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CASE STUDY

How to Persuade Poor Families to Get Primary Health Care

The Urban Primary Health Care Project in Bangladesh required a systematic behavior change communication program in order to improve the delivery of services geared toward women and children. Photo credit: ADB.

A project in Bangladesh used behavior change communication as a large-scale health care intervention to help women and poor households access health care.

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Overview

This case study focuses on the behavior change communication program for the second phase of the Asian Development Bank - supported Urban Primary Health Care Project in Bangladesh, but it also refers frequently to the first and third phases of the project. The campaign was designed by using established best practices in behavior change communication, an evidence - based and theory - driven communication approach proven to be effective in promoting individual and community - level changes in perception, attitudes, and practices toward healthy behaviors.

Project snapshot

Dates	• **2005:** Start of project • **2012 :** End of project
Cost	• **US$ 1,785,324:** Phase II • **US$ 1,182,174 :** Phase III
Institutions and Stakeholders	**Executing agency** • Local Government Division, Ministry of Local Government, Rural Development, and Cooperatives, Bangladesh **Implementing agency** • City corporations and municipal governments

Challenges

Bangladesh's urban health system is fragmented and underdeveloped, with the urban poor suffering poor health outcomes, such as high child mortality. Poor people cannot afford private doctors and hospitals, while public sources of primary health care are often based not in communities but in inaccessible, centralized hospitals.

The Urban Primary Health Care Project, an initiative supported by the Asian Development Bank (ADB) across three phases, links health departments from cities and towns with nongovernment organizations (NGOs) to deliver services geared toward women and children. The project brings key public health services to urban slumswhich include maternal and child care, vaccination, treating infectious diseases, family planning, and counseling for women experiencing violence. This is critical for Bangladesh, which is beset by systemic problems of access and quality.

The project completion report for the first phase of the project called for a more sophisticated and strategic behavior change communication approach beyond information dissemination and awareness raising. The three project phases required the establishment of 400 health centers to improve the health status in 10 city corporations and four municipalities through 25 partnership agreements with NGOs. This scale required a systematic behavior change communication strategy with greater coverage to reach a diverse urban poor audience, and cohesiveness to coordinate all the project implementers. Hence, a more rigorous approach was incorporated into plans for phase II and phase III.

The need for behavior change

The target of the second phase was to provide 30% of services free to poor and very poor clients. The project also needed to increase the number of paying clients to ensure the financial sustainability of the health centers, with at least 12% of the total cost of services raised through user fees and other mechanisms.

Poverty and poor health conditions are intertwined. Based on lessons learned in the first phase of the project, very poor urban residents are less likely to avail of health care services because of the lack of access and the ability to utilize quality services, and the lack of awareness on where to get them.

A comprehensivebehavior change communication strategy was needed to increase the number of poor as well as paying clients utilizing the services of the health centers. It needed to specifically increase:

- the proportion of women and girls accessing basic curative services by at least 60%,
- the proportion of attended births by 10%, and
- the prevalence of use of modern contraception methods among married women to 60%.

Behavior change communication activities were expected to also increase the target urban population's awareness of environmental health, safe sex, HIV/AIDS and sexually transmitted infection prevention, nutrition, and disease prevention by at least 25% from the baseline.1

Solutions

Under phase II, the project incorporated a communication component to change the health behavior of stakeholders at the community level. This required evidence-based approaches to map stakeholders and adapt messages to different project areas and audiences.

The project contracted the Bangladesh Center for Communication Programs, a national NGO with extensive experience in behavior change campaigns, to develop and implement the behavior change communication component of phase II.

The center developed a behavior change communication strategy to inform and motivate potential clients, especially the urban poor, to know about the health centers and use their services. It used a multipronged approach with media campaigns, capacity development of service providers to increase their communication abilities, health advocacy to empower community leaders to positively influence others, and community mobilization. This mixed approach helped messages reach more potential clients and strengthened broad stakeholder support.

The project also contracted partnership-agreement NGOs to provide health and communication services in different project areas. Using these NGOs as dissemination channels for communication activities was advantageous because each NGO was familiar with local cultures, customs, and dialects, and delivered health care services. The NGOs adapted their own materials to the local dialects and cultural style of their particular audiences.

The Bangladesh Center for Communication Programs ensured that the NGOs' localized messages and approaches were consistent with the BCC strategy and that these were regularly disseminated across the project areas. To support implementation, it also trained all levels of project staff, from senior government officials and project managers to health service workers, counselors, field workers, and volunteers.

Understand the audience

The project's behavior change communication strategy was based on research of the target audiences' current attitudes and behaviors toward the new services offered, and the behavioral, social, and attitudinal barriers to adopting new behaviors.

The project funded a 2-month knowledge, attitude and practice survey related to maternal and family health care practices; people's perceptions of health care services, including actual or perceived barriers to their use; and current information-seeking and communication practices.

The survey sampled 1,850 adults and 500 adolescents across the project areas. It was conducted before behavior change communication interventions were implemented, and helped the Bangladesh Center for Communication Programs select channels and refine messages while helping health centers adapt their services to the needs of clients.

Focus and refine the messages and approaches

Survey results helped communication planners focus their message and communication activities. The data provided a number of insights into the media habits and preferences of poor households, which helped guide the design of the behavior change communication strategy.

Sample Questions from the Knowledge, Attitude, and Practice Survey

- Which TV channels do you prefer?
- Have you heard about the campaign on health services in your community?
- Do you have information about the abuse of women in your community?
- Do you know that giving or taking a dowry is a criminal offense?
- What services do you seek when you visit our health center?
- How many health center visits were made during pregnancy? Any complications?
- Which methods are you aware of to avoid having a child "unexpectedly"?

For example, survey results showed that audiences had a clear preference for TV over other mass media, which led the program planners to prioritize TV programming over radio and print in their media mix. Results also showed that people considered friends, relatives, and health workers the strongest motivators to visit health centers, so the communication planners decided to combine door-to-door, community-based approaches with mass media. This underscored plans of the Bangladesh Center for Communication Programs to empower local leaders as community influencers, and to train health service providers in interpersonal communication.

Research also revealed local and cultural sensitivities affecting messaging. House-to-house fieldwork suggested that the urban poor attached a stigma to "free" services, leading them to question whether a free clinic would deliver high-quality services.

Bangladesh Center for Communication Programs ensured that the messages highlighted the quality of service, while making services attractive to residents above the poverty level. The research insight led the center to develop and market a "rainbow logo" not just to lead poor clients to the health centers, but also to associate the "rainbow" with quality services despite their being free.

The overall approach of the strategy emphasized the delivery of the key messages through four areas of work: health advocacy, interpersonal communication, media, and branding approaches.

Conduct health advocacy campaigns

The communication strategy included health advocacy, engaging different stakeholders like local media, elected officials, and religious leaders through multiple channels. Advocacy campaigns such as "special days" organized big rallies gathering community members, service providers, and leaders. Safe Motherhood Day, for example, highlights the safe delivery of babies. An "advocacy tool kit" for staff included ready-to-go communication activities and materials.

Use interpersonal communication

Interpersonal communication from field-workers and health center staff contained carefully prepared messages to raise awareness and persuade clients and residents to use clinic services. Each NGO formed communication action plans. They worked door to door in promoting health services, while organizing group discussions and courtyard meetings with groups of 5-10 women using flipcharts, folk songs, and short films.

Counselors served as primary channels for health education. They conveyed sensitive messages on topics such as contraception, nutrition, and violence against women, privately at the health centers. Aside from having strong technical skills and experience, they needed to communicate empathy and have good listening skills to earn clients' trust. Coming from the same communities, they share the same culture and language with clients. Depending on their communication style, a counselor could either attract people to a clinic or repel them. When women leave the health centers, they tell friends and neighbors about the staff and the quality care they received. Behavior change communication approaches reinforced these positive word-of-mouth referrals.

Use different media

Many forms of media were used, including posters and leaflets. These printed materials often promoted the project's "red card" system, which entitles the poorest members of the community to receive free access to health care services.

Rickshaw "miking" used mobile sound systems to play pre-recorded announcements about HIV and health care services for women and children over large megaphones.

Another example of media usage was the television drama serial, Gari Chole Na (The Vehicle Does Not Move), a soap opera about the lives of poor people. Thirteen weekly primetime episodes raised awareness about health problems, the rainbow health centers, and the "red card" system. Each episode addressed a different health message woven into an entertaining storyline written, produced, and acted by well-known actors. Viewers learned about the urban health centers and the treatments available. However, even though the project conducted campaigns during the 13 weeks with TV ads, posters, and leaflets, funds for publicity were insufficient, and so the impact was limited to 7% of the viewers in that timeslot.

Send a consistent message with branding

Since other private sector providers, not focused on the poor, spent massive amounts advertising their well-equipped facilities, a distinct and easily recognizable brand was needed for the health centers. The "rainbow" logo identified every clinic in all partnership areas and distinguished them from other providers. The rainbow logo was developed in phase II through a systematic process of stakeholder consultation.

The brand has earned a good reputation for high-quality health care, shown by the steady increase of visitors. When clients move to a different area served by another urban health center, they recognize the rainbow logo. Constant promotion is needed, however, as new people constantly move into different project areas.

Results

With behavior change communication incorporated in the project's design, the project achieved its target of reaching 30% of very poor people for free services. Communication also helped the project surpass its target of having paying clients utilize health care services from 12% to 17% for health centers to become financially sustainable.

Moreover, phase II of the project showed that behavior change communication works effectively on a large scale. The completion report for phase II concluded that the communication strategy substantially contributed to the project's outcomes. Among the urban poor, health care knowledge, recognition of symptoms and treatments, and awareness of services at the health centers increased. Both project staff and evaluators concur that, due to lack of funding, some communication activities were not implemented to their full potential.

Similarly, the end line survey conducted by Bangladesh Center for Communication Programs for phase II concluded that a majority of community leaders are well aware of the services, and have been taking increased initiative to create awareness about health care services and related issues such as violence against women among their communities.

The end line survey also measured a decrease in child mortality by 25.9%, associated with increases in safe deliveries (maternal mortality ratio was reduced by 41.3% from a target of 15%), improved nutrition (child malnutrition declined by 10.1%), and effective treatment of sexually transmitted infection (prevalence reduced by 87.9% from baseline to the end of the term.

Key statistics

Over 26.5 million people provided health care services
233 health centers reached
About 7 million people reached through the awareness program
63% increase in recognition of the rainbow brand among respondents
15% increase in the number of women experiencing abuse who received services
Nearly 16% increase in the number of adolescents who visited the health centers for tetanus shots
6% increase in the number of people who sought clinic services
13% increase in services for vaccination, 9% for antenatal care, and 2% for deliveries

Lessons

Work with people on the ground in designing and implementing the communication strategy

Local NGOs that were contracted as health service providers also served as dissemination channels for communication activities.

BCCP conducted communication planning workshops for field workers and other key stakeholders. Since the NGOs were familiar with the political and cultural contexts of their audiences, they customized the approaches and materials—and this provided a strong incentive to implement effective behavior change communication in their project area.

As a result, while the core content remained the same, the exact crafting of the message and materials differed from one project area to another.

This decentralized approach strengthened ownership of communication materials and increased their use by health care workers, field-workers, and other stakeholders.

Community-centered events and workshops created a common vision helping communities develop action plans to implement the behavior change communication strategy. Over 5,000 influential people have joined orientations and sessions, which strengthened local ownership of the project.

Integrate communication research into the process

The engineering and construction contractors had already begun their work before the recruitment of the Bangladesh Center for Communication Programs and partnership-agreement NGOs, which took longer because of the protracted competitive bidding process. The results of the communication research would have given construction teams insights on the architecture and layout of the health centers.

For example, having private counseling rooms could have encouraged poor clients to talk about sensitive issues on gender violence, HIV/AIDS, and sexually transmitted infections. Entrances to these private rooms could have been constructed to encourage discretion, and located away from the eyes of waiting clients. Waiting areas could have been equipped with effective communication paraphernalia (i.e., TV sets, audio systems, handouts, and posters) to maximize the use of the clients' waiting time by educating them on various healthy behavior.

Building research into the process avoided costly mistakes by helping messages resonate with their target audiences. The survey also served as a baseline to measure the effectiveness of communication activities in raising awareness, changing health behaviors, and increasing the use of health centers.

Political support from other key stakeholders is important

At the lowest political level, the ward, the priority of mostly male local leaders was infrastructure development over health. They do not consider the health status of their constituents as their responsibility, let alone their priority. As the health centers focused on women and children, only 20% of

clients were men. The male leaders' views affected budgets, support for health centers, and coordination of clinic services in the community. Yet, even after advocacy activities, many did not give full active support—showing the need to further tailor messages to promote the benefits of the health centers in their areas.

This case study is based on interviews with the following resource persons:

- *Brian Chin, Project Officer at ADB; Hayman Win, Former Project Officer at ADB;*
- *Gobinda Bar, External Relations Officer of ADB's Bangladesh Resident Mission;*
- *Abu Bakr Siddique, Project Director at ADB;*
- *Yasmin Khan, Program Director, Bangladesh Center for Communication Programs (BCCP); and*
- *Mohammed Shahjahan, Director and CEO, BCCP.*

Resources

ADB. 2014. *Completion Report: Second Urban Primary Health Care Project in Bangladesh*. Manila.

Bangladesh Center for Communication Programs. 2007. Second Urban Primary Health Care Project: Behavior Change Communication & Marketing Strategy. Dhaka City.

Rx: The Value of Communication in Health Projects

Related Links

Case Study: *Improving Women's Health Through Public-Private Partnerships*

Video: *Providing Primary Health Care Services in Urban Bangladesh*

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