Stop Stunting I No Time to Waste
Scaling up Care for Children with Severe Wasting in South Asia

REGIONAL CONFERENCE
May 16th – 18th 2017 I Kathmandu, Nepal

Country Presentation: Bangladesh
Bangladesh - A Brief Country Profile

POPULATION

Total Population 160 million
Under 5 Population 17 million
Pregnant Women 3.8 million

POVERTY RATES AND GDP

NUTRITIONAL STATUS OF CHILDREN (UNDER-5)

MORTALITY RATES

NMR : 23 per 1000 live births (2015)
IMR : 33 per 1000 live births (2015)
U5MR : 38 per 1000 live births (2015)
MMR : 176 per 100,000 live births (2015)

GINI Index : 32 (2010)

National Polices to address Childhood Undernutrition

1. Nutrition underscored in the Article 18 (A) of the Constitution 1972
2. 7th Five Year Plan (2016-20) targeting reduction of stunting
5. New Multi-sectoral National Plan of Action on Nutrition 2016-2025 endorsed
In the past decade, the stunting has declined from 43% in 2004 to 36% in 2014. However, 5.5 million still are stunted. Disparities exists. A child belonging to the lowest wealth quintile is 3 times more likely to be undernourished.

Source: BDHS, 2000 - 2014;
Nutrition Status : Wasting

SAM prevalence in Bangladesh by District

from the equity lens

Poor progress in reduction in wasting in the past decade

SAM and GAM prevalence in Bangladesh

GENDER
Male 3.7%
Female 2.4%

WEALTH
Poorest 3.7%
Richest 2.8%

AGE GROUP
36-47 months 1.7%
12-17 months 6.0%

NATIONAL
3.1%

GEO-LOCATION
Rangpur 5.0%
Dhaka 2.1%

GEO-LOCATION

SAM < 1%
SAM between 1 - 2%
SAM between 2 - 3%
SAM > 3%

Half a million Children Severely Wasted
Understanding the Causes of Wasting

1. Size at Birth

- A baby with low birth weight is more likely to be wasted.
- Poor IYCF practices
- High prevalence of Wasting despite low rates of acute infections (ARI & Diarrhoea)

2. Poor IYCF Practices

<table>
<thead>
<tr>
<th>Levels of IYCF Practices and change over years</th>
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<tbody>
<tr>
<td>Early initiation of BF</td>
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<tr>
<td>Exclusive breastfeeding</td>
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<tr>
<td>Continued breastfeeding at 2yr.</td>
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<tr>
<td>Introduction of solid, semi-solid, or soft foods (6-8 months)</td>
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<tr>
<td>Minimum dietary diversity</td>
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<tr>
<td>Minimum meal frequency</td>
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<tr>
<td>Minimum acceptable diet</td>
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• A baby with low birth weight is more likely to be wasted.
• Poor IYCF practices
• High prevalence of Wasting despite low rates of acute infections (ARI & Diarrhoea)
National programme for addressing Wasting

• The national policy, strategies and plans underscore the importance of addressing wasting.
• The National Nutrition Policy calls for treatment of moderate and severe acute malnutrition both at health centres and in the community.
• The new health population and nutrition (HNP) sector plan calls for treatment of uncomplicated cases of SAM at the community level.

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National Nutrition Services (NNS)

- A primary minimum package of nutrition specific and sensitive interventions focusing on 1000 days and life cycle approach
- Implemented in all 64 districts
- Includes management of acute malnutrition
National Policy and Programmatic Response to Childhood Wasting

- Robust national guidelines
- NNS has been rolling out inpatient treatment in tertiary, district and sub districts levels
- Capacity development of frontline workers on screening and referral of children with acute malnutrition is ongoing.
- Information management system strengthened
**Key Milestones in Expanding Care for Children with SAM**

### National Plan for expansion of inpatient Care

<table>
<thead>
<tr>
<th>Facility type</th>
<th>Total facilities</th>
<th>Targeted for SAM</th>
<th>Facilities currently providing SAM management</th>
<th>Proportion covered (%)</th>
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<tbody>
<tr>
<td>District Hospitals</td>
<td>61</td>
<td>61</td>
<td>52</td>
<td>85</td>
</tr>
<tr>
<td>Tertiary level hospitals</td>
<td>76</td>
<td>76</td>
<td>29</td>
<td>38</td>
</tr>
<tr>
<td>Upazila Health Complex</td>
<td>425</td>
<td>425</td>
<td>238</td>
<td>56</td>
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<tr>
<td><strong>Total</strong></td>
<td><strong>562</strong></td>
<td><strong>562</strong></td>
<td><strong>319</strong></td>
<td><strong>57</strong></td>
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*1.8 million children have been screened and 8,000 children have been admitted since 2015.*
Key Milestones in Expanding Care for Children with SAM

- SAM management integrated into IMCI – particularly screening and referral
- The Government is procuring all supplies - in the past 3 years, approximately 23 million Taka spent on SAM management supplies
- 27,000 government frontline health workers in 26 districts have been trained on nutrition anthropometry including screening
- The training is complemented with mentoring and supportive supervision
- Key indicators related to SAM treatment integrated to national HMIS and monthly reporting through DHIS-2 operationalized
Critical Challenges

• **Rate of Screening is low**
  - At present, only children brought to IMCI&N corners are actively screened and referred.
  - Active screening and referral from Community Clinics and Family Welfare Centers is very weak
  - Reach of screening is very low - in 2016, only 1 million children were reached, out of 17 million under five children in the country

• **Admission rates are low**
  - 10,324 children were identified with SAM, of which only 4,662 children were admitted, less than 1% of the total estimated burden of SAM children in the country. This is due to
    (a) Limited capacity of facilities to admit and treat SAM
    (b) Limited understanding or demand for services from families, due to length of stay and wage loss

• **Quality of care is an issue**
  - Cure rate is 62% and default rate is 21%
Community Based Management of SAM

• Community based approach for addressing SAM is essential
• Facility based care alone can never adequately meet the case load
• While there is a strong acceptance for community based approach, main resistance is related to the use of RUTF as part of the SAM management
• A local RUTF is developed. Two recipes of RUTF with local ingredients developed by ICDDR’B. Acceptability and efficacy trial done. Effectiveness trial is pending.
## Opportunities to Improve Care for Severely Wasted Children

<table>
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<tr>
<th>Policy &amp; Strategic Shifts</th>
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<tr>
<td>• Policy and strategy strong for SAM</td>
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<tr>
<th>Institutional Reform</th>
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<td>• Current health delivery system is congenial for scaling up of SAM management.</td>
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<td>• Comprehensive formal health infrastructure and extensive cadre of health workers allows good platform to provide continuum of care approach</td>
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<th>Multi-sectoral nutrition plans</th>
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<tr>
<td>• NPAN and new NNS provides opportunity to scale up the treatment of SAM and improve the quality of care.</td>
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<td>• Competency based training to be rolled out to cover all districts in the country.</td>
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<tr>
<th>Programmatic shifts</th>
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<td>• Need to intensify efforts to initiate the community based approach</td>
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<td>• Active screening</td>
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<td>• Referrals</td>
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<td>• Treatment protocol at home</td>
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<td>• Capacity and data system strengthening</td>
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<th>Financing</th>
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<td>• Government is in good position to finance NNS-new operational plan with a funding of $90 million.</td>
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<td>• However need to advocate and ensure adequate funds are planned and released for SAM specifically</td>
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Future of care for children with severe wasting

- Scale up inpatient treatment to all 562 facilities
- Address barriers to care seeking - link with social protection
- Strengthen institutional capacity to enhance quality of care
- Institutionalize active screening beyond IMCI corners, in CCs and FWCs
- Improve IYCF counselling in the IMCI and SAM units
- Develop an implementation strategy and road map to initiate community based management of SAM
- Conduct national effectiveness trial of CMAM with local RUTF
- Intensify advocacy for comprehensive programme to address wasting.