EXECUTIVE SUMMARY HOST COMMUNITY NUTRITION SURVEY- 2023

COX'S BAZAR DISTRICT, BANGLADESH

KEY HIGHLIGHTS

The prevalence of Global Acute Malnutrition (GAM) among children aged 6-59 months in Cox's Bazar District is 10.6%, which is classified as "High" according to WHO/UNICEF thresholds. This finding is close to the national GAM rate of 11% reported in the 2022 BDHS survey.

Between the 2021 and 2023 SMART surveys, GAM rates increased notably in Teknaf (from 8.9% to 12.8%), Ukhiya (from 9.9% to 11.1%), and Cox's Bazar Sadar (from 10.0% to 11.8%), with all areas now classified as "High" by WHO/UNICEF threshold. Conversely, Moheshkhali (from 14.7% to 10.9%), Pekua (from 11.7% to 10.6%), and Kutubdia (from 14.8% to 7.8%) showed improvements with reduced GAM rates.

The prevalence of underweight has risen between 2021 and 2023 in Teknaf (from 21.9% to 24.8%), Ukhiya (from 25.8% to 26.1%), and Cox's Bazar Sadar (from 24.4% to 26.8%), all now categorised as "Serious" by WHO/UNICEF threshold. In Pekua, underweight rates spiked from 26.8% to 31.0%, reaching the "Critical" threshold.

Approximately 35,753 children in the district are suffering from wasting, indicating a high level nutritional crisis, while 94,441 are underweight and 100,850 are stunted.

The district prevalence of Acute Respiratory Infection 8.7%, diarrhea (13.8%) and fever (43.8%) among children aged 6-59 months is notably high compared to the national averages of 1.4%, 4.8% and 30.5%, respectively (BDHS 2024).

Exclusive breastfeeding rates are at a promising 75%, surpassing the national rate of 55% (BDHS 2022) and the 2022 IYCF assessment district rate of 62.1%.

The Minimum Acceptable Diet (MAD) rate of the district is critically low at 27.2%, indicating inadequate acceptable diet and below the national rate of 39% (BDHS) and the district rate of 28.3% (2022 IYCF assessment).

The Minimum Dietary Diversity (MDD) rate of the district is also alarming low at 22.2%, indicating insufficient variety in diets and falling below the national rate of 29% (BDHS) and the district prevalence of 23.3% from the 2022 IYCF assessment.

The Vitamin A supplementation coverage among children aged 6-59 months of the district is 85.8%. Measles vaccination coverage for children aged 9-59 months is 89.3% for the first dose (MR1) and 95.6% for the second dose (MR2), both of which are 82.2% higher than the national averages (MR1: 89.4%, MR2: 87.7%).
Deworming coverage for children aged 24-59 months was 82.2%.

Severe Malnutrition (Body Mass Index < 16) among adolescent girls in Cox's Bazar District is alarmingly high at 22.5%, indicating approximately 1 in 4 adolescent girls are suffering of severe under nutrition, with Ramu Upazila reporting the highest rate at 28.5% and Teknaf Upazila the lowest at 19.2%.

The intake of iron and folic acid (IFA) among adolescent girls is strikingly low, 93.4% do not meet the recommended weekly consumption dosage.

Less than half of the women in Cox's Bazar District meet the minimum recommended dietary diversity, with only 45.0% achieving this standard.

Only two-thirds of pregnant women in the district are taking the recommended daily dose of iron and folic acid (IFA) tablets, with a rate of 58.3%. The highest adherence is in Moheskhali at 63.4%, while Teknaf reports the lowest at 41.2%.

In the district, 41.5% of households depend on unprotected drinking water sources, and sanitation facilities are equally concerning, with more than one-third of households (41%) lacking access to improved latrines. This situation may greatly increases the risk of environmental contamination from waterborne diseases.

BACKGROUND:

In 2021, SMART surveys conducted in Cox's Bazar district covered six upazilas (Ukhiya, Teknaf, Cox's Bazar Sadar, Moheshkhali, Pekua and Kutubdia) revealeding notable significant variations in malnutrition rates, ranging from medium to high levels based on WHO/UNICEF thresholds. The prevalence of wasting ranged from a low of 8.9% in Teknaf to a high of 14.8% in Kutubdia. The prevalence of wasting varied, with Teknaf showing the lowest rate at 8.9%, while Kutubdia recorded the highest at 14.8%. Stunting was lowest in Ukhiya at 20.7% and highest in Moheshkhali at 29.8%, placing all upazilas in the "high" stunting category according to WHO/UNICEF standards. Similarly, the underweight prevalence ranged from 21.9% in Teknaf to 32.1% in Moheshkhali, falling within the serious to critical levels. Building on these findings, the 2023 survey aimed to monitor progress in the six previously surveyed upazilas while expanding to cover the remaining two upazilas (Ramu and Chokoria)..

This comprehensive assessment was essential for supporting data-driven decision-making and implementing targeted interventions. Furthermore, the survey explored a broader set of indicators, including WASH (Water, Sanitation, and Hygiene), food security, morbidity, Infant Young Child Feeding Practice, Maternal nutritional status, Adolescent nutritional status and mortality, to better understand the underlying factors contributing to malnutrition. These additional metrics offer crucial insights into the social and environmental determinants of nutritional status within the population.

In response to these challenges, UNICEF, with technical support from ACF, initiated an integrated nutrition survey covering all eight upazilas of Cox's Bazar. This approach, recommended by the Nutrition Sector-Cox's Bazar, reflects a proactive effort to address the complex nutritional issues faced by the host communities. The goal is to enhance evidence-based programming and advocacy, ensuring interventions are tailored to the evolving needs and dynamics of the population.

OBJECTIVES:

The SMART Survey aimed to assess the nutritional, WASH, and food security conditions across eight Upazilas in Cox's Bazar, focusing on vulnerable groups: children (6-59 months), pregnant and lactating women (15-49 years), and adolescent girls (10-19 years).

MEHODOLOGY:

A cross-sectional two-stage cluster sampling approach following SMART methodology was adopted. The first stage involved selection of the clusters. The villages were considered as the smallest geographical unit (clusters). The second stage involved selection of households**.** The sample sizes were designed to achieve reasonable precision for estimates of Global Acute Malnutrition (GAM) as well as crude mortality separately for the entire district covering all Upazila. All calculations were made using ENA for SMART software (version January 11th 2020). The purpose of the sample calculation was to get a sample having the optimal units so that results are reliable; with reasonable precision. The point prevalence of GAM was used based on the 2021 SMART survey, as no other trusted recent data was available. However, due to the absence of recent data for rest two Upazilas, the MICS 2019 results were utilized to estimate the required sample size. A desired precision used based on SMART guideline considering the point prevalence and a design effect from the previous survey findings used in calculating the sample size. It was determined that a sample size of 3585 children would be statistically representative for anthropometric measurements in the district.

GEOGRAPHIC LOCATION:

The geographical areas cover all the eight upazilas (Ukhiya, Teknaf, Ramu, Moheshkhali, Kutubdia,Cox's Bzar Sadar and Chokoria) in Cox's Bazar district host community (Figure 1) and data collected from 8th November to 29th December 2023.

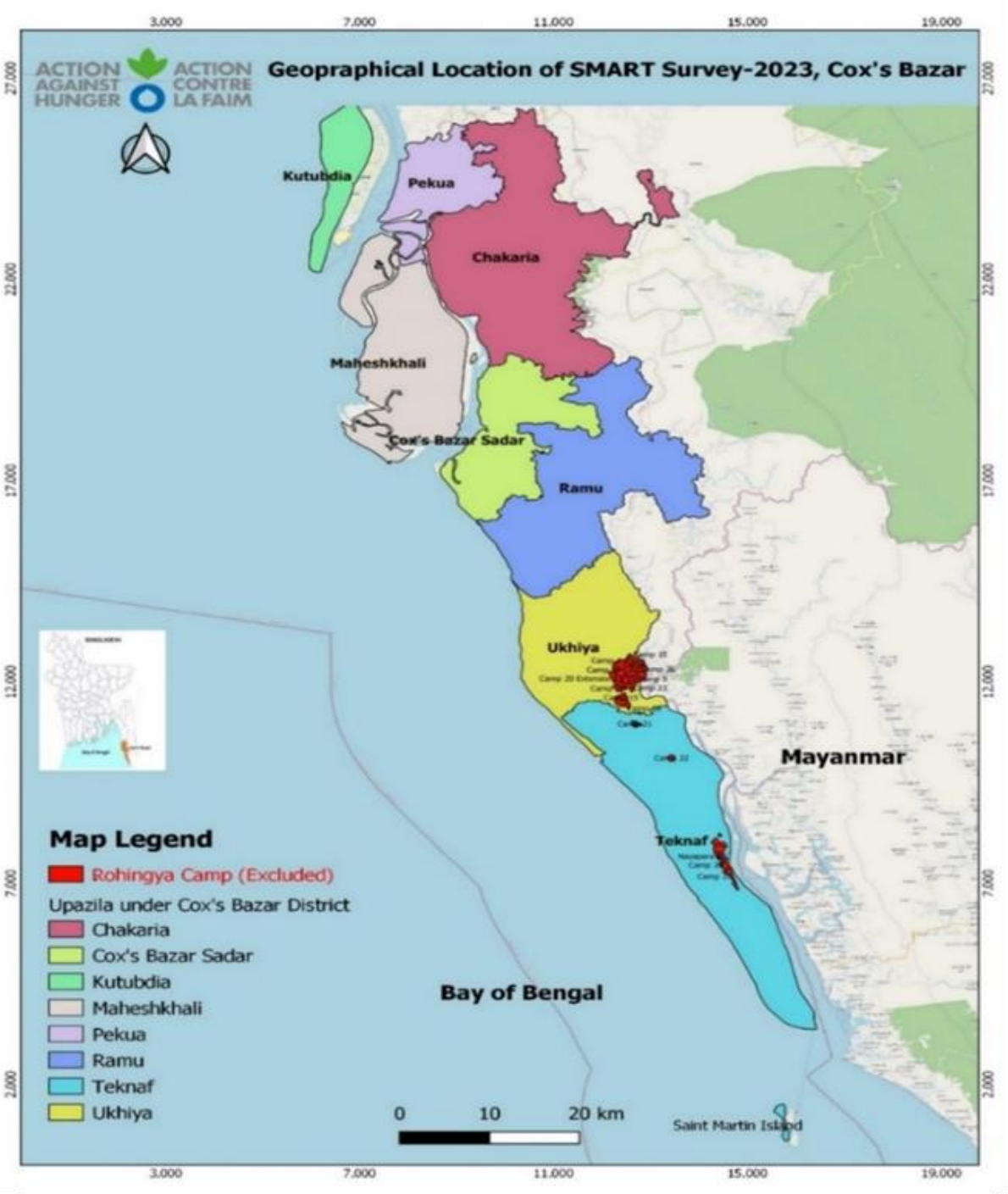


Figure 1: Geographical Location

INTERPRETATION OF SEVERITY OF MALNUTRITION:

Table 1: Cut-offs for the indices of Weight-for-Height Z-score, Height -for-Age Z-score, Weight-for-Age Z-score, and Mid Upper Arm Circumference.

Malnutrition Status	MALNUTRITION STATUS CLASSIFICATION			
	Acute Malnutrition (WHZ)		Chronic malnutrition (HA	Underweight (WAZ)
	Weight-for-/ Height [WHZ]	MUAC (MM)	Height-for-/Age [HAZ]	Weight/Age [WAZ]
Global Acute Malnutrition (GAM)	WHZ< -2 SD and/or Oedema	MUAC< 125 mm and /or Oedema	HAZ< -2 SD	WAZ< -2 SD
Moderate Acute Malnutrition (MAM)	WHZ <- 2SD to ≥ -3 SD	115 mm≤ MUAC< 125 mm	HAZ <- 2SD to ≥ -3 SD	WAZ <- 2SD to ≥ -3 SD
Severe Acute Malnutrition (SAM)	WHZ < -3 SD and/or Oedema	MUAC< 115 mm and /or Oedema	HAZ < -3 SD	WAZ < -3 SD

Table 2: WHO and/ UNICEF Classification for the Severity of Malnutrition by Prevalence among Children under Five

Indicator	PREVALENCE THRESHOLDS LEVEL [%]				
	Very high	High	Medium	Low	Very low
Wasting [WHZ]	≥ 15	10 – <15	5 - <10	2.5- <5	<2.5
Overweight [WHZ]	≥ 15	10 – <15	5 -<10	2.5- <5	<2.5
Stunting [HAZ]	≥ 30	20 - <30	10 -<20	2.5- <10	<2.5

Table 3: Nutritional Status among Adolescent Girl by Using BMI WHO range

Indictor	PREVALENCE THRESHOLDS LEVEL (BMI)					
	Severe Malnutrition	Moderate Malnutrition	Mild Malnutrition	Normal Nutritional Status	Over weight	Obesity
Body Mass Index (BMI)	<16.0	≥ 16.0 to <17.0	≥ 17.0 to <18.5	≥ 18.5 to <25.0	≥ 25.0 to <30.0	≥ 30.0

KEY FINDINGS:

Demographic status:

In Cox's Bazar District, the estimated percentage of infants aged 0-5 months is 1.4%, while children aged 6-23 months make up 4.1% of the population. Children aged 24-59 months represent 7.4%. Pregnant Women (PW) account for 1.5% of the population, and Lactating Women (LW) with infants under 6 months make up 1.3%, while those with infants aged 6 months and older account for 3.6%. Adolescents (10-19 years) comprise 20.5% of the population, with adolescent girls specifically representing 9.4% (Table 4).

Table 4: Demography Profile (Special Group)

Upazila	0-5 m	6-23 m	24-59 m	PW	LW with infant < 6 m	LW with infant ≥ 6 m	Adolescent Girl (10-19)yrs	Adolescent (10-19)yrs
Ukhiya	1.3%	3.9%	7.2%	1.5%	1.2%	2.8%	10.3%	22.1%
Teknaf	1.7%	4.0%	7.8%	1.3%	1.5%	3.3%	9.6%	22.0%
Cox's Bazar Sadar	1.7%	4.1%	8.5%	1.6%	1.4%	3.3%	8.9%	19.0%
Ramu	1.4%	4.4%	6.3%	1.6%	1.3%	4.4%	10.3%	21.1%
Moheshkhali	1.3%	4.2%	7.0%	1.2%	1.3%	3.7%	9.1%	20.5%
Kutubdia	1.4%	4.6%	8.5%	1.8%	1.3%	4.4%	9.5%	20.5%
Chokoria	1.3%	3.9%	6.6%	1.4%	1.4%	3.8%	8.7%	19.6%
Pekua	1.3%	4.2%	7.9%	1.5%	1.2%	3.3%	10.4%	21.7%
Cox's Bazar District	1.5%	4.1%	7.4%	1.5%	1.4%	3.6%	9.4%	20.5%

Retrospective crude and under 5 death rates:

The findings reveal varying mortality rates across the eight Upazilas in Cox's Bazar, Bangladesh. However across the upazilas the crude and under 5 death rates were below the WHO emergency threshold of 1/10,000/day and 2/10,000/day respectively (Table 5).

Table 5: Retrospective crude and under 5 death rates

Upazila	Mid-interval population	Crude death rate Deaths/10,000/day	Mid-interval under 5 population	Under 5 death rate Deaths/10,000/day
Ukhiya	4771	0.11 (0.05-0.26)	577	0.17 (0.07-0.46)
Teknaf	3671	0.17 (0.07-0.43)	474	0.22 (0.03-1.66)
Cox's Bazar Sadar	3678	0.15 (0.06-0.38)	489	0.19 (0.01-2.56)
Ramu	5177	0.12 (0.04-0.34)	612	0.14 (0.01-1.89)
Moheshkhali	3398	0.07 (0.02-0.23)	419	0.20 (0.03-1.48)
Kutubdia	3469	0.02 (0.00-0.24)	505	0.00 (0.00-0.00)
Chokoria	5161	0.06 (0.02-0.15)	621	0.24 (0.06-0.96)
Pekua	3106	0.15 (0.06-0.37)	408	0.56 (0.18-1.73)
Cox's Bazar District		0.10 (0.07-0.15)		0.22 (0.11-0.41)

Prevalence of acute malnutrition based on weight-for-height z scores and/or oedema[1]:

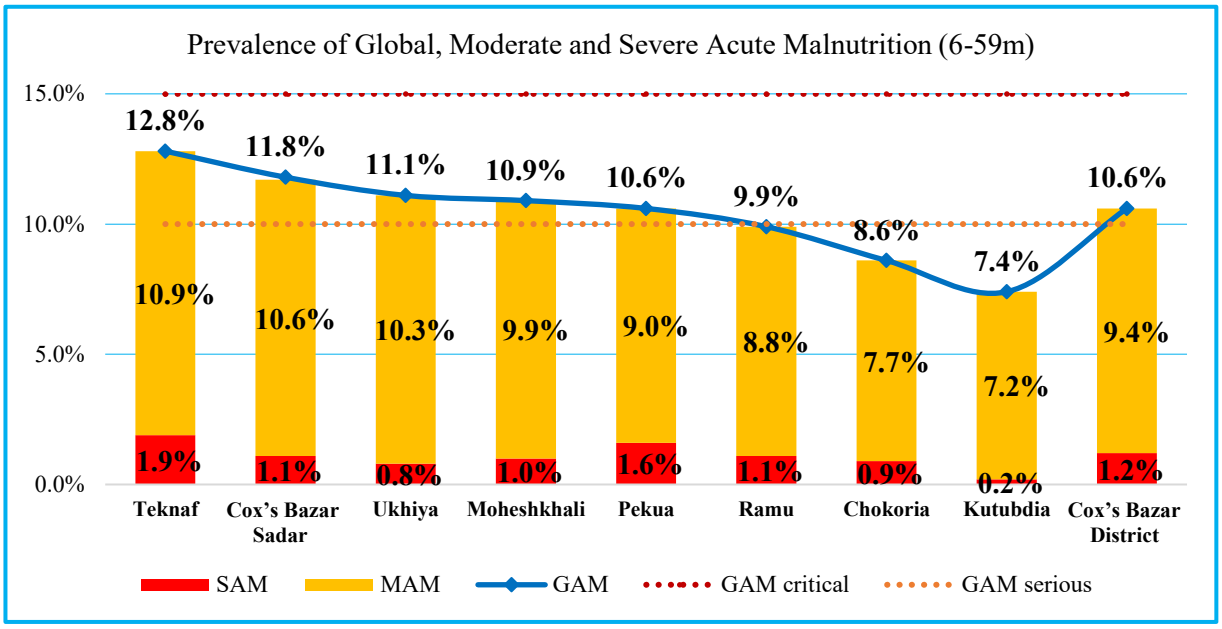
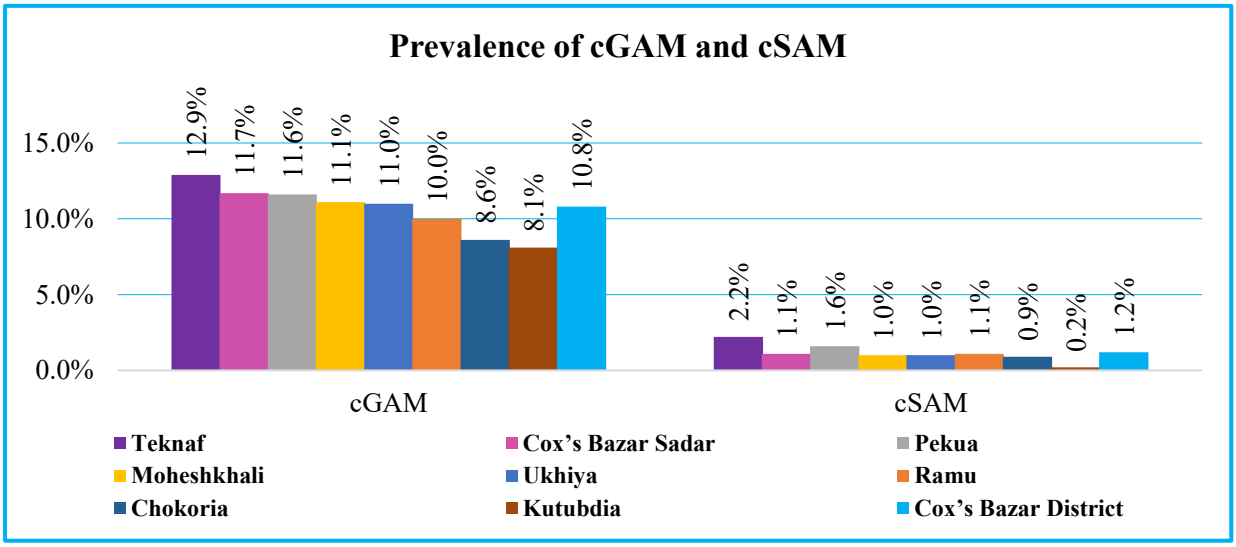


Figure 2: Prevalence of acute malnutrition based on weight-for-height z scores

The highest prevalence was found in Teknaf at 12.8% (95% C.I 9.4-17.1), while the lowest was observed in Kutubdia 7.4 % (95% C.I 5.5 -10.0) (Figure 2). Overall, the district's status was categorized as high according to the WHO/UNICEF emergency threshold, with a prevalence of 10.6% (95% C.I 5.5-10.0) while severe acute malnutrition was weighted at 1.2% (95% C.I 0.8-1.6). These findings underscores the critical need for urgent interventions to address malnutrition and improve child health outcomes across the region.

Prevalence of combined Wasting (WHZ and MUAC):



[1] No oedma cases identified

Figure 3: Prevalence of combined Wasting (WHZ and MUAC)

Overall, the district's weighted combined Global Acute Malnutrition (cGAM) based on WHZ and MUAC prevalence is 10.8% (95% C.I 9.6-11.9), indicating a high level of wasting prevalence as per WHO/UNICEF classification (Figure 3). Teknaf , Ukhiya , Cox's Bazar Sadar , Ramu, Moheshkhali, and Pekua fall under the high level indicating the acute wasting are high concern of these upazila. Chokoria and Kutubdia fall under medium level of threshold.

Prevalence of Underweight based on Weight-for-Age Z-scores (WAZ):

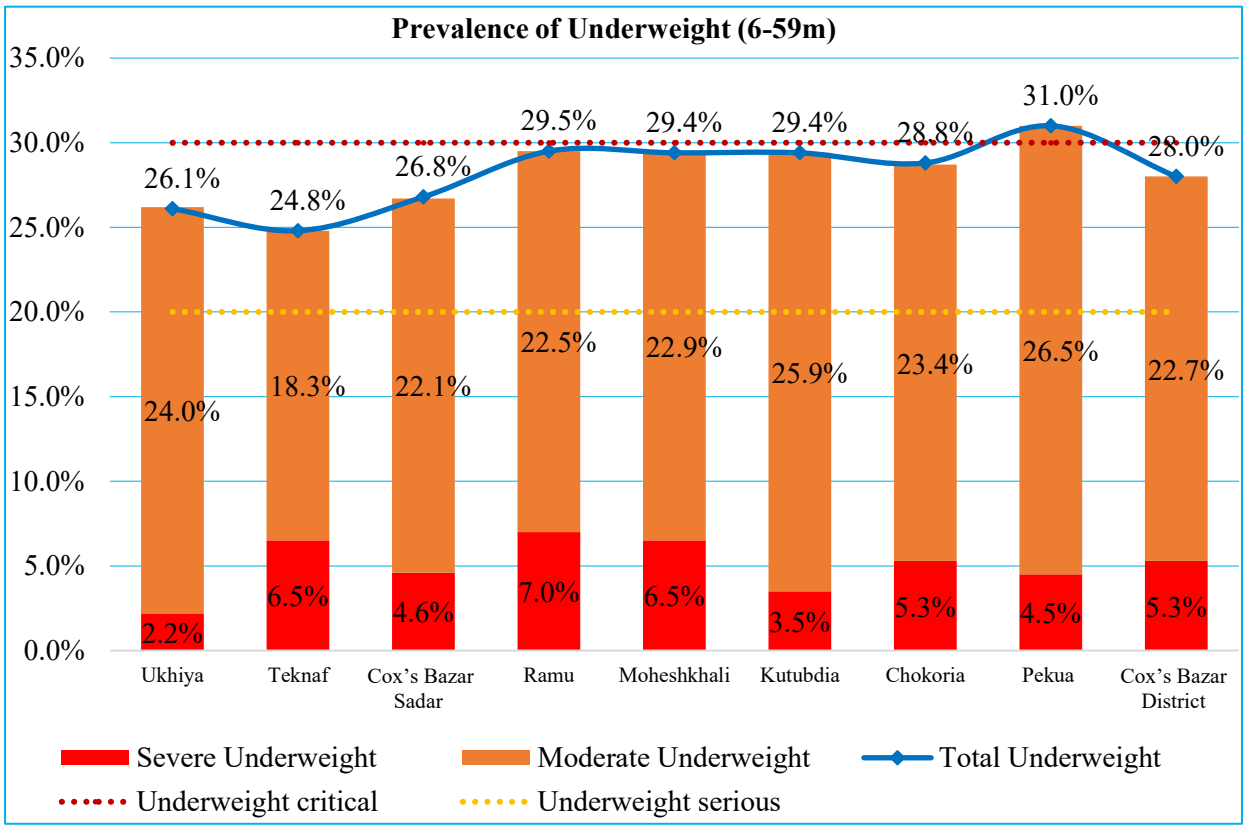


Figure 4: Prevalence of underweight (WAZ)

The prevalence of underweight across the upazilas was found to be at a serious level in seven upazilas, with one Upazila (Pekua) within the critical emergency threshold (Figure 4). Overall, the district prevalence of underweight was observed at 28.0% (95% C.I 26.4-29.6), classified as a serious level by WHO/UNICEF threshold. These findings emphasize the urgent need for intensified nutrition interventions to address the widespread undernutrition and prevent further deterioration of child health in the district.

Prevalence of Stunting based on Height for Age Z-scores (HAZ):

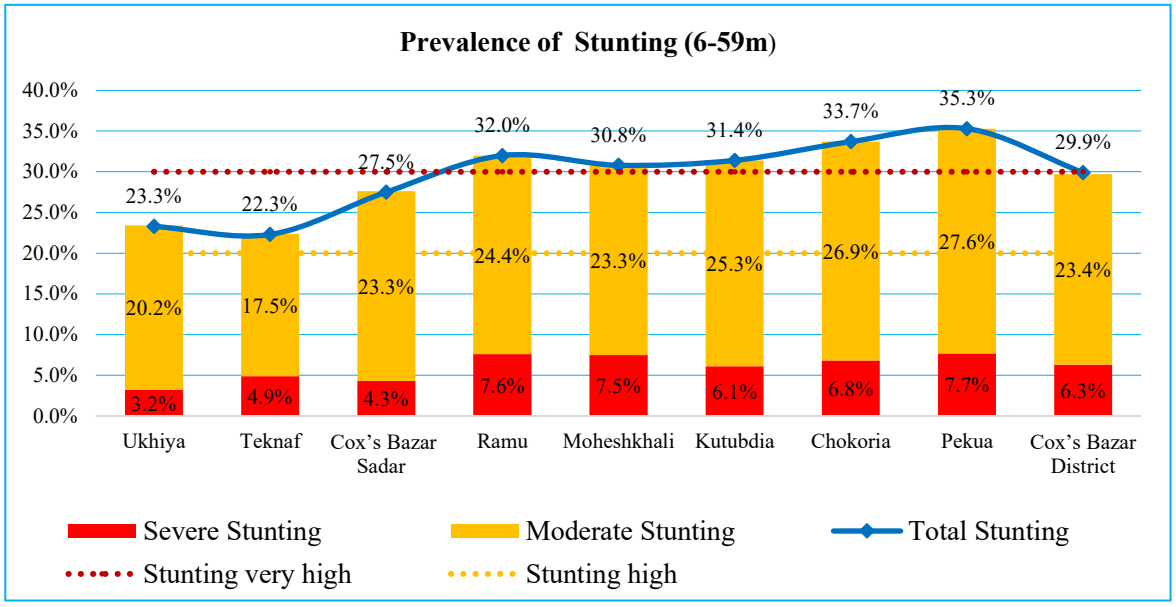


Figure 5: Prevalence of stunting based on height-for-age z-scores

Stunting prevalence was notably very high across the five upazilas; Ramu, Moheshkhali, Kutubdia, Chokoria, and Pekua exceeding the ≥30% WHO/UNICEF threshold (Figure 5). In Ukhiya, Teknaf, and Cox's Bazar Sadar, stunting prevalence was classified as high. The highest prevalence was observed at Pekua upazial 35.3% and less found in Tekna 22.3%.

Acute Malnutrition 2021vs 2023 SMART Survey:

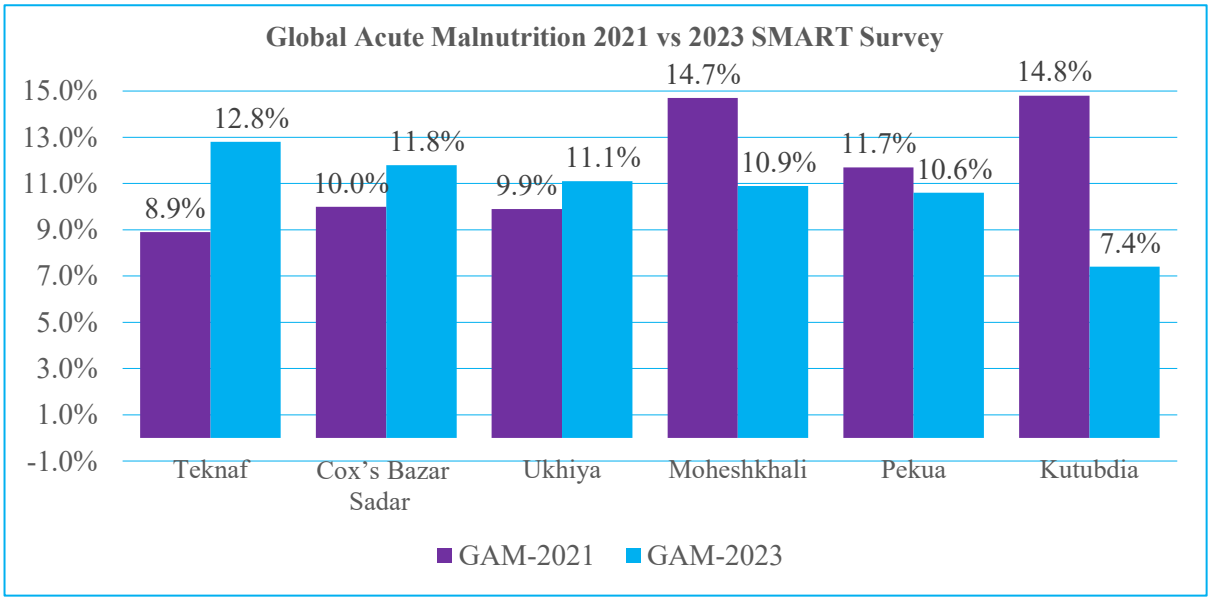


Figure 6: Acute Malnutrition 2021 vs 2023

In Teknaf, Cox's Sadar, and Ukhiya, there has been an increase in acute malnutrition at 2023 compare to 2021. Conversely, in Moheshkhali, Pekua, and Kutubdia, there has been a decrease in acute wasting, the decrease in Kutubdia is statistically significant compared to 2021 (p-value < 0.05). All Others

upazila found no statistically significant either increase or decrease (Figure 6). These trends underscore the need for targeted interventions in areas experiencing worsening malnutrition, while maintaining progress in regions showing improvement.

Underweight and Stunting 2021 vs 2023 SMART Survey:

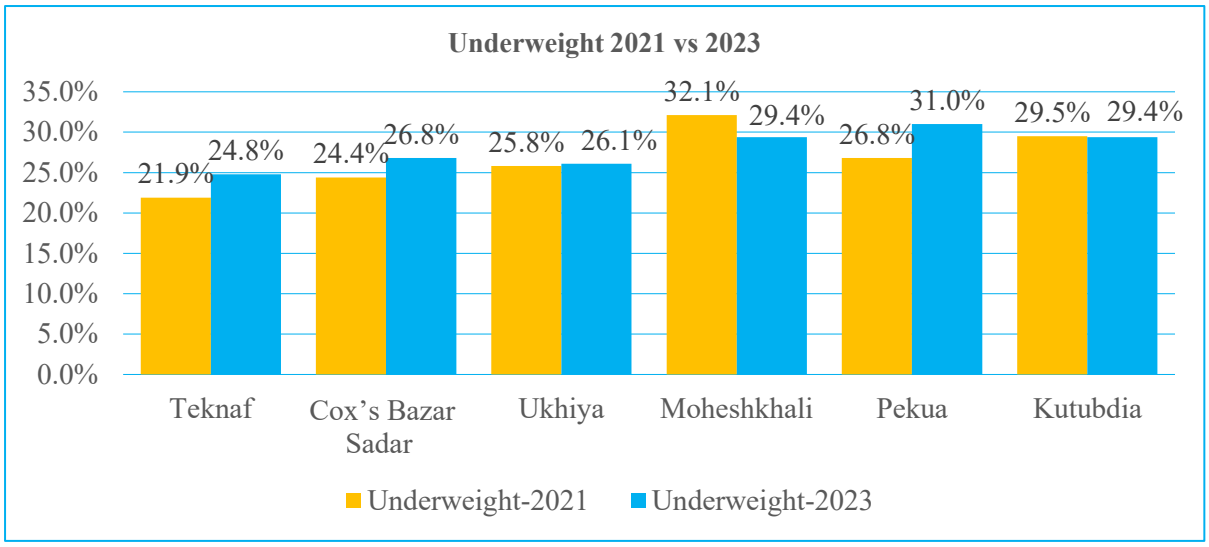


Figure 7: Underweight 2021 vs 2023 SMART Survey

Underweight prevalence has increased in 2023 all Upazilas except for Moheshkhali and Kutubdia (Figure 7). However, these changes in trends are not statistically significant comparing to 2021, indicating a need for further investigation into the underlying factors contributing to these fluctuations and the effectiveness of existing interventions in addressing undernutrition in the district.

Stunting 2021 vs 2023 SMART Survey:

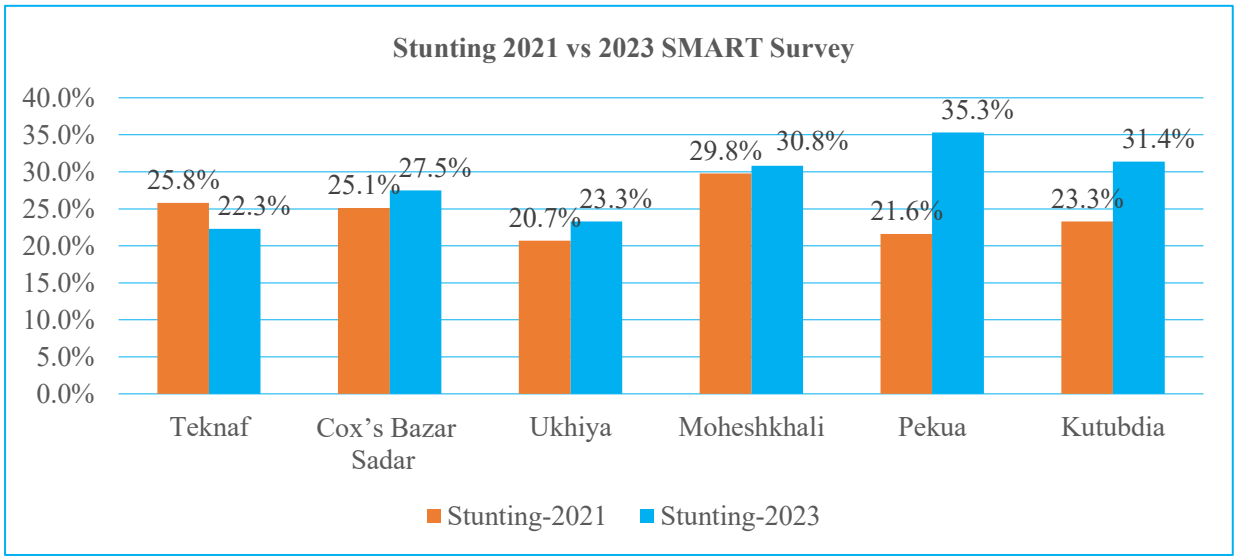


Figure 8: Stunting 2021 vs 2023 SMART Survey

The prevalence of stunting has increased in 2023 across all Upazila compared to 2021, except for Teknaf (Figure 8). Notably, there is a significant increase in the prevalence of stunting in Kutubdia and Pekua in 2023 ($p<0.05$), raising urgent concerns about child growth and nutrition.

Key Breastfeeding Practices:

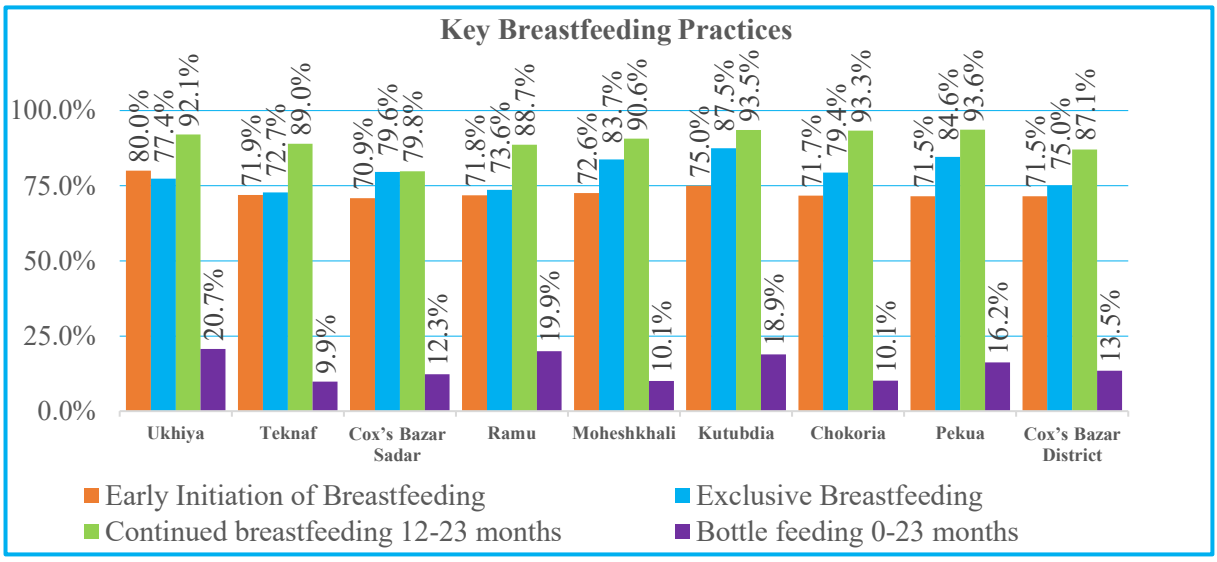


Figure 9: Key Breastfeeding practices among infant and young children 0-23 months

In Cox's Bazar District, early initiation of breastfeeding (EIBF) stands at 71.5%, exclusive breastfeeding (EBF) at 75%, and continued breastfeeding at 87.1%. Ukhiya leads with the highest EIBF, while Kutubdia achieves optimal EBF at 75%. However, all other upazilas fall below the desired EBF threshold of 75%. Notably, Ukhiya struggles with a high rate of bottle feeding. Despite these challenges, all upazilas demonstrate commendable continued breastfeeding rates reflecting while continued breastfeeding is consistently strong, there is a need to address exclusive breastfeeding, reduce bottle feeding, and improve early initiation rates across upazilas (Figure 9).

Complementary feeding practices:

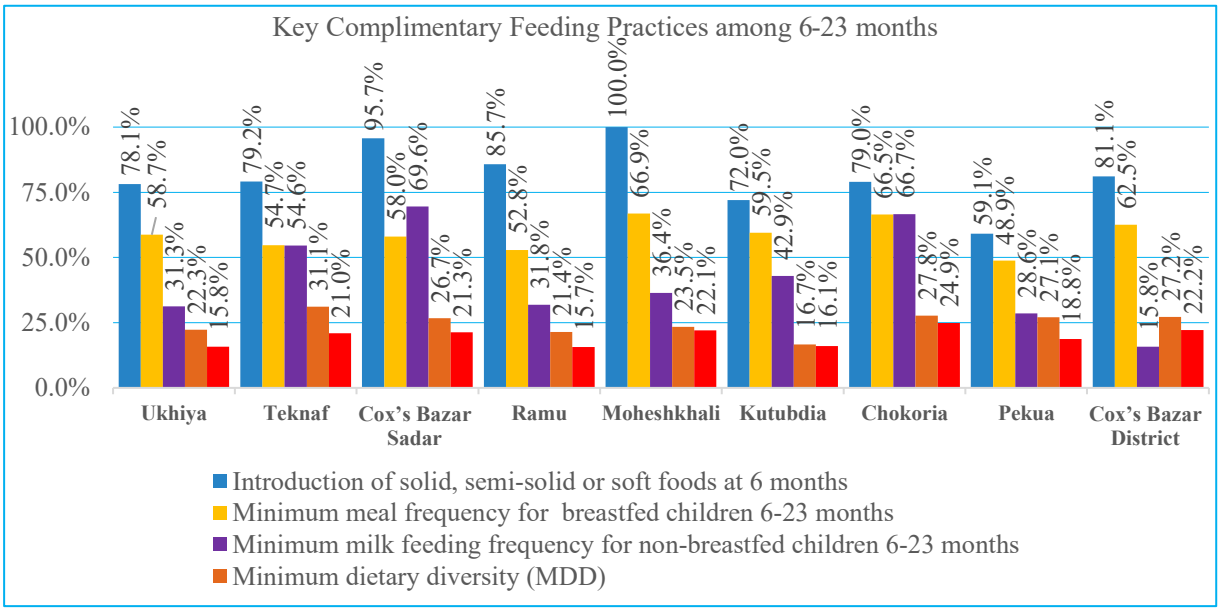


Figure 10: Key Complementary feeding practices among children 6-23 months

In Cox's Bazar District, while 81.1% of children aged 6-8 months are introduced to solid, semi-solid, or soft foods—an optimal rate—key feeding practices remain suboptimal. Minimum meal frequency for breastfed children (62.5%) and minimum milk feeding frequency for non-breastfed children (45.9%) are below acceptable levels. Furthermore, Minimum Dietary Diversity (MDD) is alarmingly low at 27.2%, and Minimum Acceptable Diet (MAD) is critically low at 22.2% (Figure 10).

Morbidity prevalence among children 6-59 months:

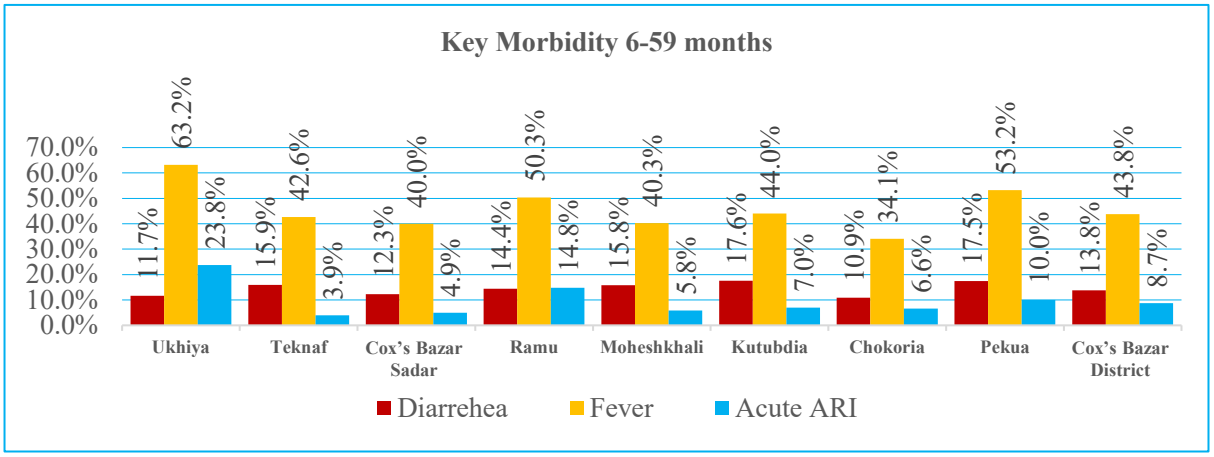


Figure 11: Morbidity status among 6-59 month following last 2 weeks

The overall prevalence of diarrhea (Figure 11, above) is 13.8%, fever 43.8%, and acute respiratory infections (ARI) 8.7%. Significant variation is seen across upazilas, with the highest diarrhea prevalence in Pekua (17.5%), fever in Ukhiya (63.2%), and ARI also highest in Ukhiya (23.8%). This variation points to the need for targeted interventions to address the specific health challenges faced by children 6-59 months in these high-prevalence areas.

Nutritional Status of PLW:

The overall district prevalence of acute malnutrition among Pregnant and Lactating Women stands at 1.7% (95% C.I 0.8-2.5).

Minimum Dietary Diversity for Women (MDD-W):

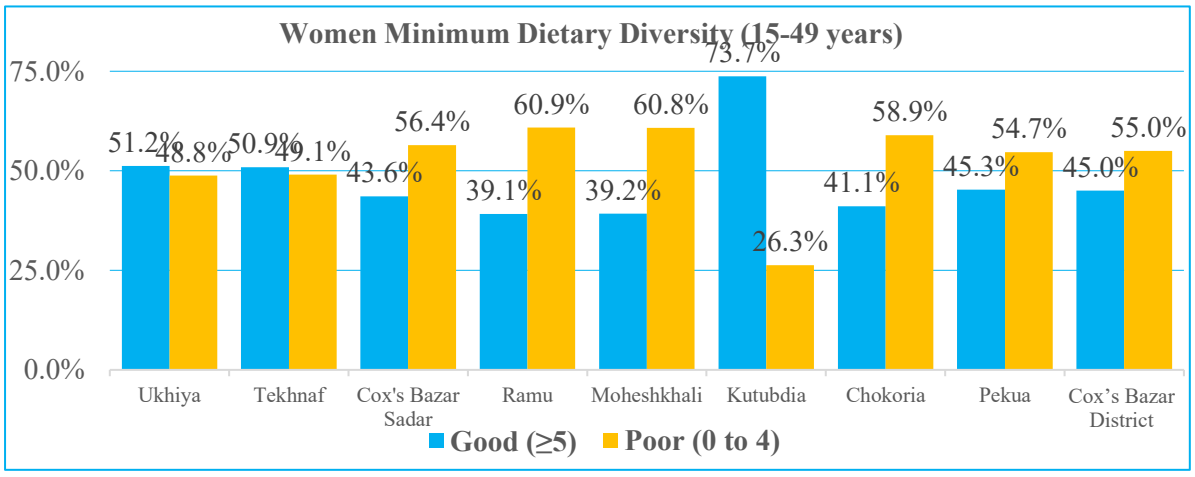


Figure 12: Minimum dietary diversity for women of reproductive age (15-49 years).

On average, only 45% of women in the reproductive age 15-49 years consume adequately diversified diets, meeting the minimum intake of five out of eight essential food groups daily. Alarmingly, the remaining 55% experience poor dietary diversity (Figure 12), highlighting a significant gap in nutritional intake that urgently needs to be addressed.

Nutritional status- Adolescent Girl by Using BMI WHO range:

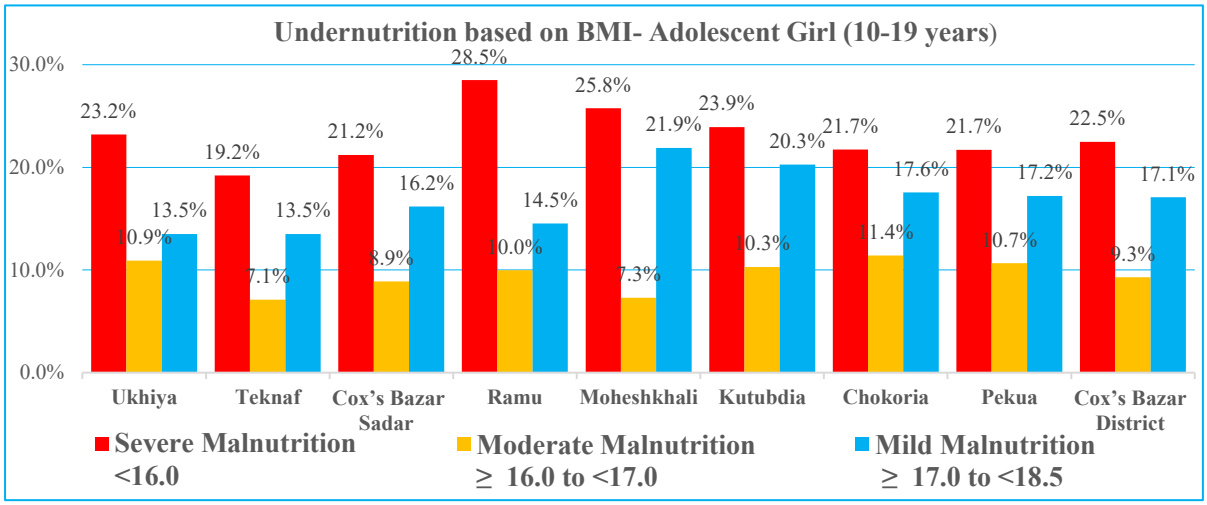


Figure 13: Under nutritional status- Adolescent Girl by Using BMI WHO range

The survey reveals alarming rates of adolescent undernutrition across Cox's Bazar district (Figure 12). A staggering 22.5% of adolescents suffer from severe malnutrition (BMI < 16.0), 9.3% experience moderate malnutrition (BMI 16.0-17.0), and 17.1% are classified with mild malnutrition (BMI 17.0-18.5). These figures underscore the urgent need for targeted interventions to combat the widespread malnutrition affecting adolescents across the district.

Iron and Folic Acid (IFA) Consumption Status by Pregnant:

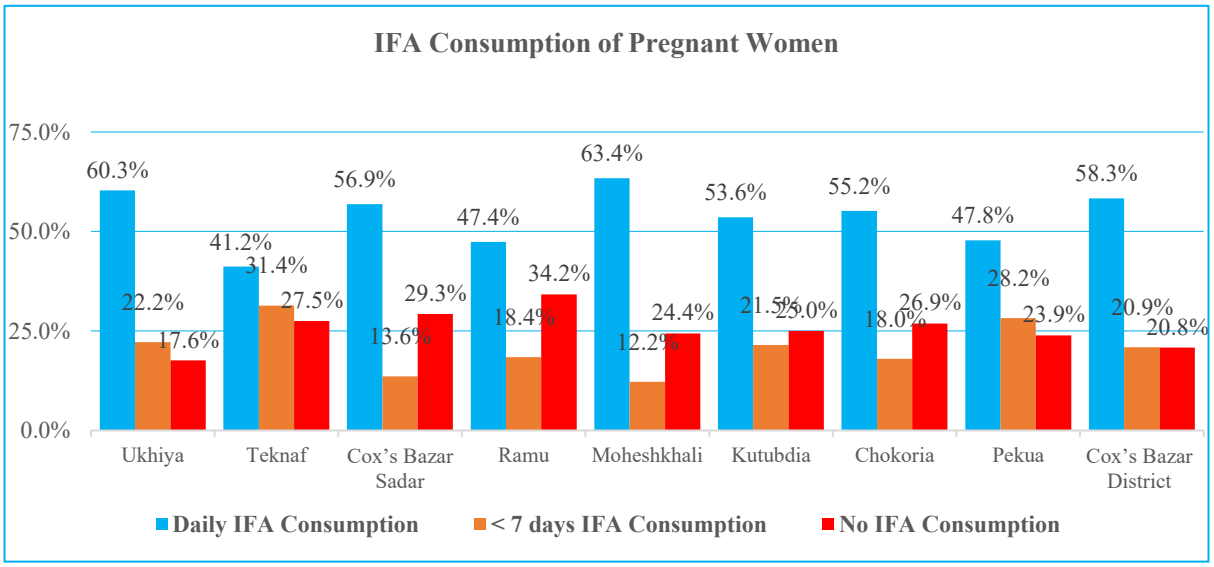


Figure 14: IFA consumption by Pregnant Women

Across the district, only 58.3% of pregnant women consume iron-folic acid (IFA) supplements daily, while a concerning 20.8% do not take them at all (Figure 14). This gap in IFA supplementation highlights a critical need for enhanced nutrition programs to ensure pregnant women receive essential nutrients for their health and the well-being of their babies.

Iron and Folic Acid (IFA) Consumption Status by Adolescent Girls (10-19 years)

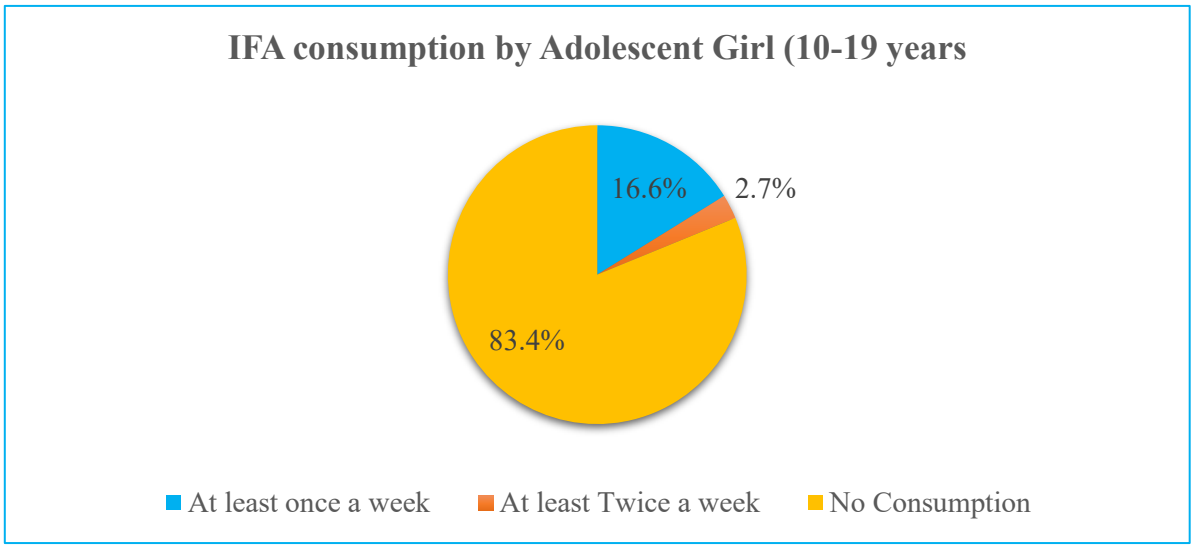


Figure 15: IFA consumption by Adolescent Girl

The findings reveal a deeply concerning situation regarding iron and folic acid (IFA) consumption among adolescent girls in Cox's Bazar district, with a staggering 89.3% not consuming any IFA supplements where only 16.6% at least once a daily and only 2.7% twice a week (Figure 15, above). This critical gap in nutrition poses serious concern across the Upazila to the health and development of adolescent girls, underscoring the urgent need for targeted interventions to improve IFA supplementation and combat potential long-term health consequences

Main Food Sources:

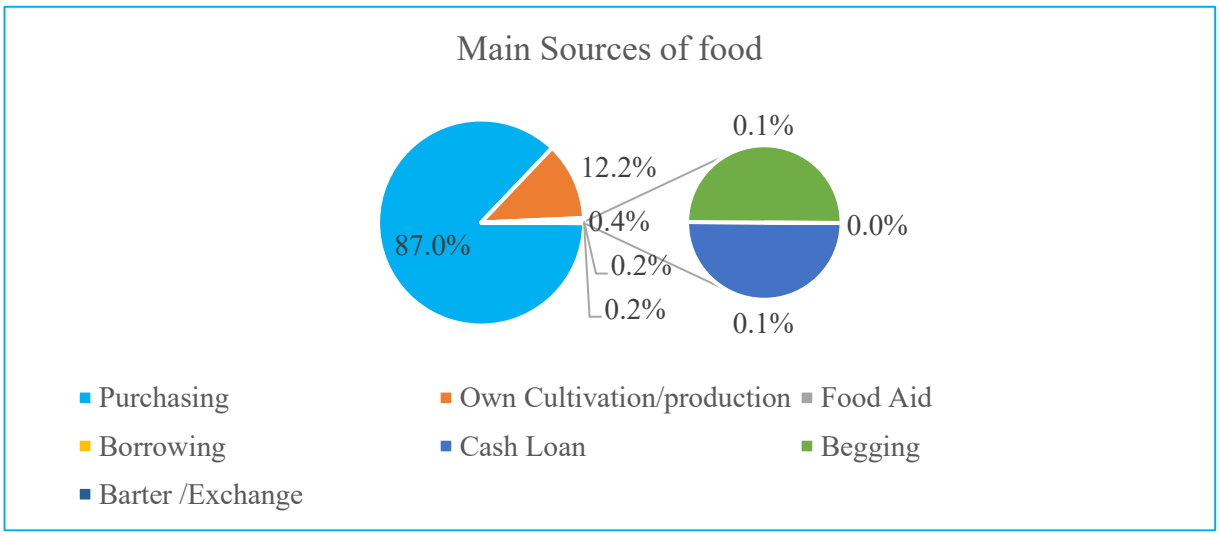


Figure 16: Main food sources

The district the exhibits a strong reliance on market-based food procurement, with 87.0% of households purchasing their food. Only 12.2% of households supplement their food needs through self-cultivation or production (Figure 16, above). This reliance on market purchases, despite efforts at self-sufficiency, is notable given the relatively modest average monthly household income of BDT 23,052. These figures

highlight potential vulnerabilities in food security, particularly for households with limited income and access to resources for self-production.

Negative Coping Strategy:

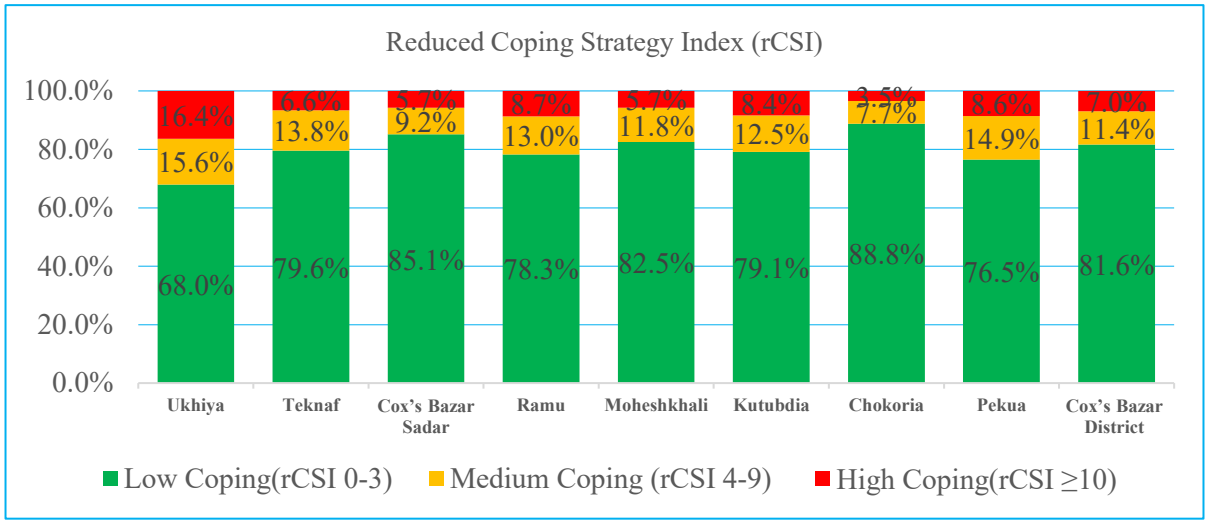


Figure 17: Reduced Coping Strategy Index (rCSI)

The rCSI highlights widely variation in household coping mechanisms across upazilas, with some areas demonstrating stronger resilience to food security. District-wide, 81.6% of households are in the no or low coping category, indicating relative stability. However, 11.4% of households are in the medium coping category, and 7.0% are in the high coping category, revealing that a notable portion of the population faces medium to severe stress and relies on more extreme measures to meet basic needs (Figure 17, above). Urgent support is needed for these vulnerable households to reduce reliance on negative coping strategies.

Sources of drinking Water

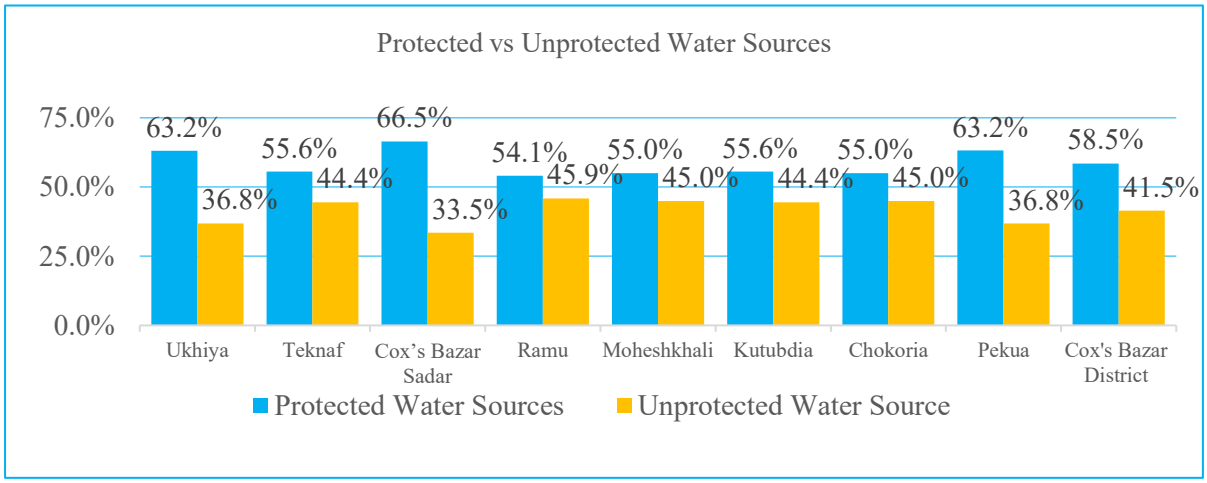


Figure 18: Type of Drinking Water Sources

The availability of protected water sources across Cox's Bazar district is concerning, with only 58.5% of drinking water sources being protected[2]. Cox's Bazar Sadar, Ukhiya, and Pekua show relatively higher rates of protected sources at 66.5% and 63.2%, respectively, but nearly half of the district's households still rely on unprotected[3] water sources (Figure 18). These households are at significantly higher risk of waterborne diseases such as cholera, dysentery, and gastrointestinal illnesses due to exposure to pathogens, chemicals, and pollutants from inadequate infrastructure and poor drainage. Immediate interventions are needed to improve water protection and reduce health risks.

Household Sanitation Status:

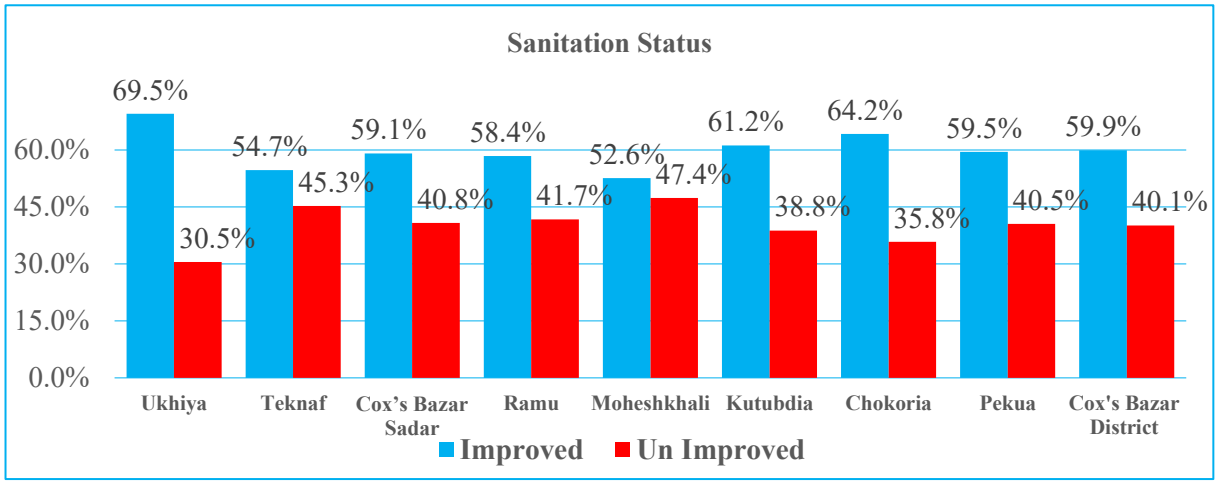


Figure 19: Sanitation Status

The data reveals a stark disparity in sanitation across different upazilas in Cox's Bazar district, distinguishing between improved[4] and un[5] improved facilities, with nearly two-thirds (40.1%) of sanitation facilities classified as unimproved (Figure 19, above). This highlights a significant and ongoing challenge in ensuring adequate sanitary conditions. Addressing these deficiencies is crucial for improving public health outcomes and reducing the prevalence of waterborne diseases in the district. Urgent action is needed to enhance sanitation infrastructure and protect vulnerable populations from preventable health risks.

[2] Protected water sources include deep or shallow tubewells with platforms and proper drainage, protected wells, piped water systems, and rainwater collection systems.
[3] Unprotected water sources consist of deep or shallow tubewells without platforms and proper drainage, unprotected wells, and open sources.
[4] Improved sanitation facilities include Bio Fill Latrine, Latrine with water seal, Latrine with Septic Tank, and Others such as public toilets or shared options
[5] Un improved sanitation facilities consist of Hanging Latrine, Latrine with broken or unmanaged pits mixed with nearby water bodies, Latrine without water seal, and Open defecation.

CONCLUSION

Nutrition surveys across eight Upazilas in Cox's Bazar District expose severe challenges in addressing malnutrition and others determinants. Despite some localized improvement, such as reduced wasting in Kutubdia, Moheshkhali, and Pekua, the situation in Teknaf, Ukhiya, and Cox's Bazar Sadar has worsened, with rising wasting rates. Overall, the district faces a critical situation, with Global Acute Malnutrition (GAM) remains high. Chronic malnutrition (stunting) remains close to WHO/UNICEF's emergency threshold, while underweight levels have reached a serious to critical stage, underscoring the urgent need for targeted interventions.

Boys and older children are disproportionately affected, and widespread diarrhea and fever among children may exacerbating the malnutrition crisis. Although breastfeeding practices are strong, the rates of minimum acceptable diet and dietary diversity among children aged 6-23 months remain critically low. Similarly, women of reproductive age face poor dietary diversity, and severe undernutrition among adolescents is an escalating concern, especially for adolescent girls, and pregnant women.

The district's poor access to safe drinking water, inadequate sanitation, and suboptimal hygiene practices are driving high rates of diarrhea and malnutrition, highlighting the critical link between health and environmental factors. These findings call for urgent, comprehensive interventions that not only address immediate nutritional needs but also target underlying causes such as poor WASH conditions and gender inequalities.

A robust, multi-sectoral nutrition approach—integrating healthcare, WASH, agriculture, and social protection—is essential to tackle malnutrition head-on and improve health outcomes across Cox's Bazar District.

KEY L RECOMMENDATION:

1 Implement WHO's 2023 wasting management and prevention guidelines in Bangladesh, tailored to the local context. This includes adapting and endorsing the guidelines to ensure effective implementation and addressing the specific needs of the population.

2 Scale up severe wasting treatment and comprehensive care for moderate wasting using a child health-centered approach, along with a mother/caregiver-infant pair care approach, as outlined in WHO's 2023 guiding principles. This approach ensures holistic care for both the child and their caregiver, promoting better health outcomes and sustainable interventions.

3 Tailor and implement specific Adolescent health Programs aiming at engaging with them in order to address the significant malnutrition burden among adolescents in the district.

4 Strengthen the delivery of basic health services to address identified morbidity levels, especially in high burden areas. Mobilize community outreach services and capacity building of to local health facilities staff to enhance quality services.

5 Ensure continued and effective coverage of essential health interventions such as micronutrient supplementation, deworming, and measles vaccination, particularly in low coverage areas and hard-to-reach areas. Utilize community sensitization efforts and biannual maternal and child health week campaigns during Vitamin A plus campaign to increase uptake.

6 Supporting a point-of-care approach in delivering high-quality Infant and Young Child Feeding (IYCF) counseling through health service providers, including community workers, is crucial.

7 Support local health facilities to maintain adequate IFAS supplies and strengthen screening for acute malnutrition among women of reproductive age, with timely referrals for nutritional support.

8 Integrate nutrition program with food fortification, income generation activities, and nutrition garden initiatives to improve dietary diversity, household food security, and overall nutrition security comprehensively.

9 Improve access to improved water sources, sanitation, and hygiene facilities by increasing infrastructure such as boreholes, wells, and rainwater harvesting systems. Strengthen community health education on proper toilet usage and promote handwashing practices, complemented by soap distribution and handwashing campaigns.

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