

BARRIERS, BOTTLENECKS AND SOLUTIONS FOR NUTRITION PROGRAMMING IN RAKHINE STATE, MYANMAR

REVIEW

A review conducted
by the HARP Facility in
collaboration with Access to
Health and LIFT

Authored by Janine Roelofsen.
Reviewed by Nicki Connell and
Joanne Chui. April 2022



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

Introduction

Key nutrition services in Rakhine could not be implemented as planned in 2021. The nutrition dashboard for Rakhine (January to December 2021) showed that 41% of the target for severe acute malnutrition (SAM) treatment was reached (3,758 children out of 9,105 targeted), while for moderate acute malnutrition treatment (MAM) only 20% of the target was reached (6,425 children out of 31,509 targeted). Many more (185,401) children 6-59 months of age were screened with mid-upper arm circumference (MUAC) in 2021 as compared to the Humanitarian Response Plan (HRP) target for the year of 87,327. The 4W overview (UNICEF August 2021) showed that MUAC screening was done in half of all villages and wards in Rakhine. The fact that many more children were screened and that substantially less were reached for MAM/SAM treatment (as compared to the annual targets) suggests that there is a discrepancy between screening and treatment.

Purpose

It is well-known that the context in 2020/2021 has been difficult and nutrition partners have faced many barriers, some of which were beyond their control. To increase coverage of nutrition services in Rakhine State, Myanmar, it is essential to understand and address the key barriers. This report aimed to identify key challenges and bottlenecks within the current situation and to develop realistic actionable solutions to overcome identified challenges for the treatment of wasting/ acute malnutrition as well as other nutrition services: infant and young child feeding (IYCF) services, blanket supplementary feeding programmes (BSFP), cash/food distributions and maternal and child cash transfer (MCCT) programmes).

Methods

A secondary literature review and key informant interviews (KII) with key stakeholders were conducted to identify barriers and solutions. A workshop with the Nutrition Cluster was conducted virtually to validate the key findings and prioritise barriers and solutions. Information was triangulated to formulate seven key barriers and recommended solutions.

Findings

The following are the priority barriers and solutions identified. There are five priority barriers related to nutrition treatment services and two priority barriers related to other nutrition services.

| Barriers and solutions related to nutrition treatment services | |
|---|--|
| BARRIERS | SOLUTIONS |
| <p>Priority Barrier 1: Limited accessibility for service providers, due to authority restrictions, with the following related barriers:</p> <ul style="list-style-type: none"> ● Difficulty obtaining and limitations of provided travel authorisation (TA) and memorandum of understandings (MOUs).¹ ● Dual administration (government & Arakan army). ● No permission to work in some geographical areas (some long-term, some temporary). ● No permission to implement certain activities (some long-term, some temporary). ● Staff not able to access communities or camps or conduct activities due to COVID-19. | <p>While some restrictions are out of the control of implementing agencies, within allowed locations/ activities it is important to continuously adapt to new requirements to get TA. With the uncertainty of staff travel, more nutrition services should be implemented through community-based volunteers:</p> <ul style="list-style-type: none"> ● Active case finding through volunteers using MUAC. ● Preposition ready-to use food supplies at the office level so even if TA is not provided, distribution can be done by volunteers. ● Staff to give instructions to volunteers either in person at the office, outside or at the camp/ village, or otherwise by phone, depending on what is possible at that time. ● Staff to give instructions on what nutrition education should be given to who and what to do in specific situations. This would allow volunteers to conduct follow up visits for SAM/ MAM cases through home visits if needed. ● Outpatient therapeutic programme (OTP) staff to give instructions to mothers/ caretakers of serious cases by phone, to monitor their progress, encourage absentees/ defaulters to return to the OTP, and to encourage them to accept help from village-based volunteers when offered. |
| <p>Priority Barrier 2: Limitations in working with government, due to strategy for minimum engagement with government or insufficient/disrupted government services:</p> <ul style="list-style-type: none"> ● Unable to follow up or refer cases to government treatment services, resulting in absent or missing referrals. ● Unable to scale-up through the government . ● Organisations previously working with the government have to change modality. ● High need for treatment services puts more pressure on non-government treatment services. | <ul style="list-style-type: none"> ● UNICEF to continue to support and facilitate nutrition supplies for government treatment facilities; if the government lacks supplies, organisations can inform UNICEF about the specific locations. ● Switch to non-government treatment services if possible (e.g. OTP in Pauktaw camps also accept cases from villages). ● Consider following up cases referred to government treatment services to ensure services are accessed; if not with the government, then with the mother or caregiver. ● Conduct advocacy to allow implementation of non-government nutrition services where needed, with NGOs expanding to those areas. ● NGOs to scale-up treatment services to cover gaps in geographic coverage (see priority barrier 3). |

¹ A memorandum of understanding (MOU) is obtained from the government and it allows implementing partners to provide specific activities in specific locations within a project. Travel authorisation (TA) is also obtained from the government each time an organisation needs to travel in Rakhine and typically includes limitations such as which activities are allowed and in which locations.

| | |
|---|---|
| <p>Priority Barrier 3: Difficult to scale-up services and limited coverage of treatment services:</p> <ul style="list-style-type: none"> Restrictions by authorities, long/ difficult process to change MOU's, current limitations to scale-up through government services and limited capacity and interest of NGOs to scale-up. Treatment services should be available for those who are referred. Women who do not seek treatment for their child have no time to seek treatment due to being further away from available services, find transportation and travel difficult, and find it very difficult to get authorisation to travel. | <ul style="list-style-type: none"> Scale-up through 'new' NGOs, including health partners (MSF, IRC, Malteser International, others). Scale-up by integrating treatment services into mobile services. Scale-up by working with and investing in community-based volunteers. Where possible, scale-up by increasing the number of nutrition centres and mobile services in different areas of townships. Scale-up by recruiting more community-based volunteers and staff. Ensure good coordination between different implementing partners in order to scale-up effectively and to have sufficient geographic and population coverage. Ensure good coordination among donors through keeping 4Ws updated and facilitating discussions on how to fill existing gaps for 2022. Accept lower quality services and allow some relaxation of protocols, as proposed in the revised guidelines published during the COVID-19 pandemic (not mentioned in KII's). For example, this may include a lower number of follow-up visits for mothers/ caregivers who live very far from the OTP and who do not have access to local services. Follow-up referrals to assess whether they have accessed treatment. Provide more comprehensive programmes where one organisation does the screening and treatment of SAM and MAM. Develop a standardised system providing transport costs depending on distance and ensure mothers know about it. |
| <p>Priority Barrier 4: Limited accessibility to treatment services due to:</p> <ul style="list-style-type: none"> Women not knowing where treatment services are available and not being confident that they can complete the necessary treatment. Women are not seeking treatment as they have less confidence in NGO-led nutrition services and prefer treatment by a doctor or hospital. The husbands of women who do not seek treatment being more likely to not approve of the mother taking their child for wasting treatment compared to women who do seek treatment. Women seeking treatment for their child as they believe their child can be cured if he/ she receives treatment, while other women not seeking wasting treatment as they are less likely to believe their child would be cured. | <ul style="list-style-type: none"> Share information with beneficiaries on where treatment services are available and functional. Support women who do seek treatment for wasting to work with their family members and neighbours to share how treatment has cured their child and why they support and encourage treatment. Share information with beneficiaries on which treatment services are and are not provided at a nutrition centre, and that cases with complications are always referred. Discuss with mothers what specific support they need to complete the recommended treatment and provide this support if possible, including support for transport costs if needed. Explore why husbands disapprove of their wives seeking treatment; if those who seek treatment are further away from treatment services, or if husbands think it is too difficult, too costly, too time-consuming etc. for their wife. In that case, providing transport costs may help as well as expanding treatment services closer to their home. |

| | |
|---|---|
| <p>Priority Barrier 5: Lack of data and limited understanding of the actual, current situation.</p> | <ul style="list-style-type: none"> Partners to utilise the simplified tool for assessing the nutrition situation, including MUAC screening and IYCF assessment, and training provided by UNICEF (in progress) to better understand the current situation in various locations in Rakhine. |
| <p>Barriers related to other nutrition services</p> | |
| <p>Priority Barrier 6: It is difficult for people to adopt optimal IYCF practices and other recommended practices given the current economic, political and humanitarian situation, including seeking and receiving healthcare/ treatment and not sharing food/ cash intended for women and children with other family members.</p> | <ul style="list-style-type: none"> Implement a variety of interventions to prevent further deterioration of household income and food security, for example food/ cash distributions, cash for work, support to local food production, cash grants to support local businesses etc. Considering the humanitarian context, it is crucial that BSFP, MNP distribution and MCCT programmes which particularly target mothers and children are continued and scaled-up if needs increase. To take into account sharing within the family, increase the quantity of food/ cash distributed to mothers and children to accommodate some sharing and ensure women and children still receive sufficient amounts. Implement multisectoral nutrition programmes including livelihoods, behaviour change communication, water, sanitation and hygiene (WASH), food security etc. to address the causes of malnutrition. Without addressing these, malnutrition rates will remain high and may even increase. Ensure that IYCF counselling is continued and tailored to the needs of mothers and their families. If needed, this can be done by staff over the phone if mothers have a phone, or by community-based volunteers if they are trained and coached, possibly using a targeted number of messages. |
| <p>Priority Barrier 7: Restrictions to meet in larger groups due to COVID-19 restrictions, affecting BSFP, cooking demonstrations, awareness sessions and mother support groups</p> | <ul style="list-style-type: none"> For BSFP distributions, set up food management committees in each location. This committee would be responsible for distributing food to 2-3 beneficiaries who represent a group of 10 families. The distributions can still be done once a month with the same amount of food, but this approach will help to reduce the number of contacts. As advised by the Nutrition Cluster in Rakhine, if a gathering of around 10 people is allowed, it is possible to set up mother groups safely with physical distancing, temperature checks, good ventilation and face mask wearing. If a gathering with around 10 people is not allowed, consider reducing mother groups to 3-5 people instead. Cooking demonstrations and community awareness sessions may not be possible if there are restrictions to group sizes. |

Recommendations

The following are recommendations for next steps to ensure the findings from this report are utilised effectively.

1. **Rakhine Nutrition Cluster to facilitate a session with existing and new potential implementing partners to determine how the key findings can be taken forward in projects and programmes in Rakhine.** The following should be considered:
 - a. *Identify locations where government services have been suspended.* Implementing partners and UNICEF as the cluster lead agency to seek funding and authorisation for implementing partners to provide nutrition services in locations where government services have been suspended.
 - b. *Identify what modalities are feasible and effective by which partners in what contexts.* For example, the optimal modality to scale-up wasting treatment services depends on what resources are available and what services already exist in each location. Options include:
 - i. Recruit and train new implementing partners such as health-focused organisations (e.g. Malteser International);
 - ii. Expand services by existing partners already in locations where there are service gaps;
 - iii. Integrate services in existing community health systems such as mobile services or through community-based volunteers who already conduct screening.
 - c. *Determine how simplified approaches can be used to address barriers.* While the adoption or scale-up of simplified approaches was not identified to be a priority solution, these can support a more effective and efficient approach. Nutrition partners in Rakhine prefer to follow national guidelines as they believe it improves the quality of the programmes. If research-based information is available on the effectiveness, feasibility and limitations of simplified approaches, this could be used to inform discussion and scale-up of relevant simplified approaches.
2. **Implementing partners to determine how relevant solutions from this report can be integrated or adapted** in their programming to improve coverage of nutrition services. This may require seeking additional funding to support increased coverage of services.
3. **Findings should inform the Rakhine-level communications and advocacy strategy.** Barriers which require advocacy include implementing partners gaining access to implement in areas where government services have been suspended.
4. **Donors to provide funding to partners to incorporate the solutions to priority barriers that have been identified in this report.** Ensure flexibility in donor agreements based on the identified barriers, such as allowing adaptations to locations and programming as needed. This may include providing funds for transportation so cases can access treatment services at health facilities.

5. **Conduct further research to address the identified barriers for which solutions were not identified**, including a) the reasoning behind men/ husband's decision-making, and b) how simplified approaches can be used in the Rakhine context.

Abbreviations

| | |
|--------|--|
| ACF | Action Contre la Faim |
| BCC | Behaviour change communication |
| BSFP | Blanket supplementary feeding programme |
| ENN | Emergency Nutrition Network |
| GMP | Growth monitoring promotion |
| HARP-F | Humanitarian Assistance and Resilience Programme Facility |
| HRP | Humanitarian Response Plan |
| IDP | Internally displaced person |
| IMAM | Integrated management of acute malnutrition |
| IP | Implementing partner |
| IRC | International Rescue Committee |
| IYCF | Infant and young child feeding |
| IYCF-E | Infant and young child feeding in emergencies |
| KAP | Knowledge, attitude and practices |
| LIFT | Livelihood and Food Security Trustfund |
| MAM | Moderate acute malnutrition |
| MAMI | Management of at-risk infants under 6 months and their mothers |
| MCCT | Maternal and child cash transfers |
| MHAA | Myanmar Health Assistant Association |
| MIMU | Myanmar Information Management Unit |
| MMK | Myanmar kyawt |
| MNP | Micronutrient powder |
| MoHS | Ministry of Health and Sports |
| MSF | Medicins Sans Frontieres |
| MUAC | Mid-upper arm circumference |
| NCC | Nutrition Cluster Coordinator |
| NRS | Northern Rakhine State |
| OTP | Outpatient therapeutic programme |
| PIN | People in need |
| PLW | Pregnant and lactating women |
| PPE | Personal protective equipment |
| RUSF | Ready-to-use supplementary food |
| RUTF | Ready-to-use therapeutic food |
| SAG | Strategic advisory group |
| SAM | Severe acute malnutrition |
| SBCC | Social and behaviour change communication |
| SCI | Save the Children International |
| SMART | Standardised Monitoring and Assessment of Relief and Transitions |
| TA | Travel authorisation |
| TSFP | Targeted supplementary feeding programme |
| UNHCR | United Nations High Commission for Refugees |
| WASH | Water, sanitation and hygiene |
| WFH | Weight for height |
| WFP | World Food Programme |

Contents

| | |
|--|-----------|
| Executive Summary | 2 |
| 1. Introduction | 10 |
| Background | 10 |
| 2. Overview of Nutrition Services in Rakhine State | 12 |
| 3. Key Informant Interviews (KII) on nutrition services in Rakhine State | 19 |
| A. General information on the implementation of nutrition services | 19 |
| B. Barriers and solutions identified by key informants related to treatment services, experienced by implementing partners as well as beneficiaries | 20 |
| C. Barriers and solutions identified by key informants related to other nutrition services (prevention services such as IYCF, MNP provision, BSFP, food/ cash distributions, SBCC for nutrition, growth monitoring promotion (GMP) and MCCT) | 24 |
| 4. Solutions Workshop | 26 |
| 5. Conclusions | 28 |
| 6. Recommendations | 32 |
| <i>Annex 1: Key informant interview questionnaire</i> | 33 |
| <i>Annex 2: Terms of Reference</i> | 37 |

Cover template: © Molly Webster

Cover Photo: © Quavatholochness/ Pixabay

1. Introduction

Background

To effectively increase coverage of nutrition services in Rakhine, it is important to fully understand the barriers and bottlenecks for implementation. This consultation aimed to identify challenges and bottlenecks within the current situation and to develop realistic actionable solutions to overcome those challenges.

The primary focus of the analysis was on treatment services for wasting/acute malnutrition. The analysis also took a secondary look at other nutrition services, such as infant and young child feeding (IYCF) services, blanket supplementary feeding programmes (BSFP), food distributions and maternal and child cash transfer (MCCT) programmes.

This summary report is divided into five sections: (1) Overview of the nutrition services in Rakhine; (2) Results of key informant interviews (KII); (3) Solutions workshop results; and (4) Conclusions and recommendations.

Methods

Secondary literature review: Assessment of which nutrition services are already in place

A secondary literature review was conducted from October to November 2021 to assess the current nutrition service provision. The 4W updated in August 2021², the Myanmar Information Management Unit (MIMU) baseline data updated in March 2021 (MIMU), the United Nations High Commission for Refugees (UNHCR) Q3 report for Rakhine, the Dashboard for Rakhine updated in October 2021 (UNICEF) and the Rakhine subnational Nutrition Cluster meeting minutes were used to assess the current situation and determine which nutrition services are in place.

Key informant interviews (KII)

The KII's were conducted from November to December 2021 with organisations who were either implementing nutrition programmes themselves in Rakhine State or who were supporting implementation of nutrition programmes through implementing partners in Rakhine State. A total of 19 organisations were invited for the KII's through emails and through the Nutrition Cluster. Eight KII's were conducted with a total of 10 people from seven organisations who accepted the invitation.

Solutions workshop

An online workshop with the Rakhine Nutrition Cluster was conducted on the 17th of December 2021 to discuss the results and agree on solutions. Over 35 key stakeholders from organisations involved with nutrition interventions in Rakhine State were invited, both through personal emails as well as through an announcement at the Rakhine Nutrition Cluster meeting.

The workshop started with an introduction on the purpose of the assessment on barriers, bottlenecks and solutions for nutrition programming in Rakhine State and how it fits with the Joint Nutrition Action Plan supported by HARP-F, LIFT and Access to Health. The presentation and discussions that followed were structured around three main questions:

² [UNICEF August 2021 4W](#)

1. What is the current situation (as of 1st February 2021): which nutrition services are in place?
2. What are the barriers and bottlenecks (and associated root causes) to improved coverage of nutrition services?
3. What solutions are recommended to overcome the identified barriers and bottlenecks?

Limitations

One organisation invited to join the KII's mentioned that sharing information and in particular discussing barriers is sensitive because of the current political situation and they decided not to participate because of that. As a result, it was emphasised in the invitations that all information would be treated anonymously and that the names of those who were interviewed and their organisations would not be mentioned in the report. It could be possible that more organisations were hesitant to join as less than half of the invited organisations agreed to be interviewed.

The barriers and bottlenecks, as well as potential solutions, presented during the workshop were based on those identified in the secondary literature review and some of the KII's. Some information from the KII's was not included as those findings were not yet available at the time of the workshop. Another limitation of the workshop was that some participants could not hear the whole presentation due to internet disruption and therefore may have missed some of the information.

2. Overview of Nutrition Services in Rakhine State

Rakhine State has a total of 17 townships. Included in the 2021 Humanitarian Response Plan (HRP)³ for nutrition there are 12 townships: Ann, Buthidaung, Kyaukphyu, Kyauktaw, Maungdaw, Minbya, Mrauk-U, Myebon, Pauktaw, Ponnagyun, Rathedaung and Sittwe (Figure 1). UNICEF’s 4W⁴ shows the locations international and local non-governmental organisations (NGOs) report on to UNICEF. According to UNICEF’s 4W, nutrition services are implemented in 11 townships - none in Ann and Kyaukphyu, but they are implemented in Thandwe (table 1). In these 11 townships, there are 2,662 villages/ wards in total. The total number of villages/ wards by township is taken from the MIMU baseline which was updated in March 2021.⁵

Figure 1: Map of Rakhine State⁶



Table 1 shows the geographic coverage of different interventions, calculated using the number of villages/ wards where the intervention is implemented divided by the total number of villages/ wards per township. In this overview, duplications where multiple donors were funding the same activities in the same village were taken out, which means each village/ ward was only counted once.⁷

Out of all interventions, screening and referral using mid-upper arm circumference (MUAC) has the highest geographic coverage (50.0%) (table 1). All other activities are implemented in fewer locations. Wasting treatment is available in 15.1% of villages, while IYCF is conducted in 20.8% of villages. The lowest coverage is BSFP at 12.5%. There are large differences in coverage by township.

Similarly, the number of internally displaced person (IDP) camps that were covered with the five selected nutrition interventions is presented in table 2. The total number of IDP camps was taken from the UNHCR Q3 overview.⁸ The number of locations with screening & referral is high as compared to the other nutrition activities, with screening & referral in 60.0% of camps (table 2). The lack of IDP camps in Buthidaung and Maungdaw may explain the higher coverage of services in the villages.

³ OCHA January 2021. [Humanitarian Response Plan Myanmar](#).

⁴ UNICEF August 2021. [4Ws](#).

⁵ MIMU March 2021. MIMU Baseline. <http://themimu.info/baseline-datasets>

⁶ MIMU April 2020 <http://themimu.info/gis-resources>

⁷ Some organisations would have multiple donors funding activities in the same village. In that case, the village was only counted once.

⁸ UNHCR December 2021. CCCM Camp Profiles, Central Rakhine, Myanmar.

<https://reliefweb.int/sites/reliefweb.int/files/resources/4%20pages%20online%20dashboard%20pdf%20-%20camp%20profile%20%28Q4-2021%29.pdf>

MUAC screening & referral being the most common intervention implemented is also confirmed by the total number of children who were reached with MUAC screening by December 2021, where more children were screened compared to the HRP targets (figure 2).

Table 1. Geographic coverage of the number of villages/wards where the key nutrition interventions are implemented by NGOs, disaggregated by township⁺

| Township | Wasting/ Acute Malnutrition Treatment | | Screening & referral | | IYCF | | BSFP | | Micronutrients | | Total # of villages/ wards per township* |
|--------------|---------------------------------------|--------------|----------------------|--------------|------------|--------------|------------|--------------|----------------|--------------|--|
| | | | | | | | | | | | |
| Ann | 0 | 0.0% | 0 | 0.0% | 0 | 0.0% | 0 | 0.0% | 0 | 0.0% | N/A |
| Buthidaung | 163 | 47.1% | 98 | 28.3% | 166 | 48.0% | 154 | 44.5% | 163 | 47.1% | 346 |
| Kyaukpyu | 0 | 0.0% | 0 | 0.0% | 0 | 0.0% | 0 | 0.0% | 0 | 0.0% | N/A |
| Kyauktaw | 11 | 3.8% | 259 | 89.6% | 28 | 9.7% | 11 | 3.8% | 11 | 3.8% | 289 |
| Maungdaw | 91 | 23.5% | 70 | 18.0% | 91 | 23.5% | 65 | 16.8% | 91 | 23.5% | 388 |
| Minbya | 14 | 5.5% | 116 | 45.7% | 59 | 23.2% | 11 | 4.3% | 14 | 5.5% | 254 |
| Mrauk-U | 12 | 4.7% | 231 | 90.6% | 16 | 6.3% | 9 | 3.5% | 12 | 4.7% | 255 |
| Myebon | 0 | 0.0% | 155 | 91.7% | 4 | 2.4% | 0 | 0.0% | 0 | 0.0% | 169 |
| Pauktaw | 1 | 0.5% | 179 | 97.3% | 89 | 48.4% | 1 | 0.5% | 0 | 0.0% | 184 |
| Ponnagyun | 0 | 0.0% | 32 | 16.2% | 0 | 0.0% | 0 | 0.0% | 0 | 0.0% | 198 |
| Rathedaung | 21 | 10.4% | 102 | 50.7% | 21 | 10.4% | 12 | 6.0% | 12 | 6.0% | 201 |
| Sittwe | 75 | 62.0% | 75 | 62.0% | 65 | 53.7% | 71 | 58.7% | 37 | 30.6% | 121 |
| Thandwe | 14 | 5.4% | 14 | 5.4% | 14 | 5.4% | 0 | 0.0% | 0 | 0.0% | 257 |
| Total | 402 | 15.1% | 1,331 | 50.0% | 553 | 20.8% | 334 | 12.5% | 340 | 12.8% | 2,662 |

⁺There are no nutrition services conducted by NGOs in Ann and Kyauktaw according to the 4W

Source: UNICEF August 2021 4W. *From MIMU Baseline updated March 2021; no data for Ann and Kyaukpyu.

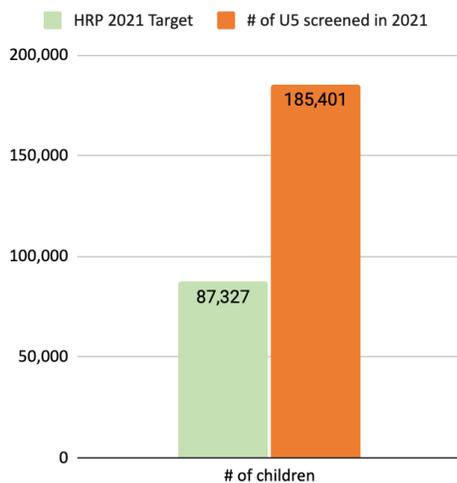
Table 2. Geographic coverage of the number of IDP sites where the key nutrition interventions are implemented by non-government partners, disaggregated by township⁺

| Township | Wasting/ Acute Malnutrition Treatment | | Screening & referral | | IYCF | | BSFP | | Micronutrients | | Total # of IDP sites per township* |
|-------------------------|---------------------------------------|--------------|----------------------|--------------|-----------|--------------|-----------|--------------|----------------|--------------|------------------------------------|
| | | | | | | | | | | | |
| Buthidaung | | | | | | | | | | | 0 |
| Kyauktaw | 6 | 33.3% | 10 | 55.6% | 6 | 33.3% | 0 | 0.0% | 6 | 33.3% | 18 |
| Maungdaw | | | | | | | | | | | 0 |
| Minbya | 3 | 30.0% | 3 | 30.0% | 3 | 30.0% | 0 | 0.0% | 3 | 30.0% | 10 |
| Mrauk-U | 3 | 10.7% | 3 | 10.7% | 3 | 10.7% | 0 | 0.0% | 3 | 10.7% | 28 |
| Myebon | 0 | 0.0% | 0 | 0.0% | 0 | 0.0% | 0 | 0.0% | 0 | 0.0% | 16 |
| Pauktaw | 5 | 55.6% | 5 | 55.6% | 5 | 55.6% | 5 | 55.6% | 5 | 55.6% | 9 |
| Ponnagyun | 0 | 0.0% | 0 | 0.0% | 0 | 0.0% | 0 | 0.0% | 0 | 0.0% | 9 |
| Rathedaung [†] | 2 | | 7 | | 2 | | 0 | | 2 | | 0 |
| Sittwe | 14 | 31.1% | 53 | 117.8% | 18 | 40.0% | 18 | 40.0% | 18 | 40.0% | 45 |
| Thandwe | | | | | | | | | | | 0 |
| Total | 33 | 24.4% | 81 | 60.0% | 37 | 27.4% | 23 | 17.0% | 37 | 27.4% | 135 |

It is unclear why the UNHCR Q3 overview does not include # of IDP sites in Rathedaung, but interviews confirm there are IDP sites.

Source: UNICEF August 2021 4W. *From UNHCR Q3 overview

Figure 2: Comparison of targeted number of U5 screened and number of children actually screened from January to December 2021



Source: Rakhine Nutrition Cluster 2021. Nutrition Dashboard 2021 - December 2021

The UNHCR Q3 overview⁹ showed gaps in moderate acute malnutrition (MAM) and severe acute malnutrition (SAM) treatment services in IDP sites (in brackets are the number of people in the IDP camps):

- Kyaukpyu Township, Kyauk Ta Lone IDP site had no MAM or SAM treatment services (1,001 people)
- Myebon Township, Taung Paw IDP site: no MAM treatment services, have SAM treatment services (3,548 people)
- Sittwe Township, Maw Ti Ngar IDP site: no MAM or SAM treatment services (3,929 people)
- 12 IDP sites in Sittwe, 1 site in Kyauktaw and 5 sites in Pauktaw have both MAM and SAM treatment services
- The UNHCR overview did not mention if the remaining camps have MAM or SAM treatment services: 7 IDP sites in Ann, 17 in Kyauktaw, 10 in Minbya, 28 in Mrauk U, 15 in Myebon, 4 in Pauktaw, 9 in Ponnagun and 32 in Sittwe

The nutrition dashboard (January to December 2021)¹⁰ showed that 41% of the target caseload for SAM treatment services was reached and for MAM treatment only 20% of the target was reached (box 1). This was different for prevention services (BSFP, micronutrient powders (MNP) for children 6-59 months, IYCF, micronutrient tablets for pregnant and lactating women (PLW)) where 88% were reached (109,015 people out of 123,306 people targeted) [box 1].¹¹

Not all children who were identified with SAM/ MAM actually received treatment since many more children were screened than planned (HRP target), while only a limited number of children received treatment out of the planned HRP target (figure 2).

Table 3 shows the targeted SAM and MAM cases for treatment by township compared to the geographic locations providing treatment. Most outpatient therapeutic programme (OTP) and targeted supplementary feeding programme (TSFP) services are in NRS (68.4% and 64.4% respectively). However, only 29.2% of SAM cases and 28.1% of MAM cases targeted for treatment were in NRS. Conversely, in Central/Southern Rakhine 70.8% of SAM cases were targeted, yet only 31.6% of OTP sites are in this location. In the same location 71.9% of MAM cases were targeted, yet only 35.6% of TSFP sites are available in this location. This shows a mismatch between the number of treatment services compared to where cases are targeted for treatment. However, this does not mean that the number of treatment

⁹ UNHCR December 2021. [CCCM Camp Profiles, Central, Rakhine, Myanmar](#) as of December 2021

¹⁰ Rakhine Nutrition Sector December 2021. Myanmar: Rakhine Nutrition Sector Dashboard 2021

¹¹ Rakhine Nutrition Sector December 2021. Myanmar: Rakhine Nutrition Sector Dashboard 2021

sites in NRS should be reduced, as they may be needed to reach the targeted number of cases. For example, in Maungdaw 2,973 cases were targeted for MAM treatment and there are 91 locations where MAM treatment is provided. At the same time, 13,876 cases were targeted for MAM treatment in Sittwe while there are also 91 locations where MAM treatment is provided. It is not well understood whether the workload of and capacity required to reach the targets is evenly distributed throughout locations.

Table 3. Number of targeted SAM and MAM cases (HRP 2021) compared to the distribution of geographic locations providing SAM and MAM treatment (4W Aug 2021) disaggregated by township.

| Township | OTP (SAM Treatment) | | | | TSFP (MAM Treatment) | | | |
|--------------------------------|-------------------------|----------------|--|----------------|-------------------------|----------------|--|----------------|
| | HRP 2021 | | 4W Aug 2021 | | HRP 2021 | | 4W Aug 2021 | |
| | Target U5 SAM treatment | % per township | # villages and IDP sites with U5 SAM treatment | % per township | Target U5 MAM treatment | % per township | # villages and IDP sites with U5 MAM treatment | % per township |
| Ann | 62 | 0.7% | 0 | 0.0% | 208 | 0.7% | 0 | 0.0% |
| Buthidaung* | 1,545 | 17.0% | 163 | 40.2% | 5,123 | 16.3% | 175 | 39.0% |
| Kyaukpyu | 47 | 0.5% | 0 | 0.0% | 147 | 0.5% | 0 | 0.0% |
| Kyauktaw | 647 | 7.1% | 17 | 4.2% | 2,096 | 6.7% | 17 | 3.8% |
| Maungdaw* | 760 | 8.3% | 91 | 22.5% | 2,973 | 9.4% | 91 | 20.3% |
| Minbya | 334 | 3.7% | 17 | 4.2% | 1,065 | 3.4% | 17 | 3.8% |
| Mrauk-U | 373 | 4.1% | 15 | 3.7% | 1,208 | 3.8% | 15 | 3.3% |
| Myebon | 146 | 1.6% | 0 | 0.0% | 393 | 1.2% | 0 | 0.0% |
| Pauktaw | 1,001 | 11.0% | 5 | 1.2% | 3,543 | 11.2% | 6 | 1.3% |
| Ponnagyun | 36 | 0.4% | 0 | 0.0% | 131 | 0.4% | 0 | 0.0% |
| Rathedaung* | 271 | 3.0% | 23 | 5.7% | 746 | 2.4% | 23 | 5.1% |
| Sittwe | 3,881 | 42.6% | 60 | 14.8% | 13,876 | 44.0% | 91 | 20.3% |
| Thandwe | 0 | 0.0% | 14 | 3.5% | 0 | 0.0% | 14 | 3.1% |
| Rakhine (North) Total* | 2,576 | 28.3% | 277 | 68.4% | 8,842 | 28.1% | 289 | 64.4% |
| Rakhine Central +2 south total | 6,529 | 71.7% | 128 | 31.6% | 22,667 | 71.9% | 160 | 35.6% |
| Rakhine Total | 9,105 | 100.0% | 405 | 100.0% | 31,509 | 100.0% | 449 | 100.0% |

*Buthidaung, Maungadaw, Rathedaung are in NRS. Remaining townships are part of Central/ Southern Rakhine.

The Nutrition Dashboard showed that coverage of IYCF counselling in 2021 was low with only 33.5% of children reached - 11,523 out of 34,447 targeted (box 1). The targeted distribution of IYCF services per township is more in line with the number of actual locations where IYCF counselling is provided, as compared to SAM and MAM treatment (table 4). Finally, BSFP services only reached around a quarter of children 6-59 months and PLW targeted, showing that a greater coverage of BSFP services is required (box 1).

Box 1: Percentage of women and children reached with nutrition services in 2021 compared to 2021 HRP targets

- SAM treatment: 41.3% reached (3,758 out of 9,105 target)
- MAM treatment: 20.4% reached (6,425 out of 31,509 target)
- IYCF counselling: 33.5% reached (11,523 out of 34,447 target)
- BSFP children 6-59 months: 25.5% reached (21,518 out of 84,352 target)
- BSFP PLW: 27.8% reached (10,298 out of 37,103 target)
- Prevention services*: 88% reached (109,015 out of 123,306 target)

*BSFP, MNP for children 6-59 months, IYCF, micronutrient tablets for pregnant and lactating women (PLW)

Source: Rakhine Nutrition Sector December 2021. [Myanmar: Rakhine Nutrition Sector Dashboard 2021](#).

Table 4. Overview of people in need (PIN) and targeted number of mothers for IYCF counselling according to the 2021 HRP versus the number of locations IYCF counselling was implemented by non-government nutrition partners, by township.

| Township | HRP 2021 | | 4W Aug 2021 | |
|--------------------------------|-------------------------|----------------|------------------------------|----------------|
| | Target IYCF counselling | % per township | # locations IYCF counselling | % per township |
| Ann | 226 | 0.7% | 0 | 0.0% |
| Buthidaung* | 7,873 | 22.9% | 166 | 28.8% |
| Kyaukpyu | 160 | 0.5% | 0 | 0.0% |
| Kyauktaw | 3,143 | 9.1% | 34 | 5.9% |
| Maungdaw* | 4,774 | 13.9% | 91 | 15.8% |
| Minbya | 1,573 | 4.6% | 62 | 10.8% |
| Mrauk-U | 2,003 | 5.8% | 19 | 3.3% |
| Myebon | 489 | 1.4% | 4 | 0.7% |
| Pauktaw | 2,221 | 6.4% | 94 | 16.3% |
| Ponnagyun | 249 | 0.7% | 0 | 0.0% |
| Rathedaung* | 1,198 | 3.5% | 23 | 4.0% |
| Sittwe | 10,538 | 30.6% | 83 | 14.4% |
| Thandwe | 0 | 0.0% | 0 | 0.0% |
| NRS Total* | 13,845 | 40.2% | 280 | 48.6% |
| Central/Southern Rakhine Total | 20,602 | 59.8% | 296 | 51.4% |
| Rakhine Total | 34,447 | 100.0% | 576 | 100.0% |

*Buthidaung, Maungadaw, Rathedaung are in NRS. Remaining townships are part of Central/Southern Rakhine.

Summary

Key nutrition services could not be implemented as planned in 2021 due to multiple challenges, including the coup d'état and the COVID-19 pandemic, which led to the coverage of nutrition services and number of reached versus targeted cases being off track (box 1). However, the need for these interventions is high. Several surveys from 2015-2016¹² showed that stunting is very high across Rakhine State and wasting is medium to very high depending on the location. In addition, the article 'The impact of the COVID-19 crisis on maternal and child malnutrition in Myanmar' (Oct 2020)¹³ estimates an additional 38,600 MAM and 25,057 SAM cases nationally due to the COVID-19 economic crisis, with Rakhine State having the highest additional caseload of SAM cases (8,934).

¹² Demographic and Health Survey 2016; ACF 2015. Preliminary Report SMART nutrition survey Maungdaw and Buthidaung Townships, Maungdaw District, Rakhine state; Save the Children 2016. SMART Survey Pauktaw and Sittwe (Rural and Urban) Internally Displaced Persons Camps of Rakhine State, Myanmar)

¹³ Headey et al. October 2020. [The Impacts of the COVID-19 crises on maternal and child malnutrition in Myanmar: what to expect, and how to protect.](#)

3. Key Informant Interviews (KII) on nutrition services in Rakhine State

The KII questionnaire is included in [annex 1](#). The findings of the KIIs are discussed in the following sections:

- A. General information on the implementation of nutrition services
- B. Barriers and solutions identified by key informants related to treatment services, experienced by implementation partners as well as beneficiaries
- C. Barriers and solutions identified by key informants related to other nutrition services: prevention services such as IYCF, MNP provision, BSFP, food/ cash distribution, social behaviour change communication (SBCC) for nutrition, growth monitoring promotion (GMP) and MCCT

A. General information on the implementation of nutrition services

Organisations are responsible for different nutrition activities instead of implementing a full package

Out of the seven organisations who participated, three are implementing nutrition programmes directly, while four are implementing through partner organisations. One of the three implementing organisations only integrates nutrition as a topic in their mainstream activities but does not implement any treatment or prevention activities specifically.

Three organisations are implementing in all areas of Rakhine (NRS as well as Southern/ Central Rakhine). Two organisations have focused on Southern/ Central Rakhine until now and one of them is starting to implement in NRS. Another organisation is working in all areas but with a much bigger focus and presence in Southern/ Central Rakhine.

All interviewed organisations are implementing both treatment and prevention nutrition services (a full package). However, not all individual projects include both treatment and prevention services, e.g. an implementing partner has projects which fund both treatment and prevention but also has projects which only fund prevention services. This is an interesting finding as it seems that those organisations have the capacity to do both but are funded to do 'only' part of the package. It seems however that if an organisation 'only' does the prevention services in a specific location, that another organisation or government is already providing treatment services there. One organisation stated that they do both treatment and prevention services in certain IDP camps but they only implement prevention services in the host communities, as the government provides treatment services there, and they also only implement prevention services in some IDP camps because another NGO provides treatment services in those camps. In that case, it is logical that organisations complement each others' services by implementing only those interventions in locations where there are identified gaps.

Recent changes in treatment services: progress to harmonising services

Looking at treatment services alone, the World Food Programme (WFP), UNICEF and their implementing partners shared that since 2021 they changed their modus operandi by having all of their implementing partners (IP) implement both MAM and SAM treatment services instead of only doing one of them. WFP and UNICEF also decided to work more closely together through conducting joint monitoring visits, as well as streamlining contracts with their IP's. This also meant that IP's had to discuss and reorganise who

implemented which services where and hand over certain locations between each other. Last but not least, sufficient training on both integrated management of acute malnutrition (IMAM) and IYCF was made available to all IP's (and other nutrition partners) to improve the quality of implementation.

B. Barriers and solutions identified by key informants related to treatment services, experienced by implementing partners as well as beneficiaries

Both barriers and solutions experienced by nutrition partners (either those who directly implement or those who support IP's) in implementing treatment services identified by participants have been presented in this section. If a certain barrier relates to a specific location (e.g. NRS, Southern/ Central Rakhine) it is mentioned. If the barrier relates to all of Rakhine State, no specific location is mentioned. Supporting quotations for each barrier are included in a separate report.

Limited accessibility for service providers due to authority restrictions

The most commonly mentioned barrier was the difficulty obtaining travel authorisation (TA) and limitations of provided TA's. TAs have limitations including which activities are allowed and in which locations, mention other specific restrictions, and often suffer delays in being granted. As a result, staff cannot visit the villages or camps to conduct necessary activities, and it is only possible to conduct passive case finding where mothers come to the OTP directly. Staff could also only conduct remote monitoring and work through volunteers who were present and trained. When this happened in 2021, treatment services continued but the number of admissions dropped.

There are no solutions to implementing activities in locations not allowed by the government. However, in permitted locations, the following solutions were proposed by the participants:

- Depend more on local volunteers:
 - Instructions to volunteers can be given by phone.
 - Active case finding can be conducted through local volunteers using MUAC.
 - Preposition supplies at the office level so even if TA is not provided, ready-to-use therapeutic food (RUTF)/ ready-to-use supplementary food (RUSF) distribution can still be done by a community-based volunteers.
 - Staff can give necessary instructions to community-based volunteers on what counselling should be given and what to do in which situation. Then volunteers can do follow-up visits for SAM/ MAM cases and home visits.
 - Staff can provide capacity-building and coaching to community-based volunteers.
 - Consider which tasks community-based volunteers can take on to ensure continuation of services.
- OTP staff can reach out to absentees or defaulters by phone and persuade them to keep coming to the OTP. Staff can also give instructions to caretakers of serious cases to follow the progress of the patient and to encourage them to accept help from community-based volunteers when undertaking follow-up visits.

There is dual administration in some areas, with approvals needed from both the government and the Arakan army, which is a barrier to efficiently responding due to increased paperwork, the need to visit different offices, additional fees increasing the cost of delivery and the time taken to accommodate dual

processes. Participants mention that in some areas where there is no official control, the Arakan army and the government are asking questions making it more difficult for organisations to quickly obtain approvals. No solutions were identified by participants for this barrier, as UN OCHA leads the discussion on how to communicate with armed groups.

There is limited coverage of treatment services but scaling up is restricted by the procedures required to work with the government and/ or the need for minimum engagement with the government. There is also limited government interest in nutrition and so there is a limited coverage of government nutrition services. It is difficult to scale-up nutrition services, particularly if NGOs are not allowed to conduct nutrition services instead of the government services due to the difficulty obtaining TAs and inflexible MOUs. Also, nutrition partners are not able to follow-up cases referred to the government system because traditionally nutrition partners communicate with the government health centres and hospitals, but due to the minimum engagement approach with the government, this cannot be done. These barriers related to the government are not easy to solve, even more so now with the approach of limiting government engagement. No participants mentioned any solutions, but alternative solutions are discussed below in the recommendations.

A memorandum of understanding (MOU) is obtained from the government and it allows implementing partners to provide specific activities in specific locations. Obtaining the MOU is a long and difficult process and there is little flexibility to change activities and locations. Additional approvals at the local level from local administration and/or armed groups are required, making scaling-up nutrition services difficult. An analysis of screening and treatment data shows that many more children are screened and referred compared to those who receive treatment. Due to the limited coverage of treatment services, referrals between treatment services can be lost. This occurs even in townships where NGOs are present. Lost referrals can be attributed to a lack of coordination between nutrition partners, in particular organisations who only do screening and referral and those who only provide OTP services. Funding limitations from WFP and UNICEF have also contributed to limited coverage of treatment services. Beneficiaries from remote locations live far from nutrition centres. Due to lack of money for transportation costs, many hours required to travel, requiring additional documents to travel, and the stress of going through checkpoints, beneficiaries do not always travel to nutrition centres to seek treatment. To reduce the time and distance beneficiaries travel, it is important to scale-up nutrition services and increase the number of locations where beneficiaries can seek care.

The following were solutions identified by participants to scale-up nutrition services:

- Consider implementing treatment and prevention services together as a comprehensive package to improve coordination, and streamline referrals and staff training. This may result in more funding available to increase coverage of wasting treatment. Combine treatment programmes funded by WFP/ UNICEF with prevention programmes to cover all staff costs. If a comprehensive programme is not possible due to lack of capacity, prioritise implementing MAM treatment to prevent cases deteriorating to SAM as MAM treatment is simpler and easier to implement.
- Implement activities in those locations with the highest needs and coordinate nutrition services systematically. Donors should continue reporting to the 4W and coordinating with the nutrition sector to fund gaps in priority locations.
- Organisations which have permission and capacity to expand within a given township should consider running additional OTPs in that township. Where permission is not granted, advocate for running activities in those townships where there is no organisation present.

- Modalities for scaling up include:
 - Increasing the number of nutrition centres and mobile services in different areas of the township. Identify key decision-makers in the health department and identify how additional supplies will be funded.
 - Recruiting and training more community volunteers and staff. By bringing treatment and screening closer to the community, beneficiaries are more likely to seek treatment.
 - Integrating treatment services into existing nutrition programmes and/or mobile teams, including case finding, RUTF/ RUSF distribution, and providing training to ensure ability to manage SAM/ MAM cases.
- Organisations who screen and refer cases should follow-up on whether the referred case reaches the OTP/ TSFP.
- Support transportation costs for MAM/ SAM cases. There are standardised guidelines for emergency referrals of cases. A standardised amount could be considered depending on distance, for example, Area A (5-10 miles away) receives 5,000 MMK, Area B etc. (MHAA has standard guidelines that could be adapted).

Barriers related to health-seeking behaviours

Community perception and taboos related to treatment of acute malnutrition/ wasting prevent optimal health-seeking behaviours. Communities might believe that acute malnutrition/ wasting is not serious enough to seek treatment and men may not support families to seek treatment. To address this, participants suggested finding the root causes of these perceptions and helping them understand their misconceptions.

Lack of data and limited understanding of the current situation

There is little understanding of the current situation or needs due to a lack of up-to-date data and surveys. Official permission to conduct nutrition surveys is difficult to obtain. Missing data includes wasting prevalence, dietary diversity, and available nutrition services. To address this, UNICEF shared that there is a plan to use MUAC and oedema as a proxy indicator for wasting for 2022, but is awaiting ethical approval. Additionally, UNICEF with the support from the Global Nutrition Cluster (GNC) have trained and provided tools for nutrition partners on the use of a simplified approach to assessing the nutrition situation, with the support of various initiatives such as the Leveraging Actions to Reduce Malnutrition (LEARN) initiative.¹⁴ 35 partners have received training on MUAC screening and IYCF assessments.

Potentially decreased quality of nutrition services due to adaptations to standard treatment protocol

With COVID-19, follow-up visits may be reduced to biweekly or monthly which may affect the quality of treatment services. If treatment of wasting is carried out by community-based volunteers when staff are not able to go to the field, it is difficult to monitor the quality of the provided services. Active screening has also been limited during COVID-19 outbreaks.

Participants suggested the following solutions. To ensure children are compliant with treatment between follow-ups, it may be possible for volunteers to provide home-visits weekly for children with SAM and biweekly for children with MAM in suitable settings such as in camps. Many volunteers are already trained but refresher training is required to ensure they are updated with the latest guidelines.

¹⁴ LEARN is a technical service provider funded by LIFT to provide technical support to civil society actors.

Video training is available in Myanmar language (e.g. MUAC measurement) and could be used to remotely increase capacity-building efforts. Staff and volunteers can conduct some services together (staff remotely online and volunteers physically present with mother) to provide on-the-job coaching and improve monitoring of quality of services. Quality of treatment services can be monitored by checking if cure and defaulter rates are within Sphere standards (cure rate >75% and defaulter <15%).

To ensure active screening continues, train existing village-based volunteers, community health workers, nutrition volunteers and mother group leaders on how to measure MUAC. Consider the use of the Family MUAC approach, where mothers are taught to read MUAC tapes based on colours instead of numbers. Encourage mothers to report results to community volunteers during community/ home visits and volunteers can use VIBER to report findings to the health centres.

Adhering to recommended COVID-19 infection protection control has increased the time it takes to screen and treat acute malnutrition/ wasting. It is important to adhere to the recommended guidelines and factor in the additional time it takes.

Difference in barriers related to treatment services between NRS and Southern/ Central Rakhine, and camp and non-camp settings

Participants of the KII's had differing opinions on whether there were differences in barriers between NRS and Southern/ Central Rakhine, and camps and villages, but agreed that accessibility and authority restrictions were the main barriers in all locations.

There was a lack of consensus over whether it was more difficult dealing with authoritative restrictions in NRS compared to Southern/ Central Rakhine. This includes obtaining TAs in NRS, increased fees to pass checkpoints, whether women are given permission to travel by their husband, and increased areas of no go zones.

There was also a lack of consensus on whether camps or villages have more travel restrictions affecting access to treatment. While people in camps have restricted movements, health services including wasting treatment are available. According to KIIs, people in villages are reliant on government services where NGOs are not allowed to operate, but these have been disrupted since the civil disobedience movement. While there may be differences between townships, all nutrition partners depend on permission and approval from the state health department and recommendation from the township health centre to apply for TA. The living standards and level of capacity is much lower in the IDP camps in Pauktaw as compared to Sittwe, therefore it is very difficult to find good volunteers and difficult to build their capacity. Furthermore, in Mrauk-U and Kyauktaw staff are not allowed to distribute supplies directly and need to work through township committees, which is not the case in Sittwe or Pauktaw.

Topics mentioned by participants which were not difficult in 2021 in relation to treatment services (no barriers)

The following were not identified barriers in 2021: Availability of nutrition supplies for NGO programmes (RUTE/ RUSF), adapting to new emergency guidelines, having sufficient human resources available, beneficiaries' access to OTPs in camp settings and regular coordination among all service providers.

- C. Barriers and solutions identified by key informants related to other nutrition services (prevention services such as IYCF, MNP provision, BSFP, food/ cash distributions, SBCC for nutrition, growth monitoring promotion (GMP) and MCCT)

Many of the barriers which apply to providing treatment services also apply to providing nutrition prevention services. Both barriers and solutions experienced by nutrition partners (either those who directly implement or those who support IP's) in implementing treatment services identified by participants have been presented in this section. If a certain barrier relates to a specific location (e.g. NRS, Southern/ Central Rakhine) it is mentioned. If the barrier relates to all of Rakhine State, no specific location is mentioned. Supporting quotations for each barrier are included in a separate report.

Restrictions to meet in larger groups

COVID-19 restrictions have prevented larger groups from meeting which affects BSFP, cooking demonstrations, awareness sessions and mother support groups. The following solutions were mentioned by the participants:

- To manage BSFP distributions, food management committees are formed in the village. This committee distributes the food to two to three beneficiaries who represent a group of 10 families. They then distribute it further to those 10 families (instead of calling all mothers/ caregivers to the distribution point as was done before). The distributions are still done once a month. This can be done temporarily with further assessment on whether it is suitable as a longer-term solution.
- The Rakhine Nutrition Cluster held an orientation session for nutrition partners on how to set up mother groups with physical distancing, temperature checks, good ventilation, and mask wearing. This solution was most effective as it allowed face to face sessions. However, if meeting in standard group sizes is not possible, consider conducting mother groups with less people (e.g. 4-5 people). If staff are not allowed to conduct sessions in person, coaching the mother group leader online during the mother group session should be considered.
- IYCF counselling can be conducted remotely online or by phone (through collecting mothers' phone numbers) and arranging face to face appointments for one-to-one counselling. Another approach could be to focus on one-to-one counselling through existing community health workers using a targeted approach, with a set number of messages and timely contact with mothers. Note that because basic health staff are under the supervision of the township medical officer, it may be too sensitive/not feasible to continue IYCF counselling through basic health officers as adaptations to standard national guidelines are being used. Also, for most basic health staff, nutrition was not a priority and now is definitely not, given COVID-19 and other challenges.
- In general, invest in having as many services as possible in the community using existing community structures.

It is difficult for people to adopt optimal IYCF practices and other recommended practices

Due to increasing food insecurity and lack of income, people are often unable to follow recommended IYCF practices, and/ or give food or cash intended for women/ children to other members of the household. Solutions identified by participants include:

- Supporting multisectoral nutrition programmes including livelihoods, behaviour change interventions, water, sanitation and hygiene (WASH), food security etc. to address underlying needs. Without this, malnutrition rates will remain high.

- Considering the economic difficulties, continue or scale-up food and cash grants.

Nutrition is not prioritised

Some volunteers who provide other health services in addition to nutrition may not prioritise nutrition or have sufficient time for it. Solutions, as suggested by participants, might include:

- Consider working with village-based community nutrition volunteers who may have more available time. Activities may include awareness-raising on pre-planned topics through individual home visits. This can be especially useful if people are not allowed to meet in groups.
- Consider providing more systematic support to community volunteers so that they are better able to run activities if office-based staff are not available.
- Assess and consider the capacity of volunteers and what they can take responsibility for. Mother leaders often do not have the capacity to run activities in the same way as health/ nutrition volunteers. It is important to improve capacity-building of community-based volunteers and to have sufficient funding for that.

4. Solutions Workshop

Nutrition partners operating in Rakhine were invited to participate in a workshop to discuss the identified barriers and bottlenecks (and associated root causes). During the workshop, barriers were prioritised and potential solutions were discussed.

Prioritisation of barriers and bottlenecks (and root causes) to improved coverage of nutrition services

The identified barriers and bottlenecks (and associated root causes) that were presented at the workshop are included in a separate report. Five barriers (listed below in order of importance) were identified as being the main barriers to improving coverage of nutrition services through group discussions:

1. **Limited accessibility for both service providers and beneficiaries related to authority restrictions.** Both implementing partners and beneficiaries have difficulty obtaining TA and women face travel restrictions in NRS and Central Rakhine.
2. **Low livelihood opportunities/ income** which affect the adoption of optimal practices, for example seeking acute malnutrition/ wasting treatment. Livelihood opportunities are limited by conflict, army presence and movement restrictions. These, coupled with increasing prices in Myanmar, high living costs and food shortages in Rakhine, mean many families are unable to consume nutritious foods.
3. **Limited cohesion & harmonisation between and within nutrition treatment and prevention services at the field level.** Nutrition and health services are seen as separate programmes and sectors.
4. **Limited capacity of implementing partners** to increase coverage of nutrition services. Workshop attendees agreed that capacity-building is ongoing but needs to continue with existing and potentially new implementing partners, including national/ local organisations.
5. **The operating environment is constantly changing** making it difficult to predict and adapt accordingly.

Solutions to address the identified priority barriers and bottlenecks

The overview of recommended solutions presented at the workshop are included in a separate report. The following solutions to address the identified priority barriers and bottlenecks were identified through small group discussions:

1. **Expand coverage of nutrition services through non-nutrition partners**, including health partners e.g. MSF, International Rescue Committee (IRC), Malteser International and others.
2. **Work and invest in community volunteers** where possible to increase coverage of screening, treatment and other nutrition services. Community volunteers are a valuable asset able to work directly with the communities.
3. **Continue to support IMAM programming** and continue using the IMAM guidelines despite change in approach with working with the authorities.
4. **Prioritise capacity-building**, including IMAM, IYCF and simplified assessment training on use of MUAC and knowledge, attitude and practice (KAP) surveys. Include training for non-nutrition partners (MUAC screening and referral, provision of MNPs etc.).

5. **Advocate to the state health department to allow flexibility** and provide permission to expand nutrition service provision to additional locations.

All groups chose coverage expansion as a priority considering the accessibility issues and the need to increase access to wasting treatment services. There is an option to expand nutrition services through existing health and non-nutrition partners, which has started already and can be further explored. Integrating comprehensive treatment services into existing mobile clinics is one possibility. The Nutrition Cluster can advocate with existing health partners (and their donors) to integrate nutrition services into their programming, including SAM treatment which is currently only implemented by three IP's. Furthermore, simple nutrition prevention activities, such as MUAC screening or MNP provision, can be integrated into non-nutrition programmes e.g. WASH programmes or child protection programmes. To do this, it will be important to provide basic nutrition capacity-building to non-nutrition partners. Participants note that it will also be important to think about hard-to-reach areas in Southern/ Central Rakhine as well.

UNICEF (and/ or the (future) lead of the nutrition sub-cluster for Rakhine) can advocate on behalf of NGOs with the state health department and state nutrition teams on important issues, such as permission to work in areas which are not reached. Although there is currently limited government engagement, some issues are crucially important and require advocacy efforts regardless. In addition, it may be useful to advocate for permission for NGOs to handle acute malnutrition/ wasting cases with medical complications, which is currently only allowed in hospital-based units in Rakhine State i.e. township and state hospitals.

The prioritised solutions are mostly related to the barriers on limited accessibility (barrier #1), limited cohesion and harmonisation (barrier #3) and limited capacity of implementing partners (barrier #4). To some extent they also relate to the barrier that the situation continues to change and the difficulty to adapt (barrier # 5): investing in community volunteers and in a wider variety of implementing partners may help to continue services in a rapidly changing environment. Most of the prioritised solutions are being implemented already, although some have only started recently. The only barrier that was not addressed in these prioritised solutions was barrier #2: low livelihood opportunities and income.

5. Conclusions

A lot of information has been collected on barriers, bottlenecks and solutions for nutrition programmes in Rakhine State. The barriers and bottlenecks identified through the literature review, the KII's and the workshop have been prioritised for action. While there was a lack of consensus over the degree to which each barrier impacted acute malnutrition/ wasting treatment between NRS versus Southern/ Central Rakhine, and camp versus village settings, the identified barriers are relevant to all contexts.

Priority barriers and solutions

While it is good to have a complete overview of all the different barriers, we cannot and we would not want to address each and every issue identified. Seven barriers were therefore selected as priority barriers based on how many times they were mentioned by different participants and their potential to have the biggest impact on implementing and scaling up nutrition services (table 7). The first five priority barriers are barriers related to acute malnutrition/ wasting treatment services, either as experienced by service providers or by mothers. The last two priority barriers are barriers related to other nutrition services. Solutions outlined in Table 7 are specific to each priority barrier but also incorporate the overall priority solutions identified in the solutions workshop.

Low-priority barriers

Low-priority barriers are barriers only mentioned a few times by KIIs, which had limited impact on implementing and scaling-up nutrition services, or where there was a lack of consensus amongst partners on whether they were barriers or not. Solutions have not been prioritised for these barriers. These barriers include:

- Possible limited or lower quality nutrition services when carried out by community volunteers.
- Limited or lower quality treatment services due to relaxation and adaption to COVID-19 guidelines.
- Limited possibility to conduct active screening during spikes in COVID-19 cases.
- Whether health volunteers/ staff have limited time and/ or interest to implement nutrition services if nutrition services are further scaled-up through the health sector.

Gender-related barriers

There were suggestions that men are the key-decision makers in their family or household. In the workshop, it was discussed that women have limited decision-making power and are not allowed to go outside, especially in camp settings and in NRS. This suggests that to ensure women seek services for their child, husbands/ men need to be convinced that nutrition services are important. The reason for why husbands do not allow their wives to seek treatment has not been explored, but ideas on this can be inferred. Is it because they are against nutrition services or because they see other barriers their wives have to face to access services?

Table 7: Priority barriers and solutions related to nutrition treatment services and other nutrition services

| BARRIERS | SOLUTIONS |
|--|---|
| Nutrition treatment services | |
| <p>Priority Barrier 1: Limited accessibility for service providers, due to authority restrictions, with the following related barriers:</p> <ul style="list-style-type: none"> ● Difficulty obtaining and limitations of provided travel authorisation (TA) and memorandum of understandings (MOUs).¹⁵ ● Dual administration (government & Arakan army). ● No permission to work in some geographical areas (some long-term, some temporary). ● No permission to implement certain activities (some long-term, some temporary). ● Staff not able to access communities or camps or conduct activities due to COVID-19. | <p>While some restrictions are out of the control of implementing agencies, within allowed locations/ activities it is important to continuously adapt to new requirements to get TA.</p> <p>With the uncertainty of staff travel, more nutrition services should be implemented through community-based volunteers:</p> <ul style="list-style-type: none"> ● Active case finding through volunteers using MUAC. ● Preposition ready-to use food supplies at the office level so even if TA is not provided, distribution can be done by volunteers. ● Staff to give instructions to volunteers either in person at the office, outside or at the camp/ village, or otherwise by phone, depending on what is possible at that time. ● Staff to give instructions on what nutrition education should be given to who and what to do in specific situations. This would allow volunteers to conduct follow up visits for SAM/ MAM cases through home visits if needed. ● Outpatient therapeutic programme (OTP) staff to give instructions to mothers/ caretakers of serious cases by phone, to monitor their progress, encourage absentees/ defaulters to return to the OTP, and to encourage them to accept help from village-based volunteers when offered. |
| <p>Priority Barrier 2: Limitations in working with government, due to strategy for minimum engagement with government or insufficient/disrupted government services:</p> <ul style="list-style-type: none"> ● Unable to follow up or refer cases to government treatment services, resulting in absent or missing referrals. ● Unable to scale-up through the government . ● Organisations previously working with the government have to change modality. ● High need for treatment services puts more pressure on non-government treatment services. | <ul style="list-style-type: none"> ● UNICEF to continue to support and facilitate nutrition supplies for government treatment facilities; if the government lacks supplies, organisations can inform UNICEF about the specific locations. ● Switch to non-government treatment services if possible (e.g. OTP in Pauktaw camps also accept cases from villages). ● Consider following up cases referred to government treatment services to ensure services are accessed; if not with the government, then with the mother or caregiver. ● Conduct advocacy to allow implementation of non-government nutrition services where needed, with NGOs expanding to those areas. ● NGOs to scale-up treatment services to cover gaps in geographic coverage (see priority barrier 3). |

¹⁵ A memorandum of understanding (MOU) is obtained from the government and it allows implementing partners to provide specific activities in specific locations within a project. Travel authorisation (TA) is also obtained from the government each time an organisation needs to travel in Rakhine and typically includes limitations such as which activities are allowed and in which locations.

| | |
|---|---|
| <p>Priority Barrier 3: Difficult to scale-up services and limited coverage of treatment services:</p> <ul style="list-style-type: none"> Restrictions by authorities, long/ difficult process to change MOU's, current limitations to scale-up through government services and limited capacity and interest of NGOs to scale-up. Treatment services should be available for those who are referred. Women who do not seek treatment for their child have no time to seek treatment due to being further away from available services, find transportation and travel difficult, and find it very difficult to get authorisation to travel. | <ul style="list-style-type: none"> Scale-up through 'new' NGOs, including health partners (MSF, IRC, Malteser International, others). Scale-up by integrating treatment services into mobile services. Scale-up by working with and investing in community-based volunteers. Where possible, scale-up by increasing the number of nutrition centres and mobile services in different areas of townships. Scale-up by recruiting more community-based volunteers and staff. Ensure good coordination between different implementing partners in order to scale-up effectively and to have sufficient geographic and population coverage. Ensure good coordination among donors through keeping 4Ws updated and facilitating discussions on how to fill existing gaps for 2022. Accept lower quality services and allow some relaxation of protocols, as proposed in the revised guidelines published during the COVID-19 pandemic (not mentioned in KII's). For example, this may include a lower number of follow-up visits for mothers/ caregivers who live very far from the OTP and who do not have access to local services. Follow-up referrals to assess whether they have accessed treatment. Provide more comprehensive programmes where one organisation does the screening and treatment of SAM and MAM. Develop a standardised system providing transport costs depending on distance and ensure mothers know about it. |
| <p>Priority Barrier 4: Limited accessibility to treatment services due to:</p> <ul style="list-style-type: none"> Women not knowing where treatment services are available and not being confident that they can complete the necessary treatment. Women are not seeking treatment as they have less confidence in NGO-led nutrition services and prefer treatment by a doctor or hospital. The husbands of women who do not seek treatment being more likely to not approve of the mother taking their child for wasting treatment compared to women who do seek treatment. Women seeking treatment for their child as they believe their child can be cured if he/ she receives treatment, while other women not seeking wasting treatment as they are less likely to believe their child would be cured. | <ul style="list-style-type: none"> Share information with beneficiaries on where treatment services are available and functional. Support women who do seek treatment for wasting to work with their family members and neighbours to share how treatment has cured their child and why they support and encourage treatment. Share information with beneficiaries on which treatment services are and are not provided at a nutrition centre, and that cases with complications are always referred. Discuss with mothers what specific support they need to complete the recommended treatment and provide this support if possible, including support for transport costs if needed. Explore why husbands disapprove of their wives seeking treatment; if those who seek treatment are further away from treatment services, or if husbands think it is too difficult, too costly, too time-consuming etc. for their wife. In that case, providing transport costs may help as well as expanding treatment services closer to their home. |

| | |
|---|---|
| <p>Priority Barrier 5: Lack of data and limited understanding of the actual, current situation.</p> | <ul style="list-style-type: none"> Partners to utilise the simplified tool for assessing the nutrition situation, including MUAC screening and IYCF assessment, and training provided by UNICEF (in progress) to better understand the current situation in various locations in Rakhine. |
| <p>Other nutrition services</p> | |
| <p>Priority Barrier 6: It is difficult for people to adopt optimal IYCF practices and other recommended practices given the current economic, political and humanitarian situation, including seeking and receiving healthcare/ treatment and not sharing food/ cash intended for women and children with other family members.</p> | <ul style="list-style-type: none"> Implement a variety of interventions to prevent further deterioration of household income and food security, for example food/ cash distributions, cash for work, support to local food production, cash grants to support local businesses etc. Considering the humanitarian context, it is crucial that BSFP, MNP distribution and MCCT programmes which particularly target mothers and children are continued and scaled-up if needs increase. To take into account sharing within the family, increase the quantity of food/ cash distributed to mothers and children to accommodate some sharing and ensure women and children still receive sufficient amounts. Implement multisectoral nutrition programmes including livelihoods, behaviour change communication, water, sanitation and hygiene (WASH), food security etc. to address the causes of malnutrition. Without addressing these, malnutrition rates will remain high and may even increase. Ensure that IYCF counselling is continued and tailored to the needs of mothers and their families. If needed, this can be done by staff over the phone if mothers have a phone, or by community-based volunteers if they are trained and coached, possibly using a targeted number of messages. |
| <p>Priority Barrier 7: Restrictions to meet in larger groups due to COVID-19 restrictions, affecting BSFP, cooking demonstrations, awareness sessions and mother support groups</p> | <ul style="list-style-type: none"> For BSFP distributions, set up food management committees in each location. This committee would be responsible for distributing food to 2-3 beneficiaries who represent a group of 10 families. The distributions can still be done once a month with the same amount of food, but this approach will help to reduce the number of contacts. As advised by the Nutrition Cluster in Rakhine, if a gathering of around 10 people is allowed, it is possible to set up mother groups safely with physical distancing, temperature checks, good ventilation and face mask wearing. If a gathering with around 10 people is not allowed, consider reducing mother groups to 3-5 people instead. Cooking demonstrations and community awareness sessions may not be possible if there are restrictions to group sizes. |

6. Recommendations

The following are recommendations for next steps to ensure the findings from this report are utilised effectively.

1. **Rakhine Nutrition Cluster to facilitate a session with existing and new potential implementing partners to determine how the key findings can be taken forward in projects and programmes in Rakhine.** The following should be considered:
 - a. *Identify locations where government services have been suspended.* Implementing partners and UNICEF as the cluster lead agency to seek funding and authorisation for implementing partners to provide nutrition services in locations where government services have been suspended.
 - b. *Identify what modalities are feasible and effective by which partners in what contexts.* For example, the optimal modality to scale-up wasting treatment services depends on what resources are available and what services already exist in each location. Options include:
 - i. Recruit and train new implementing partners such as health-focussed organisations (e.g. Malteser International);
 - ii. Expand services by existing partners already in locations where there are service gaps;
 - iii. Integrate services in existing community health systems such as mobile services or through community-based volunteers who already conduct screening.
 - c. *Determine how simplified approaches can be used to address barriers.* While the adoption or scale-up of simplified approaches was not identified to be a priority solution, these can support a more effective and efficient approach. Nutrition partners in Rakhine prefer to follow national guidelines as they believe it improves the quality of the programmes. If research-based information is available on the effectiveness, feasibility and limitations of simplified approaches, this could be used to inform discussion and scale-up of relevant simplified approaches.
2. **Implementing partners to determine how relevant solutions from this report can be integrated or adapted** in their programming to improve coverage of nutrition services. This may require seeking additional funding to support increased coverage of services.
3. **Findings should inform the Rakhine-level communications and advocacy strategy.** Barriers which require advocacy include implementing partners gaining access to implement in areas where government services have been suspended.
4. **Donors to provide funding to partners to incorporate the solutions to priority barriers that have been identified in this report.** Ensure flexibility in donor agreements based on the identified barriers, such as allowing adaptations to locations and programming as needed. This may include providing funds for transportation so cases can access treatment services at health facilities.
5. **Conduct further research to address the identified barriers for which solutions were not identified,** including a) the reasoning behind men/ husband's decision-making, and b) how simplified approaches can be used in the Rakhine context.

Annex 1: Key informant interview questionnaire

Introduction

The Humanitarian Assistance and Resilience Program Facility (HARP-F) is funding humanitarian assistance in Myanmar since 2017. HARP-F, LIFT and Access to Health are supporting a range of implementing partners to address nutrition needs in camps and non-camp settings. They have jointly drafted a Nutrition Action Plan with the aim of reducing the prevalence of wasting and stunting in Rakhine State. One activity in this action plan is to conduct an analysis to identify barriers and bottlenecks for implementation of nutrition programming in Rakhine State. The analysis would look at all nutrition services being provided, with a particular focus on wasting treatment, and identify solutions to challenges identified.

We would like to ask you some questions to get your opinion, experience and ideas on the barriers with regards to nutrition services in Rakhine. We plan to interview all key service providers of nutrition services to get a good understanding of the actual situation. In this interview, we will focus primarily on barriers and bottlenecks. After collecting and grouping these, we plan to organise an (online) workshop on Friday December 10th to discuss the results and to agree on possible solutions.

We would like to focus on the provision of nutrition services since 1st of February 2021 onwards, given the acute change in context from this date.

Therefore, in your answers please consider the time period from that date onwards.

Note that we will not record anyone's name or organisation and that answers are recorded completely anonymously.

1. General questions

| | | |
|----|---|---|
| 1a | Does your organisation implement nutrition services yourself or through implementing partners? | <ul style="list-style-type: none"> A. Implement ourselves B. Through implementing partner C. Both own implementation and through partner |
| 1b | Where does your organisation or implementing partner(s) work? | <ul style="list-style-type: none"> A. Northern Rakhine only B. South/Central Rakhine only C. Both NRS and South/Central Rakhine |
| 1c | Which nutrition services does your organisation or your implementing partner(s) provide? (Select all that apply.) | <ul style="list-style-type: none"> A. Treatment of moderate acute malnutrition (MAM) B. Treatment of severe acute malnutrition (SAM) C. Screening and referral of acute malnutrition D. IYCF counselling E. Mother groups F. IYCF safe spaces G. Baby WASH H. BMS code monitoring I. Blanket Supplementary Feeding Program (BSFP) J. Growth Monitoring K. Food/cash distribution/MCCT (Maternal & Child Cash Transfer) L. Other.... (specify) |

If A or B, continue with Section 2. If not involved in A or B, continue with Section 3.

2. Organisations who provide treatment services (MAM or SAM treatment)

The following questions are exclusively for treatment of acute malnutrition, NOT for other nutrition services.

| | |
|----|---|
| 2a | <p>Your organisation or implementing partner is providing treatment services and/or screening and referral for acute malnutrition. This year, were you able to provide the treatment services in Rakhine as planned? If not, what were you not able to do? (Consider period from February 2021 up to now.)\ Why were you not able to do them?</p> <p><i>Probing questions:</i> Able to do community mobilisation / sensitization? Able to do case finding (active/passive)? Able to provide counselling? Able to follow up cases? Able to provided targeted supplementary feeding (TSFP); able to provide RUTF or RUSF? Able to refer children to different programs as needed (ITP or SC, OTP, SFP2)?</p> <p>Able to provide services in all planned locations? Or, in case you work though mobile clinics, where you able to implement those as planned?</p> |
| 2b | <p>Are you aware of the Adapted Emergency Nutrition Programming Guidance during COVID-19 in Myanmar which was produced by the Strategic Advisory Group of the Myanmar Nutrition in Emergencies working group (under MNTN)?</p> <p>It includes simplified procedures, approaches and adaptations for nutrition services, such as on IMAM guidelines, during these challenging times. This includes for example reducing follow up services during treatment, using MUAC only for admission and discharge, or using mother or family MUAC. What changes in treatment services or screening & referral for acute malnutrition did your organisation apply to support continuation of treatment after February 2021?</p> <p><i>Probing questions: Any other changes? Changes to ensure safety of staff? Changes to make mothers feel safe and comfortable to join?</i></p> <p><i>Changes in frequency to follow up cases? Changes to prevent COVID transmission? Any changes in dosage of RUTF or RUSF? Any changes in admission or discharge procedures?</i></p> |
| 2c | <p>When providing treatment services or screening and referral for acute malnutrition, did you experience any barriers and bottlenecks to provide those services in Rakhine? If yes, what barriers and bottlenecks did you experience?</p> |
| 2d | <p>Do you think that there are differences in barriers to provide treatment services in different locations in Rakhine; for example, NRS versus South/Central Rakhine, or camp versus non-camp setting? If yes, what are those differences?</p> |
| | <p><i>Probing questions for 2c and 2d:</i> Any barriers related to service provision? Human resources, other resources, knowledge, safety? Any supply chain issues? Availability of donor funding? Availability of clear guidelines and guidance for treatment programs? Adequate coordination mechanism in Rakhine? Sufficient capacity and training for staff? Any barriers related to mothers being able to come?</p> |

| | |
|----|---|
| 2e | Wasting prevalence is quite high in Rakhine and considering both the impact of COVID and the coup, it may have even increased in 2021. Did your organisation consider to scale up treatment services? (If 'no', go to 2f. If 'yes', go to 2g.) |
| 2f | If no, why not? |
| 2g | If yes (you considered to scale up), did you manage to do so? (If 'no', go to 2h. If 'yes', go to 2i.) |
| 2h | If you did not manage to scale up, why not? |
| 2i | If you managed to scale up, how did you organise that? What did you need to scale up? |
| 2j | Wasting prevalence has been high in Rakhine for a long time although different organisation and donors are supporting treatment, screening and referral. Do you think that treatment services for acute malnutrition are proficient in Rakhine (=sufficient coverage according to need)? If no, what do you think are the main reasons that it is difficult to increase the coverage of treatment programs in Rakhine? |
| 2k | Are those reasons different in different locations in Rakhine; for example, NRS versus South/Central Rakhine, or camp versus non-camp setting? If yes, what is different? |
| 2l | In your opinion, what can we do to improve coverage of treatment services? |

3. Organisations who provide other nutrition services (other than treatment services)

The following questions are exclusively for any other nutrition services = other than treatment of acute malnutrition. This may include IYCF, BSFP, growth monitoring, cash/food distribution, MCCT, micronutrient supplementation and other interventions that are not related to treatment.

| | |
|----|---|
| 3a | Your organisation or implementing partner is providing other nutrition services (other than treatment services). This year, were you able to provide those nutrition services in Rakhine as planned? If not, what were you not able to do? (Consider period from February 2021 up to now.) |
| | <i>Probing questions:</i> <i>What other nutrition services were you not able to do?</i> <i>Not able to provide services in all planned locations? Or, if you work through mobile clinics, were you able to implement as planned?</i> |
| 3b | What changes in nutrition services did your organisation apply to support continuation of interventions after February 2021? |
| | <i>Probing questions:</i> <i>Any other changes? Changes to prevent COVID transmission?</i> <i>Changes to ensure safety of staff? Changes to encourage mothers and to make them comfortable to join?</i> <i>Any changes in items distributed or amounts distributed (e.g. cash, BSFP)?</i> |
| 3c | When providing nutrition services, did you experience any barriers and bottlenecks to provide those services in Rakhine? If yes, what barriers and bottlenecks did you experience? |
| 3d | Do you think that there are differences in barriers to provide nutrition services in different locations in Rakhine; for example, NRS versus South/Central Rakhine, or camp versus non-camp setting? If yes, what are those differences? |
| | <i>Probing questions for 2c and 2d:</i> <i>Any barriers related to service provision? Human resources, other resources, knowledge, safety?</i> <i>Any supply chain issues? Availability of donor funding? Availability of clear guidelines and guidance for nutrition programs? Adequate coordination mechanism in Rakhine? Sufficient capacity and training for staff?</i> <i>Any barriers related to mothers being able to come?</i> |

| | |
|----|---|
| 3e | Malnutrition prevalence is quite high in Rakhine and considering both the impact of COVID and the coup, it may have even increased in 2021. Did your organisation consider to scale up nutrition services? (If 'no', go to 2f. If 'yes', go to 2g.) |
| 3f | If no, why not? |
| 3g | If yes (you considered to scale up), did you manage to do so? (If 'no', go to 2h. If 'yes', go to 2i.) |
| 3h | If you did not manage to scale up, why not? |
| 3i | If you managed to scale up, how did you organise that? What did you need to scale up? |

| | |
|----|--|
| 3j | Malnutrition prevalence has been high in Rakhine for a long time although different organisations and donors are supporting nutrition specific and nutrition sensitive interventions. Do you think that nutrition interventions are proficient in Rakhine (=sufficient coverage according to need)? If no, what do you think are the main reasons that it is difficult to increase the coverage of nutrition programs in Rakhine? |
| 3k | Are those reasons different in different locations in Rakhine; for example, NRS versus South/Central Rakhine, or camp versus non-camp setting? If yes, what is different? |
| 3l | In your opinion, what can we do to improve coverage of nutrition services? |

4. Final question to all organisations

| | |
|----|---|
| 4a | Did you ever hear about MAMI = M anagement of small and nutritionally a t-risk infants under six months and their m others? This approach supports the identification, assessment and management of small and nutritionally at-risk infants under 6 months as there is often no specific support for those small infants. Do you think that this could be an important intervention in Rakhine? Does your organisation have any specific approach to identify and support infants at risk under 6 months? |
|----|---|

5. Any other suggestions

| | |
|----|---|
| 5a | Thank you very much for sharing your time and ideas. We really appreciate it. Are there any other comments or suggestions that you like to share before we close? Please feel free to do so. |
| 5b | If we have any specific questions or clarifications, may we contact you? |

Closing

Thanks again for your kind participation.

As mentioned in the beginning, we plan to conduct a workshop on Friday 10th of December to share the results and also to discuss together about possible solutions to address the barriers and bottlenecks related to nutrition services. It will be an online workshop. You are warmly invited to join as well.

Annex 2: Terms of Reference

Barriers, Bottlenecks and Solutions for Nutrition Programming in Rakhine State, Myanmar

Background and context

Humanitarian Assistance and Resilience Programme Facility (HARP-F)

The Humanitarian Assistance and Resilience Programme Facility (HARP-F) is an innovative instrument funding humanitarian assistance in Myanmar, specifically designed to strengthen the role of national civil society in rapid onset and protracted crises. Through our partners, we have been working to address acute humanitarian needs, build resilience and reduce the vulnerability of populations affected by successive crises and natural disasters in Myanmar and on the border with Thailand since 2017. We have channelled over £74 million of UK humanitarian funding to local, national and international partners to provide assistance to the most vulnerable populations, primarily internally displaced persons (IDPs) and refugees. We have granted another £4.3 million for COVID-19 prevention and control.

We aim to strengthen the role of national and local partners in humanitarian response in Myanmar, through our grant programme and our extensive capacity enhancement training programme. This strong reliance on local partners, as well as context-specific, adaptive programming, is what enabled HARP-F to quickly mount a COVID-19 response in 2020 in Myanmar and to continue to operate and meet the humanitarian needs of the most vulnerable populations following the February 2021 military coup.

Nutrition Situation in Myanmar and Rakhine State

Good nutrition at an early age and for women is the foundation to a child's survival and development. In the first 1,000 days between woman's pregnancy to her child's second birthday are crucial to a child's development; the baby needs the right nutrients at the right time to feed the brain's development. Poor nutrition in the first 1,000 days causes wasting (too thin for height) in children, increasing mortality. In the long-term, inadequate nutrition can cause irreversible damage to the child's growing brain affecting their ability to do well in school or earn in the future. Some studies have linked early childhood undernutrition to adult obesity, diabetes and other chronic diseases. With Myanmar plagued by conflict and highly vulnerable to natural disasters and climate change, malnutrition is a major concern in Myanmar. Under-five mortality in Myanmar remains one of the highest in the South-East Asia region and Myanmar is one of Asia's poorest countries.

Nutrition-specific and nutrition-sensitive service provision in Rakhine specifically 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 Family Mid-Upper Arm Circumference (Family MUAC), which has been shown to be feasible, and piloting simplified approaches to wasting treatment, for example for low-literacy health workers and volunteers or in the absence of sufficient quantities of RUTF. Other opportunities also include integration of nutrition services into mobile health clinics and the use of modified protocols. 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. Yet, nutrition has been neglected in the humanitarian response. Urgently, this calls for a new coordinated strategy to prioritise nutrition as a central part of the humanitarian response in Myanmar.

HARP-F's role in prioritising nutrition in Myanmar

In March 2021, HARP-F finalised a nutrition baseline report to assess the challenges impacting nutrition programming in Rakhine State, and to make recommendations to better address malnutrition moving forward. One recommendation was to 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).

Alongside this effort, HARP-F, LIFT and Access to Health are supporting a range of implementing partners to address nutrition needs in camp and non-camp settings and have drafted a joint Nutrition Action Plan with the aim of reducing the prevalence of wasting and stunting in Rakhine State. The Nutrition Action Plan consists of ten actions and associated activities with a humanitarian focus, designed to address the recommendations arising from the nutrition baseline report. These actions are to be completed with the support of FCDO as required, and in collaboration with the nutrition sector, their activities and strategies, from June 2021 through to June 2022.

The key intended outcomes of the area under evaluation are:

One activity included in the Nutrition Action Plan, under priority 2 to increase coverage of nutrition services, is to conduct an analysis to identify the barriers and bottlenecks for implementation of nutrition programming in Rakhine State, Myanmar. This analysis would look at all nutrition services being provided, with a particular focus on wasting treatment, and identify solutions to challenges identified.

Purpose of the analysis and target audience

The purpose of this research is to understand what the current situation is regarding nutrition service provision, in particular for lifesaving services such as wasting treatment, in order to determine needed solutions to identified challenges. As there is a lack of understanding of the common barriers and bottlenecks to nutrition programming in Rakhine State in Myanmar, this research aims to identify such challenges and bottlenecks and develop realistic actionable solutions to overcome the challenges.

Recent changes in the nutrition context in Myanmar are likely to have created further challenges to an already inadequate service provision in Rakhine State. Changes to the Myanmar context include the COVID-19 pandemic, the military coup in February 2021, the resulting violence and conflict, and disruption to health service provision due to participation in and arrests related to the civil disobedience movement.

This work would build off of previously conducted work and already known barriers, such as a poor referral system for wasting treatment, weak supply management, reporting issues, poor linkages for case management etc. This work should also include a gender analysis as a known barrier to access. The results of this analysis will inform future adaptations required to increase coverage of nutrition service provision by the nutrition sector, improving access to services by the population in need and identifying how the nutrition sector, partners and broader humanitarian response can support this effort. This work may also influence FCDO's future funding priorities.

Analysis objective and scope

Geographic scope

This analysis will focus on Rakhine State in Myanmar.

Target groups to be included in the analysis

While nutrition programming tends to focus on children under 5 years of age, plus pregnant and lactating women (PLW), this analysis should include any beneficiary of nutrition programming including fathers, male caretakers, grandmothers etc. as relevant.

Nutrition services to be included in the analysis

- Severe and moderate wasting treatment (inpatient severe wasting care, outpatient therapeutic programmes (OTP) for severe wasting, targeted supplementary feeding programmes (TSFP) for moderate wasting treatment and community mobilisation, including referrals between all services (this should be the main focus of the analysis given the lifesaving nature of this service)
- Infant and young child feeding (IYCF), including in emergencies (IYCF-E) e.g. IYCF individual counselling, mother support groups, IYCF safe spaces, Baby WASH, breastmilk substitutes (BMS) code monitoring
- Maternal/ female adolescent nutrition services including micronutrient supplementation, blanket supplementary feeding programmes (BSFPs), food/cash distributions and social and behaviour change communication (SBCC) strategies for nutrition, maternal and child cash transfers (MCCT)
- Growth monitoring and BSFPs for children under 5 years of age
- Nutrition services, e.g. MUAC screening, integrated into other sector activities, e.g. water, sanitation and hygiene (WASH), and vice versa

Time period to be covered by the analysis

This analysis will focus on the provision of nutrition services since 1st February 2021 onwards, given the acute change in context from this date. The analysis will concentrate on where nutrition service provision has stabilised to now, given this is the 'new normal', looking at the barriers and bottlenecks in existence currently and recommending solutions relevant for the current context, in order to improve coverage of nutrition services moving forward.

Analysis questions and tasks

Primary questions of the analysis:

1. What barriers and bottlenecks exist in Rakhine State to increasing coverage of wasting treatment services? Consider Northern Rakhine State (NRS) versus South/Central Rakhine State, and camp versus non-camp settings.
2. What are the root causes of the identified barriers and bottlenecks for increasing coverage of wasting services?
3. What solutions are recommended to overcome the identified barriers and bottlenecks to increasing wasting treatment services? What solutions are proposed by key informants familiar with the context? Identify immediate, medium-term and long-term priorities in order to achieve the recommended solutions. Consider NRS versus South/Central Rakhine State, and camp versus non-camp settings.

Secondary questions of the analysis:

4. What barriers and bottlenecks exist in Rakhine State to increasing coverage of other nutrition services including IYCF/IYCF-E, MNP distribution, BSFP, food/cash distributions, SBCC for nutrition, GMP, MCCT and nutrition activities integrated into other sectors? Consider NRS versus South/Central Rakhine State, and camp versus non-camp settings.
5. What are the root causes of the identified barriers and bottlenecks for increasing coverage of other nutrition services?
6. What solutions are recommended to overcome the identified barriers and bottlenecks to increasing coverage of nutrition services other than wasting treatment? What solutions are proposed by key informants familiar with the context? Identify immediate, medium-term and long-term priorities in order to achieve the recommended solutions. Consider NRS versus South/Central Rakhine State, and camp versus non-camp settings.

Approach and Methodology

This analysis can be completed in various ways, with the final methodology to be discussed with the successful consultant. A proposed scope of work is as follows:

- Secondary literature review of existing documentation available from previous studies/ analyses relating to the barriers/ bottlenecks to increasing coverage of nutrition services
- Collection and analysis of all relevant data available e.g. data on stock-outs, data on referrals vs arrivals at wasting treatment sites in public and private sectors etc.
- Multi-stakeholder consultation to interview ~15-20 key informants to identify key barriers, bottlenecks and root causes of these, and to identify potential solutions e.g. Nutrition Sector Coordinator, UNICEF, WFP, INGOs including Save the Children and ACF, NNGOs including MHAA and State health Department (where feasible)
- Report writing including identified barriers and bottlenecks, with solutions recommended for each. Solutions to be determined by best practice from global/similar contexts and from suggestions made in interviews with key informants
- Workshop with key informants to present draft report and agree on potential solutions
- Incorporation of internal and external feedback to produce final report