Comprehensive Social and Behavior Change Communication Strategy

Ministry of Health and Family Welfare

Health

Nutrition

Population

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Acronyms

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

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

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

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

Section C

Annexure

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Annex 1

Glossary of Terms

Glossary of Terms

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Gender norms – Gender norms are a set of "rules" or ideas about how each gender should behave. They not based in biology, but instead determined by a culture or society. [xi]

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

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

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

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

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

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

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

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

Knowledge Management (KM) – The systematic process of capturing, distributing, and effectively using knowledge.[xix]

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

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

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

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

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

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

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

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

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

[xxvii] Social support can be an important factor when working to change behaviors.

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

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

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

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

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

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i *http://www.who.int/maternal_child_adolescent/documents/adolescent_friendly_services/en/*

ii *https://www.k4health.org/toolkits/sbc-trm/key-terminology#_edn3*

iii *http://www.unicef.org/cbsc/index_42352.html*

iv *http://www.bitpipe.com/tlist/Best-Practices.html*

v *http://www.merriam-webster.com/dictionary/community*

vi *http://ccp.jhu.edu/documents/A%20Field%20Guide%20to%20Designing%20Health%20Comm%20Strategy.pdf*

vii *http://www.merriam-webster.com/dictionary/cost-effective*

viii *http://www.who.int/violence_injury_prevention/violence/norms.pdf*

ix *http://www.idph.state.ia.us/IDPHChannelsService/file.ashx?file=5BF7A59D-F4E3-4BAC-B02C-C4B4D197C78A*

x *http://www.merriam-webster.com/dictionary/efficacy*

xi *http://www.nsvrc.org/sites/default/files/SAAM_2012_Gender-norms.pdf*

xii *WHO Terminology Information System [online glossary] http://www.who.int/health-systems-performance/docs/glossary.htm ; Health Systems Observatory. Glossary for Health System. World Health Organization, Eastern Mediterranean Regional Office. http://gis.emro.who.int/HealthSystemObservatory/PDF/Instruments%20And%20Tools/Glossary.pdf*

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xiv *Green, L. W., and Kreuter, M. W. Health aPromotion Planning: An Educational and Ecological Approach. (4th Edition). New York: McGraw-Hill, 2005.*

xv *http://www.healthcommcapacity.org/wp-content/uploads/2014/10/Ideation.pdf*

xvi *http://www.emro.who.int/child-health/community/information-education-communication.html*

xvii *WHO Terminology Information System [online glossary] http://www.who.int/health-systems-performance/docs/glossary.htm*

xviii *Presentation by James Bon Tempo, Director of ICT and Innovation, Johns Hopkins CCP, to the Bangladesh BCC Working Group on October 28, 2015*

xix *http://www.kmworld.com/Articles/Editorial/What-Is-.../What-is-KM-Knowledge-Management-Explained-82405.aspx*

xx *http://www.cdc.gov/pcd/issues/2010/jul/10_0005.htm#Definitions; Starfield B. Basic concepts in population health and health care. Journal of Epidemiology and Community Health 2001;55:452-454. doi:10.1136/jech.55.7.452*

xxi *http://www.who.int/hia/about/glos/en/index1.html*

xxii *http://www.participatorymethods.org/glossary/participatory-learning-and-action-pla*

xxiii *National Population Policy 2012, MoHFW*

xxiv *http://www.who.int/healthsystems/hss_glossary/en/index9.html*

xxv *WA glossary of technical terms on the economics and finance of health services. World Health Organization, Regional Office for Europe. 1998. Available at: http://www.euro.who.int/__data/assets/pdf_file/0014/102173/E69927.pdf*

xxvi *WHO 2006. The World Health Report 2006 – Working Together for Health. Geneva. Accessible at http://www.who.int/whr/2006/en/index.html*

xxvii *http://www.sanjeshp.ir/phd/phd_91/Pages/Refrences/health%20education%20and%20promotion/[Karen_Glanz,_Barbara_K._Rimer,_K._Viswanath]_Heal(BookFi.or.pdf*

xxviii *http://www.unicef.org/cbsc/index_42352.html*

xxix *http://www.sanjeshp.ir/phd/phd_91/Pages/Refrences/health%20education%20and%20promotion/[Karen_Glanz,_Barbara_K._Rimer,_K._Viswanath]_Heal(BookFi.or.pdf*

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xxxi *Understanding the sustainability of health programs and organizational change. A paper for the Victorian Quality Council. La Trobe University, Faculty of Health Sciences, June 2007. Available at: http://www.health.vic.gov.au/qualitycouncil/downloads/sustainability_paper.pdf*

Annex 2

Suggested Outline of OP-level SBCC Strategy

Suggested Outline of OP-level SBCC Strategy

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

Annex 3

Bangladesh HPN SBCC Situation Analysis

HEALTH

Neonatal, Infant & Child Health

Neonatal, Infant & Child Health Current Situation

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

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

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

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

Neonatal/Infant/Child Health: Existing Communication Activities*

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

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

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

Neonatal/Infant/Child Health Communication Gaps

Knowledge/Information Gaps

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

Neonatal/Infant/Child Health Communication Opportunities

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

Neonatal/Infant/Child Health Keys for Successful Communication

- Strengthen collaboration regarding SBCC in other units of DGHS

Adolescent Health

Adolescent Health Current Situation

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

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

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

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

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

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

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

Adolescent Health Existing Communication Activities

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

Adolescent Health Communication Gaps

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

Adolescent Health Communication Opportunities

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

Adolescent Health Keys for Successful Communication

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

Maternal Health

Maternal Health Current Situation

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

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

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

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

Maternal Health Existing Communication Activities

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

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

Maternal Health Communication Gaps

Knowledge/Information Gaps

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

Gaps in Approaches

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

Maternal Health Communication Opportunities

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

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

Maternal Health Keys for Successful Communication

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

Non-Communicable Diseases

Non-Communicable Diseases Current Situation

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

Non-Communicable Diseases Existing Communication Activities

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

Non-Communicable Diseases Communication Gaps

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

Non-Communicable Diseases Communication Opportunities

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

Non-Communicable Diseases Keys for Successful Communication

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

Communicable Diseases

Communicable Diseases Current Situation

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

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

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

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

HIV/AIDS

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

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

Risk factors for HIV infection in Bangladesh include:

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

Among the general population:

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

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

Tuberculosis (TB)

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

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

Avian Influenza (AI)

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

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

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

Nipah Virus

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

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

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

Communicable Diseases Existing Communication Activities

HIV/AIDS

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

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

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

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

Tuberculosis

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

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