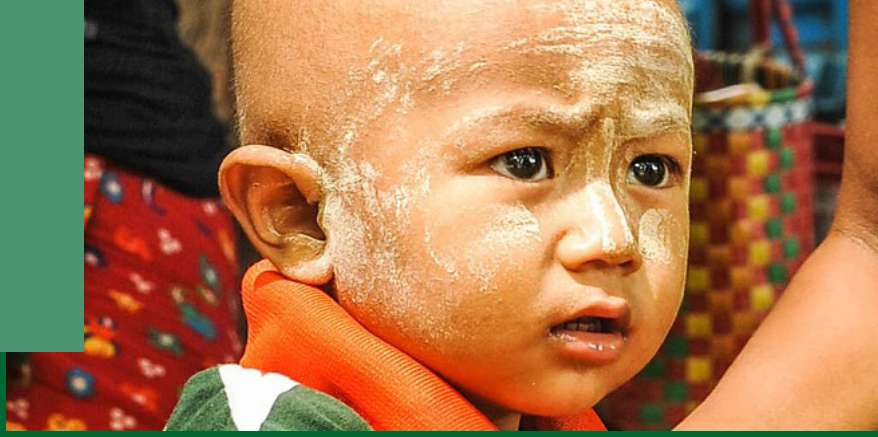
BARRIERS, BOTTLENECKS AND SOLUTIONS FOR NUTRITION PROGRAMMING IN RAKHINE STATE, MYANMAR

REVIEW



Executive Summary

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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.

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Barriers and solutions related to nutrition treatment services

Solutions	Solutions
Priority Barrier 1: **Limited accessibility for service providers, due to authority restrictions**, with the following related barriers: • 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.	• 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: • 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.
Priority Barrier 2: **Limitations in working with government,** due to strategy for minimum engagement with government or insufficient/disrupted government services: • 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.	• 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.

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Barriers and solutions related to nutrition treatment services

Barriers	Solutions
Priority Barrier 3: **Difficult to scale-up services and limited coverage of treatment services:** • 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.	• 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.

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Barriers and solutions related to nutrition treatment services	
Barriers	**Solutions**
Priority Barrier 4: **Limited accessibility to treatment services due to:** • 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.	• 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.
Priority Barrier 5: **Lack of data and limited understanding of the actual, current situation.**	• 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.

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Barriers related to other nutrition services	
Barriers	**Solutions**
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.	• 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.
Priority Barrier 7: **Restrictions to meet in larger groups** due to COVID-19 restrictions, affecting BSFP, cooking demonstrations, awareness sessions and mother support groups	• 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.

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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.

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