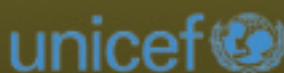




Case Study

Bangladesh

Bangladesh Nutrition Cluster:
A case in preparedness



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This case study is one of six case studies produced through a year-long collaboration in 2015 between ENN and the Global Nutrition Cluster (GNC) to capture and disseminate knowledge about the Nutrition Cluster experiences of responding to Level 2 and Level 3 emergencies. They each provide very rich insights into the achievements of the cluster approach and the challenges of working in complex environments.

The findings and recommendations documented in this case study are those of the authors. They do not necessarily represent the views of UNICEF, its Executive Directors or the countries that they represent and should not be attributed to them.

Authors & Acknowledgments

Andrew Musyoki, Nutrition Specialist, UNICEF Bangladesh and Anuradha Narayan, Chief, Nutrition Section, UNICEF Bangladesh. The ENN team supporting this work comprised Valerie Gatchell (ENN consultant and project lead), with support from Carmel Dolan and Jeremy Shoham (ENN Technical Directors). Josephine Ippe, Global Nutrition Cluster Coordinator, also provided support.

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Summary

Given gaps in preparedness and emergency response highlighted in a number of reviews, in 2012 the Government of Bangladesh (GoB) established a national cluster system to address emergency preparedness and response directly (without Inter-Agency Standing Committee (IASC) support or declaration). Specifically, the NC aims to support the GoB in the coordination of effective emergency preparedness and response to humanitarian crises. This case study highlights the significant work the NC has conducted during this period, particularly with regard to nutrition programming, coordination and assessment of gaps, and identifies challenges and learning.

Country overview

Bangladesh has the highest percentage of its total land area and 97.7% of its population at risk of multiple hazards (World Bank, 2005). The country also has the second-highest absolute and relative mortality risk for floods¹. Over 20 districts are highly vulnerable to cyclones, floods, flash floods and water-logging.

Bangladesh also has persistently high levels of acute malnutrition (wasting) across the country, with a national average of 14% global acute malnutrition (GAM), of which 3% is severe acute malnutrition (SAM). Stunting is 36% nationally and underweight is 33%. While stunting decreased from 51% to 41% over 2007 to 2011,

Bangladesh is unlikely to meet the World Health Assembly target of a 40% reduction in stunting of children under five years of age by 2025. Key Infant and Young Child Feeding (IYCF) practices, such as exclusive breastfeeding for the first six months of age, has significantly decreased from 2011 (65%) to 2014 (55%)². Additionally, Bangladesh is characterised by sub-optimal complementary feeding, indicated by the low quality and diversity of meals for children aged 6-23 months (Bangladesh Demographic and Health Survey, 2014). Micronutrient deficiencies also remain a challenge. The 2013 National Micronutrient Survey reported the prevalence of anaemia in pre-school age children at 33.1% and 26.0% among pregnant and lactating women.



¹ Global Assessment Report, Disaster Risk Reduction, UN 2009.

² Bangladesh Demographic and Health Survey 2014.

History of the NC

The NC in Bangladesh was initially activated by the IASC in 2007 in response to Cyclone Sidr. However, unlike other clusters, no dedicated cluster coordination staff were put in place for the NC. UNICEF Nutrition programme staff chaired a few of the national-level cluster meetings, which focused on the identification of needs, shortly after Sidr hit. There was no consolidated NC response plan. NC partners, including UNICEF, WFP and a few national and international non-governmental organisations (NGOs) implemented responses mainly related to IYCF, blanket supplementary feeding and the distribution of multiple micronutrient powders for children under five and pregnant and lactating women in cyclone-affected areas. Discussions on the progress in the emergency response programming for the 6-12 month duration of the response were held in the Nutrition Working Group (NWG) meeting, an information coordination group recognised by both the Ministry of Public Health and IPHN, co-chaired by UN agencies and NGOs), which had a standing agenda point on Nutrition in Emergency (NiE) response updates.

During this time it became clear that emergency response experience was very limited in the government and local NGOs. Not one of the 36

local NGOs prequalified by the UN agencies to undertake emergency response had the capacity to respond to nutrition. Additionally, while some nutrition policies provided structure and guidance for emergency response (such as the IYCF and anemia strategy) there was an absence of guidance on management of acute malnutrition, assessments and supplementary feeding.

Four months post-Sidr, the UNICEF regional office commissioned a review of the coordination structure and preparedness need. This review identified recommended actions for preparedness and suggested how national and sub-national level coordination structures should be organised and led (and by which government body), with support from UNICEF. Recommendations were not reflected in subsequent UNICEF and government plans due to ongoing discussions on how to harmonise nutrition functions across the government (IPHN, the Nutritional Nutrition Programme (NNP) and MoHP). Additional analysis conducted by UNICEF in 2012 again documented gaps in NiE response capacity and preparedness. These were:

- Weak pre-crisis/routine nutrition programming within government facilities, including mainstreaming of proven direct nutrition

Kamrul Hasan Khan, 2014



interventions into the existing health system, especially management of SAM.

- Inadequate nutrition information systems for routine monitoring at national and sub-national levels (including acute malnutrition).
- Low capacity of service providers, cluster members and partners in Nutrition in Emergencies (NiE), including area-based nutrition assessment, planning and response.
- Lack of national guidelines on area-specific nutrition assessments.
- Weak orientation of district and sub-district authorities on NiE.
- Lack of strong coordination within the nutrition sector in general, impeding linkages between development and humanitarian actions.

In August 2012, after years of advocacy and lobbying by humanitarian actors (including donors) for a formal mechanism to address NiE and

preparedness for nutrition, the GoB agreed to the establishment of a national cluster system for all sectors to focus on preparedness for a predictable response. (This is not an IASC-mandated cluster system, but one mandated by the GoB). For nutrition, this mandated mechanism complements other nutrition coordination forums such as the UN Ending Child Hunger and Undernutrition Partnership (UN REACH), Scaling Up Nutrition movement (SUN) and the NWG. UN REACH works on upstream nutrition advocacy issues, bringing together the different UN agencies and supporting the SUN movement. The NWG brings together nutrition stakeholders to discuss and share emerging issues in nutrition. The NC is a member of the NWG and has been engaged in the preparation of advocacy documents such as the common narrative on undernutrition in Bangladesh produced by UN REACH.

Bangladesh NC: purpose, national and sub-national governance and funding

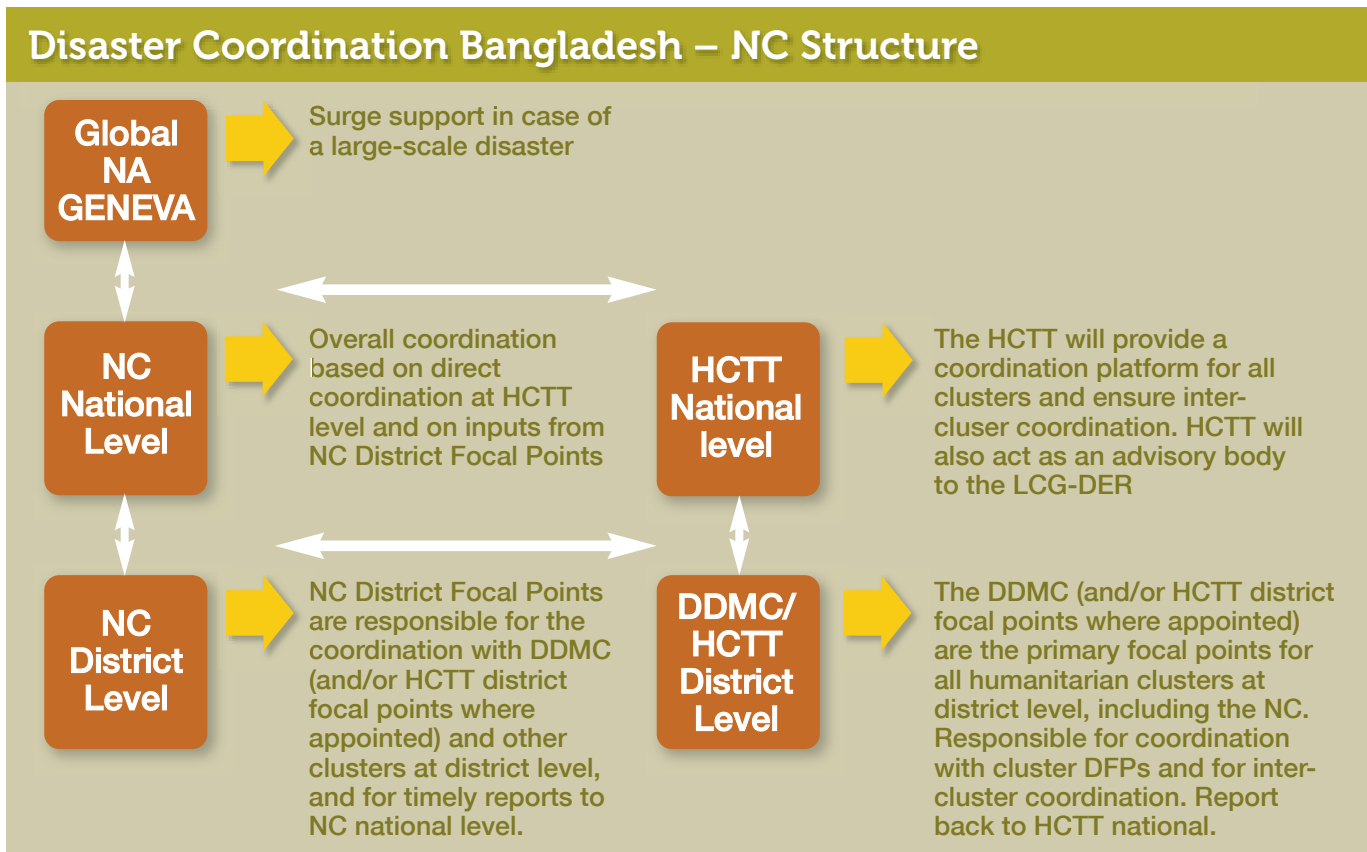
The aim of the NC in Bangladesh is to support the GoB in the coordination of effective emergency preparedness and response to humanitarian crisis that meets core commitments and standards through strengthening the collective capacity of humanitarian actors working in the area of nutrition in Bangladesh. The NC operates under the Government's policy body for emergencies, the Local Consultative Group-Disaster Emergency Response (LCG-DER). The LCG-DER is mandated to ensure effective coordination of the national and international stakeholders in the broader scope of disaster management (risk reduction, preparedness, relief/response and recovery/ rehabilitation) and is the central forum for decision-making on disaster management. Under the LCG-DER is a Humanitarian Coordination Task Team (HCTT), a government body that functions in a similar way to the Humanitarian Country Team (HCT) mechanism in IASC cluster countries. The HCTT is led by the UN Resident Coordinator (UNRC) with a co-chair from the Ministry of Disaster Management (MoDM). Membership of the HCTT is composed of all cluster leads, a representative of the NGOs and donor

agencies (European Commission Humanitarian Aid and Civil Protection Department (ECHO) and DFID).

The NC focuses particularly on preparedness and is available to provide support to the GoB and LCG-DER in times of both slow and sudden-onset emergencies. For example, the NC has provided support to people affected by floods in Satkhira district through blanket supplementary feeding to over 1,000 beneficiaries.

UNICEF and the Institute of Public Health Nutrition (IPHN), which sits under the Ministry of Health and Family Welfare (MOHFW)³, co-chair the NC. All meetings are held at the IPHN and the government co-chairs the meetings with UNICEF. The NC consists of over 15 member organisations, including UN agencies, international and local NGOs, national institutes and research/academic institutions. At sub-national level, the civil surgeon

³ The cluster works under the Ministry of Health and Family Welfare as the technical ministry; however actual disaster preparedness and response falls under the Department of Disaster Management (DDM). The clusters usually come under the DDM umbrella as part of the humanitarian coordination task team (HCTT).



leads the district-level nutrition coordination, while UNICEF’s District Nutrition Support Officers (DNSO) act as facilitators and co-lead.

The national NC has two working groups focusing on acute malnutrition and assessments; IYCF issues are addressed by the active IYCF alliance movement in Bangladesh. Other working groups are established on an as-needed basis. The NC has a communication tree that outlines clear lines of communication from district to national level in the event of a disaster.

In addition to emergency response coordination, sub-national NC forums are used to further the agenda of mainstreaming Direct Nutrition Interventions (DNIs) into the health sector and to engage other sectors to influence them to implement nutrition-sensitive interventions. DNSOs have actively been engaging multi-sectoral partners (including health, education, agriculture and water) in routine coordination meetings to identify and address bottlenecks to mainstream DNIs. Routine meetings have also facilitated the setting of targets on DNIs and in reviewing progress routinely. The dual focus of coordination for emergency response and routine nutrition programming at the district

level was determined the most cost-effective way to utilise district resources.

The NC in Bangladesh is managed by two full-time staff, an NC Coordinator (NCC) and an Information Management Officer (IMO), both employed by UNICEF. Both staff are based at national level and focus on coordination as well as nutrition programming. The two cluster staff spend a significant amount of their time (>50%) supporting nutrition programming through the provision of technical support to UNICEF’s Nutrition Programme, with less than half of their time on NC activities and coordination. The NCC is also the focal point for the scale-up of management of SAM and is in charge of nutrition mainstreaming in the field, to which he provides day-to-day technical support and supportive supervision to over 40 field-based nutrition staff.

The NC has been largely funded by ECHO since 2013 with co-financing from UNICEF. The 2015 annual budget of the NC is 0.5 million USD. UNICEF is funding the sub-national cluster coordination through internal resources. Cluster partner organisations have also contributed staff time in some of the cluster activities.

NC strategy

The NC has six strategic areas of focus:

- Nutrition coordination;
- Nutrition assessment;
- Information management;
- Capacity development;
- Nutrition programme support;
- Cross-sectoral engagement.

Nutrition coordination

At the national level, the NC has developed and routinely updates cluster documents, including a “4W mapping” (who, what, when and where), cluster contingency plan, and cluster contact list. The national NC organises monthly cluster meetings as well as ad hoc ones as needed. The national NC provides orientation on coordination for district-level cluster focal points, supportive supervision during initial meetings, and ongoing technical support and mentoring to government and partners.

At the sub-national level the NC has trained over 300 members of disaster management committees on NiE interventions in 16 disaster-prone districts classified as highly disaster-prone by the UN and the GoB.

The sub-national NC actively supported post-Cyclone Viyaru (formerly known as Cyclone Mahasen) relief efforts in Barisal and Chittagong divisions in May 2013. Cyclone Viyaru affected the two coastal areas and caused damage to infrastructure as well as food crops. Entire populations were affected and many had to move away from their residences. In response, the NC organised coordination forums for nutrition partners involved in the response. Partners were assigned to provide nutrition interventions in areas where they had presence and this avoided duplication of efforts. For example, Concern Worldwide was supporting the MoH to run a SAM treatment unit in the main hospital in Chittagong. All partners were requested to do screening for acute malnutrition and refer all patients to this facility for treatment.

Nutrition assessment

In 2013 it was recognised that the lack of a standardised methodology/guideline for implementing small-scale, area-based nutrition surveys was resulting in poor data quality and challenges in comparing assessments and monitoring over time. A training needs assessment



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Standard nutrition indicators in the HMIS

- No. of children aged 0-2 months who were breastfed within one hour of birth.
- No. of children aged 0-5 months exclusively breastfed.
- No. of children aged 6-23 months who are fed four or more food groups.
- No. of children aged 6-59 months screened for nutritional status (wasted, stunted, underweight).
- No. of newborn babies with low birth weight.
- No. of pregnant women weighed during pregnancy.
- No. of mothers counseled on nutrition.
- No. of pregnant and lactating women who received iron and folic acid.
- No. of children aged 0-5 years who are anaemic and referred.

was conducted in 2013 with partners and in response to identified gaps, the cluster organised a training course on the SMART methodology for partner staff, where a total of 17 staff were trained. Following this a Rapid Nutrition Assessment Team (RNAT) was formed, housed within Dhaka University's Institute of Nutrition and Food Science (INFS). The RNAT has since carried out three localised nutrition surveys and has supported other organisations to implement surveys within the country. The team remains available for quick deployment to any disaster-affected area to carry out nutrition assessment. In non-response time, the team has worked to integrate the SMART methodology into the nutrition curriculum for undergraduate students.

The RNAT, comprised of national staff, will continue providing technical support on nutrition assessments into the future. Individuals on the RNAT work with partner organisations or Dhaka University and are available for hire by any organisation that requires their services. They have been hired several times by agencies in response to assessment needs so far.

The NC has also supported the GoB to develop National Nutrition Assessment guidelines based on the SMART methodology. An Assessment Working Group has been formed to support organisations to conduct quality nutrition surveys.

Nutrition information management

The focus of the NC in terms of information management has been improving the availability and utilisation of nutrition information. NC advocacy resulted in the establishment of the Nutrition

Information and Planning Unit (NIPU) at the IPHN. Since inception, NIPU has effectively advocated for the inclusion of standard nutrition indicators (see below) in the Health Management Information System (HMIS).

District coordination meetings have also contributed to the improved availability of data as, during meetings, data are reviewed with health workers for planning purposes. Once collected, data are published by the NIPU in reader-friendly "nutrition bulletins" (two issues have been printed to date), which are circulated among district and national stakeholders.



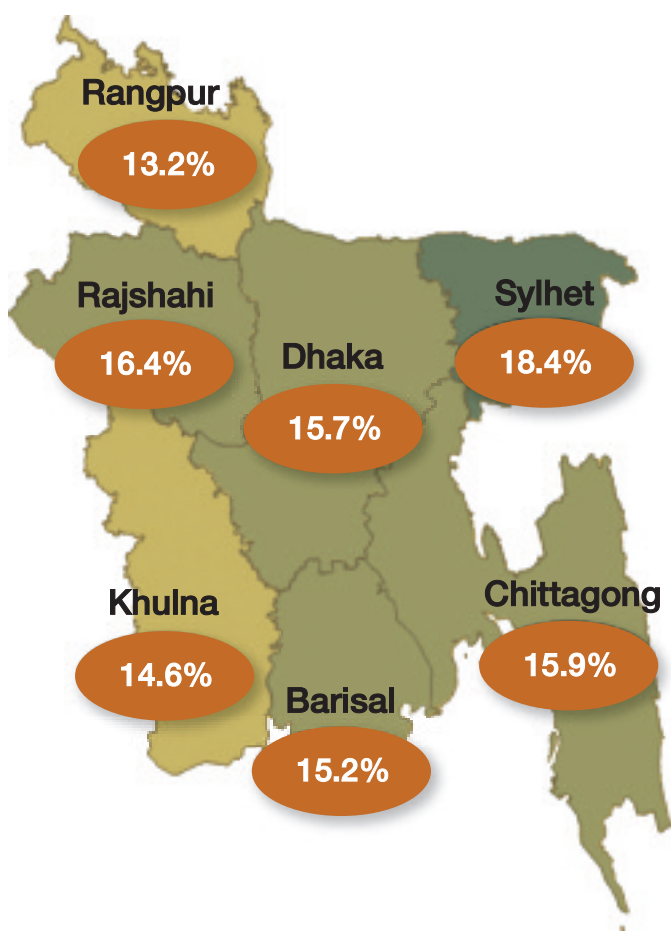
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While this is a significant step forward for monitoring nutrition indicators in Bangladesh, the NC has had limited engagement in overall information management for preparedness in response.

Capacity development

The training needs assessment (2013) revealed gaps among cluster partners at both national and sub-national levels. To address this the NC, in partnership with Helen Keller International (HKI) and INFS of Dhaka University, contextualised the Global NC's Harmonised Training Package (HTP) for NiE for Bangladesh. This package was then used by INFS and UNICEF to roll out trainings in ten disaster-prone districts and among partner staff at national level. Partners have also used the materials to train staff countrywide. Collectively, more than 400 people have been trained, most of whom are members of district disaster management committees (DMC). The cluster plans to reach an additional 175 partner staff with NiE training and 150 members of DMCs in 2015.

Figure 1
Wasting (WHZ<-2) prevalence at divisional level



Discussions with other sectors such as Food Security, Water and Sanitation as well as Health indicate gaps in knowledge on NiE issues. To address this the NCC has advocated with other clusters to integrate key issues on NiE in their training packages. With support of the IMO, nutrition indicators have been added to the Food Security Cluster's assessment tool. The IPHN has also integrated NiE in its five-day, basic nutrition training package for frontline government health workers in community clinics and sub-district hospitals.

NiE interventions are now included in the National Nutrition Policy and the national operational plan of the IPHN incorporates NiE as an area of focus. The contextualised HTP has also been incorporated into the government's basic nutrition module. The basic nutrition module is a government training package aimed at frontline health workers as an overall orientation on diverse nutrition topics covered under the national operation plan for nutrition.

Working with multiple stakeholders and pushing the nutrition agenda has been challenging. Additionally, significant follow-up is required to ensure that the NiE materials incorporated in different areas are utilised in the correct way.

Nutrition programme support

For many years, management of SAM has been led by NGOs due to the absence of nationwide programming within government-led facilities. Due to the geographical focus of NGOs, SAM programming has been limited to pockets in certain districts, despite the relatively even distribution of wasting throughout the country (see map below). The NC has therefore focused on supporting the management of SAM given the high burden in Bangladesh and the extremely limited capacity in this area.

While national guidelines on the management of SAM were approved in 2008 and all districts are now implementing inpatient treatment of SAM (to varying degrees), the Government has yet to approve a strategy for rollout. Additionally, as the GoB does not allow the use of Ready-to-Use Therapeutic Food, community management of SAM is impossible. The NC and UNICEF have therefore focused efforts on capacity-building, supply provision and the development of a

database for inpatient treatment, while WFP has focused on the management of MAM.

To expand SAM programming, the NC has supported the MOHFW to scale up SAM management through dedicated use of the NCC's time and the coordination support from the Acute Malnutrition Working Group (AMWG) comprised of the GoB and NGO partners. The AMWG has reviewed SAM management tools and guidelines and implemented a bottleneck analysis (conducted in collaboration with IPHN) addressing identified issues. The NCC reviews monthly SAM reports regularly and provides feedback to implementing teams. The NCC and AMWG also provide ongoing technical support to public health facilities.

At national level the NC has supported the establishment of a database at IPHN that is maintained by IPHN. Discussions are at an advanced stage to incorporate the SAM reporting tool in the HMIS. A training of trainers at central level has been conducted and over 1,000 government health workers in 102 hospitals have been provided with on-the-job training in inpatient SAM management. This represents 76% of all hospitals targeted for SAM management (21% of all hospitals in the country). Submission of monthly reports has improved by 50% (from less than 30%

to over 80% of facilities submitting reports). Consequently, the number of facilities providing inpatient management of SAM has been scaled up from five facilities at the start of 2013 to 134 by end of 2014.

The main challenges to the scale-up of SAM management include:

- Lack of strategy to roll out SAM management;
- Low capacity of health workers on inpatient management for SAM;
- Lack of ability to scale up community-based therapeutic care due to inability to import ready-to-use therapeutic food (government policy) and absence of local production;
- Lack of motivation among health workers to take on SAM management as they perceive it as 'additional' work;
- Ensuring regular and accurate reporting.

Work remains to ensure that performance indicators are maintained at desired levels and capacity development initiatives for health workers continue since the trainings so far have reached a small percentage of health workers. Coverage and access to SAM management services remain low with only about 30% of government hospitals offering services. In the event that all facilities were covered with inpatient management, one would still expect low coverage due to absence of a community-based treatment.

Cross-sectoral engagement

The NC actively collaborates with other clusters and humanitarian coordination team activities. In addition to the work mentioned above at district level, the national NC has been working collaboratively with the Food Security Cluster on assessment initiatives, including the Integrated Phase Classification (IPC). The NC has supported planning, training, field data collection, analysis and reporting of nutrition surveys, which have fed into the IPC analysis. In collaboration with the IPC, the NC conducted the very first IPC nutrition pilot in 2014. The pilot has provided the foundation and informed subsequent pilots globally. IPC analysis maps have been used by nutrition partners and other stakeholders to inform prioritisation of most vulnerable areas for programming. Additionally, the IPC maps have been applied in ranking the most



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needy areas whenever a joint needs assessments (JNA) is undertaken. The NC has also engaged actively in the JNA of the HCTT with data collection, reporting and response.

The NC participates in sectorial coordination mechanisms such as the NWG and food security and WASH clusters. As part of the NWG, the NC is the focal point for NiE and provides regular updates on NC activities. The NC has collaborated with the WASH and Food Security Clusters to develop a joint emergency response plan which was used following flooding in 2013 to channel funding for both WASH and food security interventions.

While UN REACH is represented in the NC, the NC has not had any meaningful interaction with the SUN movement in-country. This is largely due to the fact that SUN architecture is located at a high level within government and at a level where the NC is not represented.

Challenges

1. **Capacity gaps remain.** While district nutrition coordination is improving in the 16 target districts, huge technical capacity gaps remain among health workers on collection, analysis and utilisation of data. Many facilities have limited nutrition services and are not reporting nutrition indicators or are not capturing data accurately. Additionally, coordination gaps are evident in non-target districts. While there have been significant activities to develop capacity in NiE in terms of trainings, it remains to be seen whether capacity-building efforts in NiE overall will translate into actual capacity to respond in a future emergency.
2. **Building preparedness capacity in high burden and high-risk context.** Building strong

preparedness requires long-term funding. The cluster has received limited funding for its preparedness activities (i.e. capacity-building of DMCs) and thus these have been implemented in a phased manner.

3. **Coverage of SAM treatment is limited.** The majority of cases of SAM are not treated due to the lack of community services for managing SAM. Given the huge burden of SAM in Bangladesh, scale-up of outpatient therapeutic services to the community level is necessary.
4. **Sustaining interest.** Sustaining interest in the cluster mechanism and preparedness efforts in a development context is a continuing challenge. The NC does not have influence on funding for disaster/emergency response as is the case in IASC-activated clusters, where there is mobilisation of resources around the costed Humanitarian Response Plan; thus interest in cluster activities has not been as strong as in contexts of IASC-activated clusters.
5. **Funding.** To sustain and increase sub-national coordination and expand treatment of SAM, additional funding is required. UNICEF has been advocating for pooled funds to address these nutrition gaps.
6. **Cross-sectoral activities.** Engaging with actors from other sectors and advocating for them to implement nutrition-sensitive interventions (as part of preparedness actions) has been challenging, particularly in the absence of a policy document on nutrition-sensitive actions or a framework on how this could be facilitated. UNICEF is increasing efforts to engage with the SUN secretariat in Bangladesh to define and address multi-sectoral approaches.

Learning

- **Support to routine nutrition programming.** Bangladesh has a high burden of SAM. Natural disasters and emergencies can quickly result in increased levels of SAM. The ability to manage SAM effectively is a key emergency preparedness activity, yet the provision of technical support to routine programming is time-consuming and has

over-ridden the core responsibilities of the cluster. This has resulted in a missed opportunity to build greater emergency preparedness.

- **Information management (IM).** IM is a crucial component of preparedness for nutrition emergencies. While the NC has built capacity in information systems for nutrition and nutrition

assessments, work remains to be done in information management for preparedness.

- **Nutrition coordination beyond emergencies.** While momentum and advocacy for linking emergency and development approaches for nutrition preparedness and programming is building at national level through the UN REACH and SUN movement, guidance documents and a policy framework are essential to forge these links and inform actors involved in nutrition-sensitive programming.
- **Multi-sector coordination.** Leveraging other sectors to implement nutrition-sensitive activities

is challenging due to time required and lack of evidence and guidance on how to do this effectively.

- **Sub-national clusters can be effective in coordinating a response.** As witnessed by the response to Cyclone Viyaru in May 2013, DNO preparedness activities built the foundation for the coordinated response.
- **Engagement with academic institutions.** Partnerships with academic institutions and government bodies can have great benefits in terms of designing and conducting assessments, developing training materials and capacity-building.

Moving forward

Nutrition coordination in Bangladesh is in transition. A deliberate effort is being made to transform the nutrition architecture at country-level to ensure that coordination forums adequately support the Government to strengthen routine nutrition programming. The goal is to establish coordination forums that address routine development programming, preparedness and emergency response. It is envisaged that one coordination forum led by the IPHN and co-led by UNICEF will be set up at national level with a mandate to support nutrition programming. A key focus of this

new forum will be increased advocacy for preparedness. Sub-working groups within this forum will address various nutrition issues, such as NiE (currently the NC); Capacity and Learning (currently the Nutrition Working Group); IYCF (currently the IYCF Alliance); and Information Management (currently the Information Management Group). Discussions with the Government and multiple partners are underway to agree on roles and responsibilities in a new structure. The new architecture is expected to be in place effectively by the end of 2016 or early 2017.



Kamrul Hasan Khan, 2014