

LESS GUESS.

The art of using data for strategic behavior change design



GETTING STRATEGIC WITH *interpersonal* communication

Improving feeding practices in Bangladesh

People talking to people	2
<i>Thinking big, REALLY BIG</i>	4
<i>It works! Results</i>	7
Focus, focus, focus: on how behavior changes	9
Building a system that works: 8 ways to ensure quality	12
Change happens when the community is behind it	13
Reaching even greater scale	15



People *talking to* people

A mother rarely acts alone when deciding how to feed her child. Feeding decisions are family decisions and are shaped by community norms. To encourage improved child feeding practices, a strong program finds ways to enter that social process. What better way to do that than through face-to-face conversations?

When Alive & Thrive began in 2009, we had the evidence in hand: ***interpersonal communication could help mothers adopt the recommended feeding practices.***

But was it “scalable”? To reach millions of Bangladeshi mothers to improve the ways they fed their children, we took a fresh look at this familiar intervention.

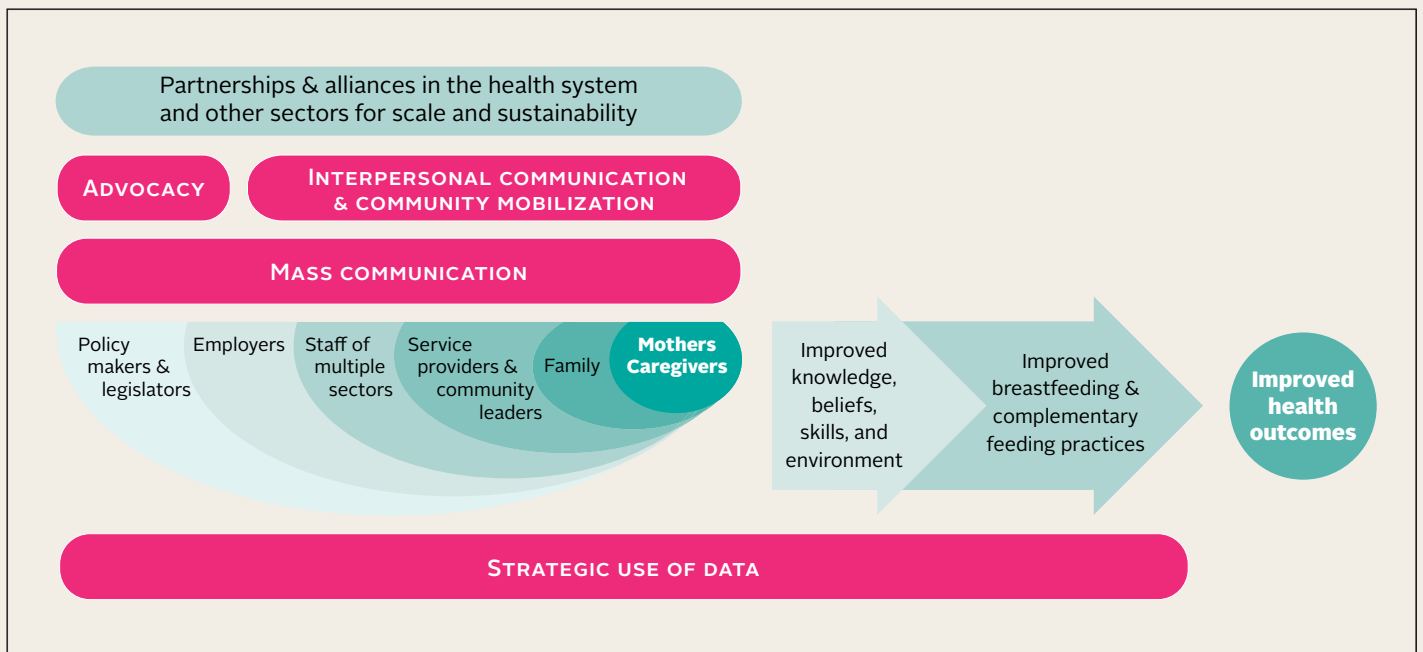
In this e-magazine, Alive & Thrive goes behind the scenes to show how we “scaled up” interpersonal communication, reaching millions of families in a way that still felt highly personal.



“People talking to people is still how the world’s standards change.”

— Atul Gawande, a surgeon and journalist

FRAMEWORK FOR BEHAVIOR CHANGE AT SCALE



One of Alive & Thrive's components for behavior change at scale is interpersonal communication and social mobilization. Especially when combined with advocacy, mass communication, and strategic use of data, interpersonal communication can drive behavior change.

In Bangladesh, the interpersonal communication component was implemented by BRAC, a large NGO with

an extensive network of frontline workers in communities throughout the country. BRAC began training and supporting these frontline workers, mostly women who worked or volunteered in the communities where they lived, to add counseling on breastfeeding and complementary feeding to their tasks.

Scaled up, the interpersonal communication component worked directly to change feeding and handwashing behaviors by:

- Bringing a personal and tailored touch to promotion of recommended child feeding practices
- Introducing priority feeding practices at just the right time, based on the baby's age
- Coaching the mother as she tries out the practices
- Guiding families to change the home environment to support recommended behaviors
- Bringing all family members into the conversation so they will support the new behaviors
- Engaging community leaders to support the feeding practices and the frontline workers' activities

BRAC is one of the world's largest nongovernmental development organizations. As an Alive & Thrive partner in Bangladesh, BRAC was responsible for implementing the interpersonal communication and community mobilization component. BRAC began implementation in 50 subdistricts, then scaled up further.

THINKING BIG, REALLY BIG



Interpersonal communication for infant and young child feeding (IYCF) requires the presence of skilled and motivated frontline workers in every community to provide information, coaching, support, and problem solving from pregnancy through the first 2 years of a child's life. To reach **SCALE** in a country of over 155 million people meant mobilizing a huge workforce of paid and volunteer community members. With 100,000 frontline workers throughout the country, BRAC proved a ready and experienced partner for implementing the interpersonal communication component of the program.

Although a large percentage of BRAC's frontline workers provided door-to-door basic health services, before Alive & Thrive they had not counseled on feeding practices. Formative research revealed that mothers thought that their milk was insufficient and complained that their young children had poor appetite. BRAC recognized that lives could be saved and stunting reduced by improving feeding practices.

Where to start?

First, with **TARGETS**. In 2009 Alive & Thrive set a target of reaching, by 2013, 3.5 million children under 2—almost half of the country's children in that age bracket—through intensive community interventions. A sense of **URGENCY** pushed us to find ways to accelerate the scaling up process. For example, we facilitated an alliance of implementing agencies to align all messages, conducted simultaneous trainings at multiple venues, and developed a single pocket-size job aid that the IYCF alliance members recommended. At the same time, concern for **QUALITY** drove us to roll out the program in stages, ensuring adequate time to test innovations such as performance-based incentives for volunteers.

STRATEGIC USE OF DATA ACCELERATED SCALE UP.

To bring face-to-face support to all the households with children under 2 years in the 50 subdistricts that would make up the A&T program areas, BRAC would need to train more than 11,000 frontline workers and supervisors. Using 5 of BRAC's training sites, they had trained workers from only 22 of the districts in 9 months. At this rate, the program would be almost over before they even got everyone trained! Doing the math, they decided to use 11 additional BRAC training sites to prepare workers to deliver interpersonal communication. With that change they managed to train up workers for the remaining 28 subdistricts in only 6 months.

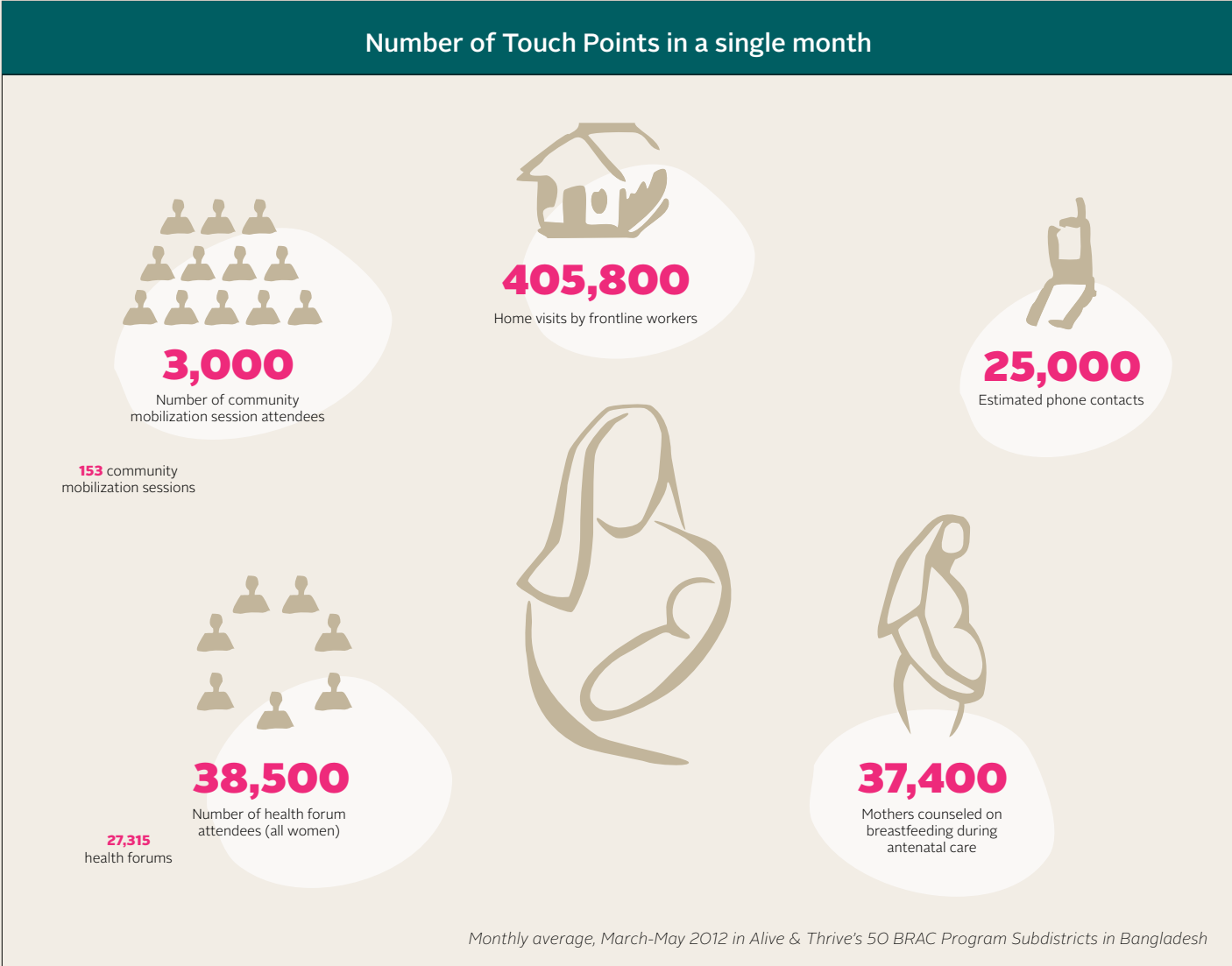


Click to hear directly from
mothers on their interaction
with frontline workers



By 2012 we had reached approximately 1.7 million children under 2 through BRAC's Essential Health Care Program in 50 subdistricts. Our commitment to reach 3.5 million children made us constantly look for **OPPORTUNITIES** to expand reach through other platforms, partners, and donors. The approach and tools were customized for government and NGO maternal, neonatal, child health, and family planning services and for poverty reduction programs. Through Alive & Thrive and other programs, interpersonal communication on infant and young child feeding exceeded our original target.

The interpersonal and community mobilization component was based on the belief that the more times and the more ways a family is "touched" with the same messages, the more likely they are to adopt recommended practices. The program **REACH** and the community "touch points" for counseling, discussion, and community mobilization on feeding practices are illustrated below. These numbers cover a single month of program activities in the 50 BRAC Alive & Thrive program subdistricts in Bangladesh.





IT WORKS! RESULTS

Bangladesh has documented recent and remarkable improvements at scale in life-saving behaviors: better breastfeeding practices, improved and timely complementary feeding, and food-related handwashing behaviors. Through an ongoing external evaluation we know that the Alive & Thrive program has contributed to these changes.

We learned from routine monitoring that interpersonal communication interventions can scale up fast. In less than 3 years, in Bangladesh, we:

- Trained more than 11,000 of frontline workers and supervisors
- Reached, through household visits, an estimated 1.7 million mothers with face-to-face communication

Midterm results of the external evaluation, representative of the areas where BRAC first

implemented the interpersonal communication and community mobilization component, indicated that where this component was operating at its peak, behavior change was greater than in comparison areas. Early findings indicated that:

WHERE ALIVE & THRIVE'S INTENSIVE INTERPERSONAL COMMUNICATION COMPONENT WAS IMPLEMENTED, ALMOST ALL MOTHERS WITH CHILDREN UNDER 2 YEARS OF AGE WERE VISITED AT HOME BY A FRONTLINE WORKER. In these areas,

85% of all mothers interviewed in 2013 reported that a frontline worker had visited the home and talked with them about infant and young child feeding, compared with 21% in comparison areas.

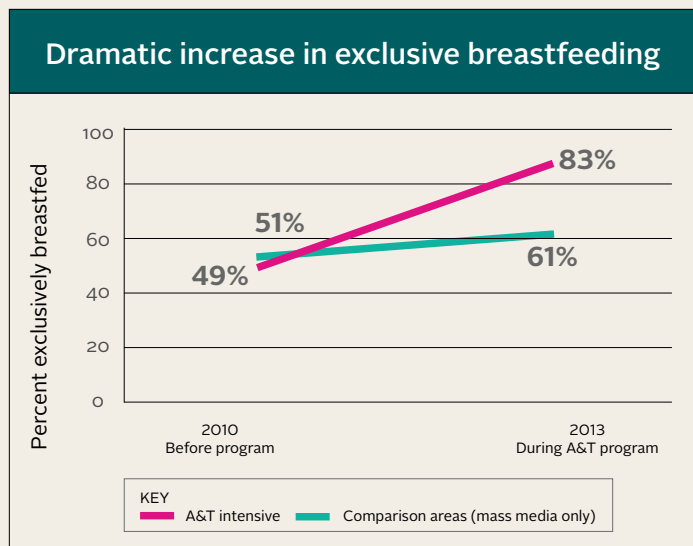


CHANGES IN FEEDING PRACTICES HAPPENED FAST. For at least 15 years, rates of exclusive breastfeeding in Bangladesh had remained the same. In Alive & Thrive intensive areas (those with interpersonal communication and mass media), exclusive breastfeeding increased from 49% in 2010 to 83% in 2013. In comparison areas, where the only Alive & Thrive intervention was mass media, exclusive breastfeeding increased

by 10 percentage points in the same period. We estimated that during this period an additional 132,000 babies in these areas were exclusively breastfed (above baseline).

A GREATER PROPORTION OF WOMEN PRACTICED THE RECOMMENDED BEHAVIORS WHEN THEY HAD FACE-TO-FACE CONTACT

with frontline workers plus mass media (TV spots) than did women who only saw the TV spots. Both groups reported much higher rates of several recommended practices for breastfeeding and complementary feeding than mothers interviewed in the same areas before the program's launch. For example, while 64% of mothers exposed to both frontline worker and mass media fed their 6- to 23-month-old children from four or more food groups in the previous 24 hours, 37% of mothers exposed only to mass media did so. This represents an improvement for both groups, compared with the baseline (31%).



focusfocusfocus




on how behavior changes

Yes, we would be able to reach the needed numbers of families, but unless mothers changed their feeding practices, we would fall short of our goal. We decided to focus on a few, clearly defined priority behaviors to promote. Before investing in training over 11,000 people, we needed to know which feeding practices would have the greatest impact on child health and growth, and which would be feasible for families to adopt.


DECIDING ON A FEW PRIORITY BEHAVIORS.

In our formative research, we collected the data to help us select the priority behaviors. To find which behaviors would be effective, we identified documented gaps in existing feeding practices. Field trials (like trials of improved practices, or TIPs) helped us learn which practices families found acceptable and “doable.”


**Infant & Young Child Nutrition
Complementary Feeding**

Things to Remember





Infant 6 to 8 months



1/2 Bowl
1/2 Bowl
1/2 Bowl


Bowl size 250 ml

- Give mashed family foods: solid/semi solids, not watery food
- Give fish or egg or chicken liver daily + thick lentils + dark green leafy vegetables or yellow fruits + fried foods
- Feed 1/2 bowl two times a day
- Give iron supplement according to the recommendation of health worker

Solid/ semi solid food Liquid food


Infant 9 to 11 months



1/2 Bowl
1/2 Bowl
1/2 Bowl

Bowl size 250 ml

- Spend time and teach child to feed himself/herself
- Give fish or egg or chicken liver daily + thick lentils + dark green leafy vegetables or yellow fruits + fried foods
- Feed 1/2 bowl three times a day and nutritious snacks 1-2 times (ripe papaya, ripe mango, jackfruit, boiled egg)
- Give iron supplement according to the recommendation of health worker





Click to read a strong example of a national IYCF communication strategy with a focus on behaviors



Click to download this IYCF job aid that reminds the frontline worker of the priority behaviors for each age group.

*The right environment can make the behavior almost “automatic.”
With soap and water near the home’s food preparation area, the mother
didn’t really need to think about why she should wash her hands.*



FOCUSING ON THE MOST POWERFUL BEHAVIORAL DETERMINANTS.

Additional rounds of research helped us name the factors that drove those behaviors for families: the behavioral determinants. Knowledge of the recommended feeding behaviors would be important, but in most cases, not sufficient to prompt uptake of the behaviors. That is why we needed to take a new look at the frontline workers’ tasks during home visits.

Our studies showed that a mother was more likely to adopt a behavior when:

- The mother knew what the recommended behavior was **[KNOWLEDGE]**
- The mother believed that adopting the behavior would result in something she wanted. **[BELIEFS ABOUT OUTCOMES]**
- The mother perceived the practice as the “new norm.” **[PERCEPTION OF SOCIAL NORMS]**
- The mother believed “I can do it.” **[SKILLS AND SELF-EFFICACY]**
- The mother considered it “easy and convenient.” **[SELF-EFFICACY]**
- The home was set up to make the behavior easy. **[ENABLING ENVIRONMENT]**

With this fresh look at the behavioral determinants, we redesigned the activities or tasks for a home visit. Through training, a pocket-size job aid, on-the-job supervision, and incentives, we reminded frontline workers of the strategic ways to use their time during each home visit.

*More than simply providing information, frontline workers needed to **listen, counsel, coach, demonstrate, and encourage.***

A NEW KIND OF HOME VISIT

Behavior change was everyone's aim. Up and down the supervision line, each player knew that performance was assessed—and incentives were awarded—by how many mothers adopted the behaviors.

Here we break down for you the tasks that made up a typical home visit to promote improved infant and young child feeding, which shifted from a focus on exclusive breastfeeding in the first months to proper complementary feeding with continued breastfeeding. Note that the frontline worker's tasks addressed the behavioral determinants we had identified.

FOCUS ON THE PRIORITY BEHAVIORS FOR THE CHILD'S AGE.

Feeding priorities change with age. In each home visit the frontline worker focused on just three or four age-appropriate behaviors.

COACH THE MOTHER TO TRY A PRIORITY BEHAVIOR.

The frontline worker could help the mother ensure proper attachment for breastfeeding. For older babies, worker and mother washed their hands, then selected and mashed nutritious foods. With the baby seated in front of her, the mother could see how much the child liked the improved meal.

OBSERVE AND HELP FIX THE HOUSEHOLD ENVIRONMENT.

The frontline worker reminded families how to make it easy to practice the behaviors. To increase handwashing before feeding, she observed whether a water container and soap were near the place where the child was fed. If not, she helped the father create this "handwashing station."



WORK WITH THE WHOLE FAMILY.

The baby's grandmothers and aunts often shared child feeding chores and needed to be coached in the new practices too. Since the father did the food shopping, he was encouraged to bring home the recommended foods, especially "animal-source" foods like fish, eggs, and chicken liver.

ADDRESS SPECIFIC CONCERNS.

The frontline worker reminded the mother how to maintain her supply of breastmilk or to avoid problems of "poor appetite" before they occurred. Some frontline workers gave families their mobile phone numbers for future consultations.

RECORD VISIT AND MOTHER'S PRACTICES.

The frontline worker recorded details about each visit in a register, documenting the topics discussed and the mother's current feeding and handwashing practices. This task kept the worker focused on being accountable for behavior change.

eight ways

BUILDING A SYSTEM THAT WORKS

to ensure quality

We trained workers in the skills needed to deliver this new kind of home visit. But training was just one of 8 ways we built a system that supported high quality delivery by the frontline workers.



1 List and map households with children under 2 years of age



2 Allocate staff for manageable workloads and clarify roles



3 Build frontline worker knowledge and skills, ensuring they know the job requirements and how their performance will be judged



4 Provide job aid and on-the-job guidance

Videos of role plays of home visits helped frontline workers learn new ways to interact with the family.



[Click here for a sample training video](#)



5 Offer supportive supervision

Everyone saw the supervisors' observation checklists during training, so expectations were clear.



6 Through regular meetings and refresher training, continue capacity building and focus on achieving enrollment targets



7 Recognize good performance with cash incentives and other means

Incentives were awarded to the community health volunteers for each mother who performed the recommended behaviors. Rewards helped push registration of eligible mothers to around 85%.



8 Use data to see if program adjustments need to be made

We kept on top of data, and analyzed reports to see if we needed to fix the strategy.

Change

when community is behind it

Happens



Community mobilization was another well-established intervention to spread behavior change. The purpose of community mobilization was to reach out to community members and opinion leaders to:

- Engage everyone in contributing to the health and nutrition of the community's infants and young children
- Shift people to accept the recommended behaviors as the "new norm"
- Reduce barriers to practicing the behaviors
- Pave the way for frontline workers to visit mothers, especially in areas where young women were discouraged from talking with strangers
- Ensure consistent messages were given by staff and health providers from other programs

In areas where BRAC operated, we held community forums. The goal was to get community leaders to commit to encourage frontline workers and



WHAT CAN OPINION LEADERS DO?

We were clear in letting opinion leaders know exactly what they could do to help. For example:

- **Religious leaders** can use religious events to tell families that the new feeding practices are consistent with religious beliefs.
- **Traditional birth attendants** can place the baby at the breast in the first hour after birth.
- **Local government** and **business leaders** can encourage frontline workers and supervisors to enter the communities to make home visits.
- **School teachers** can remind parents that nutrition improves brain development and learning.
- Informed **health care providers** can encourage exclusive breastfeeding and not prescribe or suggest breastmilk substitutes

help spread the program's messages. We were systematic about inviting a variety of opinion leaders to the forum, where we showed videos and gave updates on how feeding practices were improving. Opinion leaders actually signed commitments on actions they would take. After the forum, we made follow-up visits or calls.

A second approach was borrowed from the commercial world to extend our mass media campaign to areas without power or broadcast media (also known as "media dark" areas). We contracted with a private firm to hold events similar to the ones they used to sell mobile phone services in remote communities. A team visited the community a day or two in advance and invited each family with a child under 2 or with a pregnant woman. Events were timed so fathers and local authorities could attend. Transporting a projector and a generator, the firm showed the Alive & Thrive TV spots and animated films. Discussions, Q&A, and a quiz on child feeding, with prizes, kept the crowd engaged.



Click to hear a religious leader's view on how imams can support improved feeding



Click to view "Tiny Tales," following a family as they make feeding decisions in the child's first year

Reaching even greater scale

Once the basic model of face-to-face or interpersonal contacts was developed, tested, and improved, Alive & Thrive promoted its uptake through other programs in Bangladesh. The aim was to affect national level changes in behaviors. By 2014, BRAC reported that they had integrated Alive & Thrive-inspired interpersonal communication and community mobilization in 222 subdistricts. Over 60% of the country's children under age 2 (that is, 4.8 million children in the target age group) reside in these 222 subdistricts.

POVERTY REDUCTION AND LIVELIHOODS PROGRAMS OF DFID:

This carefully targeted program, funded by the UK's Department for International Development (DFID), had proven strategies to reach the very poor and hard-to-reach segments of the Bangladesh population with programs to improve employment and asset generation. They had found, though, that even as families' resources increased, infants and young children remained undernourished, since feeding practices had not improved. Three large programs beyond BRAC funded by DFID adopted the Alive & Thrive model of face-to-face interpersonal contacts with mothers, using dedicated full-time teams of community workers.

FEED THE FUTURE INITIATIVE OF USAID:

While food production and incomes are rising through agricultural interventions, this program seeks to ensure that the benefits translate into improved child nutrition by supporting mothers to make better use of the foods. The program contracted BRAC to replicate the Alive & Thrive model for improving feeding practices using incentivized volunteers and BRAC health workers combined with community mobilization and a mass media campaign. Intensive monitoring will help to ensure that feeding practices are improving.

MNCH PROGRAMS OF BRAC AND SAVE THE CHILDREN/ GOVERNMENT:

Once BRAC's Maternal, Neonatal and Child Health (MNCH) interventions were successfully launched and scaled up, these programs sought to build a preventive child health component in MNCH programs. Incorporating an adapted and streamlined version of the Alive & Thrive model for children below two years brought promotion of improved feeding practices to thousands more families in 82 subdistricts in rural areas and slums in nine city corporations.



Click for a short video
on how we scaled up
nutrition in Bangladesh

ACKNOWLEDGMENTS. *Writing and editing:* Silvia Alayón, Ann Jimerson, Luann Martin, Tina Sanghvi. *Visual design:* Rica Rosario, Jill Vitick. *Program design and implementation:* Kaosar Afsana, Faruque Ahmed, Shirin Akhter, Morseda Chowdhury, Rukhsana Haider, Raisul Haque, Sanjeeda Islam, Sumitro Roy, Tina Sanghvi, Saydur Siddique, Saiqa Siraj. *Evaluation studies:* Andrew Kennedy, Adiba Khaled, Purnima Menon, Rahul Rawat, Kuntal Saha.

ALIVE & THRIVE is an initiative to improve infant and young child feeding practices by increasing rates of exclusive breastfeeding and improving complementary feeding practices. The first two years of life provide a window of opportunity to prevent child deaths and ensure healthy growth and brain development. The first phase of Alive & Thrive aimed to reach more than 16 million children under two years old in Bangladesh, Ethiopia, and Viet Nam through various delivery models. Learning is being shared widely to inform policies and programs throughout the world. Alive & Thrive's first phase was funded by the Bill & Melinda Gates Foundation and managed by FHI 360. Other members of the A&T consortium included BRAC, GMMB, International Food Policy Research Institute (IFPRI), Save the Children, University of California-Davis, and World Vision.

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



Alive & Thrive, FHI 360

1825 Connecticut Avenue, NW

Washington, DC 20009 USA

T 1.202.884.8754

F 1.202.464.3966

✉ aliveandthrive@fhi360.org

📘 facebook.com/fhi360.aliveandthrive

🐦 [@aliveandthrive](https://twitter.com/aliveandthrive)

www.aliveandthrive.org