DISTRICT NUTRITION MINIMUM PACKAGE

A multi-sectoral sub-national nutrition planning process in Bangladesh

Bangladesh National Nutrition Council (BNNC)

With Technical Support from

DRAFT

Introduction

Minimum district nutrition package are activities those should be considered, conducted and make available at lowest administrative structures (i.e. district and upajilla) and service delivery outlets/platforms of Bangladesh. The minimum district nutrition package would serve to identify priority minimum nutrition services/interventions/activities by different line department in any District and Upazilla given the demand and needs of that area. For examples, Bandarban district where water and sanitation is the priority problem. Furthermore, the approaches for implementation of the package would be different based on the context of the uniqueness of geographical location and population groups. For example, in Sunamgonj where access for services often limited due to marooned water for six months of a year, in Moulvi Bazar where tea gardener community lacked amenity and education for long. Therefore, order of priority of nutrition package and their implementation approached are likely to be different.

Ultimate aim of development of a service package for district multisectoral nutrition package is to prioritize nutrition interventions (specific and sensitive) as deemed necessary to meet the demand of a particular area and the people so that no one is left behind. In addition, this prioritization will ensure focus on high impact low cost interventions by specific sectors and departments including e.g. health and population, agriculture, livestock, fisheries, DPHE-WASH, social protection, education, social welfare, MODRM and NGOs, civil societies and other partners presence in the area.

A Technical Working Group has been formed by BNNC to develop a multi-sectoral district nutrition package. Discussions on planning of design and inclusion of interventions and indicators in a minimum package of nutrition for district and upazila began and further elaborated and eventually narrowed down the list to 20 indicators and related activities/interventions as a minimum package. Finally, technical committee after several day long meetings with support from UNICEF, WHO, WFP, CARE and GAIN scrutinized all the activities to common set of activities for a minimum multisectoral package of nutrition interventions. This would be carried/implemented out by the DNCC and UNCC through respective service outlets/platforms.

In developing the minimum package of nutrition for nutrition for district critical importance were provided to engage the local stakeholders at Union Parishad level. Initially the development of minimum package started in Bishawamvarpur Upazila in Sunamgonj district. BNNC efforts to develop this minimum package for nutrition was supported by partners having practical field level working experiences, pioneering in carrying out multisectoral

nutrition through their ongoing programmes for long. Local Government representative at Union Parishad (UP) including Chairman and members of all UPs of the Upazilla were also engaged. Activities were identified, prioritized and clustered in different meaningful ways and finally made available to BNNC for finalization. Technical committee members within BNNC had reviews, interactive discussions on those draft district nutrition package before finalization. The nutrition package has been validated in several stages, e.g. with district and upajilla officials of various line departments during the field visits by BNNC and partners, and finally endorsed through a consensus building workshop.

This package has been prepared built on and aligned with: i) 20 priority nutrition indicators labelled by the BNNC (out of a total 64 indicators and related activities envisaged in NPAN2 monitoring framework; ii) activities included in the Sectoral Annual workplan/OPs of the respective ministry at national level; iii) activities emerging from and meeting the geographical and cultural needs/demands; and iv) nutrition specific interventions under DLI 13, 14 and other related DLIs.

Contents of the nutrition package

There are 20 priority indicators and total 115 activities included in multisectoral district nutrition package which belong to 7 ministries and their respective line departments at District and Upajilla. 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. Though apparently the total number of activities are large, however, some of these activities are undertaken by several sectors thus counted more than once making the number high. It is also important to note that indicators and activities are confined in only 7 ministries at operation levels which are in-line with the findings of Public Expenditure Review on Nutrition (PERN) report where they also found that most nutrition money are being spent by these ministries those spend.

Table 1: District nutrition package by sectors

MOHFW/ LGD-UPHCSDP II		
SL	**Priority Indicators**	**Activities/Task**
1	A. Increase the initiation of breastfeeding in the first hour of birth B. % of children (0-5m) exclusively breastfed	1.Promote breastfeeding during ANC & PNC including IYCF
		2.Scale up SBCC campaigns for breastfeeding
		3.Implementation and monitoring of BFHI at health facilities.
		4.Building capacity of health care providers/other service providers from front line workers of different sectors
		5.Promote re-lactation method (e.g Oketani etc.)
		6.Monitoring of BMS code
		7.Observance of special days and weeks (nutrition week, breast feeding week etc.)

3	% of children (0-23 m) receiving MAD	1.Promote appropriate and safe complementary feeding of infants and young children while continuing breastfeeding up to 2 years of age
		2.Promote hygienic practices (WASH) for complementary feeding of infants and young children while continuing breastfeeding
		3. Scale up counseling on relevant complementary feeding issues
		4. Conduct SBCC campaigns on breastfeeding and MAD (Minimum Acceptable Diet)
		5. Promote production of nutrient dense diversified foods by small farmers/producers/Household level.
4	Percentage of infants born with low birth weight (<2,500 grams	1.Promote to avoid early marriage and adolescent pregnancy.
		2. Promote disease prevention and treatment during pregnancy
		3. Micronutrient supplementation for pregnant women
		4. Promote increase intake of diversified foods
		5. Provision for FP services to promote birth spacing
		6. Monitor weight gain during pregnancy
		7. Support implementation of cash transfer and food assistance programs for poor and malnourished pregnant women (where it is applicable) along with SBCC
5	% of women of reproductive age (15-49 yrs.) with Anaemia	1. Iron and Folic acid supplementation to all PLWs
		2. Promote iron rich food production by the small farmers/producers/Household level
		3. Promote consumption of iron and other micronutrient rich foods through nutrition education
		4. Deworming
6	% of adolescent girls (10-19 yrs.) with Anaemia (school & out of school)	1.Undertake SBCC programs on balanced diets for adolescent and healthy cooking practices including intake of iron rich food
		2.Promote nutrient dense food production by the small farmers/producers and consumption at household level
		3.Deworming tablets to school attending and non-attending children every six months)
		4.Micronutrient supplements to all adolescents
		5.Increase coverage and utilization of school health program/little Doctor program
		6.Establish/increase coverage of school nutrition garden
		7.Establish adolescent forum in all communities and arrange health and nutrition education for them (nutrition club, Scouts, Girls guides, Shwarna Kishori club)
		8.Introduce school meal program (where applicable)
		9.Provide orientation/training on adolescent nutrition to the relevant stakeholders (School teacher, school management community etc.)
		10.Promote to avoid early marriage and adolescent pregnancy
		11.Promote to continue in school
		12.Promote personal hygiene including menstrual health, hand washing
7		1.Undertake SBCC programs on balanced diets for adolescent and healthy cooking practices including intake of iron rich food

	% of adolescent girls with height <145 cm (for school and non-	2.Promote nutrient dense food production by the small farmers/producers and consumption at household level
		3.Deworming tablets to school attending and non-attending children every six months)
		4.Micronutrient supplements to all adolescents
		5.Increase coverage and utilization of school health program/little Doctor program
		6.Establish/increase coverage of school nutrition garden
		7.Establish adolescent forum in all communities and arrange health and nutrition education for them (nutrition club, Scouts, Girls guides, Shwarna Kishori club)
		8.Introduce school meal program (where applicable)
		9.Provide orientation/training on adolescent nutrition to the relevant stakeholders (School teacher, school management community etc.)
		10.Promote to avoid early marriage and adolescent pregnancy
		11.Promote to continue in school
		12.Promote personal hygiene including menstrual health, hand washing
8	% of adolescent girls thin (total thinness)	1.Undertake SBCC programs on balanced diets for adolescent and healthy cooking practices including intake of iron rich food
		2.Promote nutrient dense food production by the small farmers/producers and consumption at household level
		3.Deworming tablets to school attending and non-attending children every six months)
		4.Micronutrient supplements to all adolescents
		5.Increase coverage and utilization of school health program/little Doctor program
		6.Establish/increase coverage of school nutrition garden
		7.Establish adolescent forum in all communities and arrange health and nutrition education for them (nutrition club, Scouts, Girls guides, Shwarna Kishori club)
		8.Introduce school meal program (where applicable)
		9.Provide orientation/training on adolescent nutrition to the relevant stakeholders (School teacher, school management community etc.)
		10.Promote to avoid early marriage and adolescent pregnancy
		11.Promote to continue in school
		12.Promote personal hygiene
9	% of caregivers with appropriate hand washing behavior	1.Hand washing practice among mothers/caregivers in four critical times (After defecation, after cleaning of babies after defecation, before cooking, before eating, before serving food)
		2.Health education about hand washing steps and duration of hand washing in mothers/caregivers
		3.Orientation of front line workers of all sectors including health, teachers and School management committee about hand washing practices.
		4.Establish hand washing station and ensuring utilization.
		5.Observe world hand washing day and Sanitary latrine month

10	Change in per capita consumption of	1.Promotion of SBCC activities on reduced consumption of salt and sugar according to guideline
	i. salt ii. Sugar Consumption	2.Promote food producers to ensure limited level of salt and sugar
11	% of women (15-19 yrs) who have begun child bearing	1.Conduct media campaigns, community awareness program to prevent early marriage and adolescent pregnancy and identify appropriate messages for mass awareness raising
		2.Identification of newly married couple (15-19 years) and provide counseling and family planning services to delay pregnancy
		3.Provide life skills training for dropped out adolescents girls
		4.Include nutrition education with 'school stipend' for all school going children/ adolescents
		5.Scale up and activate adolescent club/ Swarna kishori program/Scout/Girls guide/ Youth friendly hospital initiative to motivate against early pregnancy
		6.Promote universal secondary female education coverage
		7.Counseling by mother support group for preventing early child bearing

DPHE, LGED		
District nutrition package		
SL	**Priority Indicators**	**Activities/Task**
12	% of population that use improved drinking water	1.Identify need/gap of safe drinking water source and improved sanitary latrine.
		2.Establish safe water sources and sanitary latrine to meet the need based on identified gaps
		3.Organize media campaign and community mobilization on linkages between WASH and nutrition.
		4.Orientation of service provider, community people, student, school management committee etc.
		5.Set up, maintain and promote use wash block in schools
13	% of population that use improved sanitary latrine (not shared)	1.Identify need/gap of safe drinking water source and improved sanitary latrine.
		2.Establish safe water sources and sanitary latrine to meet the need based on identified gaps
		3.Organize media campaign and community mobilization on linkages between WASH and nutrition.
		4.Orientation of service provider, community people, student, school management committee etc.
		5.Set up, maintain and promote use wash block in schools
District nutrition package		
MOWCA		
14	% of women age 20-24 who were first married by age 18	1.Conduct media campaigns, community awareness (eg: during Khutba in mosque) program to prevent early marriage and adolescent pregnancy and identify appropriate messages for mass awareness raising

		2.Scale up and activate adolescent club/ Swarna kishori program/Scout/Girls guide/ Youth friendly hospital initiative to motivate delaying age of marriage
		3.Promote universal secondary female education coverage
		4.Prioritize vulnerable adolescent girls for Income Generating Activities

MoFood, MoA, MOFL		
15	Per capita consumption of fruits and vegetables	1.Promotion of production of fruits and vegetables including indigenous varieties (households level)
		2. Conduct trainings that promote diversified nutrition gardening /homestead gardening (fruits and vegetables)
		3.Introduce specialized agriculture technologies (such as hydroponic, floating gardens)
		4.Promote nutrition gardens in the schools
		5.Promote activities (Conduct training and technical assistance) on post harvesting losses (including nutrition sensitive processing and packaging where it applies
		6.Promote 'Storage and Marketing Facilities' at sub-national and community levels
		7.Scale up 'One House One Farm' (eekti bari, eekti khamar) program
16	Increase consumption of fish, meat, milk and eggs	1.Promote backyard poultry/livestock production
		2.Promote aquaculture and open water fishing (including mola, carplet)
		3.Promote diversified mixed farming
		4.Promote activities (Conduct training and technical assistance) on post harvesting losses (including nutrition sensitive processing and packaging where it applies)
		5.Promote 'Storage and Marketing Facilities' at sub-national and community levels
		6.Scale up 'One House One Farm' (eekti bari, eekti khamar) program
17	% share of total dietary energy from consumption of cereals	
		1.Promotion of SBCC activities to increase consumption of non-cereals foods including fruits, meat, vegetables, pulses, fish, milk and eggs and reduce consumption of cereals

MoPME		
18	of children (36-59 m) who are attending an early childhood education program/(ECD)	1.Implement ECD programmes where applicable
		2.Promote SBCC activities on the importance of ECD.
		3.Scale up protective and responsive care giving & feeding practices and stimulation
		4.Establish creche/ day care centers, pre-schools in the community

MOE		

19	% of women who completed secondary/higher education	1.Conduct media campaigns, community awareness program to prevent early marriage
		2.Scale up ‘school stipend’ for all school going children/ adolescents belonging to the poor and vulnerable households
		3.Motivate the adolescents to complete education

MoDMR / LGD		
20	Number of Social Safety Net Programs which incorporated nutrition sensitive & nutrition specific objectives	1.Revise existing SPPs to become adequately nutrition sensitive (e.g. inclusion of nutrition SBCC component, appropriate targeting and transfers and access to health services and specific nutrition interventions)
		2.Design and implementation of nutrition sensitive SPP for vulnerable urban population
		3.Establish strategic linkages and coordination among relevant multi-sectoral nutrition specific and sensitive interventions and SPPs

Monitor of the implementation of the package by BNCC, DNCC and UNCC

To ensure effective implementation of the district nutrition package, monitoring system is a pre-requisite. DNCC and UNCC will be ones to execute the function of monitoring and evaluation. Data reporting prepared for district nutrition package will be conducted through two levels of decentralized structures (Sub-district and District) which will collect information developed considering pragmatic criteria of DNCC and UNCC. In addition, a well-functioning computerized system would be introduced to facilitate transmission of data at different levels. Data processing will be done in BNNC office. The monitoring tool will encompass activities included in this minimum package included annual work plans, including budgets, and district-level nutrition advocacy plans as well as in their implementation levels.

Conclusion

Global evidences suggest leverage of the better outcome on nutrition improvement can be achieved only through synchronizing multi-sectors at multi-level by multi stakeholders. Better improvement of nutrition can be achieved if performances at the field are at its best in its efficiency, effectiveness and evidence. Best known simple way to achieve those for better nutrition will be a reality when these activities are included in the respective District and Upajilla annual nutrition plans by DNCC and UNCC respectively. Implementing the minimum package and monitoring their progress by DNCC and UNCC will be cornerstone for its success.