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Delivering for Nutrition in South Asia

Towards Impact at Scale

Feasibility of Implementing Integrated Community-based Maternal Infant and Young Child Nutrition and Primary Health Care Package in Bangladesh

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Background

- Bangladesh has made strong progress in health and nutrition indicators over the past decade
- Child stunting declined from 41% (2011) to 24% (2022)[1] – a major improvement toward World Health Assembly 2025 target of a 40% reduction in stunting
- In 2011, the National Nutrition Services (NNS) was launched to embed nutrition within existing health and family planning services, integrating it into routine Primary Health Care (PHC) and progressively strengthening the skills of community health workers
- Despite a decade of nutrition mainstreaming and a wide network of community health workers, significant gaps remain in delivering integrated Maternal Infant Young Child Nutrition (MIYCN)–PHC services at the community level

[1] National Institute of Population Research and Training (NIPORT) and ICF. 2024. Bangladesh Demographic and Health Survey 2022: Final Report. Dhaka, Bangladesh, and Rockville, Maryland, USA: NIPORT and ICF.

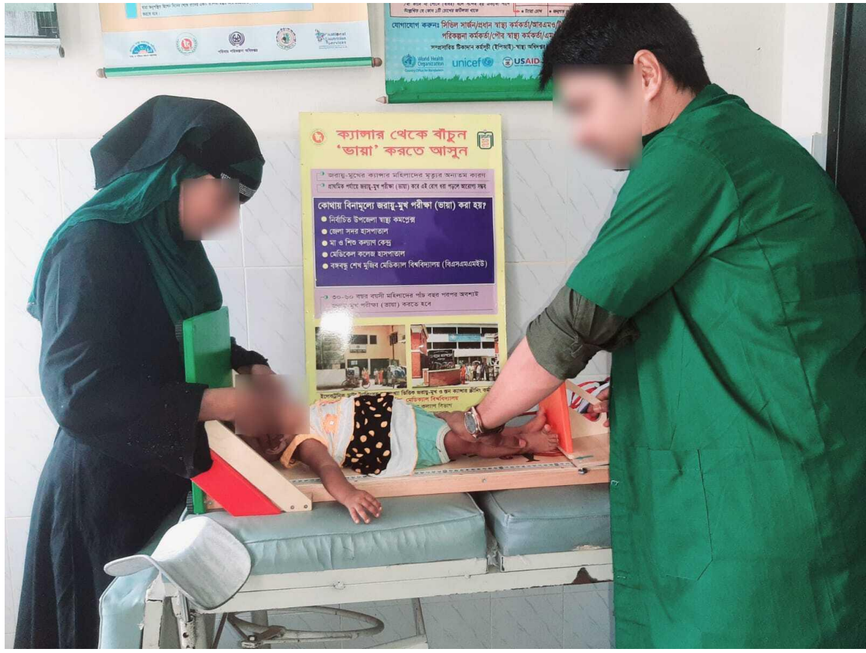
Background

- NNS, together with UNICEF and FHI 360, successfully introduced and tested a Community-Based Engagement (CBE) strategy to strengthen integrated MIYCN-PHC services during 2022-2023

- CBE strengthened community outreach and accountability platforms for the last-mile MIYCN services, including ANC/PNC, GMP, counselling and follow-up through the community-based PHC platforms like

  - ✓ Home visits
  - ✓ Courtyard meetings
  - ✓ Satellite clinics at outreach and community clinics
  - ✓ Community clinics
  - ✓ GMP at outreach

- This package did not create new platforms nor recruit new service providers, rather streamlined services and supportive supervision of the existing platforms



Objective

To explore the key barriers and facilitators affecting the delivery of integrated MIYCN–PHC services in rural Bangladesh, focusing on factors related to intervention design, system context, individual capacities, and implementation processes to inform sustainable service delivery and scale up

Health Care System in Rural Bangladesh

TERTIARY

- Medical college hospitals
- Specialized hospitals

Bangladesh's health system is pluralistic, with the Directorate General of Health Services (DGHS) and the Directorate General of Family Planning (DGFP) running separate services, workforces, and facilities

SECONDARY

- District hospitals
- General hospital

PRIMARY

- Upazila Health Complexes
- Union Sub-centres
- Family Welfare centres (FWC)
- Community Clinics (CC)
- Satellite Clinics (SC)

Directorate General of Health Services		Directorate General of Family Planning	
CHCP	HA	FWA	FWV
Stationed in CCs	▪ Community outreach ▪ CC for 3 d/w	▪ Domiciliary FP services ▪ CC for 2 d/w	▪ Stationed at union-level ▪ Satellite clinics

CBE Intervention Package

Streamlining of Services

- Organized home visits, courtyard meetings, satellite clinics
- Integrated Growth Monitoring and Promotion (GMP) into EPI outreach

Strengthened Supervision

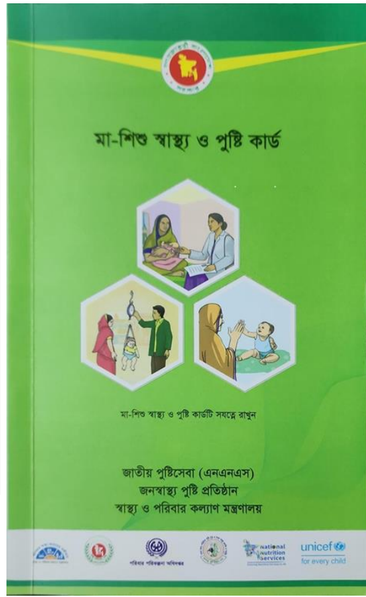
- Introduction of supervision job aids and structured tools
- Guidance on: whom, where, and what to observe, how to debrief
- Use of supervision data in system meetings

Community Engagement

- Utilized existing structures: Community Groups (CGs), and Union Parishads
- Built community ownership in service delivery and accountability
- CGs/CSGs mobilized community use of CCs and health services

Tools and Protocols for CHWs

- Job aids and protocols for home visits and courtyard meetings (n=28)
- MCHN[1] card innovatively consolidated ANC/PNC, EPI and GMP information in one booklet



[1]MCHN card: Mother Child Health & Nutrition Card

Methods

Qualitative Study in two rural sub-districts: Noakhali and Satkhira

May–June 2023

December 2023–January 2024

Key informant interviews n=48

In-depth interviews n=87

Direct observations n=40

135

- National, district, and sub-district programme managers
- Frontline workers and supervisors
- Local government representatives

- Purposive and snowball sampling
- All interviews were conducted in person
- Interviews were audio-recorded and transcribed verbatim

Consolidated Framework for Implementation Research (CFIR)

- Inner and outer settings
- Capacity of the providers
- Intervention characteristics
- Implementation processes

- Transcripts coded using ATLAS.ti version 9
- Thematic analysis

Findings

Consolidated Framework for Implementation Research

- High-level coordination/ outer setting
- Intervention characteristics
- Capacity of the service providers
- System-level issues/ inner settings
- Implementation process

High-level Coordination

Facilitators

- **TWG[1] established:** involving all key OPs, UNICEF and FHI 360 with clear ToR for oversight and guidance
- **Strong partner support** from UNICEF and FHI 360 for technical assistance, monitoring and meetings
- **Functional vertical coordination**: NNS and OPs routinely provide directives to districts and upazilas

Barriers

- **Limited national stewardship in practice:** Only one formal TWG meeting held; reliance on informal discussions
- **Weak DGHS–DGFP coordination** at both national and sub-national levels
- **Low engagement of local government** (UP[2]/upazila, reducing ownership and support

There has always been a coordination gap between Health and Family Planning directorates because one directorate does not have oversight over the other," - KII, Noakhali

[1]TWG: Technical Working Group
[2]UP: Union Parishad

Intervention Characteristics

Facilitators

- **Use of existing platforms**—CCs, EPI outreach, satellite clinics, home visits, courtyard sessions; no new cadre required. GMP was successfully integrated with EPI
- **MCHN card was highly valued** for consolidating ANC/PNC, EPI and GMP information in one durable booklet by mothers and CHWs
- **Job aids and supportive supervision checklists** were useful and valued by CHWs
- **Simplified supervision tools** (tick-mark checklist, compilation sheet) made monitoring more practical and systematic

Having the nutrition book has been very beneficial…..we can show them (mothers) age-appropriate recommendations, type of foods they should feed etc.. with its help, we can explain very easily. Even if they forget, seeing the nutrition book reminds them." IDI,, Noakhali"

Barriers

- **MCHN card drawbacks**: high documentation load and time burden
- **Inconsistent job aid use**: some CHWs did not carry/use job aids, or confused them with flyers/MCH cards

"We have received job aids and we provide service consulting the job aids. It is very helpful and providing service has become easier than before."
IDI, Noakhali

Capacity of Providers

Facilitators

- **Positive attitudes and strong motivation:** CHWs felt respected by communities; managers and staff show high optimism toward CBE
- **Growing competence with tools:** More CHWs correctly identify and use job aids; supervisors use simplified tick-mark checklists and compilation sheets
- **Emerging reflective practice:** CHWs and supervisors use supervision findings and MCHN card data to improve counselling and follow-up

Job aids, checklists, and booklets are available to us. We use job aids to provide health/nutrition education on what to do in various situations….. I have noticed that when job aids are used, beneficiaries' knowledge improves significantly…" IDI, Satkhira

Barriers

- **Training gaps**: One-day orientation perceived as insufficient; strong demand for longer and refresher training
- **High workload**: CHWs struggle to manage GMP, EPI, counselling and extensive MCHN documentation in busy sessions

"I received the first training in January 2023 However, it was not sufficient. It was just a one-day training. Here, refresher training was necessary. If they had provided us with a 3-5 day training, it would have been better for us. Everyone cannot catch everything in just a one-day training." - IDI, Noakhali

System-level Factors

Facilitators

- **Improved system readiness**: Increased availability of MCHN cards, MUAC tapes, SBC materials, and updated protocols
- **Functional routine platforms**: District quarterly, upazila monthly, and UH&FWC fortnightly meetings continue to review CBE progress facilitated by UNICEF/FHI 360 representative
- **Active CG meetings:** CGs increasingly supported community engagement and service utilization

"In our meetings, there is discussion about nutrition…. Our relatives, sisters, daughters, wives, and neighbors get pregnant. Therefore, if there is no discussion about nutrition in our meetings with them, they may not be aware of certain aspects of available services." IDI, Satkhira

Barriers

- **Severe HR shortages:** Unfilled DGHS/DGFP posts; CHWs covering large catchment populations, GMP during EPI was constrained
- **High workload and task strain**: CHWs juggle GMP, EPI, ANC/PNC, counselling and extensive MCHN documentation; supervisors overloaded with supervision + reporting
- **Unsustainable meeting structures:** Ward coordination and men's meetings were likely to stop without government directive; CSG meetings remained irregular
- **Financial/logistical burden on CHWs:** No budget for sessions (refreshments), and CHWs personally carried heavy logistics and MCHN card bundles to outreach sites

Implementation Process

Facilitators

- **Strong early design phase:** with active OP/TWG involvement in developing CBE, training modules and CHWs roles
- **Functioning multi-level review structures:** TWG ToR, district quarterly reviews, upazila monthly meetings, and increased joint field visits by Round 2
- **Annual microplanning**
- **Strengthened supportive supervision:** Planned supervisory visits; simplified tick-mark checklist and compilation sheet improve data use and follow-up
- **Community engagement platforms activated:** CG/CSG meetings used for mobilisation and nutrition messaging; ward coordination meetings improved DGHS–DGFP collaboration at frontline level
- **Adaptive implementation:** Adjusted supervision tools, refresher trainings, improved logistics; strong TA support from UNICEF and FHI 360 for troubleshooting and reporting

Barriers

Weak institutionalization: Formal TWG meetings were infrequent; reliance on informal meetings

Irregular or unsustainable platforms: Men's meetings and ward coordination meetings likely to discontinue without directives/budget

Limited local government engagement and persistent DGHS–DGFP coordination gaps.HR shortages and workload pressures continue to constrain implementation quality and scale-up potential

No budget for meetings or logistics transport, creating operational hurdles for CHWs and supervisors

Implications for Scale Up and Policy

- Scale-up in South Asian settings requires strong coordination mechanisms, particularly between health and family planning directorates (or equivalent agencies), along with active engagement of local government institutions that anchor community-level service delivery
- Ensuring adequate workforce, continuous financing, and strengthened integrated MIS and supervision systems is essential for maintaining service quality at scale
- Partnerships with technical agencies, donors, community-based structures, and civil society groups are also crucial to provide technical guidance, community mobilization, and sustained support across diverse local contexts
- Longer-term studies on impact at scale, service quality, equity and cost-effectiveness, and testing adaptable delivery models in diverse South Asian settings are required

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