

Joint UNICEF Bangladesh – Government of Bangladesh Nutrition Programme Mid- Term Evaluation 2017-2020

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On behalf of NRMCC

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Final Report**

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**Joint UNICEF Bangladesh – Government of Bangladesh Nutrition
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ABBREVIATIONS

A&T	Alive and Thrive
AFHC	Adolescent Friendly Health Corners
ANC	Antenatal Care
ARI	Acute Respiratory Infection
BDHS	Bangladesh Demographic and Health Survey
BFC	Breastfeeding Corner
BINP	Bangladesh Integrated National Plan
BIRTAN	Bangladesh Institute of Research and Training on Applied Nutrition
BMI	Body Mass Index
BMS Act	Breast Milk Substitutes Act
BNNC	Bangladesh National Nutrition Council
C4D	Communication for Development
CBT	Competency Based Training
CC	Community Clinic
CIP	Country Investment Plan
CHW	Community Health Workers
CHCP	Community Health Care Provider
CP	Country Programme
CNUs	Child Nutrition Units
CS	Civil Surgeon
CSG	Community Support Groups
DALYs	Disability Adjusted Life Years
DFID	Department for International Development
DGFP	Directorate General Family Planning
DGHS	Directorate General of Health Services
DHIS2	District Health Information Software 2
DNCC	District Nutrition Coordination Committee
DNI	Direct Nutrition Interventions
DNSO	District Nutrition Support Officers
DLI	Disbursement Linked Indicator
DSCC	Dhaka South City Corporation
ECD	Early Childhood Development
EPI	Expanded Programme on Immunization
FAO	Food and Agriculture Organization of the United Nations
FGD	Focus Group Discussions
FIVDB	Friends In Village Development Bangladesh
FLWs	Frontline Workers
FSNSP	Food Security and Nutrition Surveillance Project
FWA	Family Welfare Assistant
FWV	Family Welfare Volunteer
GAIN	Global Alliance for Improved Nutrition
GDP	Gross Domestic Product

GMP	Growth Monitoring and Promotion
GNC	Global Nutrition Cluster
GoB	Government of Bangladesh
HA	Health Assistant
HDI	Human Development Index
HQ	Head Quarters
HMIS	Health Management Information System
HNAP	Health-National Adaptation Plan
HNPSP	Health, Nutrition and Population Sector Programme
HNP	Health Nutrition Population
HPNSDP	Health Population Nutrition Sector Development Programme
ICN2	Second International Conference on Nutrition
IDD	Iodine Deficiency Disorder
IEC	Information, Education, Communication
IFA	Iron Folic Acid
ILO	International Labour Organisation
IMCI	Integrated Management of Childhood Illness
IPHN	Institute of Public Health and Nutrition
IYCF	Infant and Young Child Feeding
KII	Key Informant Interviews
LCBCE	Local Capacity Building and Community Empowerment
LMIC	Low-and-Middle-Income Countries
MAM	Moderate Acute Malnutrition
MDGs	Millennium Development Goals
MIC	Middle Income Country
MIYCN	Maternal, Infant, And Young Child Nutrition
MoHFW	Ministry of Health and Family Welfare
MoLE	Ministry of Labour and Employment
MoLGRD&C	Ministry of Local Government, Rural Development and Co-operatives
MoW&CA	Ministry of Women and Children Affairs
MUAC	Mid-upper arm circumference
MUCH	Meeting the Under-nutrition Challenge
NFNP	National Food and Nutrition Policy
NGO	Non-Governmental Organisations
NIPORT	National Institute of Population Research and Training
NNP	National Nutrition Policy 2015
NNS	National Nutrition Service
NPAN	National Plan of Action for Nutrition
NPAN -2	Second National Plan of Action for Nutrition 2016-2025
NPNL	Non-pregnant non-lactating
NRMC	NR Management Consultants Private Limited
NUPRP	National Urban Poverty Reduction Programme
NWG	Nutrition Working Group
OP	Operational Plan
ORS	Oral Rehydration Solution

ORT	Oral Rehydration therapy
PEDP	Primary Education Development Programme
PNC	Post Natal Care
RMG	Ready Made Garment
SACMO	Sub Assistant Community Medical Officer
SAM	Severe Acute Malnutrition
SBCC	Social Behaviour Change Communication
SCANU	Special Care Newborn Unit
SDG	Sustainable Development Goals
SIDA	Swedish International Development Cooperation Agency
SKNF	Shornokishori Network Foundation
STC	Save the Children
SUN	Scaling Up Nutrition
ToC	Theory of Change
UHC	Upazila Heath Complex
UHFPO	Upazila Health ad Family Planning Officer
UHFWC	Union Health and Family Welfare Centre
UNCC	Upazila Nutrition Coordination Committee
UNDAF	United Nations Development Assistance Framework
UNICEF	United Nations Children's Fund
UNICEF-BCO	UNICEF Country Office Bangladesh
USAID	United States Agency for International Development
VDG	Vulnerable Group Development Programme
VGf	Vulnerable Group Feeding Programme
WASH	Water, sanitation, and hygiene
WFHI	Women Friendly Hospital Initiative
WFP	World Food Programme
WHA	World Health Assembly
WHO	World Health Organization

EXECUTIVE SUMMARY

The Joint UNICEF and GoB nutrition programme has been designed to address two key headline results on accelerating the reduction of childhood stunting and improving adolescent health and well-being. Following a life-cycle approach, the nutrition interventions have a direct focus on the first 1000 days of life, as well as on adolescents aged 10-19, pregnant and lactating women. The nutrition programme aims to improve the coverage of nutrition-specific interventions, in both public and private sectors, with a particular focus on urban slums, hard to reach and disaster prone areas.

UNICEF Country Office Bangladesh (UNICEF-BCO) commissioned the evaluation of the Joint UNICEF-Government of Bangladesh (GoB) nutrition programme 2017-2020. The objective of this evaluation is to determine, systematically and objectively, the relevance, appropriateness and coherence of UNICEF Bangladesh nutrition programme; the effectiveness and (early) impact or impact potential of the programme in relation to its objectives; the efficiency with which its project outputs and activities are being delivered and their connectedness to those produced by other actors; as well as the programme's sustainability. The purpose of the evaluation therefore, is to understand whether all of these aspects are on track and how they can be enhanced, as well as serve as a key document for planning and designing the focus of the nutrition programme in the next country programme.

The evaluation focused on the nutrition outcomes in the current CP (2017-2020) by examining the implementation and performance in the last two years (2017-2018) and generating learnings for planning and design of the nutrition programme in the next CP.

The evaluation took stock of the programme implementation experience and environment, reviewed the results frameworks and assumptions, and documented success and lessons learned. Based on an assessment of these, it suggested modifications that may be necessary to effectively and efficiently meet the stated objectives. Thus, rather than an intervention focused evaluation, this evaluation focused on the whole programme including its logic, strategies and partnerships, to suggest where improvements can be made to better achieve the results that have been envisaged under the current Country Programme (2017-20).

The evaluation adopted a mixed method approach to answer the questions under the evaluation criteria. An extensive desk review of available secondary data was undertaken which included quantitative information from secondary sources¹, a detailed review of the various national policies and strategies related to nutrition² and relevant reports of sector partners. In addition, UNICEF programme documents³ were also reviewed for the evaluation.

The evaluation also undertook primary data collection which was mainly qualitative in nature, through Key Informant Interviews (KII) at the district, upazila and community level and Focus Group Discussions (FGD) at the community level. In addition to the interviews, physical observation of the facilities was conducted to better understand the effectiveness of the interventions.

The divisions were sampled purposively on the basis of the nutritional outcomes in the country by divisions. Two out of eight divisions were selected for the evaluation. These included the division with the lowest rate of stunting, i.e. Khulna, and the division with the highest rate of stunting i.e. Sylhet. Within each selected division, two districts were selected in line with the sampling approach of the divisions. Within the sample divisions, two districts where UNICEF has done extensive work were identified. In addition to the UNICEF

¹ Bangladesh DHS, Multiple Indicator Cluster Surveys, 2013 and 2019, DHIS-2, Coverage of Basic Social Services in Bangladesh 2017, 2018

² NNP 2015, NPAN-2, NNS and National Strategy for Adolescent Health 2017-2030

³ UNICEF programme documents such as annual reports, past evaluation and management responses, rolling work plans, and communication documents

intervention districts, the evaluation also sampled one district in each sampled division where the UNICEF nutrition programme does not have a presence to allow a comparative analysis between UNICEF and non-UNICEF areas.

Relevance

The examination of the relevance of UNICEF Nutrition Programme's interventions and implementation strategies highlights that the mix of strategies has ensured a balance between upstream and downstream work against the background of the transition of Bangladesh towards middle-income status.

The nutrition programme's strategy of supporting policy and advocacy, promoting partnerships and coordination, providing technical assistance and capacity development towards nutrition systems strengthening, are in alignment with the UNICEF Global Nutrition Strategy, UNICEF Strategic Plan 2018-21 and Bangladesh UNDAF 2017-20. Further, UNICEF's nutrition programme aligns with the strategies of NNP, key action areas of NPAN2, strategic objectives of NSAH 2017-30 and the priority areas of the National Strategy on Prevention and Control of Micronutrient Deficiencies (2015-24) and MoHFW's Bangladesh Essential Health Service Package (ESP). Furthermore, the nutrition programme was also found to be aligned with the 7th five year plan and the Bangladesh EECD Policy Framework. It was found to be partially aligned to the National Urban Health strategy since UNICEF yet to adequately address the need for preventive care.

Learnings from past evaluations have fed into the interventions of the UNICEF Nutrition programme. This has enabled the programme to adequately respond to the needs of various target groups in the country. UNICEF supported adolescent clubs encourage inclusion of differently abled as well as out of school adolescents, making the targeting inclusive in addressing stunting amongst adolescents from various backgrounds. Further, the Mothers@Work initiative creates an enabling environment to adequately respond to the needs of working mothers and their children in the urban context. In addition to this, the focus of UNICEF's interventions on hard to reach areas, urban slums and tea estates makes UNICEF's strategy to address stunting, adequate and responsive to the needs of beneficiaries from varying geographies. Furthermore, UNICEF's role in the nutrition cluster (of enhancing country level capacities to respond to nutrition needs in emergency settings) and the use of community based programmes is appropriate and adequate to address the needs of beneficiaries, specifically in the emergency context. However, the lack of a uniform strategy to scale up these community based programmes in development settings renders UNICEF's interventions as inadequate in addressing stunting in young children and adolescents in a comprehensive manner, across both development and emergency contexts.

UNICEF's focus on building the capacities of community health workers through CBT to improve nutrition counselling and services, promoting the use of evidence based decision making and fostering sectoral coordination through deployment of DNSOs and support provided for DHIS2 were found to be responsive to the needs of the government. By focusing interventions towards systems strengthening, it is evident that UNICEF gave due consideration to governmental expectations to select priority programme elements. Further, leveraging of partnerships (amongst development partners) with ILO, World Bank, NI, GAIN, among others, provides evidence that UNICEF considered its comparative strengths and that of other development partners in selecting the program priority areas and catering to them. Moreover, through the piloting of interventions and subsequent identification of successful ones, UNICEF's approach of demonstrating efficacy through documentation and dissemination was found to be relevant for influencing policy and supporting scale up of interventions by GoB.

Effectiveness

Using the implementation strategy of leveraging partnerships with development partners and the private sector and ensuring coordination within UNICEF sections, the nutrition programme has been effective in increasing awareness and realization of maternal and child rights through availability of an enabling environment for breastfeeding at the workplace. Similarly, the nutrition programme's support towards meeting the nutritional needs of adolescents through adolescent clubs have been effective in ensuring equity by targeting both in and out-of-school adolescents. The platform has also enabled a discourse amongst adolescents on important aspects of nutrition, among other issues. Further, generating evidence on the efficacy of these interventions, the nutrition programme's efforts have been effective in building a case for scale up and adequately meeting the needs of target groups, especially in urban areas.

While the programme has been effective in ensuring the participation of various line departments on a common platform (DNCC/UNCC) and facilitating regular discourse on nutrition, the extent of effectiveness is constrained by the lack of convergent planning and vertical accountability. In the urban context, despite the establishment of nutrition coordination committees in city corporations, the absence of any facilitation (through DNSOs as in rural areas) and lack of coordination between MoHFW and MoLGRD&C has constrained the functioning of committees.

While DNSO support on use of MIS and CBT has been an effective intervention to strengthen service delivery, there remains a significant amount of potential to increase its effectiveness. Evidence suggests that these interventions have resulted in regular reporting and monitoring of data on nutrition and have even improved counselling services. Additionally, the technical assistance provided by NIPU at national level has enabled analysis of data reported under DHIS2 and identification of priority areas for targeted interventions and adequate resource allocation. However, despite the institutionalization of systems and capacities enhanced, no evidence on utilization of data for planning and budgeting at the district and upazila level was found. Without evidence-based planning, the momentum created by these interventions will not translate into significant improvements in service delivery. Another challenge towards ensuring effectiveness of such interventions, is the unavailability of data from private health facilities in urban areas, resulting in a missed opportunity to comprehensively track nutrition services in an integrated manner.

Evidence suggests that the support provided by UNICEF towards SAM screening and management has helped build the capacity of health workers to screen SAM cases and refer them to facilities at the upazila or district level. However, a major barrier for effective management of SAM is the lack of mechanism to (i) track patients post referral to district/upazila facilities and; (ii) follow up with the patients on compliance with the treatment protocol, post discharge.

Efficiency

The allocation of regular resources across the interventions is in accordance with the planned budgets. However, there is a major resource gap in case of allocation through other resources. While the higher allocation towards operationalizing integrated nutrition information systems, institutionalization of DNSO and, capacity building of health workers through CBT approach helped achieve the desired objectives, the budget did not have adequate provisions to support other activities such as effective management of SAM, CMAM, adolescent nutrition, IYCF and maternal nutrition. Allocation for interventions in urban areas was also inadequate.

The effectiveness of Mothers@Work Programme has provided evidence on leveraging of funds through development partners and private sector and working with shared services as an efficient mechanism to achieve common objectives. Further, the minimum financial support provided by the programme for incremental infrastructure support/refurbishment as in case of breastfeeding corners and AFHCs, has efficiently strengthened service delivery. However, due to a lack of clear delineation of roles and

responsibilities amongst development partners, there is often duplication of efforts. While there are instances of joint programming amongst development partners, it is happening on an adhoc basis.

The targeting of the programme is inclusive and provides support to areas affected by climate change, disasters and high prevalence of stunting. However, owing to challenges related to access to roads, continued supply of power in *haor* areas and lack of sensitisation of tea estate managers on development oriented interventions, the efficiency in service delivery interventions has been affected.

Impact

Evidence suggests that the nutrition programme has been able to support GoB in its efforts towards accelerating the reduction in stunting. Using a straight line trend function, it can be inferred that through the programme support, GoB is likely to achieve its target on underweight and BMI (among adolescent girls). However, in case of reducing wasting and the incidence of early marriage, the estimate suggests that the country may not be able to achieve the set targets. While majority of the programme targets may be achieved, the current rate of progress is not enough to create a significant impact with regard to undernutrition in the country.

While the design of the programme ensures equal distribution of nutrition support services in rural and urban areas, the indicators suggest that the rural–urban differential will continue to persist unless the interventions are tailored to the specific needs of urban and rural areas. This will also help ensure equity based targeting.

Connectedness

Leveraging the strengths of sections within UNICEF, the nutrition programme collaborated with the Child Protection, Health, and Education, WASH and CAP section to address the needs of specific target groups, namely, adolescents (including out-of-school children), children in schools and those below 6 years of age as well as working mothers. By integrating nutrition within existing adolescent clubs, mainstreaming nutrition within education (school) curricula and leveraging the strengths of the CAP section to implement C4D interventions to promote maternal and child nutrition at the workplace, the nutrition section has effectively coordinated with other sections to cater to the nutritional needs of target groups, as per the lifecycle approach. The nutrition programme ensured that priority areas of other sections such as health, hygiene and adolescent issues such as early marriage and early pregnancy are recognized as determinants of nutrition. With the support from other sections the nutrition programme further ensured that the factors affecting the nutritional status of children and adolescents are adequately and comprehensively addressed through joint initiatives

Partnerships with a wide range of actors resulted in strengthened institutional capacities of government agencies, regional and local service institutions, and civil society organizations to implement nutrition interventions and work towards closure of equity gaps for all target groups. Moreover, UNICEF's joint work with other sector actors, along with the support from GoB, has brought notable contributions towards building an institutional environment through the development of official guidelines to facilitate provision of nutrition services. These contributions have had a valuable effect on accelerating the pace of change and giving direction to nutrition reforms.

UNICEF and GoB (as part of operationalization of NPAN 2) have made efforts to strengthen multi stakeholder partnerships to address the complex issue of undernutrition. The evaluation also found evidence of inter-sectoral collaboration within UNICEF and partnerships between GoB, UNICEF and other stakeholders (development partners, implementing organizations and the private sector) for addressing nutrition related challenges. However, there is scope for greater coordination and creation of an integrated multi-sectoral joint action plan to support GoB in improving the status of nutrition.

Sustainability

The regularity in the conduct of BNNC, DNCC and UNCC meetings and participation of various line departments demonstrates the willingness of government stakeholders to come together on a common platform and coordinate efforts to address undernutrition. Additionally, GoB's commitment towards appointing DNCs for technical assistance in each district (as a part of scaling up the DNSO initiative by UNICEF) is a positive indication towards ensuring sustainability of the established mechanisms to enhance service delivery.

Evidence of government ownership and scale up of initiatives like appointment of DNCs, adolescent clubs and M@W indicate that these initiatives are sustainable. A potential barrier to the sustainability of the nutrition programme efforts surfaces when it comes to tea estates wherein the reach of all basic services is highly dependent on the discretion of the tea estate managers. Due to the lack of sensitization on the importance of nutrition interventions among tea estate owners, initiatives like adolescent clubs are perceived as a threat since they stand to promote demand generation. As a result of this, there is reluctance amongst tea estate owners to allow nutrition interventions in their areas, hampering the scale up and replication of a successful intervention, thereby affecting sustainability.

Another barrier to ensuring sustainability is the absence of data from private health facilities in urban areas. While efforts to establish DHIS2 is ensuring quality data monitoring and reporting in rural areas; if data from the private health facilities is not captured within the DHIS2, it would remain incomplete and restrict the sustainability of interventions.

As a dedicated unit for nutrition related planning and monitoring, the institutionalization of NIPU is an enabler to sustain regular monitoring of nutrition interventions. However, the unit's independent functioning post withdrawal of UNICEF's support will be critical for the sustained use of evidence based planning and decision making.

Overall, the lack of a uniform and sustained preventive intervention for the nutrition program both at the facility and community level may prove to be a major threat to the sustainability of all nutrition interventions so far.

Lessons Learned

Given its technical capacity and high level of trust from the government and changing economic environment, UNICEF is well placed to play a catalyst role in identifying and promoting innovations and best practices that can be replicated and scaled up. However, modelling innovative services or approaches in a context where absorption capacity is limited and resources to support scale-up are insufficient, require a long-term operational plan to be supported with careful assessment of readiness, investment requirements and commitment before implementation. This is particularly important when multiple pilots are planned at the same time. Therefore, when introducing innovations, UNICEF has to be mindful that approaches to be scaled up consider local resources from the beginning. Cost-effective replicable innovations should be costed out from the outset and involve the Ministry of Planning and Finance.

Programmes that operate at a system level and seek to address complex needs of children, namely nutrition and address key bottlenecks/barriers to equity, require integrated cross-sectoral programming and careful examination of externalities and government change processes to sustain programming and optimize results. A programme theory with a precise definition of causal linkages within and across its components is needed to enable concerted efforts and closer monitoring of progress. This also applies when coordinating with other sector actors, such that comprehensive services can be provided. This can be achieved through the creation of joint action plans including a joint resource mobilisation strategy that presents clear logic and correlations for sectoral integration.

System level reform support must be accompanied by comprehensive C4D strategies to ensure system changes take up root across society. Traditional communication approaches are insufficient to tackle the deeply ingrained social norms and entrenched practices within society that hamper uptake of (nutrition) services and adoption of positive (nutrition) behaviours. Therefore, C4D efforts embedded within and integrated with nutrition's programmatic interventions are essential to ensure results from improved service delivery through the uptake and utilization of services.

Continual course correction during implementation of nutrition programmes is critical to addressing factors that might limit coverage and potential for impact. Programme improvement requires rigorous scientific inquiry to identify and address implementation pathways and the factors that affect them.

Recommendations

1. In order to sustain the gains of DNSOs, UNICEF should advocate fast tracking of appointment of DNCs by GoB. Further, in the urban context, UNICEF should consider advocacy with the MoLGRD&C, GoB for creation and deployment of a cadre of nutrition officers to lead nutrition service delivery in urban areas. This will facilitate GoB in implementation of nutrition interventions through existing government mechanisms and overcome dependence on external funding.
2. UNICEF should advocate for the integration of health services provided by DGFP into DHIS2 in order to ensure coordination amongst DGHS and DGFP on reporting SDG indicators. Additionally, towards addressing the challenge of capturing data from the private health facilities in urban areas and resistance from tea estate owners, UNICEF must liaise with MoLGRD&C for issuance of an official mandate to ensure compliance among private health facilities to report data on nutrition indicators through DHIS2.
3. While technical support provided by UNICEF to facilitate reporting through MIS has strengthened the delivery of services, to further enhance the effectiveness of delivery of services, it is essential that the MIS also captures data on: i) aspects related to consumption (IFA and other micronutrient supplementations), ii) tracking the movement of patients post referral to health facilities (at district /upazila level) from the community clinic, iii) compliance to treatment protocol and iv) quality of delivery of services. In addition to focusing on the use of data for planning and budgeting (that is currently not taking place), UNICEF must also ensure inclusion of indicators on these aspects within DHIS2. GoB, with support from UNICEF nutrition programme, can consider using the supportive supervision mechanism to monitor the quality of services provided by CHWs and track uptake and utilization of services. Supportive supervision will also enable appropriate feedback to CHWs and help highlight specific capacity gaps that need to be addressed. In this manner, use of data for decision making regarding all aspects of service delivery would be encouraged.
4. Towards acceleration of reduction in wasting and the incidence of early marriage, the programme needs to focus more on preventive and proactive counselling (rather than curative counselling) to overcome prevalent social norms and thereby, promote positive nutrition behaviours. This will help increase both the reach as well as effectiveness of counselling services. Towards this, UNICEF needs to focus on advocacy with the GoB to improve counselling through home based visits and fast track efforts towards strengthening the supportive supervision mechanism.
5. Evidence on leveraging of funds through development partners and private sector and working with shared services being an efficient mechanism to achieve common objectives has been established. Going forward, this must be considered as a basis for joint programming (using comparative advantage for complementary interventions) and resource mobilization with other development partners for extending support to GoB in achieving nutrition goals.
6. While coordinated efforts amongst the UNICEF sections are leading towards comprehensive coverage of services, it is important to bear in mind that such an approach carries the risk of considerable lack of strategic orientation and depth of engagement in several areas. Therefore, to strengthen internal

coherence among UNICEF sections and the resulting interventions, it is advisable for all the sections to collectively discuss their respective objectives and plans to develop a unified approach, demarcating contours of engagement such that joint action plans can be created towards more coordinated efforts to mainstream nutrition.

7. UNICEF should consider coordination with partners like WFP to generate evidence on the efficacy of interventions promoting dietary diversity and positive nutrition behaviours through training and demonstration, such that similar programmes are introduced for adolescents. WFP's school feeding programme (currently being implemented in 2 upazilas of Cox's Bazar), as part of an Essential Learning Package, focuses on enhancing dietary diversity by providing support to the vegetable gardens in schools. Additionally, they also create "Little Agriculturists" to increase knowledge on desired nutrition practices through peer-to-peer sharing. While this programme is targeted towards primary students, it demonstrates the integration of various sectors including education, nutrition, WASH and health. UNICEF may consider leveraging such interventions of other partners and advocating for government ownership and scale up of such integrated interventions that are likely to aid achievement of nutritional targets.
8. Owing to the success of the M@W initiative, representatives of Ministry of Labour and Employment, GoB are considering hosting a workshop to share RMG sector's experience on M@W, with the aim of replicating the intervention in other sectors. This offers an opportunity to scale up the M@W initiative to other private sector industries and ensure the sustainability breastfeeding-friendly workplaces. However, there is a need for UNICEF to fast track partnership with the Bangladesh Garment Manufacturers and Exporters Association to ensure that more garment manufacturers are committed to establishing an enabling work environment for the realization of maternity and child rights. The wide scale adoption of the intervention by the RMG sector will further set a precedent for other private sector industries and encourage replication.
9. As a result of multi-stakeholder and multi-sectoral approaches to deliver nutrition services, the augmentation of field force through each line departments (apart from MoHFW), is likely to be an enabler for the sustainability of nutrition-sensitive interventions. It is suggested that capacities of community front-line workers of each department be utilized for nutrition information dissemination, awareness generation as well as monitoring and reporting of malnutrition cases. This can help accelerate improvements in undernutrition and achieve the desired nutritional outcomes in a sustained manner.
10. As Bangladesh transitions towards becoming a MIC, there is a greater need for UNICEF to play an advocacy role and provide technical assistance rather than supporting direct service delivery on behalf of the government, as the latter does not promote ownership and sustainability. UNICEF is well placed to play this advocacy role effectively due to its strong subject matter expertise, ability to respond to the evolving context of the country and government systems. Therefore, UNICEF should prepare an exit strategy to phase out its support in various interventions so that the initiatives can be more sustainable and scaled up faster by GoB. In the meanwhile, GoB may consider taking forward the successful interventions independently by ensuring adequate financial resources to leverage the gains and sustain the results.
11. Despite the programme's alignment with the National Guidelines for CMAM, all community based programmes remain as pilots, largely as a response to emergency situations, without a uniform strategy to scale up. In order to ensure long-term improvements in the management of SAM, CMAM needs to be implemented through the existing ministry of health infrastructure as a part of a standard primary health care package. Going forward, there is a need to strengthen the capacity of GoB to engage with the community (not limited to emergency response) for timely diagnosis and effective treatment of acute malnutrition. This coupled with other preventive interventions (for instance counselling through home based visits) will ensure UNICEF's efforts to address stunting are responsive and adequate. UNICEF may therefore, consider focusing on preventive programming in the next CP.

12. While the current CP focuses on accelerating the reduction of stunting and improving adolescents' health and well-being, it is recommended that the new CP also focuses on another emerging spectrum of malnutrition in Bangladesh i.e. rising levels of overweight and obesity among adolescents. This would essentially mean that UNICEF in the next CP should support GoB in addressing the double burden of undernutrition/malnutrition and overweight/obesity among adolescents –both who are married and unmarried.

CONTEXT

Determinants of undernutrition in Bangladesh and its consequences

Adequate nutrition is critical to a child's survival, development, and long-term well-being. Undernutrition and micronutrient deficiencies during childhood and pregnancy manifest themselves in various ways, including stunting (low height for age), underweight (low weight for age) and wasting (low weight for height) of children. Not only does undernutrition contribute to infant, child, and maternal morbidity and mortality, in the long term it impedes physical and cognitive development of children by reducing their learning capability, and as adults, their productivity and income earning capacity. Chronic undernutrition can lead to poverty, creating a vicious cycle. The generational effect of undernutrition has far-reaching adverse consequences on human capital, economic productivity, and overall national development. Undernutrition costs Bangladesh more than 7,000 Crore Taka (US\$ 1 billion) in lost productivity every year⁴, and even more in health care costs⁵. Hence, improving nutrition is critical for reducing poverty and accelerating the development of low- and middle-income countries.

The causes of child undernutrition are not just limited to lack of adequate, nutritious food, but also include frequent illness, poor care practices, lack of access to healthcare and other social services⁶. *UNICEF's Conceptual Framework of Child Undernutrition* first outlined these multifaceted determinants in 1990, identifying the immediate, underlying and basic causes of undernutrition. Over the years, the framework has evolved to incorporate new knowledge and evidence on the causes, consequences and impacts of undernutrition (attached in Annexe XII⁷).

As indicated in the conceptual framework, the *basic factors* refer to the social, economic and political context of the affected population, and structures and processes that perpetuate poverty leading to limited household access to adequate resources that support maternal and child nutrition. Poor households have lower purchasing power resulting in inadequate food access, poor dietary diversity and food intake. Moreover, lack of sufficient knowledge about safe nutrition practices in poor households leads to inadequate care and feeding practices for children, unhealthy household and surrounding environments (including quality of sanitation and drinking water, and personal hygiene) and inaccessible and often inadequate health care. These underlying factors contribute to a child's inadequate dietary intake and exposure to diseases. Together these factors have a long-term influence on maternal and childhood undernutrition.

Rationale for a multi-sectoral approach to address undernutrition

Updates from the Lancet Nutrition Series 2013 indicated that direct nutrition interventions such as addressing maternal nutrition, infant and young child feeding (IYCF), micronutrient deficiencies and management of acute malnutrition, will avert only part of the global stunting cases. To accelerate progress in nutrition, the four part Lancet series examined the potential of effective, large-scale nutrition-sensitive programmes that address key underlying determinants of nutrition by enhancing the coverage and effectiveness of nutrition-specific or direct nutrition interventions⁸. It concluded that nutrition sensitive

⁴ FAO, WFP and IFAD. 2012. The State of Food Insecurity in the World 2012. Economic growth is necessary but not sufficient to accelerate reduction of hunger and malnutrition. Rome, FAO.

⁵ UN Renewed Efforts Against Child Hunger (REACH), Undernutrition in Bangladesh A Common Narrative. 2014

⁶ United Nations Children's Fund. UNICEF's approach to scaling up nutrition for mothers and their children. Discussion paper. Programme Division, UNICEF, New York, June 2015

⁷ *ibid*

⁸ Ruel M & Alderman, H (2013) Nutrition-sensitive interventions and programmes: how can they help to accelerate progress in improving maternal and child nutrition? The Lancet. 382(9891), 536-551.

approaches can address key underlying determinants of nutrition and potentially enhance the scale and effectiveness of nutrition-specific interventions. Some, albeit growing evidence, indicates that interventions in the sectors of social protection, early childhood development, education and water, sanitation, and hygiene (WASH), also have immense potential to improve nutrition outcomes in specific country and local contexts⁹.

Moreover, the series highlighted the need for *increased focus on reducing stunting (as compared to underweight)* because it is highly prevalent in nearly all low-and-middle-income countries (LMICs), and has significant health and development consequences¹⁰. Data also suggests that specific groups including children under two years of age, adolescent girls, pregnant and lactating mothers are more affected by undernutrition compared to the general population. The 1,000 days between the start of a woman's pregnancy and the child's second birthday offer an extraordinary window of opportunity for preventing undernutrition and its consequences¹¹.

However, concerns such as intrauterine growth restriction that contribute to poor child nutrition outcomes, indicate the need for a second window of opportunity for interventions among pregnant women, women of childbearing age, and adolescents. In countries with high burden of undernutrition and young age at first pregnancies, adolescents become a key target group for attention in stunting-reduction programmes as not only are they approaching child bearing age, but are also at the cusp of their own development that will determine their well-being.

Increasing evidence on the consequences of stunting and the impact of related interventions has also strengthened advocacy for nutrition as a sound investment for poverty reduction and sustainable social and economic development¹². Nutrition networks and partnerships with an increased focus on multi-sector programming to address underlying determinants of malnutrition, especially stunting, have been strengthened over the years across regions. These partnerships are facilitated through various initiatives such as the Scaling Up Nutrition (SUN) movement, the United Nations Zero Hunger Initiative, No Wasted Lives coalition, and Global Nutrition Cluster (GNC) guided by the Sustainable Development Goals (SDG) including SDG-2 (end hunger and all forms of malnutrition by 2030) and nutrition targets approved by the World Health Assembly (WHA).

Nutrition situation in Bangladesh

Prevalence of stunting and its contributing factors

Despite its numerous challenges, Bangladesh has made sustained progress in reducing child undernutrition in the last two decades. Data trends from the Bangladesh Demographic and Health Survey (BDHS) indicate decline in prevalence of stunting from 55 percent in 1997, to 41 percent in 2011, 36 percent in 2014 and 31 percent in 2017¹³.

⁹ The Lancet, Executive Summary of The Lancet Maternal and Child Nutrition Series, 2013

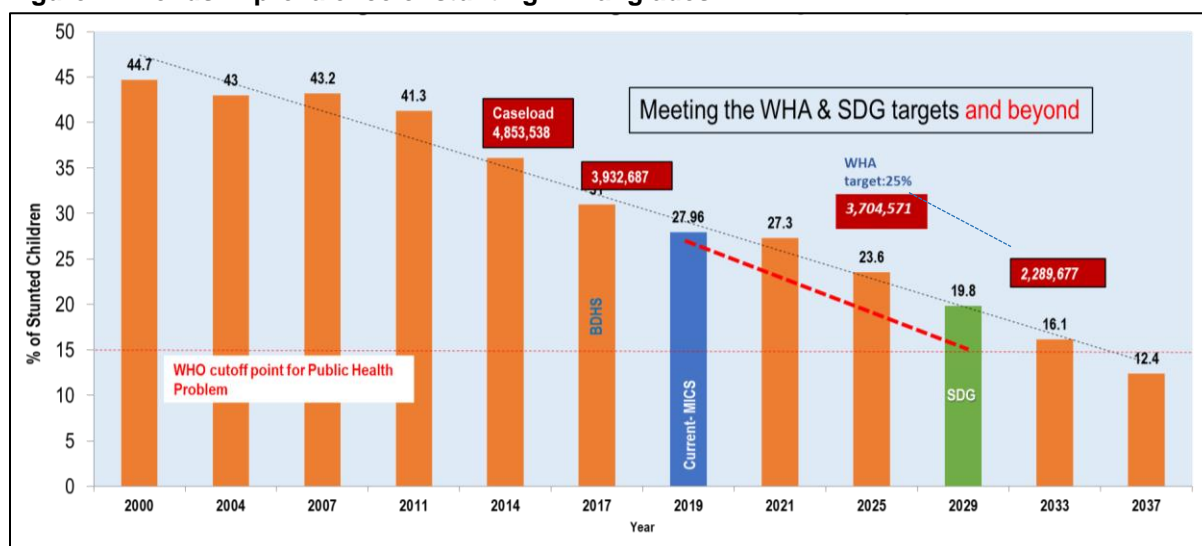
¹⁰ Bhutta ZA, Das JK, Rizvi A, et al, The Lancet Nutrition Interventions Review Group, and the Maternal and Child Nutrition Study Group. Evidence-based interventions for improvement of maternal and child nutrition: what can be done and at what cost? Lancet 2013; published online June 6. [http://dx.doi.org/10.1016/S0140-6736\(13\)60996-4](http://dx.doi.org/10.1016/S0140-6736(13)60996-4).

¹¹ United Nations Children's Fund. UNICEF's approach to scaling up nutrition for mothers and their children. Discussion paper. Programme Division, UNICEF, New York, June 2015

¹² *ibid*

¹³ National Institute of Population Research and Training (NIPORT), Mitra and Associates, and ICF International. 2016. Bangladesh Demographic and Health Survey 2017. Dhaka, Bangladesh, and Rockville, Maryland, USA: NIPORT, Mitra and Associates, and ICF International.

Figure 1: Trends in prevalence of stunting in Bangladesh



Source: NNS-OP Presentation

As can be seen from the figure above, stunting is on a decline and the SDG target of reducing prevalence of stunting to 27 percent is likely to be achieved by 2025. Thus adequate efforts that are prioritized by regions and population groups due to wide disparity in prevalence of undernutrition in specific geographies and demographic groups are imperative and need to be sustained¹⁴. As per BDHS 2017 data, stunting is observed to be highest in the Sylhet division (43 percent), second highest in Mymensingh division (36 percent) and lowest in Khulna and Dhaka at 26 percent¹⁵. Chittagong division's stunting levels have reduced from 38 percent in 2014 to 33 percent in 2017. Rural children (33 %) are more likely to be stunted than urban children (25 %). Stunting was observed to be similar among boys and girls (30.8% and 30.9% respectively) at the national level.

Data also indicates a strong relationship between household poverty and undernutrition. 40 percent of children whose mothers are in the lowest wealth quintile are stunted compared with 17 percent of those in the wealthiest quintile¹⁶. While these figures of inter-quintile differences indicate the existing socio-economic inequities in under-five child stunting, what's concerning is that undernutrition is not restricted to the poorest households but also has a significant prevalence in the richest quintile. Almost one out of five children are stunted even in the highest wealth quintile in Bangladesh. This demonstrates that addressing poverty alone is not sufficient to improve child undernutrition¹⁷. Other drivers of nutrition such as knowledge about proper diet, undernourishment of the foetus, low birth weight¹⁸ (which has little variation by wealth quintile), and women's power in the household to take decisions, also require specific attention to reduce stunting across all wealth quintiles¹⁹.

¹⁴ Ministry of Health and Family Welfare, GOB, 2017. Second National Plan of Action for Nutrition (NPAN-2)

¹⁵ National Institute of Population Research and Training (NIPORT), Mitra and Associates, and ICF International. 2016. Bangladesh Demographic and Health Survey 2014. Dhaka, Bangladesh, and Rockville, Maryland, USA: NIPORT, Mitra and Associates, and ICF International.

¹⁶ National Institute of Population Research and Training (NIPORT), Mitra and Associates, and ICF International. 2016. Bangladesh Demographic and Health Survey 2017. Dhaka, Bangladesh, and Rockville, Maryland, USA: NIPORT, Mitra and Associates, and ICF International.

¹⁷ Ahmed, Akhter. (2017). Strategic Review of Food Security and Nutrition in Bangladesh. 10.1314/RG.2.2.24673.71529.

¹⁸ According to the recent UNICEF/WHO global report, Bangladesh has the highest prevalence of low birth weight of all countries with available data (28%).

¹⁹ *ibid*

It is notable that the prevalence of stunting among children under age 5 in the richest quintile of other South Asian countries ranges from 17 percent in Nepal²⁰ to about 22 percent in India²¹ and Pakistan²². This indicates that high prevalence of stunting among children under age 5 is not unique to Bangladesh but is a characteristic of the South Asian region.

The underlying determinants of wasting and stunting in South Asia are similar, but not universal across geographies. However, the prevalence of wasting, severe wasting and the co-occurrence of being wasted and stunted, is higher in rural areas than in urban areas in all countries²³.

As with stunting, children in the poorest households are more likely to be underweight or wasted compared to children in the wealthiest households²⁴. Female children are only slightly more likely to be underweight (33%) compared to male children (32%)²⁵. Furthermore, studies²⁶ have shown that children who were stunted were also more likely to be wasted in Bangladesh. More than five per cent of Bangladeshi, Indian and Pakistani children exhibit both manifestations of undernutrition simultaneously, raising is a serious concern. The combined effects of wasting and stunting are likely to amplify the risks associated with each condition separately. Moreover, both conditions increase susceptibility to morbidity²⁷. Therefore, both wasting and stunting share causal pathways, which suggest that action on one is very likely to impact the other. Literature also suggests that rural Bangladeshi children are more likely to be wasted if they have a mother of short stature and children with working mothers are more likely to be wasted than children of mothers who are not working.

The relationship between low maternal BMI and child wasting may be mediated through poor birth outcomes that have been associated with low maternal BMI previously, wherein underweight women were 1.3 times more likely to have children with stunting and 1.6 times more likely to experience wasting compared to normal weight women²⁸.

Children whose mothers have completed secondary and higher education (18%) are less likely to be stunted compared to those whose mothers have no formal education (47%)²⁹. Stunting is most prevalent among children in the age group of 18-23 months compared to other age groups of children under five years³⁰. Inadequate complementary feeding practices and unhealthy household and surrounding environments are likely to have contributed to stunting in this age group. Therefore, maternal nutrition reflected in BMI and short stature and maternal literacy are all predictors of wasting, just as they are for stunting.

The extent of undernutrition and the disparity in its prevalence across different demographic groups in the country are a reflection of the basic, underlying and immediate causes of undernutrition. Among these, lack of maternal education, IYCF practices, limited access to food and healthcare, poor quality of drinking water

²⁰ Ministry of Health, Nepal; New ERA; and ICF. 2017. Nepal Demographic and Health Survey 2016. Kathmandu, Nepal: Ministry of Health, Nepal.

²¹ International Institute for Population Sciences (IIPS) and ICF. 2017. National Family Health Survey (NFHS-4), 2015-16: India. Mumbai: IIPS.

²² National Institute of Population Studies (NIPS) [Pakistan] and ICF. 2019. Pakistan Demographic and Health Survey 2017-18. Islamabad, Pakistan, and Rockville, Maryland, USA: NIPS and ICF.

²³ Harding, K. L., Aguayo, V. M., & Webb, P. (2018). Factors associated with wasting among children under five years old in South Asia: Implications for action. *PLoS one*, 13(7), e0198749.

²⁴ National Institute of Population Research and Training (NIPORT), Mitra and Associates, and ICF International. 2016. Bangladesh Demographic and Health Survey 2014. Dhaka, Bangladesh, and Rockville, Maryland, USA: NIPORT, Mitra and Associates, and ICF International.

²⁵ *ibid*

²⁶ <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6029776/>

²⁷ McDonald, C. M., Olofin, I., Flaxman, S., Fawzi, W. W., Spiegelman, D., Caulfield, L. E., ... & Nutrition Impact Model Study. (2013). The effect of multiple anthropometric deficits on child mortality: meta-analysis of individual data in 10 prospective studies from developing countries. *The American journal of clinical nutrition*, 97(4), 896-901.

²⁸ Khan, M. N., Rahman, M. M., Shariff, A. A., Rahman, M. M., Rahman, M. S., & Rahman, M. A. (2017). Maternal undernutrition and excessive body weight and risk of birth and health outcomes. *Archives of Public Health*, 75(1), 12.

²⁹ National Institute of Population Research and Training (NIPORT), Mitra and Associates, and ICF International. 2016. Bangladesh Demographic and Health Survey 2014. Dhaka, Bangladesh, and Rockville, Maryland, USA: NIPORT, Mitra and Associates, and ICF International.

³⁰ *ibid*

and sanitation and hygiene, and the status of girls and women in the social structure and within the family, contribute to the high prevalence of undernutrition in the country.

IYCF Practices

Exclusive breastfeeding of children under 6 months has increased from 55 percent in 2014 to 65 percent in 2017³¹. However, despite this increase, only 32 percent of children between 4-5 months are exclusively breastfed³². Only 34 percent of children aged 6-23 months are fed appropriately as per recommended IYCF practices^{33,34} which is far below the revised target of 45 percent for 2016 set by the Health Population Nutrition Sector Development Programme (HPNSDP), MoHFW, GoB 2014. While gender disparity is not observed in feeding as per IYCF practices, adherence to IYCF practices is better in urban areas (39%) than in rural areas (32%). Further, recommended IYCF practices are least observed in Sylhet division and most common in Rangpur division followed by Dhaka. Compliance with IYCF practices increases with wealth levels, however, even in the highest wealth quintile, approximately 50 percent of the children receive appropriate feeding, and reflecting the likelihood of lack of knowledge on these practices in the richest quintile as well³⁵. Additionally, while there has been an increase in the percentage of children (6-23 months) receiving a minimum acceptable diet (from 23 percent in 2014 to 34 percent in 2017), the numbers are still far from achieving the 4th Health, Population and Nutrition Sector Programme (HPNSP) target of 45 percent of children consuming a minimal acceptable diet by 2022.

This may have a significant bearing on the malnutrition levels of infants in the country, especially combined with the high stunting prevalence.

The impact of poor IYCF practices on undernutrition is exacerbated by a lack of access to improved sanitation facilities, which increases the risk of illness and infections that can impair nutrition and growth. Only 45 percent of households have an improved toilet facility and, although most households have a handwashing station (96 percent), only 21 percent of rural households and 48 percent of urban households have both water and soap for handwashing³⁶. A study on state of food security and nutrition in Bangladesh stated that almost three out of four caregivers do not practice recommended hygiene behaviour with only 2 percent of caregivers reporting to wash their hands with soap before feeding a child. Safe disposal of child's solid waste also remained low with only 50 percent of the households following safe practices³⁷. This situation worsens in slum areas of urban towns and cities with high population density and poor sanitation facilities. Only 13 percent of households in slums had access to improved sanitation compared to over 50 percent in non-slum and other urban areas³⁸.

Poor sanitation and hygiene practices result in diarrhoea and other infectious disease contributing to undernutrition. The BDHS (2014) survey showed that almost 6 percent of children under five years had diarrhoea in the two weeks preceding the survey and among them only 38 percent received both oral rehydration therapy (ORT) and zinc. About 5.4 percent of children under age five had symptoms of acute respiratory infection (ARI) and of these only 34.2 percent were given antibiotics to treat the illness. While

³¹ National Institute of Population Research and Training (NIPORT), Mitra and Associates, and ICF International. 2016. Bangladesh Demographic and Health Survey 2017. Dhaka, Bangladesh, and Rockville, Maryland, USA: NIPORT, Mitra and Associates, and ICF International.

³² Benedict, R. K., Craig, H. C., Torlesse, H., & Stoltzfus, R. J. (2018). Trends and predictors of optimal breastfeeding among children 0–23 months, South Asia: Analysis of national survey data. *Maternal & child nutrition*, 14, e12698.

³³ *Ibid* (44)

³⁴ As per the Bangladesh DHS 2017, the percentage of children who are fed with appropriate IYCF practices is calculated by taking into account current guidelines on the number of food groups and the number of times a child should eat during the day or night preceding the survey. The figure presented here means that 34 percent of children of age 6-23 months are given milk or milk products and foods from the recommended number of food groups and are fed at least the recommended minimum number of times.

³⁵ Na, M., Aguayo, V. M., Arimond, M., Narayan, A., & Stewart, C. P. (2018). Stagnating trends in complementary feeding practices in Bangladesh: An analysis of national surveys from 2004-2014. *Maternal & child nutrition*, 14, e12624.

³⁶ *Ibid* (48)

³⁷ Helen Keller International (HKI) and James P. Grant School of Public Health (JPGSPH). (2016). State of food security and nutrition in Bangladesh: 2014. Dhaka, BD: HKI and JPGSPH.

³⁸ National Institute of Population Research and Training (NIPORT), International Centre for Diarrhoeal Disease Research, Bangladesh (icddr), Measure Evaluation (2013). Bangladesh Urban Health Survey. Dhaka, Bangladesh.

Bangladesh has achieved nearly universal access to drinking water and close to ending open defecation, the quality of access is not sufficient to guarantee holistically safe WASH environments³⁹. As observed earlier, the risk of sanitation and hygiene related infections is three times greater for the poorest wealth quintile compared to the richest quintile⁴⁰. Likewise, children residing in urban slums are more prone to falling sick due to poor sanitation services, lack of availability of clean drinking water and inadequate hygiene practices than those living in non-slum urban areas.

Maternal and adolescent girls' nutrition

Maternal undernutrition plays a significant role in perpetuating an intergenerational cycle of malnutrition and poverty. In Bangladesh, women of reproductive age suffer from high prevalence of early pregnancy and anaemia, which are significant contributors to chronic undernutrition⁴¹. Early pregnancy and childbirth are not only a risk to health and well-being of adolescent girls but also increase the risk of stillbirths and neonatal deaths, low birth weight, premature birth, asphyxia, and stunting⁴². After early childhood years, adolescence provides the second and last window to support growth and development to break the inter-generational cycle of undernutrition⁴³. However, teenage pregnancy and motherhood are a serious concern in Bangladesh with almost half of women 25-49 of age giving birth by age 18 and about 31 percent of women aged 15-19 years already beginning childbearing. Childbearing among adolescents is more common in rural than urban areas and, within urban areas, it is more prevalent among adolescent girls who reside in slums⁴⁴. Early childbearing among adolescent girls showed almost no change between 2011 and 2014. Hence, a programmatic focus on the nutritional status of adolescent girls is of critical importance in reducing childhood undernutrition.

Maternal undernutrition in Bangladesh is highest among adolescent girls 15-19 years of age (31%)⁴⁵ (body mass index < 18.5 kg/m²) and about 18 percent of pregnant women are undernourished with a mid-upper arm circumference (MUAC) of less than 230 mm⁴⁶. Fifty percent of pregnant women and 40 percent of non-pregnant non-lactating (NPNL) women suffer from anaemia, 57 percent of NPNL women are zinc deficient, and 22 percent of NPNL are deficient in B12⁴⁷. More than half of women aged 15-49 who had a child birth in the last three years did not receive a postpartum vitamin A dose. Receipt of post-partum vitamin A dose was lowest in the Sylhet division. Women in urban areas (53%) are more likely to receive vitamin A supplements compared to those in rural areas (43%) which may be related to enhanced nutrition service coverage, and better knowledge level of mothers in urban areas.

Micronutrient deficiencies among children and women

Low coverage of micronutrient supplementation, especially vitamin A and iron, affects child health and contributes to child morbidity and mortality. Bangladesh has witnessed significant improvements in reducing iodine deficiency in children under five years through the National Salt Iodization Programme. More than three-quarters of children under 5 are living in households with adequately iodized salt and the median urinary iodine concentration is in the "optimal" range among school-age children⁴⁸. However, deficiencies

³⁹ World Bank. (2019). Nurturing the 'early years' of life with water, sanitation, & hygiene: Evidence and Policy Levers for Bangladesh: 2019. The World Bank: Washington

⁴⁰ ibid

⁴¹ The Global Nutrition Report 2018, classifies Bangladesh as experiencing two forms of malnutrition – anaemia and stunting.

⁴² Black RE, Victora CG, Walker SP, and the Maternal and Child Nutrition Study Group. Maternal and child undernutrition and overweight in low-income and middle-income countries. *Lancet* 2013

⁴³ United Nations Children's Fund. The State of the World's Children 2011. Adolescence An Age of Opportunity. New York: UNICEF, 2011.

⁴⁴ National Institute of Population Research and Training (NIPORT), International Centre for Diarrhoeal Disease Research, Bangladesh (icddr,b), Measure Evaluation (2013). Bangladesh Urban Health Survey. Dhaka, Bangladesh.

⁴⁵ National Institute of Population Research and Training (NIPORT), Mitra and Associates, and ICF International. 2016. Bangladesh Demographic and Health Survey 2014. Dhaka, Bangladesh, and Rockville, Maryland, USA: NIPORT, Mitra and Associates, and ICF International.

⁴⁶ GoB (2014). Country Nutrition Paper Bangladesh. International Conference on Nutrition 21 years later, November 2014. Rome, Italy.

⁴⁷ icddr,b, UNICEF, Bangladesh, Global Alliance for Improved Nutrition (GAIN), Institute of Public Health and Nutrition (IPHN) (2011-12). National Micronutrients Survey. Dhaka, Bangladesh

⁴⁸ National Institute of Population Research and Training (NIPORT), Mitra and Associates, and ICF International. 2016. Bangladesh Demographic and Health Survey 2014. Dhaka, Bangladesh, and Rockville, Maryland, USA: NIPORT, Mitra and Associates, and ICF International.

in vitamin A, zinc, iron folate and B12 among children and women remain a concern. About 20.5 percent and 45 percent of pre-school children suffer from vitamin A and zinc deficiency respectively⁴⁹. Prevalence of anaemia among children under 5 years is 40 percent as per World Bank's estimates in 2016⁵⁰. Zinc deficiency affects 57 percent of NPWL women⁵¹. Twenty-two percent of NPWL women are deficient in B12 and 57 percent are deficient in zinc⁵². Prevalence of calcium deficiency is almost 25 percent for pre-school children, 18 percent for school-aged children and 26 percent for NPWL⁵³.

Food security and dietary diversity

The Food Security and Nutrition Surveillance Project reports⁵⁴ shows that while food insecurity has declined for all the quintiles, it has declined relatively slowly for the poorer ones. In 2010, the proportions of food insecure households were found to be 68 percent for the bottom two quintiles and 20 percent for the top two quintiles. By 2014, these proportions had come down to 43 percent among the bottom two quintiles and 6 percent among the top two⁵⁵. These figures suggest that the rate of progress was much slower for the poorer groups⁵⁶. Moreover, existing household level food insecurity is exacerbated by poor access to food and limited dietary diversity, which in turn, worsens the situation of undernutrition.

Bangladeshi diet is dominated by consumption of rice and cereals which contributes around 70 percent of the per capita total caloric intake. As per the estimates of Food and Agriculture Organization of the United Nations (FAO) in 2016, Bangladesh achieved self-sufficiency in rice in 2012, producing enough rice domestically to meet its consumption needs. However, about 15 percent of the population is still considered undernourished, with insufficient access to calories, high prevalence of micronutrient deficiencies and low dietary diversity⁵⁷. About thirty-five per cent of the population had mean dietary diversity scores of less than 6 out of 12 food groups⁵⁸. While rice, vegetables and fish are important part of the diet, dietary intake also varies by income groups, social groups and residence. For instance, poorer groups have gained more slowly than richer groups, and women still suffer further from unequal distribution of food when there is not enough food for the family⁵⁹.

Humanitarian context and climate related emergencies

Bangladesh is one of the countries expected to be worst affected by climate variability and change. Shifting rainfall patterns, frequent flooding, extreme weather patterns, high population density, and low resilience to economic shocks, puts the country at high risk to climate related emergencies. Between 1980 and 2008, the country has faced over 200 natural disasters causing loss of over 190,000 lives and an estimated damage of US\$16 billion. Bangladesh was ranked the highest for deaths per 100,000 inhabitants by the Global Climate Risk Ranking 2007. Bangladesh's Health-National Adaptation Plan (HNAP) also recognizes the impact of climate variability on exacerbating the burden of health and nutrition outcomes.

⁴⁹ icddr,b, UNICEF, Bangladesh, Global Alliance for Improved Nutrition (GAIN), Institute of Public Health and Nutrition (IPHN) (2011-12). National Micronutrients Survey. Dhaka, Bangladesh

⁵⁰ World Bank.WDI: Health Statistics. Prevalence of anaemia, children under age 5, World Health Organization, Global Health Observatory Data Repository/World Health Statistics, <https://data.worldbank.org/indicator/SH.ANM.CHLD.ZS?locations=BD>

⁵¹ icddr,b, UNICEF, Bangladesh, Global Alliance for Improved Nutrition (GAIN), Institute of Public Health and Nutrition (IPHN) (2011-12). National Micronutrients Survey. Dhaka, Bangladesh

⁵² ibid

⁵³ ibid

⁵⁴ The National Food Security and Nutritional Surveillance Project (FSNSP) was a project conducted from July 2008 - June 2015, the aim of which was to track nationally representative estimates for food security and nutrition in Bangladesh. The project provided up-to-date, seasonal information from 2010 - 2014 on the situation of food and nutrition security in Bangladesh for six agro-ecological zones as well as the nation as a whole. The main target group of the surveillance were women and under-five children.

⁵⁵ Helen Keller International and James P. Grant School of Public Health). (2015). State of Food Security and Nutrition in Bangladesh: 2014. BRAC University: Dhaka

⁵⁶ Ahmed, Akhter. (2017). Strategic Review of Food Security and Nutrition in Bangladesh. 10.13140/RG.2.2.24673.71529.

⁵⁷ 2018 Global Hunger Index | Chapter 04 | A Closer Look at Hunger and Undernutrition

⁵⁸ BBS (2010). *Household Income-Expenditure Survey 2010*. Bangladesh Bureau of Statistics (BBS), Government of the People's Republic of Bangladesh: Dhaka.

⁵⁹ ibid

The impact of climate related shocks and stresses on food security and nutrition in Bangladesh could be particularly severe given the reliance of a majority of poor rural households on agricultural livelihoods⁶⁰. Climate change effects, the resulting rising water levels and increased salinity are likely to impact agricultural production and food security which in turn, will have adverse consequences on availability and access to food at household and individual level, compounding the threat of undernutrition. This exposure to risk of food security and undernutrition are also expected to vary substantially across different geographies and population groups.

Since August 2017, about three-quarters of a million Rohingya refugees from Myanmar took refuge in Bangladesh's Cox's Bazar districts. This massive influx of refugees has caused a major humanitarian emergency being the largest concentration of refugees in the world, requiring immediate and comprehensive relief support as around 80 percent are vulnerable to food insecurity⁶¹. A nutrition survey in October 2017 indicated that malnutrition rates among children in northern Rakhine were already above emergency thresholds. The survey found the prevalence of global acute malnutrition among children of 6–59 months ranged from 14 to 24 percent, exceeding the World Health Organization (WHO) emergency threshold of 15 percent in two of three areas covered⁶². As of November 2017, around 26,000 people now live in the Kutupalong camp faced with an acute shortage of food and water, unsanitary conditions and high rates of diarrhoea and respiratory infections⁶³. This further increases stress on resources in a country with poor and food insecure population.

Nutrition challenges in urban context

With continued economic progress, Bangladesh is also facing serious challenges posed by rapid urbanisation. The urban population expanded by 35 percent between 2001 and 2011 with almost 23 percent of the national population residing in urban areas in 2011. By 2050, more than half of the country's population is expected to reside in urban areas⁶⁴. One of the key drivers of increasing urbanisation has been the growth in job opportunity in urban areas between 2003 and 2015⁶⁵. As detailed in the next section, this growth has also led to a rapid increase in participation in the workforce by women. With increasing urbanisation, population of slum settlements have increased with almost 60 percent of urban population residing in approximately 14,000 slum settlements across the country⁶⁶. This rapid influx of population in urban areas is leading to high population density with congested spaces, poor infrastructure, and lack of adequate basic services such as clean drinking water, sanitation, and health facilities.

As observed earlier, nutrition situation of children, mothers and adolescent in urban slums is much worse compared to non-slum areas. Delivery of health services in urban areas is constrained due to the complex urban health governance structure which does not have clear accountability and divides roles and responsibilities among multiple service delivery actors - MOLGRD&C, MOHFW, and urban governments⁶⁷. Further, limited clarity on strategic guidelines, capacity and accountability of MoLGRD&C on results based programme implementation makes the current service delivery environment weak⁶⁸. Significant knowledge gaps also exist in the institutional structure regarding the financing, delivery, and regulation of urban health services affect the nutrition service delivery in urban areas. Moreover, continued focus of health and

⁶⁰ Bénédicte C., Waid J., Jackson-deGraffenried M., Begum A., Chowdhury M., Skarin V., Rahman A., Islam N., Mamnun N., Mainuddin, K., and Amin S.M.A. (2015) "Impact of climate-related shocks and stresses on nutrition and food security in selected areas of rural Bangladesh" Dhaka, the World Food Programme, 150 p.

⁶¹ USAID 2018. Bangladesh: Nutrition Profile, USAID

⁶² USAID 2018. Bangladesh: Nutrition Profile, USAID

⁶³ UNICEF 2017 Press release. accessed from <https://www.unicef.org/press-releases/malnutrition-rates-among-rohingya-refugee-children-bangladesh-appear-be-least-double>

⁶⁴ UN DESA (United Nations Department of Economic and Social Affairs). 2015. World Urbanization Prospects: The 2014 Revision. New York: United Nations

⁶⁵ Qimiao Fan. World Bank. 2017. What can Bangladesh do to deliver more and better jobs for everyone?

<https://blogs.worldbank.org/endpovertyinsouthasia/what-can-bangladesh-do-deliver-more-and-better-jobs-everyone>

⁶⁶ GOB. 2015. Preliminary Report on the Census of Slum Areas and Floating Population 2014. Report, Bangladesh Bureau of Statistics, GOB, Dhaka

⁶⁷ World Bank Health and Nutrition in Urban Bangladesh <http://dx.doi.org/10.1596/978-1-4648-1199-9>

⁶⁸ UNICEF Bangladesh 2016, Nutrition Strategy: Addressing the Urban Imperative 2016-2020

nutrition services in rural areas has also contributed to poor improvements in health and nutrition outcomes in urban slums.

Gender dimensions to undernutrition

Gender inequality in decision making related to household production and consumption acts as an underlying determinant of subsequent poor nutritional status of women and young children. As per the Human Development Report, Bangladesh ranks 136 out of 187 countries on the Gender Inequality Index in 2018 indicating that women lag behind men in education attainment, employment and well-being. These inequalities manifest themselves in the form of high prevalence of early marriage and adolescent pregnancy that contribute significantly to the high prevalence of chronic undernutrition in their children. As noted earlier, adolescent girls and women in Bangladesh exhibit high-levels of micronutrient deficiencies and almost half of all women suffer from anaemia. The Food Security and Nutrition Surveillance Project (FSNSP)⁶⁹ report, 2015 shows that 25 percent of adolescent girls of age 10-18 years are stunted⁷⁰. More than half of adolescent girls and women consumed inadequately diverse diets nationally in 2014⁷¹. The percentage of adolescent girls attending school between 11-15 years is 85 percent but it drops to 35 percent among adolescent girls of 16-20 years⁷². Loss of these critical school years is likely to affect their knowledge of nutrition practices.

While there has been a rapid increase in participation in the workforce by women, they do not have adequate decision making power regarding various matters. For instance, only thirty-two percent of currently married employed women who earn cash make decisions mainly by themselves on how to use their own earnings⁷³. BDHS 2014 data indicates that 46 percent of women of childbearing age 15–49 years reported participating in decisions about their own health, major household decisions, and their children's health and that of visiting relatives. However, only 20 percent of adolescent girls of 15-19 years reported to be participating in these decisions. In addition to the adverse effects of early marriage and childbearing, adolescent girls with children under 24 months of age have little or no decision making power and poor access to required resources when their children have the greatest nutritional needs. In this light, Bangladesh's new Child Marriage Restraint Act, 2017 prohibits marriage for children under the age of 18 years. The Act is an important step towards securing the future of young girls in Bangladesh but it also contains a provision under article 19 that allows marriage of children under 18 years if it is deemed to be "in the best interests of the child". This provision opens up opportunities to violate the rights of young girls. Hence, joint advocacy of UN, donors and civil society has resulted in the Government revising the provision, limiting its application within strict conditions of the Rules of Law and with prior Court consent⁷⁴.

Policy response and initiatives to improve nutrition

The consequences of undernutrition and its considerable social and economic costs, in terms of reduced economic returns and a loss of Disability Adjusted Life Years (DALYs), are of a significant concern for policy makers in Bangladesh. As stated earlier, undernutrition costs Bangladesh more than 7,000 Crore Taka (US\$ 1 billion) in lost productivity every year⁷⁵, and even more in health care costs⁷⁶. The NPAN-2

⁶⁹ The national Food Security and Nutritional Surveillance Project (FSNSP) was a project conducted from July 2008 - June 2015, the aim of which was to track nationally representative estimates for food security and nutrition in Bangladesh. The project provided up-to-date, seasonal information from 2010 - 2014 on the situation of food and nutrition security in Bangladesh for six agro-ecological zones as well as the nation as a whole. The main target group of the surveillance were women and under-five children.

⁷⁰ James P Grant School of Public Health and National Nutrition Services. (2016). State of food security and nutrition in Bangladesh 2015. Dhaka, Bangladesh: James P Grant School of Public Health and National Nutrition Services

⁷¹ Nutrition in Adolescence, June 2018, GAIN

⁷² *ibid*

⁷³ National Institute of Population Research and Training (NIPORT), Mitra and Associates, and ICF International. 2016. Bangladesh Demographic and Health Survey 2014. Dhaka, Bangladesh, and Rockville, Maryland, USA: NIPORT, Mitra and Associates, and ICF International.

⁷⁴ UNICEF Annual Report 2017, Bangladesh

⁷⁵ FAO, WFP and IFAD. 2012. The State of Food Insecurity in the World 2012. Economic growth is necessary but not sufficient to accelerate reduction of hunger and malnutrition. Rome, FAO.

⁷⁶ UN Renewed Efforts Against Child Hunger (REACH), Undernutrition in Bangladesh A Common Narrative. 2014

acknowledges that ensuring effective investments in nutrition is estimated to lead to economic gains in Bangladesh, through an estimated increased productivity, exceeding 70,000 crore taka by 2021⁷⁷ and presumably even more⁷⁸. In this context, GoB has taken significant steps to improve the nutrition and food security situation of the country.

Global commitments to address undernutrition

Bangladesh has been widely acclaimed as one of the forerunners of *Millennium Development Goals (MDGs)* implementation achieving many targets ahead of time and others within the 2015 deadline. The country made remarkable progress in the areas of poverty alleviation, ensuring food security, primary school enrolment, and gender parity in primary and secondary level education, lowering infant and under-five mortality rate, maternal mortality rate, and reducing the incidence of communicable diseases⁷⁹. However, within MDG 1 (Eradicate Extreme Poverty and Hunger), weaker nutritional outcomes and rising regional and group disparities were identified as key challenges to performance on MDG outcomes⁸⁰.

Keeping up with the achievements made under the MDG, the Government of Bangladesh made significant efforts towards embracing the *SDGs* by completing all groundworks for implementing the *SDGs* as well as embedding the global development agenda into the 7th Five Year Plan⁸¹. While the report on progress of *SDGs* acknowledges Bangladesh's efforts towards reducing stunting and wasting, it also acknowledges the regional and demographic inequality in distribution of hunger and malnutrition across the country. These existing regional, demographic, and economic disparities pose serious challenges for nutrition policy in Bangladesh.

In 2014, Bangladesh participated in the *Second International Conference on Nutrition (ICN2)* and committed to improving nutrition by endorsing both, the Rome Declaration on Nutrition and the Plan of Action for the next decade (until 2025) and its targets⁸². It committed to strengthening and implementing policies, programmes and plans to address the multiple challenges of malnutrition⁸³. In 2017, Bangladesh held a meeting to track its progress on the ICN2, where integration of multi-sectors for nutrition policy implementation, strengthening the Bangladesh National Nutrition Council (BNNC) to coordinate and collaborate nutrition activities, support for MoHFW to implement the **NPAN-2**, implementation of the **Second Country Investment Plan (CIP2)** to support **nutrition-sensitive food systems**, and addressing inadequate resource allocation for nutrition, were discussed as some of the key priorities⁸⁴.

Bangladesh has also been one of the lead signatory countries of the *SUN* movement since 2012. Some of the key areas of support identified under the initiative include strengthening of the BNNC through capacity development and resource allocations, implementation of short term priorities outlined in the NPAN-2, strengthening of nutrition information systems, and improvement in evidence building for targeted nutrition interventions. In the same year, Bangladesh also endorsed the six global nutrition targets by 2025 at the *World Health Assembly (WHA) (2012)*.

⁷⁷ Howlader, et al. (2012). Investing in Nutrition Now: A Smart Start for Our Children, Our Future. Estimates of Benefits and Costs of a Comprehensive Program for Nutrition in Bangladesh, 2011– 2021. PROFILES and Nutrition Costing Technical Report. Washington, DC: Food and Nutrition Technical Assistance III Project (FANTA), FHI 360

⁷⁸ Ministry of Health and Family Welfare, Government of Bangladesh, 2017. Second National Plan of Action for Nutrition (2016-2025)

⁷⁹ General Economics Division (GED), Bangladesh SDGs Progress Report 2018,

⁸⁰ United Nations Development Assistance Framework UNDAF 2012-2016

⁸¹ General Economics Division (GED), Bangladesh SDGs Progress Report 2018

⁸² Ministry of Health and Family Welfare, Government of Bangladesh, 2017. Second National Plan of Action for Nutrition (2016-2025)

⁸³ FAO 2014, Bangladesh In The Second International Conference On Nutrition (ICN2)

<http://www.fao.org/bangladesh/news/detail-events/en/c/213823/>

⁸⁴ FAO 2014, Bangladesh In The Second International Conference On Nutrition (ICN2)

<http://www.fao.org/bangladesh/news/detail-events/en/c/1073282/>

National policy context

The GoB has, over the last few decades, developed policies and instruments to address the food security and nutrition situation in the country focusing on both nutrition specific and sensitive interventions. In particular, the National Five Year Plans have prioritized nutrition and food security as national issues.

The Seventh Five Year Plan (2016-2020) of Bangladesh recognises the role of concerted, multi-sectoral efforts in reducing the prevalence of child malnutrition. In this light, it includes four key sectors that impact food security and nutrition in the country. These are: Agriculture (Crop and Non-crop); (2) Environment and Climate Change; (3) Health, Nutrition and Population Development; and (4) Social Protection⁸⁵. Through these sector engagements, the plan aims to address the impeding factors related to nutrition improvement and strengthen the enabling environment for scaling up nutrition.

In 2015, the Government of Bangladesh revised and updated the NFNP 1997 to the Bangladesh National Nutrition Policy (NNP) 2015 which takes into consideration both global policies (such as SDGs, ICN2 and SUN) and relevant national policies, focusing on nutrition specific and sensitive interventions reflecting the multi-sectoral nature of ensuring nutrition. To fulfil these global and national commitments, the GoB formulated and adopted the NPAN2 in 2017 based on the priorities of the NNP 2015 and learnings from CIP and HPNSDP. The NPAN2 has been developed with support from development partners, NGOs and private sector to address malnutrition in alignment with the Vision 2021 and the Seventh Five Year Plan of the GoB, and to deliver on global commitments of the GoB⁸⁶.

Some of the other policies and strategies developed by the GoB in this period include the National Strategy on Prevention and Control of Micronutrient Deficiencies, Bangladesh (2015-2024), the National Strategy for Adolescent Health (2017-2030) and the National Social Security Strategy 2015.

Key social security programmes that impact nutrition in Bangladesh

Bangladesh has provided assistance to the poor and vulnerable groups including those facing nutrition vulnerability through social protection programmes focused on building food based safety nets such as the School Feeding Programme, Vulnerable Group Feeding (VGF) Programme, Vulnerable Group Development (VGD) Programme, Food-for-Work Programmes, Maternity Allowance Programme and Lactating Mother Allowance^{87,8889}. Moreover, the Bangladesh National Women Development Policy 2011 makes comprehensive provisions for women's rights and empowerment with a vision of improving nutrition. The National Social Security Strategy 2015 also offers opportunities to integrate nutrition in social safety nets.

Challenges in nutrition governance in Bangladesh

The interim assessment of the NNS commissioned by the World Bank⁹⁰ brought to fore a number of serious challenges for nutrition governance in the country. These issues underlined the critical requirement for improving capacity among the NNS staff at different levels of implementation, enhancing the clarity among frontline workers on nutrition delivery, and increasing the number of staff with adequate skill levels at the community clinics (CC) for nutrition service delivery. Even though Community Healthcare Providers (CHCPs) from the MoHFW are responsible for nutrition at the CC level, there is a lack of dedicated staff to deliver nutrition services. This points towards a low priority for nutrition and subsequently a lack of

⁸⁵ Ministry of Health and Family Welfare, GOB, 2017. Second National Plan of Action for Nutrition (NPAN-2)

⁸⁶ Ministry of Health and Family Welfare, GOB, 2017. Second National Plan of Action for Nutrition (NPAN-2)

⁸⁷ ICN2—2014: Country Nutrition Paper, FAO <http://www.fao.org/3/a-at608e.pdf>

⁸⁸ Ministry of Women and Children Affairs: Progress report

⁸⁹ In 2018, the Ministry of Woman and Children Affairs (MoWCA) combined the existing Maternity Allowance Programme and Lactating Mother Allowance to design the Improved Maternity and Lactating Mother Allowance (IMLMA) which aims to facilitate rolling enrolment, provide monthly Government to Person payments and improve behavioural change communication.

⁹⁰ Saha, K. K., Billah, M., Menon, P., El Arifeen, S., & Mbuya, N. V. (2015). Bangladesh National Nutrition Services: assessment of implementation status. The World Bank.

accountability for nutrition services. Further, the assessment highlighted the need for more effective inter-Ministry and inter-departmental co-ordination and strengthening the mechanisms of evidence generation for nutrition related interventions.

The NNP 2015 has taken adequate steps to make the MoHFW the lead coordinating agency among the ministries and by reviving the BNNC as the overarching supra-ministerial coordinating body. However, the BNNC is located within the MoHFW which in turn, poses a challenge in coordinating with other ministries. Furthermore, its capacity to lead on Nutrition remains a challenge. Therefore, multi-sector coordination along with management of multiple coordination structures require adequate support from all stakeholders to support the implementation of the NPAN-2.

Moreover, while Bangladesh has a plethora of food or cash based social safety net programmes, their outreach needs to be expanded through better targeting of pregnant and lactating women, infant and young children and adolescent girls.

It might also be worth mentioning that the Bangladesh Public Expenditure Review on Nutrition indicates 98 per cent being spent on nutrition sensitive interventions and only a mere 2 per cent on nutrition specific interventions. As a result, the amount overestimates investments on nutrition since it includes programmes that do not have nutrition outcomes as its primary target.

Development assistance in Bangladesh

The GoB aims to transition to Middle Income Country (MIC) by 2021. The Vision 2021 plan and the associated Perspective Plan 2010-2021, adopted by the Government of Bangladesh lay out a series of development targets for 2021 to achieve a MIC status. This, along with other factors such as country's advances in development and development partner policies, has triggered a gradual change in development assistance in Bangladesh⁹¹. These changes include technical assistance by some partners moving away from direct intervention and towards greater emphasis on building national capacities and technical training. Bangladesh is also likely to witness an increase in ratio of loans to grants in total bilateral official development assistance (ODA).

As Bangladesh progresses towards a MIC status, new challenges related to nutrition emerge. In light of rapid urbanisation, there is an urgent need for policy to take cognizance of the shifts in the demographic profiles of urban areas, the operating environment, and the special requirements of a working population, particularly in urban settlements. In addition to this, adolescents constitute about one-fifth of the country's population and contribute immense value to the economy's growth and in the journey towards reaching MIC status. Hence, investments in nutritional status of adolescents, especially girls, at this stage will help maximize demographic dividend and break the intergenerational cycle of malnutrition.

In this light, GOB recognizes the critical role of development networks and partnerships to realize its nutritional goals. The NPAN-2 was formulated by the GoB with coordinated support and technical assistance from partners including UNICEF, The World Bank, FAO, WHO, World Food Programme (WFP) and United States Agency for International Development (USAID). The HPNSDP 2011-2016 with a significant focus on mainstreaming nutrition at scale across the country, was funded by the World Bank and a Multi-Donor Trust Fund (consisting of USAID, Australian Aid, Department for International Development (DfID), and Swedish International Development Cooperation Agency (SIDA)).

Bangladesh also joined the global SUN movement in 2012 which has supported the Civil Society Alliance for SUN in Bangladesh to adopt and implement a costed national nutrition plan. The SUN priorities for 2018-19 include the implementation of the NPAN-2, strengthening of the BNNC office through human resource

⁹¹ Secretariat of the Committee for Development Policy, United Nations Department for Economic and Social Affairs, Apr 1, 2019

allocations and capacity development, improvement in the nutrition information system, and evidence building for nutrition interventions. UNICEF is part of the UN network for SUN and helps leverage the collective strength of the UN agencies to support the Government and SUN agencies in delivering nutrition at scale.

An established Nutrition Working Group (NWG) comprised of UN agencies, bilateral donor agencies, and civil society partners are working together to support nutrition initiatives in Bangladesh. The REACH initiative 2009-2016 in Bangladesh, led by UNICEF, FAO, WHO, and WFP, assisted the GoB in utilizing multi sectoral coordination mechanisms to scale up nutrition in the country. Over the years, the initiative contributed to the drafting of the CIP 2011 and development of the HPNSDP 2011-2016. The Food Planning and Monitoring Unit of the Ministry of Food, GoB also partnered with USAID and FAO for Meeting the Under-nutrition Challenge (MUCH) to support the Ministry in design, implementation and monitoring of policies and programmes in food security and nutrition⁹².

The WFP supported School Feeding Programme in Bangladesh is also in a phase of transition from an externally-funded and executed programme towards full government ownership and implementation. The GoB is also in the process of formulating its first national school feeding policy and strategy.

UNICEF has played a central role in supporting the GoB in addressing undernutrition in the country. Through its 2012-2016 CP, UNICEF promoted cross-sectoral collaborations within the GoB structure between education, health and water and sanitation and nutrition creating opportunities to increase multi-sectoral partnerships. UNICEF also supported the GoB in mainstreaming “direct nutrition interventions” (DNIs) in existing health and family planning services. These nutrition-specific interventions focused on IYCF and hygiene, micronutrient powder supplementation, deworming, consumption of nutrient-rich fortified foods, SAM management, and maternal nutrition.

⁹² FAO 2018: Meeting the Undernutrition Challenge (MUCH) accessed from <http://www.fao.org/partnerships/resource-partners/stories/story/en/c/1161073/>

OBJECT AND SCOPE OF EVALUATION

The Joint UNICEF and GoB nutrition programme has been designed to ensure its alignment with the seventh five-year plan and sectoral plans of the Government of Bangladesh to address two key headline results on **accelerating the reduction of childhood stunting** and **improving adolescent health and well-being**. Following a life-cycle approach, the nutrition interventions have a direct focus on the first 1000 days of life, as well as on adolescents aged 10-19, pregnant and lactating women. Additionally, pre-school children aged 3-6 years and school aged children of 6-10 years have been identified as the indirect target population for nutrition programme through Early Childhood Development (ECD) centres and nutrition curriculum strengthening at schools, respectively.

The nutrition programme aims to improve the coverage of **nutrition-specific interventions**, in both public and private sectors, with a particular focus on urban slums, hard to reach and disaster prone areas. In addition to this, UNICEF is also trying to promote **nutrition-sensitive interventions** within the health, WASH, education, agriculture, local governance and social protection sectors to increase the coverage of quality services at the national and sub-national levels. It is envisaged that nutrition-specific and nutrition-sensitive interventions and approaches will increase access to nutrition services, as well as enhance the understanding and demand for services.

To achieve this, strategic emphasis is laid on a) evidence generation, policy dialogue and advocacy, b) equity-responsive and resilient service delivery, and c) partnership and participation.

Evaluation Purpose and Rationale

UNICEF Country Office Bangladesh (UNICEF-BCO) commissioned the evaluation of the Joint UNICEF-Government of Bangladesh (GoB) nutrition programme 2017-2020.

The objective of this evaluation is to determine, systematically and objectively, the relevance, appropriateness and coherence of UNICEF Bangladesh nutrition programme; the effectiveness and (early) impact or impact potential of the programme in relation to its objectives; the efficiency with which its project outputs and activities are being delivered and their connectedness to those produced by other actors; as well as the programme's sustainability. The purpose of the evaluation therefore, is to understand whether all of these aspects are on track and how they can be enhanced, as well as serve as a key document for planning and designing the focus of the nutrition programme in the next country programme.

Scope of the Evaluation

The **evaluation focused on the nutrition outcomes in the current CP (2017-2020)** by examining the implementation and performance in the last two years (2017-2018) and generating learnings for planning and design of the nutrition programme in the next CP.

The evaluation took stock of the programme implementation experience and environment, reviewed the results frameworks and assumptions, and documented success and lessons learned. Based on an assessment of these, it suggested modifications that may be necessary to effectively and efficiently meet the stated objectives. Wherever appropriate, the evaluation took into account the efforts undertaken and milestones achieved during the 2012-2016 CP which are likely to have influenced the design of CP and interventions under the current programme. Thus, rather than an intervention focused evaluation, this evaluation focused on the whole programme including its logic, strategies and partnerships, to suggest where improvements can be made to better achieve the results that have been envisaged under the current Country Programme (2017-20).

Toward this end, the evaluation examined each of the main projects and sub-projects subsumed under the programme (i.e., the policies, interventions, structures, capacity-building efforts, and so forth) to evaluate the programme's overall success in achieving its overarching objectives.

Since only two years had passed, which may have had an effect of how advanced the interventions were and on the measurement and existence of results themselves, effectiveness, impact and sustainability aspects were looked at in terms of the potential for the programme to be effective, have impact and be sustainable, and of the capacity to measure these aspects at a later stage. The evaluation was carried out during May- October 2019.

The geographical scope of the evaluation was in line with UNICEF's priority areas:

- 1) 24 low-performing districts, where there will be convergent programming;
- 2) districts with a high prevalence of early marriage and stunting;
- 3) urban areas; and
- 4) special attention areas, such as the Chittagong Hill Tracts (CHT); tea estates in the northeast; enclave (border) areas in northern Bangladesh; and areas most affected by climate change/ disaster.

Evaluation Team

The core team for the evaluation consisted of one Lead Evaluator, one Subject Matter Expert, one National Consultant, one International M&E Expert, one gender expert and one research manager. The core team was supported by field enumerators. The team had a rich cultural diversity with experience of working in Bangladesh on similar issues, experience of handling multiple evaluation assignments for United Nations and a gender balance with three out of six core team members being women (Subject Matter Expert, Gender Expert and Research Manager).

As part of each of its three implementation strategies, UNICEF undertook various interventions as given below.

Evidence Generation, Policy Dialogue and Advocacy	Partnership and Participation	Equity Responsive Service Delivery
Mothers@Work Programme	Support in revitalization of Bangladesh National Nutrition Council (BNNC) and establishment of District Nutrition Coordination Committees (DNCC) and Upazila Nutrition Coordination Committees (UNCC).	Capacity building support for community health workers and upazila and district officials
Advocacy and assistance in amendment of the Salt Act.	Support nutrition campaigns and implementation of C4D strategies	Appointment of DNSOs/DNCs
Support in adolescent friendly health services through adolescent clubs	Enhance engagement and coordination between multiple stakeholders coordinating mechanisms	Support in strengthening MIS
		Infrastructure support to health facilities (including height and weight scale, MUAC tape, supplements)
		Establishment of breastfeeding corners in health facilities

APPROACH AND METHODOLOGY

Conceptual framework for the evaluation

The current evaluation adopted both a reflective and forward looking approach. It aimed to contribute towards learning about issues that are central to strategic decision-making for the UNICEF nutrition programmes and related actions that affect the ability to achieve planned results. Hence, the evaluation encompassed the processes and outcomes of the programme and sought to provide an evidence-based assessment of its performance and progress.

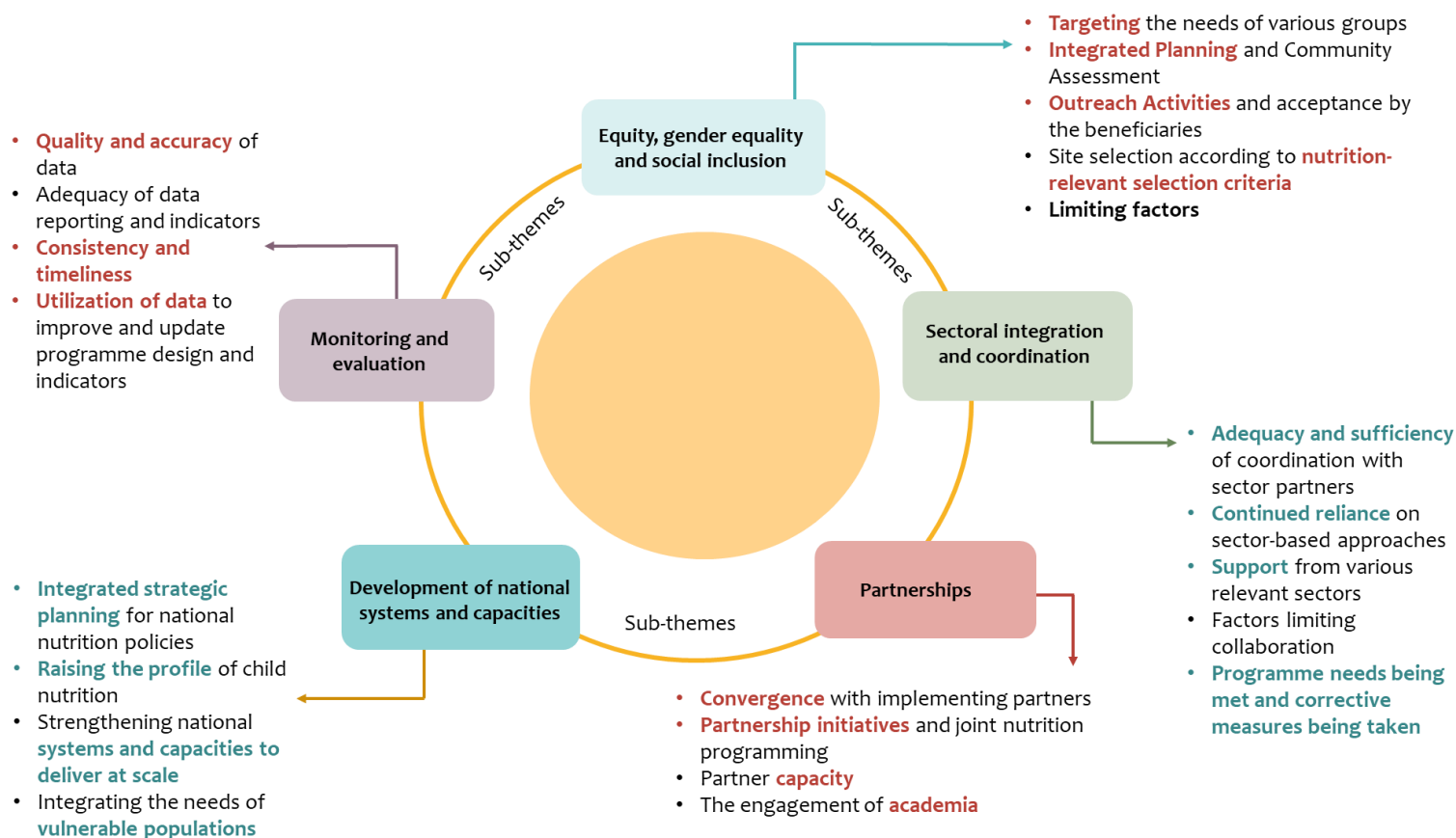
Towards this, the *logic model*⁹³ was used as a conceptual framework for the evaluation. Using the three central themes of the implementation strategy outlined in the ToC, that is evidence generation and policy, partnership and participation, and equity responsive and resilient service delivery, for analysis, the logic model helped in creating a valuable evidence base, by establishing what worked for which groups in what contexts and informing the transferability of key learning.

This model assessed the *logical linkages among the programme resources, activities, outputs, primary, secondary and tertiary audiences, and short, intermediate, and long-term outcomes related to the identified issues*. The model helped refine the various elements of the ToC, further strengthening the assumptions and the foundation for measurement and evaluation. It was also valuable in drawing out gaps between the different components of the programme, its underlying assumptions, and the risks as outlined in the ToC. By following a systems approach and illustrating a sequence of cause-and-effect relationships, the logic model helped analyse the ToC informing the progress in outcomes.

Drawing upon the learnings from the 'Meta-analysis of UNICEF's nutrition programme evaluations (2009-2013)', the evaluation examined the central and sub-themes outlined in the ToC of the CP 2017-2020. The emerging sub-themes from the three central themes of the ToC are a) Development of national and subnational systems and capacities, b) Sectoral integration and coordination, c) equity, gender, and inclusion, d) partnerships, and e) monitoring, evaluation and evidence generation. The central and sub-themes *guided the narrative of the evaluation, provided the necessary tools to answer the evaluation questions, and demonstrated the alignment with and fulfilment of the objectives of the nutrition programme*. The schematic below summarises the aspects of the themes that were explored in the evaluation.

⁹³ https://www.measureevaluation.org/resources/training/capacity-building-resources/basic-me-concepts-portuguese/LM_FSNE_full.pdf

Figure 2: The central and sub-themes of the ToC that will be examined in the evaluation



Since only two years have passed, the model was used to assess the potential of the programme to achieve its intended and unintended outcomes. Towards this, in addition to the new projects, the evaluation also identified the strategy/projects that are running from the CP 2012-16 cycle to the present one. The evaluation was cognizant of such interventions and examined their outcomes and impact from an accountability perspective to the various stakeholders including the GoB, donors, UNICEF executive board and other partners. From a learning perspective, the evaluation examined if learnings from the evaluation of the previous CP have been included in the design and implementation strategy of the new CP. The impact, replicability and sustainability of those interventions that were undertaken during CP 2012-16 and continue to be a part of the CP 2017-20, were also assessed.

As per the terms of reference (Annex 1), the evaluation used the following criteria to evaluate the nutrition programme: relevance, appropriateness, coherence, connectedness, effectiveness, early or potential impact, efficiency and sustainability of the nutrition programme. Using the logic model, the ToC and these criteria, the evaluation assessed UNICEF's contribution to the results, while keeping in mind the multiplicity of factors that may have affected the overall outcome.

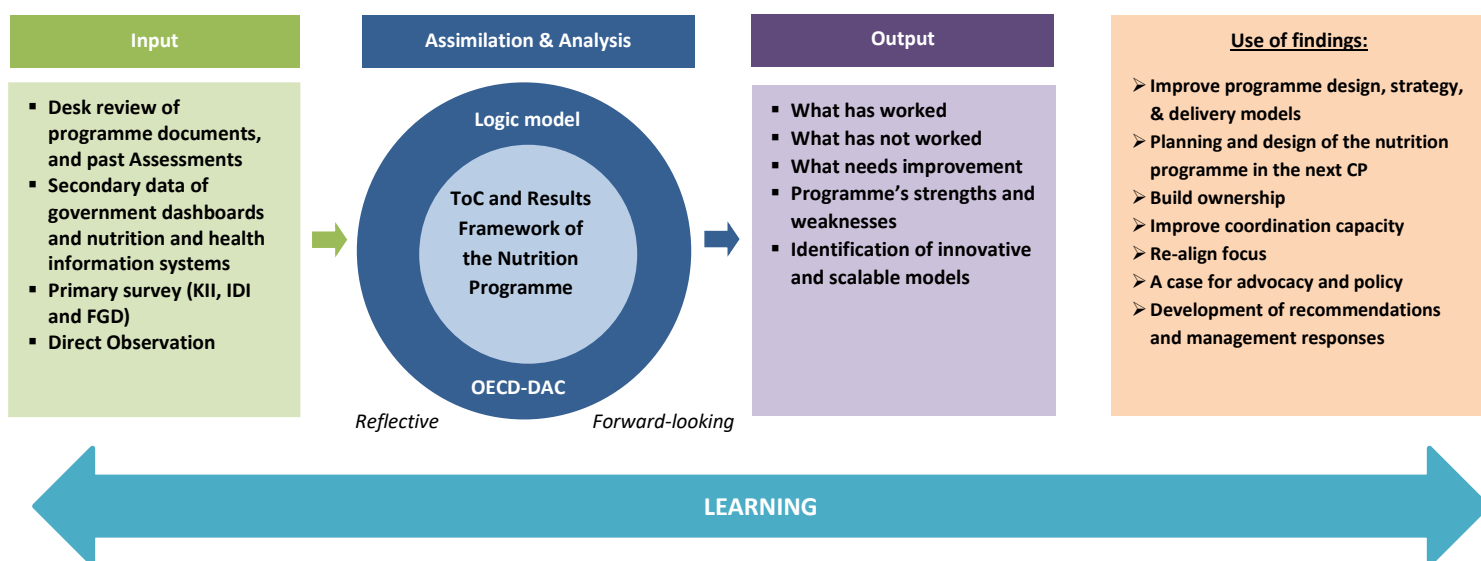
In accordance with the UNEG criteria⁹⁴, one of the important components of this evaluation was understanding how the programme has addressed issues of equity, inclusion, and human rights and gender

⁹⁴ UNEG's Guidance document on UN-SWAP Evaluation Performance Indicator Technical Note, April 2018

*equality*⁹⁵. Thus the analysis viewed the outcomes from the perspectives of gender, vulnerable groups, and those residing in hard to reach geographical areas or areas affected by emergency situations.

The approach allowed the evaluation to *gain insights to programme strategies, stakeholder participation, policy criteria and formulation, as well as capacities and institutions built, particularly for leveraging national resources and for addressing critical emergency issues*. The process of collecting authentic data strengthened the learning approach as insights were also gained in the process of data collection itself. Through this holistic approach, the evaluation aimed to capture the journey of the programme components on strengthening the nutrition programme as a whole through collective pieces of evidence that narrate its success, highlight its learning, and recommend the way forward. Figure 5, summarizes the conceptual framework that was adopted for the evaluation.

Figure 3: Conceptual framework for the evaluation



⁹⁵ UNEG's Guidance document on Integrating Human Rights and Gender Equality in Evaluations, August 2014

Methodology for the evaluation

Within the approach is embedded a learning component that examines the evidence to inform dissemination strategies and innovation in future programmes. With learning as an essential component, three key stages constituted the methodology to fulfil the objectives of the evaluation of the nutrition programme:

Stage 1- Contextual analysis: the relevance and appropriateness of the programme was examined; key issues were identified that affect the cross-cutting factors across the domains of the framework; the policy environment was examined; the physical, institutional and social structures that determine the nutrition behaviours of children, adolescents and women were understood. (Desk review and primary data)

Stage 2- Comprehending design and implementation of the programme: The design to address the contextual issues and how they were implemented in consideration of locally specific priorities of the stakeholders was examined. The direct and indirect outcomes of the programme and the extent to which it has been effective was analysed; the impact of the interventions and their sustainability was assessed and the efficiency of programme partnerships and strategies was analysed. (Desk review and primary data collection)

Stage 3- Analysing data, findings and dissemination: The evaluation examined the contribution of the programme, what is working, what is not working, reasons for success, impeding factors, unexpected outcomes of the initiatives; recommended the way forward highlighting resource requirement; recommended key factors to be considered before the next phase; generated evidence based best practices and innovations, and outlined the risk factors associated.

Evaluation design

As stated earlier, the evaluation systematically assessed the relevance/appropriateness, effectiveness, early and potential impact, efficiency and sustainability of the programme. Additionally, the coherence and connectedness of the nutrition programme was also assessed.

The evaluation adopted a mixed method approach to answer the evaluation questions under the given criteria. An extensive desk review of available secondary data was undertaken. Quantitative information from secondary sources such as Bangladesh DHS, Multiple Indicator Cluster Surveys, 2013 and 2019 , DHIS-2, Coverage of Basic Social Services in Bangladesh 2017, 2018 and from available national and sub-national surveys and assessments such as Child Well-being Survey, 2016 and Landscape Analysis on Adolescents and Nutrition in Bangladesh 2017, was examined. A detailed review of the various national policies and strategies related to nutrition such as NNP 2015, NPAN-2, NNS and National Strategy for Adolescent Health 2017-2030 was undertaken. Relevant documents of UNICEF's programme strategies such as CP 2017-2020, CP 2012-2016, and the nutrition strategy note were examined in light of national priorities to establish the relevance of the programme. In addition, UNICEF programme documents such as annual reports, past evaluation and management responses, rolling work plans, and communication documents were reviewed for the evaluation. Relevant reports of sector partners were also assessed for developing a holistic perspective on the programme connectedness with other sector actors. Details of the desk review are provided in Table 1 and later in Annexure VIII.

The evaluation also undertook primary data collection which was mainly qualitative in nature, through Key Informant Interviews (KII) and Focus Group Discussions (FGD). The primary data helped the evaluation gain insights from the programme stakeholders on the aspects noted in the desk review. The district, upazila and community level discussions added validity to the discussions held at the national level and also provided a deeper understanding of the service delivery mechanisms at the last mile.

Table 1: Summary of the evaluation design

Methods of data collection	PRIMARY SURVEY (Urban and Rural perspective)		DESK REVIEW
	Focus Group Discussions (FGDs)	Key Informant Interviews (KIIs) and stakeholder workshops	
Target Group/ Sources of Information	<ul style="list-style-type: none"> • Pregnant women • Lactating Mothers • Employed Mothers (in M@W programme) • Adolescent Boys • Adolescent Girls • Other community members relevant to the programme (Community support groups, fathers, mother in laws) 	<ul style="list-style-type: none"> • Key staff at GoB and different ministries at technical and decision making level, and division, district and upazila level, DNSOs, Community Health Workers (CHW), staff at nutrition corners • Development Partners (World Bank, ILO, WFP, FAO, WHO, GAIN, Nutrition International, Save The Children, CARE, BRAC, Implementing NGOs) • UNICEF staff in nutrition, health, WASH, C4D, education, Planning, monitoring and reporting, and SPEAR, gender, adolescents, regional, HQ and field offices; • Observation at nutrition corners 	<ul style="list-style-type: none"> • Bangladesh DHS 2014 • DHIS-2 • MICS - 2013, 2019 • Coverage of Basic Social Services in Bangladesh 2017, 2018 • Surveys and assessments such as Child Well-being Survey, 2016, Landscape Analysis on Adolescents and Nutrition in Bangladesh 2017, Maternal and Young Child Nutrition Security Initiative 2015, Survey on situation of children in tea garden 2018, DHS comparative report on adolescent nutrition, 2018, Bangladesh Urban Health Survey 2013 <p>Policy documents</p> <ul style="list-style-type: none"> • NNP 2015, NPAN-2, 7th FYP, National Urban Health Policy, National Strategy for Adolescent Health 2017-2030, National Strategy on Prevention and Control of Micronutrient Deficiency in Bangladesh 2015-2024 • UNICEF CP 2017-20, CP 2012-16, UNDAF 2017-22, UNICEF Nutrition strategy note 2017, rolling work plans, UNICEF Urban Nutrition Strategy <p>Others</p> <ul style="list-style-type: none"> • UNICEF COAR, related evaluations (including evaluation of CP 2012-2016), • School nutrition programme WFP-BRAC, review of NNS-OP World Bank, • Material related to Mothers@Work, relevant reports from other UNICEF sections, • Relevant national/sub-national surveys and reports such as Analysis of the Situation of Children and Women in Bangladesh 2015, Report on Skills Based Assessment of Service Providers Trained on Nutrition Specific Competency Based Training, Bangladesh

Methods of data collection	PRIMARY SURVEY (Urban and Rural perspective)		DESK REVIEW
	Focus Group Discussions (FGDs)	Key Informant Interviews (KIIs) and stakeholder workshops	
Outputs of data collection	<ul style="list-style-type: none"> • Relevance of the programme activities to the needs of children, adolescents and women • Extent of gender sensitive and inclusive design • Felt issues and challenges in accessing quality nutrition support services; issues, availability of information, constraints, adaptation to new social and cultural contexts • Perceptions of beneficiaries towards quality of services being received • Triggers and barriers in accessing quality and inclusive nutrition support services 	<ul style="list-style-type: none"> • Alignment of programme components with the country context and responsiveness to the needs of target groups • Networks created, resources utilised; platforms created for collaboration • Issues identified by staff and workers in delivering services to target groups and support to GoB • Gaps in design, resources and partnerships, innovation and learning • Ownership of the components of programme by GoB 	<ul style="list-style-type: none"> • Build context, relevance and appropriateness of the programme • Resources utilised • Key design elements that contribute to direct and indirect change • Pathways created for sustainability; key considerations for recommendations

In addition to the interviews during primary data collection, a physical observation of the facilities at which the staff was undertaking interventions with beneficiaries was conducted to better understand the effectiveness of the interventions. These observations added to the evaluation data and findings to corroborate with other methods of data collection.

The primary data collection for the evaluation was mainly qualitative in nature. Quantitative data was obtained and analysed from relevant secondary programme related documents especially past evaluations, relevant national/sub-national surveys, and monitoring reports to supplement and strengthen the evaluation findings.

The data from the secondary review and the primary survey was triangulated and synthesised to arrive at the findings and document the story of how the programme components have performed on the set criteria, the enabling factors, challenges faced and overcome, contribution towards improving the nutrition context, innovations and good practices, and key considerations for future programming needs.

Evaluation matrix

The evaluation matrix (Annexure III) mapped the evaluation questions with the key information areas, the source of data collection, and the methods used for data collection. These key information areas played an instrumental role in the development of data collection tools and data analysis. Few important observations for the evaluation matrix are as follows:

1. The evaluation matrix aimed to examine the contextual factors that influence the programme design and its implementation and the extent to which such factors have been considered to tailor the programme design to suit the local needs (which vary by regions) and address gender and inclusion issues.

2. Wherever appropriate, gender dimensions and other equity criteria such as wealth quintiles, regional disparities, rural and urban divide, and slum and non-slum differences were factored into the sub-questions, judgement criteria, and indicators for each evaluation question.

Therefore, the evaluation matrix aimed to elaborate upon the following main evaluation questions:

Relevance/Appropriateness

1. How closely aligned is the nutrition programme, its interventions and plans, with relevant planning and policy frameworks of the GoB (including the Nutrition Action Plan)?
2. How relevant and appropriate are the country programme strategies and interventions (including clarity of the theory of change (including its assumptions) /programme logic/indicators and their use; multi sectoral focus, targeting less reached and disadvantaged children; addressing gender equality including intra-household dynamics, supporting enabling environment) to address stunting?
3. How closely linked are the specific interventions chosen with the full scope and scale of beneficiaries' needs in Bangladesh, both in an emergency and a development setting? How adequate and responsive are the strategies for addressing stunting in young children and adolescents in various specific contexts?
4. How well is the programme preparing for changing needs as Bangladesh transits to a middle income country (MIC)?
5. How appropriate is UNICEF's current approach for nutrition systems building focusing on nutrition system strengthening in light of Bangladesh's context of lower middle income country? How appropriate is UNICEF's approach to following a path of evidence building for influencing policy towards supporting government scale up?
6. Where within the Nutrition Sector has the UNICEF nutrition programme been established as a critical actor that must remain present? Where has UNICEF not achieved critical status and needs to either become better or to consider exiting in favour of a better equipped stakeholder?
7. Taking as a starting point the Bangladesh Situation Analysis, did UNICEF select priority programme elements with due consideration for its comparative strengths, governmental expectations, and the capacities of other sector actors?

Effectiveness

8. Development and implementation of nutrition and multisector policies, strategies and costed action plans?
9. Strengthening sector coordination and governance?
10. Creating an evidence base and building capacity at national and sub-national level for evidence and equity based planning and budgeting
11. Identifying successful interventions for scale up and scaling them up through government systems?
12. Strengthening management information systems?
13. Delivering quality nutrition services that are inclusive, equitable, sustainable, cost-effective, gender-responsive and climate-resilient?
14. Adopting a nutrition system strengthening approach for achieving effective coverage of nutrition services and an integrated service delivery?
15. Mobilizing and engaging families, communities, local government bodies and key influencers through C4D strategies to address socio-cultural barriers and bottlenecks, increase demand for utilization of nutrition services and promote practice of desired behaviors?
16. Supporting the Government to reach the global goals set by the World Health Assembly and SDG goals?

17. In addition, have unintended outcomes, positive as well as negative, resulted from the programme?
18. Is the country programme structure of a life cycle approach where different sections work jointly within? Outcomes (life phases) conducive to achieving the results of the nutrition programme and in particular, reducing stunting and improve adolescent health and wellbeing?

Impact

19. How successful has the programme been to date in *accelerating* reductions in stunting and in improving adolescent health and wellbeing? Are there signs of early/short term impacts? Have the impacts been distributed equally among different groups of society (girls and boys, different wealth quintiles, geographical areas, etc.)
20. To what extent are these (early) gains directly attributable to the programme's interventions?

Efficiency

21. How efficiently has UNICEF used the resources dedicated to the programme to deliver high-quality outputs in a timely fashion, and to achieve targeted objectives (i.e. is UNICEF expending the least amount of resources to achieve programme effects)?
22. How successfully has UNICEF coordinated with other key actors (e.g., implementation partners, MOHFW, Ministry of Industries, and other line ministries, other entities conducting complementary interventions) to ensure non-duplication of efforts, a clear delineation of roles and responsibilities within joint programmes, and the overall success of the programme's implementation?
23. How has the focus on 22 districts, tea gardens, city corporations and enclaves and their type (i.e. poor performing, child marriage, and climate change) affected efficiency in service delivery interventions?

Connectedness

24. How effectively has the nutrition programme coordinated with other UNICEF sections (e.g. C4D, Health, WASH, SPEAR, CAP, Education) to ensure that further building blocks of child and women's nutrition that lie outside the scope of the present programme are in place?
25. What is the perception of partners (e.g. GoB, MOH&FW, Ministry of Industries, Local Government, City corporation, WFP, WB, ILO, FAO, BRAC, Save the Children, SKNF, emergencies NGOs) of the UNICEF nutrition programme in terms of technical salience, comparative advantage, cooperativeness, and sectoral alignment with other stakeholders?
26. How successful has the programme been in setting up and strengthening key and innovative partnerships such as Better Work of ILO, and Government-NGO-private sector partnerships for promoting and delivering high quality and integrated nutrition services?
27. How well is the Bangladesh Country Office nutrition programme supported by and effectively draws from UNICEF HQ Nutrition teams and staff? Are the benefits of being in a multi-tiered organization being maximized?

Sustainability

28. How successful has the programme been in equipping the government and strengthening government systems to scale-up and sustain the successfully proven interventions once UNICEF?

Target groups, tools and techniques

Target groups

As summarised in the evaluation design and the evaluation matrix, the key stakeholders who played a central role in planning of the evaluation and participated as stakeholders in the data collection process are listed as follows.

Government

- Key staff at GoB and relevant ministries at technical and decision-making level including
 - MoHFW (HPNDSP, DGHS and DGFP)
 - Ministry of Industries
 - Ministry of Women and Children Affairs (MoW&CA)
 - Ministry of Agriculture
 - Ministry of Labour and Employment
 - Ministry of Education
 - IPHN
 - Directorate of Secondary and Higher Education (DSHE)
- International Centre for Diarrhoeal Disease Research, Bangladesh (icddr,b)
- District and Upazila level officials from relevant line departments of the ministries (MoHFW, MoA, MoW&CA, Ministry of Education, MoLGRD&C); DNSOs, CHWs, and staff at nutrition corners;

UNICEF

- UNICEF staff including
 - Nutrition section
 - Other UNICEF sections such as WASH, Health, Child Protection, Gender and Education
 - C4D, Planning, monitoring and reporting, and SPEAR section
 - Representatives of various sections at divisional offices in Sylhet and Khulna

Other Development Partners

- Other development and implementing partners including:
 - World Bank
 - WFP
 - GAIN
 - Nutrition International
 - CARE
 - BRAC
 - Implementing NGOs

Community

- Pregnant Women
- Lactating Mothers
- Employed mothers (in M@W programme)
- Adolescent boys

Ready-made Garment Manufacturers

Secondary information resources

As stated earlier, a systematic and detailed desk review was carried out using available resources. Some of the relevant data sources were as follows. An exhaustive list of these resources is attached in Annexure VIII.

Table 2: Relevant data sources for the desk review

Type of data source	Details
Quantitative data (Survey and evaluation reports)	<ul style="list-style-type: none"> • Bangladesh DHS 2014 and 2017 • DHIS-2 • MICS 2013, 2019 • Coverage of basic social services in Bangladesh 2017, 2018 • Data from surveys and assessments such as: <ul style="list-style-type: none"> • Child Well-being Survey, 2016 • Landscape Analysis on Adolescents and Nutrition in Bangladesh 2017 • Maternal and Young Child Nutrition Security Initiative 2015 • Survey on situation of children in tea garden, 2018 • DHS comparative report on adolescent nutrition, 2018 • Bangladesh Urban Health Survey 2013
Policy documents	<ul style="list-style-type: none"> • NNP 2015, NPAN-2, 7th FYP, National Urban Health Policy, National Strategy for Adolescent Health 2017-2030, National Strategy on Prevention and Control of Micronutrient Deficiency in Bangladesh 2015-2024 • UNICEF CP 2017-20, CP 2012-16, UNDAF 2017-22, UNICEF Nutrition strategy note 2017, UNICEF Urban Nutrition Strategy, Rolling Work Plans
Others	<ul style="list-style-type: none"> • UNICEF COAR, related evaluations (including evaluation of CP 2012-2016, C4D programme evaluation, Rohingya response evaluation, Rolling Work Plans), • Strategic Review of Food Security and Nutrition In Bangladesh, WFP 2016 • School nutrition programme WFP-BRAC, • Review of NNS-OP World Bank, • Material related to Mothers@Work, • Relevant reports from other UNICEF sections, • Relevant national/sub-national surveys and reports such as Analysis of the Situation of Children and Women in Bangladesh 2015, Report on Skills Based Assessment of Service Providers Trained on Nutrition Specific Competency Based Training, Bangladesh

Tools and techniques

The qualitative tools included discussion guides for FGD and KII with relevant stakeholders. The tools are attached in Annexure VI for reference. The FGD guides departed from the conventional mode of linear discussions and used participatory learning tools.

As advised by UNICEF, in addition to these tools, the evaluation used the U-report platform⁹⁶ created by UNICEF to gather the perception of the community on nutrition related aspects. U-Report Bangladesh is a tool available via SMS, Facebook and Twitter where communities, especially young people can express their opinion. It works by gathering opinions and information from young people on topics they care about – ranging from employment to discrimination and child marriage. The data and insights are shared back with communities and connected to policy makers who make decisions that affect young people.

The evaluation created a set of eight to nine questions relevant to nutrition among the community members to receive their response on the same. The data gathered through this method was used to supplement the FGD findings.

Sampling design and methodology

The following sections describe the rationale and method of selection of divisions, districts and upazilas for the evaluation.

Selection of divisions

The divisions were sampled purposively on the basis of the nutritional outcomes in the country by divisions. The effect of external factors like geography, economic status, migration, emergencies on the service delivery and uptake of services in the divisions was also assessed.

Two out of eight divisions were selected for the evaluation. These included the division with the *lowest rate of stunting*, that is, Khulna, and the division with the highest rate of stunting, that is, Sylhet. The evaluation of the programme in these divisions helped compare the factors inducing the differential on the development indicators including nutrition between these divisions.

It must be noted that though the field work was conducted in two divisions only, the evaluation findings are broadly representative for the whole country. As stated earlier, the primary data collection in the divisions supported the evaluation in gaining deeper insights and validating the information from the desk review for the CP and the discussions held at the national level. Moreover, given the variation in the context and nutrition outcomes in the selected divisions, the evaluation findings provide a broad representation of the wider country's context. The sampling strategy was guided by the terms of reference and used an approach that has enabled the evaluation to provide a general insight into the situation in non-UNICEF (comparison) areas versus UNICEF (intervention) areas.

Selection of districts

Within each selected division, two districts were selected in line with the sampling approach of the divisions. The purposive selection of the districts enabled the evaluation to objectively assess the factors supporting or constraining effective service delivery and the uptake of services.

The districts were selected on the basis of the Child Development Index (CDI) rankings along with the presence of UNICEF operations in the districts. The CDI takes into account the geographical challenges, exposure to climatic pressures along with health and nutritional indicators. In Khulna division, Bagherhat and Satkhira districts and in Sylhet division, Habibganj and Sunamganj districts were selected.

However, post discussions with UNICEF Bangladesh, the selection of the districts was further modified. The level of UNICEF engagement was considered as an additional factor while selecting the districts. Therefore, within the chosen divisions (i.e. Khulna and Sylhet), those districts where UNICEF has done extensive work were identified. Of those, Khulna and Jashore districts from Khulna Division and Sunamganj and Moulvibazar districts from Sylhet Division were finally selected for the evaluation.

⁹⁶ <https://bangladesh.ureport.in/about/>

Guided by the terms of reference and discussion with UNICEF, in addition to the UNICEF intervention districts, the evaluation also sampled one district in each sampled division where the UNICEF nutrition programme does not have a presence. This allowed a comparison of the situation of nutrition service delivery between UNICEF and non-UNICEF areas. The two non-UNICEF districts that were finalised in consultation with UNICEF-BCO and the evaluation reference group were Satkhira district in Khulna Division and Sylhet district in Sylhet Division.

Selection of upazilas

The selection of the participants for the FGD was conducted through the following mechanism:

- a) The participants for the pregnant women and lactating mother’s group discussions were recruited from the community level health and nutrition facilities. The FGD team arrived well in advance of the FGD and interviewed the frontline health worker at the facility (CHCP in CCs). The frontline health worker was requested to ask 6-7 women arriving at the facility to stay for the FGD. The FGD was conducted at the facility itself. The women who were present at the facility and were in line for meeting the health personnel with a longer waiting period were requested to be a part of the FGD. Considering that the women in these groups were not be able to stay for long, the discussions with them were held for 45 minutes to 1 hour only.
- b) The participants for the employed women’s group were recruited from identified garment factories in urban areas. The factories were selected in consultation with UNICEF. The factory supervisors were contacted one day in advance to take his/her permission to allow 6-7 women from the respective groups to participate in the discussion for 30-45 minutes during their break time or lunch hour. This allowed the group to be more relaxed and not worry about any loss of work time.
- c) The adolescent boys and girls were recruited with support from the adolescent friendly health corners (AFHC). With support from the staff at the AFHCs, the parents of the adolescents were contacted to seek their consent for participation of their children in the FGD, a day in advance of the discussion. Then the adolescents were contacted to gather their consent for participation in the FGD. Thereafter, the discussion was conducted at the AFHCs. Separate FGDs were conducted with adolescent boys and adolescent girls.

Operationalisation of the Evaluation

The evaluation was undertaken in the following three phases:

Table 3: Phases of the evaluation

PHASE I: INCEPTION	PHASE II: DATA COLLECTION	PHASE III: DATA ANALYSIS AND REPORT WRITING
<ol style="list-style-type: none"> 1. Inception meeting 2. Briefing with the commissioning team, joint review of the ToR 3. Preliminary review of relevant project materials and literature 4. Finalisation of evaluation methodology and tools based on desk review and discussions with UNICEF and ERG 5. Review by UNICEF- BCO 	<ol style="list-style-type: none"> 1. In-depth desk review of secondary reports and available data 2. Scheduling meetings at national and divisional level with support from UNICEF 3. Training of field team for in-country qualitative data collection 4. Preparation of field movement plan 5. Primary data collection 	<ol style="list-style-type: none"> 1. Documentation of findings and data analysis as per the analysis plan 2. Preparation, submission and presentation of Draft evaluation report 3. Incorporating comments and suggested changes from UNICEF-BCO

<ol style="list-style-type: none"> 6. Finalisation of evaluation tools after review by UNICEF-BCO 7. Review by ERG 8. Finalisation of evaluation tools after review by ERG 9. Submission to the IRB for approval 10. Finalisation and translation of evaluation tools after approval by IRB 11. Development of analysis plan 12. Submission and presentation of the inception report to the commissioning team 13. Preparation of final inception report incorporating comments 	<ul style="list-style-type: none"> ○ Observations in camps and nutrition service centres ○ FGD and KIIs ○ Interaction with key stakeholder groups through IDIs at central level (Dhaka) and regional levels <ol style="list-style-type: none"> 6. Debriefing UNICEF on preliminary observations 7. Data monitoring for quality control 	<ol style="list-style-type: none"> 4. Submission of draft final report to ERG 5. Incorporating comments and suggested changes from ERG 6. Submission and presentation of final evaluation report
<p>Key Outputs</p> <ul style="list-style-type: none"> • Inception Report with audit trail • Presentation of inception report • Final translated evaluation tools 	<p>Key Outputs</p> <ul style="list-style-type: none"> • Training of field teams • Field movement plan • Field work progress and completion report 	<p>Key Outputs</p> <ul style="list-style-type: none"> • Draft evaluation report with audit trail • Presentation of evaluation findings • Final evaluation report with audit trail

In order to keep a check on processes and timeliness through the evaluation, the UNICEF-BCO received weekly updates of the progress on evaluation activities from the evaluation team. These weekly communications listed the activities that were complete and ongoing. Any anticipated changes in timelines due to unforeseen issues were highlighted in advance through the weekly updates.

Data triangulation, analysis, findings and report

The data from the secondary review and the primary qualitative study was triangulated to assess the reliability and validity of the data. The evaluation matrix presents the sources from where the data for the evaluation questions was collected. Triangulation was undertaken within methods, where appropriate, by comparison of perspectives of different stakeholders on the same issue. In some cases, complementary observations and narratives of all stakeholders were taken into account to compare with secondary data. The findings were then synthesised to document the story of how the programme has performed on the set criteria, the enabling factors, challenges faced and overcome, contribution towards government’s agenda, and innovations and good practices.

The analysis and findings focussed on examining the evidence to answer the evaluation questions under the six evaluation criteria. Towards this, the content analysis technique was used wherein the qualitative data from KIIs and FGDs was summarised to identify key themes that were then linked with the conceptual framework. The components of the conceptual framework were as follows: development of national systems and capacities; monitoring, evaluation and evidence generation for advocacy and multi-sectoral integration, coordination and partnerships. As per the identified themes, data was entered for each

respondent category leading to the creation of a content analysis sheet, which was thereafter referred for second stage data summarization, and identifying patterns within the thematic areas. These emerging patterns were then assessed in response to the evaluation criteria. Relevant case studies of specific interventions and innovations were also highlighted to identify these patterns.

The quantitative data from secondary sources was examined in alignment with the monitoring indicators proposed in the nutrition strategy note 2017-2020. Data sources such as MICS 2013 and MICS 2019, were compared to understand the changes in the nutrition indicators in Bangladesh over the last 5 years. Similarly, facility level data from DHIS-2 and service level data from Coverage of Basic Social Services in Bangladesh, 2018 supported analysis at the district level. These data points were triangulated to assess the outcome and impact level changes in the nutrition indicators and their likely determinants. The qualitative and quantitative data from primary and secondary sources respectively helped understand the investments made by UNICEF to arrive at the contribution made by UNICEF towards the achievement of these outcomes.

The findings aimed to highlight the key factors and trigger points in the institutions that helped certain activities be a success. At the same time, barriers to implementation and the ways they have been resolved were identified. *Intended and unintended impact* was documented as per the approach stated in the conceptual framework. The findings focussed on how the learnings and best practices can be carried forward, replicated and scaled up and the evaluation strived to make evidence backed recommendations on informing future programming.

Quality Control Measures

The evaluation team maintained various checks throughout the evaluation to ensure quality of the outputs. Quality assurance mechanisms were adopted during data collection.

Some of the key steps to ensure data quality were as follows:

- **A three stage internal review process of key deliverables:** The evaluation team was structured in such a way that all deliverables including data collection tools, inception report, data analysis plans, and reports were reviewed by the external technical backstopping expert for the project.
- **Strong monitoring measures during data collection:** The evaluation team travelled extensively to the field work areas to ensure excellent quality data collection. The core evaluation team was engaged to travel for field visits especially for qualitative interviews with sensitive populations. Efficient and effective methods were used to deploy coordinators and supervisors to monitor the data collection process continuously, with the wide network of field level researchers.
- **Strong support teams:** Trainings for field teams were conducted by core team members from the evaluation team. A professional editor also ensured that all reports were edited before sharing.

Ethical considerations

The evaluation team had an understanding of the United Nations Evaluation Group (UNEG) Code of Conduct, norms, standards and ethical guidelines and strictly adhered to the same.

Considering that the data collection engaged adolescents, and pregnant and lactating women, special care was sought in ensuring ethical behaviour and understanding during the process. As advised by UNICEF, an IRB approval was also taken for the evaluation tools and methodology (IRB approval attached in Annex XI).

The team for this assignment was constantly guided by the UNEG and UNICEF (2015) ethical guidance principles⁹⁷ which ensured that no violations, like collecting data without consent, collecting data not pertaining to this assignment, accessing areas within the institution premises for which approval has not been taken etc., were committed during the data procurement from various institutions.

The evaluation team also ensured respect for differences relating to culture, religion, age, gender and local customs by adapting and modifying interview protocols and discussion guides and by utilising national consultants and interpreters.

While conducting FGDs with adolescents, the protocol adopted by the evaluation team was to initiate the discussion with an ice-breaker activity to ensure utmost comfort of the participants. This also helped ensure the quality and authenticity of the data collected.

The evaluation team took measures to avert any potential conflict of interest during data collection, For example, a potential conflict of interest between UNICEF and other partners was averted by the evaluation team by approaching implementing partners and other sector actors directly rather than through UNICEF.

For the interviews, a consent form was administered to the respondents which stated to the respondent their voluntary participation and confidentiality of information being collected.

The evaluation team's Internal Ethics Committee adhered to the following three categories of ethical norms:

Integrity	Data Quality	Data Security
<ul style="list-style-type: none"> •The staff on payroll or contract will always demonstrate honesty, integrity, and professionalism at all times. •The staff will be aware of applicable statutes, regulations, practices, and ethical standards governing data collection and reporting. •The team will report information accurately and without bias. •The team will be accountable, and will hold others accountable, for ethical use of data. 	<ul style="list-style-type: none"> •The team will promote data quality by adhering to best practices and operating standards. •The team will provide all relevant data, definitions, and documentation to promote comprehensive understanding and accurate analysis when releasing information. 	<ul style="list-style-type: none"> •The team will treat data systems as valuable organizational assets and hence data backup will be a mandatory affair. •The team will safeguard sensitive data to guarantee privacy and confidentiality as the team's servers will be accessible to limited staff only.

Measures taken by the evaluation team included:

- **Informed consent:** All interviews and FGDs were conducted with prior consent of the participants through a consent form that was administered at the start of the discussions. In case of adolescents, consent was sought from their parents/guardians for their participation in the FGDs. The participants were clearly briefed on the intent of the discussions and the use of the findings towards research purposes. The participants had a right to decline their participation in the interview/FGD or not disclose any information that they did not want to reveal.

⁹⁷ UNICEF. (2015). UNICEF procedure for ethical standards in research, evaluation, data collection and analysis. Document Number: CF/PD/DRP/2015-001 Effective Date, 1.

- **Right to safeguard integrity:** No information obtained from the responses was made public at any stage of the data collection and thereafter. The database did not have the name of the participant or family members. All such information was encrypted. Complete privacy of the participant was maintained.
- **Protection from physical, mental and emotional harm:** During the data collection it was ensured that enumerators did not ask any question or pose any cross-questions that were personal or sensitive, or that might have physically, mentally or emotionally harmed the participant. Special care was taken to ensure a well-judged use of the participants' time during data collection.
- **Access to information regarding research:** Data collectors provided all information related to the evaluation and its objectives. If the participant wanted to seek more information, he/she was requested to contact the senior team member for answers.
- **Protection of privacy and well-being:** Personal information of the participant was not shared with anyone and was kept confidential. It was used for evaluation purposes only.

Limitations and Biasness

Limitations

- The evaluation findings were highly dependent on the availability and quality of data from other reports and evaluations.
- The evaluation team faced a lack of access to raw data. Therefore, baseline figures were extracted purely from other sources like BDHS and MICS. Due to this heavy reliance on data from other actors, the scope of analysis was very limited.
- While measures were taken to incorporate districts with and without UNICEF presence for comparative analysis, the evaluation team faced challenges in fully estimating attribution to the results obtained from the UNICEF nutrition programme.
- During the period of data collection, there was only one health camp that was scheduled in the sampled areas for the evaluation. Therefore, instead of four as planned, the evaluation team was only able to observe one EPI site (Ghoyghar) in Rajnagar upazila, Moulvibazar district, Sylhet division.
- The FGDs with adolescent girls and boys were mainly conducted with members of adolescent clubs. Since the members of these clubs were only school going individuals, the evaluation was unable to reach the dropout or out of school population in the sampled areas.
- In the interest of time and to ensure smooth data collection, the health facilities were informed a day in advance of the evaluation team visit. While this helped the evaluation team collect data on time, it is possible that the frontline workers were able to pre-prepare for this visit and project an ideal scenario for the evaluators.
- Another key limitation is that many of the questions on the extent to which UNICEF's decentralization helped achieve results, the extent to which it consistently implemented programmes with an equity focus or the extent to which it used its comparative advantage and that of others to achieve results for children were not well documented. As a result the evaluation team had to piece together fragmented pieces of information from UNICEF reports and relay to a large extent on key information interviews.

Biases

A bias in the selection of the respondents (specifically those selected for KIIs) may have resulted in an information bias as there was heavy reliance on information provided by GoB officials involved in the

implementation of the programme. However, efforts were made to overcome this bias by presenting the evaluation findings post triangulation of information from FGDs with beneficiaries and other stakeholders.

Further, from the evaluation assessment and discussions with UNICEF BCO staff, no factors that may have compromised independence were identified. No areas of potential conflict of interest were identified. The evaluators had access to a variety of stakeholders and UNICEF did not interfere with the conduct of the evaluation at any point. UNICEF staff members expressed a keen interest and willingness to support and engage in the evaluation process, and mentioned their eagerness to see what progress has been made in the CP, and to gain lessons for further improvement. Many also stressed the importance of this evaluation for the next programme cycle, and expressed a keen interest in understanding the more strategic role that BCO could play vis-a-vis the GoB, as the latter takes on more responsibilities for development initiatives as its capacity and resources increase.

EVALUATION FINDINGS

Relevance

Presented below is a summary of the evaluation findings on relevance in the form of short answers for each evaluation question.

Evaluation Question	Short Answer/Finding
<p>EQ 1: How closely aligned is the nutrition programme, its interventions and plans, with relevant planning and policy frameworks of the GoB (including the Nutrition Action Plan)?</p>	<p>The nutrition programme’s strategy of supporting policy and advocacy, promoting partnerships and coordination, providing technical assistance and capacity development towards nutrition systems strengthening, are in alignment with the UNICEF Global Nutrition Strategy, UNICEF Strategic Plan 2018-21 and Bangladesh UNDAF 2017-20. Further, UNICEF’s nutrition programme aligns with the strategies of NNP, key action areas of NPAN2, strategic objectives of NSAH 2017-30, overarching goal and guiding principles of the CIP2 and the priority areas of the National Strategy on Prevention and Control of Micronutrient Deficiencies (2015-24) and MoHFW’s Bangladesh Essential Health Service Package (ESP). Furthermore, the nutrition programme was also found to be aligned with the 7th five year plan and the Bangladesh EECDF Policy Framework. However, it was found to be partially aligned to the National Urban Health strategy since UNICEF is yet to adequately address the need for preventive care. A lack of interventions focussing on community based nutrition interventions and services remains a missed opportunity to further align the UNICEF nutrition programme with the national policy frameworks.</p>
<p>EQ 2: How relevant and appropriate are the country programme strategies and interventions (including clarity of the theory of change (including its assumptions) /programme logic/indicators and their use; multi sectoral focus, targeting less reached and disadvantaged children; addressing gender equality including intra-household dynamics, supporting enabling environment) to address stunting?</p>	<p>UNICEF’s strategy to address the needs of working mothers and their children in urban areas, leverage partnerships to improve nutrition services and their reach, promote use of evidence based decision making and inter-sectoral coordination with a focus on capacity building to improve nutrition counselling and services has been found to be relevant, appropriate and responsive to the needs of the government. Further, UNICEF’s multi-sectoral approach is an appropriate strategy to ensure coordinated efforts to address stunting in a comprehensive manner.</p>
<p>EQ 3: How closely linked are the specific interventions chosen with the full scope and scale of beneficiaries’ needs in Bangladesh, both in an emergency and a development setting? How adequate and responsive are the strategies for addressing stunting in young children</p>	<p>Learnings from past evaluations have fed into the interventions of the UNICEF nutrition programme. This has enabled the programme to adequately respond to the needs of various target groups in the country. UNICEF supported adolescent clubs encourage inclusion of differently abled as well as out of school adolescents, making the intervention adequate in addressing stunting amongst adolescents from various backgrounds. Further, the Mothers@Work initiative creates an enabling environment to adequately respond to the needs of working mothers and their children in the urban context. In addition</p>

Evaluation Question	Short Answer/Finding
and adolescents in various specific contexts?	to this, the focus of UNICEF's interventions on hard to reach areas, urban slums and tea estates makes UNICEF's strategy to address stunting, adequate and responsive to needs of beneficiaries from varying geographies. Furthermore, UNICEF's role in the nutrition cluster (of enhancing country level capacities to respond to nutrition needs in emergency settings) and the use of community based programmes is appropriate and adequate to address needs of beneficiaries, specifically in the emergency context. However, the lack of a uniform strategy to scale up these community based programmes in development settings renders UNICEF's interventions as inadequate in addressing stunting in young children and adolescents in a comprehensive manner, across both development and emergency contexts.
EQ 4: How well is the programme preparing for changing needs as Bangladesh transitions to a middle income country (MIC)?	UNICEF's interventions focusing on urban areas (M@W), its efforts towards coordination with the MoLGRD&C and the private sector along with its efforts to strengthen the capacities of GoB finds relevance given Bangladesh's impending middle income status. Furthermore, UNICEF's strategy to leverage partnerships to improve nutritional services and its reach in urban areas is appropriate. A greater focus on preventive interventions will be more appropriate to strengthen the responsiveness of the nutrition programme towards Bangladesh's changing needs.
EQ 5: How appropriate is UNICEF's current approach for nutrition systems building focusing on nutrition system strengthening in light of Bangladesh's context of lower middle income country? How appropriate is UNICEF's approach to following a path of evidence building for influencing policy towards supporting government scale up?	UNICEF's focus on building the capacities of community health workers to improve nutrition counselling and services, promoting the use of evidence based decision making and fostering sectoral coordination through interventions such as DNSOs, CBT and support provided for DHIS2 were found to be responsive to the needs of the government. UNICEF's approach was therefore found to be relevant and appropriate for systems strengthening and building national and subnational capacities. Through the piloting of interventions and subsequent identification of successful interventions, UNICEF's approach of demonstrating efficacy through documentation and dissemination is relevant for influencing policy and supporting scale up of interventions by GoB.
EQ 6: Where within the Nutrition Sector has the UNICEF nutrition programme been established as a critical actor that must remain present? Where has UNICEF not achieved critical status and needs to either become better or to consider exiting in favour of a better equipped stakeholder?	UNICEF has led implementation of interventions related to strengthening MIS. The operationalisation of NIPU, deployment of DNSO and adoption of CCTN was solely supported by UNICEF. As a result, GoB considers UNICEF as a critical actor for supporting implementation of NPAN2. UNICEF's network of partners and its capacity to lead evidence generation and advocacy provides a unique opportunity to anchor coordination among development partners for establishing complementarities in interventions using comparative advantage.
EQ 7: Taking the Bangladesh Situation Analysis as a starting point, did UNICEF	Learning from past studies and evaluations, UNICEF selected priority areas recognizing the need to focus on hard to reach geographical

Evaluation Question	Short Answer/Finding
<p>select priority programme elements with due consideration for its comparative strengths, governmental expectations, and the capacities of other sector actors?</p>	<p>areas like <i>haors</i>, urban slums and tea estates and prioritize the needs of adolescents, working mothers and their children, specifically in urban areas.</p> <p>Towards this, UNICEF leveraged the on-ground presence and acceptance of SKNF and BRAC to reach out to various groups in the community including adolescents and working mothers. Further, responding to the needs of the government, UNICEF's strategy focussed on nutrition systems strengthening to fulfil the gap in skills and capacities of GoB. This included interventions towards capacity building, promoting evidence based planning and decision making using a real-time data monitoring platform and facilitating inter-sectoral coordination through DNSOs.</p> <p>The leveraging of partnerships serves as evidence that UNICEF gave due consideration to its own comparative strengths and that of other development partners. Moreover, by catering to the needs of the government by focusing interventions towards systems strengthening, it is evident that UNICEF gave due consideration to governmental expectations to select priority programme elements.</p>

Evidence Generation, Policy Dialogue and Advocacy

As part of its efforts to address the increased needs of women and children in urban areas, the nutrition programme supports the realization of rights of women and children in the workplace. The focus has been on efforts to strengthen infant and young child feeding practices, especially early initiation and exclusive breastfeeding up to 6 months and thereafter improving the frequency and quality of complementary foods. This is being done through UNICEF's Mothers@Work initiative, further generating evidence and building a case for maternity protection and the need for an enabling environment to support breastfeeding at the workplace.

This initiative aims at strengthening maternity protection legislation and encouraging employers to incorporate breastfeeding- and child-friendly care, support and services within their workplaces. This mother- and baby-friendly workplace initiative was also implemented to generate evidence on the operational feasibility, effectiveness and cost-effectiveness of supporting breastfeeding in the workplace, and to showcase its benefits for children, families, communities and businesses. Therefore, it is an appropriate strategy to address the needs of mothers and children in urban areas by facilitating increase in working mothers' demand for and access to facilities and services that support appropriate breastfeeding practices and care in the workplace.

Despite there being an enabling environment for CMAM⁹⁸ intervention in Bangladesh⁹⁹, its wide-scale adoption remains a challenge due to various barriers in the health system. To address these challenges, the 'National Guidelines for Community based Management of Acute Malnutrition (CMAM)' was developed

⁹⁸ Community-Based Management of Acute Malnutrition (CMAM) is a decentralised community-based approach to treating acute malnutrition, by providing timely diagnosis and effective treatment of acute malnutrition, and through building local capacity (health system and community) in the identification and management of acute malnutrition. It is an appropriate model to address acute malnutrition, both in development and humanitarian contexts. This approach enables community volunteers to identify and initiate treatment for children with acute malnutrition before they become seriously ill and CMAM programmes also work to integrate treatment with a variety of other longer-term interventions.

⁹⁹ Ireen, S., Raihan, M. J., Choudhury, N., Islam, M. M., Hossain, M. I., Islam, Z. & Ahmed, T. (2018). Challenges and opportunities of integration of community based Management of Acute Malnutrition into the government health system in Bangladesh: a qualitative study. *BMC health services research*, 18(1), 256.

in the context of 4th HNPSP and NPAN2. The guidelines focus on the integration of the management of acute malnutrition into ongoing routine health services for children 0-59 months which is also usable in emergency programming. UNICEF, as part of the National CMAM guideline development group, has been engaged in advocacy for this approach to generate evidence to highlight its adequacy and effectiveness in rehabilitating malnourished children and reducing the number of children who die from acute malnutrition.

However, even with the nutrition programme's alignment to the above mentioned guidelines, wherein it commits to developing CMAM and strengthening it through training, increased supplies and generating policy influence, all community based programmes remain as pilots, largely as a response to emergency situations, without a uniform strategy to scale up. In order to ensure long-term improvements in the management of SAM, CMAM needs to be implemented through the existing ministry of health infrastructures as a part of a standard primary health care package. Adopting strategies to ensure this will make the nutrition programme more responsive to address stunting in both urban and rural contexts.

Partnership and Participation

To ensure integrated action and participation to address the nutritional needs of Bangladesh, UNICEF's strategy to form alliances with different sectors finds relevance. The nutrition programme facilitated development of synergies through multi-stakeholder committees such as Bangladesh National Nutrition Council (BNNC), District Nutrition Coordination Committee (DNCC) and Upazila Nutrition Coordination Committee (UNCC) to build national and sub-national platforms for scaling up nutrition activities through multi-sectoral, multi-stakeholder and multi-level approaches. Discussions with the officials at the national, district and upazila level also confirmed that such committees are relevant to ensure synergies between various line departments and formulation and implementation of joint action plans on nutrition. Furthermore, UNICEF assists in sectoral coordination and engagement between activities of ministries, departments, agencies, divisions and directorates through (the deployment of) DNSOs for the successful implementation of NPAN 2 and to improve the overall nutritional status of the citizens of the country. During discussion with GoB officials across levels, a clear need for external facilitation was expressed to ensure such coordination, especially during the initial phases of implementation, hence rendering UNICEF's actions as relevant and appropriate.

Additionally, UNICEF co-leads, with the Government, the nutrition cluster to ensure that the country-level capacity for responding to nutrition needs in emergencies remains strong. While this may be a responsive strategy, a greater focus on preventive interventions will be more appropriate to strengthen responsiveness towards addressing the need for climate-change resiliency.

Globally, nutrition networks and partnerships have been established through active participation in the SUN movement, the United Nations Zero Hunger Initiative, No Wasted Lives coalition, and Global Nutrition Cluster (GNC) guided by the SDG, to adequately respond to the nutritional needs of children through coordinated efforts.

Towards creating horizontal coordination, the nutrition programme also develops synergies with Health, WASH, C4D and Gender sections within UNICEF to scale up nutrition sensitive and nutrition specific interventions. This multi-sectoral approach is an appropriate strategy to ensure coordinated efforts to address stunting in a comprehensive manner.

An assessment of adolescent health facilities in Bangladesh conducted in 2016¹⁰⁰ recommended the need to ensure a separate sitting space/room for adolescents, safe drinking water in the facility, service hours suitable for adolescents as well as privacy and confidentiality. There emerged a need to understand adolescent health and meet their nutritional needs using a multi-sectoral and multidisciplinary approach.

¹⁰⁰ Project Report of Adolescent Health Facility Assessment in Selected Districts of Bangladesh, *Department of Public Health and Informatics (DPHI) and Bangabandhu Sheikh Mujib Medical University (BSMMU), Dhaka, Bangladesh, 2016*

Adolescent health related programmes, under the purview of the MoHFW, include the provision of Adolescent Friendly Health Services (AFHS), school health programmes, counselling and raising awareness among adolescents. While the MoHFW has the primary responsibility for addressing the health and nutritional needs of adolescents and providing quality services, Non-Governmental Organizations (NGOs) have played a pioneering role in providing adolescent friendly health services in Bangladesh. Despite their extensive engagement, the lack of coordination and collaboration between civil society organizations resulted in interventions not being large enough in scale to generate a critical national response. Therefore, understanding the need for comprehensive adolescent programmes, the MoHFW decided to develop an adolescent health strategy that focuses not only on adolescents but also on their social environment including families, peers and communities. The NSAH (2017-2030), developed with inputs from UNICEF, adopts a convergent model of health promotion and service delivery. With adolescent nutrition as one of its four strategic thematic areas, it aims to actively engage adolescents through primary health care providers and platforms within community spaces such as schools and adolescent clubs to secure and strengthen mechanisms for access.

Towards this, UNICEF has leveraged key partnerships to build capacities of health personnel and implementation partners through sensitization and training for improved counselling of adolescents and provided infrastructural support to AFHCs to deliver effective services to meet the nutritional needs of adolescents. UNICEF leveraged the field presence of partners like SKNF and BRAC, to integrate nutrition within existing school and community based adolescent clubs and support the formation of new ones so that they may serve as a platform to engage adolescents more directly in their own health and nutrition. Further, in order to mainstream nutrition within the education and health system, UNICEF supported the Institute of Public Health Nutrition (IPHN), Ministry of Health and Family Welfare and Directorate of Secondary and Higher Education (DSHE) in establishing adolescent clubs in secondary schools. The formation of these clubs also ensures the inclusion of differently abled adolescents to ensure equity. By planning for interventions like adolescent clubs and well-equipped AFHCs, UNICEF has incorporated learnings from previous evaluations to develop an appropriate adolescent health and nutrition strategy to adequately meet their nutritional needs.

UNICEF has taken into consideration its comparative strength and leveraged the strengths of other sector actors in order to address nutritional needs of the population. For instance, UNICEF has leveraged the on-ground presence of SKNF to reach out to adolescents due to their prior experience of having engaged with adolescents extensively. Similarly, NI's expertise on micronutrient supplementation has been leveraged to deliver fortified food and ensure last mile delivery. UNICEF has also demonstrated use of partnerships with organizations like ILO, World Bank and BRAC to address the urban needs of nutrition through the Mothers@Work initiative. Herein, the partner's existing work in the RMG sector and acceptance in the community was leveraged. Therefore, the UNICEF's strategy to leverage partnerships to improve nutritional services and its reach in urban areas as well as to expand UNICEF's area of intervention within Bangladesh is appropriate.

Equity Responsive and Resilient Service Delivery

While the impacts of climate change have seen large numbers of people moving from climatically vulnerable and damaged coastal areas to major urban centres, population growth, has in itself, accelerated the rate of urbanization. Although most of the population remains rural, 23 percent people now live in urban areas (GOB 2014). From 2001 to 2011, the country's urban population expanded by 35 percent with an annualized growth rate of 3 percent. However, limited access to safe and nutritious food, social services and poor public health infrastructure leave the urban populations at high risk of nutritionally inadequate diets and infectious diseases. Unlike a strong network of primary health family planning services that exists in the rural areas of Bangladesh (where there is a CC per 6,000 people, a Health and Family Welfare Centre

in each Union, a Health Complex in each upazila), there is lack of a similar network and programme in the urban areas. This gap adversely affects the primary health care of one-third of the country's population who are living in the urban areas. The poor are particularly deprived of essential health care services. Towards this, UNICEF's nutrition programme aims to strengthen leadership and governance for nutrition in urban areas and develop models of nutrition service delivery in urban slums.

Previous evaluations have highlighted some key challenges to effective implementation of nutrition services wherein management capacity to plan interventions at district and sub-district levels required strengthening, as did monitoring and reporting of performance. Second, knowledge and skills among managers and frontline workers remained inadequate, constraining delivery of nutrition services.

Government of Bangladesh, through AINNS aimed to address these critical bottlenecks. As part of developing national and subnational systems and capacities, the implementation includes two approaches i) provision of dedicated nutrition professional, District Nutrition Support Officer (DNSO) now known as District Nutrition Coordinator (DNC), at the district to empower and transform districts' capacity in planning, implementation and monitoring and reporting of the nutrition services, ii) Competency Based Training (CBT) and mentoring of health managers and service workers, which is focused on building the skills of the health service providers through practical demonstration and hands-on practice. These interventions were supported by UNICEF and led by the nutrition programme. Further, in order to alleviate the barriers^[1] related to adoption of IYCF and maternal nutrition practices, UNICEF's focus on building the capacities of community health workers to adequately provide nutrition counselling and services is appropriate. A need for this also expressed by pregnant and lactating women during FGDs, wherein they felt capacity building of CHWs is critical since they are the primary source of information on aspects related to nutrition for them.

Contributing towards this, UNICEF primarily focused on two areas: i) Using improved data to enhance evidence-based planning and responsive service delivery and ii) enhancing the competency of health workers to deliver nutrition services and counselling.

In this regard, UNICEF supported the deployment of DNSOs, to focus on nutrition and work with district and sub-district teams, while also accelerating the mainstreaming of services into the health system.

Working as counterparts of the Government at district level, DNSOs provide technical and facilitation support for evidence-based planning, monitoring, information management, capacity strengthening, coordination and addressing bottlenecks for enhanced delivery of nutrition services. Additionally, DNSOs work towards enhancing the capacities of their district counterparts to effectively engage with sub-district (upazila) health staff to execute the plans.

By facilitating data driven management and analysis, DNSOs also help support facilities to improve coverage of nutrition services and increase their utilisation. To further strengthen capacities of health workers, DNSOs visit health facilities and support frontline workers through on-the-job training on critical aspects of nutrition service delivery. Therefore, responding to the needs of the government, DNSOs serve as a "bridge" between central and sub-national levels by ensuring that national nutrition policies, guidelines and plans are effectively understood, planned, implemented and monitored.

Key to incorporating "nutrition-sensitive" services (e.g., from agriculture, education, water and sanitation, or social welfare) to complement "nutrition-specific" services, DNSOs also promote a multi-sectoral approach. They serve as advocates for nutrition by highlighting the increasing importance of nutrition as a development agenda, thereby enhancing nutrition's "visibility" as an issue in various line departments. Herein, they engage, advocate and support different line Ministries to integrate nutrition promotion into their

^[1] Barriers such as discontinuing IFA consumption due to side effects and non-disclosure of pregnancy (to health workers) fearing evil eye as also expressed during FGDs.

ongoing programmes, and provide technical support to initiate nutrition-sensitive interventions through various sectors.

Therefore, by promoting the use of evidence based decision making and fostering sectoral coordination, UNICEF's approach and implementation strategy is responsive to the government's need for strengthening district and sub-district management of nutrition services.

Further, to address the challenge of limited skills of health service providers for effective nutrition service delivery, a Competency Based Training on Nutrition, was developed and rolled out by UNICEF in partnership with the Institute of Public Health and Nutrition (IPHN), the National Institute of Preventive and Social Medicine (NIPSOM) and the Institute of Child and Mother Health (ICMH). This was complemented with continuous post-training mentoring. Previous attempts to address this capacity gap through large-scale traditional training programmes had very limited success, and hence a need for innovative learning methodologies was felt. Unlike conventional training, CBT, with its results-based training methodology, focuses more on skills with practical demonstration and hands-on training and mentoring. Moreover, supervisors and managers are also provided training for an additional two days on supportive supervision, mentoring and monitoring.

Additionally, CBT also offers a unique pay-for-performance approach. Apart from pre- and immediate post-training assessments to ascertain the uptake of knowledge and skills, an independent third-party assessment of the trained health workers is conducted every six months, to provide insights into longer-term retention of training components. Therefore, CBT, supported by UNICEF, contributes towards improving the skills and competencies of managers, supervisors and service providers, addressing a crucial need for strengthening service delivery.

Another major barrier standing in the way of effective evidence-based planning and decision making with regards to nutrition, was the lack of access and unavailability of data¹⁰¹. In an assessment of the effectiveness of the delivery of the NNS strategies and actions, a number of shortcomings in the governance and institutional arrangements, service delivery and monitoring of the operational plan were highlighted¹⁰². It also highlighted the need for establishing ownership and leadership for nutrition as well as strengthening analytical capacity within national institutions. Recommendations suggested that Bangladesh would benefit from a comprehensive approach to compilation of nutrition-specific/sensitive data, as well as strengthened analysis, interpretation and presentation for use by decision-makers in planning and advocacy. Hence, a critical need was identified for a web-based data system for data visualisation in order to analyse and review performance at district and sub-district level.

It was felt that if nutrition goals are to be achieved, multiple sectors, stakeholders and line ministries will need access to better, more coordinated data to support evidence-based planning and progress tracking. With an aim to harmonise the nutrition indicators and create a standardised system for data collection and reporting on nutrition interventions towards addressing the governance and institutional gaps identified in the assessment of the NNS-OP, UNICEF provided technical and financial support to GoB for the establishment of the Nutrition Information and Planning Unit (NIPU) as part of the Institute of Public Health Nutrition in the MoHFW.

UNICEF also supported the Directorate General of Health Services (DGHS) on HMIS, introducing an open-source digital registry platform to improve services provided by frontline health workers. The platform, which runs on health workers' tablets, marked a shift from the paper-based registration, reporting and tracking of reproductive, maternal, new-born, and child health (RMNCH) continuum of care to a mobile-based

¹⁰¹ Saha et al (2015) Bangladesh NNS: Assessment of implementation status. <https://openknowledge.worldbank.org/handle/10986/22377>

¹⁰² Challenges included data being too old to be relevant for planning and decision-making, gaps in data and poor resolution of data, varying methodologies used for other national surveys such as FSNSP, DHS, HIES and MICS, its frequency and some key indicators (such as coverage of complementary feeding interventions), specifically nutrition-sensitive data, required by programme decision-makers missing.

application powered by RapidPro. Linked with the District Health Information Software 2 (DHIS2), the application enables health workers to effectively and efficiently keep records, send out automated reminders to beneficiaries, and track compliance to improve vaccination rates and coverage of antenatal care services.

A real-time monitoring (RTM) platform on nutrition service delivery was institutionalized throughout Bangladesh with support from UNICEF. Using a mobile application on tablets or smart phones, DNSOs and frontline supervisors entered observations on quality of nutrition services at health facilities, which are linked to an online dashboard. Such real-time data visualization and performance analysis helps strengthen routine monitoring and enable timely responses.

UNICEF has also assisted in design and implementation of the DHIS2 by supporting with infrastructure (server and tablets), training of the department IT officials and the frontline workers. Such interventions responded to the needs of the government and hence, were relevant and appropriate for systems strengthening and building national and sub-national capacities.

As evident from the above findings, the multi-faceted contribution of UNICEF towards strengthening the nutrition system has combined coordination support and capacity building for service delivery, planning and monitoring, making it an appropriate and responsive strategy to address the needs of GoB to achieve Nutrition outcomes.

UNICEF's comparative advantage is derived both from its global mandate and expertise, as well as its long country experience. UNICEF's dual development and humanitarian mandate, its large-scale field presence and a capacity to engage concurrently at multiple levels including global, regional, country and local levels on common issues, and its position as a trusted advisor to governments, make it well placed to lead this work. Furthermore, synergies are realised along with its strength as an organization with multi-sectoral reach, its wide global, regional and country presence, and its network of partnerships, and together they help bring financial resources, expertise and the capacity to influence.

The examination of the relevance of UNICEF nutrition programme's interventions and implementation strategies highlights that the mix of strategies aim to ensure a balance between upstream and downstream work against the background of the transition of Bangladesh towards middle-income status.

It also reflects learnings from past evaluations that fed into the interventions and implementation strategies of the UNICEF nutrition programme, to adequately respond to the needs of various target groups through appropriate actions towards strengthening existing systems.

Alignment with priority areas and government policies

The UNICEF Nutrition programme document contains a clear analysis of the situation at the time regarding child and maternal nutrition, household food security and the effects of macro-economic changes and natural disasters. There is also clear justification, based on data available at the time, for the selection of the identified programme areas within the Nutrition sector.

The focus and direction of UNICEF's nutrition programme is intrinsically linked with the health sector, as also reflected in nutrition programme Strategy. In alignment with UNICEF Global Nutrition Strategy, the nutrition programme reflects its commitment towards building strong synergy between health and nutrition, recognizing the urgent need to look beyond and describing how to engage and coordinate with other sectors to ensure sustainable impact.

A detailed review of the UNICEF country programme strategy suggests that the nutrition programme selected its priority programme elements keeping in mind Bangladesh's dynamic and evolving context, challenges associated with increasing urbanization, the variability caused due to climate change and the fragility associated with increased humanitarian conflicts. It was found that learnings from the evaluation of

UNICEF strategic positioning in Bangladesh were incorporated wherein, in the current CP, priority was given to hard-to-reach areas, including the CHT, Southern districts and urban slum areas, which face significant bottlenecks in geographic accessibility resulting in low coverage by national programmes. Such efforts to address equity gaps primarily through targeting vulnerable communities, also establishes the nutrition programme's alignment to the UNICEF strategic Plan 2018-2021 Goal Area 1: Every Child Survives and Thrives. Further, the nutrition programme's strategy of supporting policy and advocacy, providing technical assistance and capacity development towards nutrition systems strengthening, are in alignment with the Bangladesh UNDAF 2017-20 that recommends systematic capacity development as a long term sustainability strategy to respond to the likely declining levels of international support as Bangladesh's economic status rises.

Furthermore, the programme adopts a life cycle approach to address the nutritional needs of under-five children, school aged children, adolescents and pregnant and lactating women, in alignment with the National Food Policy (2006), NNP 2015 and the NPAN2 2016-2025. Specifically, UNICEF's nutrition programme aligns with the strategies of NNP and the key action areas of NPAN2, wherein it is providing support to build the capacities of health workers, strengthen nutrition counselling, promote adolescent nutrition through formal and informal academic curricula and maternal nutrition by facilitating breastfeeding support in the workplace.

The UNICEF nutrition programme is also partially aligned with the National Urban Health Strategy (2014) of Bangladesh that aims to address i) challenges associated with rapid urbanization, ii) the need for preventive care, iii) the need to ensure coordination among activities of different organizations and iv) public sector's financial and non-financial limitations by incorporating public, private and social partnership. Towards this, UNICEF's interventions in the urban context focus on creating public-private partnerships, establishment of a coordination committee with MoHFW and MoLGRD&C and other departments involved in urban development, tailored interventions for adolescents and working mothers. However, UNICEF is yet to address the need for preventive care to adequately meet the needs of all target groups. Given the impending MIC status of Bangladesh, interventions focusing on preventive care will help Bangladesh better prepare for its changing needs.

Additionally, UNICEF's interventions to enhance micronutrient supplementation, strengthen IYCF counselling and services for adolescents and working mothers finds relevance as it responds to the needs of the urban population by trying to address the gaps and shortfalls identified by the National Micronutrient Survey 2012, the Urban Health Survey 2013, and the Child Wellbeing Survey, 2016.

UNICEF's strategy attempts to address the age and gender specific needs of adolescents as well as the bottlenecks identified in the national consultation on adolescent nutrition held in September 2016 (of which UNICEF was a part). It does so by aligning with the Strategic Objectives of the National Strategy for Adolescent Health (NSAH) 2017-30. Similar to the key strategies in the NSAH, UNICEF focuses on capacity building of service providers, community based awareness campaigns, micronutrient supplementation, mainstreaming nutrition education in systems that reach schools as well as out-of-school adolescents and promoting dietary diversification and adequacy through community and school based programmes. This is done through the support UNICEF provides to adolescent clubs and AFHCs while also strengthening the capacities of CHWs through CBT to provide better nutrition support and counselling.

UNICEF's interventions on promoting micronutrient supplementation, specifically IFA, focus on maternal and child nutrition including IYCF practices, providing infrastructural support to IMCI corners for SAM screening as well as incorporating adolescent nutrition is well aligned with the priority areas of the National Strategy on Prevention and Control of Micronutrient Deficiencies (2015-24) and MoHFW's Bangladesh Essential Health Service Package (ESP).

The nutrition programme is also in alignment with the CIP 2 (2016-20) as it adopts a multi-sectoral approach to tackle malnutrition. In alignment with the overarching goal of the CIP 2, UNICEF promotes nutrition sensitive interventions and builds capacities of community health workers to enhance knowledge about positive nutrition behaviours amongst the community. UNICEF, in alignment with CIP 2 also makes efforts to mobilize additional financial resources from multiple sources to further the nutrition agenda. Furthermore, the UNICEF nutrition programme strategy encourages policy coherence and coordination, mainstreaming of nutrition sensitive interventions, ensures targeting of vulnerable groups and places emphasis on public private partnerships in alignment with the guiding principles as laid out in CIP 2.

In alignment with the Seventh five year plan that outlines the need for training on nutrition education to improve the knowledge base and capacity of health personnel regarding nutrition, as well the need for a comprehensive approach to address issues that are supplementary and complementary to nutrition, UNICEF in collaboration with other development partners launched Accelerating Implementation of NNS (AINNS) project, led by GoB.

Additionally, UNICEF promotes and adopts integrated, cross-sectoral and collaborative approaches to meet the nutritional requirement of children, in line with the Bangladesh ECCD Policy Framework. Particularly, UNICEF's efforts towards the incorporation of nutrition indicators in the early learning and development standards (ELDS¹⁰³) to ensure holistic development of the child provides further evidence of its alignment.

¹⁰³ ELDS is a tool to monitor the development and learning of children (birth to eight years) and includes a range of indicators encompassing different dimensions.

Effectiveness

Presented below is a summary of the evaluation findings on effectiveness in the form of short answers for each evaluation question.

Key Evaluation Question	Short Answer/Finding
<p>EQ 8: Development and implementation of nutrition and multisector policies, strategies and costed action plans?</p>	<p>UNICEF has provided technical assistance in the formulation of NPAN 2, preparation of a costed action plan and its dissemination across district and sub district levels. It has also supported development of the National Strategy for Adolescent Health, National Guidelines for Community –based Management of Acute Malnutrition and Salt Law. The evidence generated through multiple indicator cluster surveys and assessments such as analysis of situation of children and women in Bangladesh, coverage of basic social services has contributed to the formulation of these strategies. The implementation strategy of the programme to generate evidence, policy advocacy and strengthen service delivery has effectively supported implementation of NPAN 2.</p>
<p>EQ 9: Strengthening sector coordination and governance</p>	<p>The deployment of DNSOs has been effective in promoting multi-sectoral coordination by ensuring participation of various line departments at a common platform (DNCC/UNCC) and facilitating discourse on nutrition. DNSOs have facilitated regular conduct of meetings, participation of line departments and preparation of minutes of meetings. However, the effectiveness is constrained by the lack of convergent planning that ensures complementarity between nutrition-sensitive and nutrition-specific interventions. While the sector coordination and governance is being strengthened by the programme in the rural context, lack of coordination between MoHFW and MoLGRD&C constrains the effectiveness of programme support in the urban context.</p>
<p>EQ 10: Creating an evidence base and building capacity at the national and sub-national level for evidence and equity-based planning and budgeting</p>	<p>UNICEF through assessment of allocation and expenditure on nutrition-specific and sensitive interventions by different ministries has supported MoHFW and other ministries to plan complementary interventions and accordingly prioritise resource allocation. The technical assistance provided by NIPU at the national level has enabled analysis of data reported under DHIS2 and identification of priority areas for targeted interventions and adequate resource allocation. The capacity building of the staff at district level and continuous mentoring of Civil Surgeons by DNSOs has facilitated timely reporting of nutrition data, as well as its use during monthly review meetings to provide guidance to the health workers so that corrective actions can be initiated.</p>
<p>EQ 11: Strengthening management information systems</p>	<p>UNICEF’s technical and financial support to GoB in establishing NIPU has resulted in the institutionalization of NIS and facilitated real time monitoring and tracking of nutrition indicators using dashboards. The health officials till CC level were found to have been sensitized on the importance of real time monitoring and regular uploading of data on DHIS 2 . The dashboards have enabled identification of low performing geographical areas and better targeting and prioritization of interventions. However, this is constrained by the lack of efforts at the district level, towards utilization of MIS data for planning and budgeting. The data on maternal, child and adolescent health indicators is reported on a separate MIS by DGFP. This has resulted in a</p>

Key Evaluation Question	Short Answer/Finding
	lack of coordinated efforts and monitoring between the DGHS and DGFP. In the urban context, use of DHIS2 for reporting and planning is limited.
<p>EQ 12: Identifying successful interventions for scale-up and scaling them up through government systems</p>	<p>Mothers@Work as a pilot initiative under the programme has demonstrated effectiveness in increasing awareness on breastfeeding practices among working mothers and realization of maternal and child rights through availability of an enabling environment for breastfeeding at the workplace. The initiative is being considered by the Ministry of Labour and Employment for scale up.</p> <p>The adolescent clubs initiative, as a pilot, has demonstrated its effectiveness in creating awareness on aspects related to nutrition, menstrual hygiene and adolescent pregnancy amongst adolescents and providing a platform for discussion among adolescents at the school and community level. The dual approach (promoting both community and schools based clubs) has enabled engagement with ‘out-of-school adolescents’ and built the adolescent club members’ capacities to act as ‘agents of change’ in promoting appropriate nutrition behaviours. The community based clubs are being scaled up (5000 clubs) by the Ministry of Women and Child Affairs. The school based clubs have been scaled to 250 schools (in addition to 40 under the programme) by the Directorate of Secondary and Higher Education.</p>
<p>EQ 13: Delivering quality nutrition services that are inclusive, equitable, sustainable, cost-effective, gender-responsive and climate-resilient?</p>	<p>In accordance with the programme’s implementation strategy of strengthening equity responsive and resilient service delivery, the targeting of beneficiaries was inclusive and supported areas affected by climate change, disasters and high prevalence of stunting. The interventions were effective in sensitization of women, adolescent boys and girls on the importance of nutrition and dissemination of nutrition related messages. The interventions also addressed the nutrition related needs of women and adolescent girls. Interventions focusing on sensitization of men and addressing their nutrition needs were not observed. Mothers@Work initiative leveraged on a platform created by another development partner, thereby generating an evidence on delivery of nutrition services in a cost effective manner.</p>
<p>EQ 14: Adopting a nutrition system strengthening approach for achieving effective coverage of nutrition services and an integrated service delivery</p>	<p>The evaluation findings highlight that the CBT approach adopted has been effective strengthening the capacities of CHWs for prioritising delivery of nutrition services and addressing nutrition needs of infants, pregnant and lactating women and adolescents. As a result, there has been an improvement in counselling on nutrition and quality of service delivery. Support from DNSOs at the district and sub district level has effectively enabled reporting on nutrition indicators as well as its use to initiate corrective actions in delivery of services by the health workers. The orientation of health workers on identification of SAM cases has helped them in SAM screening and timely referral to the health facilities at district/upazila level. The strengthening of delivery of services in areas affected by climate change and disasters augmented the capacities of health facilities and health workers to address the nutrition needs of communities in these areas. However the reach of programme interventions was limited to those visiting health facilities to avail treatment. Improving</p>

Key Evaluation Question	Short Answer/Finding
	reach of the programme through proactive counselling was a missed opportunity.
EQ 16: Supporting the Government to reach the global goals set by the World Health Assembly and SDG goals?	The evaluation findings suggest that as a result of the nutrition programme's implementation strategy of strengthening equity responsive and resilient service delivery, GoB would be able to meet 2 out of 6 World Health Assembly targets namely reduction in stunting and increasing the rate of exclusive breastfeeding (also SDG goal). The targets related to no increase in child overweight, reduction in wasting, anaemia and low birth rate may not be achieved.
EQ 17: Have unintended outcomes, positive as well as negative, resulted from the programme?	A positive unintended outcome that has emerged from the programme is the realization of a business case on children's rights and business principles by the management of RMG factories as a result of adopting the Mothers@Work initiative. The initiative has established a business case for replication by other industries. The evaluation findings does not highlight any negative unintended outcome as a result of the programme.
EQ 15: Mobilizing and engaging families, communities, local government bodies and key influencers through C4D strategies to address socio-cultural barriers and bottlenecks, increase demand for utilization of nutrition services and promote the practice of desired behaviours?	While C4D strategies have been adopted to mobilise communities and increase the demand for utilisation of services, it was observed that the demand is primarily driven by the efforts of community health workers (as result of CBT). The prevalence of myths related to consumption of IFA tablets and adequate diet during menstrual cycle is still high. The engagement with Community Support Groups and efforts to build their capacity to monitor nutrition status was effective in meeting the resource requirement for infrastructure upgradation at the CC level, mobilising the community and generating awareness on nutrition using public platforms.
EQ 18: Is the country programme structure of a life cycle approach where different sections work jointly within? Outcomes (life phases) conducive to achieving the results of the nutrition programme and in particular, reducing undernutrition and improve adolescent health and wellbeing?	Following the life cycle approach, the programme is engaging with the child protection and education sections (of UNICEF) to promote adoption of appropriate nutrition practices among adolescents who are members of adolescent clubs. Further, it is engaging with the WASH section to mainstream nutrition in WASH related interventions targeting children in primary schools. Efforts towards capacity building of health workers has led to promotion of desired maternal nutrition and IYCF practices through counselling. The country programme therefore, has engaged with different sections to address the nutrition related issues across all the life phases. These interventions have contributed to achieving results on indicators related to reduction in stunting, exclusive breastfeeding and improvement of BMI levels in adolescent girls.

Evidence Generation, Policy Dialogue and Advocacy

UNICEF continuously strives towards evidence generation supported by research and documentation with the aim of creating policy dialogue and advocacy to improve the policy environment for realization of rights and equitable service delivery. The progress made under the programme and the realization of its effect are presented ahead.

To create a breastfeeding friendly environment at the work place, UNICEF nutrition programme piloted the M@W initiative in select RMG factories to demonstrate the efficacy of the initiative so it can be scaled up in Bangladesh. Through the use of various C4D strategies, UNICEF created awareness and promoted sensitization of factory owners on maternity rights and the need for breastfeeding friendly workplaces.

Discussions with the staff at RMG factories indicated that in spite of factories' adherence to labour norms, UNICEF's role in sensitizing factory management on the need for an enabling environment for breastfeeding at the work place resulted in the construction of breastfeeding corners and a revitalization of day care centres for children above 2 years. They further indicated that the nutrition related messages they received as part of this initiative helped them understand the importance of improved nutrition and breastfeeding facilities at the workplace, design and promote lactation kits for safe breast-milk expression and storage.

Observations during the field visit to RMG factories further validated the same and it was found that the breastfeeding corners ensure privacy to lactating mothers at the workplace and that day care centres had provision of refrigerators to store expressed breastmilk. Furthermore, the provision of labelled bottle kits for storing expressed breastmilk to factories by UNICEF (observed in RMG factories) has provided an opportunity for the child of a working mother to be breastfed at home. Working mothers appreciated the provision of the labelled bottles as even when they do not bring their child to the day care centre, it eases collection of breastmilk by family members while she is working. Discussions with the lactating mothers indicate that they are more confident about practicing breastfeeding within the factory premises and have also reduced early initiation of complimentary feeding.

During FGDs, working mothers reported that the availability of breastfeeding corners and day care services at the workplace supported by regular breaks has enabled them to stay close to their babies, breastfeed them and at the same time concentrate on their work. This has also resulted in increased ease of working during pregnancy and lactation period, maintaining their productivity levels, as also reported by RMG factory owners. Moreover, working mothers also emphasised that unlike before, they felt more secure about their job during pregnancy as they were assured the same position post completion of their maternity leave. In addition to this, as observed during the field visit, pregnant women are given a white scarf to put around their head so that everyone can easily identify them and extend support whenever needed.

Therefore, towards addressing challenges related to inadequate maternity protection, encouraging breastfeeding and child care, Mothers@Work initiative has demonstrated effectiveness in increasing awareness and realization of maternal and child rights through availability of an enabling environment for breastfeeding at the workplace.

Discussions with staff at factories indicated that pregnant and lactating women are also provided health cards and are referred to NGO clinics like *Surjer Hashi* to ease access to various health-related services. They further said that the card helps bring women into the fold of the formal health delivery system and contributes towards ensuring institutional deliveries.

A positive unintended outcome that has emerged from the programme is the realisation of a business case on children's rights and business principles by the management of RMG factories, as a result of adopting the Mothers @Work initiative. Owing to the fact that mothers are able to breast feed their child and are mentally at peace while working, they are able to maintain their productivity levels. This results in reduction of accidental risks as well as wastage, thereby enabling a saving of approximately USD 50,000 per year. Furthermore, it has led to an increased retention of the female trained workers. Therefore, a business case demonstrating the merits of the initiative is established for replication of this initiative by other industries.

Therefore, continuing with these sensitization efforts and building evidence to scale up the initiative would further help increase the acceptance of breastfeeding at the workplace among factory owners and staff and contribute to the effectiveness of the initiative.

The UNICEF Child protection unit supported the formation of adolescent clubs (community based) that provide adolescents a platform to discuss issues of adolescent health and well-being. The nutrition programme leveraged this platform by introducing sessions that aimed at increasing knowledge about

nutrition services among adolescents. Moreover, as a pilot during the current country programme, the nutrition programme with support from SKNF established 40 school based adolescent clubs and 1200 adolescent peer leaders (30 boys and girls per club). Additionally, UNICEF supported GoB in upgradation of the AFHCs in the health facilities. The programme also worked with Directorate of Secondary and Higher Education (DSHE) in mainstreaming nutrition in the secondary education curriculum and providing orientation to the School Management Committee Members (SMC) for creating awareness on adolescent nutrition and established a coordination mechanism between IPHN and DSHE.

During the field visit, AFHCs in all the health facilities in the sampled upazilas in Khulna and Sylhet divisions were observed. These AFHCs were equipped with board games, story books and furniture, some of them provided through the programme. The space was conducive for adolescents and was used to conduct adolescent club meetings. During the discussions, boys and girls (members of adolescent club) expressed confidence in coming to AFHCs and participating in discussions on various aspects including nutrition. They also mentioned that counselling/ orientation provided by the adolescent club facilitators has aided their understanding on aspects related to adolescent health and nutrition, child marriage and encouraged them to demand for services. This was validated during FGDs where adolescent club members in sampled upazilas demonstrated higher awareness on nutritious food and practices as compared to adolescents not part of clubs, in both UNICEF (intervention) and non-UNICEF upazilas. Additionally, approximately 56 percent adolescent participants in Khulna and 61 percent adolescent participants in Sylhet division reported to have consumed food from more than four food categories in the last 24 hours. The boys and the girls also highlighted their awareness about implications and risks related to child marriage and adolescent pregnancy and talking to their peer group on importance of nutrition.

Discussions with adolescents at Batiaghata upazila revealed that the adolescent club members are also issued health cards that can be carried during their visit to health facilities. As the cardholders do not require registration for OPD visits, access to services has greatly been facilitated.

Moreover, during the discussions with the girls (member of adolescent clubs) it was highlighted that as a result of orientation on good menstrual practices, they have started using sanitary napkins. Further, they talked about the need for increasing iron uptake during the menstrual cycle.

Box 1: Role of Adolescent Clubs in challenging social norms

Shorna, an 11-year-old girl, was terrified when she got her first period. Clueless about what was happening to her body, she turned to her grandmother for guidance as her mother is a mental health patient and needed care herself. Her grandmother put restrictions on Shorna's food, where she slept and her mobility from stepping outside her house. She was asked not to eat her favourite food- chicken- and only ate boiled potatoes and rice for the next few days. This went on until Shatabdi, a 16-year-old member of the Gangarampur adolescent club met Shorna and inquired about her health. On learning about the situation, Shatabdi brought this issue up in the adolescent club meeting that week. She visited Shorna's house with the adolescent club in-charge from Rupantar to try and convince her grandmother about the importance of adequate nutrition, especially in adolescence. However, this effort was in vain. Shatabdi and the Rupantar staff then approached Shorna's father and counselled him on the disadvantages of this social norm and convinced him to let his daughter eat a balanced, nutritious meal even during her periods. Today there are no restrictions on Shorna's diet during menstruation. While Shatabdi takes part in the adolescent club meetings regularly, Shorna visits the AFHC to read storybooks sometimes and is waiting to join the club.

It can therefore be inferred that adolescent clubs initiative as a pilot has demonstrated its effectiveness in creating awareness on aspects related to nutrition, menstrual hygiene, child pregnancy and providing a platform for discussion among adolescents at the school and community level. The dual approach (promoting both community and schools based clubs) also provides a unique opportunity to engage with 'out-of-school adolescents' and build their capacities to act as 'agents of change' in promoting appropriate nutrition behaviours.

Partnership and Participation

UNICEF provided technical support to GoB for the dissemination of NPAN2 both at national and sub-national level. Further based on its experience of creating a multi-sectoral platform on nutrition in Sunamganj district (Sylhet division) during the previous country programme, UNICEF established District Nutrition Coordination Committees (DNCC) in 43 districts under the current CP. Further, to facilitate district coordination and planning meetings, UNICEF deployed District Nutrition Support Officers (DNSOs) in 39 districts. All the sample districts in Sylhet and Khulna division reported to have constituted DNCCs. To support coordination between various line departments and development partners at the upazila level, Upazila Nutrition Coordination Committees (UNCC) were established.

The discussions with the district and upazila level officers indicated that that 3 out of 4 sampled upazilas in Sylhet (Juri, Jagannathpur and Bishwambharpur) have established UNCC. On the other hand, none of the sampled upazilas in Khulna division reported to have a UNCC. The upazila level officials however, mentioned discussing nutrition in their monthly meetings (at upazila level). The presence of a coordination mechanism in Sylhet division can also be attributed to its identification for reporting on Disbursement Link Indicators (DLI) and the assistance it receives from other development partners. None of the upazilas identified in non-UNICEF areas for the evaluation, reported to have established an UNCC.

Moreover, the review of minutes of meeting in all the sampled upazilas and districts that have a nutrition coordination committee indicate that the UNCC/DNCC meetings were regularly conducted every alternate month. However, the agenda of these meetings was limited to discussions around what was done independently by each department in the last two months towards nutrition. There was no evidence on preparation of joint action plans or review of any planned activity. The discussions with upazila and district level officials of various departments also highlight lack of any joint planning for nutrition sensitive interventions. However, they indicated that due to the recent formation of the committees (since Jan 2019), it is expected that the agendas would now gradually comprise of inter-ministerial and multi-sectoral joint action plans aimed towards addressing nutritional challenges in the upazila/district.

The review of minutes of meeting and discussions with the officials of various line departments further revealed that the functioning of these nutrition coordination committees and conduct of meetings vary with each upazila. It also emerged that the extent of proactiveness of a UNCC/DNCC working towards addressing issues related to undernutrition was largely individual driven or highly dependent on few of its members anchoring the same. For example, the Jagannathpur UHFPO reported that basis his recommendation, the UNCC has divided itself into 5 sub-groups comprising 5 members and every two months these groups conduct nutrition awareness sessions in different areas. Further as a result of cordial relationship between the UHFPO and the Upazila Parishad Chairman, the Jagannathpur UNCC was able to garner financial support from the Upazila Parishad office for distribution of 2000 tiffin boxes to school children thereby facilitating them to carry nutritious food from home (as many students used to buy unhealthy snacks from nearby shops). The education department official in Jagannathpur reported that the teachers in this upazila impart knowledge about various issues (including nutrition) in the first period of school. Similarly, in Juri upazila, it was found that the UNCC discussed leveraging of community events

such as *maa samabesh* (Meeting of mothers' group), *Uthon baithak* (courtyard meetings) for dissemination of messages related to nutrition.

The discussions with the representatives of various line departments at the district level (and members of DNCC) also highlighted that reporting on discussions undertaken at UNCC level, for feedback from the district, was limited. As a result, DNCCs miss opportunities for cross-sharing and replication of innovative approaches undertaken by UNCCs across the district. It also limits possibilities of any advice on standardization in the functioning of UNCCs. This scenario was also observed at the national level where there is limited feedback on the actions undertaken by DNCC. As a result of this, initiatives undertaken by committees at the district and upazila level lack standardisation and remain individual driven.

In the urban context, while the nutrition coordination committees have been established in city corporations, the discussions with health officials in Dhaka and Sylhet Corporation revealed that in the absence of any facilitation (through DNSOs as in rural areas), functioning of committees is constrained by lack of coordination between MoHFW and MoLGRD&C. As a result, interventions on nutrition are limited and primarily led by MoHFW. There is no convergent planning or action.

It can therefore, be inferred that the programme has been effective in promoting multi-sectoral coordination by ensuring participation of various line departments at a common platform (at district/upazila level) and facilitating discourse on nutrition, but in a limited manner. The extent of effectiveness is constrained by lack of convergent planning and standardisation as well as irregular reporting of plans for feedback. In the urban context, there is a need to revitalise nutrition coordination committees through strengthening of the facilitation and coordination mechanism between line departments. The committees in urban areas also require facilitation support as provided by DNSOs in rural context. This will help make the initiative more effective across all geographies.

Towards supporting national campaigns to address undernutrition, the nutrition programme with inputs from C4D section supported GoB in rolling out the “#Unite4Nutrition” campaign. This campaign focused on social mobilization to enhance public awareness and accountability on delivery of nutrition services. The programme also initiated partnership with Ministry of Religious Affairs for sensitisation of over 300,000 registered Imams on key nutrition messages that can be delivered as part of weekly prayers. As a result of this engagement, sensitization on nutrition was included as an additional component under the 40 days training programme for Imams conducted by the Islamic Foundation of Bangladesh under the Ministry of Religious Affairs. The programme also supports GoB in designing and dissemination of key messages among community on aspects related to adoption of appropriate breastfeeding practices, adolescent nutrition, consumption of micronutrient supplementation and positive nutrition behaviours during Nutrition Action Week, Breastfeeding Week and the Vitamin A campaign. While C4D strategies have been adopted to promote nutrition campaign at the national level, it was observed that the demand at the community level is primarily driven by the efforts of community health workers (capacity developed as result of CBT).

While the above activities do indicate programme efforts towards promoting demand generation, in the absence of baseline values on aspects related to Knowledge, Attitude and Practices (KAP), it is difficult to measure the social behaviour change that may have occurred as a result of the same.

The programme has also engaged with different ministries and development partners to strengthen delivery of nutrition-specific and nutrition-sensitive services. The programme has undertaken advocacy with the Ministry of Industries (Mol) for strengthening the Salt Act and improving its enforcement. While in 2016, UNICEF along with Nutrition International (NI) and Global Alliance for Improved Nutrition (GAIN) had supported the Mol in drafting a new salt law, there were delays in finalisation. UNICEF continued advocacy with the ministry on the urgent approval of the act. Subsequently, the draft was accepted by the legal department and has been sent to the Cabinet division for approval before placing it in the parliament for ratification. It is expected that by June 2020, the new Salt Act will be passed. UNICEF is also

engaging with MoI, MoHFW, Bangladesh Small Cottage Industries and Corporation (BSCIC), NI and GAIN for strengthening technical capacity of the National Fortification Unit (NFU) established under MoI. Additionally, UNICEF along with the Salt Millers Association supported MoI in conducting an assessment of the salt harvesting and iodization practices in Bangladesh. The assessment led to development of a standard protocol on design and construction of salt harvesting fields. The adoption of the protocol by GoB and subsequent training of GoB appointed salt technologists provides evidence on the effectiveness of the technical support provided through the programme.

Equity Responsive and Resilient Service Delivery

To enhance evidence-based planning and data-driven decision making, the UNICEF supported Nutrition Information and Planning Unit (NIPU) was established in the Institute of Public Health Nutrition (IPHN). A ten member team supported by UNICEF provides assistance in tracking of nutrition indicators using a dashboard and promoting data-driven decisions with regard to services deployment. The team has also provided capacity building support to district and upazila level officials on data reporting and analysis for planning and budgeting. The nutrition data is collected from the facilities like CCs, UHCs etc., uploaded on DHIS2, analysed by NIPU and presented quarterly through a newsletter, e-mail and other forums. One of the key achievements of establishing NIPU has also been the inclusion of the nutrition indicators and their reporting through DHIS2 portal.

It was found that data is uploaded regularly on the DHIS2 portal at the community clinic level, despite challenges faced due to limited internet bandwidth, as highlighted in discussions with health workers at community clinics. KIs with GoB officials across national, district and upazila level confirmed the use of dashboards for monitoring progress on nutrition indicators and take corrective actions, during monthly meetings. However, data on health services provided by the Directorate General of Family Planning (DGFP), particularly on maternal, child and adolescent health, are reported on a separate MIS. This results in a lack of coordination of efforts and monitoring between the DGHS and DGFP.

District level officials further highlighted that the display of data using the dashboard in district level meetings helps in presenting improvements by different UHCs and motivates others to draw learnings from others and apply them in their own UHCs. It emerged that the ease of visualising the old data and the current data simultaneously facilitates discussions during meetings.

The discussions with MoHFW officials and representatives of IPHN, the MIS department and BNNC highlight the use of dashboards for identification of low-performing geographical areas, it also helps them identify targeted interventions and prioritize accordingly. However, this is constrained by the lack of efforts at the district level, on utilization of MIS data for planning and budgeting. This was validated during discussions with the health officials at the district level, where it was expressed that the use of MIS is currently limited to data reporting and monitoring. Additionally, the real-time data is used for providing appropriate guidance to field level workers, as illustrated in the example below.

Box 2: Use of MIS data for guidance to field level workers

" We identify whatever area seems to have an issue and review the data for that area in great depth. For example, once we identified that even though IFA and calcium supplements had been provided in the area, there had been no improvement in anaemia. So then we checked whether the counselling for these supplements was happening properly or not ... a lot of people don't take these supplements because they are conservative. Subsequently, we tried to pay more attention to the way counselling was done and tried to strengthen it." - UHFPO, Jagannathpur

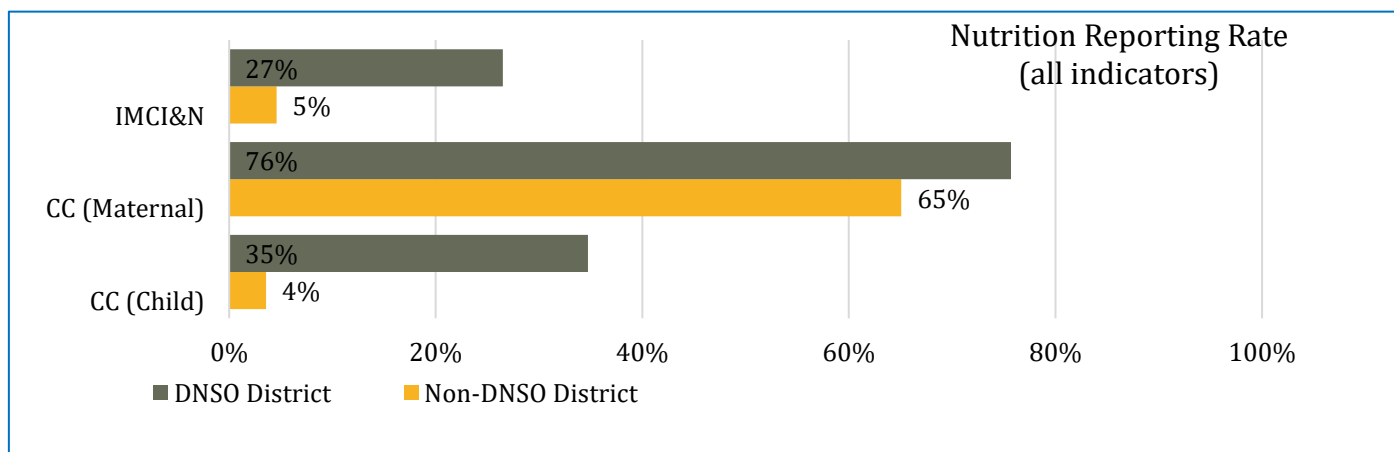
Although the MIS data is not being used for planning at the district level, the evaluation findings suggest that UNICEF's support has been effective in sensitization of health officials till the CC level on the importance of real time reporting.

In case of urban areas, discussions with health officers in City Corporations at Dhaka and Sylhet highlighted UNICEF's support in creating standardized forms for NGOs to report data on nutrition indicators, in alignment with DHIS2. However, they also highlighted that the information collected through these formats is paper-based and not regularly uploaded on MIS. These discussions also revealed that data on nutrition from private health care facilities is currently not being reported as part of MIS.

Therefore, it can be inferred that UNICEF's support to facilitate real time monitoring has been effective in rural areas. However, this remains a missed opportunity in urban areas.

With an objective of mainstreaming nutrition in the existing system and other line departments, UNICEF provided technical assistance to GoB through deployment of DNSOs. Discussions with the civil surgeons across all the sample districts in Khulna and Sylhet division revealed that the technical support from DNSOs has been instrumental in facilitating monitoring, information management and capacity strengthening for enhanced delivery of nutrition services. Further, it was indicated through KIIs with health officials at the national and district level that DNSOs have supported GoB in regular reporting of nutrition indicators as well as highlighting the importance of nutrition across various line departments. This was also evident through the DHIS2 data which highlights reporting of data, especially on indicators related to maternal and child nutrition, on a regular basis. The **Error! Reference source not found.** below also demonstrates a higher rate of reporting on nutrition indicators as compared to non-DNSO districts.¹⁰⁴

Error! Reference source not found.: Comparison on nutrition reporting rate for DNSO and non-DNSO s



upported districts.

The civil surgeons also expressed confidence in demonstrating local level planning as a result of the capacity building support provided by DNSOs. However, no evidence on the use of data for district level planning and budgeting was found.

With regard to promoting a multi-sectoral approach on nutrition, the discussions with civil surgeons in sampled districts highlighted that they benefit from the support of DNSOs in activating DNCCs and UNCCs and initiating inter-departmental dialogue on nutrition through these platforms. A review of minutes of

¹⁰⁴ AINNS project presentation provided by UNICEF

meeting (of DNCCs) indicate that the meetings are conducted on a regular basis with participation from various line departments. As stated earlier, no evidence on district level or convergent planning was observed while referring to the minutes of meeting.

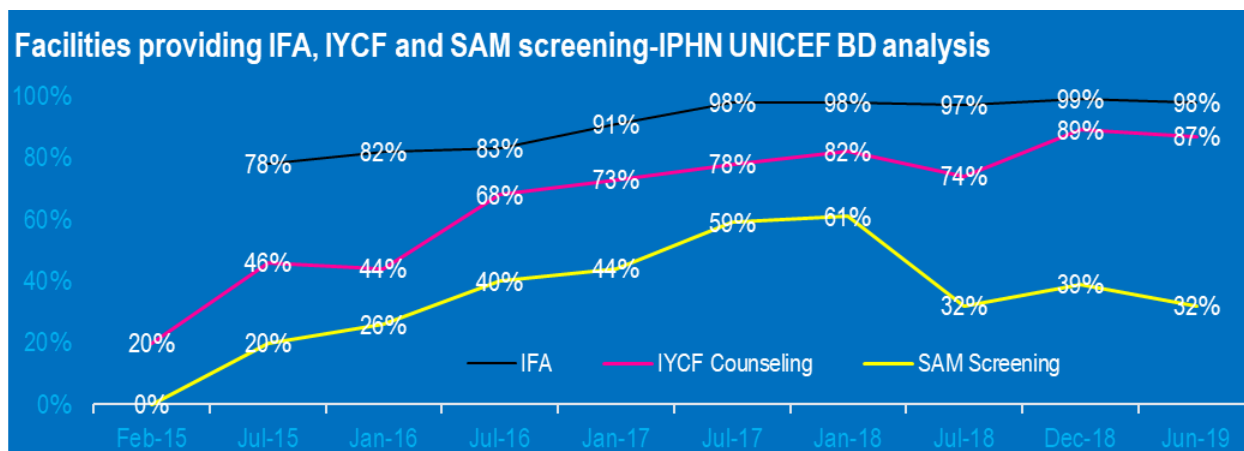
To address the challenge of limited skills of health service providers to effectively deliver nutrition services, UNICEF supported IPHN in rolling out CBT in 26 districts. CBT covered 30,000 health and family planning workers. A review of secondary literature as can be seen in the Table 4, suggests that as a result of CBT, there is an improvement in the indicators such as ANC and PNC services and deliveries through medically trained professionals.

Table 4: Comparison of maternal and new born care indicators (2007 to 2018)

Indicator	2007	2011	2014	2017-18
Maternal and new born care				
ANC from a medically trained provider (percentage of women receiving at least one ANC from a medically trained provider)	55%	53%	64%	82%
ANC-4+ (percentage of women receiving 4 or more ANC)	22%	26%	31%	47%
Medically trained provider, by place of delivery (percentage of deliveries in last three years)	21%	32%	42%	53%
Facility deliveries by poorest wealth quintiles (percentage of facility deliveries in the last three years)	6%	10%	15%	26%
Facility deliveries by richest wealth quintiles (percentage of facility deliveries in the last three years)	49%	60%	70%	78%
Caesarean Section (percentage of deliveries in last three years)	9%	17%	23%	33%
Postnatal care for mothers (percentage of mothers receiving care from medically trained providers within 2 days of delivery)	20%	27%	34%	52%

As can be observed from the table above, during the period 2014-2018, there was an improvement of 11 percentage points in facility deliveries for the poorest wealth quintiles as compared to 9 percentage points during the period 2007-14. Similarly, there is a higher increase in uptake of ANC-4+ and PNC services during the period 2014-2018. The effectiveness of CBT can further be assessed through the reach and prevalence of counselling services provided by health workers

Figure 4: Comparison of facilities providing IFA, IYCF and SAM screening (%)

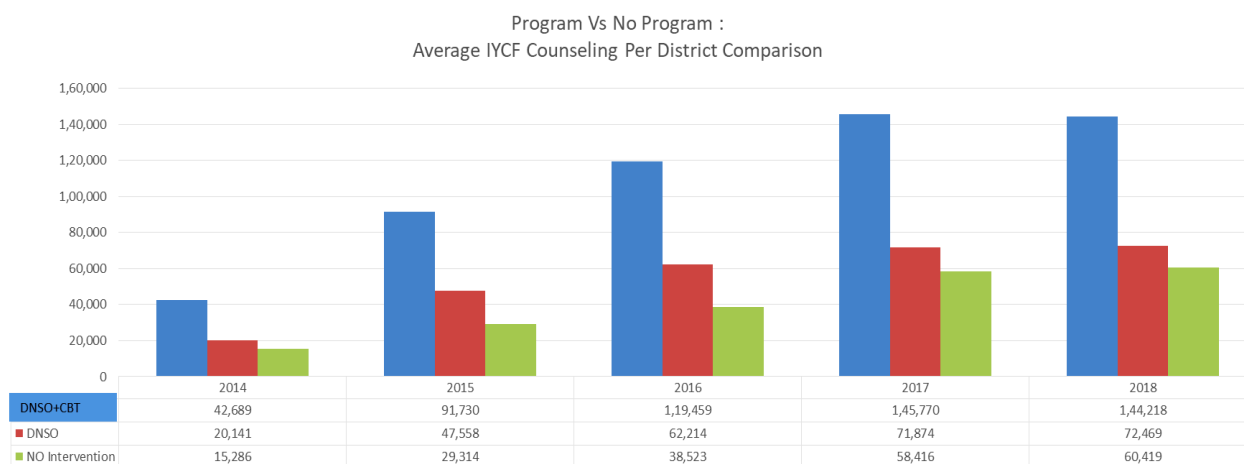


Source: NNS-OP presentation provided by UNICEF

As can be inferred from **Error! Reference source not found.** above, the percentage of facilities providing IYCF counselling has increased from 20 to 87 percent from 2015 to 2019. Similarly, there is an increase in the number of facilities providing IFA and SAM screening by 20 percentage points and 12 percentage points respectively during the last 4 years.

A review of secondary literature suggests that in districts receiving both CBT and DNSO support, IYCF counselling is higher as compared to districts only receiving DNSO support or no support at all (presented in Figure 5 below).¹⁰⁵

Figure 5: Average IYCF counselling in DNSO+CBT districts



The above findings from literature review were corroborated during interactions with community health workers (CHWs) and the community. CHWs reported that innovative approaches for training as part of CBT helped them improve the quality of counselling services offered at the CC and UHC levels. For example,

¹⁰⁵ AINNS project presentation provided by UNICEF

the Community Health Care Provider (CHCP) at Narayanpur (Batiaghata upazila in Khulna) mentioned how using a plate with illustrations of an ideal balanced diet (demonstrated during CBT) during counselling helped him communicate the recommended dietary practices more effectively to pregnant and lactating women. He also articulated how increasing number of women have begun voluntarily enquiring about recommended dietary practices and alternatives to food that is not available or affordable. He attributed this change to the adoption of improved techniques for counselling services, as result of the trainings. Moreover, pregnant and lactating women during discussions in the sampled districts, indicated an improvement in the knowledge and skills of CHWs to provide counselling services and expressed their satisfaction regarding the redressal of queries and advice provided by CHWs. Evidently, CBT has been effective in improving the incidence of counselling and its quality. The increase in institutional deliveries (as indicated in Table 4: Comparison of maternal and new born care indicators (2007 to 2018)) offers an opportunity to further increase the reach of counselling services and nutrition related messages as a result of integration of more beneficiaries into the formal service delivery mechanism.

However, while counselling has improved, a major barrier that has emerged from discussions on field has been its limited reach, wherein counselling is only provided to those (pregnant and lactating women, caregivers with under five year children and adolescents) who visit health facilities for availing treatment services. This highlights a missed opportunity for proactive counselling through home-based visits, for which limited evidence was found. Herein, various touchpoints such as IFA distribution and EPI in health facilities can also be leveraged to provide counselling services, which was not observed during the evaluation team's visit to health facilities. Therefore, to improve the reach as well as effectiveness of counselling services, there is a need to adopt preventive and proactive counselling (outside the health facility) rather than curative counselling and fast track efforts towards strengthening the supportive supervision mechanism. Towards this, UNICEF needs to focus on advocacy with the GoB to improve counselling through home based visits.

Furthermore, while DNSO support coupled with CBT and use of MIS has been effective as strategies to strengthen service delivery, there remains a significant amount of potential to increase its effectiveness. Despite the institutionalization of systems and capacities enhanced, a demonstration of learnings by using the data for evidence and equity based planning and budgeting at the district and upazila level, must take place to further improve service delivery. This will help translate the momentum created by such successful interventions into a realization of its full potential through government systems.

It was also highlighted in discussions with Health Officials at City Corporations in Dhaka and Sylhet, that since DNSOs report to Civil Surgeons, their focus remains primarily on coordinating nutrition related activities in the district and upazila level health facilities (excluding facilities managed by City Corporations). While they acknowledge the merit of DNSOs in the rural context, they expressed a similar need for dedicated support for health facilities managed by City Corporations (under MoLGRD&C). Evidence suggests that DNSOs have demonstrated effectiveness in the rural context and the same support, if extended to City Corporations, can yield desired results in the urban context.

Towards building capacities for SAM screening and management, UNICEF has provided technical assistance (through a 2 day orientation session) to GoB in building the capacities of health officials and workers. Discussions with the health officials indicate that the orientation session has helped them in SAM screening and treatment at district and upazila level health facilities. The course has also helped the health workers in screening of SAM cases at the CC level and referring them to facilities at the upazila or district level.

While such sessions have enhanced the capacity of health officials and workers to screen and treat SAM cases, the discussions also highlighted that currently there is no mechanism to (i) track patients post referral to district/upazila facilities and; (ii) follow up with the patients on compliance with the treatment protocol,

post discharge. This was validated during discussions with the pregnant and lactating women where they cited instances from their community of children not being taken to the hospital despite being screened as a SAM case and referred to district/upazila health facility. Reluctance to stay in the hospital for treatment fearing loss of daily wages or lack of availability of facilities for parents to stay, were cited as common reasons for parents not taking their children to the health facilities for treatment/completing the treatment.

Additionally, the discussions with the pregnant and lactating women revealed that despite the counselling on regular consumption of IFA tablets, often number of times they miss consuming the tablets or stop consuming them mid-way. There emerged a common perception that only a person who is severely ill (and unable to perform routine activities) should consume the tablets regularly. They also expressed that while the health workers do encourage IFA consumption, they do not check actual consumption. The review of DHIS2 dashboards also highlight that while the number of registered pregnant women who have received IFA tablets is one of the indicators to track performance of maternal nutrition, there is no specific indicator to track its consumption. It is therefore, evident that there is absence of any mechanism to track consumption of IFA tablets.

In light of above, it can be inferred that the technical support provided by UNICEF to facilitate reporting through MIS has strengthened the delivery of services. However, in order to further enhance the effectiveness of delivery of services, it is essential that the MIS also captures data on aspects related to consumption (IFA and other micronutrient supplementations), tracking the movement of patients post referral to health facilities (at district /upazila level) from the community clinic and compliance to treatment protocol. Further, it is essential to establish a system of supportive supervision that can facilitate improved monitoring (through a checklist) of the quality of services (including counselling) provided by the community health workers. The findings emerging from supportive supervision can be used to give appropriate feedback to CHWs and help highlight specific capacity gaps that need to be focused on.

UNICEF supported GoB in building the capacity of Community support groups (CSG) on monitoring the nutrition status in their areas and addressing myths and social norms that act as barriers to nutritional access, especially for pregnant women and adolescent girls. CSGs were observed to be supporting the CC (in Abhoynagar, Juri and Jagannathpur) by providing infrastructural support and emergency medicines through community fund, conducting *uthon baithaks* and creating awareness about nutrition. Discussion with the CHCP at Kota CC in Abhoynagar revealed that the CSG in that area provides infrastructural support and helps in maintaining a positive relationship between the community and health service providers. Discussions with the CHCPs in Jagannathpur and Juri upazilas (in Sylhet) highlight that they had taken support of CSG members in facilitating discussions on nutrition during *uthon baithaks*. During the interaction (FGD) with pregnant and lactating women in Jagannathpur and Juri, it was confirmed that the discussions during *uthon baithaks* aided in developing their understanding on aspects related to nutrition, thus establishing the effectiveness of the intervention. The engagement of Community Support Groups and building their capacity to monitor nutrition status has generated evidence in the form of meeting the resource requirement for infrastructure upgradation at the CC level and generation of awareness about nutrition using public platforms.

Efficiency

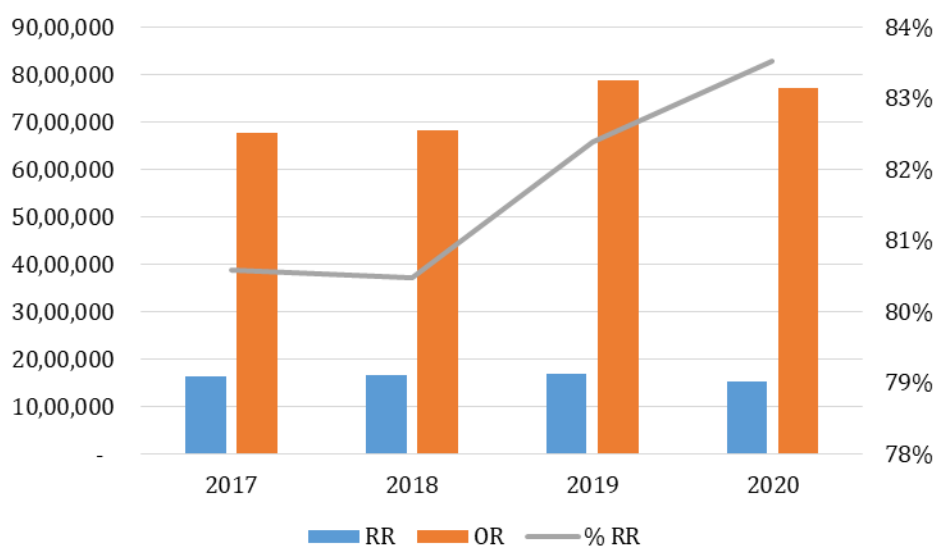
Presented below is a summary of the evaluation findings on efficiency in the form of short answers for each evaluation question.

Evaluation Question	Short Answer/Finding
<p>EQ 21: How efficiently has UNICEF used the resources dedicated to the programme to deliver high-quality outputs in a timely fashion, and to achieve targeted objectives (i.e. is UNICEF expending the least amount of resources to achieve programme effects)?</p>	<p>The allocation of regular resources across the interventions is in accordance with the planned budgets. However, there is a major resource gap in case of allocation through other resources.</p> <p>More than 60 percent of the OR funding was allocated for operationalizing integrated nutrition information systems, institutionalization of DNSO and, capacity building of health workers through CBT approach. This allocation helped achieve the desired objectives. Despite the requirement of higher allocation for these activities, the budget should have also considered sufficient funding for supporting other activities such as effective management of SAM, CMAM, adolescent nutrition, IYCF and maternal nutrition was inadequate. Allocation for interventions in urban areas was also inadequate.</p>
<p>EQ 22: How successfully has UNICEF coordinated with other key actors (e.g., implementation partners, MoHFW, Ministry of Industries, and other line ministries, other entities conducting complementary interventions) to ensure non-duplication of efforts, a clear delineation of roles and responsibilities within joint programmes and the overall success of the programme's implementation?</p>	<p>The effectiveness of Mothers @ Work Programme has provided evidence on leveraging of funds through development partners and private sector or working with shared services as an efficient mechanism to achieve common objectives. Further, the minimum financial support provided by the programme for incremental infrastructure support/refurbishment as in case of breastfeeding corners or AFHCs, has efficiently strengthened service delivery. However, due to a lack of clear delineation of roles and responsibilities amongst development partners, there is often duplication of efforts. While there are instances of joint programming amongst development partners, it is happening on an adhoc basis.</p>
<p>EQ 23: How has the focus on 24 districts, tea gardens, city corporations and enclaves and their type (i.e. poor performing, child marriage, and climate change) affected efficiency in service delivery interventions?</p>	<p>The targeting of the programme is inclusive and provides support to areas affected by climate change, disasters and high prevalence of stunting. However, owing to challenges related to access to roads, continued supply of power in <i>Haor</i> areas and lack of sensitization of tea estate managers on development oriented interventions, the efficiency in service delivery interventions has been affected.</p>

The UNICEF-GoB nutrition program draws its planned activities and financial resource planning from UNICEF CPD 2017-2020. The CPD indicates a combination of regular resources (RR) and other resources (OR)¹⁰⁶ that are estimated for delivering the results. The year-wise budget for the nutrition program 2017-2020 disaggregated by type of fund is presented in Figure 6 below:

¹⁰⁶ OR comprises funding from BMGF, BMGF US Fund CERF, CIFF, DFID, UNOPS, NI, Norwegian Committee, Swedish Committee for UNICEF, USAID etc.

Figure 6: Planned Budget for Nutrition Program 2017-2020



Source: UNICEF Bangladesh nutrition Strategy Note 2017-2020

As can be inferred from the figure above, the program envisioned a joint efforts and funding from development partners in supporting GoB achieve, nutrition goals. The total planned budget for the nutrition program is 36 million USD which is 12 per cent of the CPD budget (298 million USD). Synergizing with the individual goal of each organization, the proportion of funding planned from partnerships for this program was about 82 per cent (increasing from 81% to 84% within the program period).

The review of the annual rolling work plans (RWPs)¹⁰⁷ helps understand the estimated allocations and availability of funds across various interventions and analyze the funding gaps/ adequateness. The Table 5 below presents the estimated budget for 2018, 2019 and 2020 and allocated funds for 2018 and 2019.

Table 5: Budget and expense for nutrition program

Budget/ Allocation	Type	2018	2019	2020
Estimated Budget	RR	9,96,144	9,50,015	7,15,015
	OR	56,36,818	76,36,377	32,41,100
	ORE	1,05,39,265	37,43,564	37,43,564
Allocated Resource	RR	9,96,144	9,50,015	
	OR	43,17,147	28,85,000	
	ORE	1,05,39,265	26,95,785	
<i>Source: Rolling Work Plans</i>				
RR- Regular Resource (UNICEF)				
OR- Other Resource				
ORE- Other Resource Emergency				

¹⁰⁷ Rolling work plan covers more than a single planning period with planned activities and budgets set with two levels of detail: 1) detailed plans for the first period up to one year, and 2) indicative plans (including activities, timelines and budgets) for the second planning period (up to a maximum of one year). A review of progress is the basis for providing more detail of future activities, timelines, and budgets within the plan. This is prepared by UNICEF and approved by GoB.

As can be inferred from Table 5 above the allocation of regular resources across the interventions is in accordance with the planned budgets. However, there is a major resource gap in case of allocation through other resources (23 % in 2018, 62% in 2020). In case of requirement of resources to support interventions during emergencies, while there was adequate resource allocation in 2018, there was a 28 percent resource gap in 2019.

The table below (Table 6) highlights the status of planned budget and funding disaggregated as per interventions.

Table 6: Activity wise planned and availability of fund

Level	Activity	2018				2019				2020			
		Planned		Funded		Planned		Funded		Planned		Funded	
		RR	OR	RR	OR	RR	OR	RR	OR	RR	OR	RR	OR
1.2.0 1	Strengthen delivery of maternal nutrition interventions	-	63,216	-	-	-	337,000	-	337,000	-	299,500		
1.2.0 2	Promote, product & support breastfeeding and complimentary feeding practices	10,000	483,397	10,000	394,445	465,000	820,000	465,000	160,000	530,000	1,270,000		
1.2.0 3	Improve effectiveness of management of Severe Acute Malnutrition	-	167,816	-	-	-	-	-	-	-	-		
1.2.0 4	Strengthen service delivery for prevention of micronutrient deficiencies through supplementation and effective fortification interventions	90,000	357,907	90,000	166,193	20,000	170,000	20,000	110,000	-	170,000		
1.2.0 5	Pilot innovative approaches, generate evidence and apply it for improving coverage/quality/efficiency of service delivery	220,000	310,000	220,000	160,000	200,000	2,890,000	200,000	1,170,000	-	200,000		
1.2.0 6	Improve availability of essential nutrition supplies, equipment, job aids, IEC material	41,144	28,500	41,144	-	10,000	-	10,000	-	-	-		
1.2.0 7	Enhance institutional framework and capacity to plan, coordinate, implement, monitor and report delivery of nutrition services	180,000	2,875,649	180,000	2,875,649	100,000	1,959,277	100,000	580,000	-	905,000		

Level	Activity	2018				2019				2020			
		Planned		Funded		Planned		Funded		Planned		Funded	
		RR	OR	RR	OR	RR	OR	RR	OR	RR	OR	RR	OR
1.2.08	Enhance preparedness and response to humanitarian situations	-	94,248	-	-	-	-	-	-	-	-	-	-
1.2.09	Strengthening nutrition policy and legislation	25,000	309,144	25,000	155,144	-	105,000	-	70,000	-	-	-	-
1.2.10	Support the implementation of NPAN2 and scaling up nutrition programmes	300,000	156,163	300,000	150,700	70,015	551,600	70,015	150,000	50,015	321,600	-	-
1.2.11	Enhance the coordination and contribute to better governance for collective action on nutrition across sectors including Sun networks	130,000	-	130,000	-	50,000	-	50,000	-	50,000	-	-	-
3.2.01	Support to establish intervention package and expand platforms to improve access to nutrition services for adolescents	-	137,040	-	100,000	20,000	298,000	20,000	178,000	50,000	75,000	-	-
3.2.02	Strengthening capacity of service providers to mainstream adolescent nutrition services	-	461,997	-	320,000	15,000	135,000	15,000	75,000	25,000	55,000	-	-
3.2.03	Improve availability of nutrition supplies, guidelines, communication materials and job aides for adolescents nutrition interventions	-	191,782	-	70,000	-	370,500	-	55,000	10,000	45,000	-	-

Source: Rolling Work Plan 2017-18, 2018-2019.

As can be inferred from Table 6 above while there existed a resource gap in 2018 (from other resources), there has been a significant increase in the resource gap in 2019 to support interventions related to breastfeeding and complimentary feeding practices, generating evidence on pilots, institutional framework and capacity building, scaling up nutrition programmes and availability of nutrition services for adolescents. These constituted 6 of the 11 main activities highlighted in the RWP.

Moreover, an analysis of the fund allocation (OR) across various sub activities suggest that more than 60 percent of the funding was allocated for operationalizing integrated nutrition information systems, capacity building activities for NNS, DGFP , institutionalization of DNSO approach and, supporting capacity building of health workers through CBT approach.

The previous section highlights how the impetus given under the programme through operationalization of nutrition information system and deployment of DNSOs has enhanced real time monitoring and improved multi-sectoral coordination. The effectiveness demonstrated by these interventions highlights efficient utilization of the allocated budget. The facilitation support provided by the programme through deployment of DNSOs has also made the coordination on nutrition between line departments such as health, agriculture, livestock, fisheries, education and WASH, at a single platform (DNNC and UNNC) efficient.

Further, the effectiveness of Mothers@Work programme has provided evidence on leveraging of funds through development partners and private sector or working with shared services as an efficient mechanism to achieve common objectives. It is therefore, essential that this evidence is considered as a basis for joint programming (using comparative advantage for complementary interventions) and resource mobilization with other development partners for extending support to GoB in achieving nutrition goals.

Similarly, the evaluation findings also suggest that minimum financial support for incremental infrastructure creation or refurbishment as in case of breastfeeding corners or AFHCs provided by the programme, can also efficiently strengthen the delivery of services. Discussions with the adolescent boys and girls indicate that the engagement with local implementing partners such as SKNF and Rupantar has enhanced the efficiency of community mobilization and engagement.

Efficiency in terms of targeting and service delivery in tea gardens and haors

Two aspects govern the understanding of the efficiency for implementing the joint nutrition program in the disadvantaged areas. First is the criteria used to select the focus areas and second is the efficiency with which the program has been implemented in these areas.

UNICEF with support from GoB had selected the programme areas using criteria such as CDI ranking, vulnerability with regard to climate change, UNICEF footprint, partners' commitment, NGO/CSO presence and the presence of other donors in these areas. The criteria laid down for the selection is robust as it takes into account a combination of the development impediments along with the possibility of leveraging the strength of implementing partners and UNICEF's own experience of working in these areas. Accordingly, 24 poor performing districts with a potential for convergent programming; urban areas, CHT, Tea Estates in the North East, enclave areas in Rangpur/ Bogra, areas most affected by climate change/ disasters and districts with a high prevalence of stunting (Chittagong and Sylhet Divisions) have been selected. The implementation approach and interventions for areas such as *Haors* and tea gardens are similar to those in other programme areas.

It can therefore be inferred that the programme has been inclusive in nature and the targeted approach is helping these districts to come at par with the other districts.

However, as observed during discussions with tea estate managers, the implementation of the programme interventions in the tea gardens is constrained by their limited sensitization on development related

interventions. During the discussions with Civil Surgeon and District Education Officer in Sylhet it emerged that while the interventions under the programme are implemented in *Haor* areas as well, access to services is constrained by the challenges related to access to roads, continued supply of power for more than 6 months in a year. It therefore, clearly highlights that while the support from the programme has been equal, the efficiency in service delivery interventions has been affected.

In terms of the allocation of technical and financial resources, no unplanned activities were taken during the program timeline which would have demanded diversion of funds or human resources.

Connectedness

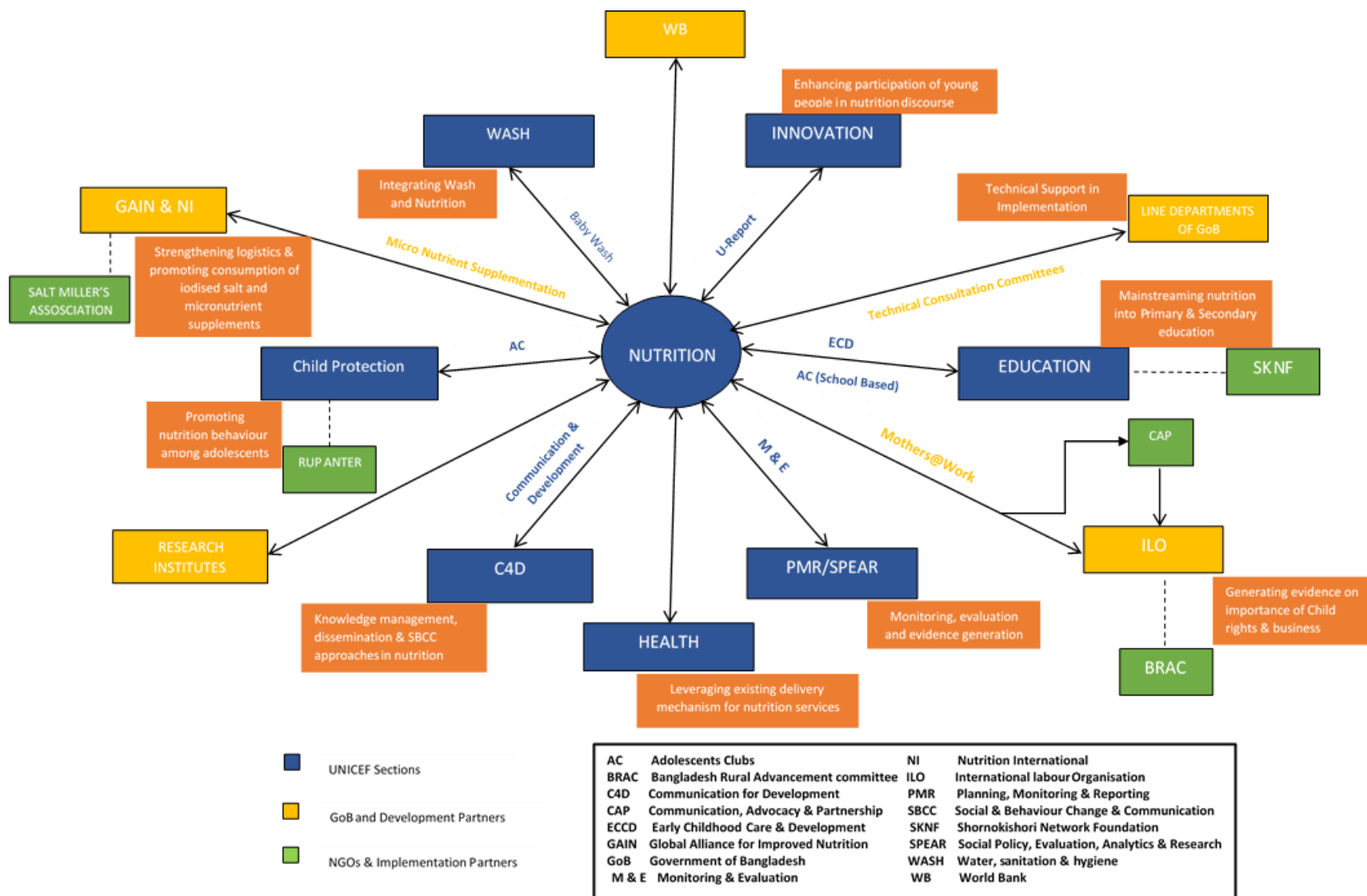
Presented below is a summary of the evaluation findings on connectedness in the form of short answers for each evaluation question.

Evaluation Question	Short Answer/Finding
<p>EQ 24: How effectively has the nutrition programme coordinated with other UNICEF sections (e.g. C4D, Health, WASH, SPEAR, CAP, Education) to ensure that further building blocks of child and women's nutrition that lie outside the scope of the present programme are in place?</p>	<p>Leveraging the strengths of sections within UNICEF, the nutrition programme collaborated with the Child Protection, Health, Education, WASH and CAP sections to address the needs of specific target groups, namely, adolescents (including out-of-school adolescents), children in schools and those below 6 years of age as well as working mothers.</p> <p>By integrating nutrition within existing adolescent clubs, mainstreaming nutrition within education (school) curricula and leveraging the strengths of the CAP section to implement C4D interventions to promote maternal and child nutrition at the workplace, the nutrition section has effectively coordinated with other sections to cater to the nutritional needs of target groups, as per the lifecycle approach. The nutrition programme ensured that priority areas of other sections such as health, hygiene and adolescent issues such as early marriage and early pregnancy are recognized as determinants of nutrition. With the support from other sections, the nutrition programme further ensured that the factors affecting the nutritional status of children and adolescents are adequately and comprehensively addressed through joint initiatives.</p>
<p>EQ 25: What is the perception of partners (e.g. GoB, MOH&FW, Ministry of Industries, Local Government, City corporation, WFP, WB, ILO, FAO, BRAC, Save the Children, SKNF, emergencies NGOs) of the UNICEF nutrition program in terms of technical salience, comparative advantage, cooperativeness, and sectoral alignment with other stakeholders?</p>	<p>UNICEF has led implementation of interventions related to strengthening MIS. The operationalisation of NIPU, deployment of DNSO and adoption of CCTN was solely supported by UNICEF. As a result, GoB considers UNICEF as a critical actor for supporting implementation of NPAN2. The development partners recognise UNICEF's comparative advantage in evidence generation and advocacy towards promoting child rights, using a multi sectoral approach. As a result, partners like the World Bank and GAIN have expressed that UNICEF should anchor the multi sectoral approach for addressing undernutrition in Bangladesh and facilitate coordination among development partners for complementarity in interventions.</p>
<p>EQ 26: How successful has the programme been in setting up and strengthening key and innovative partnerships such as Better Work of ILO, and Government-NGO-private sector partnerships for promoting and delivering high quality and integrated nutrition services?</p>	<p>Mothers@Work as a pilot initiative has been implemented in partnership with ILO (through Better Work Programme), BRAC and RMG manufacturers. The initiative has demonstrated effectiveness in increasing awareness on breastfeeding practices among working mothers and realization of maternal and child rights through availability of an enabling environment for breastfeeding at the workplace. The initiative has also established a business case on children's rights and business principles for replication by other industries and is being</p>

Evaluation Question	Short Answer/Finding
	considered by the Ministry of Labour and Employment for scale up.
<p>EQ 27: How well is the Bangladesh Country Office nutrition programme supported by and effectively draws from UNICEF HQ Nutrition teams and staff? Are the benefits of being in a multi-tiered organization being maximized?</p>	<p>The evaluation team does not have adequate information to comment on the support received by Bangladesh Country Office nutrition programme from the UNICEF HQ Nutrition team and staff. Therefore, any comment on the effectiveness and maximisation of benefits of being a multi-tiered organisation cannot be made.</p>

As part of the current nutrition programme, UNICEF has engaged with multiple sector actors including GoB, other development partners and local NGOs. These engagements along with intra-UNICEF section coordination has aided UNICEF's efforts towards promotion and delivery of high quality and integrated nutrition services. A snapshot of the internal and external connectedness with the UNICEF nutrition programme has been presented in Figure 7 below.

Figure 7: Snapshot of Connectedness



With an objective of empowering adolescents as agents of change, the Child Protection section within UNICEF (since 2012) has been establishing community-based adolescent clubs. While the clubs focused on sensitizing and training adolescents on aspects related to life skills, reproductive health and child marriage, there was no specific sensitization or training on nutrition. With the objective of addressing the challenge of under nutrition among adolescents and demonstrating the feasibility of reaching school-going adolescents with nutrition interventions, the nutrition section worked with the child protection section to introduce and incorporate a session on nutrition education for adolescents through the clubs. Herein, UNICEF provides technical content for training (on nutrition) and the community mobilization is facilitated by NGOs with strong on ground presence, such as SKNF.

Further, UNICEF supported the IPHN and DSHE in establishing adolescent clubs in secondary schools. Discussions with adolescents, teachers and parents highlight increased awareness among adolescents on nutrition leading to discussions around nutritious food at school and homes towards influencing appropriate nutrition related behaviour. The initiative is now being considered for scale up by MoWCA with the establishment of 5000 additional adolescent clubs.

Similarly, in order to integrate nutrition within the WASH programme, WASH and Nutrition sections have initiated a pilot intervention– BABY WASH (Gowainghat upazila, Sylhet district). The intervention focuses on promoting young child feeding and good hygiene and nutrition practices. Towards supporting the Primary Education Development Programme (PEDP 4), both the sections will be working towards developing a joint curriculum for schools on WASH and nutrition.

The Nutrition section with the support from Communication, Advocacy and Partnership (CAP) section initiated a pilot initiative; Mothers@Work, in partnership with the readymade garments sector. The initiative governed by the framework of Children Rights and Business Principle¹⁰⁸ aims at increasing awareness and realization of maternity protection and child rights (specifically with regard to adequate and appropriate breastfeeding). Further, it aims to build a case for factory owners/management to understand the importance of child rights in the business and use this learning to develop an action plan to minimise negative impact and maximise their positive contribution to the life of workers and their children. Towards operationalisation of the initiative, while the technical content (on nutrition) was provided by the Nutrition section, CAP helped in engaging with the factories and designing the initiative in a manner that the businesses can relate with and consider aligning this initiative with the business principles.

Leveraging the strengths of sections within UNICEF, the nutrition programme collaborated with the Child Protection section, WASH as well as CAP section to address the needs of specific target groups, namely, adolescents (including out-of-school children), children in schools and those below 6 years of age as well as working mothers.

By integrating nutrition within existing adolescent clubs, mainstreaming nutrition within education (school) curricula and leveraging the strengths of the CAP section to implement C4D interventions to promote maternal and child nutrition at the workplace, the Nutrition section has effectively coordinated efforts with other sections to cater to the nutritional needs of target groups, as per the lifecycle approach. The nutrition programme ensured that priority areas of other sections such as health, hygiene and adolescent issues such as child marriage and early pregnancy are recognized as determinants of nutrition and with support from other sections, ensured that these factors affecting the nutritional status of children and adolescents are adequately and comprehensively addressed through joint initiatives. In order to establish the initial connect with the RMG sector UNICEF leveraged on the Better Work Programme for the sector implemented

¹⁰⁸ Developed by UNICEF, the UN Global Compact and Save the Children – the Children's Rights and Business Principles (the Principles) are the first comprehensive set of principles to guide companies on the full range of actions they can take in the workplace, marketplace and community to respect and support children's rights.

by the International Labour Organization (ILO). UNICEF and ILO prepared a joint work plan for implementation of the Mothers@Work initiative.

Coordination between the public and private sector through this innovative partnership has led to positive results with regard to increased confidence among women in practicing breastfeeding at the workplace and factory worker's recognizing the benefits of creating an enabling environment for breastfeeding. Due to the success of the pilot and evidence generated, GoB is keen on replicating the same model across other sectors. Herein, a successful pilot, as a result of strategic partnerships and coordination efforts has facilitated ownership amongst the government to explore its replication and scale up across other sectors.

In addition to the Mothers@Work initiative, CAP section is helping nutrition section in mobilising private sector funding for supporting implementation of nutrition related initiatives.

The C4D section supports the nutrition section in designing the Social and Behavior Change Communication Strategy for nutrition related interventions and its implementation plan. It also provides technical support in designing communication products for dissemination of programme results and learnings across various stakeholders at national and district level. Mothers@Work initiative is an example where the C4D section supported implementation by combining advocacy and social and behavioral change communication approaches to sensitize the factory management and working mothers about seven minimum standards of breastfeeding and improving exclusive breastfeeding rates among infants of mothers in the workforce. The C4D section also supported in capacity building of implementing partners on SBCC approaches.

Towards mainstreaming nutrition in other sections' work, C4D section, through a TV show on cooking for adolescents, will incorporate dissemination of messages related to adolescent nutrition. Herein, C4D section will provide inputs for the design and content of the TV programme in association with the creative agency and the implementing partner (SKNF) will provide support to identify the best cooks from each division.

The C4D and Nutrition sections are jointly supporting GoB in designing the SBCC component of the IYCF strategy and preparing an action plan for its implementation. The C4D, nutrition and health sections are currently working on developing a standard package for community engagement (including training and communication modules) to promote IYCF practices and address issues related to maternal and child health.

Additionally, the Nutrition section is also engaging with the Health section to utilise the existing health services delivery system (facilities and health workers) for implementing nutrition related interventions. Inclusion of adolescent nutrition as part of the counselling services provided at AFHCs is one such example. The Health section on the other hand would leverage Mothers@Work initiative to provide counselling on maternal and new born health.

The Nutrition section has also worked with the education section to mainstream nutrition into the curriculum at the primary and secondary school level. Their coordinated efforts have also contributed towards developing Early Learning Development Standards (including standards related to nutrition) for 0-8 years under GoB's Early Childhood Care and Development Policy.

The Planning, Monitoring and Reporting section and Nutrition section engage for developing the country programme cycle, annual rolling work plan, internal budgeting and monitoring for the nutrition programme. PMR plays an important role to synergize the efforts of all sections, thereby preventing redundancy of programmes and ensuring financial prudence.

The Social Policy Evaluation Analytics and Research (SPEAR) section and Nutrition section engage for evaluating and generating evidence on operational feasibility and effectiveness of nutrition related interventions. This coordination contributes to evidence based policy and advocacy efforts.

The Nutrition section is also engaging with the Innovations section to leverage the social messaging tool and data collection system developed by UNICEF (U-Report) to involve the community and promote discourse on nutrition. It also helps provide feedback from communities on implementation, gaps and challenges on various nutrition related interventions to GoB and development partners.

While such coordinated efforts are leading towards comprehensive coverage of services, it is important to bear in mind that such an approach carries the risk of considerable lack of strategic orientation and depth of engagement in several areas. Therefore, to strengthen internal coherence among UNICEF sections and the resulting interventions, it is advisable for all the sections to collectively discuss their respective objectives and plans to develop a unified approach, demarcating contours of engagement such that joint action plans can be created towards more coordinated efforts to mainstream nutrition.

In relation to external coherence and connectedness, UNICEF's convening power and position as an advocate for nutrition has been driving forces for establishment of partnerships with stakeholders including the government, independent bodies, civil society organizations (CSOs), the private sector, and other national and international development partners.

The Nutrition section is working with sector partners such as GAIN and NI for advocacy on minimum package for maternal nutrition and developing strategy for strengthening procurement and supply of micronutrient supplements. Further, it is also working with these sector partners towards improving the supply and consumption of iodised salt. In the previous CP, UNICEF focussed on supporting communication and legislation component of the Bangladesh Universal Salt Iodization (USI) strategy, wherein NI and GAIN focussed on improving the quality of salt production. In the current CP, UNICEF along with the sector partners have identified key advocacy issues with Ministry of Industries, GoB for building capacity of salt growers on new technologies and best practices to enhance production of high quality raw salt. UNICEF and the sector partners are also engaging with the Bangladesh Consumer Association (BCA) to inform key stakeholders in the industry, local government division and enforcement officials with regard to tracking packaging, labelling and marketing of branded packet iodized salt by salt packers and manufacturers. In collaboration with the Mol and Bangladesh Small Cottage Industries and Corporation (BSCIC), UNICEF, NI and GAIN designed the framework for evaluating the work of salt millers. This framework was the basis for the first Annual Reward for the "Best Iodized Salt Mills 2017" in Bangladesh.

Furthermore, UNICEF has engaged with World Bank to include two nutrition related indicators as part of the disbursement linked indicators (DLIs), under the pay for performance (P4P) initiative for results through health sector financing. UNICEF in turn has supported in strengthening DHIS2 which is being used for monitoring the progress of the indicators.

UNICEF has also signed MoUs with city corporations to promote awareness and strengthen nutrition sensitive and specific interventions in urban areas. Additionally, in order to facilitate the smooth establishment of adolescent clubs in the tea garden areas of Bangladesh, UNICEF has also partnered with tea estate owners.

Therefore, partnerships with a wide range of actors resulted in strengthened institutional capacities of government agencies, regional and local service institutions, and the civil society to implement nutrition interventions and work towards closure of equity gaps for all target groups.

These contributions have had a valuable and notable effect on accelerating the pace of change and giving direction to nutrition reforms.

UNICEF's joint work with other sector actors has brought notable contributions to building the enabling environment through development of official guidelines and institutional environment for the provision of nutrition services.

UNICEF is described by stakeholders as open for cooperation and proactive in seeking opportunities for joint action, promoting effective partnerships and strategic alliances around its main nutrition outcome areas. Discussion with a representative of World Bank revealed that they envision UNICEF playing a more crucial role as an anchor to bring together multi-sector actors to reduce stunting.

Thus far, UNICEF has leveraged its convening power to bring together partners from different sectors to collectively discuss, increase the focus on nutrition and implement nutrition sensitive interventions to address the varying needs of target groups.

UNICEF's network, convening and advocacy roles, and unique set of partnerships at all levels, allows for collaborative, innovative and real-time solutions to nutrition related challenges, obstacles and constraints to realizing rights for children and achieving equity.

Impact

Presented below is a summary of the evaluation findings on impact in the form of short answers for each evaluation question.

Evaluation Question	Short Answer
<p>How successful has the programme been to date in accelerating reductions in undernutrition and in improving adolescent health and wellbeing? Are there signs of early/short term impacts? Have the impacts been distributed equally among different groups of society (girls and boys, different wealth quintiles, geographical areas, etc.)?</p>	<p>The programme has been able to support GoB in its efforts towards accelerating the reduction in stunting. Using a straight line trend function, it can be inferred that through the programme support, GoB is likely to achieve its target on underweight and BMI (among adolescent girls). However, in case of reducing wasting and the incidence of early marriage, the estimate suggests that the country may not be able to achieve the targets.</p> <p>Increased awareness among adolescents who are members of adolescent clubs, use of MIS for data reporting, increased coordination among multi-sectoral partners indicate contribution of the programme in achieving nutrition results.</p> <p>While the design of the programme ensures equal distribution of nutrition support services in rural and urban areas, the indicators suggest that the rural–urban differential will continue to persist unless the interventions are tailored to the specific needs of urban and rural areas. This will also help ensure equity based targeting.</p>
<p>To what extent are these (early) gains directly attributable to the programme's interventions?</p>	<p>Near real time monitoring, regular reporting of data on nutrition by the health facilities across all levels, supporting the operationalisation of NIPU, deployment of DNSOs, mainstreaming nutrition in secondary education, comprehensive competency training on nutrition are the programme interventions that have directly contributed to the achievement of the results.</p>

The information presented below demonstrates the change over the last 1-2 years and possible contribution of the programme in accelerating reduction in undernutrition and improving adolescent health and well-being. A comprehensive assessment of the impact of the nutrition programme will only be possible after the completion of the CP.

Table 7: Impact of the nutrition program activities

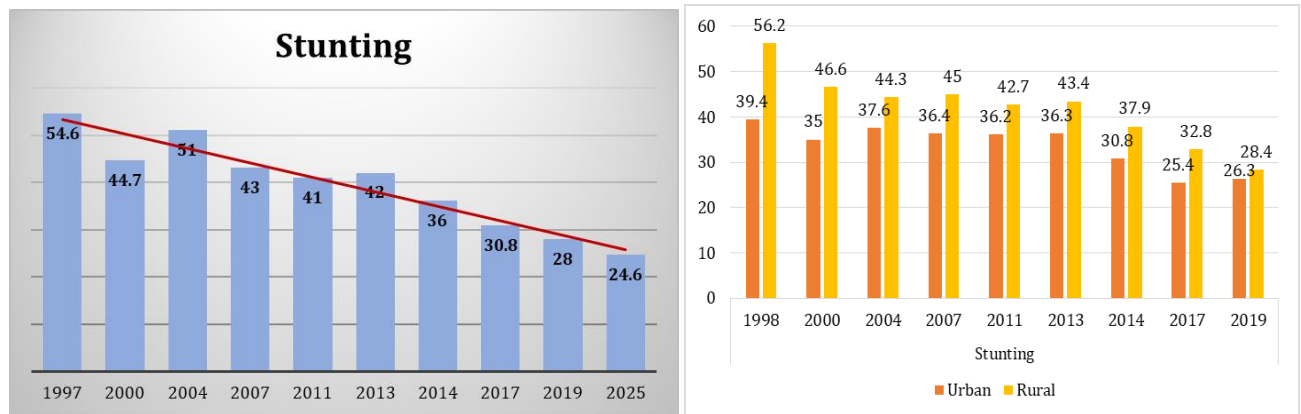
Inputs		Activities	Impact
		Evidence Generation, Policy Dialogue and Advocacy	
<ul style="list-style-type: none"> • Technical Assistance(including deployment of technical experts and hiring of NGOs) • Financial Assistance • Infrastructure Support(MUAC tapes, height and weight measuring equipment) 	Model for supporting breastfeeding at workplace(Mothers @ Work)	<ul style="list-style-type: none"> • Percentage of adolescent girls (15-19 years) with low BMI (<18.5 kg/m2) Baseline-31% (BDHS 2014) Target-25% (2020) Status- data not available 	
	Pilot school- and community-based programmes for adolescent nutrition(Adolescent Club)	<ul style="list-style-type: none"> • Proportion of children 6- 59 months receiving Vitamin A Baseline-90% Target-Maintained at least 90% Status- 98.8%(2018, DHIS2, DGHS), 79% (BDHS, 2017) 	
		Equity-Responsive and Resilient Service Delivery	
<ul style="list-style-type: none"> • Technical Assistance(including deployment of technical experts and hiring of NGOs) • Financial Assistance • Infrastructure Support(MUAC tapes, height and weight measuring equipment) 	Invest in programmes in priority district to reach vulnerable groups ,including urban slums	<ul style="list-style-type: none"> • % of caregivers of children 0-23 months old receiving age appropriate IYCF counselling at facility Baseline-<5% Target-60% Status- 33%(Rural, 2018, DHIS2, DGHS) 	
	Improve coverage and quality of services for adolescents and mothers(Strengthening delivery of nutrition services through health facilities, AFHC and IMCI)	<ul style="list-style-type: none"> • Percentage of children 0-5 months old who are exclusively breastfed Baseline- 55% (2014) Target- 70% (2025) Status-65% (BDHS 2017), 62.6% (MICS) 	
	Build capacity at district level for district evidence-based planning, budgeting and management of nutrition services		

		Strengthen capacity of service providers toward universal coverage of nutritional services(Competency Based Training)	<ul style="list-style-type: none"> Percentage of children aged 6 -23 months provided with minimum dietary diversity Baseline- 23% (2014) Target- 27% (2020) Status-39% (BDHS 2017), 34% (MICS 2019)
		Partnership and Participation	
<ul style="list-style-type: none"> Technical Assistance(including deployment of technical experts) 		Deepen national multi sectoral partnerships through support to BNNC	<ul style="list-style-type: none"> Percentage of households consuming adequately iodised salt Baseline- 54.3% (MICS 2013) Target- 80% (2020) Status-76% (provisional MICS 2019)
		Strengthen linkages with Agriculture, Livestock, and Fisheries, Education, Local Government to improve nutrition.	<ul style="list-style-type: none"> Underweight Percentage of children under age 5 who fall below minus two standard deviations (moderate and severe) Baseline- 31.9% (2013,MICS) Target- 15% (2025) Status-22.6% (provisional MICS)
		Enhance Corporate Social Responsibility for improving breastfeeding at the workplace	<ul style="list-style-type: none"> Stunted -Percentage of children under age 5 who fall below minus two standard deviations (moderate and severe) Baseline- 42% (2013,MICS) Target- 25% (2025) Status-28% (2019, provisional MICS)
		Build a coalition for nutrition campaigns to accelerate the reduction of stunting	<ul style="list-style-type: none"> Wasted- Percentage of children under age 5 who fall below minus two standard deviations (moderate and severe) Baseline- 9.6% (2013,MICS) Target- 8% (2025) Status-9.8% (2019, provisional MICS)
		Ensure mobilization, engagement and participation of families, communities and key influencers to increase utilisation of nutrition services, as well as adoption of desired behaviour and practices	

Stunting

As can be observed in the figures below, the trend at the national level indicates a steady decline in stunting in the last decade. Estimates for 2025 indicate that GoB is on the right track and is most likely to achieve its set target by 2025 (25%). The disaggregated data indicates reduction in the stunting both in rural and urban areas. The estimates for 2025, suggest that the stunting targets would be met in both the urban and rural areas.

Figure 8: Stunting prevalence trend

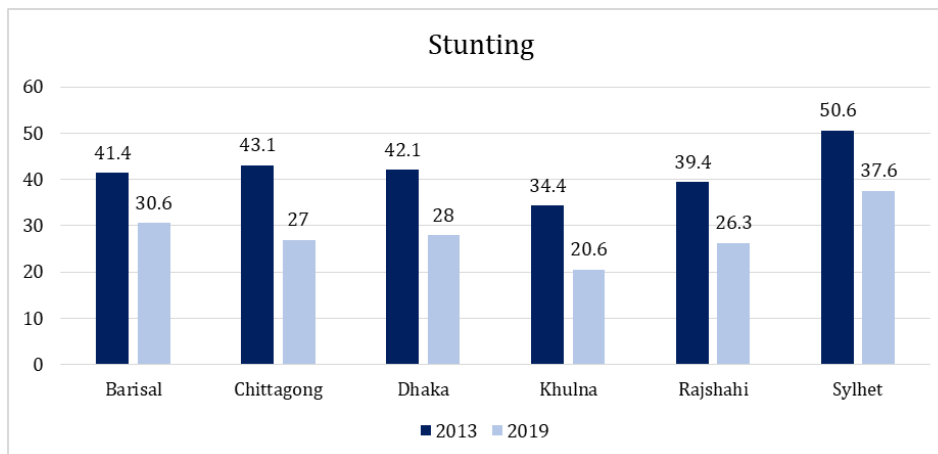


Source: BDHS and MICS

Division wise analysis of stunting indicates that Sylhet witnessed the highest rate of change (12 percentage points) in stunting as compared to other divisions.

Further, it is interesting to note that after two periods (2007-11 and 2011-14) of negative rates of change, the period of 2014-2019 not only witnessed a reverse trend but also underwent a substantial positive change in the reduction of stunting. This acceleration in the reduction of stunting can again be attributed to the various interventions on nutrition undertaken by GOB with support from UNICEF and other partners.

Figure 9: Division wise stunting prevalence

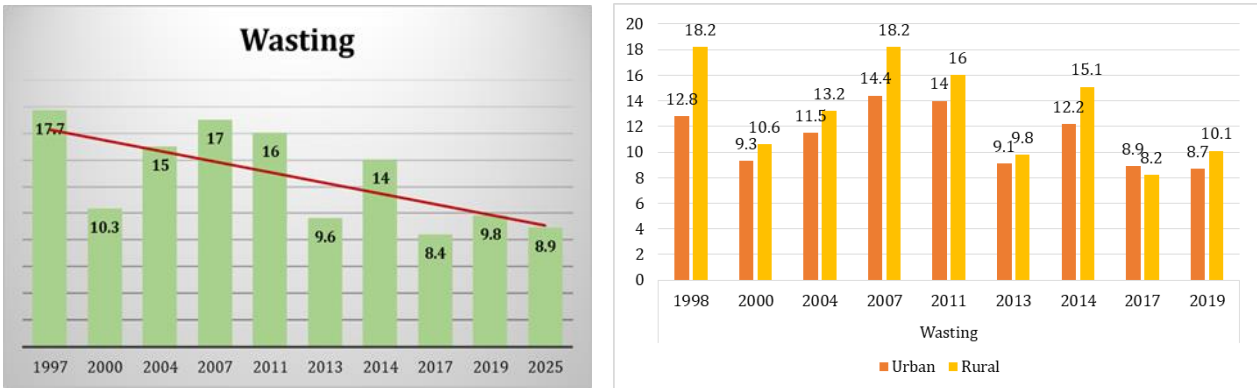


Source: MICS

Wasting

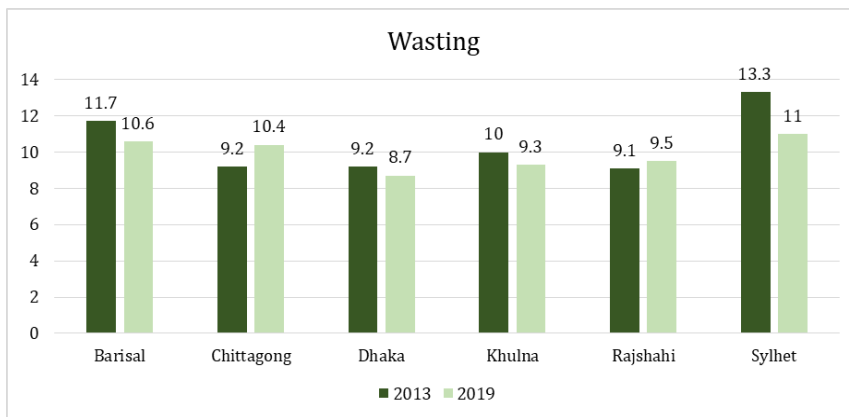
As can be observed from the figures below, the rate of wasting among children under age 5 increased during the 2000-2007 period. Since 2007, there has been a decline in wasting. However, the data from MICS shows a minor increase in wasting (from 9.6 % in 2013 to 9.8% in 2019). This is on account of increase in wasting in rural areas. Despite the increase, the estimates for 2025 indicate that the current set of interventions will aid in meeting the 2025 target (8%). In the case of urban and rural areas

Figure 10: Wasting prevalence trend



Source: BDHS and MICS

Figure 11: District wise wasting prevalence



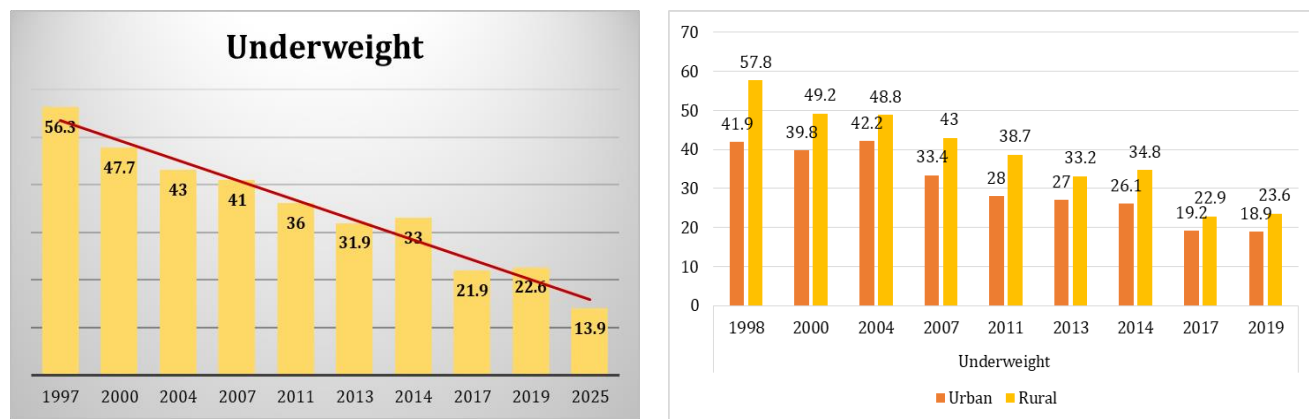
Source: MICS

The Figure 11 indicates that there has been an increase in wasting across all divisions (except Dhaka) during the period of 2011-14 to 2014-19 in majority of the divisions. This may be due to the comparison of BDHS data with the MICS (2019) as both follow a different methodology. Further, the estimates for 2025 suggest that none of the divisions might be able to meet the target.

Underweight

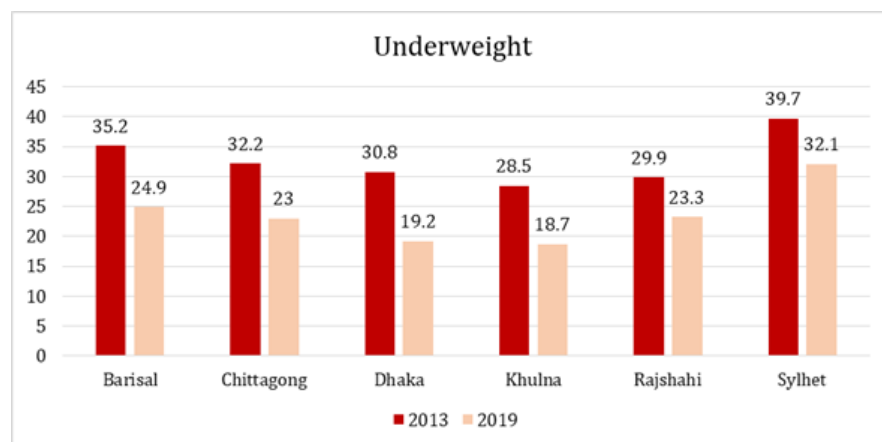
A comparison of MICS data from 2013 and 2019 indicates that the national prevalence of underweight children under age five has decreased by 9.3 percentage points from 2013 to 2019 (from 31.9 to 22.6). In the urban context, these values have reduced from 27 to 18.9, indicating an 8.1 percentage decrease. In comparison, the rural context has seen a higher decrease from 33.2 to 23.6 (9.6 percent). The current status when compared with the national target for underweight prevalence (15% as per the NPAN2 by 2025) indicates that if GoB along with development partners continue with the current set of interventions, the target for underweight by 2025 can be achieved.

Figure 12: Underweight prevalence trend



Source: BDHS and MICS

Figure 13: Division wise underweight prevalence



Source: MICS 2019

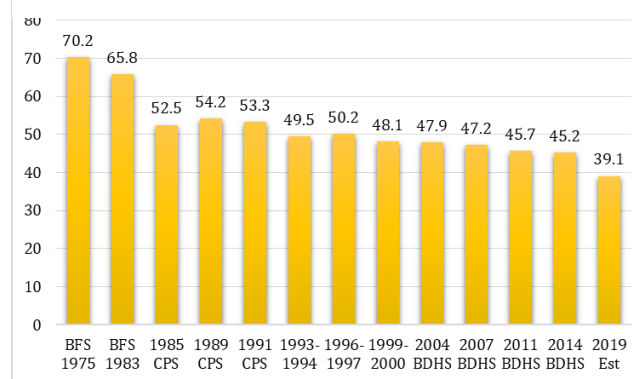
The disaggregated data at divisional level suggests that there has been a decline in the proportion of underweight children across all the divisions during the period 1998-2019. Comparison of estimates for 2025 with MICS 2019, suggests that the current set of interventions will help in reducing the proportion of underweight children across all divisions. However, despite a 9.3 percentage point decrease in 2025, as compared to 2019, Sylhet division may fall short of achieving the desired target

Adolescent Health and Wellbeing

Adolescent health and wellbeing is the second thematic area where the current CPD intends to create an impact. The evaluation has analysed the impact through two outputs (i) reduction in early marriage of adolescents; (ii) reduction in proportion of adolescents girls (15-19years) with low Body Mass Index(BMI <18.5 kg/m²)

As can be inferred from Figure 14 there has been a gradual reduction in the incidence of adolescent marriage in Bangladesh over a period of 44 years (1975 to 2019). Further, it can be observed that the rate of change during the period 2014-19 is higher than the rate of change over last two decades, as per estimates based on BDHS data. These 2019 estimates indicate that the current CPD is likely to achieve its target of reducing the incidence of early marriage to 40 percent by 2020.

Figure 14: Percentage of women aged 20-24 years reporting marriage before 18 years

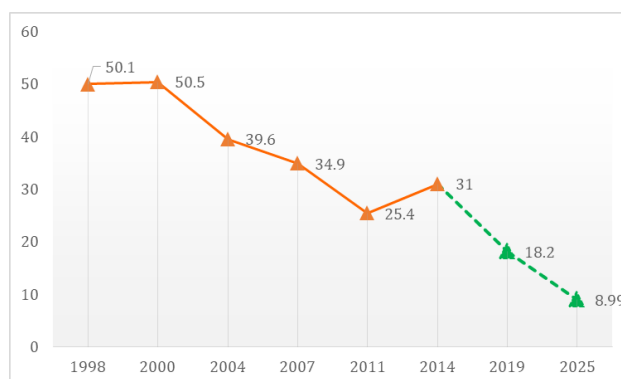


Source: BDHS 2014

However, reference to data from MICS 2019 suggests that there is 51 percent incidence of early marriage (percentage of women age 20-24 years who were first married below 18 years) in Bangladesh. The incidence has decreased by 12 percentage points since the last 6 years (63% as per MICS 2013). In the last 6 years, the incidence has also reduced in rural areas by 12 and 10 percentage points in rural and urban areas respectively. While this percentage point decrease is encouraging, 1 out of 2 adolescent women in rural as well as urban areas are still prone to early marriage. Analysis at divisional level indicates that while in Sylhet the incidence of early marriage is 31 percent, in Khulna it is 62 percent. This draws attention to the fact that adolescent girls in Khulna are vulnerable to early marriage. Therefore, considering the MICS 2019 data, it can be inferred that the programme may fall short of achieving its target of reducing the incidence of early marriage by 2020. This highlights that despite improved counselling services indicators such as early marriage is not likely to show significant progress given that it is deeply rooted in prevalent social norms.

The Figure 15 depicts a trend indicating a gradual decrease in the percentage of adolescent girls (15-19 years) with low BMI levels. 2025 estimates suggest that the proportion will further drop to approximately nine percent. Therefore, the current interventions of GoB (supported by UNICEF and other development partners) are helping in reduction of malnutrition amongst adolescent girls and achievement of set targets (15%).

Figure 15: BMI trend among ever-married women aged 15-19 years



Source: BDHS 2014

In light of above, it can be inferred that on indicators such as stunting, underweight and BMI among adolescent girls, the nutrition program has been able to support GoB in its efforts towards achieving the set targets. However, in case of reducing wasting and the incidence of early marriage, the programme needs to focus more on preventive counselling to promote positive nutrition behaviour by overcoming prevalent social norms.

While majority of the programme targets may be achieved, the current rate of progress is not enough to create a significant impact with regard to undernutrition in the country. One of the factors constraining improvement in nutrition status is inadequate IYCF practices. Review of MICS 2019 data suggests that while 62.6 percent of children under 6 months are exclusively breast fed (58.8% urban, 63.6 % rural), only 46.6 percent of infants are put to breast within one hour (early initiation of breastfeeding). The figures on early initiation of breastfeeding shows a reduction by 10 percentage points between MICS 2013 and MICS 2019. Further, only 41 percent of urban infants as compared to rural infants (48.1%) are put to breast within one hour. Evidently, more rural infants are receiving optimal breastfeeding as compared to urban infants.

However, rural infants are more likely to receive suboptimal complementary feeding as compared to children from urban communities. This is reflected from the data on indicators such as minimum dietary diversity and minimally acceptable diet. As MICS 2019 indicates, only 31.8 percent (national 33.8 %) of rural infants aged 6–23 months received foods from 5 or more food groups during the previous day as compared to 41.5 percent urban infants. Further, among breastfed infants, only 25.7 percent of rural infants received minimum acceptable diet as compared to 36.1 percent of urban infants.

While undernutrition remains a significant issue in Bangladesh, overweight and obesity are also becoming concerns, as can be observed from MICS data that indicates an increase in overweight prevalence from 1.6 percent in 2013 to 2.4 percent in 2019. This is primarily driven by the feeding habits for children in urban areas (4.8 percent in urban, 1.8 in rural)

Maternal health and nutrition continues to remain a concern for Bangladesh as evident from MICS data. While the percentage of women receiving 4 or more ANC visits has increased from 25 percent (in 2013) to 37 percent (in 2019), 2 out of 3 women still do not receive 4 or more ANC services. The coverage is lesser in rural areas (32%) as compared to the urban areas (54.5%). Similarly, while institutional deliveries have increased implying an increase in access to health services, 1 in 2 women (53%) still don't deliver their child at a health facility, thus getting left out of the formal healthcare service delivery system. Further, DHIS2 data suggests that only 38 percent of women received iron-folic acid supplementation (IFA) during 2018 and only 15 percent women received counselling on maternal and child nutrition practices. The data therefore implies that the coverage of health and nutrition services is still low (more so in the rural areas). Therefore, moving forward there is a need for UNICEF's next CPD to focus on nutrition related indicators

in a holistic manner to create a larger impact on the nutrition and wellbeing of infants, children, adolescents and mothers in Bangladesh.

Sustainability

Presented below is a summary of the evaluation findings on impact in the form of short answers for each evaluation question.

Evaluation Question	Short Answer/Finding
<p>EQ 28: How successful has the programme been in equipping the government and strengthening government systems to scale-up and sustain the successfully proven interventions once UNICEF support comes to an end?</p>	<p>The GoB has demonstrated its willingness and commitment to scale up the successful interventions supported by UNICEF. These include Mothers@Work (being scaled up by the MoLE), adolescent clubs (scaled up by MoWCA and DSHE) and deployment of DNCs (as part of scaling up the DNSO initiative).</p> <p>Furthermore, UNICEF's support towards GoB in establishing AFHCs, as a safe space for adolescents within existing facilities and institutionalizing NIPU, for continued regular monitoring of nutrition interventions, has contributed to strengthening the government health and nutrition system. This coupled with UNICEF's capacity building efforts (in the form of CBT and deployment of DNSOs) has helped equip the government to sustain the successfully proven interventions.</p> <p>However, UNICEF still needs to focus its support towards addressing myths around nutrition through C4D activities and proactive counselling as well as leveraging the field force of various line departments to enhance the sustainability of the programme.</p> <p>Most importantly, there is a need for UNICEF to now develop prevention oriented interventions for its nutrition programme in the next CP. Given Bangladesh's impending MIC status, this would ensure that the GoB can sustain the momentum of change created through the interventions, once UNICEF support comes to an end.</p>

Sustainability, in this section refers not merely to the continuity of various interventions under the programme, but rather assesses the willingness and readiness of the national systems to sustain the positive results, post the withdrawal of UNICEF's support.

Evidence Generation, Policy Dialogue and Advocacy

Financial gains as a result of increased retention of the female workforce and a reduction in accidental risks as well as wastage has helped factory owners realize the importance of creating an enabling environment for working mothers. Such gains coupled with sensitization about maternity and child rights has led to increasing interest and willingness to ensure implementation of M@W initiative to promote exclusive and continued breastfeeding.

Owing to the success of the M@W initiative, representatives of Ministry of Labour and Employment, GoB are considering hosting a workshop to share RMG sector's experience on M@W, with the aim of replicating the intervention in other sectors. This offers an opportunity to scale up the M@W initiative to other private sector industries and ensure the sustainability breastfeeding-friendly workplaces. However, there is a need for UNICEF to fast track partnership with the Bangladesh Garment Manufacturers and Exporters Association to ensure that more garment manufacturers are committed to establishing an enabling work

environment for the realization of maternity and child rights. The wide scale adoption of the intervention by the RMG sector will further set a precedent for other private sector industries and encourage replication.

By providing a space to encourage discourse on nutrition and disseminate relevant information, adolescent clubs serve as effective platforms to influence adolescents towards gaining desired knowledge and adopting positive nutrition behaviours. The continued availability of these platforms can help adolescents exercise the power to influence peers to ensure sustained and future oriented efforts towards tackling malnutrition. Moreover, GoB has allocated a separate budget to enable the MoWCA to form 5000 more adolescent clubs across the country, which makes its commitment towards nation-wide replication evident, thereby also contributing to the sustainability of the intervention.

Partnership and Participation

The regularity in the conduct of BNNC, DNCC and UNCC meetings and participation of various line departments demonstrates the willingness of government stakeholders to come together on a common platform and coordinate efforts to address undernutrition. Additionally, GoB's commitment towards appointing DNCs for technical assistance in each district (as a part of scaling up the DNSO initiative by UNICEF) is a positive indication towards ensuring sustainability of the established mechanisms to enhance service delivery. However, there is a need for the GoB to fast track the appointment of DNCs to ensure that efforts of the UNICEF DNSOs can be sustained post UNICEF's exit.

Further, as a result of multi-stakeholder and multi-sectoral approaches to deliver nutrition services, the augmentation of field force through each line departments (apart from MoHFW), is likely to be an enabler for the sustainability of nutrition-sensitive interventions. If the capacities of community front-line workers can be utilized for nutrition information dissemination, awareness generation as well as monitoring and reporting of malnutrition cases, it can accelerate improvements in undernutrition and achieve the desired nutritional outcomes in a sustained manner.

Equity Responsive and Resilient Service Delivery

Adolescent Friendly Health Corners have been established by GoB with support from UNICEF. This initiative is likely to be sustainable owing to the fact that AFHCs are constructed within the premises of the existing health facilities in Bangladesh. The absence of a need to establish separate infrastructure for the functioning of these corners would make it easier for GoB to sustain this initiative even after UNICEF's exit.

Further, discussions with adolescents revealed that adolescent club members use these AFHCs as a safe space for holding their meetings and discussions. The existence of such an infrastructure within the health facility will thus ensure the continued availability of a safe space for adolescent boys and girls to hold discussions on adolescent related issues, even after UNICEF's exit.

In addition to this, the willingness of the Ministry of Women and Child Affairs, GoB to scale community based adolescent clubs and DSHE to scale school based adolescent clubs as articulated during KIIs, provides evidence on the replicability of this pilot initiative, thus ensuring its scale up by the GoB.

As a dedicated unit for nutrition related planning and monitoring, the institutionalization of NIPU is an enabler to sustain regular monitoring of nutrition interventions. However, the unit's independent functioning post withdrawal of UNICEF's support will be critical for the sustained use of evidence based planning and decision making.

The wide scale adoption of DHIS2 by GoB provides evidence towards government ownership that serves as an enabler for sustaining regular monitoring of nutrition interventions. However, evaluation findings suggest that community health workers face challenges related to bandwidth while uploading data on the DHIS2. If not addressed, this issue can serve as a major barrier to the sustainability of the program in terms

of real time monitoring and reporting of nutrition related data and its use in evidence based planning and decision making.

Another gap acting as a barrier to ensure sustainability is the absence of data from private health facilities in urban areas. While efforts to establish DHIS2 can ensure quality data monitoring and reporting in rural areas; if data from the private health facilities is not incorporated within the DHIS2, it would remain incomplete and at a high risk of being unsustainable.

A potential barrier to the sustainability of the nutrition programme also surfaces when it comes to tea estates wherein the reach of all basic services is highly dependent on the discretion of the tea estate owners. Due to the lack of sensitization on the importance of nutrition interventions among tea estate owners, initiatives like adolescent clubs are perceived as a threat since they stand to promote demand generation. As a result of this, there is reluctance amongst tea estate owners to allow nutrition interventions in their areas, hampering the scale up and replication of a successful intervention, thereby affecting sustainability. Moreover, the absence of a government mandate to ensure compliance may hinder the sustainability of all nutrition specific and sensitive interventions in the tea gardens.

One of the biggest barriers to the sustainability of UNICEF's nutrition interventions are the prevalent misconceptions, myths and social norms with regard to certain nutrition behaviors. These were discussed during discussions with pregnant and lactating women as well as adolescent girls with regards to IFA consumption and dietary restrictions during menstruation. This pointed towards a need for the nutrition program in collaboration with the C4D section, to strengthen measures, through effective counselling, to adequately alleviate such myths. This would prevent negative beliefs from acting as barriers to the sustainability of interventions targeted towards encouraging desired nutrition behaviors.

Overall, the lack of a uniform and sustained preventive intervention for the nutrition program both at facility and community level may prove to be a major threat to the sustainability of all nutrition interventions so far. UNICEF needs to strengthen its efforts towards advocacy for a dedicated nutrition cadre at the community, union and upazila level to improve the accountability and sustainability of nutrition programs and enable preventive measures to tackle malnutrition, given Bangladesh's transition to a middle income country

LESSONS LEARNED, CONCLUSIONS AND RECOMMENDATIONS

This section summarises the cross-cutting conclusions, lessons learned, and recommendations that have derived from the findings of the evaluation and as answers to the Evaluation Questions.

Lessons Learned

1. Given its technical capacity and high level of trust from the government and changing economic environment, UNICEF is well placed to play a catalyst role in identifying and promoting innovations and best practices that can be replicated and scaled up. However, modelling innovative services or approaches in a context where absorption capacity is limited and resources to support scale-up are insufficient, require a long-term operational plan to be supported with careful assessment of readiness, investment requirements and commitment before implementation. This is particularly important when multiple pilots are planned at the same time. Therefore, when introducing innovations, UNICEF has to be mindful that approaches to be scaled up consider local resources from the beginning. Cost-effective replicable innovations should be costed out from the outset and involve the Ministry of Planning and Finance.
2. Programmes that operate at a system level and seek to address complex needs of children, namely nutrition and address key bottlenecks/barriers to equity, require integrated cross-sectoral programming and careful examination of externalities and government change processes to sustain programming and optimize results. A programme theory with a precise definition of causal linkages within and across its components is needed to enable concerted efforts and closer monitoring of progress. This also applies when coordinating with other sector actors, such that comprehensive services can be provided. This can be achieved through the creation of joint action plans including a joint resource mobilisation strategy that presents clear logic and correlations for sectoral integration.
3. System level reform support must be accompanied by comprehensive C4D strategies to ensure system changes take up root across society. Traditional communication approaches are insufficient to tackle the deeply ingrained social norms and entrenched practices within society that hamper uptake of (nutrition) services and adoption of positive (nutrition) behaviours. Therefore, C4D efforts embedded within and integrated with nutrition's programmatic interventions are essential to ensure results from improved service delivery through the uptake and utilization of services.
4. Continual course correction during implementation of nutrition programmes is critical to addressing factors that might limit coverage and potential for impact. Programme improvement requires rigorous scientific inquiry to identify and address implementation pathways and the factors that affect them.

Conclusions

Relevance

1. The examination of the relevance of UNICEF Nutrition Programme's interventions and implementation strategies highlights that the mix of strategies has ensured a balance between upstream and downstream work against the background of the transition of Bangladesh towards middle-income status.
2. The nutrition programme's strategy of supporting policy and advocacy, promoting partnerships and coordination, providing technical assistance and capacity development towards nutrition systems strengthening, are in alignment with the UNICEF Global Nutrition Strategy, UNICEF Strategic Plan 2018-21 and Bangladesh UNDAF 2017-20. Further, UNICEF's nutrition programme aligns with the strategies of NNP, key action areas of NPAN2, strategic objectives of NSAH 2017-30 and the priority areas of the National Strategy on Prevention and Control of Micronutrient Deficiencies (2015-24) and MoHFW's Bangladesh Essential Health Service Package (ESP). Furthermore, the nutrition programme was also found to be aligned with the 7th five year plan and the Bangladesh EECDF Policy Framework. It was found to be partially aligned to the National Urban Health strategy since UNICEF yet to adequately address the need for preventive care.
3. Learnings from past evaluations have fed into the interventions of the UNICEF Nutrition programme. This has enabled the programme to adequately respond to the needs of various target groups in the country. UNICEF supported adolescent clubs encourage inclusion of differently abled as well as out of school adolescents, making the targeting inclusive in addressing stunting amongst adolescents from various backgrounds. Further, the Mothers@Work initiative creates an enabling environment to adequately respond to the needs of working mothers and their children in the urban context. In addition to this, the focus of UNICEF's interventions on hard to reach areas, urban slums and tea estates makes UNICEF's strategy to address stunting, adequate and responsive to the needs of beneficiaries from varying geographies. Furthermore, UNICEF's role in the nutrition cluster (of enhancing country level capacities to respond to nutrition needs in emergency settings) and the use of community based programmes is appropriate and adequate to address the needs of beneficiaries, specifically in the emergency context. However, the lack of a uniform strategy to scale up these community based programmes in development settings renders UNICEF's interventions as inadequate in addressing stunting in young children and adolescents in a comprehensive manner, across both development and emergency contexts.
4. UNICEF's focus on building the capacities of community health workers through CBT to improve nutrition counselling and services, promoting the use of evidence based decision making and fostering sectoral coordination through deployment of DNSOs and support provided for DHIS2 were found to be responsive to the needs of the government. By focusing interventions towards systems strengthening, it is evident that UNICEF gave due consideration to governmental expectations to select priority programme elements. Further, leveraging of partnerships (amongst development partners) with ILO, World Bank, NI, GAIN, among others, provides evidence that UNICEF considered its comparative strengths and that of other development partners in selecting the program priority areas and catering to them. Moreover, through the piloting of interventions and subsequent identification of successful ones, UNICEF's approach of demonstrating efficacy through documentation and dissemination was found to be relevant for influencing policy and supporting scale up of interventions by GoB.

Effectiveness

5. Using the implementation strategy of leveraging partnerships with development partners and the private sector and ensuring coordination within UNICEF sections, the nutrition programme has been effective in increasing awareness and realization of maternal and child rights through availability of an enabling environment for breastfeeding at the workplace. Similarly, the nutrition programme's support towards meeting the nutritional needs of adolescents through adolescent clubs have been effective in ensuring equity by targeting both in and out-of-school adolescents. The platform has also enabled a discourse amongst adolescents on important aspects of nutrition, among other issues. Further, generating evidence on the efficacy of these interventions, the nutrition programme's efforts have been effective in building a case for scale up and adequately meeting the needs of target groups, especially in urban areas.
6. While the programme has been effective in ensuring the participation of various line departments on a common platform (DNCC/UNCC) and facilitating regular discourse on nutrition, the extent of effectiveness is constrained by the lack of convergent planning and vertical accountability. In the urban context, despite the establishment of nutrition coordination committees in city corporations, the absence of any facilitation (through DNSOs as in rural areas) and lack of coordination between MoHFW and MoLGRD&C has constrained the functioning of committees.
7. While DNSO support on use of MIS and CBT have been an effective interventions to strengthen service delivery, there remains a significant amount of potential to increase its effectiveness. Evidence suggests that these interventions have resulted in regular reporting and monitoring of data on nutrition and have even improved counselling services. Additionally, the technical assistance provided by NIPU at national level has enabled analysis of data reported under DHIS2 and identification of priority areas for targeted interventions and adequate resource allocation. However, despite the institutionalization of systems and capacities enhanced, no evidence on utilization of data for planning and budgeting at the district and upazila level was found. Without evidence-based planning, the momentum created by these interventions will not translate into significant improvements in service delivery. Another challenge towards ensuring effectiveness of such interventions, is the unavailability of data from private health facilities in urban areas, resulting in a missed opportunity to comprehensively track nutrition services in an integrated manner.
8. Evidence suggests that the support provided by UNICEF towards SAM screening and management has helped build the capacity of health workers to screen SAM cases and refer them to facilities at the upazila or district level. However, a major barrier for effective management of SAM is the lack of mechanism to (i) track patients post referral to district/upazila facilities and; (ii) follow up with the patients on compliance with the treatment protocol, post discharge.

Efficiency

9. The allocation of regular resources across the interventions is in accordance with the planned budgets. However, there is a major resource gap in case of allocation through other resources. While the higher allocation towards operationalizing integrated nutrition information systems, institutionalization of DNSO and, capacity building of health workers through CBT approach helped achieve the desired objectives, the budget did not have adequate provisions to support other activities such as effective management of SAM, CMAM, adolescent nutrition, IYCF and maternal nutrition. Allocation for interventions in urban areas was also inadequate.
10. The effectiveness of Mothers@Work Programme has provided evidence on leveraging of funds through development partners and private sector and working with shared services as an efficient mechanism to achieve common objectives. Further, the minimum financial support provided by the programme for

incremental infrastructure support/refurbishment as in case of breastfeeding corners and AFHCs, has efficiently strengthened service delivery. However, due to a lack of clear delineation of roles and responsibilities amongst development partners, there is often duplication of efforts. While there are instances of joint programming amongst development partners, it is happening on an adhoc basis.

11. The targeting of the programme is inclusive and provides support to areas affected by climate change, disasters and high prevalence of stunting. However, owing to challenges related to access to roads, continued supply of power in Haor areas and lack of sensitisation of tea estate managers on development oriented interventions, the efficiency in service delivery interventions has been affected.

Impact

12. Evidence suggests that the nutrition programme has been able to support GoB in its efforts towards accelerating the reduction in stunting. Using a straight line trend function, it can be inferred that through the programme support, GoB is likely to achieve its target on underweight and BMI (among adolescent girls). However, in case of reducing wasting and the incidence of early marriage, the estimate suggests that the country may not be able to achieve the set targets. While majority of the programme targets may be achieved, the current rate of progress is not enough to create a significant impact with regard to undernutrition in the country.
13. While the design of the programme ensures equal distribution of nutrition support services in rural and urban areas, the indicators suggest that the rural–urban differential will continue to persist unless the interventions are tailored to the specific needs of urban and rural areas. This will also help ensure equity based targeting.

Connectedness

14. Leveraging the strengths of sections within UNICEF, the nutrition programme collaborated with the Child Protection, Health, and Education, WASH and CAP section to address the needs of specific target groups, namely, adolescents (including out-of-school children), children in schools and those below 6 years of age as well as working mothers. By integrating nutrition within existing adolescent clubs, mainstreaming nutrition within education (school) curricula and leveraging the strengths of the CAP section to implement C4D interventions to promote maternal and child nutrition at the workplace, the nutrition section has effectively coordinated with other sections to cater to the nutritional needs of target groups, as per the lifecycle approach. The nutrition programme ensured that priority areas of other sections such as health, hygiene and adolescent issues such as early marriage and early pregnancy are recognized as determinants of nutrition. With the support from other sections the nutrition programme further ensured that the factors affecting the nutritional status of children and adolescents are adequately and comprehensively addressed through joint initiatives
15. Partnerships with a wide range of actors resulted in strengthened institutional capacities of government agencies, regional and local service institutions, and civil society organizations to implement nutrition interventions and work towards closure of equity gaps for all target groups. Moreover, UNICEF's joint work with other sector actors, along with the support from GoB, has brought notable contributions towards building an institutional environment through the development of official guidelines to facilitate provision of nutrition services. These contributions have had a valuable effect on accelerating the pace of change and giving direction to nutrition reforms.
16. UNICEF and GoB (as part of operationalization of NPAN 2) have made efforts to strengthen multi stakeholder partnerships to address the complex issue of undernutrition. The evaluation also found evidence of inter-sectoral collaboration within UNICEF and partnerships between GoB, UNICEF and other stakeholders (development partners, implementing organizations and the private sector) for

addressing nutrition related challenges. However, there is scope for greater coordination and creation of an integrated multi-sectoral joint action plan to support GoB in improving the status of nutrition.

Sustainability

17. The regularity in the conduct of BNCC, DNCC and UNCC meetings and participation of various line departments demonstrates the willingness of government stakeholders to come together on a common platform and coordinate efforts to address undernutrition. Additionally, GoB's commitment towards appointing DNCs for technical assistance in each district (as a part of scaling up the DNSO initiative by UNICEF) is a positive indication towards ensuring sustainability of the established mechanisms to enhance service delivery.
18. Evidence of government ownership and scale up of initiatives like appointment of DNCs, adolescent clubs and M@W indicate that these initiatives are sustainable. A potential barrier to the sustainability of the nutrition programme efforts surfaces when it comes to tea estates wherein the reach of all basic services is highly dependent on the discretion of the tea estate managers. Due to the lack of sensitization on the importance of nutrition interventions among tea estate owners, initiatives like adolescent clubs are perceived as a threat since they stand to promote demand generation. As a result of this, there is reluctance amongst tea estate owners to allow nutrition interventions in their areas, hampering the scale up and replication of a successful intervention, thereby affecting sustainability.
19. Another barrier to ensuring sustainability is the absence of data from private health facilities in urban areas. While efforts to establish DHIS2 is ensuring quality data monitoring and reporting in rural areas; if data from the private health facilities is not captured within the DHIS2, it would remain incomplete and restrict the sustainability of interventions.
20. As a dedicated unit for nutrition related planning and monitoring, the institutionalization of NIPU is an enabler to sustain regular monitoring of nutrition interventions. However, the unit's independent functioning post withdrawal of UNICEF's support will be critical for the sustained use of evidence based planning and decision making.
21. Overall, the lack of a uniform and sustained preventive intervention for the nutrition program both at the facility and community level may prove to be a major threat to the sustainability of all nutrition interventions so far.

Recommendations

1. In order to sustain the gains of DNSOs, UNICEF should advocate fast tracking of appointment of DNCs by GoB. Further, in the urban context, UNICEF should consider advocacy with the MoLGRD&C, GoB for creation and deployment of a cadre of nutrition officers to lead nutrition service delivery in urban areas. This will facilitate GoB in implementation of nutrition interventions through existing government mechanisms and overcome dependence on external funding.
2. UNICEF should advocate for the integration of health services provided by DGFP into DHIS2 in order to ensure coordination amongst DGHS and DGFP on reporting SDG indicators. Additionally, towards addressing the challenge of capturing data from the private health facilities in urban areas and resistance from tea estate owners, UNICEF must liaise with MoLGRD&C for issuance of an official mandate to ensure compliance among private health facilities to report data on nutrition indicators through DHIS2.
3. While technical support provided by UNICEF to facilitate reporting through MIS has strengthened the delivery of services, to further enhance the effectiveness of delivery of services, it is essential that the MIS also captures data on- i) aspects related to consumption (IFA and other micronutrient supplementations), ii) tracking the movement of patients post referral to health facilities (at district /upazila level) from the community clinic, iii) compliance to treatment protocol and iv) quality of delivery of services. In addition to focusing on the use of data for planning and budgeting (that is currently not taking place), UNICEF must also ensure inclusion of indicators on these aspects within DHIS2. GoB, with support from UNICEF nutrition programme, can consider using the supportive supervision mechanism to monitor the quality of services provided by CHWs and track uptake and utilization of services. Supportive supervision will also enable appropriate feedback to CHWs and help highlight specific capacity gaps that need to be addressed. In this manner, use of data for decision making regarding all aspects of service delivery would be encouraged.
4. Towards acceleration of reduction in wasting and the incidence of early marriage, the programme needs to focus more on preventive and proactive counselling (rather than curative counselling) to overcome prevalent social norms and thereby, promote positive nutrition behaviours. This will help increase both the reach as well as effectiveness of counselling services. Towards this, UNICEF needs to focus on advocacy with the GoB to improve counselling through home based visits and fast track efforts towards strengthening the supportive supervision mechanism.
5. Evidence on leveraging of funds through development partners and private sector and working with shared services being an efficient mechanism to achieve common objectives has been established. Going forward, this must be considered as a basis for joint programming (using comparative advantage for complementary interventions) and resource mobilization with other development partners for extending support to GoB in achieving nutrition goals.
6. While coordinated efforts amongst the UNICEF sections are leading towards comprehensive coverage of services, it is important to bear in mind that such an approach carries the risk of considerable lack of strategic orientation and depth of engagement in several areas. Therefore, to strengthen internal coherence among UNICEF sections and the resulting interventions, it is advisable for all the sections to collectively discuss their respective objectives and plans to develop a unified approach, demarcating contours of engagement such that joint action plans can be created towards more coordinated efforts to mainstream nutrition.
7. UNICEF should consider coordination with partners like WFP to generate evidence on the efficacy of interventions promoting dietary diversity and positive nutrition behaviours through training and demonstration, such that similar programmes are introduced for adolescents. WFP's school feeding programme (currently being implemented in 2 upazilas of Cox's Bazar), as part of an Essential Learning Package, focuses on enhancing dietary diversity by providing support to the vegetable gardens in schools. Additionally, they also create "Little Agriculturists" to increase knowledge on desired nutrition

practices through peer-to-peer sharing. While this programme is targeted towards primary students, it demonstrates the integration of various sectors including education, nutrition, WASH and health. UNICEF may consider leveraging such interventions of other partners and advocating for government ownership and scale up of such integrated interventions that are likely to aid achievement of nutritional targets.

8. Owing to the success of the M@W initiative, representatives of Ministry of Labour and Employment, GoB are considering hosting a workshop to share RMG sector's experience on M@W, with the aim of replicating the intervention in other sectors. This offers an opportunity to scale up the M@W initiative to other private sector industries and ensure the sustainability breastfeeding-friendly workplaces. However, there is a need for UNICEF to fast track partnership with the Bangladesh Garment Manufacturers and Exporters Association to ensure that more garment manufacturers are committed to establishing an enabling work environment for the realization of maternity and child rights. The wide scale adoption of the intervention by the RMG sector will further set a precedent for other private sector industries and encourage replication.
9. As a result of multi-stakeholder and multi-sectoral approaches to deliver nutrition services, the augmentation of field force through each line departments (apart from MoHFW), is likely to be an enabler for the sustainability of nutrition-sensitive interventions. It is suggested that capacities of community front-line workers of each department be utilized for nutrition information dissemination, awareness generation as well as monitoring and reporting of malnutrition cases. This can help accelerate improvements in undernutrition and achieve the desired nutritional outcomes in a sustained manner.
10. As Bangladesh transitions towards becoming a MIC, there is a greater need for UNICEF to play an advocacy role and provide technical assistance rather than supporting direct service delivery on behalf of the government, as the latter does not promote ownership and sustainability. UNICEF is well placed to play this advocacy role effectively due to its strong subject matter expertise, ability to respond to the evolving context of the country and government systems. Therefore, UNICEF should prepare an exit strategy to phase out its support in various interventions so that the initiatives can be more sustainable and scaled up faster by GoB. In the meanwhile, GoB may consider taking forward the successful interventions independently by ensuring adequate financial resources to leverage the gains and sustain the results.
11. Despite the programme's alignment with the National Guidelines for CMAM, all community based programmes remain as pilots, largely as a response to emergency situations, without a uniform strategy to scale up. In order to ensure long-term improvements in the management of SAM, CMAM needs to be implemented through the existing ministry of health infrastructure as a part of a standard primary health care package. Going forward, there is a need to strengthen the capacity of GoB to engage with the community (not limited to emergency response) for timely diagnosis and effective treatment of acute malnutrition. This coupled with other preventive interventions (for instance counselling through home based visits) will ensure UNICEF's efforts to address stunting are responsive and adequate. UNICEF may therefore, consider focusing on preventive programming in the next CP.
12. While the current CP focuses on accelerating the reduction of stunting and improving adolescents' health and well-being, it is recommended that the new CP also focuses on another emerging spectrum of malnutrition in Bangladesh i.e. rising levels of overweight and obesity among adolescents. This would essentially mean that UNICEF in the next CP should support GoB in addressing the double burden of undernutrition/malnutrition and overweight/obesity among adolescents –both who are married and unmarried.

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