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RESEARCH AND EVALUATION DIVISION
BRAC CENTER
75, MOHAKHALI C/A
DHAKA 1212, BANGLADESH

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CONTENTS

MUKTAGACHA: A TARGETED NUTRITION PROJECT IN BANGLADESH

A. Mushtaque R. Chowdhury
Zeba Mahmud
Sadia A. Chowdhury
Kawshiki Nasser
SM Ziauddin Hyder

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BRAC
Research and Evaluation Division
75, Mohakhali
Dhaka 1212, Bangladesh

TABLE OF CONTENTS

INTRODUCTION

Malnutrition is one of the major public health problems in Bangladesh. Since 1993, BRAC, a national non-governmental organisation (NGO), has been carrying out a targeted nutrition project in a thana (sub-district) of Bangladesh. The major emphasis of the project are nutrition education and food supplementation to the vulnerable groups. This case study, done at the request of UN Food and Agriculture Organisation (FAO), presents the project with special attention given to different aspects of 'targeting'.

BACKGROUND

Bangladesh suffers from some of the worst forms of malnutrition. It is a widespread and persistent problem, mostly affecting children under five years of age, and pregnant and lactating women. The daily per capita calorie consumption has improved from an estimated 1,943 kcal in 1981-82 to 2,019 kcal in 1992 but still far below the government target of 2,301 kcal. The high proportion of cereals in the diet (with food grains comprising 90% of the per capita daily calorie intake), the low amount of animal product, and the inadequacy of fruits and vegetables exacerbate the chronic situation of calorie insufficiency. The average weight of the women in Bangladesh is less than 50 kg; continued hard work during pregnancy coupled with low dietary intake adversely affect maternal nutrition. The influence of this on the outcome of pregnancy is reflected by the fact that almost half of all births are below 2.5 kg, the cut-off point for low birth weight; high maternal death, estimated to be over 600 per 100,000 live births, is also partly due to maternal malnutrition.

Deficiencies in essential micronutrients also characterise the typical Bangladeshi diet. Nutritional blindness due to vitamin A deficiency affects 30,000 children a year; and iodine deficiency results in a high prevalence of goitre (47%). Over 70% of pregnant women and children under 5 suffer from iron deficiency anaemia.

Malnutrition in Bangladesh is essentially a poverty driven problem; the situation for the landless and other disadvantaged sections is particularly difficult. Improving rural employment opportunities and increasing real incomes are of over-riding importance in significantly improving the nutritional status of the population, particularly the poor. Despite efforts on the part of the government and NGOs, success in the front of poverty alleviation has been modest at best. To see the effect of nutrition education and direct supervised feeding in reducing malnutrition among children, adolescents and pregnant women, BRAC carried out a pilot project in a sub-district of Bangladesh. The following case study describes this pilot project.

BRAC AND ITS TARGETED PROGRAMMES

BRAC was founded in 1972 as a response to humanitarian causes following the War of Independence. After working for about a year BRAC realised that relief, which it was doing so far, was not a solution to people's multifarious problems. They needed employment, education, social status and health care. In 1977, BRAC switched to a strategy which served only the poor, which was called the 'target group approach'; most of BRAC programmes now are based on this approach. This, in other words, meant that it worked exclusively with and for the poor and other disadvantaged sections including the women. BRAC carries out programmes targeted to different groups of people.

Depending on the nature of the intervention, the target group that BRAC serves varies. For example, the poorest remains the target of BRAC's major poverty alleviation programme called the Rural Development Programme or RDP. Similarly the target for most components of the health programme are the women in reproductive age and children under five years of age. Table 1 gives a summary of BRAC programmes along with the type of target group it serves. The table shows that the three programmes with nutrition as the direct focus are also targeted to specific groups. These are: Income

generation for vulnerable group development (IGVGD), iron supplementation, and food supplementation. The latter one, more popularly known as the Muktagacha nutrition project, is the subject of this case study.

Table 1. Examples of targeted programmes of BRAC

Name of programme	Focus	Target group
Income Generation for Vulnerable Group Development Programme (IGVGDP)	Income generation, Livestock, Nutrition	Poorest / destitute women (bottom 10% of the population in socio-economic scale)
Rural Development Programme (RDP)	Income, Employment, Institution building	Poor (owning less than 50 decimals of land)
Reproductive Health and Disease Control Programme (RHDC)	Reproductive health, Immunisation, ARI, TB	Women (15-49 yrs), children (0-6 yrs) and people with tuberculosis
Iron Supplementation Programme	Iron and folic acid	Women of reproductive age including pregnant women and children attending NFPE school.
Non-formal Primary Education Project (NFPE)	Primary education	Children from poorer families
Muktagacha Nutrition Project	Nutrition education, Food supplementation	Malnourished children, adolescents, and pregnant women .

BRAC IN NUTRITION: THE MUKTAGACHA PROJECT

BRAC has been involved in rural development over the last quarter century. It aims to empower people by alleviating poverty through three major vertically integrated field programmes - health, education, and rural development. Health has been a central concern in BRAC since its founding in 1972. The health programme has gone through several distinctive phases: experimental family planning, integrated health care, oral rehydration teaching programme, child survival and facilitation of the government's Expanded Programme on Immunisation. The culmination of all this in the nineties has been the BRAC decision to focus on the health of the marginalised, i.e. women and

children and on issues such as nutrition, reproductive health and disease control which are complex and thus neglected. This brought into effect an integration of health and development activities.

The aim of this new programme was to improve the quality of life in terms of health and nutrition and empower the community to sustain this condition. The integrated programme known as the Women's Health and Development Programme (WHDP) was launched in July 1991 in 10 thanas. WHDP aimed to improve the health and nutritional status of women including adolescent girls and children. It also aimed to mobilise communities and strengthen community-level capacities to sustain the effects of health and development activities.

As is customary, a baseline survey was conducted in each of the thanas where the programme was to be implemented.

WHDP offered a comprehensive and integrated package of health services with special emphasis on women and children. The package consisted of the following:

- Maternal, ante-natal, natal and post-natal care;
- Contraception services and education;
- Immunization services;
- Micronutrient distribution (Vitamin A and Iron);
- Birth weight recording and growth monitoring (0-2 years);
- Tuberculosis detection, treatment and control;
- ARI detection , treatment and control; and
- Water and sanitation.

In view of the appalling nutrition situation in Bangladesh the need of a comprehensive community-based nutrition programme was felt very strongly. The government of Bangladesh and the donors, however, felt the need to ascertain the feasibility of implementing a community-based nutrition programme in Bangladesh. It was felt that it

would be better, taking into consideration the experience and flexibility of NGOs, that an NGO may undertake such an experiment. Thus, an organization with credibility and innovativeness to pilot such a programme needed to be identified. BRAC was requested to implement a community-based nutrition project in 1993 with the combination of nutrition education and food supplementation to address existing food shortages and long-term behavioural changes.

Meanwhile, birth weight recorded at the household level since 1991 had shown Mymensingh district as having the highest proportion of low birth weights (42%), with Muktagacha thana registering the highest proportion for the region. Moreover, growth monitoring of the children under two years of age documented inability to achieve full growth with only intensive nutrition education to the mothers. This was seen in as many as 26% children with faltering growth. It was also seen in several projects around the world that even though food security is a principle determinant for the presence or absence of malnutrition, misinformation or lack of information and knowledge regarding child-feeding practices are often a contributing factor for malnutrition. Studies on the Tamil Nadu Integrated Nutrition Project in India had also documented impressive improvements in the nutritional status following implementation of a food supplementation programme to the targeted recipients. Therefore, BRAC decided to take the challenge of implementing a community-based nutrition project with a strong emphasis on communication and education on caring practices and supplementation demonstration.

Muktagacha thana in Mymensingh district, 160 km North of Dhaka city, was chosen for implementation of the project The distance was far enough to avoid urban influence and near enough to be supervised intensively. The baseline survey of 1991 recorded an estimated population of 156,542 including 5,000 under-two children, 20,000 women of childbearing age and 5,000 adolescent girls. The health interventions of WHDP mentioned earlier were being implemented in this thana since 1991. The intensive nutrition interventions were added to the programme as part of the nutrition project.

GOALS AND OBJECTIVES

The programme aims to reduce endemic malnutrition and consequent high mortality rates in mothers and children by improving the health and nutritional status of children, adolescent girls and pregnant women.

The specific objectives of the project are as follows:

- To determine and regularly monitor the nutritional status of children (from birth to 24 months), adolescent girls, and pregnant and lactating mothers;
- To rehabilitate the malnourished and nutritionally vulnerable children and pregnant women through short-term selective food supplementation;
- To implement an intensive education programme to attain improved feeding and food distribution practices and maternal and child care at home; and
- To establish an evaluation and monitoring system to provide continuous feedback to programme managers.

Project interventions

The following are the project interventions :

- Nutrition surveillance to identify the malnourished and faltering among children aged 0-2 years; among adolescents; and in pregnant and lactating women;
- Nutrition and health education for all the above target groups;
- Food supplementation for the severely malnourished and faltering as estimated through weight-for-age and body mass index; and
- Referral for those continuing in a state of faltering nutrition or presenting with secondary complications of and with malnutrition.

Education strategies were designed with the intent to improve awareness about health and care of women and children, appropriate child feeding practices, i.e., giving the right food at right time, in right frequency in the right way; intra-household food

distribution, and consequently enable the community to better identify and correct their own health and nutrition problems.

The Muktagacha project is an intersectoral project, comprised of community-based health and nutrition services, teamed with adolescent education and credit, along with skill development and income generation through community participation.

The concept of food supplementation has often been debated with those against saying that it works against the development strategy of empowerment, and increases dependency. To ensure minimization of dependence through the nutrition activities in Muktagacha the emphasis of BRAC staff has always been on the use of supplementation as a communication tool. The supplementation covers only a part of daily calorie requirement of women, children and adolescent girls and, therefore, would be difficult to be used as a substitute for one's daily meal. In addition, the food items used in the supplementation are those used as snacks in rural areas.

THE TARGETING

Detailed discussions took place to decide what targeting mechanism to be used. Finally it was decided that the severely malnourished, and the at-risk group (the group with growth faltering) would be targeted. This would make the programme focused, reduce costs and would also ensure proper monitoring. The beneficiaries of the programme are children under two years of age, pregnant and lactating women, and adolescent girls. The gender perspective was taken into account since it were the females who suffer from the worst cases of malnutrition. To select the nutritionally vulnerable group, an internationally accepted growth standard was used. Alternate options were not considered as the targeting mechanism chosen had been studied thoroughly and was the one that BRAC knew would be the easiest to work with and the most cost-effective. BRAC had looked into the targeting system of the Tamil Nadu Integrated Nutrition Programme and gone through other experiences on targeting. Past experiences were carefully looked into and the targeting criteria was thus finalised.

The targeting mechanism

The targeting criteria is precise allowing only those faltering in weight to come into supplementation. The malnourished women are selected by their BMI (Body Mass Index) that is their body weights in relation to their heights. If women's BMI (weight in kg / height^2 in metres) fall below 18.5, they are targeted for the food supplementation. In addition to food supplementation, they are also educated and counselled on safe motherhood, nutritional needs, lactation and breastfeeding and birth spacing. All the women in the area are asked to visit the antenatal care centres (ANCC) regularly. At the ANCC, they are weighed and given ante-natal care once every month.

As soon as a child's birth is registered he/she is enrolled in the growth monitoring programme. For babies with low birth weight (below 2.5 kg), the programme ensures intensive weight and growth monitoring every month and automatic entry into the supplementation programme at the age of six months. The following provides further details of the targeting criteria.

Women

Through the monthly household visits, all pregnant women of the community are identified and registered by the third month of pregnancy. During the provision of ante-natal care by BRAC/government staff, the women having a BMI of less than 18.5 are screened out and enrolled in the supplementation programme. The Gram Committee (see later) members distribute the supplementary food package prepared by them daily at the household level. There is a follow up visit by BRAC *Shasthya Kormi* or (female health worker) who also provides nutrition education to the women as well as to their family members. The woman remains in the programme up to sixth month after delivery and receive education on nutrition needs during lactation, breastfeeding and appropriate weaning food, and on caring practices.

Children

Each growth monitoring centre covers 20-25 children. There are three basic criteria for children to be enrolled in the food supplementation programme:

1. Born with a low birth weight;
2. Children under 12 months of age. They are weighed every month and if they do not show a gain of 500 g between three successive weighing, they are enrolled in the feeding programme; and
3. Children aged 12-23 months who fail to gain 300 g by four successive weighing, recorded as 'growth faltering, and enrolled in the nutrition education programme. These children are given food supplementation for 90 days; if their weight do not improve even after that, they are referred to the secondary and tertiary health centres and, in addition, are fed for 30 more days.

Adolescent girls

The girls aged 11-18 years attending the Non-formal Primary Education (NFPE) schools run by BRAC are provided with a mid-morning snack during their school days. This is done to provide education on and emphasize the extent of the caloric needs of the adolescents. Besides, the girls also take their own weight and height measurements once a month and discuss the results in presence of the teacher.

Referral

If any of the targeted individuals still falter in weight or are found continuing to be malnourished at the end of the supplementation period they are referred to the secondary and tertiary health facilities. To supplement government services, BRAC has opened a 'health care centre' which also caters to the referral needs of the risk group.

FIELD IMPLEMENTATION PROCESS

Involving the community at all levels of programme planning and management is a main focus in the project implementation. This approach helps in gaining community support which eventually avoids negative reaction of those excluded from the project. Initially, through a series of meetings between the project staff and the community

(village leaders, members of Gram Committee and Mohila Shova) the project objectives and targeting criteria are explained and discussed.

The new cadre of staff designated to play a crucial role in the project is a women from the community concerned. The grassroots worker is known as the *Shastho Kormi* (SK) or Health Worker. The SK is a married woman with an average of eight years of schooling, who resides in and works from the village. She has been selected through interviews with a team made up of BRAC staff and village leaders followed by a series of meetings with the community. There is one SK for each village, who is in charge of 150-200 households. All SKs are compensated for their time and labour with a monthly honorarium of Taka 500 (1 US$ = Taka 45). They make daily visits at the households and cover all the households within a month. They record vital events such as marriages, pregnancies, births, deaths and migration. They help to meet the family's contraceptive needs and are responsible for identifying and treating cases of tuberculosis and ARI. They also disseminate health and nutrition message to the community. They conduct the *Mohila Shobhas* or women's group meetings where all health needs including nutrition of children, pregnant and lactating women and adolescent girls are addressed. Through the regular household visits the SKs identify the pregnant women and children under 2 years of age and invite all of them to attend the ante-natal care centres (ANCC) and growth monitoring and promotion sessions. They also invite the adolescent girls aged 11-18 years belong to the poor families to attend the non-formal primary education schools (NFPE) where they are given supplementary foods.

At the growth monitoring and promotion sessions, organised along with the government EPI and vitamin A distribution programmes, children are weighed and mothers receive growth cards marked with the child's growth pattern. The estimation of growth faltering is done on the basis of the weight taken at the growth monitoring and ante-natal care centres. The NFPE school teacher explains the significance of the growth curve to mothers and provides nutrition education relevant to children including such issues as

breastfeeding and introduction of supplementary food. They are supervised by BRAC Programme Organisers (POs).

Adolescent girls attending the NFPE schools help conducting the monthly growth monitoring and promotion (GMP) sessions at their school premises with the help of their teachers who are women. There is one such school in each village with an average of 28 to 33 girls. The students follow 20-25 children aged under two, with each female learner being responsible for two children. She also ensures immunisation, vitamin A capsule taking, and attendance in GMP sessions of the children under her responsibility through motivation and mobilisation of the mother.

In the ANCC, all pregnant women are provided with regular ante-natal services which in addition to others includes weight and height measurements. Pregnant women with BMI less than 18.5 are included in the nutrition supplementation programme and provided with the daily supplement through home visits. Apart from the ANC services and food supplementation all women attending the centre are given intensive health and nutrition education messages.

The women's group known as the Gram Committee (GC) is an integral part of the programme. There are 9-11 members in a GC, and their time input is voluntary. Each GC member has been chosen considering their leadership qualities. As members of BRAC village women's credit groups, they are also eligible for credit, skill development and to participate in income generation activities. The committees meet monthly to discuss various issues regarding health and nutrition, identify problems and find solutions. They have an active role in the nutrition supplementation management, as they are responsible for procurement, production and distribution of food under the supervision of SKs. The money they receive from BRAC as payment for food preparation covers only the food cost and not their time or labour.

Supplementation of food intake

Women

The food supplement is prepared by the GCs with supervision from the SKs. Four *moas* (balls of food) are given to a pregnant or lactating mother every morning. These *moas* are balls of flat rice, molasses and peanuts rolled together. Four such balls provide her with 836 kcal of nutrients. The GC member who delivers these to her house make sure the mother eats at least two in front of her. The pregnant women usually eat when others are not present, because they realize that they need the food themselves. This awareness itself is of tremendous importance in a country where it has been forever believed that eating less during pregnancy would result in a smaller chiid which is easier to deliver. Table 2 gives the nutritionai value of the supplementary food given to women.

Table 2. Nutritional composition of the food supplied to women

Food ingredient	*Amount (g)*	*Energy (kcal)*	*Protein (g)*	*Calcium (mg)*	*Iron (mg)*
Flat rice	50	162	3.75	3	3
Molasses	100	394	-	10	-
Peanuts	50	280	12.00	3	1
Total	200	386	15.75	16	4

Children:

Children receive a package of roasted and powdered rice and pulse with molasses and vegetable oil. This is also prepared by the GCs under the supervision of SKs and BRAC staff. The package is supplied to the mother at the daily feeding centre, where she herself mixes the contents together with oil and water and feeds her child. One such package gives a child 160 kcal (excluding oil) of energy, which is but a fraction of its daily requirement of 1500 kcal. The severely malnourished receive two such packages. Table 3 gives the nutritional value of the food given to children under two years of age.

Table 3. Nutritional composition of the food supplied to under two children

Food ingredient	*Amount (g)*	*Energy (kcal)*	*Protein (g)*	*Calcium (mg)*	*Iron (mg)*
Rice	25	87	1.75	3.75	1.5
Pulse	10	34	2.50	1.5	0.6
Molasses	10	39	-	1.0	-
Oil	5 (ml)	40	-	-	-
Total	45	200	4.25	6.25	2.1

Adolescent girls

The adolescent girls food included a snack of puffed rice, molasses and peanuts, which supplied them 640 kcal of energy. They eat it in the school under the supervision of the SKs and the school teacher. Table 4 gives the nutritional value of the supplementary food given to adolescent girls.

Table 4. Nutritional composition of food given to adolescent girls

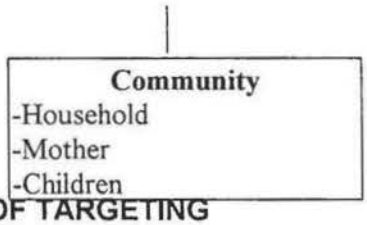
Food ingredients	*Amount (g)*	*Energy (kcal)*	*Protein (g)*	*Calcium (mg)*	*Iron (mg)*
Puffed rice	50	163	3.75	3	3
Molasses	50	197	-	5	-
Peanuts	50	280	12.00	3	1
Total	150	640	15.75	11	4

MONITORING

Monitoring system of this project was developed mainly based on learning from existing health and development programmes of BRAC. Routine monitoring is done at different levels starting from the community to the Head Office.

The data are analysed at the head office and feedback is given to the field for augmenting the quality of the programme. The Area Managers (AM) who are in constant touch with the Regional Manager (RM) supervise the POs. The RM in turn reports to the Programme Manager and Director at the head office. The Medical Officers of the thana and the Nutrition Sector Specialist based in the head office provide technical support. Though monitoring in a remote area may have been difficult, but it has been accomplished effectively. The monitoring and supervisory functions of AMs and above include other programmes in addition to the Muktagacha nutrition project. Figure 1 shows the flow for monitoring system of the Muktagacha nutrition project.

Figure 1. Flowchart for monitoring system of the Muktagacha project



EFFICACY AND ACCURACY OF TARGETING

The project reports rarely state leakage of the target population at the area of survey but according to some SKs and even some mothers, it is not reasonable to expect that a hundred percent of the target will receive their supplement. Sometimes it is because a mother is out of the village and cannot go to the centre with her child. Sometimes she sends a sibling or a grandmother and she misses out on her own monitoring. There has been one or two cases with conservative households where the workers were not even permitted to enter. Such cases were frequent in the beginning of the programme but are now very rare. Still to say that the total target population being reached would be incorrect. Past field experience prepared BRAC staff to anticipate that all under-two children would not be covered, as they would all not be motivated enough to come for the growth monitoring. Field experience, backed by independent research, shows that usually 25% of the under-two children and 10% of the pregnant women are not covered by the project. This is due to the project's inability to overcome social and personal barriers and constraints. Sometimes this absence is a matter of inconvenience on the mother's part, but often it is because social or religious constraints keep a mother from going to a feeding or growth monitoring centre. Part of it could also be due to lapses in project implementation.

LESSONS LEARNED ABOUT TARGETING

Lessons learned from the pilot project are multidimensional. On the one hand, it can be seen that the children at the centres are healthier than those in other areas. An NGO by itself can cover a very small well-defined area. Besides, most of the NGOs in Bangladesh are dependent on foreign assistance and if the assistance is stopped, the

projects could discontinue. However, now that the government has planned to replicate the Muktagacha pilot project model in 40 thanas throughout the country.

It has been noted that children not under the feeding programme and even those who had graduated from them, often asked their mothers to prepare the food for them as snacks. As the food is made of easily available and non-perishable material, mothers often make the snacks for their children.

In an interview with a woman who had been in the feeding programme and had graduated, it was learned that she had known of her under-nourishment only through the project. Her child is currently enrolled in the project and she is satisfied with the gain in weight which is also associated with fewer physical problems. According to the SKs working in the area, the superstition that colostrum is harmful for a child is said to have been almost erased and the children are now fed well.

The positive lessons to be drawn from the project is that the high risk group of the population is coming into focus. Since the recovery rate of this group is faster, cases can be shown to the community as success of the project.

There were considerably few difficulties encountered. The major difficulty encountered in this project has been with the treatment and management of the cases referred with complications of malnutrition to the government Thana Health Complexes (THCs). The accessibility of the population, particularly of the poor and women, to THCs is limited because of lack of facilities and unfriendly attitudes of the health complex staff.

Underweight children who show a gain in weight following supplementation but are, nevertheless, still below the standard weight, exit out of the supplementation programme according to the project criteria. A continuous community-based mechanism needs to be in place to rehabilitate these children and ensure that these families are given special attention.

Another problem that still has not been resolved or addressed is whether the criteria for graduation is appropriate. The graduating criteria has been adopted from the Tamil Nadu Integrated Nutrition Programme. But the project is looking into whether this criteria is appropriate for Bangladesh context or needs revision based on follow-up of the graduated children and their morbidity pattern.

Costs

This is a low cost plan requiring no sophisticated equipment or highly skilled person. The workers and volunteers at the grassroots level are adept at communicating with the target population and are skilled enough to handle most of the health and nutritional problems of the community. As costs always receive serious considerations in all projects, this project has been intentionally kept simple. Currently efforts are being focused on further reducing costs by having the role of *Shasthya Kormi* taken over by the *Shasthya Shebika* (Community Health Volunteer), who do not receive any honorarium, but basic and refresher training. The project cost is met through a UNICEF grant. As mentioned earlier, the project is being replicated to 40 thanas, the entire cost of which is borne by the government of Bangladesh with World Bank assistance.

MEASURES OF OUTCOME

Monitoring results from the field speak of impressive outcomes. In 1996, of 2,354 women provided supplementary food, 83% gave birth to infants with normal birth weight (>2.5 kg). A total of 5,948 children under 2 years of age were given supplementary food. Of them, 2,379 or 40% graduated, 55% of them being girls. Figures 2-4 and Table 5 show some further results on the performance of the programme. Figure 2 shows the percentage of children who gained the designated weights of 500 g or more. The results improved consistently over the years.

Figure 2. Percent of supplemented children gaining 500 g or more in weight by year

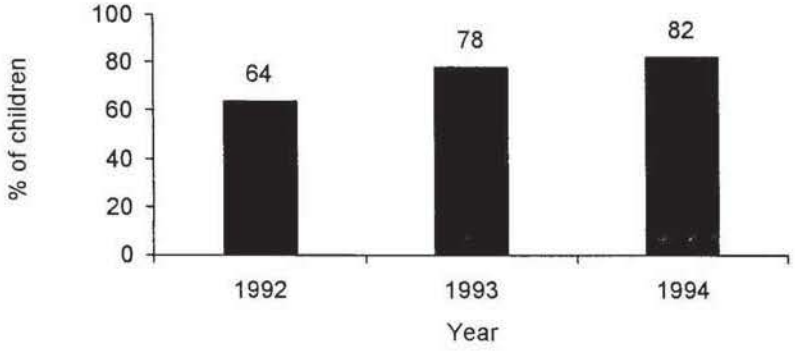


Figure 3. Percent of children weighed and those given food supplementation by year

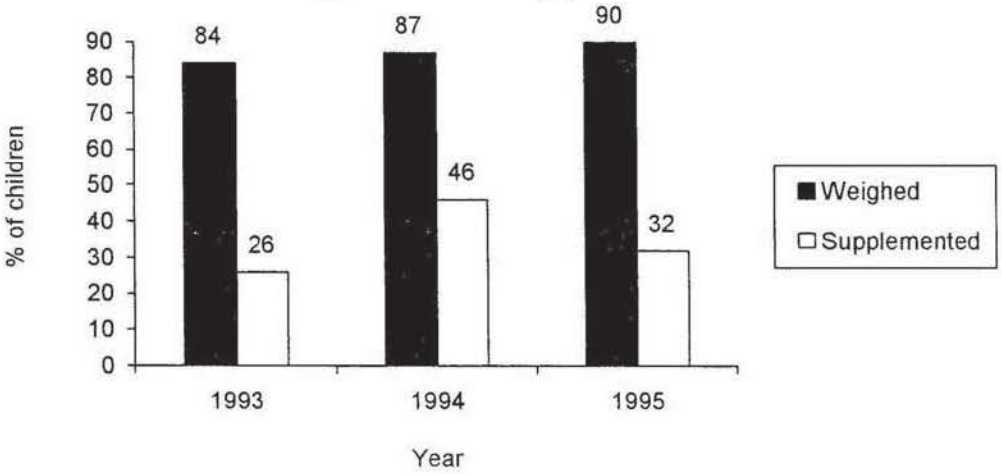


Figure 3 gives the percentage of weighed children who received food supplements from the project, in comparison to the percentage who were actually weighed. It shows that the effectiveness of the programme in bringing the children under nutritional surveillance increased over time and reached 90 percent in 1995. On the other hand, percentage who needed and received supplementation rose from 26 in 1993 to 46 in 1994 but declined to 32 in 1995.

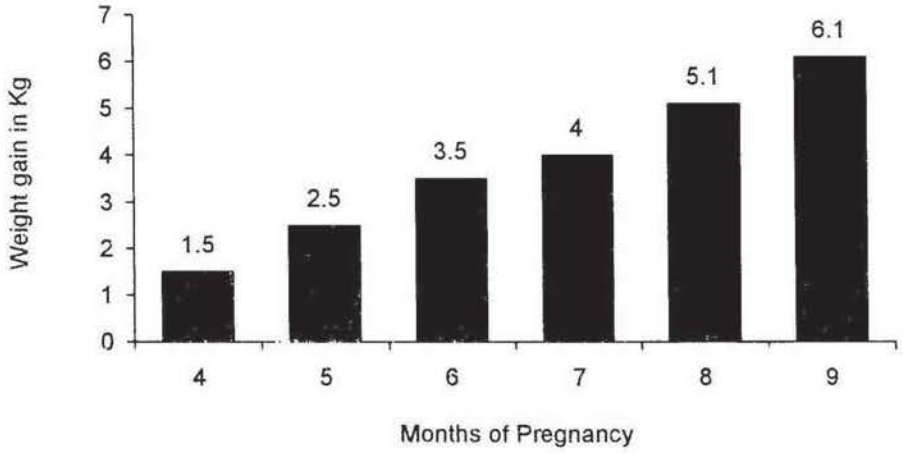
Table 5 gives the BMI and mid-upper-arm-circumference (MUAC) of adolescent girls. It shows improvements over the years between 1993 and 1995.

Table 5. Mean (and standard deviation) of MUAC and BMI of adolescent girls receiving food supplementation

Type of measurement	1993	1994	1995
MUAC	20.67±1.97	21.77±2.26	22.81±1.81
BMI	16.31±1.80	16.42±1.84	17.19±1.77

Figure 4 shows a picture of average weight gain of women under supplementation during different months of pregnancy. It shows clearly that women continued to gain their weight in pregnancy.

Figure 4. Weight gain of women under supplementation by months of pregnancy



The reasons or elements of interventions that can account for the project's above outcomes have been identified as the following:

- carefully selected set of interventions,
- training, development and supervision of BRAC staff and community health volunteers,
- adequate targeting of beneficiaries,
- community participation and mobilization,
- effective information and monitoring system,
- rationalization and review of strategies based on field needs, and
- multi-sectoral nature of BRAC's development activities.

SUMMARY AND CONCLUDING REMARKS

Bangladesh presents a test case for development where malnutrition is a major challenge towards a better future. Over the past years the gains in the nutrition field has been modest. A large proportion of the people are still malnourished, many of them severely. The major reason for malnutrition remains poverty. To test the effectiveness of nutrition education along with food supplementation, a project was undertaken by BRAC. With financial support from UNICEF, BRAC carried out a targeted programme that provided supplementation to pregnant and lactating women, adolescent girls and children under 2 years of age. Community participation at all levels of programme implementation and management was given emphasis to ensure proper implementation and to gain community support. The community was mobilised and actively participated. At the start, BRAC staff conducted a baseline survey in the project area and arranged a series of meetings with different groups in the community to identify potential candidates for SK and members of the Gram Committee (GC) and Mohila Shobhas (MS). The GCs and MSs were organised and SKs were selected through intensive community participation. Initially a six- weeks training was conducted for the SKs by BRAC staff which was followed by monthly refreshers training. The target population to be covered by the food supplementation were screened through monthly home visits by the SKs and regular weighing at the centres. The targeting mechanism was discussed with the community to avoid any misunderstanding and confusion by the

members of GCs and MSs and by respective SKs. A monitoring system was developed to monitor the project based on learning from BRAC's on-going rural development and health programmes. The monitoring data flows down from the community through the area office to the head office and again the feed back comes from the head office down to the community. Initial results indicated that the project had started well and some impressive results in terms of immediate outcomes were reported. The targeting was done well and leakage was found to be minimal. The project has already attracted wide attention. The government of Bangladesh with financial support from the World Bank has started replicating this project in 40 thanas (sub-district) of the country.

BRAC has been working with a target group approach. Most of its programmes are targeted to specific groups of the population, and the present project on nutrition is no exception. BRAC believes that in a society like ours, the development inputs do not reach the people it is meant for unless those are unambiguously targeted towards them.