

# CLP'S EXPERIENCE IN IMPLEMENTING THE DIRECT NUTRITION INTERVENTION PROJECT



## SUMMARY

After operating from 2004 – 2016, the Chars Livelihoods Programme (CLP) has accumulated vast experience working with the extreme-poor and in remote areas.

During its final year the CLP developed a series of Lessons Learnt briefs with donors and development practitioners in mind.

This brief is one in a series and shares many lessons and suggestions for other programmes implementing direct nutrition interventions.

## LESSONS INCLUDE:



Low literacy and capacity levels can hamper the gathering of accurate data.



Implementation approaches must be flexible and context-oriented.



Systemic change is catalysed when a community-wide approach is used.



Understanding the gender implications of nutrition interventions is important for efficacy.



Staff requirements should be planned from project outset to ensure efficiency of resources.



Coupled with awareness training, implementing an effective patient referral process can change the health-seeking behaviour of the extreme-poor.



A visual-oriented training / counselling curriculum approach can be more effective in increasing awareness among extreme-poor populations.

## BACKGROUND

The Chars Livelihoods Programme (CLP) was a poverty reduction programme implemented in Bangladesh and co-financed by the UK Department for International Development (DFID) and the Australian Department of Foreign Affairs and Trade (DFAT). It was managed by Maxwell Stamp PLC and sponsored by the Ministry of Local Government, Rural Development and Cooperatives (MLGRD&C) and executed by the Rural Development and Cooperatives Division (RDCD) of the Government of the People's Republic of Bangladesh.

People on the riverine islands ("chars") of north-west Bangladesh had precarious livelihoods. They were often heavily reliant on low-paid and unpredictable agricultural day labour, and there were few other stable livelihoods options open to them. They were vulnerable to environmental shocks that could have devastating effects on their livelihoods, with flooding a particular risk. Most chars-dwellers moved home several times in the last few years due to floods or char erosion. Many reported that they had lost all their possessions and assets at least once in the past.

The precariousness of their livelihoods meant that many chars households faced food insecurity and suffered from the effects of under-nutrition. Limited access to improved water sources and sanitation and low levels of services such as health, education and livelihoods support were further challenges, resulting in chars-dwellers being amongst the poorest people in Bangladesh. CLP aimed to work with these people to help them lift themselves out of poverty.

CLP operated in two phases – CLP1, from 2004 to 2010, and CLP2, from April 2010 to March 2016. Over that time, CLP accumulated substantial experience from working with the extreme-poor in remote areas.

CLP is widely recognised as having been a very successful programme. By the end of its tenure, CLP directly (and in many cases dramatically) transformed the lives of over 78,000 core participant households, and it improved the livelihoods of one million poor and vulnerable people. Moreover, it achieved this while operating in one of the most challenging environments in the world: the riverine island chars in the Jamuna, Teesta, and Padma rivers of north-western Bangladesh.

During the course of its implementation, CLP needed to undergo a number of major changes, to respond to a range of new challenges, and to test out a variety of approaches. It involved itself in many different activities, spanning everything from livelihood improvement to market development, from social protection to land reform, from education to nutrition, and from health to veterinary services. Over the years it operated, CLP learnt a number of very important lessons. These lessons are now documented in a series of Lessons Learnt briefs which are intended to share CLP's experience with donors and practitioners, both in Bangladesh and further afield.

This particular brief focuses on lessons learnt from the Direct Nutrition Intervention Project (DNIP).

## ABOUT DNIP

The context of Bangladesh is one that can be considered "high risk" from a number of perspectives, and the nature of the CLP compounded some of these risks. The pressing urgency of the need to address extreme poverty can place great pressure on systems to deliver results fast, with less attention to issues of quality and transparency.

The capacity of many stakeholders involved was often variable, meaning that, in some circumstances, people or organisations that were expected to deliver critical results struggled to achieve them. The spectre of fraud and / or corruption was a persistent one, with the danger of "leakage" or misappropriation of donor funds a very real threat.

To cap it all, the nature of the programme – asset transfers, payments of unconditional cash transfers, subsidy payments, labour payments – required large-scale cash-handling, which presented obvious targets for unscrupulous people and organisations. The wide-ranging technical activities also brought a whole spectrum of technical risks. To address these challenges CLP produced robust risk management systems, processes and guidelines.



## CHALLENGING TRADITIONAL BELIEFS

On the chars, certain traditional beliefs about nutrition and many potentially harmful practices are still pervasive. DNIP acted as a mechanism to educate CPHHs on proper nutrition and to counter such practices by replacing them with new ones.

For example, it is common practice to feed honey, boiled water and sugar water to an infant just after birth. To counter this practice, CPKs (Char PushtiKarmi, or char nutrition workers) informed pregnant women and their family members about the potential risks associated with this practice. Additionally, DNIP conducted orientation sessions on Infant and Young Child Feeding (IYCF) with adolescents, village doctors, community clinic management support groups and newly-wed couples to help increase community awareness and adoption of traditional practices.

The IYCF approach also promoted breast feeding among new and lactating mothers. On the chars there is very little knowledge of optimum breastfeeding practices for new-borns, or exclusive breastfeeding (EBF) for babies up to six months. If there are problems with correct positioning and attachment, babies often do not get sufficient breast milk and so the mother starts feeding the baby other things.

To overcome this and to encourage EBF, the CPKs conducted counselling and intensive follow-ups in the community. DNIP trained CPKs on this issue to ensure mothers were made aware about the best feeding practices for children of this age group. The CPKs also educated other family members, such as the husband and mother-in-law, on best IYCF practices.

Children on the chars tend to lack sufficiently nutritious food, and have little variety in their diets. They are fed solid foods, such as rice paste or bananas, too soon or too late, and very often they are the wrong types of foods for a child's growth requirements. The prevalence of anaemia is particularly high among children aged 7-23 months as well as among pregnant women because their nutritional requirements for growth and reproduction are relatively high.

Nutrition-specific interventions by CLP targeted the immediate causes of malnutrition. CPKs focused a lot of their counselling time on this aspect and helped the target clients to identify locally available and low-cost food items with high nutritional value.

Other interventions undertaken by CLP under DNIP that had a direct impact on the nutrition of CPHHs included:

- One-on-one counselling related to infant and young child feeding and hygiene promotion.
- Providing iron and folic acid tablets to pregnant and lactating mothers and adolescent girls.
- Supplying deworming tablets for all family members, except pregnant women during their first trimester.

CLP also implemented several interventions under different projects that had an indirect impact on nutrition of CPHHs:

- Improving access to clean water and sanitation.
- Providing social development training on Water, Sanitation and Hygiene (WASH).
- Delivering Health and Nutrition Education (HNE) through the health project.
- Promoting homestead gardening.
- Providing an income-generating asset.

The impacts of the direct interventions were assessed by a consortium led by the Institute of Development Studies, UK, with results due to be published during the first half of 2016.

## LESSONS LEARNT

After nearly a decade of experience, the Programme can offer many lessons and suggestions to other programmes implementing direct nutrition interventions.

### LOW LITERACY AND CAPACITY LEVELS CAN HAMPER THE GATHERING OF ACCURATE DATA

The recording of accurate data was of high importance to the Programme. CPKs were all married women selected from the char communities in which they work.

The criteria for CPK selection stipulated that the candidate must have completed her education up to Grade 8. However, few women in the char areas met this requirement because women with higher levels of education tend to migrate for better opportunities to the mainland. Thus, Implementing Organisations (IMOs) faced difficulties in finding qualified candidates from all villages, and sometimes there had to be some flexibility regarding the educational criteria.

Because of the limited education and experience of some CPKs, maintaining accurate data logs proved to be a challenge for them. Although initial training, on-the-job coaching and refresher training was provided by Nutrition Supervisors (NSs) and Nutrition Officers (NOs), properly recording data in the CPK Register proved to be a complex process for a few of the CPKs.

Usually, the NSs and NOs visited CPKs once a month. During this visit, the NSs and NOs checked the data that CPKs had entered over the previous month, advising the CPKs on corrections where necessary and ensuring accuracy of the recorded data by verifying details with clients. NSs and NOs also entered the hand-written, hardcopy data provided by CPKs into the CPKR register database.

None the less, this "retroactive oversight" system proved not to be sufficient enough to prevent input errors from CPKs, as mistakes were frequently made during the recording of client details. In addition, there were inconsistencies in visit dates and discrepancies in medication distribution and consumption records.

It was decided that increasing the required educational level and offering a corresponding salary for CPKs would not necessarily have fixed the capacity issue, as the reserve of literate women was already very low. It was actually not a matter of salary, but rather a problem of finding qualified and competent personnel from within the char communities.

## **IMPLEMENTATION APPROACHES MUST BE FLEXIBLE AND CONTEXT-ORIENTED IN ORDER TO BE EFFECTIVE**

In Bangladesh, and especially in remote, rural areas such as the chars, traditional beliefs and practices remain entrenched. Changing certain behaviours, such as traditional practices related to feeding babies after birth, was difficult. Efforts to convince mothers to breastfeed were often met with resistance, and it was difficult to verify if modified behaviour had taken place.

Issues with implementation of certain awareness-raising activities arose during the course of the DNIP. Take, for instance, an awareness-raising campaign about the benefits and best practices of new-born breastfeeding. IMO staff organised a screening of an educational video discussing attachment and positioning. However, as generally tends to happen in village contexts, the whole community gathered to watch the video – including men. Women and mothers felt uncomfortable and expressed to IMO staff that they felt it inappropriate. After this incident, such videos were screened in the sheds constructed for meetings, but only with women in attendance.

The implementation scale of DNIP also holds some lessons learnt. Through DNIP's one-on-one counselling, CLP was gradually able to start changing some traditional beliefs and practices at the individual level. However, it was found that a more inclusive approach to awareness-raising was more effective at the household and community level. For example, when family members of CPHHs were made aware of and encouraged to accept certain practices that may have gone against conventional beliefs, it made it easier for the women in the family to adopt new practices.

## **SYSTEMIC CHANGE IS CATALYSED WHEN A COMMUNITY-WIDE APPROACH IS USED**

DNIP targeted the CPHHs that were selected using CLP's criteria, which identified the most vulnerable and extreme-poor households. While CLP participants were targeted so that the most extreme-poor households benefited, other households that may have been only marginally better-off – but still below the poverty line with limited access to government services – were not included. Despite this "economic" distinction, there was often no difference between core and non-core households when it came to malnutrition status.

DNIP's original project design outlined four target groups:

- Pregnant women
- Mothers of children aged 0-6 months
- Mothers of children aged 7-24 months
- Adolescent girls aged 10-16 years

But these restrictions raised many questions: What about other CPHHs who did not have a member that currently fell into any one of the stipulated groups? How could DNIP help them? What would be the impact and cost-efficiency limitations of restricting nutrition interventions to just these groups?

In the second year of DNIP's implementation, it was, therefore, decided to extend basic nutrition counselling to CPHHs even where there was no client from the

mentioned categories. With the kind of deep-rooted change required to challenge conventional beliefs and practices, CLP realised it was crucial to adopt a more inclusive, community-wide approach.

One way that DNIP broadened its ability to include the wider community in various CLP working villages was by introducing the basic concepts of the IYCF approach to village doctors, to newly-weds through couples orientation, and to the communities' youth through the CLP adolescent groups. As a result, the whole community developed a greater awareness about IYCF, which went a long way towards tackling entrenched social conventions.

If DNIP had worked with the whole community from the outset, the impact of the project would have been wider-reaching. As a case in point, the adolescent groups were comprised of youth from both core and non-core participant households. Iron and folic acid tablets, however, were only provided to adolescent girls from core participant households. If these tablets had been given to both core and non-core girls, the output, results and impact would have been much greater.

Another example comes from the distribution of deworming medication. Deworming medicine was distributed to all CLP participants and their family members every six months. However, the sentiment of community members and CPKs was that this medication should have been distributed to everybody, considering the living conditions and close contact between char-dwellers. Thus, using a community-wide approach for distribution might have rendered deworming efforts much more effective.

## **UNDERSTANDING THE GENDER IMPLICATIONS OF NUTRITION INTERVENTIONS IS IMPORTANT FOR EFFICACY**

Like so many aspects of development, gender inequality also underpins nutrition interventions and affects the efficacy of various programmes. For DNIP, a central challenge was that in CLP working areas, many of the households are headed by men. Although within the household, women are more likely to prepare food and to feed it to the family members, the women often have very little authority over what they eat and when they have rest. They often do not have their own source of income and have little to no input in how the household income is used. Social and religious decision-making for the family is rarely in the hands of women.

In accordance with the original project design, nutrition and health counselling was given directly to the female participant. So, in the case of a pregnant woman or a new/lactating mother, advice may have been given on the need for specific nutrition requirements, or taking rest, etc. However, it was found that, because of the systemic patriarchal society, women often had little authority over these aspects of their daily life.

With this in mind, CLP expanded its approach so that counselling was extended to include other family members. CLP found that when the household was educated on the importance of certain practices, such as resting and nutritional intake, especially during pregnancy, it made it much easier for the women of the household to follow the health advice given to her.



**STAFF REQUIREMENTS SHOULD BE PLANNED FROM PROJECT OUTSET TO ENSURE EFFICIENCY OF RESOURCES**

With two other major programmes – SHIREE and UPPR – also hiring NOs at around the same time as CLP was operating, a huge (albeit welcome) strain was put on the market for nutrition experts in Bangladesh. It was well known that some staff were hired in one organisation, completed the training, and then switched to work for a higher paying programme. It, therefore, would have been much better to avoid this scenario by implementing a standardised salary across all three programmes.

Within CLP there were also inter-project discrepancies in pay. Within DNIP, CPKs received a fixed monthly salary while CSKs (char health workers who were hired through the Primary Health Care and Family Planning

component of the Programme) were paid based on performance. This had two negative consequences: firstly, it caused resentment between CPKs and CSKs in the same village; and secondly, by not incentivising CPKs, productivity suffered. In hindsight, it would have been better had salaries been standardised for similar level staff as well as across programmes.

In addition to this, and following on the first lesson learnt concerning data collection and CPK capacity, more consideration should have been given to staffing requirements in terms of capacity and availability of qualified candidates from the beginning of the project. DNIP also faced the problem of getting staffing numbers right to manage the work required and balancing those numbers across the specific tasks. Although DNIP hired a sufficient amount of CPKs it could have benefited from hiring more NOs for supervision purposes.

## COUPLED WITH AWARENESS TRAINING, IMPLEMENTING AN EFFECTIVE PATIENT REFERRAL PROCESS CAN CHANGE HEALTH-SEEKING BEHAVIOUR

DNIP referral services, along with malnutrition awareness-raising at the community level, aimed to contribute to the reduction of child mortality on the chars.

Severe malnutrition is an acute medical emergency, and it requires immediate treatment and management. The DNIP team found, when tackled efficiently, that treating malnutrition could serve as a feasible and affordable means by which to bring about huge health, social and economic benefits within households and communities. To this aim, DNIP started referring char-dwellers to government and non-government hospitals and clinics specialising in Severe Acute Malnutrition (SAM) and Moderate Acute Malnutrition (MAM) patients, typically children under 5, with the help of the Bangladesh Government services. These referrals not only increased the awareness of the availability of such services, but also increased the health-seeking behaviour of char-dwellers who had previously been unaware or sceptical of hospitals and clinics.

Usually malnutrition patients require longer treatment in facility-based hospitals. This posed a challenge to many CLP participants, as it was very difficult for mothers to spend so long away from home when there were often other children to be cared for. Many mothers also feared that long-term treatment out of the locality ran the risk of their child being a victim of organ harvesting or human-trafficking. DNIP staff had to slowly earn trust within communities to overcome this. CPKs and other DNIP staff had to invest a lot of time counselling families on the government services that are available and the importance of treatment for malnourished children.

Communities now have much more awareness and are now more likely to seek medical attention for their children when cases arise.

## A VISUAL-ORIENTED TRAINING CURRICULUM APPROACH CAN BE MORE EFFECTIVE IN INCREASING AWARENESS AMONG EXTREME-POOR POPULATIONS

DNIP made impressive progress on the chars, especially with regard to IYCF.

Through effective counselling, an understanding of the importance of EBF and other aspects of early child nutrition were increased and practices significantly adapted. IYCF learning materials, provided by the NGO "Alive and Thrive", included staff manuals, flipcharts and informational videos. The videos, in particular, proved very effective as they drew in a large crowd. As mentioned previously, videos on certain sensitive subjects were shown exclusively for women and adolescent girls in a private location.

This visual approach has since been taken up by the Government of Bangladesh.



If you wish to learn more about the CLP or the lessons learnt series of briefs please visit the CLP website [www.clp-bangladesh.org](http://www.clp-bangladesh.org).

Author: Lokman Hossain & Mostaque Ahamed  
Editor: Tanya Goodman & Treena Watson