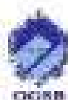
Social and Behavior Change Communication Strategy

Improving SRHR in Dhaka Project



Social and Behavior Change Communication (SBCC) Strategy

for

Promoting Healthy SRHR Behavior including Timely and Appropriate Care Seeking as Social Norms

Improving Sexual and Reproductive Health and Rights in Dhaka Project

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We would like to thank all the respected stakeholders and actors who were actively involved and played a vital role in developing this Social and Behavior Change Communication (SBCC) Strategy for Improving SRHR in Dhaka Project. The key contributors were IEM (Information, Education and Motivation) unit of DGFP, Bureau of Health Education (BHE) under DGHS, SBBC unit of UPHCSDP, representative from BKMEA, youth volunteers, General Practitioners (Physician), Ipas Bangladesh and project implementing partner NGOs- BAPSA, OGSB, RHSTEP and SERAC Bangladesh,. Their active participation and contributions including technical support were significant in shaping the strategy. The strategy incorporates a range of global and local best practices and lessons learned, tailoring them to the specific context of low socio-economic urban areas of Dhaka. We gladly acknowledge the funding support of Global Affairs Canada through HealthBridge Foundation to the Improving SRHR in Dhaka Project that applies integrated community interventions to increase awareness and social support regarding SRHR We hope, this SBCC strategy will guide the Improving SRHR in Dhaka project to undertake appropriate SBCC initiatives to address women and adolescent girls' needs; promote their knowledge, attitude, and self-efficacy; and will also guide in creating social support for ensuring healthy SRHR practices around menstrual hygiene, preventing child marriage, averting adolescent pregnancy, promote modern contraception, seeking safe menstrual regulation (MR) and postabortion care (PAC) services, and prevent gender-based violence.

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List of Acronyms

BAPSA	Association for Prevention of Septic Abortion, Bangladesh
BCC	Behaviour Change Communication
BDHS	Bangladesh Demographic Health Survey
BGMEA	Bangladesh Garment Manufacturers and Exporters Association
BHE	Bureau of Health Education
BKMEA	Bangladesh Knitwear Manufacturers and Exporters Association
CRHCC	Comprehensive Reproductive Health Care Centre
DGFP	Directorate General of Family Planning
DGHS	Directorate General of Health Services
DNCC	Dhaka North City Corporation
DSCC	Dhaka South City Corporation
FP	Family Planning
GAC	Global Affairs Canada
IEC	Information Education and Communication
IEM	Information Education and Motivation
MOHFW	Ministry of Health and Family Welfare
MOLGRDC	Ministry of Local Government, Rural Development and Cooperatives
MR	Menstrual Regulation
OGSB	Obstetrical and Gynaecological Society of Bangladesh
PAC	Post-Abortion Care
RHSTEP	Reproductive Health System. Training and Education Program
SGBV	Sexual and Gender Based Violence
SRHR	Sexual and Reproductive Health and Rights
UPHCSDP	Urban Primary Health Care Services Delivery Project

Users of the SBCC Strategy:

The SBCC strategy developed by the Improving Sexual and Reproductive Health and Rights in Dhaka Project will serve as a roadmap for communication activities that aims to raise awareness, change behaviors, and improve access to SRHR services. Key components of the strategy include targeted messaging, community mobilization, capacity building for service providers, and the use of various communication channels.

Collaboration with stakeholders is essential for the successful implementation of the SBCC strategy. By involving a wide range of actors, including government bodies, NGOs, garment industry representatives, and community health workers, the Improving SRHR in Dhaka Project can ensure that the message reaches the intended audience effectively and resonates with their needs and cultural context. The SBCC Strategy will guide communication efforts and foster partnerships for sustainable impact in the field of sexual and reproductive health.

The users of this SBCC strategy include:

- HealthBridge and Ipas team involved in urban SRHR project design, implementation, and monitoring
- Project staff under Implementing NGO partners for Improving SRHR in Dhaka Project: BAPSA, OGSB, RHSTEP and SERAC Bangladesh,
- IEM Unit of DGFP, BHE of DGHS, PMU of UPHCSDP and relevant health officials of BKMEA and BGMEA.
- Facility managers and providers of Improving SRHR in Dhaka Project supported health facilities including General Practitioners (Physicians)
- Community Outreach workers of UPHCSDP and Community Youth Leaders

Background

The Social and Behavior Change Communication (SBCC) Strategy developed by the Improving Sexual and Reproductive Health and Rights (SRHR) in Dhaka Project funded by Global Affairs Canada through HealthBridge Foundation, serves as a comprehensive framework for promoting healthy SRHR behaviors within the project's scope. The project works for improved sexual and reproductive health and rights of underserved and vulnerable women and adolescents in Dhaka. This strategy guides the project to undertake appropriate SBCC initiatives to address women's and adolescent girls' needs and to promote their knowledge, attitude, decision-making capacity, and social support for ensuring healthy practices around menstrual hygiene; preventing child marriage; averting adolescent pregnancy; promote modern contraception, safe menstrual regulation (MR), and postabortion care (PAC) services; and preventing gender-based violences. Promoting these healthy behaviors in the project areas by engaging society and the exiting health structure can be sustained if these behaviors can turn into social norms.

The strategy outlines a multi-faceted approach designed to enhance communication and social behavior change interventions related to SRHR and SGBV issues. It incorporates a range of global and local best practices and lessons learned, tailoring them to the specific context of low socio-economic urban areas of Dhaka. By integrating evidence-based approaches, culturally sensitive messaging, and community engagement, the strategy seeks to foster positive attitudes and behaviors regarding SRHR.

The SBCC strategy emphasizes the importance of collaboration with local stakeholders, governmental bodies, and community-based organizations to ensure effective implementation and sustainability. It also places a strong emphasis on monitoring and evaluation, utilizing data-driven insights to continually refine and enhance programmatic efforts. Through strategic partnerships and targeted interventions, the project aims to positively influence social norms, increase awareness, and improve access to SRHR services within low socio-economic urban areas of Dhaka.

The SBCC Strategy of Improving SRHR in Dhaka Project is closely aligned with the Bangladesh government's strategic priorities as outlined in the National Comprehensive SBCC Strategy 2016, and the National Strategy for Adolescent Health 2017-2030.

The development of the SBCC strategy for improving SRHR in Dhaka involved a collaborative effort from various stakeholders. Representatives from DGFP, DGHS, officials from UPHCSDP, representative from BKMEA,, youth volunteers, general practitioners, implementing partners and Ipas Bangladesh staff played vital roles in the process. Their active involvement and contributions were significant in shaping the strategy. Additionally, some of these stakeholders provided valuable technical support, further enriching the development process.

1. Introduction:

Bangladesh has made enormous strides regarding women and child health services in recent years, but adolescent pregnancy, child marriage, unmet need for contraception, sexual and gender-based violence (SGBV) and unsafe abortions remain public health issues in Bangladesh. These constraints are worse in urban areas especially limiting the availability of and access to SRHR services for the women and young adolescents living in poor socio-economic areas.

With this context, the 5-year Improving Sexual and Reproductive Health and Rights (SRHR) in Dhaka Project funded by Global Affairs Canada is being implemented through a partnership including HealthBridge Foundation of Canada, Ipas Bangladesh, Obstetrical and Gynecological Society of Bangladesh (OGSB), Association for Prevention of septic Abortion, Bangladesh (BAPSA), Urban Primary Health Care Service Delivery Project (UPHCSDP), Reproductive Health Services Training and Education Program (RHSTEP) and SERAC Bangladesh. The project aims to improve sexual and reproductive health and rights and address SGBV issues of women and adolescents living in low socio-economic areas under Dhaka North City Corporation, Dhaka South City Corporation, and adjacent urban areas of Gazipur and Narayanganj.

The project focuses on strengthening health system, and increasing social support, knowledge and self-efficiency related to SRHR, including SGBV resources for poor and underserved woman and adolescents in urban areas. It intervenes social and behavioral change communications along with community awareness and social mobilization to attain SRH services and address SGBV issues prevailing in the project catchment areas.

The project has been collaborating with MOHFW and its directorates -DGFP, DGHS & DGNM, local government bodies (Dhaka South and North city corporations) under MoLGRDC, NGOs and Private sectors including (Bangladesh Knitwear Manufacturers and Exporters'

Association BKMEA, BGMEA and General Practitioners (GPs) for smooth implementation of the project interventions and achieve its objectives and goal.

The development process of the SBCC Strategy of Improving SRHR in Dhaka Project offered a comprehensive and systematic effort. It began with leveraging data from secondary sources and integrating findings from focused group discussions (FGDs) conducted within the project area. Additionally, baseline findings and data were crucial in informing the strategy. Workshops served as collaborative forums, allowing for the synthesis of insights and inputs from relevant stakeholders. Furthermore, the process adhered to the principles of the User-Centered Design (UCD), ensuring that the strategy reflected the needs and perspectives of the intended beneficiaries and end-users. This multifaceted approach enabled the holistic integration of diverse sources of information and perspectives, ultimately contributing to the development of a well-informed and contextually relevant SBCC strategy for the improvement of SRHR in Dhaka.

The SBCC strategy represents a holistic and contextually relevant approach to addressing SRHR and SGBV issues. By leveraging the expertise of implementing and collaborative partners, the strategy is poised to make a meaningful impact on promoting healthy SRHR behaviors and advocating for reproductive rights in the targeted community.

2. Global and local SBCC Lessons Learned

Evidence from global and local context, and experience show that SBCC programs are more effective when the following concepts are considered:

- Effective communication and SBCC strategy play a crucial role in addressing SRHR (Sexual and Reproductive Health and Rights) and SGBV (Sexual and Gender-Based Violence) issues globally and in the context of Bangladesh.
- Tailored Messaging: One key lesson is the importance of tailored messaging. Understanding the cultural, social, and economic contexts of the target audience in local settings is critical to developing impactful communication strategies. In Bangladesh, for example, cultural norms and religious beliefs must be taken into account when crafting messages related to SRHR and SGBV to ensure that they resonate with the local population.
- Engagement of Youth and Community Leaders: Another lesson learned is the significance of engaging the youth and community leaders and influencers in the communication process. In both global and local contexts, involving the youth and trusted community figures can help in amplifying messaging and promoting behavior change. In Bangladesh, working with local youth and community leaders, religious leaders, and grassroots organizations can enhance the effectiveness of SBCC strategies.
- Multi-Stakeholder Collaboration: Effective communication strategies for SRHR and SGBV often involve collaboration among multiple stakeholders, including governmental and non-governmental organizations, healthcare providers, civil society, and private sector partners. This collaboration ensures a comprehensive approach to addressing the sensitive issues like SRHR, taking into account diverse perspectives and resources.

hannels: Utilizing a mix of communication channels is essential. While broader campaigns may leverage social media, mass media, and community events, in the context of Bangladesh, strategies should also consider local communication and enter-education, community theater, and interpersonal communication to reach diverse segments of the population, including those in low socio-economic, remote or underserved areas.

- Empowerment and Education: Empowering individuals with accurate information and skills is key. This involves providing comprehensive sexuality education, promoting gender equality, and enhancing awareness about available support services. This approach applies both globally and within Bangladesh, where promoting education and empowerment can lead to informed decision-making and positive behavioral change.
- Monitoring and Evaluation: Finally, establishing robust monitoring and evaluation mechanisms is crucial to assess the impact of communication and SBCC strategies. In both global and local contexts, it's important to measure changes in knowledge, attitudes, and behaviors related to SRHR and SGBV, enabling adjustments to be made for ongoing effectiveness.

In brief, effective communication and SBCC strategies for SRHR and SGBV encompass tailored messaging, community engagement, multi-stakeholder collaboration, diverse communication channels, empowerment, and robust monitoring and evaluation. These lessons are applicable both globally and within the specific context of Bangladesh, where cultural sensitivity and community involvement are particularly vital.

3. Situation Analysis:

Bangladesh is one of the most densely populated countries in the world with 38.95 percent of total population living in urban areas. As the 6th largest and 7th most densely populated city in the world, Dhaka has 22.4 million population as of 2022 wherein 35% of its population lives in the slums which are mostly low-socio economic areas of the city. With an estimated annual growth rate of 3.3 percent, urban population will rise to a majority by around 2030.

The "Urban Health Strategy 2020, Bangladesh (UHC 2020)" stated that the disparity between slum and non-slum population is marked widely. It found that the total fertility rate (TFR) is 2 in slum areas and 1.7 in non-slum areas. Overcrowding with poor housing, environment, water and sanitation conditions result poor Health Nutrition & Population (HNP) outcomes, particularly for slum dwellers.

The urbanization pattern in Bangladesh leads adolescent girls and young women migrating from rural areas to slum settlements in Dhaka. This population face multiple intersecting vulnerabilities that damage their sexual and reproductive health and deprive them from getting basic needs and human rights. The fulfillment of sexual and reproductive health and rights is crucial for both poverty reduction and the empowerment of women and girls.

Unmarried women and adolescents are often excluded by the health system's focus of reproductive, maternal and child health services which mostly target married women in relation to their pregnancy and childbirth with relatively less emphasis on SRHR. Unmarried women and adolescents face discrimination accessing SRH services and are often turned away from services they are entitled to.

While MR has been available in Bangladesh since 1979, stigma, social attitudes and health system barriers has contributed to unequal access to the service, and therefore unsafe clandestine abortion remains a problem, particularly among young and unmarried women. Generally, MR and PAC services are available at selected facilities

where the access is certainly not as close to the poor community. Pregnancy for the unmarried women and girls is closely related with values recognized in society. Most of the community people perceive abortion as a sin in any case and strive by stigma.

Gender inequality remains in the health governance structures, limiting the voices of women in decision making and development process. Additionally, limited awareness and understanding of women's rights and needs is also a major barrier at the community level. There is a lack of awareness and responsiveness to gender issues and women's rights among service providers in health institutions.

Violence against Women (VAW) Survey 2015 indicates that 72.6% ever married women in country face at least one type of violence i.e., almost three of every four married women face violence at any point of time.

The women and girls also face additional vulnerabilities given their age, marital status, migration patterns, threats of insecurity and violence, and the lack of infrastructure and public service provision in urban slum settlements. In recent decades, Bangladesh has made progress in addressing gender disparity in the education and employment sectors, yet in the global latest, Bangladesh ranked 119 out of 188 countries in 2015.

Adolescent Health: Adolescents of Bangladesh, both those who are unmarried and married, have low levels of knowledge and limited access to information and services on sexual and reproductive health and rights (SRHR). Bangladesh does not have any nationally representative data, which assesses knowledge levels on SRH and rights among the adolescent population. A significant concern for Bangladesh is the prevalence of child marriage and the corresponding high levels of adolescent fertility. With the highest adolescent fertility rate in South Asia, at 75.5 live births per 1000 women aged 15-19 years, there is a critical need for Bangladesh to ensure the availability of interventions to reduce adolescent fertility levels (BDHS 2022) these interventions need to start before marriage, so that young girls have adequate knowledge on SRH and can better plan their

pregnancies. According to the BDHS (2022) the Contraceptive Prevalence Rate (CPR) among married adolescents is 56 percent and the unmet need for family planning is 12.7 percent. Aside from the obligation to prevent child marriage, there is also a need to ensure the SRH status of married adolescents – so that their CPR is increased, the unmet need for FP reduced, facility-based MR, PAC and delivery services by a medically trained provider increased.

Meeting the SRH needs of unmarried adolescents, not only by providing them with information, as is the current practice, but also by making relevant services available and accessible to them becomes imperative if the Government of Bangladesh is to meet the SRH and rights of all adolescents. While there is limited documented evidence, it is known that services to meet the SRH needs of adolescents, including those who are married, are piecemeal and ad hoc. The recent systematic analysis of the effectiveness and gaps of existing adolescent SRH interventions and programs, conducted by Population Council, revealed that health services are not tailored to meet the SRHR and needs of unmarried adolescents (Ainul et al., 2016), highlighting the need to do so and ensuring the special needs of the most vulnerable adolescents are taken into account.

Family Planning: Fertility regulation is an important proximate determinant of fertility. Couples can use contraceptive methods to limit the number of children they have. The 4th Health, Population and Nutrition Sector Program (HPNSP) 2017-22 aims to increase the contraceptive prevalence rate (CPR) to 75 percent by 2022. In alignment with the 4th HPNSP, Family Planning 2020 (FP 2020) updated its commitment to increasing the use of long-acting and permanent methods to 20 percent, reducing unmet need for family planning to 10 percent, and reducing the contraceptive discontinuation rate to 20 percent by 2021 (Government of Bangladesh 2017).

The contraceptive prevalence rate (CPR) was highest in the urban slums (72 percent) and lowest in the rest of the urban areas (67.9

percent) in 2021. Between 2013 and 2021, CPR increased by 2 percentage points in the slums (from 69.6 to 71.6 percent), while in the non-slums the increase was by 3 percentage points (from 65.0 to 68.0 percent). Pill was the most widely used contraceptive method in all three urban domains (31.8 percent in the slums, 31.1 percent in rest urban and 27.6 percent in the non-slums). The next most common method was injectables (7.7 to 14.9 percent) and condoms (7.4 to 14.7 percent).

The long-acting reversible contraceptive (LARC) and permanent method (PM) including female and male sterilization, IUD and Implants use was low between four to six percent, and it was predominantly female sterilization (6.0 percent in the non-slums, 5.7 percent in rest urban, 4.4 percent in the slum areas).

The demand for these methods was also low. The private sector was the major source of contraceptive methods in each of the three urban domains. Nearly eight out of ten couples in the non-slums (77.5 percent) and seven out of ten couples in the slums (73.6 percent) or rest urban areas (68.4 percent) obtained contraceptive methods from the private sector.

Awareness of permanent method of FP among currently married women aged 15-49 was almost universal (94 to 97 percent). This awareness was found to be relatively low among married men aged 15-54 (77 to 88 percent). Among currently married non-pregnant women aged 15-49 and men aged 15-54 from slum, non-slum, and rest urban areas who did not want any more children, and were not sterilized, their intention to use a permanent method in next one year was very low (less than 2.0 percent among women and 2 to 3 percent among men).

Menstrual Regulation (MR) and Post-Abortion Care (PAC): In Bangladesh, estimate shows around 2.63 million unintended pregnancies occur annually that represents 49 percent of all pregnancies during 2015-2019. Of these, it was estimated that almost 60 percent (1,580,000) ended in induced abortion. Many of the

induced abortions in Bangladesh are unsafe, which can lead to maternal morbidity and mortality, resulting around 7 percent of the maternal deaths in Bangladesh. In 2014, public and private health facilities denied 27 percent of women who sought menstrual regulation (MR) services, and some 257,000 women were treated for complications due to induced abortion. Stigma, lack of trained providers, lack of knowledge on sexual and reproductive health and of the services available, limited resources, a fragile health system and negative attitudes among providers presents some of the barriers for women and girls to access sexual and reproductive health services, particularly menstrual regulation (MR), post-abortion care (PAC) services.

Use of Menstrual Regulation (MR) among married adolescent women is quite low (5.7%) based on the BDHS 2014 data (NIPORT et al., 2016). The use of MR services among married adolescent women are also lower than expected. Public sector contraceptives are dispensed based on marital status. Due to religious and other social situations, information regarding MR may not be properly disseminated to or reach adolescents and youths. This complicates the situation for this group. MR users may lack the capacity to properly administer MR medications purchased from pharmacies with a risk of incomplete MR. In addition, unavailability of drugs for addressing side effects, complications, and unavailability of post-MR services further compound the situation. Trained providers administer emergency contraceptive pills (ECPs) which can be promoted to avoid unwanted pregnancies among adolescents and youths. The awareness about ECPs and their availability to those in need should be created along with dissemination of risks or precautions to be observed.

Gender-Based Violence: Gender-based violence (GBV) refers to violence directed towards an individual or group based on their gender. GBV was traditionally conceptualized as violence by men against women but is now increasingly taken to include a wider range of hostilities based on sexual identity and sexual orientation. Yet, women and girls are continuing to be more vulnerable to GBV as WHO report

(2021) indicates that globally about 1 in 3 (30%) of women worldwide have been subjected to either physical and/or sexual intimate partner violence or non-partner sexual violence in their lifetime[1]. The scenario in Bangladesh is as frustrating as the global picture. Violence against Women Survey 2015 indicates that 72.6% ever married women in country face at least one type of violence i.e., almost three of every four married women face violence at any point of time. According to a 2021 UN Women report, 93% of women in Bangladesh reported having experienced or knowing another woman who has experienced violence against women and girls (VAWG). Also, Bangladesh continues to witness one of the highest rates of child marriage, with more than half of women aged between 22 and 24 married when they were still children. Persisting lack of awareness about rights, dominance of the patriarchal society, socio-cultural practice, social taboo, stigma, lack of proper implementation of laws, absence of women friendly reporting and response mechanism, no exemplary punishment, poverty, and related factors contributed to accept and continue different forms and nature of violence against women and girls.

Gender inequality remains in the health governance structures, limiting the voices of women in decision making and development process. Women, early married girls, and adolescents widely face reproductive coercion mostly unknowingly. There is a lack of awareness and responsiveness to gender issues and women's rights among service providers in health institutions. Limited awareness and understanding of women's rights and needs is also a major barrier at the community level.

Additionally, despite of Bangladesh government's formal approval to gender diverse population, there is not much progress in their social acceptability. Gender and sexual minority groups live in a feared, tabooed, and shunned life, and face challenges that include institutional discrimination, bullying, alienation, depression, and physical and sexual violence. This leads to lack of or limited access to basic rights and services, which is an inevitable part of gender-based violence in need of special attention.

SBCC Interventions: SBCC interventions on SRH component both at local and national level are in declining trend (BDHS 2022 report). BCC approach of 1980s and 1990s are still dominating in program with mass media advertisement, interpersonal communication (IPC) by community health workers (FWA) and FP messages are not contextualized with the present need and socio-economic conditions. IPC and household visits by community health workers have been reported as a decreasing trend. Contact with family planning field workers at urban area is only 14.3%. Although the percentage of viewing television has an increasing trend (47% as of BDHS 2007, and 55% as of BDHS 2017-18), only 26% women ages 15-49 had exposure to FP messages (heard, saw or read) in last one month as per BDHS 2022. Health and family planning programming has limited effort for embracing social media and telehealth and an updated SBCC strategy. Since the socio-economic and geographic context in Bangladesh has taken a sharp change with increased access to electricity in both rural and urban areas, household ownership of a mobile phone 98%, two-thirds of the currently married women having a mobile phone, and one-fourth of the ever-married women have secondary education or more (BDHS 2022), SBCC strategy and interventions need to be updated and contextualized. Coordinating at different levels; monitoring outcomes; and maintaining a high standard for quality (including interpersonal communication and counseling skills) are important challenges for SBCC in Bangladesh. However, digital archives in three units of (IEM)DGFP and DGHS (BHE and IPHN) contribute to improved coordination by documenting and making existing SBCC material available online.

Bangladesh FP 2030 commitment thrives for distinct information, education, and communication interventions to increase demand for equitable gender-responsive, climate-resilient, respectful, and quality FP information and services with special attention to adolescent, young population, the male, disadvantaged population including people living with disabilities. This commitment stated the determination to increase demand for SRH and family planning services to achieve the targets of key family planning indicators by 2030. While developing an SBCC strategy on family planning and SRHR issues for any development program, it should be aligned with this national level commitment.

4. Goal and objectives:

The SBCC interventions of the Improving SRHR in Dhaka Project aims to enhance community participation toward changing social condition and individual behaviors which will trigger to attain the project ultimate outcome of improved sexual and reproductive health and rights among women and adolescents in Dhaka.
Goal: Increased social support for, and improved knowledge, self-efficacy and healthy SRHR practices of disadvantaged urban adolescents and women.

The overall objective of the strategy is to guide Improving SRHR in Dhaka Project for undertaking SBCC initiatives-

1. To promote healthy SRHR behaviors at the household and community for menstrual hygiene, preventing child marriage, averting adolescent pregnancy, care seeking for contraception, MR, and PAC services, and preventing gender-based violence.
2. To encourage social and policy support to prevent child marriage, create zero tolerance against gender-based violence, and provide supportive environment for women and adolescents in SRHR care seeking.
3. To identify and prepare SBCC resources for uninterrupted care seeking and adapted healthy SRHR behavior during public health emergencies.

5. Target audience

- Adolescents (ages 10-19)
- Women of reproductive age (15-49) and above
- Female Garment workers
- Family members specially husband, in-laws, and parents
- Outreach workers and counselors of UPHCSDP Project
- Youth volunteers (ages 16-24)
- Government stakeholders- MOHFW, LGRDC, Political leaders
- Key influential in the community: Teachers, NGO workers, city corporation representatives, religious leaders
- Partner organizations, NGOs
- Men

6. Social and Behavioral Change Communication:

Social and Behavioral Change Communication (SBCC) is an interactive process aimed at changing social conditions and people's behavior. SBCC is a multi-level tool operating through key strategies – behavior change communication, social mobilization, and advocacy for promoting and sustaining healthy, risk-reducing behavior change in individuals and community levels. It achieves the objectives by disseminating tailored health messages to specific audiences through a variety of communication channels.

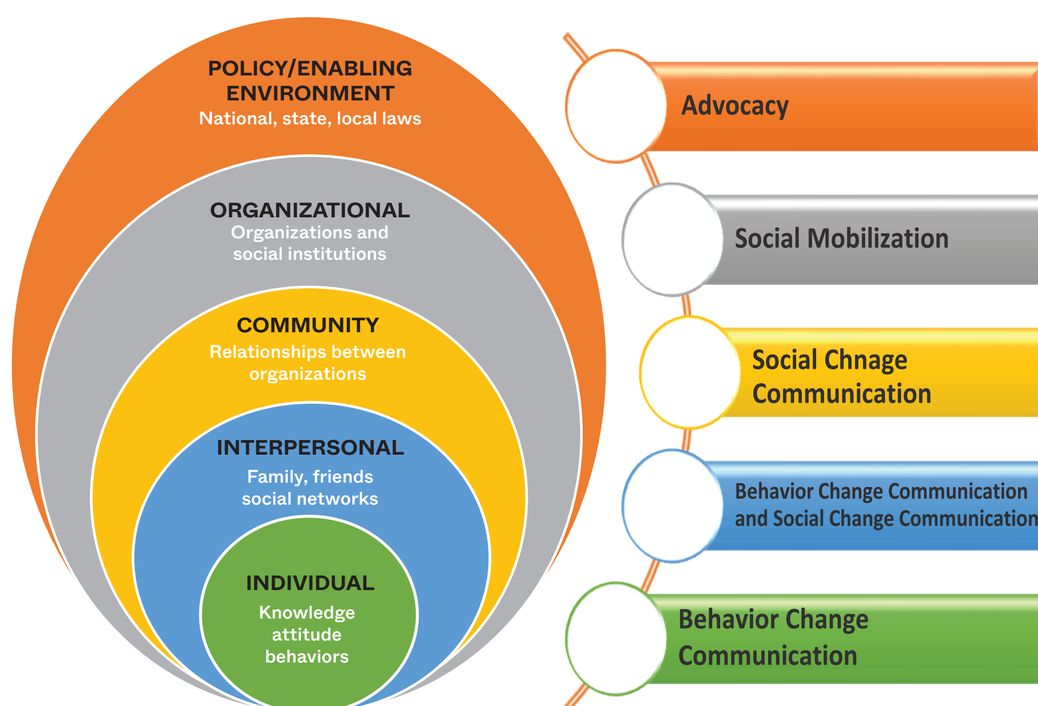


Figure 1: Steps of social ecological model and relevant SBCC strategies for behavioral change

SBCC is best understood within a Social Ecological Framework that considers the interconnected influences of family, peers, community,

and society on behavior. The social ecological model shows how behavior operates on and is influenced by five interconnected levels: individual, family and peer networks, communities, organizational, and policy environments. This model proposes that individual, interpersonal, community, organizational, and societal/policy factors should be considered when planning and implementing health promotion interventions, because they have direct and indirect influences on lifestyle, behavior choices, and health.

Guiding principles:

The SBCC Strategy has set some guiding principles that will help ensure better behavioral and health outcomes, foster consistency between communication and service delivery, set realistic expectations and improve overall coordination. The key principles stated below are essential for producing high-quality communication outputs and improving program quality.

Evidence based data driven: Strategic communication and health promotion efforts must be based on theoretical models, international and national research and tested innovations, and best practices. Research consistently shows evidence-based communication programs can increase knowledge, shift attitudes and cultural norms and produce changes in a wide variety of behaviors.

Based on theory: There are different theories for SBCC programing, and each theory or model has a different set of factors to explain behavioral change and area of focus. This SBCC strategy is based on the socio-ecological model that incorporates factors that influence behavior and behavior change at the individual, interpersonal, community, structural/organizational and policy levels.

User-centered: User-centered design (UCD), also known as human-centered design, is an approach to project design that has a clear commitment to being responsive to users' needs and preferences. The priority users for SBCC intervention of Improving SRHR in Dhaka Project include women, adolescents, garment workers, men, and

socially merginalized groups. Our “users” are also providers who use our training manuals, tools, and job aid; stakeholders from government and non-government organizations who access to, share, and collaborate in developing our SBCC and advocacy materials. The design team will involve these users throughout the design process and techniques to create highly usable and accessible SBCC tools, material, and interventions to reach the end users and build the capacity of service providers.

Process oriented: A process is a series of steps and decisions involved in the way work is completed. As the goal of the SBCC intervention is not only to produce SBCC materials, but also to engage in dialogue with audiences, it addresses barriers to social and behavior change, and adopt the intervention as needed through an iterative process. There are different processes to develop SBCC strategy. However, we will use the Shifting Gears framework that helps systematically design SBC strategy for meaningfully change the behavior of the target audience and increase access to SRH services. The shifting gears framework consists of a set of interlocking gears (See Annex-1, figure-1) that are part of the broader socio-ecological environment that influences individuals’ behavior change.

Rights based approach: The rights-based approach is underpinned by five key human rights principles- Participation, Accountability, Non-discrimination and Equality, Empowerment and Legality. It empowers the rights holders to know and claim their rights, and at the same time, build capacity of the duty bearers to be accountable for respecting, protecting and fulfilling rights holders’ rights. In SBCC interventions, we will ensure rights holders’ active participation in identifying program needs, design and develop program intervention, and build their capacity and enhance self-efficacy so they can overcome barriers in accessing SRHR services and claim their rights.

Gender responsive: The SBCC strategy will be gender responsive aiming at ensure recognition and take necessary actions to address gender inequality in the project intervention design and implementing activities. The strategy will respect gender differences, diversity and

intersectionality, with a special focus on women and adolescents living in the low socio-economic condition in urban areas. This will address gender-based barriers, meet gender specific needs of information and knowledge, apply gender-focused methodologies to design and develop gender sensitive content, messages, and materials with a strategic communication through a variety of channels and approaches.

Continuum of care (Home to facility): The continuum of care for SRHR addresses three key dimensions of service delivery across time, space, and type of care i.e. access to needed services throughout the life cycle, including adolescence, preconception period, pregnancy, childbirth, the postnatal period, and childhood. Access to interventions with functional linkages among levels of care in the health system provided by families and communities, outpatient and outreach services, and health facilities. Access to different types of health services and activities, including prevention, promotion, and curative and palliative care (World Health Assembly 2009).

Result oriented: SBCC efforts will focus on producing positive behavioral outcomes for SRHR services. Ultimately positive behavioral outcomes such as family planning use will contribute to improvements of SRH outcomes. Research should be designed to gauge increase in knowledge, approval, and adoption of healthy behaviors.

7. Social and Behavioral Change Pathway:

A well-thought-out conceptual framework can guide program design, identification of solutions and innovations, monitoring of change, and demonstration of success. **Figure 2** presents a conceptual framework illustrating pathways of SBCC strategies and process with communication outcomes to improve knowledge, self-efficacy and social support toward positive behavior and practices and ultimately improve SRHR outcomes.

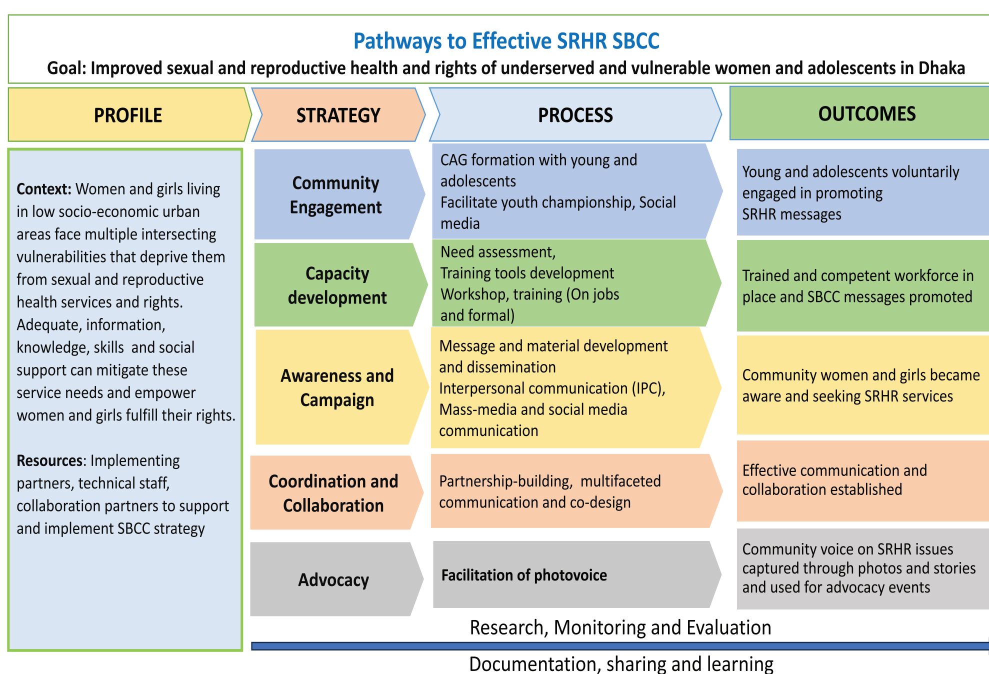


Figure 2: Social and behavioral change pathway

8. SBCC Strategic Approach

Community Engagement:

Improving SRHR in Dhaka Project implements community engagement interventions through engaging 1000 volunteers in 100 general practitioners' catchment areas. The project will orient them on SRHR issues and build their capacity on communication skills to aware and sensitize women, adolescents, and men in the community. The volunteers will form community action groups (CAG) at each general practitioners' (GP) area and the CAG members will create community support group of women, adolescents and men in the community who will be sensitized on SRHR issues through community sessions conducted by the volunteers. Youth volunteers will establish a network among themselves using social media. The project will also support forming youth alliances with existing organizations and networks working on SRHR issues, and facilitate dialogues on social issues, norms and customs that affect women's and girls' lives.

Capacity Development:

Ipas Bangladesh will facilitate capacity strengthening initiatives on SBCC for the Improving SRHR in Dhaka Project staff, partner organizations' staff and stakeholders who will ensure effective SBCC interventions. Ipas Bangladesh will engage stakeholders and build capacity of program managers and field level staff on planning, designing and implementation of interventions that will strengthen the SBCC efforts, promote SRHR messages, increase awareness, create demand of SRHR services which will ultimately yield positive behavioral change contributing to overall improvement in project outcomes. As part of capacity development interventions, the project will engage stakeholders in following activities:

- **Program planning and design:** The project stakeholders will be engaged and capacitated to use proven and systematic processes to conceptualize, plan and design SBCC programs that are audience centered, evidence-based, coordinated, and comprehensive.

- **Program management:** The program management from Ipas Bangladesh and partner NGOs will be capacitated to properly implement, monitor and evaluate the SBCC program. Stakeholders from government counterparts will be engaged in monitoring and evaluating the SBCC program of Improving SRHR in Dhaka Project.
- **SBCC program delivery (Service providers, field workers, volunteers, and mentors):** Service providers including UPHCSDP counselors, outreach workers, volunteers and mentors will be capacitated through training, orientation and equipping with job aid and logistics for implementing SBCC components at community levels. This will ensure high quality programs that are ethical, responsive to clients and free from bias.

Awareness and Campaign

The goal of community awareness is to increase the community's knowledge on SRHR issues and facilities that provide SRHR services. This is accomplished by informing the community people through various activities including rally, day observation, community miking, community meeting, door to door visits, using of signages, distributing prints materials, social media campaign etc. Improving SRHR in Dhaka Project will implement multiple activities to increase awareness among community people about SRHR issues and information about the facilities that provide SRHR services.

Awareness campaigns are extremely flexible. We can mix-and-match a variety of strategies and digital tactics to reach and engage our audience. Common strategies include: Day observation; Campaign rally; Community miking; Print material distribution; Social and digital media campaigns; Inter-personal communications.

Coordination and collaboration:

Coordination in SBCC programing involves effective communications, collaboration and networking with partners and stakeholders. It requires investment in planning, participatory message development,

regular check-ins during SBC implementation, revision of approaches and messages, and joint monitoring and evaluation (M&E) of activities. Effective coordination between services and SBCC relies on the key areas that include-development of joint strategies, defining partners' and stakeholders' roles in SBCC, capacity development, resource mobilization, harmonizing messages and materials, collaborate on research and study, and sharing of monitoring data to trac progress and make changes.

Coordination will be done in several ways including by holding regular and periodic meetings, sharing newsletters, communicating through email and online networks, and organizing seminars and conferences. Ipas Bangladesh will strengthen coordination with government stakeholders (DGFP,DGHS, MoLGRDC, UPHCSDP), development partners (GAC, HB), private organization (BGMEA, BKMEA, Nursing Institute), implementing partners (OGSB, BAPSA, RHSTEP, SERAC Bangladesh, and UPHCSDP partners) by multi-faceted communications including holding regular project coordination meeting, supporting and collaboration in SBCC material development, sharing of SBCC material, capacity development, establishing referral linkage mechanism, commodity supplies, program monitoring through joint field visits, sharing of data and harmonizing messages.

Advocacy

Advocacy is the process of using information strategically to change policies that affect the lives of disadvantaged people. Advocacy is done with policy makers and stakeholders at national and local level administrators to reform policies and laws supportive to implementation of interventions for creating SRHR outcomes. Systematic data and evidence-based information is vital for advocacy initiatives.

Ipas Bangladesh will facilitate advocacy process based on demonstrated evidence to directly and indirectly influence decision makers, stakeholders, and relevant audiences to support and

implement actions that contribute to the fulfilment of SRHR needs of women and adolescents in target geographies. Issue based and thematic research and study will be done with the support of Improving SRHR in Dhaka Project. Photovoice methodology will be used by the project to generate advocacy issues. Activities including roundtable, seminars, exhibition, community dialogue/advocacy meeting will be done to support advocacy intervention of the project.

9. Communication Strategy

SBCC is defined as the use of communication strategies to influence individual and collective behaviors that affect health. With the advent of digital technology, social media platforms and varied communication channels available among rich and poor population irrespective of urban rural geographies in Bangladesh, having a well-defined communication strategy is paramount for Improving SRHR in Dhaka Project. Through effective communication, we will strive to empower individuals, communities, and key stakeholders with accurate information, promote healthy decision- making, and ultimately improve SRHR outcomes.

9.1. Message development

The project will develop evidence-based, culturally sensitive, and rights-based key messages that address the identified knowledge gaps and social barriers. The messages aim to influence positive attitudes, norms, and behaviors related to sexual and reproductive health and rights. The project will organize a message development workshop involving multiple stakeholders including MOHFW, UPHCSDP, Partners organizations, youth volunteers and project staff. The workshop will develop a number of messages on adolescent health hygiene, menstrual regulation, contraception, post abortion care, SGBV, promotion of SRHR service facilities etc. The project will also develop messages to address stigma and biases related to SRHR and promote positive behavior and supportive environment regarding accessing services.

9.2. Communication Channels

The key to success in implementing an SBCC strategy is to use a combination of multiple communication channels, tailored to the specific context and needs of the target audience. For bringing behavioral changes regarding SRHR among the low socio-economic urban population, Improving SRHR in Dhaka Project determines the

most effective communication channels to reach the target audience. This may include a mix of interpersonal communication, digital platforms and mobile technology, traditional media, community/folk media, mass media and mid-media depending on the preferences for and accessibility to the target population.

Interpersonal Communication (Community health workers/ outreach workers): Community health workers and outreach workers can be an effective way to disseminate information and provide counseling on SRHR. Well trained community health workers and outreach workers are the vital channels for interpersonal communication who can establish trust within the community and deliver messages effectively, ensuring they are tailored to the local context.

Mobile phone: Given the widespread use of mobile phones in urban areas, utilizing mobile-based communication channels such as voice messages, SMS campaigns, and smartphone applications can be an efficient method to reach the target population. These channels can provide SRHRR information, reminders, and even allow users to ask questions or seek support remotely.

Social media: Engaging with urban communities through social media platforms such as Facebook, WhatsApp, Instagram, YouTube, etc. can be an effective way to raise awareness and provide SRHR information. This approach can particularly reach younger urban audiences who have higher access to the internet and smart phones.

Digital technology: Digital technology refers to mediums of digitized information broadcast through a screen and/or a speaker. This also includes eNewsletter, audio, video, and graphics that are transmitted over the internet for viewing or listening to on the internet. eToolkits, web sites, eForums, blogs, chat rooms/call center can be used for community awareness, network building, and promoting information and services. Improving SRHR in Dhaka Project will utilize digital platforms best suitable and effective for its target audience.

Community-based organizations: Collaborating with local community-based organizations (local clubs, co-operatives etc.) that work closely with the community can enhance outreach efforts. These organizations often have existing networks and relationships with the target audience, enabling effective dissemination of SRHR messages, organizing workshops, and facilitating community dialogues.

Mass media and print media: Although disseminating messages through national mass media (TV, radio) has been a declining trend of usage for health programming, local dish channel, FM radio and print media can help reach a larger urban audience. Posters and signages on SRHR information and promotion of services, campaigns, and provision of SRHR-related materials in the workplace can ensure easy access to information to the community.

Youth volunteers: Education through peers always helps and influences to understand the desired information delivered among target population. Peer learning and education is effective and can be facilitated through engaging the adolescents and youth volunteers of Improving SRHR in Dhaka Project.

Community influencers: Utilizing influential individuals within the program geographies can enhance the credibility and impact of communication efforts. Engaging key influencers (religious leaders, teachers, local elites) who are respected and trusted within the community can promote SRHR information and advocate for behavior change regarding SRHR and create supportive environments for women and girls accessing services.

Edutainment: Providing information through entertainment draws more attention from the target population. Edutainment helps receivers to retain and recall the message for timely action. This channel includes- community drama, interactive storytelling, community events, competitions, video group discussion, Life skills, mobile video units etc. SRHR information can easily be disseminated

through this channel. Improving SRHR in Dhaka Project will use this channel and activity as appropriate.

Traditional Communication: Use of traditional media can be a good medium and it has vast influence on community people. Considering the acceptability and wider coverage aiming at changing norms related to SRHR, this channel can help to reach the desired level of target audience. Inter-active Popular Theaters (IPT)/forum theater (FT), local cultural clubs/team are very popular mediums that draw significant level of audience attention and ensure desired success. The project will use this channel as relevant and appropriate to respective geographies.

9.3. Creative material

We will develop visually appealing, culturally appropriate, and informative materials such as brochures, posters, videos, and audio content. Additionally, we will leverage interactive tools such as mobile applications and online platforms to provide access to accurate information to the community. The project will also use evidence-based materials which have been proven effective for capacity building, community awareness and other SBCC interventions as used by government and non-government organizations. Some of the materials which will be used by the project include as follow:

Job aid/Tools:

- Outreach workers and counselor of UPHCSDP Project: Flipchart on FP-MR-PAC
- Youth Volunteers: Community session facilitation guide, Flipchart on AHH, FP-MR-PAC and referral facilities
- Manuals: Outreach workers SBCC training manual, Volunteers orientation manual, training manuals, guidelines
- SRHR Champion Toolkit
- SBCC Strategy and guidelines

Promotional material for community and facility level:

- Reprinted poster on Family Planning (for GP chamber, referral facility, garment clinics)
- New Poster on MR-PAC-SGBV (for GP chamber, referral facility, garment clinics)
- Leaflet and sticker on GP service promotion and OGSB Call Center promotion
- New take away material, flash card on FP-MR-PAC-SGBV (facility and community level)

Branding material/signages

- Creation of branding mark for GP Chamber- Women Plus signage
- Signages for GP chamber
- Desk materials/souvenir
- New: Training Video

Social media and digital technology:

- Creative contents for facebook, Youtube
- eToolkits, web sites, blogs,

Audio Visual Materials: The Project will develop audio-visual material and job aid for capacity building of service providers and display audio-videos on SRHR issues to be used at facilities including garment factories, UPHCSDP clinics and out-doors for community awareness.

10. SBCC Strategy Implementers

At the community level, implementing partners' staff, outreach workers are the key players to carry out SBCC interventions and activities. They reach to women and girls, the primary audience of the project. At the facility level, service providers, counselors, GPs also have the contact with the primary audience and can communicate some messages to the women, girls and other secondary audiences. Other than the regular employed posts, youth leaders, volunteers, community group members are volunteering and are minimally oriented and sensitized with their specified roles and responsibilities. The youth leaders play a vital role in organizing and conducting awareness session in the community groups and also carry few IEC materials to display, demonstrate and distribute to the communities

SBCC Implementers	Area of Work (in terms of SBCC interventions)
Ipas Bangladesh	Technical support to partner organizations for implementing SBCC interventions at community and facility level; Develop creative materials; advocacy and special events at national level.
Implementing partners (OGSB, RHSTEP, SERAC, BAPSA)	Mobilize youth volunteers and general practitioners, establish linkages between community and facilities.
General practitioners	Provide SRHR services and counselling from GP chamber/pharmacy linking with volunteers and higher facilities
Counsellor/service providers (UPHCSDP Facility)	Provide counselling on SRHR at facility level.
Outreach workers (UPHCSDP)	Implement community mobilization and awareness activities (home visits, courtyard meeting etc) at community level.
Stakeholders (DGFP, DGHS, UPHCSDP,	Support in developing SBCC strategy, mobilize resources for SBCC strategy

MOHFW, MOLGRD&C)	implementation, monitoring of SBCC strategy implementation at field level.
Volunteers and youth leaders, Community Action Group (CAG)	Community awareness, peer education, social media campaign

The above-mentioned workforce is deployed in different tires in the facilities and community level. They have specific job description under structured monitoring and supervision mechanism. They are trained as per the requirement and set criteria. They are the vital key factors for SBCC implementation effectively. Major success depends on their skills, sincerity and professional integrity.

11. Results

	Improved access to SRH services and reduced gender-based violence. (Ultimate outcome)			
	Increased knowledge, social support, and enhanced agency of under-served urban women and adolescents accessing SRH services and reduced sexual and gender-based violence (Intermediate Outcome)			
	Individual Level	**Interpersonal & Community Level**	**Institutional Level**	**Behavioral outcome**
IMMEDIATE OUTCOMES	• Improved knowledge on SRHR • Enhanced agency • Reduced stigma on SRH • Improved gender equality	• Increased knowledge & community participation • Strengthened networks • Improved social support • Reduced stigma and GBV	• Strengthened linkage between community & Health system • Improved accountability • Ensured equitable services	• Increased service utilization • Increased community support for SRHR care seeking
OUTPUT	- Accurate, unbiased, rights-based, non-stigmatizing SRHR information available for the individual - Individuals empowered to Change maker for sharing and supporting FP-MR-PAC & SGBV information and access - People are able to decide when and where to access	- Family members and community stakeholders engaged in activities for reducing stigma and social norms and increase social support - Women's and adolescents' demand for SRH supported through multi-level social networks	- Referral mechanism established and strengthened between community and health facilities - Community voices on SRHR issues heard - Duty bearers are accountable to provide equitable services and addressing SRHR issues including adolescent's and people with specific needs.	- Service providers provide rights-based, non-stigmatizing SRH services - Community intermediaries including volunteers and outreach workers are capacitated to provide authentic SRHR information to the community
Activity	**Behavior Change Communication:** - Develop strategy and tools - Capacity development of youth & CAG, outreach workers - Develop SBCC materials for women, adolescent, and garment workers - Use social media and digital flatforms - Events and day celebration	**Community mobilization & SBC:** - Mobilize community through CAG - Community awareness & campaign/ school campaign and male engagement (male group) - Traditional media use (street drama) - Audio-visual display and social media - Community sensitization and stakeholder engagement event	**Advocacy and social mobilization** - Training on VCAT - Photovoice exhibition - Media event - Collaboration with stakeholders	- Young and adolescents voluntarily engaged in promoting SRHR messages - Community became aware and seeking SRHR services - Diverse network established and strengthened

12. Monitoring & Evaluation:

Monitoring & evaluation of the SBCC interventions is a very crucial and integral part of this strategy to reflect and take learning from the implementation of the strategy in a periodic manner. For effective M&E of this strategy, Ipas and partners' own Monitoring and Evaluation (M&E) mechanism/system will incorporate the indicators, outcomes, and strategies of the SBCC in the form of quantitative outputs, outcomes, and impact statement and their indicators. This will be done within the rolling out of this strategy. To understand and measure the effect of SBCC interventions, the project will conduct periodic (quarterly and bi-annual) review and reflections of the SBCC interventions and take corrective measures in terms of implementation and updating the strategy.

Responsibility of M&E of this strategy lies on the project director, RM&E team, Community access team of Ipas and partner organizations. Ipas will make process documentation, collect, and disseminate the most significant changes from the community and adopt the best practices for future programming.

Table: Illustrative Indicators for Monitoring and Evaluating of SBCC for SRHR Activities

INDICATOR	DATA SOURCE
INPUT/OUTPUT: **Audience reached.**	
# of service providers (facility and community) trained on SRHR counselling and service provision	General Activity Form
# of service delivery points that have SRHR information, education, and communication (IEC) materials available	Routine monitoring data collected through Service Progress Review (SPR)
% of clients who are counselled or reported being counselled on FP-MR-PAC-SGBV during a visit to the health facility.	Client Exit Interview (CEI)
# of women and adolescents reached with FP-MR-PAC & SGBV information through	Monthly reporting format and General

outreach workers, volunteers, and social media	Activity Form
OUTCOME INDICATORS: knowledge, attitudes, and behaviors change.	
% of women aged 15–49 and adolescents who know about FP methods, MR-PAC and tell about SGBV issues	Household/community assessment during baseline and endline evaluation
#/% of individuals in program-supported areas who can accurately recall a project-supported message	Household/community survey
Improved social support score of women and girls who access SRH services at project supported facilities.	Client Exit Interview (CEI)

Annex:

Annex-1: Summary Findings of Qualitative Assessment (FGD Findings)

Annex-2: Channel Analysis

Annex-3: Comprehensive Communication Approach

Annex-4: SBCC Strategy Implementation Plan

Annex-5: Shifting Gear Framework

Annex-6: User Centered Design (UCD)

Annex-1: Summary findings of Qualitative Assessment

Improving SRHR in Dhaka Project conducted a rapid assessment regarding understand SBCC aspects of the target audience-knowledge, perceptions, attitudes and practices regarding SRH and SGBV issues among adolescent girls, adolescent boys, women, men along with existing capacity and skills of the service providers. Through the FGDs, existing communication channels and potential ways of information on SRHR issues also identified which is supportive to develop the communication strategy. Total six workshops were conducted with 87 participants including adolescent girls and boys, women, men and garment workers. Key findings from the workshops are detailed as below:

Adolescent girls (15-19 years): Most adolescent girls didn't have information about menstruation before they experienced it. They scared at their first menstruation. Most of adolescent girl maintained their menstrual hygiene while they also opined that many adolescent girls in their community do not know well management of menstruation and had their family and elder members sometimes prohibit to take some specific food like fish. Adolescent girls had experience of gender-based violence and abused at family and community level.

Women of reproductive age (20- 49 years): Most of the women expressed that they feel comfortable to share menstrual issues with close female neighbors. The participants had a knowledge gap about FP methods and other SRH services. They usually visit pharmacy, govt hospitals, NGO clinics and facilities to have these services. Most of the women had little knowledge about MR services, its duration and perceive that "abortion is illegal and a sin". Some experienced gender-based violence, had physical and mental abuse at family and society level. Some participants had got marriage at underage (below 18 years) with will of the family.

Adolescent boys (15-19 years): Participants perceive that wet dream and masturbation is bed for health and it breaks their health. They have little knowledge about FP methods and heard the term MR but do not have a clear understanding about MR procedures, duration, and service points. They expressed that eve-teasing, early marriage and gender-based violence happen in their community and it needs to be stopped. Their perception about abortion is-"it is Illegal and a sin". They perceive that "girls who wear bed dresses (which is not culturally allowed) get victim of eve teasing"

Garment workers: Some participants expressed that at their first menstruation- they were allowed only mash potato, prohibiting them from eating fish and egg during menstruation. Some participants stopped using FP method due to grown up children or husband's working far outside of home- in other district or abroad. Most of the participants had lack of knowledge about abortion. Those who know about MR, and perceive that it is illegal and a sin. Some got married at below 18 years due to poverty, discontinuation of study, and parents' decision. They shared that they had to hear rebuke, shouting and sometimes physical assault at workplace in the past. But, at present situation improved- abuse at workplace reduced specially after formation of workers' union. Some participants shared that they spend their earned money for the wellbeing of their family members, not for their health purposes.

Men (20 years and above): Men have little knowledge about FP methods and some of the participants expressed that "women should inform their husband what method they are using". Men also perceived that "abortion is illegal and a sin". Some participants expressed, "Men should not hit the women, if women(wife) do any wrong men should make them convince and teach the correct one". But they expressed that in their society hurting women physically by men (by husband) is common which they think need to be stopped.

Channel and materials preferred by the participants to access SRHR Information:

Preferred channel	Information they want	Materials
Printing		
Print/ SBC materials	SRHR information including FP, MR, PAC and GBV	Brochure, flip chart
Digital		
Digital media	SRHR information including FP, MR, PAC and GBV	Web site, you tube, Apps etc
Interpersonal communication		
Meeting/ session/ peer session (court yard meeting)/ (Rotary, morning exercise club)	SRHR information, Pubertal change, menstruation, FP, MR, PAC and GBV	Leaflet, Pictorial materials, Banner, flip chart, take way materials
Volunteers (community campaign, informal gathering)	SRHR information sharing (Adolescent boys)	Leaflet, poster, brochure
Health workers (govt. and NGOs)	FP, MR, PAC (Women), referral information	Leaflet, poster, brochure
Teachers	Class wise relevant information	Education text book, leaflet, brochure, booklet
Garment authority	SRHR information	Leaflet, poster, video documentary
Outreach worker (Who can give proper information & knowledge)	FP, MR, PAC (Women)	Leaflet, poster, brochure, pictorial
Health camp	SRHR information	Miking, leaflet, brochure
Religious leaders	SRHR information	Leaflet

Preferred channel	Information they want	Materials
Mass media		
Facebook	Menstrual hygiene management (Adolescent girls), SRHR information	FB post
Awareness campaign	SRHR information including FP, MR, PAC and GBV	Banner, leaflet
Conference hall/meeting session (garment), Dish Channel	SRHR information	Promo, Documentary, audio
Radio	Story telling, Talk show regarding SRHR	Podcast
Social media	SRHR information including FP, MR, PAC and GBV	Promotional materials
Cultural event (e.g.street drama)	SRHR issue	Poster, leaflet, flip chart
Television (TV campaign and tag line)	Menstrual hygiene management (Adolescent) Condom, pill, ECP (women) / Health program on SRHR/ Talk show	Digital banner, Advertisement, cartoon

Preferred Channel	Information	materials
Interpersonal communication		
Meeting/sessions/courtyard meeting (at local club/community)	SRHR information, Pubertal change, menstruation, FP, MR, PAC and GBV	Leaflet, Pictorial materials, banner, flip chart, take way materials
Volunteers (community campaign, informal gathering)	SRHR information sharing (Adolescent boys)	Leaflet, poster, brochure
Health workers (govt. and NGOs)	FP, MR, PAC (Women), referral information	Leaflet, poster, brochure
Teachers	Class wise relevant information	Education textbook, leaflet, brochure, booklet
Garment authority	SRHR information	Leaflet, poster, video documentary
Outreach worker (Who can give proper information & knowledge)	FP, MR, PAC (Women)	Leaflet, poster, brochure, pictorial
Health camp	SRHR information	Miking, leaflet, brochure
Religious leaders	SRHR information	

Annex-2: Channel Analysis

There is no one perfect channel. Each channel has inherent strengths and limitations due to its nature. A blend of channels can be used to capitalize on inherent strengths, allowing for greater impact. Using multiple channels can also have a cumulative and reinforcing effect, increasing the effectiveness of the messages communicated.

The table below provides examples of general strengths and limitations of channels. The SBCC team should supplement this with relevant local information.

Channel	Strengths	Limitations
Interpersonal Communication Community dialogue, peer-to-peer, health provider-client, inter-spousal and parent-child communication	• Tailored and personalized • Interactive • Able to explain complex information • Can build behavioral skills • Can increase intention to act Familiar context – enhances trust and influence	• Lower reach • Relatively costly Time-consuming
Community/Folk Media Community drama, interactive story telling, music, community events, video group discussion, mobile video units, talks and workshops, door-to-door visits,	• Stimulates community dialogue • Motivates collective solutions • Provides social support for change • Can increase intention to act Reaches larger groups of people	• Less personalized than IPC • Time-consuming to establish relationships • Relatively costly May have less control over content

demonstrations and community radio		
Mass Media and Mid-Media Radio, TV, print, film, outdoor – posters, billboards	• Extensive reach • Efficient and consistent repetition of message • Capacity to model positive behaviors • Sets the agenda– what is important and how to think about it Legitimizes norms and behaviors	• Limited two-way interaction • Available only at certain times • Relatively impersonal
Digital and Social Media Mobile phones, SMS, Facebook, Internet, twitter, eToolkits, web sites, eForums, blogs, YouTube, Chat room	• Fastest growing and evolving • Potential to mobilize youth • Highly tailored • Interactive • Quickly shares relevant information in a personalized manner Flexibility to change and adapt as needed	• Program may have less control over content • Requires literacy • Limited reach and accessibility Can lack credibility

Annex-3: Comprehensive Communication Approach

Target Population	Current behaviour, knowledge and practice	Desired behaviour and practice	Interventions	Channels/media
Adolescent girls	Lack of information and knowledge about menstrual health hygiene, FP, MR, PAC, SGBV and service facilities	Improved knowledge Know about and receive SRHR services from trained providers. Adopted healthy behaviours	Interpersonal communication (community session, peer education, school campaign) social media campaign Life skill session	Community Action Group (CAG), Volunteers, Social media, School & Teacher
Adolescent boys	Lack of information and knowledge about physical changes, misinformation about masturbations and wet-dream, hygiene,	Improved knowledge Receive pubertal changes, health hygiene information and services from providers.	Interpersonal communication (community session, peer education, school campaign) social media campaign Life skill session	Community Action Group (CAG), Volunteers, Social media, School & Teacher

Target Population	Current behaviour, knowledge and practice	Desired behaviour and practice	Interventions	Channels/media
	FP, MR, PAC, SGBV and service facilities	Adopted healthy behaviours		
Women (15-49 years)	Lack of information and knowledge about FP, MR, PAC, SGBV and service facilities Social stigma about MR-PAC-FP services	Improved knowledge Reduced social stigma on MR-PAC-FP services Receive SRHR services from trained providers. Adopted healthy behaviours	Person to person communication (household visits) Counselling Community session with women Community awareness campaign/ Health camps	Community women's groups, CAG & Volunteers, Outreach workers, Dish channel Social media & mobile messaging
Garment workers	Lack of information and knowledge about FP, MR, PAC, SGBV and service facilities Social stigma about MR-PAC-FP	Have proper information about MR-PAC-FP and SGBV services and service points. Reduced social stigma about MR-	Counselling by service providers at garment health facility/clinics Hall room session at garment factories Audio-visual display/screening/announcement and messaging on SRHR services	Service providers at garment health facilities Digital equipment (hall-room monitor, audio system at

Target Population	Current behaviour, knowledge and practice	Desired behaviour and practice	Interventions	Channels/media
	services Limited access to health facilities due to lack of time	PAC-FP services. Receive SRHR services from trained providers.		garment facilities Hall room facilitator/speaker Mobile messaging SBCC material display at garment factories
Men	Lack of information and knowledge about FP, MR, PAC and SGBV. Don't allow girls and women taking decision about FP-MR-PAC services by themselves. Patriarchal attitude about women and girls	Improved knowledge Support women and girls receive SRHR services from providers. Allow women and girls take decision by themselves about SRHR services	Counselling at facilities and household Community session with men Community campaign (health camps, large gathering, rally, miking etc.) Edutainment, interactive session (photovoice session), popular theatre.	Outreach workers and service providers Community men's groups, CAG and volunteers, Community Hall room to arrange photovoice exhibition/ interactive session with

Target Population	Current behaviour, knowledge and practice	Desired behaviour and practice	Interventions	Channels/media
				stories. Cultural team, volunteers
Youth volunteers	Lack of knowledge on SRHR issues Lack of skills on communication and other traits Lack of motivation	Increased knowledge about SRHR issues Improved skills on communication, facilitation, negotiation, and advocacy Strengthened motivation.	Basic and refreshers orientation Skill development training on communication, social media use (content development), photovoice, networking, negotiation, and advocacy Exposure visits and periodic large gathering Virtual session and interaction	Orientation Training Mentoring Exposure Virtual flatforms Social media platforms
Outreach workers and service	Lack of updated knowledge on SRHR issues	Have updated knowledge about SRHR issues.	Basic and refreshers training on SBCC including counselling and VCAT.	Orientation Training Mentoring

Target Population	Current behaviour, knowledge and practice	Desired behaviour and practice	Interventions	Channels/media
providers	Lack of confident and skills on implementing SBCC initiatives and material use Biasness and stigma on MR-PAC-SGBV issues	Improved skills on counselling and SBCC Reduced biasness and stigma about MR-PAC-SGBV services	Monitoring and supportive supervision of SBCC initiative by outreach workers Periodic assessment of SBCC knowledge and skills and the job mentoring	

Annex-4: SBCC Implementation Plan

Sl.	Key Activity	Responsibility	Timeline	Output
1.	**Strategic intervention: Capacity development**			
1.1	**Training of outreach workers and counsellors of UPHCSDP for skill development on SBCC interventions and SRHR: (**Manual development; organize training of trainers (ToT); Conduct training)	Ipas, BAPSA/ UPHCSDP	July 2022 to September 2023	Manual developed; Trainer's pool developed;
1.2.	**Refreshers training of outreach workers and counsellors of UPHCSDP for skill development on SBCC interventions and SRHR: (Refreshers** Manual development; organize training of trainers (ToT); Conduct training)	Ipas, BAPSA/ UPHCSDP	March to December 2024	Manual developed; Trainer's pool developed;
1.3.	**Orientation of youth volunteers on communication skills and SRHR issues:** Selection of GP, Selection of youth volunteers, manual development, training for partners' staff, orientation for volunteers	Ipas, SERAC/ OGSB	April 2022 to December 2023	1000 youth volunteers oriented on SRHR issues

1.4.	**Refreshers orientation for youth volunteers:** Manual revision, Conduction of refreshers orientation	Ipas, SERAC	January to December 2024	Manual developed; Volunteers' oriented
1.5.	**Skill development training for volunteers and youth leaders (Photovoice, life skills, social media use etc):** Participants selection and organize training	Ipas, SERAC	September 2022 to December 2024	Manual developed; Volunteers trained, and capacity developed
2.	**Strategic intervention: Community and youth engagement**			
2.1.	**Form Community Action Group (CAG) to mobilize the youth and create supportive environment: (**select and train youth volunteers; form 100 CAGs under 100 general practitioner's catchment areas)	SERAC Bangladesh, Ipas	April 2022 to December 2023	100 CAGs formed in project area engaging 1000 youth volunteers
2.2.	**Form community groups with women, adolescents, men by CAG members to disseminate SRHR information and create supportive environment in the community:** Form Community Groups with women, adolescents, and men; Conduct awareness sessions with community groups	SERAC Bangladesh, Ipas	From April 2022 on ward	Youth volunteers engaged in promoting SRHR messages and information to the community

2.3.	**Mobilize community by outreach workers of UPHCSDP:** - Conduct courtyard meeting - Conduct household visits and other interpersonal communication activities in the community	BAPSA to support UPHCSDP outreach workers	July 2022 to ongoing	Community people are aware about SRHR services and supportive environment created to access service
2.4.	**Facilitate youth championships:** - Develop championship toolkit. - Select champions. - Awards champions	Ipas, SERAC	September 2023 to December 2024	Developed champion toolkit. Champions selected. Champion awarded
2.5.	**Use social media platforms to engage youth, adolescents, women and men:** Create Facebook page and WhatsApp group to engage youth, adolescents, women, men and service providers	Ipas, SERAC	March 2023	Social media platforms created that engaged youth, adolescents, women, men and service providers
2.6	**Periodic gathering for strengthening network and coordination among youth volunteers and champions.**	Ipas, SERAC	Year 4 and 5	Large gathering organized with youth volunteers
3.	**Strategic intervention: Awareness and campaign**			
3.1.	**Develop message and material (SBCC message and material for awareness and**	Ipas, partner organizations	March 2022 and onward	SBCC and promotional material developed and

	campaign activities in the community): - Printed material- Poster, sticker, leaflet, brochure for health facilities and community; Job aid, manual for outreach workers; Guidelines, tools, and handouts for volunteers; Audio-visual materials: video, creative contents.			distributed in the community
3.2.	**Develop signages and campaign material for General Practitioners:** Develop signages for GP chamber and for service promotion	Ipas, partner organizations	March 2022 and onward	GP chamber branded with signages and promoted in the community.
3.3.	**Local level campaign for awareness and promotion of service facilities including GP, UPHCSDP clinics, OGSB Call Center, referral facilities:** - Organize rally and discussion on national and international events and days. - Organize health camps with general practitioners and volunteers to aware community about SRHR issues and	Partner organization-SERAC, Ipas	March 2022 and onward	Service facilities promoted in the community.

	health facilities including OGSB Call Center. - Conduct community meetings/sessions by volunteers with women, adolescents and men to aware them on SRHR issues and behaviour change and promotion of SRHR service facilities.			
3.4.	**Increase community awareness on SRHR issues through social media and interpersonal communications:** - Enhance social media campaign through regular posting on Project Facebook (message, reels, video clips, interviews ect.) - Organize periodic zoom meeting with volunteers for capacity building, networking, and motivation.	Ipas, SERAC	March 2022 and onward	Service facilities promoted in the community. Volunteers are capacitated and motivated to aware community.
3.5	**School level campaign and interpersonal communication: CSE and life skill sessions with students, meeting with teachers and parents at educational institutions (high schools/colleges/ madrashas):** Find &	Ipas, SERAC	Year 3 and onward	Adolescents students, teachers, and parents are aware about SRHR issues. Service facilities promoted in the

	listing the educational institutions in implementing GP located CC wards; select institutions which are in practice of parents' meetings; orient selected teachers; conduct CSE/SRHR sessions with students.			community through school campaign.
4.	**Advocacy**			
4.1.	**Facilitate photovoice initiatives:** Select volunteers, train volunteers, collect photos and stories, organize photo exhibition and media events with stakeholders for advocacy on SRHR issues	Ipas, SERAC	Year 3 on ward	Photo album, photo booklet, brochure and pagers, posters developed. Photo exhibition and media event held at national level
4.2.	**Interactive dialogue and community level advocacy meeting held with stakeholders on Photovoice posters and stories**	Ipas, SERAC	Year 3 on ward	Community level dialogue and awareness session organized using photovoice stories and materials.
4.3.	**Documentary and documentation developed on photovoice initiatives for wider advocacy on SRHR issues**	Ipas, SERAC	Year 4 on ward	Documentary and systematic document developed

5.	**Material development**			
5.1.	**Develop print material:** Job aid for service providers (Flipchart, checklist etc); Manual for training and orientation for volunteers and outreach workers; Develop takeaway material (brochure, sticker, poster, leaflet, booklet, etc) for awareness on SRHR issues, promotion of health facilities,	Ipas	Year 2 onward	Printing material developed as per yearly workplan
5.2.	**Signages for promotion of GP chambers:** (Signboard, light box, posters, large sticker at GP chamber)	Ipas	Year 2 to year 4	Completed signage setting at 100 GP chambers supported by the project segregated target.
5.3.	**Develop audio-visual material and video documentary:** - Audio visual material for garment factory workers and health facilities - Visual material for community awareness on SRHR issues using social media and digital media. - Video documentary for advocacy issues	Ipas	Year 3 to year 4	Audio-visual and video documentary developed as per target set as in yearly workplan

Annex-5: Shifting Gear Framework

The Shifting Gear Framework

Shifting Gears is an Ipas behavior change framework that helps systematically design SBC strategy meaningfully increase access to SRH services including MR-PAC-FP. Behavior change frameworks from other organizations and issues may be less suited for application to the contexts and dynamics most critical to addressing unsafe abortion. For example, supporting changes in norms and behaviors to shift the use of unsafe abortion options to the use of safe abortion options is different from shifting behaviors that are repeated on a daily or frequent basis, such as handwashing. Supporting shifts in norms and behaviors among providers from not providing safe abortion to providing safe abortion and adopting best practices requires addressing the context of the cultural and institutionalized stigma that influences providers' willingness and ability to provide safe abortion services. Similarly, the factors that influence policymakers to advance safe abortion legislation differ from those that influence policymakers to advance legislation focused on safety-belt wearing.

Components of Framework:

The framework consists of a set of interlocking gears (see Figure 1) that are part of the broader socio-ecological environment that influences individuals' behavior change. This visual model portrays "current behaviors" in the lower left side of the image and "desired behaviors" in the top right (both in orange). This illustration of the gears does not intend to represent precision or lock-step change—changes in human behavior and social norms are not so linear and predictable. Rather, the model is meant to emphasize the interconnectedness of these influences and to demonstrate that a change in one area can affect change in another area. Suppose a supportive environment to access abortion (MR) service in a community depends on the influence of several gears, including individuals' knowledge and decision-making powers, peer influences, social support, gender, power dynamics, etc.

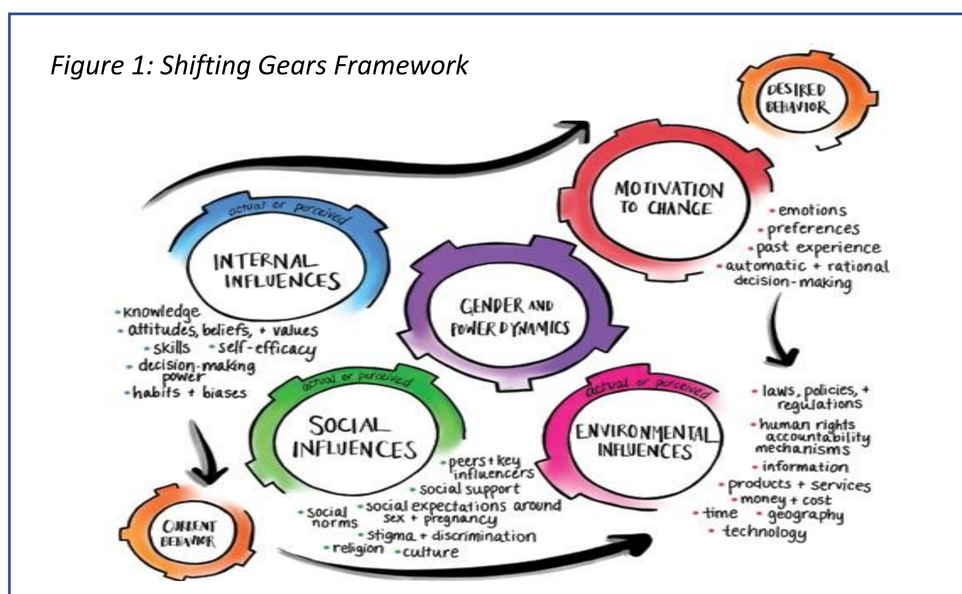


Figure 1: Shifting Gears Framework

Internal influences gear: Internal influences relate to a person's own abilities and psychology, both of which are important to the behavior change process. These include: knowledge, attitudes/beliefs/values, skills, self-efficacy, decision making power and habits/biases.

Social influences gear: Social influences relate to relationships, social networks and society. These include: peers and key influencers, social support, religion, social expectations around sex and pregnancy, social norms, stigma and discrimination and culture.

Environmental influences gear: Environmental influences are the material, structural, or institutional resources or physical properties of the environment in which people live. The Elements of environmental influences include: laws/policies/regulations, human rights accountability mechanisms, information, products/services, money/cost, time, geography and technology.

Gender and power dynamics gear: A gender and power dynamics lens allows us to explore how gender and other power dynamics influence

the different ways individuals and groups of individuals experience feeling empowered or disempowered, feeling advantaged or disadvantaged, or feeling they have control or are lacking control in the course of a given activity or situation.

Motivation to change gear: While internal, social and environmental influences and gender and power dynamics all have an impact on whether individuals will move from their current to desired behaviors, they also impact an individual's motivation to change. Motivation is a powerful catalyst to behavior change and can be a limiting factor if not considered. The Elements of the motivation to change include-emotions, preferences, past experiences and automatic/rational decision making.

However, the Shifting Gear tool is not intended to suggest that all influences need to be addressed, but rather asks us to consider the interplay of various influences to identify the most strategic levers for change.

Annex-6: User Centered Design

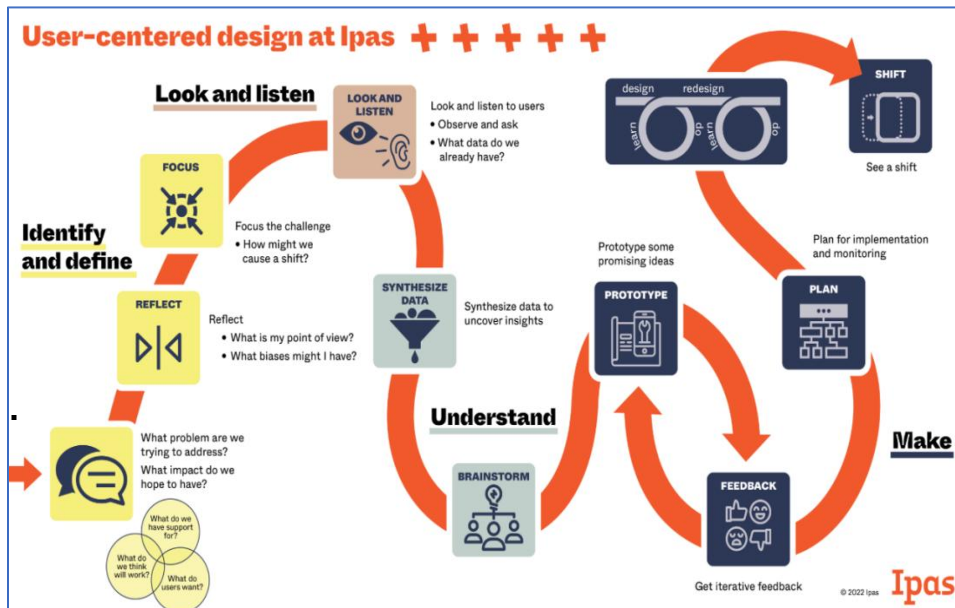
User Centered Design Model

User-centered design, also known as human-centered design, is an approach to project design that has a clear commitment to being responsive to user needs and preferences. This is accomplished by engaging with users and, or user-surrogates early in a project or intervention to gain insights about how they perceive and experience a problem, involving them in prototyping possible solutions, and continuing the engagement as interventions are being developed and refined. At Ipas, UCD triangulates considerations of what the users want or need, what is feasible for us to do to meet that need, and what will have an impact. Ipas will use UCD approach in designing of SBCC tools, workshops, and materials that are catered specifically to the needs of our users and what will be most effective for them in practice.

In UCD, design teams involve users throughout the design process via a variety of research and design techniques to create highly usable and accessible products for them.

UCD is an iterative process that involves four distinct phases:

1. **Identify and Define:** the design team decides what challenge to address in their design process and develop a design challenge
2. **Look and Listen:** the team collects information to inform their designs (directly from users or indirectly through data review, past experience, or other sources)
3. **Understand:** the team synthesizes their learnings, identifies insights about the user group, and comes up with initial ideas
4. **The Make Phase:** the team creates prototypes or drafts of their idea and tests it with users as they move towards implementing it



[Figure-2: User Centered Design]

In developing any innovative interventions and tools of this SBCC strategy, we will follow the User Centered Design principles and process.

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