



গণপ্রজাতন্ত্রী বাংলাদেশ সরকার  
বাংলাদেশ জাতীয় পুষ্টি পরিষদ কার্যালয়  
আইপিএইচ ভবন (৩য় তলা), মহাখালী, ঢাকা-১২১২  
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স্মারক: জাপুপ/সমন্বয়/১১-৫৪/২০১৮/ ৯১৬

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**বিষয়ঃ** অষ্টম পঞ্চবার্ষিক পরিকল্পনা (২০২০-২০২৫) দলিলের খাত ভিত্তিক খসড়া অধ্যায় - ১০ এর পুষ্টি সংক্রান্ত প্রস্তাবনা অন্তর্ভুক্তিকরন প্রসংগে।

উল্লেখিত বিষয়ে গত ২০/০৯/২০২০ তারিখে আয়োজিত ভার্চুয়াল পরামর্শ সভায় নিম্ন স্বাক্ষরকারী বাংলাদেশ জাতীয় পুষ্টি পরিষদ কার্যালয়ের পক্ষ হতে প্রস্তাবিত খসড়া দলিলে অধ্যায়-১০ এ পুষ্টি সংক্রান্ত প্রস্তাবনা অন্তর্ভুক্তির অনুরোধ করেন। এক্ষনে উক্ত খসড়া প্রস্তাবনা অন্তর্ভুক্তির অনুরোধসহ প্রেরণ করা হল।

**সংযুক্তিঃ**

অষ্টম পঞ্চবার্ষিক পরিকল্পনা- পুষ্টি সংক্রান্ত প্রস্তাবনা।

**প্রাপকঃ**

শিমুল সেন

সিনিয়র সহকারী প্রধান ও সহকারী প্রকল্প পরিচালক

সাধারণ অর্থনীতি বিভাগ (জিইডি)

বাংলাদেশ পরিকল্পনা কমিশন

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মহাখালী, ঢাকা-১২১২

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**অনুলিপিঃ**

১। অফিস কপি।

## Chapter 10 – Health

### 10.5 Nutrition program in 8FYP

#### Progress in Nutrition under the Seventh Five Year Plan

Since the development and approval of the 7<sup>th</sup> FYP, Bangladesh has achieved a lot in terms of developing a solid enabling policy and institutional environment for the promotion of nutrition. Most notable, and the cornerstone of further developments, was the approval of the National Nutrition Policy (NNP) 2015. Then, in 2017, the NNP was turned into an actionable plan with the development and approval of the Second National Plan of Action for Nutrition (NPAN2) 2016-2025. The NPAN2 also meant the formal revitalization of the Bangladesh National Nutrition Council, the apex body for multisectoral nutrition governance and policy coordination, which was established in 1975 by the Father of the Nation and is chaired by the Honorable Prime Minister. The fourth Health, Population, Nutrition Sector Programme (4<sup>th</sup> HPNSP) was approved in 2017, which firmly integrated prioritised nutrition specific actions/interventions into Bangladesh' health programme system, and which is the basis for this particular chapter. A Mid-Term Review of the 4<sup>th</sup> HPNSP conducted in 2020 provided useful guidance on governance, strengthening and quality nutrition services delivery. The Second Country Investment Plan (CIP2) initiated in 2018 emphasized nutrition-sensitive food systems. Finally, to ensure equity in delivery of and access to services, the National Social Security Strategy (NSSS) 2015 was approved and includes provisions for the integration of nutrition in social safety nets targeting women and young children. Besides policy and strategy development, the first ever national Public Expenditure Review on Nutrition (PER-N) was undertaken jointly by the Ministry of Finance and the Bangladesh National Nutrition Council (BNNC) which revealed allocation and expenditure on nutrition across different sectors which highlighted the need for efficient and appropriate use of scarce resources.

Bangladesh has achieved admirable progress in improving the nutrition status of its population under the 7FYP, with stunting reduced from 36.1% in 2014, to 31% in 2017/18, while wasting has reduced from 14.3% to 8.4%.<sup>1</sup> Moreover, the Exclusive Breastfeeding Rate increased from 55% in 2014 to 65% in 2017, Vitamin-A supplementation coverage from 65% in 2015 to 79% in 2017, consumption of iodised salt was 76% and between 2014 and 2017 use of ORT with zinc increased from 38% to 44%. Consumption of a Minimum Acceptable Diet (MAD) has increased from 21.2% to 34.1%, and Minimum Dietary Diversity (MDD) from 24.3% to 37.5% during the same period.<sup>2</sup> However, the COVID-19 pandemic has the potential to significantly drive back this progress. The quantity of essential health and nutrition services provided through the health system has increased significantly over the last decade, with the percentage of women between 15 and 49 years of age receiving ANC going up from 67.7% in 2011 to 92.0% in 2017/18.<sup>3</sup> The full coverage of immunization and distribution of IFA has also remained high. Bangladesh has thereby been self-sufficient in rice production since 2012 and has been targeting self-sufficiency in non-cereals as well. The target for per capita caloric intake from cereals is <60%, which was 64% for Bangladesh.<sup>4</sup> In 2016, only 27.8% of the eligible households were receiving benefits from Social Safety Net Programmes (SSNP).<sup>5</sup> About 2.9 million pre- and primary school children receive school feeding assistance. School feeding offers children a regular source of nutrients for their cognitive and physical development and helps to reduce the prevalence of anaemia by up to 20% in girls.

The 8FYP will build on the progress and strengthen the nutrition strategy to reach Bangladesh' commitments to the World Health Assembly (WHA), Sustainable Development Goals (SDGs), and the Scaling Up Nutrition (SUN) Movement. Policy guidance and inter/intra ministerial linkages will be facilitated through BNNC, existing cabinet committees, and coordination structures that address food and nutrition security at the national and sub-national levels. Nutrition specific activities will mostly be implemented through sectoral operational plan whereas nutrition sensitive activities will be implemented by nutrition relevant 22 ministries as identified in NPAN2.

#### **Impact of COVID-19 on nutrition**

A recent Lancet modelling exercise estimates that "if routine health care is disrupted and access to food is decreased [...], the increase in child and maternal deaths will be devastating."<sup>6</sup> For instance, a 50% increase in

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<sup>1</sup> *BDHS 2011, BDHS 2017/18*

<sup>2</sup> *BNNC annual monitoring report 2019/2020*

<sup>3</sup> *BDHS 2011, BDHS 2017/18*

<sup>4</sup> *HIES 2016*

<sup>5</sup> *HIES 2016*

<sup>6</sup> Timothy Robertson, et. al., *Early estimates of the indirect effects of the COVID-19 pandemic on maternal and child mortality in low-income and middle-income countries: a modelling study*, *Lancet Global Health* 2020 (Published online May 12, 2020).

wasting (acute malnutrition) prevalence due to lack of food and access to routine health services could account for an 18-23% increase in child deaths in the short term. A projection made by a BNNC Review in 2020 on the basis of earlier rates of stunting and malnutrition predicts that stunting (chronic malnutrition) may fall back from a current level of 31% in 2017-18 (pre-COVID-19) to 36%, as in 2014 or even at 41% as in 2011. Wasting (acute malnutrition) could deteriorate from the current level of 8% in 2017-18 to 14% or even 16%.<sup>7,8</sup>

Due to COVID-19, both the quantity and quality of services provided diminished; the number of ANC visits by mothers reduced by 31%, while counselling and IFA distribution at ANC reduced by 33% and 34% respectively. Analysis of routine health facility data has shown a drop in essential services provision, including a 73% reduction in admissions of children with severe acute malnutrition for treatment between February and May 2020.<sup>9</sup> A country-wide rapid assessment of nutrition facilities regarding their preparedness and functionality reveals that of all 366 units offering treatment for children with SAM, about 73% are nonfunctional. Of the functional facilities, only 2% are considered fully functional and only 5% of units have a sufficient supply of therapeutic milk. About 20% of health care providers noted having inadequate stock of Iron Folic Acid (IFA) for the next three months.<sup>10</sup>

#### **Challenges:**

- **Coverage of nutrition specific and sensitive nutrition services and interventions:** broad coverage of services in rural, urban and hard to reach areas is necessary to create impact with equity. Coverage of key nutrition services and interventions has been improved but is still not adequate. Key bottlenecks are the availability of sufficient financial and human resources, as well as targeting, monitoring and follow up.
- **Increased prevalence of non-communicable diseases** due to lifestyle changes resulting in poor nutrition and overnutrition are becoming major issues in both urban and rural areas.
- **Human Resources:** nutrition-specific human resources at the facility and community level are necessary to ensure coverage and quality of essential nutrition services.
- **Inter-OP collaboration and coordination under HPNSP:** The HPNSP contains 29 OPs, of which 9 include nutrition services. The Mid-Term Review (MTR) 2020 of the HPNSP pointed out that coordination and collaboration between different OPs can be improved.
- **Inter-operability of data and monitoring among DGHS, DGFP and other ministries:** each sector monitors activities and interventions through parallel systems. Currently, the lack of interoperability causes inefficiencies and duplications in monitoring and reporting.
- **Urban nutrition service delivery:** Bangladesh is facing rapid urbanization, which increases pressure on both public and private health facilities in urban areas. Health and nutrition services in urban areas are thereby offered through different actors, such as the Ministry of Local Government and Rural Development, the Ministry of Health and Family Welfare, and the private sector. Coordination between actors is largely lacking, which impacts the delivery of adequate nutrition services.
- **Supply chain management:** the timely and adequate supply of nutrition commodities is a systematic challenge across sectors and hampers delivery of services.
- **Budget tracking:** the Public Expenditure Review on Nutrition (PER-N) published in 2019 emphasized the need for adequate budget tracking to monitor allocation and utilization of public funds for nutrition by different sectors, and improve leveraging of resources.
- **Human Resource for Nutrition:** Dedicated human resources across sectors are necessary to ensure effective implementation of multi-sectoral nutrition interventions, as observed by the Honourable Prime Minister. An assessment conducted by BNNC in 2019 revealed that there is a significant gap of skilled human resources in all relevant sectors and at all levels.

#### **10.5.1 Strategy for Nutrition under 8FYP**

Through the 29 OPs set up under the HPNSP, and in particular through the National Nutrition Services (NNS) OP, hosted in the Institute of Public Health Nutrition (IPHN), the 8FYP will focus on strengthening the delivery of nutrition services as recommended by the MTR 2020. To facilitate the adequate provision of nutrition services through the HPNSP, as well as in collaboration with other sectoral services, the 8FYP aims to address the following priorities for nutrition:

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<sup>8</sup> BDHS 2011, 2014, 2017/18??

<sup>9</sup> DHIS2

<sup>10</sup> Rapid assessment of SAM facilities conducted by UNICEF in April 2020

- **Promote a multi-dimensional life-cycle approach** to address the intergenerational health and poverty impact by improving nutrition. Among other things, such an approach will include integrating child growth promotion with EPI, awareness on Early Childhood Development (ECD).
- **Promote human rights, equity and a gender transformative approach**, mobilize communities, build community resilience and engage community-based platforms and social media to ensure people-centered essential health, population and nutrition services for home-based care, facility care and telemedicine care, and establish referral systems to maintain continuity of care, especially for most vulnerable population.
- **Enhance maternal, child and adolescent nutrition services** by continuing and strengthening essential nutrition services in all rural and urban health facilities and communities, and building capacity of health care providers and outreach workers/volunteers.
- **Promote a community-based approach**, nutrition being mainly promotive and preventive services, community-based approach with stronger engagement of both community and linkage with referral facilities is key to successful implementation.
- **Ensure micro-nutrient adequacy** through supplementation and treatment of parasites through the health system. The half-yearly vitamin A capsules supplementation for children will be continued. Iron-folic acid supplementation among pregnant and lactating women, and adolescent girls to cover iron-deficiency anemia will be undertaken through health and family planning facilities. Monitoring of salt iodization and fortification of edible oil with vitamin A will be strengthened. Use of Zinc for treatment of diarrhea will be promoted. Expansion of intestinal parasite treatment for reducing anemia will be continued.
- **Strengthen quality improvement of the wasting prevention and treatment programme** and other nutrition services at facility and community level.
- **Improve positive nutrition practices through Social Behavior Change Communication (SBCC)** to increase awareness on uptake of essential nutrition services and adequate nutrition behaviors including food safety and healthy diet promotion through social media, Social Behavior Change Communication (SBCC) through different communication approaches and community mobilization targeting the nutritionally vulnerable populations using different platforms. Issues that are supplementary and complementary to nutrition, like water, sanitation and hygiene, diversified dietary intake, EPI, and health education will be addressed through a comprehensive approach. Nutritional education and counseling will be provided to adolescent girls, pregnant and lactating mothers on appropriate caring and feeding practices, breast feeding, supplementary feeding, micronutrients, etc.; Nutrition education will be introduced for students in text books.
- **Strengthen the supply chain** to ensure the uninterrupted availability of essential nutrition commodities in all levels of health facilities with focus on ensuring that health care facilities and Severe Acute Malnutrition (SAM) treatment facilities are equipped with adequate essential nutrition commodities.
- **Ensure a comprehensive multi-sectoral Food and Nutrition Security Response** for emergencies in line with existing health emergency response plans, in coordination and collaboration with the Ministry of Disaster Management and Relief.
- **Strengthen human resources** to improve the knowledge base and capacity of health personnel regarding nutrition, health and family planning, health workers as well as planning, management and service delivery providers in other sectors will be appropriately oriented and trained in nutrition in coordination with the National Nutrition Services (NNS) Operational Plan hosted within Institute of Public Health Nutrition (IPHN), the Department of Agricultural Extension, Department of Women Affairs and other relevant departments and organizations.
- **Strengthen monitoring, evaluation and research to generate evidence to inform policy decisions** by improving interoperability of routine information management systems, surveys, assessments and surveillance, establish feedback mechanisms, and closely monitor provision and utilization of essential nutrition services with innovative approaches to understand the level of sustainability and accountability in terms of equity, access, coverage and quality, to generate evidence for informed policy decisions.
- **Intensify multisectoral coordination** in terms of policy, implementation, resource mobilization and monitoring across sectors.

#### ***Governance, leadership and coordination***

The 8 FYP will focus on strengthening governance and leadership to enhance coordination, legislation, and policy regulation across nutrition sensitive and nutrition specific programmes and sectors. The Health, Population,

Nutrition Sector Programme 2017-2022 (HPNSP) consists of 29 Operational Plans (OPs), of which 9 are related to nutrition (lead, associated and supportive). The Mid-Term Review 2020 of the HPNSP recommends strengthened coordination between the different OPs at national and sub-national level to improve efficiency and leverage resources for nutrition. The 8FYP will build on this recommendation and strategies will be put in place to strengthen inter-OP coordination. Bangladesh' nutrition development partners are supporting the HPNSP through the HPNSP Nutrition Development Partners Group, and by participating in the Local Consultative Group for Nutrition (LCG-N). Urban nutrition services are delivered through both the Local Government Division (LGD) of the Ministry of Local Government, and Rural Development (MoLGRD) and the Ministry of Health and Family Welfare (MoHFW), as well as the private sector including NGOs. The 8FYP plan will focus on improving delivery of nutrition services through these different service providers through a coordinated and comprehensive strategy for urban nutrition services and interventions (e.g. WASH, social safety nets) to increase coverage and streamline quality of services. coordination of multi-sectoral nutrition interventions will continue to be led by the BNNC.

### **Multi-sectoral programme coordination among 22 nutrition-related ministries**

Services delivered through the health system can only reach their full effectiveness and potential if all underlying factors of nutrition are addressed. It is a Lancet report from 2013 revealed that direct/specific nutrition interventions (proven cost-effective nutrition specific interventions), even when scaled up to 90% coverage rate, would only able to reduce stunting prevalence by 20 % and severe acute malnutrition by 60%.<sup>11</sup> The other 80% of stunting and 40% of wasting will have to be addressed through nutrition sensitive interventions under relevant sectors.

Table 10.3 below represents the multi-sectoral and multi-agency activities for nutrition as envisaged under NPAN2.

*Table 10.3: multi-sectoral multi-agency approach for nutrition*

Domain	Indicator	Baseline	Target 2025	Role and activity towards scaling up nutrition	Responsible ministries
Health	1. Increase early initiation of breastfeeding	1. 69% (BDHS 2017/18)	1. 80%	1. Integrating Growth Monitoring and Promotion (GMP) in the EPI platform 2. Providing micronutrient supplementation to pregnant and lactating women, as well as supplementation and deworming for children and adolescents 3. Promoting positive nutrition behavior for adolescents e.g. balanced diets, low-cost recipes, micronutrient supplementation, menstrual hygiene etc. 4. Support quality improvement of wasting prevention and treatment, and other nutrition services at the facility level 5. Ensuring multi-sectoral collaboration for effective ECD programming at the community level using different platforms 6. Ensuring expansion of community-based nutrition services in both urban and rural areas 7. Mainstreaming delivery of nutrition services through private sector outlets 8. Ensuring quantity and quality of nutrition services through improved monitoring of services 9. Strengthen school-based health programmes e.g. little doctor etc.	Health and Family Welfare, LGD, Information, CHT Affairs, religious affairs
	2. Increase rate of exclusive breastfeeding in infants < 6 months	2. 65% (BDHS 2017/18)	2. 70%		
	3. Increase the proportion of children aged 6-23 months receiving minimum acceptable diet	3. 34.1% (BDHS 2017/18)	3. >40%		
	4. % of caregivers with appropriate hand washing behavior	4. 14% (FSNSP 2015)	4. 50%		
	5. Reduce the rate of low birth weight (<2,500 grams)	5. 23% (LBW Survey 2016)	5. 16%		
	6. % of adolescent girls (15-19 yrs.) thin (total thinness BMI<18)	6. 19% (BDHS 2014)	6. <15%		
	7. Reduce the rate of Anemia among pregnant women	7. 50% (BDHS 2011)	7. 25%		
	8. Control & reduce maternal overweight (BMI>23)	8. 39% (BDHS 2014)	8. 30%		

<sup>11</sup> Black R.E., Alderman H., et al. Lancet Maternal and Child Nutrition Series, Lancet. 2013 (executive summary)

<b>Education</b>	<ol style="list-style-type: none"> <li>1. % of children (36-59 m) who are attending an early childhood education (ECD) program</li> <li>2. % of women who completed secondary/higher education</li> </ol>	<ol style="list-style-type: none"> <li>1. 19% (MICS 2019)</li> <li>2. 17% (ever married women) (BDHS 2017/18)</li> </ol>	<ol style="list-style-type: none"> <li>1. 30%</li> <li>2. 90%</li> </ol>	<ol style="list-style-type: none"> <li>1. Establish creche/day care centers, pre-schools in the community</li> <li>2. Promote Early Childhood Development (ECD) calendar and promote good nutrition practices</li> <li>3. Incorporate Nutrition relevant Days in school calendar and promote good nutrition practices</li> <li>4. Incorporate/update health, nutrition and hygiene education in curriculum</li> <li>5. Promote universal secondary female education coverage</li> <li>6. Increase coverage of school meal programme and school stipend</li> </ol>	Primary Education, Women and Children Affairs, Social Welfare, CHT Affairs, Health and Family Welfare,
<b>Water, Sanitation and Hygiene</b>	<ol style="list-style-type: none"> <li>1. % of population that use improved drinking water</li> <li>2. % of population that use improved sanitary latrine</li> </ol>	<ol style="list-style-type: none"> <li>1. 98% (BDHS 2014)</li> <li>2. 43% (BDHS 2017/18)</li> </ol>	<ol style="list-style-type: none"> <li>1. &gt; 99%</li> <li>2. 75%</li> </ol>	<ol style="list-style-type: none"> <li>1. Ensure availability of safe drinking water at all level</li> <li>2. Set up, maintain and promote usage of WASH facilities in different settings</li> <li>3. Organize orientation on WASH for stakeholders at different tier</li> <li>4. Awareness raising on WASH and Nutrition</li> </ol>	DPHE/LGD, Primary Education, Education, Health and Family Welfare, Religious Affairs, Information, CHT Affairs
<b>Food</b>	<ol style="list-style-type: none"> <li>1. % coverage of adequately iodized salt (<math>\geq 15</math> PPM)</li> <li>2. % coverage of edible oil with vitamin A</li> </ol>	<ol style="list-style-type: none"> <li>1. 58% (MNS 2011-12)</li> <li>2. NA</li> </ol>	<ol style="list-style-type: none"> <li>1. 90%</li> <li>2. 90%</li> </ol>	<ol style="list-style-type: none"> <li>1. Initiate/expand/strengthen food fortification programs as necessary</li> <li>2. Awareness raising among producers and consumer on diversified nutritious food sale/ consumption, food safety, and promote compliance to food standards</li> <li>3. Ensure adequate food safety regulatory framework in place and monitored</li> </ol>	Food, Industry, Health and Family Welfare
<b>Agriculture Fisheries and Livestock</b>	<ol style="list-style-type: none"> <li>1. Per capita consumption of fruits and vegetables</li> <li>2. % share of total dietary energy from consumption of cereals</li> </ol>	<ol style="list-style-type: none"> <li>1. Fruits 35.8 grams/day, Vegetable 167.3 grams/day</li> <li>2. 64% (HIES 2016)</li> </ol>	<ol style="list-style-type: none"> <li>1. <math>\geq 400</math> grams/day (fruits 100 grams/day, and vegetable 300 grams/day)</li> <li>2. &lt;60%</li> </ol>	<ol style="list-style-type: none"> <li>1. Promote production of diversified and non-cereal foods, use of appropriate agriculture technologies, mixed farming, nutrition gardening, backyard livestock production</li> <li>2. Promote and increase coverage of 'Ekti Bari, Ekti Khamar' program</li> <li>3. Promote nutrition sensitive food processing, packaging, storage and marketing</li> <li>4. Promote nutrition sensitive capacity building, planning and implementation</li> <li>5. Prioritize the allocation of resources to women for agriculture, fisheries and livestock production</li> </ol>	Agriculture, Fisheries and Livestock, RDCCD, Food, Water Resources, Health and Family Welfare,
<b>Social Safety Net</b>	<ol style="list-style-type: none"> <li>1. Number of Social Safety Net Programs which incorporate nutrition sensitive &amp; specific objectives</li> </ol>	<ol style="list-style-type: none"> <li>1. 10% (assumptive)</li> </ol>	<ol style="list-style-type: none"> <li>1. 50%</li> </ol>	<ol style="list-style-type: none"> <li>1. Revise existing relevant SPPs to become adequately nutrition sensitive</li> <li>2. Design and implement nutrition sensitive SPP for vulnerable urban population</li> <li>3. Establish strategic linkages, coordination among multi-sectoral nutrition interventions and SPPs</li> <li>4. Supply nutritionally adequate supplementary food to affected populations during disasters and times of severe food insecurity</li> </ol>	Planning, Women and Children Affairs, Social Welfare, Food, Disaster Management and Relief, Health and Family Welfare
<b>Women Empowerment</b>	<ol style="list-style-type: none"> <li>1. % of women age 20-24 who were first married by age 18</li> <li>2. % of women (15-19 yrs) who have begun child bearing</li> </ol>	<ol style="list-style-type: none"> <li>1. 59% (BDHS 2017/18)</li> <li>2. 28% (BDHS 2017/18)</li> </ol>	<ol style="list-style-type: none"> <li>1. 30%</li> <li>2. 10%</li> </ol>	<ol style="list-style-type: none"> <li>1. Awareness raising on prevention of child marriage and early pregnancy</li> <li>2. Ensure maternity protection, six-months fully paid leave and workplace support for women in all sectors</li> <li>5. Empower women to access IGA activities, services, resources, market</li> </ol>	Women and Children Affairs, Labor and Employment, Youth and Sports, Education, Health and Family Welfare, Religious Affairs, Information
<b>Multi-sectoral, Multi-level, Multi-stakeholder coordination and advocacy for Nutrition</b>	<ol style="list-style-type: none"> <li>1. Number of full-time personnel for BNNC office</li> <li>2. Number of district nutrition officer recruited</li> </ol>	<ol style="list-style-type: none"> <li>1. TBD</li> <li>2. None</li> </ol>	<ol style="list-style-type: none"> <li>1. 50</li> <li>2. All districts/ upazillas</li> </ol>	<ol style="list-style-type: none"> <li>1. Strengthen nutrition services into UHC</li> <li>2. Advocacy for recruitment of nutrition cadre and creation of nutrition counsellor post</li> <li>3. Strengthening research, surveillance, knowledge management and Nutrition Information System for informed nutrition policy decisions</li> <li>4. Strengthening of BNNC Office for coordination among different ministries, SUN Networks and development partners at different levels</li> </ol>	Bangladesh National Nutrition Council (BNNC), relevant ministries, development partners