Bangladesh: Supporting Urban Primary Health Care Services Delivery Project
(Financed by Asian Development Bank)

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Behaviour Change Communication Strategy for the Urban Primary Health Care Services Delivery Project

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# Table of Contents

1. Introduction ........................................................................................................................................ 4
2. Key behaviours ..................................................................................................................................... 6
3. Other behaviours .................................................................................................................................. 23
4. Channels of communication ............................................................................................................. 25
5. Monitoring and evaluation .............................................................................................................. 28
6. References ......................................................................................................................................... 30
7. Annexes ............................................................................................................................................. 32  
   Annex 1: the PerFORM Framework .................................................................................................. 32  
   Annex 2: The Socio-ecological model .............................................................................................. 35  
   Annex 3: Organizational structure .................................................................................................. 36  
   National level project management and organization arrangements ........................................ 36
## Acronyms and abbreviations

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>ANC</td>
<td>Antenatal care</td>
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<tr>
<td>BCC</td>
<td>Behaviour change communication</td>
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<td>BCCM</td>
<td>Behaviour change communication and marketing</td>
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<tr>
<td>DHS</td>
<td>Demographic and health survey</td>
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<tr>
<td>ESD+</td>
<td>Essential service delivery package</td>
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<tr>
<td>INGO</td>
<td>International non-governmental organization</td>
</tr>
<tr>
<td>IYCF</td>
<td>Infant and young child feeding practices</td>
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<tr>
<td>LAPM</td>
<td>Long acting and permanent methods</td>
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<tr>
<td>MAMA</td>
<td>Maternal Alliance for Maternal Action</td>
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<tr>
<td>MCH</td>
<td>Maternal and Child Health</td>
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<tr>
<td>MMR</td>
<td>Maternal mortality rate</td>
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<tr>
<td>MoHFW</td>
<td>Ministry of Health and Family Welfare</td>
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<tr>
<td>NSV</td>
<td>No scalpel vasectomy</td>
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<tr>
<td>OAM</td>
<td>Opportunity, ability and motivation</td>
</tr>
<tr>
<td>PMU</td>
<td>Program management unit</td>
</tr>
<tr>
<td>PNC</td>
<td>Post-natal care</td>
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<tr>
<td>PSI</td>
<td>Population Services International</td>
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<tr>
<td>RTI</td>
<td>Reproductive tract infection</td>
</tr>
<tr>
<td>STI</td>
<td>Sexually transmitted infection</td>
</tr>
<tr>
<td>TFR</td>
<td>Total fertility rate</td>
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<tr>
<td>ULB</td>
<td>Urban local body</td>
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<tr>
<td>UNFPA</td>
<td>United Nations Fund for Population Activities</td>
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<tr>
<td>UPHCP II</td>
<td>Second Urban Primary Health Care Project</td>
</tr>
<tr>
<td>UPHCSDP</td>
<td>Urban Primary Health Care Services Delivery Project</td>
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<tr>
<td>WUPHCC</td>
<td>Ward Urban Primary Health Care Committees</td>
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1. Introduction

The Urban Primary Health Care Services Delivery Project (UPHCSDP) aims to improve maternal and child health, nutrition and family planning for the urban poor through, among others, provision of primary health care services. Behaviour change communication (BCC), outreach and counselling are key activities for the project. During the second Urban Primary Health Care Project (UPHCP II), a significant number of behaviour change communication and marketing activities (BCCM) were completed. The activities successfully established the Rainbow identity for project area health clinics and a variety of BCCM materials were produced, including mass media and print products. A recent end line survey of households within the UPHCP II project areas showed that despite high awareness among households of the types of services available at the Rainbow clinics, rates of service utilization could still be improved. In addition, there is still a significant need to increase ownership of Red Cards by poor households.\(^1\)

Behaviour change activities within the UPHCSDP will build upon past achievements in developing BCCM activities aimed at increasing buy-in and ownership of the project by the Urban Local Bodies (ULBs) responsible for urban primary health care and to increase the ownership of Red Cards by poor households in project areas. Communication campaigns will also target increasing adoption of key maternal and child health behaviours among poor, urban households. As indicated in the Terms of Reference, there is a significant need to build the capacity implementation agency staff in outreach and communication- including clear understanding of key messages for each behaviour- improving methods of communication to patients including instilling a sense of customer service towards patients, and ensuring clear understanding of how to market and uniformly promote Rainbow clinic services.

Document purpose: This document was developed for several audiences and purposes. First, it serves as a tool for the Program Management Unit (PMU), implementation agencies and donors to understand the range of key communication objectives, messages and channels for the BCCM activities with the UPHCSDP. It also serves as a guideline for the BCCM firm in development of strategic and effective behaviour change activities for the UPHCSDP, as all communication messages and materials should reflect the communications objectives outlined in this document.\(^3\) This document also sets out what should be communicated to the respective target audiences, with the BCCM firm responsible for developing how to translate that into messages, materials and activities.

Guiding principles:

1. **Employing evidence-based communication:** Evidence based programming is a scientific approach to communications whereby decisions made throughout the project cycle is supported by data, resulting in reduced speculation and guesswork. This Strategy was developed based on a search for studies conducted in Bangladesh on the behavioural determinants - factors that can facilitate or inhibit behaviour - for each of the key health behaviours. Communication objectives were then developed for the key determinants.

   A BCC program should also, ideally, be guided by a behaviour change theory or framework. There are many theories that draw upon different disciplines including psychology, sociology, 

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\(^1\) The ‘red card’ is a pro-poor targeting program that enables holders to avail themselves of free health services from UPHCSDP clinics.


\(^3\) This strategy serves only as a technical guide. The firm is accountable to the tasks and timelines as detailed in the “Urban Primary Health Care Services Delivery Project Terms of Reference for a Behavior Change Communication and Marketing Firm.”
anthropology and marketing. Theories or frameworks are useful in assisting program planners to consider the range of factors that influence behaviour. They can be used to inform the analysis of existing formative research studies (as was done for this Strategy), can guide the design of new research studies, can help practitioners to prioritize behaviours to be changed and the populations to be targeted and finally, can improve the effectiveness of interventions and identify the appropriate indicators to monitor.\(^4\) Annex 1 of this Strategy details the PERfoRM framework that has been used by an international social marketing organization in addressing a range of behaviours. The PERfoRM framework is useful in that it provides definitions of behavioural determinants. Annex 2 provides details on the Socio-Ecological Model (SEM) which recognizes the influence the community and society on individual choices and behaviour. This model is useful in identifying at which level to intervene, i.e. personal, community or through policies and regulations to increase the likelihood of behaviour change.

2. **Prioritizing behaviours:** Given the many services and subsequent health seeking behaviours addressed within the Essential Service Delivery (ESD+) package, the Strategy will focus on the priority areas of the UPHCSDP. These include: advocacy activities to enhance ULBs’ understanding of urban health challenges and to increase their buy-in to the UPHCSDP to ensure its sustainability after project funds cease; raising awareness among poor households of how they can access Rainbow clinic services and their eligibility for Red Cards; increasing the numbers of couples who adopt modern contraception; increasing the number of institutional deliveries; and improving maternal and child nutrition through adoption of proper infant and young child feeding practices (IYCF).

3. **Leveraging existing resources:** Given the large amount of work that has already been done to develop BCC materials for maternal and child health (MCH) in Bangladesh, UPHCSD communication activities will, when appropriate. Following the development of the communication objectives above, a search was conducted for relevant materials on the Knowledge4Health database of maternal child health (MCH) BCC materials. The materials on this website have all received prior approval from the Ministry of Health and Family Welfare (MoHFW) for technical accuracy and have been uploaded for use by all organisations.

   Nutrition: [http://www.k4health.org/toolkits/bangladesh-nutrition](http://www.k4health.org/toolkits/bangladesh-nutrition)
   MNCH: [http://www.k4health.org/toolkits/bangladesh-mnch](http://www.k4health.org/toolkits/bangladesh-mnch)
   Family Planning: [http://www.k4health.org/toolkits/bangladesh-fp](http://www.k4health.org/toolkits/bangladesh-fp)

4. **Utilizing technology for message dissemination:** In light of the increasing coverage of mobile phones in Bangladesh – see section four for more details- efforts should be made to leverage mobile phones as a communication channel to market clinic services, disseminating BCC messages/reminders to patients, etc.

**Document structure:** Following the above introduction, section two presents key indicators against which the overall project will be measured, including behavioural determinants identified during the literature review, communication objectives and existing materials for each behaviour. Section three presents the other behaviours that are covered within the ESD+ program and the materials that have received MoHFW endorsement. Section four provides information on the reach of various communication channels and Section 5 includes indicators for monitoring and evaluation.

2. Key behaviours

This section presents the five key project indicators related to targeted BCCM messages and materials: 1) increased commitment by local ULBs to urban PHC and greater ownership of the UPHCSDP; 2) at least 80% of poor households are properly identified as eligible for Red Cards and access UPHCSDP health services when needed; 3) 60% of couples (ages 15-49) adopt modern contraceptives; 4) at least 60% of births in project areas are attended by skilled health personnel; and 5) prevalence of underweight and stunted children reduced by 20% in project areas.

Advocacy and promotion activities, strengthening the Rainbow brand identity and recognition and capacity building are all needed to achieve the first goals, as detailed below. For the last three behaviours, although there a range of materials are available, the BCCM firm must ensure that existing materials address the communication objective. Materials may, for example, increase knowledge of the five danger signs during pregnancy but may not focus on building social support from husbands to help their wives to implement their birth plan, etc. Communication objectives not covered by existing materials will need further supporting materials. All communication products selected for inclusion in the Rainbow clinic BCCM Kit must also have a uniform look, including at minimum the Rainbow clinic logo and tagline.

A. Key behaviour I: Urban Local Bodies prioritize primary health care and have greater ownership of the UPHCSDP

Indicators:
- At least 50% increase in overall allocation to the Urban Health Sustainability Fund compared to UPHCP II (2011 baseline: Tk38.5M);
- At least 5% per annum increase of ULB annual development plans and block grants allocated for PHC and public health related services (2011 baseline: No)

Behavioural goal: Greater priority placed on urban health by the ULB as measured by increased resource allocations.

Current status: A key objective of the UPHCSDP is to strengthen institutional governance and local government capacity to sustainably deliver urban PHC services. This will require, among others, support to the ULB health departments, which are responsible for delivering urban PHC, to enable them to provide public services, including those to the poor. To enhance the sustainability of PHC services after the completion of the project, the ULBs will be required to contribute at least 1% of their local revenue to the PHC sustainability fund established by the Ministry of Finance and to gradually increase outputs for urban PHC and other pro-poor basic services to at least 20% of the development block grants.

Program intervention: To achieve the above, an advocacy program targeted at 1) ULB officials and politicians and 2) their constituencies/communities to demand healthcare from their elected leaders is needed. Development of the advocacy campaign including targets of change, indicators, communication objectives and messages need to be based on the findings of the Perceptions Survey that will reveal the ULB’s and household opinions of urban health challenges, among others refer to terms of reference. Below are suggested communication objectives, which may require further refinement and revision.

After the campaign, ULBs will:
1. Understand the challenges to maternal child health, family planning, communicable and non-communicable diseases faced by their constituents;
2. Believe in the importance of providing health care to the urban poor;
3. Understand rationale for and the roles and responsibilities within a public private partnership model of primary health care service delivery;
4. Feel that it is important to allocate financial resources to improve urban PHC;
5. Intend to contribute at least 1% of local revenues to the sustainability fund.

Communication objectives for targeting constituents also need to be developed following the results of the Perceptions Survey.

B. Key behaviour II: Poor, urban households access Rainbow clinic services

Indicators:
- At least 80% of the poor access project health services when needed (baseline: 64.7% UPHCP II 2008)

Behavioural goals: 1) Increase number of Red Cards owners and generate demand for Rainbow clinic services by poor, urban households; 2) increase ownership and uniform promotion of health centres as Rainbow clinics by City Corporations, Municipality and Partner-NGO staff clinics; and 3) improve quality of customer service provided to patients by all Rainbow clinic staff.

Current status: Sensitizing the community of their rights to be informed about health services and how they are able to participate in planning, organizing and reviewing project activities are key objectives.5 Throughout the UPHCP II, the health clinics were referred to as the “Urban” clinics or by the name of the implementing agency (non-government organisations) hired by the project to provide services on behalf of the government. Despite several years after the creation of the Rainbow logo and a variety of promotional activities, the Rainbow identity has not caught on. A branding strategy is needed to define or refine the core brand attributes of the Rainbow clinics including, friendly service, affordability, male-friendliness, etc. To this end, interviews with staff from the respective agencies and households may be required to better understand what the aspects of the Rainbow clinics should be highlighted and what would motivate staff to promote the Rainbow brand.

Program Intervention: To achieve the above behavioural objectives, a multi-pronged approach is needed to increase demand for and supply of quality services as detailed below:

a. Communication campaign for urban households so that after the campaign, they will:
   - Know that the Red Card program can provide qualifying households to free health care from the Rainbow clinics;
   - Understand the criteria needed for eligibility for the Red Card program;
   - Know that they can be involved in UPHCSDP activities through membership in the Ward Urban Primary Health Care Committees (WUPHCC).

b. Branding activities, including training, are needed to:
   - Define and strengthen the brand attributes of the Rainbow clinics;
   - Emphasize the local governments’ ownership of the Rainbow clinics and services;

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• Ensure uniform promotion of the Rainbow clinic among all implementation agencies involved in the project;
• Generate brand awareness of the Rainbow clinics as places for quality care at affordable\(^6\) prices among urban households.

c. **Capacity building** of Rainbow clinic staff in providing prompt, courteous customer service is needed to ensure that client expectations generated by the communication and marketing activities above are met. Improved quality of care combine with proper identification of the poor will increase their utilization of Rainbow clinic services. The Customer Service trainings could be in the form of stand-alone courses or as add-on modules to on-going technical trainings. When developed as ad-on modules, the trainings should be designed as practicums whereby trainees can practice their technical skills combined with customer service skills. In addition, training on the brand identity and promotion activities is needed for all institutions and staff involved in UPHCSDP to build buy-in and ownership of the project.

C. **Key Behaviour III: Couples ages 15 to 49 adopt modern\(^7\) contraceptives**

**Indicator:** At least 60% of eligible couples use modern contraceptives (baseline: 53% UHS 2006)

**Behavioural goal:** Given that most women in Bangladesh only want two children, the behaviour that needs to be promoted among recently married couples is to delay having the first child through promotion of reversible, short lasting contraception. For couples that have attained their desired family size, there is a need to promote long acting, permanent methods. (See box below)\(^8\).

<table>
<thead>
<tr>
<th>Type</th>
<th>Target group</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reversible, temporary</td>
<td></td>
</tr>
<tr>
<td>Male condom</td>
<td>Any couple</td>
</tr>
<tr>
<td>Pill</td>
<td>Newly married couples and those with at least one child</td>
</tr>
<tr>
<td>Injectable</td>
<td>Woman who has at least one living child</td>
</tr>
<tr>
<td>Reversible, long lasting</td>
<td></td>
</tr>
<tr>
<td>Intra-uterine Device (IUD)</td>
<td>Newly married</td>
</tr>
<tr>
<td>Implants</td>
<td>Couple with or without living children and newly married couples</td>
</tr>
<tr>
<td>Permanent</td>
<td></td>
</tr>
<tr>
<td>Vasectomy, tubal ligation</td>
<td>Couples with desired family size</td>
</tr>
<tr>
<td>Temporary</td>
<td></td>
</tr>
<tr>
<td>Menstrual regulation</td>
<td>Women who have had amenorrhea for 10 weeks</td>
</tr>
</tbody>
</table>

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\(^6\) This objective may need to be changed to promote the selected brand attribute(s).

\(^7\) Condoms (male and female), foams, jelly, diaphragm, pill, inter-uterine device, Norplant, injectable, vasectomy, tubal ligation, menstrual regulation

\(^8\) Bangladesh Government Family Planning manual.
Current status: As with other maternal and child health indicators, Bangladesh has successfully reduced the total fertility rate (TFR)\(^9\) within the last 30 years from 6.3 births per woman in 1971 to 2.3 births per woman in 2011. The Government aims to reduce the TFR further to 2.0 births per woman by 2016. Roughly 60% of married women in Bangladesh are currently using a contraceptive method with around 52% using modern contraception methods and almost 9% using traditional methods. The Pill is the most popular method, used by 27% of women, followed by injectable at 11%. Female sterilization is used by 5% and condoms use is at 6%. The usage rate of long acting and permanent methods (LAPM) has declined over the years and was at just 8% of married couples in 2011. Contraception discontinuation is at roughly 37%, with women citing side effects as a key reason for discontinuing or switching methods.\(^{10}\)

Although the project target is to increase the number of couples who use modern contraception, it is necessary to further segment couples age 15 to 49 into two groups according to whether they have a desire to delay the birth of their first child or a desire to limit their total number of children. In Bangladesh, women often marry young and the birth of the first child soon follows.

Existing evidence: The literature search revealed surprisingly few studies that examine behavioural determinants affecting adoption and sustained use of contraception in Bangladesh. The majority of studies use quantitative data from the Demographic and Health Survey (DHS) or project baselines to determine associations between contraception use and female education, income, the number of sons alive, etc. Fortunately, the Demand-based Reproductive Health Commodity Project has used qualitative methods to explore behavioural determinants of contraception adoption in Dhaka slums, the results of which are presented below.\(^{11}\)

With regards to adolescent reproductive health, the search revealed only one conference presentation of a study on behavioural determinants for adolescents and recently married couples. The study indicates the same barriers for recently married couples as other couples in that they also believe contraception can lead to infertility.\(^{12}\) Further formative research is needed to affirm these similarities.

Knowledge: Incomplete information on the benefits and side effects of contraception is a barrier to adoption of this practice. Although respondents knew about IUDs and Norplant, they were not aware of the process of insertion and removal or that the methods are reversible.\(^{13}\)

Attitudes/beliefs: A common barrier to uptake of LAPM is the fear of losing potency and ability to work in the case of sterilization methods. Moreover, there are religious fears about long-term and permanent methods. Some women regard undergoing sterilization as a sin and strongly believe that they will not be buried after death if they die with Norplant/IUD, or if they are sterilized. Also, women consider sterilization as one of the responsibilities of being a wife and are reluctant to motivate their husbands to undergo sterilization because they fear that their husbands will not be able to work if they are sterilized.\(^{14}\) Although women may want to use LAPM, some of their

\(^9\) Average number of children that would be born to a woman over her lifetime
\(^{14}\) Ibid
husbands do not allow them to do so and they are unable to negotiate LAPM due to the above beliefs about inability of their husbands to work.\textsuperscript{15}

**Quality of care:** Another key barrier to contraception adoption is the attitude and ability of service providers to provide quality care for couples. For example, providers do not routinely ask how many children clients currently have or whether they want more children. Nor do they ask for clients’ medical history, including symptoms of reproductive tract infections (RTIs), which need to be treated before prescribing contraceptive options. In addition, service providers are not able to promote the benefits of LAPM. They do not discuss with married women the male methods, and thus miss the opportunity to involve males in using family planning services. Service providers also do not encourage women to discuss family planning with their husbands.\textsuperscript{16}

**Recommendation:** Due to the limited data available online, further discussions with organizations working in adolescent reproductive health in Bangladesh are needed to affirm that this target group (adolescents) faces the same barriers as couples who have been married longer, after which further spot formative research may be needed to develop tailored messages for this group. The Demand-based Reproductive Health Commodity Project should be consulted for their lessons learned in working to improve service provider attitudes and practices. There may also be a need to talk with counsellors, doctors and paramedics within the UPHCSDP to understand what barriers exist in providing quality care and counselling to patients around long acting methods in counselling young couples or adolescents. In addition, the United Nations Fund for Population Activities (UNFPA), is also implementing adolescent reproductive health activities as part of the UPHCSDP and should be consulted in developing messages and materials to ensure synergies and avoid duplication of communication efforts. EngenderHealth has experience engaging Imams and religious leaders and can share their experience and resources for addressing this target group.

**Program intervention:** The matrix below provides suggested communication objectives and lists available materials to promote contraception adoption. Currently, the communication objectives are the same for recently married couples and for couples who have reached their desired family size. However, the former may need to be revised based on further consultation and/or research.

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\textsuperscript{15} S. M. Mostafa Kamal, Socioeconomic Factors Associated With Contraceptive Use and Method Choice in Urban Slums of Bangladesh, Asia Pac J Public Health September 13, 2011

\textsuperscript{16} Talukder et al. 2009.
<table>
<thead>
<tr>
<th>Goal</th>
<th>Behavioural objectives by target audience</th>
<th>Key barriers</th>
<th>Communications objective: <em>(After the campaign, the target audience will...)</em></th>
<th>Existing materials</th>
</tr>
</thead>
</table>
| At least 60% of eligible couples use modern contraceptives | Recently married couples: 1. Use long-acting reversible contraceptive methods to delay first pregnancy. 2. Make joint decision about family planning and contraceptive choice before adopting contraceptives. | Knowledge: Incomplete information on the benefits and side effects are a barrier to acceptance of contraception. Attitude/beliefs: Fear of losing potency and ability to work in the case of sterilization methods. Attitude/beliefs: Women consider sterilization as a responsibility of the wife and are reluctant to negotiate use of LAPM with husbands. | Couples will know of the various options for contraception, particularly short lasting and reversible methods. Couples will believe that contraception will not result in sterility and are reversible. Women will be able negotiate with their husbands to collectively seek advice from Rainbow clinics for contraception. Men will feel equally responsible for using contraception. | Short Term FP  
• Leaflet on condom use  
• Brochure on short acting family planning methods  
• Poster on “the responsible man”  
• TV spot on life without tension  
• Song on family planning |
| Couples who have reached desired family size: 1. Use long-acting and permanent methods of contraception. 2. Make joint decision about family planning and contraceptive choice before adopting contraceptives. | Knowledge: Incomplete information on the benefits and side effects are a barrier to acceptance of contraception, in particular of LAPM. Attitudes/beliefs: Women consider sterilization to be a responsibility of the wife and are reluctant to negotiate use of LAPM with husbands. Attitudes/beliefs: Fear of losing potency and ability to work in the case of sterilization methods. | Couples will know of the various types of long acting, permanent methods. Couples will understand the benefits and potential side effects of LAPM. Couples will believe that contraception will not result in sterility and are reversible Women will be able to negotiate with their husbands to collectively seek advice from Rainbow clinics for LAMP. Men will feel equally responsible for using contraception. | Long acting FP methods  
• TV spot on No Scalpel Vasectomy (NSV)  
• Poster on NSV  
• Two Brochures on NSV  
• Leaflet on information about LAPM  
• TV spot on LAPM  
• TV spot on life without tension  
• Poster on tubal ligation  
• Leaflet on postpartum family planning  
• Poster on responsible man  
• TV spot on life without tension  
• Song on family planning |
| Service providers are equipped with the skills and are motivated to provide patients with complete information on LAPM. | **Quality of care:** Insufficient screening for reproductive tract infection (RTI) and client’s family planning needs prior to recommending contraception. Lack of motivation and skill in explaining full benefits and side effects of LAMP.  
**Belief:** Family planning is for women and missed opportunities to engage men. | Know how to screen patients for RTIs.  
Know how to explain the benefits and side effects of all contraception options, LAMP in particular.  
Feel that it is important to provide quality contraception counselling to patients.  
Believe that it is important to encourage men to come with their wives to discuss family planning needs. | • Card on late marriage and conception  
• Guidebook for Volunteers on family planning activities |
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<tbody>
<tr>
<td>Imams, religious leaders are engaged to support and encourage family planning.</td>
<td><strong>Attitudes/beliefs:</strong> Women believe they will not be buried after death if they die with Norplant/IUD or if they are sterilized.</td>
<td>There are no materials on the Knowledge 4 Health website but materials and practical experience in working with religious leaders can be obtained from EngenderHealth.</td>
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</tbody>
</table>
D. Key behaviour IV: Women deliver with presence of skilled health personnel

Indicator: 60% of births are attended by skilled health personnel (baseline: 26.5% BMMS 2010).

Behavioural goal: In order to reach the above goal, BCCM activities must change the preference for at-home deliveries among expectant poor, urban households by generating demand for facility based deliveries while improving perceived quality of services provided by the Rainbow clinics.

Current status: Bangladesh has made great strides in reducing maternal mortality and is currently on track to meet Millennium Development Goal #5, to reduce by three-quarters the maternal mortality rate (MMR). According to the Bangladesh Maternal Mortality Survey 2010, the MMR is now at 194/100,000 live births and the Government’s goal is to reduce it to 143 deaths in 100,000 live births by 2015. Despite these achievements, only 26% of women who had a child in the last three years received the recommended four or more antenatal care (ANC) visits; only 29% of recent births took place in a health care facility. In addition, only 29 % of mothers in Bangladesh receive post-natal care (PNC) from a medically trained provider within 42 days after delivery and only 27 % of mothers receive PNC within first two days of delivery.

Post-natal check-ups for children are slightly more common at 34%. Given the difficulty in predicting which woman may face obstetric complications that could be fatal, the recommended behaviour for the UPHCSDP is to promote institutional deliveries where complications can be managed. In addition, institutional deliveries will provide the opportunity to counsel mothers on the need for PNC for both mothers and babies.

The ‘three delay model’ is the globally accepted approach to increase the likelihood of a safe delivery. The model includes prevention or mitigation of:

1. Delay in deciding to seek care
2. Delay in reaching a medical facility
3. Delay in receiving adequate treatment

In light of the UPHCSDP’s efforts to establish new facilities and ensure quality care, the BCCM activities will focus on preventing the first two delays. The Birth Preparedness program is a demand-creation intervention to promote key messages and behaviours to address the first two delays. While there is no universal set of birth preparedness, the package of behaviours that will be promoted for the UPHCSDP includes:

1. Attending at least four antenatal clinic visits
2. Knowing the five danger signs for mother and new born, and when to seek help
3. Knowing where to deliver

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17 In the context of the UPHCSDP, “attended by skilled health personnel” is defined as birth at a medical facility.
19 NIPORT, DHS. 2011
20 Ibid
21 Gabrysch Sabine, Campell Oona MR. Still too far to walk: Still too far to walk: Literature review of the determinants of delivery service use. BMC Pregnancy and Childbirth 2009, 9:34,
4. Arranging transportation
5. Arranging access to funds for medical care
6. Knowing who will deliver
7. Arranging for a blood donor
8. Attending three PNC visits: 1 within 24 hours, the second within 2-3 days and a third at 42 days

Existing evidence: The literature review resulted in a sufficient number of studies focused on uncovering behavioural determinants to institutional deliveries in Bangladesh and globally. Within Bangladesh, overall there have been more studies focused on childbirth preferences and practices in rural areas. However, there were a fair number of studies focused on urban slum women. The literature review did not uncover significant differences in behavioural determinants between urban slum and rural households with the exception of access to medical facilities and social support, which are discussed below. Findings from “Beliefs and Practices during Pregnancy and Childbirth in Urban Slums of Dhaka,” (Choudhury, et al.) confirmed that the beliefs and attitudes of urban female slum dwellers related to birthing practices are similar to rural women. They reason that this is perhaps because residents have only lived for a short period of time in the slums and attitudes and beliefs are deeply ingrained and hard to change in a short amount of time. Given this, the following evidence has been taken from both rural and urban studies to provide a comprehensive view of the barriers to and facilitators for deliveries. 23

Access: Unlike in rural areas, urban slum dwellers did not mention long distances to health facilities or financial constraints as reasons for delivering at home. This is probably because many slums have at least one health facility located within the slum itself and close proximity to health facilities reduces the need for high transport costs.

Social support: Due to the transient nature of the slum communities, female slum dwellers reported smaller social networks. The cramped living quarters - usually one-room dwellings - mean that only nuclear families reside in the city with extended family members remaining in the countryside. The smaller social networks and reduced family size decrease social support for women, particularly for informational and physical support that would otherwise be available from mothers, sisters and in-laws if they were living in the countryside. This may, among others, be the reason why many urban slum women will go home to their mother’s house to give birth, a location where they may be even less likely to be able to deliver at a medical facility. In the Manoshi Program areas, where birthing huts are provided for women residing in urban areas to rest for up to 15 hours after the birth, the majority of women stay for only six to nine hours before returning to child care and domestic responsibilities, citing lack of external assistance. 24

The role of men: Research findings regarding the involvement of men during pregnancy and childbirth are mixed. However, a study on social support suggests several opportunities for involving men. Study findings showed that husbands are the main person to mobilize money and transport for their wives should they need to be referred to a health facility, and husbands were also important sources of information. 25 A study of men’s knowledge and practices related to MCH within the BRAC’s improving maternal, neonatal and child survival, however, revealed that that despite communication efforts since 2005, only 1.5% of men were aware of all major components of birth preparedness and, like their wives, were unaware of the process of delivery unless they had to deal

with complications.\textsuperscript{26} Given the smaller social circles and the important role of men in decision making and providing support, the role of husbands is crucial.

**Program Intervention:** The following matrix includes key behavioural determinants of institutional deliveries and presents communication objectives and materials available.

<table>
<thead>
<tr>
<th>Goal</th>
<th>Behavioural objectives by target audience</th>
<th>Key barriers</th>
<th>Communications objective: After the campaign, the target audience will…</th>
<th>Existing materials</th>
</tr>
</thead>
</table>
| At least 60% of births by pregnant women in project areas are attended by skilled health personnel | 1. Pregnant women will make at least four ANC visits. | **Belief:** ANC does not benefit mother or child and is only needed to confirm/reconfirm the pregnancy. **Knowledge:** Women do not have a clear idea about the delivery process until they have experienced it themselves. | Pregnant women will believe that ANC visits to the Rainbow clinic during pregnancy will help her to have a healthy baby. | ANC  
• Brochure on ANC  
• Poster on four ANC visits  
• Brochure on nutrition of pregnant women and also danger signs |
|  | 2. Pregnant women know and feel that these five signs are sufficient reason to seek treatment at a medical facility:  
• Severe bleeding  
• Severe headache  
• Blurred vision and swelling of feet during pregnancy  
• Labour pain for more than 12 hours  
• Convulsions during pregnancy or labour, or after delivery | **Belief:** Childbirth is a natural process, irrespective of duration of labour, and can take place at home. Delivery at a facility is only for emergency cases. 
**Belief:** Women who have experienced prior, uncomplicated deliveries at home feel that institutional delivery is unnecessary. 
**Belief:** Fear that the more people hear the news about an impending delivery, the more delay in delivery will occur, thus, women are reluctant to develop a birth plan. | Pregnant women will:  
• Know how to recognize the five danger signs and seek help at a medical facility  
• Believe that any pregnancy carries risk; having a birth plan assures that she and her family have a safe delivery  
• Feels that by having a birth plan, she and her family are in control of the health of their family  
• Feel confident that choosing to deliver at a Rainbow clinic will give her good care at a reasonable price (perceived quality of care) | Safe Delivery  
• Danger signs of pregnancy and delays  
• Poster on safe motherhood  
• Poster on birth planning and birth preparedness  
• Information on prevention of maternal, neonatal and child mortality  
• Poster on three delays  
• Danger signs for pregnant women  
• Poster on safe motherhood  
• Poster on birth planning and preparedness |
|  | 3. Prepare a birth plan so she knows:  
• Which facility to deliver in  
• Who will deliver her baby  
• Arrange for transport beforehand  
• Secure money for medical care beforehand  
• Secure a blood donor | **Social support:** Women prefer to deliver at parent’s home in rural areas, where social support can be provided by family. 
**Locus of control:** Fatalistic attitude that “places trust in Allah” reduces perceived need for medical assistance | | |
| 4. Mothers and babies will attend three PNC visits after delivery: 1 within 24 hours, the second within 2-3 days and a third at 42 days. | **Knowledge:** Mother is not aware of the need for, and benefits of, PNC for both her and her child. | • Mothers will know that how many and when to go for PNC  
• Mothers will feel that PNC is needed for her health and her baby’s health |
| Service providers will: | **Knowledge:** Service provider’s knowledge on importance of PNC visit is poor and attention is given only to baby and not mother. | Service providers will understand the importance of PNC for mothers and will know when to counsel mothers to come back. | Service providers will encourage mothers to come for three PNC visit within 24 hours, within 2-3 days and within 42 days. |
| Understand the importance of providing care to mothers after their delivery; and  
Counsel mothers to come back for three PNC visits. |  |  |
| Husband, mother-in-laws and other family members will: | **Knowledge:** Men’s knowledge of process of delivery is poor unless they have to deal with any complications.  
**Knowledge:** Less than 2% of men in areas with MCH programs were aware of the four components of birth preparedness.  
**Social Support:** Husbands were found to provide financial, informational and emotional support. | Husbands, mothers-in-laws will: | |
| Provide informational, and financial support women to attend at 4 ANC visits; and  
Recognize the 5 danger signs and know to seek help at a medical facility. |  | Feel that by encouraging the wife to attend four ANC visits, this will ensure the wellbeing of the family.  
Feel that the expense of ANC visits is worth the expense of preventing an expensive delivery. |
| Village doctors and traditional birth attendants can recognize the five danger signs and know where to refer women. | **Knowledge:** Lack of knowledge of the danger signs  
**Attitude:** Reluctant to refer for fear of discrediting reputation | Village doctors and TBAs will: | |
|  |  | Know how to recognize the five danger signs and when to refer  
Feel that it is important to help women have safe deliveries given their role as health providers in their community. |

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27 Observations from field visit
E. Behaviour V: Caretakers of children under five practice improved infant and young child feeding behaviours

Indicator: Prevalence of underweight and stunted children reduced by 20%.

Behavioural goal: In order to reduce the number of underweight and stunted children, both maternal nutrition during pregnancy and infant and young child feeding practices (IYCF) must be improved. This requires the following behaviours:

1. Proper maternal nutrition during pregnancy
2. Early initiation of breastfeeding by pregnant/post-partum women:
   • Put baby to breast within first hour of birth
   • Put baby’s skin next to mother’s skin
   • Cover baby with dry cloth
3. Exclusively breastfeed baby for the first six months (nothing but breast milk)
4. Complimentary feeding by caregiver/families of children of 6 to 24 months with the correct consistency, amount and frequency
5. Washing hands with soap and water before preparing food and before feeding a child

Current status: Although there has been some progress in reducing maternal and child malnutrition, the prevalence of stunting (chronic under-nutrition) is still an alarming 41%; 36% of children are underweight in Bangladesh. With regard IYCF, although 90% of children are breastfed until the age of 2, the median duration of exclusive breastfeeding is only 3.5 months. Only one in four children is fed an appropriately diverse diet and only 65% are fed the recommended number of times with semi-solid or solid foods. Maternal under-nutrition is also of great importance, as it is strongly related to the delivery of low birth weight babies. Twenty four percent of women age 15 to 49 are undernourished (calculated as Body Mass Index < 18.5) and 42% are anaemic. Women’s nutritional status improved only slightly between the 2007 and 2011 according to the DHS, and the number of early pregnancies exacerbates this the cycle of under-nutrition with babies born with low weight.

Achievements to date: The Alive and Thrive project has already conducted formative research and developed many of the BCC materials to promote improved IYCF, including a series of TV spots and more recently a TV series called Tiny Tales (http://www.aliveandthrive.org/where-we-work/country/bangladesh). In addition, there is the National Communication Framework and Plan for Infant and Young Child Feeding in Bangladesh, the main contents of which are reflected below.

In addition to improved IYCF, a key activity in reducing child stunting is to address maternal nutrition during pregnancy. These behaviours include: encouraging pregnant women to eat at least one additional meal; eating a variety of foods including animal products, fruit and vegetables; taking iron and folic acid supplements; deworming; cooking with iodized salt; sleeping under bed nets to reduce the risk of malaria and taking malaria prevention treatment during the second and third trimesters;

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29 NIPORT, DHS. 2011
30 Ibid
and consumption of Vitamin A.\textsuperscript{32} Within the context of improving maternal nutrition, it is important for the BCCM firm to approach it with a gender perspective as inequality is one of the root causes of poor maternal nutrition in Bangladesh whereby women are not granted equal access to nutritious foods. The practice cannot by changed solely through improving knowledge or changing beliefs about avoidance of foods among mothers.\textsuperscript{33} The World Food Program, and potentially others, is working with families to address improved maternal nutrition through improved gender equality.\textsuperscript{34}

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\footnotesize
\textsuperscript{32} Essential Nutrition Actions: Key Messages and Actions. http://motherchildnutrition.org/nutrition-protection-promotion/essential-nutrition-actions/ena-key-messages-actions.html#Women’s Nutrition: Diet and Micronutrients
\textsuperscript{34} World Food Programme, Gender Assessment, http://www.wfp.org/sites/default/files/WFP%20Gender%20Assessment%20Brief.pdf
\end{flushleft}
<table>
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<th>Goal</th>
<th>Behavioural objectives by target audience</th>
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<th>Communications objective: <em>After the campaign, the target audience will</em></th>
<th>Existing materials</th>
</tr>
</thead>
</table>
| Reduction in prevalence of underweight and stunted children by 20%. | Maternal nutrition | **Belief:** Eat dry food that was cooked without water, and rice with mashed potato and black cumin seed, to keep the stomach of the woman cool and initiate the production of breast milk.  
**Belief:** Eat less during pregnancy for fear that the child will be too big at birth.  
**Roles and decisions:** Family members, primarily elderly women or mother-in-laws, advocate for traditional practices with regard to food restrictions.  
**Access:** husbands and mother-in-laws make decisions about distribution of food and do not prioritize the expectant mother.  
| Women will:  
Know that they need to consume at least one additional meal per day during their pregnancy, one that includes meat/fish, vegetables and fruit.  
Know that they need to seek and take iron and folic acid to give them strength during pregnancy.  
Know to take vitamins with juice rather than tea to improve their effectiveness.  
Feel that by taking Vitamin A, they are helping breastfed babies fight off illnesses.  
| • TV spot on prevention of anaemia due to iron deficiency  
• Poster on orsaline and Zinc (nutritional supplement)  
• TV spot on quality of orsaline  
• TV spot on orsaline  
• Brochure on vitamins. A plus Campaign  
• Flash card on discrimination of food distribution  
• Nutritious, low cost food for mother  
• Book 1 in easy language on nutrition of pregnant mother and children  
• TV spot on prevention of Anaemia due to Iron deficiency  
• Poster on Iodized salt  
• Brochure on national Vitamin A plus Campaign  
• TV spot on zinc tablets  
• Poster on nutrition information  
| 35 Nuzhat et all 2012  
| Early initiation of breastfeeding by mothers | Knowledge: Poor understanding about adequacy and importance of colostrum and dangers of pre-post-laceteals.  
| Mothers will:  
Know that their babies need to be breastfed within one hour of being born.  
Know that colostrum/mother’s milk is the only food for the baby and this is the first immunization for the | Refer to Alive and Thrive website |  

| Service providers assist mothers in early initiation of breastfeeding | Social/physical support: No skilled support given to mothers on position, attachment, expression of breast milk and feeding of newborns. | Service providers will: Increase mother’s knowledge and build her confidence in ability to properly position the baby, express milk and feed infants. Encourage husbands and mothers-in-law to support mothers to initiate breastfeeding. | • Flip chart on lactating mother and new born care  
• Poster on information of banned activities on breast milk supplementation  
• Refer to Alive and Thrive website |
|---|---|---|---|
| Exclusive breastfeeding by mothers | Knowledge: Lack of skills and strategies to increase and maintain supply for six months. Belief: Perception of insufficient milk supply. Social support: Inadequate support from family and doctors/health workers. | Mothers will: Have skills to be able to maintain their milk supply through six months of breastfeeding. Believe in her ability to provide sufficient milk for her infant. Feel that she can refer to her social network for support to exclusively breastfeed. | • Book 1 in easy language on nutrition of pregnant mother and children  
• TV spot on feeding colostrum just after birth of a baby  
• Tathya Shahayka (Information guide) on nutrition of new born, children and mother  
• Information card on breast milk and complementary feeding  
• Mobile phone sticker on breast feeding and complementary feeding  
• Booklet on child nutrition  
• TV spot on exclusive breast feeding for full six months |
| Complimentary feeding | Knowledge: Inadequate knowledge on amounts/consistency/diversity/use of animal foods. Belief: Perception of poor appetite among caregivers of children under 5. Informational support: Little support | Mothers/caretakers will: Know how to prepare nutritious food for baby including the right amount, consistency and diversity. Will feel that she has the skills to help her baby consume complimentary foods. | • Pusti Tathya Shahayka (information guide) on nutrition of new born, children and mother  
• Information on breast milk and complementary feeding  
• Mobile phone sticker on breast feeding  
• Meena, a TV serial for correct |
| Hand washing with soap by caretakers of children under 5 | Access: Soap and water are not located near food preparation and child feeding areas.  
Belief: Mothers with children less than 2 years of age do not strongly believe in the health benefits of proper hand washing.  
Belief: Only 15% of mothers believe that not washing hands with soap before feeding a child causes diarrhoea.  
Social norms: Lack of social pressure. 66% of mothers with children less than 2 years of age report that hand washing with soap is not common in their communities and therefore they do not have the support of social norms to follow this practice. | Mothers/caretakers will:  
Know that hand washing with soap can prevent diarrhoea  
Believe that hand washing is an easy way to ensure the health of her child  
Feel that others around her wash their hands with soap | - Poster on what to do for diarrhoea  
- TV spot on hand washing with soap  
- Stickers and brochure on importance of hand washing and diarrhoea  
- Unilever TV spot on importance of HWWS [https://www.youtube.com/watch?feature=player_embedded&v=UEm9ygP4uyU](https://www.youtube.com/watch?feature=player_embedded&v=UEm9ygP4uyU) |
3. Other behaviours
In addition to the key behaviours covered in section two, there are other behaviours within ESD+ that the implementing agencies will be responsible for. The matrix below lists the other behaviours and the existing materials can be used for inclusion in the “Rainbow clinic BCC Toolkit”. The column of existing messages/materials is a list of what has been approved by the MoHFW for use. However, not all materials need to be used for the UPHCSDP. Fewer and better-targeted messages are more important than larger quantities of materials. Existing materials will need a careful review and development of new messages may be requested from the client.
<table>
<thead>
<tr>
<th>Behaviour</th>
<th>Existing messages/materials</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Menstrual regulation</strong></td>
<td>New materials need to be developed</td>
</tr>
<tr>
<td>MR as a means to prevent unsafe abortion, improve maternal health and reduce maternal mortality</td>
<td></td>
</tr>
<tr>
<td><strong>Child Health</strong></td>
<td></td>
</tr>
<tr>
<td>Immunization program</td>
<td>• TV advertisement on vaccination of child</td>
</tr>
<tr>
<td>Mobilize caretakers to have their children fully immunized by 12 months of age</td>
<td>• EPI Leaflet</td>
</tr>
<tr>
<td><strong>Diarrhoea</strong></td>
<td>• Rules to keep water safe</td>
</tr>
<tr>
<td>Advise caretakers on home care (fluids, feeding, referral)</td>
<td>• When to wash hands with soap</td>
</tr>
<tr>
<td>Advise caretakers on prevention</td>
<td>• How to use machine for safe water</td>
</tr>
<tr>
<td><strong>Acute Respiratory infections</strong></td>
<td>• Procedure to keep water safe</td>
</tr>
<tr>
<td>Advise caretaker on correct home care</td>
<td>• Rules to wash hands before cooking</td>
</tr>
<tr>
<td>Advise caretakers on prevention</td>
<td>• Rules to use pot for babies</td>
</tr>
<tr>
<td><strong>Reproductive Health Care</strong></td>
<td>• How to properly dispose of child faeces</td>
</tr>
<tr>
<td>Counselling on RTI/STIs and related infertility</td>
<td>• Process of hand washing with soap and water</td>
</tr>
<tr>
<td>Health education on RTI/STIs and related infertility</td>
<td>• Importance of hand washing</td>
</tr>
<tr>
<td><strong>Adolescent Care</strong></td>
<td>• Counselling cards on hand washing</td>
</tr>
<tr>
<td>Counsel on/create awareness of:</td>
<td>• Poster on diarrhoea</td>
</tr>
<tr>
<td>• Sexuality</td>
<td>• TV advertisement on what to do if baby is suffering from diarrhoea</td>
</tr>
<tr>
<td>• Safe sex</td>
<td>• Message on when to wash hands with soap</td>
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<tr>
<td>• Menstruation</td>
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<tr>
<td>• Special nutrition</td>
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<tr>
<td>• Hygiene</td>
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<tr>
<td>• Tetanus Toxoid vaccination</td>
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<tr>
<td>• Reducing early marriage</td>
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<tr>
<td>• Pregnancy</td>
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<tr>
<td>• High risk behaviour (sexual)</td>
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<tr>
<td>• Psychological issues</td>
<td></td>
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<tr>
<td>• Gender issues for both boys and girls</td>
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<tr>
<td><strong>RTI/STI Care</strong></td>
<td>• Flip chart on AIDS and sexually transmitted infections</td>
</tr>
<tr>
<td>Counselling on RTI/STIs and related infertility</td>
<td>• AIDS leaflet 1</td>
</tr>
<tr>
<td>Health education on RTI/STIs and related infertility</td>
<td>• AIDS leaflet 2</td>
</tr>
<tr>
<td>• Brochure on reproductive tract infections</td>
<td>• Poster on role of condoms in prevention of sexually transmitted infections (STI) and AIDS</td>
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<tr>
<td>• Poster on sexually transmitted diseases and reproductive tract infections</td>
<td>• Brochure on sexually transmitted infections</td>
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<td>• Brochure on sexually transmitted infections</td>
<td></td>
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<tr>
<td><strong>Adolescent Care</strong></td>
<td>• Booklet on adolescent reproductive health</td>
</tr>
<tr>
<td>Counsel on/create awareness of:</td>
<td>• Leaflet on health messages on adolescent health</td>
</tr>
<tr>
<td>• Sexuality</td>
<td>• Booklet on adolescent reproductive health</td>
</tr>
<tr>
<td>• Safe sex</td>
<td>• Booklet on adolescent health care guide</td>
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<tr>
<td>• Menstruation</td>
<td>• Poster on adolescent reproductive health, not to neglect adolescent period</td>
</tr>
<tr>
<td>• Special nutrition</td>
<td>• Flash cards on adolescent reproductive health</td>
</tr>
<tr>
<td>• Hygiene</td>
<td>• Cards on late marriage and conception</td>
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<td>• Tetanus Toxoid vaccination</td>
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</tbody>
</table>
4. Channels of communication

The following information on mass media was obtained from the Bangladesh Media and Telecoms Landscape Guide 2012, developed by the Infoasaid project, which cites the statistics from the Bangladesh 2011 AC Nielsen Media and Demographic Survey. The authors of this BCC Strategy were not able to obtain the original AC Nielsen document. Information from other channels of communication was obtained from other publications. Selection of the channels should be evidence based and the agency should clearly articulate how the channels were selected, whether it grounded on existing evidence or through formative research.

A. Television: Within the media landscape in Bangladesh, television has emerged as an influential source of information and entertainment, replacing radio and newspapers as the main source of information. The 2011 DHS shows that 78% of urban women and 86.7% of urban men reported watching television at least once per week. In 2011, 85% of urban households and 43% of rural households owned a television. Seventy-four percent of Bangladeshis age 15 and over watch television at least once every 7 to 10 days. Formative research from Manoshi project areas in the urban slums of Dhaka also revealed that 86% of respondents reported watching television at least once a week.

Bangladesh Television (BTV) network is one of three state owned networks in the country and covers 95% of the population. Its free-to-air status makes it attractive to households who cannot afford to pay for a satellite connection to watch TV, including rural viewers. The Nielsen Media and Demographic Survey 2011 rated ATV Bangla and Channel-I the most popular overall with NTV being the third most popular station.

Viewership varies, with daytime TV audiences consisting mainly of housewives watching soap operas and evening viewership determined by men who opt for news and sports channels. TV
channels charge the highest rates for advertising between 1900 and 2300hrs, suggesting this may be peak viewing period. ATV Bangla’s evening news is the most watched TV program in the country, however, talk shows have also become popular within the last five years.

Analysis of the Bangladesh Urban Health Survey 2006 data revealed that women in slums who usually watched television were 1.53 times more likely to use any family planning method as compared to women who did not usually watch television, thus presenting an opportunity to use mass media as an effective means to promote contraception adoption.  

B. Radio: Overall, there was a decline in radio listenership from 36% in 1999 to 15% in 2011 with only 34% of listeners using radio sets while 73% of listeners tuned into stations via their mobile phones. Only 3.4% of urban women and 6.3% of urban men listen to the radio at least once a week. Radio stations are still largely owned and controlled by the government with a handful of private, FM radio stations. Most FM stations transmit music and entrainment aimed at urban youth. Radio Footti is the most popular FM station in Bangladesh, with 47% of the national FM radio audience, followed by Radio Today, with 28%.

C. Mobile phones: There has been significant growth in the use of mobile phones within the last 10 years in Bangladesh. The mobile network now covers 98% of the population according to the Bangladesh Telecommunications Regulatory Commission, with nearly 90 million active mobile subscribers as of February 2012. Roughly 65% of all individuals age 15 years and above own at least one mobile phone with an active SIM card.

Most mobile phones are used for voice calls with increasing numbers of people accessing radio (in particular youth) and the Internet using their phones. Text messaging is limited because most phones are not equipped to handle the Bangla alphabet although Grameenphone now markets handsets with Bangla alphabet keypad.

The government has used SMS messages to remind people to immunize their children and to pay taxes, and to broadcast cyclone warnings to people living in areas affected by flooding. Mobile phones have been cited as a reason for the drop in maternal mortality in Bangladesh, as health workers are able to use them in their referral efforts. Mobile phones should be strongly considered in this program as a viable channel as several communication programs already exist to promote improved MCH practices, including:

- **Healthphone**: A program whereby pre-existing messages are downloaded onto inexpensive mobile phones that could be used by health workers as a training tool or a supplemental communication tool with mothers. [http://www.healthphone.org/](http://www.healthphone.org/)

- **Maternal Alliance for Maternal Action, MAMA**: Provides free, adaptable mobile health messages for programs that are using mobile phones to inform and empower new and expectant mothers. There is currently the Aponjon program in Bangladesh where mothers can call 16227 to hear messages about MCH. [http://healthunbound.org/mama](http://healthunbound.org/mama)

D. Newspapers: Newspapers reached only 15.4% of urban women and 48.5% of urban men, who read it on average once a week.

E. Internet use: Internet use is growing quickly from a low base, but thus far access is mostly by the educated, affluent urban elite. Encouragingly, there are several initiatives to use the Internet to promote greater accountability in the government. The Amader Sthaniyo Sarker (Our Local

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38 S. M. Mostafa Kamal, Socioeconomic Factors Associated with Contraceptive Use and Method Choice in Urban Slums of Bangladesh, Asia Pac J Public Health September 13, 2011.
Government initiative has its own portal where citizens can comment on the quality of local public services, such as healthcare, education, electricity and public maintenance (www.amadersthaniyosarker.com).

The Nagorik Kontho (Citizen’s Voice) is a similar pilot project that was established in local government divisions in 2010 (www.nagorikontho.org) and allows for people to send in text, video or voice messages about specific complaints. These initiatives may serve as models for the UPHCSDP given its focus increasing citizen participation, increasing ULB’s ownership of the program and providing a means for ensuring quality service by implementing agencies.

F. Traditional channels: In Bangladesh, traditional channels of communication include drama, music, dance and puppetry. Drama and puppet shows are used for education and developmental communication, though they are more often seen in rural areas. Traditional healers, village doctors, paramedics, teachers and doctors are highly influential.

A study of rural men’s knowledge and practices on MCH revealed that roughly 93% of the men surveyed had spent time in informal meetings at tea stalls and bazaars.³⁹ In the Manoshi study of Dhaka slums, landladies emerged as influential figures, as they were able provide credits/loans and pregnancy related decisions. They also were viewed as socially empowered and had knowledge of reliable and available TBAs to assist with the birth. Slum households are typically comprised of nuclear families living in one-room flats with extended family living in rural areas.⁴⁰

The influence of religious leaders and their role in family planning programs has been well documented. During the UPHCP II, WUPHCC were formed with teachers, imams, journalists and other stakeholders to engage key personnel of the ULB with the objectives of ensuring that the poor, especially women and girls, know and can access free health services, providing a user forum for public disclosure of services provided by the health facility, ensuring that grievances and complaints relating to service provision are addressed and to coordinate between the UPHCSDP, other urban health providers and other public health initiatives. They should also serve as a key channel in advocacy.

Not surprisingly, throughout Bangladesh, men report greater access than women to media and significantly more rural Bangladeshi report no access to media than urban residents.⁴¹

Considerations:

- **Low literacy audience:** Audio visual, oral and interpersonal communication should be used to the greatest extent possible and print materials should not be text heavy; overly technical and medical terms should be avoided.

- **Empowerment of women:** The campaign should give mothers/caretakers a sense of satisfaction in their enhanced power to care for their children and model a good behaviour to other family members.

- **Social support:** Where possible, this campaign should reflect social support for women by other members of their households (i.e., husband, mother-in-law) to carry out the intended behaviours.

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⁴¹ NIPORT, DHS. 2011
• **Strengthen the male religious leaders’ dissemination of the “fatwa”** to help health workers and volunteers negotiate for family planning/birth spacing, especially on the use of FAPM.

• **Local customs/traditions**: When possible, allegories and anecdotes that closely reflect the cultures and customs of Bangladeshi people should be used.

• **Characters/visuals**: Should be appealing to low-income, urban residents - aspirational but not out of reach.

5. **Monitoring and evaluation**

Monitoring is the process of tracking campaign implementation, progress towards campaign goals and objectives, and external factors relevant to the campaign. Evaluation brings together monitoring data and findings from additional research to assess the effectiveness. The firm that performs monitoring and evaluation will be responsible for monitoring and reporting at various levels ranging from media placement, audience reach and behavioural determinants to adoption of the intended behaviours. The following are suggested indicators that will need to be further developed and agreed upon with the Client before project implementation.

A. **Media placement and audience reach:**
   - Number of mass media products aired
   - Estimated reach of mass media airings
   - Number community events, audience reach per event
   - Audience feedback from events via post event surveys
   - Number of people who have visited the project website
   - Extent the various that audiences have encountered the messages
   - Percentage of the intended target audience that have noticed the campaign and can recall (unaided) or recognize (aided) its message

B. **Behavioural determinants**: For each of the key behaviours, the firm will also be responsible for tracking changes in each of the communication objectives for these key behaviours. For example, a change over time in the number of:
   - Women age who know of the five danger signs during pregnancy
   - The number of women who report being able to discuss LAPM with their husbands
   - Number of poor households that know of the eligibility criteria for the Red Card
   - Number of women who can recognize the three danger signs of acute respiratory infections
   - Number of women who report gaining skills in breastfeeding and complimentary feeding

C. **Outcome**: Ultimately, the above efforts in BCC should result in uptake of the intended behaviours as detailed in the above sections. The baseline indicators for the project are currently being finalized and final targets for each of the above behaviours will need to be determined following discussions with the client. The following indicators are what the partner NGO will be held accountable for within the project, some of which are directly linked to BCC efforts and some of which are related to service delivery.
   - % of identified new pregnant women who completed at least three ANC visits
   - % of identified new pregnant women who received skilled birth attendance
   - % of modern contraceptive acceptance among eligible couples
   - % of eligible FP contraceptive users accepted long acting/permanent methods
• % of Growth Monitoring and Promotion performed against total number of under 5 children attended at facilities
• % of measles vaccinations by number of Bacillus Calmette Guerin vaccination for 9-to-12-month-old children
• % of children consulting for acute respiratory who receive correct treatment
• % of each major health care service by the identified poor (Red Card holders)
6. References

9. fhi 360, Center for Global Health and Marketing, globalhealthcommunication.org/strategies/behavior_change_communication
10. Gabrysch Sabine, Campbell Oona MR. Still too far to walk: Still too far to walk: Literature review of the determinants of delivery service use. BMC Pregnancy and Childbirth 2009, 9:34,
7. Annexes

Annex 1: the PerFORM Framework

A variety of BCC frameworks exists to explain health seeking behaviour - the Health Belief Model, the Theory of Reasoned Action, the Social Ecological Model to name a few.\(^{42\text{-}43}\) The PERfoRM\(^{44}\) Framework was developed by Population Services International (PSI), an international, non-governmental organization (INGO) specializing in social marketing (also known as the Social Marketing Company, or SMC in Bangladesh). The framework has been applied across multiple health interventions (family planning, child health, HIV/AIDS, malaria control, etc.) and was adapted for analysing sanitation and hygiene behaviours by the World Bank.\(^{45\text{-}46}\) It is within Level 3 under of the PERfoRM framework that is most useful as the determinants under Opportunity, Ability and Motivation offers program planners a practical means of deconstructing behaviour to determine where the barriers lie and how to address them, whether at the institutional, community or individual level.

The framework consists of four levels:

**Level 1:** The goal of the program. Namely, improved health status and improved quality of life.

**Level 2:** The objectives of BCCM program can include interventions to increase the demand or uptake of a product or service (use) and reduce high-risk behaviour (risk reducing behaviour), which does not involve the use of a product or service.

**Level 3:** Outputs are the three broad categories of behavioural determinants, Opportunity, Ability and Motivation (OAM). The “bubbles” within the three OAM categories represent factors that can help or hinder an individual to carry out a behaviour.

**Level 4:** Activities within social marketing intervention to address the above determinants through development or improvement of a product (including service), ensuring that they are accessible (place), are affordable (price) and that people know of them (promotion).

**Opportunity** determinants are institutional or structural factors that influence an individual’s chance to perform a promoted behaviour.

**Ability** is a measure of the skills or proficiencies that an individual needs to perform a promoted behaviour. Ability determinants are controllable by the individual and can be demonstrated (or have the potential to be seen) through some action.

**Motivation** is an individual’s arousal or desire to perform a promoted behaviour. Determinants under this category are the most difficult to change, as they are internal and deeply influenced by culture, context and social norms, which can prove difficult to change within the course of one campaign or program.

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\(^{43}\) fhi 360, Center for Global Health and Marketing, globalhealthcommunication.org/strategies/behavior_change_communication


\(^{46}\) Devine 2009.
According to the PERfoRM framework, in order for an individual to perform a behaviour, he or she must have the chance to perform it, have the ability to perform it and must want to perform it, and thus, social marketing programs must be able to address barriers within all O-A-M categories before behaviour change or adoption can take place.

Definitions of behavioural determinants as defined within the PerFORM framework

1. **Availability**: The extent to which the promoted product or service is found in a predefined given area. For example, the distance from urban households to a Rainbow clinic and the types of services that can be accessed at the clinics.

2. **Brand appeal**: The extent to which the characteristics of the prompted product or service’s branding (i.e., name, term, sign, design, layout, slogan, etc.) distinguish the product or service from its competitors. In this case, how Rainbow clinics are marketed to differentiate them from public facilities, private practices or Smiling Sun clinics.

3. **Brand attributes**: The extent to which the physical components of a product are practical to use.

4. **Quality of care**: The extent to which the promoted service is of high value. Quality-of-care perceptions are related to waiting times, cleanliness, privacy, reliability and suitability - female provider for female patients, trustworthy - among others.

5. **Social norms**: The rules that govern how individuals behave in a group or society so that anything outside these norms is considered abnormal. In the context of Bangladesh, the social norm is for women to deliver at home with assistance from family members and traditional birth attendants. Women who opt to have a normal, vaginal delivery at a clinic are deviating from the norm.

6. **Knowledge**: True facts accumulated through learning about objects, actions and events. For example, families know how to recognize the five danger signs during pregnancy and delivery.

7. **Self-efficacy**: The belief that an individual is able to perform a promoted behaviour effecttively or successfully. For example, if a mother is trained on strategies to increase milk flow for her baby, she will feel confident that she will be able to continue breastfeeding.

8. **Social support**: Assistance that an individual gives/receives. Emotional support is something that an individual does to make others feel loved and cared for. Instrumental support is tangible help that an individual receives/provides. Informational support is help that an
individual receives/offers through provision of information. In Bangladesh, studies have shown that husbands provide financial support for their pregnant wives whereas mothers-in-law provide informational support. Sisters-in-law offer instrumental support by helping to do household chores for the pregnant woman.

9. **Attitude:** An evaluation or assessment of an object. For example, both men and women feel that violence against women is acceptable and justified.

10. **Belief:** Perception about a promoted behaviour that may or may not be true. For example, the belief that pregnant women should avoid “hot” foods such as duck, pigeon, beef and hilsa fish, or the belief that eating less food will result in an easier delivery, etc.47

11. **Intention:** An individual’s plan to perform the promoted behaviour. Intention is the best indicator of actual behaviour change. A family that saves money for transport and medical fees is more likely to be able to have a delivery at an institution than a family that does not plan.

12. **Locus of control:** The external or internal site of control in an individual’s life. An external locus of control suggests that an individual’s health is under the control of other people who are more powerful, or is determined by fate, luck or chance. An internal locus of control suggests that an individual’s health is directly controlled by him/herself. An example is when mothers feel that the death of a child is determined by Allah.

13. **Outcome expectation:** The belief that a promoted product, service or behaviour is effective in fulfilling its purpose as intended. For example, couples believe that a vasectomy offers permanent protection from unwanted pregnancies.

14. **Subjective norm:** Perceived pressures to comply with what an individual believes others in the social group believe about the promoted behaviour. For example, a mother feels that if she opts to deliver at a clinic, she will be criticized by her family and peers because everyone expects mothers with uncomplicated deliveries to have babies at home.

15. **Threat (risk):** Perceived dangerous or harmful event that exists in an individual’s surroundings. For example, mothers do not feel that their child can die from diarrhoea, thus they do not wash their hands with soap.

16. **Willingness to pay:** A theoretical estimate of the amount in currency an individual would pay for a promoted product or service. Families are willing to pay for cigarettes but may not prioritize the cost of ANC visits.

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Annex 2: The Socio-ecological model

The Socio-ecological model recognizes that a person’s relationships and environment can influence their individual behaviour as much as individual factors. The decision to adopt a behaviour is often the result of what people see, hear and experience from their families. They are also affected by social norms, community values, and public policy. Thus, behaviour change programs should focus on addressing a range of factors addition to individual factors. The various levels are defined as:

1. **Intrapersonal Level**: Individual characteristics that influence behavior, such as knowledge, attitudes, beliefs, and personality traits
2. **Interpersonal Level**: Interpersonal processes and primary groups, including family, friends, and peers that provide social identity, support, and role definition
3. **Community Level**
   - *Institutional factors*: Rules, regulations, policies, and informal structures, which may constrain or promote recommended behaviors
   - *Community factors*: Social networks and norms, or standards, which exist as formal or informal among individuals, groups, and organizations
   - *Public policy*: Local, state, and federal policies and laws that regulate or support healthy actions and practices for disease prevention, early detection, control, and management

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48 http://carbc.ca/KnowledgetoAction/ToolsResources.aspx
Annex 3: Organizational structure

Information on organizational structure is provided for the firm in developing the BCC Capacity Building Strategy.

National level project management and organization arrangements

**Project Executing Agency:** LGD provides overall project guidance and coordination, including (a) providing policy coordination and guidance in the implementation of the Project, (b) monitoring implementation of the Project, (c) coordinating and submitting timely and accurate reports to ADB and the Co-financers, and (d) submitting to ADB for its approval, the detailed program for the implementation of fellowships, training and study tours, prior to implementation thereof.

**National Project Steering Committee:** The Steering Committee shall be responsible for providing overall policy guidance to the Project, coordinating and liaising with other government agencies and departments, monitoring the Project’s activities and outputs including the quarterly report, and providing feedback to the PMU and each PIU. The Steering Committee shall be chaired by Secretary, LGD and shall be comprised of the Project Director and representatives from LGD, MOHFW; IMED, the Planning Commission; the MOF, the Ministry of Women’s and Children’s Affairs, representatives of Co-financers, other donors involved in urban primary health care (Representatives: WB, ADB, WHO, UNICEF, UNFPA, UNAIDS, USAID, Sida, DFID Representatives from at least two PA NGOs), and nongovernmental organizations. The Steering Committee shall meet no less than twice a year.

**Chief Project Coordinator:** Director General of LGD will act as a chief Project Coordinator in addition to his duty to coordinate the Project at the national level. He will be responsible for overall coordination of the Project and with city corporations and municipalities, and will chair the Project Coordination Committee that will meet at least every quarter. The Project Coordination Committee will be attended by key officers of the PMU and Chief Health Officers/Health Officers of city corporations and municipalities, representatives of Director General of Health Services and Family Planning. He will chair the different committees of the project implementation activities.

**Project Management Unit:** The PMU will oversee day-to-day operations of the Project, including in particular procurement, disbursement, accounting, logistics management, reporting, monitoring, supervision, organization of research activities, developing programs for overseas training and study tours, local training and study tours, and coordinating with MOHFW, PIUs, City Corporations, Municipalities, Partners, and consultants.

Sub-National Level Project Management and Organization Arrangements.

**Implementing Agencies:** Each city corporation and each municipality (with exception of Gazipur and Tongi municipalities, which together will act as a single implementation agency) will be an implementing agency and will be responsible for the execution and implementation of the components of the Project to be conducted in their respective geographical areas.

**Urban Health Coordination Committee:** Present in each city corporation and municipality, the Urban Health Coordination Committees will be chaired by the CEO or Chairman of the municipality, respectively and comprise the Chief Health Officer in case of a city corporation or health officer in case of a municipality, key staff of the PIU, the Civil Surgeons or the district heads of Directorate of Health and Directorate of Family Welfare of MoHFW, representatives of Partner NGOs, and representatives of organizations representing NGOs and private sector groups working in the health sector, and representatives of other urban primary health care initiatives. In addition, these committees will have at least three women from disadvantaged neighbourhoods to represent poor women. The Coordination Committee will meet at least once every three months.
Project Implementation Units (PIU): Present in each City Corporation and Municipality, the PIUs coordinate and account for all project activities occurring in its respective partnership area, including supervising and guiding primary health care delivery under the various partnership agreements, coordinating with local officials of MOHFW from Directorate of Health and Directorate of Family Welfare to ensure regular supply of contraceptives and vaccines, preparing and implement annual plans for capacity building of the Partners.

Partnership committees with wide representation from local government and NGO partners will be established at each PIU level to ensure smooth and efficient relations between public-private contracting parties. The Partnership Committees will provide a fair and transparent forum to raise partnerships, contract implementation and accountability issues. This will include performance assessments, fund flow and payments, and other feedback and concerns.

Ward Urban Health Coordination Committee (WHCCC). Present in each city corporation and municipality headed by male and female Ward Commissioners, the WUHCC are formed to ensure knowledge and access to free health facilities by the poor, especially women and girls, coordinate UPHCSDP with other urban health providers and public health initiatives in the ward provide a user forum for public disclosure of services provided by the health facilities; and ensure grievance and complaint redress relating to service provision and any resettlement issues. The WHCCC consists of zone health officers, representative of PA NGO, in charge of CRHCC, representatives of private health providers in the ward, representatives of other NGOs providing urban PHC, community based organizations, and at least three women living in slums or from poor households.

Partnership agencies: The Local Government Division (LGD) of the Ministry of Local Government, Rural Development, and Cooperatives (MOLGRDC), the Executing Agency, will engage NGOs and private entities as partners for the delivery of an essential services delivery plus (ESD+) package focusing on maternal and child health.
Figure D12: Staffing of the Partnership Agreement Areas

PAA Head Office (6)
- Project Manager-1
- Manager (Admin & Finance)-1
- MIS and Quality Assurance Officer-1
- Family Planning Coordinator-1
- Office Attendant-1
- Driver-1

CRHCC (32)
- Clinic Manager-1
- Specialist Physician (Gyn/Obs)-1
- Specialist Physician (Pediatrics)-1
- Medical Officer-4
- Counselor-1
- Nurse-4
- Lab Technician-1
- Paramedic-3
- FWA-1
- Administration Assistant-1
- Receptionist-1
- Ambulance Driver-1
- Clinic Aide-4
- Aya cum Cleaner-4
- Messenger cum Security Guard-4

PHCC (16)
- Physician-1
- Paramedic-1
- FWA-1
- Counselor-1
- Lab Technician-1
- Field Supervisor-1
- Administration Assistant-1
- Receptionist-1
- Aya/Cleaner-1
- Messenger cum Security Guard-1

Mini Clinics/Satellite Clinic/Evening Clinic/Mobile Clinic
- Paramedic-2
- Service Promoter-2
- FWA-2