Ending malnutrition for every last child in Myanmar

What's the problem?

According to a new analysis of data from the 2010 Integrated Household Living Conditions Survey by the World Bank in 2014, an average of **37.5% of households in Myanmar are living in poverty.**[i] Myanmar is a predominantly rural society, and approximately three-quarters of the poor reside in rural areas.[ii]

Stunting[1] **prevalence in children under five is significantly higher in rural than urban areas** (38% and 27%, respectively). Children living in the poorest households are more than twice as likely to be stunted (46.6%) than those living in the wealthiest households (20.7%).[iii]

Both **Rakhine State and Ayeyarwaddy Region stand out for having both high poverty rates and large numbers of people in poverty.** Rakhine State has the *highest poverty rate* in the country, with 78% of the population living in poverty, and 15% of the country's poor live in Rakhine State. Rakhine also has the second highest rate of stunting in children in the country: 50% of children in the state are stunted. Ayeyarwaddy Region, located in southern Myanmar and bordering part of Rakhine State, has the *highest number* of poor people in the country; 18% of the country's poor live here.[iv]

It is important to note, however, that **stunting affects children across all wealth quintiles** – more than one in five children in the wealthiest households are stunted,[v] exceeding the WHO cut-off of <20% as 'acceptable'. In Myanmar, more than one third of all children under five years are stunted.[vi] This amounts to 1.6 million children, based on current population estimates.[vii] The prevalence of stunting is highest among children two to three years of age. However, nearly 15% of children under six months are already stunted, indicating poor growth and development beginning in utero.[viii]

Stunting represents a major barrier to child survival, learning and development. The immediate causes of stunting—chronic inadequate intake of food and frequent illness – are underpinned by underlying food and nutrition insecurity, poor caregiving practices for infants and young children and unhealthy environmental conditions, which are in turn shaped by income poverty, lack of access to capital and poor economic and social conditions. These underlying causes disproportionately affect children living in poor rural households in Myanmar. This is due to a variety of factors,[ix] which include: residing in villages in remote and hard-to-reach areas that lack access to basic services (health, education, etc.); few opportunities to lift children out of poverty; and political/ethnic conflicts that put children and their families at risk.

Children in poor rural households continue to lack access to their most basic needs. This is particularly the case in Rakhine State and Ayeyarwaddy Region, where ongoing ethnic and religious conflict (Rakhine State), high rates of landlessness and debt, poor accessibility to basic services and financial mechanisms, and vulnerability to natural disasters drive exclusion and the intergenerational transmission of poverty. [x]

A mother in a rural village near Pauk Taw Township, Rakhine State, said:

[1] Stunting refers to a child who is too short for his or her age. Stunting is the failure to grow both physically and cognitively and is the result of chronic or recurrent malnutrition. The effects of stunting often last a lifetime.

"I have a boy that is nearly nine months old. My husband and I are both paddy farmers. Our household income is about 100,000 kyats (US$80) per month. We spend about 70,000 kyats (US$55) on food. When my husband and I had difficulty trying to conceive a child, we went to Pauk Taw Township to see a general practitioner, who then referred us to a specialist in a hospital in Sittwe (a town in Rakhine State). The doctor in Pauk Taw cost us 8,000 kyats (US$6) including transportation, while the doctor in Sittwe cost us 90,000 kyats (US$70). I returned to Pauk Taw for four antenatal check-ups. I was afraid of pregnancy and delivery complications, so I went back to the hospital to deliver the baby. I had a normal delivery. I stayed there for eight days to make sure that everything was fine before leaving. It cost our family 200,000 kyats (US$160). In order to pay for the medical bills, I borrowed some money from my parents. I also pawned some jewellery and other assets.[xi]"

Poor rural households are at greater risk of food and nutrition insecurity and particularly vulnerable to increases in food prices and other shocks. Households living below the poverty line in Myanmar spend 74% of their total income on food, In comparison, households living above the poverty line spend on average 65% of income on food.[xii] This highlights the vulnerability of much of the Myanmar population.

Their precarious situation is compounded by the fact that rural households are less likely to have improved sanitation facilities. Fewer than 70% of households in rural areas have access to safe latrines, compared with 92% in urban areas.[xiii] Children living in households with no latrines – or unimproved latrines – are more likely to have diarrhoea, one of the risk factors for undernutrition. Rural households are also less likely to have access to safe drinking water. Only 63% of households in rural areas have access to an improved water source, compared with 87% in urban areas.[xiv] Children living in households without clean water are at least twice as likely to have diarrhoea as children living in households with clean water.[xv]

Inappropriate feeding practices affect nutrition security among all children in Myanmar, but the problem is compounded by other issues in poor households. In terms of infant and young child feeding practices, the most recent nationally representative data suggest that there are few differences in feeding practices between poor and wealthy households or between rural and urban ones.[xvi]

Our response

Save the Children is currently implementing Maternal and Child Cash Transfer (MCCT) programmes in three different rural regions of Myanmar, funded by the Livelihoods and Food Security Trust Fund. The programmes take a lifecycle approach, focusing on supporting pregnant and breastfeeding women with young children to improve their health and nutrition outcomes. **The MCCT programmes aim to prevent stunting during the critical window of the first 1,000 days** – from conception to the first 24 months of life.

The MCCT programmes **provide pregnant women with a monthly cash transfer for up to 30 months** (from their second trimester until their child is two). All beneficiaries are encouraged to attend nutrition-focused social and behaviour change activities, including mother-to-mother support group meetings, to attend four antenatal check-ups, and to have their child immunised. These are 'soft' conditions – women who are unable to fulfil all of the conditions, due to lack of healthcare access or other barriers, are not excluded from the programme.

The monthly cash transfer, complemented by the social and behaviour change communication, is expected to contribute to increased food security, improved intake of nutritious food, and **improved nutrition outcomes** in women and children within beneficiary households.

The MCCT pilot currently covers 469 women (January 2016) in 15 intervention villages (with 15 control villages). It is estimated that an additional 200 women will be enrolled in the 15 intervention villages by September 2016, when the pilot phase ends. However, the MCCT will also be scaled up, at the request of the Livelihoods and Food Security Trust Fund, to cover a total of 80 villages by the end of 2018. As of January 2016, an additional 10 villages were included, covering 325 women; these do not form part of the pilot scheme.

All three programmes align with the commitment in Myanmar's National Social Protection Strategic Plan to child-sensitive social protection and the proposal for cash allowances for pregnant women and children up to age two, to cover basic needs, including nutritional needs.

As Myanmar's National Social Protection Strategic Plan progresses, Save the Children can continue to influence the process and **advocate for a focus on achieving nutrition outcomes from social protection interventions**, building on what we have already achieved in 2014-15.

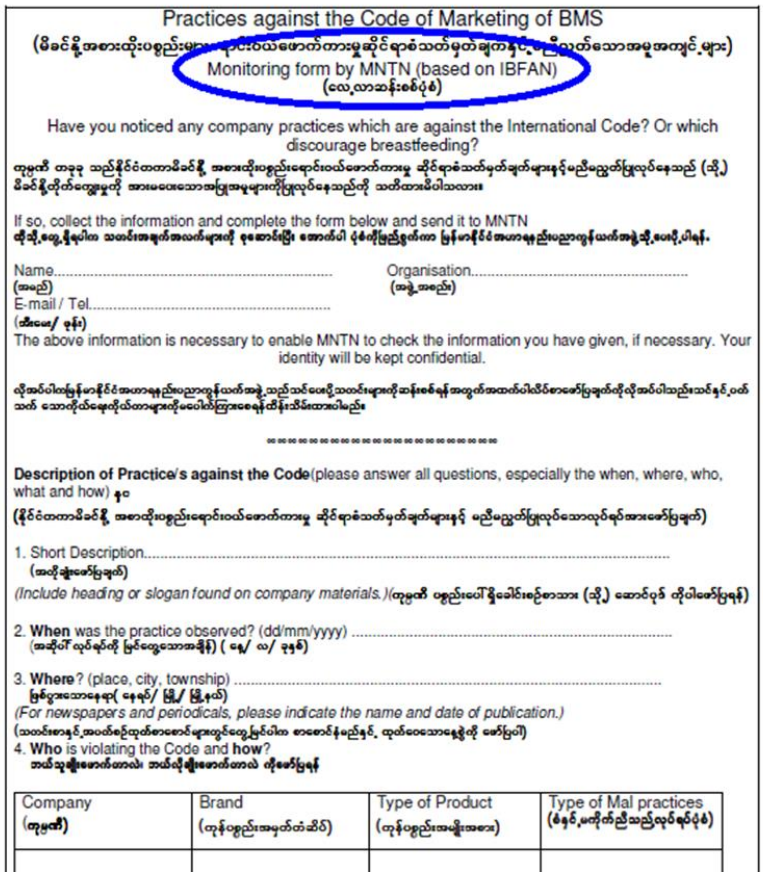
Promoting good practices during the first 1000 days

Exclusive breastfeeding and appropriate complementary feeding are key actions to prevent stunting and undernutrition in children.

Myanmar Food and Drug Board of Authority issued the **Order of Marketing of Formulated Food for Infant and Young Child.**[xvii] The Order follows the international public health recommendation for a Code of Marketing of Breastmilk Substitutes developed by WHO and adopted by the World Health Assembly in 1981. It aims to promote the health of infants and young children by protecting and supporting breastfeeding, and by ensuring the proper use of breastmilk substitutes and formulated foods for young children, when these are necessary, on the basis of adequate information and through appropriate marketing and distribution. The Order does not ban breastmilk substitutes or formulated foods, but sets out how companies are permitted to market them.

Unethical promotional methods undermine breastfeeding and encourage artificial infant feeding. The Order ensures that mothers and families are able to make appropriate and informed decisions about infant feeding.[xviii] This is important because **purchasing expensive breastmilk substitutes places a large burden on poor mothers,** who may succumb to doctors, celebrities, and other influential people and believe they can't produce enough milk, or that their milk is inferior.

Save the Children **developed a mobile application for monitoring the Order,** which was adopted by the Department of Health, National Nutrition Centre, and globally, by the International Code Monitoring Centre. This application is being widely used across the country, including in rural and remote areas, to monitor and report Order violations. An easy-to-use application, it allows the user to 'spot' a violation, take a snapshot, fill in some key data, and send the data directly to the International Code Documentation Centre and the National Nutrition Centre, where the violation is tracked and acted upon.



Practices against the Code of Marketing of BMS

(မိခင်နို့အစားထိုးပစ္စည်းများ ရောင်းဝယ်ဖောက်ကားမှုဆိုင်ရာစံသတ်မှတ်ချက်နှင့် ပြဋ္ဌာန်းထားသောအမူအကျင့်များ)

Monitoring form by MNTN (based on IBFAN)

(လေ့လာဆန်းစစ်ပုံစံ)

Have you noticed any company practices which are against the International Code? Or which discourage breastfeeding?

ကုမ္ပဏီ တခုခု သည်နိုင်ငံတကာမိခင်နို့ အစားထိုးပစ္စည်းရောင်းဝယ်ဖောက်ကားမှု ဆိုင်ရာစံသတ်မှတ်ချက်များနှင့်မညီမညွတ်ဖြူလုပ်နေသည် (သို့) မိခင်နို့တိုက်ကျွေးမှုကို အားပေးသောအပြုအမူများကိုပြုလုပ်နေသည်ကို သတိထားမိပါသလား။

If so, collect the information and complete the form below and send it to MNTN

ထိုသို့တွေ့ရှိရပါက သတင်းအချက်အလက်များကို ဒုဆောင်းပြီး အောက်ပါ ပုံစံကိုဖြည့်စွက်ကာ မြန်မာနိုင်ငံအဟာရနည်းပညာဖွန်ဒေးရှင်းအဖွဲ့သို့ ပေးပို့ပါရန်.

Name..... Organisation.....

(အမည်) (အဖွဲ့အစည်း)

E-mail / Tel.....

(အီးမေး/ ဖုန်း)

The above information is necessary to enable MNTN to check the information you have given, if necessary. Your identity will be kept confidential.

လိုအပ်ပါကမြန်မာနိုင်ငံအဟာရနည်းပညာဖွန်ဒေးရှင်းသည်သင်ပေးပို့သတင်းများကိုဆန်းစစ်ရန်အတွက်အထက်ပါလိပ်စာမှတ်တိုလိုအပ်ပါသည်းသင်နှင့်ပတ်သက် သောတိုင်ကြားတိုင်ကြားများကိုပေါက်ကြားစေရန်ထိန်းသိမ်းထားပါမည်။

Description of Practice/s against the Code(please answer all questions, especially the when, where, who, what and how) နှင

(နိုင်ငံတကာမိခင်နို့ အစားထိုးပစ္စည်းရောင်းဝယ်ဖောက်ကားမှု ဆိုင်ရာစံသတ်မှတ်ချက်များနှင့် မညီမညွတ်ဖြူလုပ်သောလုပ်ရပ်အားဖော်ပြချက်)

1. Short Description.....

(အတိုချုံးဖော်ပြချက်)

(Include heading or slogan found on company materials.)(ကုမ္ပဏီ ပစ္စည်းပေါ်ရှိခေါင်းစဉ်စာသား (သို့) ဆောင်ပုဒ် ကိုပါဖော်ပြရန်)

2. **When** was the practice observed? (dd/mm/yyyy) .....

(အဆိုပါလုပ်ရပ်ကို မြင်တွေ့သောအခိုန်) (နေ့/ လ/ ခုနှစ်)

3. **Where**? (place, city, township) .....

ဖြစ်ပွားသောနေရာ(နေရပ်/ မြို့/ မြို့နယ်)

(For newspapers and periodicals, please indicate the name and date of publication.)

(သတင်းစာနှင့်အဝတ်စဉ်ထုတ်စာစောင်များတွင်တွေ့မြင်ပါက စာစောင်နံပြုနှင့်, ထုတ်ဝေသောနေ့ရွှေတို့ ဖော်ပြပါ)

4. **Who** is violating the Code and **how**?

အဆိုသုးဖျိုးဖောက်တာလဲ၊ အဆိုလိုဖျိုးဖောက်တာလဲ ကိုဖော်ပြရန်

Company (ကုမ္ပဏီ)	Brand (ကုန်ပစ္စည်းအမှတ်တံဆိပ်)	Type of Product (ကုန်ပစ္စည်းအမျိုးအစား)	Type of Mal practices (ဖံနှင့်,ကိုက်ညီသည်လုပ်ရပ်ပုံစံ)

The Livelihoods and Food Security Trust Fund supports multiple programmes aimed at pulling rural families out of poverty in many of the country's poorest and most vulnerable regions.
Myanmar's Ministry of Health funds a school milk programme for primary school children, and UNICEF and the World Food Programme have promoted institutionalising the distribution of **micronutrient supplements** for pregnant and breastfeeding women and children through national health systems.
The international non-governmental organisation PATH has worked closely with the National Nutrition Centre to pilot test **rice fortification** in Myanmar. Rice fortification will be scaled up nationally in 2016. This is significant, because of the widespread use of rice as a 'first food' for infants.

All three of **Save the Children's MCCT programmes take a universal approach**, where all pregnant mothers and their children under two are eligible, independent of any other characteristic.

This is in contrast to **poverty-based selection methodologies**, such as means testing or proxy means testing, both of which include inherent inaccuracies and have high exclusion rates. For example, Mexico's Oportunidades excludes 70% of the poorest 20% of eligible households due to errors.[xix] Save the Children's MCCT programmes also do not enforce conditions on recipients, to minimise the likelihood of excluding the most vulnerable women due to their inability to comply with strict conditions.

Inclusive approaches, particularly when coupled with universal coverage, will **drastically reduce the exclusion error** rate for poor households.

Unlike many poverty-targeted schemes, **inclusive approaches have the potential to build greater political support** and generate higher budget allocations. Taking an inclusive and universal approach,Save the Children's MCCT benefits are made available across the wealth spectrum, reaching those living in poverty who are often politically weak, and those with middle to high incomes who wield far more influence on the political decision-making apparatus.

However, **social protection schemes are nascent** in Myanmar, and a roll out of universal coverage of MCCTs, even if adequately funded, will take time to reach very remote rural communities, especially in conflict-affected, or ethnically diverse areas. Further development and adaptation of delivery mechanisms to accommodate complex socio-economic environments where access and open engagement are highly contested will be required.

Save the Children's **pilot study in Rakhine State** has delivered promising preliminary results.[xx] The study commenced in 2013, with 15 interventions (cash plus social and behaviour change communication) and 15 control villages (social and behaviour change communication only). Monitoring data from this pilot indicate positive trends in several key areas.[xxi]

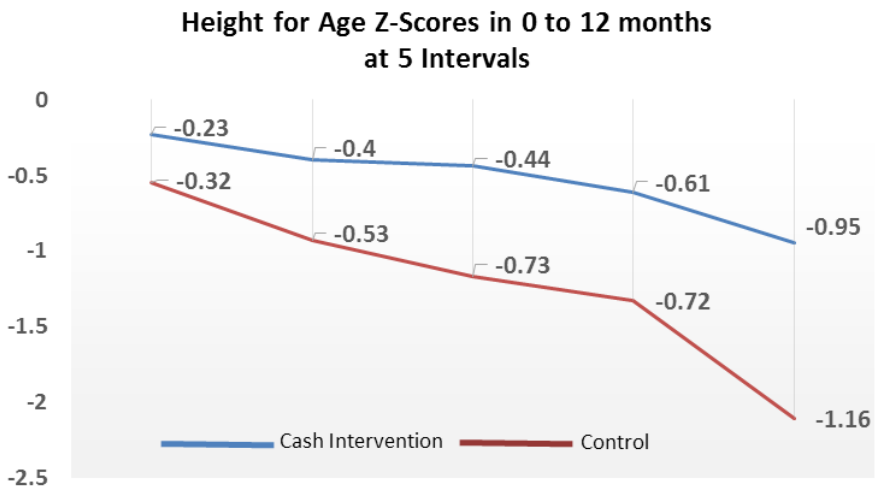
Exclusive breastfeeding rates between intervention and control groups were significantly higher at three measurement points:

- At delivery, 89.3% of intervention mothers practised exclusive breastfeeding, compared with 76.2% of control mothers (n=279) *(p = 0.004).
- At three months, 89.4% of intervention mothers continued to breastfeed exclusively, compared to 64.9% of control mothers (n=218)(p<0.001)
- At six months, the rates dropped for both groups: 23.6% of intervention mothers and 22.0% of control mothers were breastfeeding exclusively (n=156) (p=0.826), indicating that mothers were introducing complementary foods.

Individual dietary diversity was poor in both groups at six and nine months, but improved in the intervention group at 12 and 18 months. 23.5%, and 40% of children consumed four or more food groups in the Intervention villages at 12 and 18 months respectively, versus 14.3%, and 0 in the control villages. (n=62, 14) (p= 0.359, 0.134).

'Height for age' z scores', measured at five intervals to assess stunting in children, show a promising trend. Children in cash intervention villages had less stunting compared to children in control villages. The x axis represents the five intervals at which children were measured, and the y axis shows the level of stunting at each interval (average of the cohort in z scores). According to globally accepted WHO standards, children who fall <-2 z scores height for age are considered moderately stunted. Those who fall below -3 z scores are severely stunted.

Impact of cash transfer on stunting in pilot areas of Rakhine State
Delivery, 3 months, 6 months, 9 months, 12 months



Though not statistically significant, this trend implies a positive impact from cash.

The trend indicates that cash has contributed to improved breastfeeding practices, and the ability to afford a nutritious diet for children. However, further investigation will be need to determine the reason for poor dietary diversity in both groups between six and nine months.

The government's response

The government is not directly addressing inequalities and exclusion in malnutrition through their current programmes. This is partly due to the lack of resources and operational capacity.

Save the Children used global evidence, and preliminary findings from our first MCCT pilot in Rakhine, to demonstrate the impact of cash transfers combined with nutrition interventions on reducing the prevalence of stunting. This led to increasing levels of interest from major donors and government agencies, who saw our mixed behaviour change communication and cash transfer approach, within the social protection policy framework, as an innovative way to address the prevalence of stunting.

Building on this, Save the Children was heavily involved in the drafting of the Myanmar Government's National Social Protection Strategic Plan (December 2014). This includes an MCCT intervention focused on nutrition outcomes for mothers and children under two. The government also agreed in principle that the MCCT should be universal.

Subsequently, the Department of Social Welfare asked Save the Children and UNICEF to develop and submit an MCCT Feasibility Study and MCCT Operational Manual in the second half of 2015. The Department used this to advocate for, and successfully secure, additional budget for a potential MCCT-type intervention. However, with a new government coming to power in 2016, it is not clear how social protection policies and the MCCT will progress.

Save the Children has also been highly involved in developing and supporting the government's Action Plan for Food and Nutrition Security. The plan identifies both geographic and demographic criteria that contribute to

exclusion. Save the Children hosts the Scaling Up Nutrition (SUN) Civil Society Alliance network, which ensures that the voice of civil society is brought to the table in support of the rollout of the plan.

Myanmar has also endorsed the Zero Hunger Challenge, in which stunting reduction is one of five pillars aimed at improving food and nutrition security for all citizens.

As outlined above, the previous government made concerted efforts to work with development partners to draft a National Social Protection Strategic Plan (December 2014). Since 2015 was an election year, the social protection agenda stalled, and only after severe flooding across the country did the government reconsider the utility of social protection mechanisms to address both flood recovery activities and longer-term poverty alleviation. Save the Children has continued to push for a child-sensitive social protection mechanism focused on nutrition outcomes during the first 1,000 days as a priority. The outgoing government did allocate some budget for testing the MCCT along with a set of other cash transfer mechanisms in 2016, however the new government is not familiar with the MCCT approach and will require sensitisation on the social protection-nutrition nexus.

Myanmar's Department of Public Health, along with Save the Children, UNICEF and other non-governmental and UN partners, have worked to complete technical and operational guidelines for the Integrated Management of Acute Malnutrition, which will be included in health systems nationally, and for mitigating exclusion for rural children.

Lessons learned

The use of robust evidence (both global and preliminary findings from our first MCCT pilot in Rakhine) has served as a catalyst in driving broader policy reform through persistent and ongoing advocacy to both donors and government across the health and social welfare sectors. The evidence has been used strategically to demonstrate that social protection for nutrition outcomes is one of the most impactful interventions to reduce stunting. The design has focused on achieving nutrition outcomes and has been informed by a robust understanding of the drivers of nutrition, including feeding practices. The intervention takes an inclusive approach to address malnutrition by including all pregnant mothers and their children under the age of two and by encouraging participation in nutrition activities, rather than enforcing conditions for the receipt of cash transfers.

Save the Children is driving this evidence-based agenda with the continuation of the pilot research project in Rakhine and the launch of two additional studies. A randomised control trial will be conducted in one region to assess the impact of two different social and behaviour change communication approaches coupled with a cash transfer on the incidence of stunting in children. A case-control study will be undertaken in a different region to determine the efficacy of providing a cash transfer and social and behaviour change communication through existing health systems.

[i] World Bank Group. (2014). Myanmar: *Ending poverty and boosting shared prosperity in a time of transition.*

[ii] World Bank Group. (2014). Myanmar: *Ending poverty and boosting shared prosperity in a time of transition.*
[iii] Ministry of National Planning and Economic Development and Ministry of Health. (2011). *Myanmar Multiple Indicator Cluster Survey 2009-2010 Final Report.* Nay Pyi Taw, Myanmar: Ministry of National Planning and Economic Development and Ministry of Health, Myanmar.
[iv] World Bank Group. (2014). Myanmar: *Ending poverty and boosting shared prosperity in a time of transition.*
[v] Ministry of National Planning and Economic Development and Ministry of Health. (2011). *Myanmar Multiple Indicator Cluster Survey 2009-2010 Final Report.* Nay Pyi Taw, Myanmar: Ministry of National Planning and Economic Development and Ministry of Health, Myanmar.
[vi] Ministry of National Planning and Economic Development and Ministry of Health. (2011). *Myanmar Multiple Indicator Cluster Survey 2009-2010 Final Report.* Nay Pyi Taw, Myanmar: Ministry of National Planning and Economic Development and Ministry of Health, Myanmar.
[vii] Department of Population, Ministry of Immigration and Population (2015). *The Union Report: 2014 Myanmar Population and Housing Census Report.* Nay Pyi Taw: Government of the Republic of the Union of Myanmar.
[viii] Ministry of National Planning and Economic Development and Ministry of Health. (2011). *Myanmar Multiple Indicator Cluster Survey 2009-2010 Final Report.* Nay Pyi Taw, Myanmar: Ministry of National Planning and Economic Development and Ministry of Health, Myanmar.
[ix] These observations are based on Save the Children's programmatic experience.
[x] These observations are based on Save the Children's programmatic experience.
[xi] Daw Su Oo is a 23-year-old paddy farmer who lives in Thar Zay Village, Pauk Taw Township, Rakhine State, Myanmar, with her husband and nine-month-old son. She is enrolled in SCI's MCCT Pilot Project.
[xii] UNICEF Myanmar. (2015). *Social Protection in Myanmar: The Impact of Innovative Policies on Poverty.*
[xiii] Department of Population, Ministry of Immigration and Population (2015). *The Union Report: 2014 Myanmar Population and Housing Census Report.* Nay Pyi Taw: Government of the Republic of the Union of Myanmar.
[xiv] Department of Population, Ministry of Immigration and Population (2015). *The Union Report: 2014 Myanmar Population and Housing Census Report.* Nay Pyi Taw: Government of the Republic of the Union of Myanmar.
[xv] Ministry of National Planning and Economic Development and Ministry of Health. (2011). *Myanmar Multiple Indicator Cluster Survey 2009-2010 Final Report.* Nay Pyi Taw, Myanmar: Ministry of National Planning and Economic Development and Ministry of Health, Myanmar.
[xvi] Ministry of National Planning and Economic Development and Ministry of Health. (2011). *Myanmar Multiple Indicator Cluster Survey 2009-2010 Final Report.* Nay Pyi Taw, Myanmar: Ministry of National Planning and Economic Development and Ministry of Health, Myanmar.
[xvii] Myanmar released a national order under the National Food Law "Order of Marketing of Formulated Food for Infant and Young Child" in August 2014. The technical inputs and release of the order by the Department of Health of the Government of the Union of Myanmar were supported by The International Code Documentation Centre and The International Baby Food Action Network.
[xviii] Note: By exercising the authority of sub-section (b) of Section 38 of Myanmar National Food Law, to support breastfeeding to infant and young child, to ensure appropriate use of breast-milk substitutes safely and nutritiously, to introduce proper complementary food at the right time, to publish right and adequate information on these and to be marketed the formulated breast milk substitutes and complementary food under the ordinance.
[xix] Veras, F., R. Peres and R. Guerreiro (2007). *Evaluating the Impact of Brazil's Bolsa Família: Cash Transfer Programmes. In Comparative Perspective*, IPC Evaluation Note No. 1, International Poverty Centre. Brazil: Brasilia.
[xx] Save the Children International, 2014, *Pilot study – Maternity Cash Transfer in Rakhine State*. Save the Children Myanmar. Funded by the Livelihoods and Food Security Trust
[xxi] All data presented are for those children whose mothers were recruited into the study between 1 and 28 weeks of pregnancy.)