



# MONITORING REPORT

January 2022 - December 2023

## SECOND NATIONAL PLAN OF ACTION FOR NUTRITION (2016-2025)



**Bangladesh National Nutrition Council**

Health Services Division

Ministry of Health and Family Welfare

Government of the People's Republic of Bangladesh

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**Government of the People's Republic of Bangladesh**

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**Coordinated by**



Bangladesh National Nutrition Council (BNNC)



**Director General (In-Charge)**  
Bangladesh National Nutrition Council (BNNC)

## Editorial Note

During the last decades, Bangladesh has made inspiring improvements in fighting malnutrition but still we need to go a long way to confront the equity issue of nutrition especially for the poor section of the population group, while taking care of nutrition for all population of the country, so that no one is left behind.

Second National Plan of Action for Nutrition (NPAN-2) aims to reduce all forms of malnutrition from the country. Bangladesh has been making a significant improvement in achieving its target and sets herself as a role model for many other countries. NPAN-2 has successfully engaged 22 nutrition relevant ministries in implementing NPAN-2 to turn it into a real multisectoral program. Thus, nutrition activities are mainstreamed among the sectors in order to making a difference in people's life.

The Monitoring Report attempts to see the present nutrition situation through its pre-identified activities and provide suggestions.

Today, I am really overwhelmed to see the Monitoring report of January 2022- December 2023 has been published. I would like to appreciate overall guidance and support provided by Health Services Division, MoHFW I wish to express sincere thanks to the other officials of MoHFW and other 21 relevant ministries for their necessary support along with development partners, UN agencies, INGO, NGOs who supported to make it happen. I would also like to offer my heartfelt thanks to my BNNC's colleagues and related all who worked hard to make it a successful one. I am sure that this report will help in making informed decision towards improved nutrition and food security in Bangladesh. I am confident that we are on the right track and we hope we can achieve our target by 2025.

**Dr. Mohammad Mahbubur Rahman**  
**Director General (In-Charge),**  
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## ABBREVIATIONS & ACRONYMS

ANC	Antenatal Care
APIR	Annual Program Implementation Report
BARI	Bangladesh Agricultural Research Institute
BBF	Bangladesh Breastfeeding Foundation
BBS	Bangladesh Bureau of Statistics
BDHS	Bangladesh Demographic and Health Survey
BINA	Bangladesh Institute of Nuclear Agriculture
BIRTAN	Bangladesh Institute for Research and Training on Applied Nutrition
BNNC	Bangladesh National Nutrition Council
BSCIC	Bangladesh Small and Cottage Industries Corporation
BSTI	Bangladesh Standards and Testing Institution
DAE	Department of Agricultural Extension
DPHE	Department of Public Health Engineering
DGFP	Directorate General of Family Planning
DGHS	Directorate General of Health Services
DHIS2	District Health Information System 2
FAO	Food and Agriculture Organization
FFS	Farmers' Field Schools
FPMU	Food Planning and Monitoring Unit
FSNSP	Food Security and Nutritional Surveillance Project
GAP	Good Agricultural Practices
GDP	Gross Domestic Product
GMP	Good Manufacturing Practice
GoB	Government of Bangladesh
HH	Household
HKI	Helen Keller Intl
HMIS	Health Management Information System
HNP	Health Nutrition Population
IFA	Iron Folic Acid
IFPRI	International Food Policy Research Institute
IFST	Institute of Food Science and Technology
IGA	Income Generating Activities
IPHN	Institute of Public Health Nutrition
ISPP	Income Support Program for the Poorest
IYCF	Infant and Young Child Feeding
LGD	Local Government Division
LGRD	Local Government and Rural Development
M&E	Monitoring and Evaluation
MAD	Minimum Acceptable Diet
MAM	Moderate Acute Malnutrition
MDG	Millennium Development Goal
MICS	Multiple Indicators Cluster Survey
MIS	Management Information System
MOA	Ministry of Agriculture
MOEF	Ministry of Environment and Forest
MOF	Ministry of Finance
MOFood	Ministry of Food
MOHFW	Ministry of Health & Family Welfare

MOI	Ministry of Information
MOLGRD&C	Ministry of Local Government, Rural Development & Cooperatives
MOPME	Ministry of Primary and Mass Education
MOWCA	Ministry of Women and Children Affairs
MUAC	Mid Upper Arm Circumference
NCD	Non-Communicable Disease
NGO	Non-Government Organization
NNS	National Nutrition Services
NPAN	National Plan of Action for Nutrition
NPAN2	Second National Plan of Action for Nutrition
NPNL	Non-pregnant, non-lactating
NSP	Nutrition Surveillance Project
NSSS	National Social Security Strategy
OP	Operational Plan
PNC	Postnatal Care
SAM	Severe Acute Malnutrition
SBCC	Social Behavior Change Communication
SDG	Sustainable Development Goal
SSN	Social Safety Net Program
ST, MT, LT	Short Term, Medium Term, Long Term
TOR	Terms of Reference
ToT	Training of Trainers
UNICEF	United Nations Children's Fund
VGD	Vulnerable Group Development Program
VGF	Vulnerable Group Feeding Program
WASH	Water, Sanitation and Hygiene
WFP	World Food Program
WHA	World Health Assembly
WHO	World Health Organization

## GLOSSARY: Operational Definition

### Selected operational definitions relevant to the multi-sectoral nutrition

**Nutrition:** Sum of all processes involved in how we obtain nutrients, metabolize them, and use them to support growth, development, and maintenance of healthy life.

**Nutrition Specific** interventions are those that lead directly to an improvement in nutritional status (e.g., breastfeeding, vitamin and mineral supplements, reduction of diseases, etc.)<sup>1</sup>

**Nutrition Sensitive** interventions are those that have indirect effect on nutritional status by impacting on underlying and basic causes of undernutrition (e.g., keeping girls in school through secondary years to avoid adolescent pregnancies, improvements in personal and environmental hygiene through water and sanitation initiatives, etc.)<sup>1</sup>

**Clinical Nutrition:** a discipline that deals with the prevention, diagnosis and management of nutritional and metabolic changes related to acute and chronic disease and conditions caused by a lack or excess of energy and nutrients. (*European Society for Clinical Nutrition and Metabolism*)

**Public Health Nutrition** encompasses those interventions that focuses on populations, the nutritional component of public health.<sup>1</sup>

**Public Nutrition**, which goes beyond the health sector to include nutrition sensitive as well as nutrition specific interventions that form a multi-sectoral approach to sustainable improved population nutrition.<sup>1</sup>

**Food systems:** Food systems encompass the entire range of actors and their interlinked value-adding activities involved in the production, aggregation, processing, distribution, consumption and disposal of food products that originate from agriculture, forestry or fisheries, and parts of the broader economic, societal and natural environments in which they are embedded (FAO).

**Food security** exists when all people, at all times, have physical, social and economic access to sufficient, safe and nutritious food which meets their dietary needs and food preferences for an active and healthy life. (WFS 1996)

**Food Availability:** The availability of sufficient quantities of food of appropriate quality, supplied through domestic production or imports (including food aid).

**Food access:** Access by individuals to adequate resources (entitlements) for acquiring appropriate foods for a nutritious diet. Entitlements are defined as the set of all commodity bundles over which a person can establish command given the legal, political, economic and social arrangements of the community in which they live (including traditional rights such as access to common resources).

**Food Utilization:** Utilization of food through adequate diet, clean water, sanitation, and health care to reach a state of nutritional well-being where all physiological needs are met. This brings out the importance of non-food inputs in food security. (FAO 2006)

**Food Insecurity:** A situation that exists when people lack secure access to sufficient amounts of safe and nutritious food for normal growth and development and an active and healthy life. (FAO)

**Dietary diversity:** dietary diversity is defined as the number of different foods or food groups consumed over a given reference period. It is a qualitative measure of food consumption that reflects household access to a variety of foods and is also a proxy for nutrient adequacy of the diet of individuals. Dietary diversity has special significance with relation to children and women.

**Undernourishment:** is an estimate of the proportion of the population whose habitual food consumption is insufficient to provide the dietary energy levels that are required to maintain a normal active and healthy life. It is expressed as a percentage. (FAO)

**Underweight:** Low weight for age against WHO child growth standard (less than  $-2$  standard deviations). Evidence has shown that the mortality risk of children who are even mildly underweight is increased, and severely underweight children are at even greater risk. (adapted from WHO)

**Obesity:** Obesity (BMI equal to or more than 30) is a disease that is largely preventable through lifestyle changes. The costs attributable to obesity are high, not only in terms of premature death and health care but also in terms of disability and a diminished quality of life. (Adapted from WHO)

**Malnutrition:** People are malnourished if their diet is not balanced with their nutritional needs. Malnutrition includes both undernutrition (stunting, wasting, underweight, and micronutrient deficiencies) and over-nutrition (overweight and obesity).

**Multi-sectoral approach:** An approach to nutrition planning and programming in which different departments coordinate and collaborate to address both direct and underlying causes of malnutrition.

#### **Malnutrition in women:**

**Women of short stature** (less than 145 cm) are at greater risk for obstetric complications because of a smaller pelvis. Small women are at greater risk of delivering an infant with low birth weight, contributing to the intergenerational cycle of malnutrition, as infants of low birth weight or retarded intrauterine growth tend to be smaller as adults. (adapted from WHO)

**BMI (Body Mass Index):** is a simple index of weight-to-height commonly used to classify underweight, overweight and obesity in adults. It is defined as the weight in kilograms divided by the square of the height in metres (kg/m<sup>2</sup>). For example, an adult who weighs 58 kg and whose height is 1.70 m will have a BMI of 20.1:  $BMI = 58 \text{ kg} / (1.70 \text{ m} \times 1.70 \text{ m}) = 20.1$ . A BMI between 18.5–24.9 indicates normal weight.

**Moderate and severe thinness:** A BMI less than 17.0 indicates moderate and severe thinness in adult populations. It has been linked to clear-cut increases in illness in adults and has been chosen as a cut-off point for moderate risk. A BMI less than 16.0 is known to be associated with a markedly increased risk for ill health, poor physical performance, lethargy and even death; this cut-off point is therefore a valid extreme limit. (Adapted from WHO)

**Micronutrients Deficiency:** Micronutrients are vitamins and minerals needed by the body in very small amounts. However, their impacts on a body's health are critical, and deficiency in any of them can cause severe and even life-threatening conditions. Deficiencies in iron, vitamin A and iodine are the most common around the world, particularly in children and pregnant women. (WHO)

**Gender sensitive** Policies and programs that take into account the particularities pertaining to the lives of both women and men, while aiming to eliminate inequalities and promote gender equality, including an equal distribution of resources, therefore addressing and taking into account the gender dimension. (European Institute of Gender Equality)

**Gender Mainstreaming:** Mainstreaming a gender perspective is the process of assessing the implications for women and men of any planned action, including legislation, policies or programmes, in any area and at all levels. It is a strategy for making the concerns and experiences of women as well as of men an integral part of the design, implementation, monitoring and evaluation of policies and programmes in all political, economic and societal spheres, so that women and men benefit equally, and inequality is not perpetuated. The ultimate goal of mainstreaming is to achieve gender equality." (The United Nations Economic and Social Council -ECOSOC, 1997)

**Nutrition and social protection:** the common ground Social protection and nutrition are intrinsically linked by the fact that poverty (and the inadequate quantity, quality or access to human, economic and institutional resources it implies) is the most important root cause for malnutrition. More specifically, there are strong complementarities between social protection and the fight against malnutrition. (FAO 2015).

**Nutrition governance:** Nutrition governance represents actions taken to provide an institutional framework and systems to facilitate the institutionalization of nutrition in existing government structures, policies, and frameworks. Nutrition governance includes information management, coordination and partnership, advocacy, communication, and policy development and implementation.

## Operational Definition of some priority indicators of NPAN2

Output/Outcome level indicators	Operational Definition
<b>% of children aged &lt;5 years stunted</b>	Percentage of stunting (height-for-age <-2 standard deviations of the WHO Child Growth Standards median) among children aged 0-5 years
<b>% of children aged &lt;5 years wasted</b>	Percentage of (weight-for-height <-2 standard deviations of the WHO Child Growth Standards median) and/or presence of bilateral pitting oedema among children aged 0-5 years
<b>% of infants born with low birth weight (&lt;2,500 grams)</b>	Percentage of live births under 2500 g out of the total number of live births during the same period.
<b>% of children aged &lt;5 years overweight</b>	Percentage of overweight (weight-for-height >+2 standard deviations of the WHO Child Growth Standards median) among children aged 0-5 years
<b>% of women 15-49 with Anaemia</b>	Anaemia is defined as haemoglobin level <110 g/L in pregnant women and <120 g/L in non-pregnant non-lactating women aged 15–49 years.
<b>Early initiation of breastfeeding</b>	Percentage of most recent live-born children to women with a live birth in the last 2 years who were put to the breast within one hour of birth
<b>% of children (0-6 months) exclusively breastfed</b>	Proportion of infants 0-6 months who are exclusively breastfed
<b>% of children &lt;5 years with diarrhoea treated with ORT and Zinc</b>	Percentage of children aged 0-5 years with diarrhoea in the last two weeks receiving ORS and Zinc
<b>% of women 15-49 yrs who are overweight or obese</b>	Percentage of non-pregnant women aged 15–49 years who are overweight (defined as having a BMI $\geq 23$ kg/m <sup>2</sup> ) and obese (defined as having a BMI $\geq 25$ kg/m <sup>2</sup> ). BMI is calculated by dividing the subject's weight in kilograms by their own height in metres squared.
<b>% of adolescent girls aged 15-19 yrs. thin (total thinness)</b>	% of adolescent girls aged 10-19 yrs. with BMI <18.5
<b>% of women aged 15-19 yrs. who have begun childbearing</b>	Percentage of women age 20-24 years who have had a live birth before age 18
<b>% of children (6-23 months) receiving MAD</b>	Percentage of children age 6–23 months who had at least the minimum dietary diversity and the minimum meal frequency during the previous day
<b>% of population that use improved drinking water</b>	Percentage of population using an improved drinking water source (piped water into dwelling, yard or plot; public taps or standpipes; boreholes or tube wells; protected dug wells; protected springs, rainwater, packaged or delivered water) which is located on premises, available when needed and free of faecal and priority chemical contamination.
<b>% of caregivers with appropriate hand washing behaviour</b>	Proportion of caregivers in households using soap for hand washing for at least two critical times in the past 24 hours. These two critical times include after own defecation, and at least one of the following: after cleaning a young child, before preparing food, before eating, and/or before feeding a child.
<b>% of population that use improved sanitary latrine (not shared)</b>	Population using an improved sanitation facility that is not shared with other households and where excreta are safely disposed of in situ or treated off site.  Improved sanitation technologies are: flush toilet, ventilated improved pit latrine, traditional pit latrine with a slab, or composting toilet.



# Executive Summary

## Executive summary

This is the fourth annual monitoring report of the Second National Plan of Action for Nutrition (NPAN2) 2016-2025. The report presents data and analysis on the selected indicators of goals/ impact, outcomes, and outputs for January 2022 to December 2023 with a view to track the progress trend of NPAN2 target indicators, events and activities. This report aimed to ensure tracking of periodic progress by updating the monitoring report of NPAN2.

## Overall Progress

Bangladesh Demographic and Health Survey (BDHS) 2022 showed remarkable success in reducing the level of stunting among children under 5 declining from 51 percent in 2004 to 24 percent in 2022, underweight from 43 percent in 2004 to 22 percent in 2022, and after years of a critically high level of around 15 percent, prevalence of wasting came down to 11 percent in 2022 (see Figure 1). The prevalence of Low Birth Weight (LBW) reduced to 22.6 percent in 2015 in comparison to 36 percent in 2003-04.

However, there exist differences in the rate of malnutrition at various geographical and socio-economic levels. For example, the reduction in underweight was more (around 17 percent) in rural areas in comparison to the urban areas (10 percent) as per the MICS, 2019. Furthermore, nearly one in three children nationally and over 40% of slum children are still stunted. Prevalence of being overweight or obese is almost double in urban areas (36.4%) than in rural areas (18.8%). The 2018 STEPS Survey of Bangladesh identified that the percentage of women in urban areas have higher BMI and waist circumference than rural women, indicating greater risk of NCDs. An inverse association between demographic levels of household wealth, geographical differences, and nutrition indicators are evident. For example, while in rural areas, stunting is higher (38 percent) than in urban areas (31 percent) but slum children are more malnourished (40 percent) than those living in rural and non-slum areas. Prevalence of increased blood pressure, blood cholesterol and cardiovascular diseases was also found to be higher in urban areas in comparison to rural.

As per BDHS 2014, 18.5 percent of the women of reproductive age are underweight with a body mass index (BMI) of <18.5 Kg/m<sup>2</sup>, 20 percent are overweight and 4.75 percent are obese. Chronic Energy Deficiency (CED) i.e. Body Mass Index (BMI) less than 18.5 among mothers has decreased from 52 percent in 1996-97 to about 31 percent in 2019, as per a study of National Nutrition Services (NNS) and BRAC James P Grant School of Public Health. While this CED rate indicates a substantial improvement over time, it is still an issue of public health concern.

Nutritional deficiencies during pregnancy are associated with increased risk of infant LBW and childhood stunting. Therefore, combating maternal nutritional deficiencies at conception and during pregnancy is high priority to achieve nutritional outcomes. Evidence suggests that maternal undernutrition, which is a key determinant of infant and young child under nutrition, remains intractable despite efforts to improve the nutritional status of pregnant women. Anaemia during pregnancy is common in Bangladesh (41.8 percent according to BDHS, 2011), with serious consequences for both mother and newborn, including increased risk of infant low birth weight and preterm birth, as well as high risk of maternal and perinatal morbidity and mortality. Maternal undernutrition peaked at 38 percent among adolescent girls aged 15-19 years who had given birth in the past 3 years. Childbearing during adolescence (15-19 years) stood at 27.7 percent, as per BDHS 2017-18. This contributes to poor maternal nutritional status and birth outcomes, including high levels of LBW infants. Both stunting and underweight remain quite high among adolescent girls at 29 percent and 56 percent respectively, while overweight and obesity is around 7 percent and 2 percent respectively. Anaemia and micronutrient deficiencies are common in adolescents, notably vitamin A, zinc, iodine and calcium, since dietary intakes are far below requirements.

Bangladesh has started to see increasing rates of overnutrition. Between 2004 to 2022, overweight has increased from 1% in 2004 to 1.5% in 2022 and 14% women were obese (SFSN 2018-19). The rate of

overweight and obesity among children has increased from 1.4% in 2012-13 to 2.4% in 2019. Overweight (>2SD) rate was 2.7% in slum dwelling children compared to 4.1% in non-slums.

About 45% of adolescent married girls get pregnant by 18 years of age that ultimately sequences to poor maternal nutritional status and later poor birth outcomes, contributing to high rates of low-birth weight infants. Stunting remains quite high among adolescents (29%), along with underweight overweight and obesity prevalence which are 56%, 7%, and 2% respectively. Anaemia and micronutrient deficiencies are common in adolescents, women of reproductive age and children, notably vitamin A, zinc, Iron and iodine, and other deficiencies including calcium are also low.

The minimum dietary diversity for women (MDD-W) is a proxy indicator of micronutrient adequacy in their diet indicating the consumption of at least five or more out of ten food groups. There has been an improvement in quality and diversity of diets consumed by the population for example, MDD-W have gone up to 37.2% in 2017 from 26.1% in 2014 (BDHS), however, diet quality remains below global recommended level, particularly related to consumption of fruits, vegetables, animal-source foods, and pulses. According to HIES (2016) people consume 35.78 gm of fruits and 167.3 gm of vegetables against target of 100 gms and 300 gms of fruits and vegetables respectively. Overall, calorie intake per capita per day has decreased to 2210 Kcal in 2016 from 2308 Kcal in 2010 (a decrease of about 4%). This decrease amount (2210 Kcal) is below the desirable amount of 2430 Kcal/capita/day.

## Progress in thematic areas

### Thematic Area 1: Nutrition for All following Life Cycle Approach

#### Infant and Young Child Feeding Practices (IYCF)

Early Initiation of Breastfeeding (EIBF) is referred to as initiation of breastfeeding within one hour of birth. Data presented in Figure-4 clearly shows improvement in EIBF over the four years: 50% in 2011, from 57% in 2014 to 69% in 2017-18 which has dropped to 40% in 2022 (BDHS 2022). With the current rate of improvement as demonstrated by the BDHS report, the country is on off track to achieve the NPAN2 target of 80% by 2025. This status is probably attributable to less practice and awareness on initiation of breastfeeding within one hour of birth. Therefore, need to improve the ANC services, proper implementation of the Bangladesh Breast milk Substitutes Act<sup>1</sup>, functionality of Baby-Friendly Hospital Initiative (BFHI), increase the Maternity and Lactating Allowance Programs, etc. supported by Social Behaviour Change Communication (SBCC).

In Bangladesh, the Exclusive Breastfeeding (EBF) rate has ups and downs from 64% in 2011 to 55% in 2022 (BDHS report) in Figure 5. As per BDHS Report, despite a fall in EBF rates from 64% in 2011 to 55% in 2014, the rate rebounded to 65% in 2017-2018. However, in 2022 the current rate of progress has declined to 55% which indicate the indicator is off track to achieve the NPAN2 target of 70% by 2025.

BDHS findings, as depicted in Figure 6, show that among breastfed children aged 6-23 months, all three indicators—minimum dietary diversity (MDD), minimum meal frequency (MMF) and minimum acceptable diet (MAD)—in both male and female children have increased in 2017-18 compared to 2022. MDD has increased from 37.5% to 38.4%, MMF has decreased from 75% to 70%, and MAD has decreased from 34% to 31% between 2017-18 and 2022 respectively.

#### Micronutrient Malnutrition

Iron deficiency is a major cause of Anaemia among pregnant women, adolescent girls, and children. 29% of non-pregnant and non-lactating (15-49 years) are anemic and 14% have iron deficiency. It is also observed that except Anaemia and folate deficiency, the level of deficiencies for other

<sup>1</sup> Breast Milk Substitute (BMS) Act 2013

micronutrients have decreased in 2019-20 compared to 2011-12.<sup>2</sup> About 46% women had a minimum dietary score in 2015 against the target of 75% of MDD-W by 2030.

Based on administrative data it is evident that, Bangladesh's bi-annual Vitamin A supplementation program has maintained high coverage over time in achieving 98.8% in 2023 for children aged 6-59 months. The administrative coverage of the first round of vitamin A supplementation to children aged 6-59 months was 98.6% (20,523,925 children); coverage of children aged 6-11 months was 97.7% (2,420,573 children); and coverage of children aged 12-59 months was 98.3% (18,103,352 children). In Sylhet the coverage was low at 81.3% among children aged 6-59 months and 82.9% among children 12-59 months.

### Adolescent Nutrition

**% of adolescent girls (15-19 yrs) with height <145 cm-**in 2022 4.5% of the adolescent girls aged 15-19 years had height <145 cm. It has improved from 5.2% in 2018-19 to 4.5% in 2022. It is observed that the NPAN2 target of <8% by 2025 has already been achieved. Nonetheless, low height among early adolescent period (aged 10-18 years) was height at 30.9% and remained unchanged from 2018-19 findings<sup>3</sup>.

**% of adolescent girls (15-19 yrs) thin (total thinness)-** The status of total thinness among adolescent girls (15-19 yrs) has also improved from 20% in 2018-19 to 18% in 2022 against the NPAN2 target of less than 15% by 2025.

### Maternal Nutrition and Low Birth Weight (LBW)

Rate of overweight or obese (BMI  $\geq 23$  or  $\geq 27.5$ ) among women aged 15-49 years has increased from 11%, in 2004 to 39% in 2014 and 49 in 2021 and 14% women are obese (SFSN 2018-2019)<sup>4</sup> against the target of 30% by 2025. Low Birth Weight (LBW) rate among Bangladeshi infants, though it has reduced from 36% in 2004 to 23% in 2016, is still high. The overall quality of antenatal care has improved since 2007. Urban women are more likely than rural women in making four or more antenatal visits (59% urban compared with 43% rural).

### Management of Acute Malnutrition

It is estimated that at any given point of time in Bangladesh there are about 1,146,250 under-five children suffering from acute malnutrition (prevalence of Global Acute Malnutrition), of which about 859,700 suffer from moderate acute malnutrition (MAM), and about 286,600 from severe acute malnutrition (SAM). Compared to January 2021, proportion of children screened in IMCI-Nutrition corners was increased from 61% to 84% in June 2022 and this is highest percentage of screening in IMCI-Nutrition corner. SAM admission has increased to 918 from 811 in compared to last month. Present admission rate also increased 62% (January 2022). In January 2022, The IFA distribution coverage has increased to 266,989 from 252,844 (Figure 11.a). From the month of October 2021, the caregiver of counselling coverage has decreased to 404,738 from 406,914 [Source DHIS2]. Before COVID lockdown in 2021, the admission rate was 94% (in April'21) but this decreases to around and over 44% in August. In 2022 it has increased to 62%. It is set the target for SAM admission at 14,000 children in 2022. In January 2022, we have already reached 918 which is 7% of set target [Data Source DHIS2]

### Water, Sanitation and Hygiene (WASH)

84.6% of population nationally use improved sanitation, in which, 90.6% being in urban areas and 82.9% in rural areas. According to CWS 2016, only nineteen percent (19%) of the households had an

<sup>2</sup> National Micronutrient Survey, 2019-20.

<sup>3</sup> Bangladesh Multiple Indicator Cluster Survey (MICS) 2019

<sup>4</sup> BRAC James P Grant School of Public Health and National Nutrition Services. (2019). State of food security and nutrition in Bangladesh 2018-2019. Dhaka, Bangladesh: James P Grant School of Public Health and National Nutrition Services.

improved sanitation facility in slum areas compared to 51.3% of the non-slum households. The percentage of household members using improved sanitation facilities has increased from 77% in 2012-13 to 85% in 2019 (MICS 2019). The same holds true for handwashing facilities with water and soap/detergent. Percentage of households with hand washing facilities where water and soap/detergent were present has also increased from 59% to 75% during the same period. MICS 19 statistics for Water, Sanitation and Hygiene were much higher than BDHS 2017-18 statistics which show that between 2014 and 2017, the availability of a hand washing station with water and a cleansing agent (including soap) increased from 37% to 47% only. Open defecation was found to be national only 1.5%, with 0.4% in urban areas and 1.9% in rural areas (MICS, 2019).

### Urban Nutrition

As per the recent preliminary findings of the Population and Housing Census 2022 in Bangladesh, around 31.50% of the population (around 53 million) in the country are urban dwellers (BBS, 2022). Though Bangladesh has witnessed a significant improvement in the reduction of chronic undernutrition (stunting, low height for age) from 43% in 2007 to 28% in 2019, decreased by 15% in 12 years, but the reduction rate was higher in rural areas than in the urban areas (17% and 10% respectively). 40% of slums children are stunted compared to 26% of the total urban stunting level. The prevalence of wasting increased in both slum (17% to 19%) and non-slum (10% to 16%) from 2006 to 2013, but decreased in 2016, to 16% and 7% in slum and non-slum respectively (UHS, 2013; CWS, 2016); the prevalence of underweight was 20%, with higher levels among slum (31%) compared to non-slum children (18%). Overweight (>2SD) rate was 2.7% in slum dwelling children compared to 4.1% in non-slum dwelling children.

### Thematic Area 2: Agriculture & Diet Diversification & Locally Adapted Recipes

Rice is the main staple food consumed in Bangladesh. Over the last three decades, Bangladesh has managed the accomplishment of producing enough rice to keep up with population growth and has been self-sufficient in rice production since 2012<sup>5</sup>. Thus, in terms of calorie availability, it has achieved self-sufficiency, and most recently also in meat and fish production, as per Bangladesh Economic Review, 2018.

The average daily per capita intake of major food items in 2022 and 2016 (Figure 14.a). In the cereals group at the national level, the per capita daily intake was recorded at 385.0 grams, in which rice contributed 328.92 grams, wheat contributed 22.92 grams, and other cereals contributed 33.17 grams in 2022. It was observed that the consumption of cereals & rice declined in 2022 compared to 2016. At the national level, rice consumption is reduced by 38.28 grams, while rice consumption is decreased by 36.98 grams in rural areas and 32.08 grams in urban areas. This reduction may be due to a change in people's consumption behaviour. The national level consumption of some other food items like vegetables, pulses, potatoes, milk & milk products, fruits, edible oils, meat, poultry and fish, sugar and gur increased in 2022 compared to the intake in 2016. On the other hand, khasari, onion, eggs, condiments and spices decreased in 2022 compared to 2016.

### Production of Cereals

As per 2022 (HIES 2022) the per capita intake of vegetable has increased marginally from 167.3 gm to 201.9 gm in 2022 (HIES 2022) against the target NPAN2 of 300g by 2025. On the other hand, fruit intake has also increased from 35.78 gm (HIES 2022) to 95.4 gm (HIES 2022) against the NPAN2 target of 100 grms by 2025. It is also seen in table 9 that, the % share of total dietary energy from consumption of cereals have decreased significantly from 64% (HIES 2016) to 30.54% (HIES 2022) where <60% target of NPAN2 by 2025.

### Consumption

The HIES 2022 data illustrates that the share of food and non-food consumption expenditures in the HHs has changed. Non-food expenditures are increasing gradually. The percentage of food

<sup>5</sup> USDA Foreign Agriculture Service. 2015. Grain and Feed Annual.

consumption expenditure is 45.8%, and non-food consumption expenditure is 54.2% in 2022, compared to 47.7% for food and 52.3% for non-food in 2016. The average rice consumption of per person per day is 328.9 grams in 2022 which was 367.2 grams in 2016, 416.0 grams in 2010, 439.6 grams in 2005 and 458.5 grams in 2000. On the other hand, the vegetables and meat consumption have increased gradually. The average protein intake is 72.5 grams per person per day in 2022 which was 63.8 grams in 2016, 66.26 grams in 2010, 62.52 grams in 2005 and 62.50 grams in 2000. The headcount rate (HCR) in 2022 using the upper poverty line is 18.7% at the national level, 20.5% in rural areas, and 14.7% in urban areas. Whereas, the official HCR in 2016 using the upper poverty line was 24.3% at the national level, 26.4% in rural areas, and 18.9% in urban areas.

Despite positive gains in the sector, the Prevalence of Moderate or Severe Food Insecurity based on the Food Insecurity Experience Scale (FIES) provides an alternative household-level perspective by assessing people's perceptions and challenges in accessing nutritious and sufficient food. On this scale, severe food insecurity, for example, indicates no food for a day or more. Severe food insecurity, based on the FIES, has improved, falling steadily to 10.6% in 2017-19 from 13.3% in 2014-16. However, following a slight decline, the three-year average for 2016-18 and 2017-19 has stagnated at 31.5% for moderate food insecurity. These figures are noticeably below the South Asia averages, which stand at 16.0% for severe food insecurity and 33.4% for moderate food insecurity over 2017-19, respectively.

### **Thematic Area 3: Social Protection**

The spending on Social Safety Net Programs (SSNPs) as a percentage of the total national budget has slightly increased both of total (501,577 crore to 568,000 crore) and percentage (16.32% to 16.83%) between FY 2019/20 and 2020/21. The 2016 HIES data shows that 27.8% of the households have received benefits from SSPs during the previous 12 months of the survey. However, MICS 2019 report reveals that 55% of the household members from two of the lowest wealth quintiles received some/any type of social transfer in previous three months of the survey. As per the recent Bangladesh Social Protection Public Expenditure Review of the World Bank, 2021 while urban poverty was found as 18.9%, coverage of SSPs in urban areas was found to be only 10.9%, whereas coverage of SSPs in rural areas was found to be 35.7% against rural poverty of 26.4% (World Bank, 2021). The study identified only 5% of SSP expenditure being exclusive to urban areas.

### **Vulnerability and Climate Change**

As the climate changes the nutrient composition of some crops are likely to change, which adds another layer of complexity to nutrition security. Experiments on growing crops in different controlled environments have found that elevated atmospheric CO<sub>2</sub> levels and increases in temperature not only reduce crop yields but also lowers the nutrient density in a range of staple crops. A meta-analysis of the data by Myers et al showed that zinc, iron and protein concentrations in C3 crops (e.g. wheat, rice) and legumes (e.g. field peas, soybeans) were significantly lower when grown at elevated CO<sub>2</sub> (levels predicted for 2050) compared with those grown at ambient CO<sub>2</sub> levels. They reported that in the edible portion of wheat grown under warmer and higher CO<sub>2</sub> conditions, the zinc, iron and protein concentrations were lower by an average of 9.3, 5.1 and 6.3 %, respectively. The phytate content also reduced, which could potentially counter some of the losses in zinc and iron in terms of increasing the bioavailability. For rice, the reduction was 3.3, 5.2 and 7.8 %, respectively, but there was no significant change in the phytate concentration.

### **Thematic Area 4: Implementation of Integrated and Comprehensive SBCC Strategy**

#### **National Nutrition Week (NNW), 2022 & 2023 and Routine BCC Activities**

National Nutrition Week (NNW) 2023 was observed countrywide from 7-14 June 2023 (instead of 23 April-29th April) to commemorate the formation of Bangladesh's National Nutrition Council. Under the leadership of the Ministry of Health and Family Welfare, the Institute of Public Health and Nutrition and Bangladesh's National Nutrition Council, NNW was celebrated. The theme of 2023 National nutrition week was -“মজবুত হলে পুষ্টির ভিত, স্মার্ট বাংলাদেশ হবে নিশ্চিত।” The NNW 2023 was observed

country wide through rallies, discussions, different programs on day wise thematic areas, with participation from government and non-government officials, representatives from civil society both in national and at the sub national level. Other events included cooking competition, nutrition fair, school and courtyard meetings.

Certain cascading activities regarding nutrition SBCC were done through different line ministries and development partners. Technical support was provided to integrate SBCC strategy in Improved Maternity and Lactating Allowance program implement by MoWCA in alignment with National Comprehensive SBCC strategy. Moreover, under the Rice fortification program advocacy was done for commercialization under the leadership of MoFood. Public Awareness campaign on healthy diet conducted under the leadership of Ministry of Industries with technical assistance provided by relevant ministries.

### **Multisectoral Social and Behavior Change Communication (mSBCC) Strategy**

With the financial support of Global Affairs Canada (GAC) and technical support of Nutrition International, Bangabandhu Sheikh Mujib Medical University (BSMMU) has been conducting a Formative Research to develop Multisectoral Social and Behavior Change Communication (mSBCC) Strategy, Materials, and Training Package for AMAN Project in Cox's Bazar.

### **Thematic Area 5: Monitoring, Evaluation and Research**

Bangladesh National Nutrition Council (BNNC) in collaboration with Joint Action for Nutrition Outcome (JANO) funded by EU facilitated the operationalization and action planning processes of the District Nutrition Coordination Committee (DNCC) and Upazila Nutrition Coordination Committees (UNCC) in Rangpur and Nilphamari Districts to foster and coordinate nutrition initiatives at local level.

BNNC has established a monitoring progress of sectoral annual work plan of relevant ministries on six monthly basis and updated them in the central and sub-national level dashboard. More than 17 annual workplans in 2021-22 and 19 plans in 2022-23 from 22 ministries have been reported with previous year progress. M&E team collected, analyzed and used in this report as well to provide evidence for formulating appropriate strategies and policies for improvement of nutrition status.

Nutrition-based Short Message Service (SMS) platform is one of the key interventions of JANO project where various information is shared with the target participants via configured SMS service. The main objective of this service is to develop and disseminate nutrition sensitive and nutrition specific messages among the targeted audience within the project coverage area who have limited or no access to smart phones.

BNNC has developed a web-based interactive visual comprehensive mapping platform of NGOs partners who are currently working on nutrition sensitive interventions across the country. It would help BNNC to identify potential partners, overlaps or gaps of the nutrition sensitive programmes.

To enhance the health, hygiene and nutrition specific and sensitive knowledge and awareness among frontline workers and community people the project has developed four e-Learning solutions for the volunteers, frontline workers and community people, particularly targeting pregnant and lactating women, adolescents and children.

### **Budget Tracking**

At present, the Finance Division, GoB and UNICEF conducting a Public Expenditure Review on Nutrition (PER-N) to review the level and composition of public expenditure in nutrition for five fiscal years from FY 2017-18 to 2021-22. In this regard, a draft report has been prepared and waiting for the approval by the Standing Technical Committee (STC) of BNNC. In addition, a guideline has been prepared to establish an online nutrition budget tracking system. This web-based software will be interoperable with iBAS++, AIMS and other relevant GoB systems. The system will provide an option for tagging a budget line (combination of organization, operation, and other segments) as Nutrition Specific or Nutrition Sensitive activities.

## **Thematic Area 6: Capacity Building.**

BNNC prepared a Strategy and Guidelines on human resource capacity development on multisectoral nutrition. Objectives of the initiative included review of training component and scope across ministries with respect to NPAN2 implementation, identify gaps and opportunities, recommend strategies and preparing guidelines for improvement of the overall capacity context. It also analyzed and identified gaps and opportunities of existing capacity development activities in place for in-service human resources across ministries and other stakeholders. Further, strategies are recommended for improvement and coordination of human resource capacity development and prepared guidelines for training improvement which include model lessons. The document was prepared through review of relevant documents including the national policies, strategies, plans; global literatures on multisector nutrition, collection of nutrition relevant information across selected ministries, expert consultation through group, committees, platform, and individuals under the guidance of a Thematic Working Group (TWG) formed by the BNNC. It is expected that roll out of strategy and guidelines as part of ministry work plans and other operational plans, coordinated and technically supported by the BNNC will enhance HR capacity to implement NPAN2 effectively and successfully.

### **Strengthening BNNC's Nutrition Governance, Institutionalization, Coordination, and Implementation Mechanism**

BNNC continued its efforts to improve the nutrition governance both at national and sub-national level during the reporting period by improving horizontal (inter-sectoral coordination with various line ministries, platform meetings, executive committee and standing technical committee, SUN Networks, etc.) and vertical coordination (with DNCCs and UNCCs); advocacy for resource mobilisation (internal and external), developing monitoring system to monitor the functionality of sub-national committees and advocacy plan for high visibility for nutrition, etc.

### **Multisectoral Coordination at National and Sub-national Levels**

During 2020-2021, BNNC has undertaken four workshops at national level with all nutrition focal points from 22 ministries, high level government officials, partners to prepare multisectoral annual workplan aligning with the NPAN2 action and M&E matrix.

The Second National Plan of Action for Nutrition (NPAN-2) keeping alignment with the National Nutrition Policy 2015, SUN movement, ICN2, SDG, WHA and other international commitments, aims to reduce all forms of malnutrition from the country. NPAN-2 has successfully engaged 22 nutrition relevant ministries in implementing NPAN-2 to turn it into a real multisectoral nutrition governance program both at national and sub-national levels. Bangladesh National Nutrition Council (BNNC) is responsible for operationalizing NPAN2 in relevant program areas by providing technical support and hands on training in strengthening technical capacity of District Nutrition Coordination Committee (DNCC) and Upazila Nutrition Coordination Committee (UNCC), to render nutrition governance at sub-national level.

Multisectoral District Nutrition Coordination Committee (DNCC) and Upazila Nutrition Coordination Committee (UNCC) members have been orientated on NPAN2 in 60 Districts. For decentralized planning, a 'Planning Guideline' has been prepared. A detailed strategy for rollout of district nutrition plan and a multisectoral minimum nutrition package (MMNP) has been developed and shared with DNCCs and UNCCs.



# CHAPTER 1

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## INTRODUCTION AND BACKGROUND

# CHAPTER 1: INTRODUCTION AND BACKGROUND

## Introduction

The Monitoring Report is the detail progress made towards the implementation of the Second National Plan of Action on Nutrition (NPAN2) 2016-2025, during the period of January 2022 to December 2023. The report aims to highlight progress achieved within the reporting period on the selected indicators defined in the NPAN2.

Chapter one describes the summary overview of the report as well as the background of malnutrition situation in Bangladesh, compared to those of global and regional average. Background of the report includes government initiatives, progress and status of underlying causes (specific and sensitive) and their impact on nutrition in Bangladesh.

Chapter two describes the approaches (methods of report preparation) adopted to collect nutrition related information from various key sectors. It describes cascaded activities undertaken to develop a monitoring framework and identify priority nutrition indicators.

Chapter three elaborates on progress towards NPAN2 targets and outputs across thematic areas spanning: (1) Nutrition for all following life cycle approach; (2) Agriculture and diet diversification and locally adapted recipes; (3) Social protection; (4) Integrated and comprehensive social and behavior change communication (SBCC); (5) Monitoring, evaluation and research; and (6) Capacity building. The chapter also presents an overview of NPAN2 actions required to bring about progressive and sustainable change in the nutrition situation in Bangladesh. Details of trends are presented in a consolidated table in Annexure 1.

Chapter four illustrates overall progress made in terms of nutrition governance, institutionalization, coordination and implementation mechanisms made possible by the Bangladesh National Nutrition Council (BNNC) during the reporting period.

Additionally, data summarizing the monitoring and evaluation matrix, descriptive program as well as analysis of financial tracking against NPAN2 thematic areas are presented in annexures.

The major activities having target indicators, process indicator, direct and indirect interventions, timeline of the designed program have been examined. The input for this report was determined from progress reports of the respective stakeholders, ministries and from relevant documents & publications of BNNC and other relevant agencies/ organizations as deemed necessary. Secondary level quantitative and qualitative data were collected. Views of the fields and service delivery end point may not be reflected elaborately in this report.

## Objectives of monitoring report of NPAN2

- To demonstrate progress against target and outputs of selected indicators of NPAN2
- To track the overall progress of nutrition Governance, Institutionalization, Coordination and Implementation mechanism
- To inform institutional progress for implementation of NPAN2
- Provide suggestions & recommendations to implement the program effectively

## 1.2 Background

### Nutrition Situation in Brief

Bangladesh has been experiencing a long journey towards improved nutrition since its independence in 1971. This improvement has been characterized by enactments and transformation of relevant pro-poor policies and programmes. The first phase of nutrition policy formulation started just after the independence of the country in 1971 by incorporating a provision within the 1972 Constitution that declared the improvement of the nutritional status of citizens as a basic responsibility of the state. According to Article 18-1 of the constitution “the State shall regard raising the level of nutrition and improvement of public health as among its primary duties”.

From this perspective, the 1972 Constitution of Bangladesh was the first step in the journey towards a nutrition-focused singular policy. Consequently, efforts were made to devise policies that would help the state to perform its responsibilities. In 1974, the Institute of Public Health Nutrition (IPHN) was set up to assist the government in “formulating policy and strategy for nutrition related activities and programs”. This was followed by the establishment of the Bangladesh National Nutrition Council (BNNC) in 1975.

Bangladesh has made significantly good progress in improving child and maternal nutrition status over time over the last 20 years. Bangladesh Demographic and Health Survey (BDHS) 2022 showed remarkable success in reducing the level of stunting among children under 5 declining from 51

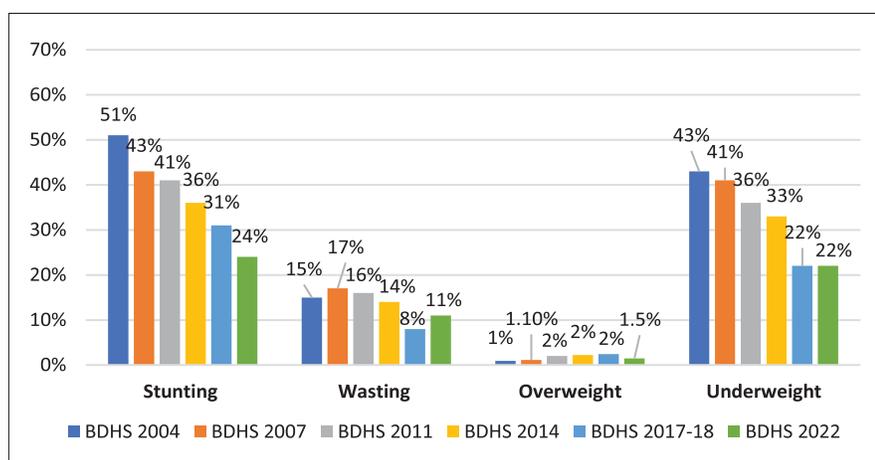


FIGURE 1: PROGRESS IN CHILD NUTRITION IN BANGLADESH

percent in 2004 to 24 percent in 2022, underweight from 43 percent in 2004 to 22 percent in 2022, and after years of a critically high level of around 15 percent, prevalence of wasting came down to 11 percent in 2022 (see Figure 1)<sup>6</sup>. The prevalence of Low Birth Weight (LBW) reduced to 22.6 percent in 2015<sup>7</sup> in comparison to 36 percent in 2003-04<sup>8</sup>.

However, there exist differences in the rate of malnutrition at various geographical and socio-economic levels. For example, the reduction in underweight was more (around 17 percent) in rural areas in comparison to the urban areas (10 percent) as per the MICS, 2019. Furthermore, nearly one in three children nationally and over 40% of slum children are still stunted. Prevalence of being overweight or obese is almost double in urban areas (36.4%) than in rural areas (18.8%)<sup>9</sup>. The 2018 STEPS Survey of Bangladesh identified that the percentage of women in urban areas have higher BMI and waist circumference than rural women, indicating greater risk of NCDs. An inverse association between demographic levels of household wealth, geographical differences, and nutrition indicators are evident. For example, while in rural areas, stunting is higher (38 percent) than in urban areas (31 percent) but

<sup>6</sup> National Institute of Population Research and Training (NIPORT), and ICF. 2020. Bangladesh Demographic and Health Survey 2017-18. Dhaka, Bangladesh, and Rockville, Maryland, USA: NIPORT and ICF.

<sup>7</sup> IPHN. 2015. National Low Birth Weight Survey, 2015. Institute of Public Health Nutrition, Dhaka, Bangladesh

<sup>8</sup> Bangladesh Bureau of Statistics. National Low Birth Weight Survey of Bangladesh 2003–2004. Planning division, Ministry of Planning, Government of the People’s Republic of Bangladesh; 2005.

<sup>9</sup> BDHS 2014

slum children are more malnourished (40 percent) than those living in rural and non-slum areas<sup>10</sup>. Prevalence of increased blood pressure, blood cholesterol and cardiovascular diseases was also found to be higher in urban areas in comparison to rural<sup>11</sup>.

As per BDHS 2014, 18.5 percent of the women of reproductive age are underweight with a body mass index (BMI) of <18.5 Kg/m<sup>2</sup>, 20 percent are overweight and 4.75 percent are obese. Chronic Energy Deficiency (CED) i.e. Body Mass Index (BMI) less than 18.5 among mothers has decreased from 52 percent in 1996-97 to about 31 percent in 2019, as per a study of National Nutrition Services (NNS) and BRAC James P Grant School of Public Health<sup>12</sup>. While this CED rate indicates a substantial improvement over time, it is still an issue of public health concern.

Nutritional deficiencies during pregnancy are associated with increased risk of infant LBW and childhood stunting. Therefore, combating maternal nutritional deficiencies at conception and during pregnancy is high priority to achieve nutritional outcomes. Evidence suggests that maternal undernutrition, which is a key determinant of infant and young child under nutrition, remains intractable despite efforts to improve the nutritional status of pregnant women<sup>13</sup>. Anaemia during pregnancy is common in Bangladesh (41.8 percent according to BDHS, 2011), with serious consequences for both mother and newborn, including increased risk of infant low birth weight and preterm birth, as well as high risk of maternal and perinatal morbidity and mortality. Maternal undernutrition peaked at 38 percent among adolescent girls aged 15-19 years who had given birth in the past 3 years. Childbearing during adolescence (15-19 years) stood at 27.7 percent, as per BDHS 2017-18<sup>14</sup>. This contributes to poor maternal nutritional status and birth outcomes, including high levels of LBW infants. Both stunting and underweight remain quite high among adolescent girls at 29 percent and 56 percent respectively, while overweight and obesity is around 7 percent and 2 percent respectively<sup>15</sup>. Anaemia and micronutrient deficiencies are common in adolescents, notably vitamin A, zinc, iodine and calcium, since dietary intakes are far below requirements.

Bangladesh has started to see increasing rates of overnutrition. Between 2004 to 2022, overweight has increased from 1% in 2004 to 1.5% in 2022 and 14% women were obese (SFSN 2018-19). The rate of overweight and obesity among children has increased from 1.4% in 2012-13 to 2.4% in 2019<sup>16</sup>. Overweight (>2SD) rate was 2.7% in slum dwelling children compared to 4.1% in non-slums.

About 45% of adolescent married girls get pregnant by 18 years of age<sup>17</sup> that ultimately sequences to poor maternal nutritional status and later poor birth outcomes, contributing to high rates of low-birth weight infants. Stunting remains quite high among adolescents (29%), along with underweight overweight and obesity prevalence which are 56%, 7%, and 2% respectively<sup>18</sup>. Anaemia and micronutrient deficiencies are common in adolescents, women of reproductive age and children, notably vitamin A, zinc, Iron and iodine, and other deficiencies including calcium are also low.

The minimum dietary diversity for women (MDD-W) is a proxy indicator of micronutrient adequacy in their diet indicating the consumption of at least five or more out of ten food groups. There has been an improvement in quality and diversity of diets consumed by the population for example, MDD-W

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<sup>10</sup> Bangladesh Bureau of Statistics (BBS) and UNICEF Bangladesh. 2016. Child Well-Being Survey 2016. Dhaka, Bangladesh (March 2017).

<sup>11</sup> Bangladesh STEPS Survey, 2018

<sup>12</sup> State of Food Security and Nutrition in Bangladesh 2018-2019, BRAC James P Grant School of Public Health and National Nutrition Services (NNS), 2019, Dhaka, Bangladesh.

<sup>13</sup> Ahmed, T., Mahfuz, M., Ireen, S., Ahmed, A. M., Rahman, S., Islam, M. M., Alam, N., Hossain, M. I., Rahman, S. M., Ali, M. M., Choudhury, F. P., & Cravioto, A. (2012). Nutrition of children and women in Bangladesh: trends and directions for the future. *Journal of health, population, and nutrition*, 30(1), 1–11. <https://doi.org/10.3329/jhpn.v30i1.11268>

<sup>14</sup> National Institute of Population Research and Training (NIPORT), and ICF. 2020. Bangladesh Demographic and Health Survey 2017-18. Dhaka, Bangladesh, and Rockville, Maryland, USA: NIPORT and ICF.

<sup>15</sup> State of Food Security and Nutrition in Bangladesh 2018-2019, BRAC James P Grant School of Public Health and National Nutrition Services (NNS), 2019, Dhaka, Bangladesh.

<sup>17</sup> State of Food Security and Nutrition in Bangladesh 2018-2019, BRAC James P Grant School of Public Health and National Nutrition Services (NNS), 2019, Dhaka, Bangladesh.

<sup>18</sup> State of Food Security and Nutrition in Bangladesh 2018-2019, BRAC James P Grant School of Public Health and National Nutrition Services (NNS), 2019, Dhaka, Bangladesh.

have gone up to 37.2% in 2017 from 26.1% in 2014 (BDHS), however, diet quality remains below global recommended level, particularly related to consumption of fruits, vegetables, animal-source foods, and pulses. According to HIES (2016) people consume 35.78 gm of fruits and 167.3 gm of vegetables against target of 100 gms and 300 gms of fruits and vegetables respectively. Overall, calorie intake per capita per day has decreased to 2210 Kcal in 2016 from 2308 Kcal in 2010 (a decrease of about 4%)<sup>19</sup>. This decrease amount (2210 Kcal) is below the desirable amount of 2430 Kcal/capita/day<sup>20</sup>.

From the aforementioned discussion, it is quite clear that, in spite of having good progress over last few years, malnutrition still remains a challenge in Bangladesh. The extent seems to have specific implications based on demographic characteristics, gender, and region in which the citizens reside.

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<sup>19</sup> Bangladesh Bureau of Statistics (BBS) 2016. *Household Income and Expenditure Survey*. Dhaka, Bangladesh: Bangladesh Bureau of Statistics (BBS)

<sup>20</sup> Nisbett, N. Davis, P. Yosef, S. and Akhtar, N. 2017. *Bangladesh's story of change in nutrition: Strong improvements in basic and underlying determinants with an unfinished agenda for direct community level support*. *Global Food Security* 13 (2017) 21–29



# CHAPTER 2

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## METHODS OF REPORT PREPARATION

## Chapter 2: Methods of Report Preparation

### 2.1 Structure of the Report

The Annual Monitoring Report of January 2022 to December 2023 of Bangladesh National Nutrition Council (BNNC) while preparing the report followed the following structures:

- Six thematic areas of NPAN2 with other emerging issues;
- Priority and related proxy indicators, targets as per NPAN2 matrix;
- Mid-term targets (2016-2020).

#### 2.1.1 Thematic areas:

One of the major goals of the second National Plan for Action (NPAN2) is to improve the nutritional status of all citizens across the lifespan. Nutrition-specific and nutrition-sensitive interventions included in the work plans of 22 aligned ministries including 13 operational plans of the Ministries of Health and Family Welfare (MOHFW) and City Corporations, Agriculture (MOA), Fisheries and Livestock (MOFL), Education (MOE) and Primary and Mass Education (MOPME), Women and Children Affairs (MOWCA), Local Government, Rural Development and Cooperatives, Social Welfare, Disaster Management and Relief, etc. were collected. This Monitoring Report is based on the following areas:

1. Nutrition for all following a lifecycle approach
2. Agriculture, diet diversification and locally adapted recipes
3. Social protection
4. Implementation of integrated and comprehensive Social and Behaviour Change Communication (SBCC) Strategy
5. Monitoring, evaluation and research to inform policy and program formulation and implementation
6. Capacity building
7. Nutrition governance, institutional development and coordination
8. **Other emerging issues:** Humanitarian responses, SUN movement and linkages with BNNC, coverage, equity in different contexts, gender and vulnerabilities

#### 2.1.2 Priority and proxy indicators, targets and baseline

Precise target indicators were the basis for annual monitoring of NPAN2 objectives at the outcome and output (results) level. While implementing partners keep track of monitoring of activities and inputs, BNNC provides overall stewardship roles to oversee monitoring results. In total, 25 program indicators and 15 operational indicators were selected as priority indicators. Those are primarily outcome and impact level indicators (Table 1). Said indicators are mainly obtained through periodic surveys conducted every three to four years. Other than priority indicators, the report also included a few related proxy indicators against each priority indicator to keep track of regular changes for decision making.

#### 2.1.3 Target Period:

For program management, NPAN2 activities are distinctly categorized into three time periods: short-term, mid-term and long-term. Of these, the short-term period spanning 2016-2018 has passed; the current period, or the mid-term from 2016-2020 is underway; and the long-term period from 2016-2025 will be a blend of the current term and others to continue until 2025. This report covers the time period from January 2022 to December 2023, which is part of the mid-term NPAN2.

## 2.2 Report formation process

### 2.2.1 Institutional arrangements

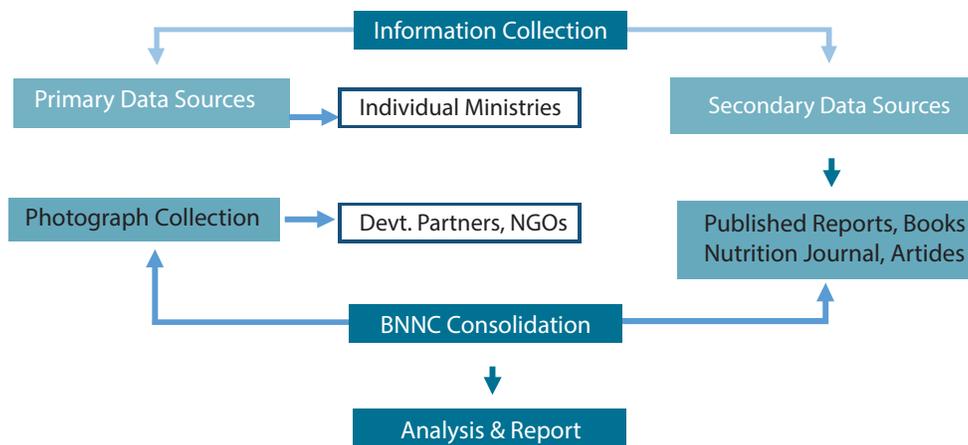
The Monitoring and Evaluation (M&E) Technical Working Group of BNNC comprised of participants from different ministries, UN, NGOs, and researchers, who prepared this monitoring report. BNNC, through its different platforms including District Nutrition Coordination Committee Meetings, and its

observance of National Nutrition Week, were able to obtain activity data to support the preparation of this report.

Through its M&E Technical Working Group members, BNNC reviewed the validity of program and operational indicators from different ministries. They analyzed data trends, progress, status quo, and in case of situations requiring explanation, approached specific ministries for further clarity.

### 2.2.2 Data Collection

The diagram below demonstrates the data collection scheme for preparation of the report. For primary sources, individual ministries and development partners were contacted for priority nutrition indicators. Published reports, books, nutrition journals and articles were secondary data sources used in the reports.



**Figure 3:** Data collection and management process for formulation of the report

**Step-1** Primary information were collected through a data collection checklist by individual departments and units of relevant sectors. Clear instructions were provided to collect updated information on relevant activities based on priority indicators. BNNC also collected a few best practice case studies implemented by both Government and NGOs.

**Step-2:** Secondary sources of data were from the Bangladesh Bureau of Statistics (BBS), Food Planning and Monitoring Unit (FPMU), Food Security and Nutritional Surveillance Project (FSNSP), international agencies, and other projects/programs that collect field data on nutrition. Information was obtained from national reports and periodic surveys such as Households Income and Expenditure Survey (HIES), Multiple Indicators Cluster Survey (MICS), Bangladesh Demographic and Health Survey (BDHS), etc.

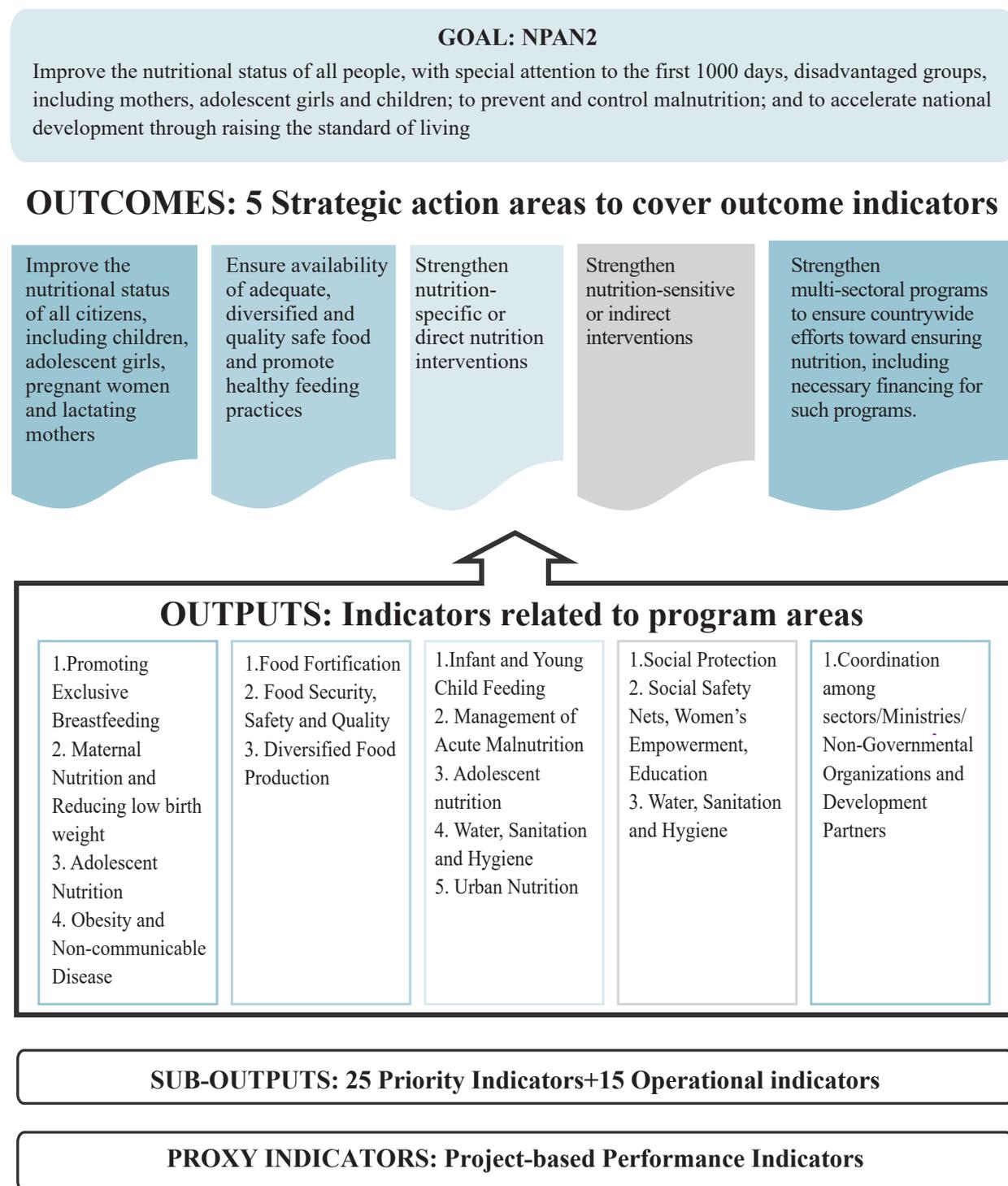
### 2.3 Data Analysis and Use

Data was checked for quality analysis after analysis for quality assurance and adjusted whenever required. The analyses ensured a transparent process conducted in line with national data analysis standards. Data was categorized and analyzed for each thematic area of NPAN2. Finally, progress on priority indicators along with proxy indicators were used for this report.

### 2.4 M&E Framework

The logframe of NPAN2 has been the gold standard and is used for reporting as references in NPAN2 clearly spell out the outcomes to be measured and related time intervals. This monitoring report helps BNNC track progress by looking at indicators for each input, output, outcome, and impact. Continuous tracking of progress, documentation of lessons learned, and replication of best practices for nutrition are the mandate for BNNC outlined in NPAN2.

The BNNC M&E framework is illustrated in Figure 4 below.



**Figure 4:** The monitoring and evaluation framework



# CHAPTER 3

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## PROGRESS TOWARDS NPAN2 TARGET AND OUTPUTS

## CHAPTER 3. PROGRESS TOWARDS NPAN2 TARGET AND OUTPUTS

### Update on 15 Target Indicators set in NPAN2 design.

NPAN2 design included following 15 higher level targets were aligned with the targets as envisaged in NNP 2015. These targets were set to reduce various forms of malnutrition among its population by 2025. The review of progress of them reveals that 11 out of 15 target indicators (related to IYCF, malnutrition, diet etc.) are on track. In fact, the target for reducing maternal overweight at 30% by 2025 has been achieved according to Multiple Indicators Cluster Survey (MICS) 2019, where they found the current level at 24%. Contrarily, overweight and wasting among children under-five showing off track, in fact, the rate has increased against the target of no-increase from baseline level. Another target indicator related to increase the proportion of children aged 6-23 months receiving a minimum acceptable diet (MAD) is also on track (29% against > 40% target). The updated information related a few key target indicators (e.g. birthweight, adolescents' nutrition are not available).

**Table 1: Progress status of higher-level targets**

Target Indicators	Baseline	Target by 2025	Current Status	Target Status
Increase the rate of initiation of breastfeeding in the first hour of birth	51% (BDHS 2014)	80%	40% (BDHS 2022)	
Increase the rate of exclusive breastfeeding in infants less than 6 months of age	55% (BDHS 2014)	70%	55% (BDHS 2022)	
Increase the rate of continued breastfeeding in children aged 20 to 23 months	87% (BDHS 2014)	>95%	85% (BDHS 2022)	
Reduce stunting among <5 children	36% (BDHS 2014)	25%	24% (BDHS 2022)	
Reduce wasting among <5 children	14% (BDHS 2014)	8%	11% (BDHS 2022)	
Reduce the rate of severe acute malnutrition (SAM) (WHZ < -3) among children under 5	8% (BDHS 2014)	<1%	2.0% (BDHS 2022)	
Reduce the proportion of underweight among <5 children	33% (BDHS 2014)	15%	22% (BDHS 2022)	
Increase Vitamin A capsule supplementation coverage in children aged 6- 59 month	62% (BDHS 2014)	99%	79%	
Increase the rate (>15PPM) of iodized salt intake	58% (NMIS <sup>21</sup> 2011-12)	90%	76% (MICS 2019)	
Control & reduce maternal overweight (BMI>23)	39% (BDHS 2014)	30%	24% (MICS 2019)	
Increase the proportion of children aged 6-23 months receiving a Minimum Acceptable Diet (MAD)	23% (BDHS 2014)	>40%	29% (BDHS 2022)	
No increase of childhood overweight (WHZ >+2) among children under 5 years	1.40%	No increase	1.5% (BDHS 2022)	
Reduce the rate of anaemia among pregnant women	50% (BDHS 2011)	25%	28.9% (NMS 2019-20)	NA
Reduce the rate of low birth weight	23% (National LBW Survey 2016)	16%	14.8% <sup>22</sup> (MICS 2019)	NA
Reduce malnutrition (Total Thinness, BMI<18.5) among adolescent girls (15-19yrs)	19% (BDHS 2014)	<15 %	18% (SFNS, 2022)	NA

### LEGEND

On track	Off track	Not Available (NA)
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<sup>21</sup> National Micronutrient Iodization Survey

<sup>22</sup> The values here are as recorded on card or as reported by respondent. The total crude low birth-weight typically requires adjustment for missing birth-weights, as well as heaping, particularly at exactly 2,500 grams. The results presented here cannot be considered to represent the precise rate of low birth-weight (very likely an underestimate) and therefore not reported as a MICS indicator.

## Update on priority nutrition indicators

To achieve the agreed upon targets a few output level indicators are used to assess the progress of monitoring framework of NPAN2 2016-2025 and monitor them intensively. Data supporting these indicators would be gathered/collected through periodic surveys and from routine program administrative data, for example, the Bangladesh Demographic and Health Survey (BDHS) undertaken by the National Institute & Evaluation Matrix. Total 25 priority indicators were identified and selected based on nutrition status and priority. Information is collected from different valid sources like, Bangladesh Demography and Health Survey, Multiple Indicators Cluster national-level Survey (MICS), Household Income and Expenditure Survey, etc. These priority indicators are used by both program managers and stakeholders.

It is evident from the Table-2 that 11 out the 25 priority indicators made progress compared to their baseline status during the reporting period. Some of the indicators made a substantive progress while some others made marginal progress. Those indicators made substantive and marginal progress are:

i) reduced stunting among children (9 percentage points); v) diarrhoea treated with ORT and Zinc (5.6 percentage points); vi) adolescent girls (15-19 yrs.) with height <145 cm (8.5 percentage points); vii) adolescent girls (15-19 yrs.) thin (total thinness) (11 percentage points); viii) women (20-24 yrs) who have begun childbearing (3 percentage points); ix) increase in per capita consumption of vegetables (1.2 percentage points); x) share of total dietary energy from consumption of cereals (6 percentage points); xi) women age 20-24 who were first married by age 18 (8 percentage points); xii) children (36-59 m) who are attending an early childhood education program (5.9 percentage points); xiii) women who completed secondary/higher education (3 percentage points); xiv) change in per capita consumption of sugar (1 percentage point). Of the total one indicator (adolescent girls (15-19 yrs.) with height <145 cm) has already achieved the NPAN2 target of <8%.

However, some targets indicators are shown less progress compared to their baseline and previous progress. Those indicators are: i) initiation of breastfeeding in the first hour of birth (reduce 20 percentage points); ii) % of children (0-6m) exclusively breastfed (reduce 7 percentage points); iii) reduced wasting among children (increase 2 percentage points);

Four targets remained unchanged compared to their baseline, which are: i) Percentage of infants born with low birth weight (<2,500 grams); ii) children under age 5 are underweight; iii) Women 15-49 yrs. with Anaemia; iv) caregivers with appropriate hand washing behaviour. Another four indicators have deteriorated compared to their baseline status, which are: i) Children under 5 years who are overweight; ii) women 15-49 yrs who are overweight or obese (BMI  $\geq 23$ ); iii) % of population that use improved sanitary latrine (not shared); ix) population that use improved drinking water; v) per capita consumption of fruits. No update was available for three indicators. Please note these three indicators need to be changed in future.

**Table 2.** Current Status of 25 Priority Indicators of NPAN2 2016-2025

SL.	Indicators	NPAN2 Target 2025	Baseline of NPAN2 2016	Current Status	Previous status
1	Increase the initiation of breastfeeding in the first hour of birth	80%	51%	40% (BDHS 2022)	69% (BDHS 2017-18)
2	% of children (0-6m) exclusively breastfed	70%	55%	55% (BDHS 2022)	65% (BDHS 2017-18)
3	% of children (6-23 m) receiving (MAD)	40%	23%	29% (BDHS 2022)	35% (BDHS 2017-18)

SL.	Indicators	NPAN2 Target 2025	Baseline of NPAN2 2016	Current Status	Previous status
4	Percentage of infants born with low birth weight (<2,500 grams)	16%	23%	NA	14.8% MICS (2019)
5	Reduce Stunting among under-5 children	25%	36%	24% (BDHS 2022)	31% (BDHS 2017-18)
6	Children under 5 years who are wasted	<8%	14%	11% (BDHS 2022)	8% (BDHS 2017-18)
7	Children under 5 years who are overweight	1.40%	1.40%	1.5% (BDHS 2022)	2.40% (MICS 2019)
8	% of Women 15-49 yrs. with Anaemia	<25%	42%	28.9% (NMS 2019-20)	28.9% (NMS 2019-20)
9	% of children under 5 with diarrhoea treated with ORT and Zinc	Not yet fixed	38%	43.3% (BDHS 2022)	43.60% (BDHS 2017-18)
10	% of women 15-49 yrs who are overweight or obese (BMI $\geq$ 23)	30%	24%	39% (BDHS 2014)	39% (BDHS 2014)
11	% of adolescent girls (15-19 yrs.) with height <145 cm	<8%	13%	4.51% SFNS (2022)	4.51% SFNS (2022)
12	% of adolescent girls (15-19 yrs.) thin (total thinness)	<15%	29%	18% SFNS (2022)	18% SFNS (2022)
13	% of women (20-24 yrs) who have begun childbearing	10%	31%	28% (BDHS 2017-18)	28% (BDHS 2017-18)
14	% of population that use improved drinking water	>99%	98%	98.50% (MICS 2019)	98.50% (MICS 2019)
15	% of population that use improved sanitary latrine (not shared)	75%	45%	59% (BDHS 2022)	43% (BDHS 2017-18)
16	% of caregivers with appropriate hand washing behaviour	50%	27%	27% (FSNSP 2014)	27% (FSNSP 2014)
17	Per capita consumption of fruits and vegetables	$\geq$ 400g per day	Fruits: 44.7 gm Vegetables: 166.1 gm	Fruits: 95.4 gm (HIES 2022) Vegetables: 201.9 gm (HIES 2022)	Fruits: 35.78 gm Vegetables: 167.3 gm (HIES 2016)
18	% share of total dietary energy from consumption of cereals	<60%	70% (HIES 2010)	30.54% (HIES 2022)	HIES
19	% of women age 20-24 years who were first married by age 18 yrs	30%	59%	51.40% (MICS 2019)	51.40% (MICS 2019)
20	Number of Social Safety Net Programs which incorporated nutrition sensitive & nutrition specific objectives	50%	10% (assumption)	15% (assumption)	10% (assumption)
21	Number of upazilas covered under VGD program to provide nutritionally enriched fortified food	50%	Nil	189 Upazilas (WFP 2019)	189 Upazilas (WFP 2019)
22	% of children (36-59 m) who are attending an early childhood education program	30%	13%	18.90% (MICS 2019)	18.90% (MICS 2019)
23	% of women who completed secondary/higher education	90%	14%	32% (BDHS 2022)	17% (BDHS 2017-18)
24	Number of ongoing comprehensive coordinated multisectoral, multichannel advocacy and communications campaign	10	NA	NA	
25	Change in per capita consumption of:				
	i. salt				
		i. <5 gm/ person/day (WHO)	i. Salt: not available	i. Salt: 25.37 gm/ person/day (HIES 2022)	i. Salt: not Available
	ii. sugar consumption	ii. <10% of total energy intake	ii. Sugar: 7.4 (gm/capita /day)	ii. Sugar: 11.64 (gm/capita /day) (HIES 2022)	ii. Sugar: 6.9 (gm/capita /day) (HIES 2016)

## Progress by Thematic Area

### Thematic Area 1: Nutrition for all following the Life Cycle Approach

#### Overall Progress IYCF in Bangladesh during the reporting period

##### Infant and Young Child Feeding practices

Infant and young child feeding (IYCF) practices include early initiation of breast milk, exclusive breastfeeding, introduction of timely feeding of solid or semi-solid foods at the age of six months, and increasing the amount and varieties of foods and frequency of feeding as the child gets older, while maintaining frequent breastfeeding.

Appropriate IYCF practices are based on three feeding practices:

- Continued breastfeeding or, if not possible, feeding of milk or milk products
- Feeding of semi-solid or solid foods at mealtimes with additional snacks
- Feeding a diverse diet.

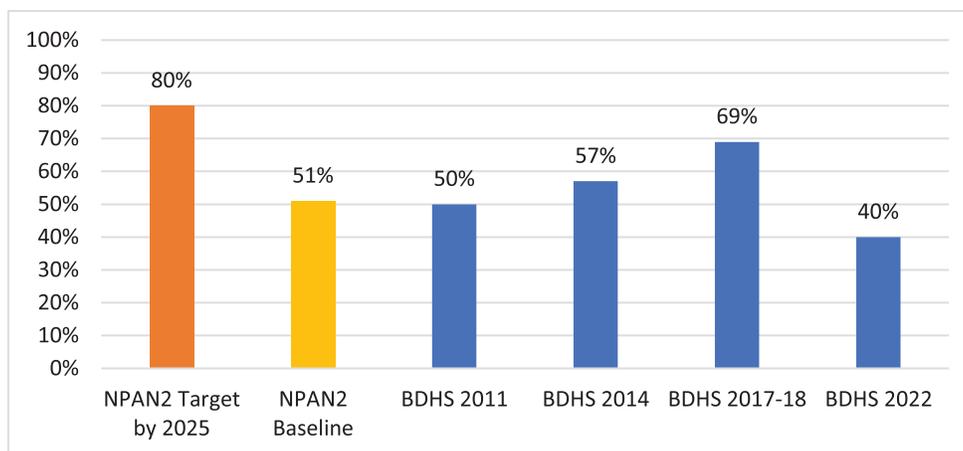
Though the exclusive feeding practices has improved at current 65% (BDHS, 2017-18) however, unsatisfactory progress especially in complementary feeding and feeding a diversified diet which among others are the important determinants of childhood under-nutrition in Bangladesh. Stunting can be prevented when appropriate IYCF practices are adopted, and children are protected from infection. The data shows that progress on IYCF practices has been mixed from different nationally representative surveys and is not up to the required level, especially for the Minimum Acceptable Diet (MAD).

##### Status of Early Initiation of Breast Feeding (EIBF)

Early Initiation of Breastfeeding (EIBF) is referred to as initiation of breastfeeding within one hour of birth. Data presented in Figure-4 clearly shows improvement in EIBF over the four years: 50% in 2011, from 57% in 2014 to 69% in 2017-18 which has dropped to 40% in 2022 (BDHS 2022). With the current rate of improvement as demonstrated by the BDHS report, the country is on off track to achieve the NPAN2 target of 80% by 2025. This status is probably attributable to less practice and awareness on initiation of breastfeeding within one hour of birth. Therefore, need to improve the ANC services, proper implementation of the Bangladesh Breast milk Substitutes Act<sup>23</sup>, functionality of Baby-Friendly Hospital Initiative (BFHI), increase the Maternity and Lactating Allowance Programs, etc. supported by Social Behaviour Change Communication (SBCC).

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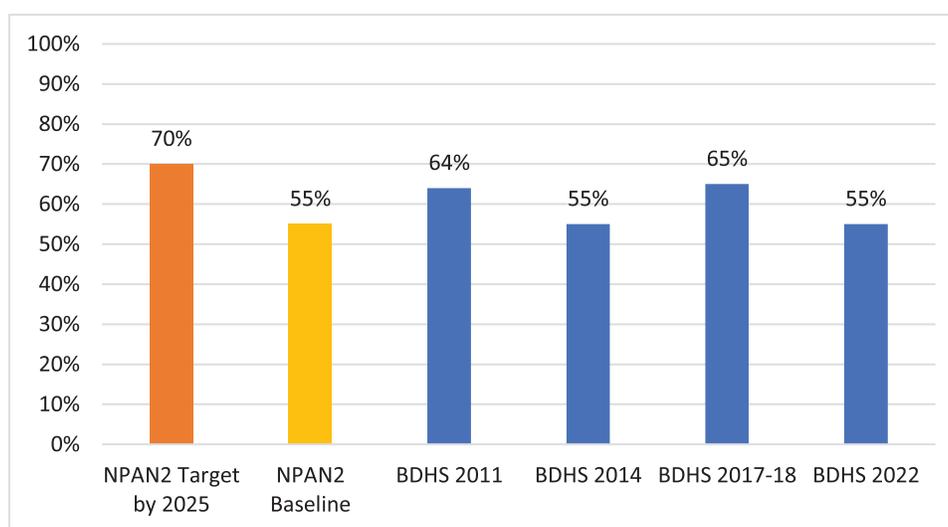
<sup>23</sup> Breast Milk Substitute (BMS) Act 2013



**Figure 4:** Trends of early initiation of breast feeding among children aged 0-5 months compared to the NPAN2 target [Source: BDHS report]

### Trends in Exclusive Breastfeeding Practices

Breast milk is uniquely tailored to meet all the nutritional needs of human babies for the first six months of life and is thus the best source of nutrition for new-born babies. In Bangladesh, the Exclusive Breastfeeding (EBF) rate has ups and downs from 64% in 2011 to 55% in 2022 (BDHS report) in Figure 5. As per BDHS Report, despite a fall in EBF rates from 64% in 2011 to 55% in 2014, the rate rebounded to 65% in 2017-2018. However, in 2022 the current rate of progress has declined to 55% which indicate the indicator is off track to achieve the NPAN2 target of 70% by 2025.



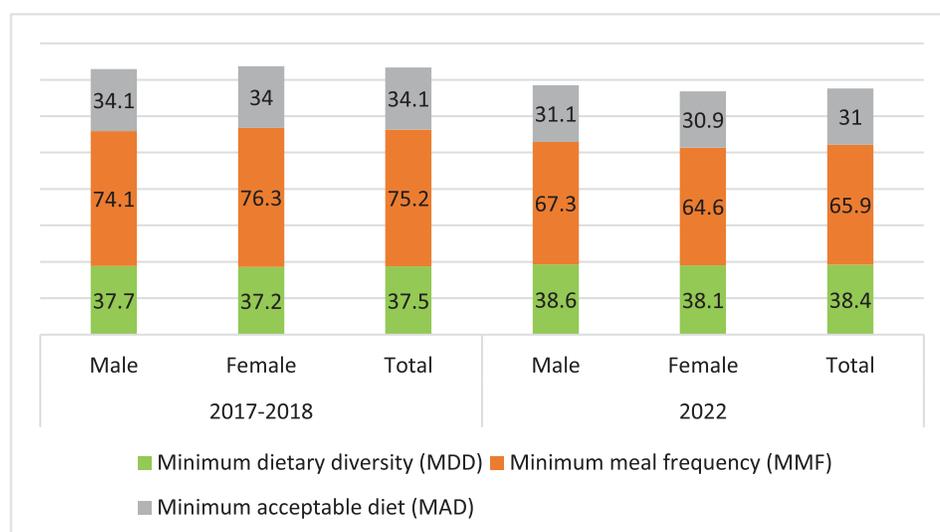
**Figure 5:** Trends in exclusive breastfeeding practices among children aged 0-5 months along with NPAN2 target [Source: BDHS report]

### Trends in complementary feeding practices

Minimum dietary diversity means feeding a child food from at least four different food groups. This cutoff was selected because it is associated with better-quality diets for both breastfed and non-breastfed children.

Meal frequency is considered a process for energy intake from foods other than breast milk; therefore, the feeding frequency indicator for non-breastfed children includes both milk feeds and solid/semi-solid feeds (WHO 2008). Minimum feeding frequencies are based on energy needs from complementary foods estimated from age-specific total daily energy requirements. Infants with low intake of breast milk would need to be fed more frequently.

BDHS findings, as depicted in Figure 6, show that among breastfed children aged 6-23 months, all three indicators—minimum dietary diversity (MDD), minimum meal frequency (MMF) and minimum acceptable diet (MAD)—in both male and female children have increased in 2017-18 compared to 2022. MDD has increased from 37.5% to 38.4%, MMF has decreased from 75% to 70%, and MAD has decreased from 34% to 31% between 2017-18 and 2022 respectively.



**Figure 6:** Trends of three indicators (e.g.MDD, MDF and MAD) in % among male and female children age 6-23 months between 2022 and 2017-18 (BDHS). [Source: BDHS report]

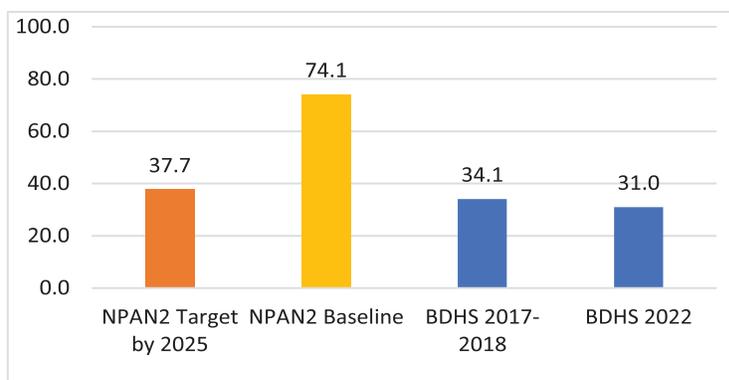
MICS 2019 findings on these three indicators were lower compared to BDHS 2017-18 findings in Table 3.2. This could be due to methodological differences among the two surveys.

**Table 3:** Level of MDD, MDF and MAD among children aged 6-23 months reported in MICS 2019

	Male	Female	Total
Minimum dietary diversity (MDD)	36	33.1	33.8
Minimum meal frequency (MMF)	64.6	64.6	64.6
Minimum Acceptable Diet (MAD)	29.2	26.4	27.8

### Minimum Acceptable Diet

Appropriate nutrition for infants and young children includes feeding children with a variety of foods to ensure all required nutrients are met through feeding. Figure 7 shows infant and young child feeding (IYCF) practices for young children aged 6-23 months. The indicator is a composite of minimum diet diversification and minimum meal frequency. It takes into consideration the age of the child in months and the status of breastfeeding based on WHO guidelines (WHO, 1998).



**Figure 7: Percentage of children 6-23 months fed with Minimum Acceptable Diet (MAD) [Source: BDHS report]**

According to BDHS 2022 results, twenty-nine percent of children age 6–23 months were fed a minimum acceptable diet according to IYCF recommendations. The target of the 4th HPNSP is to increase the proportion of children fed a minimum acceptable diet to 45% by 2023.

However, BDHS 2022 findings indicated that 31% of children aged 6-23 months were consuming a minimum acceptable diet (MAD) compared to 34% reported in BDHS 2017-18. With the current rate of progress (2.5 percentage point per year, according to BDHS report), it is probable that the NPAN2 target of 40% by 2025 will be surpassed. The evident improvement in MAD might be due to intensive mass media campaigns over the years together with effective program implementation on the part of the government and implementing partners.

Adherence of sticking to the recommendations of IYCF practices increases with the child’s age, mother’s educational level and socioeconomic status.

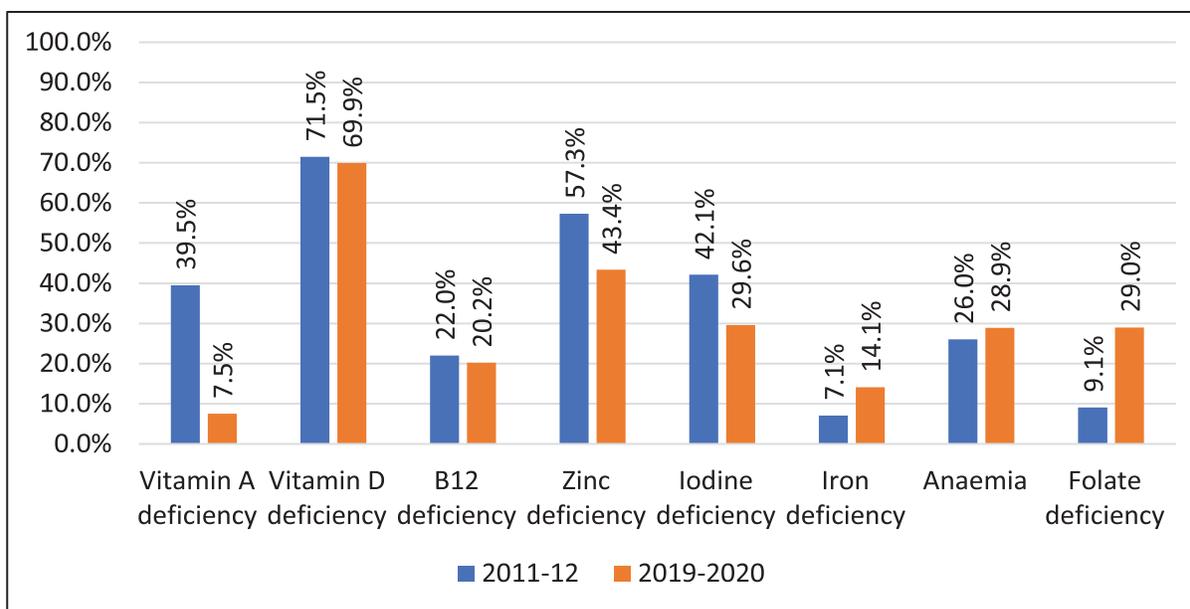
IYCF practices are followed more in urban areas (34%) than rural areas (27%), with the highest ICYF rate seen in Khulna division (45%), and the lowest in Sylhet (19%) and Chattogram (20%). The improvement is evident across all wealth quintiles, however, improvement in the richest quintile has doubled (43%) compared to only 22% in poorest quintile (BDHS 2022 report). NPAN2 targets for minimal acceptable diet by 2025 is 40% for under-five children. Although the NPAN2 target has already been achieved in the richest quintile (43%), it is evident that accelerated improvement is required among poor populations to meet NPAN2 targets at population level. Given the importance of the quality of complementary food (in terms of diversification and nutritional adequacy) in reducing childhood malnutrition, even if the NPAN2 target is met, it is assumed that it would be insufficient to meet the need to achieve the stunting target.

## Micronutrient Malnutrition

### Overall progress of the micronutrient malnutrition in the country

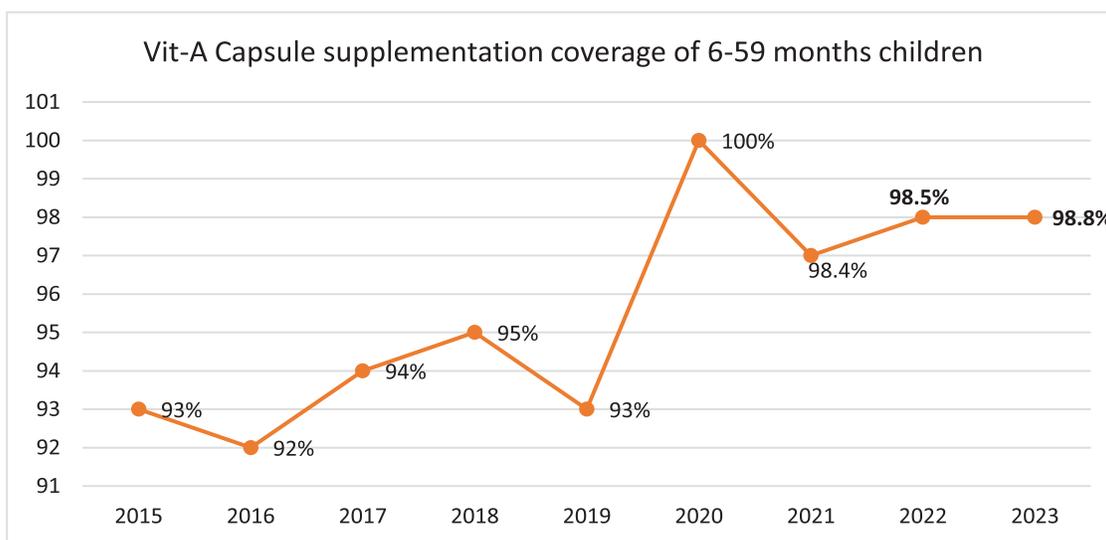
There has been a significant progress in reducing the prevalence of Vitamin A and Iodine Deficiency Disorders (IDD) among children and women of reproductive age. As seen in Figure 8, among children all form of micronutrient deficiencies except Iron deficiency have improved between 2011-12 and 2019-20. No deficiency of Vitamin E was detected<sup>24</sup>. During the same period among non-pregnant and non-lactating women (15-49 years), except Iron & Folate deficiencies and Anaemia, similar trend of improvement of micronutrient deficiencies were also observed (see Figure. 8).

<sup>24</sup> National Micronutrient surveys 2011-12 and 2019-20.



**Figure 8.** Micro-nutrient status among non-pregnant and non-lactating (NPLP 15-49 years)

Based on administrative data it is evident that, Bangladesh's bi-annual Vitamin A supplementation program has maintained high coverage over time in achieving 98.8% in 2023 for children aged 6-59 months. The administrative coverage of the first round of vitamin A supplementation to children aged 6-59 months was 98.6% (20,523,925 children); coverage of children aged 6-11 months was 97.7% (2,420,573 children); and coverage of children aged 12-59 months was 98.3% (18,103,352 children). In Sylhet the coverage was low at 81.3% among children aged 6-59 months and 82.9% among children 12-59 months.



**Figure 9:** Status of vitamin A supplementation [Source: National Nutrition Services (NNS)]

Mother's education and wealth status increased the chances of children receiving VAS. The coverage increases progressively with each successive grade of education of mothers. For example, children from mothers with no education had VAS coverage of 72%, compared with 77% children from mothers who completed primary education, and 85% children from mothers who completed secondary education. Children from the lowest wealth quintile had 79% VAS coverage compared to 83% from wealthiest quintile.

Anaemia continues to present a major challenge among women and children. The prevalence of Anaemia among non-pregnant and non-lactating (NPNL) women was 29% in 2019-20, up from 26 % in the earlier nationally representative survey (NMS, 2011-12). Prevalence of Anaemia among total preschool age children was 33.1%, and 37% and 22.8% in the rural and urban strata respectively. The prevalence of Anaemia in school age children was 19.1% in children aged 6-11 years and 17.1 % in children aged 12-14 years. The prevalence appeared to be lower than the earlier nationally representative estimates of the country (children 47%, and women 33%, NSP 2001). It is possible that this is due to the difference in the assessment methods.

In Bangladesh, the magnitude of Anaemia among children younger than five years is high, with a range that varies from 33% to 51%, according to two nationally representative surveys. Iron deficiency was thought to be the primary cause of Anaemia in the Bangladesh population and thus, a national policy for its prevention recommended iron supplementation, i.e., micronutrient powder (MNP) containing iron, for children aged 6-23 months. Consequently, the MNP supplementation (containing 12.5 mg of iron) programs have been operational for decades to prevent Anaemia in infants and children from 6 to 59 months old. Nevertheless, the coverage of the MNP program is suboptimum, and compliance is poor because of iron-related side effects such as diarrhoea, nausea, and vomiting.

Iron supplementation is associated with side effects and thus reduces the intake compliance. Because it has fewer side effects, a recent trial recommended low-iron micronutrient powder (MNP) for the prevention of Anaemia in Bangladeshi children exposed to a high concentration of iron from drinking groundwater. In the present study, we hypothesize that the low-iron MNP is a potential intervention to prevent childhood Anaemia in the low groundwater-iron settings in Bangladesh.

To address the issue of pervasive Anaemia, the National Strategy on Prevention and Control of Micronutrient Deficiencies, Bangladesh (2015-2024) emphasizes the promotion of food based dietary guidelines and food fortification in addition to Iron and Folic Acid (IFA) supplementation for targeted vulnerable groups including pregnant and lactating women and adolescent girls (weekly IFA supplementation); and Micro-nutrient Powder (MNP) for children aged 6-23 months.

## Management of Acute Malnutrition

### Overall progress of the management of Severe Acute Malnutrition (SAM) in the country

Management of Moderate Acute Malnutrition (MAM) and Severe Acute Malnutrition (SAM) as per standard guidelines through in-patient or out-patient management are included in the strategic actions. Activities to support the program include establishment of community-based programs, review and updating of guidelines, training of health workers, timely reporting, regular supply of therapeutic formulas at facilities for treating SAM, strengthening of nutrition counselling services (including cooking demonstrations), adequate nutritional support to the SAM/MAM children, and targeting of acutely undernourished Pregnant and Lactating Women (PLWs) through various programs under MOHFW and other sectors including Social Protection Programs (SPPs). Compared to January 2021, proportion of children screened in IMCI-Nutrition corners was increased from 61% to 84% in June 2022 and this is highest percentage of screening in IMCI-Nutrition corner. SAM admission has increased to 918 from 811 in compared to last month. Present admission rate also increased 62% (January 2022). In January 2022, The IFA distribution coverage has increased to 266,989 from 252,844 (Figure 11.a). From the month of October 2021, the caregiver of counselling coverage has decreased to 404,738 from 406,914 [Source DHIS2]. Before COVID lockdown in 2021, the admission rate was 94% (in April'21) but this decreases to around and over 44% in August. In 2022 it has increased to 62%. It is set the target for SAM admission at 14,000 children in 2022. In January 2022, we have already reached 918 which is 7% of set target [Data Source DHIS2]

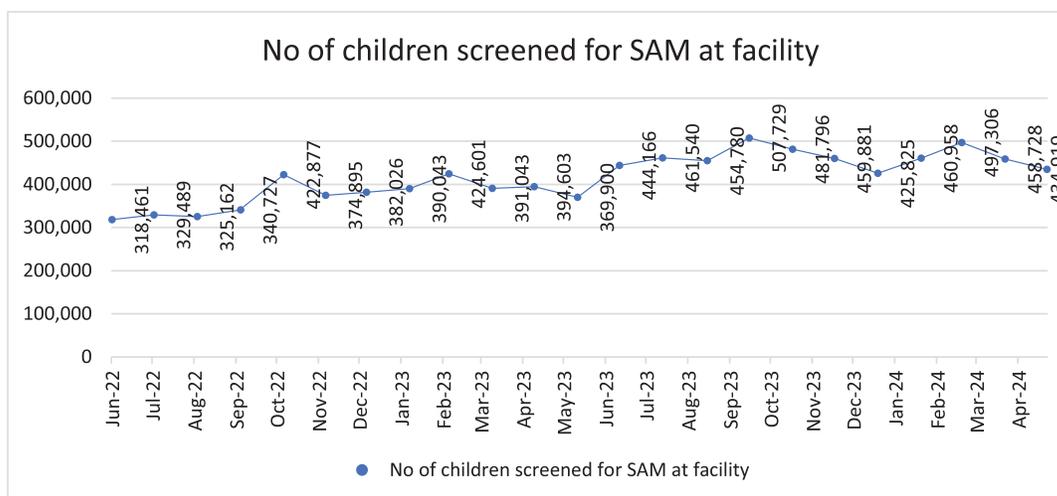


Figure 10.a: Status of maternal nutrition provided by national nutrition programs

## Maternal Nutrition and reducing Low Birth Weight (LBW)

### Overall progress of maternal nutrition and reducing Low Birth Weight in the country

Pre-pregnancy, pregnancy and the postnatal period are critical times for ensuring the health and wellbeing of women and their babies. Childbearing frequently begins during adolescence, contributing to poor maternal nutritional status and birth outcomes, including high levels of low birth weight and neonatal deaths. The low-birth weight rate is still high though it has reduced from 36% in 2003-2004 to 23% in 2016 to 14.8 % in 2019 (MICS).

Women are triple hit by undernutrition, micronutrient deficiencies and overweight & obesity. Between 2004 and 2014, there has been a shift in Body Mass Index (BMI) of Bangladeshi women of reproductive age (15-49 years). Prevalence of underweight status remained high in rural areas and prevalence of overweight increased rapidly in both rural and urban areas, creating a double burden. Chronic Energy Deficiency (CED) rate among mothers (20-59 years) with BMI less than 18.5 has decreased from 52% in 1996-97 to about 30% in 2007, which has further reduced to 11% (a 19 percent point reduction) in 2018-19 (SFSN,2018-19). At 29% undernutrition in Sylhet is strikingly higher than any other divisions in the country, and 18% higher than the national average of 11%.

On the other hand, nationally on average the overweight and obesity among women were higher compared to the underweight. Nationally, overweight among women was 49%, which was more at 32% among non-slum, 22% in slum and 13% in rural women. In addition, 24.2% in rural, 22.9% among non-slum and 19.4% in slum women were hypertensive. About 4% women had self-reported diabetes. The significant contributors to this double burden were the change in women's level of education, increased household wealth, divisional location, and rapid urbanization<sup>25</sup>.

Micronutrient deficiencies are common among women of reproductive age. As seen in Figure 5 that between 2011-12 and 2019-20, while Vitamin A, Vitamin D, B12, Zinc and Iodine deficiencies have improved, but the Iron and Folate deficiencies and Anaemia have increased during the same period. Maternal anaemia during pregnancy has serious consequences for both mother and new-born, including increased risk of becoming low birth weight and preterm birth, as well as high risk of maternal and

<sup>25</sup> Raaj Kishore Biswas, Nusma Rahman, Rasheda Khanam, Abdullah H Baqui and Saifuddin Ahmed, Double burden of underweight and overweight among women of reproductive age in Bangladesh

perinatal morbidity and mortality. Iron requirements increase substantially during pregnancy and it is difficult to meet these needs from food sources alone. Iron Folic Acid (IFA) supplementation is an important intervention to overcome anaemia, especially during pregnancy. However, only 11 percent of pregnant adolescent girls under 18 years of age received all required 100 IFA tablets, and just 1.8 percent of pregnant women under 18 received and consumed all 100 IFA tablets<sup>26</sup>.

Low quality of diets among women due to low intake of micronutrient-rich foods and low diet diversity are common underlying causes of maternal malnutrition. Women achieving minimum dietary diversity (MDD-W) during pregnancy though increased but still remains much below the NPAN2 target of 70% by 2025. The differences in MDD-W were observed, for example, MDD-W from slum women was 37%. The women from Sylhet Division had the lowest MDD-W compared to 61% in Rajshahi.

Women who do not receive clinical ANC have significantly greater odds of miscarriage compared to those who visit a clinic for ANC check-up during the first trimester<sup>27</sup>. As per BDHS 2022 report, overall, 88% of women with a birth in the 2 years preceding the survey received ANC from a medically trained provider at least once during their pregnancy. Also, women in rural areas are less likely to seek ANC than women in urban areas (95% versus 92%). Ninety-seven percent of women in the highest wealth quintile sought ANC from a medically trained provider, as compared with 76% of women in the lowest wealth quintile. Four of 10 women (41%) had the recommended four or more ANC visits during their pregnancy. Women in urban areas (57%) were more likely to have four or more visits than women in rural areas (35%).

Among mothers with at least one ANC visit, more than 90% had their blood pressure and weight measured; 80%, 81%, and 94% had a blood test, urine test, and ultrasound, respectively; 50% received information on danger signs during pregnancy; and 27% received information on postpartum family planning.

Eighty-eight percent of women Antenatal care from a skilled provider. However, there are still gaps in the quality of ANC received according to women's background characteristics. For example, women in urban areas are received Antenatal care from a skilled provider as women in rural areas (92.3% versus 85.9%). Only 8% of women in the lowest wealth quintile receive quality ANC, compared with 39% of women in the highest quintile.

**Table 6:** Proportion of women receiving antenatal care visits

Number of ANC visits	Urban	Rural	Total
Received any ANC	95.4	91.5	92.6
None	4.6	8.5	7.4
1	8.2	16.9	14.6
2	13.1	21.5	19.3
3	17.1	18.6	18.2
Received 4 or more ANC	56.9	34.5	40.5
Percentage receiving Antenatal care from a skilled provider	92.3	85.9	87.6
Number of women	970	2,640	3,610

Source: BDHS 2022 report

<sup>26</sup> Multiple Indicators Cluster Survey (MICS), 2019

<sup>27</sup> FAO. Guidelines for measuring household and individual dietary diversity.

## Progress in Maternal Nutrition and LBW program indicators (NPAN2) during the reporting period

Since data included in Table 6 are primarily derived from administrative data received from various programs, therefore, they may not exactly match with the information provided in Table 6 above, which are primarily from national surveys. Five indicators in Box-1 show trends in ANC services, nutrition counselling and weight measurement of children attending at health facilities between 2016 and 2019. The proportion of women who received four or more ANC check-ups gradually increased from 31% in 2016 to 37% in 2018 and 52% in 2019. 43% of rural women received iron-folic acid supplementation (IFA) from facilities in 2019 compared to 33% in 2016. In 2019, at the national level, about 21% of women were weighed during ANC check-ups at facilities. Between 2016 and 2019, 15% to 19% of mothers received counselling on nutrition care including child feeding practices through integrated management of childhood illness (IMCI) programs, and at every visit of the sick child to a health care facility. It is also reported that the weighing of children (aged 0-23 months) was very low, ranging from the lowest at 7% in 2017 to the highest at 11% in 2019. Table 6 clearly demonstrates that the overall coverage of all five process indicators except indicator 1 (women who received 4+ ANC) has been very low without visible improvements since 2016.

### Progress of Indicators

Box-1: Progress of the indicators

**Indicator 1: % of pregnant women who received 4+ ANC** has increased steadily from 31%, 35%, 37%, 52% and 41% in 2016, 2017, 2018, 2019 and 2022 respectively. Marked increase was observed in 2019.

**Indicator 2: % of children 0-23 months old whose weight was taken at a facility** has increased marginally from 9% in 2016 to 11% in 2019.

**Indicator 3: % of visits with pregnant women who received any IFA-** has also increased from 33% in 2016 to 43% in 2019. It was revealed from Priority Nutrition Report Indicator (NNS, 2022) that total number of PLWs received IFA from facilities has decreased from 296,778 in January 2020 to 272,065 in March 2022 (about 8% decrease).

**Indicator 4: % of times women who attended ANC check-ups during pregnancy were weighed-** has increased marginally from 17% in 2016 to 21% in 2019. However, from NNS's report on PNRI showed that the rate has increased impressively from 62% in January 2020 to 98% in March 2022.

**Indicator 5. % of women receiving maternal nutrition counselling** has also increased marginally between 2016 and 2019, from 15% to 19% respectively. However, from NNS's report on PNRI indicated that the total number of PLWs receiving counselling on nutrition during visit in facilities reduced from 548,711 in January 202 to 440,781 in March 2022, which is about 20% reduction.

**Table 7: Status of process indicators related to maternal nutrition (2022 to 2023).**

<i>Output indicators</i>	<i>2022</i>	<i>2023</i>	<i>Source</i>
1.% of visits with pregnant women who received any IFA	<b>53%</b>	<b>62%</b>	DHIS2, DGHS
2.% of times women who attended ANC check-ups during pregnancy were weighed	<b>51%</b>	<b>52%</b>	DHIS2, DGHS
3.% of women receiving maternal nutrition counselling	<b>52%</b>	<b>52%</b>	DHIS2, DGHS
SAM Admission	<b>55%</b>	<b>62%</b>	DHIS2, DGHS

## Adolescent nutrition

As observed by the NPAN2, adolescence is a critical period in the life cycle because of rapid growth and preparation for adulthood and high rate of malnutrition specifically among adolescent girls, and low program coverage demands urgent attention and actions. The NPAN2 prioritizes promotion of adolescent nutrition and healthy lifestyle through formal and informal academic curricula and training programs. Health seeking behavior of adolescents, young/teenage couples are planned to be enhanced through facility and community-based approaches.

### Progress in Adolescent Nutrition program indicators (NPAN2) during the reporting period

**1. % of adolescent girls (15-19 yrs) with height <145 cm**-in 2022 4.5% of the adolescent girls aged 15-19 years had height <145 cm. It has improved from 5.2% in 2018-19 to 4.5% in 2022. It is observed that the NPAN2 target of <8% by 2025 has already been achieved. Nonetheless, low height among early adolescent period (aged 10-18 years) was height at 30.9% and remained unchanged from 2018-19 findings<sup>28</sup>.

**2.% of adolescent girls (15-19 yrs) thin (total thinness)**- The status of total thinness among adolescent girls (15-19 yrs) has also improved from 20% in 2018-19 to 18% in 2022 against the NPAN2 target of less than 15% by 2025.

**Table 8: Indicators included in NPAN2 related to Adolescent**

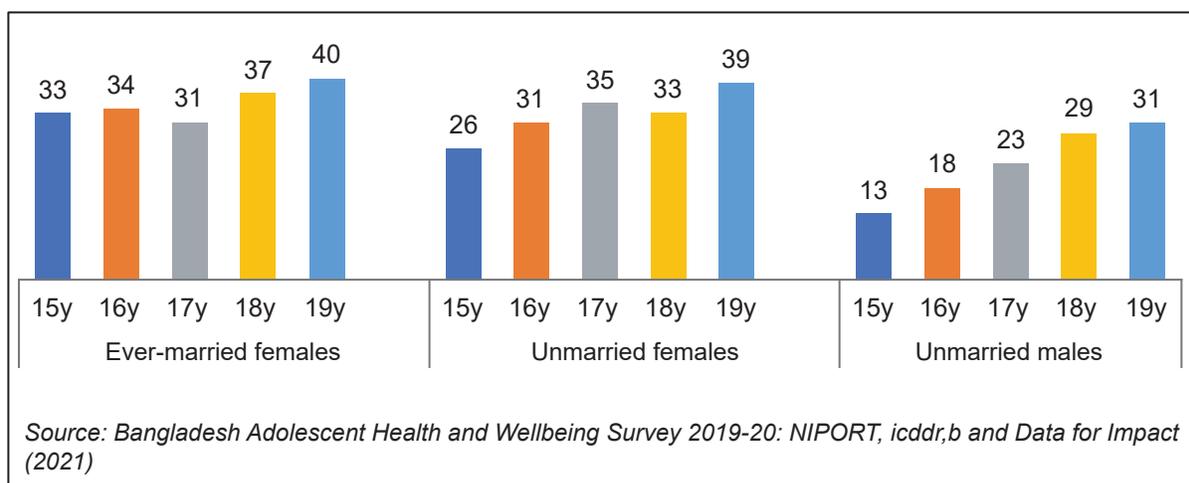
Indicator	Baseline	Current status	Target 2025
1. % of adolescent girls (15-19 yrs) with height <145 cm	13% (BDHS 2014)	4.51% (Nutrition Assessment 2022)	<8%
2.% of adolescent girls (15-19 yrs) thin (total thinness)	19% (BDHS 2014)	18% (Nutrition Assessment 2022)	<15%

### Progress in activities related to adolescent health and wellbeing in different sectors during the reporting period during the reporting period

NPAN2 also recommends that other sectors also need to plan to provide training (with modules) on adolescent nutrition to the relevant stakeholders (school teachers, school management, community etc.) and to incorporate and strengthen nutrition education programs into agriculture extension services, with a special focus on the first 1000 days and adolescent girls.

Female adolescents were stunted more than males. On average one-third of the female adolescents (36% of ever-married and 32% of unmarried) were stunted, compared to one-fifth (22%) of unmarried males (NIPORT-icddr'b-Data for Impact 2021). It is evident that with the age increases stunting also increases (Figure 11).

<sup>28</sup> Bangladesh Multiple Indicator Cluster Survey (MICS) 2019

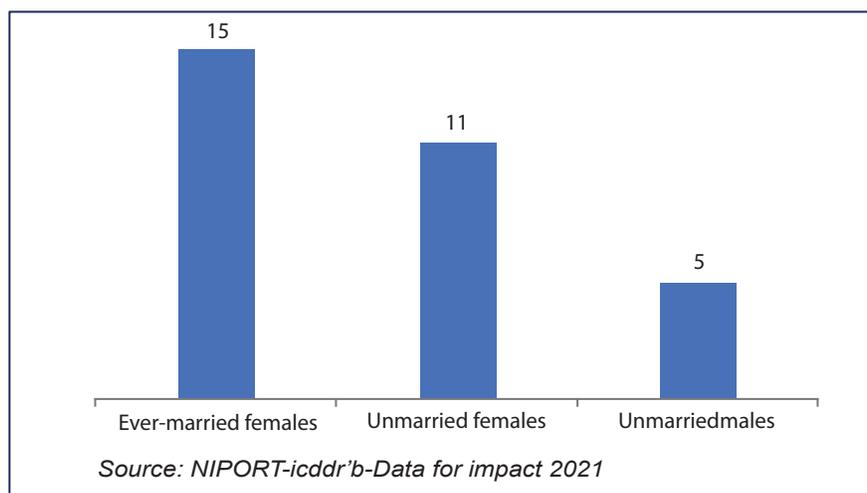


**Figure 11:** Percentage of adolescents ages 15-19 who are stunted, by age

### Mental health situation

A considerable portion of adolescents in Bangladesh experience depressive symptoms. *Bangladesh Adolescent Health and Wellbeing Survey 2019-20* reveals that female adolescents were more likely to have major depressive disorder than males; 15% of ever-married females, 11% of unmarried females, and 5% of unmarried males had major depressive disorder.

For all three adolescent groups—ever-married females, unmarried females, and unmarried males—the likelihood of having major depressive disorder decreased with increased educational attainment. The survey further explores that the proportions of ever-married females, unmarried females, and unmarried males reporting major depressive disorder were higher among those with higher levels of connectedness with friends. This pattern was particularly notable among ever-married adolescents. (NIPORT-icddr'b-Data for Impact 2021).



**Figure 12:** Percentage of adolescents ages 15-19 years with major depressive disorder, Bangladesh

### Department of Women Affairs (DWA), Ministry of Women and Child Development

DWA formed country wide Adolescent Club (Kishore-Kishori Club), which is the Forum of marginal adolescents. Its main objectives include prevention of child marriage, prevention of gender-based violence, and uphold Sexual and Reproductive Health and Rights of adolescents. Each club composed of 20 girl and 10 boy members. So far, all Unions of the country (4553) and all Pourashova (330) are having total 4883 adolescent club (Kishore-Kishori Club). Total beneficiary being 146,490.

Prevention of child marriage, gender-based violence, sexual violence, drug addiction, HIV/AIDS, women and child trafficking, dowry, eve teasing; reproductive health and rights, birth registration, marriage registration, women's right, gender inequity, child's right, family planning, legal assistance, personal safety etc. are included in its activities.

## Water, Sanitation and Hygiene (WASH)

### WASH-Nutrition linkages

WASH is closely associated with level of health and nutrition status. For instance, 9.3% of deaths and 7.4% of burden of disease are attributable to unsafe WASH in children under 5 years<sup>29</sup>, constituting 8.8% of all disability-adjusted life years (DALYs) in this age group<sup>30</sup>. Children are more likely to be undernourished and stunted if they are exposed to Faecally-Transmitted Infections– including diarrhoeal disease and Environmental Enteropathy – or intestinal worms, which are linked to poor WASH and open defecation<sup>31</sup>. Repeated parasitic infections can result in anaemia and inhibit physical and cognitive development.

A 20-year multi-country analysis revealed that, five or more diarrhoeal infections in the first 2 years of life accounted for 25% of all stunting observed (Checkley, et al., 2008). Moreover, every five diarrhoeal episodes increased stunting risk by 13% (Checkley, et al., 2008). Repeated episodes of diarrhoea or intestinal worm infections due to unsafe water, inadequate sanitation or insufficient hygiene are associated with half of all malnutrition cases globally<sup>32</sup>. Diarrhoea, in particular, is a leading cause of death of children under 5 years worldwide, and its constant presence in low-income settings contributes significantly to undernutrition<sup>33</sup>.

Although the coverage in both water and sanitation is high however, the quality of both services has been a concern, especially in urban slums. Although all improved drinking water sources should provide safe drinking water, this is not always the case. For instance, approximately 82% of the households' drinking water was contaminated with E. Coli (CWS, 2016). The process of water collection and storage itself further creates contamination. Only 25% of households in slum and non-slum areas used a proper water treatment method for drinking (CWS, 2016). While access to adequate amount of drinking water is necessary it might be insufficient to avoid the risk of disease, unless water quality is maintained, and water is free from faecal contamination of harmful pathogens. It is estimated that about 17% of diarrhoeal diseases can be reduced by improving water quality.

### Overall progress of the WASH sector

Bangladesh has made notable progress in accessing water and sanitation facilities over the last few decades. Unlike in most countries, differences in WASH coverage between urban and rural communities in Bangladesh are quite small. For example, the Multiple Indicator Cluster Survey (MICS) estimated the national average of access to basic water sources at 98.5% (99.6% urban and 98.2% rural). Almost every household in slum and non-slum areas have drinking water sources either in their dwelling/yard/plot or within a 30-minute round trip by walk.

<sup>29</sup> Pruss A, Kay D, Fewtrell L, and Bartram J. Estimating the burden of disease from water, sanitation, and hygiene at a global level. *Environ Health Perspect* 2002;110(5):537-42.

<sup>30</sup> Norman R, Bradshaw D, Schneider M, Pieterse D, Groenewald P. Revised Burden of Disease Estimates for the Comparative Risk Factor Assessment, South Africa 2000. Cape Town: Medical Research Council of South Africa, 2006. <http://www.mrc.ac.za/bod/bod.htm> (last accessed 31 May 2007).

<sup>31</sup> Cumming, O., & Cairncross, S. (2016). Can water, sanitation and hygiene help eliminate stunting? Current evidence and policy implications; Crane et al (2015). Environmental enteric dysfunction: An overview; Checkley et al. (2008).

Multi-country analysis of the effects of diarrhoea on childhood stunting; Ziegelbauer et al. (2012). Effect of sanitation on soil-transmitted helminth infection: systematic review and meta-analysis.

<sup>32</sup> Prüss-Ustün A, Bos R, Gore F, Bartram J. Safer water, better health: costs, benefits and sustainability of interventions to protect and promote health. Geneva: World Health Organization; 2008([http://apps.who.int/iris/bitstream/10665/43840/1/9789241596435\\_eng.pdf](http://apps.who.int/iris/bitstream/10665/43840/1/9789241596435_eng.pdf), accessed 16 October 2015).

<sup>33</sup> Liu L, Johnson HL, Cousens S, Perin J, Scott S, Lawn JE et al. Global, regional, and national causes of child mortality: an updated systematic analysis for 2010 with time trends since 2000. *Lancet*. 2012;379:2151–61. doi:10.1016/S0140-6736(12)60560-1.

In case of sanitation, however, the urban-rural difference is higher, with the national average of 84.6% of population using improved sanitation, in which, 90.6% being in urban areas and 82.9% in rural areas. According to CWS 2016, only nineteen percent (19%) of the households had an improved sanitation facility in slum areas compared to 51.3% of the non-slum households. The percentage of household members using improved sanitation facilities has increased from 77% in 2012-13 to 85% in 2019 (MICS 2019). The same holds true for handwashing facilities with water and soap/detergent. Percentage of households with hand washing facilities where water and soap/detergent were present has also increased from 59% to 75% during the same period. MICS 2019 statistics for Water, Sanitation and Hygiene were much higher than BDHS 2022 statistics which show that between 2014 and 2022, the availability of a hand washing station with water and a cleansing agent (including soap) increased from 37% to 47% only. Open defecation was found to be national only 1.5%, with 0.4% in urban areas and 1.9% in rural areas (MICS, 2019).

### Status of WASH indicators included in NPAN2

It is observed that all three targets for WASH indicators included in NPAN2 have been either been achieved or about to achieve.

**Indicator 1: % of population that use improved drinking water.** This NPAN2 target is about to achieve (Table 9). In 2019, 98.5% of the population used improved drinking water compared to the NPAN2 target of 99% by 2025 (MICS 2019).

**Indicator 2: % of population that use improved sanitary latrine (not shared).** The national coverage of this target was 84.6% which has surpassed the NPAN2 target of 75% by 2025.

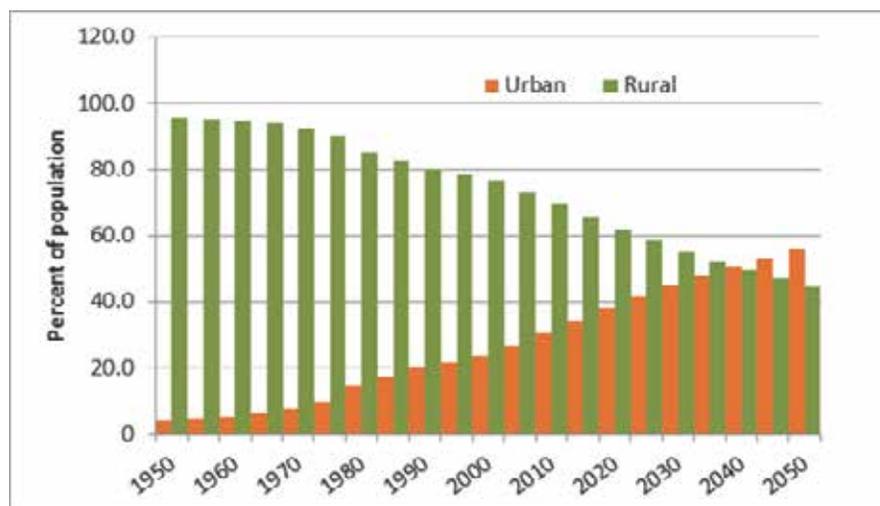
**Indicator 3: % of household members with a hand washing facility where water and soap or detergent are present.** The national coverage was 74.8%, which has also surpassed the NPAN2 target of 50% by 2025.

**Table 9: Status of Water and Sanitation condition in Bangladesh**

Indicators	NPAN2 Target 2025	Status	Source
% of population that use improved drinking water	99%	98.5%	MICS 2019
% of population that use improved sanitary latrine (not shared)	75%	59%	(BDHS 2022)
% of household members with a hand washing facility where water and soap or detergent are present	50%	74.8%	MICS 2019

## URBAN NUTRITION

The urban population is in continuous rise in Bangladesh. In 1961, the urban population was a little over 5% of the total population of the country (BBS, 2015), which became 20% in 1991, 24% in 2001,



28% in 2011 and 31.5% in 2022. The United Nations population division estimated that almost 58% of people of Bangladesh will live in urban areas in 2051 (BBS, 2015) (Fig 12.a). Bulk of these urban populations are concentrated in the large city corporations.

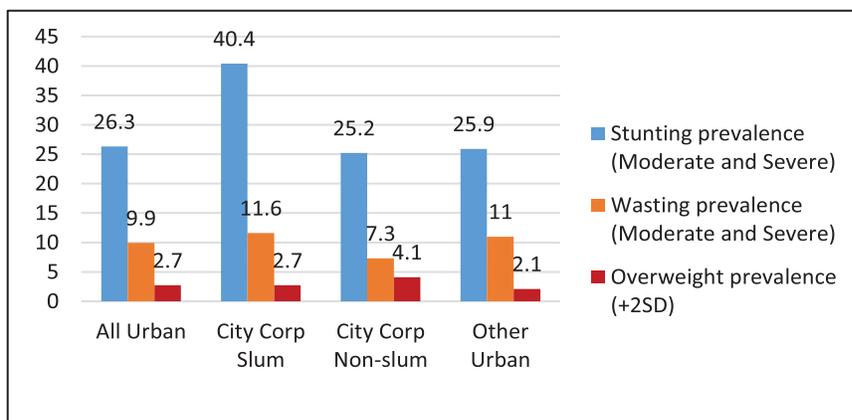
**FIGURE 12.A: URBAN-RURAL DISTRIBUTION OF POPULATION IN BANGLADESH FROM 1950 TO 2010 AND PROJECTED TO 2050.**

Bangladesh is going through remarkable demographic, economic and social transitions. These include rapid growth of urban population (at a rate of more than 3.2% in contrast with 1.37% nationally), industrialization, increased per capita income and increased prevalence of non-communicable diseases, etc. Every year, thousands of people migrate to urban areas from villages, peri-urban and disaster affected areas. As per the recent preliminary findings of the Population and Housing Census 2022 in Bangladesh, around 31.50% of the population (around 53 million) in the country are urban dwellers (BBS, 2022). Dhaka is a rapidly urbanizing megacity and is one of the world's most densely populated cities. Only the capital city Dhaka, constitutes around 20% of the total urban population of the country (BBS, 2022). Rural to urban migration occurring in thousands annually resulting in populous slums. Currently, around 35% of the urban dwellers reside in urban slums (BBS, 2022) characterised by constant fear of evictions by the residents and controlled by gang-lords who charge exorbitant rates for basic services. Government is against the 'institutionalisation' of Low-Income Communities (LICs), as their long-term vision is of a city without LICs.

Urban nutrition services are part of Bangladesh's primary health care services system, divided among service providers including the GOB, NGOs and private sector with insufficient coordination. The Bangladesh National Nutrition Policy 2015 emphasized the provision of nutrition services in urban areas, particularly for poor and slum populations, with effective coordination among providing Ministries (sub-strategies: 6.3.10, 6.3.11, 6.5.1). NPAN2 recognized gaps in nutrition services in urban slums and included specific activities to enhance urban nutrition programming through effective coordination among government ministries and NGOs, and linkages with WASH and social safety net programs<sup>34</sup>.

**Figure 13:** Segregated Urban Prevalence of Stunting, Wasting and Overweight

<sup>34</sup> United Nations, Department of Economic and Social Affairs, Population Division (2018). World Urbanization Prospects: The 2018 Revision.



Bangladesh witnessed a significant improvement in the reduction of chronic undernutrition (stunting, low height for age) from 43% in 2007 to 28% in 2019, decreased by 15% in 12 years. However, the reduction rate was higher in rural areas than in the urban areas (17% and 10% respectively). 40% of slums

children are stunted compared to 26% of the total urban stunting level.<sup>35</sup> The prevalence of wasting increased in both slum (17% to 19%) and non-slum (10% to 16%) from 2006 to 2013, but decreased in 2016, to 16% and 7% in slum and non-slum respectively<sup>36</sup> (UHS, 2013; CWS, 2016); the prevalence of underweight was 20%, with higher levels among slum (31%) compared to non-slum children (18%)<sup>37</sup>. Overweight (>2SD) rate was 2.7% in slum dwelling children compared to 4.1% in non-slum dwelling children. The consumption of Minimum Acceptable Diet (MAD), which was 30% in slum children compared to 44% in non-slum children. Exclusive breastfeeding among children under 6 months of age was 62% and 58% for slum and non-slum children respectively (Table 8).

**Table 8: Status of existing urban nutrition in Bangladesh**

Urban	Under weight	Stunting	Wasting	Low birth weight	Over-weight	Exclusive Breastfeeding	Minimum acceptable diet
All Urban	20.4	26.3	7.8	13.7	2.7	52.7	38.0
City corporation with slums	30.8	40.4	15.5	15.8	2.7	62.3	29.7
City corporation without slums	17.7	25.2	7.3	11.1	4.1	57.5	44.4
Other municipalities	20.9	25.9	7.6	15.1	2.1	50.0	36.0

Source: Child Well-being Survey 2016, BBS-UNICEF

### Implementation status of nutrition activities included in Annual Workplans under Thematic Area 1 in Fiscal Year 2021-22 & 2022-23.

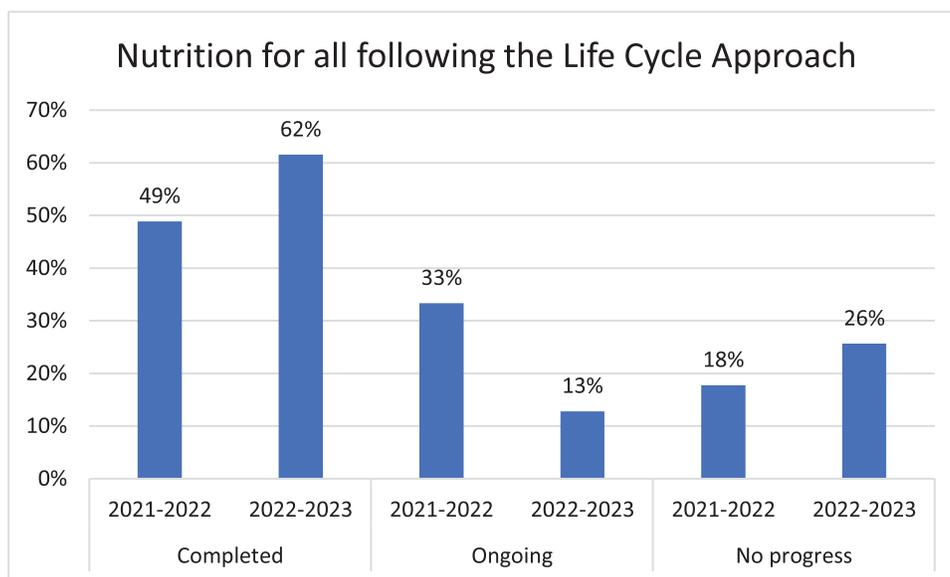
Activities covered under Thematic Area 1 include: Infant and Young Child Feeding practices, Status of Early Initiation of Breast Feeding, Trends in Exclusive Breastfeeding practices, Trends in complementary feeding practices, Minimum Acceptable Diet, Micronutrient malnutrition, Management of Acute Malnutrition, Maternal nutrition and reducing low birth weight, Progress in maternal nutrition

<sup>36</sup> (UHS, 2013; CWS, 2016).

<sup>37</sup> Child Well-being Survey 2016, BBS-UNICEF.

and LBW process indicators, Adolescent nutrition, Child Marriage, Teenage Pregnancy and Malnutrition Nexus, Water, sanitation and hygiene (WASH) and Urban Nutrition.

Total 60 nutrition activities were included in Annual Workplan 2020-21 (FY) under this Thematic area where 16 ministries were involved for implementation. According to BNNC dashboard out of the total 60 activities 23 activities were completed, 9 were on progress and 28 activities with no progress. It was observed that, in FY 2019-20, 64 activities were included of which 26 were completed and 13 were on progress and 25 with no progress (Figure. 14).



**Figure 14:** Implementation status of nutrition activities under Thematic area 1 in FY 2021-22 & 2022-23.

## **THEMATIC AREA 2: Agriculture and Diet Diversification and locally adapted Recipes.**

This Thematic area tries to operationalize the complex interplay of multiple food and non-food factors affecting the nutritional status. Safely grown, nutritious and local food production using environment friendly technologies is the primary duties of Food, Agriculture, Livestock and Fishery sectors where availability, affordability, accessibility and healthy feeding practice play definitive role.

The main goal of the food, agriculture, livestock, and fisheries sectors is to use environment friendly technology to promote the accessibility, affordability, and availability of a variety of locally produced, nutritious meals-healthy for people, producers and planet. To improve nutrition results, these foods must be encouraged to be consumed and prepared as part of a healthy diet. This starts with diverse and integrated homestead gardening, livestock development and small animal husbandry, aquaculture, and fisheries production at the household and small-scale production level. Diversified, integrated food production systems can offer more gender-equitable income generation and enable resilience to price and climatic shocks, seasonal food, and income changes.

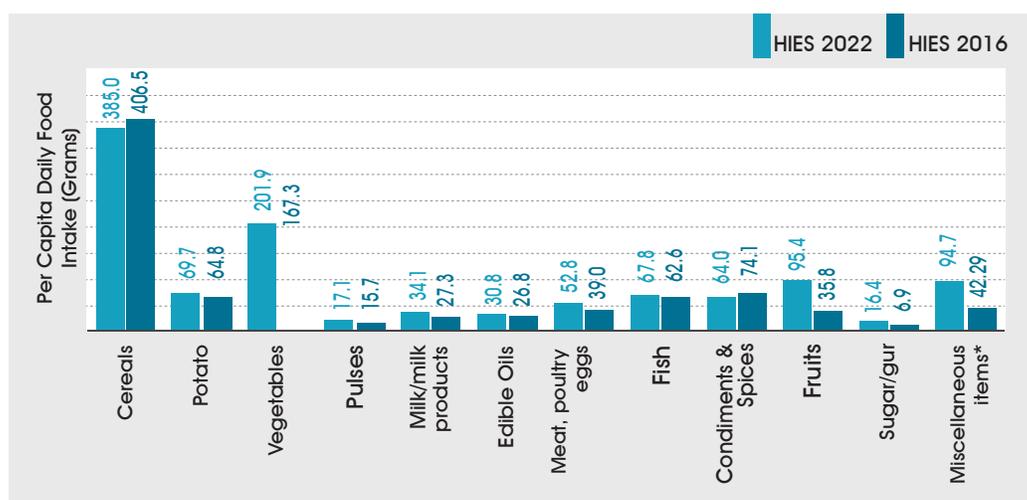
### **Overall Sectoral Progress in this Thematic area**

Rice is the main staple food consumed in Bangladesh. Over the last three decades, Bangladesh has managed the accomplishment of producing enough rice to keep up with population growth and has been self-sufficient in rice production since 2012<sup>38</sup>. Thus, in terms of calorie availability, it has achieved self-sufficiency, and most recently also in meat and fish production, as per Bangladesh Economic Review, 2018.

<sup>38</sup> USDA Foreign Agriculture Service. 2015. Grain and Feed Annual.

The average daily per capita intake of major food items in 2022 and 2016 (Figure 14.a). In the cereals group at the national level, the per capita daily intake was recorded at 385.0 grams, in which rice contributed 328.92 grams, wheat contributed 22.92 grams, and other cereals contributed 33.17 grams in 2022. It was observed that the consumption of cereals & rice declined in 2022 compared to 2016. At the national level, rice consumption is reduced by 38.28 grams, while rice consumption is decreased by 36.98 grams in rural areas and 32.08 grams in urban areas. This reduction may be due to a change in people’s consumption behaviour. The national level consumption of some other food items like vegetables, pulses, potatoes, milk & milk products, fruits, edible oils, meat, poultry and fish, sugar and gur increased in 2022 compared to the intake in 2016. On the other hand, khasari, onion, eggs, condiments and spices decreased in 2022 compared to 2016.

**Figure 14.a:** Average Per Capita Daily Food Intake (Grams) by Food Items



\* Includes tea, soft drinks, bread, biscuits, betel nut, betel leaf, etc.

The HIES 2022 data illustrates that the share of food and non-food consumption expenditures in the HHs has changed. Non-food expenditures are increasing gradually. The percentage of food consumption expenditure is 45.8%, and non-food consumption expenditure is 54.2% in 2022, compared to 47.7% for food and 52.3% for non-food in 2016. The average rice consumption of per person per day is 328.9 grams in 2022 which was 367.2 grams in 2016, 416.0 grams in 2010, 439.6 grams in 2005 and 458.5 grams in 2000. On the other hand, the vegetables and meat consumption have increased gradually.

The average protein intake is 72.5 grams per person per day in 2022 which was 63.8 grams in 2016, 66.26 grams in 2010, 62.52 grams in 2005 and 62.50 grams in 2000. The headcount rate (HCR) in 2022 using the upper poverty line is 18.7% at the national level, 20.5% in rural areas, and 14.7% in urban areas. Whereas, the official HCR in 2016 using the upper poverty line was 24.3% at the national level, 26.4% in rural areas, and 18.9% in urban areas.

Despite positive gains in the sector, the Prevalence of Moderate or Severe Food Insecurity based on the Food Insecurity Experience Scale (FIES) provides an alternative household-level perspective by assessing people’s perceptions and challenges in accessing nutritious and sufficient food. On this scale, severe food insecurity, for example, indicates no food for a day or more. Severe food insecurity, based on the FIES, has improved, falling steadily to 10.6% in 2017-19 from 13.3% in 2014-16. However, following a slight decline, the three-year average for 2016-18 and 2017-19 has stagnated at 31.5% for moderate food insecurity. These figures are noticeably below the South Asia averages, which stand at 16.0% for severe food insecurity and 33.4% for moderate food insecurity over 2017-19, respectively.

On the other hand, protein sources food items have showed a mix picture. For instance, consumption of pulse, poultry, beef, fish, mutton, and eggs has increased in both rural and urban areas from 2010 to 2016. Only the fish intake has exceeded the desirable amount in both urban and rural areas. But, the

per capita consumption of milk and milk products, sugar and fruits decreased in both rural and urban areas. Although vegetable consumption did not change at the national level, it increased in urban areas with a decreasing consumption in rural areas from 2010 to 2016. Improvements in supply chains may increase availability of specific food types but may not necessarily increase the nutrient value within the food type. For example, the fish species farmed in ponds have lower nutritional value compared to captured fish species, resulting in a decrease of micronutrient intake from fish over recent years despite increased fish consumption (Bogard et al, 2017).

The number of the poor and undernourished are increasing faster in urban slums than in rural areas. Nearly two thirds of the urban children are not getting age-appropriate diets to meet their nutritional needs and to achieve optimum growth and development. Urban slum children are having a less diversified diet. Minimum meal frequency is higher among non-slum children (76 percent) than slum children (64.5 percent) (Child Wellbeing Survey-2016).

The HIES 2022 data finds that household-level access to electricity has increased to 99.3% in 2022 from 75.9% in 2016 and 55.3% in 2010. Similarly, 92.3% of HHs have access to improved toilet facilities, and 96.1% have access to improved source of drinking water. Notably, Bangladesh's literacy rate (7 years and over) rose significantly to 74.0% in 2022 from 65.6% in 2016 and 57.9% in 2010.

Importantly, using back-calculation for comparability the HCR of HIES 2016 was 26.4% (upper poverty line) which indicates that the poverty has declined 7.7 points (pace of decreasing is 29.17%) in 2022 from 2016 in Bangladesh. The household's average monthly income has increased in nominal terms to TK. 32,422 in 2022, from Tk. 15,988 in 2016 and TK. 11,479 in 2010. The HIES 2022 data reveals that the HH's monthly total expenditure has increased nominally to TK. 31,500 in 2022 from TK. 15,715 in 2016 and TK. 11,200 in 2010.

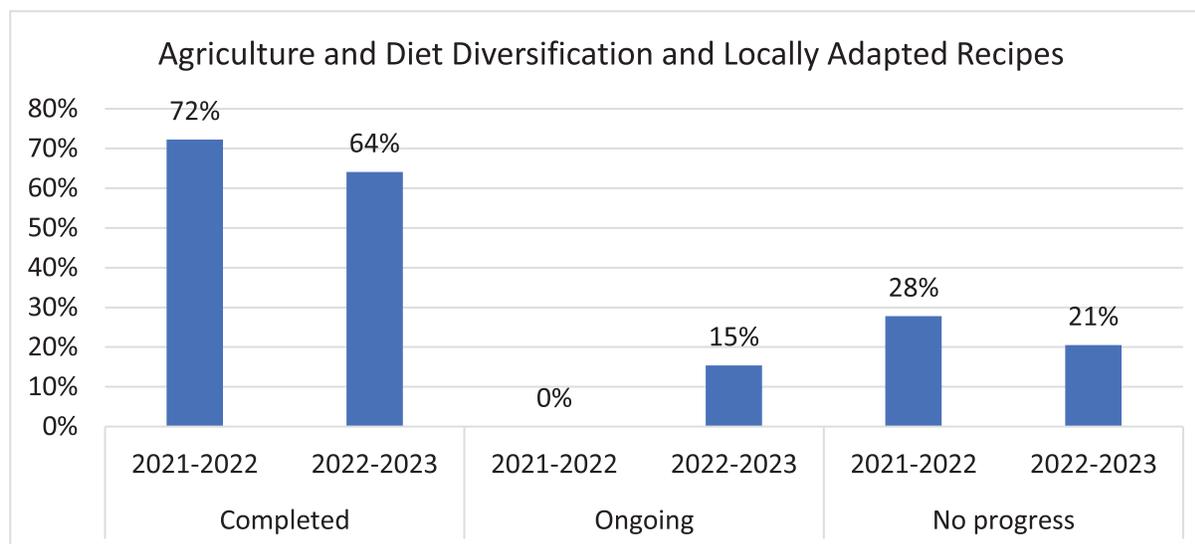
### Progress of the two indicators set in NPAN2

Table 9 shows that in 2022 (HIES 2022) the per capita intake of vegetable has increased marginally from 167.3 gm to 201.9 gm in 2022 (HIES 2022) against the target NPAN2 of 300g by 2025. On the other hand, fruit intake has also increased from 35.78 gm (HIES 2022) to 95.4 gm (HIES 2022) against the NPAN2 target of 100 grms by 2025. It is also seen in table 9 that, the % share of total dietary energy from consumption of cereals have decreased significantly from 64% (HIES 2016) to 30.54% (HIES 2022 where <60% target of NPAN2 by 2025.

**Table 9:** Status of the progress of consumption fruits & vegetables and share of dietary energy from cereals (source: HIES 2022)

SL.	Indicators	NPAN2 Target 2025	Baseline of NPAN2	Progress (2022)
17	Per capita consumption of fruits and vegetables	Fruits: 100g	Fruits: 44.7 gm	Fruits: 95.4 gm (HIES 2022)
		Vegetables: 300g	Vegetables: 166.1 gm	Vegetables: 201.9 gm (HIES 2022)
18	% share of total dietary energy from consumption of cereals	<60%	70% (HIES 2010)	30.54% (HIES 2022)

## Implementation status of nutrition sensitive activities included in Annual Workplans in Fiscal Year 2021-22 and 2022-2023.



In 2021-22, total 11 ministries were involved in this Thematic area and covered 18 activities. Among them 28 activities were successfully completed (72%); (0%) activities were ongoing, and 5 (28%) activities had no progress. It was observed that both number of activities and their implementation status have increased in 2021-22 Fiscal Year (FY) compared to 2020-21 FY.

## Thematic area 3: Social Protection

### Poverty-Malnutrition Nexus

The Constitution of Bangladesh has made the provision that the State will bear the fundamental responsibility for ensuring the right to social security for all deserving people (Article 15-D). Such constitutional provision directs the government to strive for strengthening the existing social security system of the country which has a long legacy since the independence of the country in 1971. Moreover, the unfaltering progress of the country moving towards becoming a middle-income country, free from poverty and hunger, has opened up opportunities for the Government to devise a rights-based comprehensive social security system for the people.

To address the pervasive high level poverty in Bangladesh (estimated 24.3% nationally)-one of the underlying causes of malnutrition- SSPs have been playing the most vital role. Poverty and malnutrition have the bidirectional relationship. Children who escape stunting in the first 1000 days of their lives are 33% more likely to escape poverty as adults (World Bank's blog). Furthermore, children in the poorest households were more likely to be stunted (40%) compared with children in the wealthiest households (17%), though wasting did not show a linear relationship with the wealth quintile (MICS, 2019). Wasting in the lowest wealth quintiles was 10% compared with 7% in highest quintiles (BDHS 2017-18).

Wealth status is significantly associated with proper complementary feeding practices. The acceptable dietary practice increases with the increment of households' wealth status. The proportion of children getting acceptable diet was two times higher among the children living with the richest family compared to the poorest family. Nonetheless, more than half of the children belong to the richest family were not

getting acceptable diets between 2016 to 2019<sup>39</sup>. The proportion of acceptable dietary behaviour decreased in all wealth status in the last 5 years. CWS-2016 study found that one fourth (25%) of the children of the poorest household had acceptable diets while 46 % of the children of the wealthiest family had acceptable diets in urban areas. Acceptable dietary practices are not satisfactory across all wealth group and the poorest families are practicing the lowest.

Social Security Programmes (SSPs) proffer multiple opportunities to integrate direct services as well as gender sensitive and equity focused nutrition sensitive interventions for wider beneficiaries including the poorest segments of the population in Bangladesh. These programmes can also focus on marginalized groups and communities, gender equality and women empowerment, support income generation. There are many different ways to incorporate nutrition into social protection programs. Examples include providing vulnerable individuals with food transfers (including fortified food) and cash transfers in areas of long-term or post-disaster food insecurity, as well as providing school meals and school feeding, which may include fortified foods as well as nutrition-related education. Ensuring nutrition sensitivity in the existing SSPs to improve the nutritional status of children from the poorest households, cash transfers alone will be inadequate. Alongside transfers the quality behaviour change communication (BCC) program can significantly improve the child nutritional status and anthropometric outcomes. As evidence by International Food Policy Research Institute (IFPRI) study results, adding BCC to transfers led to an increase in both “diet quantity” and “quality” in terms of household caloric intake, increased consumption of diverse food groups by children, resulting in a significant reduction in child stunting at 7.3 percentage points from the baseline level (IFPRI, 2018) (Source: IFPRI, 2018).

### Coverage of Social Security Programmes

The 2016 HIES data shows that 27.8% of the households have received benefits from SSPs during the previous 12 months of the survey. However, MICS 2019 report reveals that 55% of the household members from two of the lowest wealth quintiles received some/any type of social transfer in previous three months of the survey. As per the recent Bangladesh Social Protection Public Expenditure Review of the World Bank, 2021 while urban poverty was found as 18.9%, coverage of SSPs in urban areas was found to be only 10.9%, whereas coverage of SSPs in rural areas was found to be 35.7% against rural poverty of 26.4% (World Bank, 2021)<sup>40</sup>. The study identified only 5% of SSP expenditure being exclusive to urban areas.

### National Social Security Strategy (NSSS) of Bangladesh

Thus, constitutional provision, economic capacity and overall developmental commitment of the present government has paved the way for formulating a National Social Security Strategy (NSSS) of Bangladesh. The Cabinet has approved the Strategy on 1st of June 2015. The strategy aims to address the risk and vulnerability of the poor in the country with a view to reducing their poverty and marginalization. The core of the NSSS is coordination among the 35 ministries/divisions and programme consolidation along lifecycle risks, with programmes for children, working age people – including specific focus on youth and vulnerable women – the elderly, and persons with disabilities. The lifecycle approach also addresses current gaps in coverage of early childhood needs. The heart of the NSSS is to reform the national social security system by ensuring more efficient and effective use

<sup>39</sup> BDHS (2017-18)

<sup>40</sup> World Bank. 2021. Bangladesh Social Protection Public Expenditure Review. World Bank, Dhaka. © World Bank. <https://openknowledge.worldbank.org/handle/10986/36236> License: CC BY 3.0 IGO.”

of resources, strengthened delivery systems and progress towards a more inclusive form of social security that effectively tackles lifecycle risks, prioritising the poorest and most vulnerable members of the society.

### **Gender based Social Security Programmes**

About 27 social security programmes in the budget of 2016-17 have primary focus on women, directly or indirectly. Of the 10 largest programmes, VGD is the lone programme specifically targeting women; the others are relatively small. Programmes target women with a generalized notion of women forming the poorest segment of the population and also admitting that they have fewer opportunities. Existing programmes cover a large number of women, providing consumption and income generation support; they buttress promotion of gender equality in education, employment, income and health. Most programmes do not have the specific goal of women's empowerment, but many have had intended and unintended positive effects on women.

### **Progress of NPAN2 Indicators related to this Thematic area.**

**Indicator 1. % of women age 20-24 who were first married by age 18**, during the reporting period there has been some improvement from the baseline data of NPAN2 in this regard. In 2019, percentage of women aged 20-24 years who were first married by age 18 years reduced to 51.4% in 2019 (MICS, 2019) from NPAN2 baseline of 59% (in 2014). However, the reduction was much lower against the NPAN2 target of 30% by 2025.

**Indicator 2. Number of Social Safety Net Programs which incorporated nutrition sensitive & nutrition specific objectives.** The recently completed review of SSPs jointly by the Cabinet Division and BNNC in Bangladesh revealed that 18 (67%) out of 27 large SSPs (21-governments and 6-partners managed programmes/projects) included direct nutrition objectives in their project design. The target is to make all these large programs more nutrition sensitive with defined nutrition objectives and indicators.

**Indicator 3. Number of upazilas covered under VGD program to provide nutritionally enriched fortified food.**

Strategy on Prevention and Control of Micronutrient Deficiencies 2015-2024 as one of the strategies to address micronutrient deficiencies through two of the largest government's Social Security Programmes (SSPs) namely, the vulnerable Group Development (VGD) Programme and the Food Friendly Programmes (FFP). Currently VGD and FFP are being implemented in 94 and 24 Upajillas respectively.

**Indicator 4: % of children (36-59 months) who are attending an early childhood education (ECD) program.** As per MICS 2019 findings, about 19% of the target children (36-59 months) were attending ECD which is a good improvement compared to the baseline figure of 13% and far below of 30% of NPAN2 by 2025.

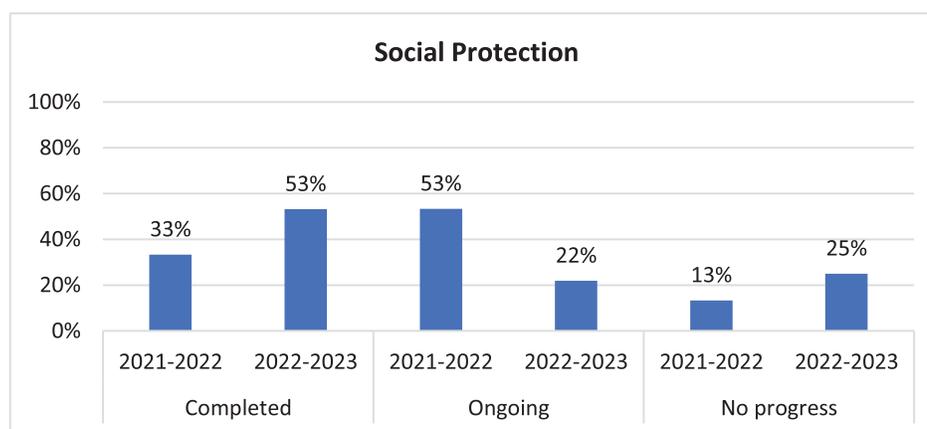
**Indicator 5. % of women who completed secondary/higher education.** Over the last two decades a significant improvement in education in terms of both Gross Enrolment Ratio (GER) and Net Enrolment Ratio (NER) for both boys and girls for the secondary level was observed. In 2016, the GER for the secondary level rose to about 74% from 43% in 2001, the GER for boys in 2016 was about 67%, which was significantly lower compared to GER for girls 82%. In 2016, the NER in secondary level was about 68% (boys and girls together), 66% for boys and 73% for girls. Though the gender parity index for secondary level was 1.15-in favour of girls.

**Table 10: Status of indicators for Social Security Programmes (SSPs) included in NPAN2**

SL.	Indicators	NPAN2 Target 2025	Baseline of NPAN2	Current status
1	% of women age 20-24 who were first married by age 18	30%	59%	51.40% (MICS 2019)
2	Number of Social Safety Net Programs which incorporated nutrition sensitive & nutrition specific objectives	50%	10% (assumption)	18 (67%) out of 27 large SSPs (BNNC, SSPs review)
3	Number of upazilas covered under VGD program to provide nutritionally enriched fortified food	50%	Nil	189 Upajillas (WFP 2019)
4	% of children (36-59 m) who are attending an early childhood education program	30%	13%	18.90% (MICS 2019)
5	% of women who completed secondary/higher education	90%	14%	Secondary (59.7%) Bangladesh Education Statistics 2021
				Higher (49%) World Data Atlas 2014

### Implementation status of nutrition sensitive social security activities included in Annual Workplans in Fiscal Year 2021-22 and 2022-2023.

Under this Thematic area in 2022-23, a total of 11 ministries included 65 nutrition sensitive social security activities into their Annual Nutrition Workplans (ANWs) compared to 37 (53%) activities in 2020-21 ANWs which is about 45.5% increase. According to BNNC dashboard out of the total 64, 34 (53.3%) activities were successfully completed, 14 activities (22%) were still ongoing and 16 (25%) activities with no progress. It is also observed that though the number of planned activities increased but the number of activities completed remained same in both Fiscal Years.



**Figure 15:** Implementation Status of Nutrition Sensitive Social Security activities under the Thematic area included in Annual Workplans in Fiscal Year 2021-22 and 2022-2023.

## **Thematic Area 4: Implementation of Integrated and Comprehensive SBCC Strategy**

### **Overall Sectoral Progress in this Thematic area**

NPAN2 stipulates that building political and society-wide awareness and commitment to food and nutrition security, advocacy and social mobilization are key. A set of initiatives were undertaken on advocacy component during the period of 2021-22 and 2022-23 to advance nutrition through improved advocacy by relevant sectors at all levels.

### **Key achievements under Advocacy area**

#### **Mid-term review of NPAN2 (2016-2025)**

##### **Context and Objectives of the Midterm Review (MTR)**

The MTR was a particular design milestone of Second National Plan of Action for Nutrition (NPAN2), mandated to be carried out during halfway of implementation of the plan of action. The main purpose of the MTR of NPAN2 has been specified to be the assessment of the progress of its implementations, finding the challenges, suggest corrective measures, way forward to accelerate implementation progress and adjustment required for remaining implementation period.

The MTR objectives have been clustered into three thematic areas: i) Operational ii) Technical and iii) Financial. Summary findings including challenges under each thematic area are presented below, followed by recommendations (at chapter five) and suggested priority actions (at chapter six).

##### **Summary of Findings in Technical Thematic Area**

###### **Major Observations:**

- a. Broadly speaking the desired improvements in the nutritional situation as stated in the NPAN-2 appeared to be on track. It is also understandable that actions are needed in many fronts and sectors and quite a few of the proposed activities are in the right directions.
- b. However, there is a problem of limited correspondence between the themes and key action areas.
- c. The process indicators which are taken to be the major activities are repetitive since some of these activities may result in more than one area of nutritional improvement. However, there is no pathway analysis as to which causes what nor the evidence shown regarding direction and extent of cause and effect. This leads to a problem of prioritization, thus too many things have been attempted and with limited resources, it becomes difficult to attain the desirable goals in quite a few cases. Even the desired outcomes where there are positive results, seem to be somewhat muted. Wasting particularly is a major issue here.
- d. On micronutrient supplementation apart from Vit A campaign, results in case of others such as IFA indicate that more vigorous attention should be given. Sometime these are tagged with ANC and PNC visits as well as with SSPs. However, the opportunities remain to be fully utilized, particularly provision of food assistance of special nature for specific groups of women and adolescents.
- e. A review has been made of the 25 priority nutrition output indicators based on the M&E matrix in NPAN-2. This review indicates several limitations, not of using these indicators as such, but rather the lack of appropriately estimated data and analysis. This problem arises mostly due to limited comparability across various data sets due to differences in methodology and the time period to which they refer to. Indeed, in some cases one also observes diametrically opposite policy

implication of estimates made from different data sets. IRT found similar difficulty arising from different sources of financial data (section 4.2).

- f. On the other hand, several emerging issues have remained less attended. The problem of urban nutrition has received much less attention than expected despite existence of apparently good sets of data and analysis on the issue. This also shows that the urge to create or use evidence appear to have played limited role in determining areas of action. On Covid-19 impact on nutrition, some good beginnings have been made but to take it to fruition, more attention will be needed, particularly the global analysis that has been done should be utilized for deciding national course of action. Climate change and its impact on food availability and nutrition has received scant attention.
- g. On synergy with national policies, the NPAN-2 is by and large in line with the 8<sup>th</sup> Five Year Plan but has paid less attention than desired regarding rights to food within the family. On global commitments and NPAN-2, there are various opportunities for aligning with those commitments and using the opportunities for generation of resources, particularly financial (through N4G commitments), but also using the analytical frameworks for understanding the country situation (as in case of GAP). Then again there are opportunities for engaging the business community under the UNFSS agreements to standardize baby food formulas and be so certified before trading.

The observations made above point to a few conclusions, and recommendations, particularly for formulating a new NPAN towards 2030. First, the new NPAN will have to be well-focused around a prioritised set of actions. The priority should be based on a pathway analysis and clear evidence as to which factors are important in determining largely the desirable nutrition outcome. The evidence will come from both available scientific and socio-economic literature and new research as necessary. In addition to others, one or two areas should receive priority for action which include equitable and nutrition-specific intrahousehold food distribution, food assistance of specific nature to specific groups particularly for those affected by SAM and specific dietary needs of those afflicted with infectious and NCDs.

Given these general recommendations, a list of some 28 recommendations has been made some for immediate and short-term actions and others over the medium term and longer run. The short-term recommendations are those which can be taken up without much administrative efforts. The medium-term recommendations may need some administrative efforts. On the other hand, while the long-term recommendations may necessitate quite some ingenuity and intensive intellectual inputs, these may lay the foundation for a more robust system of nutritional intervention in the future.

## **Summary of Findings in Operational Thematic Area**

### **Major Observations:**

The structure of BNNC has the Council, the Executive Committee (EC), the Standing Technical Committee (STC), the Office of the BNNC and the Platforms of BNNC at the national level, and District Nutrition Coordination Committee (DNCC) and Upazila Nutrition Coordination Committee (UNCC) at the subnational level. The Council is a very high-profile committee, headed by Honorable Prime Minister as the Chair, Minister of MOHFW as the Co-Chair and Senior Secretary/Secretary of MOHFW as the member-secretary. The MTR found the structure and functions of the Council to be very relevant in operationalizing NPAN2. The EC is chaired by Minister, MOHFW. The MTR found the structure of the EC as well balanced, and representative. The STC was found to be chaired by the Additional Secretary (PH&WH) and included some of the senior-most and technically competent experts of nutrition arena in the country. The STC of BNNC was found to be very active in its role and was functional even during the COVID19 pandemic situation.

The office of the BNNC provides technical, analytical and secretarial support to the Council, EC and STC. However, its organogram was not found to be approved through any official order or Gazette. Unlike other entities under MOHFW, BNNC does not have a separate financial code. Positions put in the BNNC organogram was found to be quite relevant for operationalization of NPAN2. However, some of the key positions in the organogram were found to be vacant, putting additional responsibilities on the existing personnel. No specific group of professional was found for BNNC, and the existing personnel were found to be deputed from other entities of MOHFW. This temporary deployment hinders the development of a specialized cadre of professionals and institutional memory of BNNC. Due to lack of resources, BNNC is reliant on the partners, mostly development partners, for different activities to operationalize NPAN2. While this is supportive of strengthened cohesion among GO-NGO stakeholders, it also creates administrative hassle in arranging different activities.

DNCCs and UNCCs are the multisectoral coordination structure for nutrition at subnational level and considered to be extended body of BNNC. These were formed through order of HSD, MOHFW. Both types of committees were formed in conformity with NPAN2. These have only been formed recently and were found to be reliant on DPs and their NGO partners for being effective.

Policy and strategic directions at BNNC were found to be adequate in operationalizing NPAN2. The sole meeting of the Council provided four important policy directions, which were the cornerstones for the operationalization process. EC was found to be quite active in ensuring operational and administrative directions, while STC was found providing strategic and technical directions.

The capacity building process was found to be taken by BNNC for the respective stakeholders through a number of formal processes (e.g. workshops and seminars) and informal processes (bilateral discussions, small-group meetings, one-to-one discussions). Similar process was found to be in action for the subnational level committees, in addition to formation of central and divisional level resource mechanisms.

For knowledge management, strategy for operational and implementation research has been formulated. BNNC has coordinated a number of important research, results of which have been disseminated among the important stakeholders. Among these, quite a large number was done during COVID19 period. BNNC fostered partnership by signing MoUs with 11 partner entities to support operationalization of NPAN2, and has become- a common platform for harmonization of nutrition activities.

Considering the adaptive model of institutionalization, the IRT is in the opinion that the institutionalization of NPAN2 is in the later stages of Habitualization (pre-institutionalization) and early stages of Objectification (Semi-institutionalization). The relevant stakeholders are sensitised, and are getting habituated with the action plan. They are now gradually objectifying NPAN2 into their existing systems and processes. This was, to the IRT, an important start for the journey of institutionalization of NPAN2 into the nutrition system in Bangladesh.

### **Challenges for BNNC in Operationalisation:**

- Optimistic and difficult to achieve operationalisation targets that may dilute importance (E.g. Two meetings of Council, 4 Meetings of EC and 6 Meetings of STC in a year).
- NPAN2 delegated to PM Office and the Cabinet Division the responsibility to strengthen BNNC; however, the mechanism of regular coordination of BNNC with these offices needs strengthening
- Location of BNNC in an overarching office (e.g. PMO or Cabinet Division) could have further strengthened its coordination role
- Physical location of BNNC– not suitable for regular multistakeholder discussions
- Resource constraints – reliance on partners for a number of NPAN2 activities
- Frequent changes in BNNC – including in the position of the head of the Office

- Limited regular communications with subnational level coordination committees - mostly due to resource and HR shortages

## Summary of Findings in Financial Thematic Area

### Major Observations:

Different sources of financial data (e.g. NPAN2, CIP2, PER-N and BNNC) provide estimates of funding needed, funds allocated and spent for improving nutrition outcomes in Bangladesh. However, estimates differ due to differences in methodology and coverage of entities. The IRT used incomplete and noncomparable data from three sources (PER-N, CIP2, and BNNC) for the MTR financial analysis. Noncomparability of data makes a trend analysis difficult.

Comprehensive and reliable data is required for MTR and Endline evaluation of NPAN2. A financial tracking system for nutrition is essential to make comprehensive data available for such financial analysis. This system needs to be established and institutionalized within BNNC for producing PER-N regularly.

NPAN2 provides estimates on the total funding requirement (Taka 12,463 crore or US\$ 1.6 billion) for its implementation over the 10-year period (2016-2025). However, it has not provided any baseline estimates. Funding gap has not been estimated by NPAN2. It is not clear whether the funding requirement estimated by NPAN2 is really the total funding requirement or it is the amount additionally required (i.e. funding gap). These factors make a proper evaluation of the financial part of NPAN2 difficult.

NPAN2 requires US\$0.16 billion (Taka 1,246.3 crore) per year while CIP2 requires a much larger amount of US\$1.1 billion per annum. This is counter-intuitive because NPAN2 includes both nutrition specific and sensitive activities whereas CIP2 includes nutrition sensitive activities only. Compared to CIP2, the NPAN2 estimated fund requirement appears to have been seriously underestimated.

The IRT analysing the BNNC data found that GoB allocated Taka 16,702.3 crore in two years (2018-19 and 2019-20). According to PER-N, only in one year (2017-18) GoB allocated Taka 29,347 crore for the nutrition sector, which is more than double the amount of funding requirement over 10 years estimated by NPAN2. According to NPAN2, US\$ 89.7 million is required per year for nutrition sensitive activities. In reality, in 2016-17, about US\$2.7 billion was spent on nutrition sensitive projects/operational lines according to PER-N. Compared to actual GoB allocation for the nutrition sector, NPAN2 estimates appear to be unrealistic.

Several factors could be attributed to the huge differences between NPAN2 estimates and PER-N figures. NPAN2 estimated funding requirement was based on the costing of the nutrition related activities financed by Development budget/ADP; on the other hand, PER-N included activities financed by both Operating budget and ADP. NPAN2 costing was based on the nutrition related HPNSDP activities and CIP2 activities existed at the time of costing.

Nutrition budget allocation of the 13 ministries increased by 20% between 2015-16 and 2017-18, according to PER-N data. Ranking of ministries in terms of budget allocation for nutrition during PER-N period (2015-16, 2016-17, and 2017-18) drastically changed afterwards. According to the PER-N estimates top two highest budget allocations were made by Ministries of Food (MoFood) and Health and Family Welfare (MoHFW).

According to BNNC data, between 2019-20 and 2020-21 nutrition budget increased by around 65% but in 2021-22 the budget dropped by more than 50%, perhaps due to Covid19 pandemic and non-reporting. Between 2018-19 and 2019-20 the top rank went to the Ministry of Local Government, Rural Development and Cooperatives (MoLGRD&C).

It is likely that the letter from the Cabinet Division<sup>41</sup> requesting implementation of relevant part of the NPAN2 and BNNC played a big role in this drastic change. After PER-N period BNNC actively started coordination with the Focal Person assigned by each of the allied ministries to share the respective annual workplans with budget and expenditure, and also sensitized these ministries about the importance of increasing nutrition investment. As a consequence, the number of ministries that shared respective nutrition related annual workplans and budget increased to 18 in 2021-22 from only 7 in 2018-19.

Nutrition related actual expenditure in 2016-17 increased by 11% to Taka 23,120 crore from Taka 20,891 crore in 2015-16 according to PER-N. Ranking of the top three ministries (MoFood, MoHFW and MoPME) remained the same for two years. Total nutrition spending increased slightly (by around 2%) from Taka 2650.3 crore in 2019-20 to Taka 2697.6 crore in 2020-21, according to BNNC data. Ranking of the top three spending ministries in 2019-20 completely changed in 2020-21. The COVID-19 pandemic might have contributed to this change. BNNC needs to examine these changes closely.

Nutrition specific projects/operational lines accounted for only 2% of the total nutrition expenditure in 2016-17, reported by PER-N. This is similar to the findings of the Global Nutrition Report 2017. In contrast NPAN2 estimated that nutrition specific activities would require 43.5% of the total funding requirement.

PER-N found that nutrition expenditures were broadly aligned with NPAN2 thematic area in 2016-17. Three NPAN2 thematic areas 'Agriculture and diet diversification and locally adapted recipes' (62%), 'Nutrition for all following lifecycle approach' (31%) and the 'Social protection' (6.7%) captured almost all nutrition-relevant expenditures (99.7%) in 2016-17.

The PER-N from the Aid Information Management System (AIMS) datasets of the government found 60 projects with significant funding going from funders directly to NGOs and other organisations. The figure amounts to BDT 20,855 with the proxy value for the three PER-N years of US\$ 736 million (Taka 6,182 crore). All projects/ programmes were broadly aligned with the thematic areas of the NPAN2. Non-public entities are likely to receive funds from foundations and private sources which are not captured in AIMS.

### **Key Challenges:**

- i. Lack of baseline estimates and clarity of NPAN2 costing making a proper evaluation of the financial part of NPAN2 difficult.
- ii. Lack of complete data on GoB budget and expenditure for nutrition. Comprehensive financial analysis for MTR and Endline require complete data
- iii. Lack of a system to track GoB budget and expenditure for nutrition. Tracking system makes necessary data available for financial analysis
- iv. NPAN2 budgetary requirement not linked to nutrition related budget of the relevant ministries.
- v. Inadequate GoB financing for BNNC leading to financing gap
- vi. BNNC's dependence on external funding due to financing gap

## **Multisectoral Social and Behavior Change Communication (mSBCC) Strategy**

With the financial support of Global Affairs Canada (GAC) and technical support of Nutrition International, Bangabandhu Sheikh Mujib Medical University (BSMMU) has been conducting a Formative Research to develop Multisectoral Social and Behavior Change Communication (mSBCC) Strategy, Materials, and Training Package for AMAN Project in Cox's Bazar.

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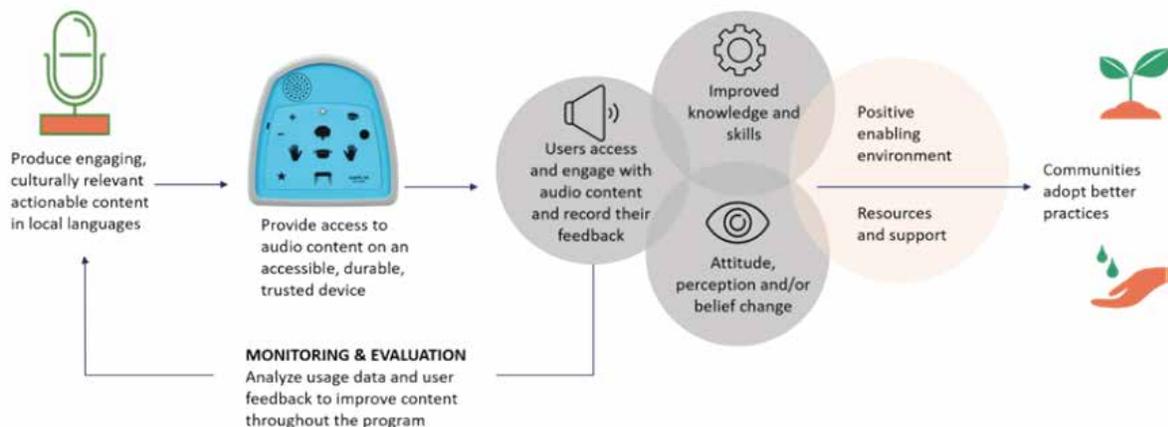
<sup>41</sup> A copy of NPAN2 was attached with the letter (Memo no. 04.00.000. 731.25.001.17-9) Dated 11 January 2018, requesting the recipient ministries to implement relevant part of the NPAN2

One of the main principles of this Multi-Sectoral Nutrition SBCC Strategy is to engage stakeholders across disciplines, fostering collaboration and synergies to address the root causes of malnutrition comprehensively. Through strategic communication, it seeks to influence knowledge, attitudes, and behaviors related to nutrition, not only at the individual level but also within the broader societal context. Besides, the strategy recognizes the need to bridge gaps between sectors, leveraging the strengths of each to create a synergistic approach towards improved nutrition outcomes. It emphasizes collaboration and coordination among diverse stakeholders, including government bodies, non-governmental organizations, the private sector, and communities themselves. Through this collaborative effort, the Multi-Sectoral Nutrition SBCC Strategy seeks to promote a holistic understanding of nutrition, addressing not only dietary practices but also the underlying social, economic, and environmental determinants.

The Strategy will facilitate the delivery of consistent and harmonized messages on Nutrition to address the needs of specific audiences through different units of government and NGOs. The Strategy is through developed following a comprehensive field analysis and participatory process. This strategy has been developed in line with the Bangladesh National Nutrition strategy and communication strategy of Health population and nutrition sector of the Ministry of Health and Family Welfare and other Ministries and departments strategies relevant to nutrition. This strategy will also complement and supplement nutrition strategy and communication specific nutrition strategy of other units/ departments, national and international organizations and private sector/s in Bangladesh.

#### Talking book: An interactive e-Learning tool

Bangladesh National Nutrition Council (BNNC) in collaboration with Joint Action for Nutrition Outcome (JANO) funded by EU developed an An interactive e-Learning tool to enhance SBCC activities. It is a talking book is an audio device that can hold a library of informational audio content in the form of songs, interviews and dramas to influence the behavior and enhance the lives of project participants by providing them with information pertaining to best practices. The audios are stored in an interactive manner guided by different icon-based button where a non-literate user can choose the topics that interest them most, replay content as often as they want, and record their own messages and feedback. The Talking Book also collects usage statistics and user feedback, which helps partners evaluate user engagement, identify barriers to program goals, and gain greater insight into the communities they serve.



#### The following strategies are identified for the advocacy plan:

**Strategy 1:** Increasing multi-stakeholder, multisectoral and multi-level coordination to mobilize nationwide support till end of NPAN2 implementation.

#### **Strategy 2. Capacity and leadership development:**

Increase capacity and commitment of policy and programme leaders at all levels for reducing malnutrition by the end of NPAN2.

#### **Strategy 3: Engagement of stakeholders**

Consolidate the ownership and engagement of all sectors and stakeholders to coordinate, formulate and implement harmonized activities on good nutrition and to build political will to invest in reducing malnutrition by end 2025.

**A set of advocacy Issues Identified to address in the Plan are as follows:**

- Limited understanding of nutrition and its impact
- Inadequate investment in nutrition
- Weak system of expenditure tracking
- Inadequate coordination among sectors
- Not enough importance paid on maternal nutrition and infant and young child feeding
- Not enough importance paid on WASH
- Inadequate consumption of diverse food
- Limited human resource
- Inadequate legislation and regulation
- Inadequate research and its dissemination
- Limited participation of private sector
- Inadequate enforcement of existing legislations
- Attention to urban and hard to reach population nutrition

**1. Progress of Nutrition SBCC activities**

Certain cascading activities regarding nutrition SBCC were done through different line ministries and development partners. Technical support was provided to integrate SBCC strategy in Improved Maternity and Lactating Allowance program implement by MoWCA in alignment with National Comprehensive SBCC strategy. Moreover, under the Rice fortification program advocacy was done for commercialization under the leadership of MoFood. Public Awareness campaign on healthy diet conducted under the leadership of Ministry of Industries with technical assistance provided by relevant ministries.

**2. Observation of National Nutrition Week (2023)**

National Nutrition Week (NNW) 2023 was observed countrywide from 7-14 June 2023 (instead of 23 April-29th April) to commemorate the formation of Bangladesh's National Nutrition Council. Under the leadership of the Ministry of Health and Family Welfare, the Institute of Public Health and Nutrition and Bangladesh's National Nutrition Council, NNW was celebrated. The theme of 2023 National nutrition week was -“মজবুত হলে পুষ্টির ভিত, স্মার্ট বাংলাদেশ হবে নিশ্চিত।” The NNW 2023 was observed country wide through rallies, discussions, different programs on day wise thematic areas, with participation from government and non-government officials, representatives from civil society both in national and at the sub national level. Other events included cooking competition, nutrition fair, school and courtyard meetings.

In addition, a number of events were organized under the leadership of the DNCCs and UNCCs in all 64 districts and 492 Upazilas. The activities and programs included rallies, display posters, gatherings of mothers, nutrition fairs, food cooking competitions, farmer gatherings, essay, art and debate competitions, awareness raising activities and prize giving ceremonies. The community, students and media representatives participated in these events. Civil Society Alliance for Scaling up Nutrition (CSA for SUN) also played an important role in ensuring the success of the program.

**Progress of NPAN2 Indicators related to this Thematic area.**

It is difficult to ascertain the progress of three indicators included in NPAN2 M&E matrix due to the lack of information in this regard. It would be useful to review these indicators in terms of their relevance, availability, data source and means of verification during the MTR of NPAN2. The status of these indicators is seen in Table 11.

Table 11. Status of progress of NPAN2 indicators during the reporting period.

SL.	Indicators	NPAN2 Target 2025	Baseline of NPAN2	Progress
1	Number of ongoing comprehensive coordinated multi-sectoral, multichannel advocacy and communications campaign	10	0	15
2	Change in per capita consumption of:	i. <5 gm/ person/day (WHO)	i. Salt: not Available	i. Salt: 25.37 gm/ person/day (HIES 2022)
	i. salt			
	ii. sugar consumption	ii. <10% of total energy intake	ii. Sugar: 7.4 (gm/capita /day)	ii. Sugar: 11.64 (gm/capita /day) (HIES 2022)

### Activities Conducted under Advocacy to Operationalize NPAN2

The activities under advocacy thematic area have been completed very recently. Typically, it requires some time for advocacy related activities to take effect. So, the substantive impacts of activities undertaken by BNNC in advocacy area may not be clearly visible yet. However, some early signs of impacts are evident. Particularly, the advocacy activities with relevant partners enabled allocation of resources in a number of activities from non-government partners (e.g. arrangement of NNW, arrangement of special advocacy programs of BNNC), which reduced the financial pressure from BNNC and increased ownership of all the stakeholders. The framework for operationalizing the advocacy plan is being used by BNNC and relevant ministries in the respective work plans and in partnership with development partners for future interventions.

The promotional materials, and particularly the special publication was a significant image booster for BNNC, which would increase its influence for nutrition governance in future. Such influence is particularly important for negotiation with development partners and coordination with large and powerful ministries. The workshops with Parliamentarians have further helped this cause, since the highest-level policy makers of the country are aware of nutrition, NPAN2 and BNNC. The subnational level activities helped clarification of multi-sectoral nutrition activities, objectives, targets, implementation modalities, roles, and responsibilities of DNCC/UNCC members.

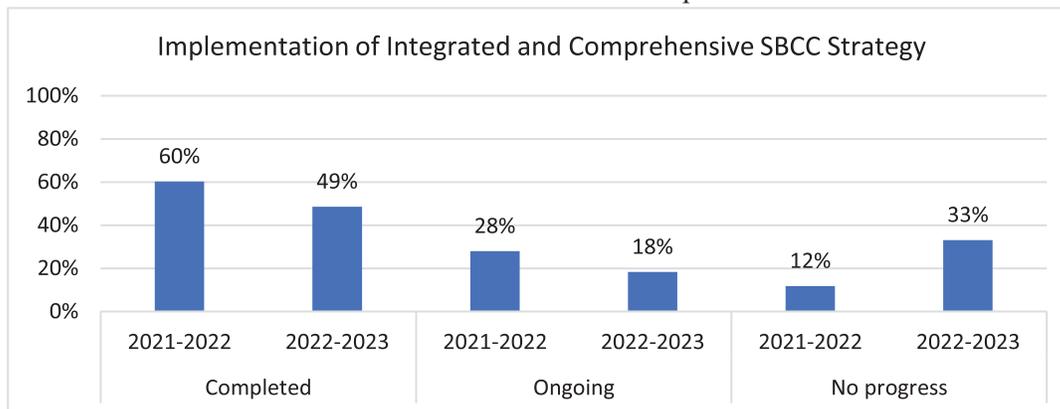
The Framework for Operationalization of the Advocacy Plan for Nutrition is set for 6 years till 2025, i.e. within the timeframe of NPAN2. This means the advocacy plan will be implemented in parallel to the operationalization of NPAN2. Moreover, with this experience, a similar advocacy plan will be part of the development of the NPAN3. The advocacy activities for nutrition along with budget have been included in all annual workplans under relevant 22 ministries. The NNW is already getting funds (approx. BDT 80 million per year) from the government. The sensitization of the Parliamentarians has increased the potentials for future mobilization of public resources.

BNNC, in its envisaged role of becoming the knowledge hub for nutrition in the country, decided to publish a series of knowledge documents on specific aspects of nutrition. Partners provided BNNC the technical support, guidance and, in cases, secretarial support in development and dissemination of these knowledge materials. The knowledge materials can be found in the webpage of BNNC, <https://bnnportal.gov.bd/site/page/405a6f3f-aa76-40e8-a7a9-856ba2f60bb0/>.

### Implementation status of Advocacy and SBCC activities included in Annual Workplans in Fiscal Year 2021-22 and 2022-2023.

It is observed that in FY 2022-23, total 142 advocacy related activities were included in Annual Workplans of various ministries of which 69 (49%) were completed, 26 (18%) were in progress and 47 activities (33%) with no progress (Fig. 16).

**Figure 16:** Status of SBCC activities included in Annual Workplans in FY 2021-22 and 2022-2023.



## Thematic Area 5: Monitoring, Evaluation and Research

### Overall Progress in this Thematic area

#### Key activities undertaken under Monitoring, Reporting and Research Thematic area during the reporting period.

BNNC with the support of partners and its Monitoring, Evaluation and Research platform developed a detailed Monitoring and Evaluation Framework of nutrition key sector's activities in line with the strategic actions from the NPAN2. This framework identified and established 25 gender sensitive priority indicators, drawn from the total 64 indicators included in NPAN2's monitoring and evaluation framework. The priority indicators were selected from nine out of 22 ministries which have the largest potential impact on nutrition. To develop the M&E Framework and formulating the priority indicators, several Multi-stakeholder workshops were conducted with the relevant ministries and key sector partners to identify ongoing or planned nutrition activities, assess existing M&E mechanisms of relevant ministries for streamlining and supporting a multi-sectoral nutrition M&E mechanism.

1. BNNC developed a common data hub and nutrition dashboard for nutrition Bangladesh – the first of this nature in Bangladesh in public sector. BNNC developed national and sub-national nutrition dashboard that tracks in real-time a priority set of nutrition indicators, expenditures on nutrition across government, the implementation of the Multi-sectoral Minimum Nutrition Package (MMNP), and the functionality of sub-national level nutrition coordination committees. The information displayed on the dashboard is available through the website of Bangladesh National Nutrition Council: <http://app.bnncc.gov.bd/dashboard/pages/>.

#### 2. Multi-sectoral online M&E system

Bangladesh National Nutrition Council (BNNC) in collaboration with Joint Action for Nutrition Outcome (JANO) funded by EU facilitated the operationalization and action planning processes of the District Nutrition Coordination Committee (DNCC) and Upazila Nutrition Coordination Committees (UNCC) in Rangpur and Nilphamari Districts to foster and coordinate nutrition initiatives at local level. In order for the Committees to effectively and efficiently support and deliver nutrition related services, coordination among all the respective departments/ministries is key. However, there was no unified, systematic and centralized information flow, which would enable the DNCCs and UNCCs to implement, monitor and review progress of their nutrition action plans, and the BNNC to conduct its regular monitoring over the Committees' performances.

To enable the information flow on nutrition between all relevant ministries and nutrition committees under the BNNC to implement, monitor and review progress of their annual nutrition plans, contributing to the realization of NPAN-2; the project supported BNNC to develop a multi-sectoral online monitoring and evaluation system. This system has strengthened planning, monitoring, coordination, accountability and decision making through easy access and sharing of nutrition-specific and nutrition-sensitive information between the different government departments, both vertically and horizontally. This system is particularly helping eight prioritized ministries of Bangladesh (Health and Family

Welfare; Agriculture; Livestock and Fisheries; Local Government and Rural Development Cooperatives; Education; Women and Children Affairs; Disaster Management and Relief; and Social Welfare) which are related with the Multi-sectoral Minimum Nutrition Package (MMNP).

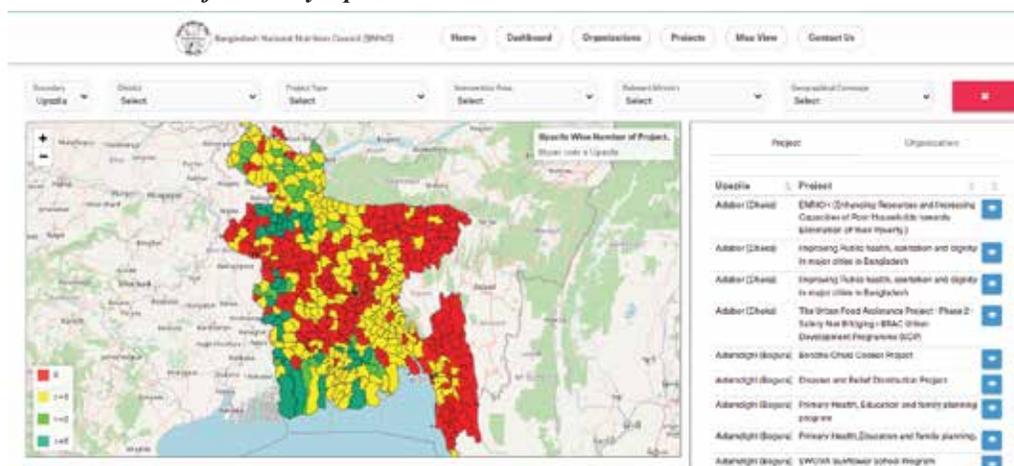
### SMS System: Nutrition-based information

Nutrition-based Short Message Service (SMS) platform is one of the key interventions of JANO project where various information is shared with the target participants via configured SMS service. The main objective of this service is to develop and disseminate nutrition sensitive and nutrition specific messages among the targeted audience within the project coverage area who have limited or no access to smart phones. The target group include pregnant and lactating women, mothers of children under 5 years of age and adolescent girls and boys. Another purpose of the intervention is to make the participants aware so, that they can apply the learnings from these SMS in their daily lives to overcome many health complications such as malnutrition, Anaemia, and blindness.

### NGO mapping application

BNNC has developed a web-based interactive visual comprehensive mapping platform of NGOs partners who are currently working on nutrition sensitive interventions across the country. It would help BNNC to identify potential partners, overlaps or gaps of the nutrition sensitive programmes. This would also help the DNCC and UNCC for planning of future programs on nutrition sensitive interventions in their respective operation areas for better operationalization NPAN2.

*Figure 16.a: Distribution of NGOs by Upazilla*



### Development and deployment of e-Learning applications

To enhance the health, hygiene and nutrition specific and sensitive knowledge and awareness among frontline workers and community people the project has developed four e-Learning solutions for the volunteers, frontline workers and community people, particularly targeting pregnant and lactating women, adolescents and children. These directly accessible applications will increase the quality of nutrition and health related services received, and promote a healthier and service oriented behavior among community people. Customized modules has been developed for different user's knowledge levels.

### DNCC/UNCC monitoring tool

To assess degree of functionality of district and upazilla nutrition coordination committees a web-based multisectoral nutrition planning and monitoring system including a set of tools has been developed based on functions of DNCCs and UNCCs to assess and inform the degree of functionality of these committees. DNCCs and UNCCs functions include planning, budgeting, overseeing implementation, and monitoring of multisectoral nutrition activities. The system has public access and a good visualization as per program demand, so that decision makers can easily access the information and ensure its utilization for decision making. Information in the dashboard is organized into the following

categories: (i) monitoring indicators to track the progress of NPAN2; (ii) monitoring of DNCC/UNCC to assess functionality and progress of MMNP activities; (iii) Bangladesh nutrition profile based on composite indicators; and (iv) progress tracking of nutrition work plans on of relevant ministries.



### Establishing a Financial Tracking System for Nutrition

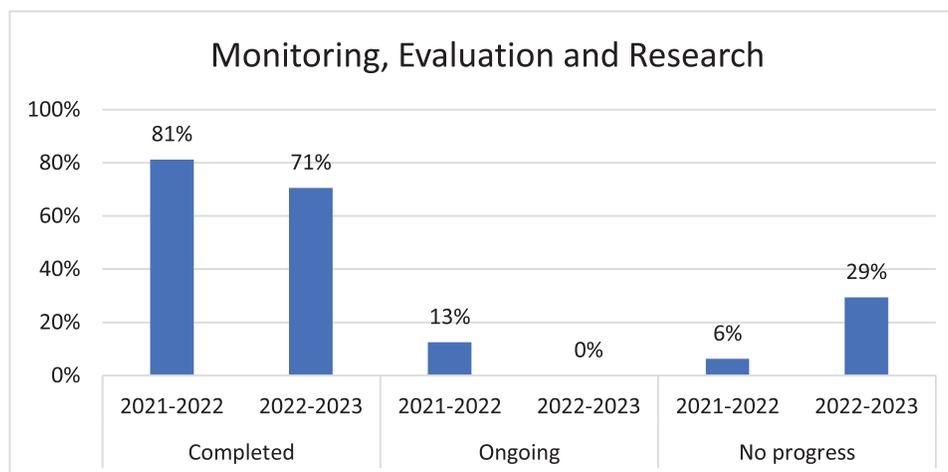
Tracking financial resources is essential for policy makers, as well as for citizens and donors. The development of common methodology to analyse expenditure for nutrition is however not straightforward. Accessing data on domestic and international public expenditure for nutrition has been a major challenge, which is also exacerbated by the multi-sectoral dimension of nutrition program.

Recently, the Finance Division, GoB and UNICEF conducted a Public Expenditure Review on Nutrition (PER-N) to analyse the level and composition of public expenditure in nutrition for three fiscal years of 2014-15, 2016-17 and the budget for 2017-18. The study estimated that the GoB spent BDT 23210 crore (USD 2.7 billion) in nutrition relevant interventions, representing around 1% of GDP and 9% of national budget in 2016-17 and the level of investment remained relatively stable during the study periods. It has also identified that the vast majority is spent on nutrition-sensitive interventions (98%) and a significant amount is on non-development operational lines.

At present, the Finance Division, GoB and UNICEF conducting a Public Expenditure Review on Nutrition (PER-N) to review the level and composition of public expenditure in nutrition for five fiscal years from FY 207-18 to 2021-22. In this regard, a draft report has been prepared and waiting for the approval by the Standing Technical Committee (STC) of BNNC. In addition, a guideline has been prepared to establish an online nutrition budget tracking system. This web-based software will be interoperable with iBAS++, AIMS and other relevant GoB systems. The system will provide an option for tagging a budget line (combination of organization, operation, and other segments) as Nutrition Specific or Nutrition Sensitive activities.

### Implementation status of M&E activities included in Annual Workplans in Fiscal Year 2021-22 and 2022-2023.

In FY 2022-23 total 17 M&E activities under five (5) ministries were included in their Annual Workplans. According to BNNC dashboard under M&E thematic area, seven (12) activities out of total 17 were completed (71%), one (0%) activity was ongoing and three (29%) activities without any progress. (Fig 17). It is also observed that in FY 2019-202 total 20 M&E activities were included of which five (25%) were completed and three (15%) were on progress and 12 (60%) with no progress.



**Figure 17.** Monitoring, reporting and research of nutrition priorities in Year 2021-22 and 2022-2023.

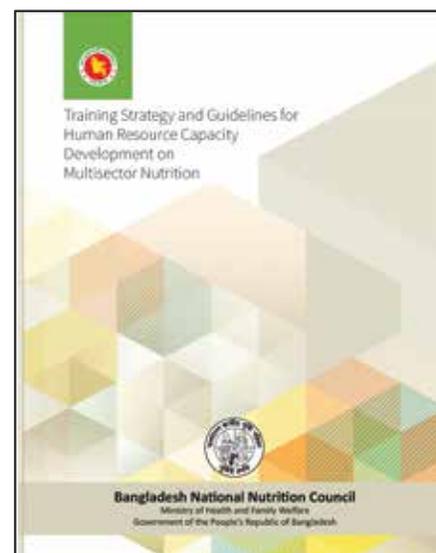
## Thematic Area 6: Capacity Building

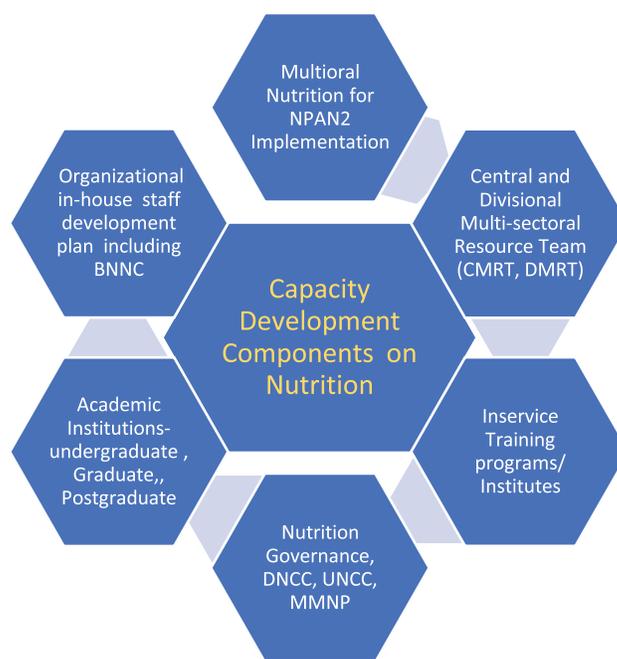
The NPAN2 observed that an essential part of an effective and functioning NPAN2 will be in building capacity, which needs to be targeted at all levels. Part of this would be to ensure that vacant positions are funded and filled. All sectors should address this in their own work plans and actions taken should be reported back to the BNNC who could be doing a broader examination of what capacity gaps there are, new needs, changing needs and the required trainings.

### Overall Progress in this Thematic area

#### *Strategy and Guideline for HR Capacity Development*

Based on the HR gap/need assessment report for nutrition, BNNC prepared a Strategy and Guidelines on human resource capacity development on multisectoral nutrition. Objectives of the initiative included review of training component and scope across ministries with respect to NPAN2 implementation, identify gaps and opportunities, recommend strategies and preparing guidelines for improvement of the overall context. It also analyzed and identified gaps and opportunities of existing capacity development activities in place for in-service human resources. Further strategies are recommended for improvement and coordination of human resource capacity development and preparing guidelines for training improvement which include model lessons.





**Figure 18:** Components of Capacity Development System on Nutrition

A three-tier effort is proposed at system, organizational and workplace level, although organizational level is the central under this review.

**System level actions:** Policy support in terms of socio-cultural, economic, and political environment that influences capacity development initiatives positively. System level may additionally be addressed through the Advocacy Plan component of the BNNC.

**Organizational level actions:** (Sectors/Ministries/training institutes)

- Competencies, Knowledge, Skills, and Attitudes of human resources of line ministries.
- Capacity and role of BNNC to coordinate, monitor and evaluate.

**Workplace level actions:**

- Job descriptions updating through review and inclusion.

### *Partnership with Universities and Institutes for Human Resource Capacity Development on Multisector Nutrition*

Under the framework of Strategy and Guideline for HR Capacity Development, BNNC arranged a consultation meeting with different public and private academic universities and institutes. The meeting discussed ways of technical collaborations. Recommended ways included reshaping curriculum inclusive of studying the nutrition policy and programmes of the country, to incorporate relevant and multisectoral issues for dissertation/thesis/research by graduate/post-graduate students, study visit by students to BNNC and visit by BNNC staffs as guest faculty to Institutes and to find scope for doing internship by post graduate students in BNNC.

### *Strengthening of BNNC office*

An essential part of an effective functioning NPAN2 would depend on building and developing the institutional capacity of BNNC and other aligned sectors. This would entail exploring (including an identification of the technical areas of expertise of the institutions) and establishing linkage with existing institutions at home and abroad. This would help to develop

systems for monitoring and evaluation including establishing a nutrition data hub, budget tracking mechanism, policy review and advocacy for resource mobilization.

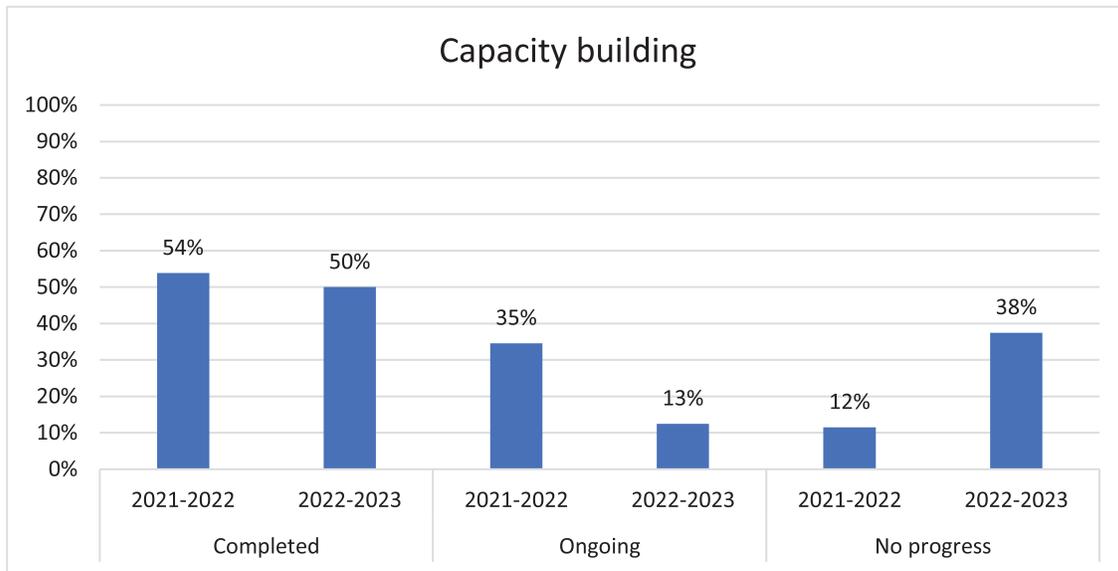
For strengthening of BNNC's institutional capacity it engaged a team of consultants to prepare a Development Project Proforma (DPP) based on the concept note on Strengthening of BNNC Office prepared earlier and approved by the Executive Committee (EC) of BNNC. This was supported by the Ministry of Planning with technical assistance from Nutrition International (NI) and UKAid. This DPP was aiming to transform the BNNC office as a learning organization to enable informed policy decisions, and to strengthen institutional mechanism for achieving the goal of the National Nutrition Policy and Second National Plan of Action for Nutrition. BNNC would be able to guide the country in the appropriate direction to overcome complex challenges and barriers for improving nutrition. Accordingly, BNNC office would be equipped with required human resources (i.e., the right mix of knowledge and skills) and physical facilities to implement its mandate.

As an interim measure, a team of consultants supported by partners (NI-UKAID, UNICEF, WHO and CARE) have been working at BNNC office to meet the current human resource gap in different disciplines, for example, overall operationalization of NPAN2 including inter-sectoral coordination, monitoring and evaluation, advocacy, etc. The aim of the consultants' support is to revitalise BNNC so that it can perform its mandate effectively. In addition, the consultant team has been working very closely with the BNNC officials so that staff may get hands on training and mentoring on technical and operational issues. There were regular interactions, meetings and discussions with the DG and other directors, which was essential for development of strategy, tactics and plans to implement the activities of BNNC. This technical assistance has helped BNNC to transform from an almost non-functional entity to an effective organisation to lead nutrition governance in Bangladesh.

During the reporting period several staff of BNNC received training on specific subjects from both international and local institutions supported by various partners (e.g. with technical support from the FAO Meeting the Undernutrition Challenge Programme (MUCH). These trainings helped the BNNC officials in developing their professional skills and knowledge.

### **Implementation status of capacity building activities included in Annual Workplans in Fiscal Year 2021-22 and 2022-2023.**

It is observed that in FY 2022-23 overall implementation performance of capacity building activities decreased in 2022-23 FY compared to FY 2020-21. For instance, total 73 activities were included in various Annual Workplans of relevant ministries/divisions/departments in 2020-21 of which 33 (45%) activities were completed, 12 (16%) were in progress and 28 (38%) activities with no progress. On the other hand, in FY 2022-23, total 32 activities were included in Annual Workplans of various ministries of which 50% were completed, 13% were in progress, and 38% were with no progress.



**Figure 19:** Status of Capacity Building activities in Annual Work Plans in FY 2021-22 and 2022-2023.

*Capacity Building Activities Undertaken to Revitalize BNNC and Operationalize NPAN2.*

1. Roll out of the Strategy and Guideline initiated through inclusion into the Platform Work plan and uptake of capacity development as an indicator for Ministry/OP work plan review. The standard orientation package can be used by the government and partners for rolling-out of nutrition planning exercise including MMNP in all districts and upazilas.
2. Sensitization and capacity enhancement of DNCC and UNCC created opportunity to strengthen planning and implementation of nutrition programs at the subnational level. The subnational level orientations have built the capacity of DNCC and UNCC to understand the prevailing nutrition issues, role of different sectors for implementation of NPAN2 to prevent malnutrition in their respective areas. DNCC and UNCC will be extended arms of BNNC at district and upazila level to enhance capacities of field level government officials on relevant issues of nutrition.
3. Capacity development has already been emphasized by the highest level of government for smooth functioning of nutrition activities in the country. Formation of CMRT and DMRT would be helpful in this regard, as it would provide a pool of ready resources on multi-sectoral nutrition across the country for national and sub-national level planning.

Activities related to HR capacity development along with required budget have been included in respective annual workplan of each of the relevant ministries.



# CHAPTER 4

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## Nutrition Governance, Institutionalization, Coordination and Implementation Mechanism

## Chapter 4: Nutrition Governance, Institutionalization, Coordination and Implementation Mechanism

### *Coordination and planning with relevant nutrition specific and sensitive ministries for operationalization of NPAN2 at central level*

Following the directive of the Council meeting, the Cabinet Division issues letter/circular to all relevant ministries to include nutrition activities into respective Annual work plan and allocate budget from own sources as required. In this regard, BNNC has proactively adopted several processes to implement the directive of the HPM and for operationalizing the NPAN2. The key activities include:

#### **i. Identification of Nutrition Focal Person in relevant Ministries**

In previous, with request from BNNC each ministry/division/department nominated one focal and one alternate focal person for nutrition. During the reporting period 2020-21 an updated list of total 121 focal/alternate focal persons was prepared and organized formal and informal orientation for them, including one to one discussion. BNNC organized eight inter-ministerial workshops with objectives to create awareness among them, to enhance inter-ministerial coordination and collaboration and to ensure incorporation of NPAN2-stated relevant activities into their Annual Development Program (ADP).

#### **ii. Formation and functionalized working level platforms to support operationalization of NPAN2**

There are five working level platforms, as envisaged in the NPAN2, for providing technical and operational support towards identification, planning, facilitations of necessary actions for implementation of NPAN2. These platforms are multisectoral in nature, having representations of government officials, development partners, UN agencies, I/NGOs, academicians, experts etc. relevant to the functions of the platforms. Due to the COVID both online and physical meetings were conducted during the reporting period for functioning of these platforms.

### *Coordination, planning and monitoring of multisectoral nutrition for operationalization of NPAN2 at sub-national level*

#### **Key Achievements under Policies and Planning Thematic Area during the reporting period. National Level**

- A comprehensive planning guideline prepared for annual nutrition work plans for the respective ministries, divisions, and departments (including OPs).
- Annual nutrition work plan developed for 21 ministries for those two consecutive years.
- Annual nutrition work plan developed for 13 OPs under MOHFW and City Corporation.
- Jointly with the Cabinet Division, a comprehensive review of 27 SSPs was completed; prepared a policy brief along with recommendations to make them more gender and nutrition sensitive.
- Strategies and actions regarding nutrition was incorporated into the 8<sup>th</sup> FYP.
- Jointly with UN agencies, a costed Global Action Plan (GAP) for Wasting resuction in Bangladesh was prepared.
- BNNC's own annual work plans were developed for FY 2021-22 and 2022-23.
- Mid-term review of NPAN2 done
- Initiation of multisectoral urban nutrition strategy development,
- Initiation of module development on "Journalism Training on Nutrition Governance"
- Initiation of financial tracking system
- Initiation of formation of BNNC Act

- Preparation for BNNC council meeting
- N4G operational framework developed
- Conducted a number of monitoring visit in DNCC/UNCC in different areas in Bangladesh
- 10th STC meeting conducted

### Subnational Level

- Tools and guidelines were prepared for subnational level planning.
- Annual nutrition work plan developed for 21 districts and 85 upazilas.

### Other Coordination with partners

#### ○ Building institutional cooperation through MoU

During 2021-22 and 2022-23 BNNC fostered partnership by signing Memorandum of Understanding (MoU) with 8 partner organizations to support operationalization of NPAN2 and other mutual areas of interest. The MoUs ensured gaining better understanding of the scope of works, roles and responsibilities of organizations, synchronizing efforts to maximize impact of nutrition actions. Apart from this, UNICEF instrumented a Rolling Workplan (RWP), as part of its wider cooperation agreement with GoB, with strong emphasis on the joint collaboration with BNNC to support multisectoral nutrition governance, coordination, and planning, as well as the tracking of nutrition investment.

### Knowledge Sharing for Establishing Nutrition Governance:

The Second National Plan of Action for Nutrition (NPAN-2) keeping alignment with the National Nutrition Policy 2015, SUN movement, ICN2, SDG, WHA and other international commitments, aims to reduce all forms of malnutrition from the country. NPAN-2 has successfully engaged 22 nutrition relevant ministries in implementing NPAN-2 to turn it into a real multisectoral nutrition governance program both at national and sub-national levels. Bangladesh National Nutrition Council (BNNC) is responsible for operationalizing NPAN2 in relevant program areas by providing technical support and hands on training in strengthening technical capacity of district nutrition coordination committee (DNCC) and upazila nutrition coordination committee (UNCC), to render nutrition governance at sub-national level.

A set of projects funded by the European Union with co-funding from the Austrian Development Cooperation, and implemented by different development partners have replicated proven best practices and scaled up innovative local nutrition governance model for better nutrition.

Following consortium that was involved for implementing the nutrition project in a well-coordinated process led by the BNNC.

- Bangladesh Initiative to Enhance Nutrition Security and Governance (BIeNGS) project
- Collective Responsibility Action and Accountability for Improved Nutrition (CRAAIN)
- Joint Action for Nutrition Outcome (JANO) Project
- Leadership to Ensure Adequate Nutrition (LEAN) Project
- Sustained Opportunities for Nutrition Governance (SONGO)
- Strengthening nutrition governance in Suchana working areas
- Livelihoods Improvement of Urban Poor Communities (LIUPCP) Project
- Building Rohingya refugee and Host Community Resilience Project

## **Sub-national level Experience from few projects:**

### **Bangladesh Initiative to Enhance Nutrition Security and Governance (BIeNGS) project**

**Background:** The Bangladesh Initiative to Enhance Nutrition Security and Governance (BIeNGS) Project is a multisector nutrition project aiming to improve maternal and child nutrition of 153,825 nutritionally-vulnerable families (1,701,100 people) in Jamalpur and Sherpur districts. The project is co-financed by the European Union, and the Australian Government through the Australian NGO Cooperation Program (ANCP). It is being implemented by a consortium of national and international development entities—Unnayan Sangha (US), the International Food Policy Research Institute (IFPRI-HarvestPlus, USA), the Institute of Development Studies (IDS, University of Sussex, UK), and World Vision (Bangladesh, Australia, and the UK). BIeNGS will cover 342379 direct beneficiaries of which 93,087 under five children, 50,732 pregnant and lactating women, 44,735 adolescent girls and 153,825 extremely poor households. The project period was from September 1, 2018 to 28 February 2023. Over the period of 4 years and 6 months, and with a budget of EUR 9.6 million.

#### **Major nutrition governance related activities:**

- Signed MoU with BNNC for annual nutrition plan under the NPAN2
- Linked DNCC & UNCC with BNNC to strengthen the implementation of NPAN2 at national to local level.
- Oriented the DNCC, UNCC & UDCC to implement the annual nutrition plan at their level
- Workshop with DNCC lead by BNNC to build capacity of the DNCC & UNCC and orient on how to develop the nutrition plan for their respective intervention area.
- Local to national level advocacy to fostering the nutrition services at community level as an outcome of the developed annual nutrition plan.
- Facilitate DNCC & UNCC to share the progress of the annual nutrition plan during DNCC & UNCC meeting as well as identifying the challenges and key lessons.
- Joint visit in coordination with DNCC & UNCC personnel to see the progress at community level and guide to achieve the plan.
- Collet and collate information from Union, Upazila & District multisector and compile to develop district nutrition plan
- Coordination and collaboration of Deputy Commissioner (DC) and Civil Surgeon (CS) in support with BNNC to make accountable to the multi-sectoral departments to execute the annual nutrition plan effectively.
- Advocacy for any change in budget allocation, resource mobilization and manpower engagement, capacity-building initiative will enhance effective nutrition governance for better outcome of nutrition services.
- Establishment of *Nutrition Model Village* to show the multi-sectoral integration of nutrition sensitive and specific interventions to demonstrate the expected changes in the community as well mobilize the multi-sectoral platforms.

#### **Challenges:**

- Less participation of key members of different departments. Attend office representatives for fulfilling corium, those are not relevant of this event.
- Developed nutrition plan at six non project upazila at Sherpur and Jamalpur district. Though, BIeNGS has no available staff at non BIeNGS six upazila of Jamalpur but by the cordial support of UNO and UH&FPO we have mitigated the challenging situation.
- Roles and activities of multi-sector platform are not used to raise local level finance mobilization.

**Lesson learned:**

- An effective meeting depends on roles of chairperson and member secretary of sub national level committee.
- Chairperson always give meeting date and time after receiving file note or request over cell phone from member secretary.
- Department wise power point presentation is the way to gather knowledge of other department.
- Union local government representative attended timely at the meeting venue along with necessary documents.
- Different department of GoB tried their best to submit perfect nutrition plan and budget.

**Collective Responsibility Action and Accountability for Improved Nutrition (CRAAIN)**

CRAAIN is a three-year project (2020-2022) focusing overall objective of the EU funded “Food and Nutrition Security Programme for Bangladesh 2015” to improve maternal and child nutrition. CRAAIN is aligned with the Government of Bangladesh’s policies specifically 8th Five Year Plan, the National Food Security Plan 2008-2015 and its related Country Investment Plan and the second National Plan of Action for Nutrition (NPAN2). The project is establishing an innovative and scalable pro-poor Nutrition Governance Model by adopting a multi-sectoral approach to improve nutrition in four upazilas (Mongla, Sharankhola, Kachua, Mollahat) in Bagerhat district.

CRAAIN is being implemented by a consortium, led by Concern Worldwide with WaterAid and local partners Rupantar and Jagrata Juba Shangha (JJS). The project collaborates with Bangladesh National Nutrition Council (BNNC) and the National Nutrition Services (NNS), Institute of Public Health Nutrition (IPHN) to operationalize NPAN2.

**Nutrition Governance related activities:**

- Media Engagement for better understanding and increase accountability on Nutrition governance
- Capacity building of District and Upazila Nutrition Coordination Committee members
- Facilitate DNCC and UNCC meeting
- Support DNCC to compile and submit annual nutrition work-plan to BNNC
- Support DNCC to monitor and support Upazila level nutrition action
- Joint monitoring by DNCC, UNCC and CSO members
- Conduct research on Nutrition Governance
- Empowering elected local government representatives on nutrition governance
- Advocacy with local government for budget allocation for Nutrition actions

**Lesson Learnt:**

- Effective Planning and implementation of nutrition actions is possible if there is proper coordination and communication among different departments, CSOs and development agencies
- Capacity Building of DNCC and UNCC members on multi-sectoral approaches to improve nutritional outcomes has a positive impact on preparation a joint annual action plan.
- Multi-sectoral engagement can improve nutrition behavior and practices at the community level
- Joint monitoring by DNCC and CSO members has huge impact

**Challenges:**

- Lack of Interdepartmental coordination among line departments for Nutrition sensitive development

- Lack of proper understanding of the importance multi-sectoral approached for improved nutrition outcomes
- Insufficient budget allocation by different GoB departments for incorporation and implementation of Nutrition actions.
- Lack of monitoring and supportive supervision to Nutrition action at different level
- Improper data management and progress tracking mechanism at sub-national level

## Joint Action for Nutrition Outcome (JANO) Project

### Background

Funded by the European Union with co-funding from the Austrian Development Cooperation, and implemented by CARE Bangladesh, PLAN International Bangladesh and ESDO, JANO will replicate proven best practices and scale innovative local governance model for better nutrition. The project will work with the Government of Bangladesh (GOB) and private sector at the national, regional and local levels, to support the effective implementation of the National Plan of Action for Nutrition (NPAN). JANO will work at multiple levels of government, especially with the Nutrition Committees at the District and Upazila levels and Union Development Coordination Committees at union levels – building their capacity for them to better develop nutrition programs, implement and budget, and to provide effective oversight in its implementation.

### Major activities (Nutrition governance related)

- Re-activate, build capacity and facilitate Community Support Groups of Community Clinics.
- Establish nutrition-sensitive climate-smart homestead garden at household level.
- Facilitate demonstration setup on high value nutritious vegetables by engaging concerned government departments.
- Training on nutrition-sensitive and nutrition-specific issues for the government front line workers
- Train teachers across 330 primary and secondary schools, to effectively teach topics on gender equitable and resilient health, hygiene and nutrition, as part of the school.
- Establishing adolescent corners, school garden, organizing cooking demonstration and other nutrition related events at 330 schools
- Nutrition plan development at CSG, UDCC, UNCC and DNCC following bottom-up approach.
- Practice of social accountability tools such as social audit, community score card engaging local government and community people
- Engage district right to food forum Bangladesh to better implement the nutrition action plan
- Engage private sector by linking them with women entrepreneurs to ensure access to nutrition related product and services at the community level
- Development of ICT-based solution which leads to both vertical and horizontal communication among government departments at the district and sub-district levels.
- Implement and maintain district and upazila level Information Portal (IP) for better monitoring of nutrition planning activities.
- Develop easy-to-use mobile phone-based ICT (information and communication technology) tools enabling communities to access nutrition-sensitive and nutrition-specific services.

### Challenges:

- Lack of understanding about nutrition
- Buy-in by different government officials and Union Parishad /Local Government
- Priority by government higher officials who lead the nutrition coordination platforms (DNCC and UNCC)
- Limited availability of CG/CSG members
- Limited knowledge of stakeholders on ICT and learning applications
- Frequent transfer of government officials slows down the overall implementation process.

### Lessons learned:

- Commitment, leadership, and investment is crucial.
- Nutrition Campaign at local level is required.
- Public-private partnership to ensure doorsteps supply.  
Evidence-based decision making
- Monitoring and Accountability
- Media engagement can play a crucial role to encourage local leader.
- Bottom-up planning process ensured the engagement of all relevant stakeholders and created ownership for development and implementation of Annual Nutrition Action Plan. Which bridges the demand vs service from community to the service providers.

## 3.4 Leadership to Ensure Adequate Nutrition (LEAN) Project

The European Union supported LEAN project has been implementing in Chittagong Hill Tracts (Bandarban, Rangamati and Khagrachari) since September 15, 2018 for achieving nutrition governance outcomes to improve maternal and child health nutrition in the CHT through intervening three areas: strengthening multi-sectoral committees at district and upazila level, creating community awareness through Social and Behavioral Change Communication on nutrition, and improving agricultural value chains. LEAN project is jointly managed by a consortium led by United Purpose; Other partners are GAIN, Helvetas, CARITAS, Jum foundation and Integrated Development Foundation. Under Nutrition governance component LEAN has three major interventions such as: 1. Promotion of multi-stakeholders' platforms 2. Advocacy for inclusion of CHT agenda as priority in national nutrition governance related policies, strategies and action plans. 3. Strengthen capacity and inter-departmental coordination in nutrition sensitive programming and service delivery of relevant government line departments, Local Government Institutions (LGIs), Hill Councils, and service providers.

Under multi-stakeholders' platforms component the first intervention area of LEAN is to implement government's 10-year nutrition plan: Second National Plan of Action for Nutrition (NPAN2; 2016-2025) and specifically triggering its two committees which are the District Nutrition Coordination Committee (DNCC) and the Upazila Nutrition Coordination Committee (UNCC) characterized as multi-sectoral and multi stakeholder platform. In addition to these committees, LEAN mobilized & formed a new nutrition platform at local level as Union Nutrition coordination committee (Union Pusti Committee in 77 union in 3 CHTs district for better nutrition coordination at local level through inclusion of traditional institutions (like *Karbari*, Headman), local GoB representative/officers & service hub). LEAN has been facilitating DNCC, UNCC and union-MSP committees for developing plan and review progress of integrated annual nutrition plan (FY 2020-2021 and FY 2022-2023) of respective committees. As a result of these interventions; a bottom-up planning process was followed which started from union level nutrition planning followed by upazila level multi-sectoral nutrition planning, and finally district level multi-sectoral planning combining nutrition-specific and nutrition-sensitive activities and worked for increasing nutritional budget provision in respective line departments. At a glance, in current DNCC plan (FY2022-2023) in Bandarban a total number of activities are 99, where budgeted activities are 38 with BDT 70870,750 budgetary allocation, the remaining 61 activities are non-budgetary activities as departmental ongoing interventions. The immediate outcome of these activities is that all nutrition platforms prepared their annual nutrition plan based on the guidelines of NPAN2 in three CHT districts. But the challenge of this interventions is lack of nutrition expert/ nutrition

focal person for each committee to monitor the programs and its progresses. Moreover, involvement from MOCHTA and HDC in the governance process of NPAN2/CIP2 is urgent to increase their participation in supportive supervision process and play a functional role in CHT. Training for GoB stakeholders on nutrition sensitive programming and orientation on NPAN-2 and CIP2 have been completed with support from BIRTAN and BNNC. District/Upazila level ‘resource pool’ were developed and capacitated on nutrition sensitive program with line agencies for supporting training on nutrition sensitive programming at upazila and union level. SAM & MAM service assessment and capacity development training for GoB doctors, nurse, CHCP, FWV, SACMO were completed with the support from IPHN. LEAN conducted assessment on policy landscape analysis for resource and coordination gap, shared the lessons among government stakeholders and organized 3 roundtable discussions on ‘Advancing Nutrition Commitments for Chittagong Hill Tracts’ to strengthen local nutrition services aligning with national commitments and plans to meet CHT nutrition needs.

## Coordination

During the reporting period BNNC proactively engaged government and development organizations at all levels to make the coordination process more participatory and sustainable. All necessary building blocks, basic works, and institutional arrangements for strengthening and institutionalizing the multi-sectoral coordination mechanism for nutrition have either been established or initiated by BNNC. These need to be rollout and sustained. For instance, some of the key activities along with budget will be included into MOUs with partners, annual workplans of BNNC, relevant ministries and D/UNCCs. As multisectoral approach and improved coordination that is required for achieving SDGs are included in 8<sup>th</sup> FYP (2021-2026), efforts will be required by all concerned parties to best use it by referring it in all opportunities, all times, at all levels, e.g. during formulation of policies/strategies, advocacy efforts and workshops/meetings, and optimal budget allocation for nutrition. BNNC continued to cease all opportunities to highlight the importance of the multisectoral coordination for improving nutrition for example, during preparation of the Global Action Plan (GAP) for wasting strategy in Bangladesh, developing country pathway document for UN Food Systems Summit (UNFSS), and 12 commitment statements for Bangladesh to N4G Summit 2021, Tokyo, etc.

The strengthened coordination capacity of BNNC resulted from support of partners have long term sustainable impact on the nutrition arena in Bangladesh. BNNC has become the knowledge hub and reference entity for the ministries and divisions in implementing respective strategies and action plans under NPAN2. To operationalize these and to ensure adequate resources, BNNC has now the capacity to guide, coordinate and follow up the development of annual work plans for nutrition in the relevant ministries and divisions. This, along with the regular meetings of STCs and inter-ministerial platforms arranged by BNNC has created a mechanism to ensure coordinated efforts in government’s nutrition interventions, instead of previous siloed approach from different ministries. Moreover, through regular interactions with stakeholders, traditionally “non-nutrition” ministries are sensitized, made aware and clarified regarding their role in implementing, particularly, nutrition-sensitive interventions. The bilateral meetings and MOUs of BNNC with the development partners, UN agencies and other non-government stakeholders has improved the planning and monitoring of relevant nutrition interventions, while avoiding duplication of efforts by, particularly, development partners and international non-government agencies. The regular interactions among the relevant stakeholders in the respective multi-sectoral thematic groups facilitated by BNNC also ensured an effective mechanism for coordinated planning, monitoring and follow up of nutrition interventions implemented by government and non-government actors, which is another vital aspect of operationalizing the NPAN2.

## Financial performance of NPAN2 during the reporting period

Since 2018, BNNC has been facilitating the processes of developing ‘Annual Nutrition Plan with budget’ of 22 relevant ministries and allied departments responsible for implementation of NPAN2. In the table below, a summary of ministry-wise budget allocation and expenditure for the planned activities in the respective period are presented:

**Table 14: Government budget allocation and expenditure for nutrition during reporting period**

Ministry	Financial Status (In lac taka)			
	Allocation		Expenditures	
	2021-22	2022-23	2021-22	2022-23
Ministry of Health and Family Welfare	10,524.07	989.59	3,306.32	703.05
Ministry of Finance	50.00	5,424.26	50.54	5,287.23
Ministry of Food	0.00	1,566,139.07	1.58	1,493,048.07
Ministry of Religious Affairs	N/A	11.70	N/A	11.10
Ministry of Agriculture	N/A	219.00	N/A	233.39
Ministry of Commerce	2,779.79	N/A	0.00	N/A
Ministry of Fisheries and Livestock	25,366.81	27,090.70	25,366.81	26,743.32
Ministry of Education	N/A	N/A	N/A	N/A
Ministry of Science and Technology	83.35	83.60	145.59	104.32
Ministry of Local Government, Rural Development and Cooperatives	1,723.00	1,863,578.00	1,723.50	1,471,742.00
Ministry of Water Resources	N/A	71.25	N/A	71.25
Ministry of Women and Children Affairs	N/A	327,843.93	N/A	306,118.92
Ministry of Youth and Sports	10,594.73	13,439.86	10,062.00	13,437.94
Ministry of Disaster Management and Relief	N/A	N/A	N/A	N/A
Ministry of Social Welfare	N/A	N/A	N/A	N/A
Ministry of Environment, Forests and Climate Change	N/A	N/A	N/A	N/A
Ministry of Labour and Employment	N/A	N/A	N/A	N/A
Ministry of Chittagong Hill Tracts Affairs	98.74	62.55	121.61	515.37
Ministry of Information	N/A	N/A	N/A	N/A
Ministry of Disaster Management and Relief	N/A	N/A	N/A	N/A
Ministry of Industry	N/A	N/A	N/A	N/A
Ministry of Planning	N/A	N/A	N/A	N/A

The financial information extracted from the sectoral workplan might be an estimate and may not be the true reflection of total budget for nutrition activities by the ministries/departments. But it is certain that there is growing sensitivity among ministries and department for incorporation of budget for specific interventions with objective to improve nutrition outcomes.

It is seen from the table that 18 ministries have submitted workplans with budget for the 2021-22 and 2022-23. Expenditure was received for two Fiscal Years 2021-22 and 2022-23. Out of 22 annual workplans from the ministries, 12 workplans have complete information for 2 years. The preliminary analysis suggests that, in 2021-22 FY a total of BDT 51,220.49 lac was budgeted by these 12 ministries of which BDT 40,777.95 (80%) was spent. In FY 2022-23 BDT. 3804953.51 was budgeted of which 3318015.96 (87%) was spent. The fund utilization rate has been increasing significantly.

Additionally, BNNC has also been working on to establish a ‘Multi-sectoral Financial Tracking System for Nutrition’ for regular/real-time monitoring and analysis of nutrition related budget allocation and expenditure by the key ministries and departments. Above all, NPAN2 could influence fund mobilization in favour of nutrition under different sectors/ministries that were likely to be spent for other purposes in absence of it.

### **New Development in Nutrition Sector needing Immediate Response**

This section highlights a few activities/events which were undertaken by BNNC as needed during the reporting period though they were not included in original NPAN2 documents. These activities/events were not included as they could not be anticipated during the time of design/formulation of the NPAN2. They evolved over the period either as consequence of the humanitarian crisis (for instance, COVID-19 pandemic, Russia-Ukraine war, etc.) or new global development in nutrition arena (for example, N4G Summit, UN Food Systems Summit, etc.), or new global commitments of the country (e.g. SUN country priorities, commitment for review of SSPs, Policy review of nutrition sensitive ministries, etc.), or to meet the real needs emanated as national priority action for nutrition to improve nutrition (e.g. bottle neck analysis of nutrition sensitive intervention to improve coverage and nutrition). Being the apex body for nutrition, in either situation BNNC was on top of the issue and proactively played its coordination role and engaged partners to take appropriate actions as needed.

Example of a few new developments during the reporting period which required actions and responses from BNNC include:

### **Operational Guideline for N4G Summit Commitments**

Nutrition for Growth (N4G) is a global effort to transform the way the world tackles malnutrition by uniting knowledge, resources, and commitments from countries, donors, non-governmental organizations (NGOs), businesses, and beyond. The latest Summit-third in the row- took place in Tokyo in December 2021—hosted by the Government of Japan—to continue the N4G legacy and further accelerate progress. The commitments of the Government of Bangladesh and its partner stakeholders to the Tokyo N4G Summit were developed based on previous commitments from first Summit 2013 in London and second Summit 2017 in Milan.

They are aligned with the Government’s Eighth Five-Year Plan (8<sup>th</sup> FYP), and in Perspective Plan (Vision 2041), as well as the National Nutrition Policy 2015 (NNP), the Second National Plan of Action on Nutrition (NPAN2) 2017-2025, the Second Country Investment Plan (CIP2), the National Food and Nutrition Security Policy (NFNSP) 2020, as well as the Bangladesh Roadmap for the Global Action Plan for Wasting (GAP) and the United Nations Sustainable Development Cooperation Framework (UNSDCF) for Bangladesh. It also complements commitments made during the United Nations Food Systems Summit (UNFSS) 2021.

Bangladesh places great importance on these commitments and fulfilling them will require the involvement of at least 22 different ministries and divisions, as well as support from development partners, United Nations (UN) agencies, organizations, academia, and civil society. Although the commitments are mainly strategic and political in nature, successful implementation will require integration into sectoral strategies and actions. This will necessitate a collaborative approach across multiple sectors, stakeholders, and levels, with an operational guideline to help plan, coordinate, implement, and monitor activities from an N4G perspective.

Therefore, an operational guideline has been prepared by BNNC with the support of relevant partners. This Operational Guideline has been prepared under the auspices of the Scaling Up Nutrition (SUN) Country Focal Point and coordinator of the N4G Commitments and the Bangladesh National Nutrition Council (BNNC) through a consultative process that involved stakeholders, different ministries



including cabinet division, the implementing agencies of these ministries, development partners, UN agencies, non-governmental organizations (NGOs), academia, researchers, and the private sector. A working group, which was led by the SUN Country Focal Point and five thematic groups comprised of members from the above stakeholders, contributed to prepare and review this document that was finalized through a validation workshop. This Guideline complements the N4G commitment document of the Government of Bangladesh (GoB).

### Support to Scaling Up Nutrition (SUN) movement in Bangladesh

Bangladesh as an early adopter joined the SUN Movement in September 2012 with a high-level commitment from the Hon'ble Prime Minister. In Bangladesh, all five SUN networks i.e. Multi-sectoral Platform (MSP), Civil Society (CSA), the United Nations (UN), Academia and Research, Businesses (SBN) and Donors are functional and working jointly to achieve the goal of SUN global movement.

“Malnutrition is the largest single contributor to physical and mental under-development and disease. The Secretary General’s SUN Movement, which aims to mobilize a global collective action against malnutrition, particularly in children, is therefore a far-sighted one. The ultimate purpose is to produce new generations of healthy people worldwide. Personally, I am committed to taking up these challenges at all levels.” Prime Minister of Bangladesh (September 2012).

The Government’s commitment towards SUN is being sustained through the boosted efforts of the BNNC. BNNC is mandated to implement the multi-sectoral, multi-stakeholder, multi-level approach envisaged in NPAN2 to improve the country nutrition situation in Bangladesh. In the reporting year, there has been an improved coordination among government sectors, development partners, civil society organizations, business communities through BNNC’s five multisectoral platforms and SUN five networks both at national and sub-national levels.

SUN networks and BNNC platforms are interlinked through the representation of members in the respective networks/ platforms. For example, at national level, SUN network members are well represented in all five platforms and actively supported for operationalizing the platforms whereas BNNC actively participates and contributes to the relevant SUN networks activities (SUN MSP, Academia networks). At sub-national level, SUN is also represented by the SUN CSA in the District multi-sectoral Nutrition Coordination Committees (DNCC) created under the BNNC by government’s official order.

SUN networks took the opportunity to utilize BNNC platforms to do more policy advocacy around national nutritional priorities. Among the SUN networks, SUN Academia Network worked closely with BNNC in the reporting year. The network undertook a study on “To Identify the Nutritional Research Gaps for Effective Implementation of NPAN2 in Bangladesh” with the technical support of the University of New South Wales, Australia and Institute of Nutrition and Food Science, University of Dhaka and financial support from Concern Worldwide. Based on the study findings and a follow-up study supported by the Nutrition International BNNC along with SUN Academia and Research Network a research strategy under NPAN2 has been developed. BNNC is now playing a pivotal role in mobilizing the academia and the nutrition researchers in Bangladesh.

Knowing the challenges of BNNC of having limited institutional and human capacity for multi-sectoral coordination to operationalize nutrition policies, strategies and programmes, SUN networks members were committed and provided technical and financial support to BNNC to perform its policy and advocacy roles. Both BNNC and SUN networks have aligned their work plans, which include activities related to strengthening of BNNC and support to the SUN SMS. BNNC received active support from the SUN networks members in the field of sectoral coordination for implementation/operationalization of NPAN2, nutrition governance and advocacy, developing/updating of nutrition policies and guideline, producing monitoring reports, financial tracking, fostering advocacy through celebrating the National Nutrition Week etc.

In 2018-19, BNNC organized 3 meetings of SUN academia (2) and Donor network (1). BNNC supported preparing SUN Joint Assessment Report 2019. Also, BNNC acts as a catalyst to achieve the

SUN priorities. For example, initiation of Multi-sectoral policy review; establishing the financial tracking system for relevant sectors; and develop a research strategy for nutrition; assessment of COVID-19 on children and adolescent girls- pre and post covid impact, etc.

Finally, BNNC along with other partners continued to provide assistance to SUN FP for effective implementation of SUN activities in Bangladesh. BNNC coordinated the country feedback for developing the SUN strategy 3.0 which has been highly appreciated by partners.

## Gender Empowerment and Nutrition

Women with low status or women's power relative to men tend to have weaker control over household resources, tighter time constraints, less access to information and health services, poorer mental health, and lower self-esteem. Women's status impacts child nutrition because women with higher status have better nutritional status themselves, are better cared for, and provide higher quality care to their children. Increases in women's status have a strong influence on both the long- and short-term nutritional status of children, leading to reductions in both stunting and wasting. IFPRI's multi country study estimates that if women and men had equal status, the under-three child underweight rate would drop by approximately 13 percentage points<sup>42</sup>. As women's status improves, so does the quality of the pathways through which it influences child nutrition. The pathways identified by the study are women's nutritional status (as measured by body mass index [BMI]), prenatal and birthing care for women, complementary feeding practices for children, treatment of illness and immunization of children, and the quality of childcare.

In Bangladesh societal norms and religious restrictions are the most severe concern of women's status issues. Urbanisation is slowly changing women's status as their economic role becomes more established through employment opportunities in export-oriented garments and electronics manufacturing. For many women, a move from the villages to the city for such job has brought an economic independence and contributing to the family and national income for the first time. Money is returning to the countryside as women working in the cities send remittances to their families.

The World Bank survey revealed that public spaces in Dhaka are often male-dominated spaces, and that this is correlated with women's decisions about employment. Women who do not feel that the environment outside of their home is safe are 10% less likely to participate in the labor market (Kotikula, Hill, & Raza, 2019).

The working women at their workplace face multifaceted problems such as salary discrimination (e.g. female workers earn 60% of the salary of male colleagues, late salary payment); sexual harassment, mocking, no leave during pregnancy and sickness, inadequate medical facilities, housing problems, insufficient transportation facilities, various diseases and unhygienic workplace due to industrial discharges (Osmani & Hossen, 2018).

In 2016, though the gender parity index for secondary level was 1.15-in favour of girls, but the completion rate in was 66% for boys and 54% for girls. The GER in higher secondary level was lower for girls than boys (41% for boys, 38% for girls) (BANBEIS, 2018).

Women and girls – bear the brunt of inadequate WASH services at home, workplace, and schools through:

- i. the loss of productive and leisure time from the hard work of water hauling and other WASH-related domestic work.
- ii. exclusion from full participation in schools due to the lack of separate WASH facilities for girls.
- iii. urinary tract infections arising from delayed urination or reduced water intake to cope with a lack of access to sanitation facilities; and

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<sup>42</sup> The importance of women's status for child nutrition in developing countries International Food Policy Research Institute (IFPRI) Research Report Abstract 131. Lisa C. Smith, Usha Ramakrishnan, Aida Ndiaye, Lawrence Haddad, and Reynaldo Martorell

- iv. the loss of dignity and threat of sexual assault due to the lack of appropriate toilets and WASH facilities both at stability and crisis periods<sup>43</sup>.

COVID19 impacts have exacerbated existing gender inequalities. Before the pandemic, the national female labor force participation rate was 36% considerably lower than the 80% male labor participation rate (BBS, 2017). Micro-surveys carried out after the COVID19 outbreak indicated that employment outcomes for women had deteriorated to a greater degree compared to men<sup>44</sup>. In urban areas such as Dhaka and Chittagong, women were disproportionately affected by job losses because of their concentration in occupations where job retrenchment had been more severe, such as the Readymade Garments sector, domestic services, and low-skilled informal work. In both cities, while unemployed men were more likely to continue to actively search for employment opportunities, women were more likely to exit the workforce altogether.

Intra-household tensions from COVID19 had also heightened the risk of gender-based violence (GBV), which disproportionately affects women's safety, productivity, well-being, and empowerment<sup>45</sup>. The prevalence of violence against women in Bangladesh has remained high, with close to 50% of women reporting physical abuse during their lifetime.

## ONGOING INITIATIVES

Two priority issues have been identified by the nutrition community which require special attention from BNNC, policy makers and partners working in nutrition arena. These two priority issues are: i) development of a multi-sectoral urban nutrition strategy; and ii) Formulation of a framework operationalization of N4G commitments.

### Multisectoral Urban Nutrition Strategy

Bangladesh is experiencing rapid urbanization resulted from shift in economy from agriculture towards more of manufacturing and services. As per the recent preliminary findings of the Population and Housing Census 2022 in Bangladesh, around 31.50% of the population (around 53 million) in the country are urban dwellers (BBS, 2022). Dhaka is a rapidly urbanising megacity in one of the world's most densely populated cities. Only the capital city, Dhaka, constitutes around 20% of the total urban population of the country (BBS, 2022). Rural to urban migration occurring in thousands annually resulting populous slums. Currently, around 35% of the urban dwellers reside in urban slums (BBS, 2022).

The National Nutrition Policy 2015 (NNP 2015) inadequately addressed the urban nutrition issue, as a result urban issue was not covered adequately in Second National Plan of Action for Nutrition (NPAN2) 2016-2025 (NPAN2). NPAN2 recognizes the gaps in nutrition services in urban slums and proposes for enhancing urban nutrition programming through effective coordination among government ministries & NGOs, and for strengthening linkages with WASH and social safety net programs. While MOHFW is responsible in rural areas, the health, population, and nutrition system in urban areas consists of different legal entities, with limited horizontal and vertical coordination. This results in blurred lines of accountability, further weakened by the lack of an effective coordination mechanism between the responsible parties. A multisectoral urban nutrition strategy is, thus required, to ensure the effective focusing and coordination among the responsible stakeholders to result in the optimum nutrition specific and nutrition sensitive interventions targeting the urban population.

The current delivery mechanisms for urban health and nutrition services are fragmented and insufficient. Though urban health and nutrition services are part of the primary health care system, the Local Government Division (LGD) of the Ministry of Local Government Rural Development and Cooperatives (MOLGRD&C) is responsible for its functioning and management, while the Ministry of

<sup>43</sup> UN-Water. (2006). Gender, Water and Sanitation: A Policy Brief; House et al (2014). Violence, gender and WASH: a practitioners toolkit; IASC. (2015). Guidelines for Integrating Gender-Based Violence Interventions in Humanitarian Action; Esteves Mills & Cumming. (2016).

<sup>44</sup> Genoni et al. 2020. Losing Livelihoods: The Labor Market Impact of COVID-19 in Bangladesh. Washington, DC: World Bank.

<sup>45</sup> <https://asiapacific.unwomen.org/-/media/field%20office%20eseasia/docs/publications/2020/07/>

Health and Family Welfare (MoHFW) provides the technical oversight. Moreover, besides the government, NGOs, and the private sector also contribute significantly. As the LGD is not well-equipped to provide such services, they primarily outsource these to NGOs with limited coverage. Hence the urban nutrition related services are divided between multiple providers without proper coordination. All these has been attributed to the lack of a comprehensive urban nutrition strategy to address both the proximate and underlying causes of malnutrition in these urban settings. Overall, while the utilization rates for nutrition services is better in urban than other areas, the rates vary significantly between wealth groups, with poorer segments barely accessing these services.

Bangladesh National Nutrition Council (BNNC) along with partner organizations from June 2022 to October 2023 to develop the first Multi-sectoral Urban Nutrition Strategy (MUNS). The strategy captures the nutrition specific and sensitive interventions across five relevant sectors that affect the nutritional status of urban population, especially those in the low-income category. These five systems are health, food, water and sanitation (WASH), education, and social protection.

### Climate Change and Nutrition

In December 2015, the United Nations Framework Convention on Climate Change drew up The Paris Agreement for commitment to tackle global climate change and more than 170 countries pledged to reduce greenhouse gas emissions (GHGE). The aim of The Agreement is ‘to strengthen the global response to the threat of climate change, in the context of sustainable development and efforts to eradicate poverty’<sup>46</sup>.

### Climate Change-Bangladesh perspective

Existing climate projections for Bangladesh include higher temperatures and sea-level rise<sup>47</sup>. These projections are expected to result in increased frequency, intensity and erraticism of cyclones, flooding, salination and drought events resulting to exacerbate the impacts of climate change on livelihoods and public health in Bangladesh. Consequently, pushing greater migration to already stressed urban centres<sup>48</sup>.

### Climate Change and Nutrition Linkages

Consequences of any climate change is linked with potential negative impact on food and nutrition security. Our current dietary habits are contributing to GHGE resulting in ever changing climate. As the climate changes the nutrient composition of some crops are likely to change, which adds another layer of complexity to nutrition security. Experiments on growing crops in different controlled environments have found that elevated atmospheric CO<sub>2</sub> levels and increases in temperature not only reduce crop yields but also lowers the nutrient density in a range of staple crops<sup>49,50</sup>). A meta-analysis of the data by Myers *et al*<sup>51</sup> showed that zinc, iron and protein concentrations in C3 crops (e.g. wheat, rice) and legumes (e.g. field peas, soyabeans) were significantly lower when grown at elevated CO<sub>2</sub> (levels predicted for 2050) compared with those grown at ambient CO<sub>2</sub> levels. They reported that in the edible portion of wheat grown under warmer and higher CO<sub>2</sub> conditions, the zinc, iron and protein concentrations were lower by an average of 9.3, 5.1 and 6.3 %, respectively. The phytate content also reduced, which could potentially counter some of the losses in zinc and iron in terms of increasing the bioavailability. For rice, the reduction was 3.3, 5.2 and 7.8 %, respectively, but there was no significant change in the phytate concentration.

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<sup>46</sup> UNFCCC (2015) Paris: Agreement. [https://unfcccint/sites/default/files/english\\_paris\\_agreementpdf](https://unfcccint/sites/default/files/english_paris_agreementpdf) (accessed October 2018).[Google Scholar](#)

<sup>47</sup> Karmalkar et al. (2010). UNDP Climate change country profiles: Bangladesh. [http://www.undp.org/content/undp/en/home/librarypage/environment,energy/climate\\_change/adaptation/undp\\_climate\\_changecountryprofiles.html](http://www.undp.org/content/undp/en/home/librarypage/environment,energy/climate_change/adaptation/undp_climate_changecountryprofiles.html), accessed March 2018.

<sup>48</sup> USAID (2016). USAID/Bangladesh comprehensive risk and resilience assessment. Washington, DC. <https://www.usaid.gov/bangladesh/documents/2016-comprehensive-risk-and-resilience-assessment>. Accessed March 2018.

<sup>49</sup> Myers, SS, Zanolletti, A, Kloog, I et al. (2014) Increasing CO<sub>2</sub> threatens human nutrition. *Nature* 510, 139–142. [CrossRefGoogle ScholarPubMed](#)

<sup>50</sup> Challinor, AJ, Koehler, A, Ramirez-Villegas, J et al. (2016) Current warming will reduce yields unless maize breeding and seed systems adapt immediately. *Nat Clim Chang* 6, 954–958. [CrossRefGoogle Scholar](#)

<sup>51</sup> Myers, SS, Zanolletti, A, Kloog, I et al. (2014) Increasing CO<sub>2</sub> threatens human nutrition. *Nature* 510, 139–142. [CrossRefGoogle ScholarPubMed](#)



# CHAPTER 5

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## CONCLUSION AND RECOMMENDATIONS

## CHAPTER 5. CONCLUSION AND RECOMMENDATIONS

### 5.1 Conclusion

Bangladesh demonstrated remarkable successes in nutrition across sectors during the reporting period including improvement in the overall nutritional status of its population. Statistics from several data are indicative of the likelihood of achieving NPAN2 targets by 2025, however a few targets demand special attention for immediate measure and are flagged in this report. Still there are challenges around coordination & monitoring, financing the projects & programmes, equity issues around socio-economic classes and geographical areas etc. NPAN2 sets a platform to facilitate harmonized efforts to achieve targets and to overcome the challenges identified in the report.

### 5.2 Recommendations

#### 5.2.1 Overall Recommendations

A comprehensive monitoring and evaluation framework of the NPAN2 is to be established under the auspices of BNNC, and be maintained throughout the year to achieve, acquire and document data and information from all available sources, so that contents of annual monitoring report can be prepared concurrently.

Strengthening capacity of the BNNC to materialize the challenging tasks of facilitating multisectoral programming, monitoring and coordination are important.

Develop a strategy for resource mobilization for implementation of the NPAN2.

Develop a strategy to improve coverage of nutrition sensitive and specific interventions both in health and beyond health sectors.

#### 5.2.2 Recommendations by Thematic Areas

##### Thematic Area 1: “Nutrition for All” following Life Cycle Approach

##### IYCF Practices and Child Malnutrition

1. Improve early initiation of breast feeding among infants delivered at all health facilities as well as in households. Reinforcing quality counselling of caregivers, family members and community influencers on importance of nutrition during the first 1000 days of life – connecting maternal, infant, and young child nutrition and care.
2. Implement government and judicial directives to create baby friendly spaces (breastfeeding corner) in all public and private facilities/utilities, and workplaces including Ready-Made Garments (RMG) sector. Enforce Breast Milk Substitute (BMS) Act 2013 with all its provisions including prevention of its aggressive promotion, marketing and distribution.
3. Utilize health and non-health service delivery platforms (e.g, agriculture, fisheries, livestock and social protection sectors, etc.) for promotion of dietary diversity along with increased feeding frequency for children 6-23 months and women. Key sectors to include those key performance indicators into their respective programs.
4. Strengthen capacity and coverage for screening, detection, referral and management of complicated Severe Acute Malnutrition (SAM) cases by ensuring adequate duration of hospital stay.

##### Micronutrient Malnutrition

1. Strengthen IFA supplementation for Pregnant and Lactating Women (PLW) by improving the coverage and compliance from health service delivery points through counselling and ensuring supply chain. Scale up the options of weekly distribution and on-spot consumption of Iron and

Folic Acid (IFA) to ensure the compliance amongst adolescent girls at school, and at community clinic and FWC for out of schoolgirls.

2. Enforce the law for mandatory edible oil fortification with vitamin A through stringent monitoring and quality control. The consumer-friendly easy to understand food labelling systems in front places of package to be made mandatory.

### **Water Sanitation and Hygiene (WASH)**

1. Improve sanitation facilities and supply of safe water for underprivileged communities (urban slum, rural). Strengthen monitoring the quality of drinking water to ensure prevention of water contamination with faecal coliforms and other harmful pathogens.

### **Urban Nutrition and Non-Communicable Disease (NCD)**

1. Formulate an urban multisectoral nutrition strategy guiding policy and programmatic directions; strengthen nutrition component across public, private and NGO urban health services with adequate coordination mechanism in place in the face of rapidly growing urban population with emerging malnutrition problems.
2. Strengthen maternal, infant and young child nutrition services in urban health setting in terms of quality counselling services through adequate human resource, capacity development, demand generation, and adjustment of messages to address urban -specific challenges.
3. Undertake public information campaign (both in urban and rural areas) on harmful effects of excessive salt, sugar, saturated fats, trans-fats including hydrogenated vegetable oil, especially in the processed and junk foods.

### **Thematic Area 2: Agriculture, Diet Diversification and Locally Adapted Recipes**

1. Ensure dietary diversity – production of affordable, nutritious, safe and local foods in adequate quantity and quality to meet the dietary and nutrient requirements in a sustainable manner.
2. Agriculture, fisheries, and livestock interventions should have nutrition objectives with a focus on improving access to and consumption of high-quality diets for all household members, especially mothers and young children.

### **Thematic area 3: Social Protection**

1. Ongoing Social Safety Net programs where possible, should be reviewed and modified to set nutrition objectives to improve nutrition situation of the vulnerable population during their designing as well as monitoring and evaluation.
2. Target women of reproductive age (15-49 years) especially the pregnant and lactating mothers, women working in formal e.g. in garments sector and non-formal sectors and households with children under two years as well as adolescent girls in social protection programs considering their nutrition vulnerability.
3. Combine high quality behaviour change communication activities with social protection programs on nutrition during implementation of the targeted social protection programs aiming to improve the quantity and quality of food intakes and reduce malnutrition among the beneficiary groups.
4. Extend the number of Social Safety Net programs (SSN) and their beneficiaries targeting to the urban poor in order to achieve SDG-1 target to attain inclusive growth targeting vulnerable.
5. Establish coordination mechanism between MOHFW and relevant ministries for/during social safety net program during designing, program implementation, monitoring and evaluation.

#### **Thematic Area 4: Implementation of Integrated and Comprehensive SBCC Strategy**

1. Include and coordinate advocacy and BCC activities into sectoral work plans and ensure their implementation by different sectors including HNP sector's Comprehensive SBCC Strategy 2016 through Advocacy and Communication Platform, and BCC Working Group.
2. Roll out 'Advocacy Plan for Nutrition (2019-2025)' under 'Framework for Operationalization of the Advocacy Plan for Nutrition' through GOB Sectors as well as BNCC-DP consortium arrangement.
3. Strategic and effective use of National Nutrition Week for nutrition advocacy at national and sub-national level.

#### **Thematic Area 5: Monitoring, Evaluation & Research**

1. Establish integrated and interoperable nutrition information system coordinated by BNNC office to capture multi-sectoral nutrition data and information in line with NPAN2 targets.
2. Develop a routine monitoring and reporting system of sub-national level Multi-sectoral Coordination Committees to monitor their functionality and implementation progress of multisectoral minimum nutrition package (MMNP).
3. Develop an implementation plan of research strategy along with a coordination mechanism and mobilization of resources.
4. Establish a sustainable multisectoral nutrition surveillance system for routine status monitoring.

#### **Thematic Area 6: Capacity Building**

1. Roll out 'Training Strategy and Guidelines for Multisector Nutrition', developed by BNNC to improve capacity of allied human resources engaged in nutrition programme planning and management.
2. Develop and sustain capacity of CMRT and DMRT for subsequent capacity development of national and sub-national level personnel relevant to NPAN2 implementation.

#### **Recommendations related to Nutrition Governance, Institutionalization, Coordination and Implementation Mechanism**

1. Roll out district nutrition plan along with multisectoral minimum nutrition package through DNCC and UNCC in all districts and upazilas.
2. Accelerate the implementation of monitoring mechanism at sub-national level to monitor functionality of DNCC & UNCC, and implementation progress of MMNP.
3. Expand partnership with the non-health development partners and other non-government agencies at national and sub-national level.
4. Advocate to address the issue of uncovered vulnerable groups (e.g, ethnic minorities, tea garden workers, floating population, etc.) in terms of targeting, SBCC activities etc.
5. Synchronize financial and administrative rules across partners to ease the transfer and utilization of the resources.
6. Implementation and monitoring of the operational plan to realize and monitor country commitments made at Nutrition for Growth (N4G) summit.



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## ANNEXURES:

Annex 1: The trend of status of primarily outcome and impact level priority indicators in light of NPAN2 targets

SL.	Indicators	NPAN2 Target 2025	Baseline of NPAN2 2016	Current Status	Previous status
1	Increase the <b>initiation of breastfeeding</b> in the first hour of birth	80%	51%	40% (BDHS 2022)	69% (BDHS 2017-18)
2	% of children (0-6m) <b>exclusively breastfed</b>	70%	55%	55% (BDHS 2022)	65% (BDHS 2017-18)
3	% of children (6-23 m) receiving <b>(MAD)</b>	40%	23%	29% (BDHS 2022)	35% (BDHS 2017-18)
4	Percentage of infants born with <b>low birth weight</b> (<2,500 grams)	16%	23%	23%	14.8% (MICS (2019))
5	Reduce <b>Stunting</b> among under-5 children	25%	36%	24% (BDHS 2022)	31% (BDHS 2017-18)
6	Children under 5 years who are <b>wasted</b>	<8%	14%	11% (BDHS 2022)	8% (BDHS 2017-18)
7	Children under 5 years who are <b>overweight</b>	1.40%	1.40%	1.5% (BDHS 2022)	2.40% (MICS 2019)
**	children under age 5 are <b>underweight</b>	NA	33% (BDHS 2014)	22% (BDHS 2022)	22% (BDHS 2017-18)
8	% of Women 15-49 yrs. with <b>Anaemia</b>	<25%	42%	28.9% (NMS 2019-20)	28.9% (NMS 2019-20)
9	% of children under 5 with diarrhoea treated with ORT and Zinc	Not yet fixed	38%	43.3% (BDHS 2022)	43.60% (BDHS 2017-18)
10	% of women 15-49 yrs who are overweight or obese (BMI ≥23)	30%	24%	39% (BDHS 2014)	39% (BDHS 2014)
11	% of adolescent girls (15-19 yrs.) with height <145 cm	<8%	13%	4.51% (SFNS (2022))	4.51% (SFNS (2022))
12	% of adolescent girls (15-19 yrs.) thin (total thinness)	<15%	29%	18% (SFNS (2022))	18% (SFNS (2022))
13	% of women (20-24 yrs) who have begun childbearing	10%	31%	28% (BDHS 2017-18)	28% (BDHS 2017-18)
14	% of population that use improved drinking water	>99%	98%	98.50% (MICS 2019)	98.50% (MICS 2019)
15	% of population that use improved sanitary latrine (not shared)	75%	45%	59% (BDHS 2022)	43% (BDHS 2017-18)
16	% of caregivers with appropriate hand washing behaviour	50%	27%	27% (FSNSP 2014)	27% (FSNSP 2014)
17	Per capita consumption of fruits and vegetables	≥400g per day	Fruits: 44.7 gm Vegetables: 166.1 gm	Fruits: 95.4 gm (HIES 2022) Vegetables: 201.9 gm (HIES 2022)	Fruits: 35.78 gm Vegetables: 167.3 gm (HIES 2016)

SL.	Indicators	NPAN2 Target 2025	Baseline of NPAN2 2016	Current Status	Previous status
18	% share of total dietary energy from consumption of cereals	<60%	70% (HIES 2010)	30.54% (HIES 2022)	HIES
19	% of women age 20-24 years who were first married by age 18 yrs	30%	59%	51.40% (MICS 2019)	51.40%(MICS 2019)
20	Number of Social Safety Net Programs which incorporated nutrition sensitive & nutrition specific objectives	50%	10% (assumption)	15% (assumption)	10% (assumption)
21	Number of upazilas covered under VGD program to provide nutritionally enriched fortified food	50%	Nil	189 Upajillas (WFP 2019)	189 Upajillas (WFP 2019)
22	% of children (36-59 m) who are attending an early childhood education program	30%	13%	18.90%(MICS 2019)	18.90%(MICS 2019)
23	% of women who completed secondary/higher education	90%	14%	32% (BDHS 2022)	17% (BDHS 2017-18)
24	Number of ongoing comprehensive coordinated multisectoral, multichannel advocacy and communications campaign	10	NA	NA	
25	Change in per capita consumption of:				
	i. salt	i. <5 gm/person/day (WHO)	i. Salt: not available	i. Salt: 25.37 gm/person/day (HIES 2022)	i. Salt: not Available
	ii. sugar consumption	ii. <10% of total energy intake	ii. Sugar: 7.4 (gm/capita /day)	ii. Sugar: 11.64 (gm/capita /day) (HIES 2022)	ii. Sugar: 6.9 (gm/capita /day) (HIES 2016)

## Annex 2: Showing the status of workplan submission of relevant ministries

SL.	Ministry / Department	Plan (2021-22)	Plan (2022-23)	Progress Report (2021-22)	Progress Report (2022-23)
1	Ministry Of Health and Family Welfare (MOHFW)	OK	OK	OK	OK
2	Ministry of Fisheries and Livestock (MOFL)	OK	OK	OK	OK
3	Ministry of Commerce (MOCOM)	OK	OK	OK	OK
4	Ministry of Finance (MOF)	OK	OK	OK	OK
5	Ministry of Food (MOFood)	OK	OK	OK	OK
6	Ministry of Youth and Sports (MOYSports)	OK	OK	OK	OK
7	Ministry of Local Government, Rural Development and Cooperatives (MOLGRDC)	OK	OK	OK	OK
8	Ministry of Science and Technology (MOST)	OK	OK	OK	OK
9	Ministry of Chittagong Hill Tracts Affairs (MOCHTA)	OK	OK	OK	OK
10	Ministry of Education (MOE)	OK		OK	
11	Ministry of Social Welfare (MOSW)	OK		OK	
12	Ministry of Disaster Management and Relief (MODMR)	OK		OK	
13	Ministry of Primary and Mass Education (MOPME)	OK			
14	Ministry of Women and Children Affairs (MOWCA)	OK		OK	OK
15	Ministry of Agriculture (MOA)	OK		OK	OK
16	Ministry of Religious Affairs (MORA)			OK	OK
17	Ministry of Information (MOI)			OK	OK
18	Ministry of Industry (MOInd)			OK	
19	Ministry of Planning (MOP)				
20	Ministry of Environment, Forests and Climate Change (MOEFF)	OK		OK	
21	Ministry of Water Resources (MOWR)	OK		OK	
22	Ministry of Labour and Employment (MOLE)	OK			

## Annex 3: Showing the status of Financial Progress based on workplan of relevant ministries 2021-22 and 2022-23

Ministry	Financial Status (In lac taka)			
	Allocation		Expenditures	
	2021-22	2022-23	2021-22	2022-23
Ministry of Health and Family Welfare	10,524.07	989.59	3,306.32	703.05
Ministry of Finance	50.00	5,424.26	50.54	5,287.23
Ministry of Food	0.00	1,566,139.07	1.58	1,493,048.07
Ministry of Religious Affairs	N/A	11.70	N/A	11.10
Ministry of Agriculture	N/A	219.00	N/A	233.39
Ministry of Commerce	2,779.79	N/A	0.00	N/A
Ministry of Fisheries and Livestock	25,366.81	27,090.70	25,366.81	26,743.32
Ministry of Education	N/A	N/A	N/A	N/A
Ministry of Science and Technology	83.35	83.60	145.59	104.32
Ministry of Local Government, Rural Development and Cooperatives	1,723.00	1,863,578.00	1,723.50	1,471,742.00
Ministry of Water Resources	N/A	71.25	N/A	71.25
Ministry of Women and Children Affairs	N/A	327,843.93	N/A	306,118.92
Ministry of Youth and Sports	10,594.73	13,439.86	10,062.00	13,437.94
Ministry of Disaster Management and Relief	N/A	N/A	N/A	N/A
Ministry of Social Welfare	N/A	N/A	N/A	N/A
Ministry of Environment, Forests and Climate Change	N/A	N/A	N/A	N/A
Ministry of Labour and Employment	N/A	N/A	N/A	N/A
Ministry of Chittagong Hill Tracts Affairs	98.74	62.55	121.61	515.37
Ministry of Information	N/A	N/A	N/A	N/A
Ministry of Disaster Management and Relief	N/A	N/A	N/A	N/A
Ministry of Industry	N/A	N/A	N/A	N/A
Ministry of Planning	N/A	N/A	N/A	N/A

**Annex 4: Showing the progress of workplan by thematic areas of relevant ministries**

	Completed		Ongoing		No progress	
	2021-2022	2022-2023	2021-2022	2022-2023	2021-2022	2022-2023
Nutrition for all following the Life Cycle Approach	49%	62%	33%	13%	18%	26%
Agriculture and Diet Diversification and Locally Adapted Recipes	72%	64%	0%	15%	28%	21%
Social Protection	33%	53%	53%	22%	13%	25%
Implementation of Integrated and Comprehensive SBCC Strategy	60%	49%	28%	18%	12%	33%
Monitoring, Evaluation and Research	81%	71%	13%	0%	6%	29%
Capacity building	54%	50%	35%	13%	12%	38%

Annex 5: Showing the status of workplan submission of relevant ministries 2021-2022 and 2022-2023

SL.	Name	Activity progress (2021-22)				Activity progress (2022-23)			
		Planned Activity	Completed (%)	Ongoing (%)	No Progress (%)	Planned Activity	Completed (%)	Ongoing (%)	No Progress (%)
1	Ministry Of Health and Family Welfare (MOHFW)	28	14 (50.00%)	12 (42.86%)	2 (7.14%)	7	4 (57.14%)	3 (42.86%)	0 (0.00%)
2	Ministry of Fisheries and Livestock (MOFL)	16	12 (75.00%)	3 (18.75%)	1 (6.25%)	21	14 (66.67%)	6 (28.57%)	1 (4.76%)
3	Ministry of Commerce (MOCOM)	14	9 (64.29%)	0 (0.00%)	5 (35.71%)	12	10 (83.33%)	0 (0.00%)	2 (16.67%)
4	Ministry of Finance (MOF)	52	4 (7.69%)	28 (53.85%)	20 (38.46%)	84	24 (28.57%)	5 (5.95%)	55 (65.48%)
5	Ministry of Food (MOFood)	1	0 (0.00%)	1 (100.00%)	0 (0.00%)	21	12 (57.14%)	1 (4.76%)	8 (38.10%)
6	Ministry of Youth and Sports (MOYSports)	2	0 (0.00%)	2 (100.00%)	0 (0.00%)	3	1 (33.33%)	2 (66.67%)	0 (0.00%)
7	Ministry of Local Government, Rural Development and Cooperatives (MOLGRDC)	2	2 (100.00%)	0 (0.00%)	0 (0.00%)	78	33 (42.31%)	16 (20.51%)	29 (37.18%)
8	Ministry of Science and Technology (MOST)	13	12 (92.31%)	1 (7.69%)	0 (0.00%)	14	11 (78.57%)	1 (7.14%)	2 (14.29%)
9	Ministry of Chittagong Hill Tracts Affairs (MOCHTA)	76	62 (81.58%)	13 (17.11%)	1 (1.32%)	81	77 (95.06%)	1 (1.23%)	3 (3.70%)
10	Ministry of Education (MOE)	0	0 (0%)	0 (0%)	0 (0%)	4	0 (0.00%)	1 (25.00%)	3 (75.00%)
11	Ministry of Social Welfare (MOSW)	0	0 (0%)	0 (0%)	0 (0%)	0	0 (0%)	0 (0%)	0 (0%)
12	Ministry of Disaster Management and Relief (MODMR)	0	0 (0%)	0 (0%)	0 (0%)	0	0 (0%)	0 (0%)	0 (0%)
13	Ministry of Primary and Mass Education (MOPME)	0	0 (0%)	0 (0%)	0 (0%)	0	0 (0%)	0 (0%)	0 (0%)
14	Ministry of Women and Children Affairs (MOWCA)	0	0 (0%)	0 (0%)	0 (0%)	5	3 (60.00%)	0 (0.00%)	2 (40.00%)
15	Ministry of Agriculture (MOA)	0	0 (0%)	0 (0%)	0 (0%)	9	2 (22.22%)	5 (55.56%)	2 (22.22%)
16	Ministry of Religious Affairs (MORA)	0	0 (0%)	0 (0%)	0 (0%)	22	2 (9.09%)	19 (86.36%)	1 (4.55%)

17	Ministry of Information (MOI)	0	0 (0%)	0 (0%)	0 (0%)	4	4 (100.00%)	0 (0.00%)	0 (0.00%)
18	Ministry of Industry (MOInd)	0	0 (0%)	0 (0%)	0 (0%)	0	0 (0%)	0 (0%)	0 (0%)
19	Ministry of Planning (MOP)	0	0 (0%)	0 (0%)	0 (0%)	0	0 (0%)	0 (0%)	0 (0%)
20	Ministry of Environment, Forests and Climate Change (MOEF)	0	0 (0%)	0 (0%)	0 (0%)	0	0 (0%)	0 (0%)	0 (0%)
21	Ministry of Water Resources (MOWR)	0	0 (0%)	0 (0%)	0 (0%)	9	9 (100.00%)	0 (0.00%)	0 (0.00%)
22	Ministry of Labour and Employment (MOLE)	0	0 (0%)	0 (0%)	0 (0%)	0	0 (0%)	0 (0%)	0 (0%)



June 2024

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