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Abstract

In the two decades since 1997, Bangladesh has recorded a sustained reduction in child undernutrition. However, despite the improvements achieved between 2004 and 2016, the decline in stunting has slowed in recent years. To achieve the ambitious World Health Assembly (WHA) targets for stunting reduction by 2025, to which Bangladesh has made a global commitment, the country needs to increase the annual reduction rate to 3.3 percent.

In an effort to accelerate progress toward this goal, the Government of Bangladesh (GoB) approved the Second National Plan of Action for Nutrition 2016–2025 (NPAN-2) in 2017.¹ The Plan aims to improve nutrition and eliminate malnutrition, with a focus on children, adolescent girls and pregnant and lactating women. In the same year, the U.S. Agency for International Development (USAID) awarded FHI 360 the Strengthening Multisectoral Nutrition Programming through Implementation Science Activity (MSNP) to improve the nutrition situation among women and children in Bangladesh.

The five-year Activity will test and refine multisectoral nutrition approaches, interventions and service delivery mechanisms in high stunting areas of Bangladesh. To achieve its goal “Nutrition policymaking and implementation in Bangladesh is informed by high-quality local evidence,” MSNP will strengthen the capacity of GoB stakeholders to collect, interpret, synthesize and utilize existing and project-generated evidence for policymaking, planning and implementation of nutrition programs.

To design strategies for improving the use of multisectoral nutrition evidence, FHI 360 conducted a mapping exercise to determine policymaking and program implementation roles and responsibilities of government and non-government stakeholders. The team then assessed the stakeholders’ capacity to use nutrition-related evidence.

FHI 360 integrated existing mechanisms with the mapping exercise to develop a relevant evidence utilization assessment tool. The tool aimed to analyze evidence-based policy and programmatic decisions of key stakeholders, focusing specifically on four areas: acquiring, assessing, adapting and applying evidence. Using a semi-structured questionnaire, FHI 360 interviewed key government stakeholders and a few non-government stakeholders at national and subnational levels.

Three central themes emerged from the assessment as main obstacles to evidence utilization: (1) human resources, (2) information tools and resources and (3) capacity

¹ Ministry of Health and Family Welfare (MoHFW). Second National Plan of Action for Nutrition (2016–2025); 2017.

development. The significant turnover of government officers contributes to poor capacity for evidence use, while a general lack of human resources was a concern at the subnational level. Most government officers are unaware of or lack the facilities to use resources that enhance evidence utilization, such as tools and databases.

Finally, evidence utilization skills are not prioritized, developed or sustained among government officials. A detailed capacity development plan is necessary, and targeted efforts in each of these areas are required to strengthen the use of multisectoral nutrition evidence.

Background

In the last two decades, Bangladesh has observed a sustained reduction in child undernutrition. The country successfully met the 2016 GoB targets defined in the Health, Population and Nutrition Sector Development Program (HPNSDP). A recent study reported that between 1997 and 2007, Bangladesh recorded “one of the fastest prolonged reductions in child underweight and stunting prevalence.”²

The changes in the undernutrition indicators from the Bangladesh Demographic and Health Survey (BDHS) validate this progress. According to the 1997 BDHS, 55 percent of children aged 0–5 years were stunted, 18 percent were wasted and 56 percent were underweight.³ In 2014, 36 percent were stunted, 14 percent were wasted and 33 percent were underweight.⁴

Despite the achievements in reducing undernutrition between 2004 and 2016, the decline in stunting has slowed in recent years, and gaps between rural and urban areas remain, in addition to disparities between the highest and lowest wealth quintiles. According to the 2014 BDHS, 38 percent of rural children under 5 years of age were stunted, compared to 31 percent in urban areas; 49 percent of children under 5 years of age in the lowest wealth quintile were stunted, compared to 19 percent in the highest quintile.

Micronutrient deficiencies also remain a challenge in the country. Approximately 21 percent and 45 percent of preschool children suffer from vitamin A and zinc deficiency, respectively, and 33 percent are anemic.⁵ In addition, 50 percent of pregnant women are anemic.⁶ The prevalence of iron-deficiency anemia among non-pregnant and non-lactating women is at 7 percent, and 11 percent of preschool children suffer from iron deficiency.⁵

² Headey D, Hoddinott J, Ali D, Tesfaye R and Dereje M. The Other Asian Enigma: Explaining the Rapid Reduction of Undernutrition in Bangladesh. *World Development*. 66 (Supplement C):749–61; February 2015. Available from: www.lansasouthasia.org/sites/default/files/the_other_asian_enigma_full_paper.pdf.

³ Mitra SN, Al-Sabir A, Cross AR and Jamil K. *Bangladesh Demographic and Health Survey 1996–1997*. Dhaka, Bangladesh, and Calverton, Maryland, USA: National Institute of Population Research and Training (NIPORT), Mitra and Associates and Macro International; 1997. Available from: www.dhsprogram.com/pubs/pdf/FR88/FR88.pdf.

⁴ NIPORT, Mitra and Associates and ICF International. *Bangladesh Demographic and Health Survey 2014*. Dhaka, Bangladesh, and Rockville, Maryland, USA: NIPORT, Mitra and Associates and ICF International; 2016. Available from: www.dhsprogram.com/pubs/pdf/FR311/FR311.pdf.

⁵ International Center for Diarrhoeal Disease Research, Bangladesh (ICDDR,B), United Nations International Children's Emergency Fund (UNICEF) Global Alliance for Improved Nutrition and Institute of Public Health and Nutrition. *National Micronutrients Status Survey 2011–12*. Dhaka, Bangladesh: ICDDR,B and UNICEF, Bangladesh; 2013. Available from: www.static1.squarespace.com/static/56424f6ce4b0552eb7fdc4e8/t/57490d3159827e39bd4d2314/1464405328062/Bangladesh+NMS+final+report+2011-12.pdf.

⁶ NIPORT, Mitra and Associates and ICF International. *Bangladesh Demographic and Health Survey 2011*. Dhaka, Bangladesh, and Calverton, Maryland, USA: NIPORT, Mitra and Associates and ICF International; 2013. Available from: www.dhsprogram.com/pubs/pdf/fr265/fr265.pdf.

The 1,000 days from pregnancy to a child's second birthday are a crucial period for establishing proper nutrition and ensuring positive health outcomes throughout the child's life. Poor fetal growth and chronic malnutrition lead to stunting in adulthood, lower attained education levels, decreased productivity, reduced income in adulthood and decreased birthweight of future offspring for women.⁷

Based on this evidence, the GoB made high-level commitments to improving nutrition and eliminating malnutrition, including a pledge to achieve the WHA targets, the adoption of a national nutrition policy and active participation in the international Scaling Up Nutrition (SUN) Movement.

In 2017, the GoB approved NPAN-2. The Plan identified the major causes of childhood undernutrition in (1) household food insecurity, (2) poor infant and young child feeding practices, (3) inadequate nutrition service coverage, (4) poverty and (5) cultural practices that negatively impact nutrition and the consumption of nutritious foods. Specific targets of NPAN-2 include reducing stunting to 25 percent, wasting to less than 8 percent and underweight to less than 15 percent among children under 5 years of age.¹

To achieve the ambitious WHA targets for stunting reduction by 2025,⁸ to which Bangladesh has made a global commitment, the country needs to increase the annual reduction rate to 3.3 percent. This acceleration requires high-level political commitment, a strong policy framework, effective coordination mechanisms, adequate resourcing, strong involvement of local civil society groups and high-impact, cost-effective, multisectoral nutrition interventions.⁹

⁷ Black RE, Victora CG, Walker SP, Bhutta ZA, Christian P, De Onis M et al. Maternal and Child Undernutrition and Overweight in Low-Income and Middle-Income Countries. *The Lancet*. 382(9890):427–51; August 2013. Available from: www.ncbi.nlm.nih.gov/pubmed/23746772.

⁸ For more information on the WHA targets, please refer to: www.apps.who.int/iris/bitstream/handle/10665/149018/WHO_NMH_NHD_14.2_eng.pdf?ua=1.

⁹ Ahmed T, Hossain M, Mahfuz M, Choudhury N and Ahmed S. Imperatives for Reducing Child Stunting in Bangladesh. *Maternal and Child Nutrition*. 12 Suppl 1(Suppl 1), 242–5; 2016 Available from: www.ncbi.nlm.nih.gov/pmc/articles/PMC5084789/.