Community Based Management of Acute Malnutrition (CMAM) **Programme Coverage Assessment Report**

Rohingya Camps
December 2021 – January 2022

WFP
World Food Programme
SAVING LIVES
CHANGING LIVES

In partnership with Canada
ACTION AGAINST HUNGER
ACTION CONTRE LA FAIM
Cox's Bazar, Bangladesh NUTRITION SECTOR
Funded by European Union Humanitarian Aid

EXECUTIVE SUMMARY

KEY HIGHLIGHTS

Programme coverage (Children aged 6-59 months):

- **High** Blanket Supplementary Feeding (BSFP) programme coverage at **98.0%** exceeding the SPHERE standards **(>90%), indicating almost all children 6-59 months are accessing BSFP services.**

- Outpatient Therapeutic Programme (OTP) coverage of **82.8%** and Targeted Supplementary Feeding Programme (TSFP) coverage of **84.6%** were also found to be close to the **High coverage classification** based on current expanded MUAC-only protocol, **but still below the SPHERE standards** of >90% as many children are not being systematically screened during distribution and not being referred to OTP/TSFP appropriately if identified as SAM/MAM.

- However, coverage for both OTP and TSFP are lower based on WHO Weight for Height protocols, compared to expanded MUAC-only protocol - OTP **(69.4% WFH versus 82.8% MUAC)** and TSFP **(80.4% WFH versus 84.6% MUAC)** as children who are SAM or MAM, based on WFH Z-score but not by MUAC, are being missed due to lack of systematic screening and excluded from the right programme.

Programme coverage (Pregnant and Lactating Women):

- **High** BSFP programme coverage **(91.0%)** exceeds the SPHERE standards **(90%).**
- TSFP programme coverage is also found to be close to be close to the **High coverage classification (85.9%)** but is still **below** the SPHERE standards **(90%).**

Community screening coverage (Children and Pregnant and Lactating Women):

- Almost all children were previously screened at household level (**97.0%)**, suggesting strong outreach activities established in the camps for wasting case detection.
- Only fifty one percent of the PLW were screened **(51.0%) at household level** due to:
    - **The prioritization of MUAC** screening for children instead of PLW;
    - Lack of female volunteers at community level for MUAC screening at the household level.

If the above problems are addressed, coverage could be >90% for OTP and TSFP across all camps.

Background and objectives

In 2017, extreme violence in Rakhine State, Myanmar, forced more than 700,000 Rohingya refugees to flee across the border into Cox's Bazar District in Bangladesh. Since then, the people and Government of Bangladesh have supported them along with the national and international humanitarian community. In October 2021, an estimated 888,000 Rohingya refugees lived in the Cox's Bazar refugee settlements in two registered and 32 makeshift camps. The populations of the camps ranged from 4,000 to 43,000 individuals.

The December 2021 Standardized Expanded Nutrition Survey (SENS) indicates that the prevalence of Global Acute Malnutrition by weight for height (WFH) remains in the second-highest category, "High," with an upper confidence level >15%, "Emergency thresholds". The prevalence rates for chronic malnutrition, commonly known as "stunting," were above the WHO/UNICEF threshold of **Very High/Critical of ≥30%** category. The anemia rates were found to be **High (>40%)** among children and non-pregnant women of reproductive age. However, there has been a significant reduction in the prevalence of wasting among women of reproductive age since 2017 (from >8.0% to <2.0%).

The Nutrition Sector of Cox's Bazar supports the management of severe and moderate acute malnutrition in children under five years of age and in pregnant and lactating women (PLW) in three inpatient Severe Acute Malnutrition (SAM) treatment facilities (for children 0-59 months) and 46 Integrated Nutrition Facilities (INF). INFs offer Outpatient Therapeutic Programme (OTP) for children 6-59 months suffering from SAM, Targeted Supplementary Feeding Programmes (TSFP) for children 6-59 months and PLWs suffering from Moderate Acute Malnutrition (MAM), and Blanket Supplementary feeding Programmes (BSFP) for all other children 6-59 months and PLWs. In October 2021, these nutrition services were implemented by two national non-governmental organisations (SHED and SARPV) and three international non-governmental organisations (Action Against Hunger, Concern Worldwide, and World Concern/Medair), with support of WFP, UNICEF and UNHCR.

Due to the COVID-19 pandemic in March 2020, all Nutrition Sector partners adopted simplified protocols for the admission and treatment of acutely malnourished children and PLWs to minimise the risk of disease transmission. Simplified protocols included reduced frequency of visits to INFs during treatment (e.g., for OTP from weekly visits to once every two weeks; TSFP for children 6-59 months and PLWs reduced from once every two weeks to once per month) and the use of expanded Mid-upper arm circumference (MUAC)-only admission and discharge criteria for children under five years of age (SAM cases admitted if MUAC is below 120mm and MAM cases admitted if MUAC => 120 and < 130mm).

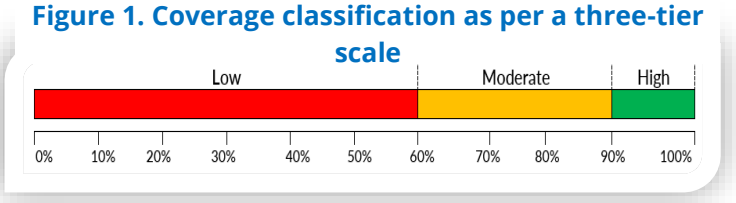
In December 2021 and January 2022, with financial support from WFP, ECHO and GAC,[1] the Action Against Hunger Bangladesh Surveillance Team conducted a Community Based Management of Acute Malnutrition (CMAM) programme coverage assessment on behalf of

[1] United Nations World Food Programme, Directorate-General for European Civil Protection and Humanitarian Aid Operations, Global Affairs Canada

the Nutrition Sector in the Rohingya refugee settlements in Cox's Bazar, Bangladesh. This was the third coverage assessment led by Action Against Hunger in the refugee camps in collaboration with the Government of Bangladesh Ministry of Health and Family Welfare through the Cox's Bazar District Civil Surgeon's and Office of The Refugee Relief and Repatriation Commissioner (RRRC), the previous two having been completed in August 2018 and December 2019.

Using the Simplified Lot Quality Assurance Sampling for Access and Coverage (SLEAC) methodology, the coverage survey aimed to assess the coverage of SAM and MAM treatment programmes[2] as well as to identify key barriers and boosters reported by caregivers and PLWs accessing treatment services. The assessment monitored the improvement of OTP and TSFP coverage through comparison with the initial assessment conducted in August 2018 and informed a timely and effective humanitarian response to improve the coverage of SAM and MAM treatment services for children and for PLWs.

Figure 1. Coverage classification as per a three-tier scale



The Sphere standard for treatment coverage in camp settings is **90%.** The SLEAC method also enables treatment coverage to be classified by zone or by camp as low, moderate, and high based on the identification of a relatively small sample size (e.g., SAM children and MAM PLW). Using the Lots Quality Assurance Sampling (LQAS) classification technique, OTP and TSFP coverage were classified on the scale above. More details about the methodology will be included in the final report.

Key findings

PROGRAMME COVERAGE - OTP (CHILDREN)

Figure 2. OTP programme coverage by zone and camp

Zone	Camp Name	Coverage status (Expanded MUAC protocol)	Coverage status (WHO protocol)
Zone 1	KRC, 1E, 1W, 2E, 2W, 3, 4, 4 Ext	**Moderate**	**Moderate**
Zone 2	5, 6, 7, 8E, 8W, 9, 10	**Moderate**	**Moderate**
Zone 3	11, 12, 13, 17, 18, 19, 20, 20 Ext	**Moderate**	**Low**
Zone 4	14, 15, 16	**Moderate**	**Moderate**
Zone 5	21, 22, 24, 25, 26, 27, NRC	**Moderate**	**Moderate**
Coverage Estimate for All Camps [95% confidence Interval]		**82.8% [78.4-87.2]**	**69.4% [64.5-74.3]**

[2] Treatment coverage refers to the proportion of a target population (e.g. SAM children) who are enrolled in the appropriate treatment programme.

The SAM treatment programme (OTP) coverage for children 6-59 months based on expanded MUAC protocol was classified as **Moderate** in all five Zones (Zones 1, 4 and 5 were Moderate but were close to High coverage). However, the **OTP coverage based on WHO protocol was found** to be **lower** than the one based on expanded MUAC-only protocol **(69.4% vs 82.8%)** as children who were SAM by WFH Z-score but not by MUAC were missed due to a lack of systematic screening or enrolled in TSFP as per their MUAC while they could have been admitted in OTP as per their Z-score. Zone 3 was classified as Low coverage and other zones were Moderate. **However, most non-covered OTP cases were enrolled in the TSFP.**

PROGRAMME COVERAGE - TSFP (CHILDREN AND PLW)

TSFP coverage for children 6-59 months was classified as **High in 9 camps, Moderate in 23 camps and Low in one camp.**

TSFP coverage for PLWs was classified as **Moderate** in Zones 1, 2 and 5 and **High** in Zones 3 and 4.

Figure 3. Coverage of TSFP and BSFP programme for children 6-59 months and PLWs

Type	Low	Moderate	High	Coverage Estimate for All Camps [95% Confidence interval)
TSFP children 6-59 months (MUAC protocol)	Camp 18 **(1 camp)**	Camp 1E, 1W, 2E, 2W, 5, 6, 7, 8W, 10, 11, 12, 13, 14, 15, 16, 17, 19, 20, 20 EXT, 22, 25, 26, 27 **(23 camps)**	Kutupalong & Nayapara RC, camp 3, 4, 4 Ext, 8E, 9, 21, 24 **(9 camps)**	**84.6%** [82.5-86.7]
TSFP children 6-59 months (WHO protocol)	Camp 25 **(1 camp)**	Kutupalong & Nayapara RC, Camp 1E, 1W, 2E, 2W, 4, 5, 6, 7, 8E, 8W, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 20 EXT, 22, 24, 26, 27 **(29 camps)**	Camp 3, 4 Ext, 21 **(3 camps)**	**80.4%** [78.1-82.7]

TSFP PLW	No camps classified as low coverage	Zone 1, 2 and 5	**Zone 3 and 4**	**85.9%** [79.7-92.2]
BSFP children 6-59 months	No camps classified as low coverage	**No camp falls under low coverage**	**All camps**	**98.0%98%** [97.7-98.2]
BSFP PLW	No camps classified as low coverage	Camp 1W, 8W, 9, 11, 12, 15, 19,21, 26 **(9 camps)**	Kutupalong & Nayapara RC, Camp 1E, 2E, 2W,3, 4, 4 Ext, 5, 6, 7, 8E, 10, 13, 14, 16, 17, 18, 20, 20 Ext, 22, 24, 25, 27 **(24 camps)**	**91%** [89.9-92.1]

PROGRAMME COVERAGE - BSFP (CHILDREN AND PLW)

For both children and PLWs, the BSFP coverage exceeds SPHERE standards (90%). BSFP coverage for children 6-59 months was greater than 95% in all camps. BSFP coverage for PLWs was greater than 90% in 24 camps and from 76-89% in 9 camps.

COMMUNITY SCREENING COVERAGE (CHILDREN AND PLW)

Figure 4: Confirmation of previous MUAC screening by nutrition workers at home				
Target Group	**Low**	**Moderate**	**High**	**Coverage Estimate**
Children Under 5	-	-	All camps high coverage	**97%**
PLW	Camp 1E, 1W, 2W, 4, 4Ext, 5, 9, 11, 12, 18, 19, 20 Ext, 21, 22, 24, 25, 26, 27 **(18 camps)**	Kutupalong and Nayapara RC, Camp 2E, 3, 6, 7, 8E, 8W, 10, 13, 14, 15, 16, 17, 20 **(15 camps)**	No camps falls under high coverage	**51%**

In every camp, more than 90% of caregivers confirmed that their children had been screened at home with a MUAC tape previously by a nutrition worker (97% for all camps).

However, only 51% of PLWs confirmed that they had been screened at home with a MUAC tape; **screening coverage was less than 50% in 18 camps** and 60-80% in 15 camps.

KEY BARRIERS TO ACCESS SERVICES

Where non-covered SAM or MAM children 6-59 were identified, the primary reason for non-attendance was due to children being enrolled in the incorrect programme or not being identified by active screening and therefore not referred to treatment services.

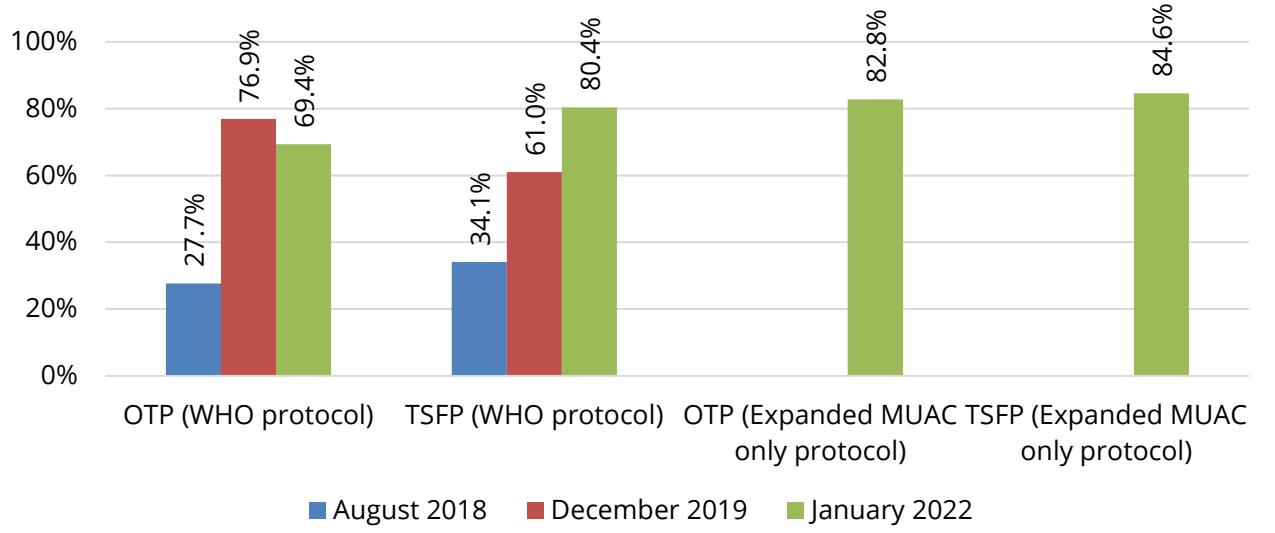
For example, children who were SAM based on the Expanded MUAC-only protocol were enrolled in the TSFP and children who were MAM were enrolled in the BSFP. **This is attributed to inaccurate screening process of cases during the bimonthly (OTP) or monthly (TSFP) child visits to INFs.**

Where non-covered MAM PLWs were identified, the primary reasons were the morbidity of PLWs and to the PLW not being aware that she was acutely malnourished.

For the OTP and TSFP for children under five years of age, community level screening by Community Nutrition Volunteers (CNVs) was the primary mechanism by which children are entered into the relevant programme. This was followed by systematic screening at INFs.

TRENDS OF PROGRAMME COVERAGE

Figure 5. CMAM coverage estimates for all camps for children 6-59 months



OTP and TSFP coverage for children 6-59 months has increased compared to the last CMAM coverage assessment in December 2019. However, neither programme exceeded Sphere standards for camps (90%). This is probably due to the expanded MUAC protocol which has been in place since the onset of the Covid-19 pandemic. Based on the standard WHO protocols, coverage of both OTP and TSFP is slightly lower indicating that children who are SAM or MAM based on Weight for Height Z-score but not by MUAC are being missed, despite the expanded MUAC admission protocols.

The improved OTP and TSFP coverage can be attributed to screening campaigns that took place in the camps following the easing of COVID-19 restrictions in the second half of 2021 and to the move from separate OTP and TSFP facilities to integrated nutrition facilities, managed by the same partner, which delivered all CMAM services in a given camp.

Recommendations and Priorities

Findings of the CMAM coverage assessment were presented to the Nutrition Sector partners on 15 February 2022. Based on the negative factors identified during the survey, partners elaborated the following recommendations to improve coverage based on the results of the assessment. More detailed activities relating to each recommendation will be included in the full report.

Children Under 5 years of age

Negative factors	Recommendations
Non-systematic screening by MUAC in some INFs leads to some SAM / MAM children being missed	• Ensure proper execution of treatment protocol in all INFs • Ensure referral mechanism is sound • Community screening should be mandatory every month
Non-response rate >10% in certain camps	• Training and orientation of INF staff • Conduct home visits • Update the child and PLW database on monthly basis and restart growth monitoring promotion activities • Ensure availability of protocols at the facility level
Inaccurate ages being recorded on Child Health Cards	• Disseminate messages to caregivers to bring Enhanced Programme of Immunization (EPI) cards during admission to OTP and TSFP • Check the EPI card and history with caregivers to ensure the age of children is correct • Maintain a register book to record the date of birth of newborn children in the catchment area
SAM and MAM children being missed due to use of MUAC-only protocol	• Advocate to the National Nutrition Sector (NNS) and Nutrition Sector to resume standard WHO protocols • Increase monitoring of anthropometric measurements at the community and facility level • Provide guidance and advice to partners to emphasize the accuracy of anthropometric measurements for the at-risk group (MUAC 13.0 cm to 13.5 cm) • Include OTP cured cases in home visit criteria

PLWs

Negative factors	Recommendations
Systematic screening of PLWs is not taking place in all camps	• Increase the percentage of female community nutrition volunteers (CNV) • Regular screening of PLWs followed by outreach supervisors • Ensure active referral of PLWs • Introduction of mass screening for PLW along with U5 mass screening
Morbidity preventing some PLWs from visiting INFs	• CNV and supervisors should ensure adequate linkage with health facilities for timely referral and management
Acutely malnourished PLWs unaware that they are eligible for treatment	• Ensure MUAC measurements of PLWs both in centres and in communities and adequate sensitization of all PLWs
Inconsistencies in reporting of PLW exit criteria	• Ensure all camps have a harmonized reporting format • Orient all staff about reporting indicators

SUPPORTED BY

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