

# NUTRITION ADVOCACY STRATEGY FOR RAKHINE STATE, MYANMAR (2022- 2024)

A report by the HARP  
Facility

Authored  
by Alex Glynn



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.

## Contents

Acknowledgements .....	3
1. Introduction and vision .....	3
2. Main problems facing the nutrition sector in Rakhine State .....	3
3. Method and process of developing the strategy .....	5
4. Overall advocacy goal .....	6
5. Advocacy change objectives and results .....	6
Objective 1: Improve collaboration, joint planning and coordination between sectors and key stakeholders, to ensure they are aware, and take ownership of, nutrition needs .....	6
Objective 2: Build local capacity to improve long-term coverage of life-saving nutrition services (infant and young child feeding (IYCF) and integrated management of acute malnutrition (IMAM) services) in village areas .....	11
Objective 3: Improve awareness and access to nutrition services by local families and communities .....	16
Advocacy action plan, timeline and roles .....	19
Advocacy strategy timeline .....	19
Advocacy action plan .....	20
Advocacy opportunities calendar .....	20
Roles and responsibilities .....	20
Annex 1: Additional activity ideas repository .....	21

Cover template: © Molly Webster

Cover Photo: © HARP-F Partner

## Acknowledgements

The development of the advocacy strategy was carried out with the help of the Rakhine State Nutrition Cluster members. The process was steered and coordinated by the HARP Facility consultants Alex Glynn and Nicki Connell with the invaluable support of the Rakhine State Nutrition Cluster lead, Kyaw Zaw Tun (UNICEF), Christoph Schuepp (UNOPS/ LIFT), and Aung Shar Mahkawnghta (UNICEF). A special thank you to Elena Gonzalez, Advocacy Specialist, and Rachel Lozano, Intersectoral Collaboration Specialist, from the Global Nutrition Cluster, who provided additional support to the core group.

Thank you also to our translators, Dr Soe Lwin and Lina Sein, for their valuable work.

## 1. Introduction and vision

This is the advocacy strategy for the Nutrition Cluster and sector in Rakhine State, Myanmar, and represents the advocacy priorities as identified by the Nutrition Cluster members between February-May 2022. The advocacy strategy is intended to guide the Nutrition Cluster and sector in their advocacy work in Rakhine State, identifying joint key problems for nutrition partners, presenting clear and unified solutions, and mitigating conflicting priorities, for increased nutritional impact.

Given the unique factors impacting the nutrition sector in Rakhine State, as explained in [section 2](#), this advocacy strategy focuses on three main areas:

1. Collaboration with other sectors and key stakeholders,
2. Capacity building of local actors, community health workers and volunteers,
3. Raising public awareness to encourage the uptake of services and good nutrition.

Due to the evolving nature of the political situation in Myanmar and Rakhine State, the strategy covers the period 2022-24, with a check-in point in January-February 2023 to see if any objectives need to be adjusted. For details on the methodology used, please visit [Annex 2](#).

The development of this advocacy strategy was funded and coordinated by the Humanitarian Assistance and Resilience Programme Facility (HARP Facility) through funding from the UK's Foreign, Commonwealth and Development Office (FCDO).

## 2. Main problems facing the nutrition sector in Rakhine State

Rakhine State currently faces a number of complex crises, including the regional ongoing conflict between the de facto government and the Arakan Army, national political instability following the February 2021 coup d'état, the covid-19 pandemic, and a high level of displacement of Rohingya and other internally displaced persons (IDPs). The following were identified by the Nutrition Cluster as the main challenges they face:

- **High malnutrition rates, including stunting and wasting.** Rakhine State has some of the most critical nutrition needs in Myanmar ([HNO 2022](#)) with the highest prevalence of undernutrition in Myanmar - wasting [13.9%] and underweight [34.2%] are approximately

double the national average and stunting (37.5%) is 8.5% higher than the national average ([HARP Focus on Rakhine State](#)). Micronutrient deficiencies are also on the rise.

- **Limited coverage of nutrition services.** The nutrition dashboard for Rakhine State (January to December 2021) shows that 41% of the target for severe wasting/ severe acute malnutrition (SAM) treatment was reached, while for moderate wasting/ moderate acute malnutrition (MAM) treatment only 20% of the target was reached ([HARP Bottlenecks and Barriers report](#)). Since the coup d'état in February 2021, the de facto authorities have limited nutrition programming implemented by international actors in Rakhine State. Due to the covid-19 pandemic, most nutrition agencies are practising adapted modalities in both nutrition prevention and treatment activities, and due to a lack of evidence generation there are concerns this may reduce programme quality as compared to standard nutrition guidance e.g., children with SAM are receiving nutrition supplies and follow up services on a biweekly/monthly basis instead of weekly. Programme quality may also have been impacted by using volunteers for household follow-up visits rather than staff to adhere to the treatment guidelines and mitigate the misuse and loss of supplies.

Difficulty in obtaining travel authorisation (TA) and covid-19 movement restrictions have resulted in a low coverage of nutrition programmes in IDP sites in Rakhine State. As there is limited nutrition programming implementation by the de facto authorities and limited access granted to international actors, service provision mostly falls on local organisations, who often have limited capacity and resources.

- **Limited access for service providers in Rakhine State due to authority restrictions.** TA is a challenge for international humanitarian actors as they need to submit requests through the de facto authorities for access to many locations, including IDP sites. Often the TA is given with little advance warning, or even retroactively, making it difficult for trips to take place and leaving implementing partners operating in an administrative grey zone. International staff cannot visit the villages or camps to conduct necessary activities, and most of the time it is only possible to see cases when mothers come to nutrition services directly. Staff can often only conduct remote monitoring and so they work through volunteers who were able to be present and who were trained. Dual administration (de facto authorities and Arakan Army) requires double permissions and double paperwork which increases the time needed to obtain authorisations. No permission is granted to work in some geographical areas or implement certain activities (some long-term, some temporary). Covid-19 restrictions remain a challenge, as they have proved a barrier for access to communities and camps and in conducting activities due to related restrictions over the last two years.
- **Limited community knowledge or ability to access services.** Women and caregivers do not always know where treatment services are available or have less confidence in non-governmental organisation (NGO) services (over doctors). Women who don't seek wasting treatment for their child were less likely to believe that treatment would help provide a cure ([HARP Barriers, bottlenecks and solutions report](#)).
- **Data and evidence on nutrition needs are lacking or out of date,** which means there is not a good understanding of the current scale of the problem. Permission for

assessments is difficult to obtain from the de facto authorities in Rakhine State and malnutrition data for specific townships is lacking. Some data is outdated - the latest demographic and health survey was in 2015 and data is available for some camps but not all) and coverage data is not consistent. Any planned research and assessments need to go through an approval process that is 1-2 years long and even then, it is not always granted. Even if nutrition partners have carried out assessments, they do not share that data officially as they often don't have official permission to conduct nutrition surveys, or don't want to be closely monitored by the authorities.

- **People cannot afford to put food on the table.** Due to the increased cost of food, cash distributions are not stretching as far as they were, which is impacting the ability of people to buy food. This is compounded by the lack of livelihood opportunities as freedom of movement is restricted (due to political instability and the covid-19 pandemic), especially in the Muslim community.
- **Difficulty engaging and getting ownership from the de facto authorities** due to their limited prioritisation of nutrition. The Multi-Sectoral National Plan of Action on Nutrition (MS-NPAN) has been halted as fighting and the covid-19 pandemic are higher priorities for the de facto authorities. They also do not use nutrition data if it does not go through official routes (even if partners have done assessments).
- **There is not enough funding for nutrition. Only 36% of the actual requirement for nutrition in 2021 (GNC 2021).** Not enough longer-term funding (5+ years) and flexible funding (so the approach can be changed) is available for nutrition, meaning that impact from programming is uncertain and often limited. Rakhine State is no longer a top priority for donors, and funds are stretched across more states because of increasing needs across Myanmar.

### 3. Method and process of developing the strategy

To ensure the progression of the advocacy strategy, two groups were created with varying levels of participation:

1. A core group was created who met fortnightly to make decisions.
2. A group consisting of the wider Rakhine State Nutrition Cluster partners was invited to attend four online workshops for each key stage of the strategy: 1) advocacy objectives, 2) audience analysis, 3) key messages, and 4) advocacy activities. These workshops had two translators attending to ensure participants could participate in Myanmar language. The members were also asked to answer two surveys (1) ideas for advocacy activities, and 2) external opportunities, and provide feedback on the first draft of the strategy, which was translated into Myanmar language.

In addition, the following members participated in a one-on-one interview with the lead consultant:

- UNICEF
- Save the Children
- LIFT
- Access to Health
- UNOPS Myanmar

- National Nutrition Cluster
- Myanmar Health Assistant Association
- Global Nutrition Cluster

This process resulted in the identification of an overall advocacy goal for the Rakhine State nutrition sector, three change objectives and desired results under each objective. The key stakeholders, core messages and a list of advocacy activities were identified for each desired result.

The advocacy strategy timeline is split into a number of phases:

- Phase 1 includes activities that will be carried out before the end of 2022: these are outlined in the [advocacy action plan](#).
- Phase 2 activities will be identified from the long list under each desired result by the Advocacy Working Group/group who leads the strategy in December 2022 (once the new Rakhine Nutrition Cluster co-lead has settled into their role).

A number of advocacy activities were identified that were not considered a priority or viable in the strategy timeframe but which may be relevant in the future as opportunities arise. These activities have been captured and included in [Annex 1](#).

## 4. Overall advocacy goal

**Reduce the prevalence of malnutrition by ensuring all sectors and key stakeholders understand the importance of prioritising nutrition in the Rakhine State humanitarian response given the increasing needs due to the COVID-19 pandemic, conflict, and access issues.**

## 5. Advocacy change objectives and results

**Objective 1: Improve collaboration, joint planning and coordination between sectors and key stakeholders, to ensure they are aware, and take ownership of, nutrition needs**

Result 1.1. Rakhine State humanitarian nutrition priorities and objectives are included in key humanitarian, Cluster (Nutrition; Water, sanitation and hygiene (WASH); Health; Food Security; Education etc.) and national plans, including the Multi-Sectoral National Plan of Action on Nutrition (MS-NPAN), for 2023 and 2024.

### Stakeholders

- Main targets: Humanitarian Response Team, Humanitarian Coordinator, Area Humanitarian Country Team (AHCT); Health partners (Médecins San Frontières (MSF), International Rescue Committee (IRC), Malteser International), Health Cluster (Ministry of Health and Sports (MoHS) & World Health Organization (WHO)), WASH Cluster (UNICEF), Education Cluster leads (UNICEF & Save the Children International (SCI)), Food Security Cluster leads (World Food Programme (WFP) & Food and Agriculture Association (FAO)), State Administration Council.

- Influencers: Maungdaw Inter-Agency Group (MIAG) are the chair for northern Rakhine State coordination; United Nations Office for the Coordination of Humanitarian Affairs (OCHA)/ Inter-Cluster Coordination Group (ICCG) [as the chair for central and south Rakhine State]; Health, Education, Food Security, WASH Cluster members; Donors (Livelihoods and Food Security Fund (LIFT), Access to Health, ECHO etc.).
- Allies: Nutrition Cluster lead (UNICEF), Nutrition Cluster members.

### Core messages

- If left untreated malnutrition can increase the risk of illness and death in the short-term and cause irreversible physical and mental damage to children in the long-term. The causes of malnutrition are multi-dimensional and require a coordinated, multi-sectoral response across sectors/Clusters to be prevented and addressed.
- Rakhine State has some of the most critical needs for nutrition in Myanmar ([HNO 2022](#)) with the highest prevalence of undernutrition in Myanmar - wasting (13.9%) and underweight (34.2%) are approximately double the national average and stunting (37.5%) is 8.5% higher than the national average ([HARP Focus on Rakhine State](#)). The prevalence of global acute malnutrition (GAM) in Rakhine State is 13.9% while the prevalence of SAM is 3.7% ([UN 2022](#)). Given the current instability in context, the prevalence of undernutrition is likely to rise through 2022 and beyond.
- Since 2020, food security in Rakhine State has deteriorated with 47% of people reporting inadequate access to food, indicating the situation is getting worse. Urgent nutrition and other nutrition-sensitive services are needed to save lives.
- Humanitarian nutrition needs in Rakhine State must be highlighted in the MS-NPAN, Humanitarian Response Plan (HRP), Humanitarian Needs Overview (HNO), and other Cluster plans.
- Non-nutrition partners in Rakhine State need to expand coverage of nutrition services and build life-saving nutrition services into their planning and programmes where feasible, e.g., MUAC screening and training for family MUAC, to support increased coverage of nutrition services. In return, nutrition partners need to incorporate other sectors' priorities into their plans to ensure effective intersectoral collaboration.
- Ensure the intersectoral coordination mechanisms and minimum response package should be reflected in Clusters' Humanitarian Response Plans to confirm alignment of responses.
- The Rakhine State Nutrition Cluster can arrange nutrition orientation training to demonstrate how nutrition can benefit the priorities of other sectors and vice versa.

### Activities

- Campaign to highlight the success to date and continued needs of multisector *humanitarian* (not only development) programmes in Rakhine State to donors:
  - Case study of a recent humanitarian multi-partner project (e.g., UNICEF nutrition-WASH programming). Social media photo story or video of the project shared on UNICEF national channels. Ask national UNICEF communications staff to share with UNICEF headquarters to encourage a global spotlight on the need for emergency programming in Myanmar/Rakhine State.

- Develop a joint policy paper with key sectors (Health, WASH, Education) on how to deliver multi-sector humanitarian, emergency-focused programming in Rakhine State.
- Develop a joint statement with relevant sectors outlining the priority humanitarian nutrition and cross-sector needs for the state-level Multi-Sectoral National Plan of Action on Nutrition (MS-NPAN) 2023 for Rakhine State.
- In September-October 2022, jointly develop key messages and collect data to highlight the unique nutrition needs and priorities for Rakhine State and share with the Myanmar Nutrition Cluster lead ahead of the development of the HRP 2023 and present a case for including Rakhine State's priority needs in the HRP and HNO.
- Develop a nutrition orientation training for other sectors focusing on the specific needs in Rakhine State, including tools such as the [HARP Facility call to action webpage](#) and animation (available in English and Myanmar language) on demystifying nutrition in Myanmar.
- Identify and develop an evidence-based case study showing the impact of funding of multi-sector programming in Rakhine State and share with donors.

Result 1.2. An intersectoral common approach and a minimum response package for nutrition is agreed with the food security and cash sectors to meet humanitarian needs (including blanket supplementary feeding programmes [BSFP] and food/cash distributions) more effectively and in a timely way, in particular for IDPs.

### Stakeholders

- Targets: Myanmar Cash Working Group (WFP, Mercy Corps & Myanmar Red Cross Society (MRCS) are co-leads); Rakhine State Food Security lead (WFP & Mercy Corps); Ministry of Social Welfare, Relief and Resettlement; State Administrative Council (SAC).
- Influencers: Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ) (provide funding for food security), Swiss Development Cooperation (SDC) (donor in 2021 for cash programming in Rakhine State), Food Security Cluster and Cash Working Group members, IDP Camp administrators (United Nations High Commission for Refugees (UNHCR) for Northern Rakhine State).
- Allies: Implementing partners (international NGOs, local organisations), the community (local leaders, religious leaders, families etc.).

### Core messages

- Since 2020 food security in Myanmar has deteriorated, with only four out of ten children under five years of age and pregnant and lactating women (PLW) able to afford a diet that adequately meets their nutritional requirements ([HNO 2022](#)). The situation in Rakhine State is likely to be worse with 47% of people reporting inadequate access to food ([Humanitarian Update April 2022](#)). This trend is expected to continue in 2022 due to conflict and the covid-19 pandemic.
- Food insecurity can worsen diet quality and increase the risk of various forms of malnutrition. Due to increasing food insecurity and lack of income, mothers and



caregivers are often unable to follow recommended infant feeding practices as food or cash intended for women/children are given to other members of the household.

- IDPs and the Rohingya are among the most vulnerable groups in Rakhine State and currently are not able to put food on the table ([HNO 2022](#)). Cash and food distributions need to reach and be sufficient to enable access for vulnerable IDPs to affordable and nutritious foods – particularly for population groups inherently vulnerable to malnutrition, like pregnant and lactating women (PLW)/children under the age of five years.
- Humanitarian partners need to come together and provide interventions to prevent further deterioration of household income, food insecurity and prevent malnutrition, including food or cash distributions, cash for work, support for local food production, cash grants to support local businesses, and blanket supplementary feeding programmes.
- Food security and nutrition partners should collaborate and incorporate nutrition goals and action where relevant, such as carrying out – and training families to carry out – mid-upper arm circumference (MUAC) screening to identify cases of wasting early.
- Increasing cash transfer programming or increasing transfer of credit to phones and conducting regular assessments of the amount to be distributed is essential to respond to the fast-changing economic environment and increasing food prices. This is important to ensure vulnerable populations and IDPs can put balanced food on the table.

### Activities

- Arrange a meeting with the Food Security Cluster and Cash Working Group to draft a common intersectoral approach and a joint advocacy plan, including a fundraising campaign, towards achieving joint objectives.
- Arrange a meeting with the subnational Food Security Cluster lead to discuss the development of an approach to monitor food price data and the impact on food basket composition and what this means for nutrition programming, including how it should be conducted to ensure cash distributed is adequate and how to target the most vulnerable groups with these programmes.
- Develop nutrition recommendations for the Food Security Cluster and Cash Working Group to include in their strategy and plans. Support other sectors to integrate nutrition activities into their ongoing programming by providing clear guidance, orientation, and capacity-building on the recommended approaches to be taken e.g., MUAC screening.

Result 1.3. Ensure Rakhine State nutrition needs are prioritised by key stakeholders, and they contribute to nutrition outcomes by integrating nutrition services into existing nutrition-specific and nutrition-sensitive programming across Rakhine State (including allowing travel authorisation to provide services).

### Stakeholders

- Targets: MoHS; Rakhine State Health Department; SAC; Ministry of Social Welfare, Relief and Resettlement; Department of Agriculture; township and village administrators.
- Influencers: OCHA (as the main contact for liaison with de facto authorities for TA), community and religious leaders, nutrition providers, Scaling Up Nutrition (SUN) Network, Nutrition Cluster, nutrition donors, Myanmar Health Assistant Association (MHAA).
- Allies: Volunteers, community health workers (CHWs).

- Against: Implementing partners who don't feel they have the resources/capacity to 'add on' nutrition services to their operations. De facto authorities who don't want to give timely access.

### Core messages

- Significant gaps in service provision are increasing malnutrition and mortality in children across Rakhine State, which has the highest prevalence of undernutrition in the country. Malnutrition in Rakhine State is increasing, and vulnerable communities are unable to access the preventative and life-saving treatment they need because of travel restrictions and other implementation barriers.
- Rakhine State has some of the highest needs for nutrition services in Myanmar ([HNO 2022](#)). Yet, in 2021 only 41% of the target for SAM treatment was reached, while for MAM treatment only 20% of the target was reached (HARP Facility '[Nutrition bottlenecks and barriers report](#)').
- Poor nutrition is an underlying cause of nearly half of all child deaths, globally. High-impact nutrition interventions are cost-effective in reducing mortality and preventing disease, which is why they should be central to all national health systems and core national policies. For every \$1 invested in nutrition, \$16 is returned to the local economy ([Nutrition for Growth, 2022](#)).
- Nutrition services need to be scaled up to provide vulnerable communities with essential life-saving services through increased funding and capacity. Updated data on nutrition needs is necessary for ensuring relevant and targeted programming.
- Travel authorisation needs to be provided in a timely way and access facilitated by the de facto national and state authorities, to ensure nutrition providers can reach those in urgent need, especially children suffering from malnutrition.

### Activities

- [Phase 1: See [Advocacy Action Plan](#)] Request LIFT and Access to Health to feed their own data into OCHA's Access Dashboard so a full picture of access needs can be developed (prior to the open letter). Send the same call to action to civil society organisations (CSOs), community-based organisations (CBOs) and ethnic health organisations (EHOs) as well, through influencers such as MHAA, the SUN Network and Nutrition Cluster members.
- Develop a joint case study to advocate for more funding from FCDO and other donors to be delivered to donor contacts (e.g., LIFT) for October 2022 in time to be included in end-of-year donor proposals. Include a one-pager showing evidence of the needs, impact on communities, and examples showing a) the impact of services, and b) what it means for communities that can't get access to services.
- Deliver a joint open letter/press statement from the nutrition sector addressing all those working in the field of health and nutrition outlining the needs of Rakhine State nutrition partners and the gaps incurred without access. Distribute the statement to local media, community leaders and religious leaders.
- Arrange a meeting with WFP/REACH facilitator Soe Nyi Nyi to develop a plan on how Rakhine State nutrition actors can support the development of the interim MS-NPAN.
- Share the [HARP Facility demystifying nutrition animation](#) with identified targets and influencers.

## Objective 2: Build local capacity to improve long-term coverage of life-saving nutrition services (infant and young child feeding (IYCF) and integrated management of acute malnutrition (IMAM) services) in village areas

Result 2.1. Appropriate funding is mobilised to support capacity-building activities to ensure local organisations, including CBOs, CSOs and EHOs, can provide nutrition services in Rakhine State.

### Stakeholders

- Targets: LIFT, Access to Health, WFP in Rakhine State, UNICEF, SCI, Action Contre la Faim (ACF), Myanmar Humanitarian Fund (MHF), donors (FCDO, United States Agency for International Development (USAID), Japan, Germany, European Civil Protection and Humanitarian Aid Operations (ECHO), etc.).
- Influencers: Nutrition International NGOs, implementing partners with a localisation agenda, OCHA (manages MHF).
- Allies: Local organisations, including CBOs, CSOs, EHOs.
- Against: Implementing partners who aren't in favour of localisation i.e., they want to retain their own agenda and presence in Rakhine State/ Myanmar.

### Core messages

- Nutrition in Myanmar is severely underfunded, with only 36% of actual requirements funded in 2021 ([GNC](#)). Underfinancing of IYCF and IMAM services is severely restricting life-saving nutrition service implementation in Rakhine State, especially in village settings and IDP camps.
- Flexible multi-year funding is needed to allow for meaningful investment in capacity-strengthening, systems, and organisational governance, allowing national/ local nutrition organisations with fewer resources to adapt to unforeseen circumstances. Nutrition is a long-term issue; therefore, long-term investment is needed.
- Instability and restricted access in Rakhine State means local actors are often the only organisations who have access to vulnerable communities and therefore they are often best placed to assess and respond to nutrition needs – yet they do not always have the same access to funding. To provide the appropriate services, they need more training, more people, and more funding/ resources.
- In the WASH sector, organisations in Rakhine State have reported that long-term funding has enabled a shift from an emergency to a protracted focus, allowing for consultations with affected populations in programme design, development of activities and programme adjustments to better meet their needs.
- Documented case studies in multiple countries across Asia, Africa, the Middle East, and South America show that community-led responses demonstrate a high degree of responsiveness, relevance and context sensitivity despite the differences in types of projects ([Corbett et al 2021](#)).
- Donors in Myanmar need to simplify the nutrition grant application process and have a flexible, facilitatory structure so national/ local organisations can apply for funding, for example accepting proposals in Myanmar language, simplifying the administrative

requirements, allowing unregistered organisations to apply, and adapting monitoring/ reporting expectations.

- Donors should deliver on their localisation commitments as outlined under [the Grand Bargain](#) and have explicit commitments and targets included in grants to support localisation of nutrition programmes and ensure that grantees are held accountable to those targets. In particular, donors should incentivise shifting behaviours by including a specific budget line/ section for capacity-building/ organisational development.
- Arrange for regular capacity-building, particularly of local organisations including CBOs/ CSOs/ EHOs, to ensure high-quality nutrition capacity exists at the Rakhine State level and that partners with resources can support increased coverage of critical nutrition services.

### Activities

- Develop a short policy brief outlining recommendations for donors drawn from the HARP Facility's 2022 Nutrition Localisation paper on how the capacity of local actors can be increased for a sustainable response to malnutrition. Ask the Myanmar Nutrition Cluster Coordinator to share donor specific recommendations with donors.
- Draft a joint statement on the funding needs for nutrition in Rakhine State with other sectors that also need services delivered by local organisations. Send email campaign with policy brief (mentioned above) to targeted donors through contacts in the nutrition sector.
- Develop a toolkit and step-by-step guidelines for donors funding local organisations in Rakhine State using examples of good practice and case studies, based on input from local organisations.
- Organise quarterly nutrition coordination meetings specifically for CSOs/ CBOs/ EHOs and managing agencies (international NGOs) to understand the capacity-building needs of local organisations and support those capacity needs and feed information back to donors for funding support.

Result 2.2. Community health workers [CHWs] and local organisations are confident and able to deliver and manage uncomplicated severe wasting/ severe acute malnutrition [SAM] treatment

### Stakeholders

- Targets: MoHS (need to persuade them to allow CHWs to administer severe wasting treatment); CHWs (need to encourage them to prioritise nutrition); donors (to fund training and support for CHWs).
- Influencers: Community health centres, midwives, doctors, the actor taking the lead on influencing the de facto authorities (UNOPS?), MHAA.
- Allies: UNICEF, SCI/ACF (larger scale training than individual organisations), MRCS, ACF & Community Empowerment and Resilience Association (CERA) (carrying out this type of programming in villages and towns already).

### Core messages

- Malnutrition is a severe threat to the survival of children under the age of five years of age. For those who survive, malnutrition will cause irreversible physical and mental damage. It is a consequence of reduced availability of nutritious food and poor diets,

poor IYCF practices, inadequate care practices and resources, lack of access to WASH services and scarce availability of and access to proper health and nutrition services. In Myanmar, only four out of ten children under five years of age and PLW can afford a diet that adequately meets their nutritional requirements.

- Severe wasting/ SAM treatment requires additional specialised nutrition supplies and medicines to avert morbidity and mortality. Children suffering from SAM are up to 11 times more likely to die than their non-malnourished peers; those suffering from prolonged undernutrition who do survive often become locked in a cycle of recurring illness and faltering growth, with irreversible damage to their development and cognitive abilities, affecting their education in the medium-term and their capacity to realise their full livelihoods and social potential in the longer-term ([HNO 2022](#)).
- Reduced community outreach and referral due to increased insecurity and the covid-19 pandemic significantly reduced numbers of children under five years of age screened for wasting. As a result, the number of admissions for SAM treatment has been reducing yearly with SAM admissions in 2020 more than threefold lower compared to the same month in 2017. CHWs can provide screening and treatment for uncomplicated SAM, but need funding, access, and the trust of communities.

#### Activities

- [Phase 1: see [Action Plan](#)] Conduct a joint collaborative campaign to celebrate CHWs during World Breastfeeding Week (1-7 August 2022) – bringing in the broader topic of nutrition (as this used to be nutrition month). The 2022 global World Breastfeeding Week’s theme is to educate and support, strengthening the capacity of actors to protect, promote and support breastfeeding across all levels of society. This opportunity can be used as a strategic opportunity to show the value of CHWs to the de facto authorities and the community, while also providing a moment to show CHWs what they can achieve through good examples.
  - Develop 10-15 technical, neutral, and broad Rakhine State-specific messages with the Nutrition Cluster members and share as joint messaging across all partner channels.
  - Develop social media content to be used by all partners with key messages (no logos or colours of agencies). Develop a media strategy to highlight CHWs and volunteers’ roles in nutrition e.g., asking [Development Media Group](#) to interview identified CHWs and ask them about the nutrition work they carry out.
  - Create a video case study of MHAA/ SCI project in Pauktaw to show the success of using CHWs, highlighting the platforms and models used. Share with key international NGOs to encourage funding and support for CHWs. Identify key influencers in the CHW community and share the video case study and [HARP Facility animation on demystifying nutrition in Myanmar](#) to highlight the importance of nutrition services to CHWs. Ask OCHA to share with the MoHS to persuade them to train and hire more CHWs.
  - Develop a press release to accompany the case study video celebrating CHWs and showing how they can deliver services with support from the remote health staff. Share with local media to ensure the value of CHWs is highlighted publicly to influence state or de facto authorities.
  - Create a joint open statement by national Nutrition Cluster members encouraging the MoHS to reinstate the 2020 Community Based Health Worker

- Policy. Provide social messages for Nutrition Cluster members and donors to share statement on their online platforms.
  - Conduct a mapping exercise to understand the most effective advocacy messages for different townships in Rakhine State.
- Ask Nutrition Cluster members to support the distribution of the [HARP Facility demystifying nutrition animation](#) on social media (Facebook) and create Facebook image cards to highlight to CHWs why nutrition is a priority and how to carry out uncomplicated SAM treatment.
- For World Breastfeeding Week (August 1-7) - Community engagement campaign using radio and posters, and engagement with community focal points and mothers' groups to encourage local communities to allow volunteers and CHWs to provide treatment to children with uncomplicated SAM.

Result 2.3. Service and capacity mappings by health and nutrition actors are comprehensive, up-to-date, and standardised (especially in IDP sites) to avoid duplication, and data is regularly analysed, and advocacy conducted to fill identified gaps.

#### Stakeholders

- Targets: Nutrition Cluster lead (UNICEF); Health Cluster lead (MoHS and WHO); UNHCR; lead of Maungdaw Inter-Agency Group (MIAG) & other northern Rakhine State IDP sites (data is missing in Northern Rakhine State - target them to increase mapping); WFP (lack of cohesion between moderate and severe wasting treatment); FCD0 funds through LIFT and Access to Health (to advocate for gaps to be filled); local organisations including CSOs, CBOs, EHOs.
- Influencers: Nutrition and Health Cluster members; MHAA (to get local actors to participate in mapping).

#### Core messages

- Lack of knowledge about local capacity: There is a lack of understanding of the current capacity and service provision delivered by local actors in Rakhine State, in particular civil society networks (HARP Facility localisation report). All organisations in the Myanmar nutrition sector reportedly work with smaller local organisations, community groups and women-led organisations to a varying degree but this is not tracked in the nutrition sector 4Ws (HARP localisation report). National and local organisations should be included in Rakhine State nutrition coordination mechanisms, 4Ws and strategic discussions, to increase the role of national/ local organisations, including women-led organisations, in direct implementation of nutrition programming. Community leaders should be included in mapping exercises and community conversations on nutrition should be reported to the Myanmar Information Management Unit (MIMU).
- Lack of knowledge on the needs in Northern Rakhine State IDP camps: Since the coup d'état, the number of IDPs in Rakhine State has nearly tripled from [92,000](#) in Dec 2020 to [237,000](#) in March 2022, significantly increasing the number of people in need. There are reportedly high levels of malnutrition in IDP sites and camps, yet due to accessibility issues due to insecurity, nutrition providers are not clear on capacity and service gaps

due to a lack of data available, especially in Northern Rakhine State. UNHCR and the MIAG should support the Nutrition Cluster to fill these gaps to ensure vulnerable populations have a better chance of accessing life-saving nutrition services.

- The Nutrition Cluster Coordinator should ensure capacity and service mappings are conducted frequently (every six months at minimum) and analysis is done to understand where the gaps are, what resources are needed to fill the gaps and advocate for gaps to be filled.

### Activities

- [Phase 1: see [Advocacy Action Plan](#)] Develop a one-page brief for donors following each quarterly analysis, answering the following questions: 1) What are the gaps, 2) What are the needs, and 3) What does that mean for communities? Share the brief with identified Nutrition Cluster members to share with their donor contacts.
- Engage with UNHCR to agree a joint strategy to improve capacity and service mapping of IDP sites in northern Rakhine State. Attend the MIAG, led by UNHCR, to initiate planning of the strategy.
- Create a template for an advocacy plan to fill capacity and service gaps (identification of gaps, desired results, activities, timeline, responsibilities) drawn from quarterly analysis of capacity and service mapping. Set quarterly Nutrition Cluster meetings to agree advocacy priorities identified from the analysis and allocate responsibilities to address identified priorities.
- Reach out to and encourage local organisations to attend and participate in Nutrition Cluster meetings, processes and contribute to mapping. Engage with them using known influencers, such as MHAA and the SUN Network. Produce key messages on why contributing to mapping exercises will help local actors and share with influencers to use in their communications. Hold a quarterly Rakhine State Nutrition Cluster meeting with local actors and include an agenda item focused on increasing their participation in mapping activities and what they need to complete 4Ws.
- Reach out to community leaders (through MHAA/ the SUN network) to ask them to engage in mapping exercises with clear step-by-step guidance on how they can report information and to where.
- Set up a Nutrition Cluster community of practice/ mailing list, inviting CSOs, CBOs and EHOs to share information (4W's/gap updates, capacity building opportunities, Nutrition Cluster resources, standards, guidelines etc.).

Result 2.4. Scale-up use of community-level volunteers through capacity-building and ensure their expenses are paid by nutrition partners

### Stakeholders

- Targets: MoHS (for access and use of volunteers); UNICEF, SCI/ACF (for training); LIFT and Access to Health (for funding); local organisations including CBOs, CSOs and EHOs; mothers and caregivers (for trusting volunteers to treat children and PLW); international NGOs (for providing training).
- Influencers: Community and religious leaders (Muslim leaders for Rohingya), mothers' groups.
- Allies: Local organisations that often use volunteers.

## Core messages

- [Note: The core messages from Objective 2.2 are relevant here.]
- To international NGOs: Nutrition providers should build capacity and supervise community volunteers to support the provision of high-quality nutrition services, including on when services can be provided and when referrals are needed to hospital or other services. A Terms of Reference for volunteers should be created and coordinated to ensure volunteers are used fairly and effectively.
- Outpatient therapeutic programme (OTP) staff should encourage mothers and caregivers to accept help from village-based volunteers when offered.
- Nutritional screening is a necessary process to identify children who are wasted or at risk of becoming so, but this crucial service is often conducted by community volunteers usually without pay. A shift from volunteering to paid positions has been credited as one of the main reasons there are better relations between national and international actors, yet this is still undervalued. Donors and international agencies must develop a community volunteer policy to ensure volunteers are paid, or expenses are covered, sustainably.
- To MoHS: Volunteers have the trust of the community and can provide the more straightforward nutrition services to malnourished children and communities. Support the scale up of volunteers to identify and treat children in need.
- To local organisations: Encourage mothers and caregivers to trust trained local volunteers to provide treatment, such as for cases of uncomplicated SAM.

## Activities

- Conduct a social media campaign to share the [HARP Facility animation on demystifying nutrition in Myanmar](#), alongside a simultaneous social media campaign on why community volunteers should be respected and valued for their role in supporting nutrition services. Use strategic partners to share with MoHS, Rakhine State Health Department and township administrators to encourage access and support to the scale up of use of volunteers.
- Develop policy guidance on using volunteers and paying their expenses using real case studies, such as MHAA's policy on volunteer payment.
- Publish articles on partner websites highlighting the work of local volunteers in Rakhine State and profiles of volunteers to show the benefits of using volunteers.
- Conduct a community engagement campaign using radio and posters, and engagement with community focal points and mothers' groups, to encourage local communities to allow volunteers and CHWs to provide nutrition services.
- Organise training for local organisations and volunteers on public engagement and community outreach to increase trust and support of volunteers.

## Objective 3: Improve awareness and access to nutrition services by local families and communities

Result 3.1. Awareness of nutrition services [particularly IYCF and IMAM interventions] is improved and local communities are encouraged to access services [especially mothers and caregivers].



## Stakeholders

- Targets: Local organisations including CSOs, CBOs, EHOs; Department of Foreign Affairs (DFA); communities; breastfeeding mothers.
- Influencers: Health staff, nutrition volunteers, the SUN network, healthcare centres, local press, MHAA, village leaders, mother groups, CHWs, volunteers, religious leaders, community focal points (who deliver messages on good nutrition to communities), fathers (reported that some fathers stop mothers accessing services).
- Allies: Nutrition implementers (international NGOs, local organisations etc.).

## Core messages

- Nutrition is a critical part of a child's health and development. Better nutrition is related to improved health, stronger immune systems, lower risk of disease, living longer and more able to concentrate at school.
- When children do not get the food and nutrients they need as they grow up it can cause irreversible damage to their bodies and brains and increase their risk of dying.
- Make sure your child is healthy and can learn and grow by taking them to nutrition services, volunteers, and CHWs. The sooner they are able to check if they are malnourished, the better chance you have at giving your child a healthy future.
- If your child is found to be malnourished, it is important to access nutrition treatment services urgently so they can receive the rehabilitative care they need and to attend regularly until they are cured.

## Activities

- [Phase 2] Bring Nutrition Cluster partners together to develop a joint stakeholder mapping exercise across all townships to identify nutrition champions/influencers amongst the local population (i.e., mothers and caregivers) who can spread the word about existing services. Make available for all Nutrition Cluster partners to use.
- [Phase 2] Conduct advocacy on current nutrition actors coming together on certain issues, such as behaviour change. Develop a common strategy and objective with nutrition providers in Rakhine State to encourage behaviour change. Make a case to donors to fund the application of behaviour change research findings in Rakhine State to increase utilisation of services, such as uptake of vitamin A supplements.
- Develop a case study (using pictures or drawings in a poster/leaflet, record a radio play or video) of a mother who shows positive deviance, who has sought help for her child from services and has improved her child's health, despite facing the same challenges as other mothers in the community. Ask local organisations to share with mother support groups and community focal points to show positive examples to mothers.
- For World Breastfeeding Week (August 1-7, 2022), carry out a joint public awareness campaign with all nutrition service partners with localised communication efforts (like those used to disseminate covid-19 health messages) in local languages, such as broadcasting recordings of key messages and real stories from mothers.
- Provide food management committees with key messages and posters to share details of services mothers and caregivers can access during blanket supplementary feeding programmes distributions.

Result 3.2. Programme implementers and donors have the tools to give local communities (e.g., mothers and caregivers) the support they need to seek services (e.g., funding for transport).

### Stakeholders

- Targets: UNICEF; SCI; LIFT and Access to Health; donors and the Dutch entrepreneurial development bank (FMO); non-nutrition implementers (e.g., Cash Working Group).
- Influencers: Nutrition Cluster lead (UNICEF), MHAA (they already do this and can show a positive case study).
- Allies: Nutrition Clusters in other regions (as they are facing the same problem).

### Core messages

- Mothers and caregivers want to get help for their children but sometimes face too many barriers to accessing nutrition services, such as travel costs. Financial hardship should not be a barrier for mothers in accessing nutrition services. Mothers and caregivers should be supported with the financial and logistical support they need to access services.
- Other barriers that prevent mothers from seeking services include husbands refusing to allow mothers to visit healthcare centres. Funding is needed to research these barriers and invest in programmes to address them ([HARP-F Barriers Report](#)).
- Restricted access for nutrition service providers leaves a gap in service provision. Advocacy is needed for better access so that once caregivers seek services, they are available upon arrival.
- Support transportation costs for cases of severe wasting/ SAM in particular. There are standardised guidelines for emergency referrals of cases. A standardised amount provided to the mother/ caretaker could be considered depending on distance, for example Area A (5-10 miles away) receives 5,000 MMK, Area B receives 8,000 MMK etc. Develop a standardised system providing transport costs depending on distance and ensure mothers know about it.
- Beneficiaries in 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.
- It is important to invest in outreach to ensure communities and mothers are aware of available funding for them to reach services.

### Activities

- [Phase 1: See [Advocacy Action Plan](#)] Send email to Nutrition Cluster members with a link to findings and recommendations outlined in the [HARP Facility barriers report](#). Request to send to members' donors to encourage funding of further research into the causes of family members blocking access to services.
- [Phase 2] LIFT to develop a case study of their family MUAC programme (video and blog/article on website), to be shared with other partners and donors, to show benefits of this decentralised approach and how to implement similar policies.

- Adapt MHAA standard guidelines on funding travel expenses into guidelines that can be used by all nutrition providers to encourage funding of transport costs for those seeking nutrition services.
- Reach out to other Clusters in the ICCG to see if they face the same issues, learn from any efforts they have made to address this issue, and investigate joint programming to fund these costs.
- Interview and create a case study on one community member whose village is far from nutrition services and what happens when they can't access services. Create a video or blog on a successful approach to decentralised services e.g., LIFT's Family MUAC programme. Share with donors and implementing partners to advocate for funding and commitment from donors, and also share with the de facto authorities if communication channels open.

## Advocacy action plan, timeline and roles

### Advocacy strategy timeline

The following table outlines the timeline for the activities to progress the advocacy strategy including meetings for Advocacy Working Group. This group will oversee the progression of the strategy and the advocacy action plan [\[see below\]](#).

Date	Action	Status	Lead
3 June, 2022	Final advocacy strategy handed to Rakhine State Nutrition Cluster	Completed	Consultant
June 2022	Set up a group (Advocacy Working Group [AWG]) or utilise existing group (IYCF-E TWG) to lead advocacy strategy	In progress	Chris Schuepp and Kyaw Zaw Tun
Mid-June 2022	<b>First meeting of the group</b> leading the strategy to discuss activities in action plan.	Not started	Chris Schuepp, Kyaw Zaw Tun
Mid-July 2022	<b>Group meeting:</b> Invite Rakhine State Nutrition Cluster co-lead to update them on advocacy strategy, review workplan, assign responsibilities.	Not started	Rakhine State Nutrition Cluster co-coordinators and group leading advocacy strategy
Mid-September 2022	<b>Group meeting:</b> Identify funding needs for advocacy strategy and collect evidence of successful implementation of phase 1 of strategy workplan to show impact - include in proposals to donors (FCDO/LIFT)	Not started	Group leading advocacy strategy and Rakhine State Nutrition Cluster co-coordinators

Date	Action	Status	Lead
Mid-December 2022	<b>Group meeting:</b> Decide on priority activities for phase 2. Invite Elena Gonzalez from GNC.	Not started	Group leading advocacy strategy
January - February 2023	Evaluate strategy given current context (early 2023) and adjust as necessary	Not started	Group leading advocacy strategy

### Advocacy action plan

The advocacy action plan is accessible via the icon below. This covers the activities in phase 1 of the advocacy strategy, from June-December 2022. The accompanying tracker is a tool the group can use to monitor the impact and progress of the strategy.



### Advocacy opportunities calendar

This calendar identifies the internal (advocacy strategy activities) and external moments identified by the Rakhine State Nutrition Cluster partners as useful for implementing this advocacy strategy. **Recommendation:** upload to Google Docs to keep the sheet editable for collaborative updating throughout the timeline of implementation of the advocacy strategy.



### Roles and responsibilities

The Advocacy Strategy will be taken forward by a newly formed Myanmar Advocacy Working Group, or the IYCF-E and IMAM Technical Working Group with additional support from Chris Schuepp, from OCHA and from the Global Nutrition Cluster’s advocacy helpdesk. The roles for each activity are outlined in the [advocacy action plan](#).

## Annex 1: Additional activity ideas repository

The following ideas for activities were considered either not a priority for the first few phases of the strategy, or unviable for the short-term. We have included them in this annex to ensure the repository of ideas is not lost and can be used by the Advocacy Strategy lead in the future.

<p>1.1. Rakhine State humanitarian nutrition priorities and objectives are included in key humanitarian, Cluster and national plans, including the Multi-Sectoral National Plan of Action on Nutrition (MS-NPAN) for 2023 and 2024.</p>	<ul style="list-style-type: none"> <li>● In Jan 2023, use HRP and HNO 2023 as a tool to advocate for more funding for nutrition priorities in Rakhine State.</li> </ul>
<p>1.3. Ensure Rakhine State nutrition needs are prioritised by key stakeholders, and they contribute to nutrition outcomes by integrating nutrition services into existing nutrition-specific and nutrition-sensitive programming across Rakhine State (including allowing travel authorisation to provide services).</p>	<ul style="list-style-type: none"> <li>● Develop a plan and identify a member to engage the Rakhine State MoHS to reinstate nutrition month in Rakhine State (previously in August). Develop a campaign to show the importance of nutrition for children in Myanmar and highlight the priority nutrition needs where the MoHS is the target. Collect stories of the impact of poor nutrition on children and other stories to support asks. Offer a presentation to the State Health Department on the state of nutrition in Rakhine State, and what is needed.</li> <li>● Ask the OCHA/ United Nations Office for Project Services (UNOPS) liaison to include nutrition priorities in their communication with the SAC and ask them to find out the nutrition priorities and needs of the SAC. Share SAC's nutrition priorities with the Nutrition Cluster members and discuss the viability of including these needs in programming to encourage support for nutrition services.</li> <li>● Share recommendations and protocols for partners to have the confidence to implement management of non-complicated cases of SAM through OTPs.</li> </ul>
<p>2.1. Appropriate funding is mobilised to support capacity-building activities to ensure local organisations, including CBOs, CSOs and EHOs, can provide</p>	<ul style="list-style-type: none"> <li>● Work with the Myanmar Nutrition Cluster Lead to create a long-term strategy or localisation note (similar to the WASH sector localisation note) for</li> </ul>

<p>nutrition services in Rakhine State.</p>	<p>capacity-building of local organisations and support efforts to secure funding.</p>
<p>2.2. Community health workers (CHWs) and local organisations are confident and able to deliver and manage uncomplicated severe wasting/ severe acute malnutrition (SAM) treatment.</p>	<ul style="list-style-type: none"> <li>● Develop cards or posters on how to deliver uncomplicated SAM treatment with key messages on why it is critical to treat SAM, disseminated through partners, including MHAA.</li> <li>● Create a toolkit and step-by-step guidelines for international NGOs, national/ local organisations, donors, United Nations (UN) agencies and other stakeholders on how to successfully draft and institutionalise policies to include the recruitment/training of and support required for CHWs and volunteers to deliver uncomplicated SAM treatment, outlining the models/platforms that could be used based on lessons learned to date e.g., mobile teams.</li> </ul>
<p>3.1. Awareness of nutrition services (particularly IYCF and IMAM interventions) is improved and local communities are encouraged to access services (especially mothers and caregivers).</p>	<ul style="list-style-type: none"> <li>● Update UNICEF counselling cards on bringing children to the health facility to fit the specific Rakhine State context - ask on a volunteer website (e.g., UN digital volunteers) for a graphic designer to provide volunteer services to update these.</li> <li>● Develop a series of cards showing comparative growth pictures of children whose caregivers are seeking services and what they would look like if services are not being sought.</li> </ul>
<p>3.2. Programme implementers and donors have the tools to give local communities (e.g., mothers and caregivers) the support they need to seek services (e.g., funding for transport).</p>	<ul style="list-style-type: none"> <li>● Consider reaching out to community workers and leaders to persuade husbands to participate in IYCF-E group discussions.</li> </ul>