MONITORING REPORT
2018-2019

SECOND NATIONAL PLAN OF ACTION FOR NUTRITION

Bangladesh National Nutrition Council
Health Services Division
Ministry of Health and Family Welfare
Government of the People's Republic of Bangladesh

June 2020

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

Annual Monitoring Report
2018-2019

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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Director General
Bangladesh National Nutrition Council (BNNC)

Message

Father of the Nation Bangabandhu Sheikh Mujibur Rahman dreamt a developed Bangladesh free of hunger and poverty and as such he established Bangladesh National Nutrition Council in 1975 which now has been running under the leadership of Her Excellency the Honorable Prime Minister. 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) keeping in alignment with the SUN movement, ICN2, SDG, WHA and other international commitments, 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 which have been able to incorporate Annual work plans of those ministries with their own budget. This was one of the key directives of Honourable Prime Minister while approving this NPAN-2 in 2017. Thus, nutrition activities are mainstreamed among the sectors in order to making a difference in people's life.

The Monitoring Report of 2018-19 attempts to have thorough investigation of the present nutrition situation through its pre identified activities and provide suggestions. This monitoring report is the first of its kind for NPAN 2 that simultaneously put forwarded the successes and challenges of 2018-19. It also outlines the budgetary analysis where sufficient funding has been recommended. Among the 64 indicators stated in the NPAN-2, on realizing practical situation, it identified different sectoral 25 priority indicators through multiple consultation process and tracks the progress accordingly.

Today, this gives me immense pleasure and I am really overwhelmed to see the Monitoring report has been published despite having significant shortcomings. I would like to take the opportunity to thank each ministry, their respective departments, UN bodies, developing partners, INGO, NGOs who contributed through their active and vibrant participation. I am truly grateful to the Health and Family welfare Ministry for the stewardship and their all-out relentless support in every spheres in preparing this document. I would also like to offer my heartfelt thanks to my colleagues, peers and related all who really worked hard to make it a successful one. I am sure that this report will help in making informed decision with basic leadership towards improved nutrition and food security in Bangladesh. I am confident that we are on the very right track and we hope we can achieve our target by 2025.

Dr. Khalilur Rahman
Director General
Bangladesh National Nutrition Council (BNNC)

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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 International
HMIS	Health Management Information System
HNP	Health Nutrition Population
ICVGD	Investment Component of Vulnerable Group Development Project
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

SL.	Output/Outcome level indicators	Operational Definition
1	% of children aged <5 years stunted	Percentage of stunting (height-for-age <-2 standard deviations of the WHO Child Growth Standards median) among children aged 0-5 years
2	% of children aged <5 years wasted	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
3	% of infants born with low birth weight (<2,500 grams)	Percentage of live births under 2500 g out of the total number of live births during the same period.
4	% of children aged <5 years overweight	Percentage of overweight (weight-for-height >+2 standard deviations of the WHO Child Growth Standards median) among children aged 0-5 years
5	% of women 15-49 with Anemia	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.
6	Early initiation of breastfeeding	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
7	% of children (0-6 months) exclusively breastfed	Proportion of infants 0-6 months who are exclusively breastfed
8	% of children <5 years with diarrhoea treated with ORT and Zinc	Percentage of children aged 0-5 years with diarrhoea in the last two weeks receiving ORS and Zinc
9	% of women 15-49 yrs who are overweight or obese	Percentage of non-pregnant women aged 15–49 years who are overweight (defined as having a BMI ≥23 kg/m2) and obese (defined as having a BMI ≥25 kg/m2). BMI is calculated by dividing the subject's weight in kilograms by their own height in meters squared.
10	% of adolescent girls aged 15-19 yrs. thin (total thinness)	% of adolescent girls aged 10-19 yrs. with BMI <18.5
11	% of women aged 15-19 yrs. who have begun childbearing	Percentage of women age 20-24 years who have had a live birth before age 18

SL.	Output/Outcome level indicators	Operational Definition
12	% of children (6-23 months) receiving MAD	Percentage of children age 6–23 months who had at least the minimum dietary diversity and the minimum meal frequency during the previous day
13	% of population that use improved drinking water	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.
14	% of caregivers with appropriate hand washing behaviour	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.
15	% of population that use improved sanitary latrine (not shared)	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.

Status of National Target Indicators for reducing various forms of malnutrition and their progress towards NPAN2 targets by 2025.

Target Indicators	Baseline	Target by 2025	Progress		Target Status
			BDHS (2017-18)	MICS (2019)	
Increase the rate of initiation of breastfeeding in the first hour of birth	51% (BDHS 2014)	80%	69%	46.6%	
Increase the rate of exclusive breastfeeding in infants less than 6 months of age	55% (BDHS 2014)	70%	65%	63%	
Increase the rate of continued breastfeeding in children aged 20 to 23 months	87% (BDHS 2014)	>95%	87%	84%	
Increase the proportion of children aged 6-23 months receiving a minimum acceptable diet	23% (BDHS 2014)	>40%	34%	27.8%	
Reduce the rate of low birth weight	23% (National LBW Survey 2016)	16%	Not Available	NA	NA
Reduce stunting among <-5 children	36% (BDHS 2014)	25%	31%	28%	
Reduce wasting among <5 children	14% (BDHS 2014)	8%	8%	9.8%	
Reduce the rate of severe acute malnutrition (SAM) (WHZ < -3)among children under 5	8% (BDHS 2014)	<1%	4%	2.3%	
Reduce the proportion of underweight among <5 children	33% (BDHS 2014)	15%	22%	22.6%	
Reduce malnutrition (Total Thinness, BMI<18.5) among adolescent girls (15-19yrs)	19% (BDHS 2014)	<15 %	NA	NA	NA
Increase Vitamin A capsule supplementation coverage in children aged 6- 59 month	62% (BDHS 2014)	99%	79%	NA	
Increase the rate (>15PPM) of iodized salt intake	58% (National Micronutrient Iodization Survey 2011-12)	90%	-	76%	
Control & reduce maternal overweight (BMI>23)	39% (BDHS 2014)	30%	NA	24%	
Reduce the rate of anaemia among pregnant women	50% (BDHS 2011)	25%	NA	NA	NA
No increase of childhood overweight (WHZ >+2) among children under 5 years	1.40%	No increase	2.20%	2.4%	

In progress **On track** **Off track** **Not Available** (NA)

EXECUTIVE SUMMARY

This is the second 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 June 2018-December 2019 and for the year's before, aiming to track the progress trend of NPAN2 target indicators, events and activities. This report aimed to ensure tracking of annual progress by updating the monitoring report.

Overall Progress

Bangladesh demonstrated a steady improvement in child nutrition status during the past decade, particularly in the recent years. Survey findings from MICS 2019 reveals that the level of stunting among children under the age of 5 years has declined from 42 percent in 2012-13 to 28 percent in 2019. But wasting has remained unchanged with slight increase from 9.6 percent in 2012-13 to 9.8 percent in 2019. The level of underweight has declined significantly from 31.9 percent in 2012-13 to 22.6 percent in 2019. These data trend demonstrates NPAN2 targets can be achieved by 2025. However, there exist differences of rate of malnutrition at various geographical and socio-economic level.

Progress in thematic areas

Thematic Area 1: Nutrition for All following Life Cycle Approach

Infant and Young Child Feeding Practices (IYCF)

Exclusive Breastfeeding (EBF) rate has increased from 56% in 2012/13 to 63% in 2019 (MICS 2019). As per BDHS report (2017/18) despite a fall in EBF rates from 64% in 2011 to 55% in 2014, the EBF rate rebounded to 65% in 2017-2018. Both BDHS and MICS surveys indicate with current rate of progress Bangladesh is on track to achieve the NPAN2 target of 70% by 2025. Early Initiation of Breast Feeding (EIBF) is also improved over the years: from 36% in 2006 to 57% in 2012/13 which has dropped to 47% in 2019 (MICS 2019). With the current rate of improvement of EIBF from 17% in 1999-2000 to 69% in 2017-18 as demonstrated by BDHS report, the country is on track to achieve the NPAN2 target of 80% by 2025.

According to MICS 2019 results, 28% among breastfed and 17% among non-breastfed children of 6-23 months age group were consuming a minimum acceptable diet (MAD). On the other hand, the 2017-18 BDHS findings reported that 34% of children aged 6-23 months were consuming a minimum acceptable diet (MAD) compared to the 21% reported in the BDHS 2011. There exist variation in MAD consumption between different geographical areas as well as in wealth quintiles. With current rate of progress, the NPAN2 target for MAD at 40% by 2025 will probably be surpassed.

Micronutrient Malnutrition

Iron deficiency is a major cause of anaemia among pregnant women, adolescent girls, and children. About 46% women had a minimum dietary score in 2015 against the target of 75% of MDD-W by 2030.

The coverage of the 1st round (held on 14 July 2018) vitamin A supplementation (VAS) was about 98.8% covering a total of 20,914,529 children aged 6 to 59 months. On the other hand, vitamin A supplementation coverage was found low at 79% in BDHS survey in 2017-18. According to MICS 2019, the consumption of iodised salt was 76%. Use of ORT with zinc increased from 38% in 2014 to 44% in 2017.

Adolescent Nutrition

In Bangladesh one-fourth of the adolescent girls aged 15-19 years are stunted. The proportion of adolescent height <145 cm (cut off level for thin) has remained unchanged at 13% since 2011. Nineteen percent adolescent girls aged 15-19 years were thin (BMI <18.5) in 2014. Adolescents living in rural areas are more likely to suffer from stunting as compared to those living in urban areas. Child marriage and

early childbearing are common practices in Bangladesh. Age at first marriage for girl, has continued to rise, albeit slowly. The median age at first marriage among women age 20–49 increased from 15.3 years in 2007 to 16.3 years in 2017 (BDHS 2017/18). Percentage of women age 20-24 years who have had a live birth before age 18 was 24%.

Maternal Nutrition and Low Birth Weight (LBW)

About one in every four (23%) adult women is chronically energy deficient. Rate of overweight or obese (BMI ≥23 or ≥ 27.5)[1] among women aged 15-49 years has increased from 17%, in 2011 to 39% in 2014 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).In 2019, 1,616,168 under-five children were screened at the community level and referred for nutrition management as compared to 1,467,138 in 2018 (DHIS2-DGHS). However, it is unclear about how many of them actually availed nutrition services and were cured of the availed services. Moreover, high number of screened cases found in counting, compared to total estimated GAM cases found in statistics could be due to over counting.

Water, Sanitation and Hygiene (WASH)

Water, sanitation and hygiene are closely associated with degree of health and nutrition status. About 99% of households use improved sources of water, either in their dwelling/yard/plot or within a 30-minute round trip. However, these sources are not always safe. For example, 40% of tested households, and about 82% of the households' drinking water, was contaminated with E. Coli.

The percentage of household members using improved sanitation facilities has increased from 77% in 2012-13 to 85% in 2019 (MICS 2019). 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 figures were much higher than BDHS 2017-18 results 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. Geographical differences of progress in figures for water quality, sanitation, and hygiene also exist.

Urban Nutrition

Currently, an estimated 37% of the total population live in urban areas, which is projected to grow over 50% by 2039 (UHS 2013, UNDESA 2018). The Child Well-Being Survey in Urban Areas in Bangladesh (2016) revealed that 26%, 20% and 8% of all children living in urban areas were respectively stunted, underweight and wasted. There was marked difference between all forms of malnutrition amongst slum dwelling and non-slum dwelling children.

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

The performance of the agricultural sector is improving as evidenced by the continued annual growth of agricultural GDP between 2015-16 and 2017-18.

[1] WHO Asian BMI cut points (overweight = 23–27.5 kg/m^2; obese ≥ 27.5 kg/m^2)

Production of Cereals

Bangladesh has been self-sufficient in rice production since 2012, which has increased to 7.3% in 2017-18 from -2.6% in 2017-18. The production of pulses, which are rich in protein, is increasing, but at a slower pace compared to rice. In 2017-18, the annual change in production was 0.7%, which declined to 0.5% in 2018-19. Unlike cereals, the production growth of fruits and vegetables slightly increased in2018-19. Bangladesh has achieved self-sufficiency in fish production, by crossing the target of 40.50 lakh metric tons in 2016-17. Although production of meat, eggs and milk is increasing every year, the percentage of increase is still low and there is a gap between production and demand, except for meat.

Consumption

With the increased availability of food, there has been an improvement in quality and diversity of diets consumed by the population. Despite this positive gain, diet quality remains below global recommendations, particularly related to consumption of fruits, vegetables, animal-source foods, and pulses. Overall, calorie intake per capita per day has decreased to 2210 Kcal from 2308 Kcal in 2010 (a decrease of about 4%). This decrease amount (2210 Kcal) is below the desirable 2430 Kcal/capita/day. This reduction could be attributable to the considerable decrease of rice consumption both in rural and urban areas in 2016 compared to 2010.

Thematic Area 3: Social Protection

The spending on Social Safety Net Programs (SSNPs) as a percentage of the total national budget has increased steadily (both total and percentage) between FY 2016/17 and 2018/19. The allocation has gradually increased from 12.88% in 2016/17 to, 13.06% in 2017/18 to 13.81% in 2018/19. The 2016 HIES data shows that 27.8% of the households have received benefits from SSNP during the last 12 months. Despite all positive moves, still a large proportion of poor and vulnerable households do not have access to these programmes. Moreover, the targeting is not always proper, and the average demanded size of the benefit is low therefore, the intended impact on poverty reduction from the amount of money spent on these programmes is less.

Social Protection Programmes offer multiple ways for integrating nutrition considerations. Prioritization of targeting for nutritionally vulnerable groups should be an important mechanism to deliver the social protection programme's potential nutrition impact. Alongside transfers a simultaneous behaviour change communication (BCC) campaign can significantly improve the child nutritional status and anthropometric outcomes. Adding BCC to transfers (cash and kinds) leads 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 (IFPRI).

Vulnerability and Climate Change

Due to geographic location of the country, calamities such as cyclone, flood, riverbank erosion, landslide, drought, and ground water contamination have become very frequent in the recent years. As a consequence, the vulnerable population are more affected than the others. The vicious cycle of poverty continues to increase their vulnerability and risks. This is important as the number of poor are likely to increase if adequate measures are not put in place to combat climate related calamities.

Thematic Area 4: Implementation of Integrated and Comprehensive SBCC Strategy

National Nutrition Week (NNW), 2019 and Routine BCC Activities

BNNC and -IPHN under the leadership of MOHFW, jointly worked with partners to organize countrywide NNW from 23-29 April, 2019. The theme of NNW was "While thinking about food, think about nutrition too" "**খাদ্যের কথা ভাবলে পুষ্টির কথা ও ভাবুন।**". The week-long programmes included rallies, fairs,

scientific seminars, nutrition olympiad, road shows, and processions and was implemented nationwide jointly by DNCCs, UNCCs and civil society organisations and development partners.

Routine BCC activities of BNNC include BNNC's orientation on NPAN2 for 53 districts, several round table dialogues, TV talk shows, and seminars to highlight progresses, challenges, and recommendations for a multi-sectoral approach for nutrition.

Bangladesh Advocacy Plan for Nutrition 2019-2025

Ten year National Advocacy Plan for Nutrition showcased its audiences, activities, timeline and required budget for implementation. To support this advocacy plan, a possible multi-trust fund has been prepared by BNNC.

Thematic Area 5: Monitoring, Evaluation and Research

Monitoring, Evaluation and Research, is one of the most important functions of BNNC aimed to track NPAN 2 activities and to make decision for policy making to achieve SDG goals. Activities from NPAN2 have been concised into 25 priority indicators from seven key ministries. Accordingly, these indicators were included in respective sectoral plans and a guiding document has been developed by the M&E platform to avoid multiple parallel nutrition information systems exist in Bangladesh. BNNC has started monitoring progress of sectoral annual workplan of relevant ministries on six monthly basis and initiated creation of a dashboard at national and sub-national levels. M&E team collected, analysed and used nutrition information to provide evidence for formulating appropriate strategies and policies for improvement of nutrition status.

Budget Tracking

Budget tracking of nutrition activities from the sectors is a part of the BNNC monitoring system. Of the total budget BDT. 121,070,610,000 for 2018-19, BDT. 1,837,840,000 (1.5%) was from six Operational Plans under the Ministry of Health and Family Welfare (MoHFW) mostly for nutrition specific interventions and BDT.119,232,770,000 (98.5%) was from nutrition sensitive interventions with 17 workplans of sectoral ministries. The allocation for 2019/2020 has increased to BDT. 149,400,397,800 of which BDT. 2,869,214,000 (1.86%) and BDT. 146,531,183,800 (98%) were for nutrition specific and nutrition sensitive interventions respectively.

Strategy to Conduct Operational and Implementation Research

To improve nutritional status of children and women in Bangladesh, BNNC jointly with SUN Civil Society Alliance and Academia Networks with support from partners have conducted a study on research gaps in nutrition.. Based on findings a strategy (2020-2025) has been developed aimed to strengthen the capacity of BNNC to manage, coordinate, supervise, outsource research as envisaged under NPAN2. Research topics have also been identified and prioritized as immediate priority, meaning that the results which are required with in next two years (2010-2022), medium priority (by 2025) and long-term priority (beyond 2025).

BNNC has initiated a process of creating a web-based repository for nutrition researches in Bangladesh. The repository will be multisectoral in nature. Beside this, the BNNC has established a journal club for sharing research findings on nutrition.

Thematic Area 6: Capacity Building.

A study commissioned by BNNC to assess the existing human resource **(**HR) competency in relevant nutrition sectors at national and sub-national levels revealed that most sectors do not have dedicated nutrition staff with the required knowledge and skillset to manage and implement nutrition programs as envisaged under NPAN2. The human resources, right from the national to the field level in all the

ministries (nutrition specific and sensitive) require basic sensitization/orientation on required competencies to implement nutrition activities.

During the reporting period several staff of BNNC received training on specific subjects from both international and local institutions supported by various partners.

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

BNNC has undertaken four workshops at national level with all nutrition focal points from 22 ministries, high level government officials, partners to prepare a 10 year work plan along with annual work plans aligning with the NPAN2 action and M&E matrix.

Multisectoral District Nutrition Coordination Committee (DNCC) and Upazila Nutrition Coordination Committee (UNCC) members have been orientated on NPAN2 in 53 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: Introduction

1.1 Overview

The Annual Monitoring Report details progress made towards the implementation of the Second National Plan of Action on Nutrition (NPAN2) 2016-2025, during the period of 2018-19. 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 behaviour 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.

1.2 Background

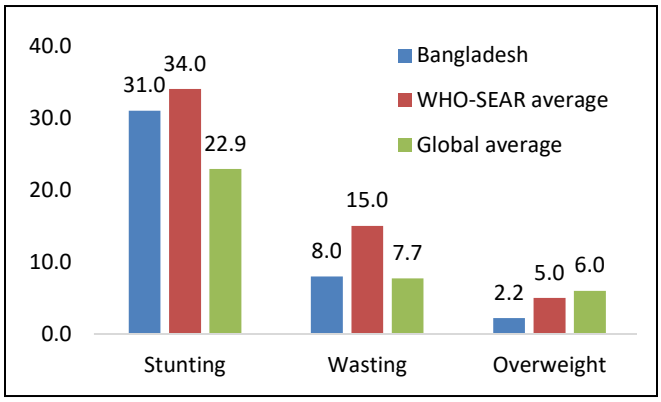
Efforts by the Government of Bangladesh, including the implementation of the first National Plan of Action on Nutrition from 1997 to 2015, have led to significant progress in improving health and nutrition in the country over the last decade. The prevalence of stunting fell from 43% in 2007 to 31% in 2017, and wasting declined from 17% in 2007 to 8% in 2017 (BDHS). Bangladesh's second National Plan of Action (NPAN2) continues to build on this progress.

Between 2007 and 2017, Bangladesh witnessed:

28%: drop in stunted children
46%: drop in underweight children
53%: drop in wasted children

Nutrition trends (stunting, underweight and wasting) among under-five children indicate that Bangladesh has made critical gains in the last decade. In fact, Bangladesh is among the 10 countries to reach SDG targets (SUN Progress Report 2019). However, it continues to reckon with a serious public health problem owing to the high prevalence of under nutrition among under-five children in the country.

Figure 1.1: Comparison of nutritional status of under 5 children (%) in Bangladesh with WHO-SEAR & Global averages



The report of the Bangladesh Demographic and Health Survey 2017-18 shows that around 31% of under-five children are stunted, 22% are underweight and 8% are wasted. Figure 1.1 shows that Bangladesh has a lower prevalence of stunting as compared to the South East Asia Region (SEAR) average, but a higher prevalence of stunting than the global average.

Figure 1.1 also indicates that the proportion of children who are wasted in Bangladesh is almost at par with the global average, and is nearly 50% lower than the regional (WHO-SEAR) average. The prevalence of children who are overweight are lower than both the global and regional averages. Critical factors behind Bangladesh's story of change in nutrition are quoted in a six country study[2]: "Much of the improvement in nutrition in Bangladesh in recent years is explained by what can be seen as nutrition-sensitive drivers within a wider enabling environment of pro-poor economic growth. Key amongst these factors have been improving incomes; smaller family sizes and greater gaps between births; parental - and particularly women's - education and wider health access."

The study further reveals, *"Community based nutrition programmes have not yet been operating at scale as in other countries and the current governance arrangements for nutrition delivery are weak. But as Bangladesh faces growing new nutritional problems and still suffers from a relatively high burden of child stunting, such 'nutrition-specific' programmes will have to play a greater role than in the past, as the further gains from some of these wider drivers may be limited and are likely to have plateaued."*.

NPAN2 is a thoroughly planned initiative that has taken care to place emphasis on reducing underlying causes of malnutrition. The box below highlights key focus elements in nutrition sensitive interventions.

[2] Nicholas Nisbett, Peter Davis, Sivan Yosef & Nazneen Akhtar, Bangladesh's story of change in nutrition: Strong improvements in basic and underlying determinants with an unfinished agenda for direct community level support (2017), available at https://doi.org/10.1016/j.gfs.2017.01.005, last seen on 29/04/2020

1.2.1 Underlying causes affecting the nutrition status of children in Bangladesh

- **High poverty level impacting on nutrition of poor.** About 40% of children from the lowest wealth quintile were found to be stunted; this was more than double the prevalence of stunting experienced by children in the highest wealth quintile at 17.0% (BDHS, 2017-18).
- **Lower food security.** The prevalence of stunting was higher among children in districts having lower food security as compared to the national average (BDHS, 2014).
- **Untreated diarrhoea.** Of 85% reported diarrhoea cases in under-five children, only 44% were treated with both oral rehydration therapy (ORT) and Zinc (BDHS, 2017-18).
- **Untreated acute respiratory infections.** While 5.4% of under-five children presented with symptoms of acute respiratory infection (ARI), only 34.2% of those reported cases were given antibiotics to treat the illness (BDHS, 2017-18).
- **Per capity calorie intake is low and share of total dietary energy from cereals is high.** Overall calorie intake per capita per day has decreased to 2210 Kcal (against the national target of 2400 Kcal/person/day) from 2308 Kcal in 2010. The percentage share of the total dietary energy from consumption of cereals was targeted to less than 60%; it has reduced from 70% in 2010 to 64% in 2016, which shows a slight reduction of 1 percentage point per year (HIES, Household Income and Expenditure Survey, 2016).
- **Minimum Acceptable Diet for women and children are low.** Staple diets typically lack important micronutrients, leading to high prevalence of micronutrient deficiencies. About 34% of children aged 6–23 months receiving a MAD in 2017/18 against the NPAN2 target of 40% by 2025. About 46% women had a minimum dietary score in 2015 as per target of 75% of MDD-W by 2030.
- **Poor water quality.** While 99% of the population has access to an improved source of drinking water, problems with water quality remain a major concern. For example, drinking water in 82% households was contaminated with E. Coli (MICS, 2019)
- **Lack of sanitary facilities and the most vulnerable report the lowest access to improved sanitation facilities..** Only 43% of households reported having an improved toilet facility, and 3.7% of households still practice open defecation (BDHS, 2014). Only 13% of households in slums have access to improved sanitation compared to over 50% in other, non-slum urban areas (BUHS, 2013).
- **Unhygienic behaviours.** 73% of caregivers do not practice recommended hygienic behaviours (FSNSP, 2015). For example, only 2% of caregivers reported washing their hands with soap before feeding a child (DPHE, 2015) and nationally, only half the households safely dispose child's solid waste. About 38% of young children defecate on the premises/yard (FSNSP, 2015).
- **Female literacy rate improving but still low.** From 2010 to 2016, female literacy increased from 54.8% to 63.4%; Primary School enrollment increased from 84.8% to 93.5%; and Secondary School enrollment increased from 77.8% to 84.3% (HIES, 2016). Mothers who completed secondary and higher education have less stunted children (18%) than mothers with no education (47%). Moreover, women's educational status is positively associated with their own height.
- **Many more poor are still not covered by the Social Safety net programs.** In 2010, 24.6% of households and program beneficiaries participated in different Social Safety Nets Programs (HIES, 2010), which increased to 27.8% households and 28.7% program beneficiaries in 2016 (HIES, 2016).
- **Expenditure of household income on food is still high.** The total share of household food expenditure is about 48% whereas that of non-food expenditure is 52%. In rural areas, the share of food expenditure and non-food expenditure is 50%. In urban areas, the share of food expenditure is 43% whereas that of non-food expenditure is 57%. Comparatively, in 2010, proportion of expenditure was 55% on food items and 45% on non-food items, which indicates an overall improvement of quality of life (HIES, 2016).

Chapter 2: Methods of Report Preparation

2.1 Structure of the Report

The Annual Monitoring Report of 2018-19 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 ten operational plans of the Ministries of Health and Family Welfare (MOHFW), 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 for 2018-19 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 (Annexure 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 June 2018 to December 2019, 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 analysed 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.

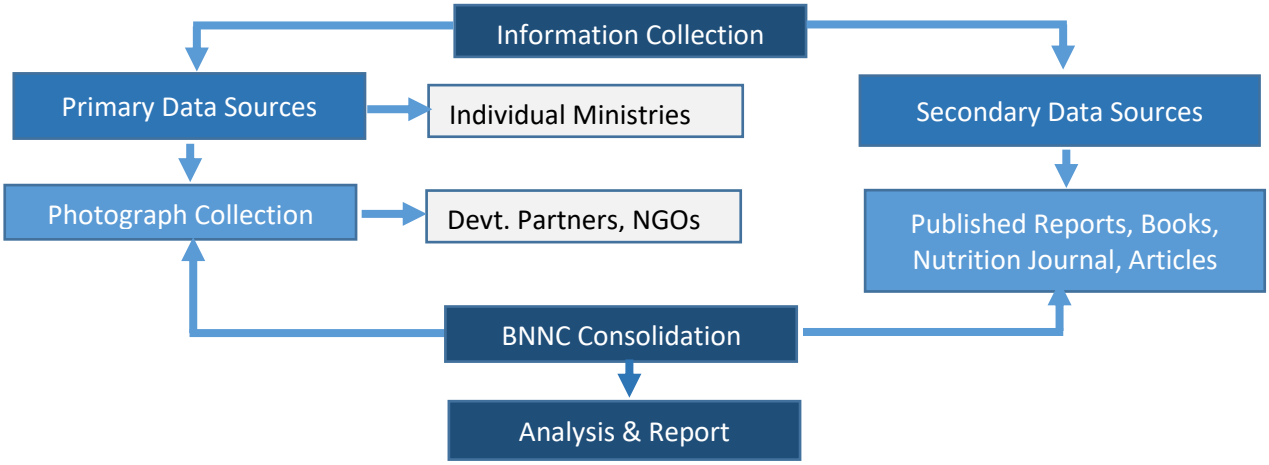


Figure 2.1: Data collection and management process for formulation of the report

Step-1 Primary information was 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 was 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 2.2.below.

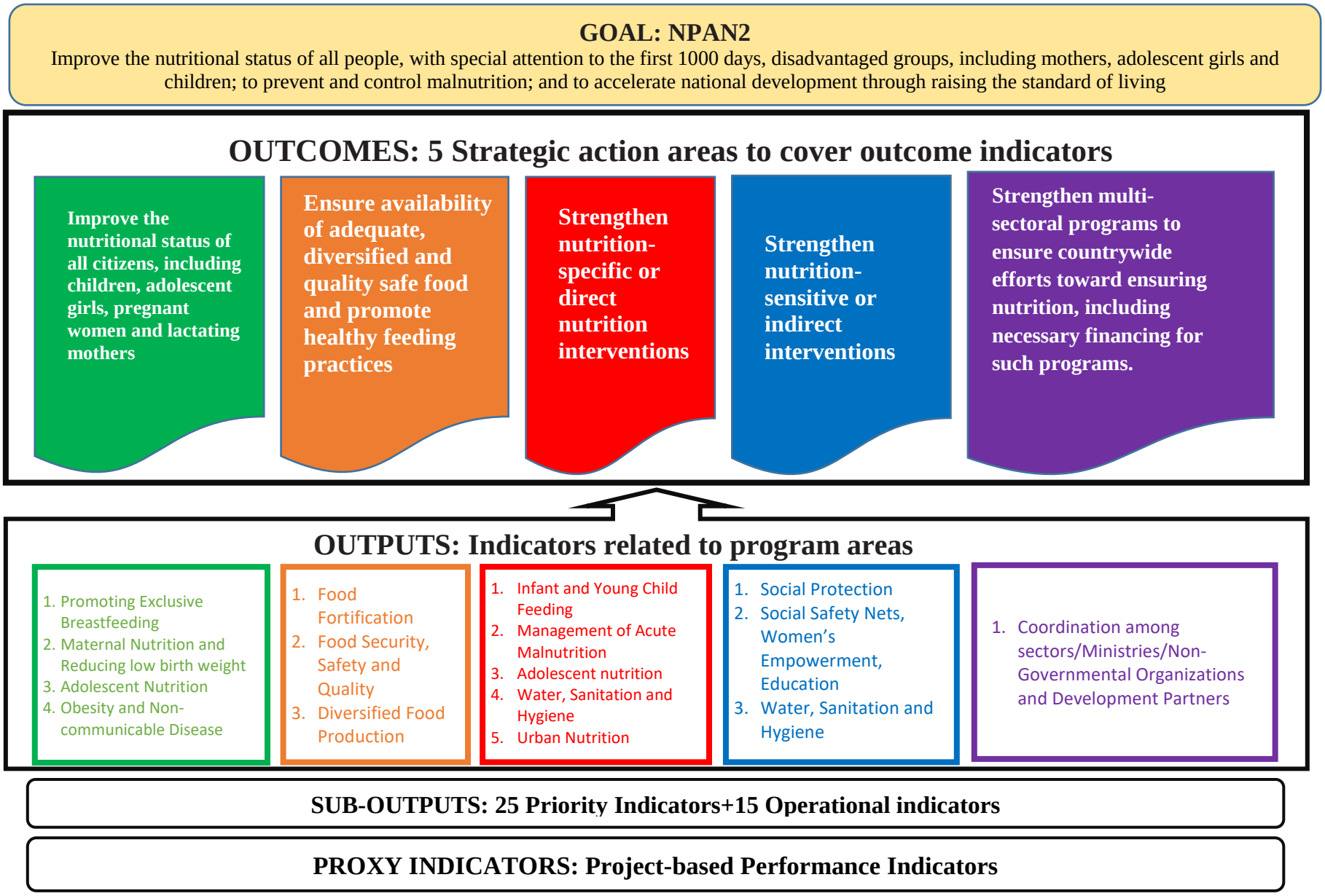


Figure 2.2: The monitoring and evaluation framework

Chapter 3: Progress towards NPAN2 Target and Outputs

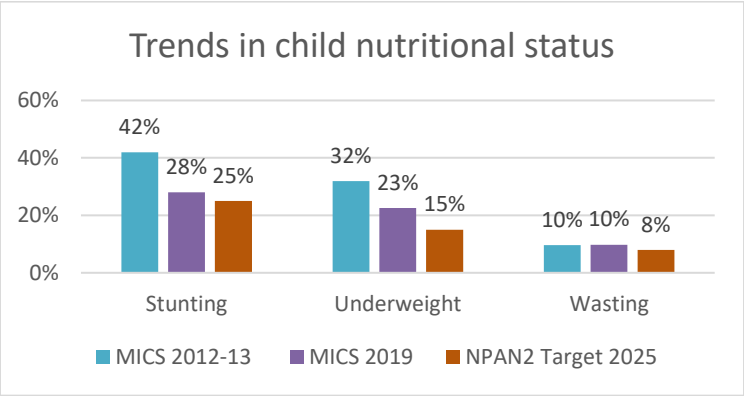
3.1 Overview of progress

Notable improvement in stunting reduction was observed between 2004 and 2007, which declined from 51% to 43%, with an Annual Average Rate of Reduction (AARR) of 2.66 percentage points per year (ppt/year) that almost plateaued between 2007 and 2011, when it went from 43% to 41%, with AARR 0.5 ppt/year. The situation of stunting has started improving again since 2011 which continued until 2017-2018, going from 41% in 2011 to 36% in 2014, with AARR of 1.66ppt/year; and subsequently to 31% in 2017-18 with AARR 1.66ppt/year. Though the pace of regaining improvement (AARR 1.66) was modest, it remained steady and kept continuing to improve.

The level of stunting among under-five children declined from 36% in 2014 to 31% in 2017 (BDHS, 2017-18). Wasting in under-five children decreased from 14% in 2014 to 8% in 2017. The level of underweight also declined significantly for this age group from 33% in 2014 to 22% in 2017. By 2025, among the same age group, the target of NPAN2 to reduce stunting, wasting and underweight are to 25%, less than 8% and 16% respectively. With the current rate of reduction of stunting, Bangladesh is on track and may achieve the NPAN2 target (25%) by 2022. The SUN Progress Report 2019 observed similar findings and noted that Bangladesh is one of the 10 countries on track to achieve the stunting target set (for NPAN2) . It is assumed that by 2025, the stunting rate will be around 20%. However, with the current rate of reduction, Bangladesh may fail to achieve global World Health Assembly/Sustainable Development Goal (WHA/SDG) target of 15% by 2025. To achieve the WHA/SDG target, sustained acceleration of the reduction rate at 2.5% ppt/year is required over the next 7 years.

Multiple Indicators Cluster Surveys (MICS, 2019) results between 2012 13 and 2019 also demonstrate downward trends in stunting, wasting and underweight among under-five children (Figure 3.1). In MICS 2019, the level of stunting, rate is lower when compared to BDHS results. On the other hand, underweight and wasting are slightly higher, which is shown in Table 3.1. This could partly be due to differences in methodologies used in the surveys.

Figure 3.1: Nutritional status of under-five children and target of NPAN2



Source: Multiple Indicator Cluster Survey (MICS)

Table 3.1: Comparison of trends and levels of stunting, wasting and underweight between BDHS and MICS survey results

Nutrition status	BDHS		MICS	
	2014	2017-18	2012-13	2019
Stunting	36%	31%	42%	28%
Wasting	14%	8%	10%	10%

Underweight	33%	22%	32%	23%

3.1.1 Geographical variation among divisions in prevalence of under-five undernutrition

All forms of malnutrition (stunting, wasting and underweight) have decreased in all divisions in the country except in Rajshahi division for the stunting rate, which has remained static at 31%. The prevalence of stunting ranged from 26% in Dhaka to 43% in Sylhet; underweight ranged from 19% in Dhaka and 33% for both Khulna and Sylhet; and wasting ranged from 7% in Rangpur to 10% in Sylhet; (Figure 3.2 and 3.3). Sylhet division continues to have the highest rates of malnutrition in children under five for all three forms including stunting, underweight and wasting in Bangladesh. Mymensingh division has emerged with the second highest rates of stunting (36%), wasting (9%) and underweight (26%). It is likely that the current situation of malnutrition of Mymensingh previously existed but was masked, as Mymensingh was administratively merged with Dhaka division until the last BDHS survey. It should be noted that Barishal division which had the second highest level of malnutrition, has moved out to third position.

Figure 3.2: Undernutrition status across 8 divisions in Bangladesh in 2014 and 2017-2018 (BDHS).

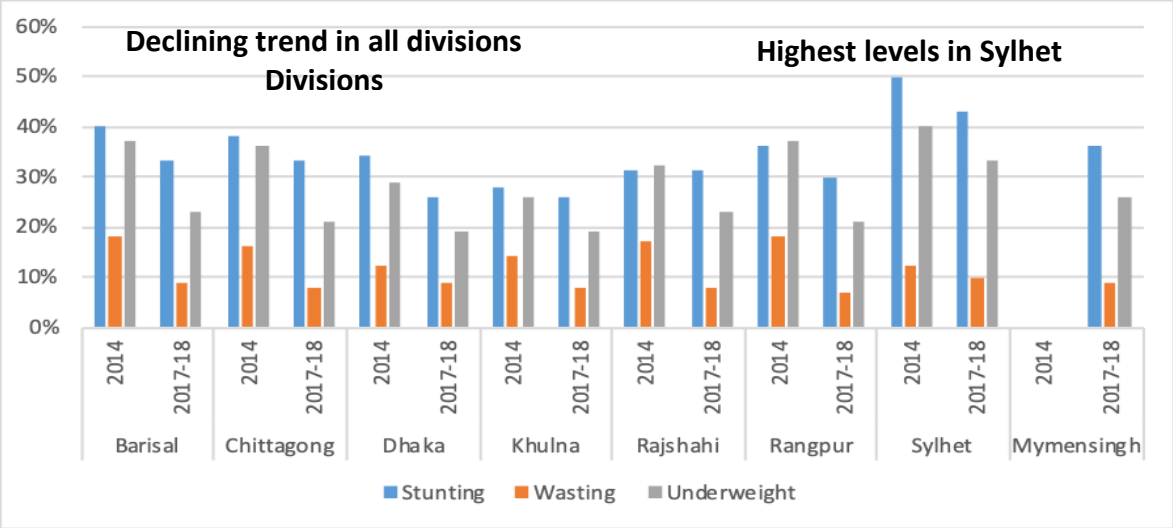
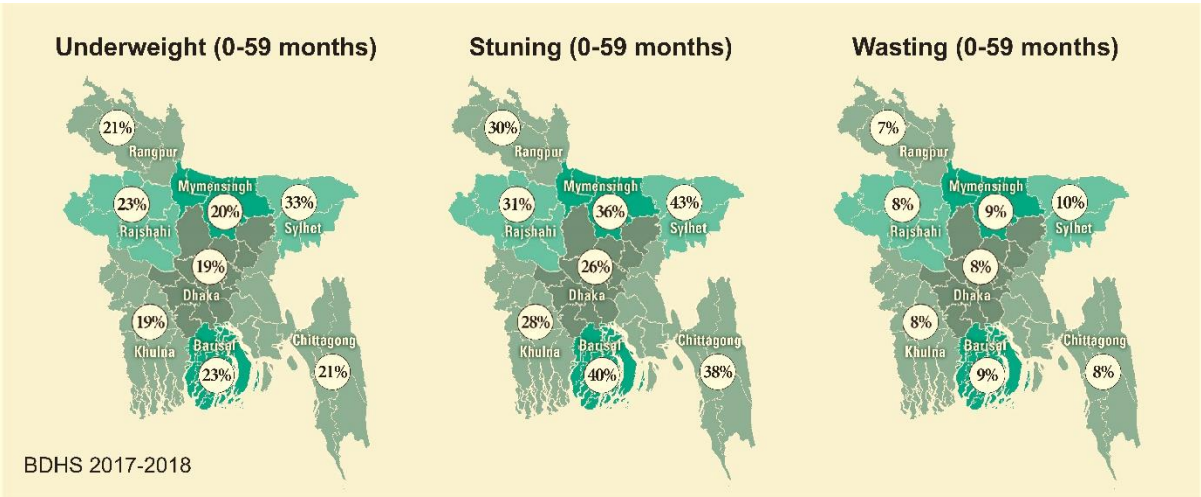


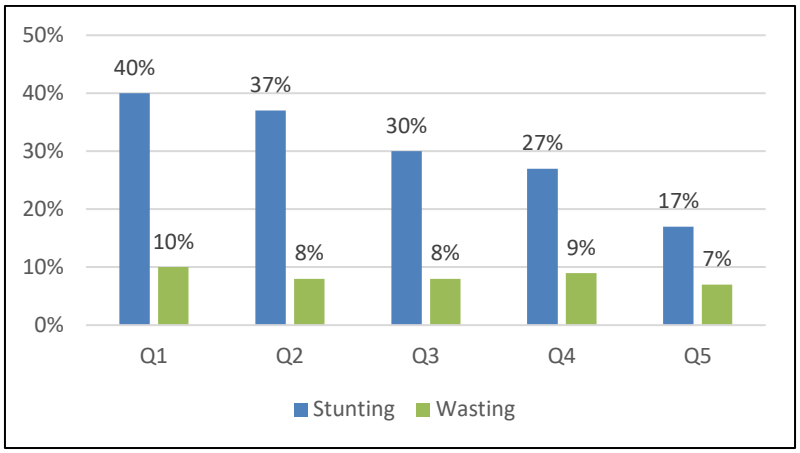
Figure 3.3: Maps depicting level of underweight, stunting and wasting among 0-59 months children in different divisions.



3.1.2 Under-nutrition and wealth

An inverse association between level of household wealth and nutrition indicators is evident (BDHS 2017-18)—as wealth of households decreased, malnutrition of under-five children increased. Higher i proportion of stunting are evident in wealth quintile Q1 and Q2 than in wealth quintile Q4 and Q5. Stunting among under-five children from Q1 (lowest wealth) and Q2 were respectively 40% and 37% , compared to 17% and 27% in Q5 (highest wealth) and Q4 (Figure. 3.4). On the other hand, for the wasting there is no marked difference in the percentage of wasted under-five children in any of the five wealth quintiles. This indicates that acute undernutrition is less sensitive to changes in wealth than chronic malnutrition, highlighting the role of other underlying determinants (e.g., frequent childhood infections like diarrhoea, acute respiratory infection) in acute malnutrition. In fact, set stunting targets (25% by 2025) have already been achieved among the Q4 and Q5 Furthermore, with the current Annual Average Rate of Reduction (AARR), Bangladesh will achieve the SDG global stunting target of 15% by 2025 among the wealthiest groups. As we know WHA targets are for all population group and the SDG motive is "no one left behind", therefore, focus should be on sustaining gains in wealthiest groups and accelerating prevention efforts among lowest wealth quintile populations in order to achieve NPAN2 stunting targets by 2025.

Figure 3.4: Undernutrition in under-five children by household wealth

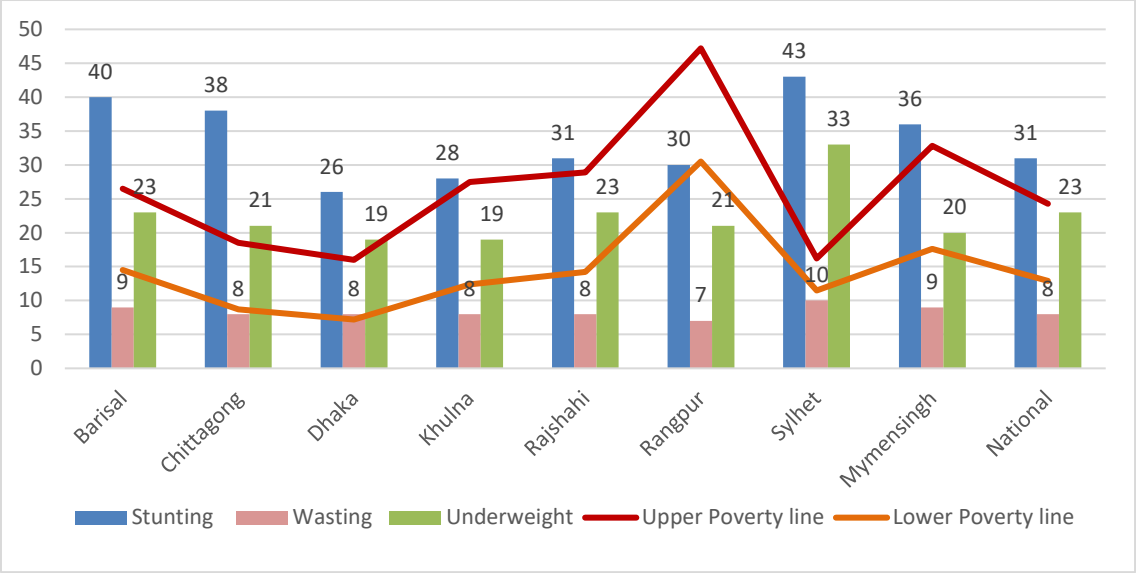


Source: BDHS, 2017-18 report

3.1.3 Level of malnutrition among children from lower poverty line (poorest) and upper poverty line (richest) in different divisions.

There is no clear relationship between poverty and stunting as evident from HIES 2016 report findings. A negative relationship can be drawn between poverty and stunting in Barishal, Rajshahi and Mymensingh, but such a relationship is not evident in Sylhet and Chittagong. After Dhaka and Chittagong, Sylhet has a smaller percentage of population living below both upper poverty lines (the moderate poor households are those households whose food expenditure is at the level of food poverty line.) and lower poverty lines (the extreme poor households are those households whose total expenditures are equal to the food poverty line.), while Rangpur has a higher percentage of population below the poverty line with a stunting rate of 30%. On the other hand, Sylhet has the second lowest level of poverty after Dhaka with highest level of all forms of malnutrition including stunting at 43%.

Figure 3.5: Level of malnutrition among children from lower poverty line and upper poverty line in different divisions.



3.1.4 Progress by NPAN2 thematic areas:

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

3.2.1 Infant and Young Child Feeding practices

Infant and young child feeding (IYCF) practices include early initiation of breastmilk, 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 meal times with additional snacks
- Feeding a diverse diet.

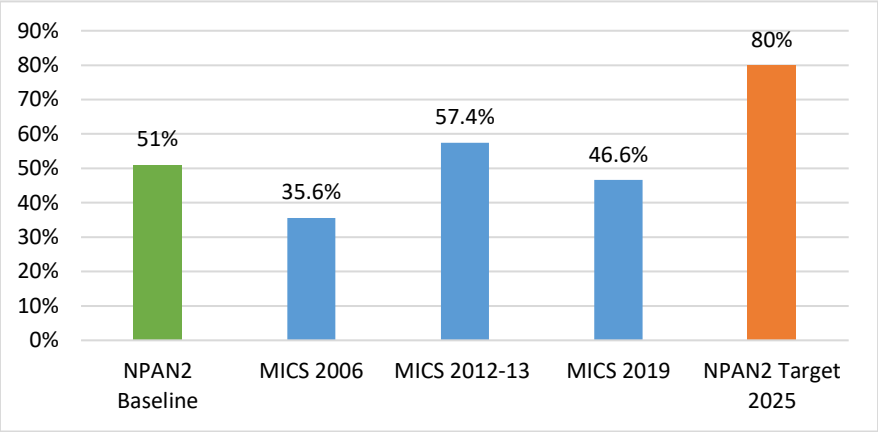
Unsatisfactory progress in IYCF practices is one of the important determinants of childhood under-nutrition in Bangladesh. Stunting can be prevented when appropriate IYCF practices are adopted and children are protected from infection. The data shows that progress on IYCF practices has been mixed from different nationally representative surveys and is not up to the required level, especially for the Minimum Acceptable Diet (MAD).

3.2.2 Status of Early Initiation of Breast Feeding

Early Initiation of Breastfeeding (EIBF) is referred to as initiation of breastfeeding within one hour of birth. Data presented in Figure 3.6 clearly shows improvement in EIBF over the years: from 36% in 2006 to 57% in 2012-13 which has dropped to 47% in 2019 (MICS 2019). However, according to BDHS reports the improvement has been more pronounced, rising from 17% in 1999-2000 to 69% in 2017-18. This difference could be due to different recall periods used in both surveys. With the current rate of improvement as demonstrated by the BDHS report, the country is on track to achieve the NPAN2 target of 80% by 2025. This is due to improvement of Skilled Birth Attendants, Antenatal Care services, implementation of the Bangladesh Breastmilk Substitutes Act3, Baby-Friendly Hospital Initiative, Maternity and Lactating Allowance Programs, etc. supported by Social Behaviour Change Communication (SBCC).

[3] Breast-Milk Substitutes (Regulation of Marketing) Ordinance, 1984

Figure 3.6: Trends of early initiation of breast feeding among children aged 0-5 months compared to the NPAN2 target

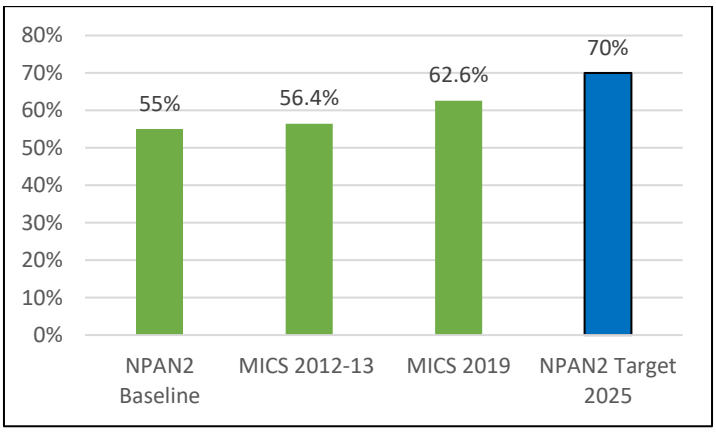


Source: MICS, 2019 report

3.2.3 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 newborn babies. In Bangladesh, the Exclusive Breastfeeding (EBF) rate has increased from 56% in 2012-13 to 63% in 2019 (MICS, 2019). As per BDHS Report 2017-18, despite a fall in EBF rates from 64% in 2011 to 55% in 2014, the rate rebounded to 65% in 2017-2018. Both BDHS and MICS surveys indicate that with the current rate of progress, Bangladesh is on track to achieve the NPAN2 target of 70% by 2025.

Figure 3.7: Trends in exclusive breastfeeding practices among children aged 0-5 months along with NPAN2 target



Source: MICS, 2019 report

3.2.4 Trends in complementary feeding practices

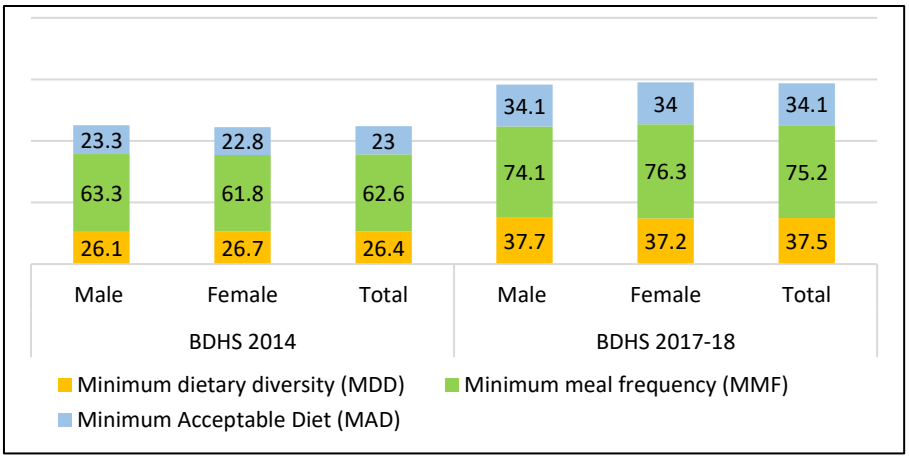
Minimum dietary diversity means feeding a child food from at least four different food groups. This cutoff was selected because it is associated with better-quality diets for both breastfed and non-breastfed children. Studies have shown that plant-based complementary foods by themselves are insufficient to meet the needs for certain micronutrients (WHO and UNICEF, 1998).

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. However, overly frequent feeding may lead to the displacement of breast milk (PAHO and WHO, 2003).

BDHS findings, as depicted in Figure 3.8, 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 2014. MDD has increased from 26% to 38%, MMF from 63% to 75%, and MAD from 23% to 34% between 2014 and 2017-18 respectively.

Figure 3.8: Trends of three indicators (e.g.MDD, MDF and MAD) among male and female children age 6-23 months between 2014 and 2017-18 (BDHS).



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.

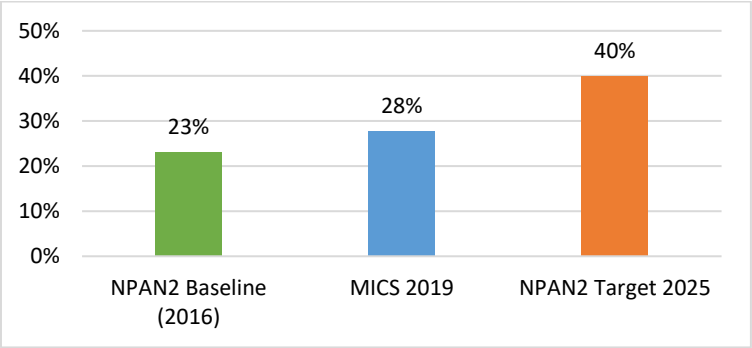
Table 3.2: Level of MDD, MDF and MAD among children aged 6-23 months reported in MICS 2019

	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

3.2.5 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 3.9 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 3.9: Percentage of children 6-23 months fed with Minimum Acceptable Diet (MAD)



Source: MICS, 2019

According to MICS 2019 results, 28% among breastfed and 17% among non-breastfed children aged 6-23 months were consuming a minimum acceptable diet (MAD) as seen in figure 3.9. However, BDHS 2017 findings indicated that 34% of children aged 6-23 months were consuming a minimum acceptable diet (MAD) compared to 23% reported in BDHS 2014. With the current rate of progress (2.8 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 (39%) than rural areas (32%), with the highest ICYF rate seen in Rangpur division (41%), and the lowest in Sylhet (27%). The improvement is evident across all wealth quintiles, however, improvement in the richest quintile has doubled (48%) compared to only 24% in poorest quintile (BDHS 2017-18 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 (48%), 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.

3.2.6 Progress in nutrition program indicators (2015-2018)

Since 2011, there has been steady progress in IYCF process indicators, with the most notable improvement in all three indicators taking place from 2016-2018. The trend of providing IYCF counselling to caregivers at health facilities increased from 19% to 52%; the number of infants breastfed within one hour of birth went from 421,517 to 603,061; and the number of health facilities certified as Baby Friendly increased from 231 to 723 facilities between 2016 and 2018.

Table 3.3: Status of process indicators for assessing IYCF status

Process Indicators	***2016***	***2017***	***2018***	***2019***	***Source***
Number of infants who are breastfed within one hour of birth	*421517 (Rural facility)*	*520759 (Rural facility)*	*603061 (Rural facility)*	*630386 (Rural facility)*	*DHIS2, DGHS*
% of caregivers of children 0-23 months old receiving age appropriate IYCF counselling at facility	*19% (Rural)*	*31% (Rural)*	*52% (Rural)*	*55 % (Rural*	*DHIS2, DGHS*
Number of health facilities certified as Baby Friendly Hospital Initiatives	*231*	*Not available*	*723*	*723*	*BBF*

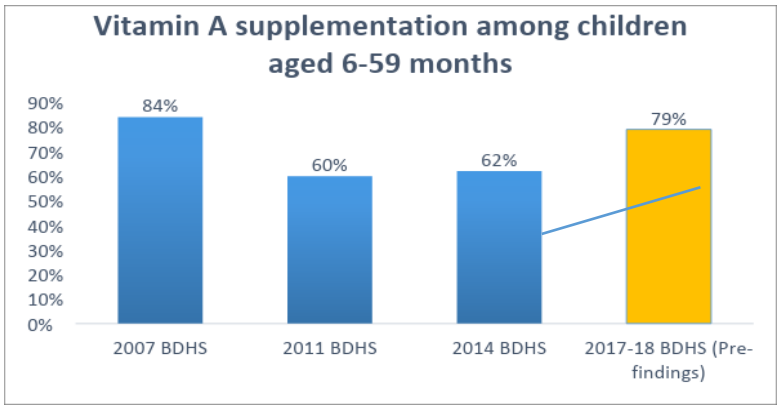
3.2.7 Micronutrient malnutrition

This section highlights the significant progress in reducing the prevalence of micronutrient deficiencies, especially Vitamin A and Iodine Deficiency Disorders (IDD) among children and women of reproductive age. Even with visible progress in mitigating said micronutrient deficiencies, anaemia continues to present a major challenge among these target groups, and needs to be reduced. To address the issue of pervasive anaemia, the National Strategy on Prevention and Control of Micronutrient Deficiencies, Bangladesh (2015-2024) emphasises 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.

The prevalence of anaemia among non-pregnant and non-lactating (NPNL) women was 26%, down from 33% 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 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. The prevalence of anaemia in school age children was 19.1% among children aged 6-11 years and 17.1 % among children aged 12-14 years.

BDHS findings suggest that between 2014 and 2017, vitamin A supplementation (VAS) coverage increased from 62% to 79%. The coverage was the highest at 84% in 2007, dropping to as low as 60% in 2011. Since then however, coverage has picked up slowly, as seen in Figure 3.10, but it is yet to reach the 2007 level and there is a long way to go to achieve universal coverage. Across divisions, VAS coverage is highest in Rangpur (84%) and lowest in Dhaka and Barishal (76%). The level of VAS coverage was higher among children aged 12-35 months and children who live in urban areas. 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 o 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.

Figure 3.10: Children 6-59 months who received vitamin A supplements in the last six months



Source: Bangladesh Demographic Health Survey (BDHS)

Based on administrative data, Bangladesh's bi-annual Vitamin A supplementation program has maintained progress over time in achieving 99% in 2019 for children aged 6-59 months (Table 3.4). The first round of the National Vitamin A Plus Campaign 2018 (NVAC+) was held on 14 July 2018. It was preceded by a child to child (CtC) search, undertaken from 15 to 18 July 2018 and covering about 21 million children aged 6-59 months across the country. The administrative coverage of the first round of vitamin A supplementation to children aged 6-59 months was 98.8% (20,914,529 children); coverage of children aged 6-11 months was 98.4% (2,384,793 children); and coverage of children aged 12-59 months was 98.9% (18,529,736 children). In municipalities, coverage among children aged 6-59 months was comparatively lower (97.5%) than among children in city corporations (99.2%) and those in rural areas (98.8%).

Bangladesh adopted the Universal Salt Iodization program in 1989 and iodized salt became available in the entire country by 1995. The most recent national salt iodization survey carried out in 2015 found that the percentage of households with adequate salt iodization was 50.5% while the percentage of household with coverage of any level of iodine in their salt was 65% (Icddr'b, 2015). However, according to MICS 2019, the consumption of iodised salt was 76%.

According to MICS 2019, between 2014 and 2017, the use of oral rehydration salts (ORS) increased from 77% to 83%, and use of ORT with zinc increased from 38% to 44%.

Beside this, the program data indicates that the number of under-five children with diarrhoea treated with ORT alone has been increasing since 2016 (Table 3.4).

Table 3.4: Status of process indicators of micronutrient supplementation from National Nutrition Services (NNS)

Output indicators	2016	2017	2018	2019	Source
% of children aged 6-59 months receiving Vitamin A supplements	98.6% (DHIS2, DGHS)	99.9% (DHIS2, DGHS)	98.8% (DHIS2, DGHS)	99.0% (DHIS2, DGHS)	DHIS2-DGHS
Number of children under 5 yrs with diarrhoea treated with ORT and Zinc	794,022 (Only ORT)	846,331 (Only ORT)	851,518 (Only ORT)	860,530 (Only ORT)	DHIS2, DGHS

3.2.8 Management of Acute Malnutrition

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).

Table 3.5: Status of Management of Acute Malnutrition as a process for progress among relevant programs from 2017-2019

Output indicators	2017	2018	2019	Source
Number of children < 5 years screened at the community level and referred for nutrition management.	1,588,960 (Facility)	1,467,138 (Facility)	1,616,168 (Facility)	DHIS2, DGHS
Number of health facilities equipped with anthropometric equipment.	Not available	427	472 (Approx.)	NNS, DGHS

It is estimated that at any given time in Bangladesh there are about 1,146,250 under-five children suffering from acute malnutrition (Global Acute Malnutrition), of which about 859,700 suffer from moderate acute malnutrition (MAM), and about 286,600 from severe acute malnutrition (SAM)—a condition that has 12 times higher risk of death compared with well-nourished children. According to DHIS2-DGHS, in 2019, 1,616,168 under-five children were screened at the community level and referred for nutrition management as compared to 1,467,138 in 2018. However, it is not known how many of them actually availed for nutrition services and were cured. Moreover, high number of screened cases compared to total estimated GAM cases could be due to over counting (i.e. same child could have been counted more than once or several times).

A little support helped the family smile

Shelly Akter (29) lives in Champoklata village under Juri Upazila of Moulvibazar District in Bangladesh.

She is a mother of five children. Her husband Selim Miah is a day labourer. The family lives on a small plot of land, and had been going through severe financial difficulties with a meagre income of BDT 6,000 per month. As a result, the children were unhealthy and malnourished. In January 2017, Shelly Akter enrolled in the Suchana Program as IGA program participant. Through the program, she was supported with a goat as well as hands-on training on goat rearing.

Photo:1 SAM child Maisha admitted in the Hospital

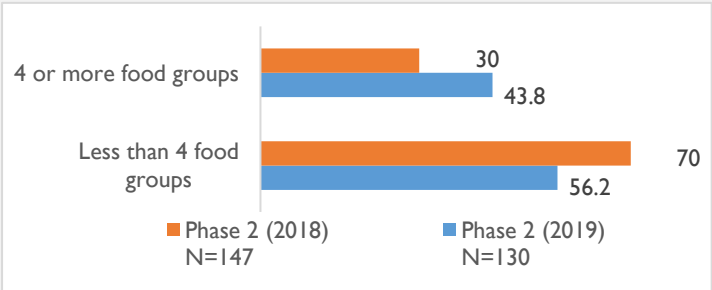
During her fifth pregnancy, Shelly did not avail any ANC services, eat nutritious food and animal protein, or maintain a healthy lifestyle. She could not take her iron tablets regularly. As a result, she gave birth to a low birthweight baby girl, Maisha, at home in 2018. Discovering this, a Suchana Community Mobilizer (SCM) brought her to local GMP and Courtyard sessions, which she has since continued.

She learned about exclusive breastfeeding and its importance, and the family routinely weighed Maisha to monitor her growth. But Maisha did not gain the expected weight. Worse still, her condition deteriorated and she was identified as SAM case with skin problems in May 2019 by the SCM. As Maisha's MUAC was 10.5 cm, she was admitted at Barlekha Upazila Health Complex (UHC). With medical treatment at the hospital, she recovered slowly, her condition improved and she was discharged with MUAC of 12.6 cm. Her care was continued at home with routine household visits by the SCM. Maisha now weighs 6.7 kg. Shelly is now a regular member of the local Mother and Child Sub-group. "Suchana provides important messages for pregnant and lactating mothers through regular court yard sessions, GMP and counselling which is very useful. I attended courtyard sessions where I learned about pregnancy diet and nutrition, antenatal and postnatal care," she says.

Photo-2 : Maisha Recoderez from SAM and Gets Care at Home

Suchana aims to achieve significant reduction of stunting incidence of stunting among children under two years of age in Sylhet and Moulvibazar districts by catalyzing support across government and others stakeholders. The program adopts an integrated approach to nutrition specific and nutrition sensitive interventions to prevent chronic malnutrition within the critical 1000 days (from conception to the 2nd birthday of a child). It focuses on improving the nutrition status of beneficiaries. To improve child nutrition, Suchana intervenes in different sectors. However, it is important to identify the status of dietary diversity of children (aged 6-23 months) to identify the effectiveness of the intervention in this regard. Among the 7 food groups, the threshold is 4 or more food groups. A study conducted by the Nielsen Company (Bangladesh) Ltd. found that 43% of a total 319 households had children consuming 4 or more foods within the last 24 hours. During phase 2 in 2018, dietary diversity was 30%, which has increased in 2019 to 43.8% (Figure 3.11).

Figure 3.11: Minimum Dietary Diversity for Children (percent)



3.2.9 Maternal nutrition and reducing low birth weight

Chronic Energy Deficiency (CED) rate among mothers with BMI less than 18.5 has decreased from 52% in 1996-97 to about 30% in 2007. While this CED rate at 30% for mothers indicates a substantial improvement over time, it is still very high. Maternal anaemia during pregnancy are common in Bangladesh, with serious consequences for both mother and newborn, including increased risk of becoming low birth weight and preterm birth, as well as high risk of maternal and perinatal morbidity and mortality. Maternal undernutrition peaked at 38% among women aged 15-19 years who have given birth in the past 3 years. Childbearing frequently begins during adolescence, contributing to poor maternal nutritional status and birth outcomes, including high levels of low birth weight. The low birth weight rate is high though it has reduced from 36% in 2003-2004 to 23% in 2016. Pre-pregnancy, pregnancy and the postnatal period are critical times for ensuring the health and wellbeing of women and their babies.

Iron deficiency is a major cause of anaemia among pregnant women. Iron requirements increase substantially during pregnancy and it is difficult to meet these needs from food sources alone. 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 has slightly improved from 29% in 2013 to 31% in 2014-15. Current data for Minimum Dietary Diversity of women (MDD-W) is not available, however previous trends suggest that Bangladesh is not on track to achieve the set target of 75% by 2030.

To address the issue of anaemia, WHO recommends daily iron and folic acid (IFA) supplementation throughout pregnancy, together with appropriate nutrition counselling during antenatal care (ANC), and promotion of diversified food intake during pregnancy. 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. At 43%, the coverage for IFA supplementation is low.

Table 3.6: Proportion of women receiving antenatal care visits

Number of ANC visits	Residence		
	Urban	Rural	Total
None	5.2	9	8
1	9.6	14.4	13.1
2	12.7	17.8	16.4
3	13.7	16.1	15.5
4 or more	58.7	42.7	47
Median visits	4.9	3.8	4.1
Total	100	100	100
Number of women	1356	3695	5051

Source: BDHS 2017-18 report

As indicated in Table 3.6, urban women (59%) are more likely to make four or more ANC visits than rural women (43%). Between 2014 and 2017, the proportion of women who made four or more ANC visits during pregnancy increased from 31% to 47%. The 4th HPNSP aims to reach 50% coverage by 2022.

The content of ANC is an essential component of service quality. The percentage of women aged 15-49 years who during their pregnancy had the most live births, had their blood pressure measured and gave urine and blood samples as part of ANC increased from 38% in 2012-13 to 58% in 2019 (MICS 2019). However, only 13% of pregnant women were informed about postpartum family planning options. During the same period, mothers whose live-born child received a health check at a medical facility or at home following delivery, or a postnatal care visit within 2 days of delivery, also rose from

41% to 67%. Institutional deliveries and skilled attendants at deliveries increased from 31% to 53%, and 44% to 59%, respectively.

Women are triply hit by undernutrition, overnutrition and micronutrient deficiencies. Nearly one-third of women are undernourished, with a body mass index (BMI) of <18.5 kg/m2. The prevalence of anaemia among young infants, adolescent girls and pregnant women is still at unacceptable levels, although the proportion of underweight decreased between 2004 and 2014. Between 2004 and 2014, there has been a shift in BMI of Bangladeshi women of reproductive age (15-49 years). It was revealed that the proportion of overweight increased from about 11% in 2004 to 25% in 2014, and proportion of underweight has decreased from 33% to 18% during the same period. 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. The significant contributors to this double burden were the change in women's level of education, increased household wealth, divisional location and rapid urbanization4.

At 29%, undernutrition (BMI < 18.5) in Sylhet is strikingly higher than any other divisions in the country, and 13% higher than the national average of 16%. The percentage of women with chronic energy deficiencies in food deficient (28%) and food insecure households (25%) is nearly double than those of women in food secure households who have lower rate of chronic energy deficiency (14%).

Partnering With the Readymade Garments Sector to Improve Nutrition

The readymade garments (RMG) sector is the largest contributor to Bangladesh's economy, employing about 4 million people, most of whom are young women. In Bangladesh, over 40% of women suffer from anaemia, which can affect their overall health and well-being. RMG factories provide a platform to reach a large number of women and men with nutrition interventions that will both improve their health and contribute to improving gender equality in the workplace.

With support from Nutrition International (NI), and in collaboration with factory owners, managers, and workers, the Bangladesh Knitwear Manufacturers and Exporters Association (the trade body that represents the knitwear sector of Bangladesh), will develop and implement a workplace nutrition program called Nutrition of Working Women (NOWW). The program aims to prevent and control anaemia by improving the iron status among women, as well as nutrition knowledge among male and female workers in Dhaka and Narayanganj regions. Key interventions include weekly iron-folic acid supplementation (WIFAS) for women; dissemination of information on a balanced diet; hygiene and the importance of WIFAS to all workers; and government and private sector advocacy for better nutrition for RMG sector workers. In total, 240,000 workers will benefit from the program, including 180,000 female workers who will be reached with WIFAS. 60,000 male workers will be provided with nutrition education.

[4] 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

3.2.10 Progress in maternal nutrition and LBW process indicators

Table 7 shows trends in ANC 4+ among rural women between 2016 and 2018. 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. It is evident that a number of pregnant women received 4+ ANC services provided by DGFP compared to DGHS facilities. Table 3.7 shows that the highest (43%) proportion of women received iron-folic acid supplementation (IFA) in 2019, during their first trimester, and the proportion was lowest (33%) in 2016 in two priority divisions: Sylhet and Chattogram. In 2019, at the national level, about 21% of women were weighed during ANC check-ups. Between 2016 and 2019, 15% to 19% of mothers received counselling for appropriate nutrition care and counselling in 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 7 clearly demonstrates that the overall coverage of all five process indicators has been very low without visible improvements since 2016.

Table 3.7: Status of process indicators related to maternal nutrition and reducing low birth weight

Output indicators	*2016*	*2017*	*2018*	*2019*	*Source*
% of pregnant women who received 4+ ANC	31% (Rural)	35% (Rural)	37% (Rural)	52% (Rural)	APIR report
% of children 0-23 months old whose weight was taken at a facility	9% (Rural)	7% (Rural)	10% (Rural)	11% (Rural)	DHIS2, DGHS
% of visits with pregnant women who received any IFA	33% (Rural)	44% (Rural)	38% (Rural)	43% (Rural)	DHIS2, DGHS
% of times women who attended ANC check-ups during pregnancy were weighed	17% (Rural)	16% (Rural)	17% (Rural)	21% (Rural)	DHIS2, DGHS
% of women receiving maternal nutrition counselling	15% (Rural)	15% (Rural)	11% (Rural)	19% (Rural)	DHIS2, DGHS

3.2.11 Adolescent nutrition

3.2.11.1 Child Marriage, Teenage Pregnancy and Malnutrition Nexus

Adolescence is a critical period in the life cycle because of rapid growth and preparation towards adulthood. In Bangladesh one-fourth of the adolescent girls (aged 15-19 years) are stunted. Adolescents living in rural areas are more likely to suffer from stunting compared to those in urban areas and girls are 5% more likely to be stunted than boys during adolescence period. Growth faltering is much greater in the early adolescent period (between 10-14 years of age) compared to late adolescence (15-19 years). While rate of undernutrition declined in both early (10-14 years) and late adolescent (15-19 years) age groups between 2012 and 2014, overnutrition, or overweight and obesity increased among older adolescents during the same period. Changes in the prevalence of undernutrition and overweight from 2012 to 2014 varied substantially by division and between rural and urban areas. Throughout the adolescence period, girls from poorest households have the highest rate of stunting. Maternal education is consistently associated with stunting in both early and late adolescent age groups.

Child marriage and early childbearing are common practices in Bangladesh, though the legal age of marriage for girls is 18 years. Age at first marriage has continued to rise slowly. The median age at first marriage among women aged 20–49 years increased from 15.3 years in 2007 to 16.3 years in 2017 (BDHS 2017-18) which is still too low. Percentage of women aged 20-24 years who were first married before ages 16 and 18 were 32% and 59% respectively. Furthermore, 33% of women aged 15-19 years are currently married. The rate has remained almost unchanged since 2012-13 (MICS 2019). The percentage of women aged 20-24 years who had a live birth before age 18 was 24%. Early childbearing has adverse effects on the nutritional status of both mother and child. Teenage pregnancy is associated with stunting. The odds of children becoming stunted significantly increase by 22% if they are born to a teenage mother. Childhood pregnancy is both a social and nutritional risk for a girl herself and for her future child (Fill the Nutrition Gap Report, 2019). Children born to young adolescent malnourished mothers are more likely to be malnourished in the future, thus perpetuating the intergenerational cycle of malnutrition.

Adolescence is the second most crucial period of a child's life in terms of physical growth and cognitive development. It is also the last opportunity to reverse growth faltering suffered during early childhood. High rates of malnutrition among adolescent girls and low program coverage demands urgent attention and action. Pregnant and adolescent girls are the household members who are most at risk of not meeting their nutritional needs. NPAN2 prioritizes the promotion of adolescent nutrition and a healthy lifestyle through formal and informal programs. The government plans to improve the health of adolescents, young people and teenage couples through facility and community-based approaches. Various nutrition related activities through schools (e.g. micronutrient supplementation, school health, stipend, school meals, etc.) target adolescent girls and could contribute to keeping girls in school. This may potentially delay the age of marriage and first pregnancy, thus breaking the intergenerational cycle of malnutrition and poverty (WB, 2018).

School attendance can be a strong determinant of achieving higher degree of nutritional status among the next generation. A mother's schooling is associated with better child and own nutritional status; mothers who completed secondary and higher education have less stunted children (18%) than mothers with who have no education (47%). Moreover, woman's educational attainment is positively associated with their own height. About 18% of uneducated women are below 145 centimeters in height compared to 7% of women who have completed secondary or higher education (BDHS).

As evident in Table 3.8, no updated information is available for three indicators related to women and adolescent girls' nutrition for the current reporting period. With respect to progress, it is also apparent that all three indicators have remained either unchanged or deteriorated further between 2011 and 2014.

Table 3.8: Status of nutrition in adolescent girls and women

Indicators	*NPAN2 Target 2025*	*2011*	*2014*	*2018*	*Source*
%of women 15-49 yrs. who are overweight or obese (BMI ≥23)	30%	17%	39%	na	BDHS
% of adolescent girls (15-19 yrs.) with height <145 cm	<8%	13%	13%	na	BDHS
% of adolescent girls (15-19 yrs.) thin (total thinness)	<15%	25%	31%	na	BDHS

3.2.12 Water, sanitation and hygiene (WASH)

Availability of water, sanitation and hygiene services are closely associated with degree of health and nutrition status. It is essential to link nutrition and WASH programs in order to accelerate and re-emphasise the promotion of good hygiene practices at all levels (personal/household/community/food production, processing, storage, preparation) as a key precursor to improving good nutrition.

Table 3.9: Sanitation practices, hand washing behaviour and their progress

Indicators	2012-13	2019	Sources
% of population that use improved drinking water	97.9%	98.5%	MICS 2019
% of population that use improved sanitary latrine (not shared)	76.9%	84.6%	MICS 2019
% of household members with a hand washing facility where water and soap or detergent are present	59.1%	74.8%	MICS 2019

Bangladesh has made remarkable progress in accessing water and sanitation facilities over the last few decades. About 99% of households use improved sources of water, either in their dwelling/yard/plot or within a 30-minute round trip. However, these sources are not always safe. For example, 40% of tested households, and about 82% of the households' drinking water, was contaminated with E. Coli. The process of water collection and storage itself further creates contamination. While access to adequate amount of drinking water is necessary it is not sufficient to get the health and nutrition benefit. Unless water quality is maintained and water is free from faecal contamination of harmful pathogens, its health benefit cannot be ascertained. It is estimated that about 17% of diarrhoeal diseases can be reduced by improving water quality.

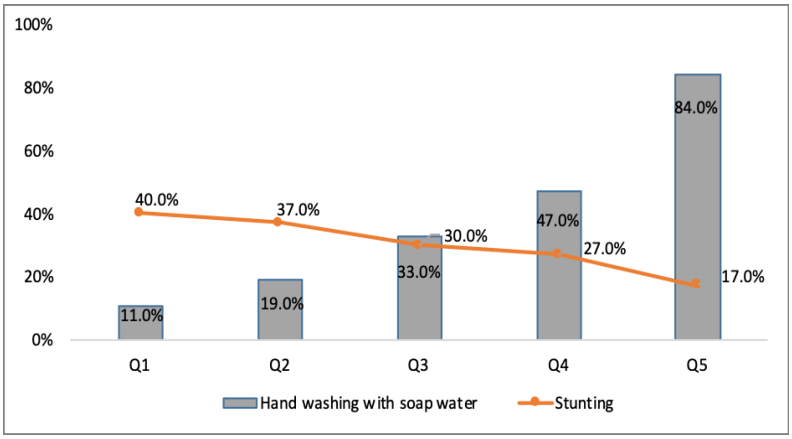
The percentage of household members using improved sanitation facilities has increased from 77% in 2012-13 to 85% in 2019 (MICS 2019). The same holds true for handwashing facilities with water and soap/detergent. Percentage of households with hand washing facilities where water and soap/detergent were present has also increased from 59% to 75% during the same period. MICS 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.

Households in urban areas, among the wealthiest quintile, and with higher education rates had positive associations with available hand washing facilities with water and soap. Findings from the survey shows that about 56% of urban households compared to 32% households in rural areas have available hand washing facilities with water and soap. Only 11% in the poorest wealth quintile, as opposed to 84% in the wealthiest quintile, have available hand washing facilities with water and soap. Additionally, 32% of families with no education, compared to 40% of families with secondary education, had hand washing facilities with water and soap. It is well known that appropriate hand washing practices reduce communicable diseases like diarrhoea, and consequently decrease stunting. Studies show that hand washing with soap decreases diarrhoeal diseases by 42-48 %. A 20-year multi-country study revealed that five or more diarrhoeal infections in the first 2 years of life accounted for 25% of all stunting.

Based on this evidence, the Government of Bangladesh together with development partners have been extensively promoting hand washing. Figure 3.12 shows how stunting decreases as wealth and hand washing rates increase.

Most households (84%) from the highest wealth quintile are in the habit of washing their hands and have the lowest rate of stunting (17%). The use of soap and water was found to be lowest among households in the lowest wealth quintile (11%) where stunting rates were also reported to be the highest (40%).

Figure 3.12: Hand washing behavior in different wealth quintiles and stunting

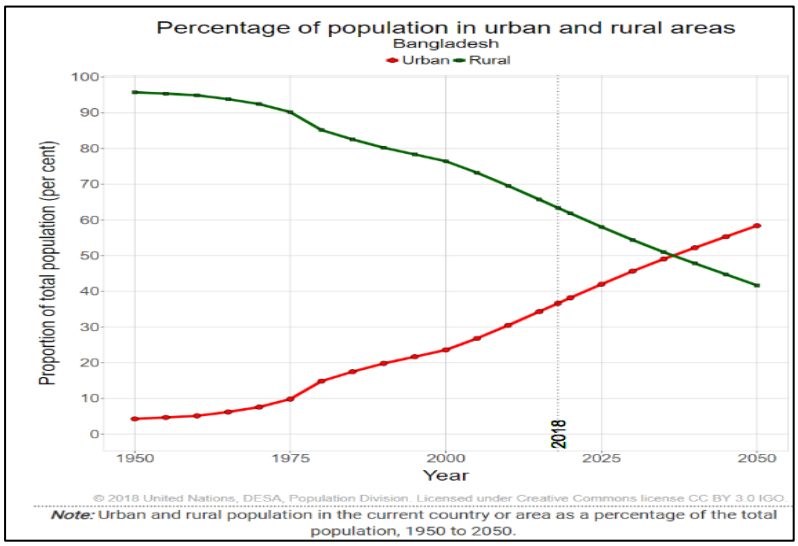


Source: BDHS 2017-18 report

3.2.13 Urban Nutrition

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. Currently, an estimated 37% of the total population live in urban areas, which is projected to grow over 50% by 2039 (UHS 2013, UNDESA 2018). Of the total urban population, more than one-third of urban population live in Dhaka city, whereas another one-third live in 5 other divisional cities. Every year, thousands of people migrate to urban areas from villages, peri-urban and disaster affected areas.

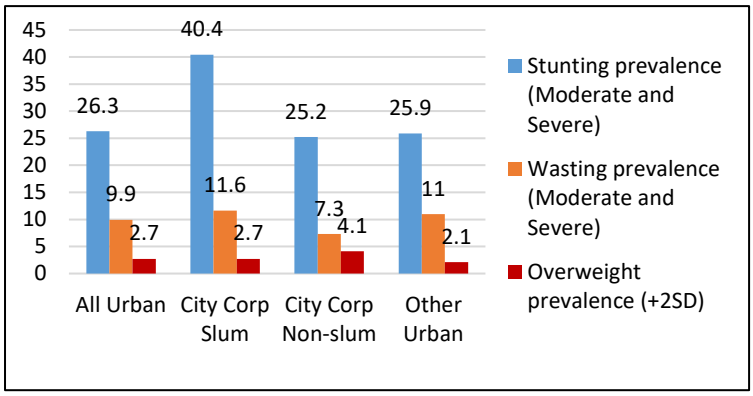
Figure 1.13: Percentage of population in urban areas of Bangladesh



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 programs5.

Figure 3.14: Segregated Urban Prevalence of Stunting, Wasting and Overweight



The Child Well-Being Survey in Urban Areas in Bangladesh (2016) reveals that 26%, 20% and 8% of all children living in urban areas were respectively stunted, underweight and wasted. There was marked difference in all forms of malnutrition between slum dwelling and non-slum dwelling children. For example, 40% of slum dwelling children and 25% of non-slum dwelling children were stunted; 31% of slum dwelling children and 18% of non-slum dwelling children were underweight; and 16% of slum dwelling children and 7% of non-slum dwelling children were wasted. On the contrary, overweight (>2SD) rate was 2.7% in slum dwelling children compared to 4.1% in non-slum dwelling children. Similar findings were observed for the consumption of Minimum Acceptable Diet (MAD), which was 30% in slum dwelling children compared to 44% in non-slum dwelling children. Exclusive breastfeeding among children under 6 months of age was 62% and 58% for slum dwelling and non-slum children dwelling respectively (Table 3.10).

Table 3. 10: 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

Use of drinking water from improved water sources is almost universal among urban households (99.2%). About 57% of the urban population are using improved sanitation facilities which are not shared with members of other households. It differed by type of urban areas, for example, with 51% in non-slum areas compared to 19% in slum areas. Use of improved sanitation facilities which are not shared was highest in Barishal (81%) and lowest in Dhaka (47%). Overall, 57% of the urban population use both improved drinking water sources and improved sanitation facilities. This practice was very low in slums (18%) compared to non-slums (51%). On the other hand, higher percentage (82%) of non-slums than slums use (58%) improved drinking water sources and improved sanitation facilities. For 66% of children aged 0-2 years, stools were disposed safely (the last time they passed stools). Overall, 55% of households had a specific place for hand washing with water and soaps available, with 67% in non-slums, 35% in slums and 51% per cent in other urban areas[6].

[5] United Nations, Department of Economic and Social Affairs, Population Division (2018). World Urbanization Prospects: The 2018 Revision.

[6] *Child Well-Being Survey 2016, BBS-UNICEF*

3.3 Thematic Area 2: Agriculture and Diet Diversification and Locally Adapted Recipes

(Ensure availability of adequate, diversified and quality safe food and promote healthy feeding practices)

The primary role of the food, agriculture, livestock and fisheries sectors is to increase the availability, affordability, accessibility and consumption of a range of safely grown, nutritious and local foods using environment-friendly technologies. These foods need to be promoted for utilization through the preparation and consumption of healthy diets to enhance nutrition outcomes. At the household and small scale production level, this begins with diversified and integrated homestead gardening, livestock development and small animal raising, aquaculture and fisheries production. Diversified, integrated food production systems also enable resilience to climate and price shocks, seasonal food and income fluctuations, and support more gender-equitable income generation.

Table 3.11: NPAN2 output indicators relating to agriculture, diet diversification and locally adapted recipes

Indicators	Target of NPAN2	Baseline of NPAN2 (HIES 2010)	Current Status (HIES 2016)
Per capita consumption of fruits and vegetables	Fruits: 100g Vegetables: 300g	Fruits: 44.7g	Fruits: 35.78g
		Vegetables: 166.1g	Vegetables: 167.3g
% share of total dietary energy from consumption of cereals	<60%	70%	64%

The current per capita consumption of fruits has decreased from 44.7g in 2010 (NPAN2 baseline) to 35.8g in 2016, although the target of fruit consumption is 100g per day. The consumption of vegetables increased slightly from 166.1g in 2010 to 167.3g in 2016, the target of which is 300g per capita per day. The percentage share of the total dietary energy from consumption of cereals was targeted to less than 60%; it has reduced from 70% in 2010 to 64% in 2016, which shows a slight reduction of 1 percentage point per year (Table 3.11). However, if efforts to increase dietary diversity are accelerated along with this trend of reduction, it is likely that the target of less than 60% can be achieved during the timeline of NPAN2 implementation.

Table 3.12: Status of process indicators and targets of food security, safety and quality as envisaged under NPAN2.

Output indicators	2015	2016	2017	2018	Source
Rate of growth of agricultural GDP at constant prices (2005-06)	3.12% (BBS)	2.50% (BBS)	2.65% (BBS)	NA	BBS Yearbook of Agricultural Statistics
Poor households engaged in home gardening and backyard poultry	46.10%	49%	NA	NA	BBS, HIES report

Table 31.3: Sectoral Growth Rate of GDP at constant prices, 2015- to 2018-19

Output indicators	2015-16	2016-17	2017-18	2018-19	Source
Agriculture	2.79% (BBS)	2.97% (BBS)	4.19% (BBS)	3.92% (BBS)	BBS

3.3.1 Agriculture - Nutrition Nexus

Being food secure does not guarantee that an individual is nutrition secure. Figure 3.15 below depicts the complex interplay of multiple food and non-food factors affecting nutritional status, including the

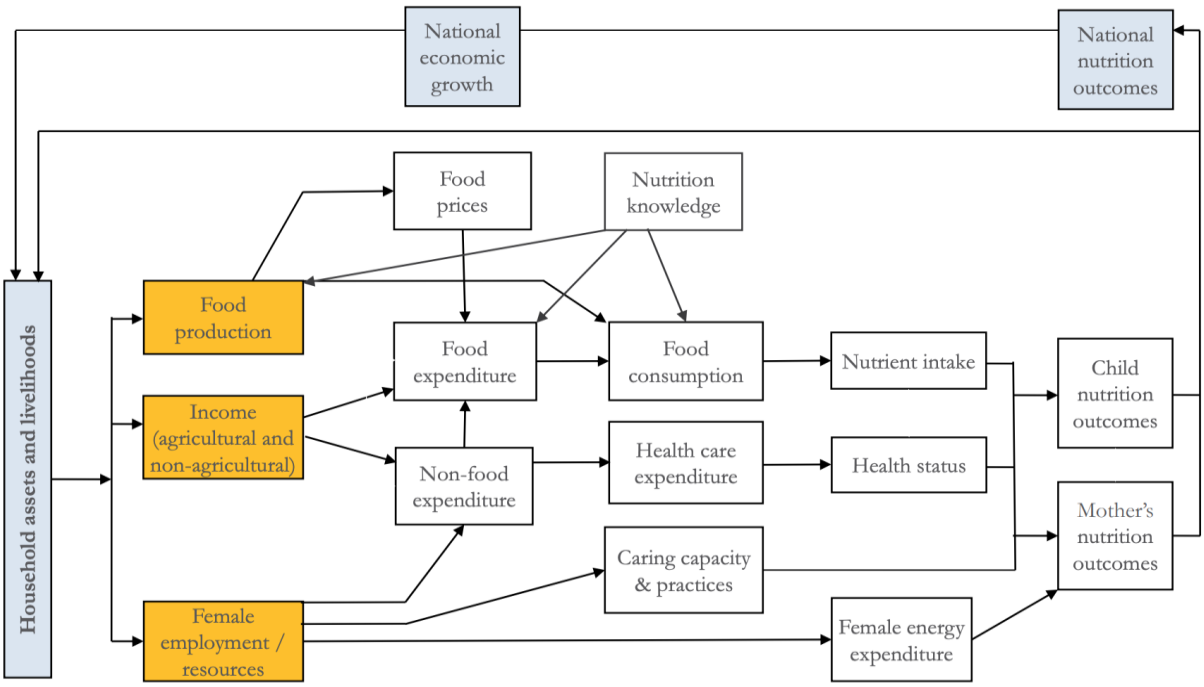
four dimensions of food security—availability, access, utilization and stability. While the anticipated link from food insecurity to child undernutrition seems to be more implicit and intuitive, more evidence is needed to understand the explicit role food security can play in improving the nutritional status of children and women.

Multiple reviews have noted that the pathways that lead from food production to markets in ways that influence food purchase, diets, and the nutritional status of populations are incompletely understood. Existing factors as summarized in Figure 3.15 points to a link between household food insecurity and stunting among under-five and low birth weight children, anaemia among women of reproductive age, and adult obesity among women.

The pathways through which agriculture affects nutrition are well documented. Improved nutrition in turn supports the agriculture sector by enhancing rural people's ability to undertake the strenuous tasks involved in small-scale farming. While the links between improved nutrition status and improved work capacity and productivity are clear, to enhance agricultural productivity and incomes, the agriculture sector must pay even more attention to nutrition. Increased attention to nutrition by the agriculture sector ensures a greater focus on the consumer, which is good for agriculture from both a public and private goods standpoint[7].

Increase in food productivity leads to a decline in food prices that enhances access to food as well as consumption of diversified foods by the grower, households and communities. Agriculture also increases income-generating activities, improves time allocation, and provides more decision making power regarding household resource allocation, especially on energy and nutrient expenditures, contributing to women empowerment. This would ultimately build resilient food systems for the future, integrate rural and urban areas and strengthen their linkages—with the involvement of all stakeholders, benefiting both small holder farmers and the urban poor.

Figure 3.15: Pathways from Agriculture to Nutrition



Source: Adapted from (Gillespie and al. 2012 and Headey and al 2012)

[7]Oshaug A and Haddad L .https://www.unscn.org/files/Publications/Briefs_on_Nutrition/Brief6_EN.pdf

3.3.2 The agricultural sector's response to address malnutrition

The Second Country Investment Plan 2016-2020 (CIP2) on Nutrition-Sensitive Food Systems

Bangladesh's Second Country Investment Plan (CIP2) 2016-2020 is a comprehensive inter-sectoral plan on Nutrition-Sensitive Food Systems that has been formulated by the Ministry of Food in partnership with 17 ministries. The CIP2 focuses on nutrition-sensitive food systems, by setting forth priority investment programs for each stage of the food value chain 'from production to plate', as well as for emerging challenges to Bangladesh's food systems. Its primary goal is to "achieve improved food security and nutrition for all at all times by making food systems nutrition-sensitive and sustainable". The CIP's strategic objective is to "ensure availability, affordability and nutritional quality of foods, and that all people have access to a variety of safe and nutritious foods, and the knowledge they need to make wise food choices for a healthy diet". These objectives are to be achieved through 13 investment programs. The total cost of the CIP2 is estimated at US$ 9.2 billion with US$ 3.6 billion still to be funded. CIP2 adopts nutrition-sensitive budgeting by identifying investments which have the potential to achieve more impact on nutrition. When prioritising nutrition-weighted funding for nutrition impact, the financing gap amounts to US$ 2.4 billion. (CIP2, 2016-2020)

The CIP2 is being monitored by Food Policy Monitoring Unit (FPMU) in close collaboration with 17 partner ministries under the direct leadership of the Ministry of Food, which produces the Annual Monitoring Report. The CIP2 Monitoring Report (MR 2019) which covers the period 2017-2018, provides Food Security and Nutrition (FSN) data and analysis that are used for the NPAN2 Monitoring Report 2016-2017, 2017-2018 and 2018-19.

3.3.3 Current situation and trends in agriculture and food security

3.3.3.1 Food production and availability

Production of some staple foods[8]

The performance of the agricultural sector is improving, as evidenced by the continued annual growth of agricultural GDP from 2015-16 to 2017-18, although a slight decline was seen from 2017-18 to 2018-19. Rice is the main staple food consumed in Bangladesh; the country has been self-sufficient in rice production since 2012[9]. However, after rice production increased to 7.3% in 2017-18 from -2.6% in 2016-17. The annual change in wheat production was negative in 2018-19 (-0.3%).

Production of some nutrient-dense foods

- Pulses and beans: The production of pulses, which are rich in protein, is increasing, but at a slower pace compared to that rapid rate of rice. In 2017-18, the annual change in production was 0.7%, which declined to 0.5% in 2018-19 (-0.5% annual change in production). An annual change in the production of beans dropped by 2% in 2017-18 (-1.9% annual change in production), while the annual change in production of beans increased to 6.8% in 2018-19.
- Fruits and vegetables: Unlike cereals, the production growth of fruits and vegetables slightly increased between 2017-18 to 2018-19. Major and leafy vegetables including brinjal, pumpkin, tomatoes and red amaranth (lal shak) all increased in annual production from 2017-18 to 2018-19, with the exception of carrots that dropped from 14.5% in 2017-18 to 3.1% in 2018-19. Similarly, annual change in the production of major fruits including banana, mango and pineapple considerably increased from 0.4%, -9.5%, -1.6% in 2017-18 to 2.8%, 4.6%, 4.3% in 2018-19 respectively, while the annual change in production of jackfruit declined from 2.4% in 2017-18 to 3.5% in 2018-19 (-3.5% annual change in production).

[8] Data from BBS, Statistical Yearbooks

[9] USDA Foreign Agricultural Service. 2015. Grain and Feed Annual. http://gain.fas.US$a.gov/Recent%20GAIN%20Publications/Grain%20and%20Feed%20Annual_Dhaka_Bangladesh_5-5-2015.pdf

- Animal Source Foods (ASF)**:** Absolute fish production continues to increase, despite a decrease in the annual growth of fish production from 3.46% in 2017-18 to 2.37% in 2018-19. Bangladesh has achieved self-sufficiency in fish production, by crossing the target of 40.50 lakh metric tons in 2016-17[10]. Pond aquaculture remains quite prominent in its production with 2,478,000 ponds in 2018-19. Marine fisheries are being developed with predominantly traditional fishing. In 2017-2018, production from marine fisheries was only 15% of the total fish production, with artisanal capture representing 81.6%[11]. Although production of meat, eggs and milk is increasing every year, the percentage of increase is still low (Table 3.14) and there is a gap between production and demand, except for meat (Table 3.15)[12]

Table 3.14: production of milk, meat and eggs in fiscal years 2016-2017 and 2017-2018

Products	FY (2016-2017)	FY (2017-2018)	FY (2018-2019)
Milk (Lakh Metric Ton)	92.83	94.06	99.23
Meat (Lakh Metric Ton)	71.54	72.60	75.14
Egg (Crore number)	1493.31	1552.00	1711.00

Source: (DLS, Livestock Economy at a glance, 2018-19)

Table 3.15: demand and availability of milk, meat and eggs in fiscal year 2018-19

Products	Demand	Availability	Gaps
Milk (Lakh Metric Ton)	152.8 Lakh Metric Ton (250 ml/day/head)	165.07 (ml/day/head)	53.57 Lakh Metric Ton
Meat (Lakh Metric Ton)	75.1 Lakh Metric Ton (120 g/day/head)	124.99 (g/day/head)	**Surplus** of 0.26 Lakh Metric Ton
Egg (Crore number)	1741.6 Crore number (104 numbers/year/head)	103.89 (numbers/year/head)	30.6 Crore numbers

Source: (DLS, Livestock Economy at a glance, 2018-19)

3.3.4 Bio-fortified crops, food fortification and food to food enrichment

Bio-fortification is a recognized long-term agricultural investment for improving nutrition and is going to be an integral component of a comprehensive package of complementary strategies to enhance agricultural and food-based interventions for nutrition. Bangladesh, through its research institutions like Bangladesh Rice Research Institute (BRRI), BARI and BINA, has already undertaken transgenic collaborative research to improve beta-carotene and iron levels for micronutrient enhancement of certain crops like orange sweet potato, legumes and other vegetables. BRRI and the International Rice Research Institute (IRRI) along with Harvest-Plus have developed and released seven zinc-biofortified rice varieties. Harvest-Plus along with partners have delivered the seeds of four zinc rice varieties to almost half a million households across 62 out of 64 districts. The aim was to reach about one million farming households with bio-fortified zinc rice by the end of 2018.

[10]Department of Fisheries of Bangladesh, Yearbook of Fisheries Statistics of Bangladesh 2016-17, December 2017

[11]https://fisheries.portal.gov.bd/sites/default/files/files/fisheries.portal.gov.bd/download/60fbae1d_570c_41ae_9117_6f611361a840/Fisheries%20Statistical%20Yearboook%202017-18_Final.pdf

[12]http://dls.portal.gov.bd/sites/default/files/files/dls.portal.gov.bd/page/ee5f4621_fa3a_40ac_8bd9_898fb8ee4700/Livestock%20Economy%20at%20a%20glance%20%20%282017-2018%29.pdf

Table 3.16: Status of process indicators and targets of bio-fortification and micronutrient supplementation as envisaged under NPAN2.

Indicators	*Status*				*Source/Remarks*
	2016	**2017**	**2018**	**2019**	
(#)/Any kind of national level information on (Salt Iodization, fortification of oil/other food with Vitamin 'A', iron etc.)	YES	YES	YES	YES	Salt - BSCIC, Ministry of Industries; Edible oil – Ministry of Industries; Rice – Ministry of Women and Children Affairs, Ministry of Food
Development of crude salt specification by BSCIC and monitoring of crude salt quality	NO	NO	NO	NO	BSCIC is developing specifications for crude salt
# of lab introduced quality control in salt industries	8	8	8	NA	There are eight labs managed by BSCIC in the salt zone for regular testing of quality of iodized salt
Build capacity of implementation and monitoring bodies, i.e. BSCIC, IPHN, BSTI, IPH, DG Food, DWA etc.	YES	YES	YES	YES	BSCIC, IPHN are being capacitated by IFST through NI finance; DG Food and DWA are being capacitated by NI and WFP in monitoring fortified rice.
Initiate activities related to Market Intervention Operation (MIO) for affordable price for consumers	NO	NO	NO	NO	Ministry of Industries planned to intervene market to stabilize price of iodized salt but didn't take place

NA= Not Available

Universal salt iodization and fortification of edible oil with vitamin A are ongoing under the auspices of the Ministry of Industries. Eight laboratories managed by the Bangladesh Small and Cottage Industries Corporation (BSCIC) in the salt zones are regularly testing the quality of iodized salt. Production and distribution of fortified rice are ongoing in selected upazilas through the Food Friendly Program under the Ministry of Food and Vulnerable Group Development (VGD) Program implemented by the Ministry of Women and Children Affairs for poor and vulnerable women and children.

Among others, fortified rice is being promoted as an intervention to address anaemia by the Ministry of Health and Family Welfare (MoHFW), MoFood and the MoWCA. The Government of Bangladesh (GoB) has adopted rice fortification under the 'National Strategy on Prevention and Control of Micronutrient Deficiencies, 2015-2024' as one of the strategies to address micronutrient deficiencies through mainstreaming fortified rice through GoB Social Safety Net programs, open market sale, etc.

Bangladesh Standard and Testing Institute (BSTI) under the Ministry of Industries (MoI), the main enforcing agency of the government, have developed the country standard of fortified rice. Fortified rice contains six most essential vitamins and minerals (Vitamin A, Vitamin B1, Vitamin B12, Folic Acid, Iron and Zinc) formulated in accordance with WHO guidelines and micronutrient requirements of the population of Bangladesh.

The scaling up of rice fortification is currently implemented by the Ministry of Women and Children Affairs (MoWCA), Ministry of Food (MoFood) with support from WFP, Nutrition International, and private sector rice millers promote fortification and distribution of rice through selected government platforms. This collaboration has resulted in production and distribution of fortified rice within two of the largest government Social Safety Nets—the Vulnerable Group Development (VGD) Program and the Food Friendly Program (FFP). It has also contributed to the establishment of public-private partnerships and domestic production of fortified rice kernels. At present, the distribution of fortified

rice under the VGD Program is being implemented in 94 upazilas. In addition, the Ministry of Food has distributed fortified rice under its Food Friendly Program (FFP) in 24 upazilas in 2019.

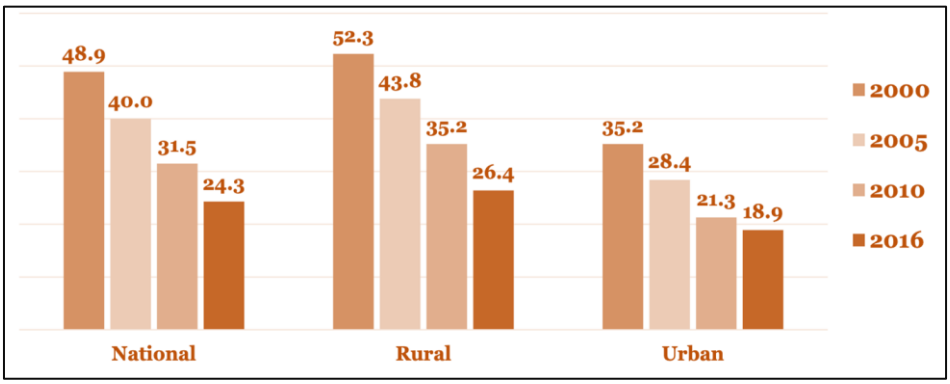
3.3.6 Food accessibility

Overall calorie intake per capita per day has decreased to 2210 Kcal from 2308 Kcal in 2010 (a decrease of about 4%). This decrease amount (2210 Kcal) is below the desirable 2430 Kcal/capita/day[13]. This reduction could be attributable to the considerable decrease of rice consumption both in rural and urban areas in 2016 compared to 2010. However, the prevalence of the population suffering from chronic energy deficiency (undernourishment) was 15.2% in 2015-2016[14].

Subsequent efforts were made to promote home gardening for vulnerable populations, in order to ensure direct access to nutrient-dense foods such as horticultural products and backyard poultry. In 2016, 49% of poor households were engaged in home gardening, compared to 46.1% in 2015, which constitutes a slight increase.

The 2016 Household Income and Expenditure Survey (HIES) showed that Bangladeshi households spent 47.7% of their household expenditure on food, compared to 54.81% in 2010. In 2016 in rural areas, the share of food expenditure was 50.49%; in urban areas however, the share of food in a household's budget fell to 42.59%. In 2016, for the first time in HIES history, non-food expenditure exceeded food expenditure at the national level and in urban areas. Expenditure on food and non-food items was almost equal in rural areas in 2016. This indicates improvement in the quality of life of Bangladeshis. However, poverty is still prevalent especially in rural and urban slum areas, despite the reduction of national prevalence of poverty from 31.5% in 2010 to 24.3% in 2016 (HIES 2016), following the same trend since 2000 (Figure 3.16). Poverty, coupled with regular food price fluctuation and generally higher cost of key nutrient-dense foods such as meat and fish, thus limits access to a quality and diversified diet.

Figure 3.16: Trend in poverty prevalence



Source: (HIES, Household Income & Expenditure Survey)

3.3.7 Diet quality and diversity

Diet quality and diversity among young children is rapidly improving, with an 11% increase between 2014 and 2017. BDHS 2014 showed that 23% of children aged 6-23 months have a minimal acceptable diet, which increased to 34% as reported by BDHS 2017. If this trend continues, the target of 40% or more by 2025 as set in NPAN2 would largely be achieved. It should be noted that this per-capita data

[13] Desirable Dietary Pattern for Bangladesh (http://fpmu.gov.bd/agridrupal/sites/default/files/ToR%2015-%20Fial%20Report%20BIRDEM.pdf)

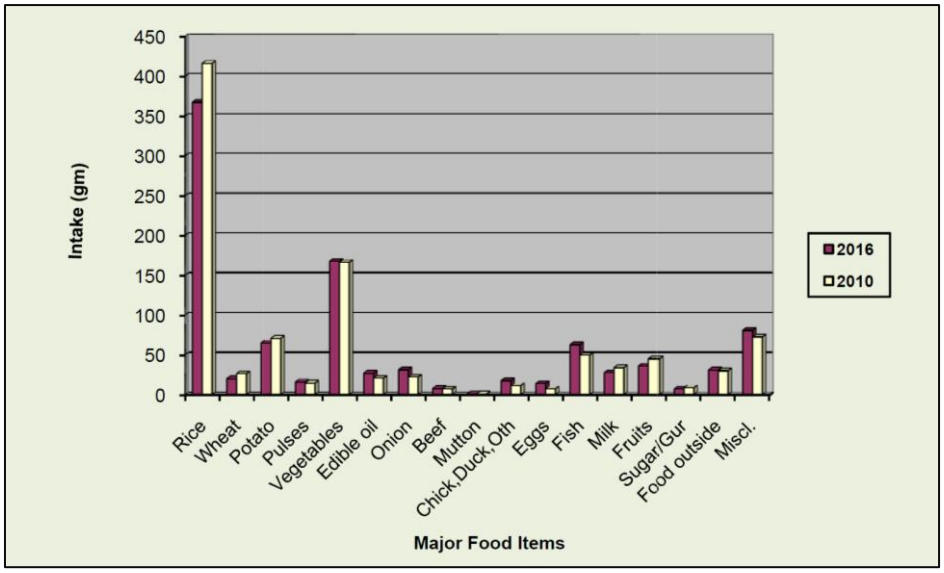
[14] FAO, IFAD, UNICEF, WFP and WHO. 2018. The State of Food Security and Nutrition in the World 2018. Building climate resilience for food security and nutrition. Rome, FAO.

neither represents socio-economic groups nor regional or seasonal variations. For example, 48% of children from the highest wealth quintile have a minimally acceptable diet compared to only 24% of children in the lowest wealth quintile. On the other hand, more efforts need to be made to achieve the target of 75% of women of reproductive age having minimum dietary diversity by 2030, if we consider the baseline of 46% in 2015.

Cereals and cereal products still constitute the main share of Dietary Energy Supply (DES), with 76.3% contributing to total DES in 2014, dropping by only 1.8 percentage points over a seven-year period (2007-2014). While updated data on DES is not yet available, it might be assumed that the same trend in the share of cereals-based foods from 2007-2014 is continuing. It is important to accelerate the diversification of Bangladesh's food production towards more availability of nutrient-dense foods, while continuing to ensure cereal sufficiency as the backbone of the diet.

While rice remains the main staple food in Bangladesh, consumption at the national level decreased from 416 g/capita/day in 2010 to 367 g/capita/day in 2016, while the average recommended range is 270-450 g/capita/day, amounting to about 56% of dietary energy/day (Dietary Guidelines for Bangladesh, 2015). The share of dietary energy intake from cereals is presently around 64%, still above the recommended norm of around 60%. Consumption of nutrient-dense foods such as vegetables and pulses has slightly increased by 0.7% and 9% respectively. On the other hand, daily consumption of fruits per capita declined from 44.7g in 2010 to 35.78g in 2016. In the area of animal sourced foods, fish consumption has seen a significant increase by 26%, along with chicken, duck and eggs. However, farmed fish is by far the main fish consumed. It is lower in micronutrients as compared to non-farmed fish, and could explain the reduction of micronutrient intake from fish observed in Bangladesh, although fish consumption has increased significantly[15]. Consumption of beef has dropped, and the same trend is observed for milk (Figure 3.17). Overall, protein intake has decreased from 66.26 g/capita/day in 2010 to 63.8 g/capita/day in 2016. It is important to note that there is still a gap between the current dietary pattern and the desirable one (Table 3.17).

Figure 3.17: Per capita per day intake (in grams) of major food items in 2010 and 2016



Source: (HIES, Household Income & Expenditure Survey)

[15] Bogard, Jessica R., et al. "Higher fish but lower micronutrient intakes: Temporal changes in fish consumption from capture fisheries and aquaculture in Bangladesh." *PloS one* 12.4 (2017): e0175098.

Table 3.17: Desirable dietary pattern for Bangladesh

Food groups	Desirable intake (g/capita/day)	Intake in 2016 (g/capita/day)	Gap (g/capita/day)
Cereals	400	409	(9)*
Potato	100	65	35
Vegetables	300	167	133
Pulses	50	16	34
Edible oils	30	28	2
Animal source foods (ASF)	260	129	131
Condiments and spices	20	75	(55)*
Fruits	100	36	64
Sugar/gur	20	7	13

*Surplus intake; *Source: Desirable Dietary Pattern for Bangladesh*[16] *and HIES 2016*

3.4 Thematic Area 3: Social Protection

3.4.1 Equity emanating from poverty

The Household Income Expenditure Survey (HIES 2016) report, indicates that poverty incidences in both rural and urban have reduced in 2016 as compared with 2010. Poverty in urban areas was 7.7% in 2010 compared with 7.6% in 2016 and in rural areas was 21.1% in 2010 compared with 14.9% in 2016. The poverty line is estimated by calculating the cost of basic needs (CBN). Data segregated as per the poverty line shows that 31 districts of 64 districts are above the national average.

Children who escape stunting in the first 1000 days of their lives are 33% more likely to escape poverty as adults (World Bank- please state which report and include reference). A negative relationship is observed between household wealth and undernutrition. Children in the poorest households are more likely to be stunted (40%) compared with children in the wealthiest households (17%). Wasting does not show a linear relationship with the wealth quintile. Wasting in the lowest wealth quintiles was 10% compared with 7% in highest quintiles. (BDHS 2017-18). Further analysis is required to fully understand the effects of household income on stunting and wealth. A comparison of stunting and wasting with data segregated by household income would provide in-depth insights. The various categorizations of household income could be as follows, zero earner households (3.03 million) single member earner households (20.30 million) two member earner households (7.01 million) and three plus member earner households (2.68 millions). Similarly, the difference in the nutritional status with regards to the education and income would further strengthen the report.

3.4.2 Poverty is on a decline, but at a slower pace

Using the upper poverty line, the incidence of poverty is estimated at 24.3% at the national level, 26.4% in rural areas and 18.9% in urban areas (HIES 2016). A reduction of Head Count Rate (HCR) was recorded at 7.2 percentage points (approximately 1.2% per annum) at national level, 8.8 percentage points in rural areas and 2.4 percentage points in urban areas during the period 2010 to 2016. The gradual decline in poverty was observed to be higher in rural areas as compared to urban areas. In rural areas, the reduction was 3.7 times higher than urban areas. This may be due to the higher number of poverty reduction interventions, such as Social Safety Net Programs (SSNP) in the rural areas compared to urban areas. Using the lower poverty line, the incidence of poverty is estimated at 12.9% at the national level, 14.9% in rural areas and 7.6% in urban areas. A reduction of HCR of

[16] http://fpmu.gov.bd/agridrupal/sites/default/files/ToR%2015-%20Fial%20Report%20BIRDEM.pdf

4.7% at the national level, 6.2% in rural areas and only 0.1% in urban areas during the period 2010 to 2016.

If this positive trend of decline in poverty continues, then the SDG 1 Target 1.2.1 of reducing at least by half the proportion of men, women and children of all ages living in poverty in all its dimensions according to national definitions by 2030, could be achieved in Bangladesh (at least at national level). In fact, the 9.7% and 3.0% poverty headcount index targets using the national upper and lower poverty lines, respectively, are likely to be reached before 2030. In 2010, poverty in the ten poorest districts of Bangladesh ranged from 42% to 70% compared to the average national poverty rate of 24.3%. Since then, both geographical and income inequalities have risen indicating that economic growth has not resulted in commensurate poverty reduction in all regions and among all groups. A more inclusive growth needs to be promoted while ensuring the most vulnerable are protected from the effects of poverty.

Despite encouraging results with regards to the attainment of SDG 1, there are other studies that show that the progress is actually slower. It has been suggested that if poverty were estimated using income rather than consumption expenditure, the poverty rates would be higher (Daily Star news article 'Poverty line needs to be redefined: experts' dated 25/10/2018, comment by Professor Mahmud). In addition, there are other assumptions that intra-household disaggregation of resource distribution would unveil important differences in individual poverty levels. For example, a study examining the dietary requirements, has shown that in adequately nourished households 55% of boys and 47% of girls are undernourished (D'Souza, A. and Tandon, S. ; 2016, 'Intra-Household Nutritional Inequities in Rural Bangladesh' Annual Meeting, July 31-August 2, Boston, Massachusetts 235832, Agricultural and Applied Economics Association).

Despite the positive improvement in overall poverty, a substantial number of people under the poverty line (close to 39 million) and under the extreme poverty line (close to 20 million) highlights the need for extending the safety nets to be more inclusive and a stronger social protection system in order to achieve SDG 1 target.

The 2016 HIES data shows that 27.8% of the households have received benefits from SSNP during the last 12 months SSNP 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 last three months. There was an increase in the total number of beneficiaries under SSNPs from 8 million in 2010 to 11 million in 2016. In 2016, the percentage of beneficiaries was 28.7, 35.7 and 10.9 at the national, rural and urban levels respectively. Among the households covered under SSNPs, primary school students benefit the most, (36.14%), followed by the elderly old age allowance (14.22%) and higher secondary students (11.42%), vulnerable group feeding (7.38%), gratuitous relief (GR) 5.88% and school feeding programme (4.44%). The remainder of the programmes are small. The spending on SSNPs as a percentage of the total national budget has increased steadily (both total and percentage) between FY 2016/17 and 2018/19. The allocation has increased from 12.88% in 2016/17 to, 13.06% in 2017/18 to 13.81% in 2018/19 (Table 3.18).

Table 3.18: Total and percentage of the National Budget for Social Safety Net Programs by year

FY	Total budget (BDT XX)	% of budget
2016-17	317,174	12.88%
2017-18	371,495	13.06%
2018-19	464,573	13.81%

There are 145 schemes being implemented under the current National Social Security Strategy (NSSS) through 23 Ministries/ Divisions. It is acknowledged by the Government of Bangladesh that unplanned growth of the portfolio has led to fragmented implementation, with both duplication and under-coverage resulting from incorrect targeting, leakages and lack of inter-ministerial coordination. Though the coverage of these programmes for poor and vulnerable households has increased and has

helped reduce poverty, a large proportion of poor and vulnerable households do not have any access to these programmes. The average size of the benefit is low and has in many cases been falling. Consequently, the impact on poverty reduction from the amount of money spent on these programmes is less than what would be possible with a more effective social security system. The programmes and activities must be evaluated to ensure they are targeting the most nutritionally vulnerable population groups, reaching them on time and yielding the desired results.

Social Protection Programmes offer multiple ways for integrating nutrition considerations. Some examples include food transfers (including fortified food) and cash transfers to vulnerable people in chronic or disaster related areas of food insecurity, school meals/ school feeding, which may include fortified foods as well as nutrition-related education. These programmes can also target gender equality and women empowerment, support income generation, and ensure a transparent targeting of the appropriate target groups.

Prioritization of targeting for nutritionally vulnerable groups is an important mechanism to deliver the social protection programme's potential nutrition impact. Wherever applicable, women of reproductive age (15-49 years) especially pregnant and lactating mothers and households with children under two years as well as adolescents will be prioritized in the targeting of social protection programmes. People in urban slum areas are particularly vulnerable to food insecurity and malnutrition, due to the congested living conditions, unhealthy environment and compromised access to basic services.

3.4.3 Benefit Cost Ratio for Social safety Net Program:

Benefit cost ratio for social safety net program is 1:29, this means that if 1 Tk. is invested in the social safety net programs the economic benefit would be about Tk.29. To improve the nutritional status of children from the poorest households, transfers alone will be inadequate. Alongside transfers a simultaneous behaviour change communication (BCC) campaign can significantly improve the child nutritional status and anthropometric outcomes. As evidence by 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 (Source: IFPRI, 2018)

3.4.4 The impact on the social protection programs

Figure 3.18 reveals a trend in reduction of the stunting rate across all wealth quantiles between 2014 and 2017-18. In addition, the reduction was highest at 18 percentage points among the lowest wealth quantile compared to among the highest wealth quantile at 12 percentage point. A similar trend was also seen with regard to stunting and wasting over the same period (Table 3.19). These achievements could partly be explained by the pro-poor policies of the government and targeting of most SSNP towards the poor.

Figure 3.18: Percentage of children under age 5 classified as malnourished according to the wealth quintile

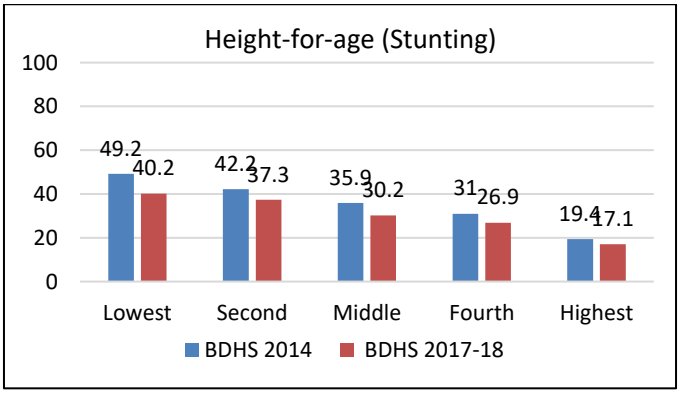


Table 3.19: Reduction in stunting and wasting among children age 6-59 months between 2014 to 2017-18 amongst the various wealth quantiles.

wealth quantiles	Height-for-age (Stunting)		Weight-for-height (Wasting)	
	BDHS 2014	BDHS 2017-18	BDHS 2014	BDHS 2017-18
Lowest	49.2	40.2	17.1	10 (42%)
Second	42.2	37.3	16.5	7.9 (52%)
Middle	35.9	30.2	12.8	7.9(38%)
Fourth	31	26.9	13.1	8.8 (33%)
Highest	19.4	17.1	11.7	7.2(38%)

3.4.5 Example of a Nutrition Sensitive Social Safety-Net Programme

Income support programme for the poorest project (ISPP), JAWTNO Project, under the Local government. Division (LGD).

A five year project (2015-2020) financed by the World Bank which covers 600,000 direct beneficiaries (poor pregnant women and under-five children) from 444 Union Parishads (local councils) of 43 Upazilas (sub districts) from seven districts. Among other coverage provided to beneficiaries, the conditional cash transfer component intends to provide cash for:

- At least four antenatal visits for pregnant women (BDT 200 per visit);
- 0-24 months children for attending monthly GMP sessions (BDT500 per visit);
- 2-5 years children for undertaking quarterly weight and height measurements (BDT 1000 per visit and;
- Attending monthly health and nutrition education sessions (for pregnant, and mothers of children in the 0-5 years age group) (BDT 500 per month).

In order to enhance the nutritional value of the food basket provided under the SSNP, the inclusion of multiple micronutrient fortified foods like fortified rice and fortified edible oil can contribute to reducing micronutrient deficiencies among targeted sections of the population. Some of the existing social protection programmes such as the Vulnerable Group Development (VGD) programme needs to be advocated and encouraged to replace regular food with fortified food soon.

The design of the social protection programmes must also address poverty, gender discrimination and child marriage, which have been acknowledged as the leading underlying causes of under-nutrition in Bangladesh. Increasing the amount and coverage of secondary school stipend programmes for girls which will encourage them to remain in schools and continue their education, empowering women, and income generation activities, vocational and skill development training for vulnerable women can be used to influence and encourage families to adopt the recommended age of marriage and pregnancy.

Table 3.20: Status of Social Protection Programme indicators

Indicators	2011	2014	Current status	NPAN2 target 2025
% of woman age 20-24 who were first married by age 18	65%	59%	51.40% (MICS 2019)	30%
% of woman who completed secondary/ higher education	12%	14%	17% (BDHS-2017-18)	90%

Information related to the percentage of woman aged 20-24 years who were first married by the age of 18 years is not available in the BDHS 20171-18 report. We have used the most recent finding from MICS 2019 which reveals that the percentage of women aged 20-24 years who were first married by age 18 years has reduced slightly to 51.4% in 2019 from 52.3% in 2012-13, which is still high compared to the 30% target set in the NPAN2.

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 is observed. In 2016, the gross enrolment rate for the secondary level rose to about 74% from 43% in 2001, the gross enrolment rate for boys in 2016 was about 67%, which is significantly lower compared to GER (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. The gender parity index was 1.15. In 2015, the overall completion rate for both boys and girls was about 60% (58% in 2014), 66% for boys (66% in 2014), 54% for girls (52% in 2014).

The GER in higher secondary level was about 40%, (41% for boys, 38% for girls). We observe that the GER is lower for girls than boys. The NER in higher secondary level is 37% (37% for boys, 36% for girls). The GER and NER of higher secondary level was 38% and 25% in 2008 but this rate increased to about 40% and 37% in 2016. In the same year, the completion rate reached 80% for both gender, 83% for boy and 76% for girls (BANBEIS, 2018). Furthermore, the trend of women who completed secondary/higher education is comparatively lower than the NPAN2 target by 2025. Therefore, in order to meet the target, the performance needs to gradually start improving.

3.4.6 Status of a few Social Protection Programmes indicators

SSNP spending as a percentage of the GDP has steadily increased to 2.58% in 2019-20 from 2.54% in 2018-19 and from 2.19% in 2015-16 (Table 3.14). The number of beneficiaries has also increased from 1,950,000 in 2018-19 to 2,030,000 in 2019-20. Between 2015 and 2019-20 the beneficiaries for the maternal allowance benefit increased substantially from 0.25 Million to 0.725 Million; the beneficiaries for the allowance for working lactating women also increased from 0.125 million to 0.265 million; and the beneficiaries for the VGD programme increased from 0.75 million to 1.04 million (Table 3.21).

Table 3.21: Status of process indicators and targets of Social Protection Programmes as envisaged under NPAN2.

Output indicators	2018-2019 (in million)	Target (in million)		Source
		2019-20	2020-25	
Government spending on social protection as % of GDP	2.54	2.58	NA	GED, Planning Commission
No. of beneficiaries (pregnant, lactating and children) covered by social protection programme	0.7 Maternal allowance	(0.725 m by 2019-20)	7.50 million by 2025	DWA
	0.25 (Working Lactating allowance)	(0.265) by 2019-20		DWA
	1.0 (under VGD program)	1.04 million by 2019-20	2.3 million by 2025	

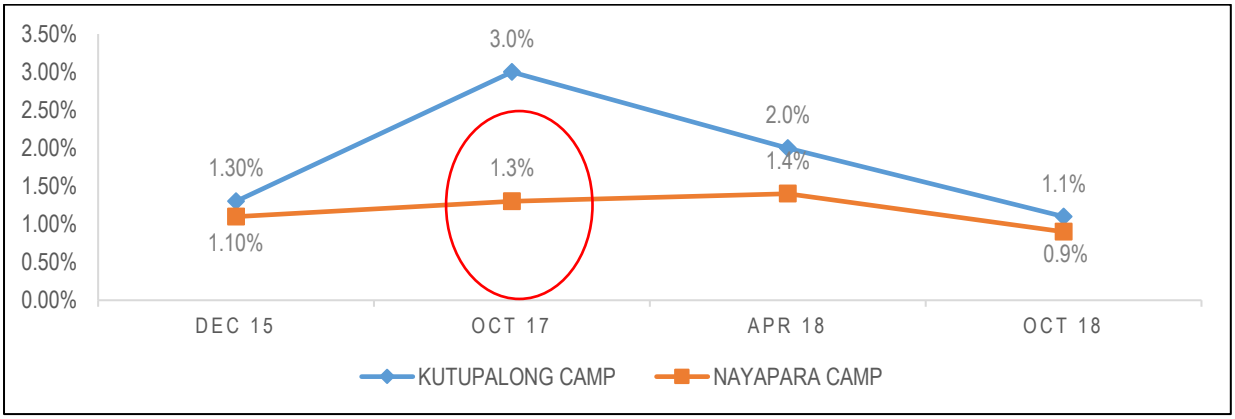
3.4.7 Vulnerability and climate change

Due to geographic location of the country, calamities such as cyclone, flood, riverbank erosion, landslide, drought and ground water contamination have become very frequent in the recent years. As a consequence, the vulnerable population are more affected than the others. The vicious cycle of poverty continues to increase their vulnerability and risks. This is important as the number of poor are likely to increase if adequate measures are not put in place to ensure those numbers do not increase due climate related calamities..

3.4.8 Emergency Nutrition Response for FDMN in Cox's Bazar

As of December 31, 2019, about 854,700 Forcibly Displaced Myanmar Nationals (FDMN) refugees (Female 441514, Male 413,190) including 161,657 under-five children (Girls 79323, Boys 82334) arrived in the Cox's Bazar district which has led to almost a doubling in the population of the Teknaf and Ukhiya sub-districts. The prevalence of Global Acute Malnutrition (GAM) in makeshift camps was 10.9 percent with a one percent prevalence of Severe Acute Malnutrition (SAM) which is considered serious, a major public health concern by the World Health Organization (GAM 10 - <15 percent). The nutrition cluster led by the Civil Surgeon (CS) in Cox's Bazar and co-led by UNICEF is active and coordinates all the nutrition activities in the camp population. In addition, UNICEF, World Food Programme and the United Nations High Commission for Refugees (UNHCR) ensure a well-coordinated nutrition response that treats and prevents malnutrition related morbidity and mortality among this large refugee community.

Figure 3.19: Trends of SAM Rate in kutupalong MS & Nayapara camps [2015-2018]



The SAM rates have increased in the camp after the new influx in 2017. However, significant reduction of the prevalence of SAM has been observed in the camps from October 2017 to October 2018, this is largely attributed to the scaling up of both curative and preventive nutrition interventions in the camps. (Source: UNICEF, Bangladesh)

Nutrition activities supported by UNICEF (from November 2017 till July 2019):

- 34 OTPs (Outpatient Therapeutic Program), seven CMAM-I sites (community-based management of at-risk mothers and infants) and two SCs (Stabilization Centers) were established and managed to treat children with severe acute malnutrition with or without medical complications.
- Every month around 135,000 children under 5 are screened at the community level by over 1000 skilled community nutrition volunteers and till now around 45,000 children with SAM were enrolled and treated in OTPs operated by UNICEF partners. Besides more than 800 children with medical complications received critical lifesaving treatment in the two SCs.
- UNICEF supported IYCF program provided counselling and messaging on IYCF to more than 100,000 pregnant and lactating women through one-on-one counselling and group demonstrations. UNICEF reached these mothers in nutrition centers i.e. OTPs, CMAM-I sites including 19 dedicated IYCF spaces.
- Three rounds of Nutrition Action Week (NAW) was observed with support from USAID-FFP. During each of these rounds around 150,000 children received Vitamin A supplementation and 85,000 children received deworming tablets.
- Around 1,200 nutrition staffs and volunteers were trained on different components of nutrition services.

3.5 Thematic Area 4: Implementation of Integrated and Comprehensive SBCC Strategy

The Second National Plan for Nutrition (NPAN2) calls for the implementation of Social and Behavior Change Communication activities aligned with the National Comprehensive SBCC Strategy 2016. NPAN2 stipulates that, for building political and society-wide awareness and commitment to food and nutrition security, advocacy, and social mobilization are key Social Behavior Change Communication (SBCC) activities. These approaches will build on the gains made in the last ten years in a number of important areas such as WASH, environmental sanitation, family planning, and the reduction in stunting. SBCC activities in Bangladesh have likely contributed significantly to improvements in food and nutrition security.

The overall aim of the nutrition SBCC part of the NPAN2 is to develop a harmonized and effective advocacy and nutrition information, education and communication strategy including resource materials for national as well as local activities. The SBCC activities go beyond the health, nutrition and population (HNP) sector to foster communications and advocate for multisectoral approaches to ensure synergy amongst sectors, joint planning and resource mobilization. Thus, many implementation activities in the NPAN2 consolidated matrix use SBCC strategies and would contribute to developing a workable implementation plan for carrying out the communication and awareness-raising activities in the most coordinated, effective and efficient manner across and between sectors.

With technical support from NI/UKAID, a costed National Advocacy Plan for Nutrition has been prepared and launched showcasing audiences, activities, timeline and required budget for implementation in the next ten years. A possible multi-trust fund to support the implementation of the detailed action plan for operationalization of the advocacy plan is being prepared by BNNC. BNNC has organized orientation on NPAN2 in 53 districts, several round table dialogues, TV talk shows, and seminars to highlight progresses, challenges and recommendations for a multi-sectoral approach for nutrition.

BNNC has developed a video documentary targeting policy makers and partners showcasing overall achievements of BNNC focusing on the combined effort of all stakeholders to achieve the nutritional goal for Bangladesh. This documentary has been technically supported by a partner organization (e.g. CARE Bangladesh) and by relevant ministries.

Table 3.22: Status of process indicators of SBCC as envisaged under NPAN2.

Output indicators	Key activities achieved
Number of ongoing comprehensive coordinated multi-sectoral, multichannel advocacy and communications campaign	• Costed Advocacy Plan prepared and shared • Video documentary on transformative leadership of BNNC • One brochure on BNNC prepared • Organized two National Nutrition Weeks in 2018 and 2019 • National Nutrition Week 2018 report has been published and 2019 report is in progress • Seized all possible opportunities to advocate for improving nutrition • Operationalized the Advocacy Plan on Nutrition by Multi-partners Consortium • One TV talk show on progress of Multi-sectoral Approach for Nutrition outcome has been organized • Ensured effective technical support for development of National School Meal Policy 2019

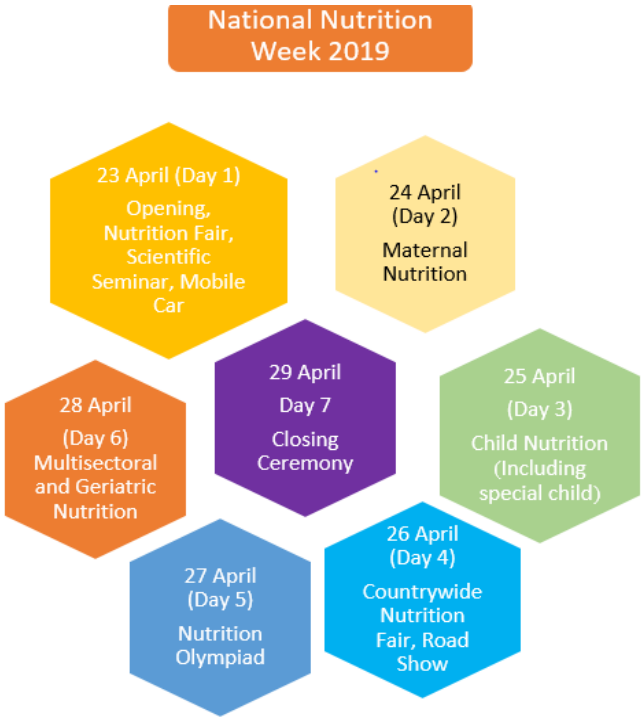
3.5.1 Organization of National Nutrition Week 2019

Each year National Nutrition Week (NNW) is arranged countrywide from 23-29 April facilitated by the Bangladesh's National Nutrition Council(BNNC) and Institute of Public Health Nutrition(IPHN) under the leadership of Ministry of Health and Family Welfare - MOHFW. Honourable Health and Family Welfare Minister Mr. Zahid Maleque, MP along with other two ministers attended the first day of the event at Hotel Inter-Continental. Under the leadership of the Ministry of Health and Family Welfare, the Institute of Public Health and Nutrition and Bangladesh's National Nutrition Council, Development partners along with relevant stakeholders, elaborate programmes were undertaken nationwide. The theme of 2019 nutrition week was - "While thinking about food, think about nutrition too" **খাদ্যের কথা ভাবলে পুষ্টির কথা ও ভাবুন।"**

Photo-3: Launching ceremony of NNW 2019 at Hotel Inter-Continental

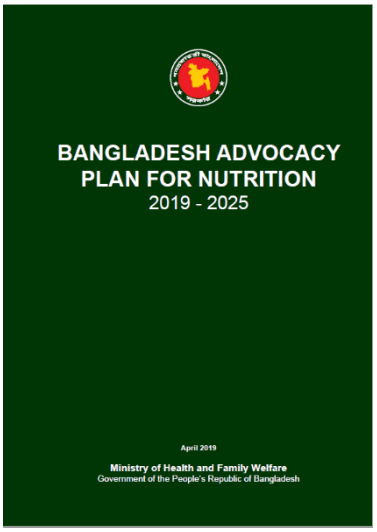
Photo-4: Campaign with rally of NNW 2019 in Noakhali UHC

Figure 3.20: Weekly plan of activities during NNW 2019



The week-long programmes including rallies, fairs, scientific seminars, nutrition Olympiad, road shows, and processions were conducted at the national level. 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 were, rallies, display posters, gatherings of mothers, nutrition fairs, food cooking competitions, farmers 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.

3.5.2 Bangladesh Advocacy Plan for Nutrition 2019-2025



Bangladesh National Nutrition Council (BNNC) in 2019 formulated the Bangladesh Advocacy Plan for Nutrition 2019-2025) with technical assistance from UKAid – Nutrition International under Technical Assistance for Nutrition (TAN) project. The goal of the Plan is to strengthen the political and legal framework, increase commitment of stakeholders, bring about a change in the organizational behavior towards the nutrition agenda, and enhance resource mobilization for nutrition.

Devlopment Process

The Plan was developed through a consultative process that involved key informant interviews, stakeholder's consultations, development and validation workshops, and finally got approved by the Advocacy and Communication Platform under NPAN2.

Strategies 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.

Advocacy Issues Identified in the Plan are:

- 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

Selected Audiences (Person and Entities) for Advocacy

1. Parliament members and national level political leaders
2. Prime Minister's Office, Relevant Line Ministries, Divisions, Directorates
3. Local Government bodies
4. Media
5. Private sectors (including food processing business)
6. Development Partners and Civil Society Organizations
7. Women's Organizations

8. Professional Organizations (including BMA)
9. Academic and Research Institutes
10. Social Safety Net and Public food Distribution Programs
11. Education Sector - Nutrition Interventions for School going Children and Adolescents
12. Nutrition Sensitive Food Production System (agriculture, fisheries, livestock)

Type of activities in the Plan

1. Assessment/ mapping/ stakeholder analysis for selective audience group
2. Development of audience specific advocacy materials
3. Organization of advocacy events
4. Mass media campaign (Electronic/Print)
5. Media award
6. Private sector award
7. Relevant priority research, research result dissemination
8. Monitoring, reporting and evaluation of activities

Cost and Financing

The total estimated cost for the plan is BDT 387.5 million (US $ 4.56 million @ 85). It is proposed in the plan that the financing to be made from sectoral plans, special projects and allocation to the BNNC.

3.5.3 Other SBCC Activities

There are certain cascading activities regarding nutrition SBCC which have been done through different line Ministries and development partners. Technical support has been provided to integrate an SBCC strategy in the Improved Maternity and Lactating Allowance programme implemented by Ministry of Women and Child Affairs (MoWCA) in alignment with the National Comprehensive SBCC strategy. Moreover, under the Rice Fortification Programme, advocacy and commercialization is being led by the Ministry of Food. A public awareness campaign highlighting the benefits of a healthy diet is due to be launched under the leadership of the Ministry of Industry and technical assistance by relevant ministries. Under this programme a database of SBCC materials on nutrition has been developed, and is currently under discussion for mainstreaming into the Government of Bangladesh's information system.

Other than the Government nutrition programme, UNICEF's support to the nutrition programme, USAID's communication support programme to Government health interventions and other nutrition programme interventions resulted only in small amounts of coverage. Nutrition communication programme supported by CARE-Bangladesh has covered two Upazilas. Save the Children's nutrition communication programme was in three Upazilas and the current Improving Nutrition through Community-based Approaches (INCA) Activity Project on nutrition communication support programmes are in 11 Upazilas. WFP created public awareness around the benefits of fortified rice under the investment component for vulnerable group development (IC-VGD) project under MOWCA. It is now crucial to review the outcomes, successes and challenges from SBCC interventions to adapt future nutrition SBCC materials.

Collective Impact for Nutrition (CI4N); *an advocacy initiative for promoting multi-sectoral approach by CARE Bangladesh.*

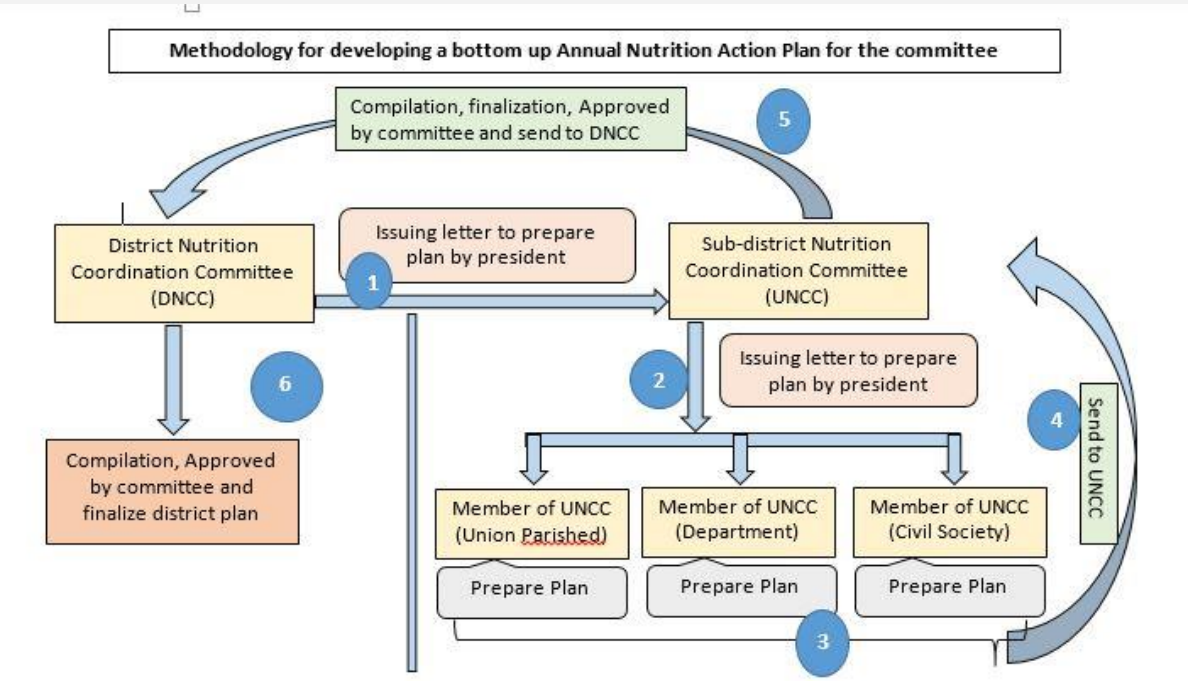
The benefits of multi-sectoral and multi-level nutrition coordination committees can be only achieved through effective planning and implementation at national and sub-national level. CARE Bangladesh launched the Collective Impact for Nutrition (CI4N) initiative which works as an external facilitator and supporting government at national and sub national level to promote multi-sectoral approach to nutrition. The highlights of CI4N key activities are as following;

1. *Assist BNNC and MOHFW to develop Terms of Reference (ToR) for UNCC and DNCC*:

Generated evidences and advocacy tool for multi-sectoral approach to nutrition from district and sub-district nutrition coordination committees created at district, upazilla and union parishad. Subsequently worked with BNNC and MOH&FW to develop the structure of nutrition coordination committees in all districts and upazillas and their Terms of Reference to be used for the entire country.

2. *Provided technical support to the development of the operational guidelines of district and sub-district nutrition coordination committee: With technical support by CARE Bangladesh, the Bangladesh National Nutrition Council (BNNC), has developed an operational guideline for the District and Upazila Nutrition Coordination Committee (DNCC, UNCC) at district and sub-district level which has been accredited and adopted by MoHFW.*

3. *Developed participatory multi-sectoral annual nutrition action plan for Sunamganj 2019-20: One of the strategic objectives of CI4N, CARE Bangladesh is to generate evidences and facilitate learning, sharing through establishing a district model of multi-sectoral approach to nutrition. A participatory multi-sectoral district annual nutrition action plan (2019-2020), has been developed led by District Nutrition Coordination Committee, Sunamganj. This is the first time in Bangladesh a participatory district multi-sectoral nutrition plan was developed where the Local government created a plan based on their local demand and shared it with UNCC. The UNCC subsequently collected plans from all the nutrition sensitive and specific departments and submitted a compiled nutrition action plan to DNCC. DNCC compiled all sub-districts (11) plans under Sunamganj district as a district plan. The whole process is articulated in the diagram below:*



The District plan is a consolidation of all 11 Sub-district plans. After compiling all UNCC plan, CI4N worked with DNCC members for data accuracy by using secondary data from the District level, validated by DNCC members, and approved by Secretary and President members of the DNCC for publication. 100% of Union Parished (88 Unions), Sub-districts (11 Sub-districts) and Sunamganj District engaged in a very structured and systematic process for Annual Nutrition Action Plan to improve the nutritional status of Sunamganj through coordination of Nutrition Specific and Nutrition Sensitive interventions. The next step is to develop a rigorous monitoring system for the Annual Nutrition Action Plan at District and Sub-district levels. As a technical partner, CI4N is facilitating the development of an effective monitoring mechanism.

Way forward: CI4N is planning to establish a monitoring system for tracking the implementation of the planned activities by coordination committees and subsequently develop an annual nutrition plan for the next fiscal year.

3.6 Thematic Area 5: Monitoring, Evaluation and Research

The monitoring, evaluation and research platform aims to track the progress and learnings and evidences from the planned activities to enable informed decisions while developing policy. This will also ensure that the programmes maintain a high level of quality while achieving their objectives. Additionally, it also enables programme management to take the required corrective measures in a timely manner.

As an approach to identify either degree of inconsistencies or similarities between the current situation and the expected planned NPAN2 outcomes, an essential step in developing the sector matrices was to conduct a gap analysis. Conducting a gap analysis is also essential to move from the current position to next one and to continue with the desired rate of progress to achieve NPAN2's desired outcomes.

Table 3.23: Status of operational level indicators to measure functionality of Monitoring, Evaluation and Research platform as envisaged under NPAN2

Progress indicators	2018-19	Source
Number of dissemination sessions of NPAN2 in District and sub-district levels	53	BNNC
Number of meetings conducted on M&E platform	5	BNNC
Number of orientations held on Multisectoral Coordination Committee at District level	31 Districts	BNNC
Number of orientations held on Multisectoral Coordination Committee at Sub-district level	86 upazila	BNNC
Establishment of updated nutrition information systems (following the selected events and systems development to measure the progress)	In progress	BNNC

3.6.1 Activities performed on Monitoring, Evaluation and Research (2018-19)

3.6.1.1 Functionality of M&E platform

Among the five platforms of NPAN2, the monitoring, evaluation and research platform is fully functional. A total of 5 meetings were completed between 2018-19, the output of which is described below. The various activities related to M&E systems, such as guidance documentations were developed and relevant trainings & orientations were conducted.

Results: The platform works to assess, develop and combine number of indicators to examine nutrition and food security trends, progress and formulate 'Annual Monitoring Report of NPAN2'.

Photo 5: First meeting of working level Platform of M, E & R Platform

3.6.1.2 Stakeholders Mapping for Nutrition M&E

Multi-stakeholder workshop conducted for multi-stakeholder mapping to identify ongoing nutrition M&E systems and surveillance mechanism. It helped BNNC to understand the different nutrition interventions and M&E practices in the country.

Results: The findings of the mapping were to set out the current situation on M&E practices around implementation of multi-sectoral nutrition interventions in Bangladesh. The exercise was also highlighted the gaps in Monitoring and Evaluation process in different sectors.

Photo 6: Picture with Participants of the workshop

3.6.1.3 Sectoral workshop for integration of NPAN2 indicators

The workshop with sectoral partners for integration of nutrition indicators into existing monitoring and reporting systems was held in April 2019. The main purpose of the workshop was to sensitize the key sector partners to integrate the nutrition indicators into their existing monitoring and reporting system.

Results: In the workshop, it was discussed and sector specific monitoring indicators were analysed in line with NPAN2 priority indicators. The scope of their integration was also discussed and analysed. With the common consensus of all participants, a draft layout was prepared for integration of priority indicators into sectoral monitoring and reporting systems.

Photo 7: Participants of the Multi-Sectoral workshop

3.6.1.4 Developed a guidance of multi-sectoral nutrition data management & reporting

A guideline document on data management framework has been developed and shared which supports the tracking of multisectoral nutrition progress in line with NPAN2 targets. The guideline combines conceptual search with practical step-by-step suggestions, processes on the data collection, data extraction, data management and data integration. In short, the guideline includes a framework which helps to understand the process of operationalization of priority indicators.

Results: In the context of capacity building of Bangladesh National Nutrition Council (BNNC) office and intermediate users from different sectors, the guideline will help with the multisectoral data management and reporting process. This integrated process would help to resolve conflict, promote harmonization of methods, and would assure high quality standards among all stakeholders.

Photo 8: Dissemination workshop on guidance on multi-sectoral nutrition data management & reporting

3.6.1.5 Gender Conformism in endogenous development of M&E

A four-day capacity building training workshop on "Nutrition data management and reporting" for BNNC technical staffs was conducted. The aim was to facilitate the streamlining of the process and to allow the BNNC staff to engage in M&E capacity building and developing strong analytical skills to interpret results and reporting. Nutrition International conducted this training workshop under the Technical assistance under the NI-TAN project. In addition to this, a session based on "Gender Mainstreaming for monitoring and reporting" was organized in the capacity building program. There was a detailed discussion on the technique to carry out gender-sensitive M&E, both at the project and at the organizational levels. Ms. Humaira Alif, Senior Expert- WIC & Gender from United Purpose was invited to facilitate the session during the training program.

Photo 9: Participants from the BNNC office and senior expert- WIC chairing the session

Results: The training was designed to engage the BNNC officials in M&E activities, build strong analytical skills to interpret results and report multisectoral nutrition data. As the training was focused on gender sensitivity, this also helped BNNC technical staff in the planning of projects and ongoing activities from a gender prospective.

3.6.1.6 Identify and prioritize key nutrition indicators that need to be monitored

To assess the progress of NPAN2 Monitoring & Evaluation framework and to achieve the agreed upon targets, a selected number of indicators were emphasized based on National nutrition status and NPAN2 targets. Initially these 25 indicators were selected from 9 key ministries out of 22 relevant ministries. Several workshops and consultation meetings were conducted to select and finalize those priority indicators from NPAN2 Monitoring & Evaluation Matrix. In total 25 priority indicators out of 64 from M&E framework have been selected and finalized as priority monitoring indicators based on existing requirement and mid-term target of NPAN2.

Results: This was of use to different sectors to orient them on the NPAN2 objectives. Also, different sectors have started to incorporate those indicators into their annual work plan and monitoring systems.

3.6.1.7 Tracking progress of sectoral annual workplan

Activities from NPAN2 have been concised into 25 priority indicators from nutrition related key ministries. Accordingly, these indicators were included in respective sectoral plans and a guiding document has been developed by the M&E platform to avoid multiple parallel nutrition information systems exist in Bangladesh. BNNC has started monitoring progress of sectoral annual workplan of relevant ministries on six monthly basis and initiated creation of a dashboard at national and sub-national levels. **(See details in Annex 4)**

3.6.2 Bangladesh nutrition profile

Evidence-based planning and data-driven decision making is important to address bottlenecks and ensure effective coverage of nutrition services. In order to empower policy makers and districts government officials to assess and track the performance of nutrition specific and nutrition sensitive interventions, the Bangladesh National Nutrition Council (BNCC), in collaboration with nutrition

stakeholders, has developed national-, division-, and district-level nutrition profiles. On April 23, 2019, a web-based Bangladesh Nutrition Profile 2019 was launched which presents indicators and information on nutrition-specific activities and allows comparison across 64 districts and eight divisions. The profiles have been designed to represent the multi-sectoral dependency of nutrition and provide an integrative understanding of the nutritional status of women and children along key nutrition specific and nutrition sensitive indicators. The indicators have been linked with the SDGs, as well as World Health Assembly targets on nutrition and include indicators on the underlying determinants of undernutrition, such as food security, health services, WASH, education, and social protection services. To provide reference and comparison, the profiles include both data on the current, and last year's status of key nutrition-related services and indicators.

3.6.3 Monitoring system for assessing functionality of DNCC, UNCC

For NPAN2 coordination at subnational level, there are district nutrition coordination committees (DNCCs) and upazilla nutrition coordination committees (UNCCs) who are entrusted with conducting coordination among multiple sectors. Ultimately, for scaling up of nutrition activities, these are sub-national platforms who should be made functional, effective and efficient to improve nutrition in the country.

To assess degree of functionality of district and upazilla nutrition coordination committees a web-based system including a set of tools has been developed based on functions of DNCCs and UNCCs in order 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 monitoring system reflects the functional status of the committees, their multisectoral nutrition actions, annual work plan, budget, and district-level nutrition advocacy implementation plan. This acts as supportive supervision and reporting tools for DNCC and UNCC. It contains nutrition-related resources that DNCCs and UNCCs and other multisectoral nutrition stakeholders have used at the local level for nutrition advocacy; multisectoral planning and budgeting; and program implementation, monitoring, and reporting. The system will have 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.

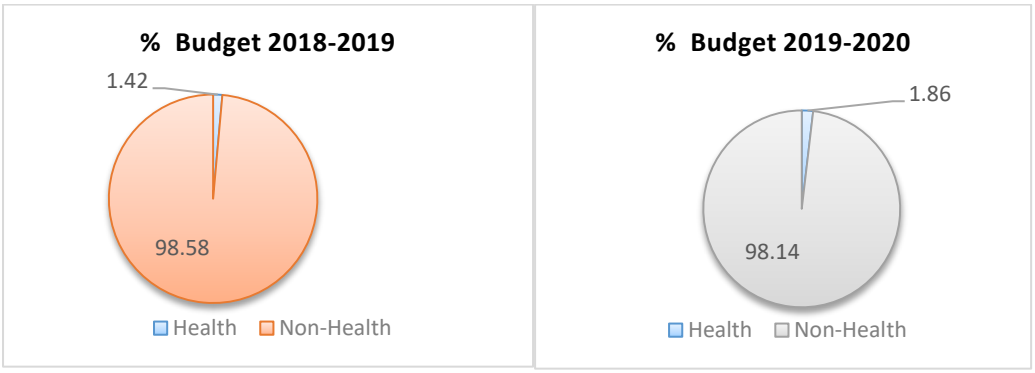
3.6.4 Budget Tracking

BNNC has initiated the systematic budget tracking to ensure existing fund is being spent efficiently towards achieving nutrition goals.

In absence of a central unique system for reviewing and tracking budget for all 22 allied ministries for implementation of NPAN2, BNNC has started with a manual process instead. This is to review the budget allocation for each individual sectoral annual workplan. A desk review of all sectoral works and their budget has already been started by BNNC. An excel format (Annex 2) has been developed to record budget data and thereafter review the budget allocations by the respective planning and finance units of different ministries by using a standard format for 2018/2019 FY.

The analysis of budget from Operational Plans (Ops) show, the total budget (for OPs under MOHFW and other Sectoral plans) for year 2018/2019 and 2019/2020 were BDT. 121,070,610,000 and BDT.149,400,397,800 respectively. Of the total budget BDT. 121,070,610,000 for 2018-19, BDT. 1,837,840,000 (1.5%) was from six Operational Plans under ministry of Health and Family Welfare (MoHFW) and BDT.119,232,770,000 (98.5%) was from nutrition sensitive interventions with 17 workplans of sectoral ministries. The allocation for 2019/2020 has increased to BDT. 149,400,397,800 of which BDT. 2,869,214,000 (1.86%) and BDT. 146,531,183,800 (98%) were for nutrition specific and nutrition sensitive interventions respectively (Figure 3.21).

Figure 3.21: Allocation of budget from Operational Plans (Ops) in MoHFW

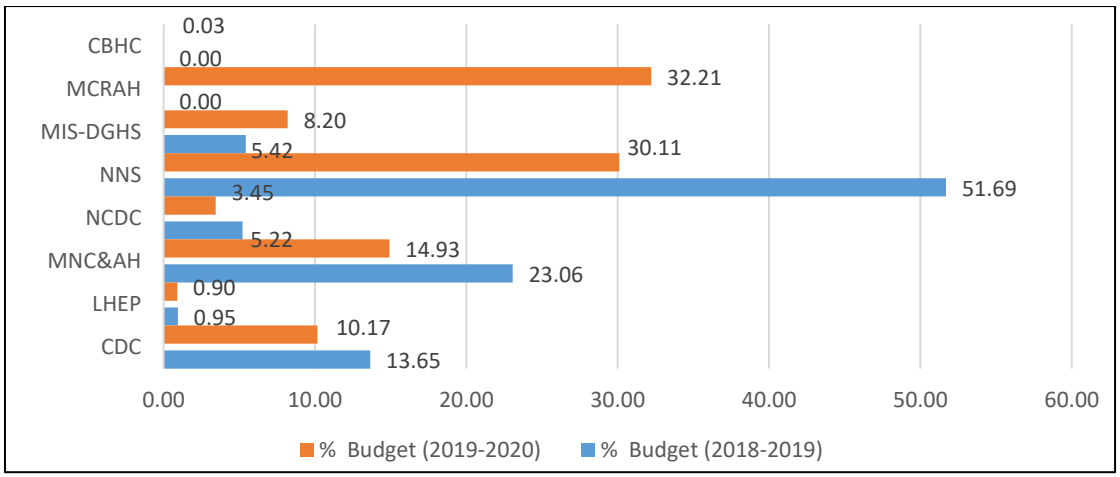


Total budget for both 2018/2019 and 2019/2010 was much lower compared to Public Expenditure Review on Nutrition (PERN) findings for yearly allocation, which was about BDT. 29,347 crore for 2017/2018. This difference is partly because of, (i) absence of any allocation in six ministries annual work plans as they have not included any budget. For example, Ministry of Food (MoFood) and Ministry of Primary and Mass Education (MOPME) two large ministries who contributed about 47% of the total expenditure in nutrition but for Sectoral work plan, approved resources figure could not be obtained until preparation of the Annual Report.

3.6.5 Comparison OP budget under MOH&FW between 2018-19 and 2019-20

The overall budget for financial year2019-20 (BDT 28,692.14 lac) for OPs in MoH&FW has increased as compared to the previous financial year 2018-2019 (BDT 18,378.4 lac). Budget for all OPs increased in 2019-2020 from 2018-2020 except NNS OP. The NNS budget, a component of the total MoH&FW budget for 2019-2020 reduced to 30.11% from 51.69% for year 2018-19 (Figure 3.22). A probable reason for this may be in 2018-19 six OPs provided a budget compared to eight OPs in 2019-20. In addition, all OPs have increased their budget other than NNS OP. Four (OPs) out of eight OPs have contributed to over 85% of total budget of MoH&FW. Please see the details in Annex-2.

Figure 3.22: Allocation of budget from Operational Plans (OPs) in MoHFW



3.6.6 Strategy to conduct Operational and Implementation Research

There are several institutions, organizations, NGOs responsible for managing and undertaking nutrition researches in Bangladesh. These researches are done on ad hoc basis primarily to meet a specific need or to fulfil the requirement of a respective organization, hence are not well coordinated, and most cases, results are not shared and remain widely unused.

In view of the above situation a strategy to conduct operational and implementation research has been developed. This strategy also aimed to strengthen the capacity of BNNC to manage, coordinate, supervise, outsource; identify the role of various research entities; mapping of related nutrition research to avoid duplication and; identify priority research areas/topics based on importance, urgency and gaps in operational and implementation researches.

BNNC is mandated to coordinate and manage operational and implementation researches (specific and sensitive) which are required for smooth implementation of NPAN2 and achieve its objectives to improve nutritional status of children and women in Bangladesh. To meet BNNC's mandate, a two-prong approach will be adopted.

i) BNNC will advocate and pursue with relevant organizations to undertake and manage some of the high priority researches using their own resources and share results for wider use as appropriate;

ii) BNNC will commission these researches through development of Terms of Reference (TOR), preparation of the Request for Proposal (RFP), review of the proposals, awarding the contract, reviewing results, etc. They will share the findings with partners and advocate for its use widely as deemed necessary to achieve NPAN2 objectives.

BNNC is in the process of creating a web-based repository for nutrition researches in Bangladesh. This would be an online database containing information related to nutrition research and programmatic evidence gathered in Bangladesh (national repository). The repository will be multisectoral in nature.

Research topics have been identified and prioritized as immediate priority, meaning that the results are required with in next two years (2010-2022), medium priority (by 2025) and long-term priority (beyond 2025).

Beside this, the BNNC has established a journal club for sharing research findings on nutrition. One of the responsibilities of the BNNC secretariat is to support and coordinate research to generate knowledge including provision of grants for conducting research reviews to identify the achievements and gaps in current knowledge on nutrition. Jointly with the SUN Civil Society Alliance and Academia Networks and Civic Engagement Alliance, it conducted a study on knowledge gaps and suggested areas for future researches.

Urban Nutrition Situation: A Formative Research by the Alive and Thrive

Alive and Thrive, an international technical assistance organization supported a Formative Research (FR) on 'Understanding opportunities and challenges of delivering maternal, infant and young child nutrition (MIYCN) services in urban Dhaka', which was conducted by the icddr,b in 2019. The objective of the FR was to gain a better understanding of the urban context, both at the facility (public, NGO and private) and community-level, which would inform the design of the urban model to improve the delivery of MIYCN services in maternal, new-born, and child health (MNCH) facilities in Dhaka City. More specifically, the FR intended to *understand* the health system's capacity for delivering MIYCN services, the approach to attracting clients, existing communication channels with community preferences; and to *identify* practices, perceptions, barriers and facilitators influencing maternal nutrition practices during pregnancy and among under-2 children.

A Few Key findings:

In Facilities:

- Public and NGO facilities are in a better position than private facilities in delivering organized MNCH services in terms of equipment, materials, supplements and data management, however with compromised quality, break in supplies and inadequate use of data.
- For pregnant women there was substantial gap between availability and implementation of breastfeeding counselling compared to other services.
- Pregnant women and mothers expressed higher satisfaction about the nutrition services they received from NGO (65.4%) followed by private service providers (60%).
- Public service providers received lower scores on cleanliness and waiting time component of the satisfaction score compared to other service providers.
- NGO facilities (90.9%) are more likely to have community health workers compared to public (45.5%) and private (0%) health facilities.

In Slum Communities:

- Non-slum pregnant mothers were more able to translate knowledge to practice as they were better off financially and had better connections with health facilities.
- Pregnant women did not know how much weight should be gained during pregnancy despite knowing that it was important to gain weight.
- Poor understanding/knowledge about exact frequency of meals during pregnancy.
- Husbands and family members were the most important and trusted source of health and nutrition information for mothers, followed by health service providers.
- Most mothers preferred face-to-face communication with health care providers.

Formative Research findings (left column) were further matched with recommended modalities of addressing identified issues (right column), as shown in Table 3.24 below.

Table 3.24: List of findings on formative research findings and recommendation

SL	*Key Urban Challenges emerged through the formative research*	*Recommended modality of addressing the issue*
1.	Exclusive breastfeeding and complementary feeding are a challenge as mothers work outside home for long hours.	• Message dissemination at HH level during home visit • Counselling at health facility • Community level mobilization events: advocacy meetings/Interactive events including film shows/nutrition fair/special day and week celebration • Targeting other home care providers: in laws, elderly siblings during home visit • Emphasizing and promoting 'expressed breastmilk technique' • Addressing women at the workplace
2.	Consumption of animal source protein is generally low given the high costs associated.	○ Counselling at health facility ○ Message dissemination at HH level during home visit • Community level mobilization events: advocacy meetings/Interactive events including film shows/nutrition fair/special day and week celebration. • Promotion of egg as a low- cost and easy to prepare animal protein
3.	Working mothers buy low-cost, processed, ready-made food for	○ Counselling at health facility ○ Message dissemination at HH level during home visit

SL	Key Urban Challenges emerged through the formative research	Recommended modality of addressing the issue
	their children due to ease of access and convenience.	Community level mobilization events: advocacy meetings/Interactive events including film shows/nutrition fair/special day and week celebration
4.	The use of primary health care services is low. Urban poor prefer pharmacies and over-the-counter medicines to health care facilities.	• Counselling at health facility • Message dissemination at HH level during home visit • Community level mobilization events: advocacy meetings/Interactive events including film shows/nutrition fair/special day and week celebration Encouraging service providers to promote services and offer quality services
5.	In some cases, the infant and young child are fed and taken care of by their elder siblings.	• Message dissemination at HH level targeting elder siblings

3.7 Thematic Area 6: Capacity building

Effective functioning of the BNNC would require building capacities at its institutional, physical facilities and human resources level. BNNC office along with 22 ministries and relevant partners is executing the second plan of action for nutrition (NPAN2). Skilled human resources are required to improve overall capacity for delivering its mandate effectively. Different sectors of nutrition also require a skilled workforce to be able to implement their own nutrition activities included in respective sectoral nutrition workplans.

3.7.1 Strengthening of BNNC office

3.7.1.1 Institutional Capacity

An essential part of an effective functioning NPAN2 will 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 mobilisation. 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 which was prepared earlier and approved by the Executive Committee (EC) of BNNC. This is supported by Ministry of Planning with financial support from Nutrition International (NI) and UKAid. This DPP is aiming to transform the BNNC office as a learning organization in order to enable informed policy decisions, and to strengthen institutional mechanism for achieving the goal of the National Nutrition Policy and National Plan of Action for Nutrition. BNNC will be able to guide the country in the right direction to overcome complex challenges that act as barriers for improving nutrition. Accordingly, BNNC office will be well-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. This technical assistance has helped BNNC to transform from an almost non-functional entity to an effective organisation to lead nutrition governance in Bangladesh.

Table 3.25: Status of Institutional Capacity of BNNC as envisaged under NPAN2.

Output indicators	2018-19
BNNC office strengthening	Yes
Number of full time personnel recruited for BNNC Office	19
Number of council meetings held	0
Number of executive committee meeting held	1
Number of standing technical committee meetings held	3
Inter-ministerial meeting/workshop held	5
Meeting with relevant Operational Plans (9) under MOHFW	1
District and Upazila nutrition coordination committee are in place	Yes
Yearly monitoring report on NPAN2 is available	Yes
Nutrition focal points in different sectors are in place and TOR available	Yes

Source: BNNC office record

During the reporting period several staff of BNNC received training on specific subjects from both international and local institutions (Table 3.26) 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.

Table 3.26: Key training of BNNC officials during July, 2018-June,2019

Name of the training	Location	Time	Duration	No of participants of BNNC
1.Improvement of Maternal and Child Nutrition	Abroad	04.11.2018-13.12.2018	40 days	1
2. Training of the trainers on management of SAM and CMAM	Local	05.05.2019-09.05.2019	5 days	3
3. Evidence Informed Policy Making Workshop	local	11.06.2019-13.06.2019	3 days	10
4. Occupational health management	local	16.06.19-20.06.2019	5 days	1

3.7.1.2 Sectoral Human Resource capacity need and gap assessment

A study was commissioned by BNNC with financial support from NI/UKAID to assess the existing human resource **(**HR) competency in relevant nutrition sectors at national and sub-national levels. The report from the study suggests that most sectors do not have dedicated nutrition staff with the required knowledge and skillset to manage and implement nutrition programs as envisaged under NPAN2. Where applicable, the human resource right from the national to the field level in all the ministries (nutrition sensitive and specific) require basic sensitization/orientation on nutrition policy, nutrition programming as well as customized technical training on required competencies for implementing ministry specific activities.

Findings from the results suggest about 72% of the nutrition focal points (at the ministry/department levels identified for NPAN2) of the 22- nutrition specific and nutrition sensitive ministries are sensitized about nutrition, the remaining 28% was yet to be sensitized.[17]

[17] Sensitization as used here would refer to the awareness of the development of Second National Plan of Action for Nutrition (NPAN2, 2016 - 2025) and understanding of the alignment of NPAN2 strategy with the activities of respective ministry.[17]

Table 3.27: Summary of required competency development training by Ministry

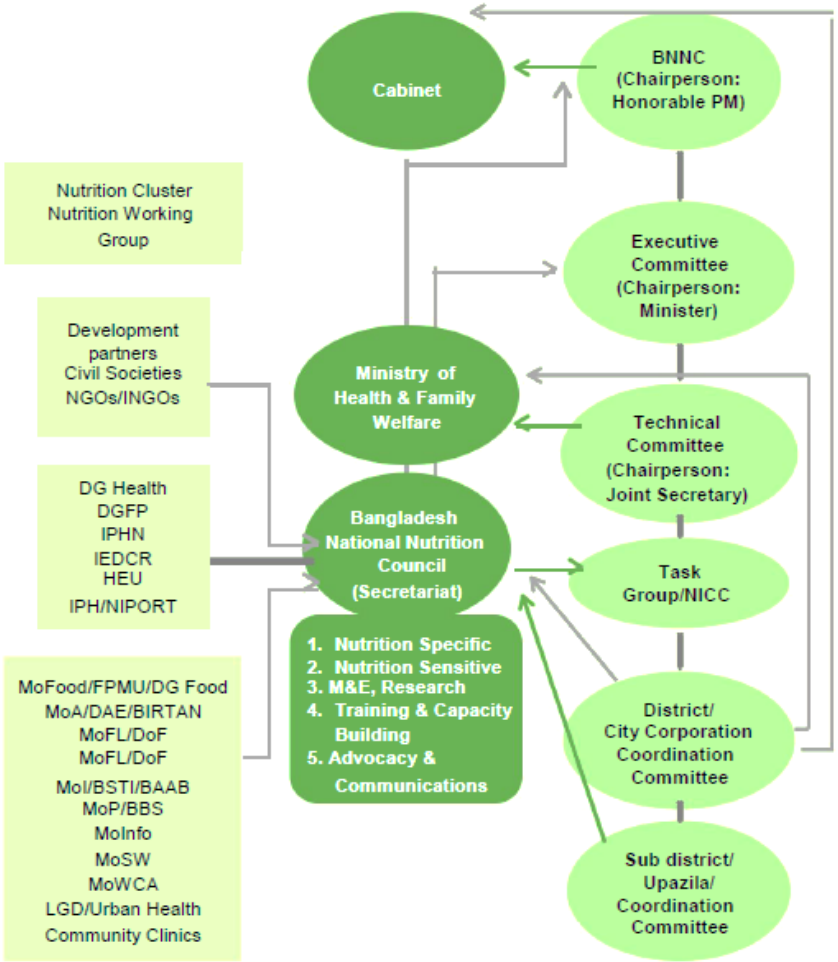
Ministry	Required training
MoFood	▪ Training on the standard process of testing fortified rice.
MoHFW	▪ Nutrition sensitization training for field level staff required ▪ Divisional level staff require training on food safety and food security ▪ All the staff of MIS OP need basic training on computer skills
MoPME	▪ Nutrition sensitization training of Upazilla Education Officers
MoWCA	▪ Nutrition sensitization training to all the staff involved in nutrition activities
MoLGRD	▪ Nutrition sensitization training for field level staff required
MoA	▪ Nutrition sensitization training required for staff at all levels ▪ Need to develop high quality nutrition-aware master trainers for DAE
MoE	▪ Nutrition sensitization training to all the staff at national level
MoFL	▪ Nutrition sensitization training from top level to field level staff ▪ Upgradation of technology to ensure safe and healthy dairy production
MoDMR	▪ Nutrition sensitization training to the field level staff ▪ Lack of skilled human resource for quality control of the nutritional quality of dry food
MoSW	▪ Nutrition sensitization training required for all levels Capacity building of human resources required to ensure improved nutrition intake of the transgender community
MoInd	▪ Nutrition sensitization training for all staff ▪ Consumer awareness needs to be developed through SBCC materials and training ▪ Increased budget requirement for increased mobile courts
MoEF	▪ Nutrition sensitization training to national level staff
MoI	▪ Nutrition sensitization training to all the staff ▪ BSS requires skilled human resources for conducting nutrition awareness programs
MoRA	▪ Nutrition sensitization training to all the staff related to nutrition activities
MoST	▪ Nutrition sensitization training to all the staff related to nutrition activities
MoLE	▪ Technical training on anti-natal check-ups, post-natal check-ups and benefits of breast feeding.
MoCom	▪ Policy level HR requires training on managerial and policy development process ▪ Field level staff needs training on recognition of pure and contaminated goods
MoFin	▪ Nutrition sensitization training to all the staff involved in nutrition activities
MoWR	▪ Nutrition sensitization training to all the staff

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

4.1 Overall Progress of coordination

For Bangladesh, nutrition governance comes from the highest level of Government with the Honourable Prime Minister as the Chair of Bangladesh National Nutrition Council (BNNC). Under this is the Executive Committee led by the Honourable Minister of Health and Family Welfare (MOH&FW) with top level representations from among the various government Ministries and agencies. The next level consists of the Standing Technical Committee (STC) headed by the Additional Secretary MOH&FW with expert members from government agencies, academia and civil society. BNNC is responsible for overall policy guidance. The Executive Committee is responsible for coordination throughout implementation of the policies, while STC is responsible for technical oversight of the policies and programs related to nutrition. There are five working level platforms consisting of members from various ministries and development partners.

Figure 4.1: Coordination Structure for Nutrition Following 3Ms Approach



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, platforms, the executive committee and the standing technical committee, SUN Networks,

etc.) and vertical coordination (with DNCC and UNCC); advocacy for resource mobilisation (internal and external), developing a monitoring system to monitor the functionality of sub-national committees and high visibility for nutrition, etc. For example, strong linkages have been established between NPAN2 and Second Country Investment Plan (CIP2), which have common objectives and engagement of the same stakeholders and sectors. Action is being taken to ensure complementarity and synergy in the implementation of these two policy actions. Training, inter-exchanges and capacity strengthening for FPMU and BNNC are being enabled with technical support from the FAO Meeting the Undernutrition Challenge Programme (MUCH) and some of the outputs included in the NPAN2 and CIP2 monitoring reports.

The Scaling up Nutrition (SUN) Movement and linkage with Bangladesh National Nutrition Council (BNNC):

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 and SUN platforms/ 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. The 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 workplans, 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 2019-20 (Initiation of Multi-sectoral policy review, Resource tracking for relevant sectors and Develop research strategy for nutrition for the year 2019-2020).

4.2 Multisectoral Coordination at central level

Planning for Nutrition

BNNC with support from partners has organized four workshops at the national level with all nutrition focal points from 22 ministries, high level government officials, partners to prepare a 10 year and Annual work plans aligning with the NPAN2 action and M&E matrix. BNNC has also arranged regular platforms meetings (meeting calendar prepared, 19 meetings held, workplan developed, WhatsApp group formed). Organized several technical working group meetings (formal and informal) on specific issues.

4.3 Multi-sectoral Coordination at Sub-national Level

Multisectoral District and Upazila Nutrition Coordination Committees headed by District Commissioner and Upazila Nirbahi Officer formed with specific TORs, and membership and orientation of these committees completed in 53 districts. To help prepare a decentralized plan a guideline was prepared.

4.3.1 Development of a Multi-Sectoral Minimum Nutrition Package (MMNP)

A Technical Working Group under guidance of BNNC helped developing a Multi-sectoral Minimum Nutrition Package (MMNP). This package has been built on and aligned with:

a. 25 priority nutrition indicators prioritized by the BNNC (out of a total 64 indicators and related activities envisaged in NPAN2 monitoring framework);

b. Activities included in the Sectoral Annual workplan/OPs of the respective ministry at national level;

c. Activities emerging from and meeting the geographical and cultural needs/demands; and

d. Interventions under DLI 13, 14 and other relevant DLIs (for nutrition specific interventions).

The nutrition package has been validated in several stages, e.g. with district and upazila officials of various line departments during the field visits by BNNC and partners.

4.3.2 Scaling Up and Rollout Strategy

A detail plan for rollout (which entails identification of number of districts and upazilas, activity calendar, engagement of DMRT/ CMRT, phasing plans and budget, etc.) has been developed by BNNC with the support of Technical Working Group. This was done in close consultation with DNNCs/UNCCs, and supporting partners. Plan for allocation of resources- both financial and manpower have been devised.

4.3.2.1 Formation of the Central and Divisional Multi-Sectoral Resource Teams (CMRT and DMRT)

BNNC aims to complete the nutrition plans and roll out of the Multi-sectoral Minimum Nutrition Package (MMNP) in all 64 districts and 492 upazilas in a shortest possible time.

Hence, to fast track the process one Central Multi-sectoral Resource Team (CMRT) and eight Divisional Multi-Sectoral Resource Teams (DMRTs) have been formed at central and divisional levels respectively. The Terms of Reference (TOR), memberships, selection criteria, orientation of the team members, etc. have been detailed out. Members are drawn from the list of nutrition focal persons of various ministries/divisions/departments, BNNC partners including civil societies, academicians.

4.4 Formation and functions of coordination platforms

As outlined in the NPAN2, the Ministry of Health and Family Welfare has formed five working level platforms with necessary terms of reference in July 2018. The Platforms are:

1. Nutrition Specific
2. Nutrition Sensitive
3. Monitoring, Evaluation and Research
4. Training and Capacity Building
5. Advocacy and Communication

Table 4.2: Progress and status of five different Platforms Meetings conducted during 2018-2019

Platforms	Number of Meeting	Date of meeting
Nutrition specific	4	25.11.2018; 07.03.2019 22.07.2019; 19.12.2019
Nutrition sensitive	2	07.01.19; 30.05.19
M&E, Research	5	16-10-2018; 09-01-2019 ; 20-03-2019 19-05- 2019; 04-12-2019
Training & Capacity Building	4	02.12.2018; 07/02/2019; 20/06/2019; 10/12/2019
Advocacy and communication	1	08.11.2018; 16.01.2019 25.03.2019; 10.07.2019

Table 4.3: Progress against Outcome indicators relating to Capacity Building, Governance and Institutional Development

Sl	Output indicators	NPAN2 Target 2025	NPAN2 baseline	Status 2018-19	Target Status
1	BNNC office functional	Yes (2017)	No	Yes	
2	Number of full-time personnel recruited for BNNC Office	34 (2017)	8	18	
3	Number of council meetings held	2 Per year (On going)	0	0	
4	Number of executive committee meeting held	4 Per year (On going)	0	3	
5	Number of standing technical committee meetings held	6 Per year (On going)	3	4	

Sl	Output indicators	NPAN2 Target 2025	NPAN2 baseline	Status 2018-19	Target Status
6	District and Upazila nutrition coordination committee are functional	Yes (2019)	No	Yes	
7	Yearly monitoring report on NPAN is available	Yes (On going)	No	Yes (1st report is available)	
8	Nutrition focal points in different sectors are in place and TOR available	Yes (2017)	No	Yes (n=119)	
The color indicators shows the progress achieved					
	In a good progress	On track		Off track	na=Not available

4.5 Multisectoral Minimum Nutrition Package (MMNP)

Multisectoral Minimum Nutrition Package are activities which should be considered, conducted and made available at the lowest administrative structures (i.e. district and upazillas) and service delivery outlets/platforms of Bangladesh. The minimum nutrition package would serve to identify priority minimum nutrition services/interventions/activities by different line departments in any District and Upazilla given the demand and needs of that area.

BNNC efforts to develop this multisectoral minimum nutrition package was supported by partners who have practical field level working experiences and have pioneered in carrying out multisectoral nutrition interventions through their ongoing programmes. The nutrition package has been validated at several stages, e.g. with district and upazilla officials of various line departments during the field visits by BNNC and partners. This package has been shared with all DNCCs and UNCCs, partners, civil society organisations and NGOs.

There are 20 priority indicators and a total of 115 activities included in multisectoral minimum nutrition package which belong to 7 ministries and their respective line departments at District and Upazilla. Of these 20 priority indicators, 11 indicators and 73 activities belong to health and family planning; 2 indicators and 10 activities belong to DPHE; 3 indicators and 18 activities belong to Agriculture; 2 indicators and 7 activities belong to MOPME/Education and 1 indicator and 3 activities belong to MoDMR/LGRD. Technical committee members within BNNC has finalized the MMNP package which has been sent to all DNNCs and UNCCs.

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. Those 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

1. Strengthen the capacity of the BNNC to facilitate carrying out coordination and multisectoral programming, advocacy, resource mobilization and, monitoring and evaluation.
2. Develop a strategy for resource mobilization, both internal and external, for implementation of the NPAN2.
3. Develop a system to track budget for both specific and sensitive nutrition programs/interventions at national and subnational level.
4. Develop a strategy to improve coverage of nutrition sensitive and specific interventions both in health and beyond health sectors.
5. Develop and finalize a consolidated monitoring and evaluation plan based on NPAN2 matrix.

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 (government, private clinics) through orientation of relevant staff followed by monitoring mechanism under baby friendly hospital initiative. 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 higher court directives to create baby friendly spaces (breastfeeding corner) in all public and private facilities/utilities; special attention to be given to workplace and Ready-Made Garments (RMG) sector. Enforce Breast Milk Substitute (BMS) Act 2013 with all its provisions including prevention of it's aggressive promotion, marketing and distribution.
3. Utilize health and non-health service delivery platforms (e.g, specifically in 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 will need to include those key performance indicators in to 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

5. Explore and 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. Strengthen IFA distribution for Pregnant and Lactating Women (PLW) by improving the coverage and compliance from health service delivery points through counselling and ensuring supply chain.
6. 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 (e.g. 'front of the package' labelling for salt, sugar, saturated fats, trans fats contained in food) should be made mandatory.

Water Sanitation and Hygiene (WASH)

7. 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)

8. Formulate an urban 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.
9. 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.
10. 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

6. Ensure dietary diversity – production of affordable, nutritious and local foods that are safely produced in adequate quantity and quality to meet the dietary and nutrient requirements in a sustainable manner.
7. 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.
8. Ensure filling up important knowledge gaps in nutrition for relevant non-health sectors.

Thematic area 3: Social Protection

1. Ongoing Social Safety Net programs where possible, should be reviewed and modified accordingly where possible, 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 based on 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

4. Establish integrated and interoperable nutrition information system coordinated by BNNC office to capture multi-sectoral nutrition data and information in line with NPAN2 targets.
5. 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).
6. Develop an implementation plan of research strategy along with mobilization of resources.

Thematic Area 6: Capacity Building

1. Prepare a capacity development/training strategy for BNNC and aligned key ministries, and national and subnational level nutrition relevant human resources for key ministries based on their activities.
2. Finalize the Development Project Proforma (DPP) document and approval process aiming to strengthen the BNNC office for both physical and human capacity.

Chapter 4: 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.

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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	Current Status	Sources
	Thematic area 1: NPAN2 output indicators relating to Nutrition for All following Life Cycle Approach				
1	Increase the initiation of breastfeeding in the first hour of birth	80%	51%	69%	(BDHS 2017-18)
2	% of children (0-6m) exclusively breastfed	70%	55%	65%	(BDHS 2017-18)
3	% of children (6-23 m) receiving (MAD)	40%	23%	34%	(BDHS 2017-18)
4	Percentage of infants born with low birth weight (<2,500 grams)	16%	23%	23%	(National LBW Survey-2016)
5	Reduce stunting among under-5 children	25%	36%	31%	(BDHS 2017-18)
6	Children under 5 years who are wasted	<8%	14%	8%	(BDHS 2017-18)
7	Children under 5 years who are overweight	1.40%	1.4%	2.4%	(MICS 2019)
8	% of Women 15-49 yrs. with Anaemia	<25%	42%	42%	(BDHS 2011)
9	% of children under 5 with diarrhoea treated with ORT and Zinc	Not yet fixed	38%	43.6%	(BDHS 2017-18)
10	%of women 15-49 yrs who are overweight or obese (BMI ≥23)	30%	24%	24%	(BDHS 2014)
11	% of adolescent girls (15-19 yrs.) with height <145 cm	<8%	13%	NA	(BDHS 2014)
12	% of adolescent girls (15-19 yrs.) thin (total thinness)	<15%	29%	29%	(FNSP 2015)
13	% of women (20-24 yrs) who have begun childbearing	10%	31%	28%	(BDHS 2017-18)
14	% of population that use improved drinking water	>99%	98%	98.5%	(MICS 2019)
15	% of population that use improved sanitary latrine (not shared)	75%	45%	43%	(BDHS 2017-18)
16	% of caregivers with appropriate hand washing behaviour	50%	27%	27%	(FSNSP 2014)
	Thematic area 2: NPAN2 Output indicators relating to Agriculture & diet diversification & locally adapted recipes				

SL.	Indicators	NPAN2 Target 2025	Baseline of NPAN2	Current Status	Sources
17	Per capita consumption of fruits and vegetables	≥400g per day	Fruits: 44.7 gm Vegetables: 166.1 gm	Fruits: 35.78 gm Vegetables: 167.3 gm	(HIES 2016)
18	% share of total dietary energy from consumption of cereals	<60%	70% (HIES 2010)	64% (HIES 2016)	HIES
	Thematic area 3: NPAN2 Output indicators relating to Social Protection/SBCC				
19	% of women age 20-24 who were first married by age 18	30%	59%	51.40%	(MICS 2019)
20	Number of Social Safety Net Programs which incorporated nutrition sensitive & nutrition specific objectives	50%	10% (assumption)	10% (assumption)	
21	Number of upazilas covered under VGD program to provide nutritionally enriched fortified food	50%	Nill	Nill	
22	% of children (36-59 m) who are attending an early childhood education program	30%	13%	18.90%	(MICS 2019)
23	% of women[18] who completed secondary/higher education	90%	14%	17%	(BDHS 2017-18)
24	Number of ongoing comprehensive coordinated multisectoral, multichannel advocacy and communications campaign	10	0	0	
25	Change in per capita consumption of:	i. <5 gm/ person/day	i. Salt: not	i. Salt: not	
	i. salt	(WHO)	available	available	
	ii. sugar consumption				
		ii. <10% of total energy intake	ii. Sugar: 7.4 (gm/capita /day)	ii. Sugar: 6.9 (gm/capita /day)	(HIES 2016)

[18] Ever-married women age 15-49

Annex 2: Showing the comparison of allocation in Public Expenditure Review on Nutrition (PERN) and Annual Sectoral Workplans

Annual Budget Review by Ministry/ Department/ Division/OP:

SL	Ministry	Department/ Division	Estimated Budget (in lac) 2018-2019	% Estimated Budget (in lac) 2018-2019	Estimated Budget (in lac) 2019-2020	% Estimated Budget (in lac) 2019-2020	Comments
1	Ministry of Agriculture	BIRTAN	192.45	0.0	87	0.01	Draft Workplan
		DAE	12563	1.3	18215	1.41	Draft Workplan
2	Ministry of Fisheries and Livestock	Fisheries Department	105953.53	10.7	97445.53	7.52	Workplan Budget- Signed
3	Ministry of Local Government, Rural Development and Co-operatives	DPHE	624805	63.2	845636	65.28	Workplan Budget- Signed
		ISPP- JAWTNO Project	4400	0.4	77643	5.99	
		UPHCP		0.0	40.49	0.00	
4	Ministry of Religious Affairs		10.8	0.0	10.8	0.00	Workplan Budget- Signed
5	Ministry of Food			0.0	6584.5	0.51	Draft Workplan
6	Ministry of Social Welfare	MoSW	3611	0.4	3549	0.27	Workplan Budget- Signed UNICEF will support partly
7	Ministry of Women and Children Affairs		237807	24.0	246118	19.00	Draft Workplan
8	Ministry of Primary and Mass Education			0.0		0.00	Draft Workplan
9	Ministry of Information			0.0		0.00	Draft Workplan
		Total	**989342.7**		**1295329.3**	**100**	

Annex 3: In-country emergency/disaster response

Type of disaster/emergency	Location	Timeline,	Nutrition related Impact	Response	Response from agencies/sectors
Monsoon Flood 2019	1. Bandarban 2. Bogura 3. Gaibandha 4. Jamalpur 5. Kurigram 6. Sirajgonj 7. Sunamgonj 8. Sylhet 9. Tangail	July 2019	▪ Around 300,000 people are in the makeshift shelters (schools, colleges) or on embankments and few returned as water started receding in their areas and there is no private space for breast-feeding which is interrupting breastfeeding practices. ▪ Children are not getting adequate breast-milk as mothers are under phycological stress or engage themselves for ration collection, home repairing and other additional household activities due to flood. ▪ Community-based nutrition services are not available in country and facility based treatment (including community clinics) are not limited, as infrastructures are damaged and not accessible in the heavily inundated areas.	1. Management of acute malnutrition was the top priority to protect under5 children. 2. IYCF was challenged as mothers couldn't feed complementary food due to lack of proper ingredients and cooking facilities.	Nutrition cluster, UNICEF, WFP and local NGOs like- Caritas Bangladesh, Grameen Bikas Foundation (GBF), Gana Unnayan Kendra (GUK), Adarsha Polly Unnayan Songstha (APUS), Mahideb Jubo Somaj Kallayan Somity (MJSKS), Manab Mukti Sangstha (MMS), Efforts for Rural Advancement (ERA), Society for Sylhet resources advancement (SRAC), Palli Unnayan Sangstha (PUS)

Annex 4: Progress of Ministry/Division/ Authorities/ Agencies/Projects etc.

Annex 4.1. Name: National Nutrition Services (NNS)

Major activities:

1. Promote, protect and support Infant and Young Child Feeding (IYCF) practices
2. Control of micronutrient deficiencies
3. Management of moderate and severe acute malnutrition
4. Growth Monitoring and Promotion (GMP)
5. Food Safety Programme
6. Social and Behavior Change Communication (SBCC) on nutrition

Progress/Achievement: 2018-19

Day Observed	• Observed 2 rounds of National Vitamin-A plus Campaign day. • Observed national breastfeeding week from 1-7 August 2018.
Maternal nutrition	• Ensured 28 CCs and UH& FWCs delivering maternal nutrition during ANCs in Sylhet and Chittagong divisions. • Ensured 24 CCs and UH& FWCs delivering infant and child specific nutrition services in Sylhet and Chittagong divisions. • 7,987 non-MOHFW personnel (Mother Support Group) attended orientation on homemade complementary feeding, breastfeeding etc.
Infant Young Child Feeding	• 2,701 field level MOHFW staff and 711 non MOHFW staff attended orientation on BMS Act-2013. • 29 central level MOHFW personnel and 11 non MOHFW staff attended training on "Oketani" to be developed as master trainers. • 132 central level MOHFW personnel, 199 field level MOHFW staff and 116 non MOHFW staff attended TOT on "Oketani". • 26 central level MOHFW personnel and four non-MOHFW staff attended observation of breastfeeding week. • 30,782 persons from community attended awareness creation orientation on maternal nutrition.
SAM and CMAM	• Ensured 350 functional SAM units at UHCs, district hospitals and government medical colleges. • 72 field level MOHFW staff (doctors) attended TOT on SAM and CMAM. • 369 field level MOHFW staff (nurses, SACMOs) attended training on SAM.
Adolescent nutrition	• 3,383 non MOHFW staff (teachers and student representatives) attended training on adolescent nutrition at district level. • 29,433 non MOHFW personnel (high school/madrasa, college & adolescent forum/club) attended orientation on adolescent nutrition at district level. • 57 central level MOHFW personnel, 12 field level MOHFW staff and 21 non MOHFW staff attended workshops on strengthening adolescent nutrition in academic curriculum.
Prevention of overweight, obesity	• 80 participants attended workshop to develop nutrition profile model to address childhood obesity in line with regional profile.
Food Safety Program	• Conducted 1500 courtyard and demonstration session for mother and caregivers for community promotion of home based complementary feeding and 500 field level MOHFW staffs and 37500 non-MOHFW personnel attended those sessions. • Completed procurement of laboratory chemical, reagents and other consumables

	• Completed procurement of laboratory instruments, equipment and other non-consumables • 100% work completed for repairing and maintenance of laboratory equipment and instruments. • Seven non- MOHFW personnel attended training on determination of Aflatoxins in food grains by HPLC. • 200 physicians, nurse, lab technicians and support staffs attended training on food-borne diseases. • Support system ready for food safety emergency response/outbreak investigation. • IEC/BCC materials on food safety and food safety emergencies (leaflet, poster, booklet etc.) ready for printing • TVC and TV spots broadcasted in different channels. • Completed Quarterly newsletters on food safety.
BFHI	• 60 central level MOHFW personnel attended workshops on updating of BFHI training module. • 1,738 field level MOHFW staff and 977 non MOHFW staff health and family planning service providers of public and private hospitals) attended training on BFHI (Baby Friendly Health Initiative) with certification. • 1,770 field level MOHFW staff and 939 non MOHFW staff (health and family planning service providers of public and private hospitals refreshers) attended training on BFHI with certification.
Capacity building	• 5,853 field level MOHFW workers have been trained in Comprehensive Competency Training on Nutrition (CCTN). • 242 field level MOHFW staff (paediatricians, doctors, nutritionists from UHC, District) ??? • 720 central level MOHFW personnel attended training on comprehensive competency nutrition. • 4,912 field level MOHFW staff (supervisors and service providers) attended training of district trainers at district and Upazila level. • 423 central level MOHFW personnel and 5,072 field level MOHFW staff attended orientation on DLIs and DLRs program at 8 divisions, 138 Upazila including Sylhet and Chattogram division. • 24 field level MOHFW staff and six non-MOHFW staff (supervisor and monitoring personnel among districts and Upazila levels) attended district orientation on food fortification. • 205 central level MOHFW personnel, 922 field level MOHFW staff and 373 non MOHFW staff attended orientation on real time monitoring and reporting (RTMR) for NVAC+ 2nd round. • 30 field level MOHFW staff attended ToT of health workers on HMIS. • 93 field level MOHFW staff and 27 non MOHFW staff attended training of health staffs on HMIS at district level. • 124 field level MOHFW staff attended training of health staffs on supply chain management at district level. • 59 central level MOHFW personnel attended dissemination workshop on IYCF strategy at national and divisional levels. • 34 central level MOHFW personnel, five field level MOHFW staff and 19 non MOHFW staff attended workshop for revision of academic curriculum (insertion of IYCF issue in academic curriculum) of pre-and-in service training of health and family planning service providers. • 57 central level MOHFW personnel, nine field level MOHFW staff and 23 non MOHFW staff attended workshops on updating of existing training module.

Challenges: (Operational/ Financial etc.)

- Delayed procurement process.
- Insufficient human resources at the field level.

Financial Progress:

Financial Year	Allocation	Expenditure
2018-19	89000000	87500000

Source: Annual Program Implementation Report (APIR) 2018-19, PMMU, MOHF

Annex 4.2 Name: Ministry of Chittagong Hill Tracts Affairs (MOCHT)

Indicators	Major activities	Physical progress				Financial Expenditure (in lac)			
		Target 2018-19	Achieved 2018-19	Target July 2019-December 2019	Achieved July 2019-December 2019	Target 2018-19	Achieved 2018-19	Target July 2019-December 2019	Achieved July 2019-December 2019
Number of motivated pregnant and maternity mothers	Backyard meetings and home inspections	5500	5100	2600	2500	0	0	0	0
Number of neighborhood workers with increased capacity	Training of neighborhood workers	225	225	150	125	10	10	7.5	6.25
Number of iron folic acid distribution in pregnant women	Distribution and intake of iron folic acid to pregnant women	5000	1700	2500	850	35	35	17.5	17.5
Number of distribution of iron folic acid in pregnant mothers	Programs on distribution of iron folic acid in pregnant mothers	5900	5233	2950	2620				
Number of lactating mothers delivering iron folic acid	Programs for lactating mothers delivering iron folic acid	5900	5322	2950	2620				
The number of adolescents who received iron folic acid	Programs for adolescents who received iron folic acid	46000	48606	23000	24303				
Number of awareness and training programs	Backyard meetings and home inspections	4300	4000	2250	2000				
Number of motivated adolescent girl	Implementation of activities of Parakendra Adolescent Club	12000	12000	6000	6000	5	5	2.5	2.5
Number of adolescent club	Informing the guardian members in the neighborhood	500	500	250	250	0	0	0	0

Indicators	Major activities	Physical progress				Financial Expenditure (in lac)			
		Target 2018-19	Achieved 2018-19	Target July 2019-December 2019	Achieved July 2019-December 2019	Target 2018-19	Achieved 2018-19	Target July 2019-December 2019	Achieved July 2019-December 2019
Number of skilled field worker	Provide capacity building training to neighborhood workers in identifying pregnant and maternity women with severe malnutrition	225	300	150	150	5	5	2.5	2.5
Number of referral of pregnant mother	Referral to health center for receiving health and nutrition services	100	80	50	48	0	0	0	0
Number of counselling on breastfeeding to husband, mother-in-law, PLW women	Backyard meetings and home inspections	168000	168000	84000	80000	5	5	2.5	2.5
Number of counselling to mother for importance of breastfeeding	Backyard meetings and home inspections	4300	4000	2250	2000	0	0	0	0
Number of neighborhood workers and field organizers taking maternity leave	For neighborhood workers, field organizers, all pregnant workers	105	100	103	50	0	0	0	0
Number of families counseled on breastfeeding and safe supplementary feeding	Backyard meetings and home inspections	168000	168000	84000	80000	0	0	0	0
Number of households counseled on hygiene and IYCF	Backyard meetings and home inspections	168000	168000	84000	80000	0	0	0	0
Number of neighborhood centers where child	By measuring GMP and MUAC in the neighborhood	388	400	194	200	0	0	0	0

Indicators	Major activities	Physical progress				Financial Expenditure (in lac)			
		Target 2018-19	Achieved 2018-19	Target July 2019-December 2019	Achieved July 2019-December 2019	Target 2018-19	Achieved 2018-19	Target July 2019-December 2019	Achieved July 2019-December 2019
malnutrition has been diagnosed									
Number of households promoting complementary feeding times and regulations??	Backyard meetings and home inspections	168000	168000	84000	80000	0	0	0	0
Preparing EPI list and providing ANC and PNC services	Backyard meetings and home inspections	4000	4000	2000	2000	0	0	0	0
Number of pregnant women receiving IFA	Pregnant with EFA	5000	1700	2500	850	10	10	5	5
The number of adolescents taking deworming pills	Activation of deworming pills for adolescents	51854	48654	25928	24327				
Number of pregnant mothers consumed vitamin A.	Vitamin A feeding activities for pregnant mothers	5100	5233	2550	2617				
Number of pregnant women received awareness of nutritional food habit	Backyard meetings and home inspections	5100	5233	2550	2617	0	0	0	0
Number of sanitary latrine	Sanitary latrine installation activities	101	101	51	51	20	20	10	10
Number of safe water sources	Safe water sources activites	131	131	66	66	100	100	50	50
The number of adolescents with increased awareness of adolescent malnutrition	Implementation of Adolescent Club activities in the neighborhood	46000	46000	23000	23000	0	0	0	0

Indicators	Major activities	Physical progress				Financial Expenditure (in lac)			
		Target 2018-19	Achieved 2018-19	Target July 2019-December 2019	Achieved July 2019-December 2019	Target 2018-19	Achieved 2018-19	Target July 2019-December 2019	Achieved July 2019-December 2019
Number of neighborhood workers in the neighborhood center to increase communication activities to change social behavior on healthy eating habits	Provide training to neighborhood workers	225	300	115	150	5	5	2.5	2.5
Number of families raised awareness on breastfeeding counseling basically for family decision makers and conducting training on IYCF, ensuring supply of SBCC materials	Backyard meetings and home inspections	168000	160000	84000	80000	0	0	0	0
Number of neighborhood workers who have increased social awareness in taking care of mothers' eating habits during breastfeeding and making health care decisions when needed.	Backyard meetings and home inspections	168000	160000	84000	80000	0	0	0	0
Increase social awareness capacity in the decision making of mothers to take care of their eating habits and take health care when needed.	Provide training to neighborhood workers	225	300	115	150	9	9	4.5	4.5

Indicators	Major activities	Physical progress				Financial Expenditure (in lac)			
		Target 2018-19	Achieved 2018-19	Target July 2019-December 2019	Achieved July 2019-December 2019	Target 2018-19	Achieved 2018-19	Target July 2019-December 2019	Achieved July 2019-December 2019
Number of neighborhoods implemented in the CHT area to create awareness among the public including pregnant and lactating mothers, husbands and mothers-in-law about breastfeeding and safe feeding.	Conducting incentive activities through the neighborhood	4300	4000	2250	2000	0	0	0	0
Number of families visited for counseling and counseling of pregnant mothers including head of household, decision makers such as husband, mother-in-law	Backyard meetings and home inspections	168000	500	84000	250	0	0	0	0
Number of trained neighborhood workers to enhance their skills	Provide training to neighborhood workers	225	300	115	150	10	10	5	5
SAM / MAM identification at community level in the neighborhood, provision of nutrition services to the affected, capacity building of service providers and number of counseling	Backyard meetings and home inspections	1443	300	722	150	0	0	0	0

Indicators	Major activities	Physical progress				Financial Expenditure (in lac)			
		Target 2018-19	Achieved 2018-19	Target July 2019-December 2019	Achieved July 2019-December 2019	Target 2018-19	Achieved 2018-19	Target July 2019-December 2019	Achieved July 2019-December 2019
Develop training plans for capacity building of neighborhood workers, organize training, counseling, increase the number of neighborhood workers	Provide training to neighborhood workers	225	300	115	150	5	5	2.5	2.5
Number of families counseled to the PLW, parents, caregivers on safety, development, care of health and nutrition	Backyard meetings and home inspections	168000	160000	84000	80000	0	0	0	0
Implement incentive activities, number of neighborhoods to observe nutrition week	Celebrate Nutrition Week	4300	4000	2250	2000	0	0	0	0

Annex 4.3 Name: Ministry of Science and Technology (MOST)

Major activities		Physical progress				Financial Expenditure (in lac)				Remarks
	Indicators	Target 2018-19	Achieved 2018-19	Target July 2019-December 2019	Achieved July 2019-December 2019	Target 2018-19	Achieved 2018-19	Target July 2019-December 2019	Achieved July 2019-December 2019	
Advertising through national newspapers and others to increase public awareness about the presence of formalin in food.	Number of promotions	10	10	5	5	10	10	1	1	
Provide training on food adulteration detection.	Number of training	2	2	1	1	NA*	NA*	NA*	NA*	*Recipient organizations pay the fee
Providing training on Food inspection and quality control	Number of training	2	2	1	1					*Recipient organizations pay the fee
Nationwide training on processing and preservation of agricultural products is provided through fair and application of appropriate technology.	Number of training	64	64	20	27	7.75	7.75	8.8	8.8	

Major activities		Physical progress				Financial Expenditure (in lac)				Remarks
	Indicators	Target 2018-19	Achieved 2018-19	Target July 2019-December 2019	Achieved July 2019-December 2019	Target 2018-19	Achieved 2018-19	Target July 2019-December 2019	Achieved July 2019-December 2019	
Provide technical advice and guidance services to food industry related organizations.	Number of services	3	3	1	2	NA*	NA*	NA*	NA*	*Recipient organizations pay the fee
Strengthen research activities on various nutrient-rich innovations, suitable food vehicle, shelf life with a focus on high nutritional fortified food, etc.	Number of Projects	12	12	12	23	160	77.67	60	2	
Innovation and supply of salt iodine detection kits	Number of kits supplied	120	120	75	90	NA*	NA*	NA*	NA*	*Recipient organizations pay the fee
Plan and organize quality training to enhance the capacity of implementation and monitoring agencies through coordination with various agencies.	Number of training	3	3	1	0	NA*	NA*	NA*	NA*	*Recipient organizations pay the fee

Annex 4.4 Name: Ministry of Primary and Mass Education (MoPME)

Priority Indicators	Major activities	Physical progress		Financial Expenditure (in lac)	
		Target 2018-19	Achieved 2018-19	Target 2018-19	Achieved 2018-19
??? of children (36-59 m) who are attending an early childhood education program/(ECD)	1.Coverage (%) of ECD programmes where applicable	100%	All school=3578384 Govt. school=1134788		
	2. Number of SBCC activities on the importance of ECD.	NA	NA	NA	NA
	3. Name of programs on protective and responsive care giving & feeding practices and stimulation	NA	NA	NA	NA
	4.Number of creche/ day care centers, pre-schools in the community established	NA	NA	NA	NA
Other activity beyond priority indicators	Students in each school in 104 upazilas were provided with high nutritious biscuits in a packet weighing 75 grams on school days on the basis of daily attendance.	42333 metric ton high nutritious biscuits	40326 metric ton high nutritious biscuits	44450.28	42342.72
	Besides, preparations are underway to launch mid-day meal program in all schools of 250 more upazilas.	In progress	In progress	In progress	In progress
	Encourage students to undertake/prepare vegetable gardens on school premises.	In progress	In progress	In progress	In progress
	Education on health, hygiene and sanitation.	In progress	In progress	In progress	In progress

Annex 4.5 Name: Ministry of Fisheries and Livestock (MOFL)

Program/ activities	Sub-activities	Physical progress		Financial Expenditure	
		Target 2018-19	Achieved 2018-19	Budget 2018-19	Expense 2018-19
1.National Agriculture Technology Program Phase-2 (**Main activity of the project)**	a. Stablish of bill/ marsh Nursery,	40 marsh (150h.)	23 marsh	13.8	13.8
	a. Exhibition establishing farm (curp mixed farming). b. The cultivation of mono-sex telapia, c. Curp nursery.	5282 marsh (550h.)	5282	1056.4	1056.4
	Sample test of the fish food	1075	1125	5	4.35
	Training of beneficiaries (CIG farmer, CIG leader, leaf, nursery operator, Farmers adopting technology, Non CIG+ CIG SME & others).	302860	302860	2011.64	2011.43
	Field Day observance	13179	13179	395.4	395.37
	Matching grant for small holder producer (AIF-2)	520	59	130	129.98
	Matching grant for sole holder producer (AIF-3)	120	10	50	48.87
	Distribution of fish catch net	4095	4095	645	598.55
	Implementation of fisheries laws				
	Board stock Management (pure line board program)	4	4	8.5	8.5
	Pure line board program (Research)	40	40	40	40
	Workshop / Seminar / Meeting / Conference / Study Tour / CIG Micro plan Formulation etc.	5393	5393	47.86	47.86
	Training to enhance the skills of the fisheries officers / employees				
2. **Project to expand fisheries technology services at Union level**	Setting up exhibition farms	3394	3394	1332.25	1332.25
	Field Day observance	560	559	80.2	80
	Provide training	20789	20777	499.87	499.79
	Knowledge sharing tour	40	40	21.32	21.32
	Sminar/workshop	8	8	6.4	6.4
	Establish sanctuary	-	4	10	10
	Exhibition establishing farm	176	176	149	149
	Alternative employment for fishermen (AIGA)		7189	290	285
	Fisheries Habitat Development /Aquaculture reform		3.86	741.75	738.46

Program/ activities	Sub-activities	Physical progress		Financial Expenditure	
		Target 2018-19	Achieved 2018-19	Budget 2018-19	Expense 2018-19
	Provide training	9540	9540	161.91	161.91
	Fisheries Habitat Development /Aquaculture reform		9.58	1474.6	1471.78
	Establish sanctuary	6	6	16.01	16.01
	Exhibition establishing farm (Thai kai, Monsox tilapia and carp are mixed farming)	40	40	9.4	9.4
	Provide training	1140	1140	40.87	40.87
	Establish sanctuary	70	70	166.25	166.25
	Fisheries Habitat Development /Aquaculture reform	69.55 lakh	69.52 lakh	9107.35	9104.08
	Provide training	3000	3000	27.6	27.6
	Fisheries Habitat Development /Aquaculture reform		2.22 lakh	321.82	307.65
	Free fish in open water reservoir		5 lakh (20 M.T)	40	40
	Establish sanctuary		3 H	9.72	9.72
	Exhibition establishing farm (Single cultivation in gulsa), single cultivation in pabda	26	26	9.1	9.1
	Provide training	4015	4015	61.15	61.15
	Kuchia Farming Exhibition, Kuchia Pona Production Exhibition	8	8	7.83	7.83
	Provide training	1320	1320	9.2	9.2
	Enhanced costal fisheries in Bangladesh				
	Alternative employment for fishermen (AIGA)	7189	7189	290	285.01
	A. Nutrition plans are the main activities implemented under various development projects				
	Provide training	3564	3564	79.99	79.99
	Training of marine research conservation management	11700	11700	397	397
	Marine Culture Training	500	500	25	25
	Bruda Bank Establishment Project (Phase III)				
	Renu Production	40	40	2.08	2.08
	Bruda Renu Producation		46.78	6225.58	6225.5
	Chinese Kups imported from China		40000	75	74.99

Program/ activities	Sub-activities	Physical progress		Financial Expenditure	
		Target 2018-19	Achieved 2018-19	Budget 2018-19	Expense 2018-19
	Provide training	1921	1921	37.35	37.35
In addition to the above mentioned projects, there are five projects proposed by the Directorate of Fisheries which, if approved, can be attributed to greater mobility in the field of nutrition.					
Nutrition planning is a functions of the implementation of the revenue sector	**Activity status**	**Physical progress**		**Financial Expenditure**	
		Target 2018-19	Achieved 2018-19	Budget 2018-19	Expense 2018-19
	Free fish in open water reservoir	-	246 M.T	615	615
	a. Stablish of bill/ marsh Nursery,	-	344	120	120
	Establish sanctuary	-	205	60	60
	Implementation of fisheries laws	-	70295	336.8	336.8
	Provide training	-	39588	416.68	416.68
	Celebrate National Fisheries Week	-	-	598.94	598.94
	Promotion and advertising	-	-	213.7	213.7
	Seminar/ workshop	-	-	47.5	47.5

Annex 4.6 Name: Ministry of Religious Affairs (MORA)

Selected Indicators	Sub-activity status	Physical progress				Financial Expenditure			
		Target 2018-19	Achieved 2018-19	Target July to Dec 2019	Achieved July – Dec 2019	Target 2018-19	Achieved 2018-19	Target July - Dec 2019	Achieved July – Dec 2019
Number of mothers, number of children, general public and administrative department (7200 persons)	Raising awareness to hygienic practices during complementary feeding of infants and young children (0-23 m) while continuing breastfeeding	**36**	**36**	**18**	**18**	**3.6**	**3.6**	**1.8**	**1.8**
	Counseling to promote complementary feeding till 2 years aged children while continuing breastfeeding								
	Campaign to strengthen social support for breastfeeding infants up to 2 years of age as well as proper and safe supplementary/complementary feeding								
Number of mothers, number of children, general public, local representatives and administrative department (7200 persons)	Prenatal care, postpartum care, postpartum care and care	**36**	**36**	**18**	**18**	**3.6**	**3.6**	**1.8**	**1.8**
	Increase social awareness for mothers to be careful about their eating habits while breastfeeding								
	Campaign to change social behavior to feed the baby breast milk and maintain minimum frequency of feeding and varied nutritious food.								
	Advise and create awareness on timely family planning								

Number of local administration, guardians, local public representatives and children and administrative department (5400 persons)	Law enforcement to prevent child marriage, awareness to prevent child marriage and early pregnancy	**36**	**36**	**18**	**18**	**3.6**	**3.6**	**1.8**	**1.8**
	Promoting the health benefits of conceiving at the right time								
	Choosing the right and safe food								
	Changing social behavior on safe food, water, sanitation, healthy habits								
	Develop balanced eating habits and healthy cooking habits for adolescents through social awareness programs, including formal and informal nutrition education.								

Annex 4.7 Name: Bangladesh Rice Research Institute (BIRRI), Ministry of Agriculture

Main Activities	Sub-activities	Physical progress		Financial Expenditure	
		Target 2018-19	Achieved 2018-19	Budget 2018-19	Expense 2018-19
1. Improvement of the physical and chemical quality of paddy oil by the application of physical heat.	Improving the quality of courier free fatty acids by oil control	Improving the quality of courier free fatty acids by oil control	Earned	15 lac	15 lac
2. Introduction of rice varieties bakery products (rice cakes and rice biscuits)	Preparation of rice varieties (bakery products / biscuits)	Preparation of rice varieties (bakery products / biscuits)	Earned	3 lac	3 lac
Prepare high calorie rich rice varieties biscuits	Preparation of high calorie-rich varieties-biscuits	Preparation of high calorie-rich varieties-biscuits	Earned	3 lac	3 lac

Annex 4.8 Name: Bangladesh Agricultural Research Council (BARC), Ministry of Agriculture

Indicators	Sub-activities	Physical progress Target 2018-19	Achieved 2018-19	Financial Expenditure Budget 2018-19	Expense 2018-19
1. Per capita consumption of fruits and vegetables	1. Amount of production of fruits and vegetables including indigenous varieties (households level)	na	na	na	na
2. Increase consumption of fish, meat, milk and eggs	2. % of targeted number of trainings that promote diversified nutrition gardening /homestead gardening (fruits and vegetables)	2	2 (100%)	300000	300000
	3.Number of specialized agriculture technologies introduced (such as hydroponic, floating gardens)	na	na	na	na
	% schools promoted nutrition gardens in the schools	na	na	na	na
	5. Number of activities (Conduct training and technical assistance) on post harvesting losses (including nutrition sensitive processing and packaging where it applies	2	2 (100%)	300000	300000
	6.Number of Storage and Marketing Facilities at sub-national and community levels	na	na	na	na
	7. Number of 'One House One Farm' (eekti bari, eekti khamar) program	na	na	na	na
3. % share of total dietary energy from consumption of cereals	1.Number of SBCC activities to increase consumption of non- cereals foods including fruits, meat, vegetables, pulses, fish, milk and eggs and reduce consumption of cereals	Developed food plate (500), slogan stone (200), sticker (1000), mug (200), leaflet (2000), T-shirt (200), Training workshops conducted	100%	250000	250000
In addition to the above mentioned activities, the followings are put as others activities					
	1. Role of food based nutrition to reducing stunting and underweight.	**2**	**2**	**250000**	**250000**
	2. Balanced diet for young children, pregnant women and lactating mother	**2**	**2**	**300000**	**300000**
	3. Food adulteration and contamination: inside fact and consumer responsibility	**2**	**2**	**32000**	**32000**

Indicators	Sub-activities	Physical progress Target 2018-19	Financial Expenditure Achieved 2018-19	Budget 2018-19	Expense 2018-19
	4. Additives and preservative in processed foods: health consequences.	**2**	**2**	**32000**	**32000**

Annex 4.9 Name of NGO: SUCHONA, Save the Children

Nutrition Output Indicators	Activities	Progress of Activities	
		January to December 20192018-2019	
		Target	Achievement
% of Children (0-6m) exclusively breastfed	Counseling session: Counseling at household level and health facilities; Nutrition education in Courtyard meeting	3,95,724	3,43,243 (87%)
% children (6-23m) receiving MAD	Counseling at household level and health facilities; Nutrition education in courtyard meeting	55,245	46,907 (85 %)
% of caregivers with appropriate hand washing behavior	Behavior Change Communication through counseling at HH and Courtyard Meeting	18,438	20,108 (109.1%)
	Cooking and feeding demonstration for Mothers and Caregivers	4,848	4,278 (88%)
% of BHHs generating profits or increased IGA asset value from IGA	Conduct technical training of IGA BHHs on -farm	13,072	13,694 (104.8%)
	Distribute/grants among IGA beneficiaries for start-up business/IGA or extend existing IGA/ business	14,422	14,750 (102%)
# of HH with home gardens	Provide vegetable seed/seedlings training to the BHHs	1,47,007	1,29,641 (88%)
	Provide vegetable seed/seedlings to the BHHs	1,47,007	1,29,641 (88%)
# of adolescents received training on life skills	Conduct Adolescent Life Skill session by Peer Leader at community level.	18,000	19,007 (106%)
	Conduct Adolescent Nutrition session by Peer Leader at community level.	13,500	13,022 (96%)

Annex 4.10 Name of NGO: SHOUHARDO III PROGRAM, CARE-BD

Nutrition Output Indicators	Activities	Progress of Activities		Expenditure	
		2018-2019		2018-19	
		Target	Achievement	Target	Achievement
From SHOUHARDO III PaBSS 2019 conducted by DATA MANAGEMENT AID (DMA)	Conduct IYCF counselling with the mothers of children age 0-2 years	36159	27386		
Prevalence of children 6–23 months receiving a minimum dietary diversity (T-50%, A-59%)	Conduct GMP services for children 0-2 years	36159	26210		
Prevalence of children 6–23 months receiving a minimum meal frequency (T-50%, A-49.9%)	Provide supplementary food rations (wheat, peas and vegetable oil) among pregnant women and mother of children age 0-2 years	42098	36845		
Percentage of pregnant and lactating women taking Iron Folic Acid supplements in last 7 days during survey (T-40, A-36.2)	Conduct maternal counseling (focusing extra food, extra rest, IFA and 4 ANC) with the pregnant women	8902	9282		
Number of live births receiving at least four antenatal care (ANC) visits during pregnancy (T-6231, A-7479)	Conduct courtyard sessions with adolescent girls for importance of adolescent nutrition and receiving services from community based health facilities	3788	3788		
Percentage of adolescent girls who supplemented with IFA (Iron Folic Acid) in 6 months in the reporting year (T-30, A-34.29%)	Conduct courtyard sessions with mothers of under 2 children about the importance of child nutrition, sanitation, hygiene and other health needs	11364	9859		
% of PEPs HHs received health and nutrition services from community level health facilities (T-45%, A-41.3%)	Train Community Group (CG) and Community Support Group (CG) members on their roles and responsibilities in improving community clinic services	4800	4265		
	Provide training to Little Doctors (in school) for promoting nutrition and hygiene messages	1725	1174		

Annex 4.11 Name of NGO: SAPLING Project, USAID-BD

Activity status	Physical progress		Financial Expenditure	
	Target 2018-19	Achieved 2018-19	Budget 2018-19	Expense 2018-19
Disaster preparedness trained population	1757	1207	-	-
The number of children under 6 years of vitamin A levels			-	-
Nutrition - The number of women who are pregnant with certain activities	2500	2483	-	-
Nutrition - The number of babies pregnant in certain activities	7112	6692	-	-
The number of farmers applying advanced technology and management practices (55,915 farmers)	42270	42335	-	-
Number of people trained in productivity or food security in the short term agriculture sector	33093	46520	-	-
The number of project participants (Household) who received government service as a result of supply	100	153	-	-
Number of children receiving health and nutrition training	11450	10490	-	-
Number of people who have access to safe drinking water	4972	781	-	-
Number of beneficiaries received sanitary latrine	3000	1538	-	-
Number of working water-use committees	35	35	-	-
The number of ha applied to advanced technology and management methods	1531	3799	-	-