Responses to: ‘An evaluation of the impact of a US$60 million nutrition programme in Bangladesh’

Letters

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The article by Hossain et al. (2005) in the January issue of Health Policy and Planning uses a flawed data set to provide a biased and unfortunate portrayal of the Bangladesh Integrated Nutrition Project (BINP), a genuinely innovative public health programme reaching huge numbers of poor women and children in that country. First, while the field methods utilized are only partially divulged (even the original 70 page report which includes the 2002 survey does not include the questionnaires, nor detailed sampling methodology), a methodology which uses as controls sub-district areas adjacent to project areas is inherently flawed. Spillover of project effects would certainly be expected, particularly after as many as 5 years of project implementation. More fundamentally, the authors readily admit: ‘This ex-post study design is inherently weak as it is not possible to control for any differences in the rates of malnutrition between project and non-project areas at the start of the intervention’ (p. 36). The importance of such weakness can be seen by differences among sub-districts at BINP baseline with height-for-age z-scores ranging from –1.9 to –2.7. There is tremendous variation in nutritional status within and between communities in Bangladesh.

Secondly, the paper takes no account of the myriad interventions implemented throughout rural Bangladesh during this same period both by the Government and a large number of non-governmental organizations (NGOs). For instance, BINP endline evaluation data found that a remarkable 95.7% of mothers of young children in project areas (98.7% in control areas) had participated in non-formal education in which nutrition and child care are integral parts.1 The reported finding in the Hossain et al. paper that malnutrition declined by 40% (30 to 18%) in the intervention area and 30% (27 to 19%) among controls in the first 3 years of the project was dismissed as a ‘secular trend’, yet is a remarkable achievement in a country with one of the highest rates of malnutrition in the world and during a period of slow growth in Gross Domestic Product (GDP). The authors admit that ‘An analysis of the children enrolled for supplementary feeding showed that children aged 12–23 months significantly improved their weight-for-age z-score...’ (p. 39), without noting that such a finding is rare internationally, and most likely reflects the synergistic effects of the broad range of project activity (Allen and Gillespie 2001).

The reduction in low birth weight among participating mothers is not even mentioned by the authors. BINP evaluations have found significant changes between BINP and control areas in pregnancy knowledge and practices, in the birth weights of the offspring of low-income women (particularly those able to participate fully in the interventions), in knowledge and behaviours relating to neonatal caring practices, and in the delivery of micronutrients (iron/folate consumption during pregnancy increasing from 16.6% at baseline to 83.9% at endline while less than doubling in control areas).

The major story to be told about nutrition in Bangladesh, in fact, is that there have been remarkable improvements in childhood nutrition, in pregnancy outcomes and in dietary practices throughout the country over the past decade, an accomplishment to be celebrated by all of us. That it was, in some cases, difficult to differentiate significant effects between BINP project areas and the so-called ‘control areas’ indicates only that valuable activities are taking place throughout the country, many of them facilitated by the very NGOs which have participated in the BINP. News about activities which work travels far and fast in Bangladesh!

The article’s contention that the BINP failed to address household food insecurity and poor health is simply wrong. Unlike previous large-scale nutrition programmes (the Tamil Nadu Integrated Nutrition Project in South India, the Iringa project in Tanzania, and the community-based Posyandu programmes in Indonesia), the BINP made a concerted effort to provide income-generating opportunities within the project for particularly food-insecure households. Nutritious gardens, poultry raising and women’s groups formed for income-generating purposes were included in the BINP from the outset. Similarly, the BINP was able to institute a remarkably effective system of ‘one-stop health care’ in which households could receive both child nutrition and health services such as immunization and antenatal care within the village, in one visit. Immunization rates were higher and pregnant women received nearly
three times more antenatal checkups in project than in control areas.

In a country now seriously threatened by human rights abuses, increasingly intolerant religious fundamentalism and widespread corruption, the BINP represented an effort by caring and altruistic Bangladeshis to make a difference in the lives of disadvantaged rural populations. Despite the problems which are inherent in any such large-scale programme, the programme, directly and indirectly, has contributed to a transformation of rural Bangladeshi women into individuals who are far more self-assured, confident, assertive and informed. Moreover, for all its problems, the BINP was carried out through the administrative structures of a government and implemented by local NGOs rather than from outside.

Instead of seeking to strengthen the hands of those Bangladeshi government and NGO individuals, the campaign by Save the Children UK (SC) has had the opposite effect, providing an excuse for inaction to those in the government who have been less committed to such a pro-poor intervention. The SC campaign coincided with a 3 year bureaucratic delay in the operational initiation of the follow-on National Nutrition Program, and has had a seriously discouraging effect on the very NGOs whose active participation in such programmes is essential. We would hope that an important international organization like SC, a powerful force for justice and equity, would, in fact, be leading the way in encouraging large-scale programmes to reduce malnutrition among the millions of poor women and children in the world.

The paper by Hossain et al. (2005) suggests that the Bangladesh Integrated Nutrition Project (BINP) budgeted at US$60 million over 5 years was an expensive and ineffective project. While every such large-scale project has faults and can be improved, we would like to clarify several points in the paper.

First, the title of the paper stresses the large price tag. Certainly US$60 million is a huge sum, but also recall that this translates into less than $1 per person per year. One could easily argue that even this amount is much less than what is truly needed to substantially improve the nutrition level among those served.

Secondly, as the authors acknowledge, the ex-post study design has significant limitations and the validity and strength of the study conclusions should be considered within this context. The BINP was certainly not designed as a randomized controlled trial, but rather was intended as a phased introduction of a national nutrition strategy.

In the discussion, the authors refer to the possibility that the project might have had a beneficial effect for particular subgroups of the BINP recipients. In fact, such a beneficial subgroup effect did occur. For example, one of the BINP operational research studies, BINP-OR/HPQR-5/2 by Shaheen et al. (2000), which investigated the optimal duration of nutritional supplementation for malnourished pregnant women and its impact on birth weight of newborns, showed beneficial subgroup effect as it relates to prenatal food supplementation and birth...