

MYANMAR COUNTRY SPOTLIGHT

In this Spotlight, the main focus is on children affected by poverty.

Introduction

• Background of the issue outlining aims and focus of the national campaign

Stunting indicates a failure to achieve one's own genetic potential for height. It is a manifestation of the severe, irreversible physical and cognitive damage caused by chronic malnutrition early in a child's life and often before birth. When compared with a stunted child, a well-nourished child completes more years of schooling, learns better, and earns higher wages in adulthood, thereby increasing the odds that he or she will escape a life of poverty.¹ **Stunting represents a major barrier to child survival and learning.** Moreover, it is estimated that young child malnutrition can cost a country from 4% to 11% of its GDP.²

• Brief overview of country situation

More than one third of all Myanmar children under-five years of age are stunted according to the Multiple Indicator Cluster Survey (MICS) 2009-2010. This means that nearly 1.6 million children under-five in Myanmar are stunted, based on current population estimates from the 2014 Census.³ The prevalence of stunting is highest among children two to three years of age. However, nearly 15% of children under-6 months of age are already stunted, indicating poor growth and development beginning in utero.⁴

Overview of social exclusion

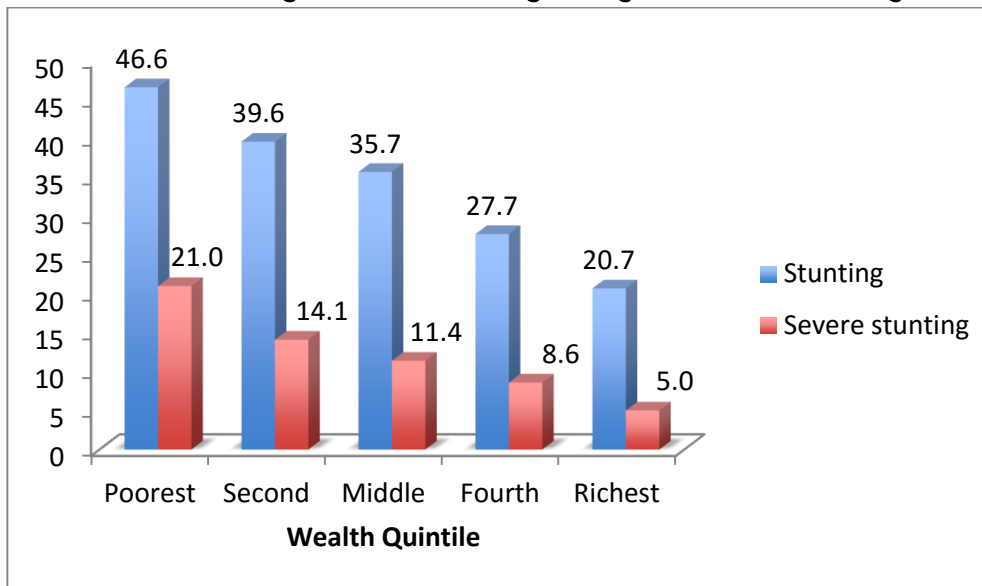
According to reanalysis of data from the 2010 Integrated Household Living Conditions Survey (IHLCA) by the World Bank in 2014, about 37.5% of households in Myanmar are living in poverty.⁵ Myanmar is a predominantly rural society, and about three-quarters of the poor reside in rural areas. Poverty is associated with landlessness or small land holdings (less than two acres) as well as ethno-linguistic identity, suggesting that social and political exclusion are a continuing challenge in Myanmar. There are also substantial regional disparities in the prevalence of poverty. The poverty rate is highest in Rakhine State at 78%, followed by Chin State at 71.5%.

Rakhine State and Ayeyarwaddy Region stand out for having high poverty rates and large numbers of poor people. Ayeyarwaddy Region, in the Delta Zone, has a moderately high poverty rate at 45.7%, but more poor people live in Ayeyarwaddy than in any other single state or region in the country (18%). Though Ayeyarwaddy Region is mostly populated with ethnic majority Burmese households, the area is characterized by high rates of landlessness, poor accessibility and vulnerability to natural disasters. Approximately 15% of Myanmar's poor live in Rakhine State, an area characterized by on-going ethnic and religious conflict, vulnerability to natural disasters and numerous hard-to-reach areas. On the other hand, while Chin State has the second highest poverty rate, it accounts for only 1.4% of the country's poor, due to its small population. Chin State, in the Uplands Zone, is extremely remote and populated mostly by ethnic minority households with small land plots and limited human capital.

Stunting disproportionately affects children living in poor households. In fact children under-five years of age living in the poorest households are more than twice as likely to be stunted (46.6%)

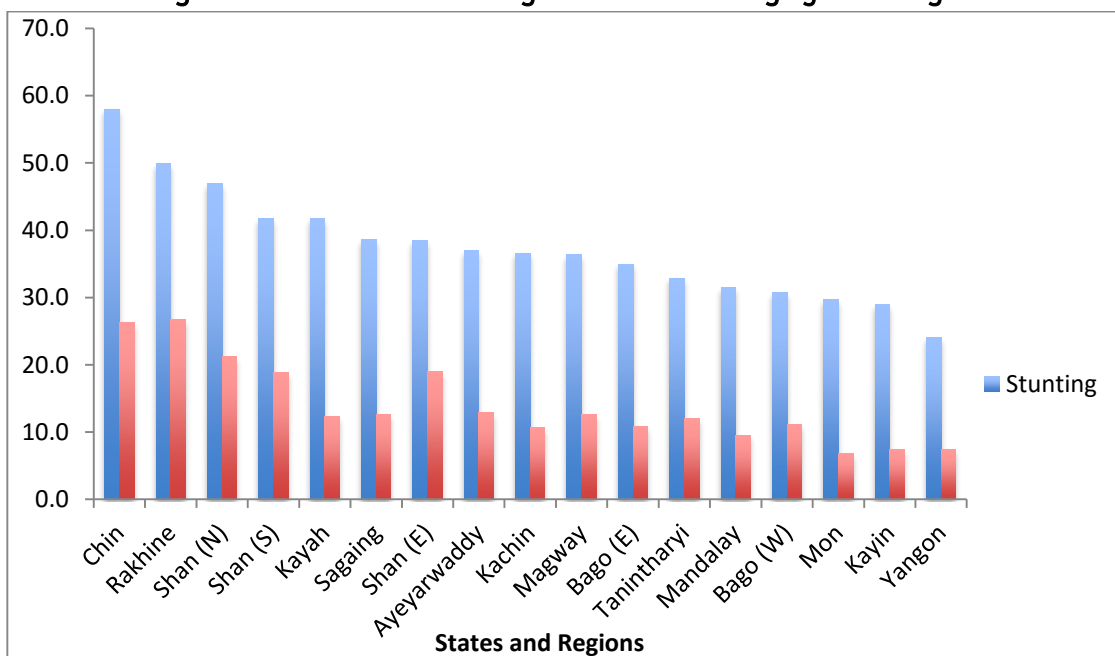
than those living in the wealthiest households (20.7%).⁶ However, it is significant to note that stunting affects children in all wealth quintiles - one in five children in the wealthiest households are stunted.

Figure 1: Prevalence of stunting and severe stunting among children under-five by wealth quintile



The prevalence of stunting in rural areas (38%) is higher than in urban areas (27%) and there are substantial differences by region. The highest rates of stunting are found in Chin State (58%), Rakhine State (50%), and Northern Shan State (47%), all areas that are mostly populated by ethnic minority groups.

Figure 2: Prevalence of stunting and severe stunting by State/Region

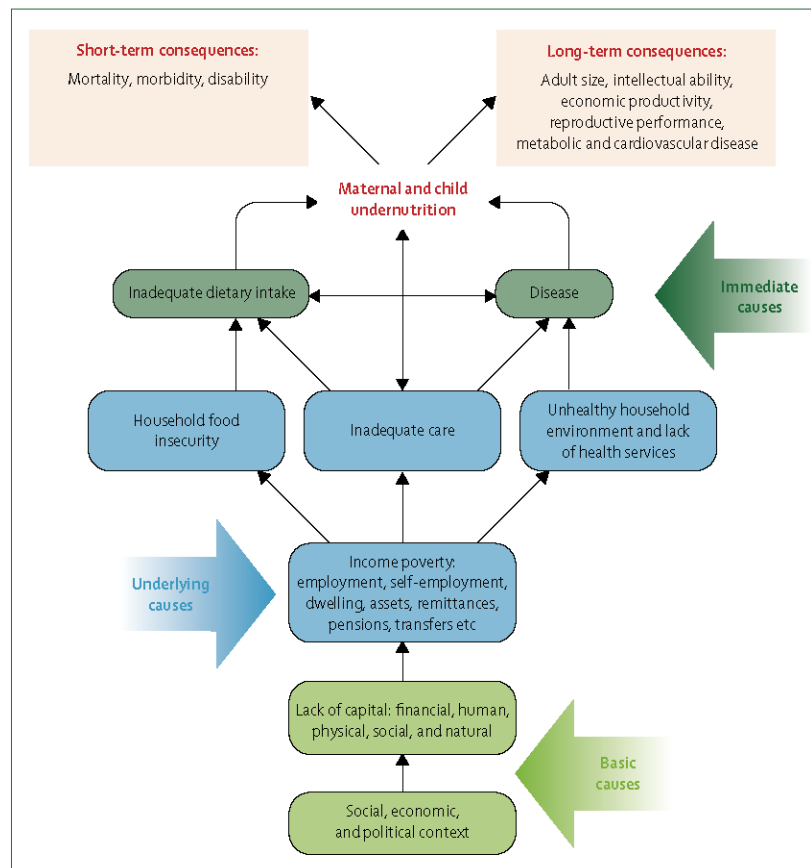


- **Qualitative analysis: details on the drivers and dynamics of social exclusion and inequality**

The immediate causes of stunting – namely, chronic inadequate intake of food and frequent illness – are affected by underlying food and nutrition insecurity, poor caregiving practices for 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 interconnected determinants are illustrated in the conceptual framework below (Figure 3), which was adapted from the 1991 UNICEF Conceptual Framework of Malnutrition and presented in the 2008 *Lancet* Series on Maternal and Child undernutrition.

Figure 3: Framework of the relationships between poverty, food insecurity, and other underlying and immediate causes to maternal and child undernutrition and its short-term and long-term consequences
(Bhutta, et al., 2008)



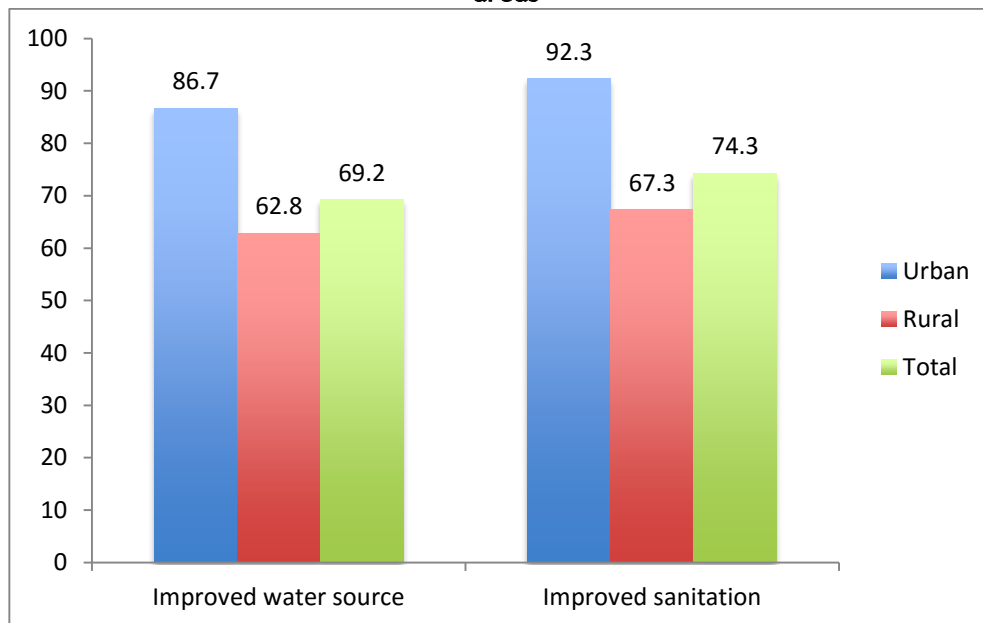
Poor households in rural areas are more likely to be food and nutrition insecure, to have poor caregiving practices and unhealthy household environments

Poor 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 about 74% of their total budget on food, compared with about 65% among households living above the poverty line.⁷

Rural households are less likely to have improved sanitation facilities. Less than 70% of households in rural areas have safe latrines, compared with about 92% in urban areas.⁸ Children living in households with no latrine or unimproved latrines are more likely to have diarrhea⁹, and in turn more likely to be malnourished. Rural households are also less likely to have safe drinking water. Indeed only about 63% of households in rural areas have access to an improved water source,

compared with about 87% in urban areas.¹⁰ Children living in households without clean water are at least twice as likely to have diarrhea than children living in households with clean water.¹¹

Figure 4: Use of improved water source and access to improved sanitation in urban and rural areas



Diarrhea is less likely to be treated correctly¹² among children living in poor, rural households than children in wealthier households in urban areas.¹³ Poor families are less likely to seek care for acute respiratory infection (ARI) from an appropriate provider than wealthier families, and better educated mothers are more likely to treat suspected pneumonia with antibiotics than less educated mothers. These are significant findings given that pneumonia and diarrhea are among the most common causes of child death in Myanmar.¹⁴

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

Evidence suggests that physical access to health facilities has improved in recent years. 81% of households surveyed in the 2010 IHLCA were within one-hour walking distance of a health facility, compared with 65% in 2005 (MNPED et al., 2011). According to MOH, in the past decade Myanmar has added more than 200 hospitals and rural health centers (MNPED & UNICEF, 2013). Despite overall progress, there are major regional disparities in healthcare access. In 2012, MNPED and UNICEF estimated that about a quarter of all townships in Myanmar were labeled “hard-to-reach” by the national Expanded Program on Immunization (EPI) due to remoteness or conflict.

In terms of human resources for health, a ratio of 23 health workers per 10,000 population is needed to achieve 80% skilled attendance at delivery according to WHO. As of 2009, Myanmar had a ratio of about 14:10,000, with most doctors concentrated in urban areas, where only 30% of the population resides. Though midwives are the first line of care for mothers and children, the

number of midwives has only increased by about 10% since 1988, while the number of medical graduates has doubled (UNFPA, 2010).

Poor households tend to have more children

Nine out of every ten poor households have children, and more than 60% of children in Myanmar are living in poverty.¹⁵ As family size increases, per capita consumption of food decreases. In fact, the addition of one child under the age of 15 years immediately reduces a household's per capita consumption by 31%.¹⁶ On the other hand, as education and labor supply within the household increases, so does consumption.

Policy analysis

There are a variety of policies and programs in place to address stunting and its underlying determinants, which address the financial and spatial barriers that exclude children and their families to varying degrees. The still draft **Myanmar National Action Plan for Food and Nutrition Security (MNAPFNS)**, which comes in response to the Zero Hunger Challenge, represents high level commitment to reducing malnutrition, and especially stunting, in Myanmar. The implementation of the MNAPFNS is overseen by the Committee on Food and Nutrition Security, which is chaired by the President. This plan also recognizes that reducing stunting requires a concerted effort across all relevant Ministries (Planning, Health, Agriculture, Livestock and Fisheries, Rural Development, Water, Social Welfare, Finance). At the same time, the scope and budget of the MNAPFNS is likely to make implementation challenging. While disaggregation of key indicators at the Regional/State level will go part of the way in identifying and addressing disparities, there is no specific plan for targeting resources to the areas and households most in need.

Recognizing the vital role of health workers in supporting optimal nutrition behaviors for women, infants, and young children, the **scale up of Auxiliary Midwives (AMWs) throughout the country** will increase access to health services in hard-to-reach, remote and underserved areas, as well as reducing the workload of overstretched midwives, doctors and nurses.

The **Social Protection Strategic Plan 2014** recognizes the need for child-sensitive social protection actions, following international evidence that returns on investments are highest at the youngest ages. Additionally, the Plan includes categorical cash transfers to reduce inequities, promote social cohesion and reduce poverty.

Policy recommendations

Malnutrition is a multidimensional issue with several underlying factors including poverty and exclusion. Consequently, **no single program or project implemented in isolation will be sufficient to sustain a significant reduction in the rate of stunting.** Instead, coordinated actions across sectors are needed. Policy priorities in Myanmar include:

Increasing investments in and coverage of social protection programs

- Recent analysis by UNICEF confirmed that “a benefit for the first 1000 days of life, when coupled with benefits to households with children aged 3-15 and households with elderly

citizens, has a staggering impact on poverty: the poverty rate drops by nearly 36%, or 13 percentage points. More than 1.4 million households would cross the poverty threshold due to these benefits.”¹⁷

- These benefits would cost Myanmar about 6% of its GDP.¹⁸
- Also according to UNICEF, “Providing universal benefits for households with children is the most efficient way to ensure resources are directed towards the poorest. Social protection boosts social cohesion, political solidarity and promotes human rights, while providing pathways for human development and economic growth.”

Appropriate allocation of resources and prioritization of key activities to improve food and nutrition security according to the evidence-base

- Any plans and strategies should include:
 - A clear focus on the first 1000 days.
 - Attention to movement and migration within Myanmar and how to support those who want to shift out of small holder agriculture into other livelihoods.
 - The role of the private sector in rolling out interventions in agriculture and national food fortification.

Targeting of resources to areas and households most in need:

- There are clear health and nutrition disparities in Myanmar. All actions to reduce stunting should include specific procedures for targeting resources and measuring their impact by disaggregating data to reveal inequities (for instance, by gender, urban/rural residence, wealth quintile, etc.).

Investments in health workers and nutrition activities at the community level

- Many of the communities that are most in need are situated in rural, remote and hard to reach areas. Health facilities are usually located far away and require multiple modes of transportation to get to. Midwives also have too large of a coverage area, and often cannot afford travel expenses to the most far-flung areas. As a result, these communities are often excluded from the health system. Investments must be made at the community level to improve the capacity of auxiliary midwives and community health workers, and cover operational expenses for the midwives, auxiliary midwives and community health workers.

¹ Martorell et al. 2010. Weight gain in the first two years of life is an Important of schooling outcomes in pooled analysis from 5 birth cohorts from low- and middle-income countries. *Journal of Nutrition*. 140:348-54. Hoddinott et al. 2008. Effects of a nutrition intervention during early childhood on economic productivity in Guatemalan adults. *Lancet*. 371:411-16. Hoddinott, J., J. Maluccio, J. R. Behrman, R. Martorell, P. Melgar, A. R.

Quisumbing, M. Ramirez-Zea, A. D. Stein, and K. M. Yount. 2011. "The Consequences of Early Childhood Growth Failure over the Life Course." Discussion Paper 1073. International Food Policy Research Institute, Washington, DC.

² Horton S. and R. Steckel. 2013. "Global Economic Losses Attributable to Malnutrition 1900–2000 and Projections to 2050." In *The Economics of Human Challenges*, ed B. Lomborg. Cambridge, U.K.: Cambridge University Press

³ 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.

⁴ Ministry of National Planning and Economic Development (MNPED) & Ministry of Health (MOH). (2011). *Myanmar Multiple Indicator Cluster Survey 2009-2010 Final Report*. Nay Pyi Taw, Myanmar: Ministry of National Planning and Economic Development & Ministry of Health, Myanmar.

⁵ World Bank Group. (2014). *Myanmar: Ending poverty and boosting shared prosperity in a time of transition*.

⁶ Ministry of National Planning and Economic Development (MNPED) & Ministry of Health (MOH). (2011). *Myanmar Multiple Indicator Cluster Survey 2009-2010 Final Report*. Nay Pyi Taw, Myanmar: Ministry of National Planning and Economic Development & Ministry of Health, Myanmar.

⁷ UNICEF Myanmar. (2015). *Social Protection in Myanmar: The Impact of Innovative Policies on Poverty*.

⁸ 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.

⁹ Ministry of Health & UNICEF. (2011). *Knowledge, Attitudes and Practices Study into Water, Sanitation and Hygiene in 24 Townships in Myanmar*. – Found that children were actually more likely to have had diarrhea in the past 2 weeks if they had an unimproved latrine than if they had no latrine at all.

¹⁰ 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.

¹¹ Ministry of Health & UNICEF. (2011). *Knowledge, Attitudes and Practices Study into Water, Sanitation and Hygiene in 24 Townships in Myanmar*. – Found that children were twice as likely to have had diarrhea in the past two weeks if they lived in a household using an unimproved water source.

¹² With Oral Rehydration Therapy (ORT), increased fluids and continued feeding

¹³ Ministry of National Planning and Economic Development (MNPED) & Ministry of Health (MOH). (2011). *Myanmar Multiple Indicator Cluster Survey 2009-2010 Final Report*. Nay Pyi Taw, Myanmar: Ministry of National Planning and Economic Development & Ministry of Health, Myanmar.

¹⁴ Ministry of Health & UNICEF. (2003). *Overall and Cause-Specific Under-Five Mortality Survey*. Yangon, Myanmar: Ministry of Health.

¹⁵ UNICEF. (2015). *Children in the 2014 Myanmar Population and Housing Census*. Yangon, Myanmar: UNICEF.

¹⁶ UNICEF Myanmar. (2015). *Social Protection in Myanmar: The Impact of Innovative Policies on Poverty*. Yangon, Myanmar: UNICEF.

¹⁷ UNICEF Myanmar. (2015). *Social Protection in Myanmar: The Impact of Innovative Policies on Poverty*. Yangon, Myanmar: UNICEF.

¹⁸ UNICEF Myanmar. (2015). *Social Protection in Myanmar: The Impact of Innovative Policies on Poverty*. Yangon, Myanmar: UNICEF.