



Comprehensive
Social and
Behavior Change
Communication Strategy
Ministry of Health and Family Welfare

Health

Nutrition

Population

Comprehensive
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Ministry of Health and Family Welfare

2016

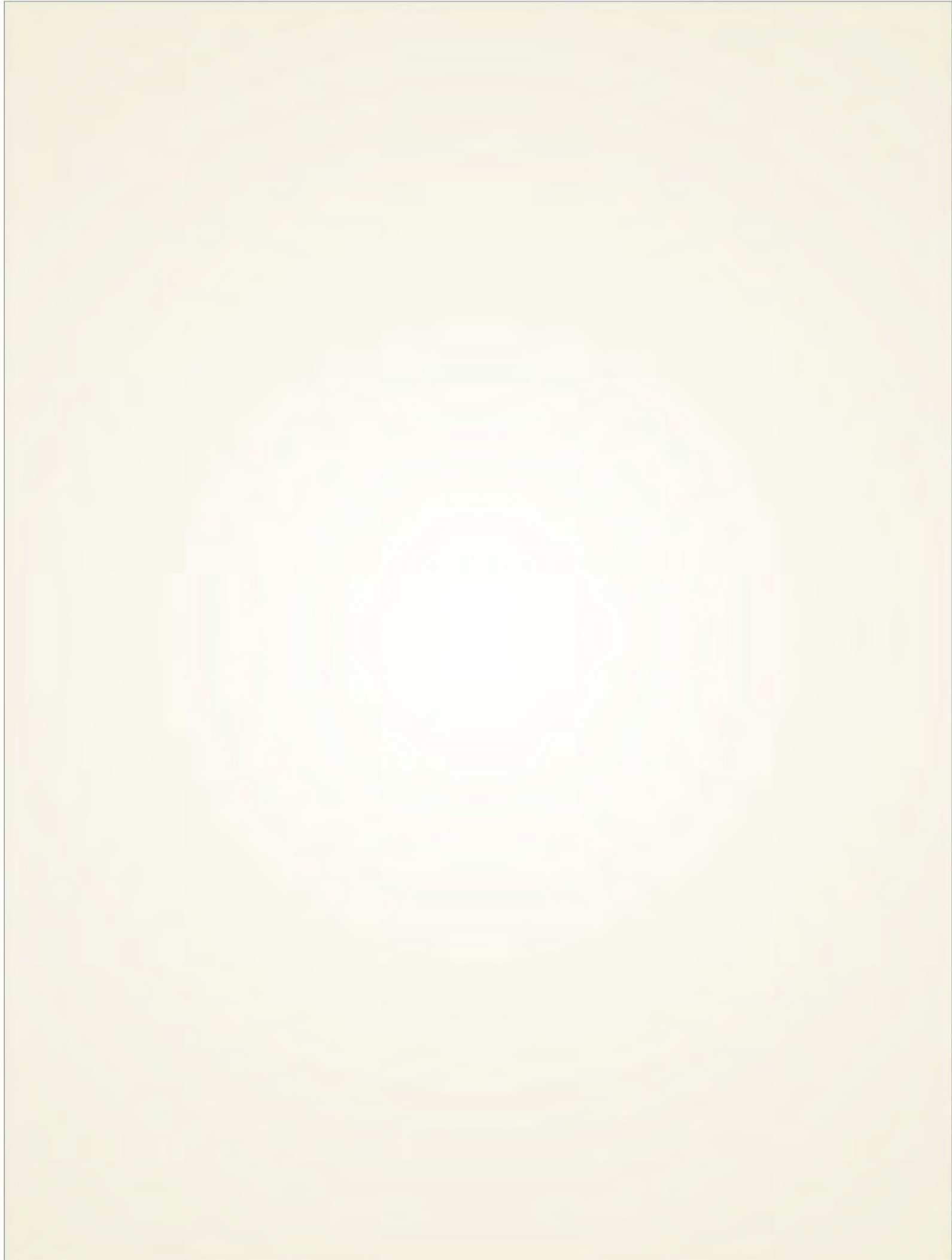


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Mohammed Nasim, MP
Minister
Ministry of Health and Family Welfare
Govt. of the People's Republic of Bangladesh



Message

I am pleased to see that this Comprehensive Social and Behavior Change Communication (SBCC) Strategy has been developed to guide the implementation of SBCC activities in Bangladesh.

Bangladesh has achieved remarkable success in the health sector. This success has been possible because of the contribution of all stakeholders. Now we have to place more emphasis on SBCC so that we will achieve the targets of the Sustainable Development Goals.

This Strategy will help to maintain coordination among different SBCC activities by different stakeholders. As our resources are limited, we need to work strategically and with a common vision for high-quality, effective SBCC.

I am happy to see that experts from different sectors provided their valuable input for the development of the Strategy.

I am also impressed to know that an Action Plan has already been developed for the proper implementation of this Strategy. I expect cooperation and support from all stakeholders to implement this strategy.

I am grateful to all who were involved in developing this Strategy.

I hope this Strategy will play an important role for the well-being of all the people of Bangladesh.

Joy Bangla, Joy Bangabandhu.

Long live Bangladesh.

(Mohammed Nasim, MP)



Zahid Maleque, MP
State Minister
Ministry of Health and Family Welfare
Govt. of the People's Republic of Bangladesh



Message

The development of this Comprehensive Social and Behavior Change Communication (SBCC) Strategy is a very timely initiative. This is the first ever SBCC Strategy in Bangladesh. This policy level strategy will guide different directorates and units to develop their own communication strategies.

Bangladesh has been a role model in the developing world for making substantial progress in achieving MDG targets. I hope this Strategy will facilitate achieving the targets of Sustainable Development Goals over the next fifteen years. It will give us direction for the maximum utilization of our knowledge, expertise, technology, tools and resources.

I believe that this Strategy will contribute effectively for the development of the Health, Population and Nutrition sector of Bangladesh. I am very much optimistic that it lead us for doing SBCC activities in a planned, coordinated and strategic way. Its success depends on all stakeholders adopting it as a guiding document for their SBCC activities through cooperation & collaboration.

I appreciate the hard work of the professionals involved in the development of the Strategy, and hope that it will be utilized properly.

Joy Bangla, Joy Bangabandhu.

Long live Bangladesh.

(Zahid Maleque, MP)

Syed Monjurul Islam
Secretary
Ministry of Health and Family Welfare
Govt. of the People's Republic of Bangladesh



Foreword

Bangladesh has shown impressive progress to achieve several of the Millennium Development Goals (MDG). We need to continue to work hard and build on this success so that we can also achieve the Sustainable Development Goals (SDG). Many of the SDG indicators will be reached at least in part by motivating healthy behaviors at the community and household levels, and by shifting social norms to support the health and well-being of all Bangladeshis. Considering this context, this Comprehensive Social and Behavior Change Communication (SBCC) Strategy has been developed.

Now we need to implement the Strategy according to the action plan contained in this document. I urge all stakeholders to follow and use this strategy as it will guide the SBCC activities of the next sector program, and will align the SBCC efforts of government, non-government, development partner and other stakeholders.

I am grateful to all who made it possible to develop this strategy.

(Syed Monjurul Islam)



Roxana Quader
Additional Secretary (PH&WH)
Ministry of Health and Family Welfare
Govt. of the People's Republic of Bangladesh



Acknowledgement

The Comprehensive Social and Behavior Change Communication (SBCC) Strategy has been developed to serve as a guiding document for the effective implementation of high-quality SBCC activities under the 2016-2021 sector plan. The highly participatory process of developing this strategy brought together key representatives from the Ministry of Information; Ministry of Social Welfare; Ministry of Women and Child Affairs; Urban Primary Healthcare Service Delivery Project of the Ministry of Local Government and Rural Development; and of course the Ministry of Health and Family Welfare (MoHFW). The senior level representatives from MoHFW's Planning Division, directors, line directors, and other senior officials from the Directorate General of Health Services (DGHS) and Directorate General of Family Planning (DGFP) provided their time and input for preparing this important document. I am really grateful to all of them.

The three communication units of MoHFW, Bureau of Health Education (BHE), and Institute of Public Health Nutrition (IPHN) of DGHS; and Information, Education, and Motivation (IEM) Unit of DGFP, led the three functional subgroups and were directly involved in preparing this document. We thank all of them individually for their valuable time and contribution.

I sincerely recognize the cooperation and valuable suggestions provided by the honorable Secretary, MoHFW Mr Syed Monjurul Islam in finalizing the strategy.

I also can't forget the contributions of two of my colleagues Mr Abdul Malek, Joint Secretary (Public Health-2), and Dr Nasreen Khan, Technical Support on Nutrition, Public Health and WHO Wing, MoHFW. Many thanks to both of them.

The critical role played by the USAID-funded Bangladesh Knowledge Management Initiative (BKMI) – in conceptualizing the content of the strategy, preparing an outline in consultation with other partners, and working hand in hand with BHE, IPHN and IEM Unit for undertaking a Health, Population and Nutrition (HPN) landscape analysis; coordinating among the three functional subgroups and facilitating rigorous stakeholder consultations; and finally developing an Action Plan for implementing the strategy involving a wide range of stakeholders – cannot go unmentioned. Due to their untiring effort and hard work, this strategy be completed within the short stipulated timeframe. Our sincere gratitude goes to them for their contribution and continued support.

We earnestly recognize the support and input of development partners, particularly USAID, WHO, UNICEF, UNFPA, WFP, DFID.

Special mention must be made to other key actors who have contributed in the development of this document, such as Alive & Thrive, Save the Children, Brac, BCCP, BBC Media Action, Asiatic- Marketing Company Limited, Helen Keller International and SPRING. We thank them for their time and input.

Finally, we would like to emphasize that developing a strategy is not the end in itself, rather a pathway towards a theory-based, consistent, coordinated and audience-specific SBCC. We hope that the concerned government and non-government stakeholders will utilize this strategy to strengthen their SBCC interventions. The government and non-government sector who will prepare and implement topic-specific or project-specific SBCC strategies for health, population and nutrition are responsible for aligning their strategies with this MoHFW-level Comprehensive SBCC Strategy.



(Roxana Quader)

Acronyms

AAYO	Advanced Adolescent and Youth Organization
ACSM	Advocacy, Communication, and Social Mobilization
AI	Avian Influenza
AIN	Aquaculture for Income and Nutrition
ANC	Antenatal Care
ARH	Adolescent Reproductive Health
ARI	Acute Respiratory Infections
ASOD	Assistance for Social Organization and Development
BBS	Bangladesh Bureau of Statistics
BCCP	Bangladesh Center for Communication Programs
BCCWG	Behavior Change Communication Working Group
BCG	Bacillus Calmette-Guerin vaccine
BDHS	Bangladesh Demographic and Health Survey
BEES	Bangladesh Extension Education Services
BHE	Bureau of Health Education
BKMI	Bangladesh Knowledge Management Initiative
BMI	Body Mass Index
BMMS	Bangladesh Maternal Mortality and Health Care Survey
BNNC	Bangladesh National Nutrition Council
BTV	Bangladesh Television
CAG	Community Action Group
CC	Community Clinic
CCSDP	Clinical Contraception Service Delivery Programme
CEmOC	Comprehensive Emergency Obstetric Care
CHW	Community Based Health Worker
CIP	Country Investment Plan
CM	Community Mobilizer
CMAM	Community Based Management of Acute Malnutrition
CNCP	Comprehensive Newborn Care Package
COMBI	Communication for Behavioral Impact
CoP	Community of Practice
CPR	Contraceptive Prevalence Rate
CSA	Community Sales Agent
CSW	Commercial Sex Worker
CWFD	Concerned Women for Family Development
DFID	Department for International Development
DGFP	Directorate General of Family Planning
DGHS	Directorate General of Health Services
DOTS	Directly Observed Treatment, Short-course
DSK	Dushtha Shasthya Kendra

EBF	Exclusive Breast Feeding
ENC	Essential Newborn Care
EPI	Expanded Programme on Immunization
ESP	Essential Services Package
FAO	Food and Agriculture Organization
FP	Family Planning
FPAB	Family Planning Association of Bangladesh
FPMC	Food Planning and Monitoring Committee
FPMU	Food Planning Monitoring Unit
FWA	Family Welfare Assistant
FWC	Family Welfare Center
FWV	Family Welfare Visitor
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
GMP	Growth Monitoring and Promotion
GoB	Government of Bangladesh
H5N1	Avian Influenza
HAPP	HIV/AIDS Prevention Project
HASAB	HIV/AIDS and STD Alliance Bangladesh
HBB	Helping Babies Breathe
HEP	Health Education and Promotion
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome
HNP	Health, Nutrition and Population
HPNSDP	Health, Population, and Nutrition Sector Development Program
HNPSIP	Health, Nutrition and Population Sector Investment Plan
HSS	Health Systems Strengthening
HTSP	Healthy Timing and Spacing of Pregnancy
ICAAP	International Congress on AIDS in Asia and the Pacific
ICDDR,B	International Centre for Diarrhoeal Disease Research, Bangladesh
ICT	Information and Communications Technology
IDU	Injection Drug User
IEC	Information, Education, and Communication
IEC-OP	Information, Education, and Communication Operational Plan
IEDCR	Institute of Epidemiology, Disease Control and Research
IEM	Information, Education, and Motivation
IHME GBD	Institute for Health Metrics and Evaluation, Global Burden of Disease
IMR	Infant Mortality Rate
IPCC	Interpersonal Communication and Counseling
IPHN	Institute of Public Health Nutrition
IYCF	Infant and Young Child Feeding
KM	Knowledge Management
KAB	Knowledge, Attitude and Behavior

LAPM	Long Acting and Permanent Methods
LARC	Long Acting Reversible Contraceptives
LARC/PM	Long Acting Reversible Contraceptive and Permanent Methods
MARP	Most At-Risk Populations
MCH	Maternal and Child Health
MDG	Millennium Development Goal
MDR-TB	Multi Drug Resistant Tuberculosis
M&E	Monitoring and Evaluation
MIH	Marketing Innovation for Health
MIS	Management Information System
MMR	Maternal Mortality Ratio
MNCH	Maternal Neonatal and Child Health
MoEF	Ministry of Environment and Forests
MoFL	Ministry of Fisheries and Livestock
MoFood	Ministry of Food
MoHFW	Ministry of Health and Family Welfare
MoI	Ministry of Information
MoLGRD&C	Ministry of Local Government Rural Development and Cooperative
MoRA	Ministry of Religious Affairs
MoSW	Ministry of Social Welfare
MoWCA	Ministry of Women and Children Affairs
MoYS	Ministry of Youth and Sports
MOU	Memorandum of Understanding
MR	Menstrual Regulation
MSH	Management Sciences for Health
MSM	Men who have Sex with Men
MTR	Mid-Term Review
NASP	National AIDS/STD Programme
NATAB	National Anti-Tuberculosis Association of Bangladesh
NCD	Non Communicable Disease
NGO	Non-governmental Organization
NHPS	National Hygiene Promotion Strategy
NHSDP	NGO Health Service Delivery Project
NIPORT	National Institute of Population Research and Training
NNS	National Nutrition Service
NSV	Non-Scalpel Vasectomy
NTP	National Tuberculosis Control Programme
NWG	Nutrition Working Group
OP	Operational Plan
OPV	Oral Polio Vaccine
ORT	Oral Rehydration Therapy
PAC	Postabortion Care

PH	Public Health
PM	Permanent Method
PNC	Postnatal Care
PLA	Participatory Learning and Action
PPFP	Postpartum Family Planning
PSA	Public Service Announcement
RCC	Rolling Continuation Channel
RH	Reproductive Health
RIC	Resource Integration Center
SBA	Skilled Birth Attendant
SBCC	Social and Behavior Change Communication
SCNI	Steering Committee for Nutrition Implementation
SD	Standard Deviation
SEED	Society for Empowerment, Education and Development
SHIKHA	"Shisukekhawano" project
SMC	Social Marketing Company
SNL	Saving Newborn Lives
SPRING	Strengthening Partnerships, Results, and Innovations in Nutrition Globally
SRHR	Sexual and Reproductive Health and Rights
STI	Sexually Transmitted Infection
SUN	Scaling-Up Nutrition
TB	Tuberculosis
TBA	Traditional Birth Attendant
TFR	Total Fertility Rate
UHC	Upazila Health Complex
UHS	Urban Health Survey
UNFPA	United Nations Population Fund
UNICEF	United Nations International Children's Emergency Fund
UP	Union Parishad
URC	University Research Company, LLC
USAID	United States Agency for International Development
WASH	Water, Sanitation and Hygiene
WFP	World Food Programme
WHO	World Health Organization

Section A



Comprehensive SBCC Strategy for MoHFW

Introduction

Social and behavior change communication (SBCC) is a research-based, consultative process that uses communication to promote and facilitate behavior change, and to support the requisite social change for the purpose of improving health outcomes.

The Ministry of Health and Family Welfare (MoHFW) has prepared this Comprehensive SBCC Strategy (hereafter, “the Strategy”) as a guiding document to inform the communication strategies of government and non-government organizations and initiatives that are working in support of the Sector Investment Plan, so that strategies will be planned and designed in a consistent manner.

The Strategy will facilitate the delivery of consistent and harmonized messages on Health, Nutrition and Population (HNP); address the needs of specific audiences; encourage the use of information and communication technology (ICT); and improve coordination.

The Strategy promotes an evidence-based and strategic approach to SBCC that is audience-centered, and that focuses on changing behaviors and shifting social norms in order to improve health outcomes. Importantly, this Strategy acknowledges the many social and environmental factors that influence behaviors at the household and community levels.

The Strategy was developed following a participatory process. It is based on global SBCC best practices, and builds on the National Communication Framework for Effective Health, Population and Nutrition SBCC that was developed by the BCC Working Group and approved by the MoHFW.

Goals and Objectives

The Comprehensive SBCC Strategy¹ is designed to serve as a guiding document for the effective implementation of high-quality SBCC activities under the MoHFW Health, Nutrition and Population Sector Investment Plan (HNPSIP) 2016-2021². SBCC is implicated in several of the Strategic Objectives detailed in the HNPSIP, particularly to promote healthy behaviors at the household and community levels; to encourage social norms that support positive health behaviors and improved health outcomes; and to drive demand for services.

In particular, the Strategy will

- Define and promote a holistic definition of SBCC;
- Articulate a common vision for SBCC in Bangladesh;
- Discuss some of the current gaps that need to be addressed in order to achieve the vision;
- Describe what high-quality SBCC consists of and looks like;
- Connect key concepts from the National Framework for Effective SBCC, particularly approaches for coordination, capacity development and engaging with communities;
- Identify the desired initial outcomes and sustainable results of implementing the Strategy;
- Define terms and concepts for monitoring and evaluating SBCC; and
- Provide an implementation and monitoring framework for the Strategy.

¹ A Glossary of Terms is included in Annex 1.

² Health, Nutrition and Population Sector Investment Plan (HNPSIP) 2016-2021, Draft 1, November 2015

How will the Strategy be used?

The MoHFW, under the leadership of the office of the Additional Secretary (PH & WH), will be responsible for operationalizing the Strategy.

The Strategy will be used as the basis for developing MoHFW unit- or sector-specific detailed strategies or national strategic plans for health, population and nutrition. Topic-specific SBCC strategies will include explicit behavioral and social outcomes and implementation plans. An outline for topic-specific SBCC strategies is included in Annex 2.

The Strategy is intended for government and non-government program designers, implementers, technical working groups and others who are using SBCC to promote healthy behaviors. Program designers are responsible for aligning their strategies with the Strategy and any relevant topic-specific SBCC strategies.

Social and Behavior Change Communication

SBCC is the use of communication to influence individual and collective behaviors. Methods include interpersonal communication (IPC), community mobilization, mass media, ICT, and others.

Well-designed SBCC for health, population and nutrition employs an evidence-based, consultative process using communication to promote and facilitate behavior change and support social change for the purpose of improving health outcomes. It is driven by demographic and epidemiological data, as well as by an analysis of social norms, current behaviors, barriers and enablers to behavior change, and audience perspectives. This process should be iterative, with data from earlier rounds being used to inform and improve later rounds.

SBCC is guided by a Socio-Ecological Model that shows how behavior operates on and is influenced by five inter-connected levels: individuals; family and peer networks; communities; organizations; and policy environments.

Reflecting the Socio-Ecological Model, SBCC seeks to exert influence at five levels:

- **Individuals:** Improve knowledge, attitudes and other ideational factors that support the adoption and maintenance of desired healthy behaviors or the changing of unhealthy behaviors.
- **Family and peer networks:** Promote positive peer influence, social support, spousal communication, and intra-family communication.
- **Communities:** Mobilize a broad range of stakeholders including community leaders and health service providers to promote shared ownership and collective efficacy, and to strengthen social capital.
- **Organizations:** Influence organizations and social institutions to support behavior change and minimize barriers to behavior change.
- **Policy environments:** Advocate to mobilize resources; to generate social, religious and political commitment to achieve positive health outcomes; and to promote supportive cultural values and norms.



Vision for SBCC

In Bangladesh, coordinated and audience-centered SBCC improves knowledge, attitudes and practices for health, population and nutrition through a multi-level and multi-channel communication approach, a skilled workforce at all levels, and the use of appropriate communication technologies. It creates a supportive social and policy environment through changes in norms, roles (including gender roles), and policies.

Situation Analysis

Bangladesh has made significant strides in the health sector, and is on track to reach Millennium Development Goals 1, 4 and 5, including a steady rise in life expectancy at birth. However, improvements have not been uniform throughout the country and challenges remain. At the same time, attention is now turning to the Sustainable Development Goals, particularly Goal #3 which aims at ensuring healthy lives and promoting well-being for all at all ages.

The communication activities of the MoHFW target three main issues: health, nutrition and population. Though there is overlap between these areas, the structure of this document will correspond with these three issues. A full situation analysis with citations is included in Annex 3.

Health

Maternal, Neonatal & Child Health (MNCH)

The Maternal Mortality Ratio (MMR) has been reduced by 75% since 1990, to 170 deaths per 100,000 live births. The rate of institutional delivery is still significantly lower than that of home delivery, and women in the lowest quintiles rarely deliver at facilities. Only 31% of pregnant women complete the recommended four antenatal care (ANC) visits, and only 36% of mothers receive postnatal care (PNC) from a medically trained provider within 42 days of delivery (Bangladesh Demographic and Health Survey [BDHS] 2014). Barriers exist to both the supply of and demand for maternal health services. Current messaging methods include government and non-government organization-produced posters, flyers, fact sheets, newsletters, workshops, television and radio spots, and newspaper ads. Other organizations engage in meetings with local religious leaders; produce outreach videos shown in local bazaars and health complexes; conduct interpersonal counseling (IPC) during ANC visits cooking demonstrations, and home visits; use mobile phone text or voice messaging; and sell socially marketed MNCH products. Gaps include insufficient coordination among implementing partners at the field level; insufficient knowledge and skills and biased attitudes of service providers; insufficient demand generation for services; and the lack of integration of nutrition and family planning with MNCH

Certain conditions affecting children under five years of age have seen great improvement in Bangladesh, such as childhood immunizations and appropriate treatment of diagnosed acute respiratory infections (ARI) and diarrhea. As a result of the Expanded Program on Immunization (EPI), Bangladesh has seen immense success in vaccine coverage; 84% of children aged 12-23 months are fully vaccinated (BDHS 2014) and, by 12 months of age full vaccination coverage (FVC) is 82% (Coverage Evaluation Survey-2014). Additionally, significant strides have been made to reduce open defecation rates from 34% in 1990 to only 3% in 2012 (UNICEF Progress on Drinking Water and Sanitation 2014). While child mortality has decreased significantly, newborn mortality remains relatively high. Currently government and non-government organizations produce various informational materials such as flip charts, posters, flyers, fact sheets, newsletters, TV spots, drama serials, radio spots, cultural programs, mobile messaging programs, and newspaper ads to continue improving child health in the country. In the future topics that require increased and continued SBCC efforts to improve child health include water and sanitation practices; sustained commitment to immunization, including the introduction of new vaccinations; understanding the causes of neonatal mortality and morbidity, including traditional beliefs and practices which may run counter to best practices; and water safety to prevent drowning.

Adolescent Health

Bangladesh has the highest adolescent fertility rate in Asia, tied with Iraq at 83 births per 1,000 women ages 15-19 (The World Bank Data Pages, Adolescent Fertility Rate: <http://data.worldbank.org/indicator/SP.ADO.TFRT>). About 23% of the total population is adolescent. Nearly one-third of girls aged 15 to 19 years have already started childbearing. Early childbearing among teenagers is more common in rural areas and among adolescents in the lowest wealth quintiles. Child marriage is also associated with early first birth and close spacing between the first and second births. Unmet need for family planning among married adolescents is high compared to all married women. Overall, adolescent reproductive health issues are under-addressed for both married and unmarried females and males. Additional efforts are needed to address adolescent health, including provider sensitization on adolescent-friendly attitudes; improved access to health services for adolescents; community mobilization and support for adolescent health; linkages to psycho-social life skills and vocational training; a strong focus on nutrition, particularly for adolescent girls; and provision and utilization of health information among adolescents (married and unmarried, male and female). Issues around puberty and nutritional needs associated with puberty, especially among young women and issues of stigma of puberty-related practices for both men and women also need to be addressed. Activities may be facilitated through schools, youth clubs, youth friendly corners of health facilities, and other means. Studies and anecdotal information reveal that most unmarried girls wish to learn about reproductive health issues from close friends or family members; whereas, young men prefer learning about reproductive health issues from Internet sources, mobile phones or friends. These and other preferences should be taken into consideration when designing future SBCC initiatives.

Communicable Diseases

Communicable diseases of most concern in Bangladesh include tuberculosis, avian influenza, Nipah virus, seasonal influenza, dengue fever, black fever, and HIV/AIDS. Currently, peer education, IPC, and outreach are commonly-used approaches to disseminate information among key at-risk populations. Mass and traditional media have also been used, in addition to community theater productions, folk songs, talk shows, and documentaries with Bangladeshi celebrities. Gaps include the need for messaging that addresses specific audiences; insufficient focus on prevention; negative attitudes of providers toward patients; and the need for coordinated, sustained long-term campaigns.

Non-Communicable Diseases

Lifestyle changes such as more sedentary work and hobbies, poor diets, tobacco use and drug use, combined with air pollution, chemically-contaminated food, food choice environments skewed toward processed, low nutritional-quality snacks and drinks, poor water quality, and loss of natural areas, are contributing to substantial increases in morbidity and mortality rates due to non-communicable diseases (NCDs) such as diabetes, cerebrovascular disease and ischemic heart disease (IHME GBD 2013). Additionally, death from drowning, road injuries, snake bites and other insect bites have been on the rise. Bangladesh is already at an advanced stage of the epidemiologic transition to NCDs. Sixty-eight percent of deaths in Bangladesh are currently due to NCDs and other chronic health conditions including complications due to old age (BBS 2011). Current SBCC approaches for NCDs include injury prevention books for school children, water safety television programs, and awareness rallies. Gaps include the need for a holistic approach that focuses on prevention in addition to linkages to service delivery; the need for guidelines for balanced nutrition and appropriate physical exercise; and the need to target parents, children, public leaders and community stakeholders alike.

Population

The 2012 Population Policy prioritizes reduction in total fertility rate (TFR), increasing availability of family planning (FP) methods, promoting safe motherhood, achieving gender equity, harnessing the population's human resources capacity, and ensuring easy access to reproductive health information. The FP program in Bangladesh has been successful in increasing the contraceptive prevalence rate (CPR) to 63% and decreasing the TFR to 2.3. However, there are still challenges regarding discontinuation, suboptimal method mix, improper usage, lack of availability of all methods, lack of trained staff, and unmet need. These program weaknesses are reflected in the estimated 1.3 million menstrual regulation and illegal abortion procedures annually. Sharp geographic differences are also present in CPR and TFR. Two Divisions are just below replacement level fertility at 1.9, but Sylhet Division has a much higher TFR of 2.9. Sylhet Division also has the lowest CPR at 48%; Rangpur Division has the highest CPR at 70% (BDHS 2014). The contraceptive method mix is heavily skewed toward short-term methods, despite the fact that the desired family size is typically reached by a woman's early to mid-20s. Only 8% of the method mix is comprised of long-acting reversible contraceptives and permanent methods (LARC/PM) (BDHS 2011). Well-designed, evidence-based and effective SBCC is an essential component of a comprehensive strategy to generate FP demand, promote consistent and correct use of FP methods, promote healthy timing and spacing of pregnancies, help increase the age of marriage, and delay the first birth. Despite current SBCC efforts, myths and misperceptions continue to prevent use of certain FP methods, particularly LARC/PM. Current communication channels for FP messages include mass media, mobile technology, traditional media such as street theater, community film showings, pamphlets and posters, community mobilization, community meetings and IPC. Future SBCC activities should be targeted to and differ by audience, focusing on addressing the social and economic drivers of early marriage; overcoming knowledge gaps about and biases against some FP methods; recognizing the changing FP needs through the life-cycle; promoting post-partum FP, post-abortion and post-MR care; and the importance of male involvement in FP.

Nutrition

Chronic undernutrition has seen some reductions over the past fifteen years. Even with the reductions, overall rates of under-nutrition are alarmingly high. Socio-economic, geographic, and cultural barriers prevent implementation of recommended women's nutrition, exclusive breastfeeding, and complementary feeding practices (WFP Strategy 2012).

In Bangladesh, 36% of children under five are stunted, or too short for their age. Stunting disproportionately affects rural (38%) compared to urban children (31%). Sylhet has the highest rate of stunting at 50% and Khulna has the lowest at 28%. Fourteen percent of children are wasted, or too thin for their height. (BDHS 2014). Since the 2011 BDHS, the percentage of infants under six months of age who are exclusively breastfed dropped from 64% to 55% (BDHS 2014). Fifty-one percent of children age 6-59 months are anemic (BDHS 2011). Twenty-four percent of ever-married women age 15-49 are undernourished (BMI <18.5), while forty-two percent of ever-married women age 15-49 are anemic (BDHS 2011).

Currently, nutrition SBCC in Bangladesh is performed via IPC, group advocacy meetings, community outreach, television advertisements, mobile technology, theatre, printed materials, and the establishment of nutrition corners in service delivery sites. Future SBCC activities should focus on building family and community capacity to prevent, identify and manage malnutrition; teaching proper breastfeeding and complementary feeding practices; promoting dietary diversity for the whole family; supporting a life-cycle approach to nutrition; educating about micronutrient deficiency diseases, and teaching husbands and mothers-in-law how to support mothers to keep themselves and their children well-nourished.

Gender-Based Violence

The Violence against Women (VAW) Survey 2011 revealed that 87% of currently married women have experienced any type of violence by current husband, and 65% of married women experienced physical violence perpetrated by their current husbands in their lifetime. According to the World Bank (2009), VAW has severe and long-lasting human health implications due to fatal outcomes; acute and chronic physical injuries and disabilities; serious mental health problems; increased risk of further victimization; gynecological disorders; pregnancy- and labor-related complications, including miscarriages, pre-eclampsia, premature labor and low birth weight, unwanted pregnancies and obstetric complications; and HIV/AIDS. SBCC activities to deconstruct traditional and harmful gender norms and practices are ongoing. However they require further strengthening and a focused health sector response to VAW

Social and Behavior Change Communication (SBCC)

A broad range of stakeholders undertake SBCC activities for Health, Population and Nutrition in Bangladesh. The IEC Technical Committee, a mostly governmental body, oversees SBCC material approval prior to production and dissemination to ensure that all SBCC information is consistent with current MoHFW policies.

Coordinating at different levels; monitoring outcomes; and maintaining a high standard for quality (including counseling skills) are important challenges for SBCC in Bangladesh. To date, several actions have been taken to address these challenges.

To improve coordination at the central level, two groups have been established:

- (1) The BCC Working Group was created in 2011 as a platform for government, development partners, NGOs, private sector, academia, and the media to network, share experiences, build SBCC capacity, and coordinate. One key output from the BCC Working Group is the National Framework for Effective HPN SBCC, which was developed via an iterative and participatory process, and approved by the MoHFW in December 2013.
- (2) The HPN SBCC Coordination Committee was created in 2012 to promote SBCC coordination within the MoHFW.

In addition, digital archives in three Units of the DGFP and DGHS (IEM, BHE, IPHN) contribute to improved coordination by documenting and making existing SBCC materials available online. Providing these resources publicly reduces duplication and makes it easier for non-government actors to coordinate and align their SBCC activities with government initiatives.

To improve the quality of SBCC planning and design, an eToolkit and two eLearning courses for program managers have been developed. The eToolkit for program managers is an online collection of tools, guidelines, theories, models, curricula, templates, case studies and other resources to plan, design, implement, monitor and evaluate SBCC for health, family planning and nutrition. An eToolkit for field workers has also been developed as a consolidated, integrated collection of print and audio-visual SBCC materials for field workers and service providers to support and improve the quality of their counseling services. The eToolkit for field workers is updated annually by the BCC Working Group. An eLearning course for field workers with eight modules was developed to help them improve the consistency and accuracy of their health messages. Best practices for SBCC in Bangladesh are identified and shared annually at a Saffolo Gatha (Success Stories) event organized by the BCC Working Group.

Despite progress in improving SBCC in Bangladesh, there is still more to accomplish. The 2011 BDHS revealed that exposure to FP messages via all media types has been in decline for several years and is currently very low. While similar data are unavailable for other topics, this finding acts as a proxy that indicates that coverage, reach and quality of SBCC programming on many important health topics is insufficient.

Further gaps to address include the lack of a central communication database and resource center; unconsolidated SBCC functions within the MoHFW; duplicative parallel structures in the DGHS and DGFP; inconsistent coordination between Ministries; lack of capacity for coordination in both the government and NGO sectors; lack of communication between development partners and counterparts on the use of SBCC in programs; and a tendency for SBCC activities to be project-focused rather than audience-focused. Regulatory mechanisms by the MoHFW are needed to avoid unintentional duplication of materials and efforts. Strong communication systems are required to respond quickly to health emergencies including epidemic/pandemic threats, natural disasters and other crises. Communication will be an important element of introducing and promoting Universal Health Care (UHC). There is also an opportunity to expand the application of ICT, social media, and mobile technology for SBCC to reflect the government's vision for a Digital Bangladesh.

Significant additional resources are needed to adequately expand the MoHFW's ability to plan, design and implement SBCC to address not only the many current but also the emerging health issues; to increase exposure to health messages by specific target audiences; and to facilitate the adoption of healthy behaviors. In the HPNSDP 2011-2016, only 0.66% of the overall sector-wide budget was allocated for the Health Education and Promotion (HEP) Operational Plan (OP), and 0.61% was allocated for the Information, Education, Communication (IEC) OP.

Guiding principles

The following principles guide the Comprehensive SBCC Strategy for MoHFW and serve as the foundation upon which it rests. For communication to be strategic, it must be:

Adequately resourced

Strategic communication seeks to achieve healthy outcomes in efficient and cost-effective ways. SBCC planners must examine costs by the type of intervention, to try to achieve the optimal mix of activities and channels. SBCC activities and interventions should maximize available resources, while advocating for additional human, financial and material resources.

Evidence-based and data-driven

A science- and research-based approach to communication requires both accurate data and relevant theory. It begins with formative research and adequate data to define a specific health problem, identify feasible solutions, and describe the intended audience – to understand their context, view the health issue from their perspective, and find out factors that influence improved practices.

Strategic communication and health promotion efforts must be based on theoretical models, international and national research and tested innovations and best practices. This includes making the most productive use of appropriate technologies based on the audiences' needs and resources available to them. Research consistently shows evidence-based communication programs can increase knowledge, shift attitudes and cultural norms and produce changes in a wide variety of behaviors.

Audience-centered

An audience-centered approach requires understanding health needs from the client's point of view, and is grounded in a rights-based philosophy. Discussions with the potential audiences provide insights about those health needs and the barriers to meeting both expressed and unexpressed needs. Through research, especially qualitative research and participatory learning and action (PLA) techniques, members of the intended audience and community can help to identify the key factors to address and shape appropriate SBCC interventions, and can offer insights for other communication-related decisions that need to be made. The audience must perceive a clear benefit to them as a result of taking the action promoted by the communication effort.

An audience-centered approach also implies understanding strategic changes in central-level policy and programming that can affect the program. Priority audiences for health SBCC include young people (including very young adolescents; unmarried and married adolescents; and young parents); men (as both users and supporters of family planning); and socially marginalized groups. Audience analysis and programs must also take into consideration geographic and socio-economic differences when designing programs. SBCC should be leveraged to improve knowledge, attitudes, and behaviors among influential audiences, including healthcare providers, parents, and community leaders. In addition, health communication efforts must address the needs of the poor, marginalized and most vulnerable, who are too often ignored.

Based on theory

Theoretical models and frameworks can guide the strategic design process. The Socio-Ecological Model is a proven and comprehensive model that incorporates factors that influence behaviors and behavior change at the individual, interpersonal, community, structural and policy levels. It recognizes that individuals live in an environment that can enable or discourage healthy behaviors. The different levels interact in complex and multi-directional ways.

Many theories have been developed and validated. There is no single behavior change theory that is sufficient on its own. It is appropriate to use a combination of theories. Different aspects of an SBCC program may use different theories, depending on the audience, the communication and behavioral objectives, and other factors. Some common theories are listed in Annex 4.

Linked to service delivery

SBCC should provide audiences with complete information regarding service delivery after ensuring that the service delivery system is in place and of high quality. Health promotion efforts should identify and promote specific services, whether through health care delivery sites, service providers, brand name products, or ways to increase access to services and products. People should be well aware what services are available, of what quality, the time frame for getting the service and the cost of availing it. This approach reinforces the concept of individual self-efficacy, or the ability to resolve a problem oneself, and also supports the concept of collective self-efficacy, or the ability of a community to assert its will.

Based on a life cycle approach

Health is best viewed holistically, as a continuum of care that starts before birth and progresses cumulatively through childhood and adolescence to adulthood and old age. The life cycle approach encompasses people's health at every stage and in every aspect of their lives.

People at different stages of their lives constitute distinct audiences. They require different types of information and support, and sometimes different approaches, whether through interpersonal channels, community channels, mass media, ICT or others. Audience segmentation based on the life cycle promotes healthy choices at critical junctures in life based on what is most important and meaningful to people at those times.

Gender-sensitive

Programs and interventions should create opportunities for individuals to actively challenge prevailing gender norms, promote positions of social and political influence for women in communities, and address power inequities between persons of different genders. This effort should be a part of a continuum of gender integration, or the integration of gender issues into all aspects of program and policy conceptualization, development, implementation and evaluation.

SBCC efforts should foster critical examination of social and gender norms that negatively impact health outcomes and promote those social and gender norms that positively influence actions. The health benefits households and communities can enjoy when men and women work together as equal partners must be actively promoted.

Process-oriented

Process places a priority on "how" things are done. Following a tested and effective process provides a solid framework and a step-by-step iterative approach that is easily applied to strategy development, project implementation, technical assistance, institution building, and training. Process models such as ACADA communication planning process, Communication for Behavioral Impact (COMBI), P Process and others are all effective models used to design and implement strategic health communication programs (see Annex 5).

SBCC is an ongoing process of working with audiences to ensure they have the relevant information, and that they live in an enabling environment so they can take actions that sustain and improve their health. It builds on what has been done in the past and serves as the foundation for future efforts. The goal of the intervention is not to simply produce SBCC materials, but to engage in dialogue with audiences, address barriers to social and behavior change, and adapt the intervention as needed through an iterative process.

Comprehensive, with complementary and reinforcing approaches

Effective strategic communication uses a variety of channels and approaches. Communication strategies often integrate IPC, community-based channels, ICT and various mass and traditional media to create a dynamic, multi-directional exchange of information and ideas, along with appropriate follow-up. Additionally, research has shown that the effectiveness of messages being understood and acted upon increases with the number and type of channels used to disseminate them. The SBCC program will be comprehensive and reinforcing with consistent, complementary messages targeted to promote healthy behavior and also reduce the unhealthy practices of intended audiences.

Some examples of SBCC approaches include, but are not limited to, the following:

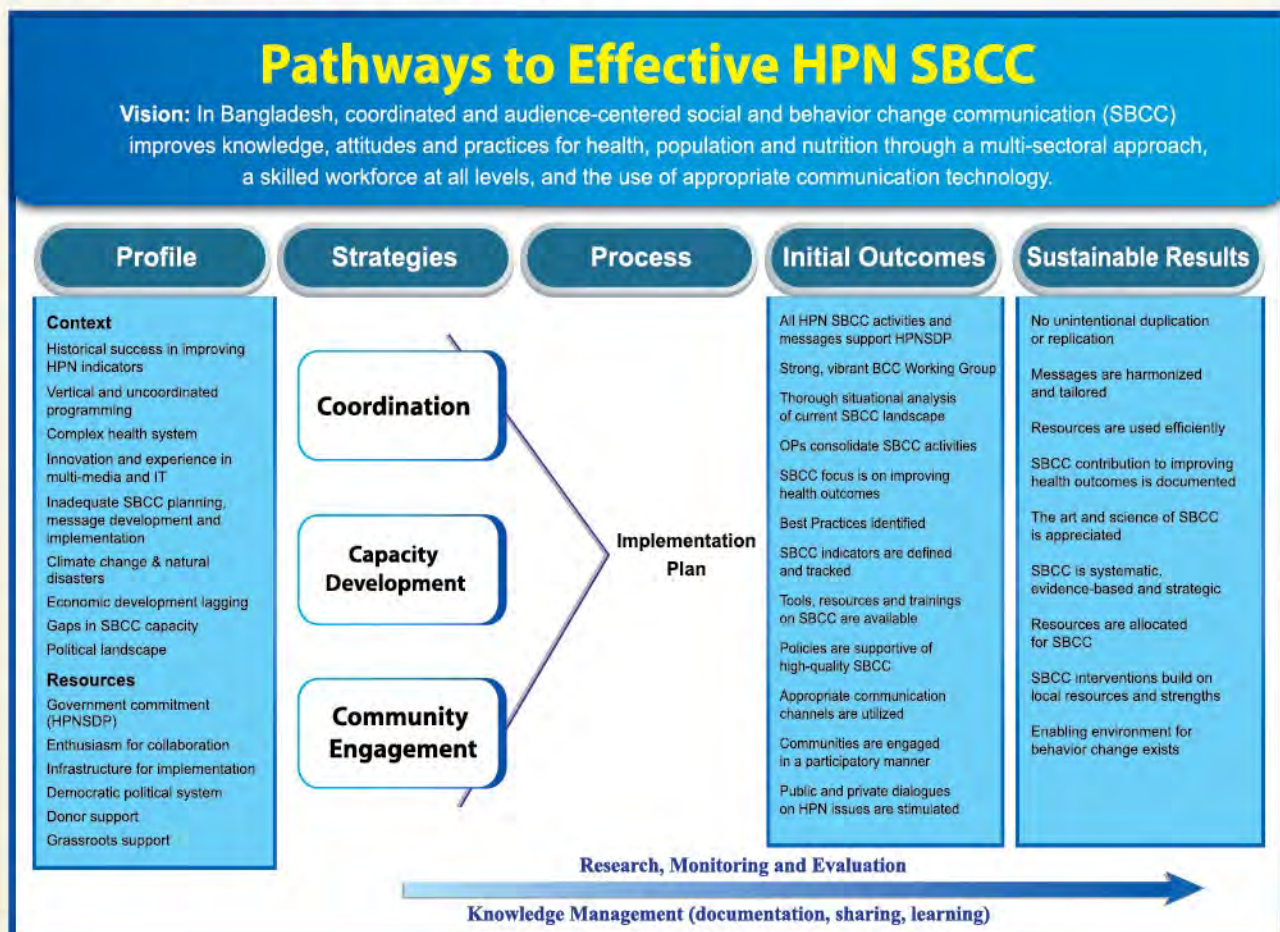
- Advocacy aims to secure leaders' commitment to policies and programs that support health and promote changes in social conditions that contribute to disease and vulnerability.

- Entertainment Education, based on traditional and popular culture and specific to the geographic context, entertains and engages while it transfers important messages and encourages dialogue and interaction. Channels include popular theater, puppetry, comics, music, dance, pageants, festivals, television or radio dramas, and more.
- ICT strategies leverage the growing access to ICT to reach a mass audience and facilitate multi-directional communication. This is especially effective in “media-dark” areas, and as a complement to other communication approaches. ICT includes mobile technology, social media, gaming, voice and text messaging, websites, and more. It is in line with the government’s vision for a Digital Bangladesh.
- Mass media, such as radio, TV, billboards, and newspapers, complement other media to raise awareness and increase knowledge of health concerns, stimulate audiences to seek services, and promote social norms that favor healthy practices.
- Social and community mobilization engages civil society and community organizations to promote social norms that support collective health objectives and challenge harmful practices.

Results-oriented

SBCC efforts should focus on producing positive behavioral outcomes for health, population and nutrition. Ultimately, positive behavioral outcomes (such as following recommended infant and young child feeding (IYCF) practices) will contribute to improvements in overall health outcomes (such as the lower rates of stunting). Research should be designed to gauge increases in audience knowledge, approval, and adoption of healthy behaviors.

National Framework for Effective SBCC



Purpose of the Pathways Framework

The National Framework for Effective HPN SBCC (hereafter, “the Framework”) assists all stakeholders to deliver consistent, reinforcing messages to priority audiences addressing key behaviors in support of the sector-wide plan. The Framework was developed by the BCC Working Group following a participatory, iterative process in close consultation with relevant key stakeholders and concerned experts including DGFP, DGHS, development partners, NGOs and civil society members. It was approved by MoHFW in December 2013.

The Framework consists of domains and approaches that can be used to align communication activities with GoB policies, strategies and plans. It identifies initial outcomes and long-term results of effective and coordinated SBCC. The Framework is a flexible and adaptable tool that can be used by any stakeholder to harmonize their individual SBCC strategies and activities with national priorities. A guideline for using the Framework is included in Annex 6.

The Framework identifies three key domains: Coordination, Capacity Development and Community Engagement. The three domains work hand-in-hand and reinforce each other to support high-quality, effective SBCC in support of the sector-wide plan.

Domain #1: Coordination

What is coordination?

Coordination encompasses aligning programs; sharing or pooling resources; harmonizing messages; conducting joint strategic planning; adapting and/or re-purposing SBCC materials; filling in programmatic gaps; designing complementary and reinforcing approaches; seeking opportunities for synergy; sharing research data and program learning widely so that others may benefit; promoting linkages with other programs and services; ensuring that local and national-level activities are complementary and reinforcing; and working collaboratively with the private sector. Strong SBCC coordination involves both horizontal and vertical efforts at all levels (from grassroots to national) and across development sectors.

Why is coordination important?

Coordination is a critical element for the successful implementation of SBCC programs. Good coordination can reduce duplication, cost and time; amplify effects; leverage resources; and create efficiencies. Coordination is needed to ensure that SBCC interventions align their messages and activities with national policies and guidelines. At the national level, coordination creates an environment where all stakeholders are aware of SBCC needs, trends and best practices. Ultimately, beneficiaries benefit from improved coordination when they receive consistent, accurate HPN information from multiple sources.

How is coordination done?

Networking is key to coordination. Through networking, different stakeholders can establish and nurture working relationships, and can look for opportunities to cooperate. Networking can be done in a number of ways, by meeting together, sharing newsletters, participating in e-mail or online networks, or meeting at seminars and conferences. For examples, in Bangladesh, executive heads of institutes may hold regular SBCC-specific steering committee meetings to facilitate coordination. Forums for networking and sharing, such as the BCC Working Group, allow stakeholders to leverage resources, and encourage stakeholders to be aware of, embrace and replicate innovative programs that are proven effective.

The BCC Working Group is an important mechanism for multi-sectoral coordination. To ensure its long-term sustainability, a Steering Committee led by MoHFW is needed. A Terms of Reference for the Steering Committee is included in Annex 7.



The HPN SBCC Coordination Committee is an important mechanism for coordination within MoHFW. To ensure its long-term sustainability, this committee needs to be institutionalized. A Terms of Reference for the HPN SBCC Coordination Committee is included in Annex 8.

To ensure synchronization across the multi-level and multi-segment stakeholders, it is essential that there is coordination at the highest levels of the government in collaboration with donors and NGOs.

Coordination can also be achieved through robust advocacy efforts to influence decision-making, and can serve as an effective tool to support coordination. Often, a persistent lack of understanding about SBCC activities results in SBCC not receiving full consideration during important decision-making. This highlights the need for the inclusion of an SBCC expert within MoHFW who can push the SBCC agenda outlined in this Strategy. Advocacy may be carried out at national to local levels, addressing both leadership and media to establish and ensure coordination. It is a continuous and adaptive process for gaining political and social commitment and can play a crucial role in proposing and implementing policies that would be beneficial in creating an enabling environment for social and behavior change across the various health areas.

Knowledge management (KM) is an important technique to promote tools that harmonize messages and minimize duplication. The eToolkit for Field Workers is one example of this. KM tools can be used to disseminate existing information and current SBCC materials and best practices in the field. This ensures that relevant data and materials are accessible and used for replication, or for new message and program design.

To facilitate coordination for SBCC in Bangladesh, a thorough landscaping of current SBCC activities is needed. Furthermore, all organizations involved in SBCC should participate in digital information sharing platforms, and must actively and regularly update their materials and activities.

Ultimately, SBCC coordination will be managed under the leadership of the office of Additional Secretary (PH & WH), MoHFW, which will clearly define horizontal and vertical mechanisms for coordination; sectors to be involved in SBCC coordination; and relevant institutions, organizations, and stakeholders in the various sectors.

Domain #2: Capacity Development

What is capacity development?

Capacity development for SBCC entails ensuring a high-performing workforce for SBCC at all levels:

- **Policymakers:** Value the full power of SBCC to address public health challenges; Appreciate the combination of art and science needed to produce high-quality SBCC; Allocate adequate human, financial and material resources for SBCC; Set high expectations for quality of SBCC programs; Create mechanisms for coordinating and aligning SBCC programs and messaging.
- **Program Planning and Design:** Use a proven, systematic process to conceptualize, plan and design SBCC programs that are audience-centered, evidence-based, coordinated and comprehensive; Identify appropriate communication and behavioral objectives and indicators for SBCC programs; Allocate program resources appropriately.
- **Program Management:** Implement, monitor and evaluate SBCC programs.
- **Program Delivery (including service providers, field workers and others):** Provide high-quality programs that are ethical, responsive to clients' needs and free from bias.

Capacity development is an ongoing process; as capacity is strengthened, the standard of quality is raised, which then requires further capacity development.

Why is capacity development important?

Strengthened capacity of SBCC practitioners and organizations will improve the quality of SBCC efforts, which will ultimately yield positive behavioral outcomes that contribute to overall improvements in health outcomes. Well-executed SBCC is data-driven, audience-centered and coordinated. It focuses on changing behavior, encouraging supportive social norms, linking clients to services, and closing the gap between knowledge and practice. It also includes a robust monitoring and evaluation system that identify specific indicators for process outputs and behavioral outcomes.

How is capacity development done?

Capacity development is needed for individuals, organizations and institutions, and for the entire SBCC system.

At the individual level, SBCC professionals' knowledge and skills can be strengthened through workshops, trainings, mentoring, networking, exposure visits, conferences, and other means, whether in-person (eg conferences) or virtually (eg eLearning, webinars, online networks). Knowledge and skills to be developed will vary greatly depending on the person's function. Examples include interpersonal communication and counseling; campaign design; message and materials development; use of ICT for SBCC; advocacy; community mobilization; monitoring and evaluation; supervision; PLA techniques; data analysis; coordination; leadership; and more.

The eToolkit and eLearning courses for SBCC Program Managers and Planners are resources for developing individual SBCC capacity.

At the organizational level, capacity development should focus on the processes, tools and structures that will make the organization viable and sustainable in the long run. Capacity can be strengthened through a variety of internal or external means, such as specialized consultancies; strategic planning; researching and modeling best practices and industry standards; and putting systems and routines in place. Importantly, an organizational culture and attitude of continuous change and improvement is essential. Creating a supportive organizational culture is the responsibility of senior leadership, and is carried out by every member of the organization, regardless of position.

Organizational competencies may include integrating SBCC with other program activities; quality assurance for SBCC; resource mobilization; program management; knowledge management; monitoring and evaluation; coordination with other stakeholders; governance; and advocacy, networking and alliance building.

The rapid growth of ICT provides opportunities for learning, sharing, dissemination, and two-way communication. Organizations must be skilled and adept at employing the latest innovations in ICT, including internet-based social media platforms.

At the system level, capacity development should focus on coordination of SBCC programs; ensuring alignment with MoHFW priorities; quality assurance; strengthening of distribution, monitoring and MIS systems; identification of best practices for SBCC in Bangladesh; integration of health, population and nutrition topics when appropriate; and coordination with other sectors and Ministries.

The office of the Additional Secretary (PH & WH), MoHFW, is responsible for operationalizing the Strategy and ensuring high-quality, coordinated SBCC programs that support the sector plan. Additional resources are needed in this office, including a budget and a number of skilled, long-term human resources with a strong baseline capacity in SBCC.

The existing IEC Technical Committee of MoHFW has a role to play in ensuring that SBCC messages and materials are correct, consistent and evidence-based, and that campaigns are coordinated and timed appropriately. If there are too many campaigns at the same time or the dissemination of conflicting messages this will create confusion and undermine credibility. The capacity of the IEC Technical Committee can be strengthened by digitizing the submission and approval process of SBCC materials; creating a system for sharing which materials have been approved by the IEC Technical Committee; and adding responsibility for coordination to the IEC Technical Committee.

Domain #3: Community Engagement

What is community engagement?

Community engagement refers to the process of engaging a broad range of stakeholders, communities and audience representatives to participate and build ownership of SBCC programs by identifying and working toward a collective vision. Community engagement is conducting a dialogue with the community, and encouraging dialogue within the community, rather than one-way, top-down communication. Community engagement requires a bottom-up approach in which the audience's context and perspectives drive decisions related to SBCC program planning and design.

Each community, irrespective of gender, socio-cultural and geographical variation, will promote SBCC through identifying needs and challenges and will address them in a participatory and sustainable manner.

Why is community engagement important?

In order to be effective, SBCC needs to strongly reflect communities' needs, priorities and context; communities need to own the program, and to believe strongly in its benefit to the community. By actively involving communities in all aspects of SBCC interventions and activities, program planners and managers can ensure that the motivation to change behaviors or social norms is internally (rather than externally) motivated, and can capitalize on existing community strengths and institutions for sustainable results.

How is community engagement done?

Community engagement can be done in a variety of ways. Activities may include advocacy with community, religious and cultural leaders; PLA and other qualitative research techniques; forming alliances with existing organizations and networks; encouraging peer, spousal and inter-family communication; widening and deepening social networks; providing opportunities for community members to raise their voices – particularly those community members who are vulnerable and 'invisible'; opening lines of communication between community members and leaders; facilitating dialogues on prevailing social norms and customs; establishing advisory communities; empowering communities to speak on their own behalf; working with communities to identify and then minimize or eliminate social, cultural or practical barriers to accessing health services and performing healthy behaviors; and more.

Expert SBCC practitioners take a strengths-based approach to community engagement; every community, no matter how impoverished or disorderly has internal resources and strengths on which to build. Proper mapping and advanced planning of internal resources can bolster programmatic efforts and enhance effectiveness. In addition to changing the behavior of individuals, SBCC looks for ways to nurture an environment that will facilitate healthy behaviors, strengthen social capital, and promote positive social and cultural norms.

Key audiences and communities inform and are involved in every step of developing and implementing SBCC activities and programs. Communities are not homogeneous; therefore SBCC interventions must recognize and plan for this through careful audience segmentation to address each group's specific needs.

Vulnerable, at-risk and marginalized populations will be given particular consideration, ensuring that all members of the community are given their voice. Linkages with other relevant programs for capacity building and coordination can also increase opportunities for community engagement by providing a forum for discussing public health challenges and solutions, and soliciting feedback from partners.

Initial outcomes

Initial results are the visible outcomes of implementing the three domains.

- All SBCC activities and messages support the sector plan
- Strong, vibrant BCC Working Group
- Strong, vibrant HPN SBCC Coordination Committee
- OPs consolidate SBCC activities
- OPs adequately funded for SBCC
- SBCC focuses on improving behavioral outcomes (which will contribute to health outcomes)
- SBCC indicators are defined, tracked, and analyzed to strengthen programming
- Best practices for SBCC are identified and replicated
- Tools, resources and trainings on SBCC are available and used

- Policies are supportive of high-quality SBCC
- Appropriate communication channels are utilized
- Communities are engaged in a participatory manner
- Public and private dialogues on HPN issues are stimulated

Sustainable results

Sustainable results describe an infrastructure that is supportive of and funded for SBCC; a community of professionals that works in a coordinated and systematic way; and an environment in which SBCC can make the biggest impact on improving health outcomes. When sustainable results (shown below) are attained, the vision can be achieved.

- The art and science of SBCC is valued
- SBCC is systematic, evidence-based, strategic and coordinated
- SBCC interventions built on local resources and strengths
- Resources are allocated for SBCC and used efficiently
- Capacity is strengthened at all levels that includes government system at district and sub district level
- An enabling environment for positive behavior change exists
- There is no unintentional duplication or replication of SBCC messages and activities
- SBCC messages are harmonized and tailored
- SBCC's contribution to improving health behaviors is documented
- SBCC interventions are mainstreamed and integrated with existing programs

Monitoring & Evaluation of SBCC

Monitoring and evaluation (M&E) is a necessary component of a successful SBCC program, as it allows for an in-depth understanding of the impact of a specific program on people's attitudes, other ideational factors, and behaviors, which ultimately affect behavioral and health outcomes.

A basic M&E framework for SBCC has three major elements: inputs, outputs and outcomes. Inputs are the resources that are put into SBCC programs. Outputs are things like audience coverage, household coverage, activities completed, knowledge, couple/household communication, and attitudes. The outcomes to be achieved as a result of SBCC programs are positive changes in people's health behaviors and social norms. Specific M&E frameworks must be developed for each SBCC intervention. An illustrative framework is included in Annex 9.

A checklist for monitoring SBCC inputs and outputs is included in Annex 10. This tool was field tested in two districts in 2014-15.

Communication objectives are different from behavioral objectives. Communication objectives will state the anticipated effect communication activities will have on the development problem; they are connected to SBCC inputs and outputs, and should reflect only what can be achieved by communication. Behavioral objectives are the desired changes in behavior that the program is working toward.

Program planners must identify the role that communication can play in achieving behavioral objectives. For example, field workers can generate demand for long-acting family planning methods; this is a communication objective. However, if the long-acting methods are not available, the behavioral objective (uptake of long-acting family planning methods) will not be achieved. Communication can affect demand, but not supply.

SBCC project indicators should all be specific, timely, measurable and attainable in nature and measured periodically during project implementation to ensure that inputs and outputs are delivered as planned, and that behavior change is taking place as expected.

Monitoring efforts regularly track program activities to ensure the program is being carried out as planned. Field workers, program staff and/or other service providers regularly collect data on program inputs and outputs. The information gathered assists SBCC programs in solving problems by identifying potential gaps and adjustments needed for more effective implementation.

Evaluation studies SBCC program outputs and outcomes to assess the overall achievement or impact of SBCC programs on the intended audiences' behaviors, and how the health behaviors (eg IYCF practices) contribute to health outcomes (eg stunting) during a set point in time. For example, an evaluation of an SBCC program might use rigorous techniques to assess impact of a program on knowledge, attitudes and behaviors (KAB) by measuring the KAB changes over time as well as the SBCC program's successes and weaknesses. Evaluation helps us to understand the linkages between program exposure (often measured against pre-determined communication objectives) and behavior change (measured against pre-determined health objectives). Evaluation results also provide input for planning future programs.

Strategy outputs

- Detailed SBCC strategies for health, population and nutrition approved by MoHFW
- Additional resources allocated for SBCC
- MoHFW (PH & WH wing) capacity to oversee and coordinate SBCC strengthened
- Steering Committee for BCC Working Group established
- HPN SBCC Coordination Committee formalized
- Role of IEC Technical Committee strengthened and expanded
- Annual review of Strategy implementation conducted
- Tools and resources for coordination, capacity development and community engagement developed and shared.
- Best practices for coordination, capacity development and community engagement identified and shared



Section B



Action Plan for Comprehensive SBCC Strategy

SL	Activity	Responsible unit/Sector/Org	Allies	Resource	Timeline	Output/Strategy Output
1. SBCC Leadership and Coordination						
1.1	Strengthen office of Additional Secretary (PH & WH wing) to provide overall leadership in national HPN SBCC program, including coordinating with donors and other ministries in early stages of program design to avoid duplication, and identify areas for synergy. (Link to 1.8)	PH & WH wing. MoHFW	Other Ministries Development Partners	Long-term seasoned SBCC experts Material to set up SBCC resource center	December, 2016	MoHFW (PH & WH wing) capacity to oversee and coordinate SBCC strengthened
1.2	Create a Ministry-level SBCC focal point and small unit under the office of the Additional Secretary (PH & WH wing) to operationalize the Strategy and implement the action plan, including monitoring topic-specific SBCC strategies.	Additional Secretary (PH & WH wing)	Relevant Ministries Development Partners	A checklist/ guidelines Allocate sufficient human, financial and material resources for SBCC.	Continuous process	Annual review of Strategy implementation conducted
1.3	Ensure the SBCC is strategically placed and adequately resourced in the next sector plan	MoHFW	Donor	-	December, 2016	Adequate resource for SBCC interventions
1.4	Include BCC Working Group in the appropriate OPs for institutionalization <ul style="list-style-type: none"> - Form steering committee - Organize bi-monthly meeting - Keep the sub-groups active - Have annual budget - Have annual work plan (Link to 1.9) 	Additional Secretary (PH & WH wing), Planning Wing Relevant OPs	Donor	Fund in the OP of IEM, BHE and IPHN	December, 2016 Continuous process	Steering Committee for BCC Working Group established

SL	Activity	Responsible unit/Sector/Org	Allies	Resource	Timeline	Output/Strategy Output
1.5	<p>Include HPN SBCC Coordination Committee activities in the appropriate OPs for institutionalization</p> <ul style="list-style-type: none"> - Approve TOR - Include one focal person from MoHFW and relevant OPs - Organize bi-monthly meeting - Organize Annual joint planning meeting for SBCC 	MoHFW (PH and WH Wing, Planning Wing) Relevant LDs of Different OPs	Development Partners	Fund in the OP of IEM, BHE and IPHN Relevant OPs	July, 2016 Continuous process	HPN SBCC Coordination Committee formalized and made functional
1.6	Following the Comprehensive SBCC Strategy outline, review and prepare topic-specific SBCC strategy with detailed action plan	Relevant OPs Public Health and WH wing, Planning Wing	Development Partners	SBCC Consultant Fund for review meetings and dissemination	December, 2016	Detailed SBCC action plan for relevant OPs prepared and incorporated
1.7	Continue to promote the use of the MoHFW-approved Framework for Effective HPN SBCC	IEC technical committee Relevant Ministries	Development Partners BCCWG	Fund for dissemination meetings	Continuous process	All relevant stakes use SBCC strategy
1.8	Create advocate within MoHFW so that resources are allocated for SBCC; strategic SBCC is prioritized to facilitate both community- and facility-based SBCC programs. (Link to 1.1)	MoHFW and relevant OPs	Development Partners	Fund for Capacity Building	Continuous	SBCC functions are consolidated
1.9	Document and share Best Practices for SBCC in Bangladesh through annual event (Link to 1.4)	BCCWG IEM, BHE, IPHN and Relevant OPs	Development Partners	Resources allocated for selection, documentation & event organization	Continuous	Best practices for coordination, capacity development & community engagement identified and shared

SL	Activity	Responsible unit/Sector/Org	Allies	Resource	Timeline	Output/Strategy Output
1.10	Identify opportunities to work collaboratively with the relevant non state actors	MoHFW MoI and Relevant Ministries	Development Partners and relevant non state actors	Meetings to involve relevant non state actors	Continuous	SBCC strategy and action plans disseminated and followed
2. Capacity Development						
2.1	Strengthen the review, approval and documentation process of IEC Technical Committees to ensure approved SBCC materials are high quality with accurate SBCC content <ul style="list-style-type: none"> - Make material review checklist available online - Digitize the submission and approval process of SBCC materials - Establish a SBCC digital archive of approved materials - Periodic orientation for the IEC Technical Committee members on developing SBCC messages, materials and review checklist 	MoHFW Department of Additional Secretary (PH & WHO wing) , Additional secretary(FW) and concern units of DGHS and DGFP IEC Technical Committee members	Development Partners, INGO, NGO related with health sector AZi	Circular on Standard review criteria ICT support for online submission system SBCC orientation guidelines	July 2016 May, 2017 July, 2016 September, 2016 - onward	IEC Technical Committee strengthened and expanded Gold standard materials
	Review function and name of IEC Technical Committee <ul style="list-style-type: none"> - Revise the SOW - Circular of new IEC Technical Committee review criteria 	PH & WHO wing	Development Partners	Revised Criteria Dissemination	December, 2016	Circular issued Role of IEC Technical Committee strengthened and expanded
2.2	Conduct annual Capacity Assessment of concerned units	BHE, IEM & IPHN	Development Partners NGO	Self assessment checklist, activity and allocation kept in the next sector programs	Annually	Relevant organizations and units of DGHS and DGFP Assess and mitigation and measures are taken

SL	Activity	Responsible unit/Sector/Org	Allies	Resource	Timeline	Output/Strategy Output
2.3	Units conduct annual vendor orientation on the process to follow in producing quality SBCC product	BHE, IEM & IPHN		Fund allocated in next sector program	Need based	Related vendors are orientated
2.4	Strengthen effective use of ICT for SBCC program design and implementation <ul style="list-style-type: none"> - Explore opportunities to use digital media - Strategic use of mobile devices by MoHFW - DGHS and DGFP establish systems for supporting ICT for SBCC - Incorporate digital tools SBCC M&E (Link to 4.1) 	DGHS DGFP BHE, IEM, IPHN & MIS units	Development Partners AZi	Resources allocated by DGFP and DGHS to purchase related technologies	Continuous process	ICT based SBCC programs functioning
2.5	Strengthen units capacity to maintain Digital archives (content and IT) Allocation of resources in OPs to support the ongoing maintenance and updating of digital archives of SBCC materials in three Units	BHE, IEM & IPHN	Development Partners DGHS & DGFP	Fund allocated in OP Development Partners and GOB in the next sector program	Annual maintenance	Units capacity on Digital Archives improved OP approved
2.6	Strengthen SBCC professionals' (program managers) knowledge and skills on SBCC program design and implementation and supportive supervision <ul style="list-style-type: none"> - Make completion of eLearning courses for Program Managers different tier mandatory - Scale up use of the eToolkit for Program Managers - Organize exposure visits, conferences, and other means, for personal hands-on learning - Promote use of virtual resources (webinars, online networks). - Promote networking with HPN SBCC professionals (Link to BCCWG) & Springboard 	DGHS DGFP BHE, IEM, IPHN & MIS units	Development Partners, NGOs	NGO support Development Partners and allocation in the next sector program	July 2017 Need Based Time Frame to be developed during the next sector program	Capacity of the program managers to design, implement and coordinate SBCC strengthened

SL	Activity	Responsible unit/Sector/Org	Allies	Resource	Timeline	Output/Strategy Output
2.7	<ul style="list-style-type: none"> - Participation in annual Advances workshop / Strategic leadership training on SBCC by the focal persons of relevant units and IEC technical committee members - Improve the quality of interpersonal communication and counseling skills (IPCC) of Field Workers and other service providers - Include IPCC course during pre-service and in-service training - Make completion of eLearning courses for Field Workers mandatory - Scale up the availability and use of the eToolkit for Field Workers 	DGHS DGFP BHE, IEM, IPHN & MIS units NIPORT	Development Partners	Allocation kept in the relevant OP	January 2017 - onward	Capacity of the Field level workers on IPCC improved and field level workers oriented on IPCC
2.8	<ul style="list-style-type: none"> - Annual review & update of eToolkit for Field Workers - eLearning courses for Field Workers - eToolkit for Program Managers - eLearning courses for Program Managers 	BCCWG BHE, IEM & IPHN	Development Partners	Funds allocated in the next sector program	Annually	eToolkit and eLearning courses are updated
2.9	Strengthen capacity of field workers to promote effective linkages between the community and the health system	BHE, IEM & IPHN	Donor/ Development Partners	Development Partners and GOB support	Continuous process May start from March 2017	Through Field workers Community involvement in health system strengthened
2.10	Design SBCC programs that <ul style="list-style-type: none"> - use a variety of complementary and reinforcing channels and approaches, including mass media, traditional media, IPCC, community dialogue, etc at unit level - Focus messages on actionable behaviors at household and community level 	BHE, IEM & IPHN, NGO & INGO IEC Technical Committee	Donor/ Development Partners	Development Partners and GOB support	Feb 2017 - onward 2016- onward	Media based SBCC program developed Every message has a call for action

SL	Activity	Responsible unit/Sector/Org	Allies	Resource	Timeline	Output/Strategy Output
2.11	Use SBCC material Distribution and Dissemination guidelines - Orientation of the focal persons on use of guidelines - Make the guidelines available online - Link the guideline with logistic management system	DGHS and DGFP BHE, IEM & IPHN		BCC Materials distribution guideline Allocation of funds in the next sector program	Ongoing and continuous start from Jan 2017-Jan 2018	BCC materials used effectively All relevant guidelines are available online
3. Community Engagement						
3.1	Ensure proper mapping and strategic planning of communities internal resources for implementation of SBCC program	BHE, IEM, IPHN, NGO & INGO	CBOs Local Gov, Local Media	Skilled Field workers Fund	Short term (July-September of each year)	Mapping report
3.2	Involve Key audiences in every step of developing and implementing SBCC activities and programs by Ops /NGOs	BHE, IEM, IPHN, NGO & INGO	Specific key audience	Skilled Field workers Fund	Regular as it is a continuous process	Ensured participation of Key audiences
3.3	Involve community leaders (religious, political, social) in SBCC efforts by the Ops /NGOs to make them responsive; ensure that all members of the community are given their voice and community resources are utilized	BHE, IEM, IPHN, NGO & INGO	community leaders (religious, political, social)	Skilled Field workers Fund	Regular as it is a continuous process	Ensured participation and accountability of community leaders
3.4	Linkages with other relevant programs for capacity building, coordination and maximize resource utilization	BHE, IEM, IPHN, NGO & INGO	MoWCA MoYS MoSW MoLGRD MoRA	Skilled Field workers	Twice a year	Meeting Minutes (Avoid duplication, ensured intersectoral coordination)
3.5	Design targeted and tailored interventions (by geographic location, behavioral indicators, "at-risk" status, age, etc) for specialized audiences including vulnerable, at-risk and marginalized populations	BHE, IEM, IPHN, NGO & INGO	MoWCA MoYS MoSW MoLGRD MoRA	Strategic document, Mapping report, Technical Experts and Program Personal	Once a year (July – September)	Intervention plan Developed

SL	Activity	Responsible unit/Sector/Org	Allies	Resource	Timeline	Output/Strategy Output
3.6	Design local interventions by recognizing the influence of social norms and values on health outcomes, (e.g reducing rates of child marriage requires social change more than individual behavior change)	BHE, IEM, IPHN, NGO & INGO	Local representatives of MoWCA MoYS MoSW MoLGRD&C MoRA	Strategic document, Mapping report, Local Technical Experts and Program Personal	Once a year (July – September)	Local level Intervention plan Developed
3.7	Identify the local champions and involve them as local level resources	BHE, IEM, IPHN, NGO & INGO	Representatives of Local Bodies	Local Technical Experts and Program Personal	Once a year (July – September)	local champion identified and actively involved
3.8	Link mass media with local initiatives	BHE, IEM, IPHN, NGO & INGO	Representatives of Local Bodies Community Radio Journalist Association	Fund Advocacy tools	Continuous process	Comprehensive campaign
4. Cross-cutting including Monitoring and Evaluation						
4.1	<p>Determine what monitoring of SBCC interventions is necessary at different level</p> <p>Strengthen monitoring functions of Units responsible for SBCC; increase accountability for SBCC outcomes</p> <ul style="list-style-type: none"> - Select SBCC project indicators that are specific, timely, and attainable in nature and measured periodically - Establish a system of regular monitoring and supervision of SBCC programs with checklists and guidelines - Monitoring efforts should regularly track program activities to ensure the program is being carried out as planned 	<p>MoHFW Resource center</p> <p>MIS unit, DGHS</p> <p>MIS unit, DGFP</p> <p>BHE (DGHS), IEM (DGFP)</p> <p>BHE (DGHS), IEM (DGFP)</p>	<p>MoLGRD&C (City Corporation & Municipalities), UNICEF, USAID, WHO</p>	<p>GoB & Development Partners</p>	<p>July 16- September 16</p>	<p>SBCC indicators selected</p> <p>Checklist and guideline developed</p> <p>System established for online monitoring SBCC activities</p>

SL	Activity	Responsible unit/Sector/Org	Allies	Resource	Timeline	Output/Strategy Output
4.2	Incorporate selected SBCC indicators into national MIS	BHE, IEM & IPHN	MIS unit, DGHS MIS unit, DGFP	GoB & Development Partners	December 2016	SBCC indicators included in national digital MIS
4.3	Conduct evaluations of SBCC program outputs and outcomes to assess the overall achievement or impact of SBCC programs	BHE, IEM, IPHN, NGO & INGO	Research unit/firm	Development Partners	Mid-term & End-line Evaluations	Evaluation Conducted
4.4	Document SBCC program success; establish evidence base for expanding/scaling up effective interventions	BHE, IEM, IPHN, NGO & INGO	BCCWG	Development Partners	Continuous process	Effective interventions disseminated and scaled up
4.5	Widely share SBCC research data and program learning	MIS unit, DGHS MIS unit, DGFP	DGHS & DGFP	Development Partners	By Yearly	SBCC research findings shared
4.6	Integration of gender issues into all aspects of SBCC program development; implementation and evaluation	MoHFW Resource center BHE, IEM, IPHN, NGO & INGO	MoWCA MoE, MoP, ME & MoLGRD	GoB & Development Partners	Continuous process	Gender issues addressed
4.7	Proper documentation to ensure that relevant data and materials are accessible (Link to1.1)	MoHFW BHE, IEM, IPHN, NGO & INGO	DGHS & DGFP	Development Partners	Continuous process	For restoring the documentation and relevant data digital archive established
4.8	Establish mechanisms to ensure that digital SBCC resources usage is tracked and monitored	MoHFW BHE, IEM & IPHN	DGHS & DGFP	GoB	Annually	Capacity of monitoring use of SBCC digital resources built
4.9	Establish mechanism for use of event specific monitoring tools such as the A-V Van Show monitoring checklist - Units with A-V Vans collect and compile monthly data on A-V Van activities	MIS unit, BHE, IEM unit	DGHS & DGFP, MoI	Checklist Fund	Monthly	SBCC activity monitored at ground

SL	Activity	Responsible unit/Sector/Org	Allies	Resource	Timeline	Output/Strategy Output
4.10	Mid Term Evaluation and Evaluation of implementation of the Strategy	MoHFW BHE, IEM, IPHN, NGO & INGO	Donor	Relevant Documents, Program Personal, Community People, Fund	Every 3rd year and end of 5th year	Evaluation report

*Detailed activity of this action plan will depend on the structure of the new sector development plan, including the # and distribution of OPs.

Section C

Annexure

- Annex 1 Glossary of Terms
- Annex 2 Suggested Outline of OP-level SBCC Strategies
- Annex 3 Bangladesh HPN SBCC Situation Analysis
- Annex 4 Communication and Behavioral Theories
- Annex 5 Process Models: ACADA, COMBI, P Process
- Annex 6 A User Guide for National Framework for HPN SBCC
- Annex 7 BCC Working Group Steering Committee
- Annex 8 Terms of Reference for HPN SBCC Coordination Committee
- Annex 9 Illustrative Monitoring & Evaluation Framework
- Annex 10 SBCC Monitoring Checklist
- Annex 11 Terms of Reference for Expert Working Group and Technical Working Group
- Annex 12 List of Sub-committees

Annex 1
Glossary of Terms

Glossary of Terms

Adolescent-friendly – Services that are tailored to meet the specific social, physical, developmental and emotional needs of adolescents in a respectful and confidential manner. i

Advocacy – The processes through which individuals or groups attempt to bring about social or organizational change for a particular health goal, program, interest, or population. Advocacy is used to mobilize resources and secure political/social leadership commitment for development actions, goals, policies, and programs that support health and promote changes in social conditions that contribute to disease and vulnerability. Advocacy activities are both similar to and different from traditional health communication in various respects and have an important role in achieving SBCC objectives. It occurs on the personal/social level and the policy/program level, which reinforce each other. ii

Behavior change – A research-based consultative process for addressing knowledge, attitudes and practices. It provides relevant information and motivation through well-defined strategies, using a mix of media channels and participatory methods. Behavior change strategies focus on the individual as a locus of change. iii

Best practices – A technique or methodology that, through experience and research, has proven to reliably lead to a desired result. A commitment to using the best practices in any field is a commitment to using all the knowledge and technology at one's disposal to ensure success. iv

Capacity development (also capacity strengthening, capacity building) – Ensures a high-performing workforce for SBCC that understands the importance of developing evidence based programs using a systematic process that is tested to achieve the best health behavior outcomes possible, given available resources and circumstances. It will result in SBCC professionals who are skilled, fairly distributed, competent, responsive, ethical and productive – and who produce state-of-the-art materials, programs, and interventions that yield the desired results.

Community – A group of people who live in the same area (such as a city, town, or neighborhood) OR a group of people who have the same interests, religion, race, etc. v

Community engagement – The process of engaging stakeholders and communities to participate and build ownership with SBCC programs by deciding upon and applying a collective vision for the community's benefit.

Community leader – Persons within a community who exert influence over others. These can be formal or informal, and can include, but are not limited to, respected individuals, elected officials, religious leaders, political figures, and others.

Community mobilization/social mobilization – A process through which action is stimulated by a community itself, or by others, that is planned, carried out, and evaluated by a community's individuals, groups, and organizations on a participatory and sustained basis to improve health. In addition to improving health, the community mobilization process also aims to strengthen the community's capacity to address its health and other needs in the future. A participatory process of communities identifying and taking action on shared concerns. vi

Coordination – A critical element for the successful implementation of SBCC programs that encompasses aligning programs; sharing or pooling resources; harmonizing messages; conducting joint strategic planning; adapting and/or re-purposing SBCC materials; filling in programmatic gaps; designing complementary approaches; seeking opportunities for synergy; promoting linkages with other programs and services; ensuring that local and national-level activities are complementary and reinforcing; and more.

Cost-effective – Economical in terms of tangible benefits produced by money spent. The World Health Organization [WHO] has a rule of thumb: Three times per-person income per quality-adjusted life year gained is a cost-effective intervention. ^{vii}

Cultural norms, cultural values – Rules or expectations of behavior within a specific cultural or social group. Often unspoken, these norms offer social standards of appropriate and inappropriate behavior, governing what is (and is not) acceptable, and coordinating our interactions with others. Cultural and social norms persist within society because of individuals' preference to conform, given the expectation that others will also conform. A variety of external and internal pressures are thought to maintain cultural and social norms. ^{viii ix}

Efficacy – The power to produce a desired result or effect.^x This can refer to the efficacy of the solution (“I believe that this will work”) as well as self-efficacy (“I believe that I can do this”).

Field worker – Community- or clinic-based workers who interact directly with clients and who primarily deliver preventive information and services. Some examples of field workers in Bangladesh include Health Assistants, Family Welfare Assistants, Family Welfare Volunteers, Community Healthcare Providers, Shasthya Kormi, and Shasthya Shebika.

Gender norms – Gender norms are a set of “rules” or ideas about how each gender should behave. They not based in biology, but instead determined by a culture or society. ^{xi}

Health – The state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity.^{xii} When used broadly, this term is inclusive of family planning and nutrition.

Health communication – The art and technique of informing, influencing, and motivating individual, institutional, and public audiences about important health issues.^{xiii} This is a general term that implies the inclusion of population and nutrition when used in the context of Bangladesh.

Health promotion – Any combination of health education and related organizational, economic, and environmental supports for behavior of individuals, groups, or communities conducive to health. ^{xiv} Here, ‘health’ is also inclusive of family planning and nutrition.

Ideational factors – Multiple social and psychological factors, as well as skills and environmental conditions that facilitate behavior. Ideational factors are grouped into three categories: cognitive, emotional and social. Cognitive factors address an individual's beliefs, values and attitudes (such as risk perceptions), as well as how an individual perceives what others think should be done (subjective norms), what the individual thinks others are actually doing (social norms) and how the individual thinks about him/herself (self-image). Emotional factors include how an individual feels about the new behavior (positive or negative) as well as how confident a person feels that they can perform the behavior (self-efficacy). Social factors consist of interpersonal interactions (such as support or pressure from friends) that convince someone to behave in a certain way, as well as the effect on an individual's behavior from trying to persuade others to adopt the behavior as well (personal advocacy). ^{xv}

IEC (Information Education Communication) – A public health approach aiming at changing or reinforcing health-related behaviors in a target audience, concerning a specific problem and within a pre-defined period of time, through communication methods and principles. ^{xvi} IEC is a pre-cursor to the more current and preferred concept of Social and Behavior Change Communication (SBCC).

Impact – (i) The total, direct and indirect, effects of a program, service or institution on a health status and overall health and socio-economic development. (ii) Positive or negative, long-term or medium-term effects produced by a program or intervention. (iii) the degree of achievement of an ultimate health objective. ^{xvii}

Information and Communication Technology (ICT) – A broad set of tools and technologies that facilitate the dissemination and exchange of information. ICT can help make knowledge, attitudes & behaviors widespread & shared among communities, providers, decision makers, and so on. ^{xviii}

Integration – In the context of SBCC in Bangladesh, integration refers to the presentation of health, population and nutrition topics in a unified manner. It recognizes that families and households are concerned about their overall welfare and productivity, rather than individual elements of the family's well-being.

Knowledge Management (KM) – The systematic process of capturing, distributing, and effectively using knowledge. ^{xix}

Multi-sectoral – (i) Involving Ministries other than MoHFW. (ii) Involving stakeholders from different spheres, e.g. government, non-government organizations, private sector, development partners, media, etc.

Outcome (Related: behavioral outcome, health outcome) – Short-term or intermediate aspects of health that result from the interventions provided by the health system, the facilities and personnel that recommend them and the actions of those who are the targets of the interventions; metrics or standards for measuring societal-level conditions may be viewed as social, economic, political, and environmental determinants of health. These might include, for example, changes in self-perceived health status or changes in the distribution of health determinants, or factors which are known to affect their health, well-being and quality of life. ^{xx xxi}

Participatory Learning and Action (PLA) – A family of approaches, methods, attitudes, behaviors and relationships, which enable and empower people to share, analyze and enhance their knowledge of their life and conditions, and to plan, act, monitor, evaluate and reflect. ^{xxii}

Population – The MoHFW works to develop a happier, healthier and wealthier population by providing family planning and reproductive health services leading to improved maternal, child and adolescent health. ^{xxiii}

Program manager/program planner/program designer – Someone who designs, plans, implements and/or manages SBCC programs, activities and interventions at any level. These terms describe a role, and may not necessarily reflect a person's official job title.

Resources – The inputs required to make health systems work (human and financial resources, drugs, supplies and equipment, and infrastructure). ^{xxiv} In the context of SBCC, inputs may include skilled personnel, adequate budget, SBCC materials, job aids, mass media, and others.

Service delivery – The provision of any service aimed at contributing to improved health or to the diagnosis, treatment and rehabilitation of sick people. ^{xxv} This can include the delivery of medical or clinical services, as well as preventive, informational and counseling services, among others.

Service provider – All people, skilled or unskilled, engaged in actions to directly deliver services with the primary intent of enhancing health. This can include clinical staff, such as physicians, nurses, pharmacists and dentists, as well as midwives, paramedics, and community health workers. ^{xxvi} This can include clinical services, as well as preventive, informational and counseling services.

Social capital/social support – Intangible resources and norms that arise from social networks.

^{xxvii} Social support can be an important factor when working to change behaviors.

Social change – Focuses on the community as the unit of change. It is a process of transforming the distribution of power within social and political institutions. For individual behaviors to change, certain harmful cultural practices, societal norms and structural inequalities have to be considered and addressed. ^{xxviii}

Social environment – The combined effect of family, friends, peers, community members, institutions, policies, social norms and other factors that may influence an individual's ability to change his or her behavior.

Social network – Linkages between people that may or may not provide social support and that may serve functions other than providing support.^{xxix}

Stakeholder – An individual, group or an organization that has an interest in the organization and delivery of health care, or an interest in a particular issue.^{xxx}

Sustainable – The potential for sustaining beneficial outcomes for an agreed period at an acceptable level of resource commitment within acceptable organizational and community conditions.^{xxxi}

- i http://www.who.int/maternal_child_adolescent/documents/adolescent_friendly_services/en/
- ii https://www.k4health.org/toolkits/sbc-trm/key-terminology#_edn3
- iii http://www.unicef.org/cbsc/index_42352.html
- iv <http://www.bitpipe.com/tlist/Best-Practices.html>
- v <http://www.merriam-webster.com/dictionary/community>
- vi <http://ccp.jhu.edu/documents/A%20Field%20Guide%20to%20Designing%20Health%20Comm%20Strategy.pdf>
- vii <http://www.merriam-webster.com/dictionary/cost-effective>
- viii http://www.who.int/violence_injury_prevention/violence/norms.pdf
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- x <http://www.merriam-webster.com/dictionary/efficacy>
- xi http://www.nsvrc.org/sites/default/files/SAAM_2012_Gender-norms.pdf
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- xv <http://www.healthcommcapacity.org/wp-content/uploads/2014/10/Ideation.pdf>
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- xvii WHO Terminology Information System [online glossary] <http://www.who.int/health-systems-performance/docs/glossary.htm>
- xviii Presentation by James Bon Tempo, Director of ICT and Innovation, Johns Hopkins CCP, to the Bangladesh BCC Working Group on October 28, 2015
- xix <http://www.kmworld.com/Articles/Editorial/What-Is-.../What-is-KM-Knowledge-Management-Explained-82405.aspx>
- xx http://www.cdc.gov/pcd/issues/2010/jul/10_0005.htm#Definitions; Starfield B. Basic concepts in population health and health care. *Journal of Epidemiology and Community Health* 2001;55:452-454. doi:10.1136/jech.55.7.452
- xxi <http://www.who.int/hia/about/glos/en/index1.html>
- xxii <http://www.participatorymethods.org/glossary/participatory-learning-and-action-pla>
- xxiii National Population Policy 2012, MoHFW
- xxiv http://www.who.int/healthsystems/hss_glossary/en/index9.html
- xxv WA glossary of technical terms on the economics and finance of health services. World Health Organization, Regional Office for Europe. 1998. Available at: http://www.euro.who.int/_data/assets/pdf_file/0014/102173/E69927.pdf
- xxvi WHO 2006. The World Health Report 2006 – Working Together for Health. Geneva. Accessible at <http://www.who.int/whr/2006/en/index.html>
- xxvii [http://www.sanjeshp.ir/phd/phd_91/Pages/References/health%20education%20and%20promotion/\[Karen_Glanz_Barbara_K_Rimer_K_Viswanath\]_Heal\(BookFi.or.pdf](http://www.sanjeshp.ir/phd/phd_91/Pages/References/health%20education%20and%20promotion/[Karen_Glanz_Barbara_K_Rimer_K_Viswanath]_Heal(BookFi.or.pdf)
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- xxix [http://www.sanjeshp.ir/phd/phd_91/Pages/References/health%20education%20and%20promotion/\[Karen_Glanz_Barbara_K_Rimer_K_Viswanath\]_Heal\(BookFi.or.pdf](http://www.sanjeshp.ir/phd/phd_91/Pages/References/health%20education%20and%20promotion/[Karen_Glanz_Barbara_K_Rimer_K_Viswanath]_Heal(BookFi.or.pdf)
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Annex 2

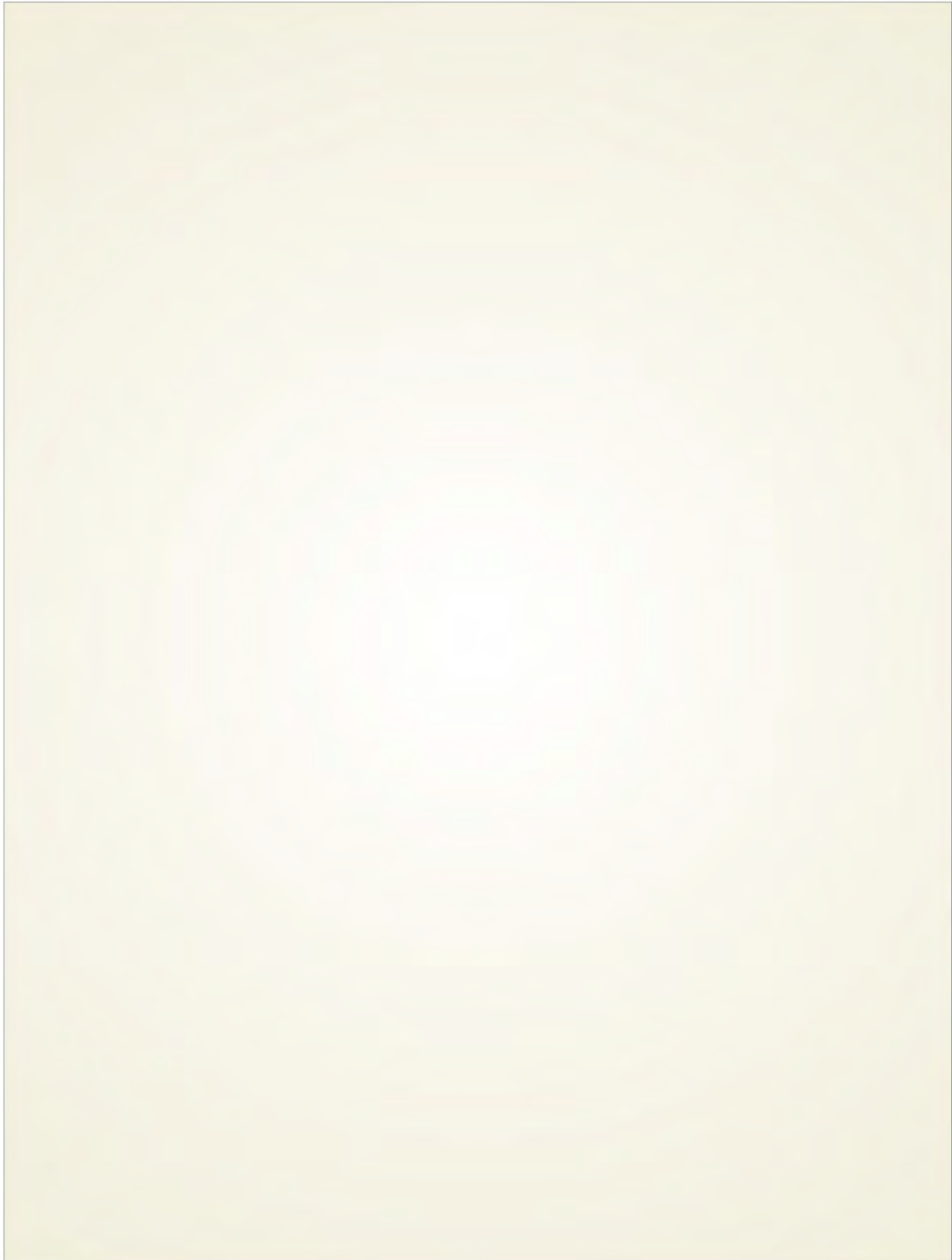
Suggested Outline of OP-level SBCC Strategy

Suggested Outline of OP-level SBCC Strategy

- **Introduction**
 - What are the key priorities of the OP
 - How this strategy supports the implementation of the OP
- **Goals and Objectives**
 - Specific and measurable
 - Communication objectives
 - Behavioral objectives
 - Who is it for? Roles of different stakeholders
 - How will it be used?
 - Connection to Comprehensive MoHFW SBCC Strategy
- **Guiding Principles (copied from Comprehensive Strategy & tailored as necessary)**
- **Vision for OP-level SBCC**
 - Desired behaviors and social norms
- **Situation Analysis**
 - Purpose (Health situation that the program is trying to improve)
 - Key Health Issue (Behaviors and/or changes that need to occur to improve the health situation)
 - Context (Strengths, Weaknesses, Opportunities, and Threats [SWOT] that affect the health situation)
 - Gaps in information available to the program planners and to the audience that limit the program's ability to develop sound strategy.
 - Formative Research
- **Action Plan**
 - Specific behaviors to address
 - Audiences
 - Primary, secondary, tertiary
 - Audience segmentation
 - Approaches
 - Which theories support selected approaches
 - How to integrate different health topics (when appropriate)
 - Key Channels
 - Platforms/Systems/Tools/Aids
 - Key message points
 - Coordination
 - Capacity Development
 - Community Engagement (includes community-level advocacy)
 - Timeline
- **Monitoring & Evaluation**
 - Process indicators (inputs)
 - Product indicators (outputs)
 - Behavior change indicators (outcomes)
- **Annexes**



Annex 3
Bangladesh HPN SBCC
Situation Analysis



Bangladesh HPN SBCC Situation Analysis

HEALTH

Neonatal, Infant & Child Health

Neonatal, Infant & Child Health Current Situation

Bangladesh has made significant progress in improving the health of its children. It has achieved its Millennium Development Goal (MDG) 4 target of reducing under-five mortality by two-thirds ahead of time. The under-five mortality rate is currently 46 per 1,000 live births, down from 53 per 1,000 live births as reported in the 2014 Bangladesh Demographic and Health Survey (BDHS). The infant mortality rate (IMR) is currently 38 per 1,000 live births, and the child mortality rate is 8 per 1,000 children. During infancy, the risk of dying in the first month of life (28 deaths per 1,000 live births) is nearly 3 times greater than in the subsequent 11 months (10 deaths per 1,000 live births). Deaths during the neonatal period account for 61% of all under-5 deaths (BDHS 2014).

Overall, 84% of children aged 12-23 months in Bangladesh are fully vaccinated (BDHS 2014), and by 12 months of age full vaccination coverage (FVC) is 82% (Coverage Evaluation Survey-2014). The vaccination rates for children by 12 months are as follows: BCG 99%; OPV1 96%; OPV2 95%; OPV3 93%; Penta1 93%; Penta2 93%; Penta3 93%; MR 87% (Coverage Evaluation Survey-2014). The percentage of children receiving their basic vaccinations by 12 months has decreased by 5% since the 2011 BDHS, which is cause for concern (BDHS 2014).

Acute respiratory infections (ARI) are a leading cause of childhood illness and death. 42% of children who were reported as showing symptoms of ARI were taken to a health facility or provider for treatment and 34% received antibiotics, which is much lower than the 2011 BDHS estimate of 71%. This can be attributed to the change in survey question format where interviewing teams for the 2014 BDHS were provided with a list of drug names to accurately identify whether the drug given to the child with suspected ARI was an antibiotic. The previously reported 71% was likely an overestimation of antibiotic use. The new reported percentage of 34% is much lower than the Health, Population, and Nutrition Sector Development Program (HPNSDP) 2011-2016 target of 50% of children 0-59 months with pneumonia receiving antibiotics. Use of oral rehydration therapy (ORT) for children with diarrhea was 84%. Furthermore, 62% of children aged 6-59 months received vitamin A supplement in the 6 months prior to the survey (BDHS 2014). Among children under 5, leading causes of death are pneumonia (22%), possible serious infections or sepsis (15%), birth asphyxia (12%), drowning (9%), and pre-term birth (7%). However, among children 12-59 months, 43% of deaths were attributed to drowning, followed by pneumonia (22%) (BDHS 2011).

There are some differences in the causes of death between under-5 boys and girls. Pneumonia is more common among girls (25%) than boys (19%). Boys (17%) are much likely to die from birth asphyxia than girls (8%). Possible serious infection is more common in rural (16%) than in urban areas (10%), while birth asphyxia is more prevalent in urban (19%) than rural areas (11%). For a large number of cases (15-27%), the cause of death for under-5 children whose mothers had less than secondary education was unspecified (BDHS 2011).

Neonatal/Infant/Child Health: Existing Communication Activities*

- **Government of Bangladesh (GoB)**
 - o Institute of Public Health Nutrition (IPHN) produces Social and Behavioral Change Communication (SBCC) materials such as flip charts, posters, leaflets, flyers, brochures, fact sheets, newsletters, TV spots, drama serials, documentaries, radio spots, cultural programs, billboards, and newspaper ads.
 - o Directorate General of Health Services (DGHS) units collaborate with other organizations such as NGOs, civil society organizations, hospitals, specialized institutions, development partners, professional associations, and the corporate sector.
- **USAID-DFID NGO Health Services Delivery Project (NHSDP)**
 - o Clinic level discussion meetings with parents; group meetings on "Tin Diner Pahara," and ARI/diarrhea at the community level; community meeting on exclusive breastfeeding.
- **WATCH Project/Plan International Bangladesh**
 - o Group Meeting: SBCC session
 - o Outreach: Theater for Development
- **Sesame Workshop Bangladesh (Sisimpur 123)**
 - o Television: Water safety; nutrition
 - o Interpersonal Communication and Counseling (IPCC): School and community-based Interactive awareness session with kids and mothers/caregivers on water, sanitation, and hygiene (WASH)
 - o Outreach: Public service announcement (PSA) on health and nutrition; school-based Life Skills activities
- **Aponjon**
 - o Outreach and Mobile Phones: Community Health Workers (CHWs) provide outreach to pregnant women, new mothers and gatekeepers to provide Maternal and Child Health (MCH) information, and to enroll subscribers in a program that delivers health messages via voice or text messages. Messages are customized for urban or rural audiences, and are available in different dialects.
- **MaMoni Health Systems Strengthening (HSS)**
 - o IPCC and Group Meeting: Implemented in Sylhet by Save the Children and two local NGOs, aims to increase the use of high impact maternal and newborn health and family planning (FP) behaviors and strengthen the Ministry of Health and Family Welfare (MoHFW) systems largely through NGO-supported CHWs and Community Action Groups (CAG) by providing home-based counseling and services.
- **Social Marketing Company's (SMC) Marketing Innovations in Health (MIH) project**
 - o Community mobilization activities are conducted by Community Sales Agent (CSA) and Community Mobilizer (CM) in 19 low-performing districts in Bangladesh with focused messaging on five core areas: healthy timing and spacing of pregnancies (HTSP); first 1000 Days of a child's life, healthy pregnancy, adolescent reproductive health (ARH), and tuberculosis (TB) prevention and management.
- **Saving Newborn Lives (SNL) of Save the Children**
 - o Outreach: Comprehensive newborn care package (CNCP) interventions for promotion of birth/neonate emergency preparedness and safe delivery.

- o Local and national media campaign on Essential Newborn Care (ENC) including chlorhexidine, maternal and neonatal danger signs and promoting care seeking behavior
- Helping Babies Breathe (HBB) of Save the Children:
 - o Outreach: Reduce newborn mortality by training providers and expanding high-quality, affordable newborn resuscitation training materials and devices, such as bag-mask ventilators, and bulb suction.

The communication activities listed above are some examples of current interventions; these lists are not exhaustive.

Neonatal/Infant/Child Health Communication Gaps

Knowledge/Information Gaps

- Access to safe water: People may not always understand what 'safe water' means and need to be sensitized to understand where they can access safe water, and how to make water safe.
- Proper hand washing: People may not always understand why hand washing is important and need to be sensitized to better understand why they need to wash their hands.
- Clean living environment (homestead): People may not always understand why a clean living environment is important and need to be sensitized to better understand the linkage with child development and health.
- Immunization (100% coverage): People may not always understand why immunization is important and have inaccurate ideas about side effects.
- Lack of knowledge about Essential Neonatal Care (drying, wrapping, early initiation of breast feeding and delayed bathing).
- Lack of knowledge among parents and caregivers on the main diseases of under-5 children, especially pneumonia (and other ARI) and drowning.
- Lack of capacity for effective SBCC because of frequent trained personnel transfer and turnover.

Neonatal/Infant/Child Health Communication Opportunities

- Implementing partners working in Child Survival can share program activities on a quarterly basis following a coordination mechanism.
- Four neonatal evidence based interventions.
- Preventive measures for drowning and other childhood diseases.
- Train journalists how to report on child health issues, including hand washing before feeding.
- More cooperation and coordination among various units in preparing new SBCC materials.
- Sustain collaboration of diverse partnerships that have competing interests and activities.

Neonatal/Infant/Child Health Keys for Successful Communication

- Strengthen collaboration regarding SBCC in other units of DGHS

Adolescent Health

Adolescent Health Current Situation

Adolescent fertility remains significantly high in Bangladesh. According to the most recent Census, adolescents represent 22% of the total population. Of those between ages 15-19, 30% have begun childbearing, about 25% have given birth, and another 6% is pregnant with their first child (BDHS 2014). The proportion of women aged 15-19 who have begun childbearing rises rapidly with age, from 9% among women age 15 to 58% among women age 19 (BDHS 2014).

Early childbearing among teenagers is more common in rural (32%) than in urban areas (27%) and highest in Rajshahi and Rangpur (37% each) compared with other divisions. Childbearing begins later in Sylhet than in other divisions. 18% of teenagers who completed secondary or higher education have begun childbearing whereas 48% of teenagers with no education have begun childbearing. Childbearing begins earlier in the lowest wealth quintile (41%) compared with the highest wealth quintile (23%). Overall, teenage childbearing has not changed since 2011 (BDHS 2014).

Teen pregnancy and motherhood is a major social and health concern. Early teenage pregnancy can cause serious health problems for both the mother and the child. Teenage mothers are more likely to suffer from severe complications during delivery, which result in obstetric fistula and other morbidities, maternal mortality, neonatal mortality, anemia and overall poor health of both the baby and mother.

In addition, young mothers may not be emotionally mature enough for childbearing and rearing. Moreover, early childbearing greatly reduces women's educational and employment opportunities and is associated with high levels of fertility. This hurts job prospects and often lowers their status in society.

Child marriage is associated with early first birth and approximately half of the women married before age 20 and one out of three girls aged 15-19 experience teen pregnancy. About 9% of the population is 15-19 years old and there are approximately three million married adolescents in Bangladesh. About 70% of married adolescent girls are not yet mothers; however, of the 30% who are mothers, 9% gave birth or became pregnant at the age of 15. The overall contribution of adolescent fertility to total fertility rate (TFR) is 25%; in other words, 750,000 adolescents are giving birth annually.

About half of adolescents report current use of contraceptives. Like older women surveyed, the majority of adolescents use modern contraceptive methods with oral pill being the most popular choice. There appears to be a growing number of young women who use contraceptives prior to first birth. About one-third of adolescents reported contraceptive use prior to childbearing. However the unmet need for FP among married adolescents is high compared to all married women (17.1% versus 12%).

The data available about ARH knowledge and behavior is extremely limited. Information about sexual behavior is not easy to obtain, partly because of a long-held assumption that young people do not engage in sex before marriage in Bangladesh's conservative culture. The limited information available indicates that conservative values may not be protecting either gender from sexual experimentation with potentially negative effects on reproductive health (RH). In most cultures, boys are more likely to experiment sexually than girls, usually because the consequences are less severe. This appears to be true in Bangladesh as well, though there are sharp urban and rural differences. Different studies and anecdotal information reveal that most unmarried girls wanted to learn about sexuality from close friends or family members; whereas young men feel the media would be most effective. The majority of boys felt either radio or television would be an appropriate medium.

Adolescent Health Existing Communication Activities

- **GoB**
 - IPCC: The Information, Education, Motivation (IEM) Unit of the Directorate General of Family Planning (DGFP) created an ARH Booklet used by FWAs in their IPCC activities; the MCH and Clinical Contraception Services Delivery Program (CCSDP) units address MCH and nutrition in their regular Maternal, Neonatal, and Child Health (MNCH) and ARH programs
- **USAID-DFID NHSDP**
 - Outreach: Adolescent girls cycling contest; rally; pictorial display
- **UNFPA and Swiss Embassy**
 - Shahana: Entertainment education addressing child marriage, physical, emotional and mental changes during puberty, adolescent pregnancy, gender-based violence and economic empowerment of women.
- **UNICEF**
 - Kishori Abhijan: Active participation, assertion of rights, empowerment, peer-pioneered actions, advocacy, change makers, role models, involvement of parents and social leaders to conduct joint sessions with adolescents, training for peer leaders, open air theater, thematic workshops, campaigning
- **Assistance for Social Organization and Development (ASOD)**
- **Advanced Adolescent and Youth Organization (AAYO)**

Adolescent Health Communication Gaps

- Lack of adolescent-friendly health services
- Uneven coverage of adolescent-friendly health services
- Adolescent nutrition is not a priority in current programs
- Lack of comprehensive information and knowledge for young women about dangers of teenage pregnancy and birth complications

Adolescent Health Communication Opportunities

- GoB's next sector program spotlights adolescent health
- National and donor support for high impact adolescent health interventions
- Support for essential adolescent health care package
- Establishment of adolescent health corners

Adolescent Health Keys for Successful Communication

- Involve parents and other gatekeepers
- Reach out to adolescent boys as well as girls
- Use social media and adolescent-friendly ICT

Maternal Health

Maternal Health Current Situation

At present, Bangladesh is on pace to achieve MDG5, a reduction of the Maternal Mortality Ratio (MMR) by 75% from the 1990 level to reach 143 per 100,000 live births by 2015. The leading causes of maternal deaths are: Indirect causes (HTP, DM, CVD, Cancer) (35%), Hemorrhage mainly PPH (31%), Eclampsia (20%), Obstructed and prolonged labor (7%), Other diseases (5%), abortion (1%) and undetermined (1%) (BMMS 2010). Though the situation has improved significantly, the MMR is still 170/per 100,000 livebirths (WB 2013). Birth rate among adolescent mothers is between 105/1,000 (BMMS 2010) to 113.3/1,000 women (BDHS 2014). The average household-size is 4.5, and life-expectancy both sexes is 70 years (WB 2013).

The institutional delivery rate (37.4%) is significantly lower than the home delivery rate (62.2%). Among institutional deliveries, people use private facilities (22.4%) more than public facilities (12.8%). NGO facilities cover 2.2% only. The HPNSDP sets a target ratio of less than 1:4 between women in the lowest and the highest wealth quintiles who deliver at facilities and the current ratio is approximately 1:5 (BDHS 2014).

Proper care during pregnancy and childbirth are important to the health of both mother and baby. The HPNSDP 2011-2016 results framework sets a target of 50% for at least 4 antenatal care (ANC) visits. Recent data show that 31.2% of pregnant women completed four or more ANC visits. The likelihood of receiving ANC from a trained provider declines rapidly with increasing age and birth order. 78.8% of urban women receive ANC from a trained provider, compared with 58.6% of rural women. Inequitable use of maternal health services is a concern (BDHS 2014).

The proportion of deliveries by medically trained providers increased to 42% in 2014, mainly due to a rise in institutional deliveries. A large portion of non-facility deliveries are still by unskilled attendants (BDHS 2014). The HPNSDP target is for delivery by a trained provider to reach 50% by 2016. Skilled attendance during pregnancy, childbirth and the post-natal period and provision of Comprehensive Emergency Obstetric Care (CEmOC) services remain critical. In 2014, 23% of births were delivered by c-section, implying that 60% of facility births were delivered by c-section, primarily among women in the highest wealth quintile (49.8%) and who completed secondary education (51.2%) (BDHS 2014). Similarly, post-natal care (PNC) is a crucial component of safe motherhood and neonatal health. Data show that 36% of mothers receive PNC from a medically trained provider within 42 days after delivery; 34% of mothers and 32% of children receive postnatal checkups from a medically trained provider within two days of delivery (BDHS 2014).

Maternal Health Existing Communication Activities

- **GoB**
 - o IPHN produces SBCC materials such as flip charts, posters, leaflets, flyers, brochures, fact sheets, newsletters, TV spots, radio spots and newspaper ads.
 - o IPCC: The IEM Unit of DGFP addresses nutrition in every single training, workshop and orientation program implemented at national and community levels. Nutrition is highlighted in IEM's flipcharts used by FWAs in their IPCC activities and National Communication Strategy for FP-RH (2008). In addition to IEM, the MCH and CCSDP units address MCH and nutrition in their regular MNCH and ARH programs.

- **BEES/MaMoni-HSS Project (Noakhali)**
 - Group Meeting: SBCC show at CAG Meeting; SBCC meeting with religious leaders; meeting with pregnant women and family members; meeting with Union Parishad (UP) Chairman, members and local elites; meeting with traditional birth attendants (TBAs); video show in CAG meeting.
 - Outreach: SBCC video at Bazaar/boat ghat/launch ghat, Expanded Programme on Immunization (EPI) center, satellite clinic, community clinic (CC) and Family Welfare Center (FWC), local community; miking session.
- **Resource Integration Center (RIC), MaMoni-HSS project (Hatia, Noakhali)**
 - Outreach: Video show in local bazaar, ghat, CC, Upazila Health Complex (UHC), FWC, and local communities; media dark campaign; miking; ANC campaign.
- **Dustho Shasthya Kendra (DSK) – MaMoni-HSS**
 - Group Meeting: SBCC video show with CAG; SBCC meeting with religious leaders, UP bodies, local elites, and pregnant women and their families.
 - Outreach: SBCC video show at local community, bazaar/boat ghat/launch ghat, EPI center, satellite clinic, CC and FWC; miking session with community; ANC campaign.
- **USAID-DFID NHSDP**
 - **IPCC: Counseling on four ANC visits**
 - Group Meeting: Clinic level discussions with parents; discussion meeting on birth preparedness; group meetings on "Tin Diner Pahara," ARI, childhood diarrhea, and Red Flag hoisting; community meeting on exclusive breastfeeding.
 - Outreach: Adolescent girls cycling contest; ANC campaign; rally; pictorial display.
- **WATCH Project/Plan International Bangladesh**
 - Group Meeting: SBCC session
 - Outreach: Theater for Development
- **Aponjon**
 - Outreach: Deliver health messages to pregnant women, new mothers and gatekeepers via mobile phones
- **EngenderHealth Fistula Care project**
 - Outreach: Community-based approach focuses on expanding access to FP and preventing and treating obstetric fistula, including preventing postpartum hemorrhage through the distribution of misoprostol by CHWs.

Maternal Health Communication Gaps

Knowledge/Information Gaps

- Lack of a comprehensive communication plan for MCH.
- For ANC: early identification of pregnancy and early start of care; timing and frequency of ANC is not well understood; quality of ANC counseling is poor – including nutrition counseling using standard materials; family involvement in maternal care; messages and services are not consistent and integrated; birth preparedness; Misoprostol awareness low.
- For safe delivery: very low uptake of skilled birth attendant (SBA) delivery and early recognition of complications and danger signs; birth planning not common.
- Lack of knowledge on neonatal care among mothers/parents and other caregivers.
- For PNC: very low PNC coverage, other than facility delivery; poor counseling at discharge/ delivery/ANC leads to low importance placed on PNC visits.

Gaps in Approaches

- Aponjon Formative Research Report: Several subscribers requested additional content about MCH and nutrition, with some reporting that existing messages lacked sufficient detail; Subscribers noted that message repetition was disappointing and expressed an expectation that content would not be repeated; Some subscribers expressed hope for expansion of the Aponjon platform; they wanted a more interactive service.
- National Neonatal Health Strategy and Guidelines for Bangladesh: Two major independent evaluations of HPNSDP including the Mid-term Review (MTR) identified critical gaps in MNCH. Relevant services are not strong enough to accelerate progress toward achieving the MDGs. Mothers are not aware of the continuum of care from pre-pregnancy through postpartum care and non-availability of skilled workers during pregnancy, childbirth and postnatal period with special emphasis on neonatal outcomes. Mothers and relevant others do not know enough about neonatal health including breastfeeding, danger signs, and so on.

Maternal Health Communication Opportunities

- GoB and major stakeholders including USAID may collaborate to develop a National Communication Strategy on MCH.
- Implementing partners in MCH to share field activities on quarterly basis following a coordination mechanism.
- Collaboration campaigns to promote prevention of teenage pregnancy, ANC, PNC and safe delivery throughout Bangladesh on yearly basis.
- The Vision for Action for Ending Preventable Maternal Mortality of USAID: USAID is committed to: (1) Enabling and mobilizing individuals and communities; (2) Advancing quality, respectful care; and (3) Strengthening health systems and continuous learning (strengthen & support health systems; promote data for decision-making & accountability).

- Demand generation for 13 life-saving MNCH/FP commodities.
- Integration of MCH, Nutrition, ARH and FP.
- Train journalists on how to report on maternal health and nutrition issues, including proper nutrition before and during pregnancy, recognizing danger signs during pregnancy, and proper hygiene practices.

Maternal Health Keys for Successful Communication

- Involve relevant gatekeepers
- Start counseling well before pregnancy to ensure proper nutrition and adequate knowledge about risk factors
- Increased intra-ministerial coordination, planning and management for integrated health communication

Non-Communicable Diseases

Non-Communicable Diseases Current Situation

Though Bangladesh has seen decreases in its burden of communicable diseases, there has been a concurrent rise in the country's burden of non-communicable diseases (NCDs) on morbidity and mortality. As of 2014, NCDs account for 59% of the country's total deaths and a majority of those deaths are attributable to cardiovascular diseases, chronic respiratory diseases, cancers, and diabetes (WHO NCD 2014). Several risk factors for these NCDs include tobacco use, unhealthy diet, and inadequate physical activity. In Bangladesh, the prevalence of smoking for adults over 15 years of age is high at 23% and 45% of adults are exposed to second-hand smoke in public spaces (MoHFW Strategic Plan 2011). Among the urban population, overnutrition and inadequate intake of fruits and vegetables coupled with a sedentary lifestyle increases residents' risk of developing NCDs. Another dietary issue is salt intake and its contribution to hypertension prevalence. According to the 2010 Bangladesh NCD Risk Factor Survey, there is a 17.9% prevalence of hypertension among adults aged 25 or older (MoHFW Strategic Plan 2011). To reduce overall morbidity and mortality in Bangladesh, it will be essential to simultaneously focus on the country's NCD, communicable disease, and injuries burden.

Non-Communicable Diseases Existing Communication Activities

- **BCCP**
 - o "Alive" mass media campaign; World No Tobacco Day; evidence-based best practices; leadership workshops; capacity building
- **Eminence**
 - o Community-based lifestyle modification health education intervention with home visits for middle-income families; NCD prevention education for urban slum residents; workplace sensitization for employees
- **BRAC NCD Programme**
 - o Frontline community health workers conduct IPC counseling and health education about healthy aging, nutrition, lifestyle, and behavior changes

Non-Communicable Diseases Communication Gaps

- No national communication strategy for NCDs
- Lack of comprehensive communication and education materials about risk factors
- Current uncoordinated involvement of stakeholders from different levels
- Lack of knowledge about risk factors among the public
- Uneven and sporadic approaches utilized
- Different approaches are needed based on the target population (e.g. urban slum residents versus middle-income professionals)

Non-Communicable Diseases Communication Opportunities

- Amendments to Tobacco Control Act
- Some existing collaboration between relevant ministries, directorate generals, NGOs, and other organizations to scale-up work on reducing risk factors and negative impacts of NCDs
- National government support for international frameworks such as the WHO Framework Convention on Tobacco Control, the Global Strategy on Diet, Physical Activity, and Health, and the Global Strategy to Reduce Harmful Use of Alcohol
- DGHS implementation of NCD prevention model interventions
- Upazila-level pilot programs for NCD prevention

Non-Communicable Diseases Keys for Successful Communication

- Focus prevention messages on limiting modifiable risk factors such as tobacco use, sedentary lifestyle, unhealthy or unbalanced diets, and excessive salt intake
- Emphasize heavy burden of NCDs in Bangladesh
- Coordinate large-scale, multi-sectoral messaging to inform people about and motivate them to adopt a healthy lifestyle
- Develop lifestyle education and communication materials geared for young audiences to encourage adoption of healthy habits at an early age
- Used a mixed approach to health promotion including mass media, community media, social mobilization, and capacity building

Communicable Diseases

Communicable Diseases Current Situation

A National Hygiene Promotion Strategy (NHPS) was developed in 2012 by the local government division of the Ministry of Local Government, Rural Development and Cooperatives. A National Communication Strategy for Sanitation, Hygiene and Safe Water Use was also developed with support from the United Nations Children's Fund (UNICEF) in 1998. Diarrheal diseases are still a top morbidity burden in Bangladesh. In 2014, a total of 2,135,220 diarrhea cases (and 23 deaths) were reported (Health Bulletin 2014).

Although communicable disease mortality is declining, indicating that Bangladesh is in the advanced stage of its epidemiological transition from communicable to non-communicable diseases, the persistent nature of diarrheal disease morbidity should be addressed while developing future communication strategies.

In terms of malaria prevention, the prevalence rate is 20.3/100,000 population (in endemic areas, in 2013) based on reported malaria cases and the malarial death rate is 0.0001/100,000 population (in endemic areas, in 2013) (Health Bulletin 2014).

TB, no longer carries a high mortality rate. TB Control Program is one of the major units of DGHS. As per the 2014 Health Bulletin, the TB (all forms) prevalence rate is 411/100,000 population and mortality rate is 45/100,000 population (Health Bulletin 2014). The TB treatment rate with Directly Observed Treatment, Short-course (DOTS) improved significantly and 92% of the new smear-positive cases registered in 2006 were successfully treated (NTP 2012).

HIV/AIDS

Bangladesh has an estimated HIV prevalence of less than one percent. However, the similarity of behavioral patterns in Bangladesh in comparison to heavily-affected regions in South and Southeast Asia suggests a possible rapid increase in HIV prevalence. With a population base of more than 150 million people, even a small increase to one percent would result in a total of 1.5 million cases. This possibility of uncontrollable epidemic proportions must be averted with appropriate preventive measures.

In Bangladesh, the first case of HIV was detected in 1989. In 2014, a total of 433 new cases of HIV infection, and 91 deaths due to AIDS, were reported. By the end of 2014, the cumulative number of recorded HIV cases had reached 3,674, and cumulative deaths had reached 563. However, a low estimate for the actual number of current HIV/AIDS cases is 9,500, indicating both the likelihood of incomplete reporting and the potential for growth of the epidemic in Bangladesh (UNAIDS 2015).

Risk factors for HIV infection in Bangladesh include:

- High rate of needle sharing among people who inject drugs
- Low condom use among key and bridging populations
- External and internal migration
- Porous border with neighboring countries where HIV prevalence is high
- Limited accurate knowledge of HIV/AIDS among young people
- High prevalence of Sexually Transmitted Infections (STI) among key populations
- Existence of punitive and conflicting laws

Among the general population:

- 70.4% of ever-married women aged 15-49 have heard of AIDS (BDHS 2014).
- Comprehensive AIDS knowledge is not widespread among women (11%) or men (17%) aged 15-49 (BDHS 2011).
- More men than women know how HIV is transmitted. Younger respondents are more knowledgeable about HIV prevention than older respondents aged 40-49 (BDHS 2011).
- The majority of ever-married women and men (92% and 82%, respectively) think that if a woman knows her husband has an STI, she is justified in refusing to have sex with him (BDHS 2011).

The communication strategies of Bangladesh, including the National HIV/AIDS Communication Strategy 2005-2010 and the Strategic Communication Plan for the HIV/AIDS Prevention Project (HAPP) Advocacy and Communication Component, include elements for a more integrated and strategic approach to addressing HIV/AIDS prevention, care, and support. They recognize the need to target vulnerable groups, improve the knowledge base, link knowledge with risk perception and preventive behavior, and increase service-seeking behavior.

Tuberculosis (TB)

TB has long been one of the most significant health problems in Bangladesh. More than 50% of the adult population is infected with *Mycobacterium tuberculosis*. Every year more than 300,000 people develop active TB; nearly 50% of them have infectious pulmonary TB and can spread the infection to others. About 64,000 people die every year from this disease. Bangladesh ranks sixth among countries with the highest burdens of TB (WHO 2014). A strategic plan for the National Tuberculosis Control Programme (NTP) was finalized in 2012. Bangladesh has implemented the Stop TB Strategy since 2006. It achieved high treatment success rates and the target of 85% treatment success was met in 2003.

One of the reasons for the spread of TB and Multi-Drug Resistant TB (MDR-TB) is the low nutritional status of patients, most of whom are poor. Drug-resistant TB and co-infection with HIV are growing concerns. The TB prevalence rate is 402 per 100,000 and the TB incidence rate is 224 per 100,000 (WHO 2014). Although the rates of MDR-TB in Bangladesh do not appear high, the absolute number may be high considering the high TB burden in the general population. A MDR-TB rate among new cases of 1% translates into approximately 3000 new MDR-TB cases per year. The Global Tuberculosis Report estimated MDR-TB rates of 1.4 % and 29% among new and previously treated TB cases respectively in Bangladesh (WHO 2014).

Avian Influenza (AI)

In Bangladesh the first outbreak of AI in poultry was declared on March 22, 2007. As of November 12, 2008, a total of 288 Human Pandemic Avian Influenza (H5N1) cases had been reported in 47 districts and 142 upazilas, resulting in the death of over 1.6 million birds. The first case of human infection with H5N1 in Bangladesh was reported in 2008, and two cases were reported in 2011. One human death due to H5N1 occurred in April 2013.

The greatest risk factor for AI seems to be contact with sick birds or with surfaces contaminated by their feathers, saliva or droppings. The World Health Organization (WHO) has confirmed a handful of cases of limited human-to-human transmission of AI. But infected birds or associated material present the greatest hazard. The pattern of human transmission remains mysterious. Young children seem especially vulnerable to the virus, although some experts note that children are more likely to have contact with sick birds or to play on ground contaminated with droppings. Moreover, people of all ages have contracted and died of AI worldwide. At this point, too few people have been infected to know all the possible risk factors for AI.

The National Avian Influenza and Human Pandemic Influenza Preparedness and Response Plan 2006-2008 (1st Plan) was prepared by a National Multi-sectoral Planning Team from the Ministry of Environment and Forest (MoEF), Ministry of Fisheries and Livestock (MoFL), and MoHFW, with joint technical support from the Food and Agriculture Organization (FAO) and the WHO. The 1st National Plan was approved by the Honorable Prime Minister of the People's Republic of Bangladesh on April 17, 2006. A Planning Team consisting of experts from MoHFW, MoFL, MoEF, and international organizations such as WHO, FAO, UNICEF and International Centre for Diarrhoeal Disease Research, Bangladesh (ICDDR,B), was formed to draft the 2nd National Avian and Pandemic Influenza Preparedness and Response Plan for 2009-2011.

Nipah Virus

Nipah virus infection is caused by the consumption of the raw sap of a date palm tree which has been contaminated with urine or saliva from infected fruit bats. When the sap is consumed, the virus infects the human body. Once infected, the patient can spread the virus to other people through physical contact.

Since Nipah virus first appeared in Bangladesh twelve years ago, 197 cases and 152 deaths have been reported. Traditionally outbreaks have taken place in 10 districts (Meherpur, Noagoan, Rajbari, Faridpur, Tangail, Thakurgaon, Kushtia, Manikgonj, Rajshahi and Lalmonirhat) known as the “Nipah belt” where raw date palm sap is a popular drink. However, Dhaka, reported its first Nipah case in January 2015.

Winter (December to early February) is the traditional date palm sap gathering season in Bangladesh. Outbreaks coincide with this season, appearing between December and May. The Institute of Epidemiology, Disease Control and Research (IEDCR), in collaboration with ICDDR,B, established Nipah virus surveillance in ten district-level government hospitals in 2006. Presently, a surveillance system is functioning in five hospitals in the Nipah belt.

Communicable Diseases Existing Communication Activities

HIV/AIDS

Save the Children's Global Fund for AIDS, Tuberculosis and Malaria (GFATM): Targets high-risk-behavior populations with Drop-in Centers using peer education and outreach. Currently, the Rolling Continuation Channel (RCC) portion is due to conclude in December 2015. ICDDR,B is implementing limited targeted interventions among men who have sex with men (MSM) and Hijra to increase awareness about HIV/AIDS, STI treatment, correct and consistent condom use, testing, and counseling.

Link Up: A multi-country program funded by Dutch Foreign Ministry-BUZA to reduce unintended pregnancies, HIV transmission and HIV-related maternal mortality among young people affected by HIV (aged 10-24). It uses a peer educator model emphasizing IPCC to promote better sexual and reproductive health and rights (SRHR) and age-appropriate information and services. Key populations are defined groups who, due to specific high-risk behaviors, are at an increased risk for HIV infection. Implemented by HIV/AIDS and STD Alliance Bangladesh (HASAB), Marie Stopes and Population Council.

National AIDS/STD Programme (NASP): Scaled up communication efforts in collaboration with Save the Children, ICDDR,B, and CARE Bangladesh to inundate communication channels with information about HIV/AIDS. These channels included electronic and print media (talk shows, documentaries), souvenirs (coat pins, t-shirts), and open dialogue by famous persons.

Mattra Foundation and Save the Children's Expanding HIV Prevention Information through Mass and Print Media Campaigns: Targets young people, most at-risk populations (MARPs), and the masses in a limited scale through IPCC, group meetings, outreach, mass media, and World AIDS Day.

Tuberculosis

NTP: Works to eliminate TB using the DOTS strategy; implemented in November 1993.

TB CARE II: A five-year project (2010-2015) implemented by a consortium of health and development organizations led by University Research Co., LLC (URC). Aligned with the GoB's TB strategic plan and the USAID/Bangladesh TB strategy, the project aims to reduce mortality and morbidity due to TB by improving universal access to diagnosis and treatment, providing high-quality DOTS through all levels, and increasing access to prevention, diagnosis and treatment of MDR-TB.

Challenge TB: The fourth global USAID TB control program led by Management Sciences for Health (MSH).

GFATM-Funded Reduction of TB Prevalence by 6% by 2017: NTP has established a partnership with different NGOs and the private sector. Currently, 44 partners are working with NTP in different areas.

BRAC: Works with community stakeholders to identify patients, ensure treatment adherence, and reduce stigma. Some specific groups include: cured TB patients, local opinion and religious leaders, girls guides and scouts, other NGO workers, village doctors, pharmacists, and private medical practitioners. To broaden the reach of TB messaging, BRAC also utilizes local popular theatre shows and folk songs.

National Anti-tuberculosis Association of Bangladesh (NATAB): Signed a memorandum of understanding (MOU) in 2004 with the MoHFW and BRAC, and became a partner of the NTP funded by GFATM. Organizes quarterly divisional, district and upazila-level advocacy meetings with civil society members in all 7 divisions and 64 districts of the country. Celebrates World TB Day with NTP & partner NGOs in all 64 districts.

Society for Empowerment, Education and Development (SEED): Collaborates with the government (DGHS and NTP) to develop innovative programs to improve the effectiveness of community-based health service delivery.

NHSDP: Works with the NTP to combat TB through the Smiling Sun clinic network. NHSDP organizes Advocacy, Communication and Social Mobilization (ACSM) activities, and provides basic and need-based training for TB program implementation, especially among garment workers, pharmacists, HIV/AIDS workers, religious leaders, and others using IPCC, group meetings, outreach, mass media, and World TB Day.

Avian Influenza

The GoB prepared a National Avian Influenza and Human Pandemic Influenza Preparedness Plan 2006-2008 in order to prepare an epidemic of H5N1. A massive campaign program was developed and implemented under this strategy across the country.

The major communication activities are:

- **IPCC:** One-to-one communication at the community level, especially with poultry farmers, poultry workers, and factory owners.
- **Group Meetings:** At poultry farms and at the community level
- **Outreach:** Videos, folk shows, posters, leaflets, and stickers
- **Mass Media:** TV spots and newspaper advertisements
- **Materials:** A number of materials were produced by IEDCR, UNICEF and FAO including posters, leaflets, brochures, stickers, media kits, pocket books, and booklets for health workers.

Nipah Virus

With no treatment or vaccine available for either humans or animals, public awareness is key for prevention. The Bureau of Health Education (BHE) has undertaken awareness-raising campaigns to warn people against drinking raw date palm sap. BHE disseminates messages via leaflets, newspaper advertisements, talk shows, local TV discussions, and community mobilization.

Communicable Diseases Communication Gaps

HIV/AIDS

- No national communication strategy for the NASP. Limited scope for scale-up of communication activities among high-risk groups and no separate strategic objective for advocacy and communication in the current 3rd National Strategic Plan for HIV and AIDS Response 2011-2015.
- Barriers of displaying communication materials at border entry points

Tuberculosis

- No national communication strategy for the TB program.
- Communication activities are focused on service delivery, not prevention and behavior change.
- Communication activities and messages are not reaching hard-to-reach populations (underserved geographic areas, prisons, slums, pavement dwellers, etc.)
- Inadequate/poor knowledge about TB, accessing services, and treatment adherence by providers and the community, especially regarding TB in children.
- Poor attitudes and behaviors of service providers toward patients.

Avian Influenza

The Bangladesh National Communication Strategy and Action Plan for Avian Influenza and Human Pandemic Influenza 2007 and the 2nd National Plan for 2009-2011 has not been updated or revised for the next course of action. At present, there are no ongoing or regular communication campaigns or advocacy activities except for surveillance by IEDCR, and occasional message dissemination by BHE.

Nipah Virus

At present there are no regular ongoing communication activities and there is no national program designed for long or medium-term communication implementation to prevent the spread of Nipah virus. Also, there is no synergistic coordination mechanism within GoB or between GoB and NGOs.

Communicable Diseases Communication Opportunities

HIV/AIDS

- Target injection drug users (IDUs), commercial sex workers (CSWs), and vulnerable adolescents to reduce needle sharing and unprotected sex.
- The International Congress on AIDS in Asia and the Pacific (ICAAP) will be hosted in Dhaka in November 2015. Opportunity to create visibility and momentum for HIV communication.
- Comprehensive information on all aspects of HIV (prevention, transmission, testing, sero-status, living with HIV, treatment, and reducing stigma).
- Teach psycho-social life skills such as negotiation, conflict resolution, and decision-making while promoting HIV prevention.
- Link people living with HIV to nutrition programs and projects.

Tuberculosis

- Create a long-term, evidence-based, results-oriented SBCC communication plan.
- Integrate proper and adequate nutrition information in TB-specific messaging.

Avian Influenza and Nipah Virus

- Develop an extensive mass media campaign involving decision makers, community leaders, health workers, and livestock departments to increase awareness among the general population regarding the AI pandemic. Produce and distribute information, education and communication (IEC) materials through IPCC and group meetings to develop local-level solutions for adopting behaviors.
- Orient school teachers to educate students on hygiene practices to prevent the spread of AI.
- Use local folk media (e.g. folk songs, gomvira, street drama, etc.) designed for general population that can be presented in villages, schools and workplaces followed by discussions.
- Via the Sisimpur project, create awareness and educate school-age children.

Communicable Diseases Keys for Successful Communication

- In the case of epidemics, do not use fear-based messaging
- Make sure that messages are harmonized and targeted
- Develop adequate infrastructure to deliver messages to target audience
- Communication should reflect a realistic indication of the threat and highlight preventative measures and behaviors

POPULATION

Family Planning (FP): Current Situation

The national FP program has seen significant success during the last four decades. Overall Contraceptive Prevalence Rate (CPR) has risen from 7.7% in 1975 to 62.4% in 2014, while TFR has declined from 6.3 to 2.3 during the same time period. Contraceptive use is equally high regardless of education level or economic status (BDHS 2014).

However, use of modern contraceptives is only 54.1%. Discontinuation rates are high at 30%. The national unmet need for FP is 12% among married women, and much higher in Sylhet (17.7%) and Chittagong (17.3%) divisions. Sharp geographic differences are also present in CPR and TFR. Met need for FP ranges from a low of 47.8% in Sylhet to a high of 69.8% in Rangpur; TFR ranges from 1.9 in Khulna and Rangpur to 2.9 in Sylhet. Variations can also be seen between urban and rural areas: the urban TFR is 2.0, while the rural TFR is 2.4 (BDHS 2014).

In Bangladesh, the median age at first marriage for girls is 15.5 years, and median age at first birth is 18.1. By age 20, 30% of women have had a baby or are pregnant. 53% of currently married women aged 15-19 are not using any contraceptives (BDHS 2011).

The contraceptive method mix is heavily skewed toward short-term methods, despite the fact that the desired family size is typically reached by a woman's early to mid-20s (BDHS 2011). While overall awareness of Long-acting and reversible contraceptives (LARC) and permanent methods (PM) is high at over 90%, specific knowledge of individual LARC/PM varies widely by division. Among men and women who have completed their desired family size, the intention to use permanent methods is low: less than 3% according to the Bangladesh Urban Health Survey (BUHS). Reasons for not choosing LARC/PM include fear of side effects, associations of some LARC/PM with certain socio-economic groups, and other myths and misperceptions (BUHS 2013).

Annually, 25% of all pregnancies result in abortion or menstrual regulation (MR). Each of these 1.3 million procedures represents a girl or woman in need of FP (BDHS 2011).

The GoB Strategic Plan for HPNSDP 2011-2016 includes goals of reducing the TFR; promoting HTSP; improving the quality of the national FP program; reducing the contraceptive discontinuation rate; and promoting LARC/PM.

At the 2012 FP Summit in London, the GoB committed to the following targets:

- Reduce TFR to 2.0 by 2016, and further reduce to 1.7 by 2021
- Increase CPR from 61% to 80% by 2021
- Increase share of LARC/PM from 7% to 20% by 2016, and to 30% by 2021
- Reduce unmet need from 12% to 7% by 2021
- Reduce discontinuation rate of FP method from 36% to 20% by 2021

SBCC to generate demand for FP, and to promote consistent and correct use of FP methods, is an essential component of a comprehensive strategy to meet these targets.

Family Planning: Existing Communication Activities

Current SBCC activities are in place at national and local levels, with MoHFW DGFP, the United Nations Population Fund (UNFPA), USAID and Marie Stopes playing leading roles.

DGFP, mainly through its IEM Unit, promotes themes of appropriate family size, appropriate age of marriage and initiation of childbearing, HTSP, ARH, and LARC/PM. DGFP spreads its messages and generates demand for FP via mass media (television, radio, short film, newspaper, billboards, etc.), traditional media (street drama, folk song shows, etc.), community mobilization (trainings/orientations for local and religious leaders and influential gatekeepers, AV vans, service campaign weeks, World Population Day, etc.) and IPCC via Family Welfare Assistants (FWA) and Family Welfare Visitors (FWV).

UNFPA launched a national FP campaign in November 2013, with implementation taking place from July 2014 to December 2016. The campaign is in partnership with DGFP and Engender Health, and focuses on specific geographical areas and vulnerable age groups, i.e. adolescents and young people ages 15-24. Key messages include delaying marriage and pregnancy, using modern contraceptives to delay first pregnancy, HTSP, and using LARC/PM to space births and limit family size. Communication channels include electronic media, social media, print media, outdoor media, and IPCC.

Four **USAID** implementing partners are involved in FP demand generation:

- **EngenderHealth's Mayer Hashi project** primarily promotes LARC/PM and post-partum FP (PPFP) via community mobilization and IPCC. The project also provides trainings for journalists, religious leaders, and FP providers.
- **USAID-DFID NHSDP** provides the full Essential Services Package (ESP) including FP through its nationwide network of static and satellite clinics. NHSDP also employs Service Promoters to generate demand for FP at the community level.
- **SMC's MIH project** aims to promote healthy behaviors, reduce harmful practices, and increase care-seeking practices while reaching out to new audiences. MIH complements SMC's promotion of its branded contraceptives. MIH works with four local partners in 19 districts to promote HTSP; 1,000 Days; healthy pregnancy; ARH; and decrease tuberculosis (TB) using a variety of SBCC approaches.

- **Save the Children's MaMoni HSS project** integrates FP services into a comprehensive MNCH/FP/Nutrition package, with service delivery at both the household and facility level. MaMoni HSS uses a variety of SBCC approaches and methods (including community meetings, video shows, job aids, billboards, cable tv, etc) to generate demand for FP and link eligible couples to services.

Another USAID-funded project, Bangladesh Knowledge Management Initiative (BKMI), supports the GoB, USAID implementing partners and other stakeholders to create consistent, coordinated, effective and evidence-based SBCC for FP and other topics.

Bangladesh Center for Communication Programs (BCCP) is the SBCC partner for NHSDP, and was the SBCC partner during the first phase of Mayer Hashi.

Marie Stopes has service delivery sites in 62 districts, including static clinics and roving teams, and collaborates with the GoB in 45 of those districts. Marie Stopes uses a variety of communication channels that are targeted to the intended audience, such as slide shows for garment workers; community volunteers in hard-to-reach areas; peer education via tea vendors to promote non-scalpel vasectomy (NSV) among men; and targeted, comprehensive mass media campaigns.

Other organizations such as BBC Media Action, Ipas, Family Planning Association of Bangladesh (FPAB), BRAC, Plan, Concerned Women for Development (CWFD) and Jica are also working in the realm of SBCC for FP. Some have a particular focus on MR or post-abortion care (PAC), while others have been more active in the past than at present.

Family Planning Communication Gaps

- While overall awareness of FP is very high, specific knowledge of each FP method is lacking. In addition, heavy reliance on short-term methods points to the need for a more complete and accurate understanding by FP users of LARC/PM and the dispelling of myths and misperceptions.
- Communication to help users understand how FP needs change throughout the reproductive life cycle is lacking.
- Unmarried adolescents have difficulty in accessing information on RH and FP.
- Need to target the adolescent population and provide correct ASRH information and quality services.
- Counseling on PPF is generally lacking. Some challenges include the preference of most women to deliver at home, and the fact that institutional deliveries at public facilities aren't equipped with FP knowledge or services since they are operated by DGHS. Overall quality of FP counseling appears to be weak.
- A huge number of abortions and MRs take place in Bangladesh each year, which are generally associated with unplanned pregnancies. Post-abortion and post-MR FP counseling needs to be improved.
- The majority of the responsibility for FP continues to fall on women, there is a lack of information given at service delivery points, and there is no comprehensive program for male involvement in FP.
- Insufficient focus on geographic differences in FP acceptance and use, social norms, community support, language, etc.

Family Planning Communication Opportunities

- Integrate FP with MCH and Nutrition at the household level, positioning FP as a natural, important, and changing part of one's life cycle.
- Improve the reach and effectiveness of PPF.
- Provide PPF counseling during field worker home visits within 48-72 hours of birth.
- Improve the reach and effectiveness of FP counseling as part of PAC and post-MR.
- Consider innovative and socially acceptable ways to introduce RH and FP topics to unmarried adolescents, so that individuals enter marriage with RH knowledge and an intention to use FP.
- Use positive deviants to counter myths and misperceptions and provide role models and promote LARC/PM.
- Involve communities and imams/religious leaders to strengthen social support for FP users, especially for LARC/PM.
- Engage men to increase their FP knowledge and to participate in and/or support FP decisions.
- Expand communication efforts to focus not only on message delivery, but also to facilitate dialogue on how to remove barriers to FP use (in general and for specific methods).
- Communicate MoHFW's attitude shift about providing FP information to unmarried adolescents to service providers and gatekeepers at the grassroots level, and also address social norms that traditionally have forbade providing RH, FP and SH information to unmarried adolescents.
- Design communication activities that address geographic differences in FP acceptance and use, social norms, community support, language, etc.
- Expand urban FP programs and introduce evening satellite clinics for female garment workers.
- Partner with expert agencies and promote the involvement of private sector in lifestyle and environment issues (e.g. the 'Call Centre' partnership with SMC).
- Establish 'folk-teams/theatre groups' in seven divisions to arrange folk-shows/street theatre in local dialects and also closely work with IEM-DGFP and SMC AV-Van programs.
- Strengthen the Management Information System (MIS) of DGFP and reporting mechanisms/tools for SBCC to map progress.
- Strengthen the capacity of the Population Cells of Bangladesh Betar and BTB.

Family Planning Keys for Successful Communication

To achieve high quality outcomes in population and FP initiatives, an SBCC program should follow a process (e.g. research and analysis, strategic design, development and pretesting, implementation and monitoring, and evaluation.) Effective SBCC also requires skilled managers and staff.

SBCC activities cut across all service delivery plans of DGFP units. However, IEC-Operational Plan (IEC-OP) requires capacity strengthening to perform in a more comprehensive and coordinated manner. SBCC activities need to be implemented nationally with a strategic focus to capture the differential needs of regions with varying socio-economic conditions (e.g. low-performing areas, target groups, vulnerable populations, ethnic variations, cultural practices, etc.).

- Regional variation in uptake of certain services indicates a need for effective SBCC interventions specific to low performing areas;
- Early marriage associated with early birth of the first child is not addressed properly and coordination between different ministries needs to be strengthened;
- Create specialized interventions to increase CPR, lower TFR, MMR, IMR, and neonatal mortality, and increase use of LAPM;
- Address unmet need and drop-out rates to reach replacement level fertility and recommended birth spacing;
- Promote the consequences of child marriage and benefits of delayed pregnancy;
- Vigorously promote FP as a lifestyle for women empowerment;
- Design a special campaign to promote PFPF;
- Foster innovations for health promotion activities; carry out research and SBCC impact study activities in regular intervals to feed into policy and program processes, which include
 - periodically assessing SBCC program performance and modalities
 - exploring effective SBCC approaches (media, target population, etc.) based on evidence
 - establishing SBCC monitoring system
 - wider use of social media, information and communications technology (ICT), community radio, mobile technology to reach adolescents and young population
 - digitize the FP Couple Register
- **Apply key approaches for FP**
 - Life Cycle Approach
 - ICT and Social Media
 - Entertainment-education
 - Knowledge Management (KM)
 - Evidence-based programming
 - Capacity Building at individual, system and organizational levels

NUTRITION

Nutrition Current Situation

The prevalence of chronic under-nutrition in children under five has reduced over the past fifteen years. The level of stunting among children under 5 has declined from 51% in 2004 to 36% in 2014 (BDHS 2014). However, progress has been mixed due in part to natural disasters, food price fluctuations, and ongoing poor feeding and care practices. Rates of under-nutrition remain alarmingly high. The World Food Programme (WFP) Bangladesh Nutrition Strategy 2012-2016 reported that children 6-23 months have the highest risk of wasting, stunting and being underweight (WFP 2012). 36% of children under five years are stunted, while 12% are severely stunted (below -3SD). Rural children are more likely to be stunted than urban children (38% vs. 31%), and children of mothers with no education are more likely to be stunted (40%) than children of mothers who have completed secondary and higher education (29%). A similarly large differential exists by wealth quintile. Also, 14% of children are considered wasted or too thin for their height. Furthermore, 33% of children are underweight (low weight for age), and 8% are severely underweight (BDHS 2014). 20% of the population exists under the poverty line and often cannot easily identify or access nutritious food. Large families with limited income are unable to meet additional nutrition requirements during a child's critical first 1000 days of life. Also, mothers and families are not fully aware of the benefits and consequences of appropriate complementary feeding; they do not know appropriate feeding approaches and doable means; socio cultural norms and beliefs prevent implementation of recommended practices, especially with regard to maternal nutrition and breastfeeding (WFP 2012).

Progress on many nutrition indicators, including infant and young child feeding practices (IYCF), has been slow or is stagnating. Rates of early initiation of breastfeeding and exclusive breastfeeding (EBF) before 6 months have remained at 45% over the past 20 years according to surveillance data, while BDHS 2011 reports that intensive SBCC played a contributory role in increasing EBF to 64% (BDHS 2011). However, recent data show a decline in EBF to 55% due to lack of a sustained community-based campaign. Bottle feeding is common in Bangladesh; 22% of infants 6-9 months are fed with a bottle (BDHS 2014). IYCF practices among children 6-23 months slightly increased, but are still very low even among the children of highest wealth quintile. IYCF practices among children 6-23 months is 23% according to BDHS 2014. Complementary foods are introduced at an early age. While 62% of children start receiving complementary food after 6 months, both quality and quantity of food tend to be insufficient. Only 23% of children are fed with at least four food groups and with the recommended meal frequency (BDHS 2014). According to the Nutrition Background Paper for Preparation of 7th Five-Year Plan, less than 40% of children under two years of age received a minimum acceptable diet (BUHS 2013). 75% of the population do not practice recommended hygiene behaviors.

Overall, 13% of ever-married women fall below the cut-off average height of 145cm (BDHS 2011). Ideally, women should have optimal nutrition prior to becoming pregnant. Malnutrition during pregnancy can cause severe complications for the mother, and can result in a low birth-weight baby. Following birth, a woman continues to need proper nutrition and sufficient caloric intake to support breastfeeding and recover from delivery.

IYCF and WASH activities are very poor in urban areas, especially in the slums, and inequality is high for complementary feeding and handwashing (BUHS 2013). The Food Security and Nutrition Surveillance Project identified insufficient handwashing, poor maternal diet and reduced IYCF practices as key contributory factors to increasing the rate of undernutrition.

Facility-based SBCC has been given adequate focus, but community-level SBCC has not. Lack of privacy has been observed in both public and private facilities. Hospital readiness in terms of SBCC has not yet been assessed. Proper nutrition from pregnancy through a child's second birthday is vital for optimal brain development and physical growth. This time period is a unique 1,000 day window of opportunity that can give children the best possible start in life.

Undernutrition in the first 1,000 days has lifelong and largely irreversible impacts because it impairs physical and mental development. It increases risk of chronic diseases and premature death in adulthood, and negatively affects the lifelong ability to learn, be economically productive, and earn income, which perpetuates poverty. In short, undernutrition undermines all aspects of development.

Well-nourished children are better able to learn in school, have higher IQs and earn higher wages as adults, which allows them to contribute more to the economic and social development of their family and the country. Every \$1 spent on improving nutrition can have a \$30 return on investment. In Bangladesh, seven million children under the age of 5 are chronically undernourished and one in four mothers is undernourished, including a high proportion of adolescent girls. Making nutrition a top priority will boost national growth and development, improve social equity and empower girls and women. Today's challenge is ensuring good nutrition for all.

The GoB has taken several important steps to improve IYCF, including the adoption of a National IYCF Strategy (2007). In September 2012, the Prime Minister indicated her high level commitment by stating, "Malnutrition is the largest single contributor to physical and mental under-development and disease."

Remaining challenges include meeting HPNSDP 2011-2016 targets and MDGs 4 and 5 by 2015 due to geographical disparities, urban-rural differences, lack of adequate information and support, provider limitations, and clinical and health system challenges. Another major gap identified in reaching the MDGs is the vertical nature of the health system including SBCC interventions with little integration and coordination. As a result, there is duplication of activities, messages, materials, and activities are often inconsistent or contradictory.

Nutrition Existing Communication Activities

- **GoB National Nutrition Services (NNS) Operational Plan 2011-2016/IPHN, MCH, IEM units**
- **Strengthening Partnerships, Results, and Innovations in Nutrition Globally (SPRING):**
 - o IPCC: Nutrition counseling
 - o Group Meetings: Coordination with GoB; advocacy meetings
 - o Outreach: Farmer Days for Nutrition; World Breastfeeding Week; Global Hand Washing Day
- **SPRING (with SHIKHA, AIN and USAID Horticulture Project):**
 - o Outreach: Media Dark Campaign
- **SHIKHA:**
 - o Promotes pregnant women's diet and IYCF practices in 26 Feed the Future sub-districts in Barisal and Khulna divisions using multiple channels of SBCC.
 - o Media Dark Campaign is targeted to villages that are fully or partially not electrified and with limited access to media.

- o Outreach: Seven national TV advertisements on IYCF and hand washing, which address specific barriers to good IYCF practices. The project conducts mass media campaigns using audio-video aids in villages that otherwise lack access to national media.
- **WFP/Improving Maternal and Child Nutrition:**
 - o Group Meetings: SBCC on nutrition and hygiene practices through awareness-raising sessions (face-to-face interaction between SBCC provider and beneficiaries)
- **Increasing awareness/knowledge through IPCC, outdoor media, mobile phones, websites, mass media**
- **Outreach activities; Observation of special national/international days; theater, celebrity endorsement, etc.**
- **Establishment of 130 nutrition corners that train health workers and provide logistics**

Nutrition Communication Gaps

Knowledge/information:

- Families and communities are unable to identify symptoms of moderate and severe acute malnutrition.
- People may not always understand why dietary diversity is important for a child's development.
- Poor understanding about the adequacy of colostrum and the danger of pre-post-lacteals; insufficient skilled support given to mothers on position, attachment, and expression of breast milk and feeding of small newborns. (Identified in the National Communication Framework and Plan for IYCF in Bangladesh, October 2010)
- Insufficient information on micronutrient-deficiency diseases, and the availability of micronutrients from food or supplements.
- Iodized salt is directly linked with the development of a child's brain. In Bangladesh, 57% of the population uses iodized salt.

Approaches:

- Growth monitoring is not done; materials and messages are not adequately harmonized; nutrition counseling is not conducted; community management of acute malnutrition (CMAM) and supplementary feeding are not properly executed.
- Media do not give proper attention to nutrition or have capacity for nutrition coverage.
- Lack of a comprehensive communication plan for nutrition throughout the life cycle.
- NNS SBCC activities are mainly facility-based, not focused on the community level.
- Inadequate focus on post-disaster nutrition need, adolescent nutrition, food safety, and good manufacturing practices.
- IPCC is not taken seriously as a specialized skill

Nutrition Communication Opportunities

Nutrition is a multi-sectoral issue. This presents both challenges and opportunities to reinforce knowledge and skills, and to create an environment that is supportive of nutrition throughout the life cycle.

- Train journalists on how to report on child nutrition issues (proper IYCF practices) and maternal nutrition issues (proper nutrition before, during, and after pregnancy).
- A Nutrition Advocacy and Communication Strategy was developed and shared with MoHFW for approval. It is multi-sectoral guide for promoting good nutrition throughout Bangladesh.
- Continue to explore innovative ways to link with other sectors, such as Agriculture, Information, Education, and Food to promote nutrition.
- Orient mothers of young children to the information contained in the Growth Monitoring and Promotion (GMP) card. Teach mothers and other caregivers recommended care, feeding, and hygiene practices for young children.
- MoHFW hosts the national Focal Person for the Scaling-Up Nutrition (SUN) movement, is in charge of NNS, and has set up a Steering Committee for Nutrition Implementation (SCNI). It also coordinates multi-sectoral contributions and seeks to mainstream nutrition across ministries and health services.
- The Ministry of Food (MoFood) is in charge of implementing the National Food Policy, which requires coordination between 13 lead ministries including the MoHFW and a multitude of implementing agencies. Within the MoFood, the Food Planning and Monitoring Committee (FPMC) was set up to provide strategic high-level inter-sectoral collaboration at the Cabinet level.
- The MoFood, through the Food Planning Monitoring Unit (FPMU), is also responsible for spearheading the Country Investment Plan (CIP) which focuses on food security with multi-sectoral nutrition components.
- The launching of the 2015 National Nutrition Policy, the reinvigoration of the Bangladesh National Nutrition Council (BNNC) and the finalization of 7th Five Year Plan, offer a potentially strong policy environment for nutrition.
- Civil Societies, NGOs and private sectors are actively engaged with the GoB through different platforms such as Nutrition Working Group (NWG) and Civil Society Networks.

Nutrition Keys to Successful Communication

- Use Nutrition-Specific and Nutrition-Sensitive Interventions to prevent and reduce malnutrition.
- Increase rural women's understanding and ownership of nutrition in their families through participatory community-based nutrition services such as preparation of Pusti Packets.
- Generate community ownership of nutrition services through a carefully planned and implemented social mobilization process that engages and empowers local communities.
- Integrate and coordinate nutrition interventions into all relevant sectors.

GENDER BASED VIOLENCE

The Violence against Women (VAW) Survey 2011 revealed that 87% of currently married women have experienced any type of violence by current husband and 65% of married women experienced physical violence perpetrated by their current husbands in their lifetime. According to the World Bank (2009) GBV has severe and long-lasting human health implications due to: fatal outcomes, acute and chronic physical injuries and disabilities, serious mental health problems and behavioral deviations increasing the risk of subsequent victimization, gynecological disorders, pregnancy and labour related complications – including miscarriages, pre-eclampsia, premature labour and low birth weight, unwanted pregnancies, obstetric complications and HIV/AIDS. SBCC activities to deconstruct traditional and harmful gender norms and practices are ongoing, however require further strengthening and a focus on health sector response to GBV.

SOCIAL AND BEHAVIORAL CHANGE COMMUNICATION (SBCC) COORDINATION

SBCC Coordination Current Situation

Coordination is crucial for successful implementation of SBCC. Good coordination can reduce duplication, amplify effects, leverage resources and create efficiencies. Ultimately beneficiaries benefit from improved coordination when they receive consistent, accurate information on HPN from multiple sources.

Coordination can include aligning programs; sharing or pooling resources; harmonizing messages; joint strategic planning; adapting and/or re-purposing SBCC materials; filling in programmatic gaps; designing complementary approaches; seeking opportunities for synergy; promoting linkages with other programs, including services; ensuring that local and national-level activities are complementary and reinforcing; and more.

Coordination (or lack thereof) of SBCC activities can take place in a variety of ways. For example, at the central level, coordination among USAID implementing partners; coordination between USAID implementing partners (individually or collectively) and the GoB; coordination within the GoB (between and among directorates and units of the MoHFW; and between MoHFW and other Ministries); and coordination among diverse stakeholders (government, development partners, local and international NGOs, private sector, etc.) can all be considered.

At the district level and below, significant coordination among diverse actors is necessary to maximize SBCC resources and engage effectively with audiences. As this situation analysis will inform a national strategy, this section focuses primarily on central-level coordination.

SBCC Coordination Existing Activities

Two of the main objectives of BKMI are to improve coordination around SBCC within MoHFW, and to cultivate a multi-sectoral Community of Practice (CoP) for SBCC in Bangladesh, in the interest of facilitating coordination. Although BKMI works primarily with MoHFW, the broader range of stakeholders also benefits from the following coordination activities:

The **BCC Working Group (BCCWG)** began in 2011 as a CoP for HPN SBCC professionals. Members include representatives from government, development partners, NGOs, private sector, universities and the media. The group meets regularly to network, share experiences, improve coordination, and strengthen their SBCC capacity. The BCCWG was formally recognized by the MoHFW in May 2013 and operates under the guidance of Additional Secretary Roxana Quader. BKMI is establishing a sustainable leadership structure for the group so that it lives beyond the life of the project.

One of the key outputs of the BCCWG is the **National Communication Framework for Effective HPN SBCC**. The need for a common framework arose following a review of government and non-government communication strategies in 2012. The framework was developed via an iterative and participatory process, and was approved by the MoHFW in December 2013.

The **HPN SBCC Coordination Committee** was formed in order to promote coordination around SBCC within the MoHFW. The committee first met in December 2012, and consisted of representatives of three units: BHE in DGHS, IEM in DGFP and IPHN in DGHS. Over time, other units such as MCH and CCSDP of DGFP have also begun attending the bi-monthly meetings. The committee, with support from BKMI, has written a Terms of Reference, and is seeking formal recognition from MoHFW in the interest of sustainability.

BKMI is supporting the establishment of **digital archives** in three units (BHE, IEM, IPHN). The digital archives contain a record of all SBCC materials that have been produced by the three units in recent years, and can be viewed via the internet. Making the materials publicly accessible will reduce duplication, and make it easier for non-government actors to harmonize their SBCC activities with government initiatives. IEM's digital archive is currently online (<http://dgfpbd.org/digitalarchive/>), while BHE's and IPHN's are still under construction.

The **HPN SBCC eToolkit for Field Workers** (<https://www.k4health.org/bangladesh-toolkits>) is a consolidated and integrated resource to support counseling by field workers and service providers. Similar to the digital archives, the HPN SBCC eToolkit for Field Workers contributes to reducing duplication, and helps to identify gaps and opportunities for collaboration in existing communication materials.

The **IEC Technical Committee** oversees the process of approving SBCC materials before they are produced/disseminated. This is mainly a government body, while one seat is occupied by BCCP. The IEC Technical Committee mainly assures that all information is consistent with current MoHFW policies and guidelines. BKMI works with the IEC Technical Committee to strengthen its capacity by providing training in Leadership for Strategic Communication, and by standardizing the committee's review criteria.

SBCC Coordination Gaps

- The vertical nature of the MoHFW poses a challenge to coordination, with parallel structures in place for DGHS and DGFP.
- The SBCC function in MoHFW is not consolidated. While three units (BHE, IEM, IPHN) have the main responsibility for HPN SBCC, other units also conduct their own SBCC activities.
- Coordination between MoHFW and other Ministries is sporadic and inconsistent.
- Development Partners do not always know how their counterparts are using SBCC in the programs and projects they are supporting.
- Many national and international NGOs (including USAID implementing partners) focus on achieving the objectives of their respective projects. As a result, SBCC activities tend to be project-focused. This is a missed opportunity to create a more comprehensive, strategic and synergistic SBCC approach.
- Capacity for coordination is limited, in both government and NGOs. While it is easy to agree that it is important, coordination does not happen easily or naturally. Coordination requires dedicated, sustained effort; resource allocation (including extra time); diplomacy, facilitation, and KM skills; and a lot of patience.

SBCC Coordination Opportunities

- Continue to nurture and promote the coordination activities mentioned above:
 - o Support the transition of the BCCWG leadership to a multi-sectoral Steering Committee.
 - o Promote the use of the National Framework for Effective HPN SBCC among all stakeholders to strengthen institutional capacity and combat capacity loss due to frequent personnel turnover.
 - o Support the formalization of the HPN SBCC Coordination Committee.
 - o Promote the digital archives of three units and the HPN SBCC eToolkit for Field Workers as tools to minimize duplication and harmonize messaging.
 - o Further strengthen the IEC Technical Committee; Digitize the submission and approval process, and make the process more transparent; Maintain a publicly-accessible digital archive of approved materials; Explore applications for the use of ICT, social media, and mobile technology.
 - o Promote the practice and culture of sharing best practices and lessons learned related to coordination.
- Align efforts for coordination between MoHFW and other Ministries, such as Ministry of Local Government, Ministry of Youth and Sports, Ministry of Women and Children's Affairs, Ministry of Religious Affairs, Ministry of Social Development, and others to address health from a life-cycle approach.
- Explore collaboration around SBCC with the private sector.
- Promote coordination at different levels: central, regional, grassroots.
- Create temporary working groups to develop specific campaigns that increase visibility and impact.
- Support dialogue among Development Partners regarding SBCC initiatives.
- Ensure service delivery matches with proper demand generation and vice versa.
- Strengthen capacity for planned, data-driven, theory-based, and audience-focused SBCC.
- Coordinate with different stakeholders to balance messaging between risk reduction and reasonable and accessible treatment options.

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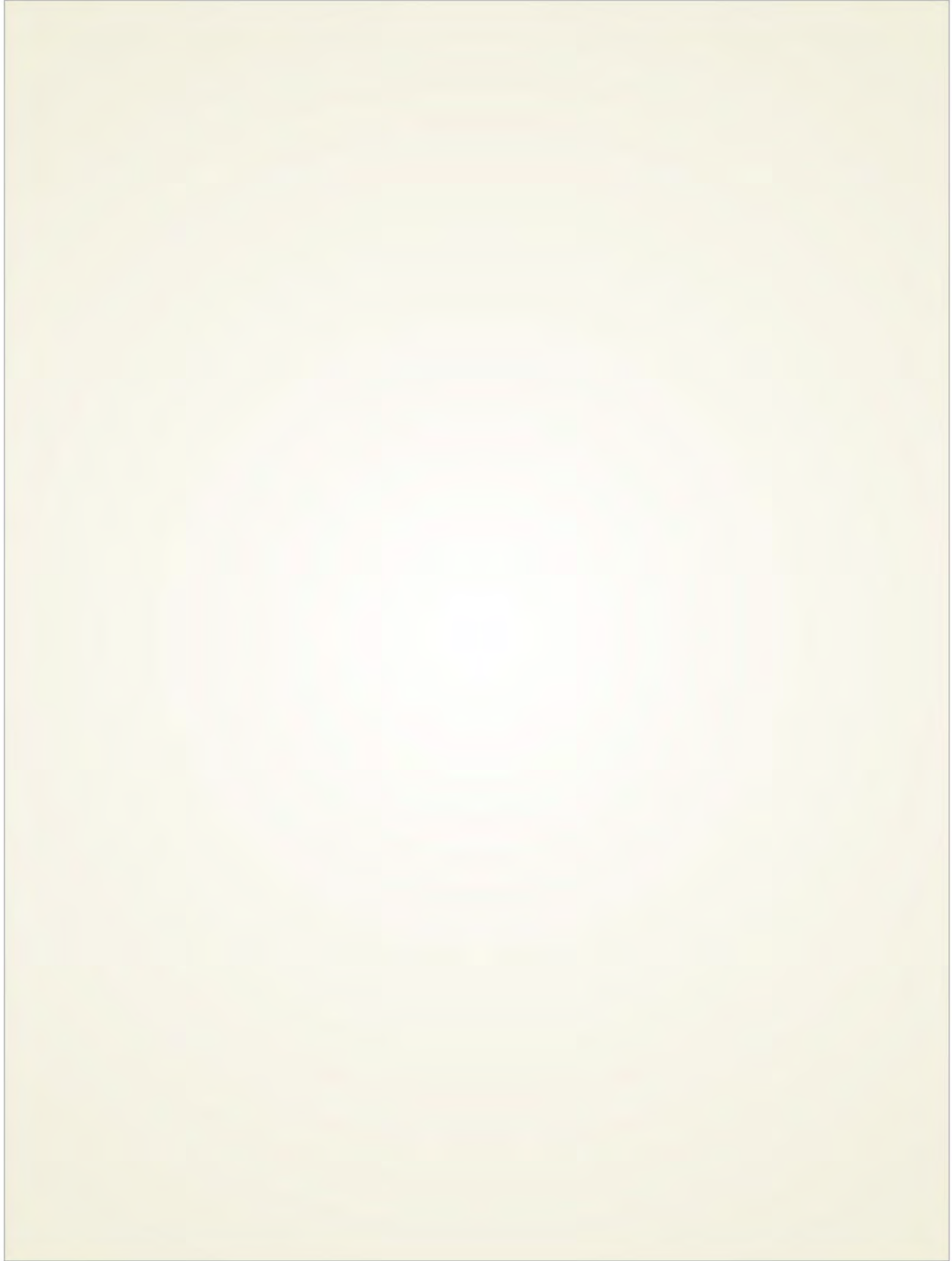
Annex 4
Communication and Behavioral Theories

Communication and Behavioral Theories

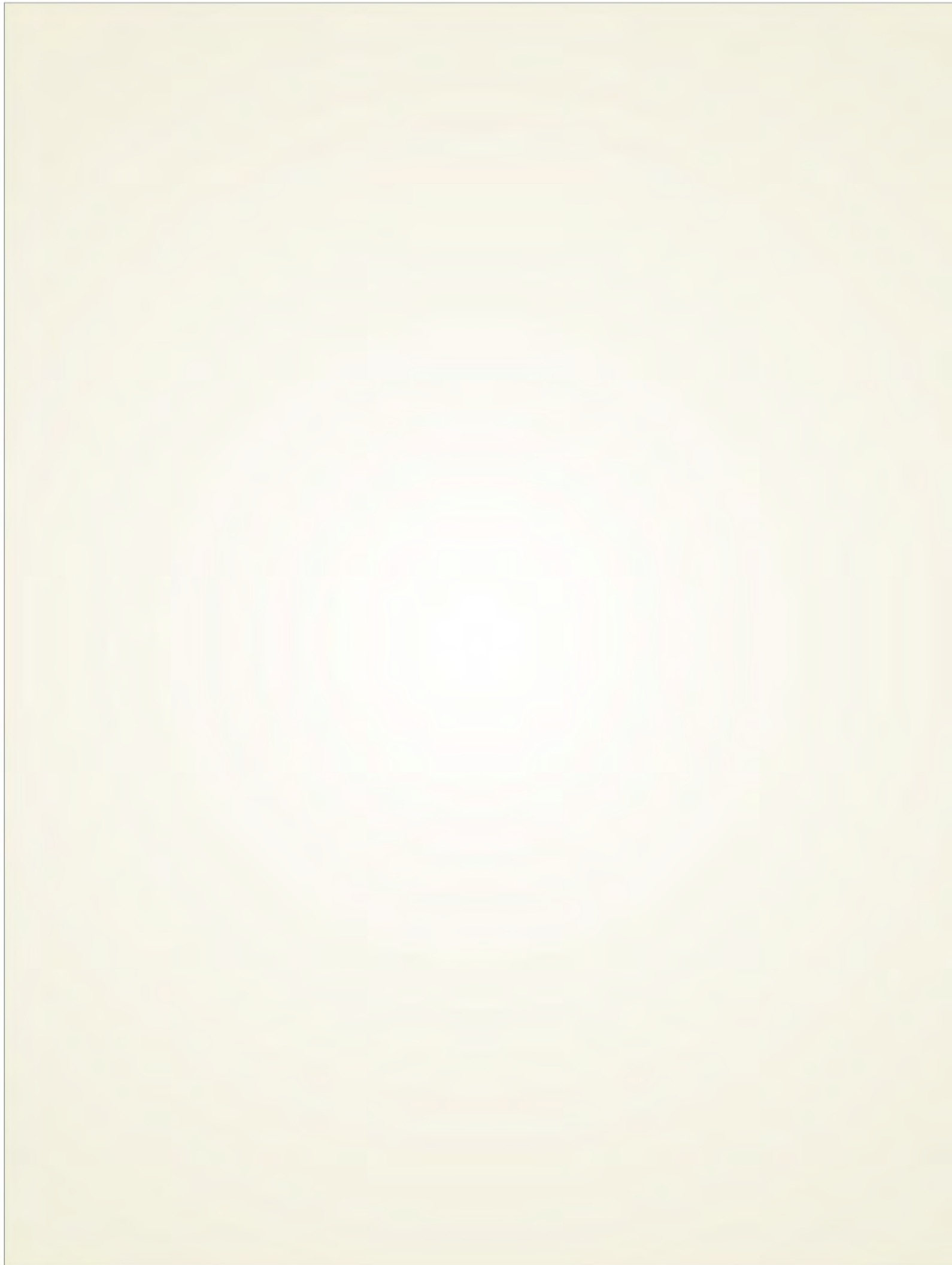
Behavior change models and theories attempt to explain why behaviors change. These theories cite personal, behavioral, and environmental, characteristics as the major factors that determine behavior. There is no single behavior change theory because behavior itself has multiple determinants. Each behavioral change theory or model focuses on different factors as they try to explain and predict what changes behavior the best.

Strategic communication also depends upon the selection of appropriate social science models or theories of behavior change, which might include:

Theory/Model	Resource Link
Cultivation Theory	https://www.utwente.nl/cw/theorieenoverzicht/Theory%20clusters/Media%2C%20Culture%20and%20Society/Cultivation_Theory-1/
Diffusion of Innovation	https://www.k4health.org/sites/default/files/diffusion_of_innovation_1.pdf
Health Belief Model	http://sphweb.bumc.bu.edu/otlt/MPH-Modules/SB/SB721-Models/
Ideation Model	https://www.k4health.org/sites/default/files/jhuccp_ideation_0.pdf
Input/Output Persuasion Model	http://www.corwin.com/upmdata/13975_Corcoran_Chapter_1.pdf
Integrated Model of Communication for Social Change	http://www.healthcommcapacity.org/wp-content/uploads/2014/08/Integrated-Model-of-Communication-for-Social-Change-An-HC3-Research-Primer.pdf
Theory of Reasoned Action/Planned Behavior	http://www.k4health.org/sites/default/files/theory_of_planned_behavior.pdf
Threat-Efficacy Model	https://www.k4health.org/sites/default/files/jhuccp_extended_parallel_processing_model.pdf
Social Ecological Model	http://www.thehealthcompass.org/sites/default/files/strengthening_tools/Social%20Ecological%20Model-Ch04%20Storey-Figueroa.pdf
Social Cognitive/Learning Theory	https://www.k4health.org/sites/default/files/jhuccp_social_learning_theory.pdf
Social Norms Theory	http://sphweb.bumc.bu.edu/otlt/MPH-Modules/SB/SB721-Models/
Transtheoretical Model (Stages of Change)	http://www.prochange.com/transtheoretical-model-of-behavior-change



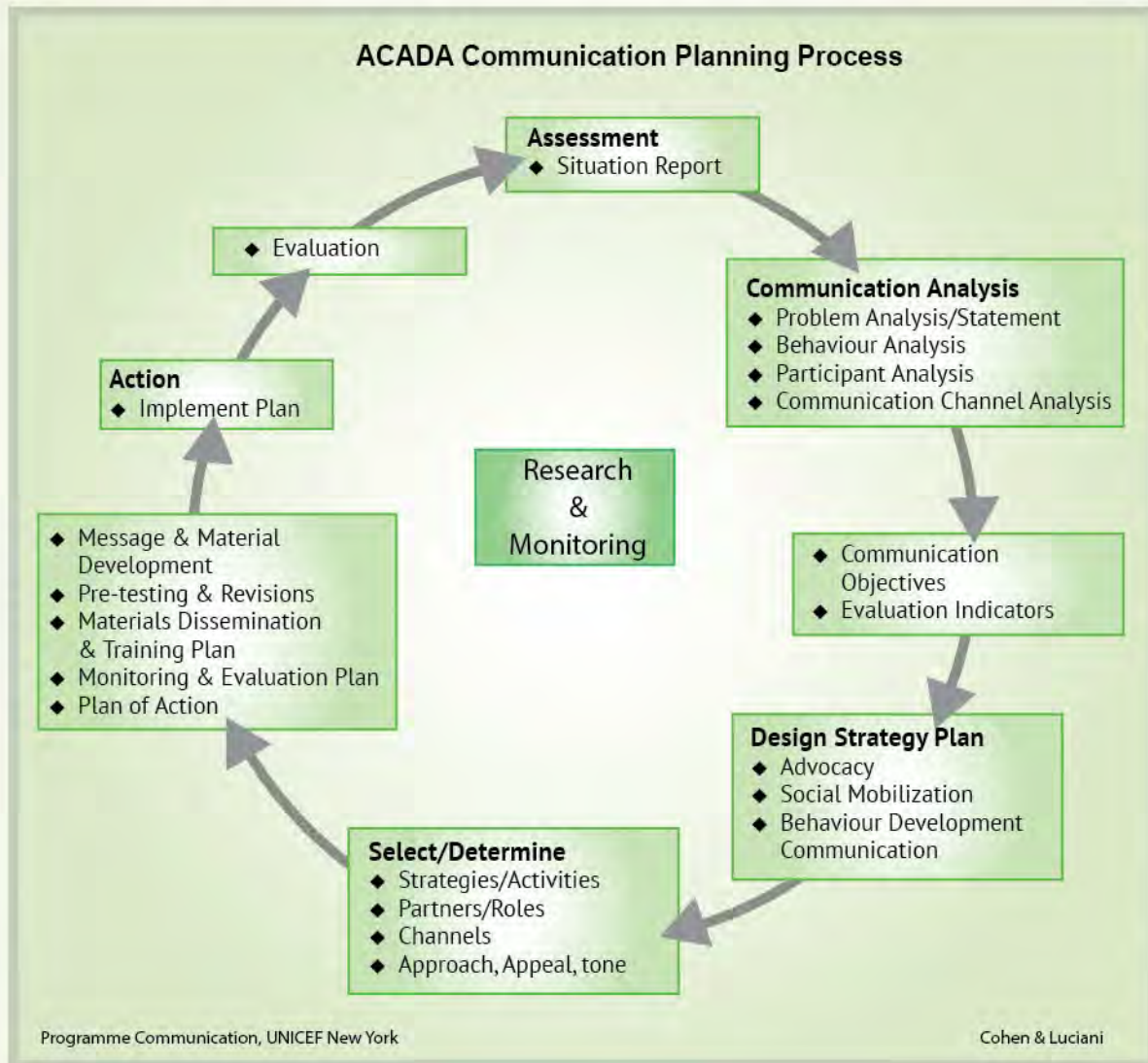
Annex 5
Process Models



Process Models

Assessment, Communication Analysis, Design, Action (ACADA) Communication Planning Process

The ACADA model explains the process of linking an integrated communication strategy to a development problem using data and evidence. Additional information is available via the following link: http://www.unicef.org/cbsc/files/Writing_a_Comm_Strategy_for_Dev_Progs.pdf



Communication for Behavioral-Impact (COMBI)

COMBI integrates SBCC interventions into public health programs through its planning framework and implementation method. Below is a seven-step, feedback-driven process with which to apply COMBI in an outbreak response. Additional information is available via the following link:

http://apps.who.int/iris/bitstream/10665/75170/1/WHO_HSE_GCR_2012.13_eng.pdf?ua=1

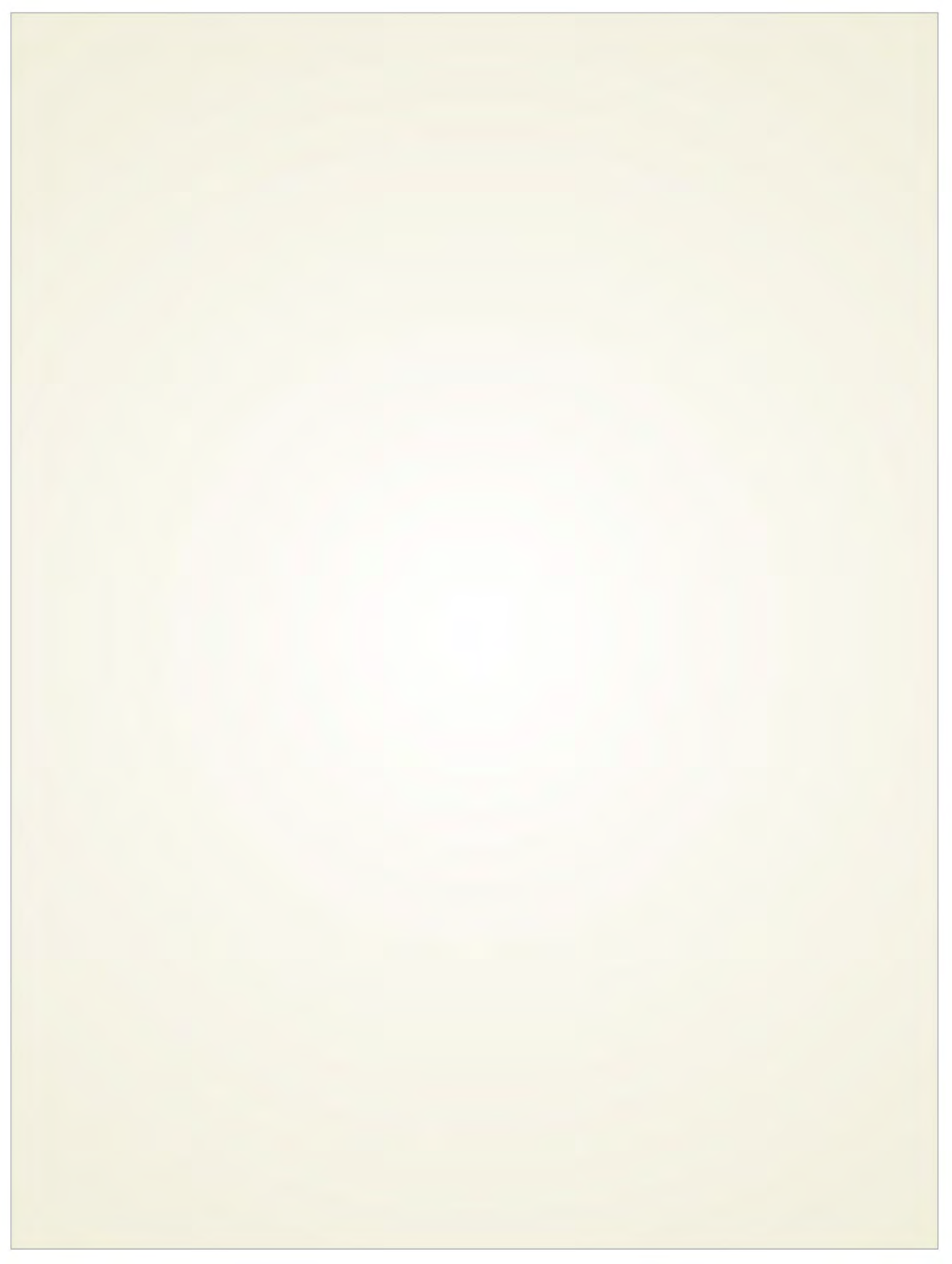
Step	Tool	Outcome
Programme, management and administrative response structure	Tool 1. Reflective questions for assessing the organizational context of outbreak management and response	
	Tool 2. Identifying stakeholders	
	Tool 3. Mapping existing expertise and capacity	
	Tool 4. Frequently asked questions about monitoring and evaluation	
COMBI planning step		
Step 1. Identify the preliminary behavioural objectives	Tool 5. Preliminary behavioural objectives	Preliminary behavioural objectives
	Tool 6. Risk Factors in the sociocultural context	
	Tool 7. Environmental scanning	
Step 2. Conduct a rapid situational market analysis	Tool 8. Tips for interviewing	Barriers and facilitating factors for adopting prevention and control measures; what communication can and cannot do
	Tool 9. Checklist for conducting a situational market analysis	
	Tool 10. Semi-structured interviews	
Step 3. Refine the behavioural objectives, state your communication objectives	Tool 11. HIC-DARM	Behavioural and communication objectives
	Tool 12. Template for channels and settings	
	Tool 13. Communication and non-communication issues	
Step 4. Design an overall strategy	Tool 14a. Restated behavioural objectives	A strategy
	Tool 14b. Restated communication objectives	
Step 5. Prepare implementation and monitoring plans and budget	Tool 15. Detailed implementation plan	Detailed implementation plans for the strategy and for monitoring and evaluation
	Tool 16. Monitoring table	
	Tool 17. Monitoring implementation plan	
Step 6. Implement and monitor the strategy, identify trends and adapt if necessary	Apply tools 15-17	Feedback and adjustments to the strategy
Step 7. Evaluate once the outbreak is over	Tool 4. Frequently asked questions about monitoring and evaluation	Impact, lessons learnt and good practice
	Tool 10. Semi-structured interviews	
	Tool 16. Monitoring table	
	Tool 17. Monitoring implementation plan	

P Process

The P Process is a step-by-step roadmap for planning strategic, evidence-based, and theory-driven communication programs. Additional information is available via the following link:

https://www.k4health.org/sites/default/files/p_process_brochure_-_new.pdf





Annex 6
A User Guide for
National Framework for HPN SBCC

A User Guide for National Framework for HPN SBCC

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The User Guide

What is the purpose of the User Guide?

This user guide is an explanatory document that walks users through the National Framework for Effective HPN SBCC step-by-step. Its purpose is to build understanding about how users can structure HPN SBCC strategies, programs, and campaigns based on the framework. It is meant to be a self-paced guideline and helpful reference document.

Who is the User Guide for?

Stakeholders involved in the development and implementation of SBCC strategies, programs, and campaigns should consult this user guide to improve their understanding of the National Framework for Effective HPN SBCC.

How can the Guide be used?

The guide aims to build capacity for all SBCC stakeholders by walking them through the steps for using the National Framework for Effective HPN SBCC.

1. Provides background information and motivation for Framework creation
2. Delineates the main steps of the framework
3. Gives sample case studies from each of the HPN focal areas
4. Identifies key questions that users should consider when developing and implementing SBCC strategies and programs. These questions ensure that users fully understand the framework and can effectively incorporate it in the development process.

National Framework for Effective HPN SBCC

What is the Framework?

The Framework is a flexible and adaptable tool that can be used to harmonize SBCC strategies and activities with national priorities. It was developed by the Bangladesh Behavior Change Communication Working Group (BCCWG) following a participatory, iterative process in close consultation with relevant key stakeholders and concerned experts including the Directorate General of Family Planning (DGFP), Directorate General Health Services (DGHS), development partners, NGOs, and civil society members.

What is the purpose of the Framework?

- Supports implementation and alignment of SBCC activities with GoB policies, strategies, and plans
- Ensures high quality SBCC activities
- Facilitates stakeholder coordination
- Identifies initial outcomes and long-term results of SBCC
- Fosters development of consistent, reinforcing messages for priority audiences
- Guides resource allocation

Who is the Framework for?

The framework is for all stakeholders involved in planning, designing, allocating resources for, implementing, monitoring, and evaluating SBCC strategies and programs.

How can the Framework be used?

The Framework can be adapted for use on two levels:

- Conceptual
 - o To inform communication strategies
 - o To guide resource allocation
- Practical
 - o To identify coordination opportunities
 - o To inform a national Community of Practice (CoP) such as the BCCWG
 - o To guide implementation of SBCC activities

Definitions

SBCC

The use of communication to influence individual and collective behaviors pertaining to health. Methods include interpersonal communication (IPC), community mobilization, mass media, information communication technologies (ICT), and others.

Well-designed SBCC for health, population and nutrition employs a research-based, consultative process using communication to promote and facilitate behavior change and support social change for the purpose of improving health outcomes. It is driven by demographic and epidemiological data, as well as by an analysis of social norms, current behaviors, barriers and enablers to behavior change, and audience perspectives. This process should be iterative, with data from earlier rounds being used to inform and improve later rounds.

SBCC is guided by a social ecological model that shows how behavior operates on and is influenced by four inter-connected levels: individuals; family and peer networks; communities; and social environments.

Reflecting the social ecological model, SBCC seeks to exert influence at four levels:

- Individuals: Improve knowledge, attitudes and other ideational factors that support the adoption and maintenance of desired healthy behaviors or the changing of unhealthy behaviors
- Family and peer networks: Promote positive peer influence, social support, spousal communication, and intra-family communication.
- Communities: Mobilize a broad range of stakeholders including community leaders and health service providers to promote shared ownership and collective efficacy, and to strengthen social capital.
- Social environments: Advocate to mobilize resources; to generate social, religious and political commitment to achieve positive health outcomes; and to promote supportive cultural values and norms.

Sustainability

The capacity to maintain programs and activities at a level that will provide ongoing prevention and treatment for a health problem after termination of major financial, managerial, and technical assistance from an external donor. [1, 2]

Knowledge Management

A way to leverage knowledge externally and internally to improve collaboration and communication, and to work with greater efficiency using people/culture, processes, and technology. It encompasses creating, organizing, sharing, and using information and experiences about what has been proven effective to achieve greatest impact and improve outcomes. [3]

Walking Through the Framework

SBCC Vision

In Bangladesh, coordinated and audience-centered Social and Behavior Change Communication (SBCC) improves knowledge, attitudes and practices for health, population and nutrition (HPN) through a multi-sectoral approach, a skilled workforce at all levels, and the use of appropriate communication technology.

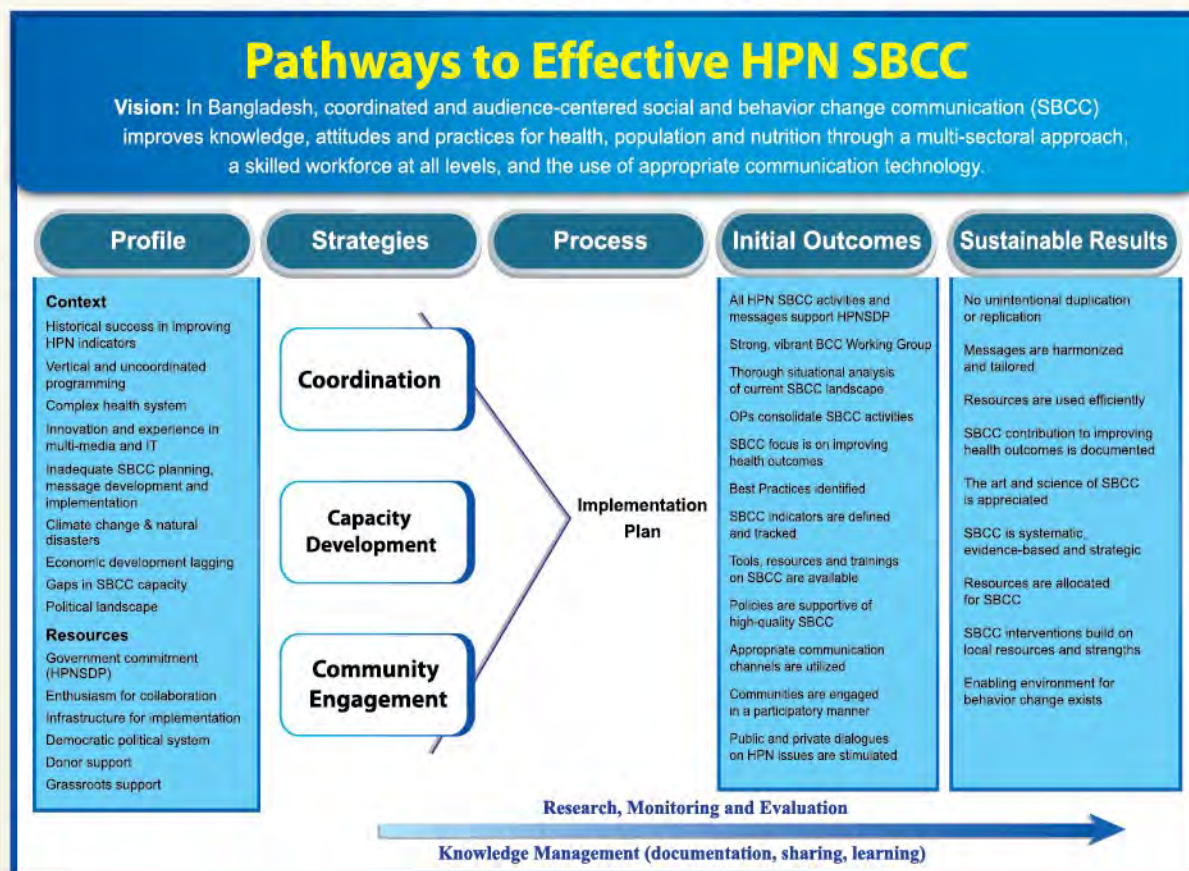
National Priorities

Since national priorities are constantly evolving, it is important to identify relevant and current priorities that your SBCC strategy or program supports.

Some national priorities include the following:

- Stimulate demand and improve access to and utilization of HPN services to reduce morbidity and mortality
- Reduce population growth rate
- Improve nutritional status, especially of women and children

Pathways to Effective HPN SBCC Framework



Framework Steps

Step 1: Profile Development

- Research current SBCC situation and identify available resources
- Identify strengths, weaknesses, opportunities, and threats (SWOT analysis)



A SWOT analysis allows a user to view a program, strategy, or organization from both internal and external perspectives and assess the overall probability of success in context. Strengths can include organizational/programmatic resources, capabilities, and attitudes. Weaknesses can include organizational/programmatic limitations and reasons for past failings. Opportunities are external in origin and can include unfulfilled niches and political or other support. Threats can include an unsupportive environment, cultures and norms, and competing programs.

Step 2: Strategic Design

Use Coordination, Capacity Development, and Community Engagement strategies to:

- Leverage strengths
- Address weaknesses
- Take advantage of opportunities
- Minimize threats

Coordination

- Process that ensures synchronization of interventions
- Occurs across all levels of stakeholders, organizations, and sectors
- Networking, advocacy, and KM are effective tools that can support coordination

Capacity Development

- Nurtures a high-performing SBCC workforce, from grassroots to policy level
- Supports data and evidence-driven SBCC
- Some approaches include workshops, seminars, webinars, and eLearning among others

Community Engagement

- Builds ownership among stakeholders and communities
- Stimulates dialogue between SBCC practitioners and audiences
- Gives a voice to communities and ensures that SBCC activities are audience-oriented

Step 3: Designing an Implementation Plan

Develop an implementation plan with:

- Detailed steps
- Time frames
- Expected outputs
- Indicators
- Partners/Stakeholders
- M&E strategies
- Mechanisms to continuously document all processes, outcomes, and results

Cross-Cutting Themes

The following cross-cutting themes should be considered and applied during each step of the framework:

Research, Monitoring, and Evaluation

- Provides critical information about context, audiences, and intervention impact
- Feeds back into the planning cycle for continuous quality improvement

Documentation

- Ensures measurement of successes and reasons for failure
- Provides “Best practices” and “Lessons learned” about what does and does not work in different communities, leading to more successful interventions
- Can be cost-effective and time saving through the use of Information and Communication Technology (ICT)

Knowledge Management

- Uses tools and techniques to capture, develop, share, and effectively use knowledge
- Leverages knowledge externally and internally to improve collaboration and communication, and increase efficiency
- KM is a continuous process

Gender [4]

- Gender considerations can impact the level of understanding and acceptance of new behaviors
- Can guide culturally appropriate methods to influence existing beliefs and social norms

Sample Case Studies

These case studies are meant to provide basic guidance to framework users. They are designed to walk the user through each step of the framework process using examples, but are not comprehensive.

Infant and Young Child Feeding (IYCF)

Program Description

Train community health workers (CHWs) on IYCF counseling for mothers of children under five

Step 1: Profile Development

- **Current SBCC situation and context**
 - **Successes:** Stunting rate below the WHO threshold, reduced neonatal mortality, adoption of National IYCF Strategy, alignment of programs with HPNSDP priorities, SBCC programs such as the WFP Improving Maternal and Child Nutrition Project, SPRING, and SHIKHA
 - **Challenges:** EBF has seen a sharp decline, dietary diversity is lacking, nutrition needs long term planning, uneven improvements in IYCF practices, and the urban population is largely ignored
 - **Available resources:** Necessary donor and grassroots support, government supportive of increased multi-sectoral engagement
- **SWOT Analysis**

<p>Strengths</p> <ul style="list-style-type: none"> • Nutrition is a national priority • Relevant policies are in place • IYCF alliance • Existing IYCF SBCC materials 	<p>Weaknesses</p> <ul style="list-style-type: none"> • Vertical, uncoordinated programs • Poor monitoring of SBCC • Lack of HR for SBCC • Poor urban SBCC delivery system
<p>Opportunities</p> <ul style="list-style-type: none"> • Strong donor interest • Next sector program focus • Available technology 	<p>Threats</p> <ul style="list-style-type: none"> • BMS Code Violations and unregulated private sector communication • Lack of coherent communication

Step 2: Strategic Design

- **Coordination Strategy**
 - Strengthen NNS multi-sectoral engagement platform
 - Share and promote nutrition SBCC materials across 13 ministries when appropriate
 - Better engage nutrition sensitive stakeholders
 - Strengthen and update counseling materials
 - Promote updated counseling materials
 - Incorporate IYCF education in school curriculum
- **Capacity Development Strategy**
 - Build capacity of nutrition-sensitive stakeholders within GoB
 - Orient ministerial staff, program managers, and planners on available IYCF counseling materials
 - Train CHWs on counseling techniques with IYCF materials
 - Develop ICT tools for counseling
- **Community Engagement Strategy**
 - Disseminate IYCF SBCC material through CHWs to target audiences in the community
 - Build resources within community, target the youth and women prior to pregnancy
 - Engage males on topics of MNCH and nutrition
 - Promote champions and role models

Step 3: Designing an Implementation Plan

Strategy	Activity	Output	Step	Timeline	Responsible Party	Partners/ Allies	Documentation Plan
Coordination	Share SBCC materials across 13 ministries	SBCC materials are actively and regularly shared between ministry officials and staff	Gather relevant materials	4 months	BCC Working Group	GoB, NGO, and other stakeholders	Documentation team will coordinate monthly updates with responsible parties to document activities, processes, and decisions
			Review and format materials	2 months	Nutrition subgroup	Members of BCC Working Group	
			Disseminate materials to 13 ministries	2 months	GoB representative	Nutrition subgroup	
Capacity Development	Train CHWs on counseling techniques with IYCF materials	CHWs are adequately trained to provide high quality IYCF counseling to their clients	Identify CHWs to train	2 months	Research team	GoB, health facilities, NGOs	
			Develop and test materials	4 months	BCC Working Group, technical experts	GoB, CHWs, NGOs, IEC technical committee	
			Train selected CHWs using pretested materials	3 months	Experienced trainers	GoB, NGOs, health facilities	
Community Engagement	Build resources within the community	Communities actively and regularly participate in developing and sharing IYCF SBCC resources	Target audience and resource identification	2 months	BCC Working Group	GoB, NGOs	
			Stakeholder engagement	2 months	BCC Working Group	NGOs, women's groups, health facilities	

Male Involvement in Family Planning (FP)

Program Description

Raise male FP awareness and encourage male involvement in and responsibility for FP

Step 1: Profile Development

- *Current SBCC situation and context*
 - o Successes: Government leaflets promoting NSV and men/husbands, incorporation of male contraceptive methods in family planning materials, research about male attitudes toward and awareness of NSV and other male contraceptive methods
 - o Challenges: Not enough materials and tools that specifically address males, lacking in advocacy, lack of understanding of family planning benefits and how to be supportive of female contraceptive choices and methods, lack of initiative for male contraceptive methods such as non-scalpel vasectomy (NSV)
 - o Available resources: Positive government commitment, an enabling policy environment, donor support, collaboration between government organizations and NGOs

- **SWOT Analysis**

<p>Strengths</p> <ul style="list-style-type: none"> • Current programs have some emphasis on male participation • Focus on couples counseling and spousal • Availability of male contraceptives • Simplicity of male contraceptive methods 	<p>Weaknesses</p> <ul style="list-style-type: none"> • Female-focused SBCC programs • Males are not aware of FP benefits • Lack of advocacy and family planning materials targeting men • Insufficient male counseling
<p>Opportunities</p> <ul style="list-style-type: none"> • Global attention for male participation in FP • Tools for social marketing of male contraceptives 	<p>Threats</p> <ul style="list-style-type: none"> • Male-dominated society • Limited male contraceptive methods • High illiteracy rates among married couples • Incorrect and inconsistency use of condoms • NSV takes 3 months to be effective • Stigma for male contraceptives • Low motivation for male contraceptive use

Step 2: Strategic Design

- **Coordination Strategy**
 - o Incorporate more male-targeted messaging into existing FP materials
 - o Coordinate increased male involvement in other aspects of health (e.g. nutrition, pregnancy care)
 - o Harmonize health provider messages emphasize male responsibility in FP
- **Capacity Development Strategy**
 - o Cultivate high-performing SBCC staff
 - o Conduct sensitization and advocacy workshops for service providers
 - o Train family planning staff on importance of male involvement in FP
- **Community Engagement Strategy**
 - o Take a bottom-up and socio-culturally sensitive approach
 - o Focus on client satisfaction
 - o Advocacy and sensitization of religious/public/local leaders
 - o Youth involvement

Step 3: Designing an Implementation Plan

Strategy	Activity	Output	Step	Timeline	Responsible Party	Partners/ Allies	Documentation Plan
Coordination	Incorporate more male targeted messaging into existing FP materials	Existing FP materials have been updated to include male targeted messaging. Future materials are designed to include male involvement information	Map existing FP materials	3 months	BKMI	GoB, NGOs, CHWs	Documentation team will coordinate monthly updates with responsible parties to document activities, processes, and decisions
			Design male targeted FP messages	2 months	BCC Working Group, FP technical experts	GoB, NGOs, designers, community	
			Disseminate messages to material developers	2 months	BCC Working Group, IEM	GoB, NGOs	
Capacity Development	Conduct sensitization and advocacy workshops for service providers	Service providers offer high quality FP services and inform clients of all options in a supportive manner	Identify relevant service providers	2 months	BKMI	GoB, NGO, health facilities and clinics	
			Develop workshops	3 months	Technical experts	BKMI, BCC Working Group, NGOs	
			Conduct workshops	3 months	IEM, FP subgroup members	GoB, NGOs, service providers	
Community Engagement	Sensitization of religious/public/local leaders	Community leaders support male involvement in FP and the rights of married and unmarried women and men to use FP	Identify leaders	2 months	BKMI	GoB, NGOs, community members	
			Elicit leaders' input	2 months	BCC Working Group	NGOs, community organizations	
			Promote key messages	2 months	IEM	GoB, NGOs, other ministries	

Institutional Delivery (ID)

Program Description

Disseminate messages about importance and benefits of institutional delivery and encourage women to deliver in a health facility

Step 1: Profile Development

- *Current SBCC situation and context*
 - o Successes: DGFP introduced 24-hour normal delivery services at selected Family Welfare Centers, approximately 27,000 nurse-midwives have been trained in general nursing & midwifery, the Prime Minister has committed to the United Nations General Assembly to train another 3,000 midwives by 2015, delivery by medically-trained attendants doubled between 2004 and 2011 to 32%

- o Challenges: Only 32% of deliveries are attended by medically-trained attendants, over 50% of births assisted by untrained traditional birth attendants, only 29% of births are delivered at a health facility [5]
- o Available resources: government commitment to encourage institutional delivery among women, donor support, robust NGO clinic network

• **SWOT Analysis**

<p>Strengths</p> <ul style="list-style-type: none"> • Understands importance of ID • All promotional activities include ID • Materials and information are available about ID (e.g. 5 danger signs, 3 delays) 	<p>Weaknesses</p> <ul style="list-style-type: none"> • Poor counseling techniques • Inadequate IPC • Negative health provider attitudes
<p>Opportunities</p> <ul style="list-style-type: none"> • Have resources, material, and providers • Next sector plan focus on ID 	<p>Threats</p> <ul style="list-style-type: none"> • Cultural barriers and traditions • Poverty and lack of information • Distance from health services • Cost of transport • Women's lack of autonomy in decision-making

Step 2: Strategic Design

• **Coordination Strategy**

- o Enhance coordination between DGHS, DGFP, and other stakeholders at all levels
- o Institute monthly/quarterly coordination meetings among all stakeholders at national, district and upazila levels
- o Increase sharing of SBCC resources, including any action and implementation plans
- o Include coordination as an integral element of the DGHS and DGFP operational plans

• **Capacity Development Strategy**

- o Conduct training and counseling for providers on the benefits of institutional deliveries, the five danger signs of pregnancy, the three delays model, and birth planning and preparedness
- o Supervise and monitor providers to ensure good quality of care

• **Community Engagement Strategy**

- o Hold courtyard meetings with family members, neighbors, community birth attendants, and community leaders
- o Conduct local-level advocacy meetings
- o Use frontline health workers to disseminate messages door-to-door using modern technology (eHealth toolkits, etc.)
- o Form community support groups at the grassroots level to promote institutional delivery

• *Designing an Implementation Plan*

Strategy	Activity	Output	Step	Timeline	Responsible Party	Partners/ Allies	Documentation Plan
Coordination	Increase sharing of ID-related SBCC resources	All relevant stakeholders actively and regularly share ID-related SBCC resources through formal and informal channels	Gather existing materials	4 months	BCC Working Group	GoB, NGO, and other stakeholders	Documentation team will coordinate monthly updates with responsible parties to document activities, processes, and decisions
			Review and harmonize messages	2 months	Maternal and Child Health subgroup	BCC Working Group; technical experts	
			Disseminate materials to relevant stakeholders	2 months	BCC Working Group	Maternal and Child Health stakeholders	
Capacity Development	Conduct training and counseling for providers on the benefits of institutional deliveries	Providers fully understand and can articulate the benefits of ID. They can also effectively communicate these benefits to their clients	Identify health providers	2 months	NGO network	GoB, health facilities, NGOs	
			Develop and test counseling materials	4 months	BCC Working Group, technical experts	GoB, providers, NGOs	
			Train health providers using pretested materials	3 months	Experienced trainers, technical experts	GoB, NGOs, health facilities	
Community Engagement	Form community support groups at the grassroots level to promote ID	Community support groups meet regularly and often to actively promote ID at the grassroots level	Identify key community stakeholders	2 months	NGOs, community groups	Relevant GoB and other stakeholders	
			Establish support group	2 months	NGOs, community groups	Community leaders and members, technical experts	

Key Questions

While designing your SBCC strategy or program plan, check to see if you have answered the following:

- What are the national priorities?
- How have you leveraged your network to create this strategy/program?
- Who is an advocate for this strategy/program? Do the advocates represent differing organizations/ departments/ levels of stakeholders?
- What existing best practices, materials, or evidence were used to develop this strategy/program?
- How does the strategy/program build capacity and at which levels?
- Which community needs are addressed by this strategy/program? How did the community help to identify these needs?
- How does the strategy/program incorporate research, monitoring, and evaluation?
- How does the strategy/program plan to document best practices, processes, decisions, and lessons learned?
- How does the strategy/program make use of internal and external knowledge to increase collaboration and communication?

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3. <https://www.k4health.org/toolkits/km>
4. Zaman, F. and Underwood, C. (March 2003). *The gender guide for health communication programs.* Center Publication No. 102. Baltimore: Johns Hopkins Bloomberg School of Public Health/Center for Communication Programs.
5. *Bangladesh Demographic and Health Survey (BDHS) 2011.* Dhaka, Bangladesh and Calverton, Maryland, USA: NIPORT, Mitra and Associates, and ICF International. 2013.

Appendix A: Sample Worksheet

Topic:

Description:

Step 1: Profile Development

- *Current SBCC situation and context*

- o Successes:

- o Challenges:

- o Available Resources:

- **SWOT Analysis**

Strengths	Weaknesses
Opportunities	Threats

Step 2: Strategic Design

- Coordination Strategy

- Capacity Development Strategy

- Community Engagement Strategy

Step 3: Designing an Implementation Plan

Strategy	Activity	Output	Step	Timeline	Responsible Party	Partners/ Allies	Documentation Plan
Coordination							
Capacity Development							
Community Engagement							

Annex 7
BCC Working Group Steering Committee

BCC Working Group Steering Committee

Background

One of the important approaches acknowledged in the HPNSDP 2011 – 2016 that would contribute to achievements in Health, Population and Nutrition (HPN) is Social and Behavior Change Communication (SBCC). Lack of coordination and harmonization of SBCC activities have been identified across donors, NGOs and government units working in Bangladesh. Coordinated and harmonized SBCC can contribute to further reductions in MMR, IMR, TFR and under-nutrition, and further increases in CPR, health care service utilization, and proper nutrition towards the achievement of MDGs 1, 4 and 5. The forth coming HNPSIP 2016-2021 will focus on these indicators 2021 towards achievement of SDG-3.

The BCC Working Group was started in 2011 as a platform for communication professionals in government, non-government, private, and development agencies to harmonize and coordinate SBCC activities in the HPN sector in Bangladesh. The MoHFW has recognized the Bangladesh BCC Working Group in May 2013 and assigned Additional Secretary (PH & WH) to oversee and coordinate the HPN SBCC activities in Bangladesh through the Bangladesh BCC Working Group. Currently, meetings are held approximately every 2 months.

Objective of creation of BCC WG Steering Committee

Since its inception, the BCC Working Group has been supported by BKMI, a USAID-funded capacity-strengthening project. BKMI would like to ensure that the BCC Working Group continues to thrive beyond the life of the BKMI project.

A Leadership temporary sub-group of the BCC Working Group was formed in 2014 to draft a Terms of Reference (ToR) for a sustainable leadership structure for the BCC Working Group moving forward. The members of the Bangladesh BCC Working Group approved the ToR in April 2015.

Name for the Leadership Group

BCC Working Group Steering Committee

Members of the Steering Committee

- Five (5) permanent members from MoHFW;
 - o Additional Secretary (PH & WH) is the Chair
 - o Joint Chief (Planning Cell), MoHFW
 - o Director, IEM, DGFP
 - o Director, IPHN, DGHS
 - o Chief, Bureau of Health Education, DGHS
- Six (6) rotating members that represent NGOs, INGOs, development partners and private sector

If a vote is needed, a quorum of at least six members must be present to vote. A simple majority is needed to pass a vote. (If six members are voting, at least four votes are needed to pass a motion.)

Selection criteria of Steering Committee members

Steering Committee member organizations must be active in HPN BCC, and must be active BCC Working Group members. They also must be willing to serve as Member Secretary for one year, if selected to do so by the Steering Committee.

Steering Committee seats will be filled by organizations, which then designate their representatives. If one representative leaves the organization, the organization retains its seat and names a new representative. The organization should also name primary and secondary representatives, for the sake of continuity.

Organizations' representatives must be senior enough to interact with high-level government officials; and must be available, motivated and passionate about strengthening and providing leadership to the BCC WG.

For the first Steering Committee

- Five MoHFW permanent members in consultation with one member each from CCP and BCCP will select the other four members based on expressions of interest that are submitted.
- Thereafter, the entire Steering Committee will select new rotating members.
- Efforts will be made to balance the rotating seats (four for the first Steering Committee, six thereafter) among different types of organizations.

Tenure of members serving on the Steering Committee

- For the first Steering Committee, three of the rotating members will have a two-year seat and three will have a one-year seat. This will help to ensure continuity so that all six members do not rotate off at the same time. Assignments to two-year or one-year seats will be made by the permanent members of the Steering Committee. Subsequently, all rotating seats will be held for two-year terms.
- Organizations may hold a rotating seat for a maximum of two consecutive terms (= four years). Exceptions may be made if seats remain vacant and other suitable organizations are not available to fill the seats.

Roles of the Steering Committee

- Develop Strategic vision for the BCC Working Group:
 - Mission statement
 - Purpose
 - Objectives, etc
- Select Member Secretary
- Meet bi-monthly, or more frequently if necessary
- Call meetings of the BCC Working Group & set agenda for meetings
- Monitor and guide sub-groups of the BCC Working Group; establish new sub-groups as needed
- Advocacy for BCC; inform MoHFW of BCC WG activities, concerns, recommendations, etc
- Coordinate with other ministries that also work on HPN related BCC
- Identify priority activities for BCC WG
 - Events
 - Workshops
 - Communications (website, social media, etc)
 - Training/capacity building

- Create annual work plan and budget, and ask WG member organizations to host, sponsor and fund different meetings and activities
- Define BCC Working Group policies, such as
 - membership criteria
 - which information is posted on website
 - criteria for sending emails on behalf of members
 - how to select/elect new members of Steering Committee when terms are over etc.

Roles within the Steering Committee

- Additional Secretary (PH&WH), MoHFW in charge of BCC WG is Chair. When the Chair is not present, the next senior-most member from MoHFW will chair the Steering Committee meeting.
- Each year, the Steering Committee will select one of its members to serve as Member Secretary for a 1-year term.
- The Member Secretary will have following major tasks:
 - Organize Working Group meetings, Steering Committee meetings and other activities
 - Keep records (meeting minutes, attendance, etc)
 - Send emails/communications
 - Maintain BCC Working Group website, Facebook page and Springboard group
 - Follow-up work plan
 - Update membership list
 - Other related activities
- The organization of the incumbent Member Secretary will host and manage the WG secretariat.
- All Steering Committee members will have equal status, and no votes shall be given more weight than others.

Timeline

- With Chair's approval;
- Have nominations of CCP and BCCP
- Invite Expression of Interest from the member organizations
- Identify criteria for selection of members based on EOI
- Select 4 rotating members
- Host introductory meeting of Steering Committee
- Develop/adopt plan for transition

Annex 8
**Terms of Reference for HPN Coordination
Committee**

Terms of Reference for HPN Coordination Committee

HPN SBCC Coordination Committee

In order to facilitate functional coordination around Health, Population and Nutrition (HPN) communication activities within the Ministry of Health and Family Welfare (MoHFW), the HPN Coordination Committee was created in 2012 with technical assistance from the Bangladesh Knowledge Management Initiative (BKMI). Funded by USAID and led by Johns Hopkins Center for Communication Programs, Baltimore, USA, BKMI is implemented by Bangladesh Center for Communication Programs (BCCP).

Since its inception, this committee has met approximately every two months, hosted in turn by the Bureau of Health Education (BHE), Information, Education and Motivation (IEM), and Institute of Public Health Nutrition (IPHN). Although the units mentioned above form the core of this committee, any unit within MoHFW that does SBCC for HPN is welcome to participate.

Terms of Reference

The HPN SBCC Coordination Committee will contribute to reduced MMR, IMR, TFR and under-nutrition, and increased CPR, healthcare service utilization and proper nutrition by:

1. Coordinating, integrating and harmonizing Social and Behavior Change Communication (SBCC) in support of the Health, Population and Nutrition Sector Development Program (HPNSDP) under the MoHFW;
2. Mainstreaming nutrition messages and activities with other health and family planning messages and activities;
3. Providing support for coordinated, harmonized and integrated HPN messages and products to the community at all levels;
4. Creating a platform to exchange HPN SBCC knowledge and share best practices within the MoHFW; and
5. Co-opting members in the committee as and when necessary.

This Committee will work at the functional level to strengthen effective coordination of HPN SBCC within the MoHFW. It will complement to the over-arching high-level role of the 'IEC/BCC Sector Management Task Group' as well as another functional forum, the 'BCC Working Group'. The BCC Working Group was created for multi-sectoral coordination and networking including government, non-government, development partner, private sector organizations and others. The BCC Working Group was formally recognized by the MoHFW in 2013, and has developed a National Framework for Effective HPN SBCC.

HPN Coordination Committee Membership

Core members will be representatives from Bureau of Health Education (BHE) and Institute of Public Health Nutrition (IPHN) of DGHS; and Information, Education and Motivation Unit (IEM) Unit of DGFP, which are primarily responsible for SBCC activities under the HPNSDP. In addition to the government representatives, the BCC focal person or representatives from UNICEF, USAID and DFID will also be core members of this Committee.

Representatives from other interested units from DGHS and DGFP are also encouraged to attend regular meetings.

Chair

Additional Secretary (PH & WH), MoHFW, will Chair the HPN SBCC Coordination Committee.

Secretariat

BHE, IPHN and IEM Units will serve as the secretariat of the HPN SBCC Coordination Committee in turn.

Scope of work:

- Preparing a meeting calendar at the beginning of the year and getting approval from the Chair
- Preparing meeting agendas,
- Sending out meeting notices, and
- Preparing meeting minutes.

Meeting Frequency

The HPN SBCC Coordination Committee meetings will be held bi-monthly. BHE, IPHN and IEM Units will host the meetings by rotation.

Tasks and Deliverables

1. Review BCC components of existing Operational Plans (OPs) of MoHFW, and strategies & work plans of BHE, IPHN & IEM
 - a. Identify areas of duplication and over-lapping
 - b. Identify opportunities for collaborative and coordinated SBCC interventions for HPN; and develop strategies to leverage those opportunities, ensuring that HPN activities are cross-pollinated with other DGHS and DGFP components, programs and activities that reach priority audiences/participant groups

Deliverable: A coordinated and consolidated annual SBCC plan for 3 units to maximize the coverage of service recipients.

2. Develop an action plan for the SBCC units of MoHFW to implement National Framework for Effective HPN SBCC to ensure consistent, reinforcing messages are delivered to priority audiences addressing key behaviors outlined in the HPNSDP, communication strategies and Results Framework

Deliverable: A consolidated SBCC Action Plan across MoHFW

3. Develop plans to integrate technology into HPN SBCC delivery including dissemination of messages through mobile phones, computers, laptops and netbooks

Deliverable: Plan for SBCC dissemination through the use of technology, and guiding standards/best practices for using technology identified and shared

Reviewing tasks and deliverables from time to time and adding/subtracting/ modifying as necessary.

Expected Outcomes

- Coordinated, integrated and harmonized messages for HPN delivered to individuals, families and communities that motivate improved health, family planning and nutrition behaviors, and positively impact MMR, IMR, TFR, CPR, and nutrition
- Healthcare service utilization increased
- Duplication & over-lapping reduced in SBCC interventions and service coverage increased reaching more priority audience
- Nutrition messages mainstreamed with health and family planning activities.

Annex 9
Illustrative Monitoring & Evaluation Framework

Illustrative Monitoring & Evaluation Framework

Sample project: Community outreach to promote marriage of girls after 18 years of age

Planned Inputs	Indicators	Expected Outputs	Output Indicators	Expected Outcomes	Outcome Indicators
Train outreach workers	# of workers trained	Outreach workers skilled in facilitating community dialogues/counseling on child marriage	Average score on training post-test Observation checklist completed by trainer during role play; constructive feedback given	Girls not married before age 18	Increase in average age of marriage Increase in rate of secondary school completion
Hold group meetings with community members	% of households in upazila that participated in group meetings	Household-level discussion about appropriate age of marriage for girls and importance of girls' education	Baseline/endline surveys	Girls complete secondary education Delay first pregnancy	Increase in rate of secondary school completion Increase in average age of first pregnancy
Hold advocacy meetings with community leaders	# of meetings with community leaders, including notes from meeting discussions	Community leaders publicly discuss appropriate age of marriage and strategies to support girls' education	Baseline/endline surveys		



Annex 10
SBCC Monitoring Checklist

SBCC Monitoring Checklist

**Ministry of Health and Family Welfare
Directorate General of Health Services and Directorate General of Family Planning
BCC/IEC Activity Monitoring Checklist**

Name of the Monitor :	Designation and Place of posting :
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Name of the monitored staff Union : Upazilla :	Date and place of monitoring District : Division :
--	--

Sl No.	Indicators	Present Status		Remarks
		Yes/No/ Partial/ Not Applicable*	Number	
A	Home Visit			
i.	Is there any plan for regular home visit?			
ii.	Is there any updated register for documenting home visit?			
iii.	How many home visited last month? (a. Planned and b. Visited)			
iv.	Does FWA/HA use BCC materials during home visit?			
v.	Does FWA/HA segregate house hold based on client segmentation form?			
B.	Counseling			
i.	Is there any plan for counseling?			
ii.	Is there any provision in existing format “monthly progress report” for documenting counseling activity?			
iii.	Does FWA/HA/CHCP/FWV record and report on counseling?			
iv.	Does FWA/HA/CHCP/FWV use any IEC/BCC materials for counseling? (mention name of most used materials)			
v.	How many counseling session done last month? (Note down the issues in the remarks column.)			
vi.	How many people attend (average) in one group counseling?			

* For Yes (Y), No (N), Partial (P) and Not Applicable (NA)

Sl No.	Indicators	Present Status		Remarks
		Yes/No/ Partial/ Not Applicable**	Number	
vii	How long each counseling session last on average?			
viii	During counseling session, FWA/HA/CHCP/FWVs promote which positive behaviours? (Note down the issues in the remarks column.)			
C.	Courtyard Meeting			
i.	Is there any plan for courtyard meeting?			
ii.	Is there any provision in existing format monthly progress report" for documenting Courtyard meeting?			
iii.	Does FWA/HA report regularly on court yard meeting?			
iv.	Does FWA/HA use any IEC/BCC materials for court yard meeting?			
v	How many court yard meeting done last month? (a. Planned and b. accomplished) (Note down the issues in the remarks column.)			
vi.	How many people attend (average) in one courtyard meeting? (Mention the average number for pregnant women/ lactating mother in the remarks column)			
vii	How long each courtyard meeting last on an average?			
viii	During courtyard meeting, FWA/HA/CHCP/FWVs promote which positive behaviours? (Mention the issues in the comment column.)			
ix	Do participants provide any comments in the court yard meeting? Do FWAs/HAS document it? (If observe during session)			
x	How many participants could recall given messages at the end of the session? (If observe during session)			

* For Yes (Y), No (N), Partial (P) and Not Applicable (NA)

Sl No.	Indicators	Present Status		Remarks
		Yes/No/ Partial/ Not Applicable*	Number	
D.	Mass Media Campaign			
i	How many film-show/ Video show arranged in last three months? (Mention issues in the remark column)			
ii	How many people attended in these film shows/video shows? (Mention the topics of the shows in the remark column)			
iii	How many Health Education Sessions organized at health facilities in last month? (Mention issues in the remark column)			
iv.	How many of local events (Street Drama, Folk show, Jatra etc.) organized in last month? (Mention issues in the remark column)			
E	Advocacy			
i.	How many advocacy sessions organized in last three months? Mention the main issues and who participated in the event in the remarks column.			
F.	Distribution of IEC/BCC Materials			
i.	How many IEC/BCC materials distributed last three months?	Poster/ Sticker/ Leaflet/ Flipchart/ Others		

* For Yes (Y), No (N), Partial (P) and Not Applicable (NA)

Signature:

Date:

Note: Please specify which areas (Village, Para, and/or Mohalla) require more inputs for improving specific behaviors. For example, Khadimpara is low in maternal health behaviors; or Sultanpur is low in nutrition behaviors; FP method adoption rate among the men of Dighinala is low. So, the maternal health related BCC activities need to be strengthened in Khadimpara or nutrition related BCC activities need to be increased in Sultanpur. In order to encourage men of Dighinala to use LAPM, separate court yard meeting needs to be held, etc.

Guideline from Supervisor to field worker (FW):

In order to improve work (1) Identify behavioral actions during home visit; (2) Conduct follow up; (3) Select appropriate “non-user” audience for courtyard meeting (4) Repeat behavioral action 3-4 times during home visit and courtyard meeting (5) Encourage FW to ask audience to discuss the visit/courtyard meeting with their spouses, neighbors and family.

The field testing of monitoring checklist is being conducted with the direct participation of BHE and IPHN units of Directorate of Health Services and IEM unit of Directorate of Family Planning. Technical support is being provided by Bangladesh Knowledge Management Initiative (BKMI), financed by USAID, BKMI is implemented by Johns Hopkins Center for Communication Programs in collaboration with Bangladesh Center for Communication Programs (BCCP) as an in-country partner.

Annex 11
**Terms of Reference for Expert Working Group
and Technical Working Group**

Terms of Reference for Expert Working Group and Technical Working Group

গণপ্রজাতন্ত্রী বাংলাদেশ সরকার
স্বাস্থ্য ও পরিবার কল্যাণ মন্ত্রণালয়
জনস্বাস্থ্য-২ অধিশাখা

নং: ৪৫.১৬১.০০৪.০০.০০.০০১.২০১৫-৩১০

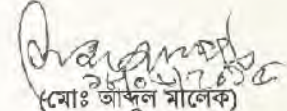
তারিখ: ১৮/০৫/২০১৫ খ্রি.

বিষয়ঃ Expert Working Group (EWG) এবং Technical Working Group (TWG) এর Composition and ToR প্রেরণ সংক্রান্ত।

গত ৫-৪-২০১৫ তারিখে এ মন্ত্রণালয়ের অতিরিক্ত সচিব (জনস্বাস্থ্য ও বিশ্বস্বাস্থ্য) মহোদয়ের সভাপতিত্বে Implementation of priority action plan of MTR'2014 of HPNSDP on BCC Develop a comprehensive social and behaviour change communication (SBCC) Strategy with implementation plan and monitoring framework including necessary indicators- বিষয়ে এক সভা অনুষ্ঠিত হয়।

২। উক্ত সভার সিদ্ধান্ত মোতাবেক Expert Working Group (EWG) and Technical Working Group (TWG) এর Composition and ToR সদয় অবগতি ও প্রয়োজনীয় কার্যক্রম গ্রহণের নিমিত্ত নির্দেশক্রমে এতদসঙ্গে প্রেরণ করা হলো।

সংযুক্তিঃ ০৩ (তিন) পাতা।


মোঃ আব্দুল মালেক
যুগ্মসচিব
ফোনঃ ৯৫১৫৫৩১

বিতরণ (জ্যেষ্ঠতার ক্রমানুসারে নয়):

১. যুগ্ম প্রধান (পরিকল্পনা), স্বাস্থ্য ও পরিবার কল্যাণ মন্ত্রণালয়।
২. পরিচালক, (আইইএম), পরিবার পরিকল্পনা, পরিবার পরিকল্পনা অধিদপ্তর, ঢাকা।
৩. উপ প্রধান, স্বাস্থ্য শিক্ষা বুরো, স্বাস্থ্য অধিদপ্তর মহাখালী, ঢাকা।
৪. পরিচালক, (এমসিএইচ-এফপি), পরিবার পরিকল্পনা, পরিবার পরিকল্পনা অধিদপ্তর, ঢাকা।
৫. পরিচালক, আইপিএইচএন ও লাইন ডাইরেক্টর এনএনএস, মহাখালী, ঢাকা।
৬. ডাঃ নাসরিন খান, জনস্বাস্থ্য ও বিশ্বস্বাস্থ্য অনুবিভাগ, স্বাপকম।
৭. প্রজেক্ট ডাইরেক্টর, বিকেএমআই, মিরপুর, ঢাকা।
৮. প্রতিনিধি, ইউএসএআইডি

সদয় অবগতির জন্য অনুলিপি প্রেরণ করা হলোঃ

- ১। সচিব মহোদয়ের একান্ত সচিব, স্বাস্থ্য ও পরিবার কল্যাণ মন্ত্রণালয়।
- ২। অতিরিক্ত সচিব (জ ও বি) মহোদয়ের ব্যক্তিগত কর্মকর্তা, স্বাস্থ্য ও পরিবার কল্যাণ মন্ত্রণালয়।
- ৩। অতিরিক্ত সচিব (জনস্বাস্থ্য) মহোদয়ের ব্যক্তিগত কর্মকর্তা, স্বাস্থ্য ও পরিবার কল্যাণ মন্ত্রণালয়।

**Composition and ToR of
Expert Working Group (EWG) and
Technical Working Group (TWG) for
development of Comprehensive Social and Behavioural Change Strategy (SBCC)**

Expert Working Group (EWG)

I. Composition

1. Additional Secretary (Public Health), Ministry of Health and Family Welfare- **Chair**
2. Director, BHE and Line Director, HEP- **Member Secretary**

Member (s):

3. Joint Chief (Planning), Ministry of Health and Family Welfare
4. Additional Director General Planning and Development, and Director, MIS, DGHS
5. Director, PHC and LD, MNCAH, DGHS
6. Director, CDC and LD, CDC, DGHS
7. Director, IEM, DGFP
8. Director, MCRH and LD MCRAH, DGFP
9. Director, IPHN and LD, NNS, DGHS
10. Director MBDC and LD TB, DGHS
11. LD, NCDC, DGHS
12. LD, NASP, DGHS
13. Two Representatives from BKMI

II. Terms of Reference (ToR)

The Expert Working Group would be responsible to execute the following activities to develop the SBCC strategy to strengthen SBCC activities on Health, Population and Nutrition Activities in Bangladesh:

1. Facilitate development of Comprehensive Social and Behavioural Change Strategy (SBCC) through providing policy directives to TWG
2. Ensure that all existing HPN related BCC strategy (Approved and draft) are taken into consideration to formulate the SBCC strategy



3. Facilitate TWG to arrange stakeholder consultation through three workshop and website
4. Review the draft document for finalization
5. Take necessary steps for final endorsement
6. Take consultation from Additional Secretary (Public Health and WHO) as and when required.
7. If necessary, Request Additional Secretary (Public Health and WHO) to facilitate Technical Assistance from Development Partners/ Technical Agencies
8. The Member Secretary would be responsible for the necessary Secretarial Support.
9. The committee would finalize the strategy through 4 meetings (**Maximum**)
(It necessary the committee may co-opt any member)

1. **Deliverable**

Comprehensive Social and Behavioural Change Strategy (SBCC) with Implementation Plan and monitoring Frame-work and necessary indicators for monitoring

Technical Working Group (TWG)

I. **Composition**

1. Deputy Secretary (Public Health-2), Ministry of Health and Family Welfare- **Chair**
2. Program Manager, HEP- **Member Secretary**

Member (s):

3. Senior Assistant Chief (Planning), Ministry of Health and Family Welfare
4. Program Manager, IEM, DGFP
5. Program Manager, MNCAH, DGHS
6. Program Manager, MCRAH, DGFP
7. Program Manager, CDC, DGHS
8. Program Manager, NCDC, DGHS
9. Program Manager (BCC), NNS
10. Program Manager, MBDC, DGHS
11. Program Manager, NASP, DGHS
12. Program Manager, HIS and E Health, DGHS
13. Dr. Nasreen Khan, TSN, Public Health and WHO Wing, MoHFW



14. Representative from WHO
15. Representative from UNICEF
16. Representative from UNFPA
17. Representative from DFID
18. Representative from USAID
19. Two Representatives from BKMI

(It necessary the committee may co-opt any member)

II. Terms of Reference (ToR)

The Technical Working Group would be responsible to execute the following activities to develop the SBCC strategy to strengthen SBCC activities on Health, Population and Nutrition Activities in Bangladesh:

1. Prepare a draft Comprehensive Social and Behavioural Change Strategy (SBCC) in the line of policy directives of EWG
2. Ensure that all existing HPN related BCC strategy (Approved and draft) are taken into consideration to formulate the SBCC strategy through stocktaking of all HPN related BCC strategy (Approved and draft)
3. Provide necessary technical support to TWG to arrange stakeholder consultation through three workshops.
4. Submit the draft document to EWG for finalization
5. Provide technical support to finalize the SBCC strategy till final endorsement
6. Take consultation from EWG as and when required.
7. The Member Secretary would be responsible for the necessary Secretarial Support.
8. The committee would develop the strategy through 6 meetings (**Maximum**).
(It necessary the committee may co-opt any member)

III. Deliverable

2. Comprehensive Social and Behavioural Change Strategy (SBCC) with Implementation Plan and monitoring Frame-work and necessary indicators for monitoring



Annex 12
List of Sub-Committees



List of Sub-Committees

Member of Health Sub-Committee

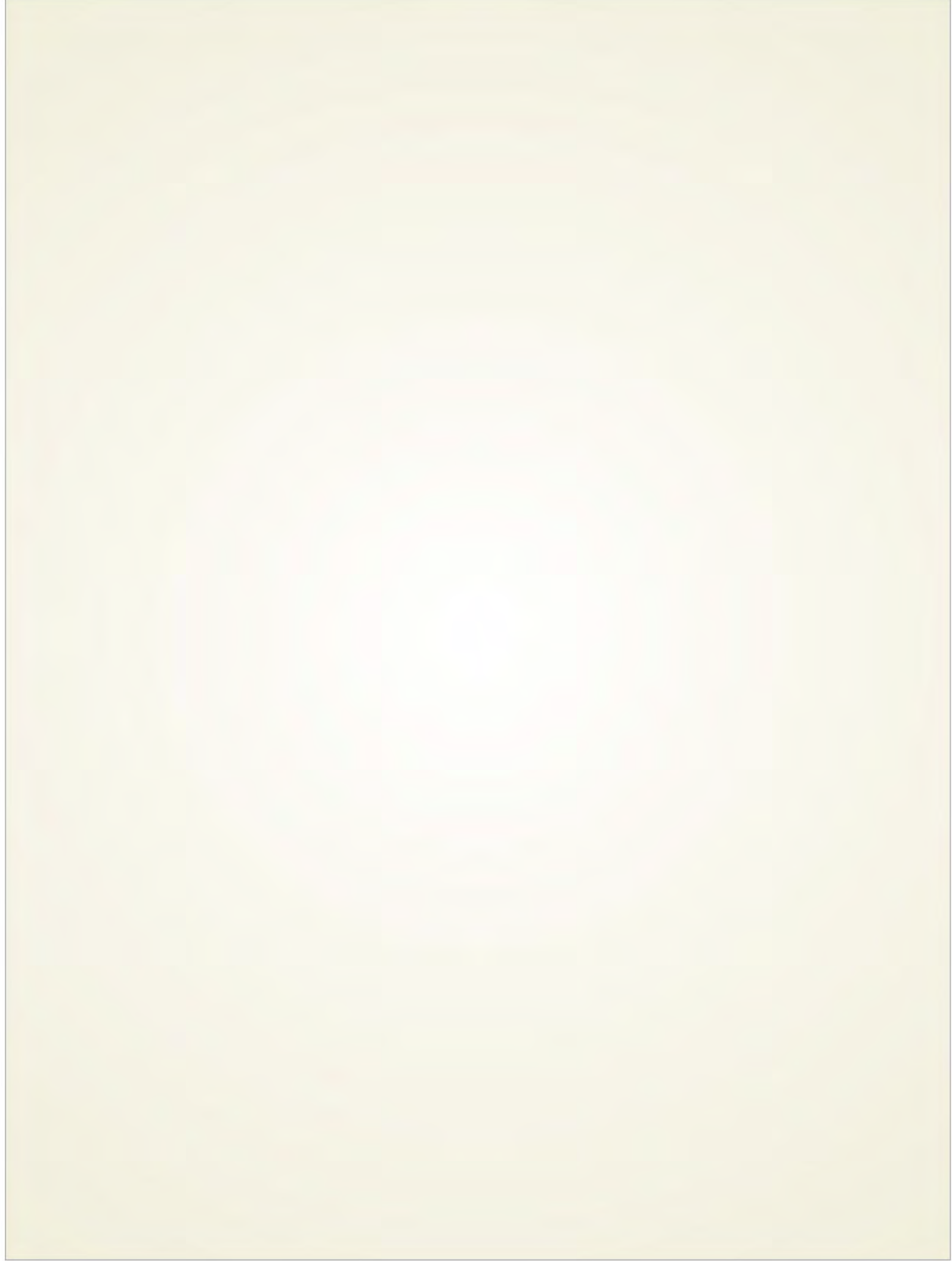
SL. No.	Name of the Representative
1.	Dr. Md. Altaf Hossain, Program Manager, MNCAH, DGHS
2.	Dr. Tapan Kr. Biswas, Program Manager, NNS, DGHS
3.	Md. Abdus Salam, Deputy Chief, HEP & Program Manager, BHE, DGHS
4.	Dr. Md. Tanvir Ahmed, Program Manager, NCDC, DGHS
5.	Dr. Md. Jahangir Alam, Program Manager, NTP, DGHS
6.	Dr. Md. Anisur Rahman, Program Manager, NASP, DGHS
7.	Dr. Md. Lokman Hakim, Program Manager, MIS & eHealth, DGHS
8.	Dr. Md. Nasir Ahmed Khan, Deputy Program Manager, CDC, DGHS
9.	Dr. Gita Rani Deby, Deputy Program Manager, RCHCIB, DGHS (Community Clinic)
10.	Dr. Shimul Koli Hossain, Program Manager (ASRH), MCH, DGFP
11.	Ms. Zakia Akter, Deputy Director, IEC, DGFP
12.	Dr. M. Mostafa Zaman, Advisor, Research & Publication, WHO
13.	Ms. Syeda Salina Parveen, BCC Specialist, UNFPA
14.	Dr. Md. Shahidul Alam, Deputy Director, BCCP
15.	Ms. Shirin Hussain, Communication for Development Specialist, UNICEF
16.	Md. Mamunur Rashid, Senior Communication Specialist, BKMI

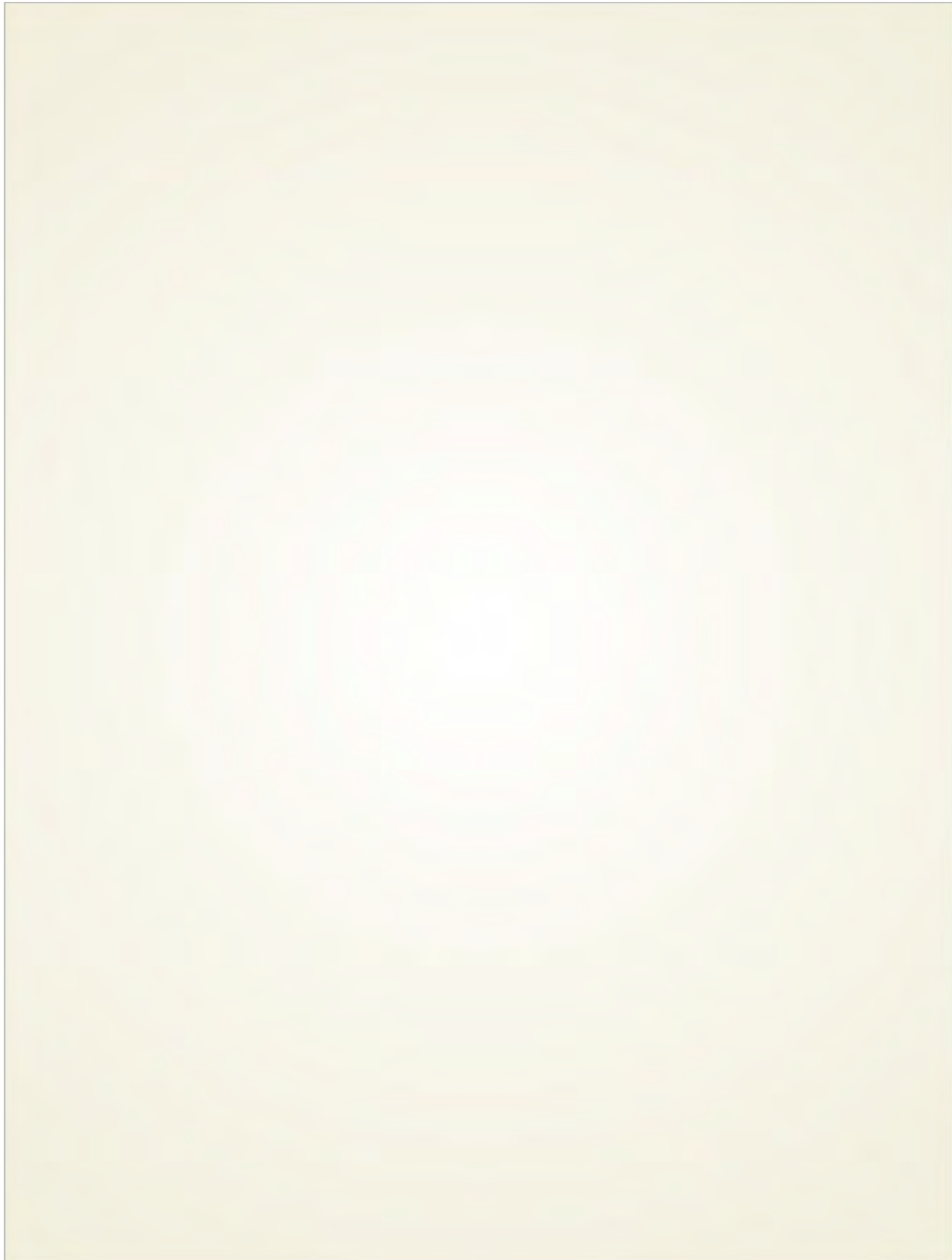
Member of Population Sub-Committee

SL. No.	Name of the Representative
1.	Director, IEM Unit, Convener
2.	Dr. Shimul Koli Hossain, PM (ASRH), MCH, DGFP
3.	Mr. Humayun Kabir, Planning Unit, DGFP
4.	Dr. Nurun Naher, PM, CCSDP, DGFP
5.	Mr. Mahbubul Alam, DPM, FSDP, DGFP
6.	Mr. Khandaker Mahbubur Rahman, PCO, DGFP
7.	Representative from BHE, DGHS
8.	Representative from IPHN, DGHS
9.	Ms. Syeda Salina Parveen, UNFPA
10.	Ms. Shirin Hussain, Communication for Development Specialist, UNICEF
11.	Representative from Save the Children
12.	Dr. Zeenat Sultana, Senior Deputy Director, BCCP & Deputy Project Director, BKMI
13.	Shahid Hossain, BCC Advisor, EngenderHealth
14.	Mohiuddin Ahmed, Senior Communication Specialist, BKMI
15.	Ms. Zakia Akhter, Deputy Director (PM), IEM Unit

Member of Nutrition Sub-Committee

SL. No.	Name of the Representative
1.	Dr. Md. Moudud Hossain, (Chair of the committee), Deputy Director DGHS & Program Manager , NNS
2.	Mostafa Faruq Al Banna, Associate Research Director, FPMU, MoF&L
3.	Dr. Shimul Koli Hossain, PM (ASRH), MCH, DGFP
4.	Dr. Nasreen Khan, Technical Support on Nutrition, Public Health and WH Wing, MoHFW
5.	Mohammad Aman Ullah, Deputy Program Manager, NNS, DGHS
6.	Md. Mukhlesur Rahman, Assistant Chief (TSD) and Deputy Program Manager, HEP
7.	Dr. Zeba Mahmud, Country Manager, Alive and Thrive
8.	Dr. Mohsin Ali, Nutrition Specialist, UNICEF
9.	Dr. Lalita Bhattacharjee, Nutritionist, FAO
10.	Dr. Zeenat Sultana, Senior Deputy Director, BCCP & Deputy Project Director, BKMI
11.	Ms. Kanta Devi, Deputy Director, BCCP & Project Coordinator, BKMI
12.	Dr. Mohammad Raisul Haque, Deputy Director, HNPP, BRAC
13.	Dr. Foisal Mahmud, Health Specialist, BCC Media Action
14.	Dr. Monira Parveen, Program Officer (Nutrition), World Food Program (WFP)
15.	Ms. Saiqa Siraj, MNCH Advisor - Nobo Jibon, Save the Children
16.	Dr. Tofail Md. Alamgir Azad, Senior Communication Specialist, BKMI





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