



## Scaling Up and Sustaining Support for Improved Infant and Young Child Feeding:

BRAC's Experience through the Alive & Thrive Initiative in Bangladesh

August 2014



**Recommended citation**

BRAC. Scaling up and sustaining support for improved infant and young child feeding:  
BRAC's experience through the Alive & Thrive Initiative in Bangladesh. Dhaka, Bangladesh:  
BRAC, 2014.

BRAC  
75 Mohakhali  
Dhaka 1212  
Bangladesh  
[www.brac.net](http://www.brac.net)

# Contents

<b>Acknowledgments</b>	<b>4</b>
<b>Acronyms</b>	<b>5</b>
<b>Context and Background</b>	<b>6</b>
<b>Overview of BRAC's Role in Improving Nutrition</b>	<b>7</b>
<b>Introduction of Alive &amp; Thrive's IYCF community-based model</b>	<b>8</b>
<i>Overall strategy</i>	9
<i>Design of the community-based model for IYCF</i>	9
<i>Phased scale up of the model in Alive &amp; Thrive/BRAC program areas</i>	10
<b>Results in Alive &amp; Thrive Program Areas</b>	<b>14</b>
<b>Scaling Up Beyond Alive &amp; Thrive Program Areas</b>	<b>15</b>
<i>Scaling up in other Essential Health Care districts</i>	15
<i>Scaling up through MNCH programs</i>	15
<b>Sustaining Support for Improved Infant and Young Child Nutrition</b>	<b>19</b>
<b>Conclusion</b>	<b>23</b>
<b>References</b>	<b>24</b>
<b><u>Tables</u></b>	
1. Community-based IYCF interventions scaled up in various program platforms in Bangladesh	17
2. IYCF community mobilization sessions and TBA orientation sessions in 50 sub-districts of Bangladesh	21
<b><u>Figures</u></b>	
1. IYCF community model implemented in Alive & Thrive/BRAC areas	10
2. Touch points for IYCF in a single month in program areas in 50 sub-districts	12
3. BRAC human resources for Alive & Thrive community program, 2013	13
4. BRAC scale up of IYCF in Essential Health Care and MNCH Programs	16
<b><u>Boxes</u></b>	
1. BRAC's frontline workers	6
2. Resources on IYCF community activities in Alive & Thrive/BRAC program areas	7
3. BRAC's involvement in nutrition, 1975-2013	8
<b><u>Appendices</u></b>	
1. Map of A&T program areas through BRAC's Essential Health Care Program	25
2. List of A&T program areas	26
3. Map of BRAC Essential Health Care areas with IYCF activities, 2014	27
4. Map of BRAC MNCH areas with IYCF activities	27

## Acknowledgments

BRAC's experience and success in scaling up infant and young child feeding would not have been possible without the kind support and help of many individuals and organizations. Any project is successful largely due to the effort of a number of wonderful people who have always given their valuable advice or lent a helping hand. We would like to extend our sincere thanks to all of them.

We sincerely appreciate the inspiration, support, and guidance of all those people who have been instrumental in making the Alive & Thrive project a success. We are highly indebted to the Alive & Thrive Dhaka Office and FHI 360 for their guidance, supervision, and support. We would like to express our gratitude to the Bill & Melinda Gates Foundation for financial support, cooperation, and encouragement throughout this project.

We express our special gratitude and thanks to Ms. Jean Baker for her commitment and constant support and for giving us such attention and time. We extend a special word of gratitude to Dr. Tina Sanghvi, Alive & Thrive's Senior Country Director in Bangladesh, for her stimulating suggestions and encouragement and for helping us coordinate our project and write this report, and we recognize Mr. Sumitro Roy for his leadership and support. We would also like to acknowledge with much appreciation the crucial role of Ms. Luann Martin, who guided us in documenting our experience and lessons. A special thanks goes to Dr. Kaosar Afsana, Director of BRAC's Health, Nutrition, and Population Program, for her direction and suggestions for project implementation.

Last but not least, many thanks go to the staff including the frontline health workers (SS, SK, and PK), as they have invested their full effort in implementing project activities to achieve the goal. We appreciate the guidance of colleagues whose comments improved our presentation and communication skills and to our colleagues in finance and accounts, procurement, and transport departments who helped us carry out our responsibilities.

## Acronyms

BINP	Bangladesh Integrated Nutrition Project
CSA	Civil Society Alliance
EHC	Essential Health Care
HPNSDP	Health, Population and Nutrition Sector Development Program
IFPRI	International Food Policy Research Institute
IYCF	Infant and Young Child Feeding
MNCH	Maternal, Neonatal and Child Health
MNI	Mainstreaming Nutrition Initiative (MNI)
PK	Pushti Kormi (IYCF promoter)
PS	Pushti Shebika (nutrition volunteer)
SK	Shasthya Kormi (community health worker)
SS	Shasthya Shebika (community health volunteer)
SUN	Scaling up Nutrition

## Context and Background

Although Bangladesh has made impressive gains in health and development indicators in the last decade, malnutrition rates in Bangladesh are among the highest in the world. Undernutrition is a major public health concern as more than 80 percent of young infants and 40 percent of pregnant women suffer from anemia, largely as a result of iron deficiency, and more than 400,000 children suffer from severe acute malnutrition.<sup>1</sup> Until recently, the exclusive breastfeeding rate remained stagnant. High levels of stunting still persist.

Alive & Thrive, funded by the Bill & Melinda Gates Foundation, is an initiative that aims to reduce undernutrition and death caused by sub-optimal feeding practices in children aged 0-24 months. When Alive & Thrive was initiated in 2009, it aimed to improve these practices through advocacy and policy dialogue, intensive community-based interventions (interpersonal communication and community mobilization), and a national media campaign.

BRAC, Bangladesh's largest nongovernmental organization, coordinated community-based activities in Alive & Thrive program areas. Activities included counseling on infant and young child feeding during home visits by community volunteers (Shasthya Shebikas—SSs) and infant and young child feeding promoters (Pushti Kormis—PKs). Community health workers (Shasthya Kormi—SKs) promoted improved feeding practices during health forums and provided breastfeeding counseling during antenatal and postnatal visits. (See box 1.). BRAC's program organizers planned and facilitated community mobilization sessions.

This report summarizes BRAC's experience in implementing the infant and young child feeding (IYCF) community-based model in the 50 Alive & Thrive program areas from 2009 to mid-2014, describes BRAC's replication and adaption of the model in other programs and platforms, and discusses the elements that were put in place to ensure sustainability.

### Box 1. BRAC's Frontline Workers

#### **Shasthya Shebika (SS):**

multipurpose female health worker who is a resident where she works and earns money through sales of subsidized health products and performance-based cash incentives; ratio of 1 SS to 250-300 households in Essential Health Care Program and 1:150-200 in MNCH Program

**Shasthya Kormi (SK):** focused primarily on antenatal and postnatal care and essential newborn care; many provide delivery care; earn monthly salary

**Pushti Kormi (PK):** IYCF promoter who supports SS in some Essential Health Care Programs

**Pushti Shebika (PS):** temporary position to support IYCF functions of SS until she receives additional training in other basic health services and becomes a SS



Shasthya Shebika (SS)



Shasthya Kormi (SK)



Pushti Kormi (PK)

## Overview of BRAC's Role in Improving Nutrition

BRAC was created in 1972 as a small relief organization after Bangladesh's war for independence. Through implementation of the Oral Therapy Extension Program (OTEP) in the 1980s, BRAC developed its army of volunteer community health workers, known as Shasthya Shebikas. These volunteers are vital in undertaking household visits throughout Bangladesh and are the backbone of BRAC's health, nutrition, and population programs, including Alive & Thrive.

Prior to Alive & Thrive, BRAC's role in improving nutrition focused on supplementary feeding for children and pregnant women. The World Health Organization defines this as 'the provision of extra food to children or families beyond the normal ration of their home diets, and can take place in the home, feeding center, health-care center, and schools.'<sup>2</sup> In Bangladesh, the first large-scale government intervention to improve nutrition was the Bangladesh Integrated Nutrition Project (BINP), initiated in 1995 and funded by the World Bank. BINP developed into the National Nutrition Program (NNP) in 2003. The aims of the BINP were to 1) reduce child malnutrition through growth monitoring and supplementary feeding of children aged 6–24 months and 2) increase pregnancy weight gain and, hence, reduce the incidence of low birth weight through supplementary feeding for pregnant women.

In the BINP supplementary feeding program, BRAC, as the major NGO player, implemented activities at the community level through its extensive network throughout Bangladesh. However, there has been much debate surrounding the impact in intervention areas of the BINP and NNP on child nutritional status, weight gain during pregnancy, and birth weight. Studies suggest that the BINP's impact on improving malnutrition in Bangladesh was modest and that the supplementary feeding component did not yield nutritional gains, perhaps due to weaknesses in design and targeting.<sup>3</sup>

The next step in BRAC's efforts to address malnutrition was the Mainstreaming Nutrition Initiative (MNI), initiated in 2007. MNI marked a significant milestone as BRAC's role in nutrition shifted from supplementary feeding to promotion of appropriate IYCF practices in BRAC's existing maternal, newborn, and child health (MNCH) program. Nutritional inputs included the promotion of initiation of breastfeeding within 1 hour of birth in maternal and neonatal services, emphasis on exclusive breastfeeding in neonatal and child health services, and promotion of appropriate complementary feeding practices in child health services.

In 2008 BRAC became one of the core partners on Alive & Thrive. Detailed descriptions of the community component in Alive & Thrive program areas are available in **resources** listed in **box 2**. The success of the program resulted in funding from other donors to replicate the IYCF community-based model in the USAID-funded SHIKA project and to adapt it for DFID-funded poverty alleviation and nutrition programs. The **evolution of BRAC's nutrition programming** is illustrated in **box 3**.

### Box 2. Resources on IYCF community activities in Alive & Thrive/BRAC program areas

- Using multiple platforms for change in the context of high malnutrition: Alive & Thrive's approach and results in Bangladesh
- Getting strategic with interpersonal communication: Improving feeding practices in Bangladesh
- Implementation manual for BRAC's community-based Alive & Thrive infant and young child feeding program in Bangladesh
- Mobilizing community support for improved infant and young child feeding in Alive & Thrive program areas in Bangladesh
- Performance-based cash incentives for volunteers in BRAC's community-based Alive & Thrive infant and young child feeding program in Bangladesh

All resources are available at:  
[www.aliveandthrive.org](http://www.aliveandthrive.org)

## Introduction of Alive & Thrive's IYCF community-based model

### Box 3: BRAC's involvement in nutrition

- 1975:** Jamalpur Women's Project
- 1978:** Child malnutrition rehab center and prevention program
- 1979:** Oral Therapy Extension Program (OTEP)
- 1986:** Jhitka project on comprehensive nutrition actions
- 1993:** Muktagachha Nutrition Initiative
- 1995:** Bangladesh Integrated Nutrition Project (BINP)
- 2003:** National Nutrition Program (NNP)
- 2007:** Mainstreaming Nutrition Initiative Into MNCH
- 2009:** Alive & Thrive Initiative (infant and young child feeding)
- 2009:** Vitamin A supplement (VAS) in hard-to-reach areas
- 2010:** Bangladesh Sprinkles Project
- 2012:** BRAC Nutrition Project
- 2013:** SHIKHA Project

Alive & Thrive's challenge was to improve breastfeeding and complementary feeding practices at scale within five years. When Alive & Thrive started activities in Bangladesh in 2009, the following situation existed, based on findings from the 2007 Demographic and Health Survey.<sup>4</sup>

**Breastfeeding culture but sub-optimal practices.** Almost all children in Bangladesh were breastfed and continued to be breastfed until they were at least 2 years old. However, delayed initiation of breastfeeding, prelacteal feeding, and non-exclusive breastfeeding in the first 6 months was common. The median duration of exclusive breastfeeding was only 1.8 months. From 1994 to 2007, exclusive breastfeeding rates showed little change, ranging between 42 percent and 46 percent. At baseline, the exclusive breastfeeding rate was 50 percent in A&T program areas.

**High levels of stunting.** Approximately 43 percent of children under five in Bangladesh were classified as stunted. Stunting is an indication of lifelong compromised brain and physical development. Introducing complementary foods too early or too late can lead to stunting, as can a diet lacking in critical nutrients and animal foods.

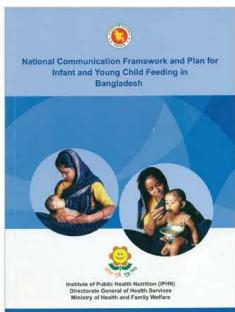
**High rates of anemia.** The baseline survey<sup>5</sup> conducted by Alive & Thrive in 2010 found that the prevalence of anemia ( $Hb < 11\text{g/dL}$ ) was very high among children 6-23 months old (75 percent) with no significant differences by child sex.

### Overall Strategy

Alive & Thrive set as its targets in Bangladesh to increase exclusive breastfeeding from 43 to 65 percent among infants 0-5 months of age, reduce stunting by 10 percent (from 43 percent to 39 percent) among children under 5 years of age, and reduce anemia by 10 percent (from 50 to 45 percent) among children 6-23 months of age in program areas within 5 years. Alive & Thrive was charged to achieve these results at scale. The target was to reach 3.5 million households with children under 2 years of age with intensive community interventions and another 5 million households with children in this age group through advocacy and mass media campaigns.

To achieve these targets, Alive & Thrive supported implementation of the National Infant and Young Child Feeding Strategy and Action Plan<sup>5</sup> in partnership with government and non-government agencies and private initiatives. Alive & Thrive's strategy was to:

- *Enhance the skills and performance of frontline workers* in delivering IYCF counseling services by training approximately 7,000 BRAC community volunteers (*Shasthya Shebikas*), 600 community health workers (*Shasthya Kormis*), and 1,000 IYCF promoters (*Pushti Kormis*) as well as frontline workers of other NGOs and government community-based programs
- *Generate demand for IYCF services and create a supportive environment* for behavior change through community mobilization, a multimedia campaign, harmonized messages and materials, and targeted strategies for different audiences
- *Build partnerships and prioritize child nutrition and IYCF activities* in agencies working in different sectors and geographical areas
- *Raise the profile of IYCF and investments in child nutrition* through engagement of the media and dialogue with national, district, and community leaders



Alive & Thrive's national media campaign and community interventions were coordinated and synchronized. They focused on the following high impact actions set forth in Bangladesh's National Communication Framework and Plan for IYCF:<sup>6</sup> 1) timely initiation of breastfeeding (within one hour of birth), 2) exclusive breastfeeding for the first 6 months, 3) quality complementary foods and appropriate feeding practices with a focus on adequate density of energy and nutrients, food diversity, especially animal foods, and micronutrient supplementation, and 4) handwashing with soap and water before preparing food and child feeding.

These high impact actions, recommended by the World Health Organization,<sup>7</sup> were selected because they have a substantial impact on health and nutrition and were not widely practiced in Bangladesh. Formative research<sup>8</sup> conducted by Alive & Thrive indicated that the main barriers to adopting these actions were mothers' perception that they had insufficient breastmilk and their observation that children lacked an appetite. Messages, materials, and TV and radio spots were developed to address these barriers.

## Design of the Community-based Model for IYCF

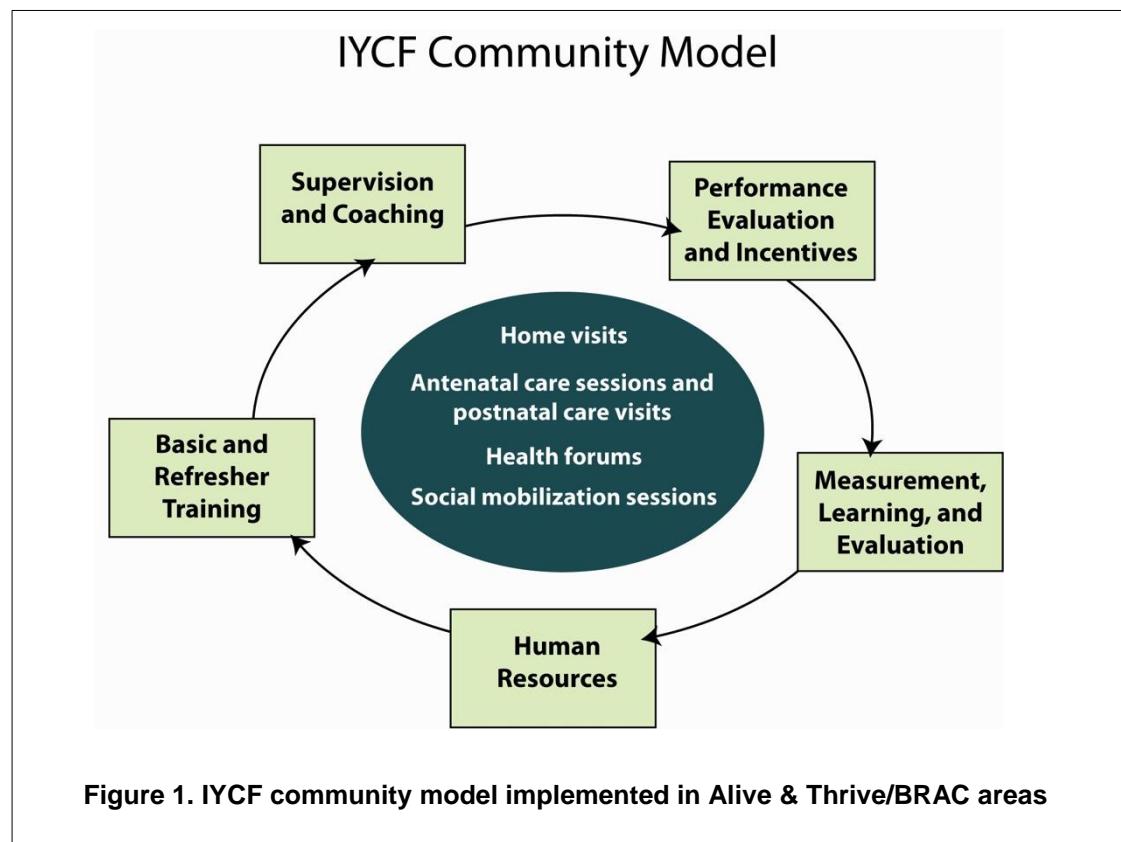
The Alive & Thrive and BRAC team designed a community-based model for IYCF focused on the above priority behaviors and the main barriers to improved practices. The model had four core interventions:

- **Home visits** to mothers of children under 2 years by the SS (community health volunteer) and PK (IYCF promoter) to provide IYCF counseling, coaching, demonstration, problem-solving, and referrals and to sell sachets of micronutrient powder from the volunteer's basket of health products
- **Antenatal care sessions and postnatal care visits** by the SK (community health worker) to discuss early initiation of breastfeeding and exclusive breastfeeding and provide support for good positioning and attachment
- **Health forums** by the SK that included discussion of IYCF issues with an average of seven pregnant women, mothers, and family members in a forum
- **Community mobilization sessions** facilitated by program organizers to raise awareness of IYCF and encourage the commitment of influential community members to take action in support of improved feeding practices. Sessions with around 20 people in attendance were held for those who could influence a mother's feeding decision including religious leaders (imams), informal health care providers (village doctors), traditional birth attendants, government health and family welfare staff, school teachers from private secondary and religious schools, adolescent girls, members of village health committees, and fathers.

To ensure effective implementation of these core interventions, BRAC adopted a performance improvement approach that involved:

- Human resource recruitment and placement to ensure acceptable coverage of the target population and adequate supervision and support
- Basic hands-on training of frontline workers, monthly meetings, and quarterly refresher training
- Supervision and coaching
- Performance evaluation to determine compliance and competence in delivering the core interventions, with cash incentives linked to performance
- Measurement, learning, and evaluation to determine the effectiveness and impact of the intervention strategies and to use the findings to revise programming

The **community model** is illustrated in **figure 1**.



### Phased Scale Up of the Model in Alive & Thrive/BRAC Program Areas

Scaling up involves the expansion, replication, and adaptation of proven interventions to new and different environments to provide coverage to a substantial proportion of the population.<sup>9</sup> An organization is often expected to reach scale soon after a program starts if resources are available and the organization knows what works to change behavior. BRAC found that it took almost nine months of preparations before rolling out the community interventions in a few sub-districts in August 2009. The model was tested in these sub-districts for 18 months and then scaled up during two more phases until all 50 sub-districts were involved in Alive & Thrive activities by 2011. These **program areas** are shown on a map in **annex 1** and listed in **annex 2**.

## **Project Design**

Most of the first year was devoted to preparing to roll out the intervention package. This involved reviewing existing materials and developing training and community mobilization modules and a pocket-size brochure to remind frontline workers of age-specific messages. BRAC hired field coordinators called program organizers to oversee the cascading of IYCF to the field level and mapping of households with children under 2 years of age in the program areas. Training of master trainers followed by training of frontline workers, supervisors, and program staff had to take place before launching the community activities. IYCF basic training provided to the frontline workers consisted of three days of classroom training followed by practice in the community.

## **Preparatory Phase**

In August 2009, BRAC introduced the IYCF community model in three rural sub-districts and one urban slum. In BRAC's well-established Essential Health Care Program, the community health volunteers provided health education during home visits, but they lacked adequate knowledge and counseling skills in infant and young child feeding. Moreover, their supervisors did not have IYCF promotion and support as an explicit part of their job responsibilities. Missing was a comprehensive, coordinated set of interventions to create an enabling environment in the community for improved practices.

During this exploratory phase, BRAC decided on the selection criteria and hiring process for a new cadre of staff (the PK), division of roles and responsibilities among three cadres of frontline workers, the timing of home visits and delivery of age-specific messages, the structure and functioning of an incentive system, and finalization of a basic set of tools.



Before scaling up beyond the first four areas, BRAC needed to figure out how to rapidly train 8,000 frontline workers. BRAC responded by increasing the number of its training venues from 5 to 16 to offer multiple trainings at the same time. Without this multiplier capability present in BRAC's extensive infrastructure, training could have become a stumbling block for rapid scale up.

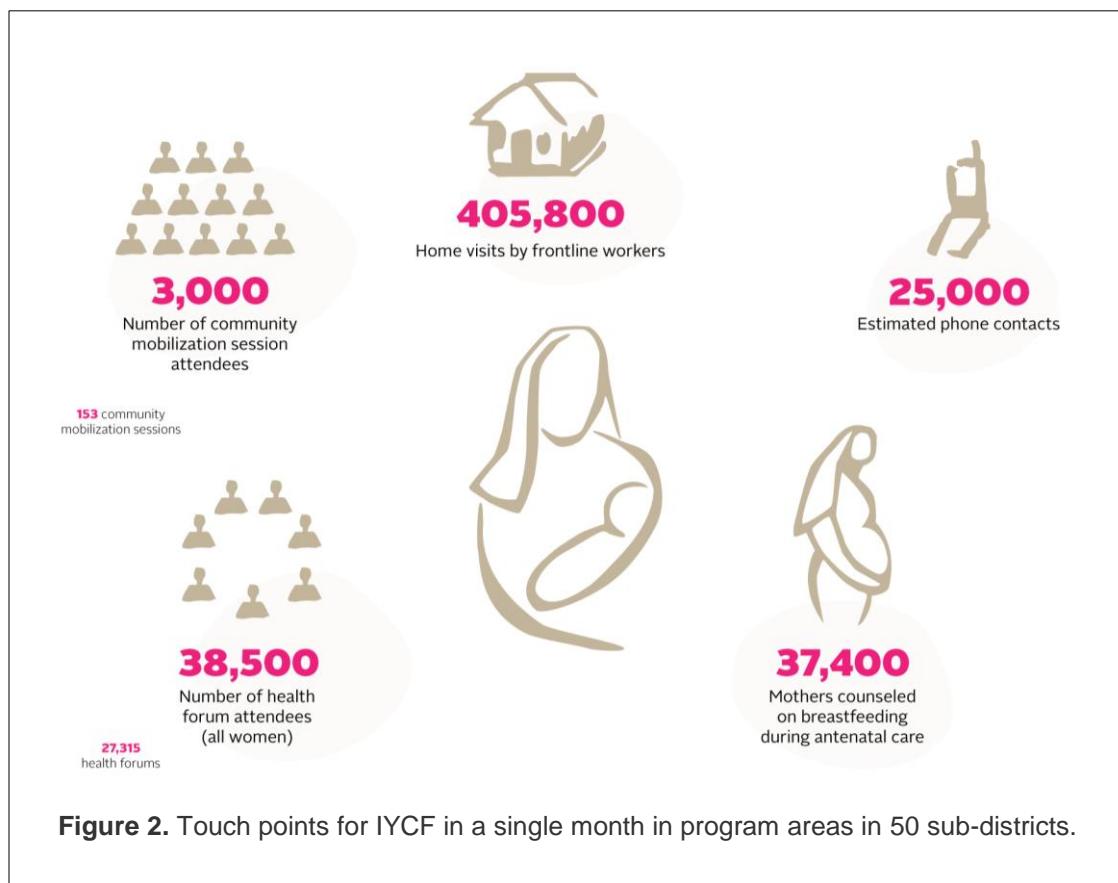
One of the learnings during the preparatory phase was that specially recruited data collectors took considerable time to identify and list households with pregnant women and children under 2 years of age. To reduce the time, program managers asked the PKs to list households in their area. These lists showed that some volunteers had more than 20 children under 12 months of age in their catchment area. To ensure reasonable workload and adequate coverage, program managers reassigned some households to other volunteers or asked PKs to spend more time in areas with higher concentrations of the target population. Another change based on learnings

from the exploratory phase included lowering the educational requirements for new recruits from 10<sup>th</sup> grade to 8<sup>th</sup> grade to fill positions and increasing hands-on experience during training.

## **Scaling Up to 50 Sub-Districts**

Although the original coverage target was 90 rural sub-districts and 10 urban areas using three BRAC platforms, BRAC decided to concentrate on 50 rural sub-districts and one platform (the Essential Health Care Program) to allow more time to refine the program and introduce new elements in its most sustainable program platform. Scale up began in 20

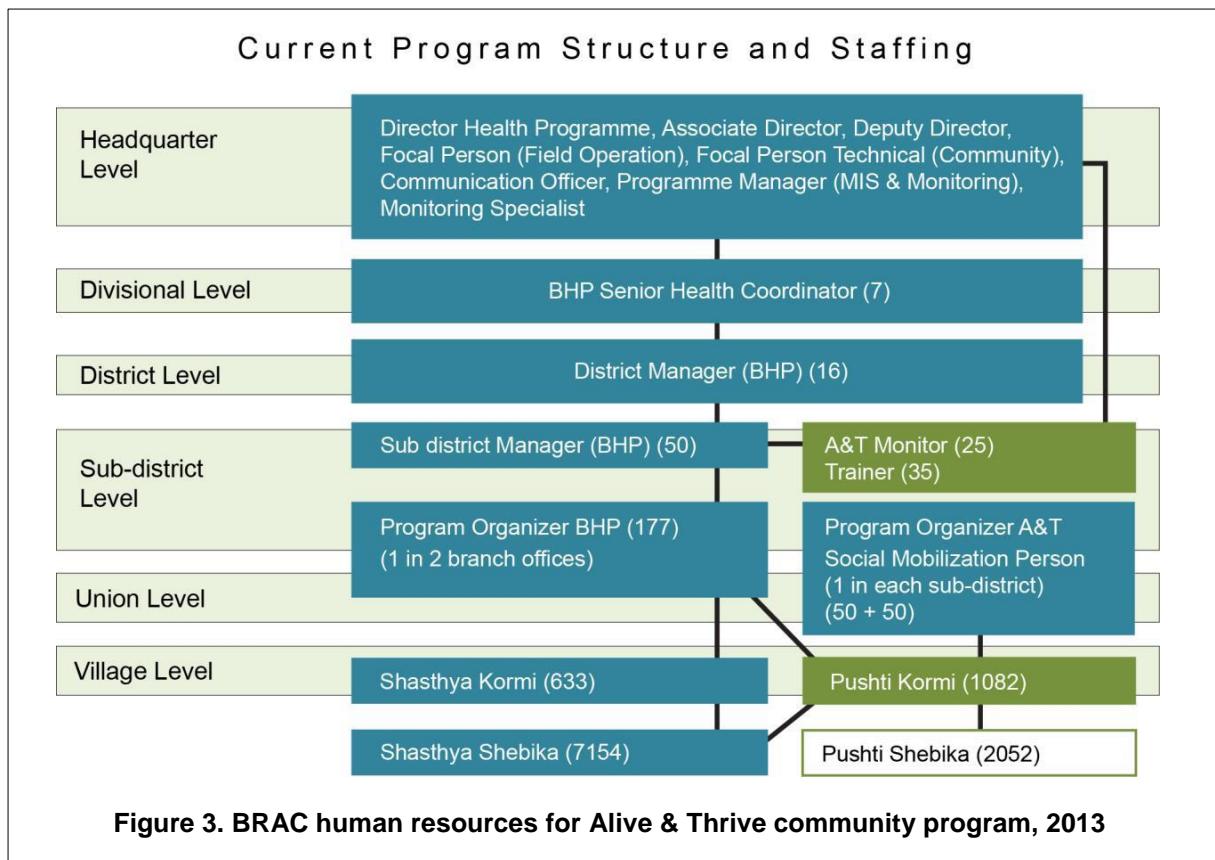
additional sub-districts in mid-2010 and another 28 sub-districts in 2011. These sub-districts, shown on the map in annex 1 and listed in annex 2) were located in various parts of the country as seen in map in annex 1. Clustering the program sub-districts would have reduced the management load, but their dispersion created learning sites throughout the country. BRAC reached 40,000 households with children under 2 with interpersonal communication in the exploratory phase in four sub-districts. By 2013, the program reached 1.7 million families of children under 2 in 50 sub-districts in 16 districts. **Figure 2** illustrates the level of **monthly activity** when the program was fully operational in the 50 sub-districts.



*Source: Alive & Thrive. Getting strategic with interpersonal communication: Improving feeding practices in Bangladesh. Washington, D.C., USA: Alive & Thrive, 2014*

Throughout the scaling up process, BRAC made various changes to improve efficiencies, respond to program needs, ensure quality, and address gaps in coverage.

Filling human resource gaps. Monitoring data showed that some volunteers were inactive or had dropped out. To fill the human resource gap, new recruits called Pushti Shebika (PS) received three-day training in IYCF so they could immediately begin to counsel and coach on IYCF. They will later receive 15 additional days of training to assume all of the responsibilities of a SS in the Essential Health Care Program. Additional program organizers were hired to organize the community mobilization sessions. The **human resources** required to implement the IYCF community-based model in the 50 sub-districts at its peak (2013) are shown in **figure 3**.



Source: *Implementation Manual for BRAC's Infant and Young Child Feeding Program in Bangladesh, 2013*

Increasing communication channels and ensuring equity. BRAC provided another channel of IYCF communication by providing a sticker with the cell phone number of a PK to 1 million households. Media monitoring results showed that messages delivered by frontline workers were not reinforced by media in some areas with no or little access to electricity. To ensure equity, in 2012 BRAC introduced in these areas interactive community events such as performances by drama troupes on nutrition-related themes and video shows. The video shows involved transporting a TV set, DVD player, and generator to "media dark" areas, showing the Alive & Thrive TV spots and animated films, and facilitating a discussion followed by a quiz with prizes.

Clarifying and reinforcing messages. Alive & Thrive revised the training module and video to address gaps or confusion. Alive & Thrive's national media campaign on handwashing linked to complementary feeding gave impetus to heightened focus on this component in refresher training, performance-based incentives, and job aids.

Prioritizing audiences. Advice provided by medical doctors conflicted at times with what Alive & Thrive promoted since the doctors were often quick to recommend breastmilk substitutes. In response, BRAC held technical updates for doctors on infant and young child nutrition. The majority of births occur at home, so BRAC increased the number of orientation sessions for TBAs and added refresher sessions



for them. Initially BRAC held community mobilization sessions for seven different categories of influential people in the community. After 2 years, the focus shifted to informal health providers (village doctors) in the community and fathers of children 7 months old with an emphasis on complementary feeding and handwashing because they play a clear and direct role in influencing household decisions.<sup>10</sup> One way of reaching fathers was through religious leaders. In addition, an orientation for graduate doctors took place in all districts.

Making it easier to adopt recommended practices. Inclusion of sachets of micronutrient powder in the volunteer's basket of health products offered a way mothers could enrich their child's food. To encourage adoption of new behaviors, the PKs distributed 250 ml bowls with images of recommended foods and markings to show the amount of food a child should eat at different ages. The bowl made the feeding recommendations clearer and visible and served as a daily reminder. BRAC piloted distribution of handwashing kits (plastic bucket, soap, and soap holder) to targeted households and encouraged the family to place the kit near the place of food preparation. Because of cost and operational challenges of distribution, BRAC did not continue distribution of the handwashing kits in all program areas, but frontline workers helped families set up a handwashing station using their own materials.

Improving performance. In response to gaps in knowledge and practice, BRAC added special quarterly refresher training on IYCF for the SS and PK in addition to holding routine monthly meetings. To help increase coverage and improve the quality of counseling, BRAC introduced performance-based cash incentives for frontline workers linked to feeding practices of those they counseled. This is the first time globally that such incentives have been provided for IYCF. In June 2010, BRAC piloted performance-based cash incentives in two of the four sub-districts that were part of the preparatory phase.

Monitoring findings, observations by program staff and monitors, administrative challenges, and the evolution of the community program called for adjustments to the incentive mechanism before introducing the incentives in the other 48 program sub-districts. For example, initially the incentives were available to the SS, SK, and PK, but were subsequently limited to the SS. Adjustments continued after the incentives were introduced in all 50 sub-districts as Alive & Thrive learned which behaviors needed to be emphasized and which incentive criteria were more reliable and easier to collect.<sup>11</sup>

Using monitoring data to track coverage and trends in key practices. Alive & Thrive estimated that 4.5 percent of the population in a sub-district would be under the age of 2 years. BRAC used its monitoring data to determine coverage, track changes in practices, and make program adjustments when needed.



*PK observes a SS counseling during a home visit*

## Results in Alive & Thrive Program Areas

Approximately 1.7 million mothers of children under 2 received counseling on IYCF in Alive & Thrive program areas by a BRAC frontline worker. A process evaluation conducted by IFPRI in 2013 found sizable improvements in feeding practices. Changes in exclusive breastfeeding between 2010 and 2013 in Alive & Thrive program areas were almost 25 percentage points higher than in comparison areas. The percentage of children who had minimum dietary diversity almost doubled, from about one-third to two-thirds of children in program areas. No changes were seen in comparison areas.<sup>12</sup>

More than 80 percent of mothers surveyed in program areas reported being visited and receiving advice on child feeding from a BRAC volunteer during their last home visit. Similar findings were reported for BRAC's IYCF promoter. On average, the frequency of visits in the previous 6 months was four by the SS and three by the PK. BRAC's monitoring data around the same time found that during a 3-month period, 92 percent of mothers had been counseled on feeding practices. What distinguished the A&T program areas from the comparison areas was the presence of the PK, more extensive training in IYCF for the Shasthya Shebikas, community mobilization activities for various community groups on infant and young child feeding, and performance-based cash incentives linked to feeding practices. The gains were much larger in the A&T intervention areas that had the full complement of community interventions than in the comparison areas. The process evaluation also found that visits by the SS and counselling on IYCF had increased since the baseline survey and were higher in program areas than in comparison areas.<sup>12</sup>

## Scaling Up Beyond Alive & Thrive Program Areas

Meeting the Alive & Thrive target for scale required expanding to other sub-districts in BRAC's Essential Health Care Program, introducing elements of the model in BRAC's MNCH platform, and leveraging other funds, both from BRAC and other donors. Customizing the approach and tools for other settings and different platforms facilitates scale up. This can mean streamlining training, setting up a different incentive structure, selecting fewer indicators, requiring fewer home visits, using different cadres of workers, etc.

### Scaling up in other Essential Health Care sub-districts

The Essential Health Care Program operates in 481 of Bangladesh's sub-districts. Through funding from DFID, BRAC is continuing IYCF activities in the 50 Essential Health Care (EHC) sub-districts where the Alive & Thrive model was introduced and is scaling up in 64 additional EHC sub-districts. In these areas, the SKs give added attention to early and exclusive breastfeeding, timely introduction of complementary foods, and handwashing linked to feeding during health forums. The PKs in the former Alive & Thrive sub-districts have become SKs that focus on nutrition. While the focus on complementary feeding is more limited at this point than in the Alive & Thrive model, greater attention is given to maternal and adolescent nutrition. Sessions are held for adolescent girls in grades 8, 9, and 10 and in the community for adolescents who are no longer enrolled in school.

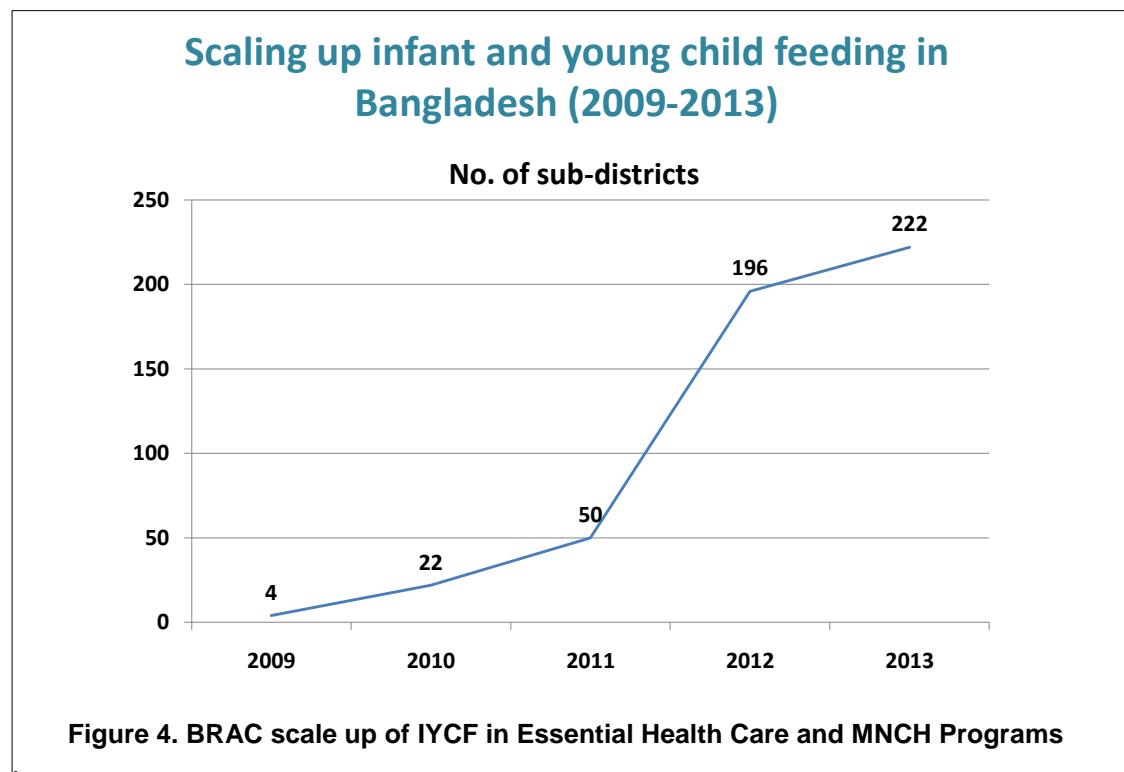
In July 2013 USAID awarded a grant to FHI 360 to replicate the Alive & Thrive model in Feed the Future sites in 26 sub-districts with BRAC implementing the community component in the EHC program areas. Many of those experienced in management and implementation of the community model in Alive & Thrive program areas are involved in its replication in the SHIKHA project. Except for the addition of a maternal nutrition component, the program is the same with the special cadre of workers (the PK – IYCF promoter), the incentive package, and social mobilization.

### Scaling up through MNCH Programs

In 2005 BRAC developed a comprehensive Maternal, Neonatal, and Child Health (MNCH) Program in rural and urban areas to reduce maternal, neonatal, and child mortality and morbidity. In 2010 BRAC added the reduction of malnutrition in children under 2 as one of the aims of the MNCH program. This platform provided an opportunity to integrate components of the Alive & Thrive model because of the same high-risk age group, appreciation by the community for the MNCH services, and the presence of well-trained and motivated frontline workers whose training and job description included support for early and exclusive breastfeeding. The Alive & Thrive model filled gaps in the MNCH program in management of breastfeeding problems and promotion and support for improved complementary feeding practices.

BRAC adopted a more streamlined IYCF model for MNCH, piloting a 3-month intervention in 6 rural sub-districts and one urban slum in mid-2011 and then scaling up to 63 rural sub-districts and 9 city corporations in 2012 and another 13 sub-districts in 2013. There was no need to recruit additional frontline workers to provide nutrition counseling because the SS in the MNCH program visited fewer households (100-150 compared to 250-300 in the Essential Health Care Program). The streamlined model did not include women's health forums, and community mobilization was limited to government health staff and local doctors. Those components of the Alive & Thrive model that BRAC incorporated in the MNCH platform were demonstrations, counseling, and coaching on complementary feeding during home visits; inclusion of sachets of micronutrient powder in SS health kit; performance-based cash incentives for SS linked to good feeding practices (although fewer in number); training sessions on complementary feeding and management of breastfeeding problems; and periodic IYCF refresher training. BRAC found that community interest in child nutrition motivated frontline workers and led to a demand for more knowledge and skills to improve feeding practices.

In summary, by 2014, BRAC had integrated IYCF in 140 Essential Health Care sub-districts, slums in 9 city corporations through the urban MNCH program, and 82 sub-districts through the rural MNCH program as shown in the **scale-up timeline in figure 4**. The number of children under 2 years of age in these areas is approximately 4.85 million (4.7 million in rural sub-districts and 0.15 million in urban areas), or 63 percent of children in this age group in a country of 155 million people. **Table 1** shows the IYCF intervention packages as implemented in the 50 Alive & Thrive program areas and then applied and adapted in other BRAC programs.



**Table 1. Community-based IYCF Interventions Scaled Up in Various Program Platforms in Bangladesh**

Intervention Package in Alive & Thrive Essential Health Care (EHC) sub-districts		Adaptation in BRAC Nutrition Project (64 additional EHC sub-districts)	Adaptation in BRAC MNCH rural program (See note on differences in Manoshi)
Counseling, coaching, and demonstration in pregnancy and first 2 years on breastfeeding and complementary feeding	Monthly home visits by SS and 12 in first 2 years by IYCF promoters (monthly in first 8 mo postpartum, 2 visits between 9 and 12 months, 2 visits between 13 and 24 months; counseling by SK at antenatal and postnatal visits	<p><b>IYCF:</b> Monthly home visits by SS and 12 in first 2 years by IYCF promoters (monthly in first 8 mo postpartum, 2 visits between 9 and 12 months, 2 visits between 13 and 24 months; counseling by SK at antenatal and postnatal visits.</p> <p><b>Maternal Nutrition:</b> Monthly home visits by SS and 4 visits by IYCF promoters during pregnancy (1 visit between 3-4 months of pregnancy, 1 visit between 5-6 months of pregnancy, 1 visit in 7 month of pregnancy and 1 visit between 8-9 months of pregnancy).</p> <p><b>Adolescent Nutrition:</b> Conducting adolescent health forum by IYCF promoters with 10-19 year old adolescent girls and program organizes conducting school forum with adolescent girls.</p>	<p>No specialized nutrition worker because have double the number of SS in the MNCH.</p> <p><b>IYCF:</b> Breastfeeding counseling and demonstration in 3<sup>rd</sup> trimester of pregnancy, 1<sup>st</sup> PNC (within 24 hour of delivery) and subsequent follow-up up to 6 months of children by SS and SK. Counseling on initiation of complementary feeding and demonstration by SS when child 181-188 days old. Monthly home visit by SS and SK up to 12 months. Quarterly home visit by SS from 13 to 24 months.</p> <p><b>Maternal Nutrition:</b> Counseling and demonstration by SK at 1<sup>st</sup> ANC visit. Coaching and follow up by SS/ SK every month up to delivery. Counselling and demonstration in 1<sup>st</sup> PNC by SK, followup visit on 28<sup>th</sup> day by SK.</p>
Skills development (basic training)	3-day classroom plus 1-3 day field-based IYCF training for frontline workers and 4-hour session for traditional birth attendants	3-day classroom plus 1-3 day field-based IYCF training for frontline workers and 4-hour session for traditional birth attendants	IYCF portion of the training module used in BRAC EHC was streamlined to 2.5 days with a focus on practice, demonstrations, and problem-solving
Problem-solving and refresher training for frontline workers	Quarterly refreshers on IYCF	Quarterly refreshers on IYCF	Discussed in monthly/regular refresher as per yearly schedule.
Cell phone counseling	Stickers provided to households with phone number of IYCF promoter	No cell phone counseling	No cell phone counseling

Job aids	Laminated pocket brochure with age-specific messages (not a counseling tool)	Laminated pocket brochure with age-specific messages (not a counseling tool)	Job aid information incorporated into MNCH handbook which provided at individual level
Feeding bowls	Feeding bowl provided to mothers when child at age of 7 months	Feeding bowl provided to mothers when child at age of 7 months	Feeding bowl provided to mothers when child at age of 7 months
Sales by volunteers of packets of micronutrient powder	Health volunteers sell packets of micronutrient powder to mothers of children older than 6 months of age	Health volunteers sell packets of micronutrient powder to mothers of children older than 6 months age	Health volunteers sell packets of micronutrient powder to mothers of children older than 6 months age
Monthly administrative meeting for frontline workers	Review and planning; distribution of commodities and incentives	Review and planning; distribution of commodities and incentives	SS and SK attend monthly administrative meetings
Supportive supervision	PK and program organizers use observation checklist during home visits	SK and program organizers use observation checklist	Existing MNCH supervision schedule and tools are used with the addition of BF problem-solving and demonstrations for CF
Incentives	Sale of health products and performance-based cash incentives for SS; honorarium for additional time for IYCF for SK	Fewer performance based incentive. No honorarium for SK.	Fewer performance based incentive. No honorarium for SK.
Community-based women's groups	Health education in small community groups	Health education in small community groups	None
Social mobilization sessions	Forums on IYCF for opinion leaders e.g. doctors, local government officials, religious leaders, fathers, adolescents	Forums on IYCF for opinion leaders e.g. doctors, local government officials, religious leaders, fathers, adolescents	Limited to government officials
Video shows with discussion, quiz, prizes	Once per 6 months in low electrified communities	No video show	No video shows
Popular theater	Performance focused on feeding issues	Performance focused on feeding issues	No theater

**Note:** The Manoshi urban platform for MNCH is similar to the rural platform except in urban locations where there are additional service providers from the community who are providing IYCF counseling and an extra cadre of newborn and trained birth attendants who are involved.

# Sustaining Support for Improved Infant and Young Child Nutrition

The scale up of IYCF in Bangladesh occurred rapidly with the introduction of the Alive & Thrive program, expansion by BRAC, and support from other donors (USAID and DFID). The question is always asked: but can the increased attention and support be sustained? Various factors that contribute to sustainability are discussed in this section. Eight factors are considered: 1) political will, 2) institutional will, 3) capacity to deliver, 4) an enabling environment and supportive social norms and trends, 5) demand for services, 6) integration of the approach and tools in multiple platforms, 7) dedicated financial resources, and 8) diffusion of evidence, tools, and innovation.

## 1. Political Will

The Government of Bangladesh sets priorities and the direction for the country. In place is a vision and a plan, a national program, and coordinating mechanisms. The Government of Bangladesh is working to accelerate progress by mainstreaming nutrition interventions into health and family planning services. The provision of community-based nutrition services is being scaled up, and the food and nutrition policies and plans are being implemented. To achieve the goals, nutrition has been made a priority for the proposed health sector program. The Health, Population and Nutrition Sector Development Program (HPNSDP) and several key sectors work together to implement priority objectives. Infant and young child feeding is the top priority intervention. Alive & Thrive's media engagement program with journalists helped elevate IYCF as a priority.

### ***Shared vision and a plan***

A shared vision and framework are the foundation for sustainability.

- National Communication Framework and Plan for Infant and Young Child Feeding. In 2010, Alive & Thrive, government agencies, NGOs, and multilateral organizations worked together to produce the framework and plan. The framework outlines the role of communication in creating demand for early initiation of breastfeeding, exclusive breastfeeding, and quality complementary feeding for IYCF. The plan sets out actions for reaching mothers and families through interpersonal and mass media channels and creating an enabling environment for them to adopt healthy behaviors through social actions and supportive policies.
- National Nutrition Services. The government's Health, Population and Nutrition Sector Development Program, adopted in 2011, made infant and young child feeding a top priority. The National Nutrition Services (NNS), under the Directorate General of Health Services (DGHS) and Directorate General of Family Planning (DGFP), is tasked to deliver nutrition services throughout the country and to ensure universal access to a comprehensive package of essential nutrition services, primarily through community clinics. All contacts with health services are to include IYCF and other nutrition interventions. The NNS also emphasizes involving multiple sectors in nutrition programming.

### ***Coordination and advocacy mechanisms***

The intent is for the National Nutrition Services to play a coordination and advocacy role and to ensure active engagement with other sectors. Bangladesh is a member of the Scaling Up Nutrition Movement, and BRAC is the convener of the Civil Society Alliance (CSA) for SUN. The CSA is composed of representatives from civil society networks across the country to work in support of the government and to advocate for the further development of the national nutrition agenda. It aims to promote sustainable improvement in nutritional status of

adolescents, women, and children of Bangladesh using the ‘1,000 days approach’ by creating a strong, coordinated, and vibrant civil society constituency alliance to support development and implementation of the nutrition agenda under the leadership of the Government of Bangladesh. BRAC also participates in coordination meetings of the IYCF Alliance organized by the Institute of Public Health Nutrition and in the Nutrition Working Group of nongovernmental organizations convened by UNICEF.

## **2. Institutional Will**

BRAC’s programs have witnessed dramatic declines in child mortality but not comparable drops in malnutrition. For that reason, BRAC has placed renewed emphasis on nutrition as reflected in the addition of “Nutrition” to its program name, the Health, Nutrition and Population Program. BRAC generates sufficient funds to finance up to 70 percent of its development programs, so its investment in nutrition is not dependent solely on donor funds.

## **3. Capacity to Deliver**

Systems need to be in place and have the capacity to deliver IYCF services. There must be an adequate number of skilled human resources, the capacity to keep them motivated, and resources to maintain quality and equity of service delivery.

### ***Skilled and motivated human resources***

Health professionals and frontline workers are the backbone of the delivery system. To ensure that current and future providers have the knowledge and skills to provide counseling and support, Alive & Thrive invested in in-service training and training institutions to build systems-wide capacity and foster scale and sustainability. A strategy to engage and motivate doctors was another way in which Alive & Thrive aimed to ensure sustained support for IYCF from those who play a major role in influencing feeding behaviors.

- National training module. The government set up a National Technical Committee to review the Alive & Thrive training module. The module was revised based on feedback from the committee and serves as the reference for training of trainers.
- Master trainers at training institutes. BRAC trained 35 master trainers to provide IYCF training at 16 training venues. With the exception of BRAC trainers, there were no master trainers or training institutions prepared to train using the module. Alive & Thrive identified four training institutes with good facilities and experience in conducting trainings in MNCH and family planning and trained 72 of their master trainers in the IYCF module.
- Ongoing training and refresher training of frontline workers, performance improvement, and supportive supervision. BRAC now has in place 15,538 frontline workers (SS-11,952 and SK-3,586) in its Essential Health Care Program and 32,835 frontline workers (SS-29,094 and SK-3,741) in its MNCH program that have been trained in IYCF. These workers are supervised using an observation checklist that focuses on recommended feeding practices and good counseling skills. Refresher training, supportive supervision, and performance-based incentives aim to motivate and improve performance. To ensure continuous motivation of the frontline workers to deliver quality services, BRAC conducts monthly special refresher training for them.
- Advocacy for medical doctors. BRAC’s district-level advocacy seminars for doctors aim to ensure that they are aware of the latest scientific evidence and feeding recommendations and know how to support mothers to adopt good feeding practices. Without their support, BRAC’s efforts could be undermined and threaten sustainability of good feeding practices. BRAC conducted 100 seminars for 1,894 doctors in Alive &

Thrive program areas to raise awareness of their role in promoting good feeding practices. BRAC is continuing to conduct seminars for doctors in the SHIKA project.

#### 4. Enabling environment and supportive social norms and trends

BRAC helped create an enabling environment in the community through its unique use of social mobilization to raise awareness of appropriate IYCF practices and available services among influential members of the community and to elicit their commitment to take action in support of improved practices. From December 2010 through May 2014, BRAC held 4,897 **community mobilization sessions** in the 50 program sub-districts with an average of 20 people at each session (**table 2**). In addition, almost 1.5 million community members attended popular theater with dramas on IYCF themes, and approximately 98,000 attended interactive video shows. The use of popular theater as part of BRAC's Community Empowerment Program facilitated the dissemination of key IYCF messages, particularly to those who are not literate, through the use of entertainment. The plays, usually held in the evening, drew large audiences of women, children, and men with popular actors and musicians presenting issues surrounding undernutrition based on real life scenarios familiar to the audience. These various types of community mobilization activities helped empower community members to exercise proper IYCF practices and motivate and teach others for years to come.

**Table 2. IYCF community mobilization sessions and TBA orientation sessions in 50 sub-districts of Bangladesh**

Audience	Number of Sessions	Total Number of Participants
Religious leaders (Dec. 2010 – Nov. 2012)	<b>488</b>	<b>9,224</b>
Alternative health care providers (village doctors) (Dec. 2010 – May 2014)	<b>549</b>	<b>10,358</b>
Traditional birth attendants (Dec. 2010 – May 2014)	<b>756</b>	<b>15,598</b>
Health & family planning officers and staff (Dec. 2010 – Nov. 2012)	<b>374</b>	<b>7,421</b>
School teachers (Dec. 2010 – Nov. 2012)	<b>640</b>	<b>12,470</b>
Adolescent girls (Dec. 2010 – Nov. 2012)	<b>805</b>	<b>15,955</b>
Village elders and elites (Dec. 2010 – Nov. 2012)	<b>678</b>	<b>13,247</b>
Village committee members (Dec. 2010 – Nov. 2012)	<b>145</b>	<b>2,833</b>
Fathers of children under 2 years (Dec. 2012 – May 2014)	<b>462</b>	<b>8,894</b>
<b>TOTAL</b>	<b>4,897</b>	<b>96,000</b>

Getting the support of many groups in the community for recommended IYCF practices and making these practices the social norm make it easier for mothers and caregivers to adopt and sustain healthy feeding practices. Many of the recommended practices have reached a tipping point where the majority and up to 80 percent of mothers have adopted the practice. One of the objectives of Alive & Thrive's national mass media and advocacy campaign was to create support among the general population for improved feeding practices.

## **5. Demand for Services**

Sustainability is also dependent on demand for services. Anecdotal reports indicate that households request visits by frontline workers with people asking when the SS and PK are coming for their next visit and fathers saying, "Please come to my house. My wife is asking for you." The large number of people attending the community mobilization sessions and video and theatrical shows indicates the high level of interest in the topic of child feeding.

## **6. Integration of the Approach and Tools in Multiple Platforms**

As noted, BRAC has integrated key IYCF interventions into the Essential Health Care program in rural areas and into MNCH programs in urban and rural areas. BRAC has ensured that frontline workers are recruited from the local community. These workers are more likely to stay in the community in which they work, which fosters sustainability since they will continue to share their knowledge, demonstrate and support good practices, and mentor those in their families and communities. BRAC is also exploring integrating IYCF in other platforms such as WASH, agriculture, and education.

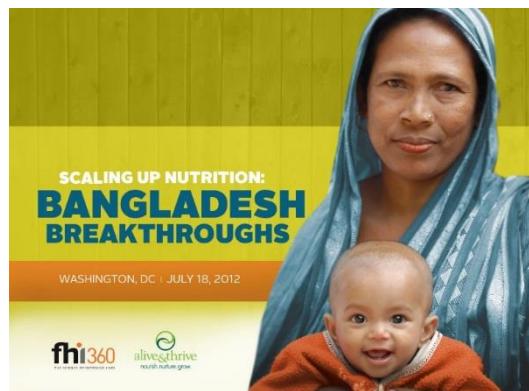
## **7. Dedicated Financial Resources**

Since 2009 when Alive & Thrive began program activities, almost \$40 million has been leveraged for IYCF. This includes \$4.7 million from USAID for the SHIKA Project implemented by BRAC and managed by FHI 360, \$25 million from DFID for BRAC's Nutrition Project, \$6.8 million from CIFF for promotion of micronutrient powders and IYCF in 170 sub-districts, \$2.5 million from the Department of Foreign Affairs, Trade, and Development Canada to Alive & Thrive to integrate maternal nutrition in BRAC's rural MNCH program, and \$0.5 million from SUN (2012 to 2015). Continued advocacy is required to ensure future financial resources for IYCF, including government financing.

## **8. Diffusion of Evidence, Tools, and Innovations**

Evidence that an approach works in changing behaviors and the ready availability of tested tools such as job aids, training manuals and videos, and observation checklists make scaling up IYCF more attractive because of savings in time and money. Alive & Thrive held dissemination workshops to share results; distributed hard copies and CDs of tools; translated resources into English for broader dissemination; participated in working groups; prepared an implementation manual, papers, and briefs describing the program; presented at conferences, meetings, and seminars; and arranged site visits, including for a large delegation from Madagascar.

Alive & Thrive resources developed in Bangladesh are readily available through the Alive & Thrive website [www.aliveandthrive.org](http://www.aliveandthrive.org).



*An event held in Washington, DC on scaling up nutrition was one of many events where BRAC presented on the community-based IYCF program*

# **Conclusion**

Several factors facilitated scaling up improved infant and young child feeding practices in Bangladesh. These factors included BRAC's pre-existing nationwide platforms and ability to rapidly position dedicated (full-time) managers for IYCF, the availability of donor funds, clear targets and accountability for their achievement, and data showing that the program resulted

in large changes in practices. A ready-made and field tested IYCF intervention package accompanied with technical support for problem solving expedited the scaling up process. A complete listing of children under 2 proved to be critical for determining where and how to reach mothers and to redistribute workloads and catchment areas of frontline workers when necessary.

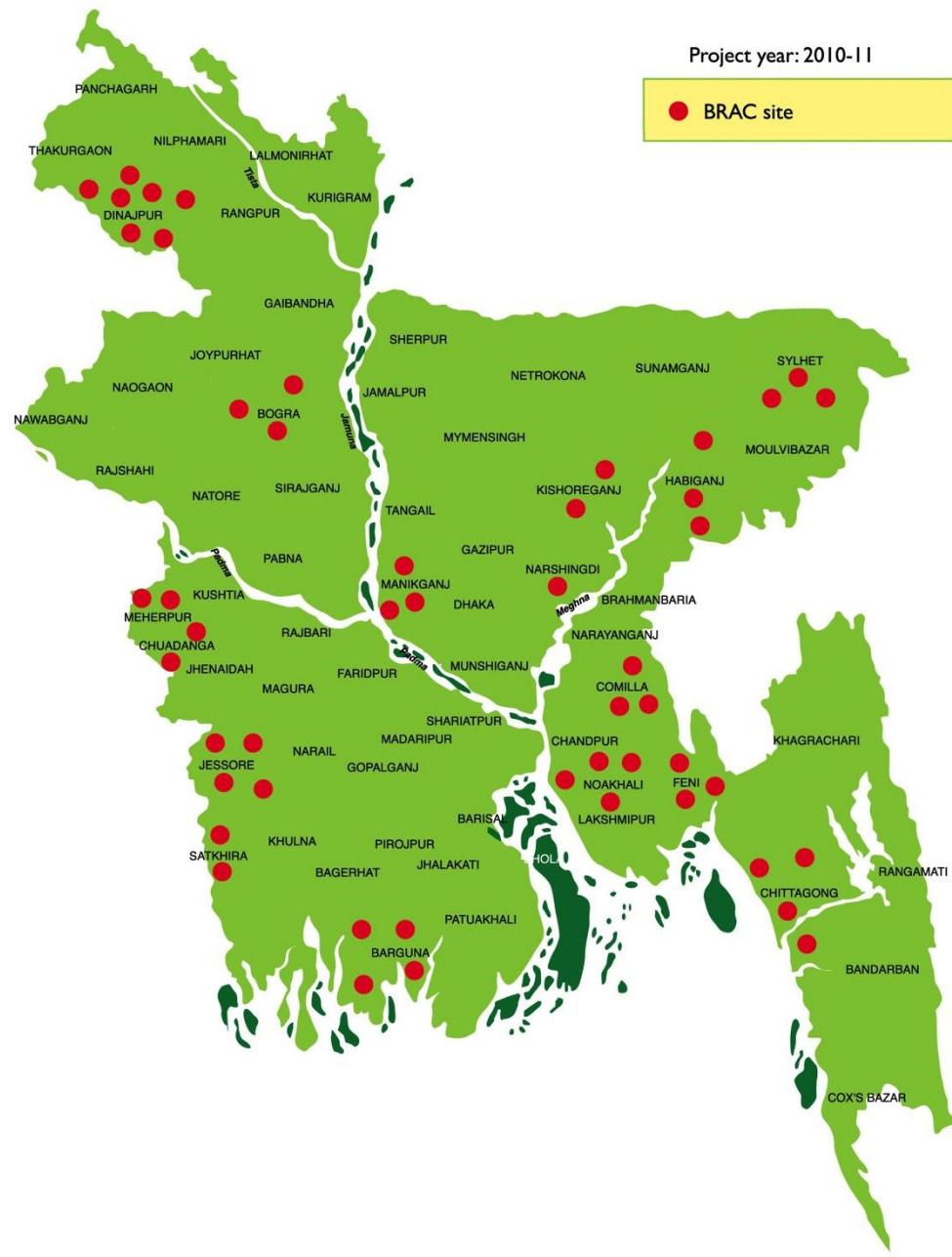
The process of scaling up showed the need for systems strengthening as well as flexibility. Basic training was not enough to ensure scale with quality. At a minimum, performance of adequate IYCF counseling requires well-trained frontline workers, substantial follow up and supervision to monitor quality and provide motivation, refresher training, and recognition of achievements of frontline workers.

The opportunities now for scaling up and sustainability should not be squandered. Program results show that families are open to change. There is global, national, and institutional pressure to reduce malnutrition. Evidence of success and the availability of tools and assistance should encourage others to join the movement. If taken to scale, proven IYCF interventions can achieve many development objectives including prevention of neonatal and child deaths and improved long-term growth, educational achievement, and future economic opportunities. BRAC's commitment to improving child nutrition will continue because doing so aligns with its mission to achieve large-scale, positive changes through programs that enable all to realize their potential.

## References

1. Ahmed T, Ahmed AM. Reducing the burden of malnutrition in Bangladesh. *BMJ* 2009; 339:b44490.
2. WHO. 2013. Supplementary feeding in community settings for promoting child growth. Available: [http://www.who.int/elenatitles/child\\_growth/en/index.html](http://www.who.int/elenatitles/child_growth/en/index.html) (accessed 22.07.2013)
3. White H. Comment on contributions regarding the impact of the Bangladesh Integrated Nutrition Project. *Health and Policy Planning* 2005; 20:408-411.
4. National Institute of Population Research and Training (NIPORT)/Mitra and Associates/Macro International. *Bangladesh Demographic and Health Survey 2007*. Dhaka and Calverton, Md, USA: NIPORT/Mitra and Associates/Macro International, 2009.
5. Saha KK, Bamezai A, Khaled A, Subandoro A, Rawat R, Menon P. *Alive & Thrive Baseline survey report: Bangladesh*. Washington, D.C.: Alive & Thrive, 2011.
6. Institute of Public Health Nutrition (IPHN), Directorate General of Health Services, Ministry of Health and Family Welfare. National communication framework and plan for infant and young child feeding in Bangladesh. Dhaka: IPHN, October 2010.
7. World Health Organization. Infant and Young Child Feeding Fact Sheet No. 342. Updated February 2014. <http://www.who.int/mediacentre/factsheets/fs342/en/>
8. Alive & Thrive. Perceptions, practices, and promotion of infant and young child feeding in Bangladesh: Results and program implications of assessments in Bangladesh. Dhaka, Bangladesh: Alive & Thrive, 2012.
9. Lin JF ed. Scaling up in agriculture, rural development, and nutrition. *Focus* 19. Washington, DC: IFPRI, June 2012.
10. Martin L, Haque MR. Mobilizing community support for improved infant and young child feeding in Alive & Thrive program areas in Bangladesh. Washington, DC: Alive & Thrive, 2013.
11. Martin L, Haque MR. Performance-based cash incentives for volunteers in BRAC's community-based Alive & Thrive infant and young child feeding program in Bangladesh. Washington, DC: Alive & Thrive, November 2013.
12. Alive & Thrive. Using multiple platforms for change in the context of high malnutrition: Alive & Thrive's approach and results in Bangladesh. Washington, DC: Alive & Thrive, July 2014.

## Annex 1. A&T Program Areas through BRAC's Essential Health Care Program

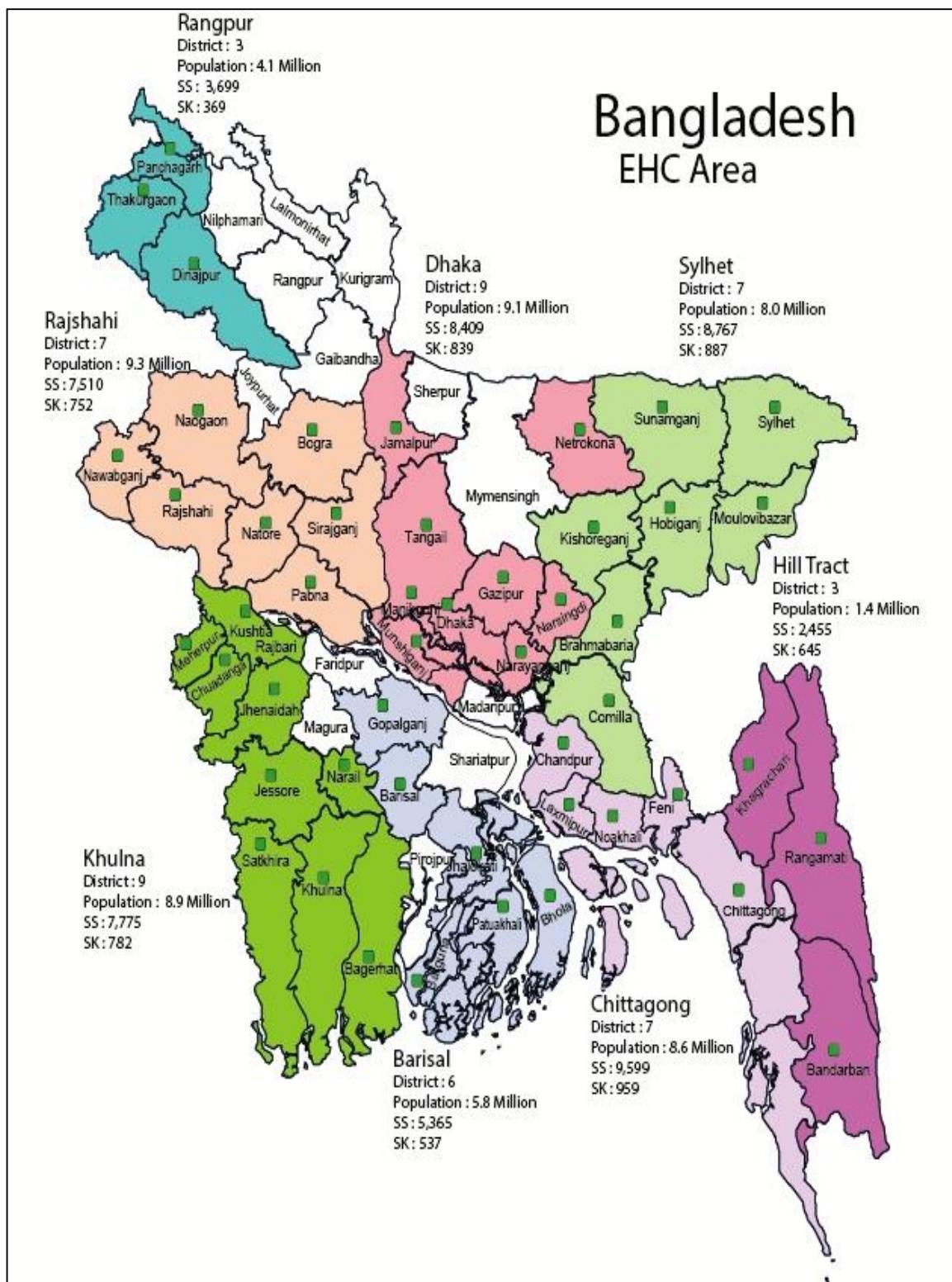


## Annex 2. List of A&T Program Areas

### Sub-districts for Alive & Thrive Community Component

Upazila	District	Upazila	District
1 Bianibazar		28 Shajahanpur	
2 Fenchugonj	Sylhet	29 Kahaloo	Bogra
3 Balagonj		30 Nandigram	
4 Chunarughat		31 Kesobpur	
5 Madhabpur	Hobigonj	32 Chougacha	Jessore
6 Lakhai		33 Jhikorgacha	
7 Chandanaish		34 Monirampur	
8 Satkania		35 Debhata	Satkhira
9 Boalkhali	Chittagong	36 Kaligonj	
10 Lohagara		37 Meherpur Sadar	Meherpur
11 Sadar Dakshin		38 Mujibnagar	
12 Barura	Comilla	39 Alamdanga	Chuadanga
13 Laksam		40 Damurhuda	
14 Senbag		41 Borguna Sadar	
15 Chatkhil		42 Betagi	Borguna
16 Companigonj	Noakhali	43 Bamna	
17 Sunaimuri		44 Pataharghata	
18 Parashuram		45 Shibalay	
19 Fulgazi	Feni	46 Ghior	Manikgonj
20 Chagolnaiya		47 Saturia	
21 Nawabgonj		48 Hossenpur	Kisoregonj
22 Ghoraghata		49 Pakundia	
23 Birampur		50 Pollash	Norsingdi
24 Hakimpur	Dinajpur		
25 Kaharul			
26 Bochagonj			
27 Birol			

### Annex 3. BRAC Essential Health Care Areas with IYCF Activities, 2014



#### **Annex 4. BRAC MNCH Areas with IYCF Activities**

