সূর্যের হাসি
স্বাস্থ্যসেবায় আন্তরিক

Behavior Change Communication (BCC)

Strategy for NHSDP

June 2015

USAID
আমেরিকার জনগণের পক্ষ থেকে

USAID-DFID NGO Health Service Delivery Project

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Table of Contents

PREFACE

USAID-DFID NHSDP has developed the Behavior Change Communication (BCC) and Knowledge Management (KM) Strategy to provide guidance to its program managers and staff on strategies/interventions to improve availability of BCC materials, interventions as well as creating the demand for services at the clinic and community levels. An important component of the strategy is "knowledge management" (KM) which involves development, production, storage and management of materials and knowledge for the project. An integrated and coordinated BCC approaches address the need of the target audience with provision of appropriate messages. It is designed to harmonize efforts across the Shurjer Hashi (SH) NGOs to reach families to help them make healthy decisions as well to improve the capacity of local partners to implement sound SBCC programs and interventions. It has focused on cost effective, user friendly approaches and strategies to generate community demand in the current public health context with a good blend of modern and traditional approaches.

As the Behavior Change Communication (BCC) played a key role in the success of health and family planning program in Bangladesh, this strategy will be implemented through alignment with national priorities and policies, creating an enabling environment, building local capacity, empowering and engaging local populations including the poor, and ensuring open community dialogue, collaboration, and coordination.

This strategy emphasizes on coordination and partnerships at the national level as well as at the local level to work with and motivate the community members, youth clubs, community-based organizations, SH Community Support Groups. Other important stakeholders are community networks, such as, City Corporation/Municipalities, Union Parishad, Ansars, VDP, and members of CBOs. The strategy will support to maintain a continuous relationship with the community, to engage them and thus help overcome social barriers through effective promotion of SH clinic services.

I believe NGOs and their network clinics will be immensely benefited with this strategy. The locally appropriate BCC approaches will ultimately allow them to increasing the proportion of poor and vulnerable populations in their service contacts. The strategy will help enhancing the access of the community people to high-quality Family Planning, Reproductive Health, Maternal, Newborn, and Child Health (MNCH) services to improve overall health indicators of the community they serve as well as the sustainability of the NGOs.

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Acronyms

ANC	Antenatal Care
BCCP	Bangladesh Center for Communication Programs
BDHS	Bangladesh Demographic and Health Survey
BMMS	Bangladesh Maternal Mortality Survey
BRAC	Bangladesh Rural Advancement Committee
BKMI	Bangladesh Knowledge Management Initiative
BSSFP	Bangladesh Smiling Sun Franchise Program
CPR	Contraceptive Prevalence Rate
CSP	Community Service Providers
DFID	Department for International Development
DID	Difference in Differences
DPT	Diphtheria, Pertussis and Tetanus
EPI	Expanded Program on Immunization
ESP	Essential Service Package
FP-MCH	Family Planning, and Mother and Child Health
FWA	Family Welfare Assistant
FWV	Family Welfare Volunteer
GOB	Government of Bangladesh
HA	Health Assistant
HC3	Health Communication, Collaboration Capacity 3
HPN	Health Population and Nutrition
HTSP	Healthy timing and spacing of pregnancies
IPCC	Interpersonal Communication and Counseling
IUD	Intra-uterine Device
JHU CCP	Johns Hopkins Center for Communication Programs
LARC	Long-acting Reversible Contraceptives
LOC	Letter of Collaboration
MAMA	Mobile Alliance for Maternal Action
MGD	Millennium Development Goal
MOHFW	Ministry of Health and Family Welfare
MOLGRD	Ministry of Local Government and Rural Development
MOU	Memorundum of Understanding
MTP	Medically Trained Provider
NGO	Non-governmental Organization
NHSDP	NGO Health Service Delivery Project
NSDP	NGO Service Delivery Program
ORS	Oral Rehydration Solution
PM	Permanent Method
PRACHAR	Promoting Change in Reproductive Behavior
REACH	Reflection and Action for Change
SBCC	Social Behaviour Change Communication
SES	Socio-economic Status
SH	ShurjerHashi
SMC	Social Marketing Company
SS	Smiling Sun
TB	Tuberculosis
TFR	Total Fertility Rate
UPHCP	Urban Primary Healthcare Project
UNDP	United Nations Development Program
USAID	United States Agency for International Development

Executive Summery

Background

The USAID-DFID funded NHSDP supports the delivery of an ESP through a network of NGO clinics that primarily target the poor and underserved in rural and urban areas of Bangladesh. Expanded access to and use of the ESP will measurably improve health outcomes and thus will contribute to decreasing fertility and maternal, infant, and child mortality.

Behavior Change Communication (BCC) played a key role in the success of health and family planning program in Bangladesh. The BCC strategy will be implemented through alignment with national priorities and policies, creating an enabling environment, building local capacity, empowering and engaging local populations including the poor, and ensuring open dialogue, collaboration, and coordination. This strategy will guide NGO management to ensure:

- The delivery of correct and consistent messages for each audience segment;
- Achieving the desired behavior outcomes; and
- Cost effectiveness in BCC program interventions

Strategy development process

The development of the strategy followed a process that involved three assessments, a desk review and alignment with the GoB Ministry of Health and Family Welfare (MoHFW) strategies and priorities. Broadly, they identified a need for training, ensuring updated materials are utilized at the clinics, and prioritizing messages.

Pathways Framework

This strategy has adapted the national Pathways to Effective HPN SBCC, developed by the National BCC Working Group. The Pathways Model addresses both supply and demand. Supply includes: capacity strengthening of the providers and services and consistency and coordination of messages. Demand includes: creation of demand for services through improved and supportive IPCC, national and local media, and creation of a supportive environment leading to social norms in and around positive health behaviors.

Key Audience segment

As the messages are to be targeted and specific to make an environment of real behavior change the key audience segment also has two of its working components as; the Demand side and the supply side. The demand side has women, men, couple, youth, poor and local influential as key audience while the supply side has Project Director, Project Manager, Medical Officer, Paramedics, Counselor, Service Promoter and Clinic Aide as the key audience.

Coordination and partnership

Coordination and partnerships at the national level as well as at the local level are a key component of the strategy. It is important to work with and motivate the community members, youth clubs, community-based organizations, SH Community Support Groups, and community networks. such as; UP, Ansars, VDP, and members of CBOs, to maintain a continuous relationship with the community to hear their voices and overcome social barriers through effective promotion of SH clinic services. Partnerships with existing NHSDP partners and other

implementing agencies can be leveraged by expanding to other activities. These partners include: BKMI, CARE, Social Marketing Company (SMC), Engender Health, Save the Children, MAMA, HC3 and others.

Capacity Development

Capacity development is ongoing evidence driven process to improve the ability of an individual, team, organization, network, sector or community to create measurable and sustainable result. Capacity development is a continuous process with multiple interventions such as training, self-learning, assessment and feedback. Capacity Development will be targeted to:

- Understand the specific capacity required and commit to developing that capacity over the long term
- Build local ownership and partnership
- Develop program management quality
- Develop work force as well as leadership

Knowledge Management (KM)

KM is the process of capturing, storing, sharing, organizing, synthesizing and evaluating knowledge for the purposes of improving an organization's ability to have impact. This strategy explored the possibility of leveraging knowledge externally and internally to improve collaboration and communication, and to work with greater efficiency to achieve better results using people, processes and technology.

National and local level campaigns

Integrated demand generation at national and local level help mobilizes mass people to create and establish a community voice like health, population and nutrition. The national level campaign can use print and electronic media while the local level campaigns can use community media, folk talents and group communications. ICT based social media on issue based campaigns can bring people together to act on and mobilize others establishing a community norm through Facebook, You tube and Tweeter etc.

Community outreach BCC

In order to reinforce and sustain messages this strategy will also targeted to build with community outreach BCC activities so that instead of 'one way communication' it can establish a 'two way communication'. Health issues will create a community 'dialogue' rather than simply a 'monologue' to bring people in to a behavior change process. Community outreach activities by conducting street drama, school based debate/quiz competition, service promotional meetings and observation of special events will establish a linkage between the community and facility.

Monitoring and evaluation

There is a need for low-cost, sustainable and ongoing M&E systems and strategies to ensure ongoing and timely feedback and measuring the success and impact of all BCC and IPCC interventions in addition to the planned surveys. These could include use of standard protocols and tools for self-assessment and peer assessment for providers as well as mystery client and exit interviews to assess IPCC skills ability from both the providers and clients' perspective. Random exit interviews of clients leaving clinics or attending events to get their reactions to the event and retention and attitude toward any messages will also help to gauge program impact and allow for mid-course corrections if needed.

1. Introduction

The purpose of this document is to outline thebehavior communication change (BCC) strategy for theUSAID-DFID NGO Health Service Delivery Project (NHSDP). The BCC strategy is comprehensive and provides guidance to program managers and staff on strategies/interventions to improve the supply of BCCmaterials/interventions as well as building the demand for services. Generation, storage and management of materials and knowledge will be addressed as "knowledge management" (KM) and is a subcomponent addressed in the strategy. The strategy draws upon evidence-based approaches and was developed in consultation with stakeholders, providers, community members, and partners over a six month period in 2013-2014. It is designed to synergize efforts across the ShurjerHashi (SH) NGOs to reach families to help them make healthy decisions as well to build the capacity of local partners to implement sound SBCC programs and interventions.

The BCC strategy for NHSDP presents a unique challenge and an opportunity for the consortium to apply its strengths in service delivery, BCC and institutional capacity building. The principal approach to increasing the poor and vulnerable populations' service contacts, access to high-quality FP/RH/Maternal, newborn, and child health (MNCH) services has focused on developing a strong, independent, and sustainable NGO network.

2. Overview of Health Scenario

Bangladesh has made remarkable strides in meeting many millennium development goals (MDGs), including improved maternal and child health (MCH) and increased primary school enrollment, especially for girls. These successes are a result of dedicated efforts by the government of Bangladesh (GoB), the complementary work of donor-funded programs, and the steady economic growth and rapid social transformation underway. Despite these laudable successes, however, many challenges must be overcome to realize the GoB's goal of "quality and equitable health care for all."

USAID's decades-long investments in Bangladesh have included several flagship non-governmental organization (NGO) service delivery programs, including the Pathfinder-led NGO Service Delivery Project (NSDP, 2002-07) and the Smiling Sun Franchise Program (SSFP, 2007-12). To further USAID's investments, SSFP's emphasis on franchising and cost recovery must be recalibrated so a better balance is struck between service sustainability and the primary goal of expanding an essential service package (ESP) encompassing long-acting reversible contraceptives and permanent methods of family planning (LARC/PM), maternal health (MH), nutrition, newborn care (NC), and accutre respiratory infection (ARI) treatment among the poor and underserved. Greater NGO autonomy and ownership must be fostered by targeted capacity strengthening activities so that NGOs are able to develop dynamic service delivery models to increase access, engage target populations and reduce inequities, thereby playing a more vibrant role in the national health sector.

Family Planning/Fertility: Bangladesh has the eighth largest population in the world, half of whom live in poverty. This widespread poverty, combined with rapid urban growth, infrastructure deficiencies, reliance on a poorly regulated private sector, environmental degradation, and marked gender disparities, directly affect the nation's health, particularly that of the poor. Despite substantial reductions in fertility rates, Bangladesh's population is projected to reach 220 million by 2050, threatening the durability of current successes and projected development. Further

decline beyond the current total fertility rate (TFR) of 2.3 requires efforts to reduce inequalities (e.g., poor women have a TFR of 2.5, (BDHS2011), whereas the wealthiest women have achieved replacement fertility). To close this gap, dedicated attention must be given to groups with the greatest unmet need for family planning (FP)—namely poor and adolescent girls and women living in underperforming and underserved areas like Sylhet and Chittagong. At the same time, low uptake of long-acting reversible contraceptives and permanent methods (LARC/PMs) and high discontinuation rates must be addressed.

According to Bangladesh Population Policy 2012, Bangladesh had set a target to achieve replacement fertility by 2015. To achieve this target, contraceptive prevalence rate (CPR) should reach 72%. Though current CPR is 62%, the modern method usage rate is only 54% and only 8.1% of currently married couples use a long-term or permanent method (BDHS 2014), such as sterilization, an IUD, or an implant. The desire to stop childbearing among currently married women with two children has increased from 66% in 1999-2000 to 82% in 2011,and Bangladeshi women have 0.7 more children than their desired number. (BDHS 2011). This implies that the TFR would be 30% lower if unwanted births were avoided. Increasing popularity of LARC/PMs can contribute to reduce unwanted pregnancies as well as to attain replacement fertility.

To reduce fertility and improve health outcomes, deeply ingrained gender inequalities and the resultant disproportionate burden of poverty that falls on Bangladeshi girls and women must be addressed. By the age of 18, 65% of women are married and 50% of women have given birth. Targeted investments addressing socioeconomic, age, gender, and geographical inequities and barriers are needed to expand health service delivery. It is only through combined efforts to increase access to services that Bangladesh will realize further declines in fertility and maternal, infant, and child mortality.

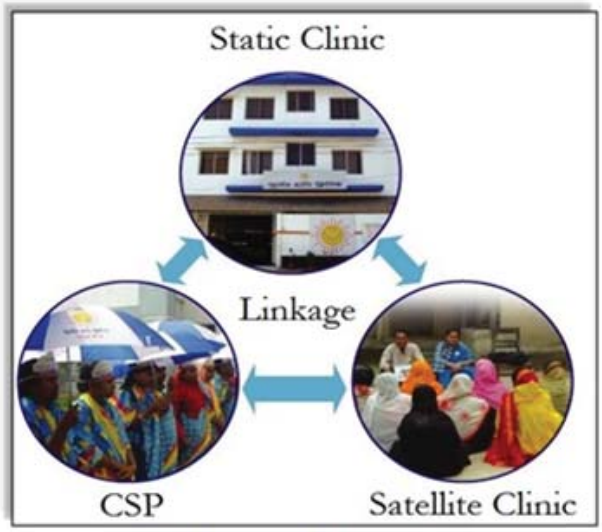
Maternal Health: Similarly, while maternal, infant, and under-five (u-5) mortality rates have declined, coverage and uptake of MCH services remain inadequate and inequitable. For example, the BMMS 2010 found that 30.3% of urban deliveries are attended by a skilled birth attendant (SBA) versus 14.7% (BMMS 2010) in rural areas, and wealthier women are seven times more likely to deliver in a facility than their poorer counter parts (BMMS 2010). Treatment for obstetric complications has increased, but access to emergency obstetric and newborn care (EMONC) remains limited, especially for the poor and in rural areas. NHSDP service delivery data and BDHS 2011 data support the need for special emphasis on certain BCC interventions, especially ANC and PNC which show 79% of pregnant women going for at least one ANC visit amongst them 64% are visited by medically trained providers. In respect to PNC only 32% are receiving services within two days of giving birth (BDHS 2014).

Child Health: Care seeking for acute respiratory infections (ARI) is low, especially among the poor, with pneumonia being the leading cause of childhood death. Furthermore, about 600,000 Bangladeshi children suffer from severe acute malnutrition (BDHS 2011). ARIs are responsible for one-fifth of child mortality worldwide, making it the biggest single killer of children. Every child typically experiences four to seven bouts of ARI each year, many of them mild or moderate. The draft WHO/UNICEF statement identifies three strategies for improving quality of care and access to both care and drugs:

- Improving accessibility and quality of care for children with ARI at first-level facilities
- Improving quality of care in the private sector (especially in urban areas)
- Increasing accessibility of well-trained community health workers who can administer antibiotics and counsel parents

3. NHSDP

NHSDP is providing health service delivery from a 3-tier inter-linked service delivery system which includes the Static Clinic, Satellite Clinic and the Community Service Providers (CSPs). This service delivery model is illustrated in Diagram-1.



NHSDP Service Delivery Model
Source: NHSDP
Diagram- 1

The USAID-DFID funded NHSDP supports the delivery of an ESP through a network of NGO clinics that primarily target the poor and underserved in rural and urban areas of Bangladesh. Expanded access to and use of the ESP will measurably improve health outcomes and thus will contribute to decreasing fertility and maternal, infant, and child mortality. Successful project implementation will contribute to:

- The Global Health Initiative/Bangladesh (GHI/B) country strategy and principle of women, girls, and gender equality;
- USAID's Country Development Cooperation Strategy (CDCS); and
- GoB's Health, Population, and Nutrition Sector Development Program 2011 – 2016 (HPNSDP).

Specifically, activities will contribute to the GHI/B results framework and CDCS development objective 3: Health status improved, and will result in:

1) Increased use of effective FP and reproductive health (RH) services
2) Increased use of integrated, essential FP, health, and nutrition services
3) Strengthened health systems and governance

At the field level this will be achieved by ensuring linkages and coordination of three key components of the program: Static Clinic, Satellite Clinic and the CSPs. This BCC strategy addresses both the supply and the demand sides of health the key health to create an enabling environment that ensures positive behavior change and improved health outcomes.The project supports USAID's emphasis on serving the poor and prioritization of five ESP components: Maternal Health, Child Health, Limited Curative Care, Communicable Disease Control and BCC. It also supports maintenance of quality standards, and institutional strengthening. The overall project focuses on three main pillars: Organizational Sustainability, Financial Sustainability and Program/Community Sustainability and addresses the following four dimensions of performance: 1) coverage and uptake, 2) quality, 3) equity and 4) institutional strengthening that move NGOs toward achieving local ownership and sustainability objectives.

4. Strategy Justification and Implementation

The BCC strategy will be implemented through alignment with national priorities and policies, creating an enabling environment, building local capacity, empowering and engaging local populations including the poor, and ensuring open dialogue, collaboration, and coordination.

The BCC strategy puts the client at the core of the program to ensure support at all levels, to create an environment where people are enabled and encouraged to protect their personal, and their family's health, and supported with all necessary resources to continue and maintain that behavior. Community activities at the local level working with project partners and through existing committees, local groups, local influential, and leaders will ensure that the beneficiaries are an integral part of the dialogue and program.

4.1 Overarching Approach

This strategy will guide NGO management to ensure:

1. The delivery of correct and consistent messages for each audience segment;
2. Achieving the desired behavior outcomes; and
3. Cost effectiveness in BCC program interventions

This strategy will create a common understanding of the NHSDP and NGO/clinics to develop program interventions for the community and the target audiences to change key behaviors.This strategy will be used to support the following supply side activities:

NGO/Clinics:

- Plan and implement appropriate and consistent program interventions
- Determine needs-based program interventions
- Build capacity
- Mobilize local resources
- Train on the job
- Share program success stories
- Maintain a process of knowledge sharing
- Establish linkage with other USAID program communication activities
- Monitor and evaluate

NHSDP headquarters:

- Select appropriate program interventions
- Ensure adequate training/TOT
- Monitor and evaluate

On the demand side the strategy proposes guidelines to ensure that the community is a key partner in all interventions at all times, and that the voice of the community and the participation of the community as equal partners is present in planning and implementation. This will be achieved by:

- Linking with existing community groups, e.g. credit, agriculture, education, religious, youth, etc. to tap into their networks and share information
- Linking to national health days, local melas and events to promote services
- Identifying and working with local community leaders to ensure their acceptance of and active promotion of the program goals in all their activities and fora
- Transforming SH Health Groups into SH Community Support Groups which will assess the local situation and prioritize health needs
- Facilitating linkages with other USAID and other development programs at the local level

The local partners will implement the community-based interventions working closely with project staff along with the national and local level NGOs to plan and execute the most effective community interventions using the Community Support System (CmSS) model described in section 8.

5. Intermediate Results (IRs),Strategy Development Process and Framework

This strategy is designed to address the BCC component of the program, specifically Intermediate Result 2 (IR2) (Optimal Healthy Behavior Promoted) and its two sub-results: IR2.1: Health behaviors and care seeking, and IR 2.2: Communities are actively engaged in promotion of healthy behaviors and care seeking practices.

Sub IR 2.1 Healthy behaviors and care seeking practices improved through BCC/KM.

The expected results under this Sub-IR include:

- Key messages in line with GoB guidelines are developed/adapted and disseminated through a wide array of channels, such as mass media, Smiling Sun and public sector clinical facilities, partnerships with other community-based organizations, community dissemination (e.g. drama, songs), social media, cell phones, and school-based programs
- At least 80% of clinics have at least one service provider trained in Interpersonal Communication and Counseling (IPCC) to include BCC messages while counseling on ESP interventions
- At least 80% of clinics implement monitoring systems (e.g. mystery client) to assess the quality of counseling services
- BCC strategies are harmonized across communities and health facilities and with other USAID-supported projects
- Healthy behaviors and care seeking practices are adopted among target client audiences

Sub IR 2.2 Communities are actively engaged in promotion of healthy behaviors and care seeking practices.

The expected results under this Sub-IR include:

- At least 90% of targeted communities report increased satisfaction with NGO clinic services
- At least 90% of supported NGO clinics are linked with community groups that participate in health planning and mobilization activities by the end of the activity
- At least 90% of communities served by supported NGO clinics are supported by groups of mobilized local influential stakeholders by the end of the activity

The health areas to be addressed by the project include:

Reproductive Health:

- Modern methods of family planning, particularly LAPMs
- Prevention of RTIs/STIs
- Maternal nutrition (including control of anemia and Vitamin A)
- Safe motherhood, including antenatal care (including tetanus toxoid), clean and safe delivery and postnatal care
- Post-Abortion Care (PAC)
- Neonatal care
- Adolescent Reproductive Health (e.g., information/counseling)

Child Health

- Child immunization
- Child nutrition (including anemia, breastfeeding, micronutrients and infant/young child feeding practices
- Acute respiratory infection (ARI)
- IMCI (including diarrheal disease)

Limited curative care

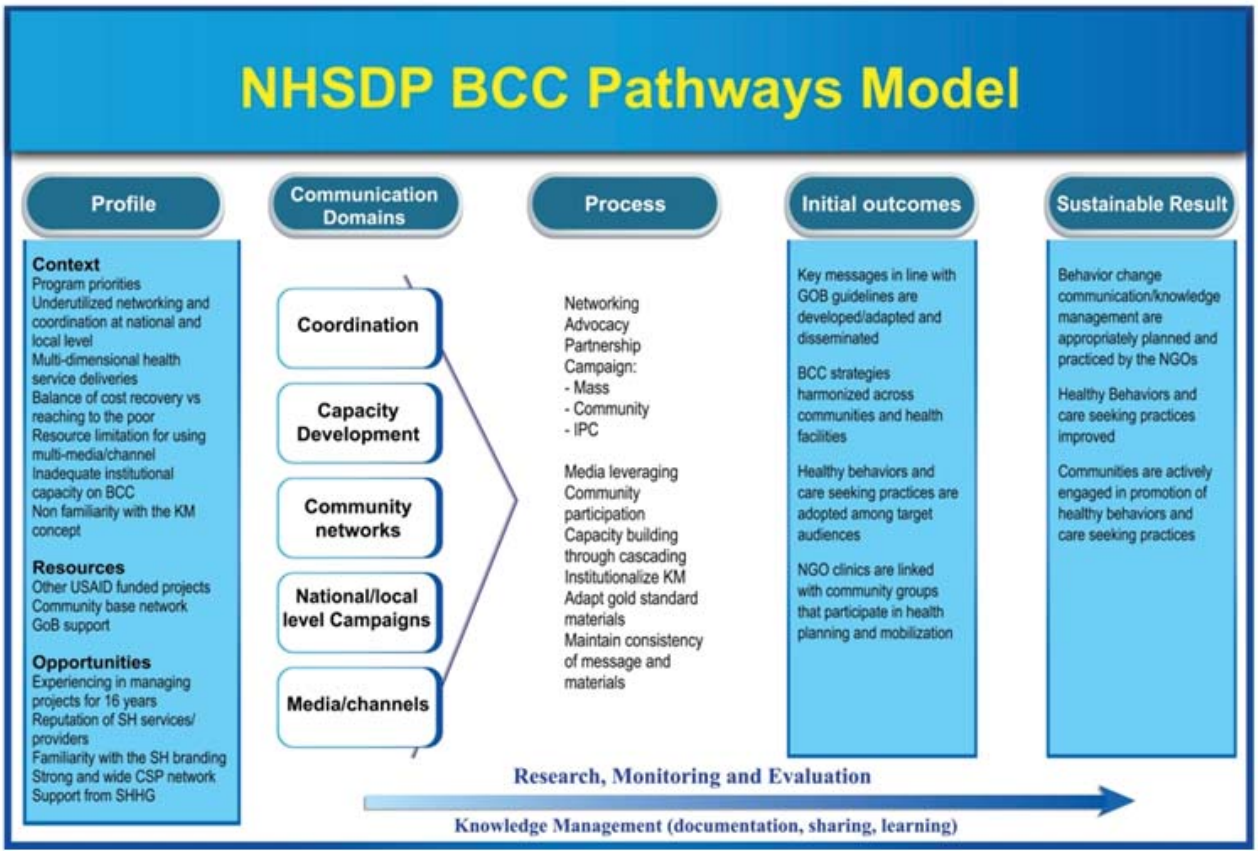
- Communicable diseases
- Tuberculosis (all types)
- Malaria
- Non-Essential Service Provision
- Lab test
- Commodity/medicine sales from pharmacy
- Ultra-sonogram
- Ambulance
- TT vaccine
- Rubella vaccine
- Reproductive Health counseling
- Gender-based Violence

Strategy development process

The development of the strategy followed a process that involved three assessments, a desk review and alignment with the GoBMinistry of Health and Family Welfare (MoHFW) strategies and priorities. The process followed and the results of these assessments are included in annexs 1 and 2. Broadly, they identified a need for training, ensuring updated materials are utilized at the clinics, and prioritizing messages.

Pathways Framework

This strategy has adapted the national Pathways to Effective HPN SBCC, developed by the National BCC Working Group.



Source: JHU/CCP
Diagram 2

The Pathways Model addresses both supply and demand. Supply includes: capacity strengthening of the providers and services and consistency and coordination of messages. Demand includes: creation of demand for services through improved and supportive IPCC, national and local media, and creation of a supportive environment leading to social norms in and around positive health behaviors

6. Key Audience segments

The audience for the BCC interventions includes traditional audiences with a special focus on adolescents and the poor, since the project is designed to include a client base of 40% defined as poor. The selection of audiences addresses both the demand and the supply side as well as influential and opinion leaders to ensure synergies and to provide a supportive environment.

Audience	Current Situation	Future
Women: Women are a key audience, especially low parity and women with 2 or more children. Spacing methods and, for higher parity women, awareness of the benefits of LARC/PM.	Women are coming for services but the mix of LARC/PM is lower. Some women are not aware of the benefits of LARC/PM for higher parity women and the fears, rumors and misconceptions regarding these methods need to be reduced.	The mix of a methods includes a higher percentage of LARC/PM

Audience	Current Situation	Future
Women need to receive the optimal number of ANC check-ups. They also need PNC visits within 48 hours of delivery	Women do not consider ANC check-ups as an essential care for her as well as for her baby's health. Their family members, especially in-laws, do not provide supportive roles.	Extensive promotion/campaigns in the community and community outreach BCC will be able to play a supportive to infuse care seeking practices
Men: Men need to be supportive and encouraging as either clients themselves for condoms or vasectomy, or for encouraging and supporting contraceptive methods for their wives. Men also need to understand and be supportive of ANC and PNC including birth preparedness and recognition of danger signs.	Men are not as involved in FP counseling and do not go to the clinic with their spouse due to the perception that clinics are for women only.	Men are equal supportive partners in FP decision making and attend counseling sessions. Spousal communication is increased
Couples: Couples include both audiences above. Encourage couples counseling and shared decision making including the importance of spousal communication on all key health issues affecting the family	Currently spousal communication on FP (54%, BDHS 2007) and ANC/PNC is low.	Spousal communication increased and men are supportive and engaged in positive FP and ANC/PNC decisions.
Youth (Male and Female): Youth are a special audience for messages on puberty, health and hygiene, preparing for career and marriage and an understanding of the dangers of early marriage and childbirth at too early an age. Youth are an audience with a huge potential for preparing thoughtfully for their family life. RH information and life planning skills are crucial for this group	Currently youth are not addressed with reproductive health and hygiene messages in a systematic and organized manner. They lack this information and life planning skills.	Youth understand reproductive health and prepare themselves and their eventual family for good health and healthy timing and spacing of pregnancies. Smaller family size becomes the norm across all socio economic groups
Poor: The poor are an additional key audience since the mandate of the project is to have a client base which is made up of 40% poor. The poor need to be addressed through creative means since their literacy rates are low and they have less access to media and mainstream communication channels.	The poor are marginalized due to low literacy rates, physical and financial access to services and lack of knowledge and awareness of services They may be shy or intimidated by clinical services due to a variety of reasons.	The poor are 40% of total clients served by SH clinics and are welcome and active participants in clinic services
Local influentials/opinion leaders: Local opinion leaders are key to provide and nurture a supportive environment. Opinion leaders can include elected officials, religious leaders, teachers, heads of local groups, and business leaders.	Opinions leaders are passive about health issues at the local level and do not actively promote SH services. Health issues are not their priority and they have not been mobilized to see how better health in the community benefits the community at large.	Local opinion leaders are proactive in mentioning SH services at every opportunity including meetings, rallies and among their friends and the business community

Table 1

Targeted interventions for special audiences:

Youth –Youth have been traditionally underserved with regard to family planning (FP) and reproductive health (RH). Adolescent fertility in Bangladesh is very high and adolescents need correct information on RH. Youth can also develop their capacity to act as peer educators to discuss delayed marriage, consequence of pregnancy at an early age, girls' education, RH, etc. There should also be adolescent friendly health service facilities at the SH clinic. In addition, the youth clubs could serve as FP and RH resource centers for the adolescents.

BCCP developed, tested and rolled out an Adolescent Reproductive Health (ARH) package in 2003. This could be reprinted and introduced in the local schools and possible clinics. These modules address health and hygiene issues of youth through a series of interactive videos and booklets that include information relevant to youth such as changes during puberty, Eve teasing, hygiene, dealing with emotional changes, gender equity, career, and planning for the future including planning for family size.

The Poor- Rapid assessments and FGDs will be conducted at the local level in both urban and rural areas to determine the best means of reaching the poor. This will include the most appropriate channels, media, networks, etc. The poor are a specific segment because they may not know about services, may be intimidated by clinics if they do know and have no money,or fear they cannot afford it to go to the clinic. Their current knowledge, attitude and practice will be assessed and will leverage existing programs that work with them.

Existing local programs which serve the poor should be identified and tapped into to extend information about the SH clinics. These could include BRAC, Grameen Bank, religious charities, TMSS,ASA, Proshika, GUK, Swanirvar Bangladesh, Buro Bangladesh, Padakkhep, and other development organizations which already have contacts and credibility with these segments of the population.

Management and Providers/Program Personnel (Supply- side):

Audience	Current Situation	Future
Project Directors (PD): The PD at the central level needs to understand the basics of BCC in order to see it as a priority and to set policy and monitoring protocols to ensure it is supported	Not all PDs have a clear understanding of the importance of BCC, IPCC and KM	PDs direct resources to support BCC, IPC/C and ensure supportive supervision and monitoring of these interventions
Project Managers (PM): The PM performs the monitoring visits to the local level clinics and needs to understand the basics of BCC, Interpersonal Communication and Counseling (IPCC) and KM in order to monitor and support it at the local level and see it as a priority	Not all PMs have an understanding of the need for BCC, IPCC and KM and therefore do not consider or support it during monitoring visits	PMs develop protocols to support BCC, IPCC and implement supportive supervision and monitoring of these interventions
Clinic Managers: The Clinic Managers are the ones who set the tone for the entire clinic system at the local level. Their understanding of the program and support for ensuring quality BCC and services at every level is critical to the success of the program.	The clinic managers, as shown by the assessments are lacking in knowledge about strategic BCC concepts as well as the importance of consistent and good quality IPCC. They need to understand these so as to be able to conceptualize and implement community mobilization campaigns and to provide supportive supervision to frontline staff in the area of IPCC.	Managers understand and can initiate local level BCC interventions and give supportive supervision to all staff ensuring best practices in IPCC are followed.

Audience	Current Situation	Future
Medical Officers (MO): These personnel need to understand the key aspects of the program and be able to provide messages on PNC/ANC and post-partum FP as well as nutrition for the mother and child and immunization schedules. They need to ensure that there are no missed opportunities for delivering additional health messages, as appropriate, at each and every contact with clients.	The majority of staff in all the categories below have not had any IPCC training in over 6 years (if at all). They do not fully understand the new project priorities nor do they follow any proper IPCC protocols. They need to ensure respectful care for all including adolescents and the poor.	MO's are trained in IPCC techniques and use these in every encounter with clients. They are aware of and can articulate program priorities.
Paramedics: These are the key personnel to provide services, counseling and information to clients at the satellite clinic and report to the MO at static clinics. In most of the rural clinics they are the only trained medical personnel. They need IPCC and BCC training.	The majority of Paramedics have not had IPCC training in over 6 years and counseling materials in some cases are out of date and not consistent across clinics. They need to ensure respectful care for all including adolescents and the poor.	Paramedics are trained in IPCC, have appropriate materials and use best practices in every counseling session. They are able to self-assess the effectiveness of their sessions
Counselors: These are key players as they are the entry and exit point at the clinic level. They require IPCC training including self-assessment techniques to ensure that they are conducting counseling sessions correctly and consistently and using the appropriate messages and materials at the right time with the right audiences.	The majority of Counselors have not had IPCC training in over 6 years and counseling materials in some cases are out of date and not consistent across clinics. They need to ensure respectful care for all including adolescents and the poor.	Counselors are trained in IPCC, have appropriate materials and use best practices in every counseling session. They are able to self-assess the effectiveness of their sessions
Service Promoters: Meets with community influentials to create an enabling environment for service delivery. Assesses community to determine potential customers, then disseminates information to the community and mobilizes different existing community groups. Maintains liaison with community level GoB frontline workers	Lack skills and knowledge on current program priorities information for conducting community level meetings. Lack support materials to conduct these sessions. They need to ensure respectful care for all including adolescents and the poor.	SPs are equipped with the knowledge and skills needed to effectively reach out to the community and have the proper tools and materials to carry out their job.
Clinic Aides: They welcome and register the client and direct them to the appropriate service or person. If there is no counselor they counsel the client directly. If there are satellite clinics they also attend.	This staffs are not available at all clinics, but in the clinics where they are present theyare not trained in the counseling skills needed when they must step in and do this job. They need to ensure respectful care for all including adolescents and the poor.	Clinic Aides are well trained in their job and perform their tasks effectively and efficiently with a client centered focus.

Table 2

7. Coordination

Coordination and partnerships at the national level and especially the local level are a key component of the strategy and the first of the Communication Domains in the HPN SBCC Framework. It is important to work with and motivate the community members, youth clubs, community-based organizations, community support groups, and community networks (such as Ansars, VDP, and members of CBOs) to maintain a continuous relationship with the community to hear their voices and overcome social barriers through effective promotion of SH clinic services. SH NGOs can establish community information centers at the community health club, strengthen SH Health Groups now reformed as SH community Support Groups, as a channel of communication to bridge the gaps between communities and services facilities.

Implementing partnerships:

Partnerships with existing NHSDP partners can be leveraged by expanding to other activities. These partners include: Social Marketing Company (SMC), CARE, and Nari Uddung Kendra (NUK). Partnerships can be created or strengthened by creating MOUs and LOCs with such groups as Engender Health, MAMA, HC3 and others. It will also tap into their programs for support and extending the reach and network of the static clinics.

The program plans to utilize the existing SH Health Groups around each SH Clinic catchment area and transform them into SH Community Support Groups. These SH Support Groups will follow the CmSS model and will directly develop local community action plans based on their needs and the specific needs according to the local situation, including identifying barriers in the community to utilizing services, and any other local constraints or opportunities. The project will implement and monitor the interventions at the community level in coordination with the local clinic managers.

The strategy also recommends exploring opportunities for tapping into Corporate Social Responsible (CSR) innovations through partners such as ReckitBenkizer, Dutch Bangla Bank, Unilever; mobile phone operators including Grameen Phone, Banglalink, Robi, Airtell, etc.; and local corporate organizations situated in clinic areas.

Linkages with other programs:

USAID funds many projects in other sectors including Feed The Future, Democracy and Governance, Food for Peace, Agriculture and Food Security, Environment and Global Climate Change, Gender Equality and Women Empowerment, WorldFish, etc. At the national level USAID can inform these programs or hold an orientation session between the Chiefs of Party (COPs) of these programs and the NHSDP COP and Director BCC to inform them of the SH programs, services available, and the health benefits to their audiences and programs. By mapping the locations of these other programs and seeing where there are geographical areas of overlap, local clinics and local programs can be informed by headquarters, and partnerships can be formed at the local level to leverage these resources to become advocates for improved health and directing potential clients to the SH clinics and services.

8. Capacity Development

Capacity development is an ongoing evidence driven process to improve the ability of an individual, team, organization, network, sector or community to create measurable and sustainable result. Capacity development is a continuous process with multiple interventions such as training, self-learning, assessment and feedback.

Capacity Development will be targeted to:

- Understand the specific capacity required and commit to developing that capacity over the long term
- Build local ownership and partnership
- Develop program management quality
- Develop work force as well as leadership

There are many opportunities to integrate innovative training and capacity building of NGO staff in IPCC and BCC across NHSDP's network of partners. It is evident from the assessments that there is a great need at all levels from clinic management to frontline workers for training in BCC and IPCC, which the NHSDP is addressing.

The program will apply several methodologies to strengthen local NGO partners' BCC capacity. This blended learning approach will include a range of activities and tools to build capacity at both the organizational and individual levels. Intensive capacity building workshops on effective communication strategies and program design and implementation will be conducted for the NGOs' senior program managers and field staff associated with BCC activities. These training sessions (IPCC, BCC and Marketing [BCC/M]) will focus on strengthening NGO staff's understanding of and capacity to conduct outreach, train, mentor, and monitor ongoing progress of BCC activities being carried out by community health workers.

Capacity building on IPCC skills for the service providers can contribute to providing the required and appropriate health information to the intended community groups or individuals to enable them to increase their health seeking behaviors. Increased BCC capacity will also enable NGO service providers to conduct in-clinic and community outreach BCC activities in more organized and strategic ways to promote quality ESP services by expanding their service areas. Based on the findings of BCC assessments, NHSDP is providing training on IPCC to the NGO clinic staff to enhance their skill and knowledge on the elements of effective communication to deliver correct and consistent ESP health messages for the targeted individual/groups. This training is provided in the form of a ToT so that the participants can act as trainers to transfer skills to other members of the clinic staff at the local level and to the CSPs as well.

NHSDP has organized and conducted two four-day TOTs for capacity building of SH clinic staff. The first training module was on IPCC and the second is on BCC and BCC/M.

Once the face-to-face and step down training is completed these skills will be reinforced by the video eLearning courses loaded on the netbooks and these will also be downloaded on the clinic computers so that these courses can be used as refresher and follow up training by field level staff.

Project Directors and Deputy Directors at the national level and Program Managers and their Deputies at the clinic level will be given an orientation on BCC and the importance of Monitoring and Evaluation (M&E). This will include simple checklists and tools for ensuring and reinforcing the continuity of quality of these interventions. If appropriate they will be encouraged to attend and be part of the BCC Working Group or its sub committees to ensure coordination of programs and messages.

8.1 BCC Capacity development at NGO/clinic level:

BCC Capacity building Matrix

Level	Current situation and need	Process	Monitoring /follow up
NGO	Each NGO should have their internal expertise on BCC to guide their BCC program strategically. Each NGO requires a mechanism to strengthen the BCC capacity of the service providers and promoters, and equip them with appropriate tools for IPC	A key person should be trained, especially on BCC so that he/she can provide support in this aspect Provide TOT on BCC/M Cascading the TOTs to service providers in IPCC to include BCC message while counseling on ESP component Arrange in–clinic discussion sessions fortnightly or bi-monthly	Each NGO should have a standard monitoring tool for BCC interventions and there should be specific BCC indicators for evaluation
Clinic	All clinics should have a BCC strategy implementation guideline The service promoters have to be trained on BCC which will help them in motivating clients, especially the poor, to practice healthy behaviors and promote the service at local level	Following the user friendly BCC strategy implementation guideline,they will act accordingly Arrange needs based training Use effective interpersonal communication and counseling service providers have learned from IPCC training Through conducting effective group counseling and group meetings using BCC materials and practices they have learned from IPCC training Observance of national & international BCC health related events	Visits and checklists from headquarters monitoring visits
Local	Have a system to assess the BCC interventions required to address the audience needs and service priorities at the local level	■ Community mapping ■ Client interview checklist ■ Questionnaire	Exit interview

Table 3

8.2 Knowledge Management (KM)

KM is the intentional process of capturing, storing, sharing, organizing, synthesizing and evaluating knowledge for the purposes of improving an organization's ability to have impact.It is a way to leverage knowledge externally and internally to improve collaboration and communication, and to work with greater efficiency to achieve better results using people, processes and technology.

KM involves:

- Getting the right information, to the right person, at the right time and cost
- Organizing, distilling and presenting information in a timely, relevant, accurate and simple manner

- Leveraging both tacit and explicit knowledge in a systematic way
- Using the information delivered to enable informed decision making

KM techniques and tools will be used to facilitate more efficient communication within SH clinics as well as between clinics and clients, and between clinics and district- and national-level supervisors. The use of KM within this strategy will support participation in more effective communities of practice, foster dedicated systems strengthening and provide capacity building to create, capture and share knowledge.

In the context of public health, KM is a systematic approach to ensure that the latest research is accessible and applied to public health practice. It emphasizes application of KM theory, principles and methods to public health. It also maximizes knowledge assets to attain public health objectives. Adopting KM can help to accomplish the following objectives:

- Create knowledge repositories that will store knowledge and information that will be documented.
- Provide and improve access to knowledge databases to every individual and also facilitates its transfer.
- Enhance knowledge environment, so that the environment is conductive to more effective knowledge creation.
- Manage knowledge as an asset and recognize the value of knowledge in an organization.

Achieving these objectives will strengthen the program by building on past knowledge, applying what works and capturing new best practices to be shared within and outside of the NGOs.

KM has to be established in the NHSDP NGOs and clinics as part of normal practice. Quality, consistent and client-friendly messages through the right channels will only be possible when NGOs are managing their own knowledge to disseminate better information. This management of knowledge will be possible through job aides, collection of reading materials, working groups, communities of practice and using social media/internet.

Steps to ensure KM:

At the national level the NHSDP project will ensure active participation along with other USAID partners in the BCC Working Group, which meets bi-monthly in Dhaka quarterly, as well as in a newly formed mHealth Working Group to ensure high-level knowledge exchange and provide key coordination and collaboration between related projects in country. At the local level, it is expected that NGOs and clinics will actively

participate in the following activities to support KM:

⏩ District coordination meetings, local level community group meetings, workshops, seminars and support groups attended by the clinic managers will be a key mechanism to share information with clinic personnel, e.g. all health related circulars on new policies and guidelines, and any special events at the local or national level. A mechanism will be put in place to share this information with all clinic staff and to document this sharing. This will include a monthly clinic staff meeting following the district meeting and other meetings to ensure that pertinent information is passed down, that concerns are addressed and questions asked and answered.

- Guidelines, documents, program descriptions, factsheets and other directives supplied by NHSDP should be properly stored, implemented and followed. Proper filing and ability of all staff to be able to readily access this information is a key component of good KM.

- NHSDP email accounts and a group email list will be created for all district-level supervisors and clinic managers to ensure the opportunity for information to be shared easily with at least one contact point in each facility, which is then tasked with leading the discussions at each monthly meeting. Materials such as PDF posters, dosing charts, etc. may also be shared with each clinic in this manner. This will support improved content management and streamline the flow of messages.

- One netbook computer will be provided to each NHSDP clinic in a handover from the Bangladesh Knowledge Management Initiative (BKMI). Each netbook contains an eToolkit of SBCC resources, and eight video-based eLearning courses, that have been vetted by the MoHFW and BCC Working Group. This tool can be used to support clinic-based training (for counselors, clinic managers, service providers) and direct counseling, and support knowledge and capacity for IPCC and the ESP. Training on the netbooks will be completed by NHSDP staff or via DVD instruction handed down from the Project Directors.

- The netbooks will also be updated by NHSDP with the project materials that can be used during counseling, NHSDP will also be tasked with monitoring and evaluating the use of the netbooks in two ways: by measuring the knowledge captured and retained by clinic-based counselors using the netbooks and tracking clients exposed to messaging who act on the information as part of their decision making process.

- Training on and use of the digital resources at all levels from headquarters to field staff will ensure capacity building from project director to clinic staff and the ability for staff to provide improved information sharing with clients across health areas.

- Linkages with national partners, including BKMI, UNICEF, BCC Working Group, and the GoB will be ensured and nurtured to maintain high quality and synergistic efforts for health promotion. This process will ensure collaboration with the organizations that have program interventions on various health issues in the SH clinic catchment areas.

Knowledge Management Process

KM is a relatively new concept for the NGO/clinics, however if it is practiced systematically, it can be an excellent tool for information dissemination through the clinic networks.

KM Capacity Building Matrix

Level	Need	Process	Monitoring/follow up
NGO	The NGOs should be oriented on the basic concept of KM to ensure learning as a continuous process NGOs need to build KM as a part of their service delivery and BCC activities in order to enrich their service quality and innovativeness.	Arrange orientation and training Properly capture knowledge, synthesis and sharing should always be practiced Maintaining proper documentation Top to bottom and vice versa sharing of knowledge & information By arranging in –clinic discussion session fortnightly or bi-monthly	Each NGO should have a standard monitoring tool for KM interventions and there should be specific KM indicators for evaluation
SH clinic	Clinics need to build KM as a part of their service delivery and BCC activities	■ Arrange orientation and training ■ Maintain proper documentation ■ Share knowledge & information to the right people, in the right format, at the right time ■ Encourage use of knowledge ■ Facilitate learning ■ Create new knowledge ■ Synthesize and adapt knowledge ■ Organize knowledge ■ Arrange fortnightly discussions to keep the process ongoing	A clinic based monitoring tool will be developed on the basis of NGO level monitoring tool to assess the clinic level practice and progress of KM
Local level	KM process to be continued at the local level	Sharing of knowledge & information with the community, in the right format, at the right time through the right channel. Disseminating information through this process will foster behavior change of the community/individuals.	

Table 4

9. Community Networks– bringing the community as partners in the program:

The participation of the communities surrounding the SH clinics is key to the success of the program. Assessing and understanding the needs, barriers and perspective of the community and then involving them in a meaningful way with the clinics and satellite clinics is important. Outreach and community events are needed to raise awareness and ensure the active participation of the whole community at the local level of the services available, where and what they are and how these services can benefit the individuals and families in the community. Involving community leaders and all existing community groups in a dialogue and truly understanding the community will benefit the program, both the provider side and the client side.

The chart below outlines some of the methods to ensure that the needs of the community are understood and acted on.

Method	Purpose	Outcome
Focus Group Discussion with potential clients	To understand the perceptions, barriers and constraints to using services as well as preferred sources of information	Clinic managers and staff will tailor programs, outreach and communication to meet the needs and expectations of the clients
SH Community Support Groups	The groups will develop community action plans based on the local situation and needs to address and overcome any barriers to utilization of services	Barriers identified and overcome by mutual understanding and facilitating of a mutually respectful environment
Meetings with local groups and associations including truckers, rickshaw pullers, farmers, teachers, religious leaders, Local Government representatives, youth groups, etc.	Listening to and understanding the health and information needs of these groups will enable program and clinic managers to better serve the community	Clients become an integral part of the planning process and managers and clinic staff understand and are more sympathetic and empathetic with clients

Table 5

There are many existing community groups and personnel including CSPs, Family Welfare Assistants (FWAs), Health Assistants (HAs), Family Welfare Volunteers (FWVs), Agricultural Extension Workers, environmental, school, religious, and youth groups, sports clubs and others which can also be made a part of the support for disseminating messages in creating and reinforcing social norms around the desired behaviors among their communities and members, at no additional cost to the program.

At local level there are NGOs/CBOs working on issues like micro credit, income generation, formal and non-formal education, health, nutrition and family planning, women's rights, environment, poultry, fisheries and livestock, water supply and sanitation, human rights, legal aid, etc. who formed groups or samity for their beneficiaries. SH clinics may consider these samitys as their networking points and establish a functional linkage with them to use those as sources of SH service information around communities to create and reinforce social norms that will help attain the desired behaviors.

At the local level there are different forms of cultural groups like drama groups, local musical bands, folk song groups, etc. SH clinics can establish partnerships with them to use these channels for disseminating priority health messages through entertaining events.

All SH clinics have an opportunity to work with different committees of local government such as Union Parishad, Upazila Parishad, Ward counselor etc. SH clinics can also use these networks. The existing SH Health Groups now transformed into SH Community Support Groups can be linked with clinics as a key means of linking the community to the clinic as well as supporting and communicating about all community level events and activities.

NHSDP has conducted a mapping exercise to identify existing programe mbers and ms and organizations in each catchment area of the SH clinics, and can leverage these programs and organizations. Once the Clinic Managers are made aware of the potential health benefits to their

and constituencies it is a natural fit for them to network and partner with these programs to utilize them to spread the messages of the program.

The following matrix illustrates the interconnections of local level networking and partnership with the SH clinics:

Prospect	Purpose	Stakeholder	Activities
Partnership with micro credit NGOs/CBOs	▸ To have access to micro credit groups/samity	Program Managers	- Highlight the community welfare issues using one to one communication & meetings
Networking with micro credit groups/samity	▸ To inform the group members on LARC/PM and to make them aware of MH, Nutrition and RH issues ▸ Demand generation for LARC/PM, MH, and MH services	Program organizers	▸ Health session during their regular team meeting ▸ Special satellite for these types of groups
Networking with district/upazila women affairs office/youth development office	▸ To have access to women's groups/samity ▸ To have access to the training sessions for youth groups ▸ To create awareness of MH, Nutrition and RH practices	District/upazila women affairs officer and District/upazila youth development officer	▸ Liaison with the district/upazila women affairs officer and district/upazila youth development officer ▸ Health session during their regular group meeting / training
Networking with district/upazila level Poultry/ Fisheries/ Live stock /Agricultue offices	▸ To have access to growers / farmers group in order to make aware them of LARC/PM, MH, NC, ARI, Nutrition and RH	District/upazila level Poultry/ Fisheries/ Live stock/ Agriculture offices	▸ Health session during their regular group meeting / training
Partnership with schools, youth clubs, Community police, Ansar & VDP office	▸ Create an understanding of the SH clinics activities ▸ Highlight the community welfare issues which are covered by SH clinics ▸ Use them as volunteer for SH clinics	School Management Committee, Head Master, Chairperson of club, Ansar Adjutant	▸ Discussion ▸ Arrange visits to particular service delivery sites
Partnership with local level amateur cultural groups and local professional cultural group	▸ Use them for disseminating messages to the target audience through entertainment at minimum cost	Dolonata	▸ Discussion ▸ Highlight the community welfare issues using one to one communication or meetings
Networking with groups and committees of local level LGED units	▸ Use them for disseminating messages to the target audience	Union/upazila/ municipal/ward counselor	▸ Discussion ▸ Arrange visit at particular service delivery sites
SH Community Support Groups	▸ These groups will be active participants in developing community action plans based on local needs, including identifying barriers to uptake and use of SS services	SH group members	▸ Regular meetings designed to develop action plans and their follow through

Table 6

Local influential and networking partnerships

At the local level, partnerships will be built with local influentials including religious leaders, teachers, political and business leaders, journalists, and others to brief them on the available services, and the benefits to the health of the community, so they become advocates who support and spread awareness of the program in all their encounters with the community. They can be reached individually or through the organizations in which they participate or lead. Program managers will be oriented on the advantage of reaching out to these people to further the goals of the program.

Involving respected persons of the community	Rationale
In order to ensure active participation of those who play important roles in this campaign, and create an enabling environment with their help, special measures will be taken to involve the following personalities	
Elected Representatives of Local Government	Upazila and Union Parishad (UP) members play a very important role in social development. To use them effectively they need to be oriented on their role in the campaign. Support materials/ information sheets need to be provided during various campaign activities.
Religious Leaders	Local level religious leaders like madrasa teachers, Imams etc. can be involved with this campaign at different stages.
Satisfied Clients	Satisfied clients can become advocates. Advocacy by satisfied clients is not only the final step in individual behavior change but also a powerful force to establish a community norm and encourage others to adopt new practices. They should be identified by the field workers and be encouraged to act as role models. To use them effectively, they should be prepared and coached by CSP.
SH community support group member	They can work as a grassroots level source for information and can also encourage the community leaders to discuss aspects of healthy behavior. The CARE intervention will transform these SH health groups into SH support groups and will employ their CmSS model with the transformed groups.

Table 7

In addition, the program will establish linkages with government programs that are working to improve local level social awareness interventions at different tiers in the country. These organizations implement social and community awareness interventions and conduct trainings for marginalized communities in their catchment areas which can be expanded to include health awareness sessions. These interventions are conducted by the Department of Women Affairs (DWA), Department of Social Services (DSS), Islamic Foundation (IFB), Youth training centers, etc. In these trainings there is an opportunity to add health awareness sessions. SH clinic's outreach activists can conduct these health awareness sessions and can build mutual relationships to leverage promotion of SH clinics.

10. National and Local Level Campaigns

National level

Integrated demand generation campaigns

Mass media and Information and Communications Technologies (ICT) present opportunities to reinforce messages delivered at the local level and to provide an overarching umbrella to generate demand and direct people to available services.

TV- the budget for TV spots is limited but the project can produce two quality spots to remind people of the services available at the SH clinics. While recognition of the Smiling Sun logo is quite high at 76% (according to respondents in the SSFPendline assessment), the range of quality services available at an affordable price needs to be reiterated. There is limited budget for national broadcast airtime, but the spots can be purchased for local TV cable companies and local FM radio stations for rebroadcast at a much lower cost than national broadcast and with a greater potential of reaching the local population. National broadcast, due to budget constraints, will not have the reach or intensity of local "narrow" cast opportunities, which have the potential of amplifying and spreading the messages in targeted communities. Since the Netbooks were given to the clinics and counselors, the TV spots can also be loaded on the netbooks which proved popular with clients in the pilot test of this intervention with the NHSDP program. Radio spots produced under the strategy can also be rebroadcast on local FM and community radio at a much lower cost and with more targeted reach in the catchment areas of the SH.

Mobile phones:

Mobile phone technology is another opportunity to deliver health messages and reminders about ANC and PNC visits as well as immunizations to clients in a cost effective manner. SH clinics can keep a register for keeping record of ANC client's mobile number. This register can be used to follow up the missing ANC clients and when they are close to their expected delivery date (EDD) it will help them to select an appropriate facility for delivery and care seeking practice of PNC, and their child's immunization reminders. ANC/PNC visits and immunization schedules can be sent through SMS to mobile phones at predetermined and individualized dates for each client.

Social Media Programs and initiatives

Social network and media tools are available for free. Facebook, Twitter and YouTube are key social media platforms. Facebook and Twitter are the most prolific in terms of activity, and lend themselves to timely content posted in these media pages. Audience responses vary in quality from heavily engaged comments to quick remarks. Content is evenly spread between 'light' posts and richer material, and can be adapted to the specific social platform.

Facebook can be used to inform people of events and to encourage them to interact with the site (page) to make comments and to seek answers to questions. This platform can be successfully used in promoting service delivery sites, providing event information and sharing success stories related to SH. In particular, the youth are conveniently accessible for ARH services and may have an opportunity to share their health needs and ideas with their peer groups.

YouTube is a website that allows anyone to upload, share, and view videos. Video training materials and TVCs produced under the program and relevant materials produced by other programs can be collected under one YouTube channel dedicated to advancing the objectives of NHSDP and SH clinics.

We need to determine the use of these social media channels promoting community engagement, generate support of the stakeholders and peer groups and disseminate information at the local level. It will also involve NHSDP and the NGO network to share success stories, best practices, program updates and share program related audio-visual materials. These sites will need to be monitored, updated and managed by a dedicated staff person of NHDSDP.The social media channels can be good alternatives to, and supplement mass media. A relevant matrix for targeting message/communication to certain audience groups in order to reach objectives, is illustrated in the chart below.

Social media channel	Message/ Communication	Objective	Audience	Expected outcomes
Facebook	▸ Promote clinic sites and services ▸ Share success stories ▸ Create peer groups on certain health issue ▸ Create a response group on priority health issues ▸ Publicity and announcement of events ▸ Post BCC material images ▸ Direct counseling on certain health issues	▸ Provision of consistent messages ▸ Maintain an information hub ▸ Create a Facebook page at central level to post and share success stories, best practices and program updates	▸ Adolescent ▸ Youth ▸ Literate group of audience ▸ NHSDP HQ and SH NGO network	▸ Adolescents and youth have greater access to RH and hygiene related information ▸ Community support ▸ Pubic informed about the SH network information, message and program updates
YouTube	▸ Upload NHSDP audio-visual materials ▸ Upload videos of the local level NGO/clinic events ▸ Postevent photographs ▸ Share uploaded materials through links in Facebook	▸ Disseminate health messages through audio-visuals ▸ Involve SH networks with the sharing of messages/events	▸ Adolescent ▸ Youth ▸ Literate group of audience ▸ NHSDP HQ and SH NGO network	▸ Health information through audio-visual at community level ▸ Get informed about the SH network information, messages and program updates

Table 8

Media Advocacy:

Media advocacy is the strategic use of media opportunities to create news through TV, radio and newspapers to promote public debate, and generate community support for changes in community norms and policies in general. In particular, media advocacy leverages the use of media professionals for sensitizing the community and the targeted social development beneficiaries, to highlight program benefits and successes to generate community support for changes in community norms and policies by airing/publishing news/features/articles through TV, radio and newspapers.

Media Advocacy harnesses the tools of the digital age to monitor the online space, raise the volume, change the conversation, and leave an impression.

Media is cost effective for promotion of health issues and to air/broadcast messages at a reduced or discounted rate.

- To introduce program expertise in health programs which are commonly aired on specific health issues
- To increase greater understanding instilling a sense of urgency among the media professionals on different emergency health situations such as the high child and maternal mortality rate, and create demand for health care seeking behavior and practices
- To involve media in media partnership with different events on health to focus on health interventions organized by the SH NGO networks
- To ensure that a certain percentage of space can be allocated by the media groups for health message coverage
- To publish/air article/features based on the success stories of SH clinics and focus the contribution of SH clinic networks in the health arena.

The NHSDP NGOs can leverage media at the national, local and community level to sensitize the community to extend their support for the health program initiatives, foster changing current norms of health behavior and promote the services being offered from the SH clinics. National and local level Media Dialogs have been held and are planned for key members of the media. The following matrix illustrates the interconnections of media opportunities with the expected behaviors of the SH program beneficiaries.

Level of media advocacy	Issue to address	Purpose	Activities
National	The SH health delivery programs Contribution of SH service delivery programs to HPNSDP Role of media in promoting this initiative	Create an understanding of the SH health delivery programs National level support to the reporters at the local level	Media dialogue
Local	The SH health delivery programs Priority services to cover through news reports Identify issues to generate community support	Highlight the community welfare issues to cover as a news item Generate community support for SH health delivery programs	Media dialogues at the local lever and liaison with the local press clubs
Community	How particular SH clinics or its services improve the health of the community	News reporting for print and electronic media with necessary information and service delivery data	Arrange journalists visits at particular service delivery sites

Table 9

Local Level Community campaigns and community outreach:

The local outreach activities that also involve local community, youth and other stakeholders will intensify the reach of information of the potential clients through accessible channels and will

contribute to service promotion of SH clinics. The local level campaigns have a special focus on integrating popular local media and enter-educate components to increase reach of messages and embed them within the community.

The campaign will promote better health seeking behavior, information on services, and encourage people to adopt the desired behavior along with promotion of service delivery sites to enable client awareness. The community events are a shared two-way communication between the providers and the recipients whereby each learns from the other in a dialogue geared to increase awareness, understanding and, ultimately, sustained behavior change where healthy behaviors become a community norm.

The local level campaign will be designed to disseminate priority messages and create dialogue using the following local events:

Local level events		Materials
Street drama and folk songs/ other local popular folk program	Organize street drama and folk songs with specific message themes at local level, especially at the village level to reach the potential clients. Utilize locally popular talents.	Script in local dialect with message consistency
Video Screening through Local TV Cable Network	The video documentary and TVCs can be screened through local TV cable network based on the agreement with the cable network owners to generate public support. The video will air two/three times a day in a month at least for two to three months.	Issue specific video documentary
Mobile phone message	Use mobile phone to disseminate BCC campaign messages. Follow up reminder for ANC, PNC, EPI	Messages on special days. Call for action/reminder of ANC/PNC immunization visits. Follow up
Service fair	Arrange special "Service Fair" in line with promotional events and national/international health days information booths, satisfied clients meeting, sharing views of community influentials, commitment of local level advocates, list and location of service facilities.	BCC materials from SH clinics
Community-based workshops	Conduct community-based workshops by the service promoter on LARC/PM, institutional delivery, maternal health, male involvement, gender issues etc. A key part of these workshops will be to define practical steps that community members can take to influence others in the community concerning male involvement, RH, and importance of LARC/PMs etc.	Guideline, Factsheet
Workplace meetings	Conduct workplace meetings with different categories of workers (male and female groups) to discuss male involvement, RH, importance of LARC/PMs; liaison with the factory owners to establish referral linkage with SH facilities to ensure health services for their employees.	Interactive meeting guideline, Factsheet, BCC materials (leaflet, sticker)
School-based debate, group meeting, quiz program	Conduct school based awareness program on ARH, and encourage them to seek services to live a healthy life and act as community volunteers.	Interactive meeting guideline, Factsheet, BCC materials (leaflet, sticker), ARH Kit materials

Local level events		Materials
"Happy Couples" Program	Interviews of local couples who are FP acceptors or recipients of services from the clinics. These interviews can be video recorded and rebroadcast at local events. These satisfied users become role models for other couples in the catchment area.	Hand held video cameras to record interviews.
Group meeting	Facilitate interactive community group meetings with the potential clients and decision makers.	BCC materials (flip chart, eToolkit, pictorial card, game, leaflet)
Promotion in public place	Messages may be disseminated through loud speakers, leaflets, and banners at public places.	Leaflet, miking script, call for action

Table 10

Observation of special days: Linking communities with facilities

Program managers will be given ideas and strategies and encouraged to utilize designated days such as international World Population Day, World Breastfeeding Week, World AIDS Day, World TB Day, International Women's Day, and national days like Safe Motherhood Day, National Immunization Days. to create local awareness building events and promote services delivery. This will include reaching out to other programs including GoB and any community groups and other development partners to involve them in these events as well. Activities can include booths at melas, miking, local folk talent and other entertainment programs, school and sporting events, and any other local opportunities that can be leveraged for creating awareness and providing on the spot services if appropriate (e.g. blood pressure checks, information on nutrition, ARI, vaccination, etc.). Clinics could provide discounted offers according to the day and the promotion. With these promotional activities the SH clinics will be able to leverage the opportunity of establishing linkages between the facility and the community.

Community events and outreach activities are opportunities to create a synergistic partnership and dialogue at all levels between community groups and individuals and the clinics and clinic personnel. The counselors, outreach workers and volunteers are from the community, and are part of the community. Through these activities and interactions, the voice of the clients and community will be part of the dialogue and direct feedback on the quality of provision of the services and the community perspective can be provided.

11. Messages, Media and Communication Channels

A strong linkage and inter-relation needs to exist between uses of different media to increase the reach of consistent messages in the course of the campaign. Messages and interventions will be mutually reinforcing to ensure maximum impact.

Selection of the communication approach and campaign depends on audience profile, preferred channel of the audience, and behavior change needs. Utilizing multiple media i.e. inter-personal communication, community mobilization, outdoor facilities and mass media combined with the improved services of trained service providers will create a synergy for maximum impact. This strategic approach will not only help to foster behavior change but also facilitate the total dynamics of communication to reap benefits from the BCC investment. In addition, this effort will maintain the integrity of the ongoing campaigns and enhance the technical processes of transferring SBCC capacity to NGOs, bringing innovation and synergy in the program.

To achieve the objectives of the campaign and to achieve the desired results, it is important to formulate effective key messages, identify the best mediums/materials to reach the target audience, develop a set of required materials and prepare a distribution or promotion plan to get maximum coverage. A range of diversified mediums including mass media, print media, social media and use of mobile phone can be used to gain the attention of the audience and motivate them to seek positive behavior change. Messages in all media will be developed and designed based on audience needs research, perceptions and behaviors and, based on the findings include key "triggers" to behavior change. All materials will be pre-tested with the intended audiences through FGDs and other methods.The following matrix illustrates the proposed NHSDP message and material plans.

Messages and Materials:

Messages and materials must be designed to address the informational needs and perceptions of the target population. Their needs and perceptions have to be determined through simple community level surveys and FGDs to understand their media habits, fears and misconceptions. This formative research will benefit the service providers when meeting with the clients, which is a priority since service providers are the first-hand informants in providing health messages for clients.

Messages should be simple and attractive, and clarify the benefits. They should not only provide information, but also inspire and motivate the audience to adopt desired changes. It is important to ensure that these messages are accurate and consistent with the program priorities, policies and activities. The messages should be developed and used in the selected materials in a way to encourage the desired behavior in the target audience. It is important that the messages and materials link to real-life situations so that they are interesting and credible to the target audience. A set of materials with proper presentation of messages can bring expected synergy in the campaign and thus can ensure positive change among the target audiences.

For NHSDP, the project will establish a firm foundation for BCC activities through the development of BCC materials and using existing materials where appropriate. A set of materials consisting of both existing and new messages have been developed to reinforce and increase the knowledge level of the target audiences to enable the audience to make informed decisions to change their behaviors and practices. These messages will promote healthy behavior and improve care seeking practices through behavior change communication/knowledge management. The materials will mainly focus on maternal health, child health and Family Planning. The set of materials should be designed in way to cater to the needs of different target audiences starting from NGOs, to service providers, general users and beneficiaries. The materials will be designed, based on audience research, to convey the benefit of the behavior, encourage discussion around the behavior and thus create new social norms in the communities to sustain the behavior.

Correct and complete knowledge is the first step to behavior change. Considering the stages of behavior change we know that knowledge and awareness is the first step followed by approval of the behavior, intention to act, trying the behavior, successfully completing the desired behavior, internalizing and continuing the behavior consistently over time, and, ultimately, promoting the behavior to others.

Message priorities:

The program mandate is to continue to promote healthy behaviors with an increased emphasis on the following priority areas:

- Promote knowledge of and access to LARC/PM and healthy timing and spacing of pregnancies (HTSP)
- Promote safe motherhood and optimum nutrition among pregnant women and young children
- Improve essential and sick newborn care
- Increase demand for acute respiratory infection (ARI) treatment
- Promote early and exclusive breastfeeding, complementary feeding, and hygiene (especially hand washing practices for newborn and child health and survival).

To achieve the above, messages will focus on the priority health behaviors listed above, but will also:

- Ensure that information is provided on all services available in the ESP;
- Stress the range and affordable price of services available from SH clinics and providers;
- Promote SH clinics and providers as friendly and caring;
- Encourage people to take responsibility for their own health through practices they can perform at home and through adhering to ANC/PNC best practices; and
- Encourage dialogue between spouses, within families and among the community as a whole to foster healthy behaviors which become social norms within these communities.

Message framing:
BCC materials

Materials and messages were prioritized to include nine key materials: five of which were updated and reproduced, and an four new materials. The materials are packaged and distributed with an orientation package on how to use these materials in an optimal manner at both the clinic and outreach opportunities.This will ensure the quality, accuracy and consistency of messages and reduce duplication of messages.

The following chart describes the BCC materials to be produced:

BCC Materials			
Print materials A set of print materials developed, focusing on FP, child and maternal health to reach the target audience and to assist the SH clinic staff and outreach workers to conduct more efficient and effective IPCC sessions.			
Materials	**Key messages**	**Target audience**	**Distribution/ Promotion Plan**
Brochure: A brochure on FP will be developed focusing on LARC/PMs.	The brochure will detail the available LARC/PMs and their advantages, side effects, etc.	The target audiences are the men & women of reproductive age residing in both urban and rural areas and the clinic staff and service providers who will use these materials in their IPCC sessions.	SH clinics and service providers to distribute among end users during IPCC sessions

Materials	Key messages	Target audience	Distribution/ Promotion Plan
Flip chart A flip chart will be developed on FP methods to inform the target audience regarding the available methods and the pros and cons of using the specific method. This flip chart will be used by the health workers/service providers to counsel with their clients	The key messages will contain the currently available FP methods especially LARC/PMs, the benefits of using it and the best suitable methods for a couple.	The primary target audiences are the health workers and service providers. The secondary target audience are the men & women of reproductive age	Service provider of SH clinic
Poster A poster will be developed on child health with special focus to combat diarrheal diseases.	The poster will promote healthy behaviors with an increased emphasis on BCC focused dos and don'ts to prevent and cure diarrhea.	The primary target audiences are the parents and caregivers of children under the age of five. The secondary target audiences are the teachers, service providers and other influential members of the family.	NGO clinic and outlets of health service providers
Wall calendar A wall calendar will be developed on child health to promote healthy behavior especially on nutrition.	The key messages will be related to nutrition especially supplementary foods, weight, nutrition status and dos and don'ts related to nutrition.	The primary target audiences are the parents and caregivers of children under the age of five. The secondary target audiences are the teachers, service providers and other influential members of the family.	SH Clinics and service providers to distribute among the parents/ end users.
Information card An information card will be developed on child health to disseminate some of the most important issues related to child health.	The key message will contain dangers sign and symptoms for a child, when to refer to hospital, preventive and curative care etc.	The primary target audiences are service providers of NGO clinics. The secondary target audience are the parents and caregivers of children	Service providers to use when counseling parents
Skin to skin care card This child health related card will be developed with a focus to reduce neonatal mortality and promote proper care for the newborn	The key messages will promote skin to skin care to reduce neonatal mortality, the benefits of skin to skin care and the dos and don'ts regarding newborn care.	The primary target audiences are the mothers and parents of the newborn. The secondary target audiences are the elders, influential family members, doctor, clinics and service providers	Clinic, service providers, end users
Leaflet A leaflet will be developed on Maternal Health to promote desired behavior regarding ANC/PNC and healthy practice for pregnant mothers	The key messages will contain information on regular checkups for pregnant mothers, its benefits, the available services of SH clinics, some do's and don'ts for a pregnant mother.	The primary target audiences are pregnant mothers, women of reproductive age. The secondary target audiences are the husbands, elders, other family members and peer groups.	General population, end users

Materials	Key messages	Target audience	Distribution/ Promotion Plan
EOC card An EOC card will be adapted/developed on maternal health with the objective of reducing maternal mortality	The key messages will contain the danger signs of pregnancy, the critical issues during pregnancy and some other do's and don'ts to reduce maternal and neonatal mortality	The primary target audiences are the pregnant mothers, women of reproductive age. The secondary target audiences are the husbands, elders, other family members and peer groups.	SH clinic to distribute among the users
Location Signboard A location sign board will be developed and installed in the vicinity to promote SH clinic and to inform the people regarding the availability and location of SH clinics	The key message will contain the availability of SH clinics and its friendly atmosphere to provide health services	General population of the vicinity	Vicinity/ locality of SH clinic

Table 11

Media Channels

Materials	Key messages	Target audience	Distribution/ Promotion Plan
Mass Media Mass media is an effective medium to reach the general population. An integrated approach consisting of TV, radio, press, magazines, etc. can bring synergy in the campaign and achieve the desired results.			
TV Spots TV is an importantchannel toattract the attention of the audience. For NHSDP, two new TVCs can be developed with specific messages. It will be possible to reach the audiences from different demographic and socio economic segments.	Two TVCs with key messages focusing on two issues- 1. Create awareness about the available services of SH Clinics and its friendly atmosphere. 2. To encourage people to visit SH Clinics and avail themselves of the health services.	The Primary Target audience of this TVC will be the men and women who live in urban and rural areas and come from a lower middle class to middle class economic background. The secondary audience will be the elders, other influential family members, social leaders, local entities and the general population	TV Channels including BTV and satellite channels, Local Cable Networks, Clinics for display in CD/DVD, health workers to include in theeToolkit (if available)
TV Magazine – Adolescent health program with Channel-i	Technical Assistance to produce a 26 episode program on adolescent reproductive health topics	Primary target audience is adolescents	Broadcast weekly through Channel-i TV.
Radio Spots (RDC); It is developed and aired to disseminate messages especially in remote places where other media can't reach. It is a very effective medium to reach the audience of different	The key messages of the RDC will focus on two issues- 1. Create awareness about the available services of SH clinics and its cordial atmosphere.	The primary target audience will be the people of both urban and rural areas and come from a lower middle class to middle class economic quantum.	Public Radio channels (Bangladesh Betar), FM Radio channels.

Materials	Key messages	Target audience	Distribution/ Promotion Plan
socioeconomic strata asradio is becoming more popular. Through public radio channels and community radio channels it is possible to reach the audience of rural and remote areas. Through FM radio channels it is possible to reachan urban population of different ages and income segment.	2. To encourage people to visit SH Clinics and avail of health services.	The secondary audience will be the elders, other influential family members, social leaders, local entities and general population	
News articles In print and electronic media	Informing about the health care services available at SH clinics including the location of the clinic. Focus on priority services and quality care, especially for the poor delivered from the SH clinics	The literate, relatively well-off and aware persons of the community who read newspapers and watch TV and can also pass the information to their family members, peers, relatives and neighbors	Mobilize journalists of print and electronic media and make clinic visits by them to create stories and publish/broadcast it in the newspaper/TV channel
Press ads Press ads can be published in the daily newspaper and local newspaper to reach the educated groups of society.	The key message of the press ad will focus on informing about the existence of SH clinics and its friendly atmosphere. It will also encourage the audience to avail themselves of the services from SH clinics.	The primary target audiences are the educated people of lower middle, middle and upper middle income segments of the society who reside in both urban and semi urban areas. The secondary audience will be the students, youths, social/religious leaders and other influential members of the society.	Daily newspapers and local newspapers with high circulation
Advertisement in magazines Advertisement can be published in famous magazines or health related magazines which will reach the target audience of different levelsespecially females, health workers and service providers.	The key message of these ads will focus oninforming people regarding the existence of SH clinics and its friendly atmosphere. It will also encourage the audience to avail themselves of the services from SH clinics.	Educated people specially females, students, health workers and service providers	Popular magazines, Health-related magazines

Table 12

12. Project Dissemination Plan

USAID wants to ensure that both the achievements of the NHSDP project and the funding source of the project are disseminated nationally. This sectionis a subset of the BCC Strategy but has a separate purpose and intent. As discussed with USAID, this is part of the Modification No. 2 to the contract, specifically section "D.3 Communication Strategy." The project will adhere to the Branding Implementation and Marking Plan guidelines for co-branding of all project materials and commodities with USAID and DFID's logos. It is a marketing plan for all public events, press releases, social media, TV and radio news programs, talk shows or discussions, outdoor media, PSAs and any public promotion of the program and its achievements which will be prominently branded with the tagline in writing or verbally, "This assistance is from the American People" and "From the Department of International Development" (UK).

The sections below address the four components required under "D.3 Communication Strategy" in Modification #2:

Key messages

The key messages can include, but are not limited to, the following illustrative messages:

- The Smiling Sun program is designed to benefit the men women and children of Bangladesh through improved healthy behaviors.
- The Smiling Sun program supports 388 clinics and 3300 health workers in facilities while 7348 part time workers are in the community all across the country to provide quality health services at an affordable price.
- The Smiling Sun program has achieved XXX (TBD and tailored to program achievements to be publicized in a timely manner as news items).

All of the illustrative messages would end with the written or spoken tag line with some variation of "Brought to youby (or "this assistance is from") the American People and the Department of International Development" (or "from the British people"). The final messages will be developed, pre-tested and finalized in close coordination with USAID.

Key Target Audiences:

- General public
- Media
- Youth
- Government officials
- Other donors

Channels for dissemination of messages and project promotion

- TV and radio spots
- Newspaper ads
- Press releases
- Social media including Facebook and Twitter
- Newspaper articles

- TV talk shows, round tables and forums
- Public service announcements
- Articles in popular magazines and newspaper supplements
- Articles in College and University publications
- Speeches of local officials in project catchment areas

Illustrative calendar and timeline for events

In some cases this component will be opportunistic and use existing events to disseminate information about the program and its achievements. It is also recommended that the program work with well-known TV and radio personalities who are hosts of popular talk shows and the COP and other project stakeholders appear as guests on these shows to discuss and promote the program and its achievements. Once a relationship is established the program can provide a steady stream of guests for the talk show including USAID officials, Ministry officials, project partners, etc. all of whom can discuss various aspects and achievements of the program and promote it and the donors supporting the program.

Newspaper articles and advertisements can be developed and run on a weekly basis highlighting the program achievements and successes.

Stories can be developed for popular Bangladeshi websites and the US Embassy and USAID/Bangladesh Facebook pages and the public encouraged to “like” and comment on these stories.

13. Monitoring and Evaluation

There is a need for low-cost, sustainable and ongoing M&E systems and strategies to ensure ongoing and timely feedback and measuring the success and impact of all BCC and IPCC interventions in addition to the planned surveys. These could include use of standard protocols and tools for self-assessment and peer assessment for providers as well as mystery client and exit interviews to assess IPCC skills ability from both the providers and clients’ perspective. Random exit interviews of clients leaving clinics or attending events to get their reactions to the event and retention and attitude toward any messages will also help to gauge program impact and allow for mid-course corrections if needed.

To measure the reach and effectiveness of community level outreach, events and BCC interventions, simple questionnaires will be developed to assess knowledge of location and types of services available and through which channels or events people were made aware of these services. Monitoring and feedback on BCC and IPCC interventions will also be incorporated into SMS systems as described above.

Program Managers at the national level will develop simple tools and checklists for use during their regular monitoring visits as an ongoing means of monitoring the compliance with IPCC protocols, along with other indicators of success including number and success of community events and partnerships conducted/developed during their regular monitoring.

National level MRE Strategies:

The following table proposes a tentative list of BCC indicators corresponding to the NHSDP Sub-IR to be checked periodically:

Sub-IR	Approach	Indicator	Activity
Sub-IR 2.1: Healthy behaviors and care seeking practices improved through BCC/KM.	› Capacity building › Awareness › Monitoring	› % of women who communicate regularly about FP with their husbands › % of women and men who have heard of at least one LARC/PM › % of clinics that have at least one service provider trained in IPCC to include BCC messages while counseling on ESP interventions › # of BCC materials (e.g., print messages, radio spots) developed/adapted from BCC WG-identified best practices and resources › % of clinics with monitoring systems (e.g., mystery client) to assess quality of counseling services implemented › BCC strategies harmonized across community and health facilities with other USAID project	› Capacity Building: › Provide training in IPCC to improve counseling › Synchronized BCC messages for service providers › Awareness: › Develop, adapt and disseminate BCC key messages › Build awareness on healthy behaviors and care seeking practices
Sub-IR 2.2: Communities are actively engaged in promotion of healthy behaviors and care seeking practices.	› Community support system › Networking › Monitoring	› % of targeted communities reporting increased satisfaction with NGO clinic services › % of communities served by clinics supported by groups of mobilized local influential stakeholders › % of clinics linked with community groups that participate in health planning & mobilization activities	› Community support system: › -Mobilized local influential stakeholders › Networking: › - NGO clinics are linked with community groups

Table 13

Local level M&E Strategies:

The following table illustrates proposed local level participatory monitoringprocesses corresponding to BCC baseline indicators:

Task indicators	Activities	Target group	Resources	Monitoring tools	Frequency
1. Spousal communication on FP	› Counseling › Campaigns › Peer education › Courtyard meeting	› FP users and non-users	› BCC materials › Training guidelines › Logistics	› Checklist › FP record books	Monthly
2. Knowledge of LARC/PM	› Counseling › Campaign › Home visits › Courtyard meeting	› FP users and non-users	› BCC materials › Outreach coordination › Logistics	› Checklist › Service record books	Per visit

Task indicators	Activities	Target group	Resources	Monitoring tools	Frequency
3. Knowledge of the five components of essential newborn care	› ANC and PNC Counseling › TBA training › Courtyard meeting	› Pregnant mothers and other family members	› Training guidelines › BCC materials › Logistics	› Checklists for counselors › Self-assessment	Quarterly
4. Knowledge of early and exclusive breastfeeding	› Social intervention › Counseling › Courtyard meeting	› Lactating mothers › In-laws	› BCC materials › Logistics	› Forms/ checklists	Per visit
5. Knowledge of the five danger signs of pregnancy	› Counseling pregnant mother › Training of root level health worker	› Pregnant mothers and other family members	› BCC materials › Logistics › Outreach coordination	› Checklists › Training module	Per activity
6. Knowledge of the three delays for childbirth	› Counseling family members › Referral system	› Couples and newlyweds, low parity couplesand other family members, pregnant women?	› BCC materials › Outreach coordination	› Checklists › Referral form	Monthly
7. Promotion of safe delivery kits for home deliveries	› Skills of TBA › Availability of delivery kits	› Pregnant mothers and other family members	› Training guidelines › Provision of supply	› Records/ Forms	Quarterly
8. Promotion of Mayer Bank as part of birth planning	› Client advocacy › Introduce promotional activities	› Reproductive age women, pregnant women	› Advocacy › BCC materials › ICT training	› Checklists › Training module	Per visit

Table 14

The following table illustrates proposed quantitative evaluation methods corresponding to BCC baseline indicators:

Task indicators	Output/Major Activities	Means of Verification	Resources/ Person Involved	Frequency
1. Spousal communication on FP	› Group Counseling › Campaign › Peer Education	› Assessment › Survey › Interview of peers (spouse)	› NGOs and Consultant	Mid-term and endline
2. Knowledge of LARC/PM	› Group Counseling › Campaign › Client Visits	› Assessment › Sample survey › Analysis of register books	› Project implementation team	Periodic and endline

Task indicators	Output/Major Activities	Means of Verification	Resources/ Person Involved	Frequency
3. Knowledge of the five components of essential newborn care	› Training › Counseling › ANC & PNC provision	› Interview of Participants › Survey on exit client › Record books assessment	› Training team › Consultant	Periodic and endline
4. Knowledge of early and exclusive breastfeeding	› Social intervention › Counseling	› Interviews of key informant › Assessment	› Supervisors	Periodic
5. Knowledge of the five danger signs of pregnancy	› Counseling pregnant mother › Training of root level health worker	› Assessment through record book › Participant reaction forms	› Supervisors › Training team	Periodic and endline
6. Knowledge of the three delays for childbirth	› Counseling family members › Referral system	› Household Survey › Assessment of referral forms	› Consultant › Supervisor	Periodic and endline
7. Promotion of safe delivery kits for home deliveries	› Skills of TBA › Availability of delivery kits	› User review assessment › Stock inventory	› Project implementation team › Procurement personnel	Mid-term and endline
8. Promotion of Mayer Bank as part of birth planning	› Client advocacy › Introduce promotional activities	› User survey › Assessment of promotional material	› Consultant › Supervisor	Mid-term and end-line

Table 15

14. Appendix

14.1 Appendix 1: Strategy Development Process

Assessments:

Three studies were conducted to assess key BCC needs of the program:

- BCC and KM Capacity Assessment of NGO personnel
- IPCC Training Needs Assessment of NGO service staff
- Assessment and selection of BCC materials

(See Appendix A for the detailed findings of these assessments)

The findings of both the BCC and KM Capacity Assessment and the IPCC Training Needs Assessment confirmed the need for training. It was evident that the majority of frontline personnel were new or had not had any IPCC training in five to six years on average. In addition, the key client orientation and counseling materials such as the flipchart were not being used or used incorrectly.

Knowledge of BCC/KM is low and the personnel have very limited ideas about the standard communication processes and the importance of local level outreach/campaigns nor do they possess the ability to conceptualize such campaigns to make maximum use of local resources and national programs. There has been turnover of staff at the local NGO level and this has resulted in loss of institutional memory as well as lack of or outdated training and orientation on best practices, especially in the area of IPCC. Additionally, there is little understanding of KM concepts and systems. Also missing are any benchmarks or M&E indicators that could help to measure whether their communication objectives are being met.

The analysis of the BCC materials needs assessment found a total of 272 materials gathered from a sample of clinics with much duplication of messages, incorrect or conflicting messages and outdated messages based on previous indicators and program priorities. To promote NHSDP priority service areas, adopt innovative approaches in message dissemination and avoid duplication, this strategy proposes helping the NGOs as well as NHSDP to select appropriate messages for promoting priority health services.

One-to-One with the key informants and field visit

The strategy team also met with key national partners of the program, MoHFW officials, NHSDP Management, USAID, and visited two Smiling Sun clinics in Dhaka to gain input and insights into the strategy development. The meetings with MoHFW and national partners reaffirmed the opportunities to leverage existing programs and the need to ensure synergies among the various programs. The clinic visits helped to confirm the findings of the studies and provided further insight into the needs of the Clinic Managers and the frontline staff in terms of BCC and IPCC training and the need for consistent and updated BCC materials.

Consultative Workshop on development of NHSDP BCC/KM Strategy

After collating the results of these assessments and developing recommendations, these were shared with key NHSDP program staff, NGO managers and staff, national partners, USAID, MoHFW, and journalists in a day-long Consultative Workshop on the Development of the NHSDP BCC Strategy held on October 7, 2013. The workshop participants were divided into groups by topic and tasked with reviewing the study results and coming up with a list of gaps in institutional

capacity and recommendations to address those gaps. This was then opened up for discussion and comments by all participants, the results of which are incorporated in this strategy, along with the findings of the three assessment studies.

The key findings from this meeting are as follows:

Overarching Issues:

- Lack of training
- Poor information flow
- Inconsistency in knowledge and information
- Duplication of materials
- Conflicting messages / too much information
- Lack of guidelines/policy for use at a variety of levels
- Poor information sharing between levels
- Too much work / lack of time / lack of recognition
- Time consuming recording / reporting of client data
- Weak collaboration
- Poor supervision / M&E

Overarching Recommendations:

- Improved cross-sectoral communication and partnership
- Mapping private & public sector partnership opportunities (working with local business)
- Standardization and coordination of materials and guidelines (BCC, M&E, Training) for systematic use
- Customized outreach for the poorest of the poor
- Better utilization of existing groups, local resources, media
- Active participation in the BCC Working Group

Desk review

In addition, all recent MoHFW BCC strategies for specific health components which match the health areas mandated by the project were reviewed to ensure consistency and harmony with these strategies. (See Appendix B).

14.2 Appendix 2: Assessment report of Capacity for BCC and Knowledge Management of the NGOs

Introduction:

BCCP is responsible to lead BCC activities and enhancing NGOs capacity to deliver quality BCC messages that will generate demand, enhance service uptake, and promote healthy household practices. BCCP will provide technical assistance and quality assurance to the NGOs to strengthen their capacity to develop, disseminate and evaluate behavior change information and knowledge management systems at the local level.

In view of the above perspective NHSDP need to formulate a BCC strategy harmonized across communities and health facilities and other USAID project for BCC efforts to promote healthy practices and increased demand for ESP services; and to support the NGOs' in planning, implementation, monitoring and evaluation of BCC activities. In order to develop the BCC strategy that harmonizes across the communities and health facilities, an assessment of capacity for BCC and Knowledge Management (KM) of the NGOs has been conducted with a BCC capacity assessment tool. This capacity assessment is the first step of the strategic communication planning process.

BCCP analyzed the assessment and compiled the findings to identify the BCC and KM needs, gaps and area that need support to strengthening NGOs communication and KM capacity. BCCP generate this report that guide conceptualization of the BCC strategy framework for NHSDP.

Objective of the assessment:

Objective of this assessment of BCC and Knowledge Management capacity of the NGOs is to understand their existing strength, area that needs improvement on disseminating accurate and persuasive messages to stimulate demand and adoption of health practices; identify and address community perspectives on barriers to service uptake and behavior change; and to utilize community - led approaches with the aim to develop BCC strategy.

This assessment had the following objectives:

- To gather information on NGOs needs to strengthen capacity on BCC and KM
- To identify the BCC and KM related training needs of the service providers
- To compile and synthesize the findings, and recommend a set of activities for NHSDP BCC Strategy

Process/methodology follow:

BCCP conducted focus group discussions (FGDs) with the 9 selected NGOs serving different region of Bangladesh for rapid assessment of their capacity to implement facility and community-based BCC strategies and on knowledge management. BCCP use the JHU-CCP's Institutional Capacity Assessment Tool (ICAT) as a base for developing the FGD guidelines to conduct focus group discussions with the NGOs. The participants of these FGDs were both from project management and service providers level who involved from providing strategic direction to plan and implement BCC activities of the SH clinics for promoting healthy practices, increase demand for ESP services and in establishing community support groups. BCCP conducted 9

FGDs with 9 different NGOs those delivering services in urban and rural setting in different regions of Bangladesh and having different type of clinics i.e. ultra and vital. The participants of each FGD limit to 8 -15, and a total of 79 participants those includes Project Director, Project Manager, Monitoring Officer, Clinic Manager and Service Promoter attended the FGDs.

Key findings:

To assess the BCC and KM capacity the information has been gathered mostly on following components:

Component 1: Understanding the context through Situation Analysis i.e evidence-based and theory-or model-driven planning and design

This section analyzes capacity and practice of the NGOs to conduct situation analysis for design and implementation of BCC program; and strategy of the NGOs to collaborate with other partners in BCC activity development plan.

The assessment revealed that the NGOs are organizing BCC program mostly following the guideline provided from central level by the ShurjerHashi (SH) project. They usually do not conduct situation analysis specifically for BCC program but occasionally they need to conduct the analysis when there is program requirement. They conduct this analysis when any specific ESP service such as ANC, PNC, LA/PM etc. failed to meet its projected number of customer, when the NGO plan to organize special program/health camp in area like slums, school or when they need to observe special days for service promotion.

The NGOs are following their business plan and reviewing their monthly performances on a regular basis that guide them to understand the service gap but no situation analysis has been done in last one year that focusing especially on BCC.

The NGOs are not familiar with any BCC frameworks or models for situation analysis but some of the NGOs used to follow the BCC analysis format shared with them by the SH project for developing their BCC marketing plan. They regularly review their clinic based service performances and take initiatives to promote low performing services more through their regular BCC activities.

The NGOs are mostly design their program following their clinic performance/MIS report findings. They also collect the district level data on FP performance to assess their contribution and in some rare instance (during national day observation) also use data from other source such as the BDHS data.

The BCC activities of the NGO clinics are taken placed within their catchment population. At local level they are aware about the presence of other USAID and non USAID funded program. But collaboration with these programs for BCC activities is not usually carried out unless there is programmatic collaboration- such as with MAMA project for ANC checkup or with SOUHARDO project to use their network for service promotion. The NGOs are also collaborating with public and private school to promote TT program and work very closely with Government to celebrate special days such as World population Day, Safe Motherhood day, World AIDS day etc to avoid duplication.

Component 2: The Communication Strategy

This section analyzes capacity and practice of the NGOs to develop BCC strategy, audience focused BCC program, design SMART communication objective and address situation that create barrier in accessing services.

The NGOs are not used to develop communication strategy for their program and are not very familiar with all the necessary components of a communication strategy. However in past programs (NSDP and SSFP) based on their experiences sometimes they have shared their views about effective BCC intervention with the staff of SH project management partners.

With few exceptions the NGOs are not practice to tailor audience specific BCC program and message but they strongly acknowledge the importance of audience specific message and program. They mentioned that information need varies for different category of audience considering their health need versus educational status, socio-cultural and religious factors. They mentioned that to reach the customer effectively it is needed to provide message considering specific information need of the specific group of audience to draw their attention.

Most of the NGOs stated that though the BCC program designed/outlined by the SH project at central level but during implementation at local level/ at their catchment area they have the opportunity to set their own priority based on their local need. They always focus on the BCC intervention that address issue specific barriers and also assist to bring positive change for their audience though they are not able to set SMART objective always due to lack of their enough knowledge on BCC.

To address the behavioral barrier in the community for example /such as low practice of institutional delivery the NGOs conducted IPC at household and family level to create awareness, established liaison with the community leader and motivate them for their support to address the rituals and myths exist as social barrier. The NGOs also use their community service providers (CSP) as a source of information at the community and also at client level as ANC mothers are not always exposed to information when service promoter is male.

Component 3: Materials Development

This section analyzes capacity of the NGOs to develop BCC materials for IPC/C, ensure quality of the materials use and plan for effective use of BCC materials. With few exception the NGOs does not develop original materials. However in few instance under SSFP some developed special service promotion materials such as leaflet for ANC mother with information of their home delivery service; plan BCC program and develop leaflet to celebrate special days (World Health Day, World Population Day, Safe Motherhood Day etc) at local level in collaboration with the government.

All the NGOs mentioned that they maintained good inventory of BCC materials for stock taking, to track the material use by type, as well as to assess the need for reprint considering the program necessity.

As the NGOs by themselves developed BCC massages or materials a little hence they have no experience of developing creative brief before drafting the messages or engaging audience in material development process. But they stated that following the process for message and material development such as develop creative brief, ensure audience participation, pretest the BCC message and materials are important elements for developing effective and right message. They mentioned that the process also helped to reach the audience with specific message that would draw their interest/attention.

The NGOs have a system for internal review of the materials developed by them by their

Technical staff such as doctor. But they have little experience on '7c' of message development.

NGOs are mostly use the BCC materials those developed by the SH project and rarely use some materials developed under government programs and use those without reviewing by technical staff as these are government approved materials.

Component 4: Implementation, Management, and Leadership in SBCC

Sub-component 1: Work plan development

The NGOs are developing their communication work plan both at clinic and headquarter level on a quarterly basis by involving the Project Director, Project Manager, and respective clinic manager and service promoters. Project headquarter provide the outline of BCC activities on a yearly basis considering the SH project guideline and budget allocated for BCC. At clinic level the respective clinic manager and service promoters review the monthly performances of the clinic on a regular basis then revisit their quarterly work plan to make monthly plan that address the low performing services or promote special offer. However the NGOs/SH clinics do not usually practice to plan any innovative BCC activities due to lack of expertise and also for not having enough flexibility of doing so.

The budget for BCC intervention is allocated by clinic from project headquarters on a yearly basis. The NGOs mentioned that the budget for BCC intervention is not always sufficient to carry out significant activities as proposed by them and they need to tailor made their BCC activities with the allocated budget. In a very small scale some NGO also generate resource from the community. At clinic level the service promoters (SP) are responsible to carry out the BCC activities at the community with the support of their Community Service Providers (CSP). The SPs are having their monthly field activity plan that includes BCC activity too. The BCC materials are mostly use by the CSP and SP at the community level and by the counselor and doctors/paramedics at clinic level. They used to link materials and activities to the issue they need to address.

The NGOs are having moderate to strong collaboration with government facility and with other service delivery facilities for both inbound and outbound referral and services – such as refer client who want to have FP permanent method, refer pregnant mother who need cesarean operation , collaborate with government for EPI session etc.

Sub-component 2: Staffing plans and competencies

NGOs response on capacity and skills of management staff to manage and implement BCC programs varies widely from not at all to almost all. However majority mentioned that though BCC is a special skill but as a manager they also have the experience to implement BCC programs considerably with set guidelines.

Response about technical staff's capacity and skills to develop and implement BCC programs also varies. The NGOs mentioned that they have no staff positioned as "BCC Expert" in their program, moreover frequent turnover of technical staff and service promoters challenged them further. The respective clinic manager and service promoters are mostly responsible to implement BCC program as per given guideline but rarely involved in BCC program development.

The entire respondent mentioned that capacity development on BCC is one of the important components they have considered for strengthening their staff's capacity and has planned accordingly.

They expressed their requirement for basic BCC and Marketing training for the SPs and CSPs; Inter Personal Communication (IPC)

training for the Counselor, Paramedic and Doctor and Strategic Communication training for the PD and PM. Some also expressed their need to develop their skill in writing of success stories that could be used for staff motivation.

Sub-component 3: Supervision of field workers

The clinic managers are responsible to follow up the BCC activities of the SP and CSPs at the field level, besides the respective PM also conducted field visit regularly to oversee the field activities. They mostly observed whether activities are implemented as planned or not and to some extent also identify what support needed by the staff in BCC intervention. Some of the NGO also use their own checklist for ease to analyze the strength and area of improvement of their staff. BCC materials are also use by the SP and CSP at the outreach activities of the clinics and use and distribution of these materials are also observed during field level supervision.

Component 5: Monitoring, Evaluation, and Re-planning of SBCC Programs

This section analyze the availability and use of M&E indicators that measure BCC activities

Sub-component 1: Frameworks and mechanisms for measurement

The NGOs are not having any specific set of M&E indicators to measure behavior linked to communication objectives or tools to collect and measure M&E data for BCC programs. However in monthly reporting format they mentioned the number of BCC activities they have conducted and in monitoring checklist there are indicators to see what number of customers are contacted with service message, what BCC /marketing activities contribute in increasing customer in clinics etc. The exit interview tool, suggestion box also provide some information about how much BCC activities assist in creating service demand.

The NGOs has the practice to analyze the monthly report and monitoring visit findings and provide necessary feedback to the clinics including those for BCC activities.

Sub-component 2: Use of results for re-planning

Practice of the NGOs to document and disseminate BCC programs' results, lessons learned, and best practices varies. Some mentioned that they have good documentation system for BCC program and the others mentioned they also document the BCC program considerably. Most of the NGOs responded that they use the monitoring findings on BCC intervention for further planning to address the program/BCC gap and to improve their performance. The NGOs also occasionally shared their success stories for dissemination.

It is noted that the NGO staff are not able to mention the program priority of NHSDP without assistance of the facilitator.

Assessing KM Capacity

This section analyzes the practice of the NGOs in sharing and exchange of knowledge and existing system to identify the knowledge gap.

Component 1: The KM Process

The NGOs are not very familiar with the concepts of knowledge management but as a part of program they have practice to share and exchange knowledge among SH network. They acknowledged that knowledge, information, and data are useful for developing effective programs and activities and have their own mechanism to identify the knowledge gaps of their staff such as through observation, using QMS tool, assessing the technical and non-technical staff with written test or talking on specific topic.

Based on the results of various form of assessment knowledge gaps are identified

and the NGOs, to some extent, take initiative to address this gap by arranging issue specific discussion in weekly and monthly meeting, On the Job Training (OJT), organizing mock practice with the staff when receive any new materials or message for dissemination etc. But they mentioned that these efforts are not sufficient for their staff.

Component 2: Management and Leadership in KM

None of the NGO has any management plan or strategy that directly focusing to share public health contribution of its knowledge resources, or to develop strategies to disseminate and promote these resources and lessons learned, especially to other government units or organizations working in the same field. But they have participated extensively in all national and local level program related to public health.

The NGOs consider learning as an effective way to strengthen existing skills and build new skills among staff always looking for any such opportunities that assist them to increase their service quality.

Component 3: KM Culture

Weekly meeting, monthly meeting, SurjerHasi Health group are some opportunity the NGOs mentioned as their internal forum for knowledge sharing and exchange among staff.

The NGOs does not mention any external forum for knowledge sharing and exchange among staff but they have attended monthly district coordination meeting where they have the opportunity to share or updated with new technical or programmatic information from other stakeholders and government counterpart.

The NGOs also organize health program at school and community, organize meeting with the social elite and community influential that also contribute in knowledge sharing with the stakeholders at different level.

The staff members at the HQ level are familiar with the objectives of the organization, current status of those objectives, and also have clear understanding what activities will lead to the achievement. But in case of local level staff members this understanding level varies commonly considering their duration of involvement with the project, and their responsibilities and familiarity with overall project activities.

The attitude towards accepting new idea and technology also varies among the staff considering their individual willingness to learn. None of the NGO currently has any strategy to deliver BCC programs through digital platforms but they are displaying information/ message using VCD at the clinic waiting room, at tea stall and using multimedia and projector at community level. The NGOs are also marketing their services using e-mail facility.

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Component 4: Monitoring, Evaluation, and Re-planning of KM Programs

Majority of the NGOs has no system, no indicator or use any standardized tools to collect and analyze M&E data for knowledge management. Sometimes the NGOs share their lesson learned or success stories within their SH network and in district coordination meeting.

Finalizing Scores

The average score achieved by the NGOs on different components through this assessment are given bellow:

Components	Maximum scores	Average score achieved
Component 1: Understanding the Context through Situation Analysis Sub-component 1: Evidence-based and theory-driven planning and design	16	9.2
Component 2: Focusing and Designing the Communication Strategy Sub-component 1: Development of strategies	12	6.4
Component 3: Creating Interventions and Materials for Change Sub-component 1: Materials development	28	10.1
Component 4: Implementing and Monitoring Change Processes Sub-component 1: Developing a work plan Sub-component 2: Staffing plans and competencies Sub-component 3: Supervision of field workers	36	28.2
Component 5: Evaluating and Replanting Sub-component 1: Using results for re-planning	20	11.3
Total Score (112)	112	65.3
Component 1: The KM Process	28	13
Component 2: Management and Leadership in KM	12	6.3
Component 3: KM Culture	32	18.78
Component 4: Monitoring, Evaluation, and Re-planning of KM Programs Does the organization have a specific set of M&E indicators linked to KM objectives?	20	6.44
Total Score (92)	**92**	**44.56**

Gap:

- The NGOs are not familiar with any standard model or framework to assess their BCC need considering community perception and requirement but some of the NGOs used to follow the BCC analysis format shared with them by the SH project for developing their BCC marketing plan.
- The NGOs are mostly involved in implementation of BCC activities that designed at central level by SH project rather than design a comprehensive BCC program by themselves following the process. At clinic level they review their clinic performance/MIS report to identify the low performing services for promotion.
- With few exceptions the NGOs are not practice to tailor audience specific BCC program and message though they strongly acknowledge the importance of audience specific message and program
- The NGOs have no expert on BCC at their management level and are not very familiar with all necessary component of communication strategy, they guide the program based on their program experience
- Some NGOs are developing BCC materials with their own resources, such as posters, leaflets etc at local level but they do not follow material development process i.e. creative brief, audience participation etc or consider 7c for message development

- BCC is not always carried out as a tool for bringing change in health seeking practice of the community as a whole rather the NGOs focus their BCC activities to increase clinic performance only
- NGOs are not applying any special BCC intervention to reach the hard to reach group and the poor
- Most of the NGO management have a long experience in health care activities but their internal capacity to develop staff's skill on BCC is not sufficient
- Each NGO expressed their need for building capacity of their field workers on BCC as very few received training on BCC in last program (SSFP) and they also have newly recruited staff
- There is no standard checklist to monitor and assess the BCC intervention at clinic/NGO level on a regular basis that assist to identify the gap and direct the change / type of support needed.
- The NGOs are not having any specific set of M&E indicators to measure behavior linked to communication objectives or tools to collect and measure M&E data for BCC programs
- None of the NGO has experience in institutionalize knowledge management as a strategy for learning and documenting expertise
- The NGOs are not very familiar with the concepts of knowledge management but as a part of program they practice to share and exchange knowledge among SH network
- The NGOs has no system, no indicator or use any standardized tools to collect and analyze M&E data for knowledge management.

Summary of needs/areas for improvement

BCC Capacity	
Component 1: Understanding the Context through Situation Analysis *(Evidence-based and theory- or model-driven planning and design)*	
Key issues	Summary of needs/areas for improvement
• Has a situation analysis been done? • Are tools, theories and/or models, and data used for program design? • Are reviews conducted of what is being done by local stakeholders?	Need to increase skill in assessing problem, audience and communication capacity for BCC intervention following proven model/theory.
Component 2: Focusing and Designing the Communication Strategy *(Development of strategies)*	
Key issues	Summary of needs/areas for improvement
• Is there a communication strategy that is segmented by audience and has clear communication objectives? • Does the communication strategy propose using multiple channels that are mutually reinforcing to reach audiences? • Does the communication strategy address different levels of influence on the problem?	Need to build capacity to understand the components of strategic communication, SMART communication objective and selection of different media.

Component 3: Creating Interventions & Materials for Change *(Material development)*	
Key issues	Summary of needs/areas for improvement
• Is a design process followed? • Is there an inventory of current materials? • Do concept testing, pretesting, stakeholder review, and field testing form part of material development?	Need to build capacity on designing message concept following process and involving the audience for effectiveness.
Component 4: Implementing and Monitoring Change Processes *(Developing a workplan)*	
Key issues	Summary of needs/areas for improvement
• Are there linkages to other programs and partners? • Is budgeting done during work planning? • Are the materials developed linked to and reinforce main messages in the communication strategy?	Need to give emphasis on establishing functional linkage with other program and partners. Need to increase staff capacity on effective delivery of BCC activities.
Component 5: Evaluating and Re-planning *(Using results for preplanning)*	
Key issues	Summary of needs/areas for improvement
• Are results documented and disseminated? • Is analyzed data communicated to partners? • Are data used to improve programs?	Need to develop BCC indicators to evaluate and disseminate the result for improvement of to show success.
KM Capacity	
• KM Process • KM culture • KM strategy	A new concept for the NGO. Need orientation/guidance on how to institutionalize this concept for creating a learning and experience sharing environment.

Key recommendations

Each of the NGO give emphasis on strengthening their capacity in designing comprehensive intervention and effective implementation of BCC activities based on their individual requirement which they believe would add value to their performance. The key recommendations from this assessment are as follows:

- Each NGO should have their internal expertise to understand all necessary component of communication strategy to guide the BCC program strategically
- All clinics should have a standard BCC strategy implementation guideline
- The NGO should have a system to assess their BCC need at the community including hard to reach group, tailor their BCC program to bring desire change at their catchment area keeping the program priority into consideration
- The NGO should have a standard monitoring tool for BCC intervention and there should be specific BCC indicators for evaluation
- Each of the NGO should have internal mechanism to strengthen BCC capacity of the service providers and promoters, in addition to their technical ability, to enable them to interact with the customers with friendly manner, and equip them with
- The cadre of BCC field force i.e. service promoters should receive intensive IPC/C and BCC training which will help them in motivating clients specially the poor to practice healthy behavior and promote the service at local level
- The NGO need to strengthen their capacity to design a well-planned intervention for involving/mobilizing the community through outreach activity
- The NGO need to strengthen their capacity to coordinate with relevant stakeholders for disseminating their lesson learned and success stories and also to find out opportunities for using their network for BCC
- Considering the needs and expectations of the clients all the clinic should have a strong collaboration and referral linkage with other health service center/hospital.
- Each of the NGO should orient on the basic concept of knowledge management to consider with priority to ensure learning as a continuous process
- NGO need to build knowledge management as a part of their service delivery and BCC activity that enriched service quality andinnovativeness

Next steps:

The findings revealed from this assessment will be used in formulation of BCC strategy of NHSDP involving a group of expert as panel. This will guide to plan for systematically strengthen NGOs' in-house capacity to plan, implement, monitor, and evaluate BCC activities that support ESP use, healthy household practices and social norms; strengthen links between facility and community-based BCC activities and utilize current networks of community based workers.

The next step of this activity is to organize a consultative meeting with the relevant stakeholders to share the BCC capacity assessment findings and gather their views and suggestions about the outline and proposed contents of the strategy. Following that the expert group will work to develop the draft strategy and will share with relevant stakeholders for their feedback to finalize.

Conclusion:

Capacity building encompasses human resource development which is an essential part for the efficient and effective implementation of community development programs hence for a BCC strategy. Building capacity ensures improved knowledge, attitudes, behaviors and providers' performance. The findings of this capacity assessment will assist to formulating the BCC strategy for NHSDP that empowered the NGOs to take responsibility and ownership of their BCC interventions for results-oriented outcomes and impact.

Sl. No	Name and address of the NGOs	Number of districts covered by the NGO	Number of clinics by type		
			Ultra	Vital	EMoC
1.	SWANIRVAR, Dhaka	40	3	49	2
2.	BAMANEH, Dhaka	10	7	13	2
3.	PSTC, Dhaka	32	5	18	3
4.	SHIMANTIC, Zokiganj, Sylhet	1	-	6	-
5.	FDSR, Jamtola Bazar, Karnaphuly, Chittagong	5	3	7	5
6.	KanchanSamity, New Town , Dinajpur	5	-	10	4
7.	SUS, Chittagong	1	-	6	-
8.	CRC, Khalishpur, Khulna	2	-	5	-
9.	UPGMS, Mulatola, Rangpur	3	-	5	-

14.3 Appendix 3: Documents Referenced

1. Assessment and selection of BCC materials, NHSDP-BCC Team of Bangladesh Center for Communication Programs, 2013
2. Behavior Change Communication and Knowledge Management Capacity Assessment of NGO personnel, NHSDP-BCC Team of Bangladesh Center for Communication Programs, 2013
3. Bangladesh Communication Strategy Reviews, Bangladesh Communication Working Group Strategy Review sub-group, 22 November,2011.
4. Bangladesh Smiling Sun Franchise Program Impact Evaluation Report, Measure Evaluation funded by USAID.
5. Communication Strategies and Operational Plans for Health, Population and Nutrition in Bangladesh: Synergies, Gaps and opportunities for Improved Outcomes (draft), Summary Report by Bangladesh Communication (BCC) Working Group, February 2012.
6. Improving the uptake of Long-Acting and Permanent Methods in the Family Planning Program, BCC Strategic Approach, 2010-2015, Directorate General of family Planning, Dhaka, Bangladesh, Final Draft-November 2010.
7. Interpersonal Communication and Counseling Training Needs Assessment of NGO service staff, NHSDP-BCC Team of Bangladesh Center for Communication Programs, 2013
8. Key Elements for Scaling up the Community Support System in Bangladesh, CARE Bangladesh, June 2011.
9. National Communication Framework and Plan for Infant and Young Child Feeding in Bangladesh, Institute of Public Health Nutrition (IPHN), Directorate General of Health Services, Ministry of Health and Family Welfare.
10. Strategic Plan for Health, Population and Nutrition sector Development Program (HPNSDP) 2011-2016, Planning Wing, Ministry of Health and Family Welfare, Government of the People's Republic of Bangladesh, February 2011.
11. The National Communication Strategy for Family Planning and Reproductive Health, Directorate General of Family Planning, Ministry of Health and Family Welfare, Dhaka, Bangladesh, November 2008.
12. USAID/Bangladesh: Smiling Sun Franchise Program (SSFP), Mid-term Assessment, April 2010