The levels of stunting, underweight, wasting, and childhood anemia are very high in Bangladesh, as are levels of maternal chronic energy deficiency and maternal and child anemia. A combination of poor maternal nutrition and postnatal factors cause child undernutrition, which in turn can have far-reaching consequences for national and global development, as well as individual health. Studies in Bangladesh show that infant and young child feeding (IYCF) practices, a critical determinant of child nutrition, are poor. Interventions to address them at a large scale are urgently needed, including behavior-change counseling for early and exclusive breastfeeding, age-appropriate complementary feeding and micronutrient supplementation, provision of micronutrient supplements or fortified complementary foods, hygiene interventions, and nutritional management of severe-acute undernutrition.

Alive & Thrive (A&T) seeks to develop scaled-up models for preventing child undernutrition by improving IYCF practices. Funded by the Bill & Melinda Gates Foundation, A&T's interventions focus on achieving behavior change through existing service-delivery platforms, especially the health worker network of BRAC, the largest nongovernmental organization in Bangladesh. This brief focuses on A&T's use of BRAC's Essential Health Care (EHC) program in 2009–2011 as its operational platform. During this time, 9,000 managers, mid-level staff, workers, and volunteers were trained in interpersonal counseling, and an IYCF-oriented social mobilization strategy reached 15 million people.

### Addressing IYCF in Bangladesh: The Alive & Thrive community-based interventions

The A&T model includes three cadres of BRAC community health workers who are responsible for counseling, coaching, training, and helping mothers use good IYCF practices: volunteers assigned to 250–300 households each, health workers who specialize in pre- and postnatal health services, and dedicated IYCF promoters who record services provided and fill in gaps in home visits. Mothers are counseled in the use of locally available resources to encourage healthy growth in children under two years of age. The model requires repeated home visits by trained workers, and priority is given to reaching mothers with infants less than 12 months old: the period of greatest vulnerability to growth faltering.

Through social mobilization, local opinion leaders such as imams, government health workers, and village doctors are engaged through forums and meetings to highlight the importance of nutrition, particularly in IYCF. Recently, BRAC has added forums for adolescents, parents, school teachers, local leaders, and elderly people. A&T reinforces and extends the impact of BRAC’s community interventions through national mass media campaigns, policy initiatives, and partnerships with other community-based organizations.

### Implementation: Rolling out the pilot and expanding scale

BRAC’s A&T initiative began with a pilot in mid-2009 to test the A&T model under three different program platforms: (1) the EHC program; (2) maternal, newborn, and child health (MNCH) interventions; and (3) EHC plus a water and sanitation program. The pilot phase was carried out in one urban slum and three upazilas (rural subdistricts). During the pilot, many elements were adjusted: the selection criteria and hiring process for a new cadre of staff (the IYCF promoter) and their integration into BRAC’s structure; division of roles and responsibilities among frontline workers; and an improved basic training module to account for local foods, the quantities needed to satisfy age-specific nutrient requirements, typical feeding bowls, the limited educational level of many of the frontline workers, global recommendations, and findings from the formative research. The pilot provided time to test and improve the data collection indicators, incentives for service delivery, and the process for identifying children and tracking home visitation.

The final selection of EHC as the program platform on which IYCF would be built was a major outcome of the pilot phase. The pilot resulted in a scaling-up target of 50 upazilas across the country, a decision to scale up in two phases, and the development of methods for ensuring accountability of cash incentives. Examples of lessons learned from the pilot:

- The listing of target households by child’s age was initially done by data collectors. Later, during scale up, the IYCF promoters conducted child listing in their catchment areas, which was less costly and more efficient.

- Basic training was conducted in the pilot through 20 batches consisting of mixed groups of health workers, staff, and volunteers at five BRAC training venues. The project later increased the training venues to 16, allowing multiple simultaneous sessions.

- The roles and responsibilities of frontline workers and the timing and number of home visits evolved during the pilot. When worker gaps were identified, new workers were hired using modified criteria when needed to ensure adequate coverage without losing momentum.

### Reflections on the scaling-up experience

Since IYCF promotion and counseling was already a known effective intervention, A&T relied on expansion through replication. IYCF was integrated into existing programs reaching the same target age groups. This was more rapid and affordable than establishing a new infrastructure and helped ensure that other preventive and disease control interventions would be offered alongside IYCF interventions. Adapting and simplifying the IYCF intervention for BRAC’s EHC was considered essential, since it would be
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Field experiences helped ensure that the program reflected cultural sensitivities. Practical yet comprehensive M&E and knowledge-sharing processes were established to foster ongoing adjustments.

The drivers of scale for A&T in Bangladesh included ideas and models from former successes in breastfeeding and complementary feeding programs and endorsement of proven, high-impact IYCF programs. Visionary leaders at BRAC, A&T, and the Gates Foundation, with the encouragement of the government’s nutrition leadership, drove the scaling-up process forward. In the aftermath of the dismantling of Bangladesh’s National Nutrition Program, in part due to its limited scale, the search for a better option worked as an external catalyst. The Gates Foundation’s “learning grant” program acted as an incentive, as it required a high level of accountability for results at scale.

Overall, the framework for scaling up developed for this series was broadly validated, with some caveats. A phased scaling up with key learning objectives at each phase is critical given the nature and challenges of sustaining IYCF behavior change. Reviewing experiences when operating at scale helped identify core processes for ensuring quality at scale. A strong technical team to adapt innovations was key, as was BRAC’s ability to address variable needs such as staffing up volunteers and adding support for social mobilization. Different monitoring modalities, reporting to different units, also contributed to assessing and addressing program quality.

Finally, a conducive, preexisting national policy environment for IYCF, created by an existing national IYCF Strategy (2007), and a more detailed and comprehensive national communication plan that was endorsed and adopted by the government (2010) helped ensure that all core processes and players were approved, and no additional clearances were required once scale up started.

These various factors came together to form an ideal environment for replicating and expanding IYCF interventions. Monitoring data indicate that IYCF practices have continued to improve in program areas during scale up, and early process evaluation data suggest services provided are of good quality. It is anticipated that the A&T approach will help achieve and maintain the impact of good IYCF practices at a large scale in Bangladesh for years to come.