge and with the economy already affected by COVID-19 related lockdowns, with livelihoods disrupted especially in urban areas, further disruption is a concern. While COVID-19 related relief efforts were provided by the government, particularly for the urban working poor, with the recent political instability it is not clear if such support will be available in the future (interviews).
- **Communications continue to be hampered, with increased disruption since the coup.** Internet connections and mobile services are frequently suspended across conflict-affected townships, disrupting coordination amongst organisations as well as communication with the community. Recent reports state that Myanmar's internet connectivity has reportedly dropped to 50% of normal levels following the coup ([BBC, Jan 2021](#)) and internet blackouts are becoming more frequent ([BBC, Feb 2021](#)). Reportedly communications have been possible through Chinese and Thai mobile networks but the means by which to communicate remains unpredictable.

The long running political and civil unrest and armed conflict between Myanmar Armed Forces (MAF) and Arakan Army (AA) has left a large humanitarian need in Rakhine and ongoing insecurity. The Rohingya, a mostly Muslim minority in Rakhine, are not considered one of the officially recognised ethnic groups in Myanmar and are viewed to be illegal immigrants from Bangladesh. In 2017, violence from Myanmar's military forced more than 700,000 Rohingyas from Myanmar into Bangladesh ([New Humanitarian, 2020](#)).

- **Humanitarian needs have increased over the past year due to the increased armed conflict in Rakhine, with intense fighting frequently taking place in and around populated areas** ([HNO 2021](#)). Host communities are also affected by the conflict itself, including growing landmines and unexploded ordnance contamination ([HNO 2021](#)). UNICEF also reported civilian casualties and injuries due to an unexploded ordnance detonated in Sa Pa Htar Village in Minbya Township in Rakhine on 10 January, 2021 ([OCHA, Jan 2021](#)). Since the recent political instability in February 2021, there have been a number of reported explosions, gunfire and protests, although the situation in Rakhine has remained relatively calm.
- **The protracted crisis has left large numbers of people displaced in Rakhine.** As of 31 December 2020, 92,000 individuals were displaced across 190 displacement sites in Rakhine ([UNHCR Operational update December 2020](#)). Eight years of intercommunal violence in Rakhine has left hundreds of thousands of stateless Rohingya vulnerable and has driven displacement to neighbouring Bangladesh, where they continue to face challenges with accessing education, healthcare and livelihoods support.
- **There are many nondisplaced stateless Rohingyas in extreme need.** The majority of non-displaced stateless Rohingya (68%) are categorised as experiencing extreme severity of need and the remaining 32% in the highest level of relative severity of needs. The [HRP 2021](#) estimates there are currently approximately 470,000 non-displaced stateless Rohingya facing discrimination.

In Rakhine State, restrictions on the movement of NGO staff means access to vulnerable populations is severely restricted, particularly in Northern Rakhine State and in camp settings. Even prior to the coup, many challenges existed as outlined below.

- **Limited access and movement restrictions due to insecurity and lack of roads and infrastructure in Northern Rakhine State hinders access for humanitarian assistance.** More than a third of displacement sites and villages in Rakhine were off limits to most aid organisations as of late January 2021 according to OCHA ([OCHA, Jan 2021](#)). As of 16 Jan 2021, 56 out of 158 displacement sites and half of 32 host communities in Rakhine and Chin remain inaccessible ([OCHA, Jan 2021](#)). The Rakhine Yoma mountains separate Rakhine from the rest of the country resulting in limited road connectivity ([HNO 2021](#)).
- **Movement is subject to multiple government approvals, which takes time.** Organisations, including NGOs, require travel authorisations (TA) to access villages, camps and other project sites. The surge of COVID-19 in August also resulted in a stay-at-home order followed by full lockdown. This meant all TAs from the government were stopped in Sittwe and from mid-August 2020, due to COVID-19, new restrictions were applied to movements of humanitarian personnel to minimize transmission risk ([HRP 2021](#)). Outpatient therapeutic programmes (OTP) were closed starting in mid-August 2020 ([ACF/HARP, Oct 2020](#)) and other services were also disrupted. Existing TAs were withdrawn and activities were suspended due to multiple personnel testing positive for COVID-19 ([HRP 2021](#)). Since the coup in February 2021, there have been further reported delays in applying for TAs whilst determining the new mechanism through which to apply, although once TAs were submitted approval was forthcoming (interviews).
- **Challenges with obtaining travel authorisations (TA) hinder health actors from providing care or referring children to hospital.** Due to difficulties with obtaining TAs, health workers cannot be mobilised in camps and catchment areas of other health centres to provide home visits, nutrition service provision during normal clinics, or care for children with medical complications in the Sittwe General Hospital or other health facilities (interviews). The recent coup and resulting insecurity will make this even more difficult.

In addition to the political unrest, Rakhine is vulnerable to climate change and natural disasters including cyclones and heavy rains, increasing the community's vulnerability. Along the coastline, Rakhine is highly vulnerable to natural hazards and the broader effects of climate change ([HNO 2021](#)). Much of the state's farmland is poorly adapted to these challenges,

including salinity from flooded tidal waterways [HNO 2021]. A UN report ranks Myanmar among the three most vulnerable countries to extreme weather events, with as much as 3% of Myanmar’s gross domestic product (GDP) lost annually due to disasters triggered by natural hazards [HARP-F, June 2018].

Implications of Operating Environment on Humanitarian Approach

Further deterioration of the political situation is anticipated as a result of the coup and the risk of rising COVID-19 cases creates new uncertainty for humanitarian operations. Organisations will be operating with increased sensitivity to the political situation and there is a risk that operations will be suspended or shut down as a result of the political uncertainty (interviews). Communications are unlikely to improve and the difficulty in accessing cash will likely disrupt provision of all services, as paying suppliers and staff salaries will become more difficult. With the political unrest, testing for COVID-19 has reduced significantly and with health workers joining the CDM, treatment for COVID-19 in health facilities even when identified may be unavailable. The COVID-19 pandemic has also compounded the challenges for internally displaced persons (IDPs), with further restrictions on mobility and access for IDPs due to subnational and national border closures. Frequent fighting in populated areas adds pressure on host communities who are already facing conflict. This rapid increase of new internal displacement has in addition compounded challenges for host communities who are in many cases also affected by conflict itself [HNO 2021].

Due to the longstanding restrictions to direct implementation and travel authorisations, international organisations and health workers have operated through partnership with local groups, such as national NGOs, civil society organisations (CSOs) and community-based groups [Asia Foundation, Jan 2021]. Local partnerships should be further strengthened and the capacity-building of local groups should be continued. The capacity of local organisations to manage an increased number of small grants and the modality by which to do so will need to be explored further, and investigations into how best to build the capacity of local groups should be conducted.

There is a high level of uncertainty in terms of the operating environment. However, in the short term, the military is likely to continue to maintain control which will have an impact on all aspects of nutrition service provision. Below are potential scenarios for each element of the operating environment which the nutrition community will need to prepare for. These scenarios are built on the assumed continued military control at national and state levels. Regardless of the potential scenarios (Table 1), there is an assumed likely increase in humanitarian needs that will need to be addressed.

Table 1: Potential scenarios for nutrition sector needs to prepare for (not scenarios may differ at any given time between different elements)

Element	Scenario 1	Scenario 2	Scenario 3
Access/ movement	<p>Reduced access or complete loss of access either due to military control</p> <p>NGOs are unable to operate and or face increased risks to operate</p> <p>Tighter COVID-19 restrictions in place meaning less access to the population and deterioration of the humanitarian situation</p>	<p>NGOs maintain presence and can ensure service provision</p> <p>Current likelihood of obtaining TAs remains in effect</p>	<p>Humanitarian access is improved with fewer restrictions and reduced need for TA and procedural approvals</p>
Communication	<p>Communication is frequently blocked and disrupted</p> <p>Access to cash is limited due to banking constraints and</p>	<p>Communication via encrypted messaging (Signal) and other methods possible</p> <p>Occasional internet blackouts</p>	<p>Communication channels open without restriction, internet blackouts are stopped</p>

	difficulty of some beneficiaries to use mobile money		
Safety and security	Heightened exposure of national staff to insecurity and violence International staff evacuated	Mostly safety and security are ensured, with the risk of isolated incidents occasionally that may affect staff and the wider population	Safety and security are improved, no staff (national or international) feel at risk Beneficiary population do not feel at risk of insecurity and feel safe
Displacement of Rohingya and other IDPs	IDP camp closures Increased persecution of vulnerable groups such as the Rohingya and other IDPs in Rakhine Large scale movement of Rohingya due to worsening of conflict Bangladesh shuts its border to prevent increase in arrivals of Rohingya Myanmar and Bangladesh agree to forcibly return Rohingya refugees to Myanmar Insecurity and violence results in additional IDPs in Myanmar within and across states	Rohingya remain in IDP camp settings where movement is restricted and livelihoods outside the camp prevented Other IDPs in Rakhine State remain displaced	The human rights of the Rohingya are respected IDPs are able to return home safely
COVID-19	Health services are overwhelmed as there are spikes in the COVID-19 caseload and a reduction in availability of health staff to work due to the CDM Reduced COVID-19 testing causing mass uncontrolled outbreaks	Limited COVID-19 testing facilitating COVID-19 spread in all settings, especially IDP camps	Mass testing in place facilitating early identification of COVID-19 cases and timely treatment, to prevent the spread of COVID-19 Vaccination campaign conducted successfully

Policies and Guidelines

Note: While the environment within which to operate has changed in Myanmar at large, national policies already in place/ draft policies in the process of being approved should still be adhered to. The below is a list of nutrition-related policies that provide the framework under which nutrition programming and nutrition service provision should operate.

- The **Multi-Sectoral National Plan of Action on Nutrition [MS-NPAN]** was developed by multi-sectoral partners led by the National Nutrition Centre (NNC) of the Ministry of Health and Sports (MoHS) and supported by UNICEF. The MS-NPAN has specific targets and key results for sectors and ministries - MoHS; Ministry of Education (MoE); Ministry of Agriculture, Livestock, and Irrigation (MoALI); and Ministry of Social Welfare, Relief and Reconstruction (MoSWRR). Since the launch, state-specific plans have been developed in Chin, Kayah, Shan South, Kayah and Ayarwaddy against a set

of prioritised nutrition interventions, which include monitoring and evaluation plans with indicator lists, capacity assessments and initial costs for prioritised interventions. However, given the MS-NPAN is government-led, recent political instability has meant implementation of the MS-NPAN and development of any further work plans have been put on hold, for example in Rakhine [interviews]. UNICEF, the SUN Network and the nutrition community will need to determine how to build off of the MS-NPAN platform in place in the absence of government leadership, to ensure any nutrition implementation moving forward, including humanitarian, builds off of this framework. Box 1 illustrates the goal and specific nutrition objectives for the MS-NPAN. An analysis of the MS-NPAN by MQSUN+ highlights strengths and further recommendations to address gaps [\[MQSUN+, 2018\]](#).

Box 1 Multi-Sectoral National Plan of Action on Nutrition (MS-NPAN): Goal, Objectives, Indicators, Targets

Goal: To reduce all forms of malnutrition in mothers, children, adolescent girls with the expectation that this will lead to healthier and more productive lives that contribute to the overall economic and social aspirations of the country

Specific Nutrition Objectives:

- All students, especially girls, complete secondary education well-nourished and with knowledge of optimal nutrition behaviours
- Increased quality and utilisation of nutrition-related services and optimal nutrition behaviours among PLW, children and adolescents
- Regular access and consumption of safe and diverse foods
- Nutritionally vulnerable population groups benefit from social and relief assistance and nutrition promotion
- Government and partners at all levels coordinate nutrition interventions
- Quality nutrition data is accessible and used to enable program decisions

Key Indicators and targets of the MS-NPAN:

1. Reduced prevalence of stunting among children 0-59 months from 29% in 2015 to 21% in 2025 (WHA indicator target 1);
2. Reduce the prevalence of acute malnutrition (wasting) among children 0-59 months from 7% in 2015 to less than 5% in 2025 (WHA indicator target 6);
3. Reduced prevalence of low birthweight from 8% in 2015 to less than 6% in 2025 (WHA indicator target 3);
4. Reduced prevalence of anaemia among women of reproductive age (15-49 years) from 46.6% in 2015 to 25% in 2025 (WHA indicator target 2);
5. Reduced prevalence of anemia among under five children from 47.8% in 2015 to 25% in 2025
6. Maintain median urinary iodine concentration of women of reproductive age (15-49 years) between 100-299 µg/L.

- The [2021 Humanitarian Response Plan \(HRP\)](#) was developed by the United Nations Resident Coordinator and Humanitarian Coordinator. It prioritises non-displaced stateless people (in Rakhine State).
- A **Treatment Protocol for the Integrated Management of Acute Malnutrition** was developed in 2017 with accompanying job aids and tools. It includes outpatient and inpatient care for children 6-59 months with severe wasting, and inpatient care for infants under 6 months with severe wasting.
- A **Guideline for Infant and Young Child Feeding (IYCF)**, including key messages and participant manuals, are available in Burmese.
- The **“Order of Marketing of Formula Food for Infants and Young Children”** has been adopted by the Government of Myanmar, but despite this violations of the International Code of Marketing of Breastmilk Substitutes (BMS) have been reported in Myanmar in 2020 by UNICEF increasing the risk of unsafe use of BMS [\[UNICEF 2020\]](#). There was inadequate labelling, including no health hazard warning, inappropriate language, no statement on breastfeeding superiority and no information on safe preparation, which is prohibited by the order. Unsafe use of BMS can lead to ingestion of foodborne pathogens and/ or contracting other illnesses related to poor hygiene, increasing the risk of diarrhoea and illness in infants and young children. In September 2020, there was a risk of poor quality BMS potentially in Myanmar, given that UNICEF reported six batches of one of the BMS companies’ (Nutralatt) products in Cambodia was found to have inadequate levels of iron and zinc [\[NIE, 17th Sept 2020\]](#).

METHODS AND LIMITATIONS

The consultant was initially requested to provide an update to HARP-F's understanding of the nutrition situation in Rakhine state in Myanmar. In addition, recommendations for action by HARP-F partners (where feasible), the FCDO or other FCDO funded projects were requested. This work aimed to monitor, evaluate and learn from previous HARP-F work on nutrition, with a view to demonstrating impact by the end of the project in 2022.

Two weeks after work began, the coup d'état occurred in Myanmar on 1 February 2021. This altered the scope of work significantly given the rapidly changing context. As a result, the work focused on Rakhine but also incorporated recommendations on the national nutrition context in Myanmar. The work also included recommendations related to the anticipated shift to a more emergency-focused approach to nutrition and focused on the likely scenario that military control will prevail in Myanmar.

The consultant conducted a desk review of secondary literature including policies, reports, assessments, meeting notes and news articles. The consultant also interviewed key stakeholders to assess:

- The nutrition situation in Rakhine state and the impact of COVID-19 on nutrition
- The nutrition situation in Myanmar as a whole, including national level coordination
- The nutrition-specific and nutrition-sensitive programming in place and gaps existing
- Recommendations to improve the nutrition of women and children, coordination and programming

The interviews were done remotely via Skype, Teams and Zoom. See annex 1 for a list of the stakeholders interviewed and meetings attended. Daily updates from the HARP-F team were also followed on Signal.

The limitations of the consultancy include:

- The original scope of work was provided prior to the coup. Two weeks after the onset of the work the coup occurred, meaning the scope of work had to be significantly adjusted and the development of recommendations became much more difficult given the uncertainties in the situation that resulted.
- Because of the coup, partners and staff were often unavailable due to competing priorities and emergency meetings. This meant some partners were unable to be interviewed.
- Due to COVID-19, the consultant was not able to travel to Myanmar to conduct in person interviews or conduct field visits.
- Given the rapidly changing context in Myanmar due to the recent political instability, the recommendations have been developed to respond to uncertainty where possible but may well become irrelevant over time depending on how the context changes.

FINDINGS

Nutrition Situation

Note: While recent data on nutrition in Myanmar and in Rakhine state is not available, it is assumed that given the recent conflicts, the COVID-19 pandemic and the coup that the nutrition situation has not improved, and if anything it has deteriorated. Therefore the information provided below is useful to consider as a baseline in the absence of any updated data and with the assumption that more up-to-date data will be difficult to obtain in the short-term.

Trends in under-5 undernutrition² and mortality rates

- **Myanmar has made progress in reducing under-5 child wasting and stunting in the past decade, but progress remains highly vulnerable to shocks.** In the latest national survey [DHS 2015] wasting is 7.0% [based on weight-for-height [WFH]], underweight is 18.9% [based on weight-for-age [WFA]], and stunting is 29.0% [based on height-for-age [HFA]]. See Figures 1 and 2. However, Myanmar has a high risk of shocks, ranking 20th most at risk out of 191 countries in 2021 [INFORM Index for Risk Management]. Myanmar also currently ranks as one of the lowest developed countries in the region and 147 out of 189 in the world [2019 Human Development Index].
- **Infants under 6 months of age and between 12-27 months are particularly vulnerable to wasting and have an increased risk of death as a result.** Table 2 shows the prevalence of wasting and stunting disaggregated by age. It shows prevalence of wasting to be highest in infants under 6 months of age (12.9%) and between 12-27 months (10.1%) [DHS 2015].
- **These national rates hide subnational inequities where Rakhine state has the highest prevalence of undernutrition.** Wasting (13.9%) and underweight (34.2%) in Rakhine is approximately double the national rate. Stunting in this state (37.5%) is also 8.5% higher than the national average [DHS 2015]. See figures 1 and 2.
- **Within Rakhine, stunting and wasting levels vary by township.** See Figure 3, Figure 4, and Figure 5. Using available 2015/ 2016 national datasets³, the small area estimation method estimated township level undernutrition. It showed large variations of stunting and wasting within Rakhine, with Northern Rakhine having stunting estimates above 40%⁴ [Department of Population Ministry of Labour, Immigration and Population, 2020]. These estimates excluded three townships (Maungdaw, Buthidaung and Yethedaung) in Northern Rakhine which lacked data. Recent data, not publicly available, showed that while the prevalence of wasting in Maungdaw and Buthidaung is high, in terms of absolute numbers Sittwe has the higher burden [interviews].
- **The nutrition situation is likely worse as no township level nutrition surveys have been conducted since the Rakhine crisis in 2017 due to lack of approval given by the government.** The last available survey by ACF in 2015 in Maungdaw in Northern Rakhine indicated the prevalence of wasting in children 6-59 months was 19.0% [severe wasting 3.9%] based on WFH and 14.9% [severe wasting 3.3%] based on mid-upper arm circumference (MUAC). The rates were slightly lower in Buthidaung [wasting 15.1%/ severe wasting 2.0% using WFH; wasting 10.6%/ severe wasting 1.6% using MUAC] [ACF, 2015]. In Pauktaw and Sittwe, based on Save the Children International's (SCI) SMART survey conducted in 2016, wasting ranged from 5.5% in rural Sittwe to 6.1% in Pauktaw [SCI, 2016]. With the recent political instability with little hope of resolution in the short-term, the nutrition situation is likely to worsen.
- **The estimated additional caseload of severe wasting among children under 5 years of age due to the COVID-19 pandemic in Myanmar is most extreme in Rakhine** compared to the other states with 8,934 additional cases of severe wasting, which is quadruple the cases in Bago region which has the lowest predicted additional caseload of 2,158 [Heady et al. 2020]. COVID-19 was found in conflict-generated IDP camps in Kyauktaw township in Rakhine State

² The analysis concentrated on undernutrition and excluded overweight and obesity due to the restricted scope of the assignment

³ Using the 2014 Myanmar Population and Housing Census and DHS 2015

⁴ These estimates exclude Maungdaw, Buthidaung and Yethedaung due to limited information from the 2014 census preventing the use of small area estimation to estimate nutrition outcomes

in October 2020 [\[Radio Free Asia, Oct 2020\]](#) but due to limited testing in IDP sites, COVID-19 is likely more widespread than reported [interviews].

- When applying a multi-country model to Myanmar, [Heady et al. 2020](#) predicts that a projected 8.6 percentage point drop in the rate of national income growth in Myanmar in 2020 [due to the COVID-19 pandemic] alone may lead to over 110,000 extra children under five becoming wasted because of the joint economic and reduced essential health care crisis. This is likely to be exacerbated through the further impact of the recent coup.
- Significant progress has been made in improving the national under-five mortality rate, but Myanmar still has one of the highest mortality rates for children in the South-East Asia region. The under-five mortality rate has decreased by 2.5 times from 115 deaths per 1000 live births in 1990 to 44.7 deaths per 1000 live births in 2019 [\[UNICEF, 2019\]](#). However, this is still double the regional under five mortality rate in South-Eastern Asia [24 deaths per 1000 live births] [\[UNICEF, 2020\]](#). This equates to approximately 42,000 under-5 deaths in 2019. Given the nutrition situation in Rakhine is worse, mortality rates are likely to be higher in Rakhine.
- Programme implementation, monitoring and evaluation activities are subject to multiple government approvals and run the risk of the worst-case scenario where permission is not given. Prior to the coup, approval for all types of surveys [baselines, endlines, SMART surveys and other types of nutrition surveys] had not been forthcoming, with some partners reporting that assessments have been banned altogether, making it hard to monitor the prevalence of malnutrition [interviews].

Figure 1: Wasting prevalence in Myanmar and Rakhine State [weight-for-height z-score [WHZ] <-2]

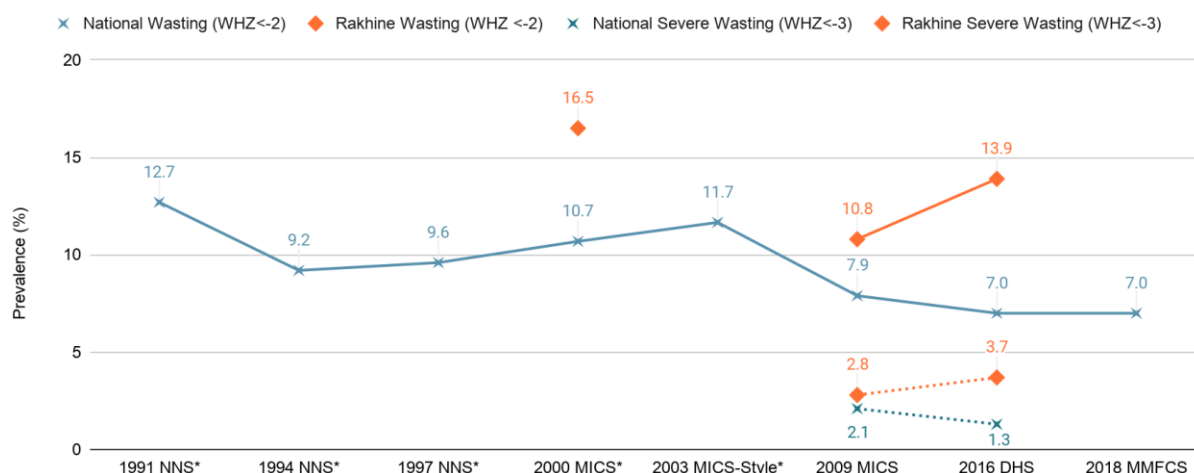


Figure 2: Stunting prevalence in Myanmar and Rakhine State [height-for-age z-score [HAZ] <-2]

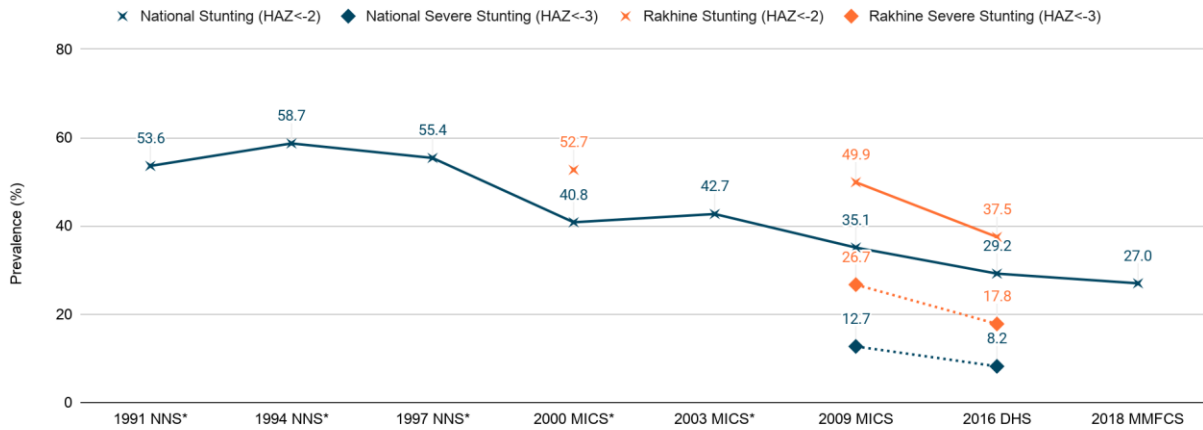
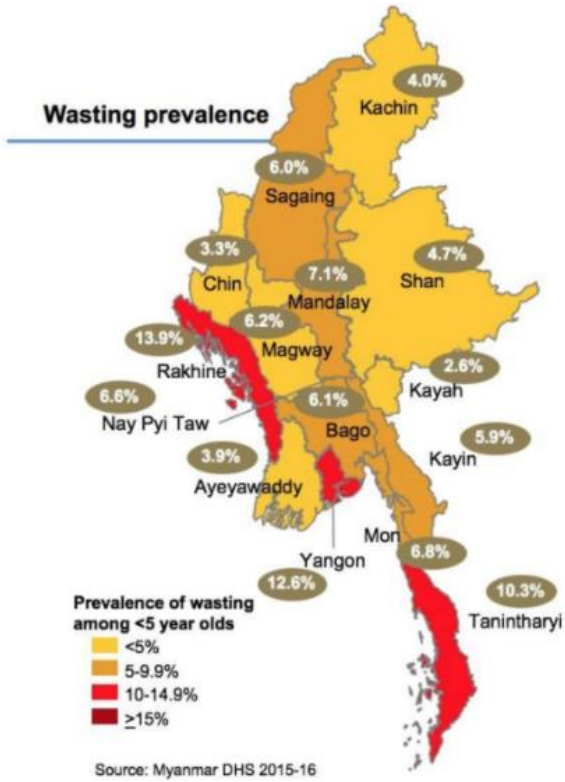
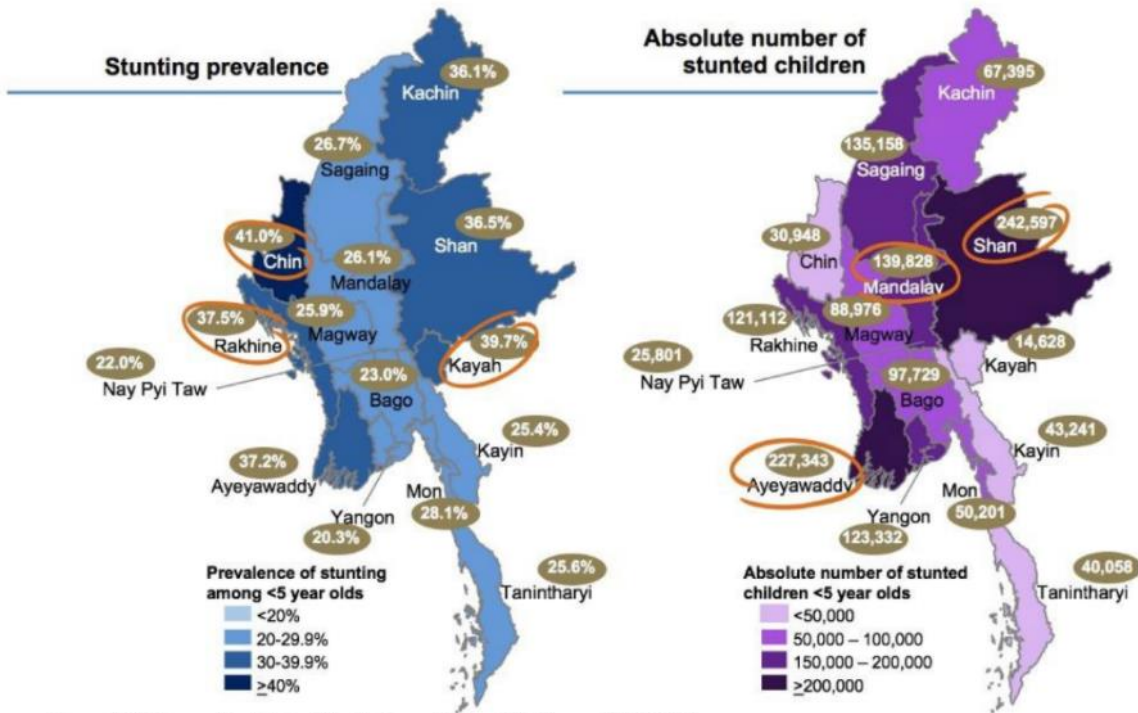


Figure 3: Prevalence of wasting by state/ region in Myanmar



Source: Multi-sectoral National Plan of Action on Nutrition (MS-NPAN) - Costed Action Plan 2018-2021

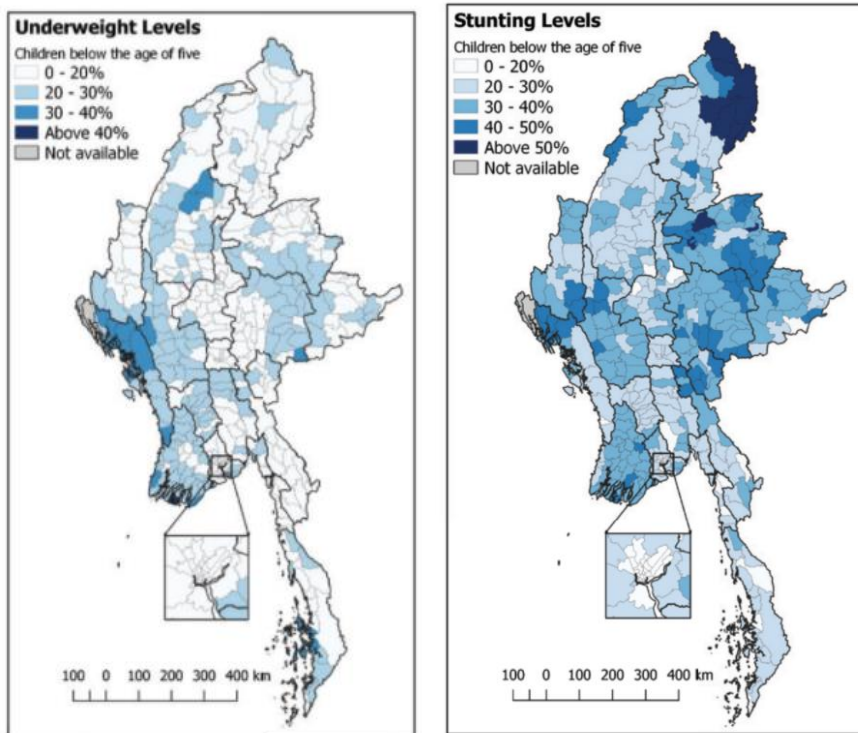
Figure 4: Prevalence of stunting by state/ region in Myanmar



Sources: 2014 Myanmar Population and Housing Census (Volume 4-F); Myanmar DHS 2015-16

Source: Multi-sectoral National Plan of Action on Nutrition (MS-NPAN) - Costed Action Plan 2018-2021

Figure 5: Prevalence of underweight and stunting at the township level in Myanmar



Source: Department of Population Ministry of Labour, Immigration and Population. Mapping Myanmar's Nutrition in 2015. A Small Area Estimation. March 2020.

Table 2: Prevalence of wasting [based on WFH] and stunting [based on HFA] disaggregated by age in Myanmar

Age	Wasting	Severe Wasting	Stunting	Severe Stunting
<6	12.9	4.5	6.6	2.7
6-8	4.9	0.3	14.5	5.7
9-11	8.7	0.4	15.3	2.7
12-27	10.1	2.5	6.1	4.2
18-23	5.8	1.6	31.4	10.8
24-35	5.7	1.1	40.6	12.1
36-47	5.4	0.5	35.9	10.3
48-59	6.6	1.9	32.9	7.4

Source: Myanmar DHS 2015-16

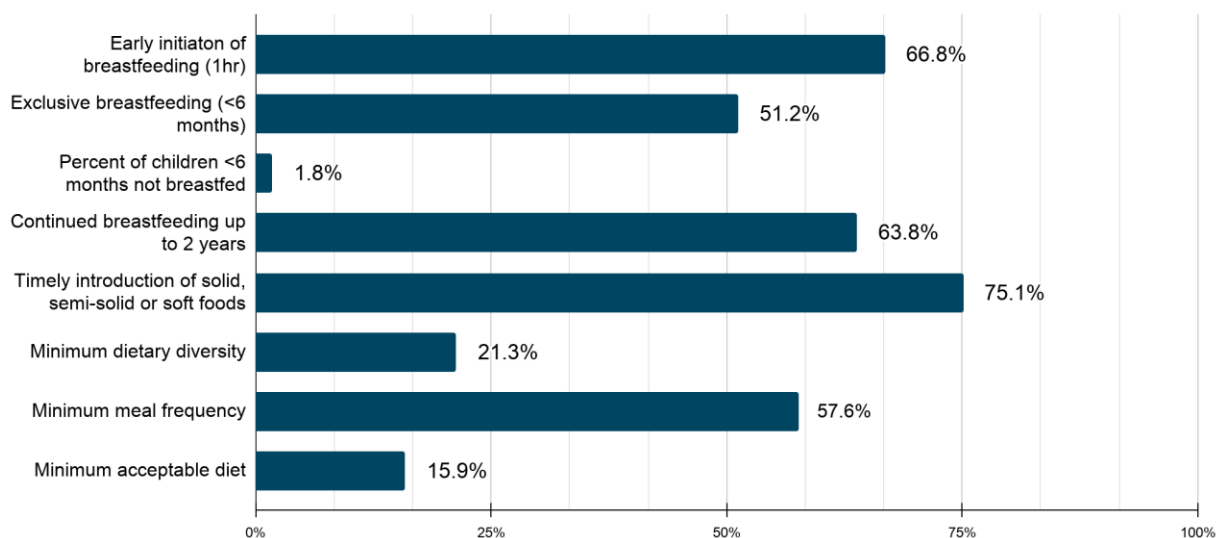
Key Drivers and aetiology of undernutrition in Rakhine

Children do not receive diets adequate in quantity, quality or frequency for their healthy development.

- **Half of infants under six months of age are not exclusively breastfed increasing their risk of undernutrition and death.** While exclusive breastfeeding has improved from 23.6% in 2009-10 [MICS 2009-10], exclusive breastfeeding rates remain low. Only half of infants under six months of age are exclusively breastfed [51.2%], with many of these children fed plain water [18.5%] and complementary foods [20.9%] in addition to breastmilk [DHS 2015]. See Figure 6 for IYCF indicators.
- **Qualitative research conducted in IDP camps in Sittwe showed that in Muslim households, initiation of breastfeeding may be delayed due to ritual washing.** Children are breastfed for the first time only after being given the ritual washing of the whole body and after receiving prayers from the Mullah [Boutry, M., 2015]. There have also been indications that Muslim women in Sittwe stop breastfeeding when they become pregnant again due to the belief that continued breastfeeding could transmit illness to the elder child [Boutry, M., 2015].
- **Despite launching a Breast Milk Substitute Order of Myanmar in 2014, 11.7% of children under 24 months are being fed using bottles, which places infants at unnecessary risk of infections and increased mortality [DHS 2015].** Safe preparation of breastmilk substitutes may not be possible, putting the infant at high risk of ingesting foodborne pathogens and/ or contracting other illnesses related to poor hygiene.
- **Timely introduction of complementary foods is also poor.** Nationally, only 75.1% of children aged six to eight months are introduced to solid and semi-solid foods in a timely manner [DHS 2015]. In Pauktaw and Sittwe townships, the proportion of children who received complementary food at the age of six months was even lower at about 64% (ranges from 58.3% in urban Sittwe to 65.6% in rural Sittwe) [SCI, 2016].
- **Of particular concern, only 15.9% of children 6-23 months in Myanmar receive a diet adequate in micronutrients, adequate meal frequency and continued breastfeeding [DHS 2015].** Myanmar has the lowest dietary diversity in South-East Asia [UNICEF 2021]. Nationally, children in rural areas, which is the majority of Rakhine state, are less likely to meet all three of these criteria [14.2%] [DHS 2015]. Additionally, breastfed children are less likely to receive the minimum number of food groups than non-breastfed children, 21.5% and 42.4% respectively [DHS 2015], indicating that mothers rely on breastfeeding as a source of nutrients for their child. Consumption of vitamin A rich foods is also below 40% in both breastfed and non-breastfed children between 6-23 months [DHS 2015]. With the recent disruption to cash and food distributions for vulnerable populations as a result of the coup, there is an elevated risk that an increased number of children aged 6-23 months will not receive an adequate diet (interviews).
- **As a result, micronutrient deficiencies in children are prevalent in Rakhine.** Anemia in children under five years of age from all causes is highly prevalent nationally [57.8%] and even more prevalent in Rakhine state [61.5%] [DHS 2015].

More recent results from the Myanmar Micronutrient and Food Consumption Survey (MMFCS) in 2017–2018 suggests anemia in children has reduced nationally but remains high at 36% [\[MMFCS 2017-18\]](#).

Figure 6: Infant and young child feeding (IYCF) practice rates in Myanmar



Source DHS 2015

Poor maternal nutrition and health may lead to malnutrition in children.

- An analysis of key drivers for stunting and wasting in Myanmar at the national level based on the DHS in 2015 showed poor maternal nutrition, inadequate coverage of maternal health services and early child growth restriction were leading drivers of child undernutrition [\[Blankenship et al., 2020\]](#). No similar analysis was found at the Rakhine level.
- **Maternal mortality in Myanmar remains higher than the regional average.** Maternal mortality increases risk of infant malnutrition and death following lack of breastfeeding [\[Finley et al. 2015\]](#). Maternal mortality in Myanmar has fallen from 340 to 250 deaths per 100,000 live births from 2000 to 2017. However this remains significantly higher than the East Asia and Pacific maternal mortality rate (69 deaths per 100,000 live births in 2016) [\[WHO, 2017\]](#).
- **Short stature and thinness among women of reproductive age in Rakhine state is higher than the national average.** 20.0% and 7.4% of women in Rakhine are thin [body mass index (BMI) <18.5] and have a short stature respectively [\[DHS 2015\]](#). A SMART survey conducted in 2015 indicated 34.5% and 45.0% of women aged 15–45 in Maungdaw and Buthidaung respectively had a MUAC <230mm [\[ACF, 2015\]](#).
- **Low birth weight (<2.5 kg) indicates poor maternal nutrition and health.** Nationally, the prevalence of low birth weight has declined from 13.9% in 2000 to 8.1% in 2015 [\[DHS 2015\]](#). In Rakhine, the prevalence of low birth weight was reported to be 20.0%, however this is inconclusive as the sample size was too small [\[DHS 2015\]](#).
- **Prevalence of anemia in women of reproductive age in Myanmar is a major public health problem.** Nearly half of women aged 15–49 (46.5%) are anemic [\[DHS 2015\]](#) and of particular concern are pregnant women, who are more likely to be anaemic than those who are lactating (47.5%) or neither pregnant or lactating (46.8%). Out of all states, women in Rakhine state (55.4%) are most likely to be anemic [\[DHS 2015\]](#).
- **In 2020, there were indications that maternal dietary diversity was decreased due to reduced income.** In rural dry zones across Myanmar, poor maternal dietary diversity rose from 16% in July 2020 to 25% in September 2020, possibly due to COVID-19 lockdown restrictions preventing people from going to work (interviews). By October, this reduced to 18% [\[Heady et al., Nov 2020\]](#). A phone survey conducted in June and July 2020 in Yangon and rural areas of Myanmar found mothers reporting consuming fewer food types and consuming smaller quantities [\[Headey et al., Jul](#)

2020]. 80% of households who reported income losses from COVID-19 had significantly lower consumption of non-staple foods, especially eggs, beans, meat and fish [Headey et al., Sep 2020]. While this is not in Rakhine specifically, it provides insight into the possible changing behaviours due to COVID-19 in Rakhine.

Reduced food security may reduce dietary diversity in children and mothers and disrupted livelihoods may increase poverty.

- **Women in Rakhine are particularly vulnerable to reduced food security.** A gender analysis in 2020 highlighted that in Rakhine not only are the proportions of females working significantly lower [38%] compared to males [83%], over 50% are employed in the agriculture industry where wages are low [Care, 2020]. Additionally, within agriculture, they also suffer from unequal pay and with migration common in Rakhine, men often leave the workload behind for the women. Muslim women are even more vulnerable and have fewer choices due to lower levels of education and increased movement restrictions [Care, 2020]. In Rakhine, gender discrimination regarding the types of livelihoods is not affected. Rakhine women work in daily labour, for example for water and sanitation construction in the IDP camps. Communities which practice a stricter form of Islam have strong gender differentiation on livelihoods and mobility [Boutry, M 2015].
- **The majority of the workforce in Rakhine is in the informal sector without social protection and is therefore vulnerable to shocks.** Nationally 85% of the rural population are employed in the informal sector [Annual Labour Force Survey, 2017]. The population of Sittwe and Pauktaw townships in central Rakhine is heavily reliant on unreliable sources of income [ACTED, 2020] and almost all income is dependent on seasonal labour demands. The Living Conditions Survey in 2017 reported 24.8% of Myanmar's population as poor and a further 32.9% vulnerable to falling into poverty due to unanticipated shocks [Care, 2020]. The various potential impacts of the coup on livelihoods are likely to increase vulnerability to shocks.
- **In 2020, due to the COVID-19 pandemic there are reports of a loss of livelihoods and reduced income as a result.** A series of phone interviews conducted in Yangon and rural dry zones showed increasing income-based poverty and widespread income loss amongst urban and rural households in September 2020, possibly due to enforced COVID-19 lockdown restrictions [interview]. 80% of households reported lower than normal income in October 2020 [Heady et al., Nov 2020]. This trend is more drastic in urban households due to a higher number of COVID-19 cases and stricter prevention measures in cities. The primary reasons for this trend were loss of employment (34%), reduction in daily labour opportunities (34%) and inability to work due to travel movement restrictions (30%). While this study is not conducted in Rakhine, it provides insight into what is likely occurring in Rakhine [Heady et al., Nov 2020]. ACTED also reported a sharp decline in remittances domestically (50%) and internationally (30%) in 2020 [LIFT 2020].
- **Even prior to the COVID-19 pandemic, an estimated 70% of households in Rakhine could not afford a diet that met their nutritional needs [WFP, October 2019].** Based on WFP's Fill the Nutrient Gap analysis conducted in October 2019 in Myanmar, Rakhine was among the top five states which had the highest cost of a nutritious diet. Amongst the family, adolescent girls and pregnant and lactating women have the most expensive nutritious diets in the modelled household due to high nutrient requirements compared to energy intake.
- **In Sittwe, food consumption scores are lower in Muslim villages and Muslim camps compared to Rakhine (non-Muslim) households.** The [Sittwe Profiling Report 2017](#) conducted in Sittwe in Rakhine villages, Rakhine relocated sites, Muslim camps and Muslim villages sheds light on food security in Rakhine. They found 95% of Rakhine households had acceptable food consumption compared with 67% in Muslim villages and 73% in Muslim camps. Compared to Rakhine communities, over half of households report food insecurity in Muslim households. Additionally, those who had poor food consumption were nearly twice as likely to have a serious health issue in the past month compared with those who have acceptable food consumption. This trend is likely similar in other areas of Rakhine state. This report should be completed every 1-2 years but has not been conducted since 2017, when there was widespread displacement of the Rohingya people [interviews].
- **A large proportion [58%] of households in Rakhine relocated sites and Muslim camps in Sittwe rely on food distribution as their main source of food but 76% had a secondary source of food, such as own production or purchasing food in the camp.** However, 39% and 72% of households in Rakhine relocated sites and Muslim camps respectively report not having enough money or sufficient food to cover their food needs [Sittwe Profiling Report,

[2017](#)). In contrast, the main source of food in villages (Muslim and Rakhine) was through their own production. However, 69% of households in Muslim villages reported insufficient food or money to cover basic food needs. The situation evolving since the coup, especially resulting from disruptions to availability of cash, are likely to increase food insecurity across all households, particularly those reliant on cash distributions who are unable to access mobile money platforms such as the Rohingya (interview).

- **Market access declined in 2020 overall, particularly by September 2020.** In Maungdaw and Buthidaung townships in September 2020, 50% of households were dependent on daily markets to buy food for their household, 36% relied on retail shops and the remaining 10% bought from mobile markets ([HARP-F, Oct 2020](#)). In September 2020, 65% of respondents had access to the market within their village but 36% reported these were never accessible, which was increased from 0% in June 2020 ([HARP-F, Oct 2020](#)). The decreased access may have been caused by COVID-19 restrictions which forced markets to close. While the main barriers to market accessibility was related to increased conflict and COVID-19 related restrictions (lockdown [64%], checkpoints [55%] and blockades [18%]), floods were also a factor, with 14% of respondents citing this as a barrier ([HARP-F, Oct 2020](#)).
- **Since 2020, food security in Rakhine has deteriorated across all locations particularly between October-December,** with 47% reporting inadequate access to food ([LIFT, 2020](#)). Over 50% of households reported negative coping strategies related to food intake ([LIFT, 2020](#)). Other sources of food have been disrupted including school meals which had been halted, which contribute to 30% of children's usual caloric intake. According to the Mercy Corps Market Analysis conducted in six townships in Rakhine, September 2020 registered the highest prevalence of the most severe indicators of food insecurity in Rakhine farmers. From September to December 2020, 12% of respondents skipped meals due to having no food that day. This was more common amongst respondents who lived furthest from township centers. While food insecurity may have improved since September 2020, in December 2020 20-25% of respondents still worried about having enough food for healthy meals. The improvement in food insecurity indicators could also be tied to reduced conflict in the region at the time. However, with the current political instability since February 2021, food insecurity is likely to worsen.
- **Increasing market prices in February 2021 have been linked to conflict and insecurity.** Market prices for low quality rice, vegetables and fish were initially dropping in January 2021 ([Mercy Corps, Feb 2021](#)). However, in February 2021 market prices then spiked because of coup-related insecurity ([WFP, Feb 2021](#)). The increased cost of food, particularly rice in Rakhine state, means reduced household purchasing power. In a context where households are reliant on cash distributions, they may not be able to purchase food adequate in energy or nutrients as a result. Additionally, there is an anticipated shortage of food, fuel and medicines in the coming weeks from March 2021 ([WFP, Feb 2021](#)).

Lack of basic services: poor health, hygiene and sanitation practices increases risk of infection, malnutrition and child mortality

- **In Myanmar, household and environmental drivers associated with child undernutrition include low household wealth index, lack of access to safe drinking water and the practice of open defecation** ([Blankenship et al., 2020](#)). Inadequate health, hygiene and sanitation practices is a leading driver of child undernutrition.
- **The healthcare capacity in Myanmar had been steadily increasing since 2000 and reached a peak in 2017, with 8.6 doctors per 10,000 population.** In 2018, the capacity shrunk. The World Health Organization (WHO) reported that Myanmar had around 6.7 doctors and 10 registered nurses and midwives per 10,000 population in 2018 ([World Bank, 2021](#)). Progress will be further jeopardised by COVID-19 and the recent political instability.
- **Availability of and access to essential health and protection services is very limited in parts of Rakhine state.** According to UNDP, only 53% of ill or injured individuals seek treatment at medical facilities, including those run by NGOs (sex, age and diversity disaggregated data not available) ([UNDP, 2020](#)). Access to healthcare fell further due to the COVID-19 pandemic with only 48% of respondents reporting they had access to healthcare when needed ([LIFT, 2020](#)). The recent political instability has already weakened the already inadequate availability of health services.
- **There is a risk of increased COVID-19 infection due to the inability to practice safe mitigation measures, meaning the COVID-19 infection may exacerbate the malnutrition cycle.** According to IRI, 66% of Rohingya and

81% of Rakhine populations are not able to take measures to avoid COVID-19 [\[LIFT, 2020\]](#). Social distancing may not be plausible in camps due to overcrowding.

- **Low access to improved toilet facilities increases the risk of infection, diarrhoea and malnutrition.** In rural populations nationwide, more than half of the population [58%] do not have improved toilet facilities [\[DHS 2015\]](#). 14% of households have no toilet facility, while those who do most commonly have an open pit or a pit latrine without a slab [31%] [\[DHS 2015\]](#). In Northern Rakhine and in Sittwe IDP camps, a knowledge, attitudes and practice (KAP) assessment of hygiene behaviours indicated poor knowledge of the linkages between latrine use and likelihood of diarrhoea, with only 26% of respondents mentioning use of latrines to reduce likelihood of diarrhoea [\[Consortium partners, May 2016\]](#). Changes to defecation habits were also noted in the KAP survey with 5% of individuals in Muslim camps and 4% of individuals in Muslim villages reportedly practicing open defecation at night. Common reasons for these changes in Muslim camps include darkness [40%] and in Muslim villages feeling of danger/ lack of safety [33%] [\[Consortium partners, May 2016\]](#). A large proportion of respondents did not provide reasons for their change in behaviour.
- **The continued practice of open defecation in Muslim communities may also be linked to their beliefs and the lack of latrines.** Overall, there is an average of one latrine for every 21 people in Muslim camps [\[Consortium partners, May 2016\]](#). According to an anthropological study in Sittwe camps, in Muslim communities latrines are believed to be a place where individuals are particularly vulnerable to the effects of bad and evil spirits and it is believed that women are the most vulnerable [\[Boutry, M., 2015\]](#). There were also reports that due to a lack of latrines, men practice open defecation to keep latrines for women in their community.
- **Hygiene practices appear to be better in Rakhine camps compared to Muslim camps or Muslim villages.** Availability of water was found to be higher in Rakhine camps [77%] compared to Muslim villages [26%] or Muslim camps [47%] [\[Consortium partners, May 2016\]](#). Open defecation in Rakhine IDP households tend to be less of an issue compared to Muslim communities as they are generally given private latrines [\[Boutry, M., 2015\]](#).
- **Access to improved water has increased since 2015 but the use of unsafe surface water is still substantial in Rakhine** [\[MLCS 2017\]](#). According to the Myanmar Living Conditions Survey in 2017, only 17% of households in Rakhine have access to safe drinking water in the dry season [\[MLCS 2017\]](#). Interviews with stakeholders indicate that while hand pumps are available in IDP camps, 20-25% do not pump safe drinking water [interviews].

Analysis of Nutrition Situation

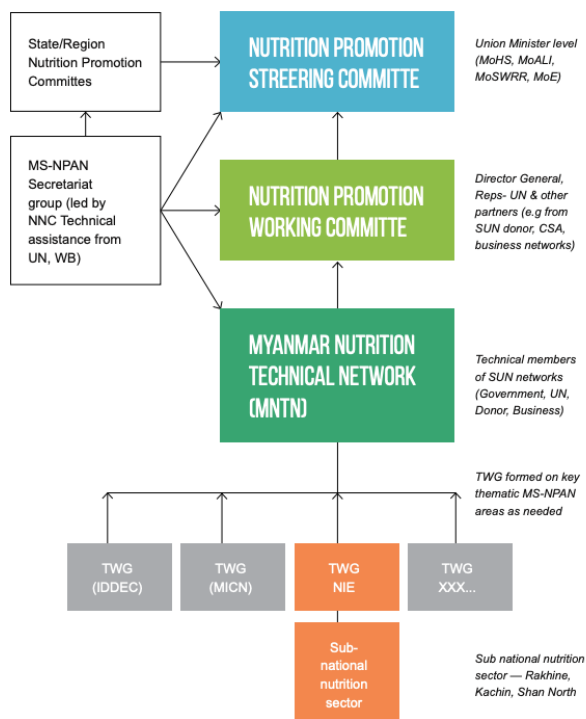
- **Available data in Myanmar and Rakhine state in particular is limited and insufficient for decision-making, resulting in a lack of understanding of the current nutrition status and needs of the population.** The latest national survey data is from 2015, prior to the most recent large-scale crisis in Rakhine in 2017. Critically, the available national data excludes northern Rakhine [Buthidaung, Maungdaw and Yethedaung]. As a result, in the township level estimates in the small area estimation model, no estimates are made for Northern Rakhine. Where data is available for Buthidaung and Maungdaw in Northern Rakhine, the SMART survey was conducted over five years ago and also may have data quality issues. Current data available on the nutrition situation also excludes camps.
- **The current nutrition situation is likely worse than indicated.** Since the most recent nutrition surveys multiple crises have affected Rakhine state, including the 2017 Rakhine crisis with widespread Rohingya displacement, the COVID-19 pandemic and the coup in 2021. As a result, the nutrition situation has likely deteriorated. There is also little information on inaccessible areas, where the nutrition situation is assumed worse.
- **Current estimates for increased wasting in Myanmar due to COVID-19 are likely far greater than indicated** as models are based on a decrease in GDP alone, which does not account for potential disruptions to healthy breastfeeding practices, reduced dietary diversity, disruptions to health services and optimal maternal nutrition. Rakhine is particularly vulnerable with the highest levels of wasting, underweight and stunting in the country. There will likely be an increased caseload requiring treatment.

- **Infant and young child feeding (IYCF) practices are inadequate and recent data on IYCF practices is not available.** Many mothers rely on breastfeeding for too long and do not introduce complementary foods at an appropriate time, likely due to food insecurity (which is at risk of worsening given the coup-related disruptions). This puts infants and young children at increased risk of malnutrition from an early age, which can have short-term consequences on their survival and long-term consequences on their growth and earning potential.
- **Maternal nutrition and wellbeing in particular need to be preserved.** Given the COVID-19 pandemic and the recent coup has disrupted basic health services, and the prevalence of poor maternal dietary diversity has risen in recent months, there are concerns that this will increasingly affect maternal nutrition status and consequently have a long-term effect on growth in utero.
- **The loss of livelihoods due to COVID-19 and the downstream effects of the pandemic, as well as the likely impacts of the recent coup and related disruptions, has seen an increase in the numbers of food insecure households and individuals.** Partners are already beginning to report a rise in food insecurity, partly due to COVID-19 related restrictions and now due to factors like escalating market prices related to the coup. In contexts where households rely on cash distributions for income, their reduced purchasing power will likely have an impact on their ability to ensure a nutritious diet for the most vulnerable household members like pregnant women, breastfeeding women and children under five years of age. With 70% of households⁵ in Rakhine already not able to afford a nutritious diet, rising fuel and food costs will likely mean most people in Rakhine state will not be able to afford a nutritious diet, placing more women and children at higher risk of malnutrition and death.
- **While there is still insufficient evidence to quantify the longer-term impact of the COVID-19 pandemic on nutrition, given the recent coup the longer-term impact of the COVID-19 pandemic will almost certainly be exacerbated.** The decline in income and wealth will reduce dietary diversity, which will increase the risk of child malnutrition. Households may replace more expensive micronutrient rich foods (vegetables, fruits and animal sourced products) with cheaper energy dense foods. Examples from the Indonesia financial crises show that when wages fell by 33%, even as prices rose, rice consumption increased while consumption of vegetables, fruits and animal-sourced foods fell.
- **There remains a lack of sufficient health, water, sanitation and hygiene (WASH) services available across Rakhine, both in camp and village settings.** Despite efforts to increase WASH services since the outbreak of COVID-19, coverage remains low and cultural beliefs run deep preventing optimal health and WASH behaviours from being practiced. This will have a direct impact on the prevalence of malnutrition in children and women, given the causal relationship between malnutrition and morbidities.

⁵ As mentioned above from [WFP's Fill the Nutrient Gap analysis](#) conducted in October 2019.

Coordination

Figure 7: Nutrition coordination structure in Myanmar



Source: Myanmar Multi-sectoral National Plan of action on Nutrition 2018/19 - 2022/23 - adapted

Source: [Global Nutrition Cluster Scaling Up Nutrition Humanitarian Development Nexus Case Study](#) which was adapted from Myanmar Multi-sectoral National Plan on Nutrition 2018/19 - 2022/23

National Level Coordination

- The Myanmar Nutrition Technical Network [MNTN], the main coordinating body, is led by the National Nutrition Centre [NNC] under the Department of Public Health. The National Nutrition Centre [NNC] is responsible for the implementation of and capacity-building for nutrition. The NNC focusses on the implementation of IMAM and IYCF protocols and cascade training of health staff for these programmes down to township health office level. The impact of the recent political instability on this coordination structure is not yet known. The previous Minister for Health has been replaced by the Permanent Secretary but it is unknown whether he is an advocate for nutrition. Despite these uncertainties, state and federal level nutrition coordination meetings are still going ahead with the message to continue business as usual [interviews]. See Figure 7 for overall structure in Myanmar.
- The Scaling up Nutrition [SUN Network] also contributes to the work of the MNTN and, in particular, has been active in the development of the MS-NPAN. Established in 2015, the SUN Network is a key platform for civil society engagement on nutrition and has a wide membership. The three branches of the SUN Network in Myanmar include UN Nutrition consisting of UN members, the SUN Civil Society Alliance to bring sustainable improvements to nutrition, and the SUN Business Network Myanmar consisting of business members who support improving diets and nutrition through product development and innovation amongst others [SUN, 2021]. Currently the SUN Network is discussing how best to move forward with the MS-NPAN given this work was government-owned and government-led. Many

questions remain on how to utilise the MS-NPAN with a shift in focus to emergency lifesaving activities in Myanmar, and how to engage (or not) with the current authorities in place.

- **UN REACH in Myanmar has been active in supporting UN agencies with nutrition activities.** The UN agencies take turns hosting the UN REACH secretariat in their office to support better coordination between UN agencies. Since 2016, this position has been held by WFP but recently this has switched to UNICEF. The UN REACH not only supports in producing a work plan for nutrition activities but also creates dashboards indicating each UN agency's activities and support needed. Another vital part of UN REACH's role is to attend the Nutrition in Emergency Working Group (under the MNTN) as a representative of UN agencies and follow-up with UN agencies on their action points. UN REACH is also active in the SUN Network in Myanmar.
- **While the nutrition cluster had been activated before⁶, since 2012, nutrition coordination has continued responding to subsequent crises such as the conflict in Rakhine 2017 without activating the cluster.** However, there are positives and negatives to activating the nutrition cluster. The positives include access to humanitarian funding mechanisms such as the Humanitarian Pooled Fund (HPF) and greater support from the global cluster mechanisms like the Global Nutrition Cluster (GNC). The negatives include a typically siloed approach where it is hard to implement integrated programming and also a risk of removing government from ownership of service provision. That said, the GNC has supported the nutrition sector in Myanmar with capacity-building on coordination and in arranging the deployment of the Technical Rapid Response Team (TRRT) in 2020 to support nutrition capacity-building and implementation of nutrition services (unfortunately postponed due to COVID-19). In addition, it is felt that even without the activation of the nutrition cluster, sufficient conversations can leverage government support. Whether this is still feasible given the recent political instability remains to be seen (interviews).
- **UNICEF is the nutrition sector lead in Myanmar as per UNICEF's global mandate and currently chairs the NIE TWG, which contributes to the efforts of the MNTN.** UNICEF are typically active, strong in nutrition and technically competent. However, they have been criticised for not being as effective as they could be in Myanmar in relation to nutrition coordination resulting in reduced progress and impact in the nutrition sector. Subsequently, nutrition is not prioritised by donors and broader stakeholders, despite the obvious nutrition needs in Myanmar and especially Rakhine (interviews).
- **The current national Myanmar Nutrition Coordinator for the nutrition sector is leaving her post on 14 April 2021.** After over a year of advocacy by the UNICEF team in the Regional Office in South Asia (ROSA), the UNICEF Myanmar country office is now in the process of advertising the post for recruitment. This post will be solely for Nutrition Sector Coordinator, with a second role being advertised for the Chief of Nutrition within UNICEF. In the interim, the GNC will second a Nutrition Cluster Coordinator (NCC) to fill the Nutrition Sector Coordinator vacancy and the identified individual also has a background in information management, which will provide urgently needed capacity in this regard.
- **In light of the recent political instability and the subsequent derailing of public health services coupled with likely increased nutrition service needs, the NIE TWG supported by the Global Nutrition Cluster (GNC) has set up a strategic advisory group (SAG) to lead on the development of an emergency response programme (ERP) plan.** The ERP is supported by OCHA and involves three key elements: 1) risk analysis and monitoring to develop scenarios; 2) contingency planning (a step-by-step process for anticipatory action and readiness); and 3) development of minimum and advanced preparedness actions. Outputs are uploaded to an online platform and advised plans are developed, which can be used by all partners to plan their response. Step one (risk analysis) has already been completed in Myanmar by OCHA, although it may need to be reexamined with a nutrition lens. Financial support has not yet been identified for recommended activities listed in the ERP plan.
- **Current data is inadequate in providing up to date information on the current nutrition situation to raise warning for any increase in nutrition needs.** However, Myanmar has an official Aid Information Management System. However the tentative, annually collected Health Management Information System data is not readily available; the last countrywide township level data available is from 2011 ([Asian Disaster Preparedness Center/ UNDRR, 2020](#)). Currently there is no dedicated Information Management Officer for the nutrition sector, although information

⁶ In 2008-2009 to respond to Cyclone Nargis and again in 2010-2011

management is well recognised as a gap. As a result, the nutrition sector is advocating to hire a dedicated Information Management Officer to improve data management in Myanmar (interviews).

- **Coordination of nutrition supplies is also a gap in Myanmar.** Access to Health, UNICEF and the NNC are the only organisations supplying nutrition materials and products as the government historically have never had enough budget for nutrition supplies. This affects ready-to-use supplementary food (RUSF) and ready-to-use therapeutic food (RUTF). There have been further disruptions in the supply chain since the political unrest in February 2021 due to challenges with importation, custom clearance processes for incoming shipments and increased fuel prices. Due to the political unrest and increasing trends in the global fuel market, the price of diesel has increased by 15% since January 2021 ([WFP Logistics coordination, 2021](#)).
- **In Myanmar there are preparedness plans in place in case of a natural disaster but it is unclear how the political unrest will change the disaster response mechanisms in place.** Depending on the severity and magnitude of the disaster, either the Permanent Secretary of the Ministry of Social Welfare, Relief and Resettlement (MoSWRR) or the Director-General of the Relief and Resettlement Department (RRD) will lead the response ([Asian Disaster Preparedness Center/ UNDRR, 2020](#)). The lead for disaster management sits in the Ministry of Home Affairs. The MoSWRR houses the Emergency Operations Centre, manages the Disaster Management Training Centre and takes the lead on the National Rapid Response Teams ([MIMU, 2018](#)). Since the political unrest in February 2021, it is unclear where disaster management will be housed.

Rakhine Level Coordination

- **The current national level Nutrition Sector Coordinator holds two other roles in addition: The Nutrition Sector Co-lead in Rakhine and Chief of Nutrition for UNICEF.** Given the multi-hatting of these roles, plus also disruption to potential travel to Rakhine as a result of COVID-19, there has been limited capacity for nutrition sector coordination and support in Rakhine. An analysis on how much funding was available for nutrition coordination found available funds to be insufficient for effective coordination (interviews). Having a functional nutrition coordination mechanism would allow for improved analysis of the nutrition context, the impact of the COVID-19 pandemic and the impact of the current political unrest on the nutrition status of the population. Having a dedicated Nutrition Sector Co-lead in Rakhine would also facilitate advocacy to the government and other partners for nutrition to be prioritised appropriately, as nutrition is rarely raised as a perceived problem currently (interviews). Given the historical involvement of the government in nutrition programming, a challenge still remains on how to openly discuss the bottlenecks and barriers to optimal nutrition programming, although whether this will change given the recent political instability is unknown (interviews).
- **It was recently agreed that LIFT would fund an NGO partner to take on the role of nutrition sector lead in Rakhine, with UNICEF developing a terms of reference (TOR) for the role.** However, this recruitment is on hold due to the recent political instability with the rationale that NGO partners may be reluctant to commit to additional responsibilities without knowing whether they will be able to operate in Rakhine or Myanmar at large. There are also concerns that NGOs will not be able to staff the role appropriately given it is in Rakhine, which is considered an undesirable location to be based in given the level of insecurity, and may not have the same leverage with the government as UNICEF. In contrast, NGOs may be able to support coordination of training with support from the TRRT better than UNICEF as they do not have as much red tape to navigate internally (interviews).
- **The nutrition sector uses the 4W to keep track of who is doing what, where and when funding starts.** In Rakhine, as of February 2021 there are a total of 17 nutrition partners with projects in Central Rakhine State (CRS), in Northern Rakhine State (NRS) and in Southern Rakhine in 17 townships (3 townships in NRS, 8 in CRS and 6 in southern Rakhine), including IDP camps in CRS. The activities are run by 4 partners in Sittwe, 3 partners in Mrauk U, Kyauk Taw, Minbya and Myaebon townships, 1 partner in Kyauk Phyu, 6 partners in NRS and 1 partner in Southern Rakhine townships. Currently, there are no nutrition activities in Paletwa.
- **Despite multiple partners delivering nutrition services in Rakhine, a lack of standardisation and harmonisation in approaches remain.** Different partners define nutrition activities differently. For example, nutrition messaging in mother support groups varies across the state (interviews). In addition, there is disjointed programming for the treatment of wasting, with different partners responsible for severe wasting treatment and moderate wasting

treatment offering services on different days in different locations, making referrals between services difficult (interviews).

- **Capacity for nutrition in Rakhine is a particular challenge.** Typically, it is UNICEF's responsibility to ensure all implementing partners have capacity to implement but in Rakhine this is particularly hard as the government has the mandate for all capacity-building activities. The government lacks capacity to provide training and once training is completed no supervision or on-the-job training for newly trained staff is provided. NGO actors have sometimes been funded to provide mentorship to ensure government training is provided but they are restricted from providing the training themselves. Also due to the hardship of living and the restrictions on foreigners in Rakhine, many NGOs struggle to staff their programmes (interviews).
- **Efforts have been made to set up early warning systems in Rakhine.** In light of recent military takeover, WFP are conducting phone calls and in-person visits with support from communities to monitor: 1) the security situation (presence of military police and armed groups); 2) rules and regulations applied post 1 Feb 2021; 3) access to basic services and assistance; 4) impact on markets; and 5) general impressions from the communities on the situation. Additionally, HARP-F has conducted an analysis of the potential scenarios in Rakhine as a result of the coup ([HARP-F Feb 2021](#)).
- **As one of the most disaster prone parts of Myanmar, agencies in Rakhine have created an interagency contingency response plan (CRP) for various natural disaster⁷ scenarios, pandemics and increased security incidents ([CRP 2020](#)).** The CRP includes a risk analysis, likelihood and impact of each scenario. It outlines specific objectives and activities for the nutrition sector focusing on the most vulnerable. Nutrition activities focus on timely identification, referral and management of wasting cases, ensuring continuation of services, protecting IYCF, increasing coverage of service points, and increasing nutrition surveillance and monitoring. This also includes specific BMS code monitoring and reporting. As part of the CRP, a Rakhine Needs Assessment template was developed to standardise the approach for data collection, compilation and analysis in both the central and northern part of Rakhine to ensure the assessment covers both camp and non-camp settings. The CRP was last updated in July 2020 but should be updated every 6-12 months. Prior to the coup, this assessment was yet to be endorsed by the government.

Analysis of Coordination

- **Given the recent political instability, it is important that nutrition partners switch their focus from solely development strategies to incorporate an emergency focus.** This means prioritising the coordination of needs assessments, tracking nutrition data to identify any increases in nutrition needs, mapping partners with a focus on national NGOs, CSOs and CBOs and those with emergency experience, mapping nutrition services and developing a strategy to mitigate engagement with the de facto government, given many nutrition projects, programmes and service have been implemented with or through the government and government systems.
- **However, the current national NIE TWG in Myanmar lacks emergency experience to drive the shift to an emergency focus.** The support of the GNC, who brings emergency expertise, is timely but partners and UN agencies with emergency experience need to dedicate staff to support continued momentum. Without this, there is a risk that monitoring systems and emergency planning will not be established in a timely manner. The delayed emergency response may result in insufficient coverage of lifesaving nutrition service provision where needed.
- **There is a need for UNICEF to continue efforts to improve the nutrition coordination at national and subnational levels.** There is currently limited capacity to establish a nutrition surveillance system and lead a prioritisation exercise to guide where programmes should be implemented, to address the areas of highest needs and to optimally target interventions. In addition, there continues to be a lack of harmonisation and standardisation in approach to providing nutrition services. It is particularly important to be able to identify the gaps in service provision now, at a time when lifesaving nutrition services need to be ensured given the impacts of the political unrest and the COVID-19 pandemic. There is a need for strong advocacy to support the approach of nutrition stakeholders as well as much better

⁷ Tsunami, earthquake, cyclone, floods, drought, storm surge, landslides and forest fire

integration with the food security sector, as the two sectors are currently delinked and lack commonality. Without advocacy for nutrition, it is hard to ensure attention is on the issue of nutrition by the right people and with adequate resources.

- **The arrival of the Nutrition Sector Coordinator is an opportunity to ensure priority activities are completed but there is a need to ensure the sector lead has necessary resources to successfully coordinate the humanitarian nutrition activities in Myanmar.** The incoming Nutrition Sector Coordinator, hosted by UNICEF, has a background in emergencies as well as development, and is provided with the necessary resources to successfully coordinate the humanitarian nutrition activities in Myanmar. There is also a need for an Information Management Officer for Nutrition to improve information management. In the interim, the incoming NCC seconded by the GNC will fill the vacancy of the Nutrition Sector Coordinator and this individual also has a background in information management, which will provide urgently needed capacity in this regard.
- **Donors must be ready to rapidly mobilise funding for the ERP.** Without funding, urgently needed emergency response activities cannot be implemented and thousands could go without emergency lifesaving nutrition services, which will impact on mortality rates in Myanmar particularly for vulnerable groups such as children under five years of age and pregnant and lactating women. This includes resourcing the main agencies providing supplies (Access to Health, UNICEF, NNC) to improve coordination of supplies.
- **There is a strong membership coordination mechanism at central level and key regions/states, but the nutrition sector in Rakhine is under-capacitated and overwhelmed without dedicated coordination capacity.** In Rakhine, monthly meetings are well attended with both humanitarian and development actors [\[GNC, Feb 2021\]](#). While the process to recruit has been agreed and the funding identified through LIFT, there has been a delay in advertising the posting due to the coup and uncertainty on whether now is the right time to publish the TOR and solicit interest from partners. A recently released expression of interest [EOI] in Kachin yielded little interest from partners (deadline February 2021). However, due to an urgent need to improve coordination in Rakhine, steps should be taken to continue the process to ensure the Rakhine Nutrition Sector Coordinator role is filled. Better nutrition coordination in Rakhine is possible if an active and effective lead takes on the role. Once in place, it would be valuable to explore options for partners to discuss and identify solutions for bottlenecks (through a mechanism where the government is not part of the discussion).
- **In Rakhine, it is important that UNICEF steps up to mobilise resources/ advocate for nutrition, especially in light of the uncertainty resulting from the recent political instability.** They must play a more active role in supporting the nutrition sector and empower the organisation taking over the nutrition sector in Rakhine to take an effective leadership role. It would be very beneficial for the national level Nutrition Sector Coordinator to spend time in Rakhine to support advocacy for prioritisation of nutrition and to assist stakeholders with solving nutrition issues.
- **With increasing political sensitivities and distrust in international agencies, there is an opportunity to build the capacity of national partners and strengthen their role to lead the nutrition response** and thus strengthen the commitment to the Grand Bargain and localisation. Strengthened collaboration between HARP-F, LIFT and Access to Health could help facilitate this, where potentially funding could go through one nutrition partner who would subgrant to national partners as required. There is a particular challenge of capacity-building in Rakhine leading to poor quality nutrition service provision, so UNICEF should be empowered to support capacity-building with funding and through advocacy to the government to facilitate support to high quality nutrition training.
- **As of February 2021, nutrition partners have had varying levels of engagement with the de facto government and ethical considerations of engagement need to be carefully managed. Commitment to nutrition by the de facto government is unclear now there has been a change in government personnel, including the Minister for Health.** With military control, there is a risk of progress in the nutrition sector being reversed and current nutrition coordination mechanisms may fail, exacerbated by the fact partners do not have a clear way forward in terms of engagement. There needs to be an analysis of the different potential scenarios given recent political events and a plan for coordination under each scenario, and ideally the nutrition sector should lead on this work. There needs to be a common approach to carefully manage the relationship of humanitarian actors, community structures and the current authorities.

- **There is a need to ensure investment in preparedness planning, disaster risk reduction and resilience building.** Without this, Myanmar will not be prepared to respond to a disaster, natural or conflict related. While there has been planning for potential natural disasters and intensified conflict scenarios in Rakhine, adequate response requires investment. Without a dedicated Information Management Officer, nutrition data will likely not be analysed or used for decision-making.

Nutrition-related Programming in Rakhine

Nutrition stakeholders

- **UNICEF has the global mandate for the majority of maternal and child health and nutrition services.** UNICEF has the oversight of these programmes in Myanmar and while technically good, the key UNICEF staff responsible for nutrition are overwhelmed as they are often double or triple-hatting. UNICEF is also under-resourced for coordination in particular. UNICEF has a good relationship with the MoHS and the NNC and liaises closely with them, although UNICEF has been criticised for not doing more to overcome nutrition issues in Myanmar. However how useful this established relationship is moving forward as a result of the recent political instability is unclear.
- **There are three main NGO partners in Rakhine: Action Contre le Faim (ACF), Save the Children International (SCI) and the national NGO Myanmar Health Assistant Association (MHAA).**
 - ACF has had a presence in Northern Rakhine for 20 years where they are the only international nutrition partner, which contributes to their profile of being the most established nutrition partner in this context. As a result, they tend to be burdened with a lot. ACF are considered to be trusted by the National Nutrition Centre (NNC) (interviews). ACF has had capacity issues at field level, as demonstrated by their failure to deliver on the recent FCDO funded nutrition project in Rakhine, although these capacity issues are not present at headquarters level necessarily.
 - SCI has long implemented nutrition programmes as part of a multi-sectoral portfolio in Rakhine funded by LIFT, Bureau for Humanitarian Assistance (BHA), Food for Peace (FFP), UNICEF and WFP. Activities include IMAM services (OTPs, TSFPs, screening and referral), BSFPs, IYCF activities focused on the first 1,000 days, SBCC programming and nutrition development activities. They are active nationally and in Rakhine but not as outspoken as they once were in terms of advocating for nutrition. This may be because the SCI Nutrition Program Managers are national staff (although they have good technical capacity) and also that as part of the recent restructure, the SCI Head of Health and Nutrition at national level is not a nutritionist. SCI do have three Nutrition Advisors at national level however, who divide support areas such as attending NNC meetings and working more closely with the government (interviews).
 - MHAA focuses on relief, recovery and development in the nutrition, food security, health and WASH sectors in Rakhine including in Northern Rakhine. MHAA is funded by Access to Health, WFP, UNICEF, BHA, GIZ and the Global Fund. In Rakhine, MHAA provides nutrition services according to the national nutrition in emergencies objectives, including wasting treatment services (OTP, TSFP, screening and referral) and wasting prevention services (BSFP, IYCF and MNPs). A particular focus of MHAA is to provide services to hard-to-reach communities and their focus includes children under five years of age and PLW. They also have a nutrition diploma project where they provide training through five modules. Through maternal and child health activities, MHAA also provides training for volunteer health workers to provide services in hard to reach areas ([MHAA, Jan 2021](#)).
- **There are many other national NGO nutrition partners in Rakhine, but they lack capacity.** The Myanmar Health Assistant Association (MHAA) is considered to have the highest capacity in Rakhine. According to the most recent 4W from the nutrition sector, there are 11 nutrition implementing partners present providing varying degrees of service quality ([4W, Feb 2021](#)). National partners do not face the same restrictions as international partners and can sometimes access populations where international partners cannot, which is a huge benefit to working more closely with national partners. However, an area where national staff may not have as easy access to is IDP camps. With the current coup, their access may be even more restricted (interviews).
- **There are also national NGO partners operating in Rakhine who currently do not provide nutrition services.** However, some have expressed interest in mainstreaming nutrition throughout their existing non-nutrition programming or adding on nutrition activities to their current portfolios to make activities nutrition-sensitive, for example CSI, who HARP-F currently fund for a variety of activities including food distributions and home gardening.

Nutrition funding

- **Public funding for health and nutrition activities remains low** ([Asian Disaster Preparedness Centre/ UNDRR, 2020](#)). Rakhine is a protracted crisis context where funding is often a challenge. In addition, bilateral funding is constrained

globally due to the COVID-19 pandemic. Finally, given the implementation of nutrition activities in Rakhine is so challenging due to the operating environment, partners often struggle to spend the funding they have if they receive it (interviews).

- **There is a lack of sufficient funding for comprehensive coverage of nutrition programming in Rakhine.** Current partners implementing nutrition seek funding from a variety of bilateral donors (e.g. BHA), pooled multi-sector funds (e.g. Myanmar Humanitarian Fund, managed by OCHA and whose main donor is FCDO), funding facilities funded by bilateral donors like FCDO (e.g. HARP-F, LIFT, Access to Health) and UN donors (e.g. UNICEF, WFP). However the amount of funding required to ensure sufficient coverage of nutrition services is not available. Also there is a lack of coordination between donors and funding facilities, which means already stretched resources are not being used optimally and efficiently (interviews).
- **The recent coup has seen donors withdraw support (including financial support) to the government, given the political uncertainty.** This will potentially have an impact on funding sources for all partners working in support of or through the government. This in turn will likely have an impact on humanitarian programming, including for the nutrition sector (interviews).
- **Flexibility of funding in Myanmar is highly valued by partners, especially given the unpredictability of the current context.** The Myanmar Humanitarian Fund provides funding for both national and international humanitarian organisations in Myanmar demonstrating some flexibility in recipient ([OCHA, Dec 2020](#)) and HARP-F have allowed flexibility in spending of existing grants and facilitated grant top-ups to accommodate the changing context.
- **The most useful source of funding for programming in Rakhine has been through multi-year grants which facilitate longer-term strategic thinking and the development of relevant context-specific strategies, with HARP-F being the only fund to provide this for nutrition programming.** Short-term [annual] funding cycles do not allow for longer-term planning, engagement with communities to see sustainable impact and to promote local ownership of programmes, which has an impact on how efficiently funds are used. Building resilience and preparedness capacity in a protracted emergency context requires multi-year funding, rather than repeated short-term funding cycles (interviews).
- **It is useful that HARP-F has technical experts in some sectors available to provide continuous follow-up on multi-year grants, which has been critical to the success of projects in multiple sectors e.g. WASH.** Successful service delivery requires discussions around advocacy and principled approaches, and this requires long-term visibility as well as long-term funding (interviews). Until recently, there has not been similar dedicated capacity at HARP-F for nutrition.
- **As a result of the coup, Access to Health is reviewing their current \$15 million USD portfolio as they used to be active in collaboration with the government and are now redirecting their funding so as to not support the authorities.** Their main funders include FCDO, the Swiss, Sweden and the USA. As one sector of focus, they aim to maintain lifesaving interventions in the thematic area of nutrition, which is one of nine thematic focus areas, in collaboration with a range of implementing partners including INGOs, national NGOs, CBOs and CSOs. Their strategy is focused on vulnerable populations in conflict-affected areas and they focus on key states in Myanmar including Rakhine. They are interested in discussing how to create synergies across partners for nutrition in Myanmar, such as UNICEF, LIFT and Access to Health themselves. Given the recent coup, they have made decisions on which activities should continue (lifesaving and essential activities) and which should be discontinued. All grants to the NNC have been discontinued apart from for the RUTF supply chain. Existing partners have been invited to submit emergency proposals and new partners with emergency expertise are being considered (interviews).
- **Nutrition is a core theme for the Livelihoods and Food Security Fund (LIFT).** LIFT is a multi-donor fund committed to strengthening the resilience and livelihoods of Myanmar's most vulnerable communities through four main thematic areas: [1] agriculture, markets, and food systems; [2] decent work and labour mobility; [3] financial inclusion; and [4] nutrition ([LIFT, 2021](#)). Under the nutrition theme, LIFT funds maternal and child cash transfers (MCCT) linked to social and behaviour change communication (SBCC) in Rakhine as well as the delta and the dry zone in Myanmar ([LIFT, 2021](#)). As a result of the recent change in political context, LIFT is trying to support partners with appropriate guidelines to adapt and potentially reprogramme their grants, including those that had previously directly supported the government. They are also working on a revised strategy and key advocacy pieces about the nutrition situation

currently and have minimised all engagement with the de facto government. LIFT is open to new partners and recently had a call for proposals for Rakhine to contribute to LIFT’s strategy around strengthening civil society, gender equality and women’s empowerment, conflict sensitivity and social cohesion, and identification and local ownership of durable solutions.

- **Previous projects saw HARP-F, LIFT and Access to Health collaborating together and coordinating support to nutrition partners. However due to the termination of the project with ACF, this collaboration for nutrition has ceased.** Previously a clear scope of work and objectives was drafted to support the coordination of these three funding platforms, and a service mapping was completed. There are currently weekly calls with FCDO where all three funding platforms attend, although nutrition has not been a focus recently. It is felt that there could be huge benefit in reestablishing this coordination and collaboration, particularly given the need to shift to an emergency focus [interviews].

Nutrition-specific and nutrition-sensitive programmes

Table 3 and Table 4 illustrate government-led and NGO-led nutrition-specific and nutrition-sensitive programming in Rakhine and in Myanmar as a whole. The nutrition-sensitive programmes aim to address the underlying causes of malnutrition. In Rakhine, there have also been programmatic adaptations in response to COVID-19 implemented, as well as innovations to simplify the treatment of wasting [Table 5].

Table 3: Government-led and NGO-led nutrition-specific activities

Programme	Description of services and activities	Targeted beneficiaries and locations	Ministry in charge
Essential Package of Health Services (EPHS)	<p>The EPHS is a critical element of Myanmar’s National Health Plan for 2017-2021. The following programmes are part of the essential health package that the MoHS, with support from the nutrition sector, was committed to providing in all clinics and hospitals in the country.⁸</p> <ol style="list-style-type: none"> 1. Blanket supplementary feeding (BSFP) 2. Infant and young child nutrition in emergency (IYCF) 3. Multiple micronutrient supplementation (MMS) for PLW, vitamin A, deworming, zinc, micronutrient powders (MNP) <p><i>Integrated Management of Acute Malnutrition</i></p> <ol style="list-style-type: none"> 4. Nutrition screening and referrals 5. Outpatient management of severe acute malnutrition (SAM)/ moderate acute malnutrition (MAM) [Outpatient Therapeutic Programme (OTP) and Targeted Supplementary Feeding Programme (TSFP⁹)] 6. Inpatient management of acute malnutrition <p>Nutrition screening is conducted using both MUAC and WFH measurements based on the IMAM guidelines, and cut-offs are based on national standards.</p> <p>In non-rural areas, RUSF is used for MAM treatment. BSFP also provides blended food (WSB+/WSB++).</p>	<p>Children <5 years of age</p> <p>PLW</p> <p>Country-wide</p>	MoHS

Table 4: Government-led and NGO-led nutrition-sensitive activities

⁸ The impact of the coup on the government’s leadership on nutrition services such as the EPHS is currently unclear

⁹ In NRS, TSFP using RUSF was suspended by the government from 2016 and resumed in March 2020 (interview)

Programme	Description of services and activities	Targeted beneficiaries and locations	Ministry/ organisation in charge
Social Protection Programmes			
Maternal and Child Cash Transfer (MCCT)	<p>A national initiative for universal cash transfer to pregnant women and mothers of children up to two years of age, to enhance their purchasing power to improve their dietary diversity and intake as well as access to healthcare.</p> <p>Aims to improve nutrition outcomes for mothers and children through nutrition-sensitive cash transfers for pregnant women during the first 1000 days.</p> <p>It includes social and behaviour change communication (SBCC) through mother-to-mother support groups.</p>	<p>PLW from 2nd trimester onwards</p> <p>Children <2 years of age</p> <p>Currently in 5 states (Chin, Rakhine, Kayin, Kaya, and Naga)</p>	<p>Department of Social Welfare Relief and Resettlement (DSW)</p> <p>MoHS</p>
Emergency Relief Assistance Asset Creation and Livelihoods ¹⁰	<ul style="list-style-type: none"> ● Emergency Relief Assistance provides unconditional food transfers and/ or cash-based transfers to populations affected by crises including in Rakhine ● Asset Creation and Livelihoods programme provides conditional food and cash-based assistance in support of the rehabilitation of assets, combined with nutrition messaging for targeted populations 	Northern Rakhine, parts of Kachin State	WFP
Rakhine Recovery and Development Support Project ¹¹	<p>Aims to improve access to economic opportunities for diverse communities in selected areas of Rakhine.</p> <ol style="list-style-type: none"> 1. Production inclusion: activities include providing access to cash-for-work program to generate short-term income, and livelihoods training combined with small asset transfers to support longer-term income generating opportunities 2. Improving livelihoods: support the growth and development of Small and Medium Enterprises (SMEs) in selected areas of Rakhine through providing grants and financial assistance 	Rakhine	World Bank MoALI
Other Nutrition-Sensitive Programmes/ Activities			
School Feeding programme (WFP) ¹²	WFP provides nutritious High Energy Biscuits or cooked lunches to primary school and pre-school children. The long-term vision is to transfer ownership of the programme to the government.	Primary and pre-school school children 11 out of 14 states including Northern Rakhine	MoSWRR and MoE
Emergency	In remote, unsafe areas and where there are significant	Populations	WFP

¹⁰ World Food Programme. [WFP Myanmar Country Strategic Plan \(2018-2022\)](#)

¹¹ World Bank. Concept Project Information Document (PID) - Rakhine Recovery and Development Support Project

¹² World Food Programme. [WFP Myanmar Country Strategic Plan \(2018-2022\)](#)

food and cash distributions ¹³	protection concerns, food is the preferred transfer modality. The food basket includes pulses, oil, rice, blended food (WSB+/WSB++), and salt. The food basket provides 2,100 kcal and is calculated for a household of five people, calculated to include one child <5 years of age, one school-age child, one PLW and adult men (interviews). In areas with functioning markets, beneficiaries are assisted through cash-based transfers (CBT). The value of the CBT is determined based on market prices, taking into consideration price fluctuations.	affected by crises in Rakhine, Kachin and Shan states	
Home Gardening	Under the WFP Asset Creation and Livelihoods programme, WFP supports the development of home gardening to improve access to nutritious and diverse food for those in need. HARP-F also funds home gardening programmes providing seeds for a variety of vegetables including gourds, ladyfingers, long beans, roselle leaves, chilli, tomato and eggplant.	Rakhine	MoHS
Food fortification	As the main staple in Myanmar, rice is fortified with iron, zinc, folic acid, and vitamins A, B1, B3, B6, and B12 in Myanmar to address micronutrient deficiencies. The distribution of fortified rice is part of the WFP Emergency Relief Assistance programme.	Rakhine, Kachin, Northern Shan	WFP
Water sanitation, and hygiene (WASH) activities	The main WASH activities are latrine building through subsidies or pan and pipe distribution, provision of safe drinking water, and hygiene promotion. The sector provides subsidies to households to encourage latrine construction. The government had been providing latrine pan and pipe materials to households to encourage construction of latrines.	All states except Sagaing	WASH Partners such as Oxfam and Solidarities International MoHS
Health services	The Basic Essential Health Package includes services for sexual and reproductive, maternal, newborn, adolescent and child health care. Activities include immunisations (measles vaccination for children 9 to 18 months) and antenatal and postnatal care. A key strategy in health is the use of mobile health clinics where community health workers (CHW) provide support for basic health services and malaria treatment. As a result of the recent political unrest, makeshift community clinics are emerging to compensate for the loss of the public health system. Private community clinics are also being established.	Countrywide	MoHS
Protection services	The protection sector has two subsectors ¹⁴ : <ul style="list-style-type: none"> ● Child protection working group ● Gender-based violence subsector <p>In Rakhine, the sector advocates for access to critical lifesaving services and advocates to OCHA to remove challenges faced by patients to ensure access to health services, in particular barriers to reach Sittwe General Hospital.</p> <p>Gender-Based Violence (GBV) partners continue to provide critical GBV services, including case management and psychosocial support, remotely and in-person.</p>	Rakhine Countrywide	UNHCR

¹³ World Food Programme. <https://docs.wfp.org/api/documents/WFP-0000105025/download/>

¹⁴ MIMU. Humanitarian Protection Sector. <https://themimu.info/emergencies/protection>

Table 5: Innovations and adaptations to programming to improve coverage in response to the COVID-19 pandemic

Programme	Description of services and activities	Targeted beneficiaries and locations
<p>Innovative Actions to Treat Malnutrition¹⁵</p> <p>Action Against Hunger (ACF) and Humanity & Inclusion (HI)</p>	<p>This programme was launched in 2019. The purpose of this initiative was to improve early detection and treatment of wasting and to improve IMAM programme coverage in Rakhine. It was originally planned for 11 villages in Thandwe, 9 villages in Sittwe and 4 OTPs. The aim was to address key barriers to improving coverage of IMAM, including limited human resources and cultural barriers.</p> <p>The key activities include:</p> <ol style="list-style-type: none"> 1. Mother MUAC (Minbya and Thandwe) 2. Simplified protocol (Minbya and Thandwe) 3. Strengthening treatment of acute malnutrition with disability inclusion and disability-specific interventions by integrating early childhood interventions in OTP centres, including providing community-based rehabilitation services for children with acute malnutrition, early childhood stimulative therapy (EC-ST) providing training to parents and caretakers for playful stimulation exercises, and awareness raising for PLW disability and inclusion and COVID-19. (Sittwe) <p>Due to substandard grant management, funding coordination challenges, delays to gaining travel authorisation (TA), lack of government approval for piloting the simplified protocol and COVID-19, the project only achieved minimal project activities on mother MUAC and was terminated in December 2020.¹⁶ See below in this section for further information.</p>	<p>14 camps and 11 villages in Thandwe and Sittwe, Rakhine</p> <p><i>Original proposal included Minbya township</i></p>
<p>COVID-19 Technical Guidance Adaptations</p>	<p>Technical guidance packages for nutrition adapted to the COVID-19 pandemic in Myanmar have been developed to ensure continuity of essential nutrition services and to mitigate the secondary impacts of nutrition.</p> <p>Available guidance includes:</p> <ul style="list-style-type: none"> ● WFP General Guidelines for food and nutrition assistance in the context of the COVID-19 outbreak (March 2020) ● Emergency Nutrition Sector Adapted Emergency Nutrition Programming Guidance COVID-19 pandemic in Myanmar (April 2020) ● Nutrition-sensitive guidance in the context of COVID-19 in Myanmar (September 2020) ● Concept note for the establishment of a hotline service for IYCF counselling and support and MNCH services during the COVID-19 pandemic ● Recommendations for Food Distribution and Food Basket (June 2020) ● Joint statement on appropriate infant and young child feeding (IYCF) and caution about unnecessary use of milk products in the current COVID-19 pandemic (April 2020) 	<p>Myanmar, including Rakhine</p>

¹⁵ Innovative Actions to Treat Malnutrition in Rakhine Technical Application. Submitted on 14 May 2019

¹⁶ Win et al., 2020. 'Innovative Actions to Treat Malnutrition' Rakhine State, Myanmar Project Review Final Report November 2020. ACF and HARP-F

Other COVID-19 Adaptations	<p>The following were also proposed in the NIE TWG SAG to maintain lifesaving services in Rakhine in response to COVID-19 [NIE SAG, 2020]:</p> <ul style="list-style-type: none"> ● Prepositioning of supplies ● Adapted IYCF counseling card ● Hotline for continuation of IYCF counselling to mothers in critical need of support ● Regular monitoring and mapping based on the agreed plan 	Rakhine
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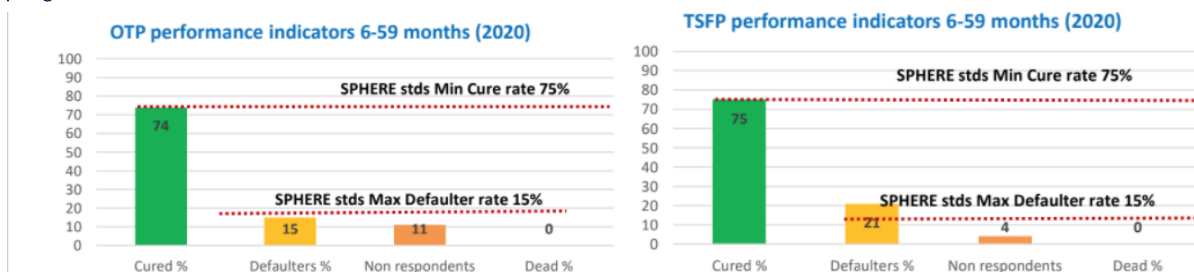
Nutrition and Programme Assessments

- Historically it has been very difficult to obtain government approval to conduct surveys and assessments, particularly in Rakhine state where assessments have been reportedly banned since 2017, and the situation is not likely to improve given the recent political instability. Where permission is granted it is usually due to extensive advocacy by nutrition partners to highlight that survey results will support government priorities e.g. in Nagaland there was a rickets outbreak and the government approved a SMART survey to assess the situation to support their decision-making (not yet completed due to the COVID-19 pandemic). For surveys conducted where the results are not favourable, there are examples where the government has not given permission to publish results. Partners are now not inclined to apply for permission for assessments as this may be seen as supporting the de facto government. Partners are also not inclined to share assessment and survey results with UNICEF, the nutrition sector lead, as UNICEF are at liberty to share information with the government and this may lead to severe sanctions for partners by the government in cases where full permission has not been given for the assessment. Partners do adapt assessments that are needed e.g. by doing lot quality assurance sampling (LQAS) assessments as baseline or endline surveys, although mostly any assessment data generated is kept internal resulting in a perceived lack of available data. The next DHS survey was planned for 2020 but it was delayed due to COVID-19, and it is now unclear whether it will happen at all due to the political instability (interviews).

Wasting Treatment Programmes

- The OTP and TSFP programme performance across Rakhine state through all actors met Sphere minimum standards, apart from the defaulter rate in TSFPs. Between January to June 2020, the performance indicators were 74% cure, 15% defaulter and 11% non-responder rate for OTPs, and 75% cure, 21% defaulter and 4% non-responder rate for TSFPs (Nutrition Subsector June 2020). See Figure 8.

Figure 8: Performance indicators for outpatient therapeutic programme (OTP) and targeted supplementary feeding programme (TSFP) in Rakhine



Source: Rakhine: Nutrition Subsector Dashboard 2020 as of June 2020

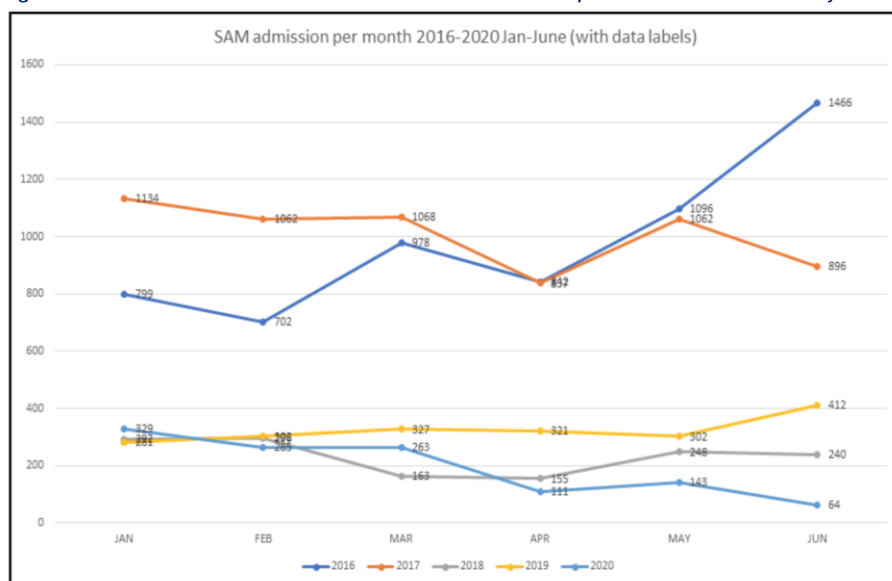
- In both IDP camps and northern townships, severe wasting admissions normally increase 20-30% from May to October during the monsoon season, reaching a peak in June and July [\[Nutrition sector, 2019\]](#). However, during the lean season between November and December, severe wasting cases rise in IDP camps whereas they fall in northern townships. The sector has yet to discover the reason for this.
- Reduced community outreach and referral due to increased insecurity significantly reduced numbers of children under five years of age screened for wasting. From 2016 to 2017, the numbers of children screened were

above 200,000 per month. By 2018, active case finding was reduced with no community outreach implemented due to increased insecurity [\[Nutrition sector, Aug 2020\]](#). The numbers of children screened dropped below 120,000 children per month [\[Nutrition sector, Aug 2020\]](#). In 2020, due to the COVID-19 pandemic, even fewer children were screened. In March 2020, the numbers of children screened was the lowest in the year and in several townships¹⁷ no children were screened the following month. This trend continued for several months in 2020 due to the COVID-19 pandemic [\[Nutrition sector, Aug 2020\]](#). While mother MUAC has been implemented by ACF which could contribute to increased screening coverage, the programme was limited to Sittwe only through one programme.

- **As a result, the number of SAM admissions have been reducing yearly with SAM admissions more than threefold lower compared to the same month in 2017 [\[Nutrition sector, Aug 2020\]](#).** This indicates a large proportion of wasted children are left untreated and wasting prevention activities are substandard. See Figure 9

¹⁷ Pauktaw, Myebon, Minbya, Mrauk-U, Kyauktaw, Rathedaung

Figure 9: Severe acute malnutrition (SAM) admissions per month from January to June from 2016 to 2020 in Rakhine



Source: Nutrition Sector. [Nutrition Response](#), 11 August 2010

- **The Semi-Quantitative Evaluation of Access and Coverage (SQUEAC) assessment from 2014 in two townships in northern Rakhine shows coverage of wasting treatment is low.** In the accessible areas of Maungdaw and Buthidaung townships, the period coverage of ACF’s programme for treatment of wasting in 2014 was 35.3% [95% CI; 27.7% - 43.8%] which is below the Sphere standard of 50% in rural areas ([ACF, 2014](#)). No SQUEAC assessments have received permission to be conducted since this time, apart from one in 2020 which was postponed due to the outbreak of COVID-19.
- **The main barriers to access to treatment for wasting in Maungdaw and Buthidaung, in Northern Rakhine, are the caregiver’s inability to identify malnutrition, distance, security issues (mainly fear of checkpoints) and women/ gender inequality ([ACF, 2014](#)).** Aspects of gender inequality included women’s low decision-making power, not being fit to travel and requiring the husband’s permission to bring children to the nutrition facility. While this analysis was conducted more than six years ago and is specific to Maungdaw and Buthidaung, these barriers are likely to be similar in other townships today.
- **Another barrier to treatment is reportedly related to TSFP and OTP services being offered on different days.** TSFP and OTP services may not always be provided by the same implementing partner and referrals between the two are suboptimal. In addition there is a lack of cohesion and coordination cited between the nutrition actors responsible for these services [interviews].
- **While OTPs in IDP camps in Pauktaw and Sittwe townships are functioning, access has been reduced since the Covid-19 pandemic began.** OTPs operate on limited hours in the mornings only and women and children are not able to access the OTPs due to restricted movements in Sittwe camps [interviews]. Additionally village leaders prevent people from leaving their villages, which prevent mothers and children from accessing nutrition services in neighbouring localities [interviews].
- **Referrals for moderate wasting, wasted children with medical complications and active screening continues to be limited due to the COVID-19 pandemic.** Nutrition coverage information for camps from the nutrition sector indicates limited referrals of children with medical complications, who are at the highest risk of mortality, due to lack of technical support from non-camp-based staff and no medical staff from nutrition teams able to go to camps [interviews]. Disruptions to mobile clinics and a lack of ambulances have also limited medical referrals to inpatient care and even if access to inpatient care is successful, reported care for Muslim minorities in Sittwe General Hospital (and other hospitals) is poor. Inpatient services are only found in general hospitals which tend to be far from the households of cases. A range of documents usually issued by international organisations are required for families to

travel for medical referrals. With the closure of some of these international agency run clinics in the camps, accessing these documents has become difficult (interviews).

- **Alternative measures to fill gaps in reduced health services since the COVID-19 pandemic and the coup have been implemented.** These include free service provision from private providers, opening of military hospitals to the public and provision of health services for protesters. However, significant gaps still remain ([HARP-F, 12 Feb 2021](#)).
- **In Northern Rakhine the plan had been to integrate nutrition services into the mobile health teams to bring treatment closer to the community.** However a requirement of the government is that every mobile team has a medical doctor, so there was a delay to the integration of nutrition services as it is hard to find medical doctors to recruit (interviews). Also the COVID-19 pandemic has seen disruption to the operation of the mobile health teams and now with the recent political disruption, it is unclear whether the mobile health teams will resume operations.
- **ACF was able to implement the Mother MUAC pilot despite other programmes not being given travel authorisations (TA) to allow implementation.** Other programmes which aimed to improve community mobilisation and awareness to address lack of active case finding were the mother MUAC approach implemented by Myanmar Health Fund (MHF) partners, such as People In Need (PIN), and the mother care group model approach implemented by Save the Children International (SCI) and other partners. However, the mother MUAC project by MHF fund partners was suspended due to the COVID-19 pandemic and while the mother care group model functioned in some villages, the linkages between the mother leaders to provide health and nutrition education was a challenge ([ACF, Nov 2020](#)).
- **However, ACF's Innovative Actions to Treat Malnutrition programme faced multiple challenges resulting in no activities in Minbya and the simplified protocol for wasting treatment was ultimately not piloted.** The programme was initially launched at the end of 2019 but did not start until August 2020 at the field level. Because of the delay, there was no evaluation of the effectiveness of the programme. Procurement and delivery of nutrition supplies and commodities also inhibited effective nutrition service delivery. To procure supplies ethically and cost-effectively, there was a long procurement process to obtain quality products. Supplies distributed to targeted townships from Yangon was also a challenge due to TA restrictions ([ACF, Nov 2020](#)). Health workers were not able to provide outreach services as planned since health workers were not able to stay in the assigned villages due to conflict and security issues in Rakhine. While this project initially also included piloting a simplified protocol for wasting treatment and included Minbya township, the simplified protocol was not implemented because the government did not give approval for piloting the simplified protocol and Minbya was also not part of the pilot ([ACF, Nov 2020](#)) (interviews).
- **While IRC has been one of the newer partners in Myanmar, they have been able to implement multi-sectoral programmes, including IMAM, in Rakhine and Kaya state almost solely through national partners.** IRC's first programme in Myanmar funded by Access to Health was implemented in 2017 in Rakhine which included health programming, IMAM, mother to mother support groups and cooking demonstrations. A key enabler to the programme was developing strong relationships with national partners as well as building their capacity (interviews). In this programme, national partners were able to move more freely than INGOs thus covering a wider area. Adaptations to the programme guided by key learnings from the Rakhine programme resulted in the expansion of the programme into Kayah state, where LIFT now provides funding. In Rakhine, a proposal to expand the programme, which includes SBCC, GBV, WASH and cash, has been submitted to the Bureau of Humanitarian Assistance (BHA) for funding.

Other Nutrition-related Services

- **The long-term agenda to reduce stunting has been more successful in Myanmar than attempts to reduce wasting.** The government has historically taken responsibility for reducing stunting, demonstrating sufficient political will to facilitate this, as they have a good understanding of the economic impact and opportunity outcomes of addressing stunting (interviews). One example in Rakhine is where MCCTs were implemented, which were then scaled up nationally thanks to government resources and action. This included for Rohingya residing in camps, which was a rare example of the government recognising their right to receive this assistance.
- **IYCF interventions include mother-to-mother support groups, health education/ behaviour change communication, cooking demonstrations, one to one counselling, problem solving sessions and infant feeding in emergency kit distribution.** A KAP survey in 2015 showed that since implementation in 2013, improvements in IYCF indicators have been variable ([SCI, 2015](#)). The main barriers to optimal IYCF practices in Sittwe and Pauktaw townships

in 2015 were self-efficacy, cues to action and positive and negative attributes to the behaviour [\(SCI, 2015\)](#). Doers were able to identify the positives and negatives and the implications of practicing a behaviour.

- **There are no programmes in place, either inpatient or community-based, to manage at-risk infants under six months despite it being part of the basic health service package and included in part in the IMAM guidelines.** In 2017, SCI applied for approval from the government for operational research on the management of small and nutritionally at-risk infants under six months and their mothers (MAMI) which identifies and manages mothers and infants under six months who are at-risk of growth faltering. Unfortunately, that approval was never provided (interviews). Therefore activities for this vulnerable age group are limited to generic IYCF activities, which are not designed to identify and manage those most at-risk. Given the high rate of wasting in this age group in Myanmar, this is a gap in programming.
- **While the micronutrient programme is designed for children under five years of age, the government provides MNPs for children under two years of age leaving other actors to fill in the gap** (interviews). However, because of funding, there are gaps in MNP services.
- **While the home gardening programme enabled families to produce their own production especially for families with small land holding, there was little effect on dietary diversity.** In a survey conducted in October 2020, 55% of beneficiaries of home gardening programmes were found to have a borderline food consumption score [\(HARP-F, Oct 2020\)](#). While the home gardening has provided additional crops for household consumption, dietary diversity remains low amongst these households and yields from the home gardening are consumed quickly after harvesting. As a result, 65% of households of the home gardening project relied on the market to purchase additional food. Additionally, pest control was a key challenge limiting production [\(HARP-F, Oct 2020\)](#).
- **Cash and food distributions are provided in multiple programmes including the MCCT, HIV/TB programme, general food distribution, school feeding programme and the asset creation and cash distribution programme.** This support is provided by WFP and their partners.
- **The MCCT programme has had beneficial impacts on stunting, although adaptations to the programme are required to ensure the most at-risk groups are prioritised** [\(Heady et al., July 2020\)](#). The programme is currently rolled out nationwide and links conditional cash transfers to attendance at nutrition centres [\(GNC, Sept 2020\)](#). The MCCT programme has contributed to a reduction in the prevalence of stunting among children in beneficiary households from 30% to 26% over 3 years [\(Headey et al., July 2020\)](#).
- **Even though food distributions [based on a minimum food basket] only meet the basic caloric needs of a household of five, beneficiaries reported a range of benefits as they no longer need to purchase basic food items regularly eaten in the household.** There are many partners who provide food distribution with the standard Myanmar food basket. In a survey in October 2020 of households receiving the food distribution, the top five impacts were being able to eat more types of food (56%), spending less money on staple foods (51%), spending less money on medical expenses (47%), looking healthier and gaining weight (40%) and children eating more often than before (36%) [\(HARP-F, Oct 2020\)](#). Tracking food consumption scores from February to September 2020 across those who received the food distribution showed that consumption of organ meat increased between June to September 2020, but at the same time consumption of eggs, fish/ shellfish and meat fell. While food distributions have been helpful in maintaining overall food consumption scores, many households were not able to access their regular and preferred foods [\(HARP-F, Oct 2020\)](#).
- **There have been Initial steps taken to address nutrient inadequacy of the minimum food basket.** Nutrition modelling, using fill the nutrient gap methodology, for potential nutritious food options to be added to food baskets to cover a family's basic macronutrients and most micronutrient requirements has been completed [\(Nutrition sector, June 2020\)](#). The options are focused on food options and do not include WSB+/WSB++.
- **Assistance has largely shifted from a food to a cash modality between late 2019 and early 2020 in locations where markets are functioning.** Contrary to common perceptions on the cash modality, this is a feasible approach in Rakhine. Although not widely shared due to restrictions on assessments, research and feasibility assessments on the cash modality were conducted in Rakhine which showed cash was a feasible approach (interviews). Post distribution monitoring showed 60% was spent by women and 70-80% discussed the use of money within the

household. It has also been useful for people who move out of IDP camps as they gain improved financial literacy (interviews). In Rakhine, there are two cash modalities including rice + cash or cash alone. Factors that contributed to the shift included:

- Products from the food basket were not preferred by the beneficiaries: With the rising fuel prices, pulses, a less consumed food from the food basket, were sold to pay for fuel.
- Pipeline breaks required more flexibility than the food baskets could provide.
- Market linkages showed the markets were able to meet the demands of food products by beneficiaries directly without inflation.
- Inflation of rice in Rakhine: Rakhine produces high quality rice which is usually exported to other parts of Myanmar. The limited supply results in price increases. To ensure families are getting their staple, rice is distributed along with cash.

- **However, there are still challenges with the cash modality especially in Northern Rakhine.** There are reports of households spending cash on household needs instead of food, leaving families with not enough rice (interviews). Other complaints have been an inability to manage cash, mobility restrictions preventing access to markets and lack of storage space. While efforts by the Cash Working Group have been made to improve financial literacy, they were halted due to the COVID-19 pandemic. This cash modality is also challenging in the Rohingya population and in Rohingya IDP camps where beneficiaries need an ID card to open a bank account, as the Rohingya population cannot obtain one. Recent adaptations for cash distribution in Rakhine include mobile money, which means cash distributions are therefore restricted to non-Muslim communities (interviews).

Impact of COVID-19 and the Coup on Nutrition Programming

Table 6: Service disruption in child nutrition services in Myanmar up until August 2020 (% drop-in services compared to the same time period the previous year)

Child wasting treatment	Child wasting Screening	Protection promotion of breastfeeding	Diet promotion (6-23 months)	PLW nutrition counselling & weight monitoring	School feeding, take home rations	IFA supp. [adolescent girls]	Vit. A supp. [6-59 month]	Home fortification [MMN]	Food fortification [salt/oil/wheat]
10-24% drop	10-24% drop	10-24% drop	10-24% drop	10-24% drop	25-49% drop	50-74% drop	<10% drop	Increase/new	<10% drop

Source: [UNICEF Tracking the situation of children during COVID-19](#)

- According to UNICEF, as of late August 2020, there has been a reported drop in the coverage of nutrition-specific and nutrition-sensitive services ([UNICEF, Feb 2021](#)). See Table 7 for percent drop-in services up until late August 2020 compared to the same time period in the previous year. Screening for wasting cases, wasting treatment, protection and promotion of breastfeeding, optimal diet promotion for children 6-23 months, nutrition counselling for PLW and weight monitoring have dropped by 10-23% ([UNICEF, Feb 2021](#)). The school feeding programme was not implemented in 2020 due to COVID-19 restrictions (interviews).
- In 2020, technical adaptations of programmes to accommodate COVID-19 guidelines enabled nutrition services to continue but disruptions to services decreased access. As of June 2020, UNICEF and partners have been able to maintain essential nutrition services while adapting guidelines and increasing infection prevention and control measures in IDP camps ([UNICEF, June 2020](#)). OTPs in camps are functioning covering all IDP camps in Pauktaw and Sittwe Townships but OTPs in villages (Sittwe) have been closed since the end of August 2020 ([Nutrition sector, Jan 2020](#)). The sector reports that approximately half of the villages normally receiving support for severe wasting treatment have not accessed treatment (interviews).
- There has been dissemination of COVID-19 nutrition messages to promote continued breastfeeding through UNICEF and its partners ([UNICEF, June 2020](#)). However, this is limited to beneficiaries of existing programmes only. Interviews revealed that there is a lack of counselling expertise within the government health worker cadre which may impact the quality of counselling given through government health services. Given there is likely limited coverage of messaging on maintaining optimal nutrition practices during the COVID-19 pandemic, there is a risk of decreasing breastfeeding rates, replacement of breastfeeding with infant formula and unprevented donations of formula milk ([Nutrition sector, Jan 2020](#)). Mother to mother support groups have been halted since March 2020 in seven IDP camps in Sittwe and Pauktaw limiting outreach and IYCF education (interviews). While the capacity to conduct home visits varies, when possible nutrition staff in IDP camps have been focusing on screening and admissions but have limited

time to conduct nutrition counselling fully during home visits (interviews). In response to movement restrictions and COVID-19, partners set up IYCF counselling hotlines in respective implementing areas [\[NIE SAG, Sep 2020\]](#).

- **In response to the increased risk of milk product donations in the context of the COVID-19 pandemic, the SUN Government, UN, CSA and Donor and Business's Network issued a joint statement on appropriate IYCF and caution about unnecessary use of milk products in the COVID-19 pandemic.** The COVID-19 pandemic has drawn attention to the risk of BMS donations and COVID-19 related guidance have included the management of milk products. Any BMS donations or distributions should be redirected to the designated coordinating body which is led by the NNC and MoHS [\[SUN, UN, CSA, Donor and Business's Network, April 2020\]](#).
- **In recognition of the indirect socio-economic impacts of COVID-19 restrictions and multiple pathways to undernutrition, the NIE TWG developed and published guidance on nutrition-sensitive programming in the context of COVID-19 in September 2020.** The aim is to leverage existing nutrition-sensitive programmes to ensure they respond to nutrition. The guidance covers nutrition-sensitive agriculture and food systems, school meal programmes, nutrition-sensitive social protection programming, nutrition-sensitive WASH, relevant programming priorities and nutrition-sensitive programme indicators. It provides prioritisation of target groups recognised as the most vulnerable [\[NIE SAG, Sep 2020\]](#).
- **While the MCCT programme was adapted in September 2020 to provide one-off cash transfers to address COVID-19 related challenges, in a phone survey in Yangon and the rural dry zone low uptake was reported.** Only 16% of pregnant mothers received payments [\[Headey et al., Nov 2020\]](#). This was even lower in rural communities where only 8% and 10% received MCCT in September and October 2020. The reason for this was not investigated.

Analysis of Programming

- **There is huge potential value in improved coordination and collaboration on nutrition programming between HARP-F, LIFT and Access to Health.** Given the shift to an emergency response approach given the recent political instability, a united front by these three funding platforms providing financial support and technical expertise could promote an efficient, timely response to ensure adequate coverage of lifesaving nutrition services. A joint service and partner mapping to identify gaps and eliminate duplication of effort would be useful, as well as agreement on how to prioritise available funding [regarding what services are funded and in what geographical locations]. Coordination on capacity-building of partners as well as representation in national fora would be beneficial. Improved collaboration could really lead the way in emergency response coordination and support the NIE TWG to facilitate an adequate emergency response.
- **Being unable to conduct nutrition assessments will have an impact on the ability of the nutrition sector to understand the true nutrition context in Rakhine.** This will affect the ability to make informed decisions on programming and prioritisation of resources as efforts are escalated moving forward.
- **There are no programmes that aim to jointly address both wasting and stunting.** There are common drivers of both these forms of malnutrition and it is largely agreed that addressing the causes of wasting will in turn support a reduction in the prevalence of stunting. Given the protracted emergency context in Rakhine, and the recent political instability which is likely to lead to spikes in increased needs, both wasting and stunting should be tackled through a common framework. Development and emergency actors should come together to develop a joined-up approach to tackle both forms of undernutrition and ensure the approach is relevant for the context.
- **Reduced nutrition service provision due to the COVID-19 pandemic, the coup and other factors may increase the burden of wasting and stunting in Myanmar.** The impact of reduced service hours, untreated cases, limited referrals of children with medical complications and the lack of mother-to-mother support groups will likely have a consequential effect on wasting and stunting. Interruptions to routine nutrition and health services have already been seen as a result of the COVID-19 pandemic and further disruption will increase the risk of malnutrition, morbidities and mortality. Regardless of the political situation, there is a need to restart and ensure continuation of nutrition services, particularly those that are lifesaving, in all areas where programming has been disrupted. Challenges with health staffing have disrupted provision of care and referrals to nutrition and health services, which means there is a risk that resuming and increasing service provision will likely be further delayed.

- **Reduced screening for wasting, reduced functioning of referral mechanisms and passive wasting case detection means a large proportion of children in need of wasting treatment are left untreated, increasing their risk of mortality and morbidities, later life stunting and income earning potential.** In addition to reduced community outreach, opportunities for case finding through other programmes such as mother-to-mother support groups have been disrupted. Also opportunities to implement wasting screening in nutrition-sensitive programmes has not been explored. As a result, wasting treatment coverage remains low and many children are consequently currently left untreated.
- **The lack of cohesion between the treatment of severe and moderate wasting may increase the risk of children missing lifesaving treatment.** Treatment of severe and moderate wasting are implemented by different partners. As a result, treatment of severe wasting and moderate wasting services are sometimes provided on different days. When a child is screened for wasting and is referred for treatment which is not available on that day, children may not return the following day to access the service since they may have travelled a long distance. A common approach to treating severe and moderate wasting, and referring between services, is needed, irrespective of who implements the service.
- **There is a need to strengthen referral links to and quality of inpatient therapeutic programmes to effectively treat complicated wasting cases.** Interviews suggest one challenge in IMAM implementation in Rakhine is due to a lack of functioning inpatient therapeutic programmes as currently the government provides this service so quality is a concern, access for many is constrained and coverage of the service is low. As a result, communities' resort to informal treatment like traditional healers.
- **Ensuring adequate and sustainable supplies is essential for continuation and scale-up of IMAM in priority areas.** There were concerns highlighted amongst partners in the nutrition sector that a barrier to scale-up in 2021 is management and coordination of the supply chain [\[NIE SAG, Sep 2020\]](#). Often nutrition supplies are provided by an agency as a gift-in-kind. However insufficient planning often leaves a gap in stock or a late request to fill a supply gap by the implementing agency to the agency who manages the supplies, which cannot always be accommodated leading to stock outs. There is also a disconnect between humanitarian and development programming and supply provision which exacerbates this issue [interviews].
- **Addressing discrimination of Muslim households and those who do not speak fluent Burmese is vital to improving coverage and ensuring access to lifesaving nutrition services for this vulnerable population.** Households who do not speak fluent Burmese continue to face health care discrimination. Addressing social and ethnic discrimination for those who are not fluent in Burmese is essential, as language barriers are linked to perceptions of discrimination.
- **Mobile health clinics provide an opportunity for integration of nutrition services.** The nutrition sector will need to ensure mobile health workers have capacity to provide nutrition screening and treatment for this modality to be effective.
- **Mother MUAC is a feasible approach¹⁸ to improve active case finding given current operational challenges and political uncertainty.** Despite challenges with the COVID-19 pandemic, the effectiveness study of the ACF mother MUAC programme found the programme was not only feasible in Myanmar with very simple training and distribution of MUAC tapes, MUAC measurements by mothers were accurate. This builds on globally available evidence and explains why UNICEF are prioritising the roll out of mother MUAC globally. Further research on sustainability and effectiveness at scale in Myanmar however is required.
- **ACF's long-standing presence in Myanmar allowed them to implement research on mother MUAC despite other programmes not being given TA to allow programming.** The mother MUAC programme is an example of innovative informal research in Myanmar and the good relationship ACF has with the government to obtain approvals. Considering the limited number of basic health staff and overstretched capacity, conflicts and hard to reach areas, coverage of IMAM is a challenge. Although a full effectiveness study on increased screening and treatment coverage and change in mothers' knowledge, attitudes and practices was not completed due to the shortened duration of the

¹⁸ It was well received in the community by both male and female caretakers. Timing of trainings was adapted to the working time of farms to allow men to attend the training sessions.

project, mother MUAC programming should be expanded due to its success. Continued research and lessons learned can be recorded alongside the expansion.

- **The difficulty with implementing ACF's programme highlights the systemic barriers to programme implementation and innovation that all partners can learn from moving forward:**
 - **Lack of advocacy and engagement with key governing bodies and decision-makers at the start of the pilot.** The NNC were not involved in the designing of the pilot project, so were not supportive of ACF's efforts (interviews). Introducing innovative approaches or new programmes requires proper briefing and engagement with the appropriate decision-making body at the design stage of a project.
 - **Slow recruitment process.** There are challenges with obtaining approvals for personnel, particularly international personnel, in Rakhine state. In addition national staff often do not want to relocate to Rakhine for employment as it is a periodically insecure context. These reasons, plus also a need to adhere to internal NGO recruitment processes, meant that recruitment of key personnel for the project was delayed, which led to delays in initiating the project and starting activities.
 - **Difficult operating environment requiring multiple government approvals resulted in delayed implementation.** The struggle with obtaining approvals is not unique to ACF. Difficulty obtaining TA meant field staff were not able to access the population and permission to implement the simplified protocol was denied. Added restrictions of the COVID-19 pandemic, beyond the control of ACF, further delayed progress.
 - **The geographic coverage of the programme was too large for a pilot.** The pilot programme focused on a large area covering 70 townships. A crucial part of developing a successful large-scale intervention is conducting a pilot in a smaller area to evaluate feasibility, cost, adverse events and improve upon the study design, even if a larger geographic coverage through scaling up is the end goal.
 - **Inefficiencies with managing multiple funds without a common approach also delayed implementation.** The programme was funded by HARP-F, LIFT and Access to Health. The coordination structure of the programme funders, including lines of communication between the three funders, was not always clear. This made reporting and information sharing time-consuming and difficult.
 - **Nutrition expertise within HARP-F was lacking, which challenged the provision of sufficient leadership.** While Access to Health and LIFT had internal nutrition expertise and could discuss technical issues in the project, HARP-F did not have the same level of expertise which made equal communication more challenging.
- **The current response to maintaining nutrition services during the COVID-19 pandemic is likely insufficient in maintaining breastfeeding.** Nutrition and COVID-19 awareness is currently limited to beneficiaries involved in projects and face to face interactions (interviews). Breastfeeding rates are already poor in Rakhine. In the context of COVID-19, mothers may delay or discontinue breastfeeding due to misinformation around COVID-19 infection transmission and reduced support from breastfeeding counsellors. This runs the risk of causing growth failure in breastfeeding infants, which can lead to wasting.
- **There is no standardised approach and or guidance adapted for IYCF programming in Rakhine, so mother to mother support groups and other IYCF services likely vary across implementing partners (interviews).** Because of this, there are likely gaps in IYCF messaging and a lack of consistency in key messages across nutrition partners.
- **There is a gap in identifying and managing at-risk infants under six months and their mothers.** Where growth faltering is not identified early, the child is predisposed to malnutrition for the rest of their life. As well as screening for wasting in children 6-59 months, MUAC screening for infants under six months should be considered alongside questions on breastfeeding. Once an at-risk infant is identified, there should be provision of more in-depth follow up of the infant through existing IYCF programmes, ideally following the MAMI care pathway or the community management of nutritionally at-risk Infants under six months and their mothers [C-MAMI] Tool¹⁹.

¹⁹ <https://www.enonline.net/c-mami>

- **Despite the Government of Myanmar adopting the "Order of Marketing of Formula Food for Infants and Young Children", continued violations undermine optimal breastfeeding practices.** With the recent political instability, there may be a need to identify non-governmental leadership to lead this accountability mechanism. Given the risks to infant growth as a result, there is a need for accountability mechanisms to be established to more accurately monitor this mechanism to identify and prevent future violations.
- **The nutrition-sensitive guidance in the context of COVID-19 in Myanmar creates a foundation to strengthen and expand on nutrition-sensitive programming and should be continually updated and adapted to the current context regardless of COVID-19.** The COVID-19 response plan has also leveraged existing programmes to provide in-kind food transfers to vulnerable households and at risk populations, emergency rations through community-based food banks and associations, top-up benefits for MCCTs and social pension beneficiaries, and cash transfers to the most vulnerable affected households ([Headey et al., Sep 2020](#)). In addition there are other nutrition-sensitive programmes, such as those run by CSI on home gardening, and WASH programmes run by Oxfam, which could be used as a platform for integrating nutrition services.
- **Given the current volatility in the market systems and in the value of currency in Myanmar, the amount of cash provided through cash distributions needs to be continually assessed.** With food monitoring prices showing rising food and fuel prices and potential decreased funding, the cash distribution may be falling short of providing adequate support for the poorest and most vulnerable in Rakhine ([WFP, Mar 2021](#)). The increasing price of rice and other basic staples mean households are not able to purchase as much as they used to. There needs to be an ongoing adjustment to the amount of cash provided. Another limitation is the exchange rate which varies substantially, particularly now when there is political insecurity in Myanmar.
- **There should be continued efforts to incorporate more nutritious foods in the minimum food basket.** This will help mitigate the impacts of increased food insecurity, which is a likely scenario and one already being reported by some actors as a result of the recent political instability.
- **Nutrition service provision continues to be under threat and there is further risk of service disruption due to political unrest.** While there is uncertainty whether humanitarian access will be reduced, there is a need to plan for remote monitoring. IRC's strategy of direct implementation by national partners can be used to increase collaboration with national organizations, given the successful implementation of a nutrition programme in Rakhine led by national NGOs.

RECOMMENDATIONS

R1. Invest in coordination to facilitate an adequate nutrition emergency response considering the changing operating environment, building on existing development frameworks e.g. MS-NPAN.

This is critically needed to ensure good coverage of lifesaving services in needed locations, to avoid duplication, to identify and fill gaps, to support capacity-building of partners and to support troubleshooting conversations to address bottlenecks. There is a lack of momentum around emergency nutrition coordination in Myanmar, which means nutrition is not always prioritised or remembered in important funding discussions and decisions. As a result, stakeholders assume nutrition is not a problem in Myanmar.

Recommendation	Suggested next steps and considerations
Immediate priorities	
Ensure the approach taken by the nutrition sector in Myanmar builds on existing long-term development plans and frameworks, to ensure an adequate emergency response centred on critical lifesaving nutrition services where needed	<ul style="list-style-type: none"> ● The arrival of an interim NCC seconded from the GNC is an opportune moment to strengthen the NIE TWG coordination, which has previously been development focused. This role will need to build on existing development-focused platforms, for example the SUN Network, to avoid creating parallel systems and structures. ● It is important to build on groundwork already completed under MS-NPAN when prioritising emergency response activities, which contain many relevant development-focused state-specific prioritised nutrition interventions, M&E plans and indicators, capacity assessments and funding plans. ● Ensure nutrition partners dedicate staff with emergency experience to support the ERP process. ● Ensure support is provided for a smooth transition from a development focus to a humanitarian focus, as elements like terminology are different.
With the support of the GNC, develop a comprehensive multi-sectoral emergency response plan (ERP) for nutrition which includes specific priority activities and geographic areas for nutrition	<ul style="list-style-type: none"> ● Leverage the MS-NPAN and build on the CRP and HRP when developing the ERP. ● Ensure adequate support to the emergency response programme plan development process led by the GNC. ● In addition to the standard content according to the ERP guidelines, the ERP should also include: <ul style="list-style-type: none"> ○ Scenarios for increases in malnutrition and future movement restrictions as illustrated in the operational environment. ○ Criteria to prioritise geographic locations and lifesaving nutrition services. ● Determine the frequency the ERP should be updated, for example annually, biannually.
Ensure that all nutrition actors (INGOs, NGOs, UN agencies and national organisations) consult the central nutrition coordination body prior to designing and implementing activities in order to coordinate and prioritise geographic areas and programmes for nutrition support	<ul style="list-style-type: none"> ● The central coordination body was the NCC headed by MoHS. This may need to change given recent political unrest. ● In the meantime, partners in the nutrition sector should coordinate through another coordination mechanism such as the SUN Network or the NIE TWG (ideally both will be working together) to ensure a comprehensive nutrition response. ● Conduct a stakeholder mapping of humanitarian and development actors (including INGOs, UN agencies, national organisations, CSOs, CBOs) to ensure all stakeholders know who is working where/ when and doing what, and what gaps exist, given circumstances have recently changed in Myanmar and some partners do not have the same capacity.
UNICEF, as the cluster lead agency for nutrition, should continue to ensure nutrition coordination is prioritised in Myanmar and identify a dedicated sector leadership position for Rakhine	<ul style="list-style-type: none"> ● UNICEF to ensure recruitment of the permanent national Nutrition Sector Coordinator is prioritised and completed in a timely manner. ● UNICEF to publish the TOR as soon as possible to ensure LIFT can fund an NGO to take on the role of the Rakhine Nutrition Sector Coordinator. ● Encourage SC/ACF, as key nutrition actors in Rakhine, to apply for the Rakhine Nutrition Sector Coordinator role.
Ensure nutrition is prioritised in Myanmar and Rakhine state (and other priority states and regions)	<ul style="list-style-type: none"> ● Establish and build capacity of dedicated nutrition focal points at state and regional levels through ensuring nutrition sector leadership positions and SUN secretariat roles are in place. ● The nutrition sector lead should ensure nutrition is part of all multi-sectoral response planning, discussions and funding. ● Amend the Humanitarian Response Recommendations: Military Coup Myanmar

	<p>response plan (confidential) and HARP-F situational reports to include nutrition.</p> <ul style="list-style-type: none"> ● When advocating for nutrition, ensure there is a common framework for stunting and wasting, highlighting the fact they share common drivers and risk factors.
Longer-term future recommendations	
Once the approach to working with authorities in Myanmar is agreed, finalise the costed nutrition plans for Rakhine based on the MS-NPAN when work on MS-NPAN is reinstated	<ul style="list-style-type: none"> ● Finalise the MS-NPAN work plan for Rakhine ensuring: 1) women, adolescent girls and children are targeted; 2) it addresses specific needs for the Rohingya population; and 3) multi-sectoral convergences and opportunities are identified. ● The costed plan should enable sufficient funding for nutrition advocacy. ● Nutrition plans to include targets and milestones for building national capacity, given access in Rakhine is so challenging and national partners are best suited to lead on service delivery as a result. ● The nutrition plans should build on experiences from implementation of the ERP and include various scenarios and preparedness planning. ● Recommendations by MQSUN+ should be considered when developing the MS-NPAN work plan for Rakhine.
Nutrition sector to hold a list of all training to provide better oversight and efficient coordination	<ul style="list-style-type: none"> ● Nutrition sector to hold a list of all training being conducted to avoid duplication and to improve resource efficiency. ● Ensure a collaborative approach where agencies can join training provided by different agencies where feasible.
Create a safe space for partners to discuss bottlenecks regularly and set up secure communication systems/ internet platforms in view of political sensitivities	<ul style="list-style-type: none"> ● Establish a separate bottleneck discussion regularly where the government does not attend, to encourage open discussion between partners. ● With increased authoritative scrutiny for not only INGOS but also national NGOs, there is a greater need for safe communication platforms and information sharing to enable effective coordination, regardless of what scenarios result. Set up secure communication systems and internet platforms, such as VPN, where possible.

R2. Ensure funding is increased and coordinated optimally, to allow for flexibility given the changing operational environment.

Recommendation	Suggested next steps and considerations
Immediate priorities	
Improve collaboration between FCDO-funded mechanisms which can be better utilised together to optimally address malnutrition (HARP-F, LIFT, Access to Health)	<ul style="list-style-type: none"> ● HARP-F brings humanitarian experience, Access to Health brings nutrition-specific expertise and LIFT brings nutrition-sensitive expertise. The three should come together with their relevant expertise and skillsets to identify how to build on the MS-NPAN framework and work plans, to allow implementation of emergency lifesaving nutrition activities as required. ● Update scope of work and objectives for ways of working together. ● Discuss how to jointly prioritise geographic scope of service provision: agree on whether to focus on two states (for example Rakhine and Kachin), the prioritised areas of the HRP or to focus nationally. ● Conduct joint nutrition partner mapping and discuss how to support and build capacity of partners. Assess where nutrition sector leadership and SUN secretariat roles are in place at the state and regional levels and if necessary, support recruitment and capacity-building of these roles. ● Conduct nutrition service gap analysis and determine how to support gaps in nutrition service provision, particularly for emergency lifesaving activities, including how to support the nutrition supply chain. ● Consider a 3-funder model (HARP-F/LIFT/Access to Health) without undermining overall leadership: <ul style="list-style-type: none"> ○ Appoint a nutrition focal point in each organisation to streamline communication as HARP-F, LIFT and Access to Health jointly fund programmes. ○ Determine the best model to manage this including (1) level of involvement in programming (2) joint programming or not (3) joint strategy thinking vs joint funding of programmes. ● Fund HARP-F to ensure there is nutrition technical expertise to provide continuous

	<p>follow-up to the 3-funder model and on multi-year grants which include a nutrition focus, as this strategy has been critical in the success of programming in other sectors such as WASH and cash.</p>
<p>Donors to provide increased and flexible funding to allow for adaptability given the changing operational environment</p>	<ul style="list-style-type: none"> ● Design of programming in Myanmar has been focused on working with the government to develop systems within the country. However, given the coup, donors should allow for flexibility to re-programme to address changing needs. ● Increased funding is needed to meet the increased needs as a result of the current changes in context. The funding should be flexible to reflect changing priority geographic locations, programming, modalities, surveillance and monitoring.
<p>Identify solutions to the cash flow and liquidity challenges and plan for disruptions to bank services, to prevent disruptions to nutrition and nutrition-related services</p>	<ul style="list-style-type: none"> ● Work with the Cash Working Group to assess and identify solutions to cash flow disruptions. ● Nutrition sector to collaborate with the Cash Working Group on joint advocacy to promote movement of money to ensure minimal disruption to nutrition programming. ● Support the nutrition sector to develop a cash flow plan to increase financial flexibility and increase cash available at the subnational level. Likely that M-Pitesan and Wave Money will be best options although they have transfer fees and limits on transfer amounts. ● Donors to allow flexibility and anticipate the potential for increased transfer fees.
<p>Longer-term future recommendations</p>	
<p>Advocate for investments in nutrition in existing multi-sectoral funding mechanisms</p>	<ul style="list-style-type: none"> ● An opportunity is to better utilise the multi-sectoral Myanmar Humanitarian Fund (MHF) for nutrition. To obtain funding for MHF, the nutrition lead needs to be proactive in obtaining funds for nutrition by clearly highlighting the needs.
<p>Provide for multi-year funding with flexibility to encourage a longer-term approach</p>	<ul style="list-style-type: none"> ● Nutrition partners have flagged the usefulness of flexible multi-year funding to allow longer-term planning. Despite the current need to shift focus to emergency response activities, all programming currently builds off a long-term development approach. Assuming this will prevail, even if there is an immediate emergency focus, ensure access to multi-year funding as this is essential to allow longer-term plans to come to fruition.
<p>Ensure funding for the nutrition sector is coordinated</p>	<ul style="list-style-type: none"> ● Ideally, donors and partners should consult the central coordination body prior to contracting to guide funding of priority interventions and geographic locations. ● Use the costed MS-NPAN plan to guide funding of priority interventions.

R3. Increase the capacity of national organisations to lead the nutrition response.

This is particularly important in the context where, potentially, INGOs may lose humanitarian access.

Recommendation	Suggested next steps and considerations
<p>Immediate priorities</p>	
<p>Conduct a partner mapping and capacity assessment to identify which national partners (NGOs, CBOs, CSOs) can immediately scale-up their nutrition response and which national partners can redirect attention to lifesaving activities</p>	<ul style="list-style-type: none"> ● Conduct a capacity assessment of all national partners to identify needs, opportunities and gaps. Of particular interest are CSI and MHAA. This should include all partners who manage maternal and child health and nutrition services and may also include partners who currently do not provide nutrition services. Results should be widely shared with agencies. ● Entry level activities include conducting MUAC screening and community outreach. For organisations who have a higher capacity such as CSI, increase capacity to enable them to implement services to treat wasting (OTP/TSFP). ● IRC to provide a list of national organisations they are currently working with to contribute to national stakeholder mapping.
<p>Develop a capacity-building strategy and establish a mechanism for high-capacity nutrition partners to provide mentorship to national organisations</p>	<ul style="list-style-type: none"> ● Examine the enablers and barriers partners have faced to build national organisational capacity. ● Potentially utilise partners who have experience with capacity-building of national organisations to lead on establishing this mechanism.

	<ul style="list-style-type: none"> ● The mechanism should explore ways to include: <ul style="list-style-type: none"> ○ Training on leadership and soft skills. ○ Opportunities for national organisations to join leadership positions.
Consider a central funding mechanism to channel funding through a high-capacity nutrition partner who then subgrants to lower capacity nutrition partners and provides nutrition technical support	<ul style="list-style-type: none"> ● Consider a mechanism where funding is channelled through a high-capacity nutrition partner and sub-granted to lower capacity (perhaps national) partners. This will overcome access issues some partners face and may help facilitate adequate capacity-building. ● Ensure the high-capacity partners provide adequate nutrition technical support and capacity-building to ensure the quality of the nutrition services provided.
Longer-term future recommendations	
Fund and support UNICEF to lead on nutrition capacity-building , particularly of lower capacity national partners	<ul style="list-style-type: none"> ● With the shift towards national organisations and civil societies leading direct implementation, there is a need to increase capacity building activities. With UNICEF having the global mandate to ensure nutrition partners have the capacity to implement services, UNICEF should be supported, including financially, to lead on capacity-building. ● The FCDO-funded mechanism should set aside direct funding for UNICEF to enable adequate resources to oversee capacity-building in the nutrition sector and provide technical expertise without needing to compete for funding with implementing partners.
Advocate for community members to be part of discussions on service provision [with protection for IDPs]	<ul style="list-style-type: none"> ● Build on the established community-based mechanisms in different sectors (for example WASH) to advocate for community members to be part of discussions and decision-making around the services they are being provided with, to encourage ownership and buy-in and to ensure their needs are being met.
Once the approach to working with authorities in Myanmar is agreed, use the development of MS-NPAN Rakhine work plan to include capacity-building with milestones and targets	<ul style="list-style-type: none"> ● Include milestones and targets for national capacity building within the Rakhine nutrition plan. ● These should be integrated across programming and coordination activities.

R4. Improve collection, analysis and use of data for decision-making, to enable a greater understanding of the evolving nutrition situation and trends and to inform the nutrition emergency response.

Recommendation	Suggested next steps and considerations
Immediate priorities	
Conduct an information needs assessment of available data and gaps to improve data availability	<ul style="list-style-type: none"> ● The nutrition sector should identify information needs and how gaps can be filled. Identify available sources of information, entity responsible, frequency of assessment and resources required. ● Consider using the CRP Rakhine Needs Assessment template which was developed to standardise the approach for data collection, compilation and analysis in both the central and northern Rakhine, to ensure the assessment covers both camp and non-camp settings. ● For data gaps, identify the reasons, bottlenecks and barriers, and how these gaps can be filled. ● Where data is not accessible, consult experts on possible modelling techniques and assess alternative methods using modelling/estimates in comparable contexts. ● The data needs assessment and gap analysis can be used by donors to fund the identified gaps.
Establish a nutrition surveillance system to ensure trends are monitored as the situation evolves, to facilitate decision-making on appropriate lifesaving activities	<ul style="list-style-type: none"> ● From the results of the information capacity assessment, identify the most appropriate nutrition data collection mechanism to collect critical nutrition data so monitoring can be conducted on an ongoing basis. ● Use data analysis to understand the evolution of trends to inform the nutrition emergency response. The data can then be used to inform what nutrition activities are needed as a priority as the focus shifts to provision of lifesaving activities.

	<ul style="list-style-type: none"> ● Given restrictions on assessments, identify how information can be collected on the nutrition situation, even if informally.
Use available MUAC screening data from all partners and all relevant services (including non-nutrition-specific) to continually analyse the nutrition situation	<ul style="list-style-type: none"> ● Compile, analyse and report MUAC screening data to obtain an analysis of the current nutrition situation. This may only be available in camps but may provide an indication of the current situation in the absence of population representative data.
Fund information management capacity to increase ability to coordinate and conduct emergency assessments and data monitoring	<ul style="list-style-type: none"> ● Recruit a dedicated Information Management Officer (IMO) to focus on addressing major gaps in the current nutrition surveillance system and early warning systems. The GNC and the interim/ new Nutrition Sector Coordinator can help support this. ● Train all nutrition sector organisations on nutrition information management.
Longer-term future recommendations	
Agree on alternative monitoring and assessment methods including remote monitoring in view of increasing access difficulties	<ul style="list-style-type: none"> ● Explore the possibility of remote and phone surveys, photos, videos and mobile supervision checklists. Determine the risk and benefits of face-to-face versus remote data collection methods. ● In inaccessible areas, obtain sample nutrition data from arrivals at camps. While this may not be representative data, it provides insight into the nutrition situation. In North East Nigeria, the nutrition sector analysis of MUAC screening data from children arriving at camps from inaccessible areas/ neighbouring locations helped build on the contextual information available.
Ensure all partners have timely access to assessments, surveys and reports, where it is feasible to share.	<ul style="list-style-type: none"> ● Update the MIMU website to house all recent survey assessments and reports. Ensure coordination of resources between the SUN Network and the NIE TWG. Explore the use of logins with passwords to protect information housed on the website, which would facilitate restricted access. ● Ensure an information management officer updates the MIMU website on a regular basis. Determine the frequency it is updated. ● Ensure the 4Ws, contact list, dashboards and maps are updated quarterly and uploaded onto the agreed shared platform and shared with all partners.
Mainstream gender within data to enable targeted and appropriate interventions	<ul style="list-style-type: none"> ● Where possible, data should be sex- and age-aggregated for nutrition-specific indicators and relevant nutrition-sensitive indicators.
Develop a roadmap for nutrition data including the development of visualisations	<ul style="list-style-type: none"> ● Developing automated data visualisations and housing data on a cloud platform requires investments and time. Use the data needs assessment to develop a roadmap for nutrition data to improve collection, analysis, presentation and use of nutrition data. ● The roadmap should include the development of visualisations including automated dashboards and interactive maps, reporting tools, information sharing in MIMU, use of 4W and contact lists. Ideally, the map can be easily updated to monitor gaps in geographic locations. ● Explore the use of Tableau and other data visualisation tools (although these may require additional funding). Where possible use automated dashboards. Consult TRRT and or GNC Technical Alliance for available dashboards. ● Develop indicators, milestones and targets for data tool development and incorporate them into nutrition plans to ensure data development is a priority. ● The roadmap should be used to guide donors on funding for data developments and gaps.

R5. Protect the collapse of basic maternal and child health and nutrition services and scale-up lifesaving nutrition services in priority locations in anticipation of increased nutrition needs.

Recommendation	Suggested next steps and considerations
Immediate priorities	

<p>Ensure nutrition is funded and mainstreamed in multi-sectoral response plans and in non-nutrition programming to increase access to nutrition services, especially for vulnerable groups</p>	<ul style="list-style-type: none"> ● Increase resource mobilisation efforts for nutrition to allow the scale-up of essential lifesaving nutrition services through nutrition-specific and nutrition-sensitive programmes. ● Explore entry points for nutrition activities, such as screening for wasting, in existing programmes in all sectors where approval for the programme has already been given. Engage with NGOs, CSOs and INGOs to explore opportunities to mainstream nutrition activities. Opportunities include: <ul style="list-style-type: none"> ○ NGOs <i>with a multisectoral portfolio</i> including nutrition who can mainstream nutrition within their own programming, for example establishing breastfeeding support in protection programmes. ○ NGOs <i>not currently implementing nutrition</i> who support multi-sectoral programmes whose capacity can be built to mainstream less complex nutrition activities, for example wasting screening at food distribution points and referral to nearby wasting treatment services. ○ <i>Specific sectors</i> can mainstream nutrition and conversely nutrition activities can mainstream that sector also, for example WASH and nutrition.
<p>Ensure scale-up of lifesaving nutrition services is aligned with the new Emergency Response Programme [ERP] (priority locations, services and scenario planning) and builds on the MS-NPAN framework already in place</p>	<ul style="list-style-type: none"> ● Scale-up should focus on the priority activities and locations identified in the emergency response plan (ERP) which should build on those identified in the MS-NPAN. ● Given funding constraints, prioritise severe wasting treatment, IYCF activities and support for maternal nutrition, and ensure sufficient geographic coverage of services in priority locations. ● Scenario planning should include the changing operational environments outlined in the 'Operating Environment' section of the report. ● Ensure scale up of services is matched with funds for increasing supplies. ● Support the realignment of current nutrition activities and strategies to incorporate and prioritise lifesaving nutrition activities.
<p>Plan for delivery mechanisms in the absence of a functioning government</p>	<ul style="list-style-type: none"> ● In view of the current political situation, there is now a greater need for UN agencies, NGOs and civil societies to play a larger role in both coordination and direct implementation to offset reduced government leadership and engagement. ● Prioritise the reprogramming of funding that was earmarked for government support which can no longer be implemented e.g. NGO support to build capacity of government to lead on MS-NPAN implementation. ● Monitor where access to health and nutrition services are reduced to ensure the most vulnerable have access. Develop a plan for how these gaps will be filled and by who. ● Respond to health workers joining the CDM and leaving gaps in services, for example plan for NGOs to fill in gaps.
<p>Plan for potential interruptions in the supply chain to prevent gaps in nutrition service provision</p>	<ul style="list-style-type: none"> ● Given mobility challenges and access constraints, ensure there are adequate supplies in locations where they can be more easily transported. Preposition larger quantities of key supplies in IDP camps and villages. ● The sector will need to work with the logistics sector to regain transportation access when lost.
<p>Address the fear and administrative barriers limiting access to health centres</p>	<ul style="list-style-type: none"> ● Ensure basic essential services are available in townships and increase the number of health centres in high population catchment areas. ● If needed, advocate for the continued freedom of movement for the community and for health workers. ● Address how to communicate with beneficiary populations on disruptions of activities to maintain trust within the community and ensure continued access/ compliance. ● Communication, education and information materials should be accessible to all. Ensure information is available in multiple languages. Use multiple modes of communication keeping in mind literacy rates, language barriers and gender gaps.
<p>Longer-term future recommendations</p>	
<p>Contingency plans should be made that include a fully remote response based from outside Myanmar</p>	<ul style="list-style-type: none"> ● Provide funding for and increase the capacity of national organisations including NGOs, CBOs and CSOs.

	<ul style="list-style-type: none"> ● In areas where humanitarian access is limited, explore the use of mobile teams for nutrition services to bring treatment services closer to the community. ● Develop and promote the use of virtual learning to build capacity. Such efforts could build on existing initiatives, such as the hotlines for counselling on maternal, newborn, and child health and on infant and young child feeding.
Ensure preparedness planning includes maternal and child health services to ensure continuation of services	<ul style="list-style-type: none"> ● In Cox's Bazar, the nutrition sector had an emergency preparedness document in place that only required updating to the COVID-19 context and this enabled the continuation of nutrition programming despite COVID-19 restrictions. Ensuring Myanmar has a similar document is essential, given the increased likelihood of continued disruption politically and otherwise moving forward. ● As well as priority nutrition services such as wasting treatment, IYCF activities and maternal nutrition, ensure preparedness planning includes maternal and child health services such as vitamin A supplementation and antenatal/ postnatal care, which are also critical services in the first 1000 days.
Further expand nutrition service coverage by funding gaps identified in the ERP building on the MS-NPAN framework already in place	<ul style="list-style-type: none"> ● Continually assess the priority geographic locations and nutrition services given the evolving context. Continue to scale-up nutrition services beyond the lifesaving and ongoing activities already implemented in priority geographic locations.
Address discrimination and ethnic/ gender barriers to accessing nutrition services, especially in stabilisation centres	<ul style="list-style-type: none"> ● Work with the protection sector to identify solutions to alleviate identified barriers to accessing health and nutrition services. ● Conduct informal interviews and assessments with those affected with a focus on identifying specific solutions. ● Fund potential solutions, which may include: <ul style="list-style-type: none"> ○ Hiring staff from the community to address language barriers. ○ Incorporating training on how to address discrimination. ○ Hire female Rohingya translators in health centres including at the main referral hospitals. ○ Ensure there is adequate waiting space where beneficiaries feel safe. ○ Train Muslim health workers in the camps and support a two-hour health centre in IDP camps.
Ensure nutrition coordination and implementation uses a common framework to bridge the divide between stunting and wasting and humanitarian and development programming.	<ul style="list-style-type: none"> ● Ensure all humanitarian programming builds off the MS-NPAN framework and work plans, given the solid foundation to nutrition programming this provides. ● Continually assess nutrition coordination and implementation to ensure that parallel systems for development and humanitarian are not being established or reinforced. ● Support partners to implement a shift to a more humanitarian approach in IDP camp settings, where development approaches are not realistic or feasible given the restrictions in place including on movement.

R6. Increase coverage of wasting treatment services, including screening and referral, with a focus on severe wasting treatment of children 6-59 months and management of small & nutritionally at-risk infants under six months & their mothers (MAMI).

Recommendation	Suggested next steps and considerations
Immediate priorities	
Intensify active nutrition screening using MUAC and home visits to increase referrals of cases of severe wasting (including with medical complications) and moderate wasting	<ul style="list-style-type: none"> ● Support national partners to screen for wasting using MUAC as national organisations have better access to communities that INGOs may not have access to. This can be done by programme staff or by caregivers in the presence of programme staff (mother MUAC), in view of COVID-19 related infection protection and control measures. ● Expand coverage to new IDP camps which currently do not have active screening. ● Fund existing nutrition partners to increase the coverage of screening around nutrition

	<p>services.</p> <ul style="list-style-type: none"> ● HARP-F to consider funding MHAA, a national NGO, who has existing screening and treatment of wasting programming, to expand their nutrition coverage. ● Identify opportunities for MUAC screening by partners implementing nutrition-sensitive services (protection, food security, health and WASH sectors). Specific opportunities to consider include: <ul style="list-style-type: none"> ○ Oxfam, who has the largest camp coverage and scope with WASH activities, to add MUAC screening to their programming e.g. while conducting hygiene kit distributions. ○ CSI to screen using MUAC tapes at their food and cash distribution points/ hygiene kit distribution point/ other community interactions. ○ Screening during PNC and ANC activities by health partners. ○ Screening during vitamin A supplementation activities, learning from experiences in Bangladesh. ● Ensure adequate communication and coordination with the nutrition sector to plan for increased caseloads as a result of increased screening.
<p>Strengthen referral mechanisms between nutrition services to ensure continuation of care and that cases of wasting do not miss out on treatment</p>	<ul style="list-style-type: none"> ● This includes referrals between OTP, TSFP, inpatient care, IYCF, community mobilisation and screening activities. ● Strengthen/ establish referral mechanisms to nutrition centres, like OTPs and TSFPs, for treatment of wasting. ● This requires better coordination of nutrition services and that services are not provided in silo. For example, TSFPs and OTPs should be open on the same days to ensure children are not missed. There is a risk that children who have been screened for services unavailable on the day will not return for treatment especially when they have travelled far. ● Where possible, agencies to provide transportation for patients. Referrals to inpatient care is a challenge as services are provided in hospitals (e.g. Sittwe Hospital) and tend to be expensive. Where possible, fund the use of ambulances.
<p>Prioritise and fund the scale-up of severe wasting treatment through OTPs (as opposed to TSFP or inpatient care) given funding constraints</p>	<ul style="list-style-type: none"> ● The rationale for this is: <ul style="list-style-type: none"> ○ While TSFP services are important, the service is less lifesaving compared to treating severe wasting. Children with severe wasting are at highest risk of mortality being 12 times more likely to die than a healthier counterpart. A child with moderate acute malnutrition is 4 times more likely to die from all-cause mortality compared to a non-malnourished counterpart.²⁰ ○ The caseload for TSFP can be four times higher than OTPs, thus requiring more funding but treating children with a lower mortality risk. ○ The technical expertise required to effectively treat a severely wasted child with medical complications is high and will likely require longer-term continued support for sustainable benefits. ○ Supporting inpatient care, currently provided in paediatric wards in government owned hospitals, has political implications and will require overcoming increased sensitivities around government engagement. ● Methods for expansion of severe wasting treatment should focus on: <ol style="list-style-type: none"> (1) Scaling-up operations by existing implementing partners (e.g. ACF/ SCI/ MHAA) who have relevant technical expertise. (2) Increasing the capacity of national organisations to directly implement wasting treatment services. (3) Assess whether additional partners can support additional OTP services. ● Ensure scale-up is matched with adequate funding for more frequent training, personnel and supplies.
<p>Use the shift to lifesaving activities as an opportunity to pilot MAMI services²¹, building on the learning from the Rohingya refugee response in Bangladesh in 2017.</p>	<ul style="list-style-type: none"> ● Adapt, pilot and test the suitability of existing tools to use in Rakhine. Use the learnings from the community-MAMI tools in the Rohingya response in Bangladesh to guide the pilot. ● Adapt the MAMI programme to work alongside the IYCF programming to avoid duplication. ● Evidence generation should be conducted alongside the pilot where possible and in consideration of political sensitivities.
<p>Longer-term future</p>	

²⁰ Lancet Maternal and Child Health series

²¹ MAMI is the management of small and nutritionally at-risk infants under six months and their mothers recommended by WHO

recommendations	
Use the continuing COVID-19 related restrictions to increase coverage of the mother MUAC programme with infection protection and control measures in place	<ul style="list-style-type: none"> ● ACF's mother MUAC programme showed mothers were able to accurately identify malnutrition. Given the uncertainty in access, increasing insecurity and continued COVID-19 restrictions, mother MUAC may be one of the best options to increase screening coverage. ● Use the results from the pilot to advocate for the programme to be rolled out to a wider geographic area. ● Run more frequent training to train mothers, fathers and caretakers closer to their community using local staff and existing networks to improve coverage. ● Reinforce the use of MUAC tapes through radio messaging and other community-level communications.
In addition to the mother MUAC approach, explore the opportunity to implement innovations and other simplified approaches to treat wasting	<ul style="list-style-type: none"> ● In the context of a potential reduced need for approvals, now is the time to pilot innovations around simplified approaches to wasting treatment. ● ACF could lead on piloting simplified approaches as this had been previously planned in Rakhine. With the current political environment, this may be an opportunity to restart conversations with key stakeholders to ensure adequate buy-in. ● Explore new partners with capacity to pilot simplified approaches to wasting treatment e.g. IRC. ● Explore the use of low literacy MUAC to expand screening. ● Coordinate with UNICEF and the sector lead on the strategy for simplified approaches in Rakhine and Myanmar as a whole. Conduct a mapping of the available evidence on simplified approaches of wasting in Myanmar (if any) to determine which approaches to pilot. ● Conduct a feasibility assessment and conduct a pilot in a limited geography creation (several townships) to improve on programme design before expanding.
Support UNICEF's strategy of utilising mobile teams for nutrition service provision	<ul style="list-style-type: none"> ● Mobile health clinics, as illustrated in the HRP 2021, provide another modality to increase the coverage of severe wasting treatment. ● Address barriers to integrate OTP services with mobile health teams. Identified barriers include CHWs feeling overburdened. ● When possible hire CHWs from the community they are providing services in, to avoid language barriers, discrimination and access restrictions. ● Utilise partners who implement OTPs to support capacity-building as needed.
Use existing community structures and influential role models to conduct MUAC screening	<ul style="list-style-type: none"> ● Train traditional healers, who are well trusted and well connected in the communities within many areas of Myanmar such as Rakhine State.²² This can include raising awareness on the importance of nutrition or other nutrition-related messages. ● Strengthen the nutrition capacity and skills of midwives in villages.
Advocate for ongoing MAMI programming with donors (funding) and partners in country (implementation)	<ul style="list-style-type: none"> ● Nutrition sector to produce MAMI guidelines with standardized messaging, job aids and training manuals. ● Ensure MAMI is part of the ERP and longer-term nutrition plans, such as the future MS-NPAN.
Improve and expand inpatient care when government resumes authority	<ul style="list-style-type: none"> ● A major gap in wasting treatment services is inpatient care for severe wasting with medical complications where currently inpatient care is provided in paediatric wards in government hospitals rather than in dedicated stabilisation centres. ● Ensure quality inpatient care is a priority when the government authority resumes. In the meantime, continually assess the provision of this lifesaving service to ensure it continues to be available.

R7. Increase coverage and quality of infant and young child feeding (IYCF) services, including support for exclusive breastfeeding <6 months and continued breastfeeding up to 2 years of age, timely introduction of complementary feeding, and monitoring of breastmilk substitutes (BMS) and violations of the Code.

²² McKay, M 2019, 'The Religious Landscape in Myanmar's Rakhine State', Peaceworks, No. 149, United States Institute of Peace.

Recommendation	Suggested next steps and considerations
Immediate priorities	
Support the identification of any violations of the Code of Marketing of BMS , including untargeted distributions/ donations of infant formula	<ul style="list-style-type: none"> ● While the donation of BMS may not be a huge problem in Myanmar and in Rakhine due to the mobility restrictions in and out of state, there should still be a system to identify violations as per international law as stated in the Code. ● Ensure the current system is adequate in identifying any violations including prevention of donations of infant formula, monitoring and managing donations. In an emergency setting, there is a risk of untargeted donations of infant formula which risks displacing breastfeeding and thus increasing child mortality. ● There may be a need to reassess the coordination of BMS, including violations, given it is managed under the NCC with reports directed to the MoHS. UNICEF as the nutrition sector lead, should lead on this.
Extend the coverage of one-to-one breastfeeding counselling and mother support groups to ensure exclusive breastfeeding in infants under six months and continued breastfeeding for children up to two years, in both camps and villages	<ul style="list-style-type: none"> ● Providing support for breastfeeding issues is critical as mothers may stop breastfeeding before the child reaches two years of age and/ or provide alternative foods and drinks. A child who is inadequately fed may become malnourished. Children under six months of age who are exclusively breastfed have an 11 times lower risk of death from infections than a non-breastfed child. ● Examine what capacity agencies currently have to provide individual counselling (MHAA, SCI and ACF) and mother support groups (IOM, MHAA, SCI, PIN, ACF, CPI), what their capacity needs are and what support they need to increase coverage. Use the coverage map and prioritisation exercise as guidance for priority locations. ● Establish formal breastfeeding referral protocols for all sectors including the nutrition sector. Consider supporting CSI to formally include the referral of breastfeeding cases to ACF in northern Rakhine. ● Given current mobility restrictions, continue with video counselling where face-to-face counselling is not possible. Continue expanding the coverage of the IYCF hotline service.
Explore opportunities for new entry points in existing programming to increase support for optimal and timely introduction of complementary foods for children at six months of age	<ul style="list-style-type: none"> ● Currently this is done through the same modalities as for breastfeeding support - either individually or in group settings such as mother support groups. Additional opportunities include linking with partners such as CSI to integrate education and cooking demonstrations with food distributions. ● Other platforms to provide complementary feeding messaging and support are through community volunteer screening, immunisation, quarantine checks and hygiene kit distributions. ● Continue remote/ video food demonstrations while contact restrictions due to the COVID-19 pandemic are in place.
Where possible, conduct an IYCF rapid assessment to assess the evolving IYCF situation	<ul style="list-style-type: none"> ● This should form part of nutrition surveillance activities and work to identify key IYCF services needed. There are many types of IYCF assessments, including a multisectoral initial IYCF rapid assessment which would help identify how multiple sectors could support the IYCF needs identified.
Longer-term future recommendations	
Adapt and standardise the national IYCF messaging, approach, referral mechanisms and training in Rakhine and Myanmar more broadly	<ul style="list-style-type: none"> ● Develop standardised breastfeeding and complementary feeding messaging for IYCF counselling activities. ● Ensure IYCF messaging is aligned with nutritious foods available in the markets. ● For partners who currently informally refer IYCF cases, such as CSI to ACF in northern Rakhine, consider formally including this as an activity to make sure staff know how to spot IYCF issues and refer accordingly. ● Conduct refresher trainings with a mentoring and coaching approach, to support the accurate identification of children and mothers in need of breastfeeding support.
Translate IYCF guidelines and job aids into the Rohingya language to enable tools to be used in the Rohingya population	<ul style="list-style-type: none"> ● Currently the guidelines are in Burmese, these would need to be translated for them to be accessible for health workers from the Rohingya population who are not able to understand Burmese.

<p>Aim to recruit and train female IYCF staff from the target communities to improve compliance and reduce language barriers.</p>	<ul style="list-style-type: none"> ● Given the cultural sensitivities around IYCF activities, and in particular breastfeeding, it can improve the chance of successful behaviour change if staff can speak the language of the population they are assisting, and also if they are female staff. Where feasible, ensure recruitment of IYCF staff follows these principles.
<p>Extend the monitoring of BMS to improve accountability and quality of BMS</p>	<ul style="list-style-type: none"> ● Test BMS for nutritional content to ensure the available BMS meets minimum quality standards. ● Establish/ strengthen the accountability mechanism to ensure BMS control mechanisms are adhered to and repercussions are in place for entities who violate the Code.

R8. Ensure specific nutrition vulnerabilities faced by women and adolescent girls are considered and their nutrition needs, including micronutrient needs, are comprehensively addressed.

Recommendation	Suggested next steps and considerations
Immediate priorities	
<p>Ensure the continuation of social safety net programmes (food and cash distributions) to reduce the risk of food insecurity for women and children</p>	<ul style="list-style-type: none"> ● As distributions in January were not completed and February distributions delayed, children and women were left hungry increasing the risk of infant and child malnutrition. Ensure there are contingency plans in place for March and ongoing distributions through multiple modalities to address this issue. ● Support the Cash Working Group to identify the best modality for distribution in Rakhine which addresses Rakhine specific barriers, gaps and risks. This should take into consideration the vulnerabilities of women and adolescent girls to ensure their safety. ● Ensure cash flow plans include risks and mitigations for cash and food distributions.
<p>Prioritise women with young children for social safety net programmes</p>	<ul style="list-style-type: none"> ● Amend the targeting criteria for food and cash distribution to include PLWs, adolescent girls and children up to age 2 years of age to ensure adequate nutrition in the first 1000 days of life (including maternal nutrition). This includes existing programmes implemented by Mercy Corps, WFP and CSI. ● While the existing food basket may not be optimal to meet the needs of PLWs, ensuring the provision of this food basket (or cash equivalent) in the immediate future will help with increasing calories in the diet. ● Use the village and household list held by CSI to identify women, adolescent girls and children who fit additional criteria to ensure they receive support through distributions.
<p>Prevent service disruption to antenatal care, postnatal care and other sexual and reproductive health services, with specific attention to women and adolescent girls of ethnic minorities</p>	<ul style="list-style-type: none"> ● Health sector to ensure antenatal care, postnatal care, contraceptive information and services continue to prevent early impact on foetal growth, pregnancies and infant growth. ● Interrupted ANC visits will likely have reduced the coverage of iron and folate supplementation/ multiple micronutrient supplementation for pregnant and lactating women increasing the risk of anaemia, preterm and low birth weight deliveries, neural tube defects as well as postpartum complications for the mother.
<p>Ensure communication, education and information is accessible, taking into consideration barriers for women in accessing services</p>	<ul style="list-style-type: none"> ● Ensure the use of multiple methods of communication and education to address literacy rates, internet shutdowns and ethnic and language barriers (radio, phones, women's support or saving groups, religious and community leaders). ● This applies to nutrition education (breastfeeding, complementary feeding) and promotion of programmes (psychosocial, food/cash distributions, health, vaccination etc.).
Longer-term future recommendations	
<p>Ensure adequate micronutrients in maternal diets</p>	<ul style="list-style-type: none"> ● Explore the potential for MNPs to be added to food distributions for PLWs. ● For nutrition-sensitive programming to improve dietary diversity, there needs to be more focus on translating why dietary diversity is important and improving home gardening of nutritious food yields. Opportunities include: <ul style="list-style-type: none"> ○ Restarting efforts to ensure cash distributions are used to purchase nutritious foods

	<p>through improved messaging and other forms of SBCC.</p> <ul style="list-style-type: none"> ○ Ensuring provision of seeds prioritises seeds of nutritious foods such as vitamin-A rich vegetables. ○ Providing SBCC on the importance of nutritious foods for home consumption to prevent selling of the produce and ensuring women (including adolescent girls) are prioritised for nutritious foods in the household.
<p>Actively seek women's participation and representation in decision-making and leadership</p>	<ul style="list-style-type: none"> ● Low female participation in decision-making may result in poor maternal and child health outcomes. Work with civil societies, women-led and women's rights organisations to identify barriers to meaningful engagement of women in nutrition activities. Attention should be placed on ensuring women and girls are meaningfully engaged/ participate in decision-making processes and take on leadership roles in their communities, to shape and implement nutrition interventions. ● Ensure women are part of programmes from the start including the assessment, design, implementation, and monitoring and evaluation of programmes within all sectors, including WASH, shelter and livelihoods. ● Where possible, build on Care's gender analysis and conduct a yearly barrier analysis to identify barriers specific to women.
<p>Support ongoing adjustments to the amount of cash distributed to ensure amount is adequate for the food security of women and children, and ensure food is adequately supplied and affordable in markets</p>	<ul style="list-style-type: none"> ● Given current volatility, market price fluctuations and large variability in exchange rates, the amount of cash provided means recipients have reduced purchasing power. Leverage the existing food monitoring data by Mercy Corps/ WFP to provide ongoing adjustments to cash distributions, to address the increasing price of basic staples including rice. ● Include nutritious food items in price monitoring and market assessments. This should include at least 1-2 perishable food items (e.g. eggs, vegetables). ● The assessments should also anticipate fluctuations in currency and exchange rates, particularly now when there is insecurity. ● Where possible secure the free movement of all food and agriculture goods, including inputs to prevent food shortages, and facilitate safe imports and transportation of agricultural commodities.
<p>Re-explore the possibility to include nutritious foods in food distributions/ the minimum food basket</p>	<ul style="list-style-type: none"> ● Use the Myanmar recommendations for food distributions and food baskets developed in 2020 to reassess the most suitable foods to include in the food basket, leveraging the existing modelling on the lowest cost nutritious diet to guide discussions. This may need to be recalculated based on the current changing environment. Identified foods may include: <ul style="list-style-type: none"> ○ Eggs ○ Dried fish which is reportedly inexpensive. In many cost of the diet analyses, dried fish is included in the lowest-cost nutritious diet (consult with World Fish). ● Find reliable sources for identified foods. Aim to cover most nutrient requirements if funding allows, if not prioritise to cover basic macronutrient requirements.
<p>Explore entry points for nutrition services in nutrition-sensitive activities in other sectors, to support and empower mothers and communities to prevent malnutrition</p>	<ul style="list-style-type: none"> ● Advocate for other sectors, such as food security and education, to include nutrition into their guidelines/ guidance packages. For example, UNICEF recently shared the regional guidance on nutrition in education to facilitate the mainstreaming of nutrition into education programmes. ● Ensure nutrition-sensitive guidelines prioritise women, adolescent girls and children.

ANNEXES

Annex 1 List of stakeholders interviewed and meetings attended²³

Stakeholders	Organisation type
Humanitarian Assistance and Resilience Programme Facility (HARPF)	Donor
Foreign, Commonwealth and Development Office (FCDO)	Donor
Livelihoods and Food Security Fund (LIFT)	Donor
Access to Health (A2H)	Donor
World Food Programme (WFP)	UN
The United Nations Children's Fund (UNICEF)	UN
Global Nutrition Cluster (GNC)	UN
Oxfam	INGO
Save the Children International (SCI)	INGO
International Rescue Committee (IRC)	INGO
Centre for Social Integrity (CSI)	National NGO
Myanmar Health Assistant Association (MHAA)	National NGO
Meetings	
Nutrition in Emergencies Sector Meeting	
Scaling up Nutrition (SUN) meeting	

²³ Individuals may be provided upon request