Nutrition Capacity Assessment in Bangladesh

A report to UNICEF EAPRO and UNICEF Bangladesh

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<tr>
<td>ABCN</td>
<td>Area Based Community Nutrition</td>
</tr>
<tr>
<td>ANC</td>
<td>Ante Natal Care</td>
</tr>
<tr>
<td>APR</td>
<td>Annual Program Review</td>
</tr>
<tr>
<td>ARH</td>
<td>Adolescent Reproductive Health</td>
</tr>
<tr>
<td>AUFPO</td>
<td>Assistant Upazila Family Planning Officer</td>
</tr>
<tr>
<td>BCC</td>
<td>Behavioral Change Communication</td>
</tr>
<tr>
<td>BCPS</td>
<td>Bangladesh College of Physicians and Surgeons</td>
</tr>
<tr>
<td>BDHS</td>
<td>Bangladesh Demography and Health Survey</td>
</tr>
<tr>
<td>BF</td>
<td>Breast Feeding</td>
</tr>
<tr>
<td>BMDC</td>
<td>Bangladesh Medical and Dental Council</td>
</tr>
<tr>
<td>BSCIC</td>
<td>Bangladesh Small &amp; Cottage Industries Corporation</td>
</tr>
<tr>
<td>CBHC</td>
<td>Community Based Health Care</td>
</tr>
<tr>
<td>CBN</td>
<td>Community Based Nutrition</td>
</tr>
<tr>
<td>CC</td>
<td>Community Clinic</td>
</tr>
<tr>
<td>CCMG</td>
<td>Community Clinic Management Group</td>
</tr>
<tr>
<td>CHCP</td>
<td>Community Health Care Provider</td>
</tr>
<tr>
<td>CME</td>
<td>Centre for Medical Education</td>
</tr>
<tr>
<td>DG</td>
<td>Director General</td>
</tr>
<tr>
<td>DGFP</td>
<td>Directorate General of Family Planning</td>
</tr>
<tr>
<td>DGHS</td>
<td>Directorate General of Health Services</td>
</tr>
<tr>
<td>DH</td>
<td>District Hospital</td>
</tr>
<tr>
<td>DPM</td>
<td>Deputy Programme Manager</td>
</tr>
<tr>
<td>EPI</td>
<td>Expanded Program on Immunization</td>
</tr>
<tr>
<td>ESD</td>
<td>Essential Service Delivery</td>
</tr>
<tr>
<td>FHA</td>
<td>Female Health Assistant</td>
</tr>
<tr>
<td>FP</td>
<td>Family Planning</td>
</tr>
<tr>
<td>LCG</td>
<td>Local Consultative Group</td>
</tr>
<tr>
<td>LD</td>
<td>Line Director</td>
</tr>
<tr>
<td>LLP</td>
<td>Local Level Planning</td>
</tr>
<tr>
<td>LCM</td>
<td>Maternal and Child Health</td>
</tr>
<tr>
<td>MCRH</td>
<td>Maternal, Child and Reproductive Health</td>
</tr>
<tr>
<td>MCWC</td>
<td>Mother and Child Welfare Centre</td>
</tr>
<tr>
<td>MDGs</td>
<td>Millennium Development Goals</td>
</tr>
<tr>
<td>MNCH</td>
<td>Maternal, Neonatal and Child Health</td>
</tr>
<tr>
<td>MNCAH</td>
<td>Maternal, Neonatal, Child and Adolescent Health</td>
</tr>
<tr>
<td>MNH</td>
<td>Maternal and Neonatal Health</td>
</tr>
<tr>
<td>MNP</td>
<td>Micro-Nutrient Powder</td>
</tr>
<tr>
<td>MO</td>
<td>Medical Officer</td>
</tr>
<tr>
<td>MOA</td>
<td>Ministry of Agriculture</td>
</tr>
<tr>
<td>MOC</td>
<td>Ministry of Commerce</td>
</tr>
<tr>
<td>MOE</td>
<td>Ministry of Education</td>
</tr>
<tr>
<td>MOF</td>
<td>Ministry of Finance</td>
</tr>
<tr>
<td>MOFDM</td>
<td>Ministry of Food and Disaster Management</td>
</tr>
<tr>
<td>MOFL</td>
<td>Ministry of Fisheries and Livestock</td>
</tr>
<tr>
<td>MOHFW</td>
<td>Ministry of Health and Family Welfare</td>
</tr>
<tr>
<td>MOLGRDC</td>
<td>Ministry of Local Government Rural Development &amp; Cooperatives</td>
</tr>
<tr>
<td>MOIn</td>
<td>Ministry of Industries</td>
</tr>
<tr>
<td>MOSW</td>
<td>Ministry of Social Welfare</td>
</tr>
<tr>
<td>MOWCA</td>
<td>Ministry of Women and Children Affairs</td>
</tr>
<tr>
<td>NGO</td>
<td>Non Government Organization</td>
</tr>
<tr>
<td>NID</td>
<td>National Immunization Day</td>
</tr>
<tr>
<td>NIPSOM</td>
<td>National Institute of Preventive and Social Medicine</td>
</tr>
<tr>
<td>Abbreviation</td>
<td>Full Form</td>
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</tr>
<tr>
<td>FPI</td>
<td>Family Planning Inspector</td>
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<tr>
<td>FWA</td>
<td>Family Welfare Assistant</td>
</tr>
<tr>
<td>FWV</td>
<td>Family Welfare Visitor</td>
</tr>
<tr>
<td>GMP</td>
<td>Growth Monitoring and Promotion</td>
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<tr>
<td>GOB</td>
<td>Government of Bangladesh</td>
</tr>
<tr>
<td>HA</td>
<td>Health Assistant</td>
</tr>
<tr>
<td>HFWC</td>
<td>Health and Family Welfare Centre</td>
</tr>
<tr>
<td>HI</td>
<td>Health Inspector</td>
</tr>
<tr>
<td>HIS</td>
<td>Health Information System</td>
</tr>
<tr>
<td>HMIS</td>
<td>Human Resource Management Information System</td>
</tr>
<tr>
<td>HPNSDP</td>
<td>Health, Population and Nutrition Sector Development Program</td>
</tr>
<tr>
<td>ICCDR,B</td>
<td>International Centre for Diarrheal Diseases Research, Bangladesh</td>
</tr>
<tr>
<td>IFA</td>
<td>Iron &amp; Folic Acid</td>
</tr>
<tr>
<td>IMCI</td>
<td>Integrated Management of Childhood Illness</td>
</tr>
<tr>
<td>INFS</td>
<td>Institute of Nutrition &amp; Food Science</td>
</tr>
<tr>
<td>IPHN</td>
<td>Institute of Public Health Nutrition</td>
</tr>
<tr>
<td>IST</td>
<td>In Service Training</td>
</tr>
<tr>
<td>IYCF</td>
<td>Infant and Young Child Feeding</td>
</tr>
<tr>
<td>NNP</td>
<td>National Nutrition Program</td>
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<tr>
<td>NNS</td>
<td>National Nutrition Service</td>
</tr>
<tr>
<td>NPSU</td>
<td>NGO and Private Sector Unit</td>
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<tr>
<td>OP</td>
<td>Operational Plan</td>
</tr>
<tr>
<td>PHC</td>
<td>Primary Health Care</td>
</tr>
<tr>
<td>PNC</td>
<td>Post Natal Care</td>
</tr>
<tr>
<td>PM</td>
<td>Programme Manager</td>
</tr>
<tr>
<td>RAH</td>
<td>Reproductive and Adolescent Health</td>
</tr>
<tr>
<td>SACMO</td>
<td>Sub-Assistant Community Medical Officer</td>
</tr>
<tr>
<td>SWAp</td>
<td>Sector Wide Approach</td>
</tr>
<tr>
<td>UHC</td>
<td>Upazila Health Complex</td>
</tr>
<tr>
<td>UHFPO</td>
<td>Upazila Family Planning Officer</td>
</tr>
<tr>
<td>UHFWC</td>
<td>Union Health and Family Welfare Centre</td>
</tr>
<tr>
<td>UHMC</td>
<td>Upazila Health Management Committee</td>
</tr>
<tr>
<td>UHS</td>
<td>Upazila Health System</td>
</tr>
<tr>
<td>UPHCP</td>
<td>Urban Primary Health Care Project</td>
</tr>
<tr>
<td>WB</td>
<td>World Bank</td>
</tr>
</tbody>
</table>
Background

To help give more children in Asia the best start in life, the European Union has teamed up with UNICEF to support a new initiative to tackle maternal and child under nutrition over four years (2011-14). The Maternal and Young Child Nutrition Security Initiative in Asia (MYCNSIA) is designed around four interrelated result areas of (1) Up-stream policy work regarding nutrition security, (2) Capacity building of decision-makers, service delivery personnel and communities, (3) Data analysis and knowledge sharing, and (4) Scaling up of key proven interventions. MYCNSIA activities are implemented in five targeted countries of Bangladesh, Indonesia, the Lao PDR, Nepal and the Philippines. Through the MYCNSIA, UNICEF will work to improve child growth and development in Asia by improving nutrition security using inter-sectoral approaches. Ways will be sought to support capacity building initiatives in these countries through a regional approach.

For capacity building to be successful and sustainable it should not be confined to the individual level, but must also consider organizational and system constraints. The aim of system level analysis is to understand the programme, policy and legal frameworks of relevance to nutrition, both from a local government and national government sectoral perspective, as well as from that of civil society and non-government organizations.

The Nutrition Agenda in Bangladesh

Recent reports have noted the important progress made in reducing under-nutrition in Bangladesh, and towards attaining the MDGs. Research and experience has also established that changing the major underlying causes of under-nutrition will involve activities across several sectors including health, agriculture, social protection, education, water and sanitation and women’s empowerment.

In 2011, in a shift from the previous stand-alone nutrition programme, the Government of Bangladesh introduced a comprehensive new strategy in the health sector to directly address under-nutrition through “mainstreaming” nutrition as part of the Health, Population and Nutrition Sector Development Programme, 2011-16 (HPNSDP). This is managed through the National Nutrition Services (NNS) and described in detail in the Operational Plan for the NNS (NNS-OP). This also identifies the need for “nutrition sensitive” interventions through other ministries and specifies aspects of the coordination needed with other ministries. The 2011 Country Investment Plan (CIP) extends this, including strategies for investment across 13 government ministries to improve agriculture, food security and nutrition.

A mapping of nutrition stakeholders in 2012 identified more than 40 entities including government agencies, NGOs, research organisations, multilateral agencies and donors. Even though there is

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1 NOTE: This report is the joint product of consultants from the World Public Health and Nutrition Association (WPHNA) and Public Health Solutions, Ltd. (PHSL). Any views or opinions presented in the report are solely those of the authors and do not necessarily represent those of UNICEF Regional or Country offices, or of the European Union (EU), which funded the work.
2 Khan AR, van der Veen A (2012a).
3 Transform Nutrition (2012b).
5 Food Planning and Monitoring Unit (2012).
active debate amongst stakeholders about aspects of the nutrition situation and strategies in Bangladesh, there is agreement on the broad agenda – that is, the nutrition priorities, support for the NNS and the need for effective action across sectors (discussed in more detail in the sections below).

**Purpose of consultancy**

The purpose was to assess the nutrition capacity in Bangladesh, with particular attention to the ability to mainstream nutrition and implement the NNS. The assessment considered factors that affect this capacity at system, organizational and individual levels. The consultancy was intended to provide recommendations to strengthen nutrition capacity in Bangladesh, and to contribute to an understanding of nutrition capacity and constraints in the region. It complements other capacity assessments conducted in three targeted countries: Nepal, Indonesia, and Bangladesh.

**Methodology**

*Country visit*

The consultants visited Dhaka from 22\textsuperscript{nd} to 30\textsuperscript{th} January 2013.

*Desk review*

A range of documents was available concerned with the nutrition agenda in Bangladesh and the strategies and capacity for addressing this. This included strategic plans, operational plans, technical reports and some recent reviews. It provided a rich background and informative data source for the consultancy. The desk review drew on these and other documentation to examine the systems and organizational level factors needed to support the performance of the nutrition workforce, the nature of the workforce responsible for delivering and supporting nutrition services, and their training.

Key documents used but not directly cited are included in the list of references. We commend the references to anyone wanting a more comprehensive background to the issues discussed here.

*Interviews*

Interviews were conducted with representatives of key government stakeholders, NGOs, professional organizations, academic organisations and other agencies supporting capacity development in the area of nutrition, including international agencies and donors. Annex A provides a list of those we met. Recent work has identified more than 40 organisations as stakeholders for nutrition policy and services in Bangladesh.\textsuperscript{7} So the interviews undertaken were not a census of opinions, but did provide a broad range of perspectives on nutrition capacity in Bangladesh.

*Analysis*

Initial analysis involved documenting the main nutrition policies and programmes, and mapping the nutrition workforce including the type and number of personnel involved (e.g. nutritionists, doctors,

\textsuperscript{7} Ministry of Health and Family Welfare (2011).
\textsuperscript{8} Transform Nutrition (2012a).
nurses, etc.). We also identified other organizations/institutions where nutrition capacity is, or could be, embedded.

The interviews and subsequent analysis aimed to assess adequacy of the capacity to implement the NNS and identify gaps/weaknesses and opportunities to build the nutrition capacity.

**Regional context**

This report focuses on the nutrition situation and capacity needs within Bangladesh; however, it is important to mention that it is part of a wider regional assessment and that some of the findings from this report will be combined with those from other countries where similar assessments were conducted. The expected outcome will be development of a regional response to cross-cutting capacity needs in the area of public nutrition, including strategic support for capacity development in this area.

**Findings and Discussion**

**The timing is good for a strengthened focus on nutrition**

1. Major new nutrition initiatives have been launched by government, with important challenges for scaling up.
   
   Introduction of the NNS in 2011 shifted the nutrition agenda in the health sector significantly with rollout of these services becoming the primary focus of nutrition activities. In other sectors the Country Investment Plan for agriculture, food security and nutrition, and associated areas of the National Food Policy present a wide ranging plan with implications for food security.

2. Stakeholders are engaged, with potential for strengthened collective impact if coordinated.

3. Funding is potentially available from development partners.

4. Recent successes in Bangladesh against some of the MDGs (particular reduction of mortality rates) suggest that a scaled up effort to address under-nutrition is feasible. Further, the core interventions in the current nutrition agenda have proven efficacy, with the main challenges being related to effective implementation.

These points will be expanded upon in sections below.
Three recent reviews of the nutrition situation in Bangladesh have particular relevance to this consultancy — the analysis of nutrition governance undertaken by Taylor in late 2011\(^9\), the Annual Programme Review (APR) of the NNS by Khan and van der Veen in late 2012\(^10\), and the 2012 review undertaken by Mousseau on behalf of the Scaling UP Nutrition (SUN) movement\(^11\). Their findings and recommendations are still largely applicable. We summarise key findings and recommendations below where they relate to nutrition capacity, and extend these from our interviews and analysis with a particular focus on development of the workforce and support systems needed to implement the current nutrition services and policies effectively. We particular focus on:

- Agenda setting and coordinating capacity
- The nutrition workforce and capacity in the health sector
- Nutrition capacity in other sectors
- Education and training in public health nutrition and public nutrition.

### Key points from earlier reviews

In her review of nutrition governance in Bangladesh, Taylor states that the multi-sectoral approach adopted “can be considered strong in that it aims to use ministries’ specialist expertise, but it is dependent on effective and powerful coordinating mechanisms to align activities and monitoring of results – something which this report will show has not been put in place”.\(^12\) She describes how a range of factors in the policy, political and funding context and disparate views on nutrition amongst stakeholders, have led to a lack of “clear and shared goals” amongst the agencies working on nutrition, and fragmentation in the services delivered. She points to the following as key areas for action to address these:

- Strengthening coordination at all levels — to align efforts amongst donors, with government and amongst government agencies and other bodies.
- Monitoring and evaluation — to make the task “real and measurable”, to provide an evidence-base to resolve different views on the problem and interventions needed, and to provide a basis for making government and donors accountable for nutrition outcomes.
- Raising the profile and perceived importance of nutrition.

The Annual Programme Review of the nutrition component of HPNSDP undertaken by Khan and van der Veen \(^13\) looked primarily at progress in implementation of the NNS Operational Plan (NNS-OP).

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\(^9\) Taylor, L (2012).
\(^10\) Khan AR, van der Veen A (2012a).
\(^11\) Mousseau F (2012).
\(^12\) Taylor, L (2012).
\(^13\) Khan AR, van der Veen A (2012a).
They found that in the first year of implementation, 9 of the 12 process indicators had been achieved, as described in the table below. These results are now 6 months out of date but demonstrate strong progress in rollout of the programme, particularly in the training. Nonetheless they comment that some aspects, especially development and merging of the monitoring system health information system, will take some years to achieve.

Their report includes 12 recommendations spanning the policy, programme and operational levels. They address aspects of multi-sectoral collaboration, increasing effectiveness of integration of nutrition into other service areas, strengthening of particular NNS components and for strengthening overall programme coverage. The reader is referred to their report for details. Importantly they include recommendations related to strengthening staff capacity at district, Upazila and Community levels.

Table: Outputs under the HPNSDP as of 30 June 2012

<table>
<thead>
<tr>
<th>OP Indicators</th>
<th>Baseline</th>
<th>Target Mid-2014</th>
<th>Achievement (July 2011-June 2012)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coverage of Vitamin A Capsule administration among 6-59 months children</td>
<td>90 %</td>
<td>90%+</td>
<td>90% (Administrative)</td>
</tr>
<tr>
<td>% of community clinics having stock of a) vitamin A capsules and b) iron-folic acid tablets</td>
<td>0%</td>
<td>40%</td>
<td>100%</td>
</tr>
<tr>
<td>Management of SAM by establishing SAM management system (hospitals in 200 priority Upazilas)</td>
<td>NA</td>
<td>18</td>
<td>38%</td>
</tr>
<tr>
<td>Percentage of UHCs having a functional Nutrition Corner established</td>
<td>5%</td>
<td>60%</td>
<td>5%</td>
</tr>
<tr>
<td>Number of CC workers trained in nutrition services delivery</td>
<td>n.a.</td>
<td>27000 (60%)</td>
<td>16778 (62%)</td>
</tr>
<tr>
<td>Number of MOs trained in nutrition services delivery</td>
<td>0</td>
<td>482</td>
<td>1568</td>
</tr>
<tr>
<td>Number of school/madrasa with teachers receiving orientation on Nutrition education</td>
<td>NA</td>
<td>10%</td>
<td>480 teacher’s (30 districts)</td>
</tr>
<tr>
<td>Training of HI/AHI on IDD</td>
<td>NA</td>
<td>50%</td>
<td>839 ( %)</td>
</tr>
<tr>
<td>Observance of National Breastfeeding week (Campaign promoting breastfeeding conducted during National BF week)</td>
<td>Yes, by DGHS</td>
<td>Yes, all stakeholders under MOHFW</td>
<td>Yes</td>
</tr>
<tr>
<td>% of pregnant women at the community clinics counselled on exclusive breast feeding up to 6 months followed by appropriate complementary feeding at 6 month</td>
<td>0%</td>
<td>50%</td>
<td>No information available</td>
</tr>
<tr>
<td>% of Upazilas providing monthly progress report on nutrition services according to data quality assessment protocol</td>
<td>0% (HIS)</td>
<td>100%</td>
<td>Plan has been agreed</td>
</tr>
<tr>
<td>Nutrition implementation committee headed by DGHS established and meetings held to monitor nutrition activities in the concerned LDs (DAAR indicator)</td>
<td>NA</td>
<td>2 mtngs/year</td>
<td>2</td>
</tr>
</tbody>
</table>

Source: Khan AR, van der Veen A

SUN is an international initiative that aims to bring together a coalition of international and domestic partners with an interest in nutrition to intensify efforts to address under-nutrition. Bangladesh was one of the earliest countries to sign-up to the SUN initiative. In his assessment of progress towards achieving the SUN aim Mousseau noted some successes in Bangladesh engaging a range of stakeholders including development partners, government agencies and civil groups, and increasing

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14 Mousseau F (2012)
a profile for nutrition issues. However he identified particular weaknesses in terms of public support, effective surveillance, and human resources and capacity. Good coordination, integrating between sectors and adequate financing were also rated poorly.

Clearly there is a lot of overlap from these reviews in the achievements noted, and priorities for areas to be addressed. We discuss relevant aspects in the sections that follow.

**Agenda setting and coordinating capacity**

The background documents show a strong rationale in support of the selection of interventions to directly address nutrition in the NNS and the focus of nutrition-sensitive initiatives in other sectors. The recent analyses presented in the “State of Food Security & Nutrition in Bangladesh 2011” support the agenda but, importantly, also add to it by documenting diversity in the nutrition situation across the country – diversity in terms of nutrition outcomes, diversity in the conditions associated with them, and seasonal changes in many of these. Experience has shown that a capacity to review and analyse the local context, and to adjust inputs and programme activities, is required to be effective. A “one-size-fits all” approach rarely works.

The most recent Bangladesh Demographic and Health Survey (2011) also shows a worrying level of overweight and chronic disease risk factors in the population. While these are not yet at a level to change the core priorities of the nutrition agenda, a similar trend associated with socio-economic changes in other countries has led to an increased diversity in the nutrition situation, and the need for more tailored responses to local circumstances – as shown in Indonesia.

The necessity to respond to this diversity in local conditions helps to further develop the requirements for nutrition capacity:

- Coordination – not just to inform others of activities underway, but also to adjust agendas and activities to meet different or changed conditions in particular areas, while delivering the same nutrition messages and set of core interventions everywhere;
- Information systems that pick up key aspects of the context in local areas, as well as programme inputs, outputs and outcomes;
- A capacity to analyse this information, and the nutrition context, and identify agenda and programme changes needed in a timely manner; and,
- Decision-making authority to make the changes needed.

The specific types of capacity needed to address these nutrition issues at a population level are generally referred to as **Public Health Nutrition** for those working in the health sector, and **Public Nutrition** for those working in other areas of public policies and programmes that affect nutrition outcomes. Both involve the skills and perspective to analyse the nutrition situation in communities, and to plan and manage nutrition programmes with an emphasis is on promoting good nutrition and disease prevention.

Mason et al (1996) have characterised Public Nutrition as the “field of study that deals with nutrition-related population problems and public policies and programmes to address these … with

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15 JPGSPH, HKI (2012).
many of the topics of relevance going well beyond the sole domain of public health”. Pérez-Escamilla and King extend this to specify three steps involving “1) the discovery and characterization of the problem, 2) addressing the problem through multisectorial initiatives, and 3) determining if the problem was properly addressed”. We use these as points of reference in the following sections.

**Policy context**

Bangladesh has a relatively strong policy mandate for food and nutrition, as reflected in the following list of nutrition related policy instruments.

<table>
<thead>
<tr>
<th>Policy instruments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Declaration on the Right to Development (1986)</td>
</tr>
<tr>
<td>National Plan of Action on Nutrition (1997)</td>
</tr>
<tr>
<td>National Food and Nutrition Policy (1997)</td>
</tr>
<tr>
<td>National Food Policy (2006)</td>
</tr>
<tr>
<td>Country Investment Plan: agriculture, food security and nutrition (2011-2016)</td>
</tr>
</tbody>
</table>

The 1997 National Food and Nutrition Policy is the current national nutrition policy. The National Food Policy and related plans are reported to provide a comprehensive approach to address food insecurity through action on food availability, access to food and utilisation of food. The policies cover some of the components of the 1997 National Food and Nutrition Policy. Because of this, changes in the food and nutrition situation, and in organisational arrangements in the government, the 1997 policy is quite outdated and should be revised. Without it, the policy mandate for action on nutrition issues is weakened.

Some informants argued that revision of the policy will provide a basis for updating the terms of reference for the Bangladesh National Nutrition Council (BNNC) andreactivating the committee. This was previously chaired by the Prime Minister and provided coordination at the highest level. It would address some of the nutrition governance issues raised in recent reviews if achieved. However as pointed out by Taylor, an assessment of the BNNC in 2003 judged that the Council was hampered by having the mandate without power to coordinate, including not being able to put in place the implementation, monitoring and evaluation guidelines required to achieve accountability.

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18 Pérez-Escamilla, King (2007).
19 Mousseau F (2012).
20 Taylor, L (2012).
Revision of the 1997 policy was recommended in the recent Annual Programme Review of the NNS\(^{21}\) and appears likely to be progressed in the medium term. Reactivation of the BNNC should include appropriate empowerment of the Council.

**Programme context**

The primary national programme that directly addresses under-nutrition is the National Nutrition Services (NNS), introduced in 2011 and implemented through the Ministry of Health and Family Welfare (MOHFW). Other initiatives aim to indirectly affect nutrition outcomes through action on food insecurity, social protection and women’s empowerment, and are implemented through the other ministries represented on the National Steering Committee for Nutrition.

The NNS strategy is to “mainstream” nutrition services; that is, providing the activities through routine programmes offered by the Directorate of Health Services (DGHS), the Directorate of Family Planning (DGFP) and Community Health Providers. In addition, some components of the NNS are to be implemented outside the mandate of the health sector; in agriculture, education and women and child affairs; these will be described in more detail later. Implementation through the existing health sector channels has the potential to reach all rural areas of the country, with other arrangements made to cover the major urban areas. The interventions selected are consistent with international best practice, targeting the first 1,000 days of life, and are expected to significantly lessen the extent of under-nutrition if effectively implemented.

In practice the majority of these services are provided at the community level through the community based health workers (Community Health Care Providers, Health Assistants, and Family Welfare Assistants), with doctors and nurses at the district and upazila levels also having specific responsibilities. The NNS Operational Plan lists 16 programme components for the DGHS, 8 for the DGFP, and 8 multisectoral, and specifies programme managers and lines of responsibility. These are being implemented in the Plan through the following 10 clusters of “priority” activities:\(^{22}\)

- NNS mainstreaming and programme management;
- Growth monitoring and promotion;

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\(^{21}\) Khan AR, van der Veen A (2012a).

\(^{22}\) Khan AR, van der Veen A (2012a).
• Vitamin A supplementation of children 6-59 months
• Iron-folate acid supplementation for pregnant and lactating women and adolescent girls
• De-worming of children (1-5 y) and adolescent girls
• Management of severe malnutrition (facility and community)
• Promotion of use of iodized salt
• Supplementation of other micronutrient (zinc, vitamin D etc.),
• Training and capacity building
• M&E / nutrition surveillance and communication

The Operational Plan covers 2011-2016 and is one of 32 being implemented by the Ministry as part of the Health, Population and Nutrition Sector Development Programme (HPNSDP). The Nutrition Plan was the latest one developed. As per the “mainstreaming” approach, specific nutrition activities, outputs and performance indicators were added to the other Plans where needed.

According to the 2012 Annual Programme Review, a “concerted effort” is needed to strengthen the nutrition indicators to make the nutrition outcomes more visible and to strengthen accountability over these outcomes. Our informants noted that some of this work is already underway.

NGOs are also very active in delivery of nutrition services. Recent mapping showed 24 agencies providing nutrition programmes of various types (e.g. Alive and Thrive; FHI360; SCF Project Thousand Days; SPRING; FAO/UNICEF supported interventions). Particular areas frequently have more than one agency working there, including 7 Upazilas with 4-7 agencies implementing programmes there.

It is planned to progressively scale-up the NNS over the 5 year funding period. In recognition of the challenges in scaling up a new set of activities and to quickly achieve large scale population coverage, the MOHFW has elected to initially focus on areas not currently well-served by NGOs, and to contract NGOs to provide services to hard-to-reach and urban populations.

It was clear from the interviews that, even with the more focussed coverage, and the achievements in training and capacity building reported in the Annual Programme Review, limited staff capacity was a significant constraint. This was raised in two ways:

• Inadequate training, supervision and support of staff at district, upazila and community levels, to undertake their responsibilities according to the Operational Plan
• A lack of Public Health Nutrition and Public Nutrition knowledge and expertise in the Health and other sector ministries respectively

A core concern of many was that the dominance of medical officers in supervision and implementation of the NNS led to a focus on the curative aspects of NNS. Even with this the treatment of severe and acute malnutrition was reported as frequently inadequate.

**National coordinating mechanisms**

Lack of coordination was raised as a significant issue in both source documents and interviews. Core to this is coordination and leadership for nutrition across government agencies to ensure appropriate and complementary activities. However poor coordination amongst donors and development partners has also led to some fragmentation of efforts.

One of the four specific objectives of the NNS is: “To develop and strengthen coordination mechanisms with key relevant sectors (especially Ministry of Food and Disaster Management, Ministry of Agriculture, Ministry of Women and Children Affairs, Ministry of Information, Ministry of
Education, Ministry of Livestock and Fisheries, Ministry of Local Government and Rural Development and Cooperative, etc.) to ensure a multisectoral response to malnutrition.”

Establishment of the multi-stakeholder National Steering Committee for Nutrition and the Nutrition Task Group directly addressed earlier criticism about inadequate mechanisms for coordination across sectors and within the MOHFW.
The formal structures for coordination across the nutrition agenda are listed in the following table.

<table>
<thead>
<tr>
<th>Nutrition related committees and other structures</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bangladesh National Nutrition Council (chair – Prime Minister) inactive in recent years</td>
</tr>
<tr>
<td>National Steering Committee for Nutrition (chair Senior Secretary for Health, 13 Ministries)</td>
</tr>
<tr>
<td>Nutrition Task Group, HPNSDP (chair Senior Secretary, co-chaired by representative of a Development Partner; to oversee nutrition programme planning and monitoring)</td>
</tr>
<tr>
<td>Food Planning and Monitoring Committee (Cabinet level committee, chaired by Minister of Food)</td>
</tr>
<tr>
<td>Food Policy Working Group (an inter-ministerial group to facilitate implementation of the National Food Policy and its associated Plan of Action)</td>
</tr>
<tr>
<td>Food Planning and Monitoring Unit acts as a secretariat to this committee</td>
</tr>
<tr>
<td>Thematic Teams (organised according to the three dimensions of food insecurity to facilitate cross-sectoral collaboration)</td>
</tr>
</tbody>
</table>

Comments from our informants suggest that the situation has improved but that these committees are still establishing their ways of working with many of the basic agreements still being negotiated – that is, agreeing on common agendas, and an agreement to adjust agendas and activities to meet local needs. As argued earlier, these agreements are core to effective coordination and need to be in the work programmes of the committees.

**Recommendations: Nutrition Task Group**

- We confirm the need for coordination amongst the development partners. In the first instance this should focus on a common nutrition agenda, but this should be extended to include common sets of nutrition indicators and other project/programme elements that will better align the activities supported by the agencies.

The limited expertise in public health nutrition across ministries appears to be a significant constraint to coordinating agreed cross-sectoral approaches to reduce malnutrition. We expand on the expected roles and responsibilities of non-health sector ministries later in this report under the section “Nutrition Capacity in Other Sectors”.

The Institute of Public Health Nutrition (IPHN) in the MOHFW was the only government agency identified as having a group of staff with nutrition expertise. The IPHN was originally established as a technical agency in the MOHFW to advise on nutrition-related issues, and to represent the ministry in international technical bodies dealing with nutrition. With introduction of the NNS the IPHN now also has oversight responsibility for implementation of the programme. From our analysis, and that of others, the IPHN has challenges both in terms of its positioning and capacity.

The IPHN does not chair any of the coordination committees listed above, although the Director of IPHN is member secretary of the National Steering Committee for Nutrition. The outcome is that the

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23 IPHN (2013).
committees have limited input from the only unit in the country with a group of nutrition specialists, which is also the unit tasked with accountability for implementing the NNS. One of our informants described the IPHN as “almost isolated”. This is a major barrier to an informed analysis and discussion of the nutrition agenda and how it could or should respond to changing or different circumstances.

IPHN has also had challenges adapting to its new responsibilities for the NNS. Informants described it as having a “mandate without capacity”. Indeed interviews with IPHN representatives raised issues about capacity in core areas including managing the budget processes required by the HPNSDP and information systems, and with limited capacity to provide input to nutrition sensitive activities in other sectors. UNICEF has recently had positions for consultants approved to provide management support including in these areas, with WHO also providing support for information systems. However development of capacity and task-specific expertise amongst the IPHN staff remains a priority. With the major changes to IPHN responsibilities it is timely to review the current staffing of the Institute and to identify expertise needed, with the aim of developing a new vision and structure for IPHN capacity.

One informant also noted that in spite of these challenges, IPHN had achieved a lot in the rollout of the NNS so far, and needs to become more able to “sell its successes” as part of a longer term process to position themselves and their achievements as the key coordinating body for nutrition.

Recommendations: Institute of Public Health Nutrition

- We confirm the need for appointment of consultants to develop management and information systems for the NNS in the Institute and to provide a capacity for these in the short-term;
- Review IPHN responsibilities, capacities and staffing requirements as a basis for identifying further short-term needs and establishing a medium term strategy to reposition IPHN;
- Study tour for senior IPHN staff, with priority to countries with health systems that take a preventive approach to nutrition, have well-developed community-based nutrition, and have largely non-medical nutrition workforces (potentially Thailand and Indonesia);
- Masters level training in public health nutrition for a group of mid-level staff in IPHN to develop public health nutrition understanding and capacity in the organisation;
- Identify other specialist capacities (nutrition and administrative) needed in IPHN and implement a plan to send mid-level staff for short term training and/or develop specific on the job training.

24 Support from UNICEF in process
25 Two universities with relevant expertise are the Institute of Nutrition at Mahidol University (INMU), and the SEAMEO-RECFON Centre at the University of Indonesia; a number of suitable programs also exist in UK, Australia and the US. It is expected that identification and development of relevant courses and opportunities will be part of the broader regional response to these capacity needs assessments.
26 We note that Annex 21 of the NNS-OP indicates plans and estimated funding requirements to support overseas training of 30 students to diploma level (short course study) 22 students to Masters level and 3 students to PhD level. Our recommendations for IPHN and training for staff at the Upazilla level will involve a substantial increase in these numbers, discussed later in the report.
Outside of the MOHFW, the only other significant nutrition expertise appears to be in the Food Planning and Monitoring Unit, Ministry of Food and Disaster Management. Discussion with informants suggests that it is frequently unclear who has carriage of nutrition within most ministries. Coordination between ministries implementing nutrition-sensitive activities would be strengthened by appointment of an identifiable ‘Nutrition Node’ in each of the core ministries. We return to this in the discussion of nutrition capacity.

**Local coordinating mechanisms**

Bangladesh has a highly centralised structure for decision making across all of the ministries involved with nutrition programmes. Decisions on staff positions and appointments, procurement and other core programme matters are made centrally with limited ‘decision space’ at lower levels. This is a significant barrier to effectively adapting programme strategies and elements to local conditions, but is unlikely to change in the near future. The outcome is that any local coordination is based on information sharing and coordination of efforts between government officers at district, upazilla and community levels, with few formal mechanisms to achieve this.

**The nutrition workforce and capacity in the health sector**

The main workforce capacity barriers to effective implementation of the NNS that were raised in the APR report and during interviews were:

i. The absence of public health nutrition/ public nutrition specialists and focal points (nutrition nodes) within the public sector (health and nutrition-sensitive programmes),

ii. The gaps in current MOHFW staffing generally; a high vacancy among all classes of medical posts and a related lack of time for existing staff to undertake additional responsibilities,

iii. The parallel lines of authority, supervision and responsibilities within the health service, which makes coordination and accountability for implementation of the NNS challenging.

This section reviews the organisation and nutrition responsibilities of the MOHFW workforce tasked with implementing the NNS. The Ministry provides most services under the responsibility of two Directorate Generals; Health Services (DGHS) and Family Planning (DGFP). There is a third channel responsible for Community Health Providers (CHP), providing health, population and nutrition services from a community base. An organogram summarising the lines of responsibility for the NNS is included as Annex B.

Annex C positions the workforce involved with implementing the NNS according to the type of intervention, the service delivery programmes within which it is being mainstreamed, the core nutrition activities to be implemented and associated responsibilities for implementation and overall supervision/accountability.

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27 Note: “public health nutritionist” (for workers in the health sector) and “public nutritionist” (for workers outside the health sector) are being used as a distinction from more clinically-based nutrition, which makes up the majority of current nutrition expertise in Bangladesh. The former are expected to have a strong field presence and a focus on cross sector interventions primarily to prevent, rather than treat, malnutrition. See Mason et al (1996).

28 Health Bulletin (2012), (slides 13, 14, 16).

29 The organogram for both Directorates at district level and below are well-described in: Mridha, Anvar, Koblinsky (2009).
Annex D provides a listing of health staff type with activities by health sector level, from community to national (including urban), along with the immediate lines of supervision. This table also gives an indication of the numbers of each personnel type within the public service in Bangladesh, the type of pre-service and/or in-service training each staff type is expected to receive, an estimated cost of the training and the typical career path expectations\textsuperscript{30}.

*At all levels it is unclear whether staff of a similar level, e.g. HA and FWA, conduct the same or different activities in the same or different areas. Whichever mechanism is in place, there will be consequences in terms of supervision, reporting and accountability.*

**Health and Family Welfare Workforce Responsible for National Nutrition Services**\textsuperscript{31}

To summarise Annexes C and D, we present below a brief outline of current health staff by facility level. A description of current achievements and plans to develop the nutrition capacity of this workforce is provided, followed by an analysis of potential capacity-related challenge areas and recommendations for addressing at least some of these.

1. **Line Director**
   Capacity in public health nutrition at the Line Directorate level exists but is not consistent across staff; which is comprised mainly of medical staff who have varying levels of post graduate or on the job training in nutrition.

   The overall leadership of NNS will be provided by the Line Director (LD), NNS who is the Director, Institute of Public Health Nutrition (IPHN). IPHN is, as mentioned in a previous section, tasked to oversee the delivery of the programme, manage the budget and procurement, liaise with other LDs of DGHS and DGFP implementing nutrition activities, coordinate with NGOs and other stakeholders, develop and establish a monitoring and evaluation system, and plan for capacity development of implementing staff\textsuperscript{32}.

   The shortfall in staff and capacity at the IPHN have been referred to briefly in the previous section on National Coordinating Mechanisms. It is of particular note that, despite the importance of the current role of IPHN as overall Line Director for the NNS, the Deputy Director position of the institute is currently vacant. As shown in Annex B, this position has a key role in NNS implementation, as direct line manager for the five programme management units under IPHN.

   Within IPHN itself, there is a recognised need for additional capacity to manage processes that are felt to currently be relatively under-resourced at the Institute, e.g. procurement, financial management of GoB and of foreign aid funds, behaviour change communication and research.

2. **Division Level – Facility based healthcare: Medical College Hospitals**

   Medical College Hospitals providing tertiary health care are located across Bangladesh’s six divisions. A wider range of specialist care is available at this level and these hospitals

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\textsuperscript{30} Personal communication with various stakeholders & Health Bulletin (2012), (slides 10 & 11).

\textsuperscript{31} Information from the Operational Plan for Nutrition Services 2011-2016, the Health Bulletin 2012 and from interviews.

\textsuperscript{32} MOHFW (2011).
function as referral institutions for the districts. The divisional health authority is the functional unit at the divisional level headed by a divisional health director\textsuperscript{33}.

Annex 14 of the NNS-OP refers to the establishment or strengthening of a Nutrition Unit at all Division, District and Upazila centres, which, if positioned as a field-based public health nutrition unit, was regarded by many of our informants as key to successful implementation of the NNS.

3. District Level – Facility based healthcare: District Hospital (DH), Maternal and Child Welfare Centre (MCWC) and Medical Colleges

The district level health facilities are mandated to provide access to all the nutrition interventions listed in the NNS Annex C and to support, supervise and monitor activities at the Upazila level and below. Although the DH holds a critical position in ensuring the effective implementation and management of NNS activities, there is currently no specific nutrition expertise at this level. There is, however, the prospect that a nutritionist may be appointed at the district level in the longer term\textsuperscript{34}. This will be discussed in more detail at the end of the section.

Currently most staff at the district level are medically trained; medical officers, specialists and nurses under DGHS and DGFP. The Civil Surgeon is the Health Manager and has responsibility for development and administration of health services in the district. Important personnel of this office include Medical Officer, Health Education Officer, EPI Supervisor, Sanitary inspector, Health Superintendent, Public Health Nurse, etc. On the other hand, Deputy Directors are the district Manager under DGFP.

4. Upazila (sub-district) Level - Facility based healthcare: Upazila Health Centre (UHC)

The NNS-OP outlines the process by which one of the UHC Medical Officers (MO) will be trained and tasked with responsibility for overseeing the delivery of health centre-based nutrition services in the UHC. An additional role for this MO (public health and nutrition) will be monitoring the implementation of nutrition interventions in all Unions and Community Clinics (CC) within the Upazila. It is stated that the focus of the position will be on health centre-based activities. In the same way as the district hospitals, there is a high level plan to appoint 500 nutritionists to work at the Upazila level across the country. Issues and recommendations related to these two roles are discussed later in the section.

The Upazila Health and Family Planning Officer (UHFPO) has overall responsibility for the delivery of health and nutrition services in the UHC.

5. Union Level – Facility based healthcare: Union Health and Family Welfare Centre (UHFWC)

Union level has two types of centres, one under DGHS and one under DGFP with a difference in staffing patterns.

The Medical Officer (Public Health and Nutrition) at the UHC level will visit UHFWCs to supervise and support staff assigned to the delivery of nutrition-related services. There is a

\textsuperscript{33} Islam, Ullah (2009).

\textsuperscript{34} The decision of the Honourable Prime Minister (as per Her letter of 8th March 2011) to appoint a nutritionist in all district and UHC hospitals. Khan, van der Veen (2012a).
recognised problem of absenteeism of higher level medical officers at these lower levels of health care, although the Government is implementing measures to try and address the problem.

6. **Community Level – Facility based healthcare: Community Clinic (CC)**

The CC is the focus for delivery of most of the 32 health OPs and, therefore, there are many competing priorities for the time of the health care workers: a Health Assistant (HA), Family Welfare Assistant (FWA), and Community Health Care Provider (CHCP) who are also responsible for delivering nutrition services. The CHCP is joined at the CC by the HA and FWA for 3 days a week each.

The CHCP is a relatively new position and around 7-8,000 posts are yet to be filled. The impression of some informants was that the CHCP are better oriented towards nutrition than the HA and FWA, since they have been trained with a nutrition component included from the start. The perception is that the HA and FWA tend to have a longer experience of delivering services in a certain way and may be less keen to take on new responsibilities on top of their existing duties. One well-informed interviewee told us that the CHCP are positioned well within the community; with a designated workspace which gives recognition and respect to their work. The Bangladesh Health Bulletin 2012 indicated that the use of CCs has been increasing; 2011 saw a 36.5% increase in average monthly patient visits to CCs compared to 2010. This highlights the potential pivotal role for the CHCP and the CC in delivering nutrition services to the community.

However, CHCPs are fixed facility-based staff, traditionally delivering limited curative care, whereas FWA and HA have many more staff (approx 40,000 vs 13,500) and more scope to deliver services in the community/at the household as part of group (courtyard) counselling during community mobilisation for immunisation and other services as well as through one-to-one counselling during home visits to pregnant women and new mothers. Therefore, training to transform HA and FWA skills to a more public health nutrition perspective is also important.

The Upazila Medical Officer (Public Health and Nutrition) will be responsible for supervising and supporting the delivery of nutrition services in community clinics, facilitated by the Community Clinic Management Committee in the designated area.

7. **Community Level – Community Based Nutrition (CBN) Service**

CBN services will be delivered by HAs, FWA, CHCP and Community Volunteers in certain areas of the country where the population have been shown to be more vulnerable to malnutrition.

Female community multipurpose volunteers are a new proposed position and are intended to be recruited following a phased approach, with 25% of Upazilas covered in each phase especially in hard to reach areas and where there are no CCs. They will work under the supervision of the CHCP. All staff will receive supervision and guidance from Health/Family Planning Inspectors (HI/FPI) and Family Welfare Visitors (FWVs) to deliver nutrition services along with their other health and family planning responsibilities.
Nutrition activities will be carried out through group (courtyard) counselling and one-to-one counselling during home visits to pregnant women and new mothers.

8. Urban Areas

Health care in urban areas is provided through the Urban Primary Health Care Project (UPHCP) under the control of the Ministry of Local Government. There is, therefore, no direct line of supervision and accountability with the above MOHFW-coordinated system. The NNS-OP states, however, that the NNS will provide technical support to implement and improve nutrition activities in urban areas, in liaison with the Ministry of Local Government.

An important consideration here is that data from UPHCP facilities do not currently feed into the health management information system (HMIS). This link should be incorporated as part of plans to develop and strengthen the nutrition component of the HMIS; there is potential for a wider impact beyond nutrition if health-related indicators are also incorporated.

Public health nutrition expertise and specialists

We have mentioned the dominance of medical officers in the MOHFW. The draft national health workforce strategy reports that “Doctors make up 70% of the total registered professional workforce.”35 In spite of institutions such as the Institute of Nutrition and Food Sciences at Dhaka University having a long history of graduating nutritionists from their programmes very few of them work in the government. We don’t have information on exact numbers working in nutrition in the public sector, however, the Director of the Institute and other informants indicated that most graduates go on to work with agencies, NGOs and within the food industry.

There is a low level of specialist public health nutrition expertise at all levels of the public health service, although there is a history of experience and expertise in clinical nutrition. We pointed earlier to the need for a capacity to review and analyse the local nutrition context, and to adjust inputs and programme activities. While supervisors from the central and district levels will bring experience and some capacity to cover these responsibilities, in a country with such diverse nutrition situations and stages of nutrition programme implementation, the staff with nutrition programme responsibilities at upazila level have a critical role in support of the nutrition activities and should be a target group for capacity development. At the moment this includes only the MO (public health and nutrition), with a plan to appoint nutrition officers to be based in hospitals at district and upazila levels.

Appointment of nutritionists at these levels will provide a most important addition to the nutrition-specific expertise needed to support the NNS. However a range of questions were raised during discussions about the positioning and role of the nutrition officers. A particular concern was the extent of clinical responsibilities of the positions. The major gain for the NNS will be through establishing these as predominantly public health nutrition positions. Well-placed informants were confident that this will be achieved. Our recommendations are framed to strengthen this capacity.

The role and responsibilities of the MO (public health and nutrition) relative to those of the nutritionist are not well described. While it is expected that the two officers will have different types of responsibilities, we recommend providing the same training opportunities to both groups to

35 MOHFW (2012b Draft).
strengthen public health nutrition capacity and to develop similar understandings and approaches to programme management and strategies for addressing under-nutrition. Graduate certificate programmes (three months) are generally sufficient for this purpose. These are a new set of professionals in the health system with the challenge of establishing their roles and professional identities. The cohorts sponsored for external training need to be large enough to establish the basis for a professional public health nutrition network and to relay their expertise to others in the same role. Based on reports of usual staff transfer procedures within the health service, it is expected that the MO will be transferred on a regular basis. We suggest that these specialist MO positions be tracked and transfers made on the basis of strengthening nutrition expertise in the division/district of transfer. We recommend also initially sponsoring professional development activities to raise the profile of public health nutrition, and provide a basis to sustain the public health nutrition network.

**Gaps in current MOHFW staffing, and lines of authority, supervision and responsibilities**

The NNS-OP acknowledges the relatively weak nutrition capacity within the public sector in Bangladesh and includes an outline plan for training and capacity building in the following priority areas: mainstreaming nutrition, maternal nutrition, infant and young child feeding and severe acute malnutrition (SAM) and community management of acute malnutrition (CMAM).

As of the middle of 2012 the MOHFW had met or exceeded the targets for training CC workers and MOs in nutrition services delivery, and with orientation of teachers. Annex E describes in more detail, the Nutrition Training Plan for all levels, from policy down to the community level.

In a recent study of experience in mainstreaming nutrition activities across five countries, including Bangladesh, Pelletier et al pointed to the need for strengthening strategic capacities. They particularly identified workload, incentives, skills, supervisory capacity and support to problem-solve programme issues. The Training Plan and related activities in the NNS-OP clearly provide an orientation and develop some core skills for existing staff, but is less clear on the follow-on and support required to achieve behaviour change and ensure programme quality. Further the apparent overlapping workforce structure and responsibilities between DGHS, DGFP and PD-CC which makes it difficult to determine accountability for some of the nutrition-related activities and supervision responsibilities. Discussion with informants suggests that much of this remains to be developed.

**Recommendations: Nutrition Officers, and MO (public health and nutrition)**

- Establish the Nutrition Officer as a non-clinic based public health nutrition manager with the skill and authority to actively manage a range of, mainly community based, interventions to improve nutrition (in line with NNS activities). Key to this will be coordination with the MO (public health and nutrition) the positioning and wording of the job description – tasks, line management, supervisory & mentoring role.

- Develop competency statements for the Nutrition Officer and MO (public health and nutrition) positions to reflect the public health nutrition content of their roles; this provides a signal to the staff, the organisation and educational institutions concerning the core skills required.

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• Ensure that the recruitment procedure is skills based; with a good understanding of and experience in the field of public health nutrition, strong managerial and data management skills and the necessary level of authority to coordinate personnel under different directorates and ministries.

• Establish opportunities for a significant group\(^\text{37}\) of the Nutrition Officers and MO (public health and nutrition) to undertake graduate certificate programmes (3 mo) in institutions that can offer programmes to develop public health nutrition skills, together with national nutrition programmes that use community based and preventive strategies, and a non-medical workforce\(^\text{38}\).

• Foster the professional public health nutrition network through sponsoring initiatives such as public health nutrition sessions in national conferences of the most relevant professional associations (nutritionist/public health).

**Recommendations: Strengthening and supporting NNS services**

The specific nutrition-related functions of community, union, upazila, and district level staff should be further clarified and guidelines on core competencies and related task-specific training, supervision and on-going development prepared as relevant to each post.

• Determine specific role-related training needs additional to those already conducted/planned (e.g. counselling skills, community advocacy, field based public health nutrition, being able to use data, planning);

• Determine the set of core nutrition messages for education and advocacy across all levels and staff types;

• Identify and develop task-specific job aids to facilitate work – not necessarily paper-based materials; investigate eHealth-related opportunities to empower community workers and the community through access to portable, interactive job aids and other material;

• Trial different models of ongoing training, types of support and supervision for different levels and personnel type to determine the most effective options;

• Establish a system and accountability for provision of these activities, including standardised monitoring of activity implementation, on-going support.

**Nutrition capacity in other sectors**

As mentioned in the section on National Coordination mechanisms, the Food Planning and Monitoring Unit, Ministry of Food and Disaster Management, is the main additional national level body with nutrition-related expertise and responsibilities. The National Food Policy plan of action (2008-2015) contains a number of objectives that overlap with those of the NNS, including supplementation, fortification, nutrition education on dietary diversification and promotion of appropriate infant and young child feeding practices. In addition, key nutrition-related objectives are described for improved “Effectiveness of Targeted Food Security Programmes and Other Safety

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\(^{37}\) The numbers that should be trained are difficult to estimate at this stage, but need to be large enough to establish the basis for a professional public health nutrition network and to relay their expertise to others in the same role.

\(^{38}\) The Institute of Nutrition at Mahidol University (INMU), and the SEAMEO-RECFON Centre at the University of Indonesia could potentially provide these programs.
Nets”\(^{39}\). The policy document outlines the need for better coordination between programmes supported/implemented by various partners that include: Ministry of Food and Disaster Management, Ministry of Women and Children Affairs, Ministry of Health and Family Welfare, Ministry of Agriculture and Ministry of Local Government.

Some of the other ministries with nutrition or key nutrition-sensitive activities and interventions are:

- The Ministry of Education; a School nutrition education programme which is important for raising awareness about nutrition among primary and secondary school students and also for provision of iron folic acid tablets and deworming medication to adolescent girls. The NNS provides training and technical assistance for nutrition education, including on school gardening and healthy diets for school children and their caregivers, and school and community support for healthy eating and physical activities. Obesity is an emerging problem in Bangladesh. Many children in urban school are overweight. NNS will work with the Ministry of Education to formulate diets designed to: “with exercise, keep a person’s weight under control allowing them to enjoy healthy and active lifestyle”.

- The Ministry of Industry; salt iodisation is coordinated through the Bangladesh Small & Cottage Industries Corporation (BSCIC) – USI

The gap in coordination between these ministries at the national level is acknowledged in NNS planning and operational documents. The Food Planning and Monitoring Unit is FAO supported and focused on food security, it is reported that few of the ministry employees have nutrition or public nutrition expertise. Developing such expertise will be essential for informed analysis and decision-making in this critical role.

As mentioned previously, coordination between ministries implementing nutrition-sensitive activities would be strengthened by appointment of an identifiable ‘nutrition node’ in each of the core ministries. This need not be a nutritionist per se in each ministry, but having a person designated with this responsibility would provide a clearer basis for linking and coordination across ministries at an operational level. Similarly, replicating this at district and sub-district level would greatly enhance capacity for coordinating planning and activities at these levels.

### Recommendations: Strengthening capacity in other ministries

- Identify senior staff in each of the ministries involved with the main nutrition-sensitive programmes to take on responsibility of being “nutrition nodes”; as well as being points of contact these staff could be targeted for professional development opportunities related to their public nutrition responsibilities.

- Establish nutrition nodes amongst the non-medical public sector working at the district and upazila levels, to coordinate with the Nutritionist and/or Medical Officer (public health and nutrition) at these levels.

- Advocate for a relevant set of nutrition outcomes in all related programmes, projects, and monitoring systems, as well as reviewing where the public nutrition component of formal pre- and in-service education could be strengthened.

\(^{39}\) Ministry of Food and Disaster Management (2008).
Education and training in public health nutrition

The above sections on current workforce capacity highlight the need to strengthen public nutrition expertise across the health sector and in relevant sections outside the health sector. We have identified 4 broad opportunities to improve this capacity in the future, which are:

- Pre-service training for all health personnel and others from the non-health sector who are likely to be involved in coordinating, implementing and/or monitoring the NNS activities.
- In-service training for existing health (and other) staff who are being requested to include NNS activities within the terms of their job descriptions.
- On the job support and mentoring, in a less structured but more needs-specific manner than pre- or in-service training.
- More effective placement and utilisation of existing nutrition graduates.

Education and training activities covered in the NNS-OP focus mainly on in-service training. However, in the medium and long-term, pre-service training as well as additional in-service training of the range of staff involved with NNS activities will have an important influence on the knowledge and skills that staff bring to their positions. We discuss here the nutrition content of programmes currently offered in Bangladesh and the opportunities to strengthen expertise relevant to public nutrition in the current and future workforce.

We were not in a position to undertake a detailed analysis of the content of these programmes, but found that the nutrition programmes/specialisations offered seemed to provide a general grounding appropriate to working in public nutrition. It is expected that the public nutrition components of these programmes will be strengthened once the career paths and job opportunities become better established, and public nutrition competency statements are available. The issue of appropriate placements and applied research opportunities for students in these programmes is discussed.

Degree programmes for nutritionists or with nutrition specialisations

The main programmes in Bangladesh with specialisation in nutrition are provided by the Institute of Nutrition and Food Science (Dhaka University), colleges with home economics programmes, and a nutrition specialisation in Master of Public Health programmes offered.

Institute of Nutrition and Food Science (Dhaka University)

The INFS offers a four year Bachelor of Science (Hons) degree and a one year Master of Science. Unfortunately we were unable to view detailed descriptions of the curricula of these programmes. Information available on the INFS website suggests that the programme covers many aspects of public nutrition, and certainly many of the Institute staff have relevant expertise. But we cannot determine whether or not all graduates complete their programmes with a sound foundation in these areas.

It is useful to note that few graduates currently progress to work with government agencies. There are a range of possible reasons, including few opportunities for employment as a nutritionist. This may change when the new nutrition officer positions are established.
IFNS has recently reactivated a three month graduate certificate in nutrition education, commencing June this year. This will likely meet the needs for some professionals but does not address the broader requirement for public nutrition expertise.

**Home economics programmes**

Three government and two private colleges offer degrees in home economics. All government programmes follow the same curriculum, with no such requirement for the private colleges. The curriculum from the Bangladesh Home Economics College is included as Annex F. The range of courses and list of topics covered suggest that graduates should have a reasonable grounding in public nutrition at graduation. Topics offered for any research projects in the programmes are unclear. Each of the three government colleges has 50-100 graduates each year.

**NIPSOM and other public health programmes**

NIPSOM is the main government institution offering postgraduate courses in public health, with a total of three government institutions accredited by the MOHFW to offer such programmes. Nineteen other non-government institutions also offer public health programmes but are accredited by the Ministry of Education / University Grants Commission and have no requirement to follow the same curriculum. About a third of these are recognised by the Bangladesh Medical and Dental Council (BMDC), the main national accrediting agency for medical education.

NIPSOM offers a total of eight specialisations in the Master of Public Health (MPH) and one Master of Philosophy programme in Preventive and Social Medicine (PSM). Nutrition is one of the core courses for all of these programmes and provides a generalist background in nutrition. An MPH (Nutrition) was introduced 10 years ago as one of the specialisations in the MPH. It has an annual quota of 5 seats reserved for government officers (i.e. fees paid and salary continued), with the course open to others on a fee-paying basis. The course has been targeted at medical officers but is open to graduates of other programmes as of this year. There is a total of approximately 50 graduates from the specialisation so far.

The MPH (Nutrition) is introducing a new curriculum in 2013 with a duration of 18 months, compared with the previous 12 month duration. The list of topics and courses suggests good coverage of topics relevant to public nutrition. The research project is a major component of the programme. Discussion on project topics suggests that many students focus on clinical rather than community/population nutrition issues.

**Degree programmes for other health professionals**

**Medical programmes**

Bangladesh has 25 government medical colleges and 50 offered by private medical colleges. They all follow the same curriculum as specified by the Centre for Medical Education (CME), with BMDC as the accrediting body. A common comment during interviews was that the health system in Bangladesh is dominated by medical officers and that, although they receive adequate training in preventive health, they are given little training in applied, public health, nutrition, which has been a barrier to improved delivery of nutrition interventions. Given this context, the revision of the national medical curriculum that is currently underway provides an important opportunity to influence the nutrition knowledge and skills of graduates for the coming 5-10 years.
The new curriculum was signed off on 29th January, but the details of how the specified topics are presented remain to be developed. There is a brief window of opportunity for the nutrition community to advocate and provide technical assistance for strengthening the preventive aspects of nutrition in the curriculum and to incorporate knowledge and skills consistent with what is required to support the NNS.

**Professional development of medical specialists**

Medical specialists can be particularly influential in providing authoritative advice on nutrition issues and establishing modes of practice. For this reason it can be very effective to work with the Bangladesh Paediatric Association and the professional associations of other specialists to include topics relevant to the NNS in continuing professional development programmes and other professional training opportunities. For example, the Society for Gynaecology and Obstetrics developed a IYCN module for an Alive and Thrive project, and this module could be reviewed for inclusion in the new curricula for medical officers and for midwives.

**Nursing**

Seven colleges offer a Bachelor of Science in nursing, with 40+ government institutions offering a diploma programme, and a range of private institutions offering programmes. A new curriculum has been approved for the BSc programmes within the last five years, so there is no opportunity for major changes in the short term. However, we were advised that it is possible to make submissions to the Bangladesh Nursing Council and that the in-service training curriculum for nurses is currently under revision, providing a timely opportunity for inclusion of strengthened public health nutrition modules. The draft national health workforce strategy includes a substantial increase in total numbers of nurses and midwives in the health workforce over the next 20 years. Because of this it will become increasingly important to strengthen the preventive nutrition aspects of the respective pre- and in-service curricula and to incorporate knowledge and skills consistent with what is required to support the NNS.

**Other observations**

International best-practice in university programmes is placing strong emphasis on final year ‘capstone experiences’ where students have the opportunity to apply the knowledge and skills gained in earlier coursework to professional practice. This can especially be a challenge for content areas such as public nutrition where the most relevant practicum / applied research experience would come through involvement with community nutrition projects or programmes. However it is not always easy to make the linkages between the university and the implementing agency, and/or for them to negotiate an arrangement that both meets the university programme needs (appropriate amount of work and level of independence, assessable etc) as well as those of the agency (contributes to their programme, not distracting from core commitments, no additional costs etc). Mechanisms should be explored to link programmes for nutritionists/ nutrition specialisations in a core set of institutions with opportunities for placements and research projects in public nutrition. In the first instance this should be considered for INFS and NIPSOM. Such opportunities

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40 MOHW (2012b Draft).
provide a very useful strategy to strengthen the public nutrition component of programmes and to make graduates more ‘job ready’.

Refer also to the recommendation earlier on competency statements for the nutrition officer and MO (public health and nutrition) positions. In the absence of registration of public nutritionists or public health nutritionists, this provides one of the few mechanisms for providing a clear signal to universities about the knowledge, skills and competencies needed of graduates.

In addition to this, in previous and following sections we note the limitations of the centralised approach to decision making and make recommendations about the potential benefit of increasing analytical skills and related decision-making capacity around nutrition interventions and service delivery at the local level. In line with this, we would again stress the importance of continued, on the job support, training and mentoring for effective application of information received during pre- or in-service training and to develop the capacity of community level staff, based on the local situation and individual capabilities.

### Recommendations: Universities and professional associations

- Take advantage of the current window of opportunity with revisions to the national medical curriculum, the new curriculum for training midwives and to the in-service training for nurses. Use this opportunity to strengthen the preventive aspects of nutrition in the respective curricula and to incorporate knowledge and skills consistent with what is required to support the NNS

- Take advantage of interest from the Bangladesh Paediatric Association and the professional associations of other specialists to support inclusion of topics relevant to the NNS in continuing professional development programmes and other professional training opportunities.

- Establish mechanisms to link educational institutions with nutrition projects and programmes to provide opportunities for appropriate practicum and research opportunities in public nutrition. These should give priority to research that will contribute to strengthening nutrition programmes such as through action and operational research.

- Advocate for changes to programmes offered by educational institutions to meet competency requirements for the Nutrition Officer and MO (public health and nutrition) positions.

### A way forward: area-based projects

UNICEF is well positioned to make progress with a cluster of the initiatives concerning operational aspects of the NNS through its Nutrition Officers based in each of six zones, and the ongoing engagement with both government and NGO nutrition activities at these levels. This provides an appropriate framework and opportunity to trial different approaches to address these recommendations as area-based projects, or through contracting elements as part of new or ongoing projects with NGOs.

Specifically we suggest that the set of recommendations for “Strengthening and supporting NNS services” should be addressed in this way. Establish area-based projects where different systems of NNS implementation can be piloted. At the community level outcomes will provide a better understanding of the demands of the position and core skills needed, identification of task-specific
job-aids, and development of best-practice guidelines for supervision and support. At other levels it will identify requirements and systems for role-specific training, continued mentoring/support, as well as the skills and other requirements for data collection and transfer, problem analysis and evidence-based planning, and job-aids to support these activities.

We suggest that this also provides an opportunity to address the recommendation to establish mechanisms to link educational institutions with programmes. With appropriate guidance and support, the student groups in nutrition programmes and specialisations are in a good position to address many of these questions through action and operational research.

This will fill an important gap in current plans and provide a set of evidence-based outputs that can be promoted for adoption in other locations.

**Expanded recommendations on a way forward**

Annex G details an expanded set of recommendations for potential development of area-based projects to establish a coordinated mechanism to deliver locally-relevant NNS interventions and services and to pilot innovative methods of in-service training and on the job support, with support from zonal UNICEF offices.

The number and location of areas, next steps and timing of implementation need to be decided based on the context of national and local recruitment plans, planned NNS roll out and other opportunities. Training of a core cadre of supervisors and support for development of this approach could potentially be part of a wider regional response to identified public nutrition capacity needs.

**Conclusions**

The purpose of this consultancy was to assess the nutrition capacity in Bangladesh, with particular attention to the ability to mainstream nutrition and implement the NNS. It followed a similar framework as used for capacity assessments conducted in Nepal and Indonesia, with the objective of also contributing to a regional approach to building capacity to plan and implement nutrition interventions. The framework considered factors that affect this capacity at system, organizational and individual levels.

Recent reviews of the nutrition situation in Bangladesh have addressed parts of this framework. The analysis of nutrition governance undertaken by Taylor\(^{41}\) pointed to the need to strengthen coordination at all levels, establish a better basis for ongoing monitoring and evaluation, and the need to raise the profile and perceived importance of nutrition amongst government decision makers and the general community. The Annual Programme Review (APR) of the NNS by Khan and van der Veen\(^{42}\) provided a detailed assessment of the rollout of the NNS. They showed strong progress in the rollout of the NNS but pointed to gaps and barriers in the current plans, and made a range of recommendations to better integrate nutrition into other service areas, and to strengthen components of the NNS. Given this previous work and context, our assessment focussed mainly on development of the workforce and support systems needed to implement the current nutrition services and policies effectively.

\(^{41}\) Taylor, L (2012).

\(^{42}\) Khan AR, van der Veen A (2012a).
Key findings and areas for sets of recommendations were as follows:

**Public health nutrition capacity in the health system** –

The assessment suggests that capacity to implement the services and policies is limited by a lack of public health nutrition knowledge and expertise in the MOHFW, and inadequate training, supervision and support of staff at district, upazila and community levels. As shown in the APR, gaps are evident in the capacity for rollout of the NNS. Any capacity to review and analyse the local nutrition context, and to adjust inputs and programme activities to address differences in the nutrition situation across the country seems particularly limited. In this context the role and capacity of the IPHN at the national level, and the nutrition staff at district and upazila levels are particularly influential and important, as they provide the main specialist nutrition input to policy, planning and implementation.

**Strengthening systems to support front-line health service providers** –

Community level staff are the major front-line service providers for the NNS. While the initial training of the Community Health Care Providers, Health Assistants, and Family Welfare Assistants and their supervisors has been progressing well, the ongoing training and support systems are less well developed. The quality of the services will depend on having a good understanding of their roles, and the appropriateness of the follow-on training, job-aids, supervision and support.

**Public nutrition capacity in other ministries** –

Coordination between ministries and adjustment of nutrition-sensitive programmes to better meet local needs is hampered by the limited nutrition capacity in the ministries, different understandings of nutrition and the factors affecting nutrition outcomes, and differences in information systems, amongst other factors. The earlier reviews have dealt with this more completely and so we have not gone over this again in detail. Nonetheless our interviews showed that there remain issues associated with poor coordination amongst stakeholders at national level, and between ministries at sub-national levels. Some recent progress has been made in addressing this as a result of acting on previous recommendations. We provide some comment on the types of nutrition capacity needed, and identify some of the areas where better linking of programmes and coordination is required.

**Education and training in public nutrition** -

There is an almost total disconnect between the degree programmes being offered for nutritionists/nutrition specialisations and the nutrition capacity in government. Most nutrition programmes appear to provide a reasonable grounding in public nutrition, with several hundred students graduating over the years. However the only nutrition graduates identifiable in government services are medical graduates who have completed the MPH (Nutrition). This is likely to change with nutritionist positions being established at district and upazila levels.

Opportunities have been identified to influence the pre-service training of medical officers, and in-service training of medical officers and medical specialists. In addition, prospects for a regional approach to develop specialist short courses in public health nutrition provide opportunities to increase national capacity to train field staff in this area. We suggest that the Professor James P Grant School of Public Health, BRAC University, could take a leading role in this.
The recommendations

The majority of our recommendations aim to directly strengthen the capacities of the individuals with responsibility for providing nutrition services, and to better orient the systems and organisations where they work. Many of these recommendations require a discrete decision and can be directly implemented if approved. Other recommendations set out an agenda for further development, and we have suggested an area-based approach to progressing these (Annex G).

Key to implementation of our recommendations will be timing and plans for recruitment and training of specialist (public health nutrition) medical and nutrition officers at the district and Upazila levels. If the target is to recruit around 500 of each position at Upazila level then we recommend providing an advanced level of training for at least 10% of these staff, in order for them to subsequently mentor and provide peer to peer training to others in the same role.

In our assessment the timing is good for a strengthened focus on nutrition Bangladesh, and the successes in addressing some of the MDGs suggest that a scaled up effort to address under-nutrition is feasible. However, poor nutrition capacity is currently a major barrier, and is required to effectively implement the current nutrition services and policies.

List of annexes (see separate document)

Annex A – List of people met during the consultancy
Annex B - Organogram for the National Nutrition Services
Annex C - Implementation of specific nutrition interventions – responsibilities & activities
Annex D - NNS Personnel Mapping by Health Facility Level
Annex E - NNS Nutrition Training Plan
Annex F - Bangladesh Home Economics College Food and Nutrition Course Units
Annex G - Expanded Recommendations for Area-Based Approach
References


