MONITORING REPORT

January 2020 - December 2021

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

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

Monitoring Report

(January 2020 - December 2021)

Bangladesh National Nutrition Council

Ministry of Health and Family Welfare
Government of the People's Republic of Bangladesh
December 2022

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Bangladesh National Nutrition Council (BNNC)

MESSAGE

Secretary
Ministry of Health and Family Welfare
Government of the People's Republic of Bangladesh

Efforts by the Government of Bangladesh, including the implementation of the first National Plan of Action on Nutrition from 1997 to 2015, followed by implementation of NPAN2 (2016-2025) have led to significant progress in improving nutrition situation in the country over the last decade.

Bangladesh has a lower prevalence of stunting (BDHS 2017-18) as compared to the South East Asia Region (SEAR) average (WHO 2017), but a higher prevalence of stunting than the global average (WHO 2017). It also indicates that the proportion of children who are wasted in Bangladesh 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.

This is the 3rd Monitoring Report of NPAN-2 (2020-21) published by the Bangladesh National Nutrition Council (BNNC) that demonstrates an impressive progress for many of NPAN-2 set indicators. The report reflected issues of food and nutrition security targets and progress, especially for the vulnerable people, women and young children. Though much progress is being made, however, much more need to be done in getting intersectoral collaboration. This is a challenge, and we must achieve this to address malnutrition and to sustain the gain.

I would like to thank BNNC for their important roles of improving horizontal and vertical coordination, advocacy for resource mobilization and developing monitoring system to monitor program implementation of relevant sectors. Also, BNNC with its efforts will find the best evidence-based ways to engage both nutrition sensitive and nutrition specific sectors to make synergistic actions in improving nutrition status in the country.

13/04/2023

Dr. Md. Anwar Hossain Howlader

MESSAGE

Additional Secretary (PH Wing)
Health Services Division
Ministry of Health and Family Welfare
Government of the People's Republic of Bangladesh

The current pro-people Government has been working relentlessly for strengthening nutrition governance in order to develop a better coordination and monitoring of the implementation of the national nutrition programs and policies. Preparation of the annual monitoring report of Second National Plan of Action for Nutrition for 2016-2025 (NPAN2) is a part of that process. Bangladesh National Nutrition Council (BNNC) is responsible for developing multi-sectoral nutrition strategy with prioritized, evidence based and cost-effective activities. Therefore, a rigorous multisectoral monitoring and evaluation system is suggested to track progress particularly in terms of attainment of expected impacts, outcomes and outputs of nutrition targets.

This is the third Monitoring Report (2020-2021) of NPAN-2 published by the Bangladesh National Nutrition Council (BNNC) that demonstrates an impressive progress for many of NPAN-2 set indicators. The report reflected issues of food and nutrition security targets and progress, especially for the vulnerable people, women and young children that demand to be on focus. Though much progress is being made, however, much more need to be done in getting intersectoral collaboration. This is a challenge, and we must achieve this to address malnutrition and to sustain the gain.

I congratulate to BNNC for its series of achievements, particularly for publishing the third monitoring report of NPAN2. I am sure, BNNC will continue to produce such report which will reflect its leadership role on nutrition. 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 in developing the report. I hope, BNNC will get all supports towards the preparation of NPAN2 monitoring report in future from all partners and stakeholder.

Syed Mojibul Huq
Additional Secretary (PH Wing)
Health Services Division, MoHFW

MESSAGE

Additional Secretary (WH Wing)
Health Services Division
Ministry of Health and Family Welfare
Government of the People's Republic of Bangladesh

Bangladesh has made good progress in improving child and maternal nutrition status over time since last 20 years. BDHS 2017-18 showed notable success with level of stunting among children under 5 declining from 51% in 2004 to 31% in 2017, underweight declining from 31% in 2004 to 22% in 2017, and after years of a critically high level of around 15%, prevalence of wasting came down to 8% in 2017. The prevalence of Low Birth Weight (LBW) reduced to 22.6% (though still high) in 2015 in comparison to the 36% in 2003-04. Much of this improvement can be explained by the combination of nutrition-specific and -sensitive drivers within a wider enabling environment of pro-poor economic growth, of which key factors are improving incomes, smaller family sizes, and greater gaps between births, parental, and particularly women's education and wider health access.

Bangladesh is one of the early riser and enthusiastic adopter of Scaling Up Nutrition (SUN) initiative. Along with its SUN commitments, the Government of Bangladesh further re-affirmed its pledge to the United Nations General Assembly 2030 Agenda for Sustainable Development in 2015, which includes a goal 'to end hunger, achieve food security and improved nutrition and promote sustainable agriculture'. So, the progress of NPAN2 is viewed as an important step towards reflecting our commitment to the SDGs, SUN, ICN2 and WHA.

The Monitoring report January 2020- December 2021 is the annual series that assess progress against the NPAN2 results indicators. The Monitoring Report shows the significant success that has been applauded by many, leading nutrition world and making examples. However, this progress may be in line with the SDG and WHA targets, but still, it remains as a concern to mitigate different challenges specially children and mother's nutrition.

I acknowledge for the proper leadership of Dr. Hasan Shahriar Kabir, Director General, BNNC to produce the report. I would also congratulate the BNNC officials and consultants' group, particularly for its important roles to produce the report on time.

Kazi Zebunnessa Begum
Additional Secretary (WH Wing)
Health Services Division, MoHFW

MESSAGE

Director General
Bangladesh National Nutrition Council (BNNC)

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 January 2020- December 2021 attempts to have thorough investigation of the present nutrition situation through its pre identified activities and provide suggestions. It also outlines the budgetary analysis where sufficient funding has been recommended.

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 Show appreciation for the overall guidance and support provided by Dr. Md. Anwar Hossain Howlader, Secretary, MoHFW who provided the right direction for successfully developing the Monitoring Report on Nutrition in the country. I wish to express thanks to Syed Mojibul Huq, Additional Secretary (PH Wing), HSD, MoHFW, Kazi Zebunnessa Begum, Additional Secretary (WH Wing), HSD, MoHFW and other high officials of MoHFW and other 21 relevant ministries for their necessary support. I would like to thank the UN agencies, development partners, INGO, NGOs who supported to make it happen. I would also like to offer my heartfelt thanks to my BNNC’s 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. Hasan Shahriar Kabir
Director General
Bangladesh National Nutrition Council (BNNC)

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ABBREVIATIONS & ACRONYMS

ANC	Antenatal Care
APIR	Annual Program Implementation Report
BARI	Bangladesh Agricultural Research Institute
BBF	Bangladesh Breastfeeding Foundation
BBS	Bangladesh Bureau of Statistics
BDHS	Bangladesh Demographic and Health Survey
BINA	Bangladesh Institute of Nuclear Agriculture
BIRTAN	Bangladesh Institute for Research and Training on Applied Nutrition
BNNC	Bangladesh National Nutrition Council
BSCIC	Bangladesh Small and Cottage Industries Corporation
BSTI	Bangladesh Standards and Testing Institution
DAE	Department of Agricultural Extension
DPHE	Department of Public Health Engineering
DGFP	Directorate General of Family Planning
DGHS	Directorate General of Health Services
DHIS2	District Health Information System 2
FAO	Food and Agriculture Organization
FFS	Farmers' Field Schools
FPMU	Food Planning and Monitoring Unit
FSNSP	Food Security and Nutritional Surveillance Project
GAP	Good Agricultural Practices
GDP	Gross Domestic Product
GMP	Good Manufacturing Practice
GoB	Government of Bangladesh
HH	Household
HKI	Helen Keller 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
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.

Executive summary

Executive summary

This is the third annual monitoring report of the Second National Plan of Action for Nutrition (NPAN2) 2016-2025. The report presents data and analysis on the selected indicators of goals/ impact, outcomes, and outputs for January 2020 - December 2021 with a view to track the progress trend of NPAN2 target indicators, events and activities. This report aimed to ensure tracking of periodic progress by updating the monitoring report of NPAN2.

Overall Progress

Bangladesh 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 % in 2012-13 to 28 %in 2019. But wasting has remained unchanged with slight increase from 9.6 % in 2012-13 to 9.8 % in 2019. The level of underweight has declined significantly from 31.9 % in 2012-13 to 22.6 %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.

Rate of malnutrition varies with geographical and socio-economic levels. For example, the reduction in underweight was more (around 17%) in rural areas in comparison to the urban areas (10%) as per the MICS 2019. Chronic Energy Deficiency (CED) rate among mothers (20-59 years) with BMI less than 18.5 has decreased from 52% in 1996-97 to about 30% in 2007, which has further reduced to 11% (a 19 percentage point reduction) in 2018-19 (SFSN,2018-19).

About 45% of adolescent married girls get pregnant by 18 years of age, that ultimately sequences to poor maternal nutritional status and later poor birth outcomes, contributing to high rates of low-birth weight infants. Stunting remains quite high among adolescents (29%), along with underweight overweight and obesity prevalence which are 56%, 7%, and 2% respectively (NMS 2019-20). Anaemia and micronutrient deficiencies are common in adolescents, women of reproductive age and children, notably vitamin A, zinc, Iron and iodine, and other deficiencies including calcium are also low.

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

Thematic Area 1: Nutrition for All following Life Cycle Approach

Infant and Young Child Feeding Practices (IYCF)

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 BDHS findings, 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.

Micronutrient Malnutrition

Iron deficiency is a major cause of anaemia among pregnant women, adolescent girls, and children. 29% of non-pregnant and non-lactating (15-49 years) are anaemic and 14% have iron deficiency. It is also observed that except anaemia and folate deficiency, the level of deficiencies for other micronutrients have decreased in 2019-20 compared to 20111-12[1]. About 46% women had a minimum dietary score in 2015 against the target of 75% of MDD-W by 2030.

Based on administrative data it is evident that, Bangladesh's bi-annual Vitamin A supplementation program has maintained high coverage over time in achieving 98.4%% in 2022 for children aged 6-59 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. 4.5% of the adolescent girls aged 15-19 years had height <145 cm. It has improved from 5.2% in 2018-19 to 4.5% in 2022. It is observed that the NPAN2 target of <8% by 2025 has already been achieved. Nonetheless, low height among early adolescent period (aged 10-18 years) was high at 30.9% and remained unchanged from 2018-19 findings. Moreover, The status of total thinness among adolescent girls (15-19 yrs) has also improved from 20% (BDHS 2017-18) in 2018-19 to 18% (Nutrition Assessment 2022) against the NPAN2 target of less than 15% by 2025.

Maternal Nutrition and Low Birth Weight (LBW)

Rate of overweight or obese (BMI ≥23 or ¬≥ 27.5) among women aged 15-49 years has increased from 11%, in 2004 to 39% in 2014 and 49 in 2021 and 14% women are obese (SFSN 2018-2019)[2] 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). The screening of SAM cases (304,069) in November 2021 was highest compared to same period in last three years. Between January 2020 to November 2022 around 52% of the prevalence of SAM among screened children attending at outdoor facilities. The admission of number of SAM cases increased from 485 in January 2020 to 840 in November 2021 which is almost 43% increase[3]. However, it is unclear about how many of them actually availed nutrition services and were cured.

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[1] National Micronutrient Survey, 2019-20.

[2] BRAC James P Grant School of Public Health and National Nutrition Services. (2019). State of food security and nutrition in Bangladesh 2018-2019.
Dhaka, Bangladesh: James P Grant School of Public Health and National Nutrition Services.

[3] Source: NNS newsletter (issue 19 & 21)

Water, Sanitation and Hygiene (WASH)
84.6% of population nationally use improved sanitation, in which, 90.6% being in urban areas and 82.9% in rural areas. According to CWS 2016, only nineteen percent (19%) of the households had an improved sanitation facility in slum areas compared to 51.3% of the non-slum households. The percentage of household members using improved sanitation facilities has increased from 77% in 2012-13 to 85% in 2019 (MICS 2019). The same holds true for handwashing facilities with water and soap/detergent. Percentage of households with hand washing facilities where water and soap/detergent were present has also increased from 59% to 75% during the same period. MICS 19 statistics for Water, Sanitation and Hygiene were much higher than BDHS 2017-18 statistics which show that between 2014 and 2017, the availability of a hand washing station with water and a cleansing agent (including soap) increased from 37% to 47% only. Open defecation was found to be national only 1.5%, with 0.4% in urban areas and 1.9% in rural areas (MICS, 2019).

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

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

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

Production of Cereals
Bangladesh has been self-sufficient in rice production since 2012. 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 in 2018-19. 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
The 2016 Household Income and Expenditure Survey (HIES) showed that the per capita intake of rice, a staple food of Bangladesh, decreased in 2016 from 2010 with the lower consumption of wheat and potato in 2016 in both rural and urban areas (HIES, 2016). The consumption of rice at national level decreased from 416 gr/capita/day in 2010 to 367 gr/capita/day in 2016 against the recommended range between 270-450 gr/capita/day, amounting to about 56% of dietary energy/capita/day (Dietary Guidelines for Bangladesh 2015). Though the rice consumption decreased, still rice intake was above the recommended amount in rural areas but it was lower in urban areas. The reduction in rice consumption was less among poor (9%) than the non-poor (13%), as rice still constitutes the major source of calorie of the poor peoples' diet. The national average of per capita calorie consumption (2210 Kcal/capita/day) decreased in both rural and

urban areas from 2010 to 2016. Per capita calorie intake was higher in rural areas than urban areas (2240 Kcal/d vs 2131 Kcal/d respectively), but in urban areas per capita per day calorie intake reduced markedly to 2130 in 2016 from 2245 in 2010. Reduction of rice/cereals consumption could be the potential factor in decreasing calorie intake (HIES, 2016) which is though, an indication of positive move towards more non-cereal foods.

Thematic Area 3: Social Protection

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

Vulnerability and Climate Change

As the climate changes the nutrient composition of some crops are likely to change, which adds another layer of complexity to nutrition security. Experiments on growing crops in different controlled environments have found that elevated atmospheric CO2 levels and increases in temperature not only reduce crop yields but also lowers the nutrient density in a range of staple crops. A meta-analysis of the data by Myers et al showed that zinc, iron and protein concentrations in C3 crops (e.g. wheat, rice) and legumes (e.g. field peas, soyabeans) were significantly lower when grown at elevated CO2 (levels predicted for 2050) compared with those grown at ambient CO2 levels. They reported that in the edible portion of wheat grown under warmer and higher CO2 conditions, the zinc, iron and protein concentrations were lower by an average of 9·3, 5·1 and 6·3 %, respectively. The phytate content also reduced, which could potentially counter some of the losses in zinc and iron in terms of increasing the bioavailability. For rice, the reduction was 3·3, 5·2 and 7·8 %, respectively, but there was no significant change in the phytate concentration.

Thematic Area 4: Implementation of Integrated and Comprehensive SBCC Strategy

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

Due to the COVID-19 pandemic situation the government of Bangladesh observed the National Nutrition Week with a very low-profile from April 23-29, 2020 with the previous theme. The week was launched through video conferencing connecting with sub-national levels from central DGHS conference room. During the observance of the nutrition week country was under in lock down due to COVID-19.

Bangladesh Advocacy Plan for Nutrition 2019-2025

Ten-year costed National Advocacy Plan for Nutrition with various audience groups, activities, timeline and required budget for implementation has been developed. 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 NPAN2 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 established a monitoring progress of sectoral annual work plan of relevant ministries on six monthly basis and updated them in the central and sub-national level dashboard. More than 17 annual workplans in 2019-20 and 19 plans in 2020-21 from 22 ministries have been reported with previous year progress. M&E team collected, analyzed and used in this report as well to provide evidence for formulating appropriate strategies and policies for improvement of nutrition status.

Budget Tracking

Budget tracking of nutrition activities from the sectors is a part of the BNNC monitoring system. BNNC jointly with Ministry of Finance is developing a Multisectoral nutrition financial tracking system for the key ministries (seven ministries who spend 92% of all nutrition budget) with the technical Assistance and financial support from UNICEF under the SUN movement in Bangladesh. In this regard, a concept note was prepared and approved by the Standing Technical Committee (STC) of BNNC. In addition, a guideline to establish the nutrition budget tracking system was prepared. Oxford Policy Management (OPM) has been engaged to undertake this task.

Thematic Area 6: Capacity Building.

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

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

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

Multisectoral Coordination at National and Sub-national Levels

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

To make them more gender and nutrition sensitive, a comprehensive review of 27 SSPs was completed including a policy brief along with recommendations with the Cabinet Division jointly. As a response

to COVID-19 pandemic, jointly with UN agencies in Bangladesh a costed Immediate Socio-Economic Response Framework (iSERF) was developed during the reporting time.

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

CHAPTER-1

INTRODUCTION AND BACKROUND

CHAPTER -1: INTRODUCTION AND BACKROUND

Introduction

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 January 2020 to December 2021. 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.

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

Objectives of monitoring report of NPAN2

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

1.2 Background

Nutrition Situation in Brief

Bangladesh has made good progress in improving child and maternal nutrition status over time since last 20 years. BDHS 2017-18 showed notable success with level of stunting among children under 5 declining from 51% in 2004 to 31% in 2017, underweight declining from 31% in 2004 to 22% in 2017, and after years of a critically high level of around 15%, prevalence of wasting came down to 8% in 2017[4]. The prevalence of Low Birth Weight (LBW) reduced to 16.2%[5] (though still high) in 2015 to 14.8% in 2019[6] in comparison to the 36% in 2003-04[7]. Much of this improvement can be explained by the combination of nutrition-specific and -sensitive drivers within a wider enabling environment of pro-poor economic growth, of which key factors are improving incomes, smaller family sizes, and greater gaps between births, parental, and particularly women's education and wider health access[8].

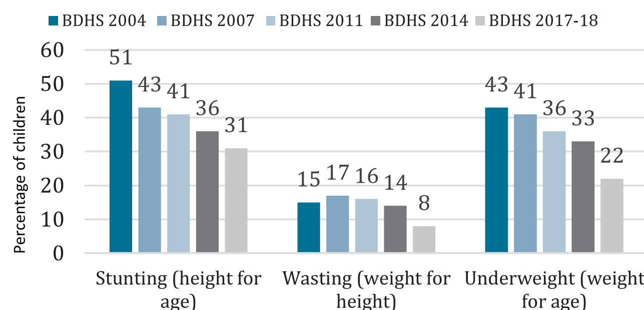


Figure 1: Progress in Child Nutrition in Bangladesh

Prevalence of underweight status remained high in rural areas and prevalence of overweight increased rapidly in both rural and urban areas, creating a double burden. Chronic Energy Deficiency (CED) rate among mothers (20-59 years) with BMI less than 18.5 has decreased from 52% in 1996-97 to about 30% in 2007, which has further reduced to 11% (a 19 percent point reduction) in 2018-19 (SFSN,2018-19).

Bangladesh has started to see increasing rates of overnutrition. Between 2004 to 2017-18, overweight has increased from 11% in 2004 to 35% in 2021 and 14% women were obese (SFSN 2018-19). The rate of overweight and obesity among children has increased from 1.4% in 2012-13 to 2.4% in 2019. Overweight (>2SD) rate was 2.7% in slum dwelling children compared to 4.1% in non-slums.

About 45% of adolescent married girls get pregnant by 18 years of age[9], that ultimately sequences to poor maternal nutritional status and later poor birth outcomes, contributing to high rates of low-birth weight infants. Stunting remains quite high among adolescents (29%), along with underweight overweight and obesity prevalence which are 56%, 7%, and 2% respectively[10]. Anaemia and micronutrient deficiencies are common in adolescents, women of reproductive age and children, notably vitamin A, zinc, Iron and iodine, and other deficiencies including calcium are also low.

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

[4] National Institute of Population Research and Training (NIPORT), and ICF. 2020. Bangladesh Demographic and Health Survey 2017-18. Dhaka, Bangladesh, and Rockville, Maryland, USA: NIPORT and ICF.
[5] IPHN. 2015. National Low Birht Weight Survey, 2015. Institute of Public Health Nutrition, Dhaka, Bangladesh
[6] MICS, 2019
[7] Bangladesh Bureau of Statistics. National Low Birth Weight Survey of Bangladesh 2003–2004. Planning division, Ministry of Planning, Government of the People's Republic of Bangladesh; 2005.
[8] 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
[9] State of Food Security and Nutrition in Bangladesh 2018-2019, BRAC James P Grant School of Public Health and National Nutrition Services (NNS), 2019, Dhaka, Bangladesh.
[10] State of Food Security and Nutrition in Bangladesh 2018-2019, BRAC James P Grant School of Public Health and National Nutrition Services (NNS), 2019, Dhaka, Bangladesh.

gone up to 37.2% in 2017 from 26.1% in 2014 (BDHS), however, diet quality remains below global recommended level, particularly related to consumption of fruits, vegetables, animal-source foods, and pulses. According to HIES (2016) people consume 35.78 gm of fruits and 167.3 gm of vegetables against target of 100 gms and 300 gms of fruits and vegetables respectively. Overall, calorie intake per capita per day has decreased to 2210 Kcal in 2016 from 2308 Kcal in 2010 (a decrease of about 4%)[11]. This decrease amount (2210 Kcal) is below the desirable amount of 2430 Kcal/capita/day[12].

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

Impact of COVID19 on Nutrition in Bangladesh

The Covid-19 mitigation measures involving economic shutdown caused massive income and job losses. A PPRC-BIGD survey, undertaken in April 2020, found that people from all population segments incurred a significant income loss between February and April 2020, while it was the extreme and moderate poor people that were hardest hit – suffering a-three-fourths loss in income on average. Hamadani et al with a pre-post study design has disentangled a precise effect of the COVID-19 related "stay-at-home" advice on household food insecurity and earnings of the families in a rural setting of Bangladesh. The authors estimated that the median monthly income of the same families dropped from US$212 (before COVID-19) to $59 during lockdown (p<0.0001)[13]. Before the COVID-19 in 2017-19 (FIES) the moderate and severe form of household food insecurity was 31.5% and 10.6%, which rose to 36.5% and 15.3% respectively during the lockdown[14]. Another study in a rural and an urban slum setting, which gathered data over the first month into the lockdown, estimated that 90% of the households were experiencing in some form of household food insecurity[15].

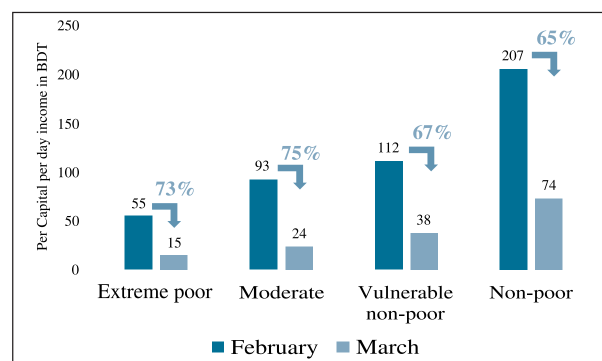


Figure 2: Income Shock Across Groups, Source: PPRC-BIGD Rapid Response Survey, April 2020≈

Due to COVID-19, both the quantity and quality of services provided has diminished; the number of ANC visits by mothers reduced by 31%, while counselling and IFA distribution at ANC reduced by 33% and 34% respectively. Admissions of children with Severe Acute Malnutrition (SAM) have reduced by 73% between February and May 2020[16]. Around 73% of all units offering SAM treatment were non-functional. Among functional facilities, only 2% were fully functional and only 5% have a sufficient supply of therapeutic milk[17].

[11] Bangladesh Bureau of Statistics (BBS) 2016. *Household Income and Expenditure Survey.* Dhaka, Bangladesh: Bangladesh Bureau of Statistics (BBS)

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

[13] Hamadani J.D., Hasan M.I., Baldi A.J., Hossain S.J.,Shiraji S, Bhiyan M.S.A. et al. Immediate impact of stay-at-home orders to control COVID-19 transmission on socioeconomic conditions, food insecurity, mental health, and intimate partner violence in Bangladeshi women and their families: an interrupted time series. The Lancet Global Health, Vol 8, Issue 11, E1380-E1389, November 01, 2020; DOI: https://doi.org/10.1016/S2214-109X(20)30366-1

[14] Same as above

[15] Das S, Rasul MG, Hossain MS, et al. Acute food insecurity and short-term coping strate-gies of urban and rural households of Bangladesh during the lockdown period of COVID-19 pandemic of 2020: report of a cross-sectional survey BMJ Open 2020;10:e043365. doi: 10.1136/bmjopen-2020-043365

[16] Rapid assessment of SAM facilities conducted by UNICEF in April 2020

[17] Idem, UNICEF 2020

CHAPTER-2

Methods of Report Preparation

CHAPTER 2: METHODS OF REPORT PREPARATION

2.1 Structure of the Report

The Annual Monitoring Report of Jan 2020 to Dec 2021 of Bangladesh National Nutrition Council (BNNC) while preparing the report followed the following structures:

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

2.1.1 Thematic areas:

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

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

2.1.2 Priority and proxy indicators, targets and baseline

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

2.1.3 Target Period:

For program management, NPAN2 activities are distinctly categorized into three time periods: short-term, mid-term and long-term. Of these, the short-term period spanning 2016-2018 has passed; the current period, or the mid-term from 2016-2020 is underway; and the long-term period from 2016-2025 will be a blend of the current term and others to continue until 2025. This report covers the time period from January 2020 to December 2021, which is part of the mid-term NPAN2.

2.2 Report formation process

2.2.1 Institutional arrangements

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

observance of National Nutrition Week, were able to obtain activity data to support the preparation of this report. Through its M&E Technical Working Group members, BNNC reviewed the validity of program and operational indicators from different ministries. They analyzed data trends, progress, status quo, and in case of situations requiring explanation, approached specific ministries for further clarity.

2.2.2 Data Collection

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

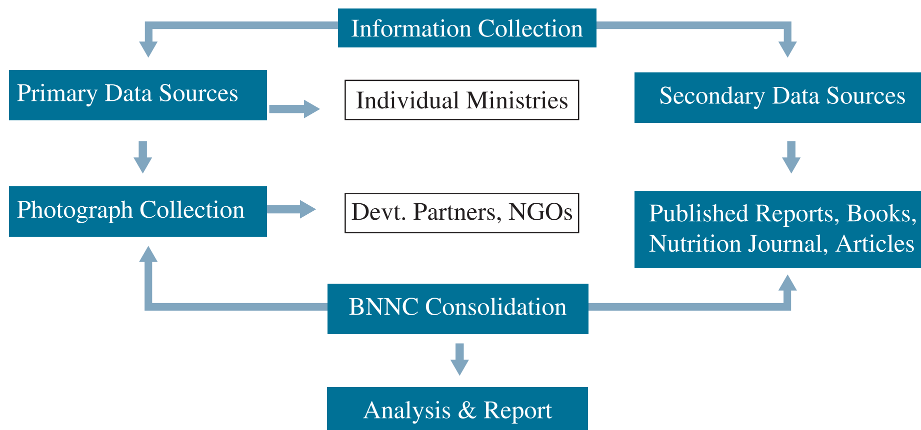


Figure 3: Data collection and management process for formulation of the report

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

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

2.3 Data Analysis and Use

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

2.4 M&E Framework

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

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

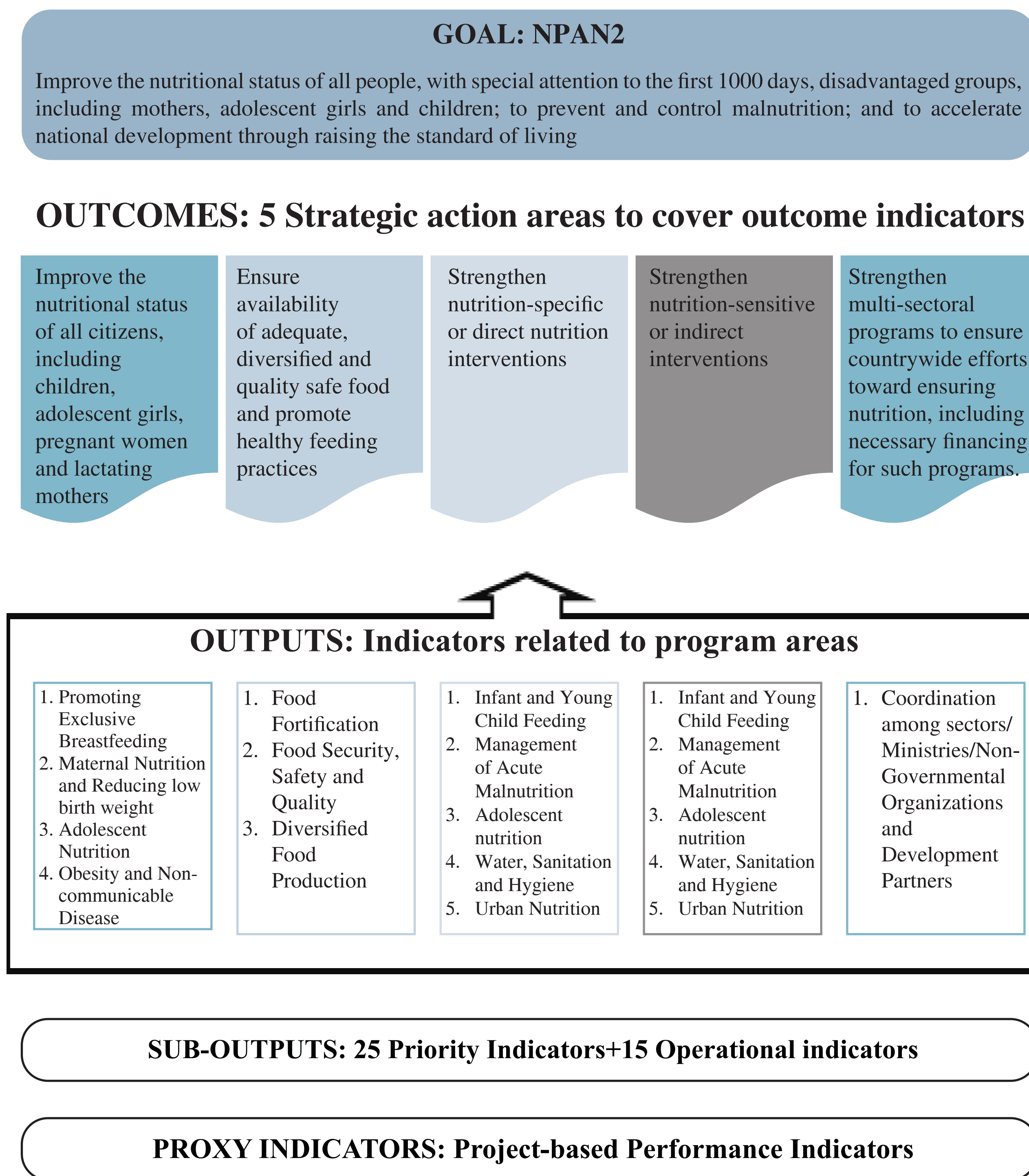


Figure 4: The monitoring and evaluation framework

CHAPTER-3

PROGRESS TOWARDS NPAN2 TARGET AND OUTPUTS

CHAPTER-3: PROGRESS TOWARDS NPAN2 TARGET AND OUTPUTS

3.1 Update on 15 Target Indicators set in NPAN2 design.

NPAN2 design included following 15 higher level targets were aligned with the targets as envisaged in NNP 2015. These targets were set to reduce various forms of malnutrition among its population by 2025. The review of progress of them reveals that 12 out of 15 target indicators (related to IYCF, malnutrition, diet etc.) are on track. In fact, the target for reducing maternal overweight at 30% by 2025 has already been achieved according to Multiple Indicators Cluster Survey (MICS) 2019, where they found the current level at 24%. Contrarily, overweight among children under-five showing off track, in fact, the rate has increased against the target of no-increase from baseline level. Another target indicator related to increase the proportion of children aged 6-23 months receiving a minimum acceptable diet (MAD) is also on track (28% against > 40% target). The updated information related a few key target indicators (e.g. birthweight, adolescents' nutrition, and few micronutrients, such as anaemia etc.) are not available.

Table 1: Progress status of higher-level targets

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%	
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%	
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%	
Increase the proportion of children aged 6-23 months receiving a minimum acceptable diet	23% (BDHS 2014)	>40%	34%	27.8%	
No increase of childhood overweight (WHZ >+2) among children under 5 years	1.40%	No increase	2.20%	2.4%	
Reduce the rate of anaemia among pregnant women	50% (BDHS 2011)	25%	NA	NA	NA
Reduce the rate of low birth weight	23% (National LBW Survey 2016)	16%	Not Available	14.8%[18]	NA
Reduce malnutrition (Total Thinness, BMI<18.5) among adolescent girls (15-19yrs)	19% (BDHS 2014)	<15 %	20%	18% (SFNS, 2022)	NA

LEGEND

On track	Off track	Not Available (NA)

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

3.1.1 Update on priority nutrition indicators

To achieve the agreed upon targets a few output level indicators are used to assess the progress of NPAN2's Monitoring of meetings and workshops to monitor them intensively. Data supporting these indicators would be gathered/collected through periodic surveys and from routine program administrative data, for example, the Bangladesh Demographic and Health Survey (BDHS) undertaken by the National Institute & Evaluation Matrix. Total 25 priority indicators were identified and selected through a series of Population Research and Training (NIPORT) every three years, Multiple Indicators Cluster national-level Survey (MICS), etc. These priority indicators are used by both program managers and stakeholders.

It is evident from the table 2 that 12 out the 25 priority indicators made progress compared to their baseline status during the reporting period. Some of the indicators made a substantive progress while some others made marginal progress. Those indicators made substantive and marginal progress are: i)initiation of breastfeeding in the first hour of birth (18 percentage points); ii) % of children (0-6m) exclusively breastfed (10 percentage points); iii) children (6-23 m) receiving MAD (11 percentage points); reduced stunting among children (8 percentage points); iv) reduced wasting among children (4 percentage points); v) diarrhoea treated with ORT and Zinc (5.6 percentage points); vi) adolescent girls (15-19 yrs.) with height <145 cm (8.5 percentage points); vii) adolescent girls (15-19 yrs.) thin (total thinness) (11 percentage points); viii) women (20-24 yrs) who have begun childbearing (3 percentage points); ix) increase in per capita consumption of vegetables (1.2 percentage points); x) share of total dietary energy from consumption of cereals (6 percentage points); xi) women age 20-24 who were first married by age 18 (8 percentage points); xii) children (36-59 m) who are attending an early childhood education program (5.9 percentage points); xiii) women who completed secondary/higher education (3 percentage points); xiv) change in per capita consumption of sugar (0.5 percentage point). Of the total one indicator (adolescent girls (15-19 yrs.) with height <145 cm) has already achieved the NPAN2 target of <8%.

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

Table 2. List of 25 Priority Indicators.

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%	14.8%	MICS (2019)
5	Reduce stunting among under-5 children	25%	36%	31%	(BDHS 2017-18)

SL.	Indicators	NPAN2 Target 2025	Baseline of NPAN2	Current Status	Sources
6	Children under 5 years who are wasted	<8%	14%	8%	(BDHS 2017-18)
7	Children under 5 years who are overweight	1.40%	1.40%	2.40%	(MICS 2019)
8	% of Women 15-49 yrs. with Anaemia	<25%	42%	28.9%	(NMS 2019-20)
9	% of children under 5 with diarrhoea treated with ORT and Zinc	Not yet fixed	38%	43.60%	(BDHS 2017-18)
10	% of women 15-49 yrs who are overweight or obese (BMI ≥ 23)	30%	24%	39%	(BDHS 2014)
11	% of adolescent girls (15-19 yrs.) with height <145 cm	<8%	13%	4.51%	SFNS (2022)
12	% of adolescent girls (15-19 yrs.) thin (total thinness)	<15%	29%	18%	SFNS (2022)
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%	98.50%	(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				
17	Per capita consumption of fruits and vegetables	$\geq$ 400 g 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 years who were first married by age 18 yrs	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	189 Upajillas	WFP
22	% of children (36-59 m) who are attending an early childhood education program	30%	13%	18.90%	(MICS 2019)
23	% of women who completed secondary/ higher education	90%	14%	17%	(BDHS 2017-18)
24	Number of ongoing comprehensive coordinated multisectoral, multichannel advocacy and communications campaign	10	NA	NA	
25	Change in per capita consumption of:				

SL.	Indicators	NPAN2 Target 2025	Baseline of NPAN2	Current Status	Sources
	i. salt ii. sugar consumption	i. <5 gm/ person/ day (WHO)	i. Salt: not available	i. Salt: not Available	
		ii. <10% of total energy intake	ii. Sugar: 7.4 (gm/capita / day)	ii. Sugar: 6.9 (gm/capita / day)	(HIES 2016)

3.1.2 Progress by Thematic Area

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

3.2.1 Overall Progress IYCF in Bangladesh during the reporting period

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

Appropriate IYCF practices are based on three feeding practices:

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

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

Status of Early Initiation of Breast Feeding (EIBF)
Early Initiation of Breastfeeding (EIBF) is referred to as initiation of breastfeeding within one hour of birth. Data presented in Figure-4 clearly shows improvement in EIBF over the 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 improvement is probably attributable to improvement of Skilled Birth Attendants, ANC services, implementation of the Bangladesh Breast milk Substitutes Act[19], Baby-Friendly Hospital Initiative (BFHI), Maternity and Lactating Allowance Programs, etc. supported by Social Behaviour Change Communication (SBCC).

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

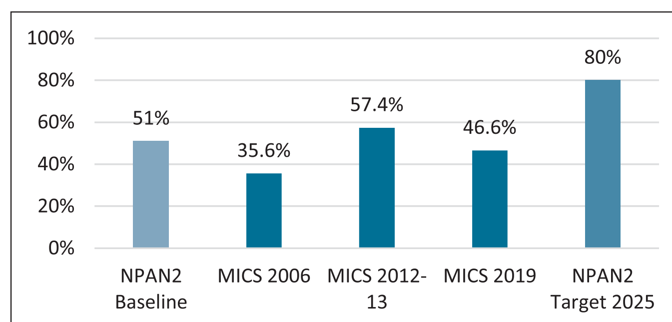


Figure 4: Trends of early initiation of breast feeding among children aged 0-5 months compared to the NPAN2 target [Source: MICS, 2019 report]

Trends in Exclusive Breastfeeding Practices

Breast milk is uniquely tailored to meet all the nutritional needs of human babies for the first six months of life and is thus the best source of nutrition for new-born babies. In Bangladesh, the Exclusive Breastfeeding (EBF) rate has increased from 56% in 2012-13 to 63% in 2019 (MICS, 2019) Figure 5. 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.

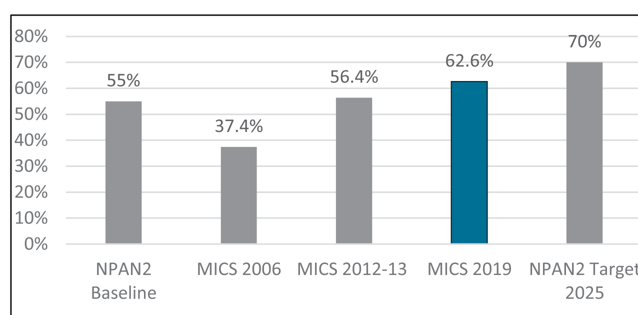


Figure 5: Trends in exclusive breastfeeding practices among children aged 0-5 months along with NPAN2 target [Source: MICS, 2019 report]

Trends in complementary feeding practices

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

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

BDHS findings, as depicted in Figure 6, show that among breastfed children aged 6-23 months, all three indicators—minimum dietary diversity (MDD), minimum meal frequency (MMF) and minimum acceptable diet (MAD—in both male and female children have increased in 2017-18 compared to 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.

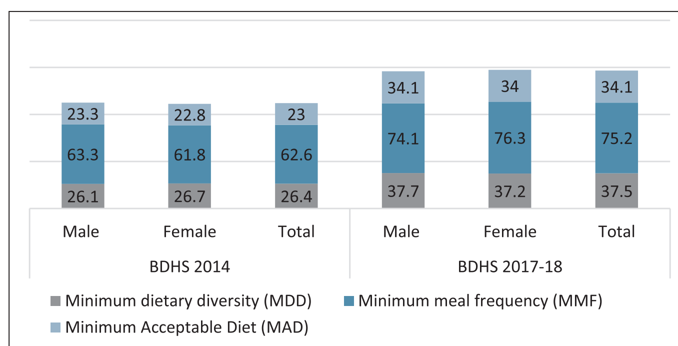


Figure 6: Trends of three indicators (e.g.MDD, MDF and MAD) among male and female children age 6-23 months between 2014 and 2017-18 (BDHS).

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

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

Minimum Acceptable Diet

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

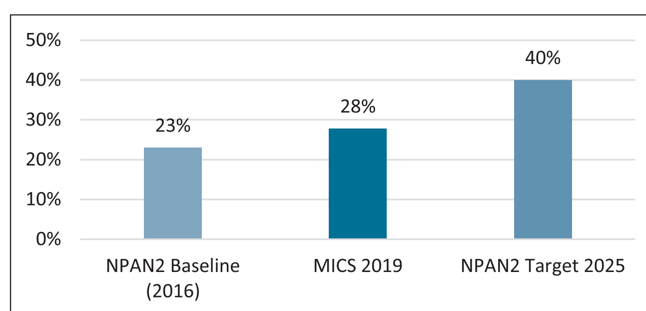


Figure 7: Percentage of children 6-23 months fed with Minimum Acceptable Diet (MAD) [Source: MICS, 2019]

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 7. 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.

3.2.2 Progress in nutrition program indicators (NPAN2) during the reporting period

Since 2016, there has been steady progress in IYCF indicators. The most notable improvement in all three IYCF related indicators included in NPAN2 to Received place between 2018-2019. The trend of providing IYCF counselling to caregivers at health facilities increased from 19% in 2016 to 55% in 2019; the number of infants breastfed within one hour of birth went from 421,517 in 2016-to 630386; and the number of health facilities certified as Baby Friendly increased from 231 to 723 facilities between 2016 and 2019.

Indicator 1: Number of infants who are breastfed within one hour of birth. It is observed that in rural facilities the total number infants who breastfed within one of birth have increased from 421,517 in 2016 to 630,386 in 2019, which is a about 50% increase.

Indicator 2: % of caregivers of children 0-23 months old receiving age appropriate IYCF counselling at facility has increased from 19% in 2016 to 55% in 2019, which is 36% percentage point increase.

Indicator 3: Number of health facilities certified as Baby Friendly Hospital Initiatives- has increased from 231 in 2016 to 723 in 2019.

Table 4: Status of process indicators for assessing IYCF status

Process Indicators	2019	2020	2021	Source
1.Number of infants who are breastfed within one hour of birth	630386 (Rural facility)	652015 (Rural facility)	702548 (Rural facility)	DHIS2, DGHS; MICS
2.% of caregivers of children 0-23 months old receiving age appropriate IYCF counselling at facility	55 % (Rural facility)	43% (Rural facility)	46% (Rural facility)	DHIS2, DGHS; MICS
3.Number of health facilities certified as Baby Friendly Hospital Initiatives	723	825	1165	NNS

3.2.3 Micronutrient Malnutrition

Overall progress of the micronutrient malnutrition in the country

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

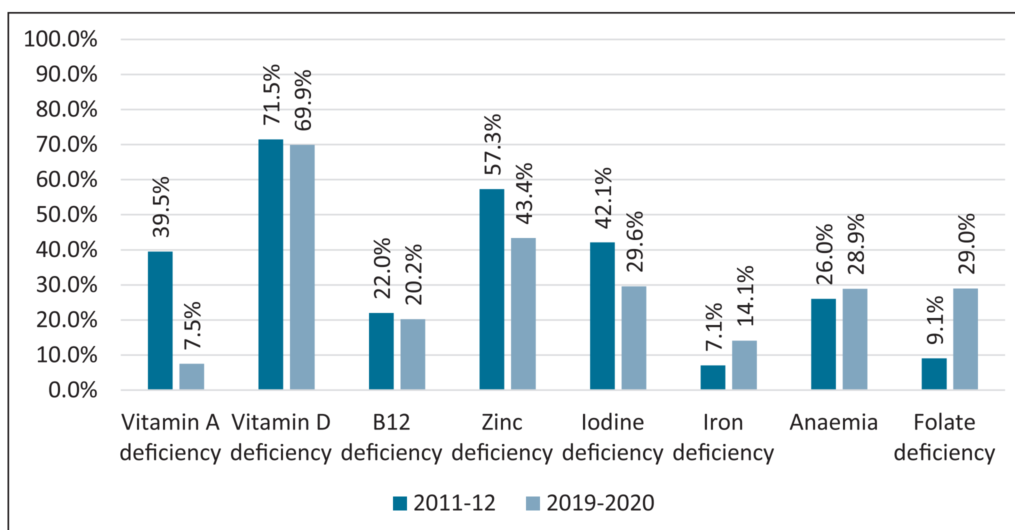


Figure 8. Micro-nutrient status among non-pregnant and non-lactating (NPLP 15-49 years)

Based on administrative data it is evident that, Bangladesh's bi-annual Vitamin A supplementation program has maintained high coverage over time in achieving 98.4%% in 2021 for children aged 6-59 months. The administrative coverage of the first round of vitamin A supplementation to children aged 6-59 months was 98.4% (20,523,925 children); coverage of children aged 6-11 months was 97.5% (2,420,573 children); and coverage of children aged 12-59 months was 98.5% (18,103,352 children). In Sylhet the coverage was low at 83.3% among children aged 6-59 months and 85.9% among children 12-59 months.

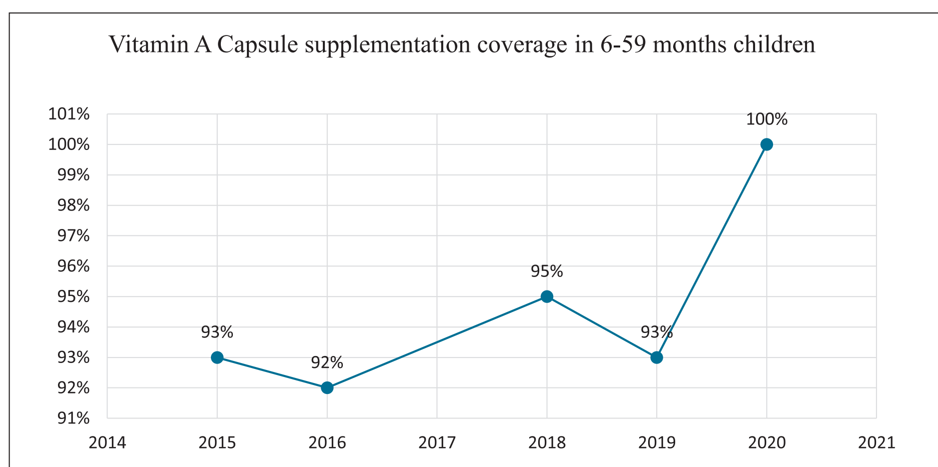


Figure 9: Status of vitamin A supplementation [Source: National Nutrition Services (NNS)]

Mother's education and wealth status increased the chances of children receiving VAS. The coverage

[20] National Micronutrient surveys 2011-12 and 2019-20.

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

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

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

3.2.4 Management of Acute Malnutrition

Overall progress of the management of Severe Acute Malnutrition (SAM) in the country
Management of Moderate Acute Malnutrition (MAM) and Severe Acute Malnutrition (SAM) as per standard guidelines through in-patient or out-patient management are included in the strategic actions. Activities to support the program include establishment of community-based programs, review and updating of guidelines, training of health workers, timely reporting, regular supply of therapeutic formulas at facilities for treating SAM, strengthening of nutrition counselling services (including co Receiveding 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).

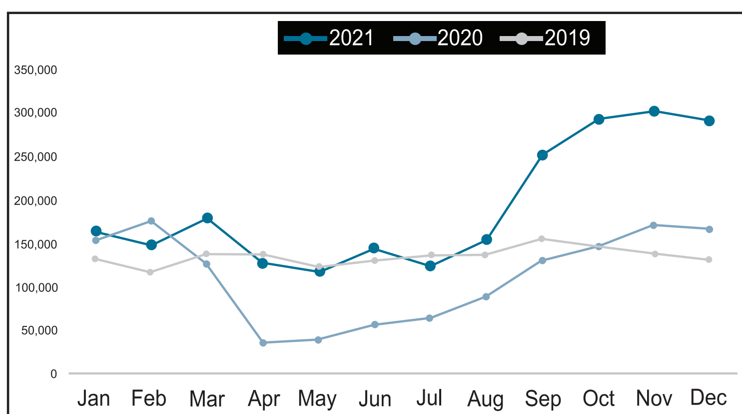


Figure 10: Trend of screening of SAM cases from January 2020 to December 2021.

The screening of SAM cases (311,015) in November 2021 was highest compared to same period in last two years. Between January 2020 to December 2021 the prevalence of SAM among screened children attending at facilities remained around at 1%. The admission of number of SAM cases increased from 485 in January 2020 to 9,702 in December 2021 which is almost 110% increase, consequently the admission rate of SAM cases also increased from 34% in January 2020 to 59% in December 2021. However, a downward trend was

observed for screening of SAM cases during April & May'2022[21] .

From recent survey, Sylhet and Mymensigh division continues to have the highest rates of malnutrition in children under five for all three forms including stunting, underweight and wasting in Bangladesh. However, out of total 394 SAM facilities, there are 8.6% facilities in Sylhet and 7.1% in Mymensingh are available in various categories of health facilities, which needs to be increased to manage the malnutrition of SAM affected children.

Table 5. SAM Units in various health facilities by division.

Distribution of SAM facilities across Bangladesh						
Sl. No	**Division**	**District Hospital/ General Hospital**	**Medical colleges Hospital**	**Upazila Health Complexes**	**Others**	**Total No of SAM Units**
1	Barisal	7	1	31		39
2	Chattogram	12	2	41		55
3	Dhaka	14	4	30	7	55
4	Mymensingh	3	1	24		28
5	Sylhet	3	1	30		34
6	Rajshahi	8	1	58		67
7	Rangpur	7	2	46		55
8	Khulna	10	1	50		61
	Grand Total	**64**	**13**	**310**	**7**	**394**

In 2020 the sharp fall of number of screening of SAM cases from February to April was probably due the effect of lockdown for COVID-19. Report produced by BNNC revealed[22] that due to COVID-19, both the quantity and quality of health and nutrition services provided had diminished: for example, the number of ANC visits by mothers reduced by 31%, while counselling and IFA distribution at ANC reduced by 33% and 34% respectively. Analysis of routine health facility data had shown a drop in essential services provision, including a 84% reduction in admissions of children with severe acute malnutrition with complications for treatment between February and May 2020. The screening of children with SAM continued to be low at 35%. A country-wide rapid assessment of nutrition facilities regarding their preparedness and functionality also found that of all the units offering treatment for children with SAM, about 73% were non-functional. Of the functional facilities, only 2% were considered fully functional and 5% of the units had sufficient supplies of therapeutic milk.

Subsequently three rounds of SAM facility assessment were conducted (May 2020, July 2021 and Feb 2022) till now to identify and mitigate the gap to improve the functionality of SAM unit. Due to COVID-19 it was observed that only 77 children were admitted in SAM units. Immediately, NNS with the technical support of UNICEF, first round rapid online assessment was conducted and collected information from 394 SAM facilities throughout the country. In that time, it was identified that only 27% SAM units were ready to deliver SAM services. The main bottleneck identified for non-functionality was due to lack of supply specially F-75 and F-100. Then UNICEF to Received the initiative and deliver supply to all SAM units. In addition, a strong follow up and regular monitoring from NNS, NIPU, Zonal Nutrition officer and DNC helped to improve the situation of functionality and reached the functionality from 27% to 49% in round-2 assessment. Capacity gap of the existing doctors and nurses was another bottleneck which was also

[21] NNS Newsletter; A bulletin of National Nutrition Services; Issue-26, Mar-April 2022.

[22] Determining the impact of COVID-19 on nutrition; Projection of the possible malnutrition burden and post COVID-19 in Bangladesh. Second Edition, August 2020. BNNC.

improved through organizing SAM training from NNS. Therefore, in round-3 assessment 53% SAM unit were found functional.

3.2.5 Maternal Nutrition and reducing Low Birth Weight (LBW)

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

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

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

On the other hand, nationally on average the overweight and obesity among women were higher compared to the underweight. Nationally, overweight among women was 49%, which was more at 32% among non-slum, 22% in slum and 13% in rural women. In addition, 24.2% in rural, 22.9% among non-slum and 19.4% in slum women were hypertensive. About 4% women had self-reported diabetes. The significant contributors to this double burden were the change in women's level of education, increased household wealth, divisional location, and rapid urbanization [23].

Micronutrient deficiencies are common among women of reproductive age. As seen in Figure 5 that between 2011-12 and 2019-20, while Vitamin A, Vitamin D, B12, Zinc and Iodine deficiencies have improved, but the Iron and Folate deficiencies and Anaemia have increased during the same period. Maternal anaemia during pregnancy has serious consequences for both mother and new-born, including increased risk of becoming low birth weight and preterm birth, as well as high risk of maternal and perinatal morbidity and mortality. Iron requirements increase substantially during pregnancy and it is difficult to meet these needs from food sources alone. Iron Folic Acid (IFA) supplementation is an important intervention to overcome anaemia, especially during pregnancy. However, only 11 percent of pregnant adolescent girls under 18 years of age received all required 100 IFA tablets, and just 1.8 percent of pregnant women under 18 received and consumed all 100 IFA tablets [24].

Low quality of diets among women due to low intake of micronutrient-rich foods and low diet diversity are common underlying causes of maternal malnutrition. Women achieving minimum dietary diversity MDD-W) during pregnancy though increased but still remains much below the NPAN2 target 0f 70% by 2025. The differences in MDD-W were observed, for example, MDD-W from slum women was 37%. The women from Sylhet Division had the lowest MDD-W compared to 61% in Rajshahi.

Women who do not receive clinical ANC have significantly greater odds of miscarriage compared to those who visit a clinic for ANC check-up during the first trimester[25] . 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

[23] 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

[24] Multiple Indicators Cluster Survey (MICS), 2019

[25] FAO. Guidelines for measuring household and individual dietary diversity.

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.

As indicated in Table 6, urban women (59%-68%) make four or more ANC visits than rural women (38%-43%). Between 2014, 2017 and 2019, 31%, 47% and 39% women respectively made four or more ANC visits during pregnancy against the 4th HPNSP target of 50% coverage by 2022. It is observed that HPNSP target has already been achieved among both urban non-slum and slum women, however, the coverage in rural women is lagging.

Table 6: Proportion of women receiving antenatal care visits

Number of ANC visits	Residence		
	Urban	**Rural**	**Total**
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 (BDHS 2017-18) 68% (SFSN 2018-19) 50% (Slum)	42.7 (BDHS 2017-18); 38% (SFSN,2018-19)	47 (BDHS 2017-18); 39% (SFSN,2018-19)
Median visits	4.9	3.8	4.1
Total	100	100	100
Number of women	1356	3695	5051

Source: BDHS 2017-18 report; and SFSN,2018-19

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

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

Progress of Indicators

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

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

Indicator 3: % of visits with pregnant women who received any IFA- has also increased from 33% in 2016 to 43% in 2019. It was revealed from Priority Nutrition Report Indicator (NNS, 2022) that total

number of PLWs received IFA from facilities has decreased from 296,778 in January 2020 to 272,065 in March 2022 (about 8% decrease).

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

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

Table 7: Status of process indicators related to maternal nutrition (2016 to 2019).

Output indicators	2019	2020	2021	Source
1.% of visits with pregnant women who received any IFA	43% (Rural)	53%	53%	DHIS2, DGHS
2.% of times women who attended ANC check-ups during pregnancy were weighed	21% (Rural)	51%	52%	DHIS2, DGHS
3.% of women receiving maternal nutrition counselling	19% (Rural)	52%	52%	DHIS2, DGHS

3.2.6 Adolescent nutrition

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

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

1. % of adolescent girls (15-19 yrs) with height <145 cm-in 2022 4.5% of the adolescent girls aged 15-19 years had hight <145 cm. It has improved from 5.2% in 2018-19 to 4.5% in 2022. It is observed that the NPAN2 target of <8% by 2025 has already been achieved. Nonetheless, low height among early adolescent period (aged 10-18 years) was heigh at 30.9% and remained unchanged from 2018-19 findings [26].

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

Table 8: Indicators included in NPAN2 related to Adolescent

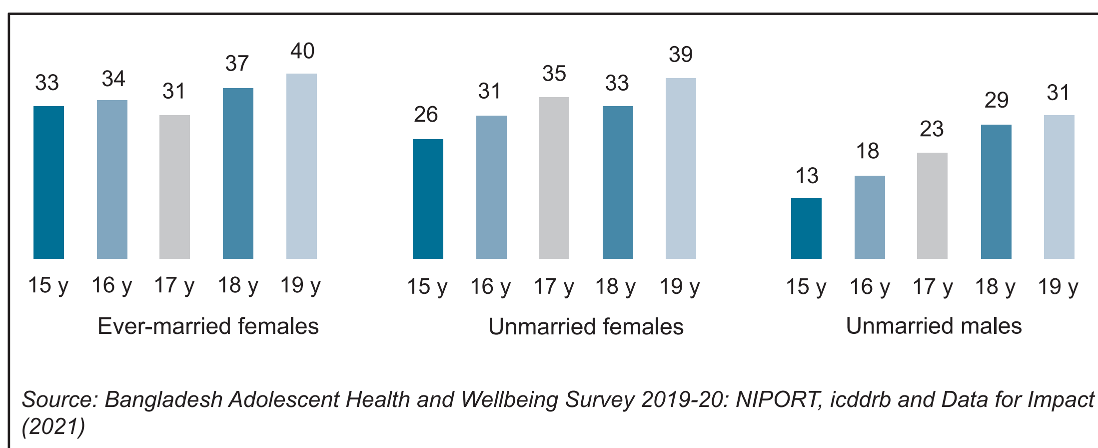
Indicator	Baseline	Current status	Target 2025
1. % of adolescent girls (15-19 yrs) with height <145 cm	13% (BDHS 2014)	4.51% (Nutrition Assessment 2022)	<8%
2.% of adolescent girls (15-19 yrs) thin (total thinness)	19% (BDHS 2014)	18% (Nutrition Assessment 2022)	<15%

[26] Bangladesh Multiple Indicator Cluster Survey (MICS) 2019

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

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

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



Source: Bangladesh Adolescent Health and Wellbeing Survey 2019-20: NIPORT, icddrb and Data for Impact (2021)

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

3.2.7 Mental health situation

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

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

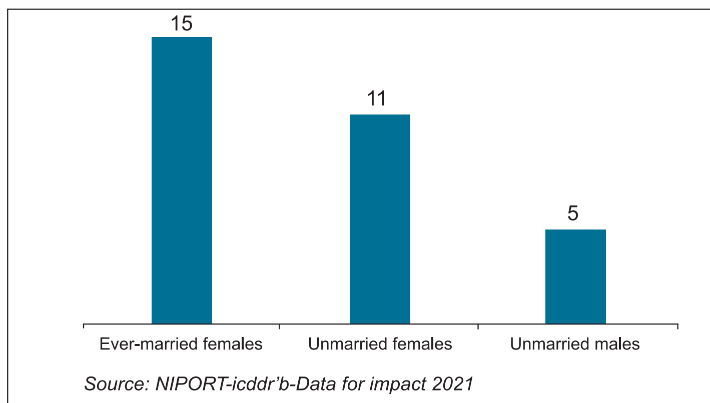
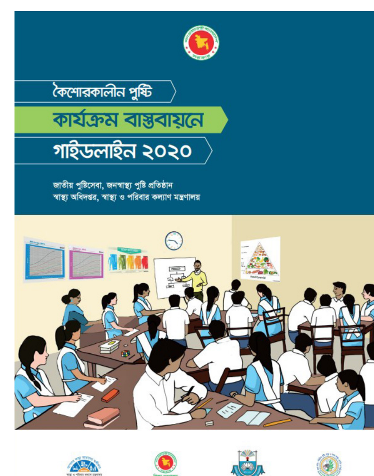


Figure 12: Percentage of adolescents ages 15-19 years with major depressive disorder, Bangladesh

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

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

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



Implementation Guideline on Adolescent Nutrition 2020

National Nutrition Services (NNS) -Institute of Public Health Nutrition (IPHN) in collaboration with Directorate of Secondary and Higher Education (DSHE) prepared a Guideline on Implementation of Adolescent Nutrition Programme.

The guidelines provide operational modality of health facility and school-based adolescent nutrition, roles and responsibilities of different stakeholders in health and education system with connectedness with community-based adolescent clubs. It also provides outline of a reporting and monitoring mechanism.

Recommended package for Adolescence Nutrition as per the Implementation Guideline

- Encourage healthy diet through nutrition education
- Monitoring of Weight, Height, and BMI
- Weekly supply of Iron Folic Acid (WIFA)
- Control of Helminthiasis
- Referral of those who need health services for undernutrition, anaemia and deficiency disorders
- Promotion of physical exercise

3.2.9 Water, Sanitation and Hygiene (WASH)
WASH-Nutrition linkages

WASH is closely associated with level of health and nutrition status. For instance, 9.3% of deaths and 7.4% of burden of disease are attributable to unsafe WASH in children under 5 years[27], constituting 8.8% of all disability-adjusted life years (DALYs) in this age group[28]. Children are more likely to be undernourished and stunted if they are exposed to Faecally-Transmitted Infections– including diarrhoeal disease and Environmental Enteropathy – or intestinal worms, which are linked to poor WASH and open defecation[29]. Repeated parasitic infections can result in anaemia and inhibit physical and cognitive development.

A 20-year multi-country analysis revealed that, five or more diarrhoeal infections in the first 2 years of life accounted for 25% of all stunting observed (Checkley, et al., 2008). Moreover, every five diarrhoeal episodes increased stunting risk by 13% (Checkley, et al., 2008). Repeated episodes of diarrhoea or intestinal worm infections due to unsafe water, inadequate sanitation or insufficient hygiene are associated with half of all malnutrition cases globally[30]. Diarrhoea, in particular, is a leading cause of death of children under 5 years worldwide, and its constant presence in low-income settings contributes significantly to undernutrition [31]. Although the coverage in both water and sanitation is high however, the quality of both services has been a concern, especially in urban slums. Although all improved drinking water sources should provide safe drinking water, this is not always the case. For instance, approximately 82% of the households' drinking water was contaminated with E. Coli (CWS, 2016). The process of water collection and storage itself further creates contamination. Only 25% of households in slum and non-slum areas used a proper water treatment method for drinking (CWS, 2016). While access to adequate amount of drinking water is necessary it might be insufficient to avoid the risk of disease, unless water quality is maintained, and water is free from faecal contamination of harmful pathogens. It is estimated that about 17% of diarrhoeal diseases can be reduced by improving water quality.

Overall progress of the WASH sector

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

In case of sanitation, however, the urban-rural difference is higher, with the national average of 84.6% of population using improved sanitation, in which, 90.6% being in urban areas and 82.9% in rural areas. According to CWS 2016, only nineteen percent (19%) of the households had an improved sanitation facility in slum areas compared to 51.3% of the non-slum households. The percentage of household members using improved sanitation facilities has increased from 77% in 2012-13 to 85% in 2019 (MICS 2019). The same

[27] Pruss A, Kay D, Fewtrell L, and Bartram J. Estimating the burden of disease from water, sanitation, and hygiene at a global level. Enoron Health Perspect 2002;110(5):537-42.

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

[29] Cumming, O., & Cairncross, S. (2016). Can water, sanitation and hygiene help eliminate stunting? Current evidence and policy implications; Crane et al (2015). Environmental enteric dysfunction: An overview; Checkley et al. (2008) Multi-country analysis of the effects of diarrhoea on childhood stunting; Ziegelbauer et al. (2012). Effect of sanitation on soil-transmitted helminth infection: systematic review and meta-analysis..

[30] Prüss-.stün A, Bos R, Gore F, Bartram J. Safer water, better health: costs, benefits and sustainability of interventions to protect andpromote health. Geneva: World Health Organization; 2008(http://apps.who.int/iris/bitstre am/10665/43840/1/9789241596435_eng.pdf, accessed 16 October 2015).

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

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

Status of WASH indicators included in NPAN2

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

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

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

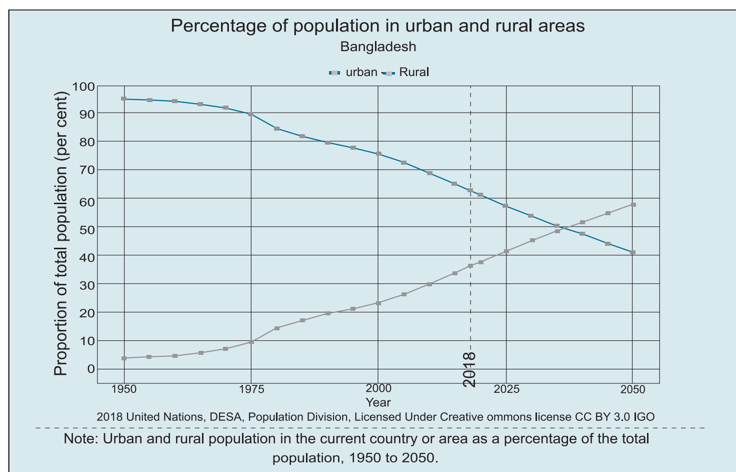
Indicator 3: % of household members with a hand washing facility where water and soap or detergent are present. The national coverage was 74.8%, which has also surpassed the NPAN2 target of 50% by 2025.

Table 9: Status of Water and Sanitation condition in Bangladesh, MICS 2019

Indicators	NPAN2 Target 2025	2019	Source
% of population that use improved drinking water	**99%**	**98.5%**	MICS 2019
% of population that use improved sanitary latrine (not shared)	**75%**	**84.6%**	MICS 2019
% of household members with a hand washing facility where water and soap or detergent are present	**50%**	**74.8%**	MICS 2019

3.2.10 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. Every year, thousands of people migrate to urban areas from villages, peri-urban and disaster affected areas. As per the recent preliminary findings of the Population and Housing Census 2022 in Bangladesh, around 31.50% of the population (around 53 million) in the country are urban dwellers (BBS, 2022). Dhaka is a rapidly urbanising megacity and is one of the world's most densely populated cities. Only the capital city Dhaka, constitutes around 20% of the total urban population of the country (BBS, 2022). Rural to urban migration occurring in thousands annually resulting in populous slums. Currently, around 35% of the urban dwellers reside in urban slums (BBS, 2022) characterised by constant fear of evictions by the residents and controlled by gang-lords who charge exorbitant rates for basic services. Government is against the 'institutionalisation' of Low-Income Communities (LICs), as their long-term vision is of a city without LICs.



Urban nutrition services are part of Bangladesh's primary health care services system, divided among service providers including the GOB, NGOs and private sector with insufficient coordination. The Bangladesh National Nutrition Policy 2015 emphasized the provision of nutrition services in urban areas, particularly for poor and slum populations, with effective coordination among providing Ministries (sub-strategies: 6.3.10, 6.3.11, 6.5.1). NPAN2 recognized gaps in nutrition services in urban slums and included specific activities to enhance urban nutrition programming through effective coordination among government ministries and NGOs, and linkages with WASH and social safety net programs [32].

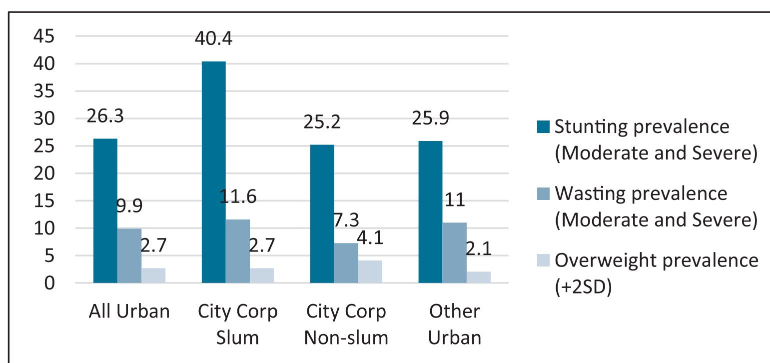


Figure 13: Segregated Urban Prevalence of Stunting, Wasting and Overweight

Bangladesh witnessed a significant improvement in the reduction of chronic undernutrition (stunting, low height for age) from 43% in 2007 to 28% in 2019, decreased by 15% in 12 years However, the reduction rate was higher in rural areas than in the urban areas (17% and 10% respectively). 40% of slums children are stunted compared to 26% of the total urban stunting level[33]. The prevalence of wasting increased in both slum (17% to 19%) and non-slum (10% to 16%) from 2006 to 2013, but decreased in 2016, to 16% and 7% in slum and non-slum respectively[34](UHS, 2013; CWS, 2016); the prevalence of underweight was 20%, with higher levels among slum (31%) compared to non-slum children (18%) [35]. Overweight (>2SD) rate was 2.7% in slum dwelling children compared to 4.1% in non-slum dwelling children. The consumption of Minimum Acceptable Diet (MAD), which was 30% in slum children compared to 44% in non-slum children. Exclusive breastfeeding among children under 6 months of age was 62% and 58% for slum and non-slum children respectively (Table 8).

[32] United Nations, Department of Economic and Social Affairs, Population Division (2018). World Urbanization Prospects: The 2018 Revision.
[33] (UHS, 2013; CWS, 2016).
[34] (UHS, 2013; CWS, 2016).
[35] Child Well-being Survey 2016, BBS-UNICEF.

Table 8: Status of existing urban nutrition in Bangladesh

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

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

Implementation status of nutrition activities included in Annual Workplans under Thematic Area 1 in Fiscal Year 219-20 and 2020-2021.

Activities covered under Thematic Area 1 include: Infant and Young Child Feeding practices, Status of Early Initiation of Breast Feeding, Trends in Exclusive Breastfeeding practices, Trends in complementary feeding practices, Minimum Acceptable Diet, Micronutrient malnutrition, Management of Acute Malnutrition, Maternal nutrition and reducing low birth weight, Progress in maternal nutrition and LBW process indicators, Adolescent nutrition, Child Marriage, Teenage Pregnancy and Malnutrition Nexus, Water, sanitation and hygiene (WASH) and Urban Nutrition.
Total 60 nutrition activities were included in Annual Workplan 2020-21 (FY) under this Thematic area where 16 ministries were involved for implementation. According to BNNC dashboard out of the total 60 activities 23 activities were completed, 9 were on progress and 28 activities with no progress. It was observed that, in FY 2019-20, 64 activities were included of which 26 were completed and 13 were on progress and 25 with no progress (Figure. 14).

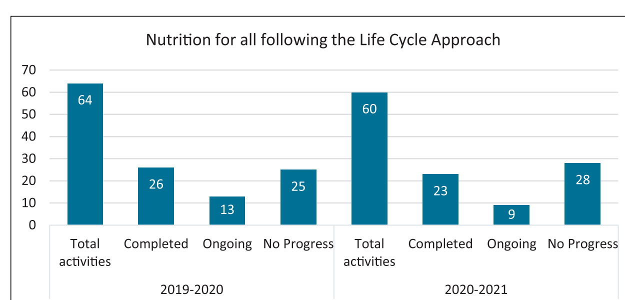


Figure 14: Implementation status of nutrition activities under Thematic area 1 in FY 2019-20 & 2020-21.

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

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

The main goal of the food, agriculture, livestock, and fisheries sectors is to use environment friendly

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

Overall Sectoral Progress in this Thematic area

Rice is the main staple food consumed in Bangladesh. Over the last three decades, Bangladesh has managed the accomplishment of producing enough rice to keep up with population growth and has been self-sufficient in rice production since 2012[36]. Thus, in terms of calorie availability, it has achieved self-sufficiency, and most recently also in meat and fish production, as per Bangladesh Economic Review, 2018. Concomitantly, people's economic capacity to access food has risen through a rapid decline in the poverty headcount -from 48.9% in 2000 to 23.2% in 2016[37], primarily due to an increasing purchasing power even among the poorest[38].

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

The 2016 Household Income and Expenditure Survey (HIES) showed that the per capita intake of rice, a staple food of Bangladesh, decreased in 2016 from 2010 with the lower consumption of wheat and potato in 2016 in both rural and urban areas (HIES, 2016). The consumption of rice at national level decreased from 416 gr/capita/day in 2010 to 367 gr/capita/day in 2016 against the recommended range between 270-450 gr/capita/day, amounting to about 56% of dietary energy/capita/day (Dietary Guidelines for Bangladesh 2015). Though the rice consumption decreased, still rice intake was above the recommended amount in rural areas but it was lower in urban areas. The reduction in rice consumption was less among poor (9%) than the non-poor (13%), as rice still constitutes the major source of calorie of the poor peoples' diet.

On the other hand, protein sources food items have showed a mix picture. For instance, consumption of pulse, poultry, beef, fish, mutton, and eggs has increased in both rural and urban areas from 2010 to 2016. Only the fish intake has exceeded the desirable amount in both urban and rural areas. But, the per capita consumption of milk and milk products, sugar and fruits decreased in both rural and urban areas. Although vegetable consumption did not change at the national level, it increased in urban areas with a decreasing consumption in rural areas from 2010 to 2016. Improvements in supply chains may increase availability of specific food types but may not necessarily increase the nutrient value within the food type. For example, the fish species farmed in ponds have lower nutritional value compared to captured fish species, resulting in a decrease of micronutrient intake from fish over recent years despite increased fish consumption (Bogard et al, 2017).

[36] USDA Foreign Agriculture Service. 2015. Grain and Feed Annual.
[37] http://www.worldbank.org/en/results/2016/10/07/bangladesh-growing-economy-through-advances-in-agriculture
[38] http://www.worldbank.org/en/results/2016/10/07/bangladesh-growing-economy-through-advances-in-agriculture

The national average of per capita calorie consumption (2210 Kcal/capita/day) decreased in both rural and urban areas from 2010 to 2016. Per capita calorie intake was higher in rural areas than urban areas (2240 Kcal/d vs 2131 Kcal/d respectively), but in urban areas per capita per day calorie intake reduced markedly to 2130 in 2016 from 2245 in 2010[39] . Reduction of rice/cereals consumption could be the potential factor in decreasing calorie intake (HIES, 2016) which is though, an indication of positive move towards more non-cereal foods. Cereals are the main food items that contribute to the major portion of energy to the total energy intake of Bangladeshi people. Cereals' contribution to energy was higher in rural areas than in urban. Cereals contributed to 80% of the total energy in 1992 which has reduced to 70% in 2010 to 64% in 2016 against the NPAN2 target of 60% by 2025 (NPAN2) and 56% target of N4G 2021 commitments by 2030. The proportion of decline was higher in urban areas than in rural areas (23% vs 11%). in 2016 (HIES, 2016). Amidst these gains, more efforts are needed with regards to dietary diversity, as consumption of good quality protein and bioavailable micronutrient-rich foods is still limited.

Production of some staple foods

Rice has been the main staple food consumed in Bangladesh; the country has been self-sufficient in rice production since 2012.

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: The production growth of fruits and vegetables slightly increased between 2017-18 to 2018-19. Major leafy vegetables including brinjal, pumpkin, tomatoes, and red amaranth (lal shak) all increased in annual production from 2017-18 to 2018-19, except for 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).

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. 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%. Although production of meat, eggs and milk is increasing every year, the percentage of increase is still low (Table 9)

Progress of the two indicators set in NPAN2

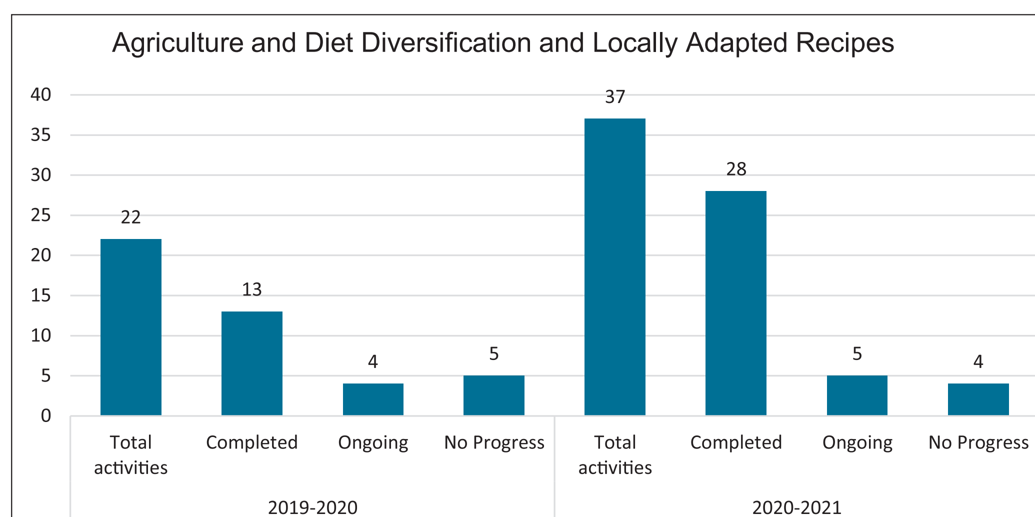
Table 9 shows that in 2016 (HIES 2016) the per capita intake of vegetable has increased marginally from 166.1 gm (from NPAN2 baseline in 2010) to 167.3 gm in 2016 against the target NPAN2 of 300g by 2025. On the other hand, fruit intake has decreased from 44.7 gm (from NPAN2 baseline in 2010) to 35.78 in 2016 against the NPAN2 target of 100 grms by 2025. It is also seen in table 9 that, the % share of total dietary energy from consumption of cereals is moving towards positive direction. Energy intake from cereals has decreased from 70% (from NPAN2 baseline 2010) to 64% in 2016 against <60% target of NPAN2 by 2025.

[39] Household Income and Expenditure Survey (HIES) 2016.Bangladesh Bureau of Statistics (BBS), Ministry of Planning.

Table 9: Status of the progress of consumption fruits & vegetables and share of dietary energy from cereals

SL.	Indicators	NPAN2 Target 2025	Baseline of NPAN2	Progress	Sources
17	Per capita consumption of fruits and vegetables	Fruits: 100g	Fruits: 44.7 gm	Fruits: 35.78 gm	(HIES 2016)
		Vegetables: 300g	Vegetables: 166.1 gm	Vegetables: 167.3 gm	
18	% share of total dietary energy from consumption of cereals	<60%	70% (HIES 2010)	64% (HIES 2016)	HIES

Implementation status of nutrition sensitive activities included in Annual Workplans in Fiscal Year 219-20 and 2020-2021.



In 2020-21, total 11 ministries were involved in this Thematic area and covered 37 activities. Among them 28 activities were successfully completed (76%); 4 activities were ongoing (11%), and 4 (11%) activities had no progress. It was observed that both number of activities and their implementation status have increased in 202-21 Fiscal Year (FY) compared to 2019-20 FY. For instance, 37 activities related to diet diversification were included in 2020-21 compared to 22 activities in 2019-2020. In addition, in 202-2021 FY 28 out of 37 (76%) activities were completed as opposed to 13 (59%) out of 22 in 2019-20.

3.4 Thematic area 3: Social Protection

3.4.1 Poverty-Malnutrition Nexus

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

Wealth status is significantly associated with proper complementary feeding practices. The acceptable dietary practice increases with the increment of households' wealth status. The proportion of children getting acceptable diet was two times higher among the children living with the richest family compared to the poorest family. Nonetheless, more than half of the children belong to the richest family were not getting acceptable diets between2016 to 2019 [40]. The proportion of acceptable dietary behaviour decreased in all wealth status in the last 5 years. CWS-2016 study found that one fourth (25%) of the children of the poorest household had acceptable diets while 46 % of the children of the wealthiest family had acceptable diets in urban areas. Acceptable dietary practices are not satisfactory across all wealth group and the poorest families are practicing the lowest.

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

Coverage of Social Security Programmes

The 2016 HIES data shows that 27.8% of the households have received benefits from SSPs during the previous 12 months of the survey. However, MICS 2019 report reveals that 55% of the household members from two of the lowest wealth quintiles received some/any type of social transfer in previous three months of the survey. As per the recent Bangladesh Social Protection Public Expenditure Review of the World Bank, 2021 while urban poverty was found as 18.9%, coverage of SSPs in urban areas was found to be only 10.9%, whereas coverage of SSPs in rural areas was found to be 35.7% against rural poverty of 26.4% (World Bank, 2021)[41] . The study identified only 5% of SSP expenditure being exclusive to urban areas.

Progress of NPAN2 Indicators related to this Thematic area.

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

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

[40] BDHS (2017-18)

[41] World Bank. 2021. Bangladesh Social Protection Public Expenditure Review. World Bank, Dhaka. © World Bank. https://openknowledge.worldbank.org/handle/10986/36236 License: CC BY 3.0 IGO."

Indicator 3. Number of upazilas covered under VGD program to provide nutritionally enriched fortified food. 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 two of the largest government's Social Security Programmes (SSPs) namely, the vulnerable Group Development (VGD) Programme and the Food Friendly Programmes (FFP). Currently VGD and FFP are being implemented in 94 and 24 Upajillas respectively.

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

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

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

SL.	Indicators	NPAN2 Target 2025	Baseline of NPAN2	Current status
1	% of women age 20-24 who were first married by age 18	30%	59%	51.40% (MICS 2019)
2	Number of Social Safety Net Programs which incorporated nutrition sensitive & nutrition specific objectives	50%	10% (assumption)	18 (67%) out of 27 large SSPs (BNNC, SSPs review)
3	Number of upazilas covered under VGD program to provide nutritionally enriched fortified food	50%	Nill	Currently VGD and FFP are being implemented in 94 and 24 Upazillas respectively
4	% of children (36-59 m) who are attending an early childhood education program	30%	13%	18.90% (MICS 2019)
5	% of women who completed secondary/higher education	90%	14%	Secondary (59.7%) Bangladesh Education Statistics 2021
				Higher (49%) World Data Atlas 2014

3.4.2 Implementation status of nutrition sensitive social security activities included in Annual Workplans in Fiscal Year 219-20 and 2020-2021.

Under this Thematic area in 2020-21, a total of 11 ministries included 105 nutrition sensitive social security activities into their Annual Nutrition Workplans (ANWs) compared to 96 activities in 2019-20 ANWs which is about 8.5% increase. According to BNNC dashboard out of the total 105, 35 (33.3%) activities were successfully completed, 15 activities (14%) were still ongoing and 55 (52%) activities with no progress. It is also observed that though the number of planed activities increased but the number of activities completed remained same in both Fiscal Years.

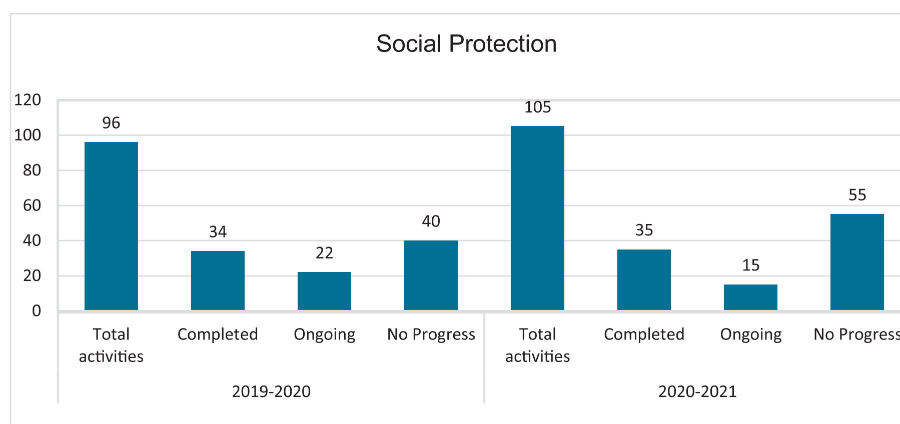


Figure 15: Implementation Status of Nutrition Sensitive Social Security activities under the Thematic area included in Annual Workplans in Fiscal Year 2019-20 and 2020-21.

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

3.5.1 Overall Sectoral Progress in this Thematic area

NPAN2 stipulates that building political and society-wide awareness and commitment to food and nutrition security, advocacy and social mobilization are key. A set of initiatives were undertaken on advocacy component during the period of 2020-21 to advance nutrition through improved advocacy by relevant sectors at all levels.

Key achievements under Advocacy area

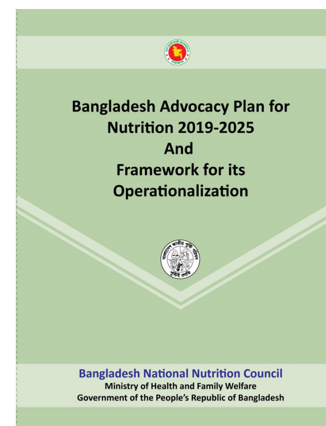
National Level

- A costed 'Bangladesh Advocacy Plan for Nutrition' for the period 2019-2025. A report on priority action plan with costing and a guideline for organizing events targeting different audience groups, as framework for operationalizing the advocacy plan.
- Special publication on the Mujib Barsha (100th birth anniversary of the Father of the Nation) titled "Towards Improved Nutrition".
- Development and dissemination of video documentary on BNNC, Info-graphs on gender and nutrition, BCC materials based on messages on COVID-19 etc. as part of promotion of gender in nutrition.
- One round table discussion at the leading print media house with nutrition stakeholders followed by publication of a full-page supplement.
- One workshop with the Parliamentarians in which 21 (6 Female, 15 Male) participated.
- Advocacy meeting during the celebration of International Women Day.

Subnational Level

Total 54 district level advocacy meetings organized. More than 2000 participants including members of DNCC, GOB officials, elected public representatives, civil society activists and media personnel were sensitized on NPAN2

3.5.2 Bangladesh Advocacy Plan for Nutrition 2019-2025 and the Framework for its Operationalization



BNNC formulated the Bangladesh Advocacy Plan for Nutrition 2019-2025 (the Plan) in 2019. The Goal of the Plan is to strengthen political and legal framework, increase commitment of stakeholders, change in organizational behavior towards nutrition agenda, and enhance resource mobilization for nutrition. The Plan was developed through processes of key informant interview, stakeholder consultation, development and validation workshops, and finally approval by the Advocacy and Communication Platform under NPAN2. The Plan set multisectoral coordination, capacity and leadership development and engagement of stakeholders as its Strategies. The Plan identified key advocacy issues with required action in Bangladesh. Further the Plan selected 12 audiences (Person and Entities) for Advocacy including Parliament members and national level political leaders; officials in Prime Minister's Office, Relevant Line Ministries, Divisions, Directorates, Local government bodies, Media, and Private sector etc.

With aim to materialize partnership and resource mobilization for operationalization of the Advocacy Plan, a 'Framework for Operationalization of the Advocacy Plan for Nutrition, Bangladesh' was also prepared in 2020. The Framework proposed that half of the total cost would be coming from GOB sectoral sources (Ministry Plans, Operational Plans under HPN sector and National Nutrition Week allocation, etc.), and other half would be incurred through partnership between the BNNC and Development Partners (DP) and other interested agencies. For the partnership arrangement, a Priority Action Plan (PAP) for the period of 2020-2025 was prepared based on some set criteria as well as use it as basis for negotiation with potential Partners.

The following strategies are identified for the advocacy plan:

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

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

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

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

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

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

- Limited understanding of nutrition and its impact
- Inadequate investment in nutrition
- Weak system of expenditure tracking
- Inadequate coordination among sectors
- Not enough importance paid on maternal nutrition and infant and young child feeding
- Not enough importance paid on WASH
- Inadequate consumption of diverse food
- Limited human resource
- Inadequate legislation and regulation
- Inadequate research and its dissemination

- o Limited participation of private sector
- o Inadequate enforcement of existing legislations
- o Attention to urban and hard to reach population nutrition

1. Progress of Nutrition SBCC activities

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

2. Observation of National Nutrition Week (2020-2021)

Due to the COVID-19 pandemic situation the government of Bangladesh observed the National Nutrition Week with a very low-profile from April 23-29, 2020 with the previous theme. The week was launched through video conferencing connecting with sub-national levels from central DGHS conference room. During the observance of the nutrition week country was under in lock down due to COVID-19. Hence as part of the day nutritious food package was distributed to the under five children in district and Upazila level. Under the leadership of The Ministry of Health and Family Welfare (MoHFW), Institute of Public Health and Nutrition (IPHN) and Bangladesh National Nutrition Council (BNNC) along with relevant stakeholders, elaborate programmes were undertaken nationwide. The theme of nutrition week was - "While thinking about food, think about nutrition too" **"খাদ্যের কথা ভাবলে পুষ্টির কথা ও ভাবুন।"** It is an achievement also because the last celebration of Nutrition week to Received place log back in 1999.

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

3.5.3 Progress of NPAN2 Indicators related to this Thematic area.

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

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

SL.	Indicators	NPAN2 Target 2025	Baseline of NPAN2	Progress	Sources
1	Number of ongoing comprehensive coordinated multi-sectoral, multichannel advocacy and communications campaign	10	0	0	
2	Change in per capita consumption of:	i.<5 gm/ person/ day (WHO)	i. Salt: not Available	i. Salt: not Available	
	i. salt				
	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)

3.5.4 Implementation status of Advocacy and SBCC activities included in Annual Workplans in Fiscal Year 219-20 and 2020-2021.

It is observed that in FY 2020-21, total 162 advocacy related activities were included in Annual Workplans of various ministries of which 65 (40%) were completed, 24 (15%) were in progress and 73 activities (45%) with no progress. On the other hand, in FY 2019-20, total 132 advocacy activities were included in Annual Workplans of which 47 (36%) were completed, 49 (37%) activities were in progress and 36 (27%) with no progress (Fig. 16). Though there has been some improvement in FY 2020-2021 still the completion rate remains low.

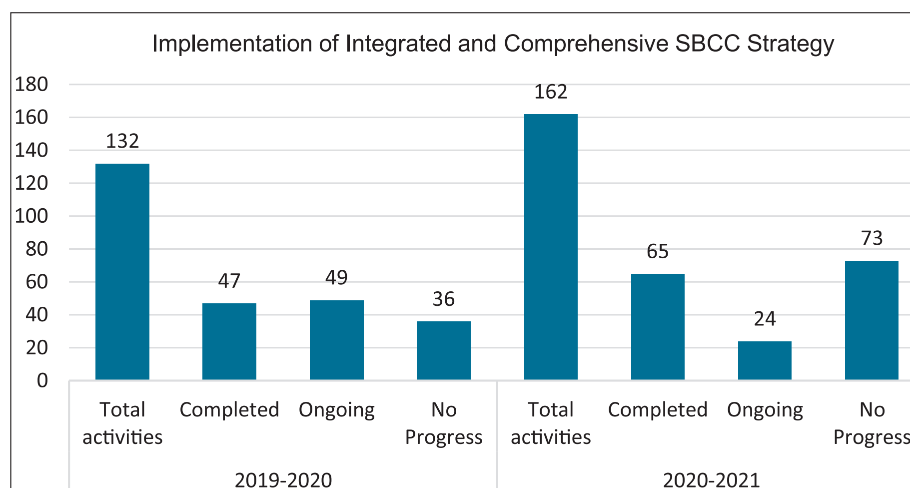


Figure 16: Status of SBCC activities included in Annual Workplans in FY 2019-20 & 2020-21.

3.5.5 Activities Conducted under Advocacy to Operationalize NPAN2

The activities under advocacy thematic area have been completed very recently. Typically, it requires some time for advocacy related activities to take effect. So, the substantive impacts of activities undertaken by BNNC in advocacy area may not be clearly visible yet. However, some early signs of impacts are evident. Particularly, the advocacy activities with relevant partners enabled allocation of resources in a number of activities from non-government partners (e.g. arrangement of NNW, arrangement of special advocacy

programs of BNNC), which reduced the financial pressure from BNNC and increased ownership of all the stakeholders. The framework for operationalizing the advocacy plan is being used by BNNC and relevant ministries in the respective work plans and in partnership with development partners for future interventions.

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

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

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

3.6 Thematic Area 5: Monitoring, Evaluation and Research

3.6.1 Overall Progress in this Thematic area

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

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

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

2. A strategy to conduct Operational and Implementation Research has been developed by BNNC with the support from partners and the Scaling Up Nutrition (SUN) Academia and Research Network (SARN). This strategy aims 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 research. For developing the strategy on implementation and operational research, two studies were commissioned to review the existing research policies and strategies on specific and sensitive nutrition programs of different organizations. A consensus building workshop and prioritization of research topics was organized with participants from research organizations, academic institutions, universities, NGOs, donors and operation people with experience in program implementation. Finally, prioritization of research needs, and topics were done during the workshops.

3. BNNC along with partners developed a "policy guideline including a broad protocol for nutrition surveillance system during and post COVID-19 situation" to support government in combating malnutrition in Bangladesh. For development of the nutrition surveillance guideline, all nutrition surveys conducted since 1962 till to date, all surveillance systems (past and current) were reviewed. It covers both humanitarian and developmental dimensions of nutrition both at short, intermediate, and long intervals. The Guideline also provides an operationalization framework of the system including the coordination mechanism among implementation agencies, supporting partners and a sustainable plan. It also provides estimated cost to establish such a system.

4. BNNC has developed a web-based interactive visual comprehensive mapping platform of NGOs partners who are currently working on nutrition sensitive interventions across the country. It would help BNNC to identify potential partners, overlaps or gaps of the nutrition sensitive programmes. This would also help the DNCC and UNCC for planning of future programs on nutrition sensitive interventions in their respective operation areas for better operationalization NPAN2.
5. To assess degree of functionality of district and upazilla nutrition coordination committees a web-based multisectoral nutrition planning and monitoring system including a set of tools has been developed based on functions of DNCCs and UNCCs to assess and inform the degree of functionality of these committees. DNCCs and UNCCs functions include planning, budgeting, overseeing implementation, and monitoring of multisectoral nutrition activities. The system has public access and a good visualization as per program demand, so that decision makers can easily access the information and ensure its utilization for decision making. Information in the dashboard is organized into the following categories: (i) monitoring indicators to track the progress of NPAN2; (ii) monitoring of DNCC/UNCC to assess functionality and progress of MMNP activities; (iii) Bangladesh nutrition profile based on composite indicators; and (iv) progress tracking of nutrition work plans on of relevant ministries.

6. BNNC jointly with Ministry of Finance is developing a Multisectoral nutrition financial tracking system for the key ministries (seven ministries who spend 92% of all nutrition budget) with the technical Assistance and financial support from SUN global secretariat and UNICEF. In this regard, a concept note was prepared and approved by the Standing Technical Committee (STC) of BNNC. In addition, a guideline to establish the nutrition budget tracking system was prepared. Oxford Policy Management (OPM) has been engaged to undertake this task.

Implementation status of M&E activities included in Annual Workplans in Fiscal Year 219-20 and 2020-2021.

In FY 2020-21 total 11 M&E activities under five (5) ministries were included in their Annual Workplans. According to BNNC dashboard under M&E thematic area, seven (7) activities out of total 11 were completed (64%), one (9%) activity was ongoing and three (27%) activities without any progress. (Fig 16). It is also

observed that in FY 2019-202 total 20 M&E activities were included of which five (25%) were completed and three (15%) were on progress and 12 (60%) with no progress.

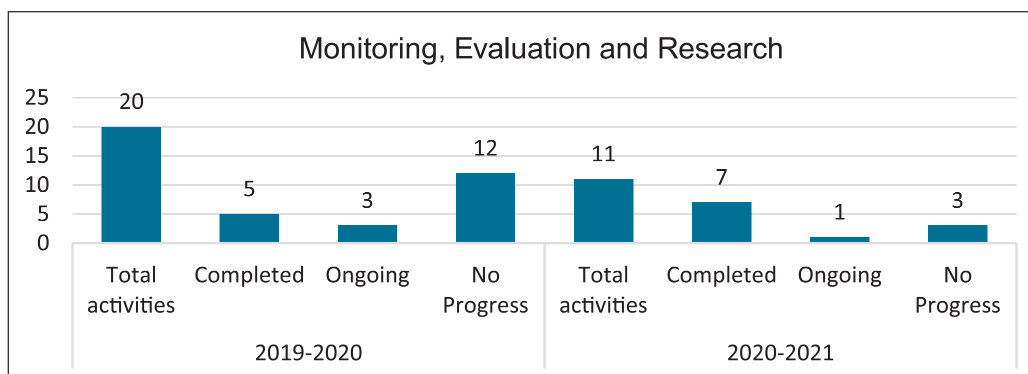


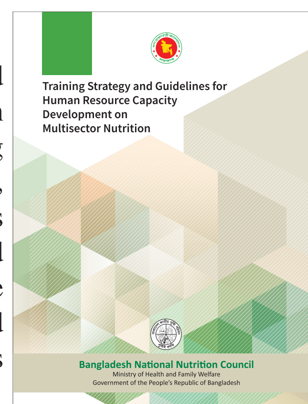
Figure 17. Monitoring, reporting and research of nutrition priorities

3.7 Thematic Area 6: Capacity Building

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

3.7.1 Overall Progress in this Thematic area

Strategy and Guideline for HR Capacity Development



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

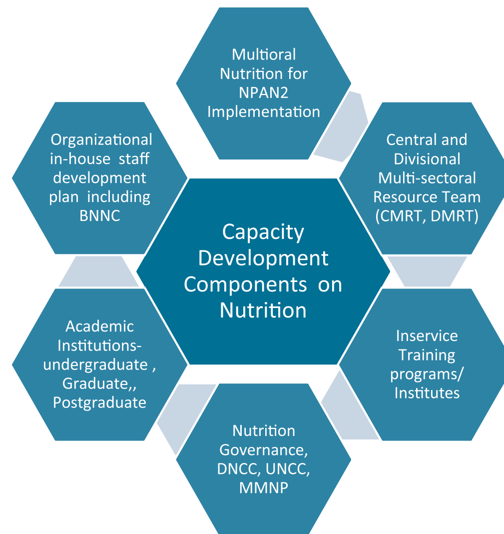


Figure 18: Components of Capacity Development System on Nutrition

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

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

Organizational level actions: (Sectors/Ministries/training institutes)
- Competencies, Knowledge, Skills, and Attitudes of human resources of line ministries.
- Capacity and role of BNNC to coordinate, monitor and evaluate.

Workplace level actions:
- Job descriptions updating through review and inclusion.

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

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

Strengthening of BNNC office

An essential part of an effective functioning NPAN2 would depend on building and developing the institutional capacity of BNNC and other aligned sectors. This would entail exploring (including an identification of the technical areas of expertise of the institutions) and establishing linkage with existing institutions at home and abroad. This would help to develop systems for monitoring and evaluation including establishing a nutrition data hub, budget tracking mechanism, policy review and advocacy for resource mobilization.

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

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

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

Implementation status of capacity building activities included in Annual Workplans in Fiscal Year 219-20 and 2020-2021.

It is observed that in FY 2020-21 overall implementation performance of capacity building activities improved in 2020-21FY compared to FY 2019-20. For instance, total 73 activities were included in various Annual Workplans of relevant ministries/divisions/departments of which 33 (45%) activities were completed, 12 (16%) were in progress and 28 (38%) activities with no progress. On the other hand, in FY 2019-20, total 77 activities were included in Annual Workplans of various ministries of which 27(35%) were completed, 14 (18%) were in progress, and (47%) were with no progress.

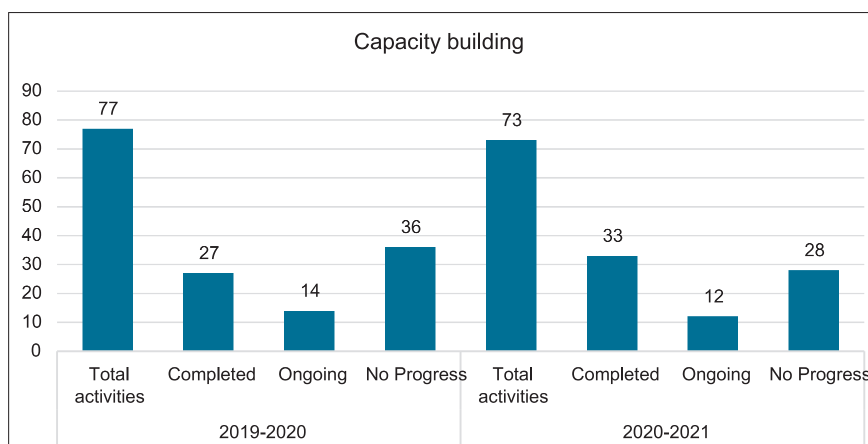


Figure 19: Status of Capacity Building activities in Annual Work Plans in FY 2019-20 &2020-21.

Capacity Building Activities Undertaken to Revitalize BNNC and Operationalize NPAN2.

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

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

CHAPTER-4

Nutrition Governance Institutionalization, Coordination and Implementation Mechanism

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

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

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

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

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

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

4.1 Key Achievements under Policies and Planning Thematic Area during the reporting period.

National Level

- A comprehensive planning guideline prepared for annual nutrition work plans for the respective ministries, divisions, and departments (including OPs).
- Annual nutrition work plan developed for 21 ministries for those two consecutive years.
- Annual nutrition work plan developed for 13 OPs under MOHFW and City Corporation.
- Jointly with the Cabinet Division, a comprehensive review of 27 SSPs was completed; prepared a policy brief along with recommendations to make them more gender and nutrition sensitive.
- As a response to COVID-19 pandemic, jointly with UN agencies in Bangladesh a costed Immediate Socio-Economic Response Framework (iSERF) was developed.
- Strategies and actions regarding nutrition was incorporated into the 8th FYP.
- Jointly with UN agencies, a costed Global Action Plan (GAP) for Wasting resuction in Bangladesh was prepared.
- Development and approval of the rollout strategy for sub-national level nutrition planning, which included a MMNP package, formation of CMRT/DMRT including TORs.
- BNNC's own annual work plans were developed for FY 2019-20 and 2020-21.

Subnational Level

- Tools and guidelines were prepared for subnational level planning.
- Annual nutrition work plan developed for 10 districts and 81 upazilas.

Other Coordination with partners

- **Building institutional cooperation through MoU**
  During 2020-21, BNNC fostered partnership by signing Memorandum of Understanding (MoU) with 11 partner organizations to support operationalization of NPAN2 and other mutual areas of interest. The MoUs ensured gaining better understanding of the scope of works, roles and responsibilities of organizations, synchronizing efforts to maximize impact of nutrition actions. Apart from this, UNICEF instrumented a Rolling Workplan (RWP), as part of its wider cooperation agreement with GoB, with strong emphasis on the joint collaboration with BNNC to support multisectoral nutrition governance, coordination, and planning, as well as the tracking of nutrition investment.

- **Mapping of nutrition projects and partners at sub-national level**
  In early 2021, BNNC started discussion with the funders, lead agency and implementers of nutrition governance projects operating in different areas in Bangladesh to bring them under a common umbrella for ensuring harmony and coordination in multisectoral nutrition governance, coordination, planning and monitoring at sub-national level. According, a mapping exercise (WHO WORKS WHERE) has been completed and started working with them.

Planning and Coordination Activities Undertaken to Revitalize BNNC and Operationalize NPAN2.
Planning

BNNC has created a culture and sustainable mechanism of planning, based on which the relevant government entities will be able to design, review and update the relevant nutrition policies and plans in future without significant external assistance. Moreover, it ensured participation, and hence, ownership of the relevant ministries, as opposed to development of plan by external entities. The consultative process of development of individual annual nutrition work plans jointly is a shift in planning process and culture for government machineries in Bangladesh, which results in synergy among the ministries, while ensures avoidance of duplication.

Moreover, the pool of focal persons and alternative focal persons established a permanent channel of internal communications across the ministries to ensure coordination and ease of communications - which are also vital for effective planning. The annual nutrition work plans in three subsequent years also guaranteed mainstreaming of NPAN2 into the respective ministerial and departmental proceedings. Moreover, these work plans are guiding documents for implementation and monitoring MMNP by the implementing agencies under the ministries and departments. The rollout strategy guided partners to assist DNCC and UNCC in planning nutrition activities and is expected to be scaled up throughout the country.

The rollout strategy for sub-national level (district and upazila) nutrition planning has been officially approved by the STC of BNNC. The rollout of annual nutrition planning by DNCCs and UNCCs has started in 14 districts and 81 upazilas. It is expected that, BNNC will continue to support DNCCs and UNCCs for scaling up rollout process in remaining districts and upazila. To expedite the process government has created a multisectoral pool of resource persons from government and partners namely the CMRT and DMRT at central and divisional levels. BNNC has trained/ oriented the members the CMRT at central level and four (4) DMRT at divisional levels, which BNNC will continue in all other remaining divisions.

Moulvibazar- one of the pilot districts to implementing NPAN2

As part of the GoB collaboration, Suchana has been working with eight ministries including Ministry of Health and Family Welfare (MoH&FW),

One of the objectives of Suchana is to strengthen nutrition governance at subnational level, through strengthening the technical capacity of government staffs, including system strengthening. Suchana has facilitated the first district nutrition coordination committee meeting under the leadership of BNNC. Following the meeting, Suchana has sensitized platform members and provided technical support to the respective department to prepare their annual nutrition plan.

Up until now, Suchana has been providing facilitation support to the district and upazila multisectoral nutrition coordination committees, in conducting bi-monthly platform meetings in three districts, including monitoring of implementation. This is expected that these districts will continue preparing their yearly multisectoral nutrition plan and implement accordingly, which would be reflected in the annual performance agreement (APA) of the respective department as appropriate.

Meanwhile, Suchana has extended facilitation support to prepare the annual nutrition plans and submit at the sub-national level using UNCC platform. Once all the plans were submitted to the Civil Surge office, it was reviewed and compiled with the support of Suchana. Suchana has documented the entire process and lessons learned and scaled it to the Sylhet district in 2021 and Habiganj district in 2022, under the leadership of BNNC.

LEAN – A Case Story on Local Nutrition Governance

This case study captures an approach of nutrition governance process led by the Union Parishad (UP), the bottom tier of local government structure in Bangladesh. The story is derived from the implementation of a project titled ‘Leadership to Ensure Adequate Nutrition (LEAN) is funded by the European Union (EU). LEAN is a 6-partner consortium project, led by United Purpose, aims to contribute to improving maternal and child nutrition in Chittagong Hill Tracts (CHT) region; and is designed to go beyond scattered small scale direct interventions and focused on sustainable & integrated nutrition governance towards nutrition-sensitive interventions linked with nutrition-specific services through a multi-sectoral coordinated approach to fulfil the desired goal of 2nd National Plan of Action for Nutrition: 2016-2025 (NPAN2). The Government of Bangladesh (GoB) approved this NPAN2 with the goal of improving the nutritional status of all citizens, including children, adolescent girls, pregnant women, and lactating mothers, ensuring the availability of adequate, diversified, and safe food, and promoting healthy feeding practices, strengthening nutrition-specific, or direct nutrition interventions, as well as, strengthening nutrition-sensitive, or indirect nutrition interventions. The primary prerequisite for reaching the NPAN2 targets is to establish multi-sectoral and multi-stakeholder coordination and integration among government ministries and agencies, as well as other stakeholders involved in providing nutrition services at the grassroots level.

According to the directions from NPAN2, the Ministry of Health and Family Welfare (MoHFW) circulated a Terms of Reference (ToR) for District and Upazila level Nutrition Coordination Committees (DNCC & UNCC) in August 2018. LEAN has been engaged in strengthening these committees in CHT districts (Khagrachari, Rangamati and Bandarban) following the ToR. The Global Alliance for Improved Nutrition (GAIN) as a consortium partner has been leading implementation of the nutrition governance portfolio of LEAN. In course of working with D/UNCCs it is revealed that Union Parishad (UP) has a good role for accelerating nutrition services at the community level, however, there is no directives in NPAN2 regarding UP level any platform. LEAN persuaded this agenda and facilitated D/UNCCs and

relevant stakeholders to develop a UP led Multi-Stakeholders Platform (MSP) to steer a multi-sectoral coordination mechanism with various service providing entities (government, non-government, private sectors etc.) along with local government bodies. LEAN facilitated 77 UPs under 18 Upazilas of 3 CHT districts, and in turn, they developed Union-MSP in each UP with a defined operation procedure was approved by the three Hill District Councils (HDC). The Union-MSP is headed by the UP Chairman and consisted of elected UP members, standing committees, traditional leaders (Headman, Karbari), local elites, and frontline representatives from different line agencies and stakeholders. Union-MSP focuses on integrated nutrition governance process through a coordinated approach with grassroot level service providing organisations.

LEAN has been providing capacity building training and support to UP and empowering them to emphasise nutrition as a priority agenda. The Union-MSP members are trained on basic nutrition and food system, nutrition-sensitive programming, annual plan development process and scope of increasing budget allocation for nutrition activities. All 77 Union-MSPs developed their annual nutrition action plan since last two years. Their plans are varied from UP to UP as per local demand and context. LEAN facilitates UP to analyse their annual budget and provided technical support to develop multi-sectoral annual nutrition action plan based on local resources and in line with the ministries'/agencies' operational plans. Some of their planned activities are included in the UNCC-DNCC's annual plans.

LEAN also facilitates UP to review the annual action plan to track the implementation process engaging people from all relevant departments to provide services in a coordinated manner. During review process of annual nutrition action plan, it is found that more than 80% MSPs accomplished 60% of their planned activities. They faced different challenges of planning and implementation of nutrition activities like budget gap, nutrition knowledge gap, inaccessible communication in remote areas, traditional food habit, superstition in ethnic community, poverty, and insufficient income of UP. Shortage of workforce in different sectors is also an identified barrier to disseminate nutrition messages and services for the communities. The MSPs raised that a district-based designated focal person should be placed to keep tracking of nutrition action plan at UP-MSP, UNCC and DNCC level in coordination with respective departmental nutrition activities, as well as, for further persuasion for accelerating implementation to achieve NPAN2 goal. Through implementing the MSP approach at the UP level, LEAN learnt that a bottom-up approach is more effective to serve the people as the UP-MSP considers local needs, and places demand to concerned agencies for getting on-time quality services. The community people also can raise their demand through the Union-MSP to UNCC to place the demands to DNCC and other relevant line agencies for ensuring services. Strengthening the intra- and inter-departmental coordination is especially important to make the UP-MSP more functional.

This case study is prepared based on the assessment was conducted in consultation (KII and FGD) with Union-MSPs, UNCCs and DNCCs of three CHT districts, and relevant stakeholders, as well as review of relevant documents and reports. It is to be concluded that LEAN has aimed to build a model of community-based, multi-sector coordination platform to promote nutrition-sensitive and nutrition-specific interventions using existing government structures and resources. LEAN brought together actors from the public, private and corporate sectors, non-governmental organizations, and local government bodies at Union Parishad level to understand whether a multi-sector approach is beneficial in achieving significant nutrition gains. It is learnt that the UP level Multi-Stakeholder Platform is functional to coordinate nutrition activities being only a multi-sectoral forum rooted in the bottom tier of the local government structure that can thought for nationwide scale up in Bangladesh.

Coordination

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

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

4.1.1 Financial performance of NPAN2 during the reporting period

The status of financial progress for implementation of NPAN2 cannot be measured in monetary means, as it has no specific budgetary allocations. Considering this limitation, a qualitative appraisal of BNNC's advocacy efforts for building awareness for increased investment and resource mobilization would better serve the purposes. In this regard, it is notable that the Honorable Prime Minister, at the first Council Meeting of revitalized BNNC, instructed the concerned authorities for the inclusion of nutrition into all related ministries' work plans with budget from their own sources as needed. Following this directive, Cabinet Division issued a letter to all ministries to include nutrition activities into respective Annual Plan with budget.

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

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

Ministry	Financial Status (In lac taka)			
	Allocation		Expenditures	
	2019-20	2020-21	2019-20	2020-21
Ministry of Health and Family Welfare	17,303.51	18,701.24	3,847.43	9,785.14
Ministry of Finance	5,289.67	4,789.75	2,026.38	4,750.00
Ministry of Food	255.99	530,552.80	15.99	0.00
Ministry of Religious Affairs	10.80	5.40	10.80	5.40
Ministry of Agriculture	670.00	48,922.00	490.50	40,053.99
Ministry of Commerce	0.00	0.00	NA	0.00
Ministry of Fisheries and Livestock	41,026.62	9,224.92	54,441.17	9,183.10
Ministry of Education	19,533.88	0.00	9,606.27	0.00
Ministry of Science and Technology	67.75	81.35	40.00	97.40
Ministry of Local Government, Rural Development and Cooperatives	563,748.49	301,572.48	182,058.17	1,976.51
Ministry of Water Resources		1,013.43		1,123.67
Ministry of Women and Children Affairs		184,005.29		183,914.71
Ministry of Youth and Sports	8,180.23	8,958.65	8,144.23	7,878.60
Ministry of Disaster Management and Relief	146.60	7,000.00	147.54	5,998.00
Ministry of Social Welfare	24,249.00	4,468.00	NA	4,398.00
Ministry of Environment, Forests and Climate Change	20.00	493.07	NA	288.07
Ministry of Labour and Employment	250.00	10.50	125.00	10.50
Ministry of Chittagong Hill Tracts Affairs	138.00	264.95	111.57	298.73

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

It is seen from the table that 18 ministries have submitted workplans with budget for the 2019-20 and 2020-21. Expenditure was received for two Fiscal Years 2019-20 and 2020-21. Out of 18 annual workplans from the ministries, 11 workplans have complete information for three years. The preliminary analysis suggests that, in 2019-20 FY a total of BDT 636,831.67 lac was budgeted by these 11 ministries of which BDT 251,442.79 (39%) was spent. In FY 2020-21 BDT.584,549.96 was budgeted of which 265,075.75 (45.3) was spent. The fund utilization rate has been low. As we are aware that the implementation of all programs across the board were badly hit by COVID-restriction in FY 2019-20 and 2020-2, thus the low utilization of nutrition budget could be partly explained due to similar reason. Allocation of budget for nutrition activities by these ministries is unpresented in Bangladesh history. BNNC should continue its advocacy with these ministries so that this practice is institutionalized, sustain and increase expenditure from current low leval.

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

4.1.2 New Development in Nutrition Sector needing Immediate Response

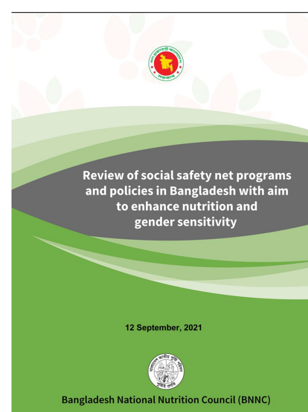
This section highlights a few activities/events which were undertaken by BNNC as needed during the reporting period though they were not included in original NPAN2 documents. These activities/events were not included as they could not be anticipated during the time of design/formulation of the NPAN2.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

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

4.1.3 Review of Multisectoral Nutrition Related Policies in Bangladesh 2021

BNNC conducted a review of nutrition related (specific and sensitive) policies, plans, strategies, legislations of the Government and development partners in Bangladesh to determine whether and how these have adequately addressed and incorporated nutrition issues. The objective was to create potential opportunities to mainstream and operationalize nutrition issues into policies and programs of relevant ministries and development partners. A total of twenty-four policies of the Government of Bangladesh (GoB) and two relevant policies of the UN and the country development strategy of USAID were reviewed. A policy Brief was also prepared.

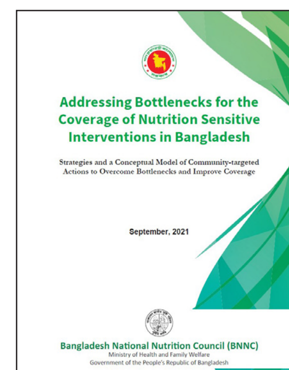
Review of social safety net programs and policies in Bangladesh with aim to enhance nutrition and gender sensitivity



BNNC in collaboration with the Cabinet Division and development partners have conducted a review of relevant social security programmes supported by the Government of Bangladesh (GoB) and development partners to determine whether these programmes are aligned with NPAN2 and National Social Security Strategy (NSSS, 2015) outcomes, have adequately addressed and incorporated nutrition activities. A total of twenty-one SSPs of GoB managed and six SSPs of development partners' managed were reviewed. Lessons learned from the extensive review of relevant SSPs in country, regional and international settings were also documented, accordingly recommendations provided.

A 'Policy brief' has been prepared based on the findings and recommendations which would immensely help the policy makers to appropriately design nutrition sensitive SSPs in future for the improvement of the livelihood, food security and nutrition of the vulnerable population in Bangladesh. The review will have profound impact in mainstreaming nutrition into social protection programs of different ministries by addressing the underlying and basic determinants of malnutrition as envisaged under NSSS, enable equitable access for vulnerable population into nutrition interventions, improve nutrition status and eventually will contribute to the poverty reduction

4.1.4 Assessment of the Key Bottlenecks for the Coverage of Nutrition Sensitive Interventions in Bangladesh

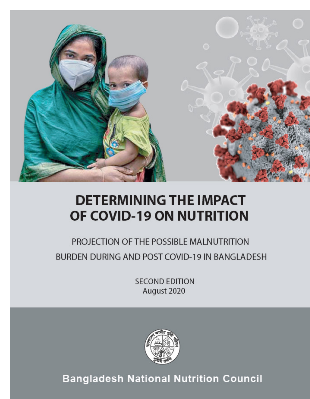


BNNC conducted a bottleneck analysis to identify the constraints hindering the coverage of nutrition sensitive interventions. This was not only the first assessment of this nature of the country, but very few countries have ever done such an assessment. A rigorous qualitative research methodology was conducted, involving relevant national and international experts from government, academies, research institutes and development entities. The analysis identified the prevailing bottlenecks hindering the coverage of the nutrition sensitive interventions implemented by different ministries and departments, and came up with a series of short, medium and long-term recommendations along with a strategy for improving the coverage and quality of nutrition programs/ interventions. The recommendations are also classified into policy level recommendations requiring multi-stakeholder and longer-term involvement, and programmatic level recommendations with shorter-term involvement. BNNC has also developed a community-based model which will be piloted in one upajilla as operation research. The result will encourage relevant ministries and departments to adapt similar interventions to address programmatic level bottlenecks in all programs across the country. BNNC has also developed a policy brief to inform the relevant stakeholders on the bottlenecks and the recommended steps to address those.

4.1.5 Nutrition Sensitive 'Food Packages in Emergency' for Disaster Affected Population in Bangladesh

At the request of MoDMR, an 11-member Technical Expert Committee (TEC) was formed by the MoHFW under the leadership and guidance of the Director General, BNNC, and the Line Director, NNS to revise the existing food packages with increased attention to their nutritional value. BNNC played a key advocacy role in bringing together the Ministry of Disaster Management and Relief (MoDMR) and the Ministry of Health and Family Welfare (MoHFW) in this endeavor.

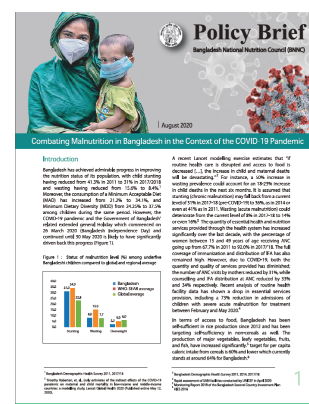
The Expert Committee lo Receiveded at: 1) food requirements of different age and target groups affected by any disaster including the COVID-19 pandemic; 2) the contents of current dry food relief packages; and 3) nutritionally balanced food considering their cost, nutrition value, safety, availability, accessibility, transportation, distribution, storage, preparation, etc. The resulting recommended guidelines and messages were followed by immediate relief responses from the government both in cash and kinds. This technical guideline along with its recommendations has been mainstreamed by the Ministry of Disaster Management and Relief (MoDMR) which will be used for any disaster affected population in Bangladesh.



4.1.6 Impact of COVID-19 on Nutrition: Assessment and Recommendations

At the onset of the COVID-19 pandemic crisis in Bangladesh, the immediate need from the government was to know the potential impact of COVID-19 on nutrition in the short, medium and long term in order to prevent a fall back of the country's current nutrition situation and also to avoid this health crisis to turn into a food security and nutrition crisis. Being the nutrition Apex body in the country, BNNC formed an expert committee on food security and nutrition. Members were drawn from eminent research organizations, academic

institutions, UN agencies, NGOs, and members from the nutrition and food security clusters, etc. The task was to estimate the malnutrition case burden during and post COVID-19 period; prepare a policy brief with recommendations for higher authorities; and develop workable solutions for the Government to respond to the nutrition crisis in a most effective manner. COVID-19's impact on nutrition would likely manifest itself through multiple pathways considering the multiplicity of factors related to malnutrition. In the process, social inequalities would contribute to differential impacts. Therefore, the key focus was to assess the impact of COVID-19 on the various underlying drivers linked to nutrition outcomes. A few highlighted issues were access and uptake of health and nutrition services; food security issues as food chain continuity, panic buying, access to market, food prices and the availability of nutritious food; on-going Social safety net programs and their status; employment, income and coping mechanism adopted by poor for survival; and small and medium enterprises (SMEs) which are key drivers of the Bangladesh economy. The combination of these underlying determinants lead to poor dietary intake and utilization, combined with increased occurrence of illness, resulting in increased malnutrition as well as higher morbidity. In July 2020, The Lancet published an impact projection, based on the LiST modeling methodology and macroeconomic and micro-economic analysis of multiple indicators in 118 countries including Bangladesh concluded that wasting may increase by 14.3% in 2020. The expert committee predicted that though the Government-imposed extended general Holiday which continued until the end of May might have a prolonged impact on the economy, there would be a moderate deterioration of underlying determinants considering other factors. However, in practice, even a moderate deterioration of underlying determinants of malnutrition could lead to dramatic increases of acute malnutrition. An increase in wasting has serious consequences on morbidity and mortality. A recent Lancet modeling exercise estimates that "if routine health care is disrupted and access to food is decreased […], the increase in child and maternal deaths would be devastating". A 10-50% increase in wasting prevalence could account for an 18-23% increase in child deaths in the next six months. Another Lancet article predicts a 14.3% increase in wasting in LMICs due to COVID-19. If the Lancet's prediction would come true for Bangladesh, the number of acutely malnourished children would rise from 5.4 million to 6.2 million within 2020 alone. Prompt actions by policy makers based on evidence, mobilizing and coordinating all partners together and putting a system in place to monitor progress and accountability mechanism would be required to prevent such increases in wasting and eventually mortality.


Policy Brief
Bangladesh National Nutrition Council (BNNC)

August 2020

Combating Malnutrition in Bangladesh in the Context of the COVID-19 Pandemic

Introduction

Bangladesh has achieved admirable progress in improving the nutrition status of its population, with child stunting having reduced from 41.3% in 2011 to 31% in 2017/2018 and wasting having reduced from 15.6% to 8.4%.[1] Moreover, the consumption of a Minimum Acceptable Diet (MAD) has increased from 21.2% to 34.1%, and Minimum Dietary Diversity (MDD) from 24.25% to 37.5% among children during the same period. However, the COVID-19 pandemic and the Government of Bangladesh' related extended general Holiday which commenced on 26 March 2020 (Bangladesh Independence Day) and continued until 30 May 2020 is likely to have significantly driven back this progress (Figure 1).

Figure 1 : Status of malnutrition level (%) among underfive Bangladeshi children compared to global and regional average

A recent Lancet modelling exercise estimates that "if routine health care is disrupted and access to food is decreased […], the increase in child and maternal deaths will be devastating."[2] For instance, a 50% increase in wasting prevalence could account for an 18-23% increase in child deaths in the next six months. It is assumed that stunting (chronic malnutrition) may fall back from a current level of 31% in 2017-18 (pre-COVID-19) to 36%, as in 2014 or even at 41% as in 2011. Wasting (acute malnutrition) could deteriorate from the current level of 8% in 2017-18 to 14% or even 16%.[3] The quantity of essential health and nutrition services provided through the health system has increased significantly over the last decade, with the percentage of women between 15 and 49 years of age receiving ANC going up from 67.7% in 2011 to 92.0% in 2017/'18. The full coverage of immunization and distribution of IFA has also remained high. However, due to COVID-19, both the quantity and quality of services provided has diminished; the number of ANC visits by mothers reduced by 31%, while counselling and IFA distribution at ANC reduced by 33% and 34% respectively. Recent analysis of routine health facility data has shown a drop in essential services provision, including a 73% reduction in admissions of children with severe acute malnutrition for treatment between February and May 2020.[4]

In terms of access to food, Bangladesh has been self-sufficient in rice production since 2012 and has been targeting self-sufficiency in non-cereals as well. The production of major vegetables, leafy vegetables, fruits, and fish, have increased significantly.[5] target for per capita caloric intake from cereals is 60% and lower which currently stands at around 64% for Bangladesh.[6]

[1] Bangladesh Demographic Health Survey 2011, 2017/18

[2] Timothy Roberton, et. al., Early estimates of the indirect effects of the COVID-19 pandemic on maternal and child mortality in low-income and middle-income countries: a modelling study, Lancet Global Health 2020 (Published online May 12, 2020).

[3] Bangladesh Demographic Health Survey 2011, 2014, 2017/18

[4] Rapid assessment of SAM facilities conducted by UNICEF in April 2020

[5] Monitoring Report 2019 of the Bangladesh Second Country Investment Plan

[6] HIES 2016

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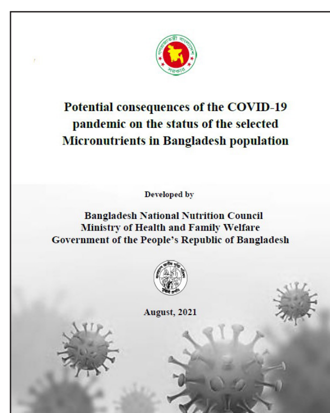
4.1.7 Policy Brief: Combating Malnutrition in Bangladesh in the Context of the COVID-19 Pandemic

In August 2020, founded on the Impact of COVID-19 on Nutrition assessment report and its recommendations BNNC produced a Policy Brief – Combating Malnutrition in Bangladesh in the Context of the COVID-19 Pandemic for making policy decisions by the appropriate authorities in Bangladesh. This has been widely shared with the government agencies and partners organizations. The policy brief includes an overview of the improvements of nutrition situation in pre-COVID-19 time, the emergency response of the government of Bangladesh, the projected burden of malnutrition due to COVID-19, and policy recommendations. A three-pronged action strategy was recommended, which includes: (1) a comprehensive food and nutrition security response framework; (2) a multi-sectoral approach; and (3) a robust monitoring, evaluation, and surveillance system.



4.1.8 Assessment of micronutrient deficiencies due to COVID-19

Micronutrient malnutrition which is known as the "hidden hunger" often

coexist with other major form of malnutrition. In Bangladesh during the last two decades there has been notable progress in child nutrition, with reduction of stunting, wasting and underweight, including micronutrient deficiencies. However, the impending negative impact of ongoing COVID-19 pandemic on food security, income, employment & other relevant socio-economic factors and compromised programs and services might have diminished such gain achieved in nutrition.

Underscoring the need to determine the potential consequences of the COVID-19 on the status of micronutrient nutrition and their future outlo Received, the Bangladesh National Nutrition Council (BNNC) with technical support from Institute of Nutrition and Food Science (INFS), icddr,b, Griffith University (Australia), UN agencies, conducted a contextual appraisal. The appraisal and the projection included vitamin A, zinc, iron, iodine and vitamin B12 which have public health significance in Bangladesh population. A reference level dating back to a past pre-pandemic time (National Micronutrient Survey 2011-2012) was identified and established through the review where the probable decline of the micronutrient status was projected. Furthermore, the review findings were found comparable with preliminary findings of the recently completed NMS 2021, undertaken by NNS and icddr,b during the covid-19 period. On the backdrop of the COVID-19, the prospective status of the key micronutrients in Bangladesh population suggested a varied outlo Received. For instance, iodine, zinc, and vitamin B12 forecast a "High" risk of the regress towards the reference period. Overall, vitamin A, poses a "Moderate" risk of sliding back, whereas the risk in urban-slum areas would be "High". Generally, iron poses a "Low" risk of decline worse than the reference level, however, the disadvantaged population in the large cities, Barind-Tract areas and Southern coastal areas exposed to very low levels of groundwater iron are considered in a "High" risk of the decline. Pregnant women were exposed to a "Moderate" risk of decline towards the reference level.

The appraisal undertaken by BNNC to assess the contemporary status, impact of COVID-19 on key micronutrients and future projections is considered a gallant and pioneering work not only in Bangladesh but also globally. Based on the findings and- specific recommendations for both operational and policy issues, a policy brief has been prepared to help policy makers to plan a well-coordinated, harmonized, and mitigating approach for emancipation of a declining micronutrient status in Bangladesh.

4.1.9 Bangladesh's Commitments at Nutrition for Growth (N4G) Summit 2021, T Receivedyo, Japan

Nutrition for Growth (N4G) is a global effort to transform the way the world tackles malnutrition by uniting knowledge, resources, and commitments from countries, donors, non-governmental organizations (NGOs), businesses, and beyond.

The latest Summit-third in the row- to Received place in T Receivedyo in December 2021—hosted by the Government of Japan—to continue the N4G legacy and further accelerate progress. The commitments of the Government of Bangladesh and its partner stakeholders to the T Receivedyo N4G Summit were developed based on previous commitments from first Summit 2013 in London and second Summit 2017 in Milan. An assessment was made of their continued relevance, and adjustments were made based on this. In addition, new commitments were added. The commitments have been

Bangladesh Commitments

1.Reduce childhood stunting

2.Reduce the prevalence of wasting

3.Reduce the incidence of low birth-weight

4.No increase of childhood obesity (WHZ >+2) among children under 5 years

5.Reduce the anaemia among women of reproductive age

6.Recruitment of 64 District Nutrition Officers

7.Prevalence of Undernourishment

8.Prevalence of moderate or severe food insecurity in the population, based on the Food Insecurity Experience Scale

9.Reduce dependence on cereals for Dietary Energy Intake

10.Increase the coverage of nutrition-related social safety net programs

11.Strengthen and mainstream the multi-sectoral nutrition surveillance system

12.Strengthen multisectoral tracking of financial allocation for nutrition

based on the current country nutrition context and emerging needs due to COVID-19. They are aligned with the Government's Eighth Five-Year Plan (8th FYP), and in Perspective Plan (Vision 2041), as well as the National Nutrition Policy 2015 (NNP), the Second National Plan of Action on Nutrition (NPAN2) 2017-2025, the Second Country Investment Plan (CIP2), the National Food and Nutrition Security Policy (NFNSP) 2020, as well as the Bangladesh Roadmap for the Global Action Plan for Wasting (GAP) and the United Nations Sustainable Development Cooperation Framework (UNSDCF) for Bangladesh. It also complements commitments made during the United Nations Food Systems Summit (UNFSS) 2021.

The N4G Commitments are made towards five thematic areas, and across six commitment types. The five thematic areas consist of three core thematic areas (health, food, and resilience), and two cross-cutting thematic areas (accountability and financing). The six commitment types are: 1) political and governance; 2) policy; 3) financial; 4) operational; 5) monitoring, reporting and research; and 6) impact.
Three working groups consisting of the relevant Government officials, SUN networks members, and cluster groups, each responsible for one of the core thematic areas, worked to develop Bangladesh' commitments. Finally, 12 priority commitment areas were decided upon which were finalized by the groups. The estimated cost for the 12 N4G commitments is $81 billion.

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

"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).

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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.

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

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

SUN networks to Received 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 underto Received a study on "To Identify the Nutritional Research Gaps for Effective Implementation of NPAN2 in Bangladesh" with the technical support of the University of New South Wales, Australia and Institute of Nutrition and Food Science, University of Dhaka and financial support from Concern Worldwide. Based on the study findings and a follow-up study supported by the Nutrition International BNNC along with SUN Academia and Research Network a research strategy under NPAN2 has been developed. BNNC is now playing a pivotal role in mobilizing the academia and the nutrition researchers in Bangladesh.

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

In 2018-19, BNNC organized 3 meetings of SUN academia (2) and Donor network (1). BNNC supported preparing SUN Joint Assessment Report 2019. Also, BNNC acts as a catalyst to achieve the SUN priorities. For example, initiation of Multi-sectoral policy review; establishing the financial tracking system for relevant sectors; and develop a research strategy for nutrition; assessment of COVID-19 on children and adolescent girls- pre and post covid impact, etc.

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

4.1.11 Gender Empowerment and Nutrition

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

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

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

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

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

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

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

i. the loss of productive and leisure time from the hard work of water hauling and other WASH-related domestic work.
ii. exclusion from full participation in schools due to the lack of separate WASH facilities for girls.
iii. urinary tract infections arising from delayed urination or reduced water intake to cope with a lack of access to sanitation facilities; and
iv. the loss of dignity and threat of sexual assault due to the lack of appropriate toilets and WASH facilities both at stability and crisis periods [43].

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

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

4.2 ONGOING INITIATIVES

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

Multisectoral Urban Nutrition Strategy

Bangladesh is experiencing rapid urbanization resulted from shift in economy from agriculture towards

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

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

BNNC with technical and financial support from partners has initiated the process of developing a multi-sectoral nutrition strategy. The urban nutrition strategy would be a complex, multi-dimensional roadmap to encompass proposed five important pillars under one common umbrella to ensure the positive nutrition outcomes for urban population. These important five "nutritionally interdependent" pillars are – the health and nutrition specific interventions, urban food systems, urban WASH Services, urban education systems (particularly education of women), and the social security systems. The envisaged multisectoral urban nutrition strategy will combine the relevant strategies and actions of these pillars and will layout a multiyear policy direction from a nutrition lens for the urban population. The strategy will complement the gaps in NNP 2015 in ensuring specific policy guidelines for relevant stakeholders to ensure urban nutrition and will be feeding into the development of the upcoming third National Action Plan for Nutrition (NPAN3). In addition, the strategy will encompass all relevant cross-cutting issues, which may include nutrition governance, coordination, gender, women empowerment, accountability, and reporting & monitoring system.

4.2.1 Development of the Operational Framework for N4G Commitments

Nutrition for Growth (N4G) is a global effort to transform the way the world tackles malnutrition by uniting knowledge, resources, and commitments from countries, donors, non-governmental organizations (NGOs), businesses, and beyond. The latest Summit to Received place in T Receivedyo in December 2021—hosted by the Government of Japan—to continue the N4G legacy and further accelerate progress. The commitments of the Government of Bangladesh and its partner stakeholders to the T Receivedyo N4G Summit were developed based on previous commitments from Summits in 2013 and 2017. There were 12 commitments made by Bangladesh towards five thematic areas, and across six commitment types. The five thematic areas consist of three core thematic areas (health, food, and resilience), and two cross-cutting thematic areas (accountability and financing). The six commitment types are: 1) political and governance; 2) policy; 3) financial; 4) operational; 5) monitoring, reporting and research; and 6) impact. To achieve these 12 commitments by 2025, Bangladesh would need BDT 688745.65 Crore (USD 80.42 billion) from public and development funding.

While the commitments are higher level strategic and political visions, their implementation requires initiatives from the respective ministries and entities to integrate the commitments into respective sectoral

strategies and actions. An operational framework including roadmap is required to help the respective stakeholders to better plan, coordinate, implement and monitor the activities from an "N4G" lens. In that regard, an operational framework for N4G is essential. Accordingly, being the apex nutrition body BNNC has taken an initiative along with other relevant stakeholders to prepare an operational framework to support the relevant government and non-government actors to formulate and coordinate their respective sectoral activities to achieve the N4G, 2021 commitments.

4.2.2 Climate Change and Nutrition

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

4.2.3 Climate Change-Bangladesh perspective

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

4.2.4 Climate Change and Nutrition Linkages

Consequences of any climate change is linked with potential negative impact on food and nutrition security. Our current dietary habits are contributing to GHGE resulting in ever changing climate. As the climate changes the nutrient composition of some crops are likely to change, which adds another layer of complexity to nutrition security. Experiments on growing crops in different controlled environments have found that elevated atmospheric CO2 levels and increases in temperature not only reduce crop yields but also lowers the nutrient density in a range of staple crops[49,50]). A meta-analysis of the data by Myers et al[51] showed that zinc, iron and protein concentrations in C3 crops (e.g. wheat, rice) and legumes (e.g. field peas, soyabeans) were significantly lower when grown at elevated CO2 (levels predicted for 2050) compared with those grown at ambient CO2 levels. They reported that in the edible portion of wheat grown under warmer and higher CO2 conditions, the zinc, iron and protein concentrations were lower by an average of 9·3, 5·1 and 6·3 %, respectively. The phytate content also reduced, which could potentially counter some of the losses in zinc and iron in terms of increasing the bioavailability. For rice, the reduction was 3·3, 5·2 and 7·8 %, respectively, but there was no significant change in the phytate concentration.

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CHAPTER-5

CONCLUSION AND RECOMMENDATIONS

5.1 Conclusion

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

5.2 Recommendations

5.2.1 Overall Recommendations

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

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

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

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

5.2.2 Recommendations by Thematic Areas

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

IYCF Practices and Child Malnutrition

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

Micronutrient Malnutrition

1. Strengthen IFA supplementation for Pregnant and Lactating Women (PLW) by improving the coverage and compliance from health service delivery points through counselling and ensuring supply chain.

Scale up the options of weekly distribution and on-spot consumption of Iron and Folic Acid (IFA) to ensure the compliance amongst adolescent girls at school, and at community clinic and FWC for out of schoolgirls.

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

Water Sanitation and Hygiene (WASH)

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

Urban Nutrition and Non-Communicable Disease (NCD)

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

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

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

Thematic area 3: Social Protection

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

Thematic Area 4: Implementation of Integrated and Comprehensive SBCC Strategy

1. Include and coordinate advocacy and BCC activities into sectoral work plans and ensure their implementation by different sectors including HNP sector's Comprehensive SBCC Strategy 2016

through Advocacy and Communication Platform, and BCC Working Group.

2. Roll out 'Advocacy Plan for Nutrition (2019-2025)' under 'Framework for Operationalization of the Advocacy Plan for Nutrition' through GOB Sectors as well as BNCC-DP consortium arrangement.
3. Strategic and effective use of National Nutrition Week for nutrition advocacy at national and sub-national level.

Thematic Area 5: Monitoring, Evaluation & Research

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

Thematic Area 6: Capacity Building

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

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

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

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ANNEXURES

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

SL.	Indicators	NPAN2 Target 2025	Baseline of NPAN2	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%	14.8%	MICS (2019)
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%	1.40%	2.40%	(MICS 2019)
8	% of Women 15-49 yrs. with Anaemia	<25%	42%	28.9%	(NMS 2019-20)
9	% of children under 5 with diarrhoea treated with ORT and Zinc	Not yet fixed	38%	43.60%	(BDHS 2017-18)
10	% of women 15-49 yrs who are overweight or obese (BMI ≥23)	30%	24%	39%	(BDHS 2014)
11	% of adolescent girls (15-19 yrs.) with height <145 cm	<8%	13%	4.51%	SFNS (2022)
12	% of adolescent girls (15-19 yrs.) thin (total thinness)	<15%	29%	18%	SFNS (2022)
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%	98.50%	(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					
17	Per capita consumption of fruits and vegetables	≥400g per day	Fruits: 44.7 gm	Fruits: 35.78 gm	(HIES 2016)
			Vegetables: 166.1 gm	Vegetables: 167.3 gm	
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 years who were first married by age 18 yrs	30%	59%	51.40%	(MICS 2019)

SL.	Indicators	NPAN2 Target 2025	Baseline of NPAN2	Current Status	Sources
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	189 Upajillas	WFP
22	% of children (36-59 m) who are attending an early childhood education program	30%	13%	18.90%	(MICS 2019)
23	% of women who completed secondary/ higher education	90%	14%	17%	(BDHS 2017-18)
24	Number of ongoing comprehensive coordinated multisectoral, multichannel advocacy and communications campaign	10	NA	NA	
25	Change in per capita consumption of:				
	i. salt	i. <5 gm/ person/ day (WHO)	i. Salt: not available	i. Salt: not 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)

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

SL.	Ministry / Department	10 Year Plan	Plan (2019-20)	Plan (2020-21)	Progress Report (2019-20)
1	Ministry of Food	Received	Received	Received	Received
2	Ministry of Local Government, Rural Development and Cooperatives	Not Received	Not Received	Not Received	Not Received
2.1	Department of Local Government	Received	Received		
2.1.1	Department of Public Health Engineering	Received	Received	Received	Received
2.2	Department of Rural Development and Cooperatives	Received	Received	Received	Received
3	Ministry of Social Welfare		Received	Received	Received
4	Ministry of Environment, Forests and Climate Change	Received	Not Received	Received	Not Received
5	Ministry of Information	Received	Not Received	Received	Not Received
6	Ministry of Commerce	Received	Received	Received	Received
7	Ministry of Religion	Received	Received	Received	Received
8	Ministry of Chittagong Hill Tracts Affairs	Received	Received	Received	Received
9	Ministry of Youth and Sports	Received	Received	Received	Received
10	Ministry of Labor and Employment	Not Received	Received	Received	Received

SL.	Ministry / Department	10 Year Plan	Plan (2019-20)	Plan (2020-21)	Progress Report (2019-20)
11	Ministry of Water Resources	Received	Received	Received	Received
12	Ministry of Agriculture	Received	Received (BIRTAN)	Received (BIRTAN) (DAE)	Received (BIRTAN)
13	Ministry of Fisheries and Animal Resources	Received	Received	Received	Received
14	Ministry of Women and Children Affairs	Not Received	Not Received	Not Received	Not Received
15	Ministry of Primary and Mass Education	Received	Not Received	Not Received	Not Received
16	Ministry of Disaster Management and Relief	Not Received	Received	Not Received	Received
17	Department of Secondary and Higher Education, Ministry of Education	Received	Received	Received	Received
18	Department of Financial Institutions, Ministry of Finance	Received	Received	Received	Received
19	Ministry of Industry	Received	Received	Received	**
20	Ministry of Science and Technology	Received	Received	Received	Received

Annex 3: Showing the status of Financial Progress based on workplan of relevant ministries (2019-20)

SL	Ministry	Financial Progress (In lac taka) 2019-20	
		Allocation	Expenditures
		2019-20	2019-20
1	Ministry of Health and Family Welfare	17,303.51	3,847.43
2	Ministry of Finance	5,289.67	2,026.38
3	Ministry of Food	255.99	15.99
4	Ministry of Religious Affairs	10.80	10.80
5	Ministry of Agriculture	670.00	490.50
6	Ministry of Industry		
7	Ministry of Commerce	0.00	NA
8	Ministry of Fisheries and Livestock	41,026.62	54,441.17
9	Ministry of Primary and Mass Education		
10	Ministry of Education	19,533.88	9,606.27
11	Ministry of Science and Technology	67.75	40.00
12	Ministry of Local Government, Rural Development and Cooperatives	563,748.49	182,058.17
13	Ministry of Water Resources		
14	Ministry of Women and Children Affairs		
15	Ministry of Youth and Sports	8,180.23	8,144.23
16	Ministry of Disaster Management and Relief	146.60	147.54

SL	Ministry	Financial Progress (In lac taka) 2019-20	
		Allocation	Expenditures
		2019-20	2019-20
19	Ministry of Labour and Employment	250.00	125.00
20	Ministry of Chittagong Hill Tracts Affairs	138.00	111.57
21	Ministry of Information		

Annex 4: Showing the status of workplan submission of relevant ministries

মন্ত্রনালয়ের নাম	Total activites committed (2019-20)	কার্যক্রমের অগ্রগতি ২০১৯-২০					
		লক্ষ্যমাত্রা অর্জিত হয়েছে	% target achieved (2019-20)	% target not achieved	লক্ষ্যমাত্রা অর্জিত হয়নি	% Work not started yet	% Work not started yet (2019-20)
1. Ministry of Rural Development and Cooperatives	9	0	0.0	100.0	9	0	
A) Local Government Department							
DPHE	14	6	42.9	57.1	8		
My house is my farm	1		0.0	100.0	1		
Establishment of Factories for Development of Dairy and Ensuring Multipurpose Use of Dairy in the Char Faridpur and adjoining areas of Greater Faridpur	2	2	100.0	0.0			
2. Ministry of Water Resources	17	7	41.2	58.8	9	1	5.9
3. Ministry of Commerce	13	8	61.5	38.5	5	0	
4. Ministry of Youth and Sports (Department of Youth Development + BKSP)	4	2	50.0	50.0	2	0	
5. Ministry of Agriculture							
BIRTAN	9	0	0.0	100.0	9	0	
. Ministry of Social Welfare	3	3	100.0	0.0	0	0	
. Ministry of Religion	21	21	100.0	0.0	0	0	
. Ministry of Environment, Forests and Climate Change	0						
9. Ministry of Labor and Employment (Department of Inspection of Factories and Establishments)	3	3	100.0	0.0	0	0	
10. Ministry of Labor and Employment (Department of Labor)	0	0			0	0	
11. Ministry of Chittagong Hill Tracts (Sustainable Social Services Project)	30	19	63.3	36.7	7	4	13.3
12. Ministry of Information	0						

মন্ত্রনালয়ের নাম	Total activites committed (2019-20)	কার্যক্রমের অগ্রগতি ২০১৯-২০					
		লক্ষ্যমাত্রা অর্জিত হয়েছে	% target achieved (2019-20)	% target not achieved	লক্ষ্যমাত্রা অর্জিত হয়নি	%Work not started yet	% Work not started yet (2019-20)
1. Department of Financial Institutions, Ministry of Finance							
1.1 PKSF / Prosperity Project	-	-			-	-	
1.2 SDF	27	11	40.7	59.3	14	2	7.4
2. Ministry of Science and Technology (BCSIR)	17	8	47.1	52.9	3	6	35.3
3. Ministry of Women and Children Affairs							
4. Ministry of Agriculture	9	0	0.0	100.0	9	0	
5. Ministry of Industry	-	-			-	-	
. Department of Secondary and Higher Education, Ministry of Education	16	11	68.8	31.3	3	2	12.5
. Ministry of Fisheries and Animal Resources (Livestock Division)	15	7	46.7	53.3	6	2	13.3
. Ministry of Fisheries and Animal Resources (Fisheries Department)	43	38	88.4	11.6	5	0	
. Ministry of Primary and Mass Education	-	-			-	-	
9. Ministry of Disaster Management and Relief	4	1	25.0	75.0	3	0	

Annex 5: Showing the status of workplan submission of relevant ministries (2020-21)

SL.	Name	Activity progress (2020-21)				Budget (2020-21)	
		Planned Activity	Completed (%)	Ongoing (%)	No Progress (%)	Allocation (in lakh)	Expenditure (%)
1	Ministry of Finance	79	13	46	42	4790	99
2	Ministry of Food	20	45	15	40	NA	NA
3	Ministry of Religious Affairs	23	87	9	4	5	100
4	Ministry of Agriculture	36	58	11	31	48922	82
5	Ministry of Industry	NA	NA	NA	NA	NA	NA
6	Ministry of Commerce	13	69	8	23	NA	NA
7	Ministry of Fisheries and Livestock	45	80	9	11	9225	100
8	Ministry of Primary and Mass Education	NA	NA	NA	NA	NA	NA

SL.	Name	Activity progress (2020-21)				Budget (2020-21)	
		Planned Activity	Completed (%)	Ongoing (%)	No Progress (%)	Allocation (in lakh)	Expenditure (%)
10	Ministry of Science and Technology	13	77	8	15	81	120
11	Ministry of Local Government, Rural Development and Cooperatives	NA	NA	NA	NA	301572	NA
13	Ministry of Women and Children Affairs	1	100	0		184005	100
14	Ministry of Youth and Sports	4		100	NA	8959	88
15	Ministry of Disaster Management and Relief	2	50	50	NA	7000	86
16	Ministry of Social Welfare	4	25	25	50	4468	98
17	Ministry of Environment, Forests and Climate Change	5	NA	NA	100	493	58
18	Ministry of Labour and Employment	34	3	NA	97	11	100
19	Ministry of Chittagong Hill Tracts Affairs	44	89	2	9	265	113
20	Ministry of Information	NA	NA	NA	NA	NA	NA

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