The National Communication Strategy for Family Planning and Reproductive Health

November 2008

Ministry of Health and Family Welfare
Directorate General of Family Planning
Dhaka, Bangladesh

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National Communication Strategy for FP-RH

List of Reviewers:

Md. Nurul Ameen
Assistant Representative, UNFPA

Dr. Ahmed Al Sabir
Director (Research), NIPORT

Mohammad Shahjahan
Director & CEO, BCCP

Mohiuddin Ahmed
NPPP (BCC & Advocacy), UNFPA

Md. Shahadat Hossain
Family Planning Officer, IEM Unit, DGFP

Secretary
Ministry of Health and Family Welfare
Peoples Republic of Bangladesh

Foreword

Bangladesh has made remarkable success in family planning and reproductive health programmes over the last two decades but still we have to invest more in family planning and reproductive health programmes. At the beginning of the new millennium with new challenges and opportunities all sectors need to develop their own strategies to move from where we are now today and to where we want to go. In the health, nutrition and population sector programme (HNPSP), this need has become more obvious as the success of national economy is largely dependent on its performance.

As the field of reproductive health is shifting in response to the ICPD while the current communication programs and strategies continue to view their audiences as instrumental to achieving specific health objectives, such as increased contraceptive prevalence rates, a newer generation of programs is taking a broader approach, seeking to influence social and cultural norms that shape behavior, build skills to foster behavior change among individuals and communities. Because communication programs try to affect the normative environment which influences attitude and behavior of adolescents, women and men and thereby determines their family size, birth spacing, use of contraceptives, health seeking behaviour and gender relations within communities and societies.

Government underscores the potential power of communication programmes to spotlight pressing issues related to safe motherhood, maternal and child mortality rates, dropout of FP methods, unmet needs, permanent and long-term methods and total fertility rate (TFR) etc. Comprehensive communication programmes help break the stigma and change the culture of quiet acceptance surrounding adolescent sexual and reproductive health and rights, and gender concerns in FP-RH and HIV/AIDS. Timely and targeted communication materials can impact on people in profound ways, and support and empower them to initiate change.

In this connection, the Ministry of Health and Family Welfare has been fortunate undertaking the development of National Communication Strategy for Family Planning and Reproductive Health with the generous support from the United Nations Population Fund (UNFPA). We express our sincere appreciation to UNFPA Bangladesh. This strategy has been formulated based on the feedback and inputs received from a wide range of stakeholders i.e. programme managers, researchers, communication experts of home and abroad to filed level FP/health workers and NGOs. The intelligence, expertise and intellectual labor of many persons, including DGFP and his team, members of the BCC Task Force, field level family planning officials, NGOs who generously shared their creative ideas and inputs in transforming the dream into reality, we thank them all.

This strategy reflects our firm commitment to reverse the high rate of maternal and child mortality, TFR and also to improve RH-FP status in Bangladesh through an institutionalized and strategic communication approach. Besides identifying specific target audiences, the strategy has outlined implementation plans for undertaking research, advocacy and mobilization programmes to address the emerging challenge in reproductive health and family planning sector. With this comprehensive strategy now in place, I hope, the development partners particularly UNFPA Bangladesh will continue to provide generous support and technical assistance towards implementation of different components of this strategy.

A K M Zafar Ullah Khan

Message

Communication is an integral part of the family planning and reproductive health approach to population related activities. Fundamental to the Health, Nutrition and Population Sector Programme (HNPSP) is the underlying principle, which places communication at the centre of population and development concerns. The *National Communication Strategy for Family Planning and Reproductive Heath* has been published to help the programme managers develop their action plans, to address the needs and concerns of adolescents, young people and, women and men of reproductive age for their FP and RH related education, information, counseling and services. We would like to mention here that this strategy development was a unique effort of all stakeholders, where the Directorate General of Family Planning (DGFP) and Ministry of Health and Family Welfare (MOH&FW) took a lead role together with other ministries/departments, NGOs and development partners.

Based on this strategy, we have to develop action plans to work with a 'bottom-up' approach. UNFPA Bangladesh has the privilege to work in partnership with the government particularly the Ministry of Health and Family Welfare to support the initiative of developing action plan and its implementation.

In connection with the formulation of this strategy, I would like to take the opportunity to extend my sincere thanks and gratitude to all concerned particularly the Joint Secretary (Dev), MOH&FW and his team, Director General of Family Planning and the members of the BCC Task Force who have contributed in making the 'National Communication Strategy for Family Planning and Reproductive Health' a reality.

This strategy will help guide all of us in designing IEC/BCC interventions to address the needs and choices of target audiences envisaged in the strategy. UNFPA believes that programme managers together with other stakeholders will take account of this strategy while designing and implementing IEC/BCC interventions in order to address the special needs and choices of the target population.

Let us intensify our coordinated and collective efforts towards making a long lasting impact in the lives of the people of the country in bringing a positive social change that will make every birth a safe and desired one and no woman dies while giving life because every one counts.

Arthur Erken
UNFPA Representative
Bangladesh

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Acronyms

AIDS	:	Acquired Immune Deficiency Syndrome
ARSH	:	Adolescent Reproductive and Sexual Health
BCC	:	Behavior Change Communication
BCCP	:	Bangladesh Centre for Communication Programmes
BCCU	:	Behavior Change Communication Unit
BHE	:	Bureau of Health Education (DG-Health Services)
BINP	:	Bangladesh Integrated Nutrition Programme
BRAC	:	Bangladesh Rural Advancement Committee
CBCC	:	Center for Behavior Change Communication
CBOs	:	Community Based Organisations
CC	:	City Corporation/Community Clinic
CPAP	:	Country Programme Action Plan
CPR	:	Contraceptive Prevalence Rate
CSW	:	Commercial Sex Workers
CWFP	:	Concern Women for Family Planning
FP	:	Family Planning
FPAB	:	Family Planning Association of Bangladesh
FWAs	:	Family Welfare Assistants
GO	:	Government Organizations
GTZ	:	The German Agency for Technical Co-operation
HCP	:	Health Communication Partnership
HIV	:	Human Immune Virus
HNPSP	:	Health, Nutrition & Population Sector Programme
HPSP	:	Health and Population Sector Programme
ICDDR,B	:	International Centre for Diarrhoeal Diseases and Research, Bangladesh
ICPD	:	International Conference on Population and Development
IEC	:	Information, Education and Communication
IEM	:	Information, Education and Motivation
IPC	:	Inter-personal Communication
IUD	:	Intra Uterine Device
LGRD	:	Local Government Rural Development
MDG	:	Millennium Development Goals
MOE	:	Ministry of Education
MOHFW	:	Ministry of Health and Family Welfare
MOY	:	Ministry of Youth
NCAP	:	National Council for AIDS Prevention
NGO	:	Non-Governmental Organization
NIPORT	:	National Institute of Population Research & Training
NSV	:	Non-Scalpel Vasectomy
ORT	:	Oral Rehydration Therapy
PHC	:	Primary Health Care
PLA	:	Participatory Local/Learning Appraisal
RBM	:	Results-Based Management
RH/FP	:	Reproductive Health/Family Planning
SAWA	:	South and West Asia
SDPs	:	Service Delivery Points
SMC	:	Social Marketing Company
SRH	:	Sexual and Reproductive Health
STIs	:	Sexually Transmitted Infections
TA	:	Technical Assistance
TBA	:	Traditional Birth Attendant
TFR	:	Total Fertility Rate
UNESCO	:	United Nations Educational, Scientific and Cultural Organization
UNFPA	:	United Nations Population Fund
UNICEF	:	United Nations Children Fund
USAID	:	United States Agency for International Development
WHO	:	World Health Organization
WID	:	Women in Development

Executive Summary

Bangladesh, with an estimated population of 144.6 million (BBS-2008) crammed in an area of 147,570 sq km (BBS-2008) has the highest density of population in the world (979/sq. kilometer; BBS-2008). Following a very successful population programme, TFR fell from 6.3 in mid 1970s to 2.7 in 2007 (BDHS-2007) and population growth rate has declined from 3 per cent to 1.39 per cent over the same period (BBS-2008), TFR plateaued for about a decade at 3.3 (1994-2002) and started declining again and reduced to 2.7 in 2007 (BDHS: 2007).

The demographic structure, particularly the young people (about 40% in age 10-24 years) will cause the population to continue to increase and may stabilize at around 250 million in 2075: even if the replacement level of fertility is reached in 2010. Contraceptive Prevalence Rate (CPR) has increased to 55.8 per cent in 2007 from 44.6 per cent in 1994 (BDHS: 2004). The use of modern methods constitutes 47.5 per cent, where pill is by far the most widely used method (28.5%; BDHS: 2007), followed by injectables (7.0%), female sterilization (5.0%) and condom (4.5%; BDHS: 2007). Discontinuation rate is also high and varies by method, ranging from 71.3 per cent for condom to 38.7 per cent for injectables and 44.4 per cent for pills (BDHS: 2007).

Unmet need for family planning has declined, from 15 per cent in 1999-2000 to 17.6 percent in 2007 (BDHS: 2007). There are marked regional variations in the total fertility rate and contraceptive usage. Some key factors contributing to this phenomenon are low educational levels, continued son preference, high infant mortality, gender inequality, and poor status of women. About a quarter of the population consists of adolescents. Some of the problems concerning adolescents include early marriage, high fertility and low levels of secondary and tertiary education. Maternal Mortality Ratio (MMR) among adolescents is almost double than the national average (320/100000 LB) and the Infant Mortality Rate (IMR) is also 30 per cent higher than national average (52/1000 live births; BDHS: 2007).

Statistics show that approximately half of the women in Bangladesh are less than 18 when they marry, and 58 per cent of girls become mothers or pregnant with first child before the age of 20. Early marriage and early first birth therefore go hand in hand. Consequently, adolescent fertility in Bangladesh is still one of the highest in the world, with 127 births per 1000 women below 20 (BDHS: 2007). This has a direct impact on the country's total fertility rate. Young people are also particularly vulnerable to STI/HIV/AIDS and drug abuse. Because of their curiosity, inadequate knowledge and peer pressure many of them get involved in unprotected sex and drug use. Access to appropriate SRH information and services for this group is inadequate.

Behaviour Change Communication (BCC) played a key role in the success of health and family planning programme in Bangladesh. Commendable achievement in the child immunization programme with resultant decrease in child mortality, notable increase in contraceptive prevalence rate with resultant decline in fertility and in the health and family planning programmes have been possible due to a number of successful programme interventions and, undoubtedly, communication was a major element. A close look into the past communication strategies reveals that in the 1950s, selected institutions based IEC programmes were conducted.

In the 1960s, IEC activities mainly concentrated on clinic-based counseling and limited sensitization campaigns; the next decade (1970s) witnessed a shift from clinic-based counseling to a community mobilization through involvement of different opinion leaders and domiciliary visits by the field workers; and in 1980s involvement of NGOs and private sector and a functional integration of FP and MCH was operationalized.

In 1993, Ministry of Health and Family Welfare developed the first ever IEC strategy called National FP-MCH IEC Strategy (1993-2000). Built on the past programme achievements, this strategy emphasized on fostering community ownership, improving client-provider interaction, increasing focus on low performing areas, developing audience-specific materials, promoting service sites and providers and IEC capacity building. A special feature of this strategy was its emphasis on greater use of mass media along with IPC and on following appropriate steps for IEC material production and implementation plan.

In this strategy, basic strategic concepts have been clarified, major challenges encountered on FP/RH programmes have been identified, strategic communication process have been described and functional components of strategic communication have been considered. The key communication intervention objectives are to: enhance institutional strength; reduce maternal mortality; reduce infant and child mortality; increase CPR/CAR and reduce TFR; control communicable and infectious diseases and reduce malnutrition. Here the target audiences have been brought under three broad categories: service receivers, service providers and tertiary group.

With regard to media design, greater use of mass media has been emphasized side by side with strengthening IPC, local communication networks and social and community-based institutions. Major focuses in message design are: IEC/BCC messages need to be target audience specific, messages to be designed on the basis of interpreting research findings and pre-testing; functional linkage of messages on HNPSP, NNP and HIV/AIDS; prioritize needs of poor, women, adolescents and children; address the special needs of the target population and clients' rights, providers' obligation to clients; training/orientation and advocacy programmes.

This strategy also suggests to have strong coordination among the key stakeholders, including sectoral ministries in implementing the suggested interventions. IEM Unit will be responsible for identifying an action-oriented coordinating body to spearhead the communication strategy for family planning and reproductive health, and to monitor and evaluate the activities conducted to achieve the goals and objectives of this strategy which can help achieve HNPSP objectives along with relevant MDGs.

Introduction

The Bangladesh Communication Strategy for Family Planning and Reproductive Health is designed to serve as a roadmap for (1) increasing knowledge, improving attitudes, and changing behaviors, with regard to family planning and reproductive health, (2) improving the quality of reproductive health services, and (3) increasing stakeholders' participation and coordination in the areas of family planning and reproductive health, in Bangladesh.

Individuals and communities must understand basic facts about family planning and reproductive health in order to change attitudes, learn a set of skills and must be given access to appropriate commodities and services. Reproductive_health is defined as all health events related to reproduction in the life cycle. Its components include family planning, safe motherhood, reproductive tract infections, sexually transmitted diseases, HIV/AIDS, reproductive health services for adolescents, maternal and infant nutrition, prevention of unsafe abortion, cancer of the reproductive tract, infertility, neonatal care and gender-based violence.

Communication is the process of exchanging information or ideas; it is an active process that involves encoding, transmitting, and decoding messages between intended audiences and senders. Strategic communication refers to the assessment of communication approaches or channels available to a given program, and the subsequent selection of those channels to achieve the program's objectives. Strategic communication builds on theoretical and conceptual models of intrapersonal, interpersonal, and community-level behavior change, and provides a framework for addressing the needs of specific intended audiences.

Behavior change communication (BCC) is a multi-level tool for promoting and sustaining risk-reducing behavior change in individuals and communities by disseminating tailored health messages through a variety of communication channels.

Advocacy and community mobilization are necessary elements for promoting behavior change. Advocacy is an umbrella term for organized activism, and the process for championing an issue or set of issues. Advocates generally promote measures that broadly benefit society. For example, an individual or organization can advocate for a policy to increase funding for reproductive health programs for Bangladeshi people. Mobilization is the act of assembling and organizing resources to support specific objectives; it includes activating participants, allocating resources, strengthening organizations, and using community support to mount effective campaigns. Advocacy and mobilization are continuous processes of organization, education, and collective action that are designed to achieve a high level of member participation in collective endeavors.

Communication initiatives are generally tailored for specific intended audiences. Most of the family planning and reproductive health communication initiatives are audience-

specific in Bangladeshi. This Strategy document identifies priority audiences for family planning and reproductive health programs, and defines the objectives, and activities for achieving the objectives, for each audience. Indicators for success are suggested for each of the audience objectives.

A national communication strategy for family planning and reproductive health, with strong advocacy and community mobilization elements, will provide a framework that all programme implementers and service providers can use to guide their outreach interventions without duplicating efforts. The concerted efforts of stakeholders will create program synergies, and maximize economies of scale. Collaboration between local government and private sector agencies will add strength to the delivery of effective programs. This Strategy is intended to be a "living" document, reviewed and revised as new research, best practices, and successful programs are identified in Bangladesh.

Methodology

The development of this Strategy was initiated by the Directorate General of Family Planning, Ministry of Health and Family Welfare of the Government of the People's Republic of Bangladesh. Technical assistance was provided by UNFPA Bangladesh.

In late 2005, a Task Force was formed under the overall guidance of Director General, Directorate General of Family Planning. This group consisted of individuals from concerned governmental and non-governmental (NGO) departments including UNFPA (Annex A). Four Divisional Workshops were conducted in Chittagong, Jessore, Rajshahi and Dhaka to obtain insights and inputs about reproductive health and family planning issues from grass root officials. The relevant recommendations from the group work were incorporated into this strategy document.

A review of Bangladesh-focused family planning and reproductive health literature was conducted as part of the strategy-development process. These research studies were reported in peer-reviewed professional journals, governmental and non-governmental reports and conference proceedings, and books authored or edited by experts in the field of family planning. Both qualitative and quantitative studies were included in this review. Prior strategy documents were also reviewed.

Personal interviews were conducted with experts in the fields of family planning and reproductive health in Bangladesh in order to take stock of current programs and understand the family planning and reproductive health needs for various audiences. The literature review and personal interviews revealed gaps in family planning and reproductive health knowledge, behaviors, services, and service delivery coordination.

The present communication strategy will serve to address the gaps identified in the literature review, and advance the main goal of the Health Nutrition and Population Sector Programme (HNPSP), to reduce costs and improve cost efficiency of service

delivery systems, which will contribute to the sustainable provision of essential health and family planning services.

This strategy is compatible with, and supportive of, the goals and objectives of (1) the Health Nutrition and Population Sector Programme (HNPSP), which seeks to provide quality, affordable reproductive health services to achieve sustainable improvement in the health, nutrition, reproductive health (including family planning) of the population, with special attention to such vulnerable groups as women, children, and the poor, (2) the National Population Policy (NPP), for which the objectives are to improve the status of family planning, maternal health/reproductive health services, and to improve the standard of living for the people of Bangladesh, (3) the Poverty Reduction Strategy, to reduce poverty and improve economic growth and social development indicators in Bangladesh, (4) National Strategy for Maternal Health, (5) National Adolescent Reproductive Health Strategy and (6) National HIV/AIDS Strategy.

This communication strategy, along with the above government-led initiatives, reflects the Millennium Development Goals (MDGs) for Bangladesh, namely (1) to reduce child mortality, (2) to improve maternal health, and (3) to prevent diseases including reproductive tract infections (RTIs), sexually transmitted infection (STIs), and HIV/AIDS.

How to Use This Strategy

A national program that cuts across many diverse audiences requires careful orchestration of activities in order to ensure (1) the delivery of correct and consistent messages for each audience segment, (2) the desired behaviour change outcomes, and (3) cost-effectiveness. This Strategy is meant to bring together family planning and reproductive health programme planners and implementing agencies in a concerted effort to change relevant behaviors.

The intention of the audience approach is to provide stakeholders with manageable components of the Strategy that they can adopt, and for which they will be responsible. The usefulness of this Strategy as a roadmap to achieving specific objectives will be evident when stakeholders implement activities in collaboration and coordination with one another. Following a common blueprint for communication about family planning and reproductive health will reduce duplications in behavior change communication efforts.

There may be some overlap in the objectives or activities for a few of the intended audience groups. Some duplication of messages will serve to reinforce those messages. However, the duplication of materials should be minimal.

Current Family Planning and Reproductive Health Indicators for Bangladesh

The population of Bangladesh has been increasing at an approximate rate of 1.39 percent per year (BBS, 2008). The mid-2005 population estimate was about 144.2 million (WHO, 2004). The population density, 979 persons per square kilometer, is one

of the highest in the world (BBS, 2008). Poverty is widespread and about half of the population lives below poverty line.

Table 1. Bangladesh Health & Family Planning indicators.

Indicator	Present status	HNPSP Target by 2011
Demographic and Health		
Population Growth Rate	1.39**	
Total Fertility Rate (TFR)	2.7*	2.2
Population Density (per sq. km.)	979 persons**	
Life expectancy at birth	66.7**	
Male	65.8**	
Female	70.0**	
Family Planning		
Contraceptive Prevalence Rate (CPR)	55.8%*	72%
Unmet need for family planning	17.6%*	
Contraceptive Discontinuation Rate	46.3*	
Contraceptive use among married women (15-49 years), modern methods	47.5*	
Contraceptive use among married women (15-49 years), most used method	Pill – 28.5%*	
Maternal & Child Health		
Births attended by skilled personnel	15.0%***	
Maternal Mortality Rate (per 100,000 live births)	320***	240
Infant Mortality Rate (<1) (per 1,000 live births)	52*	37
Child Mortality Rate (<5) (per 1,000 live births)	65*	52
Youth		
Currently married (15-19 years)	46.0%*	
Women giving birth by age 20	54.6% ***	

Source: *BDHS 2007; ** BBS 2008; ***BMMS 2001

Over the past three decades, Bangladesh has made important gains in indicators related to population and family planning. The total fertility rate (TFR) declined from 6.3 births per woman in 1975, to 2.7 in 2007, more than 50 percent decline in only 32 years (BDHS, 2007). Bangladesh remains a low-prevalence HIV country, yet the potential for the rapid spread of HIV/AIDS is a threat.

Despite positive decline in TFR, several health indicators remain unacceptably high in Bangladesh. The maternal mortality ratio (320 per 100,000live births) is among the highest in the world; at least 12,000 women die annually from pregnancy related complications (UNFPA 2005). Maternal morbidity is estimated to be 30 times the

maternal. Skilled birth attendants are present for not more than 18 percent of all births. Contraceptive use remains low, and the method mix is limited. Some 17 percent of married women have an unmet need for family planning. The discontinuation rate among pill-users is 44.4 percent, mainly due to poor service provider screening and counseling.

Improvements in such indicators as TFR, unmet need for family planning, and the maternal mortality ratio, were achieved, in part, as a result of the progress made by appropriate Government initiatives. For example, free education and scholarships for girls to attend secondary school helped increase female enrolment and improve literacy among girl children; literacy is closely tied to increased use of family planning (at later ages) and improved reproductive health. An explosion in micro-credit-based self-employment has helped women establish small businesses, purchase livestock, work in agriculture and food processing, and build cottage industries, leading to overall human development and bolstering women's empowerment. Rural electrification has raised the levels of social development and economic growth in Bangladesh, and higher socioeconomic status is associated with family planning adoption and improved reproductive health. The construction of new roads has allowed for increased access to healthcare facilities, and consequently with reductions in pregnancy-related mortality.

Past and Present Communication Initiatives to address the FP-RH Situation in Bangladesh

National family planning information, education, and communication campaigns were introduced in Bangladesh (the then East Pakistan) in 1953. The emphasis of the family planning programme in its first two decades was on clinic and field-based counseling. A large number of *dais* (traditional birth attendants) were trained in contraceptive methods and employed part-time to provide family planning methods to village households. These *dais* were not trained in interpersonal communication and in how to motivate clients to adopt contraception.

In 1975, the Information, Education, and Motivation (IEM) Unit was established under the Directorate of Family Planning. The key objectives of the IEM were (1) to promote the concept of small family size, and (2) to generate demand for family planning and maternal and child health services. The activities of the IEM Unit have been critical to the success of the national family planning programme of Bangladesh.

In 1976, the government formulated the Outline of the Population Policy, a multi-sectoral approach for reducing the total fertility rate (TFR). Women were selected from their communities, trained in how to supply and counsel couples to use family planning methods, and hired Family Welfare Assistants (FWAs) and Family Planning Assistants (FPAs) to provide family planning counseling and non-clinical contraceptive services to couples in their homes. Upazilla Family Planning Officers, with support from the local level leaders, influentials including the Union Parishad authorities, were instrumental in mobilizing the community to accept small family norm

Also during mid-1970s, a multi-media communication campaign was implemented. This campaign used media materials (radio, television, films, billboards, posters, and leaflets) and interpersonal communication interventions (motivational meetings and folk song

programmes) to increase awareness and knowledge about family planning for couples in urban and rural areas, union council chairmen, teachers, and religious leaders. The Ministry of Information, Social Welfare, Education, Agriculture and Labour supported the Population Policy programme, and several non-governmental organizations (NGOs), namely, FPAB, CWFP, and SMC, also partnered in the campaign activities.

During the 1980s, the focus of the population program was on improving awareness about family planning methods, and moving the population toward positive attitudes about family planning, and adoption of contraceptive methods. Family planning fieldworkers were trained in interpersonal communication. Satisfied family planning acceptors were selected by fieldworkers to become change-agents in their community. Population education was introduced into the school curriculum during this period.

The 1990s was marked by the development of the Health and Population Sector Program (HPSP). This program emphasized (1) reproductive health, (2) a multi-sectoral approach to family planning demand generation, (3) accessibility of reproductive health services through satellite clinics, and (4) family planning outreach services. Recently, the government adopted the Bangladesh Population Policy; the key objectives for this policy include (1) reducing the total fertility rate, (2) ensuring adequate availability of, and access to, reproductive health services (especially family planning services), (3) reducing maternal mortality, (4) reducing RTIs and STIs, and preventing the spread of HIV/AIDS, (5) promoting gender equity, and (6) improving linkages among relevant Ministries to strengthen the implementation of population and development programmes (Bangladesh Population Policy , 2004).

Following is a description of some recent family planning and reproductive health communication initiatives in Bangladesh.

Family Planning

In the early 1990s, the Ministry of Health and Family Welfare initiated grass roots, social network strategy to develop family planning knowledge and behaviors. Local level Field Workers worked with local opinion leaders and their networks to conduct rotating discussion groups (*jiggasha*) with men and women in the homes of volunteers. The group discussions were led by Family Welfare Assistants (FWAs). These FWAs received training in family planning, and conducted home visits to supply contraceptive users. Findings from an evaluation study of the *Jiggasha* program showed that (1) women who attended the meetings were almost twice as likely to discuss family planning with their husbands than non-attendees, (2) participants were twice as likely to know four modern methods of birth control compared to those that did not attend *jiggashas*, and (3) about 30 percent of women adopted a new contraceptive method, 22 percent maintained their current method, and 17 percent visited a family planning clinic, in response to attending a group meeting (Piotrow et al., 1997).

Support materials for family planning programmes were developed by several collaborating organizations, including Information, Education and Motivation (IEM) Unit of the Directorate General of Family Planning, and the Bureau of Health Education (BHE) of the Directorate General of Health Services. These materials included training curricula/guides for field workers, booklets about contraceptive methods, a video to

improve the skills required for safe IUD insertion and removal, and "special days", discussions, and rallies throughout the nation. The IEM Unit also conducted a series of workshops about family planning and reproductive health for journalists and correspondents; public sector providers were oriented to family planning and trained in interpersonal communication skills using group meetings.

Reproductive Health

The Directorate General of Family Planning of the Ministry of Health and Family Welfare in collaboration with development partners including NGOs developed a programme to promote awareness about danger signs during pregnancy, childbirth, and the postpartum period for both mother and child.

A toolkit was also developed to help adolescents learn basic skills and information about reproductive health. This kit consisted of 4 booklets and 4 videos to educate young people about the changes to expect during adolescence, and marriage preparedness. A television magazine, *Amra Shobai Jante Chai*, with messages including dealing with peer pressure, avoiding early marriage, was developed. A radio magazine was produced with message about breastfeeding, antenatal care, and infant care. A series of 12 comic books highlighting key messages about adolescent reproductive health was also created. These materials were designed to compliment each other and reinforce the key messages.

Enechhi Shurjer Hashi, a television drama serial was developed to promote caring and quality healthcare services. Other materials, including billboards, television spots, radio spots, and local activities extended the campaign reach. A recent radio serial include *Jante Chai Janate Chai* in 2001 (focused on adolescent reproductive health).

Activities to build the capacity of programme managers and scriptwriters, and to educate mass media personnel about family planning were implemented in the mid-1990s. Workshops were held to orient Deputy Commissioners, Deputy Directors (FP), Assistant Directors (FP), Assistant Directors (CC), Population Communication Officers (PCOs), Union Parishad Chairmen, Thana Nirbahi Officers (TNOs), Thana Family Planning Officers (TFPOs) and Medical Officer (MCH-FP) about producing training and information, education, and communication materials. Research studies, including National Media Surveys were conducted to measure the reach and impact of the media. These studies helped to determine the strategic communication approaches for family planning and reproductive health programmes.

HIV/AIDS

In October 2003, HIV/AIDS Prevention Project (HAPP) was launched with the assistance of key development partners. A series of consultations with key stakeholders have been undertaken to develop an interim HIV and AIDS communication strategy for HAPP. The National Strategic Plan (NSP) for HIV/AIDS 2004-2010 was developed by the National AIDS/STD Programme (NASP), with technical support from key stakeholders. The NASP specifies the goals and objectives for combating HIV/AIDS, including (1) conducting research studies to understand the problem and establish baseline data for program planning and evaluation, (2) ensuring access to prophylaxis

and protective services, (3) generating political support for the national response to HIV/AIDS, (4) reducing the vulnerability of youth, (5) promoting family communication about HIV/AIDS, (6) promoting safe practices in the healthcare system, and (7) providing care and support services to people living with HIV and AIDS (MOHWF, 2004).

Lessons Learned

Globally, at least 600,000 women die each year from pregnancy and childbirth complications (World Health Organization, 2001). About 99 percent of maternal deaths occur in developing countries. At least 90 percent of maternal deaths occur in Sub-Saharan Africa or in Asia. The World Health Organization (2001) reports that 15 percent of women who become pregnant each year experience complications that require treatment by a skilled provider.

In 1997, a meeting of technical experts in Colombo, Sri Lanka produced the Safe Motherhood Action Agenda, which, in 1999, was released as a Joint Statement on Maternal Mortality Reduction by the WHO, UNICEF, UNFPA, and the World Bank. This new agenda for maternal mortality reduction recommended interventions at three levels: (1) national and local governments, (2) health systems, and (3) communities. Specifically, attention was shifted towards interventions that considered the social context and status of women. The action messages included empowering women, ensuring skilled attendance at every birth (by a service provider with midwifery skills, not a TBA), recognizing that every pregnancy faces risk, improving access to quality maternal health services, and preventing unwanted pregnancies and addressing unsafe abortion (Safe Motherhood, 2002).

Evaluations of safe motherhood programmes in low-income nations suggest (1) that maternal mortality decline requires multiple and synergistic interventions, and (2) that reductions in maternal mortality ratios can be achieved without necessarily reaching a high level of economic development. In Sri Lanka, the maternal mortality ratio dropped as a result of an initiative that included universal access to prenatal, delivery, and postnatal healthcare, access to quality emergency obstetric care, access to family planning services, and skilled attendance at delivery, despite that nation's low annual income per capita (Donnay, 2000). Traditional birth attendants were trained and integrated into the health system, which led to an increase (1) in deliveries using a skilled service provider, and (2) in obstetric emergency referrals to hospitals.

For the majority of population where maternal mortality ratios are high, social and cultural dynamics factor into the decision to accept or adopt a behavior such as using a healthcare facility. In Pakistan, for example, many women who died from childbirth complications lived close to an improved healthcare facility, but their husbands were not at home to give them permission to seek care at the facility (Jafaraey & Korejo, 1995).

The communication process between husband and wife is an under-appreciated factor in the maternal mortality prevention behavior change process. Thus, strategic communication about maternal health has shifted away from a mother-centered

approach of risk management, to a more ecological approach that acknowledges the roles of family (interpersonal) and community members, and social norms, in a woman's pregnancy, delivery, emergency obstetric care, and during the postpartum period (Figure 1). Strategic communication initiatives now focus on promoting changes in social norms regarding birth, and in creating enabling environments that facilitate the adoption of new safe motherhood behaviors.

Worldwide, the safe motherhood community concurs that the majority of life-threatening obstetric complications is sudden and cannot be predicted during the prenatal period. Thus, safe motherhood programs to reduce maternal mortality

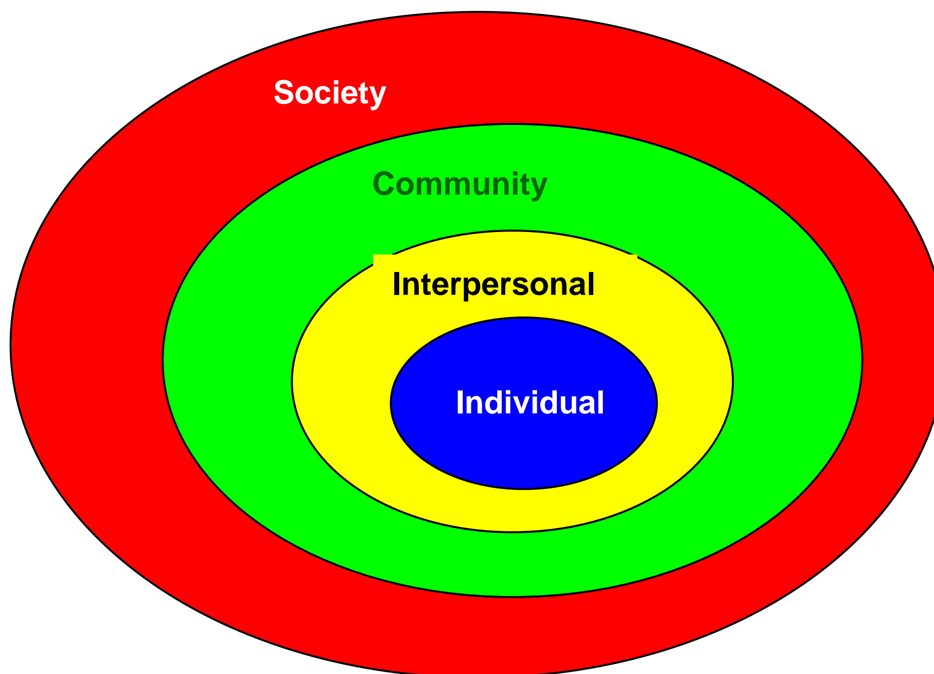

Figure 1. A Model of the Levels in the Ecological Approach

Focus on birth and the immediate postpartum period during which the risks to the mother are the highest (WHO, 2005). The most effective individual-level and population-level interventions are family planning, attendance at delivery by a skilled service provider, and timely diagnosis and treatment of complications (Fortney & Smith, 1997; World Bank, 1999; Graham, Bell, & Bullough, 2001).

Challenges to Communication, Advocacy and Mobilization (CAM) in Bangladesh

In Bangladesh, the implementation of a national communication, advocacy, and mobilization strategy faces the following challenges:

- A paucity of current baseline and formative research about family planning and reproductive health knowledge, attitudes, and practices that would facilitate the development of evidence-based communication initiatives
- Limited qualitative and quantitative studies to understand (1) attitudes toward family planning, and toward maternal health, (2) integrated health service

utilization, and (3) the impact of facility-based basic obstetric care on inequities in access to healthcare for the poor.

- A low level of correct knowledge about contraceptive methods, RTIs, and STIs among men and women
- Eleven percent unmet need for family planning
- High contraceptive user drop-out rates
- Threats to contraceptive security (i.e., the consistent availability of quality and affordable contraceptive methods)
- Inadequate male involvement in informed decision-making about contraceptive use and maternal healthcare
- Inadequate reproductive health services for men
- An insufficient cadre of male reproductive health services providers
- Service providers lack the skills to communicate with adolescents
- Family planning service providers fail to adequately screen clients about their family planning goals, and fail to inform clients about the full range of available contraceptive methods
- A low level of awareness about the need for birth preparedness (about the dangers for mother and child during pregnancy, delivery, postpartum)
- Poor nutritional status of mothers
- The norm of home-delivery without the presence of a skilled birth attendant
- The potential for the spread of HIV/AIDS
- An increasing population entering childbearing age
- The limited resources for pre-testing, producing, and disseminating quality, culturally appropriate and geographically relevant media materials
- The translation of political will into funding and coordinated action

Goal and Strategic Objectives

The purpose for the present communication strategy is to provide guidance for improving the family planning and reproductive health status of the people of Bangladesh, thus contributing to sustainable social development and poverty reduction. Following are the strategic objectives (SO)[1] for Bangladesh family planning and reproductive health programs. These SOs specify the domains for communication interventions. These domains are drawn from the national strategies for family planning, reproductive health, and HIV/AIDS, and are compatible with the HNPSP and CPAP.

SO-1 Increase knowledge about available contraceptive methods suited to client's attitudes and reproductive goals in order to enable informed decision-making about family planning.

SO-2 Improve knowledge about reproductive health, including RTIs, STIs, and HIV/AIDS, and promote the importance of early detection and treatment.

SO-3 Increase access to and community involvement in family planning and

[1] Strategic objectives relate to outcomes that strengthen the overall position and vitality of the programs.

reproductive health services and service delivery.

SO-4 Improve FP/RH service quality and service delivery (screening and counseling).

SO-5 Increase the number of adolescents that delay age at marriage.

SO-6 Increase knowledge and promote positive maternal health behaviours.

SO-7 Increase access to and community involvement in maternal health services (including skilled birth attendants, morbidities and emergency obstetric care).

S0-8 Improve the programme management capacity of family planning and reproductive health program managers and supervisors.

SO-9 Develop the media materials development and training capacity for family planning and reproductive health communication initiatives.

SO-10 Promote family planning, reproductive health, and maternal health care-seeking behavior among clients.

SO-11 Increase male involvement in family planning and reproductive health.

The Strategic Approach

The present communication, advocacy, and mobilization roadmap describes the objectives and activities that will contribute to (1) increasing knowledge and demand for family planning, and improve reproductive health (S0-1, SO-4, and SO-10), (2) delaying age at marriage (S0-5), (3) increasing knowledge and demand for maternal health services (S0-6 and S0-7), (4) improving service delivery (S0-8), (5) increasing male involvement (SO-11), and () improving the research and evaluation capacity for family planning and reproductive health programs (S0-9).

This Strategy is based on an ecological approach to behavior change. The ecological approach suggests that individual-level behavior change does not occur in a vacuum; individuals are influenced by family members, peers, community members, and social and cultural norms. Using this approach, behavior change activities will occur at national, divisional, district, and local levels:

1. At the divisional level, communication activities will be conducted to improve the capacity of health providers and managers.
2. At the district level, activities will be conducted to build the communication, advocacy, and mobilization capacity of government and NGO partners. Districts will develop relevant strategies appropriate to their geographic region.
3. At local level (upazilla, unions, wards, villages, paras, slums), community mobilization activities will be conducted to encourage communities to adopt the desired FP/RH and maternal health behaviors.

At the national level, advocacy activities will create a more favourable environment for FP/RH. Mass media activities will be conducted for the general public to increase knowledge and attitudes regarding FP/RH, and to generate demand for services. Creating or increasing demand for FP/RH in the absence of quality service delivery can be counter-productive. Demand for services should be generated only once quality

services are available. A phased approach to the communication interventions is recommended. FP/RH messages that increase knowledge and improve attitudes should be disseminated prior to messages specific to demand generation for services. It is important that the implementation of activities at the various levels be coordinated to avoid duplication of efforts.

Figure 2 shows the pathway to achieving family planning adoption and continued use, and reproductive health. Advocacy and social mobilization activities support each of the components targeted for behavior change.

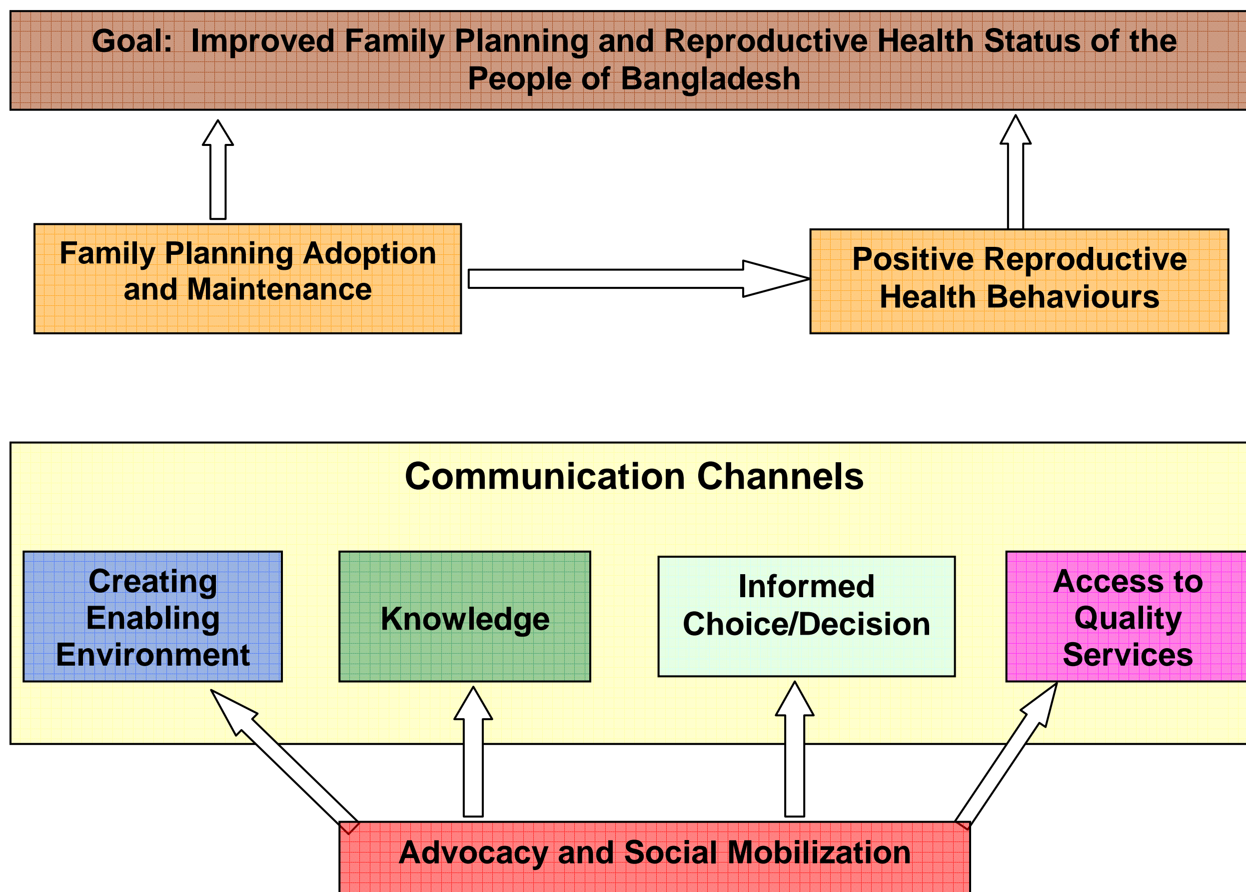

Figure 2: Model of Family Planning and Reproductive Health Behaviour Adoption.

The Intended Audiences

Based on inputs from the Task Force, personal interviews with Government policy makers and programme Managers NGOs, and development partners, anecdotal information and findings from research studies, 11 intended audiences were identified for the present strategy. This strategy also provides the objectives, sub-objectives, activities, and suggested indicators for success, for each audience.

Audience 1: Newlyweds and Low-Parity Couples

Unwanted and mistimed pregnancies are issues that affect newlyweds and low-parity couples. Unintended pregnancies constitute about one-third of the total pregnancies each year in Bangladesh (Khan, Hossain, & Rahman, 2004). In a study by Rahman and others (2001), the authors analyzed experimental data on abortion and contraception in two areas typical of rural Bangladesh, with the exception that one area had more available methods and higher-quality family planning services. They found that the rate of unintended pregnancy, and therefore the rate of abortion, was significantly lower in the area with better family planning services. They concluded that as desired fertility falls, more accessible and better quality family planning services could help prevent abortion rates from rising when they otherwise might.

At least 48 percent of the country's eligible couples use a modern contraceptive method; the pill is the most frequently adopted method (26.2%). However, the discontinuation rate among family planning adopters is generally high and varies by method; 71.5 percent discontinuation for condoms, 48.7 percent for injectables, and 46.5 percent for pills (BDHS, 2004).

Maternal mortality and morbidity are extremely high in the country. About 50 percent of all pregnant women suffer from poor nutrition and anemia. An estimated 12,000 pregnant women die each year as a result of pregnancy complications (UNFPA, 2005). Each birth poses an elevated risk of death to mothers for more than two years following the immediate perinatal period (Menken, 2003). The risk of dying may be related to pregnancy or birth, to illnesses that have onset or are aggravated during pregnancy or birth. Gender inequity and violence are contributing factors to maternal mortality. Family planning contributes to increasing a woman's life expectancy by reducing the number of times a woman is exposed to the possibility of death from extended maternal risk.

Objectives

- To increase the number of newlyweds and low-parity couples who adopt and maintain an appropriate contraceptive method;
- To decrease maternal mortality and morbidity.

Sub-objectives

- To increase the number of couples that discuss family planning and make joint-decisions about contraceptive methods;
- To increase the number of couples that use contraceptives to delay their first pregnancy;
- To increase the number of couples that use contraceptives for child-spacing;
- To increase the number of couples that discuss maternal healthcare, including emergency obstetric care and delivery with a skilled birth attendant;
- To increase the number of couples that practice birth preparedness;
- To decrease maternal morbidity (e.g., fistula, cervical cancer) among mothers.

ACTIVITIES

Research

- Qualitative and quantitative research studies on the factors that influence family planning adoption and maintenance (e.g., social norms, cultural practices, spousal communication) among newlyweds and low parity couples;
- Qualitative and quantitative studies about reproductive health-seeking behaviors among newlyweds and low parity couples;
- Qualitative and quantitative research about the knowledge, attitudes, and practices regarding birth preparedness;
- Qualitative and quantitative studies to determine the knowledge, attitudes, and practices with regard to maternal morbidity among newlyweds and low parity couples.

Communication

- A national-level multi-media campaign to promote the use of family planning for delaying first pregnancy and child-spacing;
- A national-level multi-media campaign to promote birth preparedness;
- Develop visual presentations for use at courtyard meetings at the grass-roots level to reinforce campaign messages about family planning and birth preparedness;
- Develop media materials for community-based service providers/counselors to use to educate couples about family size, birth spacing, and birth preparedness.

Advocacy

Orientation meetings for religious leaders about family planning for limiting family size and child-spacing, and the importance of birth preparedness for decreasing maternal mortality and morbidity. Orientation meetings for mass media personnel about the importance of reducing maternal mortality and morbidity through family planning and birth preparedness

Orientation meetings for community leaders (e.g., teachers, union parishad chairmen, members and others) about family planning for limiting family size and child-spacing, and the importance of birth preparedness for decreasing maternal mortality and morbidity.

- Appeal and motivate government leaders about the importance of maintaining contraceptive security, i.e., the need to strengthen supply-side efficiency;
- Appeal and motivate government leaders about increasing the number of women professionals and services providers at all levels of health and family planning services;
- Lobby government for resources to equip upazilla offices that can conduct grass-roots programs (e.g., cinema events to show relevant films with messages about family planning and reproductive/maternal health).

Mobilization

- Convene courtyard meetings to discuss family planning, reproductive health, and birth preparedness. Show entertainment-education CD films, folk songs, and community theater relevant to these topics.

Indicators of Success

1. The percentage of couples that discuss family planning and make joint-decisions about contraceptive methods;
2. The percentage of couples that use contraceptives to delay their first pregnancy;
3. The percentage of couples that use contraceptives for child-spacing;
4. The percentage of couples that discuss maternal healthcare, including emergency obstetric care and delivery with a skilled birth attendant;
5. The percentage of couples that know the elements of birth preparedness;
6. The percentage of couples practice birth preparedness;
7. The percentage of couples that use a skilled birth attendant for delivery;
8. The percentage of couples that can identify at least two contributing factors to maternal morbidity (e.g., fistula, cervical cancer);
9. The percentage of couples that know where to seek services for maternal morbidities.

Audience 2: Married Couples with Desired Family Size

Bangladeshi women's contraceptive choice is influenced by personal characteristics, their assessments of available options, and their assessment of the potential side effects of the method (Khan, 2001). The pill is the most used contraceptive method. Women find it easy to use, easy to obtain, and it has no associated cost (Mannan, 2002). Women who had experienced side effects were significantly more likely to stop using the pill, despite not wanting to have more children. Son preference and child-loss play an important role in the decision to adopt long-term and permanent contraceptive methods; women that have not borne sons, and that have lost a child are less likely to adopt long-term or permanent methods (Mannan, 2002).

Objective

- To increase the number of married couples who adopt an appropriate long-term or permanent contraceptive method.

Sub-objectives

- To increase knowledge among couples about the available long-term and permanent contraceptive methods;
- To decrease the number of couples that have misconceptions about long-term and permanent contraceptive methods;
- To improve attitudes toward long-term and permanent contraceptive methods;
- To increase access to long-term and permanent contraceptive methods;
- To increase use of long-term and permanent contraceptive methods.

ACTIVITIES

Research

- Qualitative and quantitative studies to assess current knowledge, attitudes, and practices about long-term and permanent methods, among couples, family members, and community members;
- Qualitative research to determine couples' decision-making about family size, and about long-term and permanent contraceptive methods.

Communication

- A national media campaign to raise awareness about the advantages of small family size, and the use of long-term and permanent methods to achieve small family size;
- Develop "refresher" training materials for service providers to improve their ability (1) to communicate about all available long term and permanent contraceptive methods, and (2) to encourage joint decision-making about long term and permanent methods among couples;
- Develop visual presentations about the advantages to adopting long-term and permanent methods once desired family size is achieved, to show to religious and community leaders.

Advocacy

- Convene meetings of religious leaders and community leaders to discuss the importance of limiting family size after two children have been born;
- Hold meetings with government officials at multiple levels to ensure availability of long-term and permanent methods to all interested couples.

Mobilization

- Conduct courtyard meetings to education and "remind" couples about long term and permanent methods. Involve FPIs, FWAs and FWVs in these meetings. Show entertainment-education CD films, folk songs, and theater relevant to these topics;
- Convene meetings with family members to educate them (especially in-laws) about the advantages of small family size. Involve FPIs, FWAs and FWVs in these meetings.

Indicators of Success

1. The percentage of couples that can identify the available long-term and permanent contraceptive methods;
2. The percentage of couples that know the benefits and potential side-effects of the available long-term and permanent contraceptive methods;
3. The percentage of couples that have positive attitudes toward long-term and permanent contraceptive methods;
4. The percentage of couples that have access to long-term and permanent contraceptive methods;
5. The percentage of couples that use long-term and permanent contraceptives;

6. The percentage of providers that can provide correct information about long-term and permanent contraceptives;
7. The percentage of religious and community leaders that are supportive of couples that have achieved the desired family size, using long-term and permanent methods.

Audience 3: Husbands/Males

Men are decision-makers, husbands, fathers, community leaders, and potential family planning and reproductive health clients. Men's roles in family planning, however, have been largely ignored.

Bangladeshi men have a high degree of contraceptive knowledge. A study by Islam and others (2004) found that about 19 percent of men reported knowing 4-5 modern contraceptive methods, and only 5 percent had heard of 3 methods. Men's approval of family planning is also high, and their family desires are similar to their wives. Ashraf and others (1999) found that men had higher awareness about AIDS than women, although only one-third of the male population knew how it was transmitted.

Bangladeshi men suffer from a variety of reproductive and sexual health problems (Hussain, Rahman, & Begum, 1996; Piet-Pelon, Rob, & Khan, 2000; Population Council, 1996). Men are willing to seek care for sexual health problems, but the women-centered focus of reproductive health programs in Bangladesh has left the male population underserved (Collumbien & Hawkes, 2000). Services for men are narrowly defined. Bangladeshi men have unmet needs with regard to reproductive health, namely (1) the need for greater access to health services, and (2) the need to use contraceptives. Government facilities were found to be inadequate for providing males with diagnoses and treatment of sexual health problems (Hossain et al., 2004).

Male involvement in maternal health is also limited. Men are key to decision-making about birth preparedness (e.g., transportation, funds for delivery), and may determine the fate of their wives, especially when emergency obstetric care is required. Communication initiatives for men should focus on (1) promoting male contraceptive methods, (2) improving treatment-seeking behavior by men for reproductive health-related problems (e.g., STIs), (3) increasing awareness and knowledge about birth preparedness, and (4) promoting healthcare facilities where quality services for males are offered.

Objectives

- To increase adoption of appropriate male contraceptive methods;
- To increase use of condoms to prevent sexually transmitted infections;
- To increase use of healthcare services by men for male reproductive health Issues;
- To increase adoption of birth preparedness among couples.

Sub-objectives

- To encourage joint-decision-making with wives about family planning and contraceptive choice;
- To decrease the perpetration of violence against women related to arguments about family planning and contraceptive use;

- To increase knowledge about male contraceptive methods;
- To improve attitudes toward male contraceptive methods;
- To increase use of male contraceptive methods;
- To encourage male health-seeking behavior for RTI and STI services;
- To improve male reproductive health services at healthcare facilities (e.g., communication/counseling about STIs and HIV/AIDS, and vasectomy);
- To promote the availability of male reproductive health services at facilities that offer quality care for men;
- To increase knowledge about maternal mortality and morbidity;
- To increase knowledge about birth preparedness;
- To improve attitudes about safe motherhood.

ACTIVITIES

Research

- Qualitative research to understand the role of husbands in decision-making about family planning and contraceptive selection;
- Qualitative research to determine the degree of joint decision-making about family planning and contraceptive choice;
- Qualitative studies to identify attitudes toward healthcare service delivery for males;
- Quantitative and qualitative studies to measure the level of knowledge about maternal mortality and morbidity among men;
- Qualitative studies to determine men's knowledge, attitudes, and practices with regard to birth preparedness.

Communication

- Increase communication capacity among service providers to deliver quality, effective counseling to men about contraception and reproductive health (develop appropriate training materials and conduct training sessions);
- Develop media materials (including folk theater and music) that convey correct and positive messages to encourage (1) joint decision-making about family planning and contraceptive method selection, (2) male reproductive healthcare seeking behavior, (3) the adoption of birth preparedness, for use by religious and community leaders at local gatherings;
- Train religious and community leaders in behavior change communication skills for reaching men with messages about family planning, reproductive health, and maternal health/birth preparedness;
- Develop a nationwide multi-media campaign to promote joint decision-making about family planning, and male involvement in maternal health.

Advocacy

- Advocate with Imams, religious and community leaders to regularly discuss family planning and contraception with men;
- Advocate with religious and community leaders to discuss maternal health with men and encourage husbands to seek healthcare for their wives during

pregnancy, use a skilled birth attendant (SBA) for delivery, and seek postpartum care;

- Appeal and motivate government leaders about increasing the number of male professionals and services providers for reproductive health services at all levels of health services;
- Petition government bodies to allocate resources to improve male-oriented healthcare service delivery.

Mobilization

- Convene gatherings where folk media are used to convey messages about (1) male reproductive health, (2) the importance of social support from family members regarding;
- Create male support groups at the grass-roots level where men can learn about family planning, contraceptive methods, reproductive health service delivery points, and birth preparedness;
- Create a coalition of men (male representatives from government, NGOs, community groups, youth groups) against gender-based violence that can hold meetings with men in their workplace (or other venues where men gather on a regular basis).

Indicators of Success

1. The percentage of men that have correct knowledge about male contraceptive methods;
2. The percentage of men that have positive attitudes toward male contraceptive methods;
3. The percentage of men that use male contraceptive methods;
4. The percentage of men that seeking healthcare for RTIs and STIs;
5. The percentage of men that are satisfied with the reproductive health services at healthcare facilities (e.g., communication/counseling about STIs and HIV/AIDS, and male contraceptives including vasectomy);
6. The percentage of men that know where to seek reproductive health services;
7. The percentage of men that know about maternal mortality and morbidity;
8. The percentage of men that know about birth preparedness;
9. The percentage of men that have a positive attitude toward safe motherhood;
10. The percentage of men that report making joint decisions with wives about family planning and contraceptive choice;
11. The percentage of men that report making joint decisions with wives about birth preparedness;
12. The proportion of men that perpetrate violence against women related to arguments about family planning and contraceptive use.

Audience 4: Poor and Underserved Populations

The poor and other hard-to-reach groups (e.g., those living in remote coastal areas, river eroted areas, char/island and haor areas; commercial sex workers - CSWs) are vulnerable and underserved populations with regard to family planning and reproductive health information and services. Many of these hard-to-reach populations exhibit higher total fertility rates and higher maternal mortality ratios compared to the national averages. To date, few programs to inform, educate, and motivate these populations

regarding positive family planning and reproductive health behaviors have not been conducted. The Urban Primary Healthcare Project, in collaboration with a number of NGOs, provided limited reproductive health services to urban slum areas (UNFPA, 2004). In general, geographic circumstances make it difficult for service providers to visit these intended audiences; for example, there are an inadequate number of boats to travel to people living in coastal areas, in a timely manner.

Objective

- To increase access to quality family planning and reproductive health information for the poor and underserved populations;
- To increase access to quality family planning and reproductive health services for the poor and underserved populations.

Sub-objectives

- To increase knowledge about family planning and reproductive health in traditionally underserved populations;
- To increase positive attitudes toward family planning and reproductive health in traditionally underserved populations;
- To increase use of family planning and reproductive health services among the underserved;
- To increase the capacity of healthcare service providers to communicate with low-income and low-literate audiences about informed decision-making with regard to family planning and reproductive health;
- To increase the capacity of healthcare service providers to reach the urban poor and other underserved populations.

ACTIVITIES

Research

- Qualitative and quantitative studies to determine the knowledge, attitudes, and practices regarding family planning and reproductive health among underserved populations;
- Qualitative and quantitative research to understand the health-seeking behaviors of the poor (especially the urban poor) and hard-to-reach audiences;
- Qualitative and quantitative assessments for service providers' skills for communicating with low-income and low-literate audiences.

Communication

- Develop a briefing presentation, with salient talking points about family planning and reproductive health, for religious and community leaders to use when addressing their underserved community members;
- Develop media materials and messages about family planning and reproductive health, that are culturally sensitive and appropriate for use with poor and other disadvantaged populations in various contexts (e.g., small group meetings and large gatherings).

Advocacy

- Motivate and appeal to government bodies for resources to enable healthcare service providers to reach underserved populations (e.g., to purchase boats to conduct home visits to families that can only be reached by waterways);
- Petition government entities for extended health protection for resource-poor households.

Mobilization

- Organize small and large group meetings to sensitize these audiences to the importance of family planning (small family size, birth spacing, informed and appropriate contraceptive selection, etc.), and reproductive health, and reproductive health rights and services. Provide supporting materials with information about availability and access to services;
- Use folk media performances to educate and motivate these audiences about family planning and reproductive health. Distribute supporting materials to extend the memory and reach of the performances.

Indicators of Success

1. The percentage of people in defined underserved audiences that have correct knowledge about family planning and reproductive health;
2. The percentage of people in defined underserved audiences that have positive attitudes toward family planning and reproductive health;
3. The percentage of people in defined underserved audiences that use family planning and reproductive health services;
4. The percentage of service providers that utilize appropriate methods for communicating with low-income and low-literate audiences about informed decision-making in family planning and reproductive health;
5. The percentage of healthcare service providers that reach the urban poor and other underserved populations;
6. The percentage of people in defined underserved audiences that are reached with messages about family planning and reproductive health.

Audience 5: Adolescents

Adolescence is a time when important physical changes occur, and when curiosity about reproductive and sexual health begins. It is a time when peer pressure is strong and stigma about matters related to sex is present. Taboos about discussing new feelings and physical experiences prevent the exchange of correct knowledge among peers, and between parents and children.

About 25 percent of the Bangladesh population are adolescents (between the ages of 10 and 19 years). At least 20 percent of teens engage in premarital sex without the emotional readiness and without prophylaxis against pregnancy and infection.

Many parents engage in dowry exchange, which encourages early marriage. Early marriage and early age at first pregnancy are inextricably tied together. Pregnancy during adolescence interrupts a woman's education, thus diminishing her chances of achieving her full potential, and economic success.

At least 48 percent of adolescents are married, and some 63 percent give birth before the age of 20 years. Adolescent fertility in Bangladesh is among the highest in the world, about 135 births per 1,000 women below the age of 20 years (BDHS, 2004). The maternal mortality ratio for women under the age of 20 is four times higher than the national average of 380 deaths per 100,000 births (BDHS, 2004). The adolescent audience has been a traditionally underserved audience with regard to family planning and reproductive health.

Objective

- To decrease the number of adolescents who marry before the age of 18 years for girls, and 21 years for boys;
- To increase the number of adolescents that demonstrate knowledge of hygiene and life-skills.

Sub-objectives

- Increase the number of adolescents that have correct knowledge about their bodies, and can practice proper hygiene;
- Encourage dialogue between parents and children about marriage, fertility, reproductive health, maternal health;
- Create an enabling healthcare environment where adolescents (1) can seek information about reproductive and sexual health (including HIV/AIDS), and hygiene, and (2) can seek services for sexually transmitted infections;
- Increase the number of adolescents that know the advantages of delaying age at marriage;
- Increase the number of adolescents that marry at the legal age of 18 years for girls and 21 years for boys.

ACTIVITIES

Research

- Assess current life-skills materials to determine their effectiveness and appropriateness for communicating correct and consistent information about hygiene and reproductive health for diverse adolescent audiences;
- Conduct a needs assessment to determine current gaps in knowledge, attitudes, and practices regarding contraceptive methods, reproductive health, and hygiene, among adolescents;
- Qualitative research to understand the influence of peers, parents, and other family members of decision-making about age at marriage and health-seeking behaviours;
- Assess the communication skills of service providers that serve adolescents.

Communication

- Develop a multi-media entertainment-education intervention to raise awareness about the importance of delaying marriage and first pregnancy;
- Use reinforcing folk media at the grass-roots level to convey anti-dowry messages, messages about hygiene, messages about delaying age at marriage and age of first birth, and messages about preventing sexually transmitted infections;
- Develop a cadre of field workers at the grass-roots level (1) to facilitate adolescent-friendly discussions following folk performances, and (2) to invite adolescents to seek information and services from appropriate health service venues.

Advocacy

- Advocate for a Ministry/Department for Adolescent Health to attend to the special needs of adolescents, oversee the implementation of interventions directed toward adolescents, and coordinate communication activities with other relevant organizations;
- Advocate for the inclusion of adolescent life-skills programs into the school curriculum;
- Address Ministry of Education officials to provide suitable latrine facilities for girls in schools (many girls drop out of school once they start menstruating because they do not have latrines in the schools);
- Address parents about forbidding their daughters to attend school once they have begun menses;
- Advocate for higher visibility of adolescent reproductive health issues, especially adolescent-friendly health services, with various ministries, including Ministry of Health and Family Welfare, Ministry of Youth and Sports, Ministry of Information, and Ministry of Primary and Mass Education. Develop a set of fact sheets and a PowerPoint presentation that can be used to deliver consistent messages about issues related to adolescent reproductive health.

Mobilization

- Develop the capacity of youth clubs (over 6,000 in rural Bangladesh) as resource centers for adolescents where correct information about hygiene and reproductive health are available;
- Create parent delegate groups (i.e., groups of mothers and groups of fathers that teach other parents how to listen to, and dialogue with, their adolescents about reproductive health) that conduct discussion groups with parents in their neighborhoods;
- Train service providers to communicate with adolescents about preventing sexual responsibility;
- Create an enabling environment for adolescents to seek information and services at local healthcare facilities;

- Use group discussions with trained facilitators to discuss delayed marriage and reproductive health issues with out-of-school adolescents (street children, hawkers, commercial sex workers, day laborers, domestic workers, etc.).

Indicators of Success

1. The percentage of adolescents that can correctly identify their anatomy;
2. The number of adolescents that can identify the steps to proper hygiene (e.g., menstrual hygiene for girls);
3. The percentage of adolescents that practice proper hygiene;
4. The percentage of adolescents that can identify the symptoms of RTIs, STIs, and HIV infection;
5. The percentage of female adolescents that remain in school following the onset of menses;
6. The percentage of adolescents that dialogue with their parents about reproductive health issues;
7. The percentage of adolescents that have a positive attitude toward seeking information about reproductive health from service providers;
8. The percentage of adolescents that access condoms at health services sites;
9. The percentage of adolescents that know the advantage of delaying age at marriage;
10. The percentage of adolescents that intend to delay age at marriage;
11. The proportion of adolescents that delay age at marriage;
12. The percentage of parents that feels comfortable talking with their teens about sexual and reproductive health;
13. The percentage of health service providers that feel comfortable discussing reproductive health issues with adolescents.

Audience 6: Unmarried Youth

Unmarried youth is an audience segment that comprises both in-school and out-of-school individuals. They are of marriageable age and thus ripe for messages that may influence their perceptions of potential marriage partners, the institution of marriage (especially regarding dowry and domestic violence), and of the family planning and reproductive health issues associated with marriage. Unmarried males may have unhealthy perceptions of women. Women in this audience category may be particularly susceptible to gender-based discrimination, which contributes to their inability to negotiate their rights to appropriate healthcare, and to decrease the potential for violence in their relationship (UNFPA, 2004). This audience category presents an opportunity to change the social norms associated with gender-based biases.

Objectives

- To increase awareness about gender equity;
- To increase knowledge about sexual responsibility among unmarried youth.

Sub-objectives

- Increase knowledge among youth, and among policy-makers, about the positive effects of gender equity;

- Increase awareness among youth (in-school and out-of-school) about the negative effects of gender-based violence;
- Increase knowledge about (gender-specific) sexual health rights;
- Improve the reach of life-skills/family life education programs to include greater numbers of out-of-school youth;
- Increase knowledge about sexual responsibility;
- Increase the number of unmarried youth that delay age at marriage;
- Increase the number of unmarried youth that know the advantages to having no more than two children;
- Increase the number of unmarried youth that have a positive attitude toward family planning.

ACTIVITIES

Research

- Qualitative and quantitative research to establish baselines for knowledge and perceptions about gender equity, sexual health rights, and early marriage;
- Qualitative research to understand the role of family members with regard to decision-making about marriage;
- Qualitative research to determine perceptions of risk for RTIs, STIs, and HIV-infection;
- Qualitative and quantitative research to determine the degree of service provider communication skills for counseling unmarried youth;
- Review current life-skills/family life education programs to determine consistency in messages;
- Asses the impact of peer-to-peer communication initiatives to reach unmarried youth.

Communication

- Develop culturally appropriate training modules for professional and para-professional counselors about how to communicate specifically with unmarried youth;
- Develop age-appropriate and culturally sensitive media materials to communicate messages about healthy perceptions of the opposite sex, the negative impacts of dowry exchange and domestic violence, and women's rights for unmarried youth and their parents.

Advocacy

- Hold audiences with parliamentarians to increase awareness about the impact of gender discriminatory laws on reproductive health;
- Lobby donors, NGOs, and the GOB (Ministry of Education) for training a cadre of professional and para-professional counselors that have the skills to provide information and services to unmarried youth (especially for out-of-school youth);
- Advocate for the introduction of counselors in secondary schools to address the issue of gender-based violence.

Mobilization

- Engage Imams to discuss reproductive health issues with youth;

- Conduct discussion groups with trained facilitators where youth can learn about, and practice, problem-solving skills with regard to family planning and reproductive health decision-making;
- Educate community gatekeepers (parents, teachers, religious leaders, etc.) about gender equity issues.

Indicators of Success

1. The percentage of unmarried youth that can identify the positive impacts of gender equity;
2. The percentage of youth (in-school and out-of-school) that can identify the negative impacts (immediate and distal) of gender-based violence;
3. The percentage of parents that can identify the negative impacts (immediate and distal) of gender-based violence;
4. The percentage of youth that know their sexual health rights;
5. The percentage of out-of-school youth that are reached with life-skills/family life education programs;
6. The percentage of unmarried youth that know at least 6 contraceptive methods;
7. The percentage of youth that know the symptoms of RTIs, STIs, and HIV/AIDS;
8. The percentage of young unmarried youth that delay age at marriage;
9. The percentage of unmarried youth that know the advantages to having no more than two children;
10. The percentage of unmarried youth that have a positive attitude toward family planning.

Audience 7: Service Providers

A recent evaluation of family planning and reproductive health behavior change communication efforts in Bangladesh showed that clients avoided discussing personal reproductive health issues with providers because the environment created by the provider was not private or conducive to such exchanges (Chowdhury & Maksud, 2005).

A field observation study of providers at the union level showed that counseling about contraceptive methods was biased toward Copper-T. Clients that did not want to adopt Copper-T left the clinic without a family planning method; providers failed to adequately inform clients about the complete method mix (Chowdhury & Maksud, 2005).

In general, males do not have access to trained male providers at the local level. Service providers also failed to use existing behavior change communication materials with clients during counseling sessions (Chowdhury & Maksud, 2005).

Objective

- To improve the family planning counseling skills of service providers;
- To improve the attitudes of service providers toward adolescents and youth with regard to family planning and reproductive health seeking behavior.

Sub-objectives

- To increase correct knowledge about each of the available contraceptive methods (including screening questions and potential side-effects);
- To increase knowledge about screening and treatment of RTIs, STIs, HIV/AIDS;

- To increase knowledge about birth preparedness and maternal health issues;
- To increase sensitivity toward client privacy and confidentiality (i.e., the need to counsel clients in private areas, keep confidential records);
- To increase the effectiveness of communication between client and provider (e.g., listening skills, communication styles for different audiences such as adolescents, the correct use of appropriate informational materials to educate clients about each method, the difference between informed choice and coercion, etc.);
- To encourage providers to create an environment in which adolescents feel comfortable seeking information and services;
- To increase the number of providers those discuss the negative consequences of violence against women with their clients;
- To improve the provider's ability to detect and refer cases of violence/abuse;
- To improve the provider's ability to detect maternal morbidities and refer cases to the next level of care.

ACTIVITIES

Research

- Comprehensive quantitative and qualitative studies to determine knowledge, attitudes, and practices of providers about family planning and reproductive health;
- A qualitative study to understand the influence of quotas imposed by government officials for specific contraceptive methods on provider-client relationships (especially perceptions of trustworthiness);
- A field-based study to assess the quality of service delivery points and determine the adequacy of facilities for private counseling, cleanliness, adequate seating arrangements in waiting areas, etc.

Communication

- Develop a comprehensive training curriculum for developing the communication/counseling skills of providers at various levels. This curriculum should include sessions on (1) understanding family planning, (2) understanding reproductive health, (3) understanding maternal mortality and morbidity, (4) understanding gender equity, (5) knowing your audience (e.g., adolescent clients, male clients, etc.) (6) motivating clients to make informed choices, (7) how to create an environment conducive to counseling, (8) how to discuss sensitive issues with clients, (9) couples counseling, (10) how to correctly screen clients for family planning methods, and for signs of violence/abuse (11) how to use support materials (flipcharts, pamphlets, booklets, posters, etc.) to increase client understanding, and (12) how and when to refer clients to other service delivery sites.
- Special attention should be paid to develop a module to improve service provider skills for communicating with vulnerable and underserved (possibly apprehensive) audiences.

- All trainings should be interactive, including role-playing counseling sessions. Mock counseling sessions should be recorded and played back as a teaching tool.
- A brief practicum should be arranged for providers, and these field- counseling sessions should be evaluated. Providers should leave the training with a kit containing media materials that they can use when counseling clients.
- Conduct communication exchange sessions with practitioner role-models from areas where providers have achieved family planning and reproductive health success in communicating with clients

Advocacy

- Approach appropriate ministries for resources to create counseling spaces within facilities that will allow providers to ensure client privacy;
- Request government entities to provide resources for comprehensive, culturally-appropriate counseling training for providers nationwide.

Mobilization

- Organize regularly scheduled meetings with providers within specific catchment areas to discuss family planning and reproductive health counseling issues and exchange information about challenges, successes, and opportunities.

Indicators of Success

1. The number of providers that have correct knowledge about each of the available contraceptive methods (including screening questions and potential side-effects);
2. The number of providers that know how to screen and treat of RTIs, STIs, HIV/AIDS;
3. The number of providers that know the elements of birth preparedness and maternal health issues;
4. The number of providers that are aware of the need to counsel clients in private settings;
5. The number of clients that report receiving counseling in private settings
6. The number of providers that demonstrate effective listening skills;
7. The number of providers that correctly use support materials for counseling clients;
8. The number of providers that discuss the complete method mix with clients;
9. The number of providers that discuss the negative consequences of violence against women with their clients;
10. The number of providers that know how to detect and refer cases of violence/abuse;
11. The number of providers that know how to detect maternal morbidities and refer cases to the next level of care;
12. The number of clients that report satisfaction with provider communication skills;

Audience 8: Programme Managers and Supervisors

Programme managers and programme supervisors are key communication intermediaries between governmental, non-governmental, sectoral, and inter-sectoral

agencies. Inter-organizational communication between supervisors and managers (at the district and upazila levels), and between supervisors and other involved parties, is essential for effective and efficient program implementation. Weaknesses in the operationalization of family planning and reproductive health interventions occur when the chain of communication is ineffectual.

Objective

- To increase the capacity of program managers and supervisors to coordinate, monitor, and provide feedback about multi-level family planning and reproductive health programmes in their catchment areas.

Sub-objectives

- To increase the capacity of program managers to assess programme implementation and communicate findings to supervisors;
- To improve communication between programme supervisors and programme managers about current family planning and reproductive health programme activities;
- To increase the capacity of programme supervisors to liaise with other stakeholders about on-going programmes, i.e., increase inter-organizational coordination of programme activities;
- To ensure adequate allocation of resources for communication about program activities and functional coordination of those activities.

ACTIVITIES

Research

- Qualitative research to understand programme manager's and programme supervisor's perceptions of their roles and responsibilities with regard to implementing, monitoring, and communicating about their programs;
- A network analysis of programme manager and programme supervisor communication patterns to understand the linkages between family planning and reproductive health programmes.

Communication

- Develop standardized orientation materials for managers and supervisors that details their communication responsibilities with regard to programme implementation;
- Develop a communication training module to provide managers and supervisors with the necessary skills to exchange relevant information in a timely manner (this module should include models/protocols of information reporting formats);
- Develop a communication checklist to help supervisors disseminate timely information to relevant stakeholders about programme implementation (this checklist should identify the stakeholders, the manner in which programme information will be communicated to the relevant parties, and a timeframe, or time intervals, for reporting program implementation activities);
- Develop materials to help managers and supervisors advocate for resources and other support from stakeholders and political leaders/policy makers.

Advocacy

- Petition government officials for adequate resources to strengthen the capacity of programme managers and programme supervisors to liaise with higher-level officials about programme implementation.

Mobilization

- Conduct orientation meetings with programme managers and programme supervisors to reinforce their importance in the chain of communication about program activities.

Indicators of Success

1. The number of programme managers and supervisors that can identify the roles and responsibilities associated with communication about program implementation;
2. The number of programme managers and supervisors that can identify the correct communication protocol for reporting about program activities, following the training sessions;
3. The number of programme managers and supervisors that use the correct communication protocols for reporting about program implementation;
4. The frequency of communication about programme activities between program supervisors and programme managers;
5. The number of programme supervisors that correctly use the checklist to disseminate information about program activities to relevant stakeholders;
6. The timely allocation of resources for communication about programme activities and functional coordination of those activities;

Audience 9: Religious and Community Leaders

Involvement of religious leaders through Ministry of Religious Affairs is of paramount importance in mobilizing the community people on reproductive health and rights, male involvement, HIV/AIDS and Gender issues. The audience of community leaders includes *Imams*, teachers, *Matbar*, union parishad members, social workers, labor leaders, and local opinion leaders (e.g., businessmen, homeopathic providers, and student leaders). Both religious and community leaders play important roles in the lives of their community members; they are consulted on such important matters as family planning, nutrition for pregnant women, places where individuals can/should seek healthcare, safe delivery, the marriages of children, and the treatments for diseases. These leaders are important gatekeepers in their communities.

Objective

- To increase the capacity of religious and community leaders to deliver correct and positive message about family planning and reproductive health to the members of their communities.

Sub-objectives

- To increase knowledge about family planning, contraceptive methods, reproductive health, and birth preparedness among religious and community leaders;
- To improve attitudes about family planning, contraceptive methods, reproductive health, and birth preparedness among religious and community leaders;
- To encourage Imams and community leaders to discuss family planning, contraceptive methods, reproductive health, and birth preparedness with their followers and members.

ACTIVITIES

Research

- Qualitative research with Imams about their perceptions of family planning and reproductive health issues;
- Qualitative research with community leaders about (1) their perceptions of family planning and reproductive health, and (2) their perceived role in disseminating information about family planning and reproductive health.

Communication

- Develop a training-of-trainers module for use at the Islamic Foundation's Imam Training Academy that provides trainees with the communication skills to promote family planning and reproductive health (including delaying age at marriage, use of contraception for limiting family size and child-spacing, prevention of RTIs, STIs, and HIV/AIDS, reproductive health rights, the importance of male involvement in family planning and maternal health, etc.). Other faith-based organizations could use these materials;
- Develop audience-appropriate advocacy materials for Imams to use in their Friday sermons and other religious gatherings;
- Develop audience-appropriate advocacy materials for teachers and other community leaders to use in the appropriate settings.

Advocacy

- Lobby the Ministry of Religious affairs and other government bodies for resources to train Imams and community leaders.

Mobilization

- Organize community/neighborhood gatherings (courtyard meetings, folk festivals, etc.,), that include facilitated discussions led by trained Imams and community leaders, about family planning and reproductive health issues;

Indicators of Success

- The adoption of the training-of-trainers module for educating Imams about family planning and reproductive health by the Islamic Foundation's Imam Training Academy;

- The number of religious leaders and community leaders that have correct knowledge about family planning, contraceptive methods, reproductive health, and birth preparedness;
- The number of religious leaders and community leaders that have positive attitudes about family planning, contraceptive methods, reproductive health, and birth preparedness;
- The number of Imams and community leaders that incorporated family planning, contraceptive methods, reproductive health, and birth preparedness into their sermons and meeting discussions;
- The number of community members that were exposed to community/neighborhood discussions facilitated by Imams and other community leaders.

Audience 10: Political Leaders/Policy Makers

Ministers, national, and local political leaders are influential in promoting and sustaining family planning and reproductive health programmes. They can be important advocates for policies and resources that support family planning and reproductive health, and champion relevant issues in the political agenda. The support of political leaders and policy makers helps to ensure an enabling environment for programme implementation.

Objective

- To increase the capacity of political leaders/policy makers to deliver correct and positive message about family planning and reproductive health to their constituents;
- To increase the capacity of political leaders at all levels to deliver consistent information about family planning and reproductive health;
- To keep political leaders/policy makers informed about current programs so that they can continue to earmark resources for programme support.

Sub-objectives

- To provide political leaders/policy makers with up-to-date information about family planning and reproductive health issues;
- To strengthen coordination about family planning and reproductive health activities within and across ministries;
- To provide political leaders/policy makers with concise updates about on-going family planning and reproductive health programmes;
- To ensure contraceptive security for family planning programmes.

ACTIVITIES

Research

- Qualitative research with political leaders, policy makers, Members of Parliament about (1) their perceptions of family planning and reproductive health, and (2) their perceived role in disseminating information about family planning and reproductive health;
- Quantitative and qualitative studies to measure the importance of family planning and reproductive health on the national agenda (e.g., a content analysis to

determine the number and type of policies regarding family planning and reproductive health).

Communication

- Develop briefing packets with up-to-date information and talking points about family planning and reproductive health issues for political leaders to use when talking to other leaders, the media, and constituents (each packet should contain contact names and numbers for resource persons that can provide further information as necessary).
- Develop an information-sharing system to enable better coordination of information dissemination about program activities (e.g., Internet site that can be updated on a regular basis);
- Develop a system for tracking government policies about or related to family planning and reproductive health;
- Develop a reporting and early warning system to alert political leaders about contraceptive supply-side issues.

Advocacy

- Advocate for policies to improve the visibility of family planning and reproductive health issues nationwide.

Indicators of Success

1. The number of political leaders/policy makers with correct knowledge about family planning and reproductive health issues;
2. The number of political leaders/policy makers with positive attitudes toward family planning and reproductive health;
3. The number of political leaders that discuss/advocate for family planning and reproductive health issues/programs;
4. The number of political leaders/policy makers that can provide up-to-date information about family planning and reproductive health issues;
5. The number of political leaders/policy makers that have a positive attitude toward making necessary policy changes related to family planning and reproductive health.

Audience 11: Mass Media Personnel

The media are an important link between programme implementers and the intended audiences for family planning and reproductive health programmes. Television, radio, print editors and journalists can play an important role in disseminating correct information about family planning and reproductive health, and in motivating audiences to utilize family planning and reproductive health services. Apart from the above, strong linkages could be established with the Department of Mass Communication, Press Institute of Bangladesh (PIB) and National Institute for Mass Communication (NIMCO).

Objective

- To increase the capacity of mass media personnel to deliver correct and positive message about family planning and reproductive health to various population groups.

Sub-objectives

- To raise awareness among mass media personnel about the importance of family planning and reproductive health (i.e., to raise these issues on the media agenda);
- To increase correct knowledge among mass media personnel about family planning (small family size, child-spacing, contraceptive methods);
- To increase correct knowledge among mass media personnel about reproductive health (RTIs, STIs, HIV/AIDS);
- To increase correct knowledge among mass media personnel about maternal health (nutrition, birth preparedness, morbidity, mortality);
- To provide correct information about the availability of family planning and reproductive health services;
- To encourage media personnel to contact programme implementers for (1) information about family planning and reproductive health, and (2) information/updates on family planning and reproductive health programmes.

ACTIVITIES

Research

- Conduct baseline quantitative and qualitative research to assess mass media personnel knowledge and attitudes toward family planning and reproductive/maternal health;
- Conduct a content analysis of the major mass media outputs during a current time period to assess the nature and tone of reporting about family planning and reproductive health;
- Conduct research to determine whether mass media personnel know where to obtain information about family planning and reproductive health program and new initiatives.

Communication

- Develop a briefing packet about family planning and reproductive health issues for mass media personnel to use when writing stories or developing story-lines for media materials. This packet should include a sheet on (1) how to report on such sensitive topics as HIV/AIDS and violence against women (i.e, the importance of reducing stigma and maintaining confidentiality), and (2) a list of resources and organizations, with contact names and numbers, that media personnel can contact for information;
- Develop standardized powerpoint presentations that can be used to present information about family planning and reproductive health initiatives to the press;
- Develop briefing sheets to apprise media personnel about current programme activities (e.g., launches, special days, new phases). The information from the

briefing sheets can be sent to various media outlets via the Internet where available.

Advocacy

- Arrange media opportunities for relevant government officials to discuss family planning and reproductive health initiatives
- Hold regular press junkets (briefings) to educate media representatives and keep family planning and reproductive health issues on top of the media agenda;
- Address the Ministry of Information about providing resources to maintain a central (Internet) database to house current information about family planning and reproductive health programs. Media personnel could access this database for information and stories;
- Lobby journalists for a regular news column or segment to highlight messages and activities regarding family planning and reproductive health.

Mobilization

- Invite mass media representatives to all local events involving family planning and reproductive health;
- Invite mass media representatives to tour local healthcare facilities that offer family planning and reproductive health services. Encourage them to interview providers, managers, and supervisors in order to gain a better understanding of the goals and objectives of the current programs;
- Invite mass media representatives to "shadow" family planning and reproductive healthcare workers in order to understand the nature of reproductive healthcare counseling and service provision.

Indicators of Success

1. The number of media personnel who are aware of the importance of family planning and reproductive health;
2. The amount (and type) of media coverage about family planning and reproductive in various media outlets;
3. The number of editors and journalists who have correct knowledge about family planning (small family size, child-spacing, contraceptive methods);
4. The number of editors and journalists who have correct knowledge about reproductive health (RTIs, STIs, HIV/AIDS);
5. The number of editors and journalists who have correct knowledge about maternal health (nutrition, birth preparedness, morbidity, mortality);
6. The number of editors and journalists who provide correct information about the availability of family planning and reproductive health services.

Programme Monitoring and Management

Programme managers and supervisors that will participate in the implementation of activities under this Strategy may or may not have previously worked together. It will be important for all program implementers to monitor progress on different activities, and take steps to resolve challenges in order to progress as planned.

Following are questions to consider for monitoring activities:

1. Are we implementing communication activities as outlined in our Implementation Plan?

2. How efficient are we being with regard to conducting communication activities?
3. What difficulties or challenges are standing in the way of realizing the implementation of the Strategy?
4. Are we working well together as a team?

Training and technical assistance should be provided to program implementers (1) to build their capacity to conduct regular programme monitoring activities, and (2) to manage partnerships and relationships to achieve coordination among stakeholders. Monitoring activities may include (1) site visits to programme intervention points to observe activities (e.g., counseling), (2) exit interviews with family planning and reproductive health clients to measure perceptions of services, (3) regular meetings with programme personnel to discuss challenges in programme implementation, (4) completing monitoring checklists or briefing reports (these reports can also be used to keep relevant stakeholders informed about program activities) to track the number of advocacy activities, media coverage of programme activities, etc., and (5) maintaining a newsletter (paper or web-based) with programme briefs and updates.

Learning and Sharing Opportunities:

Programme personnel and stakeholders should look for opportunities to attend meetings and conferences to learn and exchange information about innovations in family planning and reproductive health behaviour change communication strategies. Such meetings and conferences are opportunities to disseminate the knowledge and lessons learned, and to leverage and expand programme impacts (e.g., scaling up from local activities).

Communication Materials Development and Training for Capacity Building

Communication Materials Development:

The use of mass media can be instrumental in increasing awareness and knowledge about specific issues, promoting interpersonal communication about those issues, and encouraging specific behavior change. Many health promotion campaigns in developing nations use the entertainment-education strategy to change knowledge, attitudes, and social behaviors. Entertainment-education is an approach to education whereby social messages are purposively incorporated in entertainment programs with the intention of increasing audience member's knowledge about an educational issue, engendering favorable attitudes, and changing behavior (Singhal & Rogers, 1999).[2] Entertainment-education programs are characterized by an ongoing storyline about relationships between a set of characters that model positive (e.g., use a condom to prevent HIV/AIDS) and negative behaviors (e.g., violence against women), and who are rewarded for positive behaviors and punished for negative behaviours.

Most evaluations of entertainment-education programmes to change family planning and HIV knowledge, attitudes, and behaviors, have found that they have measurable effects (Piotrow et al., 1997; Rogers et al., 1999, Vaughan et al., 2000). Research studies have supported the relationship between exposure to mass media messages and (1) increases in interpersonal communication about family planning and HIV prevention, and (2) increases in self-efficacy with regard to using family planning methods and practicing HIV prevention behaviours (Bankole et al. 1996; Boulay, Storey & Sood, 2002; Piotrow et al., 1990). Recent literature suggests that mass media

[2] The entertainment-education strategy is also referred to as enter-educate, edutainment, and infotainment.

generated interpersonal communication contributed to the reach and effectiveness of health promotion campaigns (Boulay et al., 2002; Shefner-Rogers & Sood, 2004).

The multi-media behaviour change communication campaigns suggested in this Strategy should (1) use the entertainment-education approach, (2) revolve around a unifying theme (or themes), and (3) have a "Lead Team" to oversee the coordination of communication efforts at multiple levels. It is important to consider that family planning and reproductive health campaign messages will be competing with commercial messages for audience attention; the development process for creating campaign messages and materials should include careful pre-testing of all messages and materials to ensure cultural and audience appropriateness. The timely dissemination of materials should be considered a part of the communication materials development process; a dissemination plan should be developed.

A Media Materials Resource Center for media materials should be created to house family planning and reproductive health materials. Such a Center would provide access by individuals and organizations to relevant materials and potentially avoid the duplication in creation of new materials.

There are several existing repositories for communication materials about family planning and reproductive health in Bangladesh. The **IEM Unit** should explore the possibility of using one such repository as the central Resource Center and allocate funding to maintain the facility and engage individuals to operate the center. If an existing center is not suitable, the IEM Unit should create a facility to be the Media Materials Resource Center.

Training

A multi-pronged approach to improving the quality of family planning services includes communication training for service providers (especially FWAs and FWVs) in governmental and non-governmental institutions, and continuous refresher training to sustain new communication behaviors. The curricula and support materials for the trainings should be developed in collaboration with experts in the field of interpersonal communication for provider-client relationships. Special attention should be paid to (1) developing communication skills for addressing various audiences (e.g., adolescents, urban poor, etc.), and (2) training male providers. All curricula should be pretested.

NIPORT can provide the service provider trainings. Sessions should be conducted primarily as in-service (or facility-based) trainings so that service provider communication skills can be immediately put to use, observed, and evaluated. All sessions should be participatory. Training sessions should be video recorded where possible so that participants can observe their own behavior, and trainers can identify and discuss areas for improvement. All sessions should be evaluated for effectiveness.

Outcome Evaluation

Outcome evaluations should be conducted to measure the effects of program activities on the family planning and reproductive health knowledge, attitudes, and practices in the populations of interest. Ideally, these evaluations should be both quantitative (e.g., nationally representative surveys such as the BDHS), and qualitative (e.g., mystery client studies to assess changes in service provider communication skills). The triangulation of methods will provide a more complete picture of programme effects.

It is important that the evaluation plans for programme activities be developed prior to the implementation of the activities. The research designs and methodologies should be as rigorous as possible in the given context. Pre-test and post-test assessments of interventions will provide data about progress toward achieving the strategic objectives. Such evaluations will contribute to the knowledge base about family planning and reproductive health in Bangladesh, and allow for the development of evidence-based programs. Findings from these evaluation efforts should be disseminated among relevant governmental and non-governmental agencies in a timely manner.

Implementing the Strategy

To ensure implementation and coordination of this multi-level and multi-audience national communication strategy, it is essential to have coordination among the stakeholders, including multiple government Ministries. Figure 3 presents an organizational chart for implementing the present Strategy.

The **MOHFW** is the Ministry responsible for driving the Strategy. This Ministry should provide logistical support and resources to ensure the uninterrupted and timely delivery of effective family planning and reproductive health interventions. The **IEM Unit** will be responsible for identifying an action-oriented coordinating body, or “Lead Team,” to spearhead the communication strategy for family planning and reproductive health, and to monitor and evaluate the activities conducted to achieve the goals and objectives of this strategy. This Lead Team will (1) be responsible for ensuring that communication materials present consistent messages about family planning and reproductive health, (2) monitor the progress of the Lead Team, and (3) use the monitoring information to take corrective actions regarding the implementation of communication programs to achieve the Strategy objectives.

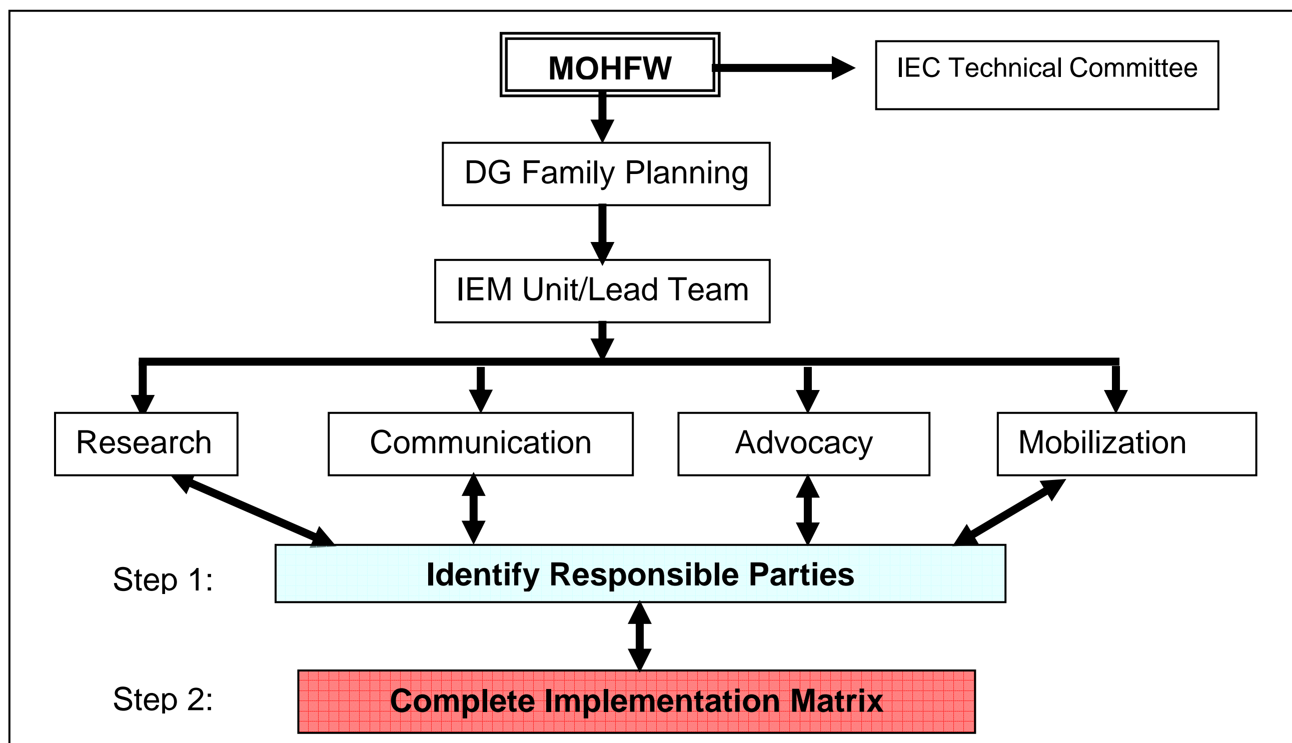

Figure 3: Organizational Chart for the FP and RH Communication Strategy

Implementation

The Lead Team should be comprised of representatives from the key Ministries, development partners, and non-governmental organizations, and include individuals with mass media and interpersonal communication expertise. Relevant Ministries may include (1) the Ministry of Information, (2) the Ministry of Education, (3) the Ministry of Women and Children Affairs, (4) Ministry of Religious Affairs, (5) Ministry of Local Government, Rural Development and Cooperatives, and (6) the Ministry of Youth and Sports. Local government agencies especially National Institute of Local Government (NILG) should also be involved. The involvement of government officials will help to ensure that necessary funds are allocated to the designated areas and programmes. Bangladesh Betar, BTV and other mass media channels should play a vital role in shepherding communication interventions. Advertising agency representatives should provide inputs, especially with regard to quality of materials. Development partners and NGOs can provide assistance with family planning and reproductive health content, mass and interpersonal communication materials development, and with the coordination of activities at multiple levels.

The role of this Lead Team should be to oversee the coordination of programmes to ensure economies of scale, and avoid duplication of interventions. Monitoring meetings should be held on a regular basis (1) to ensure consistent implementation of the strategy, and (2) as a means for identifying gaps in program coordination in a timely manner so that corrections can be made along the way. Monitoring meeting briefs should be circulated to Lead Team members in a timely manner, and Lead Team members should share the meeting outcomes with their collaborators.

Steps to Implementation

The **first task** of coordinating body should be to finalize an implementation plan (Appendix C). The implementation plan identifies the lead partner(s) for each of the objectives in the Strategic Plan, and provides a timeline for completing the activities associated with each objective. The Lead Team should invite collaborating individuals and organizations to participate in a workshop where the participants will identify the audiences, objectives, and activities for which they or their organization will be responsible.

A **second task** of the coordinating body should be to convene a meeting of relevant stakeholders to develop a matrix (Appendix D) that details the desired family planning and reproductive health behaviours, messages, and channels for each of the behaviour change objectives in the Strategy. These messages will be reinforced through the multiple media/channels used to communicate to the identified audiences. Most importantly, each set of message should have a corresponding "cue to action," that is, a defined behaviour that the audience is directly asked to adopt and maintain.

In the last 50 years, a variety of theories about how communication affects human behaviour and influences behaviour change have been developed. Diffusion of innovations theory (Rogers, 2003), stages of change theory (Prochaska, DiClemente, &

Norcross, 1992), social cognitive theory (Bandura, 1986), and others, model the steps that individuals take from knowing about an innovation (e.g., a contraceptive method), to adopting and maintaining use of the innovation. These theories (1) provide family planning communicators with indicators and examples of what influences the behaviour of individuals, couples, and groups, in what ways, and under what conditions, and (2) provide the foundations for planning, executing, and evaluating communication projects. They also suggest that reinforcement of messages help to move individuals from the knowledge-stage to the adoption-stage. Thus the repetition of messages about family planning and reproductive health by the various collaborating agencies will serve to reinforce the pro-social behaviors advocated in this Strategy. Thus, it is important that the messages be consistent.

Furthermore, the stakeholders should identify a recognizable logo and slogan for family planning and reproductive health programmes (like the Green Umbrella logo) (1) to clearly identify programs associated with the Strategy initiatives, and (2) to help audience members demarcate sites for quality family planning and reproductive health services. The unifying logo and slogan should be used on all Strategy-associated programme materials. The **third task** of the Lead Team should be to develop a protocol to facilitate the approval for communication materials by the IEC Technical Committee, i.e., to reduce the amount of time it takes from materials development to dissemination.

The Lead Team should convene an annual meeting of stakeholders and implementing agencies to allow for an exchange of information about current activities, successes, and challenges. This exchange of information will help to link relevant individuals and organizations with resources, foster collaboration, and reduce duplication of activities. An evaluation of the implementation of this national communication strategy should be conducted in order to assess the effectiveness of the strategy. Such an evaluation might include a qualitative component, for example, interviewing the agencies and organizations involved in implementing the activities to determine the degree to which coordination and collaboration was achieved.

The Government of Bangladesh has the opportunity to build on its successes in family planning and reproductive health by fostering communication initiatives that will contribute to further reducing TFR, decreasing maternal mortality and morbidity, sidestepping the HIV epidemic, and improving the health and welfare of the population. This national communication strategy for family planning and reproductive health provides a roadmap toward these future achievements.

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Annexes

Annex A: Task Force Committee Members

SL No	Name and Designation	Position
1.	**Dr. Jafar Ahmad Hakim,** Director (MCH), DGFP	Convener
2.	**Ms. Hosne Ara Begum,** Director (Finance), DGFP	Member
3.	**Dr. Ahmed Al Sabir,** Director (Research), NIPORT	Member
4.	**Dr. M A H M Bareque,** Director (CCSD), DGFP	Member
5.	**Mr. Altaf Hossain,** Deputy Director (MP), IEM Unit, DGFP	Member
6.	**Md. Nurul Ameen,** Asstt. Representative, UNFPA	Member
7.	**Dr. A J Faisal**, Country Representative, EngederHealth	Member
8.	**Mr. Mohammad Shahjahan,** Director & CEO, BCCP	Member
9.	**Ms. Yasmin H Ahmed,** Managing Director, MSCS	Member
10.	**Mr. Mohiuddin Ahmed,** NPPP (BCC & Advocacy), UNFPA	Member
11.	**Md. Shahadat Hossain,** Family Planning Officer, IEM Unit, DGFP	Member Secretary

Annex B: Implementation Plan

SL No	Audience	Objectives	Activities	Lead Partner	Timeline																			
					2006				2007				2008				2009				2010			
1	Newlyweds and Low Parity Women																							
2	Married Couples with Desired Family Size																							
3	Males/Family Members																							
4	Urban Poor/Underserved																							
5	Unmarried Youth																							
6	Adolescents																							
7	Service Providers																							
8	Program Managers and Supervisors																							
9	Religious and Community Leaders																							
10	Political Leaders/Policy Makers																							
11	Mass Media Personnel																							

Annex C: Key FP/RH Behaviors and Messages

Sl. No.	Audience	Objective	Ideal Behavior	Existing Behavior	Behavioral Determinants (Social Context)	Key Messages	Cue to Action	Channels	Linked Interventions
1	Newlyweds and Low Parity Women								
2	Married Couples with Desired Family Size								
3	Males/Family Members								
4	Urban Poor/Underserved								
5	Unmarried Youth								
6	Adolescents								
7	Service Providers								
8	Program Managers and Supervisors								
9	Religious and Community Leaders								
10	Political Leaders/Policy Makers								
11	Mass Media Personnel								