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EVALUATION

MIDTERM PERFORMANCE EVALUATION OF THE BANGLADESH MARKETING INNOVATIONS FOR HEALTH PROJECT

April 2016

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Cover photo: Meeting of married women of reproductive age in Moulvibazar. Source: USAID/Bangladesh.

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The Global Health Program Cycle Improvement Project
1301 Pennsylvania Avenue NW, Suite 850
Washington, DC 20004

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ACRONYMS

BCC	Behavior change communication
BDHS	Bangladesh Demographic and Health Survey
BSP	Blue Star provider
CBA	Community birth attendant
CPR	Contraceptive prevalence rate
CSA	Community Sales Agent
CWFD	Concerned Women for Family Development
CYP	Couple-years of protection
DGFP	Directorate General of Family Planning
DGHS	Directorate General of Health Services
DOTS	Directly observed treatment, short-course
FWA	Family welfare assistant
FWV	Family welfare visitor
FY	Fiscal year
GH Pro	Global Health Program Cycle Improvement Project
HIP	High Impact Practice
IEC	Information, education and communication
IMCI	Integrated Management of Childhood Illness
IT	Information technology
IUD	Intrauterine device
LAPM	Long-acting and permanent methods
LARC	Long-acting reversible contraceptive
LQAS	Lot Quality Assurance Sampling
M&E	Monitoring and evaluation
MCH	Maternal and child health
MIH	Marketing Innovations for Health
MIS	Management information system
MOHFW	Ministry of Health and Family Welfare

MWRA	Married women of reproductive age
NCD	Non-communicable disease
NGO	Non-governmental organization
NHSDP	NGO Health Service Delivery Project
OGSB	Obstetric and Gynecological Society of Bangladesh
ORS	Oral Rehydration Saline
PCHP	Private community health provider
PDA	Personal digital assistant
PSI	Population Services International
PSTC	Population Services and Training Center
SBCC	Social and behavior change communication
SHOPS	Strengthening Health Outcomes through the Private Sector
SK	Shasthya Korma
SMC	Social Marketing Company
SS	Shatha Shebika
TB	Tuberculosis
TBA	Traditional birth attendant
TV	Television
USAID	United States Agency for International Development
WASH	Water, sanitation and hygiene

EXECUTIVE SUMMARY

BACKGROUND

The goal of the Marketing Innovations for Health (MIH) Project, supported by the U.S. Agency for International Development (USAID), is to “Contribute to sustained improvements of the health status of women and children in Bangladesh by increasing access to and demand for essential health products and services through the private sector.” The Social Marketing Company (SMC) leads this initiative in partnership with EngenderHealth, BRAC, Concerned Women for Family Development, the Population Services and Training Center, and Shimantik, with technical assistance provided by Population Services International (PSI). The project began in July 2012 and will end in July 2016. Project funding includes \$15.0 million in federal cash funds, provision of contraceptive commodities expected to generate \$2.2 million for program use, and \$112.3 million in cost share. This project builds on the long relationship between USAID, SMC and PSI to develop social marketing in Bangladesh, heralded as “one of USAID’s greatest success stories of sustainability and sustainable development,” and previous USAID-funded work to improve private sector health care, particularly among non-formal practitioners providing primary health care services.

EVALUATION PURPOSE, QUESTIONS, AND METHODOLOGY

From September 28 to November 2, 2015, USAID commissioned a team of evaluators contracted by the Global Health Program Cycle Improvement Project to conduct a midterm review guided by three study questions:

1. How effective is the MIH Project in meeting the goal, objectives of each component, and targets?
2. Should USAID move into new program areas, and if so, what are these areas?
3. How could USAID invest in the delivery of critical public health services and measures in the future?

USAID/Bangladesh has supported a social marketing program in Bangladesh for more than 40 years, contributing significantly to the health and well-being of Bangladeshi citizens, particularly those in the lower wealth quintiles. To be enlightened on the future direction of its social marketing program, it has requested a three-dimensional assessment of social marketing activities in Bangladesh.

The first component will evaluate SMC’s achievements under the current cooperative agreement and to note any constraints of the organization relating to implementation and performance. Special emphasis will be given to how the MIH Project has: (1) contributed to contraceptive prevalence and the use of long-acting reversible contraceptives (LARC), oral rehydration solution and other maternal and child health (MCH) products; (2) made available and marketed new products in family planning, MCH, tuberculosis (TB) control and health and hygiene programs; and (3) expanded the availability of family planning and LARC services in the private sector health network.

The second component will focus on new program areas where social marketing can be expanded to contribute more to addressing public health needs, including those related to maternal, child and reproductive health, communicable and non-communicable disease prevention, nutrition, and water, sanitation and hygiene (WASH). In particular, this component will explore the offering of public health services of by private health practitioners and the leveraging of private resources under a social marketing program.

The third component will focus on best possible future directions for social marketing in the context of Bangladesh. The evaluation will look into possible options for USAID/Bangladesh to continue its social

marketing program to sustain and increase its current achievements in adoption of health products and messages. It will also identify alternative or additional approaches and strategies that USAID may consider in order to achieve its social marketing goals in the context of Bangladesh's continued economic development toward becoming a middle-income country by 2021.

The evaluation methodology consisted of: (1) reviewing data and information gleaned from a variety of background documentation, project reports and databases, the project's Monitoring and Evaluation Plan and other surveys; (2) extensive interviews (individual and group) and focus group discussions with target-group and stakeholder representatives; and (3) field visits in two of MIH's 19 high-priority areas to observe project sites and activities to gain an in-depth understanding of achievements and challenges. Analysis included triangulating information gathered from several sources and using different methods to search for common themes, and—based on the team's technical expertise and program and management experience—noting strengths, challenges, weaknesses and opportunities for growth or improvement.

FINDINGS AND CONCLUSION

MIH is projected to surpass or has already surpassed targets to (1) expand and develop private provider networks as sales outlets, (2) reach targeted populations with key health messages, and (3) sell SMC's essential health, nutrition and hygiene products.¹ SMC provision and marketing through the MIH Project of short-, medium- and long-acting reversible methods, including those donated by the U.S.

Government, continue to be a significant contributor to strengthening the national contraceptive prevalence; the 2014 Bangladesh Demographic and Health Survey (BDHS) reported that 62 percent of married women age 15-49 are using contraceptives. The innovative practice of coupling community-based product marketing and sales by local community sales agents with a "lite" dose of health education targeting married women of reproductive age, their husbands, and caregivers of children under 5, as well as at schools with older male and female students and workplace sites with male and female employees, is providing greater equity in health messages for rural populations. Promising practices are becoming evident, e.g., the effectiveness evidenced by sales as linkages were made with community sales agents during school health sessions. The development of new local entrepreneurs/community-based sales agents is bringing products to the consumer's doorstep and is credited with the increase in sales. While availability of LARC methods has increased as a result of the project, demand and administration remain poor, and more work is needed to address public fears and misconceptions.

In exploring the second question, the assessment found frequently mentioned concerns about the 12 percent unmet need for family planning, the burden of unwanted/unplanned pregnancies, an increase in menstrual regulation procedures that may be due in part to method failure, and the persistence of early marriage practices and home birthing. Additionally, concerns remain about morbidity and mortality related to communicable diseases; given the high prevalence of TB, it was noted that support is needed to intensify screening and to find low-cost, sustainable directly observed treatment, short-course (DOTS) options to prevent multidrug-resistant strains. The team noted with appreciation that USAID is already providing support to address these issue issues through various programs. To strengthen these investments, there is a need for concerted and coordinated campaigns using evidence-based marketing, behavior change and community mobilization approaches, with priority given to creating demand for and increasing adoption of LARC. There is also a growing call to give more attention to non-communicable diseases, including risk reduction, early identification through screening, and referrals for treatment and monitoring; it is recommended that USAID move into this new project area by supporting social and

¹ These include the USAID-subsidized products: Monimix, a micronutrient sprinkles product to help address poor nutrition of infants and toddlers; Safe Delivery Kit; ORS; zinc; SMC-branded locally procured oral contraceptives and condoms; and the Joya sanitary napkins are significantly increasing.

behavior change communication (SBCC) and social marketing of screening services using mass media linked with community-based marketing.

RECOMMENDATIONS

The findings of the project evaluation, assessment of critical public health issues, and exploration of the need for social marketing approaches conclude that the MIH Project objectives and aims, particularly related to improving access to and availability of private family health services, remain valid and should continue to be supported. The evaluation team was requested to provide priority recommendations in three categories. These are discussed in greater depth in the evaluation but are summarized below:

A. Immediate priority recommendations for the current MIH project

The following are recommended actions to start in the last fiscal year of this project to further assess areas needing to be strengthened and to document successes and lessons learned to guide the follow-on project:

- 1) Foster internal learning.
- 2) Identify and scale up use of role models/happy users.
- 3) Review in depth the current referral, reminder and quality assurance systems.
- 4) Expedite exploration of alternative restocking and support mechanisms for community sales agents.

B. Priority recommendations for follow-on MIH programming and new investments

Broadly, it is recommended that the follow-on project take a client-centered approach to developing marketing strategies and channels, community mobilization and BCC activities, and client information, distribution, referral and reminder systems. The following are presented as priority recommendations:

- 1) Play an active role in the design of comprehensive behavior change, marketing and community mobilization strategies for each specific health, nutrition or WASH issue.
- 2) Support the use of coordinated mass media and community-based campaigns.
- 3) Explore new marketing and BCC techniques, assessing their effectiveness.
- 4) Develop logistics, recording, reporting, referral and follow-up systems using e-technologies.
- 5) Expand and develop private provider networks for improved access to essential preventive health and family planning products, with quality assurance processes in place.
- 6) Within these are recommendations for new health programming investments, several of which are Family Planning High Impact Practices recognized by USAID:
 - Invest in district-level planning and the formation of public/non-governmental/private partnerships to address prioritized critical public health issues.
 - Invest in mobile clinics by water or land to increase access and equity to comprehensive family planning methods.
 - Invest in adolescent/youth wellness initiatives for the general population, with special focus on young or newly married couples.
 - Invest in the Total Worker Health model for disease and injury prevention and risk reduction.
 - Invest in model pharmacies for early identification of communicable and non-communicable diseases and referral for their management, as well as promotion of preventive health measures and wellness packages.

I. EVALUATION PURPOSE AND QUESTIONS

USAID/Bangladesh commissioned the Global Health Program Cycle Improvement Project (GH Pro) to conduct a midterm evaluation of the current social marketing project, Marketing Innovations for Health (MIH), to identify gaps in inputs and processes and to fine-tune implementation for the rest of the project period. At the request of USAID/Bangladesh, the evaluation was designed to look into the potential for growth of social marketing of health and family planning programs to address critical public health issues through the fast-growing private sector, as well as opportunities for developing sustainable approaches in promoting healthy behaviors and use of health products and messages. Three study questions were formulated in consultation with USAID.

Question One: *How effective is the MIH Project in meeting the goal, objectives of each component, and targets?* Within this question, USAID requested the team to look at the following elements:

- The distribution network established by the Social Marketing Company (SMC)
- The MIH community mobilization program, messaging to target audiences
- Marketing and behavior change communication (BCC) techniques to create demand and expand markets
- Training of Blue Star providers and private community health care providers to improve capacity and referrals
- SMC's and its partners' collaborations with private commercial and non-governmental organization (NGO) sectors, and male engagement

Question Two: *Should USAID move into new program areas, and if so, what are these areas?* Within this question, the evaluation team looked at critical public health issues where social marketing could play a significant role and where government can be supported:

- The need for social marketing of new health products and services to address critical public health needs, and what can be addressed by social marketing²
- The need for stronger linkages and/or integration of social marketing with the public and NGO sectors or projects working to create demand and utilization of health measures, services and products
- Alignment of social marketing and BCC approaches and products with the Government of Bangladesh's national priorities as the country develops

Question Three: *Should USAID continue to invest in social marketing programs?* How could USAID invest in the delivery of critical public health services and measures in the future? How could MIH achievements in expanding and improving family planning services in the private sector be further expanded or scaled up to assist the Government of Bangladesh's essential public health function to ensure equity of quality public health services and measures? How could new initiatives or strategies be supported to involve the private sector in responding to community needs and demands for services and critical health measures (as noted under question two)?

² Potential new products to be created, those already developed by others, help with scaling up, new innovations, or replications from elsewhere

II. PROJECT BACKGROUND

The MIH Project was developed to assist the Government of Bangladesh to further fertility reduction and to address several critical public health issues related to high maternal, neonatal and child morbidity and mortality, tuberculosis (TB) and malnutrition. A primary focus was to address unmet need for contraception and limited use of long-acting and permanent methods (LAPM). This project builds on the long relationship between USAID, SMC and Population Services International (PSI) to develop social marketing in Bangladesh, heralded as “one of USAID’s greatest success stories of sustainability and sustainable development,” and previous USAID-funded work to improve private sector health care, particularly among non-formal practitioners providing primary health care services. The following provides a brief summary of USAID’s cooperative agreement with SMC to implement MIH:

- **Duration:** July 26, 2012 to July 25, 2016
- **Issues:** Family planning, reproductive health, maternal and child health (MCH) and nutrition, TB and the development of new business and sustainable strategies (social marketing)
- **Budget:** \$15.0 million federal cash funds, \$112.30 million cost share, provision of contraceptive commodities expected to generate \$2.2 for program funding
- **Technical assistance:** PSI
- **Subcontracting:** BRAC, Concerned Women for Family Development (CWFD), Population Services and Training Center (PSTC), Shimantik and EngenderHealth, as well as contracts with training institutes, research agencies and advertising agencies

The project design includes three components: (1) commodity sales and distribution through private networks nationwide; (2) community mobilization and BCC in 19 priority districts through subcontracts with the national NGOs listed above, and (3) capacity-building for the private sector networks, in partnership with EngenderHealth. While activities under components one and three are country-wide, component two is implemented in 19 priority³ districts in Barisal, Chittagong, Dhaka and Sylhet Divisions.

The program aims to reach 6.3 million married women of reproductive age (MWRA), 3.8 million caregivers of children under 5, 1.6 million husbands of MWRA, and 0.7 million adolescents with health promotion and information about products.

³ Prioritized on the basis of low contraceptive prevalence rate (CPR) and comparatively high child mortality.

III. EVALUATION METHODS AND LIMITATIONS

From September 28 to November 2, 2015, a team of five external evaluators (four in-country and one virtual) with backgrounds in social marketing, social and behavior change communications (SBCC), community mobilization, public health, program evaluation and research conducted the field work.

The team used a case study approach with mixed methods, including:

1. Desk review of project and other relevant documents
2. Briefing from USAID and PowerPoint presentations by SMC on the company, the project components and implementation status
3. Key informant interviews with a wide range of governmental and non-governmental stakeholders, SMC management and staff, each of the four implementing partners and EngenderHealth staff
4. A short phone interview with PSI

Field visits to Chittagong Division (Comilla District) and Sylhet Division (Sylhet, Moulvibazar and Sunamganj districts) to interview staff, observe selected activities, and conduct focus group discussions with community sales agents (CSAs) and *Shatha Shebikas* (SSs) (community volunteers), community birth attendants (CBAs), and targeted groups that included MWRA (both users and non-users of modern family planning methods, including caregivers of children under 5), husbands of MWRA, and older women. For the analysis, information gathered from several sources through different methods was triangulated, searching for common themes. Drawing upon its technical expertise and program and management experience, the team noted strengths, challenges, weaknesses and opportunities for growth or improvement. Additional interpretation of findings was made in consultation with SMC and USAID.

Limitations of the evaluation included:

1. The timeframe allowed for field visits to only two of the four priority project areas (where community activities were implemented by two of the four partners).
2. The security situation in the country limited opportunities for the international team leader to observe and interview, primarily around and in communities, and restricted travel for some days in Dhaka.
3. The timing of the field visits coincided with school examinations and thus hindered the time that could be spent observing or interviewing teachers and students.
4. The organization of participants for the focus group discussions did not always meet the specifications of the evaluation plan and team.
5. The team was unable to schedule appointments as requested with all of the identified key stakeholder groups.

Further discussion of the study methodology, limitations and field visit schedule are available in Annex B.

IV. KEY FINDINGS

A. HOW EFFECTIVE IS THE MIH PROJECT?

Under this evaluation question, the evaluation team was requested to assess elements of (1) the distribution network, (2) marketing and promoting preventive health and family planning products, (3) community mobilization and BCC; and (4) building the capacity of network providers.

I. Distribution networks

MIH's objective for component one is to: "Expand commodity sales and distribution through private sector networks, including non-governmental organizations (NGOs), at an affordable price to support family planning and other healthy practices especially focused on low income populations." In looking at distribution networks, the team explored the elements and features below, noting that the project targets for expanding distribution networks are being met.

SMC is marketing and distributing a line of important preventive health and family planning products, which include USAID injectables branded as SOMA-JECT, Sayana Press—a preloaded contraceptive injectable now being test-marketed in the private sector, intrauterine devices (IUDs), implants, and various brands of condoms, including the inexpensive Raja condom supplied by the government.

MIH expanded marketing of other health, nutrition and hygiene products. These include the USAID-subsidized products Monimix (locally produced micronutrient sprinkles to help address poor nutrition of infants and toddlers) and safe delivery kits (with supplies for home births). Marketing, distribution and sales continue of ORSaline (ORS), a flagship product manufactured by SMC, zinc, SMC-branded and locally procured oral contraceptives and condoms, and Joya sanitary napkins. Plans for adding new products such as an electrolyte drink are in process, and governmental approval is pending for bundled ORS with zinc.

a) Providers and outlets

Within this project component, SMC continued its important work with the private sector, supplying products to private clinics and hospitals nationwide. The number of active Blue Star providers (BSPs), of whom a majority are practicing in municipalities,⁴ has been increased to a total of 6,324—surpassing the project target of 6,000. The project is on target to train 1,580 private community health providers (PCHP), the majority located in semi-urban areas in the priority districts, to provide the second dose of injectable contraceptive, in addition to SMC-branded oral contraceptives,⁵ the emergency contraceptive pill, condoms, micronutrient powder, safe delivery kits, zinc and ORS. They are also trained in better prescribing practices, with emphasis on treatment of common illnesses in children. BSPs and PCHPs are carrying all of the SMC products (except for Sayana Press,⁶ which during this pilot phase is only provided by selected BSP and doctors in the long-acting reversible contraceptive (LARC) network).

Since the Strengthening Health Outcomes through the Private Sector (SHOPS) Project ended, MIH has continued work with EngenderHealth to develop the LARC network. The project is on track to meet its target of 700 providers (650 had been trained/supplied by the end of fiscal year (FY) 2015), as well as to supply private hospitals with contraceptive methods. According to project staff, the initial plan to target general medical practitioners had to be modified because of lack of appropriate facilities or interest. Currently, 95 percent of LARC network providers are OB/GYN specialists. While these specialists are very interested in providing a wide method mix, they too face service delivery challenges. The LARC

⁴ These are primarily non-formal health practitioners with private practices.

⁵ Five brands: three are combined orals, one a progestin-only pill, and Norix, the emergency contraceptive pill.

⁶ While designed to be self-administered, this has not been approved by the Ministry of Health's Family Planning Department.

providers visited noted time constraints during their busy clinics; having adequate space for multitasking may also be an issue⁷ and a barrier to LARC delivery. While public sector paramedics can legally insert IUDs, in the private sector only doctors can perform this service; this is a significant limiting factor affecting the availability of a wide range of methods in the private sector outside of urbanized settings.

MIH also supported three national NGOs⁸ as implementing partners to develop more than 800 new CSAs as local entrepreneurs to promote and sell all SMC products except injectables, IUDs and implants in rural and semi-rural communities. MIH also partnered with BRAC to use its community teams and volunteers (SSs), who were already selling BRAC health products, rather than creating a new cadre of CSAs. The BRAC SSs are selling 26 products, including BRAC micronutrient sprinkles, zinc, sanitary napkins and safe delivery kits, as well as the SMC products (except for injectable and LARC methods). Though their kits are now heavier, they are positive about the addition of new products and brands as “people now have more choice.”

The past and present work by SMC to develop the BSP network is applauded by key informants interviewed and the evaluation team; those informants who are aware of the CSAs also praise this contribution to increasing availability, providing increased choice of provider and brand, and complementing the government services where family planning services are provided free, but where community outreach/distribution systems are poorly functioning. The evaluation team shared the interviewee’s appreciation of how door-to-door sales help to address limited mobility of women and sensitivities about buying sanitary napkins in the public markets.

During interviews with two large international NGOs, the evaluation team noted a high demand for their community health workers to be included as sales agents, seeing this as a way to sustain their community health promotion work.

There is a recognized need to scale up the networks of appropriate private providers of injectable contraceptives and LARC, and at the subdistrict level and in rural areas. The SMC program management team noted that if resources were available, they would set targets “to have at least one trained and equipped BSP in each Union.”⁹

While supporting the government’s family planning goals for contraceptive prevalence rate (CPR) coverage, the private family planning providers supported by MIH are challenged, because public services are provided free of charge.¹⁰ If an efficient and effective community-based system is established, this will compete with sales by private providers, including CSAs.

b) Supply chain

BSP, PCHP, CSA, LARC providers and implementing partners had few complaints about the functionality of the SMC supply chain. One BSP provider said, “We call [on our cell phones] and they [SMC] come.” The implementing partners serve as intermediaries (temporary storage and restocking) between CSAs and SMC.

To improve the quality of its warehousing and the efficiency of the supply chain, SMC mentioned plans to construct its own regional warehouses. SIAPS is providing technical assistance to SMC to improve its logistics and inventory systems, in addition to its major aim of strengthening government systems.

⁷ The private practice visited had only one suite serving as office and exam room.

⁸ Implementing partners include BRAC, CWFD, PSTC and Shimantik.

⁹ Unions are the smallest rural administrative and local government units in Bangladesh.

¹⁰ According to family planning experts interviewed, the government is working on a new policy for distribution of the emergency contraception pill for a small service charge.

While few stock-outs were reported by SMC and partners, during visits with BSP/PCHP, the team observed depleted product stocks (this varied by stock; the team observed lack of ORS, zinc and Norix, the SMC-branded emergency contraceptive pill). Private restocking is done regularly by the SMC sales agents, who also do interim restocking when providers call (which may be after stocks are already depleted). When probed, BSP and implementing partners noted that ORS stocks were low at times, and there were also shortages in Femicon. NGOs did not have complaints about the supply chain, except for noting insufficient ORS stocks during the dry season.¹¹

To keep the CSAs stocked, the implementing partners, as part of their USAID-funded subgrants, act as intermediary distributors. SMC management noted that they are exploring options for sustainable mechanisms for directly restocking the CSAs.

Several CSAs who were interviewed complained about having to get supplies from the partners' district offices, having to carry a heavy bag of new supplies, and transport costs, stating that they would like to be resupplied closer or preferably at their homes.

Initially, USAID supplied an oral contraceptive for lower-income clients. Because of spoilage while being stored in a rented warehouse, these stocks had to be destroyed. This unfortunate event heightened awareness of the need for better control of warehousing and inventories. SMC now has plans to construct its own regional warehouses.

c) Affordability of products

SMC brands are priced to be lower than or competitive with other brands, except for the safe delivery kit, which is priced higher than BRAC's kit. It should be noted that there are differences in quality, as the SMC kit includes a cord clamp. Though not heard during our field visits, the 2014 study of CSAs noted that BRAC SSs reported that the BRAC Nirapod sanitary napkins were selling better than SMC-branded Joya (which the SSs also carry) because of their lower price. The loss of market share due to competition from local suppliers of oral contraceptives, condoms, micronutrient sprinkles and now injectable contraceptives may adversely affect SMC's capacity to cost-shift to keep products affordable.

Implementing partners voiced concerns about the recent rise in prices of some SMC products; it is feared that there will be a negative effect on sales, though this has yet to be recognized. CSAs report that clients are complaining that the prices are higher than what is written on the packaging. SMC is aware of the concerns, noting that the price increase was to cover increasing costs associated with the supply chain.

Several of the BSPs visited mentioned the desire for lower, "wholesale" prices and/or the permission to set their own prices while keeping products "affordable."

During a visit to a Smiling Sun clinic, the team heard about efforts to improve cost recovery while retaining the commitment to provide free or discounted services, including family planning for the poor and the reliance primarily on government family planning methods. It was noted that the sliding fee scale for services and products was not well articulated or displayed.

¹¹ Field staff and CSA/SSs noted that ORS is used as an electrolyte drink by agricultural laborers. SMC has recently introduced an electrolyte drink, Taste Me, into the market for sale at kiosk/stores.

d) Provider satisfaction

The BSPs that were visited voiced their appreciation of the training provided prior to and during this project. During visits to BSP/PCHP, the team heard of several training programs¹² that the BSP and PCHP have received from a variety of sources. If the PCHPs visited are representative, they deserve to be vetted as BSPs. BSPs reported that being branded as a BSP has contributed to their business and status.

The CSAs/SSs met in the two divisions are enthusiastic entrepreneurs¹³—selling three oral contraceptives, three condom brands, ORS, zinc, Monimix, Joya napkins and Norix.

Dressed in blue coats¹⁴ (resembling lab coats with MIH and USAID brands), several spoke to the team about their new status in the community: “People see us like doctors.” The sense of empowerment related to their role in the community and income-generation was also noted during the 2014 CSA study: “Most of the respondents feel as they are women, clients feel comfortable talking and discussing about their personal need and can buy products from them easily.” Study respondents also expressed the value of earning “on their own” and “supporting their families.” During focus group discussions, CSAs echoed the 2014 study findings, articulating the value in being recognized in the community and by an organization such as SMC. Partners’ community mobilizers noted appreciation of the CSAs: “Agent gets benefit, clients get benefits.”

Demand for becoming part of the BSP network was noted: PCHPs voiced their desire to become BSP, and one BSP reported that he assumed the cost himself of going to another district to receive the training. (According to SMC, because of budget limitations, initial BSP training is held in a district every two years.)

Visits with CSAs found a strong demand to provide additional products and services, such as pregnancy tests, and some places may already be adding them (three CSAs disclosed that they are giving injectable contraceptives purchased from BSP, noting that they were trained to perform this when working for another project).

e) Satisfaction of clients/users

According to community members and implementing partner staff, the door-to-door delivery/sales are appreciated, particularly by women who have limited mobility or are embarrassed to go to the shop to buy Joya napkins; in addition, “Clients can hide purchases of contraceptives from her husband,” one CSA said. MIH field staff also noted that clients appreciate the convenience and cost-savings, i.e., the reduction in time and expense for travel and waiting at pharmacies or government health facilities.

Two short discussions were held with groups of CBAs who were meeting with MIH program officers. There was high awareness that supplies in the safe delivery kits are important. Misoprostol is distributed with instructions during the eighth month of the pregnancy and, according to CBAs, is being used. There is preference for the SMC kit over the BRAC kit, because SMC’s includes the cord clamp. However, most would prefer the gauze provided in the BRAC kit over the cotton provided by SMC. SMC

¹² One PCHP in Sylhet showed several certificates of training, including: Training on Rural Medical Practitioners, Mother and Child Health Service, Primary Health Care Diarrhoeal Disease Control, Acute Respiratory Tract Infection at Dhaka Shishu Hospital, and PCHP Training from SMC.

¹³ SMC and USAID recently won the award at a global Social Marketing Program for their presentation, “Engaging Women in Rural Communities to Become Entrepreneurs and Effective Behavioural Change Agents.”

¹⁴ Earlier they had been given saris, but thought that these were “too hot.” With the lab coats, the most common complaint was the “cheap” quality of the material.

mentioned that it is planning to include gloves in the package and is considering inclusion of misoprostol and chlorhexidine. CBAs would like to have a plastic sheet, soap and Savlon antiseptic added to the kit.

f) Functionality of the reminder and referral systems

Providers of injectable contraceptives and LARC are trained to gather telephone numbers of clients for reminder or follow-up calls; fields for recording are provided on the SMC ledgers.

The training program for BSPs and PCHPs includes instruction on when to refer family planning clients, pregnant or postpartum mothers with danger signs, and suspected TB cases. BSPs are expected to collect phone numbers¹⁵ and call clients when they do not return. During the few visits made to BSPs, the team observed that the TB referral forms were being used with notations, such as: “cough, with X-rays.” The family planning referral forms (duplicate) were also observed; no documentation of reasons for referrals was noted. SMC acknowledges that the system for recording and reporting both family planning and TB referrals needs to be strengthened.

Trend data from SMC¹⁶ note that referrals by BSPs for LAPM and TB screening have steadily increased over the life of the project. Another indication that a referral process is active was noted while reviewing the 2014 BSP study¹⁷: Of the women interviewed while exiting BSP practices, three quarters reported past referrals by the providers for several reasons: 30.3 percent for possible TB, 52.7 percent for pregnancy complications and 11 percent for family planning side effects.

CSAs/SSs noted that they refer and accompany community residents to government LAPM services and, in return, receive a cash payment to cover travel expenses. CSA referrals are not being tracked at this time.

During visits to the BSPs/PCHPs, no documentation was noted for follow-up of SOMA-JECT clients who did not show up for their scheduled appointments, nor was there mention of side effects or management in the ledgers reviewed. According to one BSP, clients like the Sayana Press method because it has “fewer side effects.” However, observing his ledger, the team noted that four of seven Sayana Press clients had not received their next scheduled injection (the BSP had a packed office, so the team could not ask about the reasons for these drop-outs or possible method changes¹⁸). Program officers mentioned that discontinuation/drop-out rates are high; one family welfare visitor estimated 10-20 percent for injectables and implants, with IUD discontinuation being higher “because of bleeding.” This was echoed as a widespread problem when talking with several government family planning staff. When asked about discontinuation of injectables, BSPs postulated potential dissatisfaction because of the procedure, side effects, change in service (perhaps to government where it is free), or forgetfulness, among other reasons. No phone numbers were noted with PCHP records; as one new PCHP mentioned, “I know them, they all live around here.”

2. Marketing and promoting preventive health and family planning products

This section relates both to the project’s component one, where the mass media and product advertising activities are placed, and component two, where product promotion at the community level

¹⁵ It was noted by the team that there may be cultural barriers to a woman providing her phone number; there are confidentiality concerns about demanding her to provide her husband’s phone number unless it is evident that he is informed and supports her use of an injectable contraceptive.

¹⁶ Verification of these data is challenged by lack of reporting formats and recording issues; e.g., during visits to BSPs the family planning ledgers (duplicate copies) did not have complete information to show where to and for what reason the person as named was referred.

¹⁷ CSMR, SMC. “Assessing Quality Assurance of Services Offered by Blue Star Providers.” 2014.

¹⁸ Careful monitoring of Sayana Press continuation is critical. One factor is the cost; at 150 taka, it is considerably higher-cost than SOMA-JECT, priced at 50 taka.

is implemented. Component two objectives are to: “Improve the knowledge and healthy behaviors, reduce harmful practices and increase care-seeking practices while reaching out to new audiences (youth) through creative Behavior Change Communication.” Findings and observations related to results are also presented, i.e., sales and awareness of MIH-supported product outlets/services.

a) Marketing strategies

SMC is well known as a leading social marketing organization. With assistance provided by PSI, it has successfully marketed family planning and health products, such as ORS, to consumers in Bangladesh for decades.

In reviewing SMC marketing strategies and plans, it was noted that much thought goes into sales, developing product introduction plans, and showing how brands are being promoted. It was less clear how marketing plans utilize the “4Ps”: product, price, place and promotion. Perhaps these are identified elsewhere or are assumed, since many of these brands are mature. A good marketing strategy/plan should contain a rationale for pricing, distributing and promoting products in specific ways. As SMC has noted, oral contraceptives and condoms need more distinct positioning strategies. In the marketing plans that were reviewed, little mention is made of the issue of competing products, or of how SMC will position new brands against competitors. A brand position must be unique in the consumer’s mind to distinguish it from competing brands and to build a relationship with that brand.

b) Advertising

Working with locally contracted advertising firms, SMC has developed TV spots, radio shows, dramatized infomercials, billboards, and ads in newspapers and popular magazines. Leaflets, posters, banners, handbooks and brochures have been developed for distribution in the Notun Din (health education, community mobilization and advocacy) program areas and the BSP, PCHP and LARC offices.

Several innovative channels are being used, for example, ads on “Auto” (battery-driven three-wheeler) branding, use of social media¹⁹ and web sites. SMC has launched a dedicated web site for its emergency contraceptive: www.norixbd.com. SMC has also continued online promotion of Xtreme condoms on four popular web sites and news portals during the mentioned period. Monimix brands have been displayed on overhead water tanks in rural communities.

Use of mass media is expensive. Channel TV is replacing local TV in popularity. Because of the country’s considerable cultural diversity, intended audiences may perceive or interpret symbols differently from what was designed; levels of literacy and languages spoken may differ.

During the review, it was noted that there are no apparent processes for linking mass media efforts with community marketing, except for the mobile film show, where CSAs and/or BSPs may be introduced along with the products they carry.

c) Community-based marketing and product promotion

The MIH Project has provided an opportunity for SMC to explore the use of community-based marketing with the assistance of implementing partners and CSAs/SSs, as well as to continue the SMC-led mobile film shows. MIH field staff and CSA/SSs have tools and job aids for showing the brands as they instruct targeted community groups and adolescents/youth in school on the different types of methods.

¹⁹ SMC continued its successful Facebook campaign on U&ME condoms. The followers of this page (www.facebook.com/uandmebd) have surpassed 100,000 during this time. The Facebook page, www.facebook.com/xtremecondoms, has crossed the milestone of 50,000 followers during this quarter.

BRAC notes that community marketing is preferred to mass media marketing, because “We demonstrate how to use the products,” highlighting that they do this with caregivers of small children (with funding from a nutrition project).

MIH also supports special day/week celebrations such as “Safe Motherhood Day” with t-shirts or caps (Notun Din with USAID and MIH brands and key messages), as well as partners’ activities. These are coupled with sales by CSAs/SSs.

Implementing partners have joined with local family planning officers to publicly acknowledge and award role models, i.e., those who have successfully practiced delay, spacing or limiting of pregnancies.

To promote safe delivery kits, the implementing partners meet with CBAs within the priority districts, while outside of these areas, SMC sales representatives carry out this activity. The purpose is to reinforce key messages regarding safe motherhood and to encourage CBAs to identify and appropriately address pregnancy- and delivery-related danger signs.

The project puts a strong emphasis on the delivery of health education, believing that increased knowledge plus easy access to products will result in adoption or purchase of those measures. However, it is not always clear how products are being promoted or how audience perceptions are being gauged. As an example, creating a linkage with the CBAs is noted as a potentially effective survey and marketing technique. More information is needed to understand buying or procurement practices (who is buying, where and what), as the CBAs met during the field visits say there is wide usage of SMC, BRAC or other kits. CBAs’ knowledge of what is being used, as well as those not using commercial products, can help to guide SMC product development and marketing strategies.

d) Sales

As noted in the table below, supplied by SMC’s monitoring and evaluation (M&E) department, the project is meeting its set targets for both sales of products (with the exception of LARC–IUDs and implants) and couple-years of protection (CYP).

Table I. Product Sales

Indicators	Target (FY 13-16)	Achievement (FY 13-15)	Percent of progress
CYP	16.9 million	12.6 million	74%
Oral contraceptive pill	161 million	115 million	72%
Condom	564 million	429 million	76%
Injectables	5.8 million	4.2 million	73%
Emergency contraceptive pill	2 million	1.6 million	82%
IUD	40,525	11,024	27%
Implant	21,158	4,294	20%
ORS	1,779 million	1,439 million	81%
Monimix	44.7 million	34.7 million	78%
Zinc tablet	2.7 million	1.9 million	69%
Safe delivery kit	0.6 million	0.5 million	76%
Sanitary napkin	6.2 million	3.7 million	59%

Source: SMC MIS with analysis by SMC M&E

With the expansion of private sector providers/sales outlets, evidence was provided showing significant increase in sales of SMC products. The following table from the SMC Management Information System (MIS) shows trends in sales in the 19 priority districts since 2013.

Table 2. Sales Trends

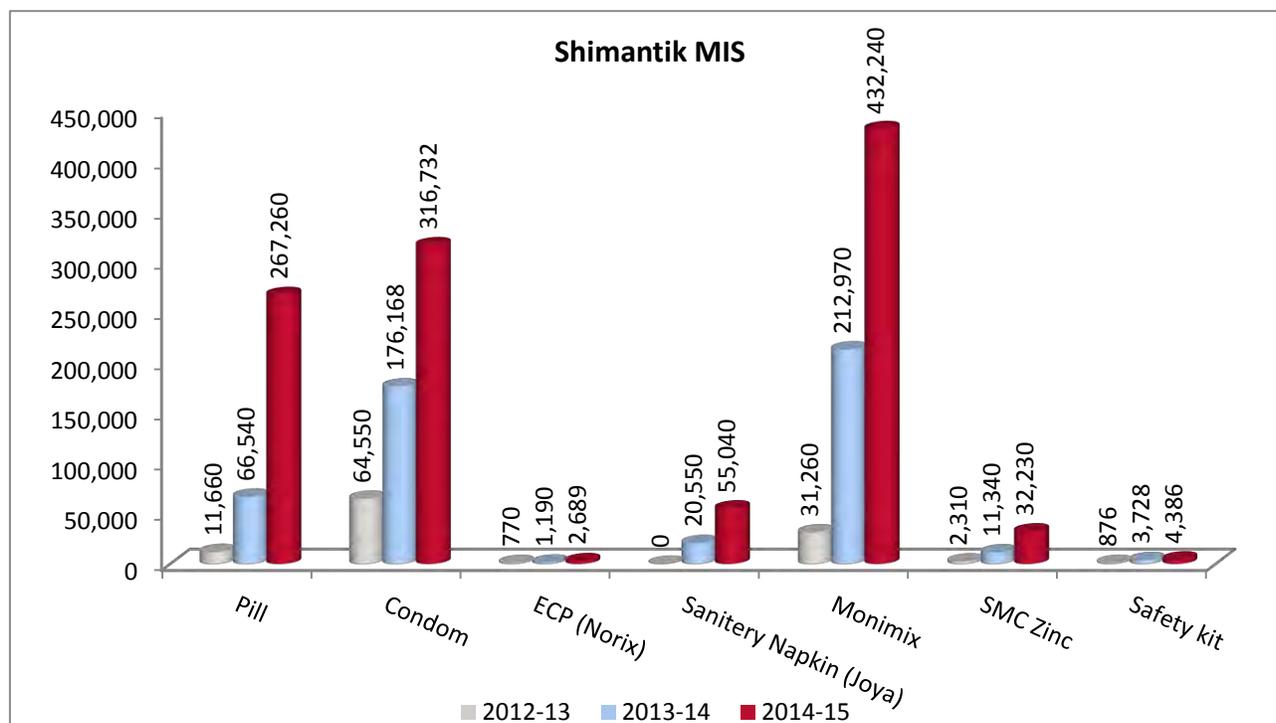
Year	Condom	ORS	Total Pill	Safe Delivery Kit	Total Sprinkles	Emergency Contraceptive Pill	Zinc	Napkin	Total Sales
	Quantity	Quantity	Quantity	Quantity	Quantity	Quantity	Quantity	Quantity	Value
2015	931,088	5,140,120	465,040	13,480	793,560	11,019	62,210	143,078	42,451,829
2014	470,842	2,189,720	183,010	10,642	524,580	5,940	37,240	72,714	18,393,730
2013	115,718	125,140	23,180	3,514	195,180	1,660	5,590	24	1,791,049
Total	1,517,648	7,454,980	671,230	27,636	1,513,320	18,619	105,040	215,816	62,636,608

Source: SMC MIS

The recognized increases are attributed in part to the expansion of providers, including the development of community-based sales agents. A review of project data in Sylhet, as illustrated below, noted significant increases in CSA sales of oral contraceptives, condoms and other products, except for Safety Kits (safe delivery kits).

Figure 1. Product Sales by CSAs in Sylhet Division

Source: Shimantik MIS



In discussions with SMV and CSAs/SSs, several factors relating to sales performance were cited, such as size of the consumer base (geography/population) and capacities of the agents (the latter has not been well studied). The factor of male mobility was noted twice in relation to high performers.²⁰

SMC and partners often highlighted that the linkage with the school health education activity has resulted in significant sales of Joya sanitary napkins. High performers in two of the districts visited credit their success to this linkage. One partner reported to have a CSA selling 80,000 taka a month; he has recruited sub-agents who are selling primarily Joya napkins at schools, and he has taken over other territories with inactive CSAs.

Both implementing partners and CSAs met mentioned the need for increased CSA access to credit to increase their sales and profits. CSAs reported that stocks are at times not sufficient, because they lack financial capacity to buy enough to meet community demand. BRAC has a credit provision (revolving fund) for SSs, but the other three partners do not have such a system. BRAC has recently increased its fund limits so that CSAs can procure equipment such as glucometers.

Injectable sales are steadily increasing and will likely surpass the set targets; SOMA-JECT and Sayana Press²¹ account for 92.9 percent of SMC’s monthly sales revenue. Sales to LARC networks are so low that, according to SMC data, personnel are not included in the regular stock reporting. Looking at trend data in the figures below from SMC’s MIS, LARC sales are increasing, but it is unlikely the project will meet those targets (IUDs: 233,000 and Implants: 116,000).

Figure 2. Sales and Insertion Status of IUD by Year

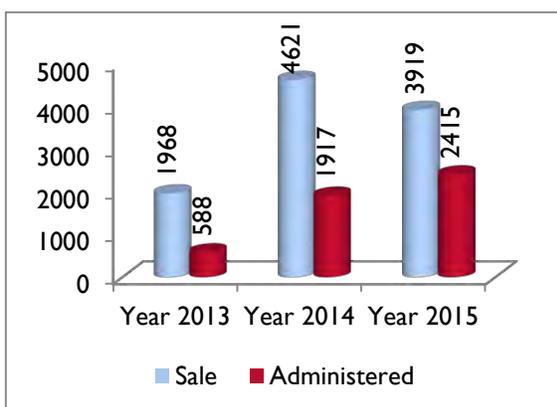
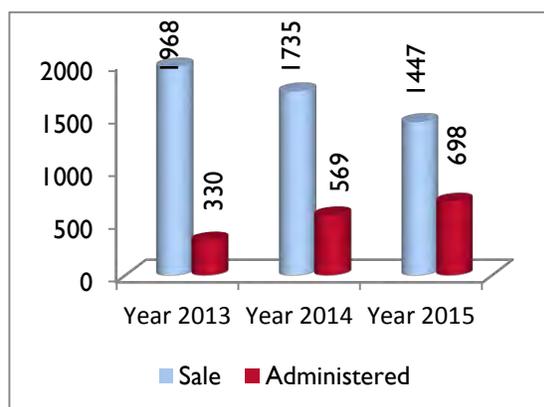


Figure 3. Status of Sale and Insertion of Implants



During focus group discussions, it was noted that more in-depth inquiry is needed relating to levels of awareness of emergency contraception, LARC services/providers, and negative perceptions and fears related to LARC. For example, only one of five non-users in a Sylhet NGO clinic meeting reported awareness of emergency contraception (she had seen ads for Norix on TV). In comparison with other methods, there was less awareness about where to obtain LARC services, and, when talking with field staff and volunteers, it was noted with concern that the negative perceptions expressed about LARC side effects far outweighed comments about the positive benefits.

Sales of safe delivery kits remain low. More inquiry is needed to understand buying or procurement practices (who is buying, where, and what), as the CBAs met during the field visits say there is wide

²⁰ Performance indicator is sales.

²¹ SMC 5-year strategy document

usage of kits. The project also covers safe motherhood topics; program officers meet with local CBAs to reinforce key messages and to promote safe delivery kits. During brief discussions with groups of CBAs in Comilla and Sylhet, the evaluation team was told that births are decreasing; they think this is primarily due to the increase in the use of birth control methods.

BRAC claims that sales of its brand of micronutrient sprinkles are steadily increasing and attributes this to linkages with its nutrition and essential health service projects and demonstrations of the product. As noted in Figure 1, Shimantik is also seeing an increase in sales of SMC's Monimix; more information is needed about other nutrition programs being implemented in Sylhet, in addition to the MIH efforts.

SMC's MIS captures data about sales of contraceptives to providers. Systems for collecting data related to administration or sales to customers are not well developed, except for the tracking of the new Sayana Press and LARC by SMC program officers. No information is being gathered about new users.

SMC is facing increased competition. In the commercial sector, oral contraceptives, condoms, emergency contraceptive pills and injectable contraceptives²² are now being manufactured locally and sold through commercial outlets. SMC remains the sole provider of IUDs and implants to the commercial sector, though there are reports of leakage from government stocks and unconfirmed reports that IUD production will start nationally. Because of the continued low uptake of LARC, SMC continues to depend on USAID funds for marketing, warehousing, distribution, and provider training and support. Though sales are increasing, Norix, Monimix and the safe delivery kits continue to require USAID subsidies to cover marketing and distribution costs. While the project is on target to reach safe delivery kit sales, there is an expectation that more growth is possible, given that in some areas 60 percent of pregnant women are delivering at home. Sales of zinc with ORS continue to be lower than desired. SMC has been working to bundle these products to promote better diarrhea treatment practices among product providers and consumers. Approval for bundling by the Drug Authority is still pending.

e) Awareness of outlets/networks

Among implementing partner field staff and community members visited, while there was high awareness that the government provides services, there is a lack of local mechanisms for staying updated on specific information, e.g., satellite or mobile clinics, other NGO²³ or private sector services. Given that government services like LAPM are not always static or regular, this is important information to gather and provide to communities. A very active OB/GYN specialist from the Directorate General of Family Planning (DGFP), who was aware of the CSAs/SSs selling oral contraceptives and condoms, applauded this intervention: "So much unmet need, women now have more choice and access."

MIH field staff in the BRAC and Shimantik project areas often had vague knowledge of BSPs and no awareness of a LARC network. CSAs who participated in group discussions in the two areas visited also expressed low awareness of the BSPs, though they were well versed about government-provided family planning services. The 2014 study of CSAs found that referrals to BSPs in the Shimantik-managed area were low (6.3 percent), but higher in the CWFD (49.4 percent) and PSTC (64.8 percent).²⁴ When asked, all field staff reported that they had not been given a list of BSP providers and that any knowledge of BSP was through personal connections. Similarly, BSPs and PCHPs visited were unaware of each other and were not familiar with the CSAs.

²² Prices are slightly below that of SOMA-JECT.

²³ There was high awareness of services provided by the implementing partner; all of the partners are Smiling Sun partners.

²⁴ Note that CWFD and PSTC project areas were not visited, so awareness of BSP may vary considerably.

In talking with users, non-users and husbands about family planning services in their area, government services were mentioned predominantly; there was infrequent mention of private facilities providing family planning services.

3. Community mobilization and behavior change communication

This section provides findings from the evaluation of MIH activities implemented to meet the component two objective to: “Improve the knowledge and healthy behaviors, reduce harmful practices and increase care-seeking practices while reaching out to new audiences (youth) through creative Behavior Change Communication.”

a) Brief description of the Notun Din model

MIH is implementing *Notun Din* (New Era/Day) in 81 upazilas of 19 priority districts where the CPR is low and child mortality is comparatively high. The *Notun Din* model is community-based and implemented by the four NGO partners. Its design comprises: (1) community mobilization, primarily organizing courtyard meetings for the targeted groups of MWRA, their husbands, and caregivers of children under 5; (2) provision of BCC, which is basically information, education and communication (IEC) using a health education approach,²⁵ with delivery of key standardized messages by NGO staff; and (3) advocacy to inform and obtain consent of local leaders to implement the project at the community level. These activities are coupled with product promotion and sales provided by the CSAs/SSs.

In addition to the community sessions, major project activities include: (1) short health education sessions provided at schools with adolescent girls and boys; (2) short sessions for women and/or men at factories; and (3) meetings of partner program officers with CBAs to promote safe pregnancy messages and use of safe delivery kits.

With USAID funding, three implementing partners have set up division and district offices and hired staff, including BCC/community mobilization district team leaders, program officers, community mobilizers and community sales agent coordinators. They oversee, supervise and supply the CSAs. MIH provides less financial input to BRAC, instead integrating the project with BRAC’s community health model; this includes a Shasthya Korma (SK), who is already involved in providing health education and basic community-based services alongside the volunteer SSs, who assist with health education and sell preventive health and family planning supplies.

b) Advocacy

Community-level advocacy is the initial step in the implementation plan. The MIH Community Mobilization and Communication Strategy describes this as meeting with community influencers to mobilize opinion in favor of the program’s core health issues and messages, support program implementation in their areas, and encourage them to be proactive advocates in the community. Key messages have been designed for Islamic clergymen, community notables and elected officials. All implementing partners noted that their meetings with community leaders allowed them to carry on their community mobilization, BCC activities, and product promotion and sales. It was indicated that community leaders assisted the three non-BRAC partners with identifying potential sales agents.

Even with the careful initial preparation, partner community mobilizers mentioned that there are times (not quantified) where they have faced hostile situations, in which community members, often elders,

²⁵ Health education usually consists one-way communication, providing information about what listeners should ideally do and the reasons why (from a public health perspective), and less about current and feasible behaviors, obstacles/strategies to change, and motivations. BCC is more of a participatory process to encourage and sustain practices or behaviors that lead to positive health outcomes.

protest the presentations on family planning methods. Aside from the initial meeting, it was not clear if an ongoing relationship is maintained during the life of the project.

c) Community mobilization

Courtyard meetings are held locally in a community setting, e.g., outside under a tree or in a courtyard, in a home, or in a local government office. SKs/SSs noted that organizing meetings for the women is easy because of their extensive work in the communities with several health and nutrition projects and in provision of services, including sales of preventive health products. Because of the partners' work day and staff travel distances, meetings are held during the day. This is a recognized weakness: Community mobilizers described difficulties mobilizing and organizing meetings, noting how targeted groups (MWRA and husbands) are hard to reach with courtyard meetings, the timing of which conflicts with work, taking children to school, and other gender-related duties. For efficiency's sake, no separate meetings are held for caretakers of children under 5, as it is assumed that most of those will fall within the MWRA category.

From the small sample visited, it was not clear how intensively CSAs are helping implementing partners mobilize and organize the meetings. All four partners noted that it is difficult to mobilize males to attend the health education sessions.

The emphasis on coverage (number of persons to be reached by category), the extensive geographical area of 19 priority districts, and budgetary limitations have affected the scope and depth of MIH BCC and community mobilization interventions. The frequency of reaching villages is likely to be one or two times during the project, though the CSAs have tools to deliver key messages as they sell their products. An exception was noted in Comilla, where BRAC supplements MIH activities and BCC with its other projects (health, MCH, nutrition and TB). With the exception of BRAC, implementing partners raised concerns about the lack of human resources.

d) Targeting/segmentation

Broad segments of the population have been identified as target groups: MWRA, their husbands, caregivers of children under 5, adolescents, employees at selected workplaces and skilled birth attendants. Finer segmentation, e.g., by age group or shared situations,²⁶ is necessary to reach those most in need with specific messages relevant to that audience. It is recognized that this is difficult, given the inputs, implementation plan and high targets for reaching broad segments such as MWRA.

A challenge for the project will be to show aggregated numbers of persons reached over the life of the project, as double counting (counting the same person at each attendance of community sessions and school health or mobile film show events) and duplicated reporting (the same person may have been reached with same topics two to three times during the project).

e) BCC messages

MIH has developed standard key messages to increase knowledge and awareness of healthy practices and products. In discussions with MEASURE, it was noted that the project has increased standardization of the health messages and educational tools—like flipcharts—across the implementing partners. The project is to be applauded for efforts to increase knowledge and awareness using simple standardized messages—this is a step in the behavior change process.

²⁶ As examples: newly married couples, women with husbands who are migrant workers, older MWRA who already want or are likely to want to limit pregnancies.

Key messages often sound like absolutes and may need to be refined for the audiences. For example, the key message, “Don’t have children after age 35,” is not appropriate if talking to an audience that may include pregnant women older than 35.

A review of BCC products found a lack of messages for addressing fears,²⁷ negative attitudes or barriers to adopting new behaviors. Also lacking are targeted strategies for engaging influencers, including religious leaders and older men and women. No BCC strategy or activity was noted to address unmet need or to move women to safer methods.

f) BCC tools for sessions with targeted groups

Review of the BCC tools and materials found portable, colorful flip charts, easy-to-carry audio recorders, and small gifts, fans, combs, cups, pens and stickers with messages in Bangla. These are usually coupled with onsite selling of SMC health and hygiene products by CSAs/SSs. Multiple (about 15) topics are covered²⁸ in one-hour sessions using primarily pedagogical methods. The project originally had 33 topics²⁹ but in the first year decreased these to 15-16. SMC and partners recognize that there are too many topics, but, as one said, “We had a consultative meeting with key stakeholders and the consensus was that all of these topics (33) needed to be covered.” The flip chart covers messages related to “1,000 days,” MCH/safe delivery, family planning methods (delay, spacing and limiting), early marriage and female hygiene.

The team heard the desire by community members and MIH field staff for new BCC channels, with preference expressed for visual products or other more interesting aids. During this project, MIH has noted changes in preferred channels: There is less interest in the audio system, as people are now used to watching TV, and they prefer visual materials. In the 2014 household tracking survey, more than half (57.3 percent) of the respondents mentioned interactive mobile video/voice call as the preferred channel for receiving health messages.

SMC and partners are well aware of several limitations of the BCC component. The component is basically “lite” health education in a short timeframe with little time allowed for dialogue. They are also aware that audiences may not find all of the information relevant. PSI, since conducting an assessment of MIH’s interpersonal communication, has made recommendations for improvements and has been working with SMC to develop more interactive communication, shifting from a lecture methodology.³⁰

g) Mobile film shows and Floating IEC

Dramatized channels have been developed, bringing an entertaining approach to delivering key messages to the general population, reinforcing messages as presented via other channels. SMC’s mobile films bring three entertaining dramas with well-known actors delivering multiple key messages. These evening community venues draw large crowds; during these sessions, CSAs/products and BSPs are usually promoted by name. Similar to the content of the community-BCC materials, multiple topics are included in the short episodes. These events have not been integrated with the community-based BCC activities of the implementing partners, and there is no follow-up dialogue with the communities. SMC noted that

²⁷ Negative perceptions of LARC (as methods) were heard frequently during the focus group discussions.

²⁸ The number of topics has decreased from 32 since the initiation of the project. MIH has felt compelled to include all recommendations that came out of a consultative workshop with USAID and other partners.

²⁹ SMC MIH BCC/community mobilization staff also recognize that these were too many topics to easily cover, but that a consultative meeting with stakeholders resulted in the many topics being included in the lesson plans.

³⁰ “Recommendations for improving IPC [interpersonal communication] Impact For SMC’s Community Mobilization Program.” PSI.

sales increased after the film, but there are limited data³¹ to document this. While these events are popular, they are also costly, and the mobile film show (large screen) cannot reach many rural communities due to poor road systems.

The Floating IEC boat, SMC-managed and implemented by a contracted advertising agency, is no longer being used in Sylhet but continues in Barisal districts. This popular venue reaches riverine communities or those where road transport is not possible during the rainy season. High-quality films use drama to deliver health messages; a TV series of 13 episodes focuses on TB. Due to time limitations, the evaluation team was not able to travel to Barisal to observe this BCC/marketing venue. SMC staff noted that support to this activity is challenging, due to high operational costs and its currently narrow focus (TB awareness-raising).

h) Community mobilization and Community-based BCC by CSAs

According to staff, linking the CSAs with community mobilizers at courtyard meetings “gives them [CSAs] more status, more credibility.” During the community-level events organized by the mobilizers, CSAs have the opportunity to introduce themselves and display their products. District teams involve the CSAs when meeting with community leaders.

MIH provides tools for CSAs, such as kits for carrying products and clothing branded with the Notun Din slogan and the USAID brand, along with pictorial job aids for promoting products. CSAs are generally assigned to a catchment area of 500 or so households, while SSs are assigned to 200-300 households.

From the brief interaction with the small groups of CSAs/SSs, the evaluation team noted how diverse the agents seemed to be in appearance, ability to articulate, attitudes, aspirations and experience. Some told of having been community health workers with other projects, and some were or are traditional birth attendants. The diversity among CSAs/SSs, including varying levels of knowledge about the targeted topics, was also noted by the 2014 CSA study. There was no evidence of how the differing capacities are being assessed or how individual agents are being developed.

It was not clear how community mobilizers support and depend on the CSAs to help with organizing and participating in meetings. CSA coordinators oversee the agents, particularly with resupplying. With the BRAC model, a close working relationship was already developed between the SKs and the SSs.

The CSAs (as well as BSP and MIH field staff) voiced their need for more promotional aids.

i) School health program

MIH’s work with schools is highly valued by the project, and project officers are providing support to teachers who are hesitant to talk about reproductive health—a subject in the national curriculum. A portable and colorful flipchart has been developed by SMC staff for use in the schools.

Multiple topics are covered in one session. The same educational tool and messages are used for both boys and girls. Content includes information about puberty, i.e., physical changes in males and females, menstruation, personal hygiene (promoting sanitary napkins), dangers of teen pregnancy, the need for regular deworming and prevention of hookworms, dangers of smoking and tobacco use, dangers of addiction and how to address addiction.

³¹ Except for injectables, which are recorded, information about administration/sales to clients is not recorded by providers (CSAs, PCHPs or BSP). The system for gathering data about administration of injectables is dependent on telephone calls by program officers.

During the consultative meeting, an implementing partner raised the issue that program officers are not sufficiently trained to answer adolescent questions, e.g., menstruation or wet dreams.

None of the implementing partner field staff had heard of the USAID-funded e-tool compiled by the Bangladesh Center for Communications. Two senior staff were aware of this but not very familiar with its contents.

MIH management and one implementing partner raised concerns about hygiene at schools, noting that schools may lack running water or soap for handwashing. More inquiry is needed to look at facilities and procedures for disposal of napkins at schools. While no evidence was provided, there is a perception that the use of sanitary napkins reduces school absenteeism.

j) Workplace health education and promotion sessions

The workplace sessions are scheduled to reach workers during their lunch break. BCC materials for courtyard meetings are used by MIH program staff for both male and female workers. During discussions with implementing partners, there was little enthusiasm for continuing this activity if there is a follow-on project (this may be due to challenges in finding/scheduling workplace sessions).

k) Tele Jiggasha program

This hotline is operated from the SMC offices with two lines, one designated for females, with a female operator, and the other for males; oversight is provided by a medical staff member.³² The hotline numbers are listed on community and school flipcharts. Implementing partner officers articulated the lack of preparation for answering tough questions, particularly around reproductive health and sexuality. No mention was made of how field staff are using or promoting use of the Tele Jiggasha Program, though the number is noted on the flip charts being used for courtyard sessions. In discussing difficult topics, psychosocial as well as health issues were raised, so there is a perceived need for resources to handle these.

l) MIH field capacities

The MIH implementing partners bring strong experience in health service delivery, though it was not clear if having health or nutrition educational or work experience is a criterion for being a community mobilizer (health educator). In addition to its health and nutrition foci, BRAC also brings community development experience. All of the partners are also contracted to manage Smiling Sun Clinics under the USAID-funded NGO Health Service Delivery Project (NHSDP); these provide integrated preventive health, family planning and primary care services.

MIH resources have been used primarily to develop BCC and marketing channels and less to develop staff and partner expertise. Community mobilizers and BRAC SKs were oriented to the SMC-developed tools during a two-day workshop, but there was no skills training in communication or more technical, complex issues related to religion, side effects of family planning methods, etc. The training provided to field MIH staff cascades from the SMC program office, which trains implementing partner program officers, who then train the community mobilizers/SS and CSA coordinators, who in turn train the CSAs/SSs to give key messages and promote the products. The topics require sufficient preparation, knowledge and communication skills, and the cascading approach requires good training skills at each of the levels, but training resources for building these capacities are limited. BRAC's SKs have had more

³² On the day of the visit to the hotline, the female operator was on duty. She mentioned having to deal with difficult questions. For example, that day, a man with a pregnant wife called asking if it was safe to have sex. When asked how she knew how to answer this, she replied, "I remembered what my doctor told me when I was pregnant." She also mentioned that if needed, she can contact the SMC doctor who oversees the hotline.

training—e.g., 15 days on health, nutrition and hygiene—and are working with other health and nutrition programs. Therefore, they have technical support, are likely to have wider experience with promoting health, family planning and nutrition practices, and also may have similar capacity for raising demand for products. Regular meetings are held with implementing partners to discuss and report on field activities and sales. It was not clear how the various studies are being disseminated and/or used. When partners were questioned, the majority denied having seen reports of studies conducted in 2014, such as Effectiveness of CSA or Knowledge, Attitude and Practice studies.

Except for BRAC, implementing partners raised concerns about the lack of human resources. Community mobilizers reported, “We have to do three meetings per day,” with several unions to cover (one or two for females and three for males). The situation for BRAC is quite different, as the organization already has staff and SSs in place; its staffing pattern has two SKs per union working with several BRAC projects (note, MIH is not covering salaries of the SKs).

m) Results

In spite of the limited resources, a review of performance related to meeting BCC targets shows that the project is surpassing its annual³³ targets. As an example, the FY 2014 report noted that 1.83 million MWRA were reached with family planning messages, 106 percent of the target of 1.73 million. Likewise, numbers of caretakers reached with the “first 1,000 days” messages, husbands reached with family planning messages, and skilled birth attendants reached with health pregnancy messages also surpassed annual targets. The project is collecting process/output data, so is able to show how well targets are being met.³⁴

While attribution is an issue, survey data provided by SMC show increases in knowledge levels related to topics and greater utilization of products in the priority project areas. A baseline survey was conducted in 2013-2014 by MEASURE and used to set activity and a few behavioral targets. This serves as a reference point for comparing ongoing and end-of-project survey findings related to the level of awareness and product/service utilization. In all, 14 indicators have been established for this component. MIH’s M&E plan includes household tracking surveys (TRaC, to be done every 12 months to monitor changes in level of awareness and behavior). The following illustrates examples of information being collected through the household surveys,³⁵ indicating that the project will meet or surpass its targets.

³³ Life-of-project performance using MIH data may be difficult to analyze, given issues of double and duplicated counting.

³⁴ Project staff report that they expect to meet targets for people reached—e.g.: 66 percent of targeted MWRA, 78 percent of husbands of MWRA—though it is recognized that double counting will be an issue if output data are aggregated over the life of the project, as the same participants may be reached with the same BCC if community sessions are held twice in one community.

³⁵ TRaC surveys

Table 3. Household Tracking Surveys

Indicators per M&E Plan	Baseline	Household Tracking Survey-intervention sites
Percent of MWRA who delivered at home within last three years and were assisted through safe delivery kit (brand name if possible) (Target=20%)	12.4%	20.7% of the MWRA interviewed used safe delivery kit during birth of last child (note this is not time-bound) (TRaC 2)
Percent of women who use(d) sanitary napkins currently or last time in targeted areas	9%	18.6% of MWRA interviewed (2014 household survey) 21.7% (Jul-Aug.'15 TRaC 2 survey)
Percent of children under 5 who have used micronutrient powder in targeted areas (Target=8%)	Baseline survey ³⁶ found 3% and 2% in the two project areas surveyed.	3.5% of children were given micronutrient powder in last 6 months (TRaC 2)
Percent of MWRA who are currently using a modern contraceptive by method (Target=51%)	46.9% (baseline study 2013-2014)	55.4% of MWRA interviewed (TRaC 2)
Percent of MWRA who intend to use a LARC in the next 12 months in targeted areas	0.8% (baseline study 2013-14)	Among the four project areas, 3-9%, ³⁷ with implants by far being the preferred method (TRaC 2)

With MIH support, several studies³⁸ in addition to the TRaC surveys have been done, providing valuable information that could be used to generate discussion and rethinking of project activities and modalities.

4. Building capacity of network providers

The objective for this project component is to: “Improve delivery of quality family planning, reproductive and child health services, referrals/[directly observed treatment, short-course] DOTS services for TB, and referrals for higher-level clinical services, including long acting and permanent method (LAPMs) through Capacity Building of local formal and non-formal private providers.” An in-depth assessment of the quality of the training program was not possible, given the scope of this midterm review and time limitations. Based on review of the project reports, training content, short interviews with three of the training partners, discussions with SMC program staff and visits with a few BSP, PCHP and LARC providers, the following are observed strengths, challenges or gaps, and noted opportunities or recommended actions.

a) Skills-training programs

BSPs/PCHPs are provided with focused skills training in provision of contraceptives, including injectables and, for selected providers, how to use the new Sayana Press. OGSB training institute and AITAM have been conducting the SOMA-JECT training, and now Sayana Press is doing training, using a curriculum developed by EngenderHealth for DGFP. AITAM, a non-governmental professional training center, brings a long history of paramedic training to the training of the private providers.

EngenderHealth continues work started during the USAID-funded SHOPS project to develop provider skills in the LARC network, primarily OB/GYN doctors. This complements the work that they are doing

³⁶ MEASURE, SMC. Bangladesh Marketing Innovation for Health Baseline Survey 2013-2014.

³⁷ MWRA in BRAC area reported highest demand for LARC.

³⁸ Ex. study to evaluate the knowledge and effectiveness of CSAs; knowledge, attitudes and practices among MWRA; Eligible Men; etc. FoQuS qualitative study covers attitudes and behaviors relating to healthy timing and spacing of pregnancy, 1000 Days and adolescent health, through 66 individual depth interviews, conducted in three locations.

through the Mayer Hashi project to build LARC capacities within the public sector. Both LARC providers and EngenderHealth noted the increases in postpartum family planning services; as one provider stated, “It’s easy to insert an IUD with C-sections.”

Concerns were heard from training experts with MIH experience that capacity building for the networks would be strengthened by closer assessment of provider training needs and contextualizing of training programs to the realities of private practitioners. An example is to find practical solutions for client reminder and referral systems. They also noted that their input to curricula development has been limited.

The basic curriculum for BSP and PCHP covers multiple topics in addition to the focused skills training on provision of family planning methods. The two-day PCHP curriculum includes topics on: interpersonal communication, counseling, health education, nutrition, safe delivery, the SMC products and the referral system, in addition to skills for providing injectable contraceptives.

MIH has developed a two-day training course for the implementing partner community mobilizers to deliver health education/BCC on multiple topics, as well as for the CSAs to promote products, using a cascading approach: SMC trainers to implementing partner program officers to community mobilizers to CSAs.

All training partners visited echoed the need recognized by EngenderHealth and SMC for more post-training monitoring, mentoring and ongoing refresher training. Within MIH, there is recognition of a need for more follow-up of joint medical detailing,³⁹ mentoring and quality assurance mechanisms.⁴⁰

b) Demand for training

BSP and PCHP noted that the training programs are highly valued and have been a factor in expanding their client base. Mention was made that other private providers would like to become part of the BSP network. All providers, including LARC and CSAs, noted their desire for more learning opportunities; BSPs/PCHPs specified expert certified training programs. Given the costs of the training programs, MIH has insufficient funding to meet the demand for expanding the basic training programs to more BSPs/PCHPs or for refresher training. In looking at project data and targets, the provision of refresher training is lagging, but if activities are conducted as planned according to the 2016 work plan, the project will be close to meeting its projections.

c) Counseling and client education

EngenderHealth reports that on its own, without funding from MIH, it is also training OB/GYN doctor assistants on counseling and infection prevention, recognizing these as critical needs.

LARC providers visited noted that there is limited time to counsel or educate their clients during their busy private practices.

Several community mobilizers expressed their wish for time to meet individually with women or couples to answer their questions, though they did not report having been trained to provide counseling. No mention was made of utilizing counseling services such as hotlines.

³⁹ Are providers short on supplies? Do providers choose not to use certain products because of storage requirements? Are providers trained properly on the health supplies they are being encouraged to use? What are the barriers to delivery, to demand, to utilization?

⁴⁰ More attention to quality issues, e.g., addressing discontinuation of methods and drop-outs, with better mechanisms for follow-up (SMS messaging) and documentation of reasons. In talking with public sector providers, this was mentioned as a widespread issue. This also relates to better documentation of referrals: why and to whom.

d) Quality assurance

A review of the 2014 BSP study commissioned during this project measured quality in terms of physical environment and equipment, looking at: cleanliness, level of privacy, visibility and condition of BSP signboard, availability of public health products, wooden frame poster, Tiahr poster, service guideline, handwashing facility, working sharp box, waste disposal container, working blood pressure machine with stethoscope, working weighing scale, apron, register, and referral slips. Using these criteria, they found that 93 percent passed the quality standard. Exit interview findings showed average clients' satisfaction with service scored 4.3 out of 5. The project recognizes a need to strengthen quality assurance processes and monitoring services to ensure quality of care according to set standards.

Discussions with staff, providers and public health officials indicated awareness that discontinuation of contraceptive methods and lack of adherence to recommended regimens (e.g., zinc with ORS for diarrhea and use of Monimix) is a poorly tracked issue.

5. Gender sensitivity and male involvement

The project design recognizes the need to involve male and female community leaders as part of the advocacy efforts, to reach the husbands of MWRA, and to educate both male and female adolescents. Sessions are held separately with males and females. When possible, male community mobilizers lead sessions with the husbands, and females lead the MVRA and caregiver sessions. Project staff noted that males (husbands) are the group most difficult to mobilize for sessions, given their work schedules and the fact that project staff only work during daytime hours. The 2014 CSA study also reported that CSAs perceive challenges in encouraging males to attend meetings or to buy products from them. "Some pointed out that if they can provide counseling on methods to wives along with their husbands accompanying them, it would be more effective."

The need for gender/sex- and age-appropriate materials, teaching methods, and community mobilization approaches was noted in the previous sections.

Project reports contain sex-disaggregated data for numbers of persons reached with community and school sessions, but not for community leaders reached with advocacy or for providers supported or trained (though various sources agreed that more than 90 percent of CSAs/SSs are female). No age-disaggregated data are reported. It is recommended that collection and reporting of sex- and age-disaggregated data be standard when reporting persons reached or supported.

6. Coordination and relationship with government

All DGFP officials met at each level were well informed and voiced their appreciation for BSP and how it has increased access to injectable contraceptives. All voiced their support for task-shifting injectables; opinions differed about task-shifting the insertion of implants to mid-level practitioners (the common concern was to ensure competency and hygienic conditions/infection control measures). Government officials, aware of the CSAs, also appreciate sale of contraceptives and condoms at the doorstep.

In the BRAC districts visited, it was noted that MIH is benefiting from the close relationships that BRAC has with the government services due to its essential health and nutrition activities and, in particular, its TB project, where BRAC provides testing, referral and follow-up (DOTS is provided by SK, with incentives provided to SK and clients for completion of the regimen).

While the district family planning officials are well informed about BSP—several having assisted with training—neither the central nor district family planning staff were aware of Sayana Press being piloted. At the central or lower levels of government, there was no awareness of the project's work with PCHP, though when probed, several central level informants recalled that SMC is doing some work with "drug sellers" (thus, this may be a branding issue).

A complaint heard from family planning officials in two unions was the lack of referrals by NGOs, including Notun Din/implementing partners, to government LARC and LAPM services.

While district and lower government voiced few complaints of MIH, a common one was the lack of reporting by implementing partners on sales and BSP services, which would provide better strategic information. Both Shimantik and BRAC reported attending district-level NGO coordination meetings, which are usually held monthly. Health and family planning officials verified that this is happening. MIH district team leaders said that they are instructed not to share sales data directly, as SMC is responsible for reporting to the government.

Several government officials noted that “SMC works in urban areas”; these same officials were unaware of the CSAs. In the more rural areas visited, local health officials mentioned that the project (and SMC) need to provide assistance to serve their hard-to-reach populations.

In visiting project areas, it was observed that a community may be served by numerous outreach staff, such as government health assistants, family welfare assistants (FWAs), MIH community mobilizers, BRAC SKs, CSAs, BRAC Ss, Smiling Sun community workers/promoters, potentially other NGO community volunteers, and the community clinics with their community management committees. No mechanism for systematic coordination of community-based services was noted. In most places, the evaluation team heard that FWAs are not adequate for good coverage because of vacant posts or new policies requiring them and health assistants to spend three days a week at the community clinics instead of out in the communities, negatively affecting their coverage and scope of work. As noted by a health system specialist, the community clinics could serve as a hub for coordination with public, NGO and private community workers and identifying gaps or unmet needs.

At several sites, government family planning personnel noted their new electronic data collection system for recording pregnant women; this source of information may provide an opportunity to track their procurement of safe delivery kits, services utilized and outcomes.

B. SHOULD USAID MOVE INTO NEW PROGRAM AREAS?

Evaluation question two was to explore: “Should USAID move into new program areas, and if so, what are these areas?” Within this question, the evaluation team looked at (1) critical public health issues where social marketing could play a significant role and government can be supported; (2) the need for social marketing of new health products and services to address critical public health needs, and what can be addressed by social marketing;⁴¹ (3) the need for stronger linkages and/or integration of social marketing with the public and NGO sectors or projects working to create demand and utilization of health measures, services and products; and (4) alignment of social marketing and BCC approaches and products with the Government of Bangladesh’s national priorities as the country develops.

I. Critical public health issues

Bangladesh is noted for its success in meeting the MDG goals, having seen significant changes in health indicators. As the country develops economically and with increasing urbanization, the nation has critical public health issues to address that are common to both developing and developed countries.

In talking with key informants and reviewing critical issues, the team noted that MIH’s areas of focus remain valid and that there is basis for more concerted attention to address priorities related to family planning, adolescents’/women’s reproductive health issues, and early identification and referral for care and treatment of non-communicable diseases and TB.

⁴¹ These include potential new products and services or help with scale-up and marketing of those already developed by others.

The following is a list of issues that were most frequently heard during the rapid review:

- a) **Unmet contraceptive need:** In discussions about unmet need, informants reported the perception that the 12 percent with unmet need (BDHS 2014) are living in rural, more remote areas or slums and—as reported after further probing—include women who are married to men working abroad (Chittagong 23 percent, Sylhet 14.8 percent, DHS 2014).
- b) **Low uptake of LARC:** The family planning community is aware that there are significant barriers to LARC related to negative perceptions, misconceptions and poor experiences, and that an aggressive, multifaceted BCC strategy is needed. This would target both providers and those wanting to delay, space or limit. It would ensure that public and private practitioners have the necessary skills and are equipped to inform, promote and deliver these services with good technique and good infection prevention.
- c) **Unwanted/unplanned pregnancy:** The majority of family planning practitioners and experts met indicated that menstrual regulation (medical and manual) is increasing, with reasons being temporary method failure, unmet need and, while less commonly discussed, being unmarried (legally, provision of family planning to unmarried women is still prohibited). With changing patterns in the provision of menstrual regulation, there is concern among the family planning and medical community about increasing risks and improper use of medical menstrual regulation with over-the-counter drugs or manual vacuum use by poorly trained practitioners; more incomplete abortions and infections are being seen.
- d) **Continued early marriage practices and early pregnancy:** Early marriage continues to be practiced: recent shifts in government policy are alarming, with family planning experts fearing early pregnancies will increase.⁴² For child health and welfare advocates, this raises concern that the adolescent development phase is a short time for readying teens to deal with their changing hormones—as well as the changing world—and to assume adult responsibilities, including parenting.

Continued high rates of home births and need for birth preparation: The large percentage of home births continues.⁴³ Considerable work by the NHSDP, MaMoni and other donor projects is being done to improve availability of skilled birth attendants, including midwives. Support will be needed to develop these as private provider services in homes and at birthing centers, as well as to address issues such as demand creation for facility (higher-level) care; public fears, e.g., of C-sections⁴⁴ (“Even rich people fear this”), which was noted in two focus groups of CBAs as a reason why home births remain high; travel costs; and the belief that if there are no complications, facility care is not needed. Concerns were raised by informants that while skilled birth attendants are needed, it is difficult for one person to attend to both the mother and the newborn. One public health advisor recommended twinning CBAs and the older traditional birth attendants (TBAs), training the latter to provide newborn care, e.g., training on helping babies breathe, warming methods, etc.

- e) **Inequity in private family planning services:** This is particularly true for those living in rural or remote areas. Addressing inequity will require stakeholders (DGFP/Directorate General of Health Services (DGHS), donors, women’s health advocates, professional associations, e.g., OGSB, and

⁴² “31 percent of adolescents age 15-19 in Bangladesh have begun childbearing; about one in four teenagers has given birth and another 6 percent are pregnant with their first child. As expected, the proportion of women age 15-19 who have begun childbearing rises rapidly with age, from 9 percent among women age 15 to 58 percent among women age 19,” BDHS 2014.

⁴³ “37 percent of births in the three years before the survey were delivered at a health facility.” BDHS Key Indicators, 2014. National Institute of Population Research and Training Ministry of Health and Family Welfare Dhaka, Bangladesh.

⁴⁴ The rate of C-sections is rising. Media coverage was noted linking this to private practices. Global Rise in C-Sections Troubles Experts, http://www.pbs.org/newshour/updates/asia-july-dec11-csect_08-09/

providers) to rethink public, private and NGO service delivery. Advocacy for more task-sharing is needed, e.g., the use of mid-level private practitioners to provide LARC. With the training of private skilled CBA and midwives, there are many opportunities for increasing skilled family planning providers and for increasing postpartum and post-abortion contraceptives.

- f) **Unpreparedness of adolescents and youth for adulthood:** Concerns were heard about the fast-changing world and societal changes intensified by rapid growth in urbanization and economic improvements. During group visits, adolescent girls commonly expressed concern about physical and social changes and unwanted touching and teasing by their male peers. Key informants often raised concerns for youth in this electronic age, facing the dangers of exposure to new and potentially risky behaviors without guidance from adults, as well as the concern that parents and teachers are ill-equipped to guide adolescents and teens.
- g) **Better non-communicable disease (NCD) detection and risk-reduction measures:** Many stakeholders, e.g., the Bangladesh Diabetic Association, articulated the need for support for community NCD (diabetes and hypertension) services: screening, education, promotion of risk-reduction measures (diet, exercise, adherence to medication) and monitoring. They noted that more than 60 percent are not aware that they have diabetes or pre-diabetic conditions and that a large population that has or is at risk for hypertension is not identified. Several studies have noted that NCD burden—specifically cardiovascular disease, diabetes and tobacco-related illness—are rising due to preventable risk factors including smoking, unhealthy diets, physical inactivity and drinking alcohol. These are similar to trends noted globally among developed and developing countries as lifestyles become less healthy due to changes in economic activity and urbanization. CSAs, too, report a high demand from their clients for blood pressure and blood sugar testing. The new national health strategy will likely have a pillar, “Lifestyle and environment,” calling for more work on addressing NCDs.
- h) **Workplace safety and health hazards for the predominantly female garment workers:** The Bangladeshi textile and garment manufacturing sector provides opportunities for young, urban workers, the majority of whom are women. These workplaces are noted for suboptimal health and safety standards. However, they also provide for opportunities for wellness, disease prevention/risk reduction and family planning services.⁴⁵
- i) **Need for sustained TB screening and DOTS:** The TB burden remains high, and more action is needed to address delays in seeking testing and care and prevention of drug-resistant TB. With changing funding levels to NGOs, there are concerns about decreased DOTS services. New, sustainable systems will need to be developed.
- j) **Better usage of zinc with ORS for diarrhea, and other Integrated Management of Childhood Illness (IMCI) protocols:** While ORS utilization in Bangladesh is high, addition of zinc is still underutilized, and acute respiratory infection continues to be the number one cause of childhood illness and mortality. IMCI guidelines have been adopted; at the subdistrict health complex there is an IMCI corner.
- k) **Sustainable malaria prevention measures:** Malaria remains a critical concern in endemic areas. Insecticide-treated bednet campaigns and distribution of free nets have reflected a successful

⁴⁵ A new report, *Our Voices, Our Safety*, published by the International Labor Rights Forum (ILRF), describes how women garment workers in Bangladesh, who account for 80 percent of the apparel industry, “are unable to speak up at all or make their voices heard when they feel unsafe or unfairly treated.”

government and BRAC partnership, but questions were raised about the sustainability of this approach.

- l) **Poor dietary practices:** Several government and NGO informants mentioned the need for a coordinated strategy to address child malnutrition, with clear role definition for government and NGOs.
- m) **Drowning as second cause of death in children:** Several local governments expressed concern about deaths due to traffic accidents, both pedestrians and drivers/passengers; recent new coverage in a WHO report noted this as well. This too will require multisectoral thinking and actions to find ways to reduce risks through awareness-raising, strengthened policies and enforcement of safety laws, skills training in risk-reduction practices, and access to protective measures.

One public health specialist pointed out a concern about arsenic exposure through contaminated water and the harmful effects on the brain and new nervous system, particularly for children. Review of the literature found that “Roughly 20 million people are still drinking water with arsenic levels exceeding the Bangladesh drinking water standard of 50 micrograms per liter.”⁴⁶ In discussions with the various public health informants, little mention was made of other WASH-related issues except for the frequent mention of the importance of and need to expand sanitary napkin access.

2. Social marketing⁴⁷ of new or additional public health products

SMC is considering new products, including high-protein snacks (currently SMC is exploring the potential for marketing/selling Nutriset soft bars—one for youth and the other for children under 5). SMC and BRAC are still exploring the addition of chlorhexidine and misoprostol to their safe delivery kits, understanding that inclusion of these products may make the kit cost-prohibitive. They also recognize that social marketing must be coupled with strong community mobilization and BCC to reach pregnant women and their influencers, and that their attendants, (i.e., private skilled birth attendants) must have strong supervision and the skills to provide clear instruction on proper usage. The evaluation team highly endorses supporting these activities, as the products are already in the marketplace and are high-impact practices and life-saving drugs approved by the government. Exploring the development of new nutritional supplement products requires an in-depth assessment of the nutritional deficiencies, populations at risk and evidence of the effectiveness, affordability and attractiveness of the products among the target groups.

Among the ideas heard during the review for potential products or marketing of new products was hand sanitizer (targeting workers and students where handwashing facilities are not available; SMC mentioned that 80 percent of the secondary schools do not have running water or soap). Field staff and CSA/SSs also mentioned community demand for door-to door sales of iron/folate pills for young women, paracetamol, calcium, deworming and antacid drugs. To ensure equity, social marketing of these preventive health products, as well as insecticide-treated bednets and water purification products,⁴⁸

⁴⁶ <http://srphsph.harvard.edu/sample-page/dhaka-bangladesh-2/#sthash.ItXjWkdH.dpuf>

⁴⁷ “Social marketing seeks to develop and integrate marketing concepts with other approaches to influence behaviors that benefit individuals and communities for the greater social good. It seeks to integrate research, best practice, theory, audience and partnership insight, to inform the delivery of competition sensitive and segmented social change programs that are effective, efficient, equitable and sustainable.” [1] International Social Marketing Association, European Social Marketing Association & Australian Association of Social Marketing (2013). Consensus Definition of Social Marketing (4 October 2013).

⁴⁸ While PUR, a water purification product had been mentioned as a potential new product to social market in the original MIH Project proposal, no further mention was noted in review of project documents nor included in the new SMC 2015-2020 strategic plan.

through the networks is recommended if a competency-based training program for the sales agents can be assured.

In talking with MIH staff and CSAs/SSs, a high demand was expressed from the community for services such as testing for pregnancy, blood sugar and blood pressure.⁴⁹ Two groups of CSAs reported that they are also doing pregnancy tests for a fee (unofficially). The BRAC SSs are already involved in performing blood pressure and pregnancy testing for set fees and plan to add blood sugar testing; this provides an opportunity to learn from their experience. It is recommended that decisions to add more clinical products for community-based sales are made with caution, as these require protocols and systems, competency-based skills training, sufficient tools, sustained supervision and quality assurance. It is recommended that these screening, referral, follow-up and monitoring services, as well as NCD risk-reduction programs, be developed in collaboration with the BSP network, community clinics and NGOs, e.g., Smiling Sun clinics and outreach programs.

Several CSAs mentioned their interest in and the demand of their clients for toiletries. The inclusion of a line of vitamins and “healthy” beauty products—perhaps packaged for target groups such as adolescents—is recommended, as this may open doors for the promotion of family planning methods or products with more preventive health significance.

3. Linkages and integration of social marketing with the public and NGO sectors

SMC has brought its social marketing expertise to several MCH, family planning, and disease prevention interventions, working with government and non-governmental partners’ projects over the years, primarily in the area of mass media marketing. Examples include designing a TB-focused drama series for TV that promoted early identification of signs and symptoms, healthcare-seeking behavior, and adherence to treatment plans. In the past year, SMC, with funding through MIH, assisted with a national awareness campaign in favor of “Clean Cook Stoves” instead of the traditional stoves that pose hazards to children’s health. Informational commercials using Computer Graphic Imaging technology aired on national and cable TV.

Until recently, SMC partnered with NHSDP to design its new female-focused pharmacies. This is an example of SMC using its social marketing and private sector experience in increasing availability of affordable products to share social marketing and cost-recovery techniques, i.e., cross-subsidizing products and cost-shifting within product lines.

SMC is working directly and through the MIH Project with the Global Alliance for Improved Nutrition (GAIN) to promote improved nutrition using mass media generic marketing of micronutrient sprinkle products.

According to MIH field staff and the CSAs, there is demand for community-based screening services. BRAC is already using social marketing techniques as it offers screening and ANC services for affordable fees through its community service delivery system (SSs linked with SKs).

SMC is also exploring the potential for adding services such as blood pressure screening and monitoring with referrals; blood sugar screening and monitoring with referrals; promotion of diet, exercise and adherence to drugs; pregnancy tests, with messages for those testing positive to reduce delays in seeking professional care; and CSA-provided weight measurement. With the development of the community clinics, there appear to be opportunities to form public/private partnerships for local health screening

⁴⁹ The 2014 CSA study noted that there is highest demand for iron, vitamins and calcium tablets, followed by gastric medicine, and blood pressure measurement ranked third.

campaigns with SMC or others providing affordable tests and linking with government health workers providing client education and referrals.

As noted by the review of the MIH, a demand was heard from several NGOs visited to link their community health workers with SMC to promote and sell preventive health products. This demand is driven by a quest to sustain community-based health education and promotion activities.

It is recommended that all relevant USAID health, nutrition, injury prevention and WASH projects incorporate behavior change and social marketing approaches and, when addressing similar issues, operate under a comprehensive strategy and plan.

4. Alignment of social marketing and BCC approaches and products with national priorities

USAID has contributed to the health status improvements and to meeting country's MDGs by funding an extensive portfolio, including the MIH Project. While not inclusive, supported projects include financial assistance to: the multi-donor pool fund to assist the Government of Bangladesh in supporting the Bangladesh Health Sector Development Program; the Mayer Hashi Family Planning Project to increase and improve government family planning services, with emphasis on LAPM; the USAID-DFID NGO Health Service Delivery Project (NHSDP) to support delivery of essential service packages, including family planning services through a network of Smiling Sun clinics managed by NGOs, primarily in rural or urban hard-to-reach areas; and the MaMoni Health Service Systems Strengthening to work primarily with government to promote integrated safe motherhood, newborn care, child health and family planning services and technical assistance to strengthen district and lower government health system. The EVIDENCE project is focusing on the study of adolescent sexual and reproductive health services and practices to advise strategies and planning, while the Health Communication Collaborative is providing technical and health system strengthening support to the Ministry of Health and Family Welfare (MOHFW) to carry out its SBCC functions and to build SBCC capacities through the Bangladesh BCC Working Group. It can be noted that these projects, along with MIH, touch on or directly address family planning needs: unmet contraceptive need, heavy reliance on oral contraceptives (despite a steady increase in injectables—a more effective and user-friendly method), prevention of unwanted/unplanned pregnancy, and continued early marriage practices and early pregnancy.

In addition, USAID's present portfolio supports the Government of Bangladesh's new Sustainable Development Goals, which include: Goal 2 to achieve improved nutrition;⁵⁰ Goal 3 to ensure healthy lives and promote well-being for all; Goal 5: to achieve gender equality and empower all women and girls; and Goal 10: to reduce inequality within and among countries. The SDGs also stress increasing the ability of countries to address social challenges and partnerships at all levels. More attention to public health risk reduction will be needed to support Goal 6: to ensure availability and sustainable management of water and sanitation for all, with focus on quality of water in rural areas and urban sanitation, and Goal 11: to make cities and human settlements inclusive, safe, resilient and sustainable, with emphasis on safety.⁵¹

Demand creation, social marketing of products and services, facilitation of community action, and behavior change approaches are vital to implementing evidence-based initiatives to improve nutritional

⁵⁰ USAID is supporting several nutrition initiatives, including SHIKHA in coordination with Feed the Future to improve feeding practices of children under age 2.

⁵¹ "An ongoing CPD study has found that among the 17 SDGs, eight goals (Poverty, Hunger and nutrition, Education, Gender equality, Water and sanitation, Energy, Combat climate change, Global partnership) are better integrated in the existing national prioritisation processes in Bangladesh while the rest are in need of further attention." <http://cpd.org.bd/> Centre for Policy Development (civil society think tank). October 2015.

and health status, to improve water, sanitation and hygiene conditions and practices, and to institute injury/disaster risk reduction measures, as well as to address social issues such as gender inequity.

While the team was not privy to the new government health strategy as it is being drafted, key informants mentioned that priorities include efficiency, equity and quality of public health services.

Social marketing using total marketing and SBCC approaches and development of private sector capacities have been shown to contribute to increasing equity of health messages and products. It is suggested that the private sector, either working alone or with the creation of public/private partnerships, is likely to improve both efficiency of delivery and quality of public health services.

C. SHOULD USAID CONTINUE TO INVEST IN SOCIAL MARKETING PROGRAMS?

The third evaluation question was: How could USAID invest in the delivery of critical public health services and measures in the future? More specifically, the team was asked to recommend programming that will: (1) expand or scale up MIH achievements in expanding and improving family planning services in the private sector; (2) assist the Government of Bangladesh’s essential public health function to ensure equity in quality public health services and measures; and (3) support new initiatives/strategies to involve the private sector to respond to community needs and demands for selected services and critical health measures.

The “Ten Essential Public Health Services”⁵² framework is used as a background for showing where USAID-funded programming with social marketing and behavior change approaches is proposed as important for supporting the Government of Bangladesh’s essential public health core⁵³ functions. In the last section of this document, recommendations are made for several priority interventions.

I. Monitoring health status

This is a core government function and one already receiving considerable external assistance from the donor community, e.g., support for the Demographic and Health (DHS) surveys. It is suggested that non-governmental institutes, organizations, and private companies such as SMC receiving USAID funding, can and should more systematically contribute to national knowledge base and learning at the central and district/lower levels by including them in the planning and carrying out of special studies⁵⁴ or joint monitoring exercises. Developing mechanisms for sharing private sector



Figure 4. Ten Essential Public Health Services

⁵² The Core Public Health Functions Steering Committee developed the framework for the Essential Services in 1994. The committee included representatives from U.S. Public Health Service agencies and other major public health organizations. <http://www.cdc.gov>

⁵³ There is considerable debate within the public health system about what constitutes governmental core public health functions. Most would concede that, at a minimum, these should include: assessment, policy development, and assurance.

⁵⁴ Lot Quality Assurance Sampling (LQAS) is a “relatively rapid approach to data collection that provides a viable alternative to traditional surveys, allows for smaller sample sizes than standard probability surveys, and the lower associated costs allow for more frequent sampling. LQAS data can also be used in conjunction with other sources of health information, such as service

service utilization and disease reporting is critical to improving the quality of strategic information for monitoring health status and planning.

2. Inform, educate, and empower people about health issues. Mobilize community partnerships and action to identify and solve health problems.

These two functions have been combined, as each requires public/private partnerships and community engagement. Given the magnitude of several of the critical public health needs and historically poor funding for this governmental function, external support in the areas of social marketing, behavior change and community mobilization expertise and interventions are required and can be provided by private/commercial and international, national and community non-governmental entities. It is recommended that USAID explore support for focused multi-channeled campaigns, e.g., promotion of LARC, as well as the development of targeted health education programs for populations most at risk or in need.

a) National and local campaigns to address high-priority public health issues

With guidance and support of central government, local (district and lower) public health services need to take a more active role in carrying out this function, working closely with the non-profit and private/commercial sectors to use data-driven processes to identify, prioritize and address the most crucial public health issues. Local government also needs to be supported to encourage grassroots organization and action. To strengthen local capacities, it is suggested that USAID support local public/private coalition building for strategizing, planning and mobilizing resources, including corporate social responsibility support to inform, empower, create demand and change behaviors/practices (grounded in the local context).

It is recommended that top priority be given to addressing family planning issues: unmet need, unwanted/unplanned pregnancies and the low demand for more effective and longer-acting methods. This will necessitate continuation of the work with the MOHSW-DGFP to develop a broad behavior change framework based on good formative research and proven behavior change theory for promoting delay, spacing, limiting and, importantly, preventing unwanted/unplanned pregnancies. The BCC Forum should develop key messages for promoting family planning practices and the benefits of using more effective methods, i.e., injectables, LARC and LAPM. USAID is encouraged to also promote structural changes, e.g., task-sharing the insertion of implants by trained mid-level practitioners and revisiting of regulations relating to marital status and utilization of family planning services.

At the district level, governmental, non-governmental and private sector partners will also need to be supported with SBCC expertise⁵⁵ to lead the situation analysis and formative studies to develop multi-pronged SBCC, social marketing and community mobilization strategies and plans that address the contextual issues and needs of the targeted populations. Bangladesh is fortunate to have social marketing⁵⁶ and SBCC expertise⁵⁷ and several non-profit and civil society organizations with proven community mobilization approaches to assist local governments with planning and developing mass media and BCC channels. It is recommended that USAID and others support proven NGOs, in

statistics, to obtain information on coverage and quality of care at the population level and to assess whether a target has been “met” or “not met” in a designated program supervisory area.” MEASURE Evaluation, <http://www.cpc.unc.edu/measure/resources/publications/fs-11-46>

⁵⁵ JHU/CCP’s work with central government BCC capacity-building could be decentralized to the districts.

⁵⁶ SMC and its technical partner PSI bring strong social marketing experience and expertise; the current/proposed follow-up project would bring resources to this proposed programming idea.

⁵⁷ Use of mass media/TV was often mentioned when Norix was discussed. There is a need to understand media coverage; where to position infomercials and ads, such as targeting middle class women, e.g., teachers who forgot pills during examination time (anecdotal story of a teacher at an international school who has had menstrual regulation seven times).

coordination with local government, to transfer community mobilization facilitation and BCC skills to local activist groups/community-based groups actively working on improving health in communities.

Support will need to be generated for orienting coalition partners to SBCC theories and for SBCC activity implementers, product salespersons and service providers to acquire good communication “pull” skills, to develop creative low-cost promotion tools⁵⁸ and to utilize good information systems for documenting results, lessons learned and promising or best practices.

There is a critical need for more rigorous M&E of what is being done (to show linkages or contributions of activities and outputs to outcomes), how well initiatives are performing and results/outcomes, e.g., changes in awareness, attitudes, demand, adoption or adherence.

Funding mechanisms will need to be developed, e.g., block grants using a competitive process to foster government commitment and ownership, coupled with local resource mobilization to implement plans.

The capacities (processes, mechanisms and skills) built by local governments and coalition partners through this family planning-focused project can then be utilized to address other critical public health issues as prioritized at the central or district levels.

b) Targeted health and wellness education and promotion programs

These would be created to address common health concerns and needs of subpopulations and would be implemented by the public, non-governmental, or private/commercial sectors. Programming areas recommended in the last chapter of this report include adolescent and youth wellness initiatives and Total Worker Health programs.

3. Develop policies and plans that support individual and community health efforts

This is a core government function, but one where NGOs and the private sector need to be actively consulted and involved in building national knowledge bases and effecting policy development, clinical guideline/standard development and regional/local planning. Non-governmental/private sector entities have a wealth of information to contribute, including service data, promising or best practices, lessons learned and findings of special formative studies. It is anticipated that collaborative processes can be accomplished if organized around a critical issue at both the central and local levels.

It is recommended that USAID support strengthening private sector guidelines/standards, starting with family planning service provision, and certified training programs for local practitioners (formal and non-formal, e.g., BSP) to acquire competencies to deliver health/wellness promotion services, including screening for NCD, referral and follow-up.

4. Enforce laws and regulations that protect health and ensure safety

This too is a core function of the government. It is suggested that USAID-supported NGOs and the private sector can support the government to carry out its regulatory role. Potential activities are: joint monitoring and performance appraisal of private sector family planning and preventive health services, and promoting community involvement in reporting fraudulent practices.

5. Link people to needed personal health services

Ensuring equitable access to personal health services is a constitutional responsibility of the government. Government preventive health services are provided free, though coverage may be inadequate in rural areas. NGOs with funding from USAID and others are playing an important role in delivering primary health services and some preventive health measures. SMC, through MIH and previous projects, has

⁵⁸ Interactive theater for change; use of role models; mobile technologies for linking targeted groups with educational dramas and experts, community support groups, e.g., for women with migrant husbands, young married couples, etc.

contributed significantly by increasing availability of local private outlets for the promotion and distribution of affordable preventive health and family planning products. This continues to be a function where social marketing of products is critical. As noted in USAID High-Impact Family Planning Practices,⁵⁹ social marketing, combined with SBCC approaches, can and should promote and link populations to private as well as public health services, with special consideration to reaching populations in underserved or hard-to-reach areas, as well as to expanding choices for service providers, i.e. mobile clinics, model pharmacies (building on work with BSPs and PCHPs) and new innovative programming, including community-based maternity/family planning centers and “total health” workplace services.

Recognizing that the government of Bangladesh is exploring universal health schemes, it may be necessary in the meantime to develop demand-side financing mechanisms to ensure greater access and equity to products and services provided by the private sector. It is recommended that further inquiry be done to explore the lessons learned in Bangladesh related to the use of a maternal health voucher scheme,⁶⁰ and elsewhere⁶¹ about the use of reproductive health vouchers (and use of electronic vouchers) that can be redeemed at private for-profit and non-profit providers. Experiences, largely in Africa, have noted that voucher systems were associated with increased utilization of methods, particularly implants, among youth and improved quality of infrastructure and services.

6. Assure competency of the health workforce

As a long-term initiative, it is suggested that USAID work with national workforce development initiatives, advocating for formalization and regulation of rural non-formal practitioners, i.e., BSP, clarifying their scope, functions, service and performance standards, and required competencies. A certification/licensing process should also be supported. The timing is critical for positioning competent BSPs to be preferred or approved providers under a Universal Health Financing Scheme.

7. Research for new insights and innovative solutions to preventing and mitigating health problems

Studies are needed in several areas to inform social and behavior change strategies and program designs. As an example, more needs to be learned about women with unmet need for contraceptives by identifying who they are and the barriers that they face.

More broadly, it is recommended that adequate funding be provided to USAID-funded projects implementing innovative concepts, to support an operational research or implementation study design, as well as for rigorous monitoring and evaluating, to better capture lessons learned and promising or best practices for national and global learning.

⁵⁹ HIP-Family Planning High Impact Practices, <https://www.fphighimpactpractices.org/resources/high-impact-practices-family-planning-list>, USAID, updated September 2015.

⁶⁰ Ahmed SI, Khan MM. Is demand-side financing equity enhancing? Lessons from a maternal health voucher scheme in Bangladesh. *Soc Sci Med*. 2011. <http://www.ncbi.nlm.nih.gov/pubmed/21546145>

⁶¹ “Vouchers for health: a focus on reproductive health and family planning services.” <http://www.poline.org/>

V. CONCLUSIONS

The complex and multi-component MIH Project is projected to meet or has already met set targets. Each of the MIH components is critical to improving access, demand and delivery of quality health promotion and disease prevention services to reach the project's goal to "Contribute to sustained improvements of the health status of women and children in Bangladesh by increasing access to and demand for essential health products and sources through the private sector."

The review of the distribution system, a major element of component one, found **increased private sector networks as outlets for family planning methods and other essential health, nutrition and hygiene products**. These networks and USAID-donated contraceptives have **increased the availability of a wider contraceptive method mix, including LARC and the new Sayana Press in the public sector** and continued social marketing of affordable family planning and preventive health products. By developing the new community-based sales agents as outlets for its products, MIH has supported SMC in the development of community-based marketing as an adjunct to its mass media efforts to increase sales. This has been very successful.

The coupling of key health promotion messages with community-based sales is a promising marketing practice. In talking with other NGOs, the team heard demand for their community volunteers to be included as sales agents. It is widely agreed that the MIH awareness-raising activities, which include community and school health sessions and SMC-led mass media and mobile film shows, have resulted in **greater equity to standardized health, nutrition and hygiene messages along with the increased product accessibility**. The review noted that this innovative approach is likely to work well where knowledge and awareness is already good and demand is increasing, e.g., contraceptives for birth spacing or sanitary napkins. To further assess the effectiveness of the community-based marketing and behavior change activities, more inquiry and documentation are needed about how targeted groups are becoming more aware and engaged and how new adopters are being reached and serviced as a result of this intervention.

As the project develops, more intensive SBCC/marketing work is needed to address complicated issues, such as creating demand where potential consumers do not recognize a need; addressing practices, e.g., birth delay, where sociocultural factors play a significant role; and adoption of LARC when uptake is low and misconceptions and negative attitudes appear to be prevalent. These will require both a "push" and "pull," as well as an SBCC process. SMC is recognized for its excellent use of mass media to "push" products through the "4Ps:" product, price, place and promotion; it is with more "pull"—creating demand among consumers—that MIH can help with behavior change. In social marketing, the emphasis has traditionally been on selling products to consumers (the "push"). The basic process used by social marketers to "pull" products through the system has been to create awareness. This has worked successfully in Bangladesh through SMC, because the demand was there and promotional venues were easily available. Creating awareness, especially for family planning, worked because the majority of identified consumers, MWRA, demonstrated they had a basic need, the price was affordable and products were accessible. Thus, after several decades of continued marketing, the CPR had risen to above 60 percent of the targeted population. Now comes the much more difficult part: convincing the remaining 30-40 percent. This population has more resistance to using these products, is more difficult to reach and is strongly influenced by other factors, hence the need for more intensive work using social and behavior change strategies.

Social and behavior change communication is a process that attempts to reach out to the more difficult audiences, addressing issues where sociocultural or traditional factors or habitual practices come into play. This process uses communication models that recognize the complex thought process of how audiences move from an existing behavior to a desired behavior. It recognizes that people change

behavior when the benefit of the new behavior outweighs the benefit they already receive in practicing their old behavior.

Social marketing focuses on selling and distributing products, while BCC focuses on the audiences that will most benefit from using these products. The ideal program in Bangladesh would use social marketing for the first three Ps (product, price and place) and BCC for the fourth (promotion), because to get to harder-to-reach audiences, it is necessary to focus on understanding the audience: where they are, what they are thinking, their needs and their motivation. SMC, as demonstrated by what it has successfully achieved, has a corporate culture of pushing products.

MIH has tried to marry these two approaches by having SMC take the lead on the “push” and by using partners in attempting to “pull.” However, because SMC is the lead organization and has specific sales goals for each product, it has changed the focus so that its partners are trying to “push” products as well. The partners have become sales agents and product promoters, rather than behavior change enablers. This has led to some confusion during this project. As noted by an implementing partner, “We thought we were doing a behavior change project but then it was just about sales.”

Strategies and plans for well-coordinated SBCC and effective community mobilization need to be developed to define how audiences, e.g., those with unmet need for contraceptives or most at-risk for unwanted/unplanned pregnancies, will be reached through mass media and interpersonal communication, what messages or measures are needed to address their negative attitudes, what will convince them (and their influencers) to change their behavior and what channels will be most effectively used in a way that will enable audiences to participate in their willingness to change. Strategies should be monitored and evaluated to ensure success. The channel strategy needs to be consistent; the messages need to be frequent; and the audiences need to be involved in the process.

Under project component three, the training of providers to perform preventive health services fits with the goal’s emphasis on the private sector. The work by EngenderHealth and other training institutions to provide skills training continues USAID’s support for development of the private sector to deliver family planning methods and essential health products. More attention is needed to develop capacities of these private provider networks to also play a role in creating demand, promoting good adherence to regimens/methods and sustained health practices, and referring for higher-level care or longer-acting, more secure methods such as LAPM. As noted by many, the need for quality and sustainable counseling services is a gap that needs to be addressed at the local level to ensure informed choice for clients utilizing private sector outlets and services.

As SMC and partners develop their demand-creation expertise using mass media linked with community-based marketing, SBCC, and community mobilization approaches, the lessons learned and private sector models being created are a valuable national resource to address critical public health issues by increasing the **availability, accessibility, equity and demand regarding critical and essential preventive health products and services, communicable disease/injury prevention measures and non-communicable disease risk reduction.**

VI. PRIORITY RECOMMENDATIONS

The evaluation team was requested to provide (1) immediate recommendations for improving the current project and (2) recommendations for a potential follow-on project and for new programming related to critical public health issues.

A. CURRENT MIH PROJECT: IMMEDIATE PRIORITY RECOMMENDATIONS

The following are recommended actions for the last fiscal year of this project to further assess areas needing to be strengthened and to document successes and lessons learned to guide the follow-on project.

I. Foster internal learning

MIH's work at the community level and with its pharmaceutical and service partners provides opportunities for gathering information about the consumer base, e.g., awareness, product and service needs, attitudes, buying practices and satisfaction with products. It is recommended that the project conduct a participatory internal audit to systematically listen to the needs and views of staff, volunteers, intended audiences and clients (including private providers) regarding project-supported activities and services.

To assess the effectiveness of the community mobilization and community-based BCC, more systematic pre- and post-testing is recommended. Implementing partners should assign their program officers to conduct group discussions or exit interviews with a sample of participants after BCC sessions, inquiring about what they learned, their information needs and perceptions of the activity (place, time, topics and teaching methods).⁶²

It is recommended to regularly conduct surveys to assess the effectiveness of advertising and marketing campaigns and audience surveys to follow up on mobile film shows and the Floating IEC, and to make this standard practice for all new marketing and BCC behaviors. Findings should be triangulated with sales, special study and evaluation data to identify what has been effective in raising awareness, engaging targeted groups and creating demand. Sharing what is learned with the SMC marketing unit will help it to be increasingly responsive to the customer base and new or potential clients.

As the development of CSAs is a major component of MIH, it is recommended that SMC field staff and implementing partner staff be mobilized to learn and document lessons learned in developing CSA internal "auditing," to learn more about their attitudes about the recommended practices and projects and how they are promoting products and services.⁶³

With three years of history, this is an opportune time to learn and document the factors related to high-performing sales agents. Implementing partners with SMC sales agents need to gather detailed information about whom the CSAs are reaching and how they are being reached, as well as who is or is not buying. This is critical to identifying and documenting promising practices and scaling up helpful hints from high performers (not just quantity of sales, but market saturation of specific types of products with geographical and demographic factors considered). It is recommended that SMC review, analyze and interpret these as well as the CSA study findings with implementing partners, and, with CSAs, plan

⁶² Do the messages speak to their needs, were the messages clearly understood (words/language: listening for where there may be misunderstanding), are they appropriate (for culture, age, sex, situation), what did they learn, what would they like to know more about and/or what they would like to discuss further?

⁶³ There may be a variation among CSAs. Respondents in the 2014 Study to Evaluate the Knowledge and Effectiveness of CSA Activities who had or recently had children under age 5 were asked if they feed Monimix to their child. It was found that 86.7 percent of CWFD, 74.4 percent in PSTC and 68.6 percent in Shimantik area use Monimix for their own children.

actions to address most critical marketing and sales issues. Follow-up is needed to understand how significant the lack of cash outlay for buying sufficient stocks is. If this is found to be a barrier to increasing sales, it is recommended that SMC explore credit programs for service providers/outlets.

Another key area of inquiry is to assess how SMC/MIH resources⁶⁴ are being tapped to meet field staff and CSA/SS needs for education and promotion materials or to deal with tough questions, e.g., utilization of the hotline.

2. Strengthen marketing strategies and plans

To strengthen the marketing strategies and plans using the 4Ps, the following is recommended:

- **Price:** Test different price points among consumers before determining a stated price. Aside from taking into consideration actual costs, the marketing plan needs to show that the price is feasible among the segmented audience. Then the pricing strategy becomes more appropriate.
- **Place:** Understand the needs of the audience as far as physical place—not only how accessible the product is to the audience, but also how easy it is for the consumer to access the product. Would an adolescent woman actually go to a pharmacy in Sylhet to purchase a sanitary napkin? Would there be a more comfortable place for the young woman to purchase the product? Also, put in place a system to avoid potential stock-outs. (See section on distribution systems.)
- **Product:** What new products are going to further the project objectives? Have these products been successfully marketed in other countries? Learn what has already been done, learn from what has worked and what has not worked, and then test feasibility in Bangladesh.
- **Promotion:** Develop a solid and unique brand strategy for each brand. To ensure efforts are consumer-driven, incorporate audience and consumer research to segment audiences, tailor messages and incorporate BCC techniques to develop channels. In addition, develop good point-of-purchase materials to reach consumers at the point of sale to further promote the brand position with consistent and clear messages.

3. Identify and scale up use of role models/happy users

As a recognized effective BCC technique, it is highly recommended that the project intensify activities to develop and use role models/mentors⁶⁵ or happy couples,⁶⁶ with special focus on those who are highly satisfied and have successfully used injectables, LARC and LAPM. Their testimonies could be incorporated into group education sessions.

4. Review current referral, reminder and quality assurance systems

It is highly recommended that SMC review client instruction and reminder practices, with specific focus on the reasons that clients did not return for a second Sayana Press injection.

Referral patterns need to be closely analyzed, with information used to further study attitudes of providers, motivating factors and the referral processes and awards. The completion of referral forms should also be examined, noting information that is missing and exploring reasons for poor documentation. It is suggested that an electronic system be explored; meanwhile, a simple tally sheet should be developed and BSPs and their assistants instructed in how to provide data about reminders

⁶⁴ While an inventory was not conducted, SMC/MIH appears to have a wealth of educational and promotion materials that would address needs of its providers for educational and promotion materials, e.g., the SMC brochure promoting TB screening. <https://www.k4health.org/toolkits/bangladesh-mnch/ykssmaa#block-views-toolkit-page-resources-block>.

⁶⁵ http://pdf.usaid.gov/pdf_docs/PNACC495.pdf

⁶⁶ <http://ccp.jhu.edu/pilot-run-of-happy-couple-competition-publicizes-family-planning-stories-in-agra-india/>

and referrals each month. It is recommended that implementing partners gather monthly data; LARC referrals could be verified, as CSAs are getting paid⁶⁷ to accompany women and men for services.

As networks continue to expand, it is important to update internal communication systems to ensure that field staff and community agents are well informed of available BSP, PCHP, LARC and permanent method providers for information sharing with communities and cross-referrals.

5. Expedite exploration of alternative re-stocking and support mechanisms for community sales agents.

As noted during the review, SMC is exploring more sustainable and cost-effective options to supply the CSAs, e.g., developing SMC district-level supply chain systems. It is recommended that this be expedited as a project exit strategy and to potentially meet the demand of NGOs to have their community health workers become sales agents.

B. PRIORITY RECOMMENDATIONS FOR FOLLOW-ON MIH PROGRAMMING/NEW INVESTMENTS

Broadly, it is recommended that the follow-on project take a client-centered approach to developing marketing strategies and channels, community mobilization, BCC activities and client information, distribution, referral and reminder systems. The following are presented as priority recommendations.

1. Play an active role in the design of comprehensive behavior change, marketing and community mobilization strategies

It is recommended that strategies be developed for each targeted behavior and specific health or nutrition issue, based on findings of situation analyses. MIH would bring its marketing expertise and private networks to this design process, led by a partner with strong SBCC expertise and in cooperation with public and NGO sector partners—with the primary focus being on improving family planning practices. Additional formative studies will be needed to learn more about these populations: their level of knowledge, attitudes, needs, and socioeconomic, environmental or structural factors affecting their behaviors. Research can show what is needed to address these issues and to more finely segment the targeted groups, e.g., women with husbands working overseas who only return home for a month or so each year.

A good “how-to” resource is available through the USAID-funded, web-based Health Compass from the Health Communication Capacity Collaborative. A communication strategy is the critical piece bridging the situation analysis and the implementation of an SBCC program. It is a written plan that details how a program will reach its vision, given the current situation, and spells out a “systematic process and behavioral theory to design and implement communication activities that encourage sustainable social and behavior change.” Behaviors to target and topics to cover need to be tailored to the situation in a specific area.

To be better prepared for designing these strategies, program staff, SMC marketing staff and partners need to have to a good understanding of demand creation (“push and pull”) and of SBCC theory. It is recommended that workshops be developed with technical expertise provided by PSI and the USAID-funded Health Communication Collaborative to further develop strategic planning knowledge and skills.

⁶⁷According to CSAs/SSs met, they receive funds when bringing clients to the government services: 300 for permanent methods, 150 (60 initial+50+50) for follow-up of IUDs, and 50-50-50 for implants. Marie Stopes provides 500 taka for permanent methods.

It is recommended that a marketing strategy be developed for each branded product or service, recognizing that competition includes competing behaviors.

SMC marketing with program teams is encouraged to move from thinking only from the seller's point of view to include that of the buyer's. Exercise: *Draw a portrait of the target audiences and tell me who she and he are, what they need, why would one brand be better for them than the other and what would convince them to use it.*

BCC messages need to be developed and tailored as needed for local situations to meet needs of targeted groups, ensuring these are age-appropriate and gender-sensitive, addressing social or cultural barriers, fears and contributing factors to non-use or low or suboptimal utilization. As a new investment, it is recommended that USAID invest in district-level planning and public/NGO/private partnerships to provide products and services as part of focused campaigns, e.g., TB or NCD screening and risk reduction. As noted in the previous section, MIH can play an important role in bringing mass media marketing expertise and private networks to this planning process.

2. Support use of mass media campaigns

To create demand and adoption of preventive health products and practices, support the use of mass media campaigns linked with campaigns that are using community-based marketing and sales promotion.

The use of mass media is essential when addressing the lack of perceived need or as an emergency or timely reminder, e.g., the use of emergency contraception if unplanned sexual encounters or contraceptive misuse/failure occur, or the proper use of products during seasonal outbreaks, such as ORS and zinc during the diarrheal seasons. Messages have to create new perceptions.

Noting that TV was the most common source of information about emergency contraceptives, further promotion of Norix should use mass media, particularly TV and videos for phones. TV can be used to convey different situations where women were not expecting to have sex, but then did. A series of 30-second TV spots could be designed, each showing a different woman in an unexpected situation—a surprise visit from her husband, or a teacher that is too busy thinking about her exams to have planned anything beforehand. These stories can be funny and emotional to appeal to the target audience; all do not have to be serious. Positioning for Norix could be: “Whew, helped me again.” Training in interpersonal communication skills for BCC advisors and field personnel/CSAs needs to be well developed. Community-based sales agents and other providers who have pre-tested tools and skills training should interface with the community, listening to audiences and reinforcing messages at product outlets. Continue to engage providers and community workers to help evaluate the effectiveness of campaigns and to monitor how specific audience segments are responding to local activities. Demand that ad agencies provide specific media coverage information by audience for each mass media channel they use in their communication campaigns. The combination of mass media information and community information could then be aggregated to get a fuller picture of who is being reached and how audiences are responding. Use network branding for the promotion of products.

LARC campaigns often are focused on method benefits, but research has indicated that audiences did not trust the competency of providers for these methods. Instead of emphasizing the product for LARCs, emphasize the provider as part of a Blue Star or LARC provider network quality branding campaign. A series of dramas could be developed in a mass media campaign, showing the provider to be professional, safe and reliable. It could highlight that one of the things they do really well is IUD insertion, a long-acting reversible family planning method that enables people to delay having children for five years. Alternatively, it could show newly married couples being provided with counseling, leading them to choose implants to be better prepared for parenthood, complete their education or have time to enjoy their entry into adulthood. As informed by the SBCC strategy, suitable BCC tools/aids may be

resourced for the network providers from the HC3 e-tool or the government's BCC forum. Nationally and globally, there are many successful m-technology experiences to tap, such as job aids like pre-loaded PDAs for facilitating virtual BCC and counseling. Ideas used globally are: short videos on smart phones with high-level endorsement from respected persons, such as religious leaders or physicians,⁶⁸ making clear, bold statements; testimonials from happy users/role models; and videotaped counseling sessions with experienced family counseling experts, explaining the benefits of recommended methods as they interact with a variety of couples, answering their questions and speaking to their fears. With a toll-free phone number and mobile tools, the facilitators could link participants with expert counselors at hotlines to answer additional questions.

Mobilize resources for continuing the Mobile Film Shows (by road or water): Given the high demand for visual BCC and the success in gathering large crowds, it is recommended that this activity be supported particularly for communities where outlets or services are new or being revised, including sales agents, BSP, PCHP or LARC providers. Because of the high cost of implementing this intervention, as well as geographical access issues (poor road systems, high waters), alternative channels may be needed, e.g., digitalizing the dramas to reach people in smaller groups and small-screen showings in remote areas or on the floating barges. If funding allows, it would be optimal to link them with other information channels and resources for follow-up with dialogue sessions with trained and equipped⁶⁹ CSAs and counseling services by well-trained personnel from the public/NGO or private sector.

Build on MIH experience, refining community mobilization approaches to engage targeted groups, ensuring that activities and IEC are relevant, grounded in understanding of the environment, gender, human development and adult learning theory. Organize events, ensuring that choice of venue and schedule is gender-friendly (works around traditional work and leisure timeframes). Develop SBCC messages and channels that are sex- and age-appropriate, and select staff and volunteers who can best communicate with and encourage engagement of the targeted populations. Encourage male involvement in promoting family planning. In reaching the 12 percent of the population with unmet need and in promoting longer-acting contraceptive methods, it is critical to understand household decision-making dynamics, gender-related roles and common attitudes about family size, methods and fears of both males and females about products or services. It is highly recommended that process, output and outcome indicators, disaggregated by sex and age group, are measured and used for monitoring project targeting and evaluating results.

3. Explore new marketing and BCC techniques

Marketing ideas to consider include: (1) Bundle products by lifestyle or life phase. As an example, soon-to-be mothers could be served by the private sector, including skilled CBAs, with a maternity kit: progestin-only pill, safe delivery kit, zinc/ORS, Monimix and, if quality concerns are addressed, provision of life-saving misoprostol and chlorhexidine. Sales agents and providers need to promote the benefits (not the features) of this package of products to ensure a healthy mother and healthy child. In addition, the project is urged to develop an adolescent wellness kit incorporating iron/folic pills, sanitary napkins, and other hygiene products such as deodorant. (2) Market services along with products, e.g., skilled CBAs and their use of safe delivery kits and high-impact practices such as misoprostol. (3) Link clients who have not used products such as micronutrient sprinkles with mothers or agents who are very positive users of these products. Perhaps provide tasting demonstrations. (4) If governmental approval

⁶⁸ An example of the importance of high-level endorsement is the 2014 recommendations from the American Academy of Pediatrics: LARC is a "first-line birth control option for adolescents." "All forms of birth control are safer than pregnancy for adolescents/youth."

⁶⁹ Equipped with facilitation skills, facilitation guides, access to experts to handle questions, tools, and mechanism for reporting what was discussed in the sessions to project marketing and community mobilization/BCC staff

can be obtained, market Sayana Press as a self-administered or CSA-administered injectable targeting rural areas where BSP or other private providers are not operating.

As a new investment, it is recommended that USAID support adolescent/youth wellness initiatives, with support provided for development of low-cost sustainable life skills training⁷⁰ for female and male youth. This could be based in communities⁷¹ or workplaces or take place after school. Topics to be considered are: preparing for motherhood and fatherhood, knowing and respecting your body, understanding reproductive health, prevention of gender-based abuse and violence, disease and injury risk-reduction skills, and skills for appropriate use of new technologies (internet/phones).⁷² In partnership with education, this programming idea could include teacher training in interactive teaching methods to cover reproductive health in the formal curriculum. As well, this programming would be coupled with marketing and sale of adolescent-focused packages of products and preventive health measures. A subset of this idea is to focus on engaged or newly married young couples with life-skills training: preparation for parenthood, family planning, or topics such as joint decision making. Special counseling and education packages using m-technology and hotlines for newly married couples or those soon to be married, coupled with marketing of appropriate contraceptive measures, e.g., implants.

4. Improve SMC logistics, recording, reporting, referral and follow-up systems

It is recommended that the new project adopt electronic systems and mobile technologies⁷³ for logistics,⁷⁴ reporting product sales and/or administration of medium- and long-acting methods, a practical reminder system (using symbol or text via SMS) for injectable contraceptive clients, and monitoring activity and performance of sales agents and providers. Establishing stronger linkages and cross-referral pathways between network providers will help to address the fragmentation of the “private family planning system.” Better tracking of clients is needed to promote continuation with and adherence to family planning methods and other preventive health measures.

5. Develop new service delivery modalities for improved access and equity

To support government priorities for greater availability and equity to services, work at the district level, using mapping data to address gaps in availability of private sector services in rural, underserved or hard-to-reach locations. A high-impact practice to consider is investment in private mobile clinics with full contraceptive methods for reaching underserved and/or rural areas by road or for seasonal service by boat for isolated communities (riverine, hoar). These could be developed as a private venture involving BSP and LARC network providers, or as private/public partners with government and private or NGO providers to provide full family planning services. Services could be expanded to provide other women’s health services—breast exams, pap smears, diet counseling—and NCD and TB screening for the wider population. A voucher or coupon system could be devised to ensure equity to care where there are no or few public sector services. As has been recommended by others,⁷⁵ these mobile clinic programs could be taken to garment factories. Good community mobilization to organize events and

⁷⁰ Resources from the HC-3 consortiums in the region and review of national best or promising practices, i.e., EVIDENCE.

⁷¹ Strong community mobilization is required for effective work with youth, using methodologies such as CARE’s Social Analysis and Action to address issues such as prevention of early marriage, pregnancy or gender-based violence.

⁷² Note D-Net’s work to develop adolescent-focused information services with m-technology and hotlines.

⁷³ A valuable resource for exploring m-technology is the mHealth Compendium Volume 5 June 2015, http://www.msh.org/sites/msh.org/files/2015_08_msh_mhealth_compendium_volume5.pdf. Other resources include D-Net work with the MAMA project or replication of methodologies used effectively by PSI, e.g., Movercado, <http://triggerise.org/>.

⁷⁴ Exploring adaptation of the SIAPS-developed electronic Logistics Management Information System (eLMIS) for SMC and private providers.

⁷⁵ SHOPS Project. 2013. Bangladesh Family Planning Private Health Sector Assessment. Brief. Bethesda, MD: SHOPS Project, Abt Associates.

clients as well as follow-up services will need to be assured. USAID is also encouraged to explore social marketing of innovative community-based maternity service modalities, e.g., privatized birthing huts⁷⁶ or birthing centers in the country or region, DKT's "Dhanka" networks in Pakistan—midwife-owned and emphasizing LARC. Secondly, as a new investment, it is recommended that USAID explores NIOSH's Total Worker Health concept and the promising or best practices that have been documented.⁷⁷ This concept, in addition to addressing environmental and structural issues related to occupational safety and health, also provides opportunity for workers to access communicable disease prevention, non-communicable disease risk-reduction and skills training for better nutrition, weight loss, smoking cessation, exercise, as well as onsite or offsite linkage with services such as family planning. This could be institutionalized through a series of campaigns or health fairs. Thirdly, invest in model pharmacies, e.g., "Blue Star Pharmacies," by adding new features: gender-friendly services; wellness packages promoting healthy lifestyles, immunizations, rapid laboratory testing (hemoglobin, NCD screening⁷⁸) and referrals—intensifying early identification and referral of suspected TB cases; fee-for-service DOTS; and health risk reduction and injury prevention instruction and measures.⁷⁹

Assuming that sustainable supply chain mechanisms are in place, refine the functions and role⁸⁰ of community sales agents and scale up these community-based outlets/providers in rural communities.⁸¹

6. Intensify development of private provider networks and capacities

The new project is encouraged to partner with an institution or NGO with proven expertise in designing, leading and evaluating competency-based skills training and capacity-building activities to further develop the various private provider networks. Initial steps to developing capacity-building for providers include: (a) clarification of provider role and functions, focusing on those related to family planning, preventive health, early identification and referral of communicable and non-communicable diseases, and less on curative skills and services; (b) establishment of care and performance standards; (c) refined criteria for inclusion in networks as needed, e.g. CSA; and (4) assessment of capacities and competencies to perform functions to standard, identifying capacity development needs.

Systems also need to be strengthened for improved communication and stronger linkages between the private providers and public referral facilities, with communication and referral systems between the networks. With the system development, training sessions will be required for providers and monitors.

External expertise will be needed to design skills training for project staff and partners in interpersonal communication skills and community mobilization approaches to listen, to effectively "push and pull" (particularly when there are complex sociocultural factors influencing behaviors, such as early marriage and pregnancy), to facilitate community action and to effectively use SBCC tools.

It is recommended that a training package be developed for all product providers, including basic entrepreneurial skills training: business planning, promoting and selling products, use of job aids,

⁷⁶ According to Save the Children, these are being developed with funding through the MaMoni Project.

⁷⁷ "Promising and Best Practices in Total Worker Health." <http://www.nap.edu/read/18947>

⁷⁸ This will require setting standard operating procedures, requiring good technical advising in laboratory testing, and quality assurance, coupled with client education and referral systems.

⁷⁹ Work with DHS (with technical assistance from Bangladesh Diabetic Association) to develop model pharmacy and conduct community-based screening, referring, monitoring and promotion (diet, exercise, drug adherence).

⁸⁰ Strong entrepreneurial potential, capacity to learn and to instruct, a positive attitude about family methods and preventive health products, commitment to being an information source and change agent in her/his community. Explore incorporating D-Net's "info ladies" concept, e.g., Community Sales and Information Agents (CSIAAs).

⁸¹ Encourage the inclusion of other community volunteers wanting to sell products, e.g., community outreach and health workers associated with NGOs.

recording sales, delivering BCC and reporting administration or sales of products, including noting first-time users.

The following are recommended as new or replicated certified training programs: (1) early identification through screening, referral and follow-up of clients with NCDs—specifically hypertension and diabetes;⁸² (2) customer education and follow-up to promote proper usage, compliance and adherence to specific products/regimens; (3) IMCI certification training for BSP/PCHP by experienced government practitioners/trainers; (4) reproductive health counseling with emphasis on LAPM and couple-counseling skills for counselors and hotline staff; (5) refresher training for networks to promote their involvement in early identification of suspected TB and referral as well as providing DOTS.⁸³

Recommended features of capacity-building programs include: (a) Trainings utilize adult training principles; (b) Skills trainings are competency-based; (c) Training programs and trainers are evaluated with trainee feedback, used for improving the training syllabus, schedule and training methods, as needed; (d) Providers that are accepted into the network have demonstrated competencies and are performing to standards; (e) Providers are mentored and nurtured as SMC clients; and (f) There is co-pay by private sector participants, based on a fee schedule for each of the certified courses. It is advised that the use of cascaded training modalities be carefully planned and rigorously monitored to ensure quality of instruction throughout.

System development should include: development of a quality assurance system to ensure quality hotline/counseling services (suggest using external evaluators), performance appraisals of private providers/outlets with action plans for improvement, and joint medical detailing led by a specific technical/training partner, e.g., EngenderHealth, with an SMC program officer/sales agent and optimally the DGFP/DGHS (technical expert) to ensure that family planning practice standards are adhered to by the network partners.

In addition to technical evaluation, it is recommended that participatory monitoring and evaluative processes be supported for ensuring quality of service and client/staff satisfaction, such as COPE (an internal audit methodology) and Community Score Card (evaluating preventive health and primary care services).

⁸² It is suggested that these training programs for NCD screening and monitoring be developed for BSP only, as they involve adhering to strict protocol and techniques, quality assurance systems, e.g., for keeping screening tools calibrated and working well, for providing client instruction and for appropriate referrals (timing, facilities).

⁸³ Explore public/private partnership to provide exploring privatized fee-based DOTS (home visits, community groups or services at the BSP/PCHP pharmacies).

ANNEXES

ANNEX A. SCOPE OF WORK

Global Health Program Cycle Improvement Project (GH Pro)
Contract No. AID-OAA-C-14-00067

EVALUATION OR ANALYTIC ACTIVITY STATEMENT OF WORK (SOW)

11-16-15

TITLE: Social Marketing Program Evaluation (097)

Requester/Client:

USAID Country or Regional Mission

Mission/Division: Bangladesh / Office of Population, Health, Nutrition, and Education

Funding Account Source(s): (Click on box(es) to indicate source of payment for this assignment)

- | | |
|------------------------------------------------------------|-------------------------------------------------|
| <input type="checkbox"/> 3.1.1 HIV | <input checked="" type="checkbox"/> 3.1.6 MCH |
| <input checked="" type="checkbox"/> 3.1.2 TB | <input checked="" type="checkbox"/> 3.1.7 FP/RH |
| <input type="checkbox"/> 3.1.3 Malaria | <input type="checkbox"/> 3.1.8 WSSH |
| <input type="checkbox"/> 3.1.4 PIOET | <input type="checkbox"/> 3.1.9 Nutrition |
| <input type="checkbox"/> 3.1.5 Other public health threats | <input type="checkbox"/> 3.2.0 Other (specify): |

Cost Estimate: *GH Pro will provide a final budget based on this SOW*

Performance Period:

Expected Start Date (on or about): September 16, 2015

Anticipated End Date (on or about): January 31, 2016

Location(s) of Assignment: (Indicate where work will be performed)

Bangladesh, with expected in-country travel to two to three of the following Divisions: Chittagong, Sylhet and Dhaka

Type of Analytic Activity (Check the box to indicate the type of analytic activity)

EVALUATION:

Performance Evaluation (*Check timing of data collection*)

Midterm Endline Other (specify): _____

Performance evaluations focus on descriptive and normative questions: what a particular project or program has achieved (either at an intermediate point in execution or at the conclusion of an implementation period); how it is being implemented; how it is perceived and valued; whether expected results are occurring; and other questions

that are pertinent to program design, management and operational decision making. Performance evaluations often incorporate before-after comparisons, but generally lack a rigorously defined counterfactual.

Impact Evaluation (Check timing(s) of data collection)

Baseline

Midterm

Endline

Other (specify):

Impact evaluations measure the change in a development outcome that is attributable to a defined intervention; impact evaluations are based on models of cause and effect and require a credible and rigorously defined counterfactual to control for factors other than the intervention that might account for the observed change. Impact evaluations in which comparisons are made between beneficiaries that are randomly assigned to either a treatment or a control group provide the strongest evidence of a relationship between the intervention under study and the outcome measured.

OTHER ANALYTIC ACTIVITIES

Assessment

Assessments are designed to examine country and/or sector context to inform project design, or as an informal review of projects.

Costing and/or Economic Analysis

Costing and Economic Analysis can identify, measure, value and cost an intervention or program. It can be an assessment or evaluation, with or without a comparative intervention/program.

Other Analytic Activity (Specify)

PEPFAR EVALUATIONS (PEPFAR Evaluation Standards of Practice 2014)

Note: If PEPFAR funded, check the box for type of evaluation

Process Evaluation (Check timing of data collection)

Midterm

Endline

Other (specify): _____

Process Evaluation focuses on program or intervention implementation, including, but not limited to access to services, whether services reach the intended population, how services are delivered, client satisfaction and perceptions about needs and services, management practices. In addition, a process evaluation might provide an understanding of cultural, socio-political, legal, and economic context that affect implementation of the program or intervention. For example: Are activities delivered as intended, and are the right participants being reached? (PEPFAR Evaluation Standards of Practice 2014)

Outcome Evaluation

Outcome Evaluation determines if and by how much, intervention activities or services achieved their intended outcomes. It focuses on outputs and outcomes (including unintended effects) to judge program effectiveness, but may also assess program process to understand how outcomes are produced. It is possible to use statistical techniques in some instances when control or comparison groups are not available (e.g., for the evaluation of a national program). Example of question asked: To what extent are desired changes occurring due to the program, and who is benefiting? (PEPFAR Evaluation Standards of Practice 2014)

Impact Evaluation (Check timing(s) of data collection)

Baseline

Midterm

Endline

Other (specify):

Impact evaluations measure the change in an outcome that is attributable to a defined intervention by comparing actual impact to what would have happened in the absence of the intervention (the counterfactual scenario). IEs are based on models of cause and effect and require a rigorously defined counterfactual to control for factors other than the intervention that might account for the observed change. There are a range of accepted approaches to applying a counterfactual analysis, though IEs in which comparisons are made between beneficiaries that are randomly assigned to either an intervention or a control group provide the strongest evidence of a relationship between the intervention under study and the outcome measured to demonstrate impact.

Economic Evaluation (PEPFAR)

Economic Evaluations identifies, measures, values and compares the costs and outcomes of alternative interventions. Economic evaluation is a systematic and transparent framework for assessing efficiency focusing on the economic costs and outcomes of alternative programs or interventions. This framework is based on a comparative analysis of both the costs (resources consumed) and outcomes (health, clinical, economic) of programs or interventions. Main types of economic evaluation are cost-minimization analysis (CMA), cost-effectiveness analysis (CEA), cost-benefit analysis (CBA) and cost-utility analysis (CUA). Example of question asked: What is the cost-effectiveness of this intervention in improving patient outcomes as compared to other treatment models?

BACKGROUND

Background of project/program/intervention:

Bangladesh has shown remarkable achievements in MDGs 4 and 5, reducing child and maternal mortality in the last two decades. In 2011, Bangladesh has surpassed the MDG 4 target and is on track to achieve MDG 5.

The infant mortality rate has been reduced from 66 per 1,000 live births in 2000 to 43 in 2011 (UN Interagency Report: 33/1,000 live births in 2013), and under-5 mortality rate per 1,000 live births has declined to 53 in 2011 from 94 in 2000 (UN Interagency Report: 48/1,000 live births). The neonatal mortality rate has fallen to 32 per 1,000 live births in 2011 from 42 in 2000 (UN Interagency report 24/1000 live birth). The maternal mortality ratio has declined from 322 per 100,000 live births to 194 between 2001 and 2010 (UN Interagency Report: 170/100,000). Bangladesh also has made significant gains in reducing population growth. In 2011, the annual population growth rate was 1.3 percent, and the fertility rate was at 2.3 children per woman.

However, Bangladesh's relatively weak public health system hinders quality health service delivery and threatens sustainability of already achieved gains in health. There are many challenges that need to be addressed in order to maximize and sustain the successes in MCH and family planning. Out-of-pocket expenditure for health care accounts for about 65 percent, and approximately 80 percent of the low-income population uses private sector services as the first line of care (National Health Account Report 1997-2012).

Despite the achievement in maternal mortality reduction, only 29 percent of deliveries occur in health facilities, and only 32 percent of births are attended by a skilled provider. Most births still occur at home, most of these attended by untrained providers. Increasing the percentage of women who give birth with a skilled birth attendant is a priority area of action for the national program.

Despite success in fertility reduction and contraceptive use, 12 percent of the population still has an unmet need for contraceptives. Although 62 percent of couples want no more children, LAPM use remains limited (8 percent). Male involvement in family planning is much below the desired levels, but

male sterilizations are increasing in some areas where quality services are offered. There is an opportunity to increase provider knowledge and strengthen referral networks for LAPM service delivery.

More than six million children under the age of 5 still suffer from malnutrition in Bangladesh, contributing to two thirds of child deaths. In addition, 41 percent of children under 5 are stunted, and 16 percent are acutely malnourished or wasted. About 24 percent of married women of reproductive age are undernourished, and 42 percent are anemic. There remains an untapped opportunity to introduce more socially marketed nutritional products to address these needs in Bangladesh.

Bangladesh has the sixth highest TB burden in the world. Although detection of smear-positive cases has increased over 70 percent with a 92 percent treatment success rate, overall only 53 percent of all forms of TB are notified in the country (WHO Global TB Report 2014). Stigma around care-seeking behavior and lack of a notification system by private sector providers result in about half of cases going undetected. Despite a recent increase in case detection and treatment, Bangladesh also has a high burden of drug-resistant TB. In coordination with the National TB Program, there is an opportunity for private sector providers to assist with scaling up the national response to TB.

The burden of poverty and cultural constraints falls disproportionately on women, who represent only 26 percent of the workforce. The average age of marriage is very young (15.3 years). Just over half of women contribute to household decision making, and these women are more likely to use family planning and receive antenatal or delivery care from a trained provider.

For a majority of Bangladeshis, including the poor, the private sector—particularly the non-formal providers because of their presence in the community—is usually the first point of contact for primary health care. The private sector is large, diverse and dynamic. It includes a range of players, from health providers to NGOs, manufacturers, suppliers and distributors, who all contribute directly and indirectly to the efficiency and advancement of overall health objectives in Bangladesh. However, current and comprehensive information is lacking to help better understand the key players, their characteristics, services offered, customers and motivations. For example, not much is known about: (1) the formal and non-formal health providers in terms of their education, experience and other qualifications, location and place of practice, profile of the clients that they serve, etc.; (2) the private sector outlets (pharmacies, grocery, kiosks) in terms of their purchase characteristics, product line, customers and services; and (3) the extent to which the private sector responds to national public health priorities and the overall health needs of the population.

USAID/Bangladesh Social Marketing Program Support

USAID assistance to social marketing began in 1974, soon after Bangladesh achieved independence. Social Marketing Company (SMC) began as an experiment in private sector distribution of subsidized contraceptive methods using commercial marketing techniques to motivate people to practice socially beneficial behaviors and purchase socially beneficial products and services at an affordable price. In 1980, SMC added oral rehydration solution (ORS) to its line of public health products. It is now one of the world's largest social marketing companies.

In 1990, SMC transformed into a not-for-profit private limited company operating under a voluntary board of directors. Although supporters included DFID, CIDA, the Government of Bangladesh, EU, UNFPA and others, USAID remained SMC's single largest financial supporter. SMC reports now show that the company covers all of its own commodities cost and 100 percent of non-program operating costs.

With USAID's support through donated commodities, technical assistance and cash grants, SMC is a major source of contraceptive products. SMC contributes to 35 percent of Bangladesh's total yearly

modern contraceptive prevalence of 48 percent. Per the BDHS 2011, SMC/Private sector provides 78 percent of condoms with about 60 percent attributable to SMC, 44 percent of oral pills with about 38 percent attributable to SMC and 21 percent of injectable with about 14 percent attributable to SMC. NGOs and the public sector provide the remaining percentages of contraceptives for a total of 100 percent per commodity. SMC has been implementing a program offering IUD and implant services through a network of graduate medical practitioners in the private sector, including obstetricians and gynecologists. SMC recently has started a test marketing of Sayana Press, a prefilled subcutaneous DMPA injection, through a subset of Blue Star providers and graduate LARC providers.

SMC has an ORS factory, which manufactures regular and fruity flavors. SMC's market share in ORS distribution is over 55 percent, with more than 380 million of sachets of ORS produced per year in its own factory. The factory is self-sustaining. SMC also markets zinc tablets, micronutrient sprinkles and safe delivery kits. Recently, SMC has introduced sanitary napkins in the market, targeted to improve women's hygiene and school attendance by adolescent girls. In order to diversify its product base and increase its revenue, SMC is exploring the possibility of marketing other health products.

In addition to the USAID-funded ORS factory, SMC has been benefited from the construction of a building for office space and rental space to others. Earlier, SMC could complete only up to nine floors of the 20-story foundation building and is now constructing the remaining floors.

SMC distributes its products through commercial outlets throughout the country. Additionally, SMC supports the Blue Star network of 6,000 "non-graduate medical practitioners" throughout the country who sell SMC products, provide injectables and limited MNH services, disseminate messages on TB and refer suspected TB cases to the nearest facilities, and refer clients for LAPM to the nearest Government of Bangladesh and NGO facilities. SMC also conducts community and media outreach programs on family planning, maternal and newborn health, and TB control. SMC TV spots broadcast quality messages on health promotion and use of SMC products.

SMC recovers 100 percent of its non-program operating costs from sales revenue since 2013, and at this time, it recovers 100 percent of its total costs through its sales and non-sales revenue. SMC is now able to generate profit and plough back the profit to support public health programs. The program is one of USAID's greatest success stories of sustainable development, and the organization is now capable of executing its corporate social responsibility.

Project Background and Context

The current relationship between USAID and SMC is governed by a cooperative agreement that commenced July 26, 2012 and will end July 25, 2016. The cooperative agreement emphasizes services in family planning and reproductive health, maternal and child health including nutrition, TB, and the development of new business as well as other sustainability strategies.

The \$132.2 million cooperative agreement includes \$15.0 million federal cash funds, \$112.3 million cost share, and \$4.9 million program income funds, which will be generated from USAID's contraceptive commodity donations and other income. In the past, USAID had provided SMC with technical assistance to focus on strategic planning, organizational development, cross-subsidization issues and financial feasibility forecasting.

Marketing Innovations for Health (MIH) Project

Program Title: Marketing Innovations for Health

Award Number: AID-388-A-12-00003

Project Dates: July 26, 2012–July 25, 2016

Program Funding: \$15,000,000 (Cash Fund) + \$5,000,000 (Commodity Support)

Implementing Organization: Social Marketing Company (SMC) Bangladesh

Agreement Officer's Representative (AOR): Sukumar Sarker

Goals and Objectives

The goal of the MIH Project is to contribute to sustained improvements in the health status of women and children in Bangladesh by increasing access to and demand for essential health products and services through the private sector.

To achieve this goal, SMC and its partners use innovative approaches to improve access to new and existing products and services, reach new beneficiaries using a private sector social marketing model, and strengthen linkages with public and private sector partners.

Project Intent

The objective of MIH is to "Improve the health status of women and children in Bangladesh." The MIH development hypothesis is: *If targeted populations have access to quality products and health services and are aware of the benefits of using these products and services, they will use these products and services, leading to improved health outcomes.*

Project results will be accomplished through the achievement of the intermediate results (IRs) as included in the results framework (Figure 1). These IRs are not isolated from one another, and within each IR, there are multiple sub-IRs, each of which is associated with one or more project interventions.

In order to achieve the results, the project focuses on components as follows:

Component 1: Expand Commodity Sales and Distribution through private sector networks, including NGOs, at an affordable price to support family planning and other healthy practices, especially focused on low-income populations.

Component 2: Improve knowledge and healthy behaviors, reduce harmful practices and increase care-seeking practices while reaching out to new audiences (youth) through creative Behavior Change Communication.

Component 3: Improve delivery of quality family planning, reproductive and child health services, referrals/DOTS services for TB, and referrals for higher-level clinical services including LAPM, through Capacity Building of local formal and non-formal private providers.

Project Approach and Implementation

SMC uses a total market approach (TMA) to increase the proportion of the target population using family planning/reproductive health, maternal health, child survival and nutrition products. TMA aims to make markets work for the poor by ensuring all segments of society are reached with high-quality products and services according to their ability to pay. A healthy market for health commodities includes commercial products reaching wealthier quintiles of the population, a range of subsidized products for middle quintiles, and free products for the poorest. SMC implements an integrated social marketing program that segments the population and provides quality products and services at different price points while increasing overall demand across the market through BCC and other promotional marketing.

SMC works with Population Services International (PSI) as a technical partner to provide assistance to the project in a range of programmatic areas, including supporting the implementation of a TMA, developing core BCC messages, increasing the use of LAPM, managing diarrheal disease, nutrition, medical detailing and provider training. By integrating a PSI social marketing expert into the project team, SMC benefits from sustained on-the-ground technical assistance in crosscutting areas to help

build a culture of evidence-based programming and continuous innovation, drawing on best practices and lessons learned from social marketing, BCC and service delivery programs around the globe. In addition, SMC works with several local NGOs [BRAC, Concerned Women for Family Development (CWFD), Population Services and Training Center (PSTC), and Shimantik] to implement community mobilization activities in the project's priority districts. SMC is also partnering with EngenderHealth to train private sector graduate providers on LAPM, and with other local training organizations, selected through a process of competitive bidding, to build the capacity of non-graduate medical providers under the SMC BSP network.

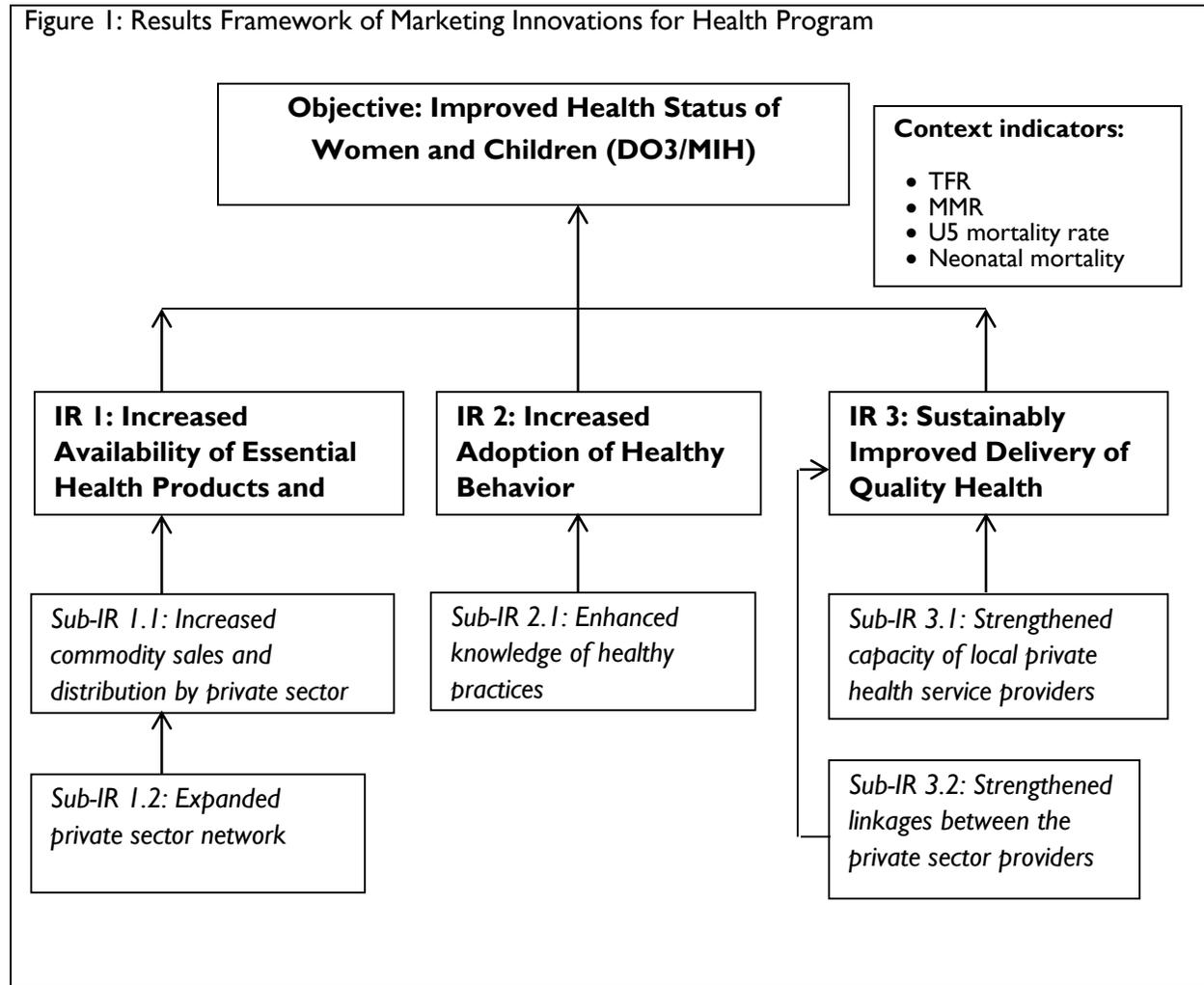
SMC targets low- and middle-income women and men of reproductive age (15-49) and mothers of newborns and children under 5 residing in areas where health needs are the greatest (Table 1). SMC products and messages continue to reach targeted populations nationwide, but a special emphasis is placed on reaching 19 priority districts across four divisions with community mobilization efforts to extend the reach of BCC messages, products and services. Per the BDHS 2011, these districts have CPR for any modern method that are less than the national average (national average is 53.8 percent), and/or under-5 child mortality above 60 deaths per 1,000 (national average is 56 deaths per 1,000).

Table I: Priority Districts with CPR and Under-5 Child Mortality

Division	District	CPR (modern method)	Under-5 Child Mortality (per 1,000)
Chittagong	Bandarban	49.1	50
	Brahmanbaria	35.4	52
	Chandpur	49.4	48
	Comilla	44.0	48
	Feni	47.5	58
	Laxmipur	52.3	71
	Noakhali	50.2	63
Sylhet	Hobigonj	30.1	75
	Maulvibazar	41.5	80
	Sunamganj	34.5	91
	Sylhet	35.1	83
Dhaka	Kishoreganj	49.7	68
	Munshiganj	48.5	46
	Narsingdi	44.8	59
	Madaripur	49.7	79
	Faridpur	48.3	44
Barisal	Barisal	48.9	58
	Jhalokati	47.4	56
	Perojpur	47.7	55

Describe the theory of change of the project/program/intervention.

Strategic or Results Framework for the project/program/intervention (paste framework below)



What are the geographic coverage and/or the target groups for the project or program that is the subject of analysis?

Chittagong Division: Bandarban, Brahmanbaria, Chandpur, Comilla, Feni, Laxmipur, Noakhali
 Sylhet Division: Hobigonj, Maulvibazar, Sunamganj, Sylhet
 Dhaka Division: Kishoreganj, Munshiganj, Narsingdi, Madaripur, Faridpur
 Barisal Division: Barisal, Jhalokati, Perojpur

SCOPE OF WORK

Purpose: Why is this evaluation or analysis being conducted (purpose of analytic activity)? Provide the specific reason for this activity, linking it to future decisions to be made by USAID leadership, partner governments, and/or other key stakeholders.

USAID/Bangladesh has been supporting a social marketing program in Bangladesh for more than 40 years and contributing significantly to the health and well-being of Bangladeshi citizens, particularly those in the lower wealth quintiles. In order to be enlightened on the future direction of its social marketing program, USAID/Bangladesh would like to conduct a three-dimensional assessment of social marketing activities in Bangladesh:

The first component will be to evaluate SMC achievements under the current cooperative agreement and constraints of the organization in performance failure, if any. The evaluation will look at the performance trend of the organization in implementing the social marketing program in the context of public health goals, with a special emphasis on: (1) contributions to contraceptive prevalence and LARC use; ORS and other MCH product use; (2) introduction of new products in family planning, maternal and child health, TB control, and health and hygiene programs; and (3) expansion of availability of family planning/LARC services in the private sector health network.

The second component will focus on new program areas where social marketing can be expanded to contribute more in addressing public health needs. Review the possibility of introducing social marketing programs for nutrition, water, sanitation and hygiene. In particular, the possibility of offering health services of public health significance by private health practitioners and leveraging private resources under the social marketing program needs to be explored.

The third component will focus on best possible future directions for social marketing in the Bangladeshi context. The evaluation will look into possible options for USAID/Bangladesh to continue its social marketing program in order to sustain and increase its current achievements in adoption of health products and messages. The focus should also be to identify the alternative or additional approaches/strategies that USAID may consider to achieve the social marketing goals, in the context of continued economic development of Bangladesh to be a middle income country by 2021.

Audience: Who is the intended audience for this analysis? Who will use the results? If listing multiple audiences, indicate which are most important.

The assessment will primarily inform USAID on how the social marketing program can best be used to maximize public health results and educate the mission in guiding the design of future social marketing programs. The assessment will recommend possible options for USAID in adopting social marketing approaches in terms of social marketing project procurement and implementation. USAID intends to use the assessment findings as an evidence base for follow-on design. The procurement-sensitive recommendations should, therefore, not be made public.

However, the findings and programmatic aspects of recommendations from the assessment will give feedback to SMC and its partners to identify loopholes and shortages in inputs and processes and fine-tune implementation for rest of the project period. USAID intends to arrange broader dissemination of the evaluation through seminars and public website. Such dissemination will help a broader range of stakeholders, including donor partners, to look into the potential for growth of social marketing of health and family planning programs through the fast-growing private sector and opportunities for developing sustainable approaches in promoting healthy behaviors and use of health products and messages.

Applications and use: How will the findings be used? What future decisions will be made based on these findings?

Evaluation questions: Evaluation questions should be: (a) aligned with the evaluation purpose and the expected use of findings; (b) clearly defined to produce needed evidence and results; and (c) answerable given the time and budget constraints. Include any disaggregation (e.g., sex, geographic locale, age, etc.), they must be incorporated into the evaluation questions. USAID policy suggests three to five evaluation questions.

Evaluation Question
<p>How effective is the MIH Project? Include the following project elements:</p> <ul style="list-style-type: none"> • Distribution network that SMC has established in Bangladesh • Community mobilization program of MIH • Messaging to target audiences • Marketing and BCC techniques to create demand and expand markets • Is the training of Blue Star providers and private community health care providers improving capacity and referrals? • SMC and its partners' collaborations with private commercial and NGO sectors • Male engagement
<p>Should USAID move into new program areas, and if so, what are these areas? Considerations might include:</p> <ul style="list-style-type: none"> • Social marketing of new products • Better coordination with the Government of Bangladesh that aligns national priorities with social marketing approaches • Sustainable approaches to maintaining and increasing contraceptive prevalence, particularly among the poor, given anticipated declining commodity donations from USAID
<p>Should USAID continue to invest in social marketing programs? Considerations might include:</p> <ul style="list-style-type: none"> • SMC's contribution to contraceptive prevalence, ORS distribution and apparent viability as a distributor of new health products, particularly to the poor • USAID's declining population funds • Alternatives to SMC • Inclusion of other interventions, i.e., newborn health, IMCI, maternal nutrition, drowning, adolescent health, school health, prevention of early marriage, etc. • Government of Bangladesh's health priorities

Other Questions [OPTIONAL]

(Note: Use this space only if necessary. Too many questions leads to an ineffective evaluation.)

Methods: Check and describe the recommended methods for this analytic activity. Selection of methods should be aligned with the evaluation questions and fit within the time and resources allotted for this analytic activity. Also, include the sample or sampling frame in the description of each method selected.

All methods listed in this section are a guide for the evaluation team. Methods will be finalized during the team planning meeting, with concurrence from USAID.

The evaluation will use a mixed-method approach (quantitative and qualitative) to gain insight on the performance and outcomes of MIH activities (mostly from quantitative) and the processes (mostly qualitative) that lead to those results. Sequential and iterative approaches will be used to integrate the mixture of methods and will seek varying degrees of dialogue between quantitative and qualitative traditions at all phases of the evaluation.

USAID requires that evaluations explore issues of gender; thus, the evaluation should examine gender issues within the context of the evaluation of MIH activities. The evaluation must collect and include gender-disaggregated data in the analysis of findings and conclusions and in making recommendations.

Methodological limitations and challenges for this evaluation are expected to include:

- Ensuring adequate representation of interview and rapid appraisal sources vis-à-vis the full scope of MIH activities and outcomes; and
- Taking systematic actions to counter any biases in (a) reporting by data collection sources and (b) interpretations of collected data by the evaluation team.

Document Review (*list of documents recommended for review*)

USAID/Bangladesh will provide the evaluation team with background documents (RFA, project’s annual work plans and reports, MOHFW health sector strategy, etc.) and data. These will be used to provide background information on the project and the Bangladeshi context, and will also provide qualitative data for analysis for this evaluation. The evaluation team is expected to conduct a desk review of the documents and data, and may request further documents from USAID, as needed. Below is a list of documents for review:

MIH Program Description

MIH Agreement

MIH Annual and Quarterly Reports

MIH Monitoring and Evaluation Plan with indicators

MIH indicator data and reports

Past program evaluations and other health sector public documents related to MIH

HIV/MCH SPA, 2014

Bangladesh DHS, 2011 & 2007

Bangladesh Multiple Indicator Cluster Survey (MICS)

Secondary analysis of existing data (*list the data source and recommended analyses*)

Data Source (<i>existing dataset</i>)	Description of data	Recommended analysis

■ Key Informant Interviews (*list categories of key informants, and purpose of inquiry*)

To gain information about successes, best practices, limitations and obstacles, and other information related to evaluation questions (above), representatives from the following organizations will be interviewed using a semi-structured question guide:

- MIH staff and management (this can also be done as a group interview)
- SMC
- PSI
- BRAC
- CWFD
- PSTC
- Shimantik
- EngenderHealth
- Others engaged in the SMC Blue Star Program (BSP) network
- USAID/Bangladesh health staff
- MOHFW counterparts
- UN agencies and other relevant donor organizations involved in programs related to MIH
- NGOs and private sector providers/entrepreneurs involved in commodity sales and distribution
- Formal and non-formal private providers who have been involved in MIH activities

■ Focus Group Discussions (*list categories of groups, and purpose of inquiry*)

Focus group discussions will be conducted among:

- SMC Sales Officers and non-formal health providers, including the Blue Star providers, to obtain information and perception about MIH support
- Low- and middle-income women and men of reproductive age (15-49) and mothers of newborns and children under 5 residing in MIH-supported communities, to obtain information about target beneficiaries' use of marketed commodities and services, and reasons for using or not using them

Female and male discussants should participate in separate focus groups to avoid potential influence of men over women due to culturally based power differentials, particularly in the beneficiary community focus group discussions.

■ Group Interviews (*list categories of groups, and purpose of inquiry*)

Some of the respondents listed for key informant interviews may be clustered and interviewed together. The evaluation team may choose to conduct group interviews, if considered to be more efficient and effective, as long as grouping respondents does not violate the informants' privacy and confidentiality, all respondents are comfortable to speak openly, and each group is free from power differentials that may limit involvement and expression of opposing opinions. For example, it may be possible to conduct group interviews with:

- SMC Board of Directors
- USAID/Bangladesh health staff

Client/Participant Satisfaction or Exit Interviews (*list who is to be interviewed, and purpose of inquiry*)

Facility or Service Assessment/Survey (*list type of facility or service of interest, and purpose of inquiry*)

Verbal Autopsy (*list the type of mortality being investigated (i.e., maternal deaths), any cause of death and the target population*)

Survey (*describe content of the survey and target responders, and purpose of inquiry*)

Optional: A structured mini-survey can be distributed to many of the key informants with questions that are asked to all that have categorical or Likert scale answers. Survey Monkey (accessible through the web or on mobile devices) can be used to expedite data collection, management and analysis. This will provide information comparable across all categories of respondents.

Observations (*list types of sites or activities to be observed, and purpose of inquiry*)

Data Abstraction (*list and describe files or documents that contain information of interest, and purpose of inquiry*)

Case Study (*describe the case, and issue of interest to be explored*)

Rapid Appraisal Methods (ethnographic/participatory) (*list and describe methods, target participants, and purpose of inquiry*)

Other (*list and describe other methods recommended for this evaluation, and purpose of inquiry*)

If impact evaluation:

Is technical assistance needed to develop full protocol and/or IRB submission?

Yes No

List or describe case and counterfactual

Case	Counterfactual

ANALYTIC PLAN

Describe how the quantitative and qualitative data will be analyzed. Include method or type of analyses, statistical tests, and what data is to be triangulated (if appropriate): for example, a thematic analysis of qualitative interview data, or a descriptive analysis of quantitative survey data.

All analyses will be geared to answer the evaluation questions. Additionally, the evaluation will review both qualitative and quantitative data related to MIH's achievements in relation to the project's objectives and targets.

Quantitative data will be analyzed primarily using descriptive statistics. Data will be stratified by demographic characteristics, such as sex, age and location, whenever feasible. Other statistical tests of association (i.e., odds ratio) and correlations will be run as appropriate.

Thematic review of qualitative data will be performed, connecting the data to the evaluation questions, seeking relationships, context, interpretation, nuances, homogeneity and outliers to better explain what is happening and the perception of those involved. Qualitative data will be used to substantiate quantitative findings, provide more insights than quantitative data can provide, and answer questions where other data do not exist.

Use of multiple methods that are quantitative and qualitative, as well as existing data (e.g., project performance indicators, DHS, MICS and HMIS data) will allow the team to triangulate findings to produce more robust evaluation results.

The evaluation report will describe analytic methods and statistical tests employed in this evaluation.

ACTIVITIES

List the expected activities, such as team planning meeting (TPM), briefings, verification workshop with implementing partners, stakeholders, etc. Activities and deliverables may overlap. Give as much detail as possible.

Background reading: Several documents are available for review for this evaluation. These include SMC's MIH proposal, annual work plans, M&E plans, quarterly progress reports, and routine reports of project performance indicator data, as well as survey data reports (i.e., DHS and MICS). This desk review will provide background information for the evaluation team and will also be used as data input and evidence for the evaluation.

Team planning meeting (TPM): A three-day TPM will be held at the initiation of this assignment and before the data collection begins. The TPM will:

- Review and clarify any questions on the evaluation SOW;
- Clarify team members' roles and responsibilities;
- Establish a team atmosphere, share individual working styles, and agree on procedures for resolving differences of opinion;
- Review and finalize evaluation questions;
- Review and finalize the assignment timeline and share with other units;

- Develop data collection methods, instruments, tools and guidelines;
- Review and clarify any logistical and administrative procedures for the assignment;
- Develop a data collection plan;
- Draft the evaluation work plan for USAID's approval;
- Develop a preliminary draft outline of the team's report; and
- Assign drafting/writing responsibilities for the final report.

Briefing and debriefing meetings: Throughout the evaluation, the team leader will provide briefings to USAID. The in-briefing and debriefing are likely to include all the evaluation team experts, but this will be determined in consultation with the mission. These briefings are:

- Evaluation launch, a call/meeting among the USAID/Bangladesh, GH Pro and the team leader to initiate the evaluation activity and review expectations. USAID will review the purpose, expectations and agenda of the assignment. GH Pro will introduce the team leader, and review the initial schedule and other management issues.
- In-briefing with USAID/Bangladesh, as part of the TPM. This briefing may be broken into two meetings: (a) at the beginning of the TPM, so the evaluation team and USAID can discuss expectations and intended plans; and (b) at the end of the TPM, when the evaluation team will present an outline and explanation of the evaluation's design and tools. Also discussed at the in-briefing will be the format and content of the evaluation report(s). The time and place for this in-briefing will be determined between the team leader and USAID/Bangladesh prior to the TPM.
- The team leader will brief USAID/Bangladesh weekly to discuss progress on the evaluation. As preliminary findings arise, the team leader will share these during the routine briefing, and in an email.
- A final debriefing between the evaluation team and USAID/Bangladesh will be held at the end of the evaluation to present preliminary findings to USAID/Bangladesh. During this meeting, a summary of the data will be presented, along with high-level findings and draft recommendations. For the debriefing, the evaluation team will prepare a PowerPoint presentation of the key findings, issues and recommendations. The evaluation team shall incorporate comments received from USAID during the debriefing in the evaluation report. *(Note: preliminary findings are not final, and as more data sources are developed and analyzed these findings may change.)*

Fieldwork, Site Visits and Data Collection: The evaluation team will conduct site visits for data collection. Selection of sites to be visited will be finalized during the TPM in consultation with USAID/Bangladesh. The evaluation team will outline and schedule key meetings and site visits prior to departing to the field.

Evaluation Report: The evaluation team, under the leadership of the team leader, will develop a report with evaluation findings and recommendations (see Analytic Report below). Report writing and submission will include the following steps:

- Team leader will submit draft evaluation report to GH Pro for review and formatting.
- GH Pro will submit the draft report to USAID.
- USAID will review the draft report in a timely manner, and send its comments and edits back to GH Pro.
- GH Pro will share USAID's comments and edits with the team leader, who will then do final edits, as needed, and resubmit to GH Pro.
- GH Pro will review and reformat the final evaluation report, as needed, and resubmit to USAID for approval.

- Once evaluation report is approved, GH Pro will reformat it for 508 compliance and post it to the DEC.

The evaluation report excludes any procurement-sensitive and other sensitive but unclassified (SBU) information. This information will be submitted in a memo to USAID, separate from the evaluation report.

DELIVERABLES AND PRODUCTS

Select all deliverables and products required on this analytic activity. For those not listed, add rows as needed or enter them under “Other” in the table below. Provide timelines and deliverable deadlines for each.

Deliverable/Product	Timelines and Deadlines (estimated)
<input checked="" type="checkbox"/> Launch briefing	September 21, 2015
<input checked="" type="checkbox"/> Work plan with timeline	October 1, 2015
<input checked="" type="checkbox"/> Analytic protocol with data collection tools	October 1, 2015
<input checked="" type="checkbox"/> In-briefing with mission	September 28, 2015
<input checked="" type="checkbox"/> In-briefing with target project/program	September 30, 2015
<input checked="" type="checkbox"/> Routine briefings	Weekly
<input checked="" type="checkbox"/> Out-briefing with mission or organizing business unit with PowerPoint presentation	November 1, 2015
<input checked="" type="checkbox"/> Findings review workshop with stakeholders with PowerPoint presentation	November 2, 2015
<input checked="" type="checkbox"/> Draft evaluation report	November 18, 2015
<input checked="" type="checkbox"/> Final evaluation report	December 16, 2015
<input checked="" type="checkbox"/> Raw data	December 16, 2015
<input type="checkbox"/> Dissemination activity	
<input checked="" type="checkbox"/> Evaluation report posted to the DEC	January 31, 2016
<input type="checkbox"/> Other (specify):	

Estimated USAID review time

Average number of business days USAID will need to review deliverables requiring USAID review and/or approval? 10 business days

TEAM COMPOSITION, SKILLS AND LEVEL OF EFFORT (LOE)

Evaluation team: When planning this analytic activity, consider:

Key staff should have methodological and/or technical expertise, regional or country experience, language skills, team leader experience and management skills, etc.

Team leaders for evaluations must be external experts with appropriate skills and experience.

Additional team members can include research assistants, enumerators, translators, logisticians, etc.

Teams should include a collective mix of appropriate methodological and subject matter expertise.

Evaluations require an evaluation specialist, who should have evaluation methodological expertise needed for this activity. Similarly, other analytic activities should have a specialist with related methodological expertise.

Note that all team members will be required to provide a signed statement attesting that they have no conflict of interest, or describing the conflict of interest, if applicable.

Team Qualifications: Please list technical areas of expertise required for this activity.

The evaluation team will consist of up to five members, including a team leader and a logistics/program assistant. The team members should represent a balance of several types of knowledge related to health service delivery in Bangladesh, health services planning and programming, as well as private sector entrepreneurship and commercial marketing. In addition to technical members, the team will include country nationals to provide support for data collection, logistics and other needed evaluation activities.

The technical team members must all have significant international health program experience. They should have some Bangladesh or Asian regional experience, along with comparative experience in social marketing and MCH-FP service delivery in other countries or regions of the world. At least one member of the team must have Bangladesh experience and be familiar with the MCH-FP service delivery structure in urban and rural areas.

Some experience in conducting evaluations or assessments is expected of all members, and experience in developing strategies would be useful. Substantial experience in international health is required. Ability to conduct interviews and discussions in Bangla and provide accurate translations into English is essential for at least one team member. The logistics/support person should have basic knowledge about interview techniques and be able to provide translation services to other team members. All team members must have professional-level English speaking and writing skills.

List the key staff needed for this analytic activity and their roles. You may wish to list desired qualifications for the team as a whole, or for the individual team members

Team leader: This is an international consultant who will be selected from among the key staff, and will meet the requirements of both this and the other position. The team leader should have significant experience conducting project evaluations. The team leader will be responsible for overall management of the evaluation, including coordinating and packaging the deliverables, in consultation with the other members of the team. These deliverables include a work plan that includes the evaluation design, timeline, data collection tools, evaluation report outline, preliminary findings presentation, draft and final report.

Roles and responsibilities: The team leader will be responsible for (1) providing team leadership, (2) managing the team's activities, (3) ensuring that all deliverables are met in a timely manner, (4) serving as a liaison between the USAID and the evaluation team, and (5) leading briefings and presentations. In addition to the technical responsibilities outlined in the scope of work for the assignment, team leader responsibilities include:

Preparations

- Finalize and negotiate with USAID/Bangladesh the evaluation work plan.
- Establish assignment roles, responsibilities and tasks for each team member.

- Ensure that the logistics arrangements in the field are complete.

Management

- Facilitate the TPM or work with a facilitator to set the agenda and other elements of the TPM.
- Take the lead on preparing, coordinating team member input, submitting, revising and finalizing the assignment report.
- Manage the process of report writing.
- Manage team coordination meetings in the field.
- Coordinate the workflow and tasks and ensure that team members are working to schedule.
- Ensure that team field logistics are arranged (e.g., administrative/clerical support is engaged, payment is made for services, car/driver hire or other travel and transport is arranged, etc.).

Communications

- Handle conflict within the team.
- Serve as primary interface with the client and serve as the spokesperson for the team, as required.
- Debrief the client as the assignment progresses, and organize a final debriefing.
- Keep the GH Pro HQ staff apprised of progress challenges, work changes, team travel plans in the field and report preparation via phone conversation or email at least once a week.
- Serve as primary interface with GH Pro in submission of draft and final reports/deliverables to GH Pro.
- Make decisions about the safety and security of the team in consultation with the client and GH Pro HQ.

Direction

- Assume technical direction lead as required to ensure quality and appropriateness of assignment and report content.

Qualifications:

- Advanced degree in public health, health management or related field
- Minimum of 10 years of experience in public health, which includes experience in implementation of health activities in developing countries
- Demonstrated experience leading health sector project/program evaluations, utilizing both quantitative and qualitative evaluation methods
- Excellent skills in planning, facilitation and consensus building
- Excellent interpersonal skills, including experience successfully interacting with host government officials, civil society partners, and other stakeholders
- Excellent skills in project management
- Excellent organizational skills and ability to keep to a timeline
- Good writing skills, with extensive report writing experience
- Experience working in the region, and experience in Bangladesh is desirable
- Knowledge of health systems and health issues in Bangladesh
- Familiarity with USAID
- Familiarity with USAID policies and practices, Evaluation Policy, results frameworks, performance monitoring plans

Key Staff 1 Title: Social marketing and BCC specialist

Roles and responsibilities: Serve as a member of the evaluation team, providing technical expertise to evaluate social marketing and BCC activities. S/he will provide insight on best practices and innovations in scaling up use of wide range of health and family planning products and services and stimulating demand for services, and the marketing of health commodities and products addressing gender issues of the country. S/He will participate in all aspects of the evaluation, including planning, data collection, data analysis and report writing.

Qualifications:

- At least 10 years of experience working with social marketing and BCC programs in developing country settings
- Experience should include mass media, community-based interventions and interpersonal communication
- Experience working with formal and non-formal private sector networks, including NGOs, regarding commodity sales and distribution
- Experience in social marketing and demand generation for family planning/reproductive health and MCH commodities, including LARC and ORS, as well as other products and services (e.g., TB control, WASH, and MNCH and other health programs)
- Experience and knowledge on evaluation methodologies related to social marketing and BCC
- Experience working in private sector health service delivery project preferred
- Experience working in the region, and experience in Bangladesh is desirable
- Experience in implementing and/or evaluating capacity-strengthening activities within social marketing programs is desirable
- Good writing skills, with experience producing evaluation and/or technical reports

Number of consultants with this expertise needed: 1

Key Staff 2 Title: Organizational development specialist

Roles and responsibilities: Serve as a member of the evaluation team, providing technical expertise to evaluate organizational capacity strengthening activities. S/He will examine public-private partnerships, including how private providers are able to develop “twinning” relationships with public sector facilities in supporting and strengthening the provision of commodities and services in the districts and subdistricts. S/He will participate in all aspects of the evaluation, including planning, data collection, data analysis and report writing.

Qualifications:

- Background and at least five years’ experience in organizational capacity development/strengthening.
- Knowledgeable in capacity building assessment (e.g., OCATs) and evaluation methodologies
- Experience working in organizational capacity development/strengthening among governmental and non-governmental entities in developing country settings to strengthen health programs/activities
- Experience working in organizational development for social and behavioral communication programs is desirable
- Experience working in the region, and experience in Bangladesh is desirable
- Experience in implementing and/or evaluating capacity-strengthening activities within social marketing programs
- Professional competency in spoken Spanish and/or French is desirable

Number of consultants with this expertise needed: 1

Key Staff 3 Title: **Evaluation specialist**

Roles and responsibilities: Serve as a member of the evaluation team, providing quality assurance on evaluation issues, including methods, development of data collection instruments, protocols for data collection, data management and data analysis. S/He will oversee the training of all engaged in data collection, ensuring highest level of reliability and validity of data being collected. S/He is the lead analyst, responsible for all data analysis, and will coordinate the analysis of all data, assuring all quantitative and qualitative data analyses are done to meet the needs for this evaluation. S/He will participate in all aspects of the evaluation: planning, data collection, data analysis and report writing.

Qualifications:

- At least five years of experience in USAID M&E procedures and implementation
- At least five years managing M&E, including evaluations
- Experience in design and implementation of evaluations
- Strong knowledge, skills and experience in developing qualitative and quantitative evaluation tools
- Experience in data management
- Able to analyze quantitative data, which will be primarily descriptive statistics
- Able to analyze qualitative data
- Experience using analytic software
- Demonstrated experience using qualitative evaluation methodologies, and triangulating with quantitative data
- Must have excellent data interpretation and presentation skills
- An advanced degree in public health, evaluation, research or related field
- Good writing skills, with experience producing evaluation and/or technical reports
- Familiarity with USAID policies and practices: Evaluation Policy, results frameworks, performance monitoring plans
- Experience working in the region, and experience in Bangladesh is desirable

Number of consultants with this expertise needed: 1

Other staff titles with roles and responsibilities (include number of individuals needed):

Local logistics/administrative coordinator will support the evaluation team in all aspects of their work for carrying out this assignment. This includes making provision for workspace, copying, internet, local transport, including any travel outside of the capital, and meeting rooms as needed for the team's internal consultations. The administrative coordinator will have a good command of written and verbal English. S/He will have knowledge of key actors in the health sector and their locations, including Government of Bangladesh, donors and other stakeholders including the private sector partners. S/he will be able to efficiently liaise with hotel staff, arrange car rentals using approved mission or hotel cars, and ensure cell phones, business center support (e.g., copying, internet) and meeting space is available for the team. S/he will work under the guidance of the team leader to make preparations, arrange meetings (including round table meetings), arrange travel outside of Dhaka and ensure note-taking at required meetings. S/he will conduct administrative and support tasks as assigned and ensure the process moves forward smoothly. S/he will be attentive to team requirements and anticipate needs for computers, AV equipment or other last-minute requests, as required. S/He may also be asked to assist in translation of data collection tools and transcripts to and

from Bangla, if needed. S/He will report to the team leader and liaise directly with GH Pro as required to satisfactorily complete assignments for support the team. (1 consultant)

Local evaluators will assist the evaluation team with data collection, analysis and data interpretation. They will have basic familiarity with health topics, as well as experience conducting interviews and focus group discussions, both facilitating and note-taking. Furthermore, they will assist in translation of data collection tools and transcripts to and from Bangla, as needed. They will also assist the team and the logistics coordinator, as needed. They will report to the team leader. (2-3 consultants)

Will USAID participate as an active team member or designate other key stakeholders to as an active team member? This will require full time commitment during the evaluation or analytic activity.

Yes – If yes, specify who:

No, but USAID/Bangladesh will maintain an active role providing technical direction to the evaluation team, and will arrange for initial communications with appropriate government and other organizations.

Staffing Level of Effort (LOE) Matrix (Optional):

This optional LOE Matrix will help you estimate the LOE needed to implement this analytic activity. If you are unsure, GH Pro can assist you to complete this table.

For each column, replace the label "Position Title" with the actual position title of staff needed for this analytic activity.

Immediately below each staff title, enter the anticipated number of people for each titled position.

Enter row labels for each activity, task and deliverable needed to implement this analytic activity.

Then enter the LOE (estimated number of days) for each activity/task/deliverable corresponding to each titled position.

At the bottom of the table total the LOE days for each consultant title in the 'Subtotal' cell, then multiply the subtotals in each column by the number of individuals that will hold this title.

Level of effort in days for each evaluation/analytic team member

Activity/Deliverable		Evaluation/Analytic Team				
		Team Leader / Key Staff 1	Key Staff 2*	Key Staff 3* / Evaluation Specialist	BCC Advisor	Logistics/ Administrative Coordinator
Number of persons →		1	1	1	1	1
1	Launch briefing	0.5			1	
2	Desk review and data synthesis	5	5	5	5	
3	Preparation for team convening in-country					2
4	Travel to country	2	2		2	
5	Team planning meeting	3	3	3	3	2
6	In-briefing with mission (2 half-day sessions, ½ day at beginning and ½ day at end of TPM)	1	1	1	1	1

Activity/Deliverable		Evaluation/Analytic Team				
		Team Leader / Key Staff 1	Key Staff 2*	Key Staff 3* / Evaluation Specialist	BCC Advisor	Logistics/ Administrative Coordinator
		Number of persons →				
7	In-briefing with MIH	0.5	0.5	0.5	0.5	0.5
8	Data collection/quality assurance workshop (<i>protocol orientation for all involved in data collection</i>)	1	1	1	1	1
9	Preparation/logistics for site visits					2
10	Data collection/site visits	15	15	15	5	15
11	Data analysis	5	5	5	3	3
12	Debriefing with mission including preparation	1	1	1		0.5
13	Depart country	2	2		2	
14	Draft report(s)	6	5	5	3	1
15	GH Pro report quality control review and formatting					
16	Submission of draft report(s) to mission					
17	USAID report review					
18	Revise report(s) per USAID comments	3	2	2	1	
19	Finalization and submission of report(s)					
20	508 compliance review					
21	Upload evaluation report(s) to the DEC					
	Total LOE	45	42.5	38.5	27.5	28

* It is assumed that at least one of the Key Staff will be from Bangladesh.

If overseas, is a 6-day workweek permitted Yes No

Travel anticipated: List international and local travel anticipated by what team members.

It is anticipated that data collection will occur in select districts within Chittagong, Sylhet, Dhaka and Barisal Divisions. Based on time constraints, we anticipate site visits to 2-3 of these divisions. During the TPM, the evaluation team will finalize list of sites for data collection, with approval by USAID.

LOGISTICS

Note: Most evaluation/analytic teams arrange their own work space, often in their hotels. However, if Facility Access is preferred, GH Pro can request it. GH Pro does not provide Security Clearances. Our consultants can obtain Facility Access only.

Check all that the consultant will need to perform this assignment, including USAID Facility Access, GH Pro work space and travel (other than to and from post).

USAID Facility Access

Specify who will require Facility Access: _____

Electronic County Clearance (ECC) (International travelers only)

GH Pro workspace

Specify who will require workspace at GH Pro: _____

Travel -other than posting (specify): _____

Other (specify): _____

GH PRO ROLES AND RESPONSIBILITIES

GH Pro will coordinate and manage the evaluation team and provide quality assurance oversight, including:

- Review SOW and recommend revisions as needed
- Provide technical assistance on methodology, as needed
- Develop budget for analytic activity
- Recruit and hire the evaluation team, with approval of USAID point of contact
- Arrange international travel and lodging for international consultants
- Request for country clearance and/or facility access (if needed)
- Review methods, work plan, analytic instruments, reports and other deliverables as part of the quality assurance oversight
- Report production: If the report is public, then coordination of draft and finalization steps, editing/formatting, 508 compliance required, in addition to submission to the DEC and posting on GH Pro website. If the report is internal, then copy editing/formatting for internal distribution.

USAID ROLES AND RESPONSIBILITIES

Below is the standard list of USAID's roles and responsibilities. Add other roles and responsibilities as appropriate.

USAID Roles and Responsibilities

USAID will provide overall technical leadership and direction for the analytic team throughout the assignment and will provide assistance with the following tasks:

Before Field Work:

SOW:

- Develop SOW.
- Conduct peer review of SOW.
- Respond to queries about the SOW and/or the assignment at large.

Consultant conflict of interest (COI): To avoid conflicts of interest or the appearance of a COI, review previous employers listed on the CVs for proposed consultants and provide additional information

regarding potential COI with the project contractors evaluated/assessed and information regarding their affiliates.

Documents: Identify and prioritize background materials for the consultants and provide them to GH Pro, preferably in electronic form, at least one week prior to the inception of the assignment.

Local consultants: Assist with identification of potential local consultants, including contact information.

Site visit preparations: Provide a list of site visit locations, key contacts and suggested length of visit for use in planning in-country travel, and provide accurate estimation of country travel line item costs.

Lodgings and travel: Provide guidance on recommended secure hotels and methods of in-country travel (i.e., car rental companies and other means of transportation).

During Field Work:

Mission point of contact: Throughout the in-country work, ensure constant availability of the point of contact, and provide technical leadership and direction for the team's work.

Meeting space: Provide guidance on the team's selection of a meeting space for interviews and/or focus group discussions (i.e., USAID space if available, or other known office/hotel meeting space).

Meeting arrangements: Assist the team in arranging and coordinating meetings with stakeholders.

Facilitate contact with implementing partners: Introduce the analytic team to implementing partners and other stakeholders, and where applicable and appropriate, prepare and send out an introduction letter for team's arrival and/or anticipated meetings.

After Field Work:

Timely Reviews: Provide timely review of draft/final reports and approval of deliverables.

ANALYTIC REPORT

Provide any desired guidance or specifications for the final report. (See *How-To Note: Preparing Evaluation Reports*)

The format of the evaluation report should strike a balance between depth and length. The report will include a table of contents, table of figures (as appropriate), acronyms, executive summary, introduction, purpose of the evaluation, research design and methodology, findings, conclusions, lessons learned and recommendations. Where appropriate, the evaluation should utilize tables, graphs and maps, and link with data and other relevant information. The report should include, in the annex, any "statement of differences" by any team member or by USAID on any of the findings or recommendations. The report will be in English and should not exceed 40 pages, excluding the executive summary, table of contents and annexes. The evaluation report should exclude any potentially procurement-sensitive information. As needed, any procurement-sensitive information or other sensitive but unclassified (SBU) information will be submitted in a memo to USAID, separate from the evaluation report. The report will be submitted electronically. Once approved by USAID, GH Pro will post the evaluation report to the Development Experience Clearinghouse (DEC) for dissemination among implementing partners, stakeholders and the general public. The DEC submission must be within three months of USAID's approval of the final report.

In addition to the evaluation report, any procurement-sensitive information will be separated from the final report and be included in an Internal Strategy Recommendation Memo that will be submitted to USAID/Bangladesh, and not for public distribution.

Discussions and recommendations related to MIH performance can be made publicly available, and matters related to SMC management can be shared with USAID and SMC, but matters related to future directions can be shared with USAID only.

The evaluation final report must follow USAID's Criteria to Ensure the Quality of the Evaluation Report (found in Appendix I of the [USAID Evaluation Policy](#)).

The report must not exceed 40 pages (excluding executive summary, table of contents, acronym list and annexes).

The structure of the report should follow the evaluation report template, including branding found [here](#) or [here](#).

Draft reports must be provided electronically, in English, to GH Pro, which will then submit it to USAID.

For additional guidance, please see the How-To Note on preparing Evaluation Draft Reports found [here](#).

Reporting Guidelines: The draft report should be a comprehensive, analytical, evidence-based evaluation report. It should detail and describe results, effects, constraints and lessons learned, and provide recommendations and identify key questions for future consideration. The report shall follow USAID branding procedures. *The report will be edited/formatted and made 508 compliant as required by USAID for public reports and will be posted to the USAID/DEC.*

The preliminary findings from the evaluation will be presented in a draft report at a full briefing with USAID/GH/OHS and at a follow-up meeting with key stakeholders. The report should use the following format:

Executive Summary: concisely state the most salient findings, conclusions, and recommendations (not more than 2 pages);

- Acknowledgement (1 page)
- Table of contents (1 page)
- Acronyms
- Evaluation purpose and evaluation questions (1-2 pages)
- Project background (1-3 pages)
- Evaluation methods and limitations (1-3 pages)
- Findings (per objective area)
 - Overall
 - Key issues by evaluation question
- Conclusions (by objective area)
- Recommendations
 - Priority recommendations
 - Future directions
- Annexes
 - Annex I: Evaluation statement of work
 - Annex II: Evaluation methods and Limitations
 - Annex III: Data collection instruments

- Annex IV: Sources of information
 - List of persons interviewed
 - Bibliography of documents reviewed
 - Databases
 - [etc.]
- Annex V: Disclosure of any conflicts of interest
- Annex VI: Statement of differences (if applicable)

The evaluation methodology and report will be compliant with the **USAID Evaluation Policy** and **Checklist for Assessing USAID Evaluation Reports**

All data instruments, data sets (if appropriate), presentations, meeting notes and report for this evaluation will be provided to GH Pro and presented to USAID electronically to the Evaluation Program Manager. All data will be in an unlocked, editable format.

USAID CONTACTS

	Primary Contact	Alternate Contact 1	Alternate Contact 2
Name:	Dr. Sukumar Sarker	Ferdousi Begum	Leyfou Dabo
Title:	Agreement Officer's Representative, MIH Program	Project Management Specialist	Nutrition Advisor
USAID Office/Mission	Office of Population, Health, Nutrition, and Education, USAID/Bangladesh	Office of Population, Health, Nutrition and Education (OPHNE), USAID/Bangladesh	Office of Population, Health, Nutrition & Education USAID/Bangladesh
Email:	ssarker@usaid.gov	fbegum@usaid.gov	ldabo@usaid.gov
Telephone:	880-2-5566 2313	+88-02-5566-2658	+88-02-5566-2474
Cell Phone (optional)	01713-009878	+88-017-5563-7029	+88-017-5564-8956

Evaluation Design Matrix

This design matrix may be helpful for connecting your evaluation methods to questions. Often more than one method can be employed in an analytic activity to obtain evidence to address more than one question. A method should be listed by question when it will include specific inquiries and/or result in evidence needed to address this specific question.

Marketing Innovations for Health Midterm Evaluation Matrix

- Evaluation questions:

Evaluation Question	Indicators	Methods	Sources of information	Analysis
I. How effective is the MIH Project in meeting the goal, objectives of each component, and targets? Include the following project elements:				
Project Component/Objective I: Expand <u>Commodity Sales and Distribution</u> through private sector networks, including NGOs, at an affordable price to support family planning and other healthy practices, especially focused on low-income populations.				
Sales to date	<ul style="list-style-type: none"> • Commodity sales of selected products by time frame, geographical area, and if possible, type of facility, e.g., BSP, for life of project • Profile of users/non-users • Buying (or utilization) practices (oral contraceptives and injectables, LARC) • New consumers (oral contraceptives and injectables, LARC) • Discontinuation practices (oral contraceptives—difference between brands, injectables, LARC) 	<ul style="list-style-type: none"> • Review sales data and analysis provided by SMC • Review available data about utilization • Interview providers (BSP, PHCP, CSA, others in study area, as well as family planning experts, focus group discussions with users and non-users) • Interview family planning providers with special focus on SMC brands, also focus group discussions 	<ul style="list-style-type: none"> • SMU/MIH MIS • Sales reports • SMV/MIH sales and program staff • Service providers 	<ul style="list-style-type: none"> • Trend analysis,⁸⁴ comparative analysis with project targets and company targets • Utilization data • Gap analysis with interpretation of SMC field staffs

⁸⁴ Change in cost-recovery and reasons for increases in sales of contraceptives during life of project.

Evaluation Question	Indicators	Methods	Sources of information	Analysis
SMC distribution network	<ul style="list-style-type: none"> • Accessibility: how network expanded • Availability of selected⁸⁵ products • Stability of supply (stock-outs), • Accessibility to targeted clients (per product) • Affordability: price calculation and defining affordability; client perception of affordability • Satisfaction of providers with SMC procedures, support and products. • Acceptability/Satisfaction of clients/users with products and services—by gender • MIH plans to address gaps 	<ul style="list-style-type: none"> • Review project documents • Interviews and observation with providers⁸⁶ • Interview with district and subdistrict staff of SMC • Review of client satisfaction reports • Potential focus group discussions with targeted populations, female users and non-users age 15-49, and also husbands of women of reproductive age • Interview/group discussions with community health workers/service providers 	<ul style="list-style-type: none"> • Project documents • Depot and service providers' record • Product inventory • Focus group discussion participants 	<ul style="list-style-type: none"> • Comparison with set targets for providers or service points per proposal • Gap analysis (type of geographical) • Status of plans to address gaps • Utilization of services by targeted groups, (i.e., is the network reaching targeted groups) • Reported level of satisfaction
Marketing to create demand and expand markets	<ul style="list-style-type: none"> • Process⁸⁷ for segmenting the population and developing marketing strategies and plans for each of the product categories and brands⁸⁸ • Pricing policies • Positioning of brands, focus on Sayana Press 	<ul style="list-style-type: none"> • Review written marketing plans • Interview SMC about its total marketing approach • Review of product and/or service utilization • Interviews with SMC sales and program officers 	<ul style="list-style-type: none"> • Project report • Marketing strategies and plans • SMC management, program and monitoring staff • Field area sales and program personnel 	<ul style="list-style-type: none"> • Quality of plans: address the four Ps • Comparative analysis of plan and achievements of new product marketing using the TMA • Trend analysis • Common themes • Gap analysis

⁸⁵ Suggest focusing on three products: injectables, ORS/zinc packages, and safe delivery kits, and special attention to assessing if injectables available, accessible and acceptable to adolescent clients.

⁸⁶ BSP, PCHP and other private providers

⁸⁷ Is SMC using PSI's DELTA process, and has it been effective? Can it be sustained without external funding/TA? Are market segments clearly defined? Tracking system provides good data about users.

⁸⁸ Special focus on IUDs, implants and newer products such as micronutrient sprinkles

Evaluation Question	Indicators	Methods	Sources of information	Analysis
	<ul style="list-style-type: none"> Utilization by segments of targeted population if data available Barriers to market promotion and activities Perceived barriers to specific products Growth: new consumers and retention by project area Effect of marketing, detailing promotional events in terms of sales 	<ul style="list-style-type: none"> Group discussions with Community Sales Agents, BSP, PHCP and other service providers Review MIS data and procedures for tracking retention Review monitoring and analysis practices 	<ul style="list-style-type: none"> Providers (BSP, PHCP LARC) 	<ul style="list-style-type: none"> Lessons learned
Project Component/Objective 2: Improve knowledge and healthy behaviors, reduce harmful practices and increase care-seeking practices while reaching out to new audiences (youth) through creative <u>Behavior Change Communication</u> .				
MIH community mobilization program	<ul style="list-style-type: none"> Objectives of community mobilization Support of local stakeholders for project Attendance of target groups at IEC events; level of participation of targeted groups 	<ul style="list-style-type: none"> Review of project reports Interviews/group discussions with MIH and implementing partners at both field⁸⁹ and central levels and local stakeholders 	<ul style="list-style-type: none"> Project documents Community mobilization strategy document MIH mobilizers, CSA and local leaders or other local stakeholders 	<ul style="list-style-type: none"> Comparative analysis with project targets Evidence of targeted approaches Identification of challenges, lessons learned, promising practices
BCC strategies, techniques and messages to targeted audiences ⁹⁰ to increase awareness, create demand and increase utilization of measures	<ul style="list-style-type: none"> BCC strategies being used (note if differ between implementing partners), note if using PSI PERForM methodology Linkages with and involvement of the national BCC TWG and other stakeholders with MIH 	<ul style="list-style-type: none"> Review written strategies for contraceptives and micronutrient sprinkles Review project reports Interview MIH/SMC and partners about use of findings Review information packages and messages 	<ul style="list-style-type: none"> Strategy report and messages TRaC, FoQus and other study reports MIH BCC staff (SMC and implementing partners) and others doing BCC in the study communities 	<ul style="list-style-type: none"> Strengths and weaknesses of SBCC strategies, approaches and messages; use of formative data; gender sensitivity Evidence for effectiveness of BCC strategy, e.g., attribution

⁸⁹ Plan to visit Chittigong (BRAC) and Sylhet (Shimantik) and to hold consultative meeting with PSTC and CWFD staff.

⁹⁰ Special focus to channels and techniques for reaching isolated or hard-to-reach populations (including where there is language or cultural diversity), male engagement, reaching other important influencers (e.g., mothers-in-law and adolescents/young married couples), using role models, and improving interpersonal communication.

Evaluation Question	Indicators	Methods	Sources of information	Analysis
	<ul style="list-style-type: none"> • Use of formative study data to develop the messages and curriculum for school health/activities, processes to develop and test messages • Documented results of BCC initiatives/campaigns, with focus on uptake of family planning methods (new users, shift to longer-acting methods) and micronutrient supplements 	<ul style="list-style-type: none"> • Individual or group interviews with MIH (SMC and implementing partners) • Observation, with special focus as is possible on innovative techniques and channels⁹¹ • Interviews with community sales agents, perhaps traditional birth attendants, MIH personnel and other BCC specialists • Focus group discussions 	<ul style="list-style-type: none"> • Government and BCC forum, other BCC experts in country • Focus group discussions: female modern contraceptive users and non-user groups, groups of husbands and also of women of reproductive age, older women (influencers). May need to add groups of pregnant women and mothers with children under 5. 	<p>of BCC in raising awareness, promoting engagement, creating demand among different segments of population⁹²</p> <ul style="list-style-type: none"> • Lessons learned relating to BCC channels and techniques in each project area • Promising practices
<p>Project Component/Objective 3: Improve delivery of quality family planning, reproductive and child health services, referrals/DOts services for TB, and referrals for higher-level clinical services, including LAPM, through <u>Capacity Building</u> of local formal and non-formal private providers.</p>				
Capacity building for Blue Star providers, PCHP and the LAPM network	<ul style="list-style-type: none"> • Selection criteria for private providers • Status of training program and participation of key stakeholders • Functionality of performance monitoring system, follow-up and mentoring activities • Quality of BSP LARC services, e.g., adherence to protocols 	<ul style="list-style-type: none"> • Review monitoring tools, process and reports, noting actions recommended and taken • Review plan and achievement reports • Interviews with SMC/MIH and partners' staff • Interviews with government stakeholders, 	<ul style="list-style-type: none"> • Activity report • Partners' staff • SMC/MIH and implementing partner staff, trainers, monitors and government stakeholders • BSP and LARC network providers 	<ul style="list-style-type: none"> • Identify themes relating to performance, quality-of-care issues • Analysis of achievements against targets • Lessons learned or promising practices related to private sector • Common themes

91 Other techniques, channels to assess include: use of CSAs to provide education and promotion of measures, use of rolemodels, use of mobile technology (MAMA, mobile video and facilitated discussion, interactive drama, mass media using TV spots and newscoverage, and brochures and bill boards

92 Project areas include tribal areas where a local language is spoken instead of Bangla.

Evaluation Question	Indicators	Methods	Sources of information	Analysis
	<ul style="list-style-type: none"> Barriers to promotion of delay, spacing and timing, and provision of family planning services among different categories of providers (BSP, PCHP, community sales agents and others in the public and NGO sectors) 	<ul style="list-style-type: none"> e.g., CCSDP and others, e.g., OGSB Interviews or group discussions with providers 		
Referral system	<ul style="list-style-type: none"> Functionality of referral systems: LARC, TB, pregnancy care System for monitoring referrals, satisfaction of referees and those referred, follow-up on referrals 	<ul style="list-style-type: none"> Interviews with referees (BSP, PCHP, CSA) and TB, LARC and maternity service providers Interviews with MIH (SMC and partner) officers Review of monitoring reports Interviews with clients if feasible, potentially include in focus group discussions 	<ul style="list-style-type: none"> Service providers who referred and to whom they are referring 	<ul style="list-style-type: none"> Strengths and weaknesses identified Gaps Lessons learned
SMC and its partners' collaboration with and NGO sectors and government agencies	<ul style="list-style-type: none"> Status of collaboration with different actors, formal and informal 	<ul style="list-style-type: none"> Interviews with NGO, central government, business and donor stakeholders Interviews with key governmental stakeholders and district and upazila level, e.g., development coordination meeting participants 	<ul style="list-style-type: none"> SMC and partners' staff District and subdistrict government officials Local stakeholders 	<ul style="list-style-type: none"> Identification of weaknesses Duplication of efforts and gap analysis Institutional and project linkage analysis, attribution of coordination in expanding access, availability, creation of demand and utilization, as well as policy strengthening, structural changes

Evaluation Question	Indicators	Methods	Sources of information	Analysis
2. Should USAID move into new program areas, and if so, what are these areas?				
Need for social marketing of new health products and services to address critical public health needs and what can be addressed by social marketing ⁹³	<ul style="list-style-type: none"> • Identification of potential new products 	<ul style="list-style-type: none"> • Review of discussions and feasibility studies for potential new products • Interviews with SMC management and field-level staff • Interviews with implementing partners and others, including international and national NGOs, UN, government offices and professional medical associations 	<ul style="list-style-type: none"> • Project documents • Focus group discussion participants • Implementing partners, UN, NGOs and relevant stakeholders 	<ul style="list-style-type: none"> • Support for proposed products; evidence from social marketing community (globally) • Analysis of public health issues and potential new products or services to market
Need for stronger linkages and/or integration of social marketing with the public and NGO sectors or projects working to create demand and utilization of health measures, services and products	<ul style="list-style-type: none"> • Needs of service delivery projects and services, i.e., newborn health, IMCI, maternal health and nutrition, drowning, adolescent health, school health, NCDs (e.g. diabetes) and prevention of early marriage, malaria, etc. • Needs that can be addressed by social marketing 	<ul style="list-style-type: none"> • Review who is doing what to address critical public health issues, with special focus on USAID-funded service delivery and health system strengthening projects. Note current linkages • Consultative discussion 	<ul style="list-style-type: none"> • Project and sector experts; key informants from the public health and medical community 	<ul style="list-style-type: none"> • Gap analysis (current services and products) • Potential strategies to involve the private sector to respond to community needs and demands for services and critical health measures

⁹³ Potential new products being discussed—need for creation, those already developed by others, e.g., help with scale-up of innovations or replications from elsewhere

Evaluation Question	Indicators	Methods	Sources of information	Analysis
Alignment of social marketing and BCC approaches and products with the Government of Bangladesh's national priorities as the country develops	<ul style="list-style-type: none"> • Alignment of MIH with national priorities and approaches, plans and policies • Coordination of efforts in geographical areas, standardization of messages, etc., joint planning and monitoring • Satisfaction of the government with the work of MIH/SMC • Potential new avenues to link with and better coordinate with government public health services 	<ul style="list-style-type: none"> • Review of MIH documents • Review of government strategies, HPNSDP, BCC and plans for next strategies • Interviews with USAID, SMC-MIH and central and district government officials and other stakeholders 	<ul style="list-style-type: none"> • Project and relevant documents • USAID and government officials and other stakeholders 	<ul style="list-style-type: none"> • Analysis of level of coordination among different actors⁹⁴ • Attribution of coordination in product marketing and addressing national priorities
3. How could USAID invest in the delivery of critical public health services and measures in the future?				
To maintain, expand or scale up MIH achievements in expanding and improving family planning services in the private sector	<ul style="list-style-type: none"> • Critical unmet needs, gaps and/or opportunities in working with the private sector • SMC ideas or plans for maintaining, expanding, scaling up with corporate funds • Needs identified for external support (funding, TA, etc.) 	<ul style="list-style-type: none"> • Review of SMC cost-recovery situation, self-financing schemes and plans for using surplus revenue since profit (Enterprise) and non-profit (Holding Program) divisions organized • Interviews with SNC management and board 	<ul style="list-style-type: none"> • SMC management (Enterprise and Holding Program) and board(s) 	<ul style="list-style-type: none"> • Viability of SMC to avail and to socially market critical measures (products) • Gap analysis, SMC perspectives about the "social" aspect of social marketing and MIH objectives, looking at future scenarios and use of Enterprise revenues • Evidence to support scaling up MIH components (findings of question one)

⁹⁴ Participation in strategic planning, sharing information, development and distribution of messages, status of feedback mechanism among actors

Evaluation Question	Indicators	Methods	Sources of information	Analysis
To assist the Government of Bangladesh's essential public health function to ensure equity to quality public health services and measures	<ul style="list-style-type: none"> Government systems for sustainable procurement and supply of contraceptives, and current or planned mechanisms to ensure health equity 	<ul style="list-style-type: none"> Consultative discussion with USAID- or other donor-funded health system strengthening and service delivery projects, DGFP and DGHS 	<ul style="list-style-type: none"> Donors, project managers and government 	<ul style="list-style-type: none"> System strengthening and service delivery or policy/structural needs identified
To support new initiatives/strategies to involve the private sector to respond to community needs and demands for services and critical health measures (as noted under Question 2)	<ul style="list-style-type: none"> Type and level of support needed for proposed initiatives to address issues of product availability, product accessibility, equity of products, availability of accessible and acceptable services, quality of services, awareness raising, demand creation, social change 	<ul style="list-style-type: none"> Review best practices, lessons learned, including decreasing support for social marketing by USAID or other donors, and donor strategies for strengthening service delivery and health equity in-country and globally Consultative discussion 	<ul style="list-style-type: none"> References, including case studies Project and sector experts; key informants from the public health and medical community 	<ul style="list-style-type: none"> Evidence to pose recommendations

ANNEX B: EVALUATION METHODS AND LIMITATIONS

Methodological Steps and Process

This midterm evaluation utilized a case study approach with qualitative methods to cover a wide range of issues, complying with the objectives stated in the scope of work. The evaluation team reviewed documents and designed the evaluation methodology in line with those objectives. The case study approach used mixed methods, including desk review of project and other relevant documents (see Annex E.). Based on a review of findings, the evaluation team identified issues and concerns matching with the objectives and relating to the study questions refined with USAID during the initial briefing (see evaluation matrix in Annex A. Scope of Work). The data collection techniques included key informant interviews with a wide range of governmental and non-governmental stakeholders, PowerPoint presentations by and interviews with SMC, interviews and consultative meetings with implementing partners, and interviews and focus group discussions with field staff and targeted groups.

Methodological Approach: With the assistance of SMC program staff and in consultation with implementing partners, a tentative field visit schedule was developed; the final schedule is presented at the end of this document. The short time frame and logistical difficulties drove the use of a convenience sampling strategy. Although it was not the intention to compare project approaches, the team was interested in observing the project as implemented by BRAC, which is using an integrated approach (as have other health and nutrition programs in the project area), and one of the other three implementing partners that are using a standardized project approach. The team desired to visit project areas with hard-to-reach populations to learn how this has affected or influenced social marketing performance and implementation challenges. Taking this into consideration, field visits were made to Comilla District in Chittagong Division, where BRAC is implementing, and to project areas in Sylhet Division, including Sylhet, Moulvibazar and Sunamganj districts, where MIH is implemented by Shimantik.

The analysis explored common themes, triangulating data from various sources, identifying innovations, and analyzing strengths, weaknesses, opportunities and threats. Interpretations were made in consultation with SMC and USAID. The evaluation team conducted separate debriefings for USAID and SMC, with time for discussion and clarification of findings.

Design of Methodology and Development of Tools: The GH Pro evaluation team was asked to conduct a three-dimensional, broad-based assessment of social marketing activities in Bangladesh. Those dimensions include (1) SMC's achievements under the current cooperative agreement and its performance constraints, including its performance trend in implementing the social marketing program in the context of public health goals; (2) new program areas where social marketing can be expanded, focusing on the best possible future directions for social marketing in the Bangladeshi context to contribute more to addressing public health needs; and (3) possible options for USAID/Bangladesh to continue its social marketing program to sustain and increase its current achievements in adoption of health products and messages. Additionally, the evaluation will explore alternative or additional approaches and strategies that USAID may consider in order to achieve its social marketing goals. To comply with these objectives, the evaluation team identified multilevel stakeholders as sources of specific data/information. Those stakeholders are as follows:

- At the national level, the Directorate of Family Planning of the Government of Bangladesh and national and international organizations are providing policy support to the government. Donor agencies and international sectoral organizations contributing in their respective areas were identified as sources of information and opinion about the status of social marketing in Bangladesh, policy loopholes that generate challenges in the social marketing of health and family planning products, and potential future directions in social marketing in Bangladesh.

- The non-governmental organizations and actors, such as international NGOs experienced in implementation of health, population and nutrition projects, and persons contributing to national policy formulation through their experience in the health, population and nutrition sectors, were identified as opinion leaders to get policy gaps, challenges and potential areas to expand social marketing of public health and nutritional products.
- District heads, especially civil surgeon of health service management, deputy director, family planning key stakeholders, and technical experts (e.g., from EngenderHealth and FPAB) were interviewed.
- At the subdistrict level, the chairperson (UNO) of the Development Coordination Committee, upazila health and family planning officers, and family welfare visitors (FWV) and FWA of family planning departments at union and subdistrict levels were interviewed by the evaluation team.
- District-level interviews included the Health and Family Planning Department; SMC area office for community mobilization, sales and monitoring; stakeholders; and consultative meetings with subcontracting partners such as BRAC, CWFD, PSTC and Shimantik.
- Subdistrict-level interviews included administration, Health and Family Planning; FWV and FWAs; and consultative meeting with four implementing partners, BRAC, and Shimantik. The community clinic and Smiling Sun clinic were interviewed regarding public health needs.
- At the field level, focus group discussions and key informant interviews were conducted with MWRA (user and non-user of family planning methods), husbands of MWRA, caregivers, CSAs, adolescents (boys and girls), workplace BCC participants, and CBAs. In addition, the team observed the BCC program (Mobile Film Show) and activity with male groups (use of audio) to understand the social mobilization, BCC and use of IEC materials.

Limitations:

- Out of four in-country team members, the team leader was an expatriate. During the time of the evaluation, the security situation in the country hampered her movement, primarily around and in communities, as well as her travel in Dhaka without accompaniment.
- Due to the limited timeframe, the team was only able to conduct field visits to two project areas; these provided an opportunity to see approaches used by two partners. To compensate, a consultative meeting was held to learn more about the work of the other two implementing partners.
- The timing of the field visits coincided with school examinations, and hence hindered the time that could be spent observing or interviewing teachers and students.
- The focus groups were not always organized to the team's specifications; e.g., two separate but large groups of MWRA as well as husbands were gathered in Comilla. A focus group specified for non-users of contraceptives was attended by women, all of whom reported that they were users. When questioned, the implementing partner said, "We only know users." There was insufficient time to have in-depth discussions with youth and community skilled birth attendants because of their other planned activities; both of these groups were eager to talk with the team.
- The team was unable to schedule appointments with several stakeholders that it would have liked to visit, including: World Bank to learn more about the new health strategies and plans being developed, UNICEF and UNFPA to learn more about their adolescent health programming, DGHS to learn more about plans for the family welfare assistants, SPRING to learn more about its nutrition project, JHPIEGO to learn more about its training modalities in Bangladesh, the Pharmaceutical Association to learn more about commercial enterprises manufacturing and perceptions about social marketing and supplying of contraceptives by USAID, and the marketing and advertising firms being used by SMC.

- To compensate for the team’s marketing and BCC (mass media) technical advisor working virtually, a phone call was arranged between the advisor and SMC marketing unit following the debriefing by the in-country team.
- As frequently encountered by team members when conducting other project reviews and evaluations, there was a lack of easy access to current and verifiable project data to meet information needs of the evaluation. Significant effort was made by both SMC and the implementing partners to meet the team’s requests for information.

FIELD VISITS: MIH Evaluation Team (October 7-18, 2015)

Team Members: Beverly Stauffer, Md. Ayub Ali, Nurjahan Begum, Ahmed Mollah Mahmud

Date	Time	Activity	Upazila/Location	District
Oct. 7	7:30 AM	Travel by Road to Comilla	Daudkandi	Comilla
	10:00-10:30 AM	BRAC subdistrict Field Office	Daudkandi (Opposite of Sonali Jute Mill, Beside Dhaka-Ctg. Highway)	
	10:40-12:30 PM	Focus group discussion with MWRA (users) Team B: Team A: Meeting with SS/SK (BRAC workers)	Daudkandi (Vill-Dauladdi, union-Daudkandi)	
	1:30-2:15 PM	Lunch		
	2:15-2:45 PM	SMC area office visit-interview with staff	SMC office in Comilla Town, Upashahar	
	4:00-5:30 PM	Focus group discussion: Husband of MWRA Focus group discussion: MWRA (non users)	Debiddar (Vill-Barera, union-Debiddar)	
	6:30-8:00 PM	Tram-Observe mobile film program	Debiddar (Rosulpur primary school field), Debiddar, Comilla	
Oct. 8	9:30 -10:00 AM	BRAC office visit and staff interview	Sadar South, Comilla	Comilla
	10:30 –11:30 AM	Visit key informant (UH&FPO, UFPO, UNO, etc.) Interview at SMC Office Sales Officer	Sadar South, Comilla UHC and UNO office complex	
	11:45-12:45 PM	Interview with teachers	Sadar South, Comilla (Bagmara Hhigh School, Bagmara)	
	1:00-2:00 PM	Observe workplace workers meeting	Sadar South, Comilla (Electric and Electronic Pvt. Lalmai, North Bagmara, Sadar South)	
	2:00-3:00 PM	Lunch in BLC Comilla		
	3:15-4:00 PM	Observe a CBA meeting	Sadar South, Comilla (Upazila office)	

Date	Time	Activity	Upazila/Location	District
	4:00-5:00 PM	Interview with SK /SS (Team A) Focus group discussion older women (Team B)	Sadar South, Comilla (Upazila office)	
Oct. 9		Rest Day in Comilla, Chittagong Division	Comilla Town, Hotel Red Roof, Racecourse area	
Oct. 10	9:00-10:30 AM	Visit Smiling Sun Clinic in Comilla Town Visit to MCWC	Comilla town Maternity clinic	
	11:00-1:00 PM	Visit BSP and PCHP in Chandina and interviews with BSP and PCHP	Team-1: Mr. Abdul Bari Sarker (BSP) Sarker Medical Hall Chandina West Bazar, Chandina Mr. Shah Alam (BSP) S.A pharmacy Borkoit Bazar, Chandina Team 2: Mr. Saleh ahamed Rasel (PCHP-P) S.R Hazi Medicine Corner Chandina Girls high school Road, Chandina Mr. Ratan Devnath (PCHP-P) Seba Pharmacy Madaya Bazar, Chandina	
	1:15-2:00 PM	Lunch in Chandina	Chandina, Comilla	
	2:30-5:00 PM	Visit with active NGO/CBO working youth (FGA-Bangladesh)	FPAB, Comilla town	
	6:00-8:00 pm	Visit LARC provider	Comilla town	
Oct 11	9:00-12:00	Interview with Family Planning Officer Visit with BRAC Return in afternoon to Dhaka	Comilla district level offices Comilla	
Oct 12	12:00-01:00 PM	Travel by Air to Sylhet		
	1:15-1:30 PM	Airport to Sylhet Area Office		
	1:30-2:45 PM	Working lunch and presentation by Sylhet AO on Sales and Program to discuss distribution and program activities	SMC Area Office East Eidgah, Sylhet	
	3:00-3:15 PM	Travel to Moglabazar	Sylhet town, Moglabazar	
	3:15-4:30 PM	Blue Star (Luna Runa Pharmacy) visit at Moglabazar		Sylhet

Date	Time	Activity	Upazila/Location	District
	4:30-5:00 PM	Travel to Station Road	Sylhet town	
	5:00-5:30 PM	Blue Star visit and PCHP (Faisal Medical Hall)		
	6:15-7:00 pm	Visit LARC provider at Mirer Moidan		
Oct. 13	9:00-10:30 AM	<i>Notun Din</i> Shimantik office visit & program briefing	Sylhet TB Gate, Shahi Edgah, Sylhet Town	Sylhet
	10:30-11:30	Journey to subdistrict Balagonj	Project Office, Sylhet	
	11:30-12:30 pm	Team A: Observe a MWRA (user) meeting and conduct focus group discussion	Chompa Rani das's house VIII – Robi das, U P – Tazpur, under Balagonj Upazila	
		Team B: Visit school with health program	Joybunnesa Girls High School, U P—Doyamir, Under Balagonj Upazila	
	12:30-1:30 PM	Team A: Focus group discussion with MWRA (non user) Team B: Focus group discussion with CSA	Manik Mia's House, Vill-Brammongram, U P-GowalaBazar Under Balagonj Upazila	
	1:30-2:00 pm	Lunch	Balagonj District Office	
	2:30-4:00 pm	CBA meeting and focus group discussion with CBA Interview BSP	Manik Mia, Vill-Brammongram, U P-GowalaBazar Under Balagonj Upazila Balagong Bazar	
	4:30-5:30 PM	Interview with key informants (UFPO)	Balagonj Upazila office complex and UNO office	
Oct. 14	9:00-12:00 pm	Meeting with key informants, e.g., GO, NGO or others (CS, DDFP)	Sylhet City at respective offices	Sylhet
	12:00-1:30 PM	Visit LARC provider and diabetologist at Diabetic Hospital, Sylhet	Sylhet town (Zindabazar)	
	1:00-2:00 PM	Lunch		
	3:00-3:30 PM	Smiling Sun Clinic brief visit	Upashahar, Sylhet town Sylhet	
	3:30-5:30 PM	Visit to Shimantik Clinic Focus group discussion with non-user MWRA Adolescent club a	Sylhet town	Sunam-gonj
	7:00-8:00 pm	Meeting with EngenderHealth Regional Quality Assurance Officer	Hotel Rose View Hotel	
Oct. 15	9:30-10:00 AM	Interview with government officials and elected representative in Chattak (UFPO)	Chattak (Chattak town)	

Date	Time	Activity	Upazila/Location	District
	10:15 AM-2:30 PM	Meeting with CSA In Notun Din office Focus group discussion with caregiver women's group Notun Din office staff	Chattak (Chattak town)	
		Lunch		
Oct. 16		Rest day in Sylhet	Sylhet town	
Oct. 17	8:30-10:30 AM	Journey to subdistrict Komolgonj	Komolgonj, Moulvibazar	Moulvibazar
	10:30-11:30 AM	Visit with government officials (UH&FPO) Visit to community clinic at Komolgonj	UH&FPO Office & Upazila office Komolgonj	
	12:00-1:00 PM	Focus group discussion with CSA	Tetuigao Rasid Uddin High School, U P – Adompur, under Komolgonj Upazila	
	1:15-2:00 PM	Lunch	Sreemongal Notun Din office	
	2:30-4:30 PM	Observe CBA meeting and conduct short focus group discussion Visit adolescent health program with health program	Vill-Uttarvag U P – Adompur, under Komolgonj Upazila	
Oct. 18	9:00-12:00 PM	Meeting with Notun Din staff at Shimantik office Meeting with sales officials at SMC office Return to Dhaka Afternoon by Air	Sylhet	Dhaka

List of Participants:

Stakeholders	Comilla		Sylhet		Moulvibazar (Kamolganj)		Sunamganj (Chatok)		Dhaka		Total	
	Number of meetings	Participants	Number of meetings	Participants	Number of meetings	Participants	Number of meetings	Participants	Number of meetings	Participants	Number of meetings	Participants
USAID briefing	0	0	0	0	0	0	0	0	1	5	1	5
Partner (SMC) briefing	1	5	1	7	0	0	0	0	1	9	3	21
Focus group, users	2	18	2	20	0	0	0	0	0	0	4	38
Focus group, non-users	1	5	1	5	0	0	0	0	0	0	2	10
Focus group, males	1	15	0	0	0	0	0	0	0	0	1	15
Focus group, CSA/SS-SK	2	6	1	7	1	9	1	9	0	0	5	31
Focus group, caregivers	1	8	1	6	1	5	0	0	0	0	3	19
Adolescent boys' and girls' sessions	1	10	1	8	0	0	0	0	0	0	2	18
Government of Bangladesh officials at UNO office	3	8	1	7	1	8	1	2	0	0	6	25
UHC	1	4	1	2	1	9	0	0	0	0	3	15
Workplace session	1	8	0	0	0	0	0	0	0	0	1	8
Partner staff (SMC)	1	6	2	14	0	0	0	0	4	26	7	46
SMC management & M&E team	1	5	1	6	0	0	0	0	1	5	3	16
Sub-contracting: PSTC, CWFD, BRAC	0	0	0	0	0	0	0	0	4	21	4	21

Stakeholders	Comilla		Sylhet		Moulvibazar (Komolganj)		Sunamganj (Chatok)		Dhaka		Total	
Staff meeting: (subdistrict and district levels)	2	9	2	13	1	6	1	7	0	0	6	35
Technical partner	0	0	1	1	0	0	0	0	2	2	3	3
Technical organizations & donors	0	0	0	0	0	0	0	0	17	27	15	25
SMC sales officers	1	5	1	4	0	0	0	0	0	0	2	9
BSP	1	1	1	1			1	1			3	3
PCHP	1	1	1	1	0	0	0	0	0	0	2	2
DGFP	0	0	0	0	0	0	0	0	3	5	3	5
Partner debriefing	0	0	0	0	0	0	0	0	1	12	1	12
USAID debriefing	0	0	0	0	0	0	0	0	1	6	1	6
Total											81	388

ANNEX C: ORIGINAL DATA COLLECTION TOOLS

The following include guides for interviews with (C-1) SMC and (C-2) implementing, technical and training partners; guides for focus group discussions with (C-3) community members (MWRA-both family planning users and non-users, husbands of MWRA and older women); (C-4) community sales agents; (C-5) community birth attendants; (C-6) schoolteachers; (C-7) workplace (observation of session); (C-8) youth meeting; and (C-9) agenda for the consultative meeting with MIH partners who were not visited in the field.

In addition to these guides, additional questions and follow-up was done to explore themes or new questions raised as information was gathered during interviews, desk review of documents and the focus group discussions.

C-1 Interview Guide: SMC management, staff and board

SMC Program Staff

1. How project was designed
2. How MIH fits within their mission and broader programming and/or specific projects—note other projects, donors, geographical area
3. Status of the project [any changes in contract, expectations since award and contract, implementation status, achievements (probe for major ones or unexpected successes, challenges, barriers), how MIH has coped with challenges, and new activities or changes in targets for 2016]
4. SMC experience as lead, relationship with partners, monitoring and information-sharing, planning, EngenderHealth as technical partner, role of OBG
5. Value of studies, e.g., TRAC, FOCUS, MEASURE baseline, probe for other studies/use of data
6. Activities, approaches newly introduced by MIH, any lessons learned or promising practices
7. Satisfaction with the partners: Probe for any issues, e.g., related to performance, reporting or cash flow
8. Monitoring of partners and information-sharing activities
9. Relationships with government, probing for how pilot projects are developed, the role of the Private Sector Initiative Technical Committee and how this has guided MIH, also with other stakeholders at the project level, any involvement in district, subdistrict or lower planning, e.g., status of district development committee
10. How has SMC initiated the total market approach? What are the defined segments?
11. What have been the changes from a program perspective since the change at SMC to be both a for-profit (Enterprise) and the Holding Company? How are decisions made about Holding Company use of revenue, probing for how this may affect sustainability/security of social marketing endeavors, e.g., contraceptives by type?
12. Ideas to improve MIH or for future programming

EQ-1 Component One:

1. Sales—how sales data are analyzed and used to address under-utilization
2. How distribution system is working from program's point of view
3. Expansion of providers: Are there gaps in the network? If so, are there areas without service providers? Are BSP providers meeting intended purposes, also PHCP, e.g., are they performing as trained and expected? Is the PHCP model sustainable? Where have plans to expand the network to meet project and SMC targets failed (probe for challenges and lessons learned developing the LARC network)?

4. Methods/brands preferred by providers (by type) or whom (category of population)
5. Acceptability of the providers chosen to targeted clients—how is this assessed
6. How are prices calculated and set for targeted segments, e.g., oral contraceptives, condoms and injectables? How do SMC prices compare with public sector fees, with other products on the market? Affordability of products from client perspective—how is this assessed?
7. Client preferences—methods and brands, satisfaction with products, with providers, mechanisms for consumer complaints, gender-friendly services, e.g., counseling
8. How and how well SMC/MIH is marketing: contraceptives (probe for “Relax” and I-plant campaigns), Monimix, Safety Kits, Joya; probe if the total marketing approach is being used.
9. Issues: e.g., discontinuation, lack of adherence, informed choice, moving from oral to medium- or long-acting methods, barriers related to unmet contraceptive need
10. Buying (or utilization) practices (oral contraceptives and injectables, LARC, safe delivery kits, micronutrient sprinkles). Probe for any perceptions of who of the targeted groups is not buying and the reasons why. Are there regional differences, and if so, how can these be explained?
11. Tracking capacity—new consumers (oral contraceptives and injectables, LARC); discontinuation practices (oral contraceptives—difference between brands, injectables, LARC)
12. What processes are in place to deal with provider and client complaints? E.g., how did SMC learn about the C-3 issues, and how long after first complaints was a decision made to stop distribution, to destroy products? What are other common complaints?
13. How does SMC work with providers to plan and provide gender-friendly services?
14. Satisfaction of providers with SMC procedures, support and products
15. What marketing strategies are available, e.g., Monimix, Safety Kits, injectables, LARC? (if written, obtain copies)
16. Probe for how the marketing strategy and plan for Sayana Press was developed and long-term plans if pilot is successful? How is it positioned among injectables, both SMC and others? How is the pilot being monitored, or how will it be evaluated?
17. In terms of quality, are there oral contraceptive products of equal quality for low-, medium- and high-income clients?

EQ-I Component Two

18. SMC role with community mobilization; partner role with community mobilization; aims and results. What events are the most attractive to the target populations (by segment)? Decision to discontinue the Floating IEC—aim of activities and how they are working. Probe if have or are using other community mobilization approaches; probe courtyard meetings, mobile film, audio presentations, workplace sessions—how they are engaging men, other groups like older persons, status of district development committee (aim and activity).
19. Advocacy, work with local leaders, probe for work with religious leaders.
20. BCC—who are the targeted groups/segmented populations, strategies for targeted BCC, tailored messages for targeted audience? How effective are the MIH BCC activities, channels and tools (probe for changes in awareness, knowledge, engagement and adoption of practices, with emphasis on family planning, Safety Kits, sprinkles and taking zinc with ORS)? Is BCC reaching the intended, targeted audiences (probe for innovations, e.g., role models)?
21. School health—what is the main aim, activities, results, any lessons learned?
22. Initiatives by others in area (family planning, nutrition, safe pregnancy, MCH services, adolescent health, school health) in the division (describe, probe for BCC activities)
23. Alignment of community mobilization/BCC with government
24. Ideas for improving BCC, for changing behaviors: delaying, spacing, limiting pregnancies; improving diets (micronutrients); use of Safety Kits (probe for how they are helping to do this); and skilled care (ANC, delivery, postpartum care, newborn care)

EQ-2 Component Three

25. Role of EngenderHealth, government, OGSB; how they have advised, supported the project, performance
26. Training programs (BSP, PHCP, CSA, TBAs)—training models, challenges
27. Effectiveness of the capacity-building component (partner staff-mobilizers, BCC, other)
28. Use and effectiveness of CSAs—probe if they were or are working with community volunteers before MIH and what they think of the idea of CHW as entrepreneurs.
29. Systems for monitoring, mentoring and quality assurance/improvement
30. Performance of providers (BSP, PHCP, and LARC) after training, how appraisal results are used, major reasons for low performance, steps to address these reasons
31. Quality of care/service—lessons learned, decision to contract out
32. Referral system—policies and procedures, how it is working, strengths and weaknesses, what is needed

EQ-2, EQ-3 Senior Management

33. Review current products being sold (SMC, Holding Company, products in development)
34. Products being explored, note status of product development
35. New ideas for products from program's point of view
36. Critical public health needs in the country
37. Financing to ensure equity in health—what is being discussed, ideas
38. Clarify that Enterprise is responsible for procurement, warehousing/storage, distribution to service points, marketing of products, and training of retailers/providers to promote, sell products and educate customers. Are any of the above functions now being performed or paid for by the Holding Company? Probe for the distinction between “For profit Brand Advertising and Communications” listed under Enterprise and “Brand Marketing of USAID donated contraceptives and SC subsidized commodities.” Is this an example of how the Holding Program (with revenues or external funds) is buying services from Enterprise, i.e., marketing?
39. Inquire if the Holding Company is contributing to any costs of the above, probing for contraceptives—oral, injectables and LARC? Inquire as to how Enterprise revenues have been used to date. How does SMC management (Enterprise and Holding as well as board) project that these revenues would be used to support Holding Company functions? Probe for SMC's commitments to use funds to provide products for the very poor (unable to pay), community mobilization, community-based distribution, behavior change, training for providers in interpersonal communication and client care, quality assurance and improvement, and for expansion of the private sector—BSP, PNC, and other?
40. If SMC would not receive external funds, explore scenarios, e.g., would SMC be able to meet its social marketing goals, probing for oral contraceptives and injectables (not including Sayana Press)? Similar products for same price? If donated IUDs would end, what would Enterprise be able to provide and at what price? If donated implants would end, what would Enterprise be able to provide and at what price?

EQ-2, 3 SMC Program and Support Staff

1. MIS-disaggregated data available
2. Ideas for addressing issues of: availability of contraceptives with focus on injectables and LARC products, micronutrients and safe pregnancy measures; accessibility of products; equity to products; availability of accessible and acceptable services; quality of services (ORS/zinc, counseling, client and family education, adherence/continuation); awareness-raising; demand creation; social change (early marriage and teen pregnancy, reproductive health education for adolescents)

3. Ideas for addressing new public health concerns: NCDs, adolescent health, school health, malaria, poor nutrition and dietary practices
4. Financial gaps or needs
5. Level of dependency on donated goods

SMC Board

6. Awareness and perspectives relating to MIH, challenges, strengths, weaknesses, achievements
7. Role of board
8. Changes at SMC with the creation of Enterprise/Holding Company—how this is working, positive and negative aspects
9. Governance, e.g., by-laws for use of revenue—note how used last year and plans for this year
10. Review the products under consideration (ideas, feasibility studies, plans) and board opinion
11. New ideas for products and areas of growth
12. New approaches for ensuring equity to health products
13. Critical public health needs in the country and how social marketing could help address them

C-2 Interview guide MIH partners

Implementing and Technical Partners: Management and MIH Project Directors

1. Role in implementing MIH, probe if they were involved in the design
2. How MIH fits within their mission and broader programming and/or specific projects—note if other linkages or partnerships with SMC
3. Previous work in geographical area
4. Status of their work with MIH (any changes in contract, expectations since award and contract, implementation status, achievements (probe for major ones or unexpected successes, challenges, barriers), probe for role with annual planning, also noting any new activities
5. Value of studies, e.g., TRAC, FOCUS, MEASURE baseline, probe for other studies/use of data
6. Activities, approaches newly introduced by MIH, any lessons learned or promising practices
7. Satisfaction with the contractual, program relationship with SMC. Probe for any issues, e.g., related to support or reporting or cash flow
8. Relationship with other partners, e.g., information-sharing, monitoring activities
9. Relationships with government and other stakeholders at the project level, any involvement in district, subdistrict or lower planning, e.g., status of district development committee
10. Ideas to improve MIH or for future programming
11. *Note: Explore with them, within their office and others at the central or field level, who would be our best informants about the above*
12. Implementing Partner—Central and Field Project Staff (as well as technical, e.g., reproductive health, MCH, community mobilization or BCC)

Note: If not part of discussion above, inquire using questions 4, 5, 6, 7, 8, 9, 10, probe for the monitoring system, feedback, actions and use of data

EQI-Component One:

13. How distribution system is working—complaints about stock-outs, special focus on system for supplying CSAs
14. Expansion of providers—are there gaps in the network, areas without service providers, are BSP and PHCP providers meeting intended purposes, availability of LARC providers
15. Acceptability of the providers chosen (from the perspective of the partner)
16. Affordability of products

17. Client preferences/unmet needs, probe for gender-friendly services, e.g., counseling
18. How and how well SMC/MIH is marketing: contraceptives (probe for “Relax” and I-plant campaigns), Monimix, Safety Kits, Joya
19. Barriers related to unmet contraceptive need

EQ1-Component Two:

20. Community mobilization—aim of activities and how they are working. Probe if have or are using other community mobilization approaches; probe courtyard meetings, mobile film, audio presentations, workplace sessions, how they are engaging men, other groups like older women, out-of-school youth?
21. BCC—who are the targeted groups/segmented populations, strategies for targeted BCC, probing for how they were involved in strategy, messaging and channel development, probe if have or are using other BCC strategies, channels
22. How effective are the MIH BCC activities, channels and tools (in Sylhet, ask about why Floating IEC was discontinued), probe for changes in awareness, knowledge, engagement and adoption of practices, with emphasis on family planning, Safety Kits, sprinkles and taking zinc with ORS. Is BCC reaching the intended, targeted audiences (probe for innovations, e.g., role models)?
23. School Health—what is the main aim, activities, results, any lessons learned
24. Initiatives by others in area (family planning, nutrition, safe pregnancy, MCH services, adolescent health, school health) in the division (describe, probe for BCC activities)
25. Collaboration, relationship with government in project areas
26. Ideas for improving BCC, for changing behaviors: delaying, spacing, limiting pregnancies; improving diets (micronutrients); use of Safety Kits (probe for how they are helping to do this); and skilled care (ANC, delivery, postpartum care, newborn care)

EQ1-Component Three

27. Perceptions about:
28. Referral system—policies and procedures, how it is working, strengths and weaknesses, what is needed
29. Effectiveness of the capacity-building component (partner staff-mobilizers, BCC, other)
30. Use and effectiveness of CSAs, probe if they were or are working with community volunteers before MIH and what they think of the idea of CHW as entrepreneurs

EQ2

31. Information about reproductive health/family planning burning issues, work on next national strategy or guidelines
 1. Critical public health needs in the country relating to reproductive health
 2. New innovations in country, promising practices, lessons learned relating to family planning and improving utilization of MCH/nutrition services/measures, adolescent reproductive health and early marriage
 3. Other critical public health needs, government priorities and plans, ideas for addressing

MIH Technical Partner: EngenderHealth Management

1. Role in implementing MIH, probe if they were involved in the design
2. How MIH fits within their mission and broader programming and/or specific projects, note if other linkages/partnerships with SMC (Mayer Hashi II) and where implementing, target sector
3. Status of their work with the project (any changes in contract, expectations since award and contract, implementation status, achievements (probe for major ones or unexpected successes,

challenges, barriers), probe for role in annual planning, also noting any new activities or changes for this next year

4. Value of studies done, e.g., TRAC, FOCUS, MEASURE baseline, probe for other studies, include evaluation of MH by World Bank. Probe for how key study findings are used.
5. Activities, approaches newly introduced by MIH, any lessons learned or promising practices
6. Satisfaction with the contractual, program relationship with SMC. Probe for any issues, e.g., related to support, reporting or cash flow
7. Relationship with other partners and government, e.g., information-sharing, monitoring activities
8. Ideas for MIH or for future programming

Note: Explore with them, within their office and others at the central or field level, who would be our best informants about the above.

EQ1

9. Marketing and BCC with MIH, targeting intended users and influencers
10. Private sector development and MIH model: BSP and now PHCP and LARC network increasing access for adolescents
11. Work by others to build capacity of public sector, other private providers (by category)
12. Introduction of Sayana Press, marketing and positioning
13. Task-shifting injectables to PHCP

EQ2 and EQ 3

14. Reproductive health/family planning community, coordination, tasks forces, etc.: Burning issues, work on next national strategy or guidelines, plans for addressing unmet need, critical public health needs in the country relating to reproductive health, barriers to contraceptives, reasons for unmet need
15. Probe for women's health issues and challenges.
16. Who is doing what new innovations in country, promising or best practices, lessons learned, noting presentations at FIGO—integration of postpartum family planning with Immunization Program at subdistrict level and below, Sanjida Hasan, EngenderHealth programming elsewhere, e.g., TARUNYA Adolescent Reproductive and Sexual Health (ARSH)
17. Availability and accessibility of services/providers issues—public, private and NGO
18. Commodity forecasting, stability of supply chain, probe for how changes at SMC may affect sustainability/security of social marketing endeavors, e.g., contraceptives by type
19. Work done, being done or planned to develop capacities and skills of private sector and public practitioners
20. Policies relating to menstrual regulation, LARC, TBAs, MCH nutrition, task-shifting, community-based distribution of misoprostol, work with TBAs
21. BCC by EngenderHealth or others, or delay (noting work to address adolescent reproductive health and to delay marriage, spacing, to increase injectables, and limiting—creating demand LARC, safe pregnancy, MCH nutrition—addressing anemia, etc.)
22. Quality assurance/improvement systems being developed
23. Financing to ensure equity to health—what is being discussed, ideas

Technical/training: EngenderHealth, OGSB, AITAM and other technical experts

EQ1-Component One

1. Distribution system, probe for opinions on the products, stability of the supplies
2. Expansion of providers—are there gaps in the network, areas without service providers, are BSP and PHCP providers meeting intended purposes, use of mobile clinics?

3. Acceptability of the providers chosen (from the perspective of the partner)
4. Affordability of products
5. Quality of products—As a technical question, ask if there are equal quality oral contraceptive products for low-, medium- and high-income clients.
6. Client preferences—methods/brands, satisfaction with products and providers, mechanisms for consumer complaints, gender-friendly services (counseling, education, retailing)
7. How and how well SMC/MHI is marketing: contraceptives (probe for “Relax” and I-plant campaigns), Monimix, Safety Kits, Joya; what is the total marketing approach being used; are there written strategies and plans?
8. Probe for how the marketing strategy and plan for Sayana Press was developed and long-term plans if pilot is successful? How is it positioned among injectables, both SMC and others? How is the pilot being monitored, and how will it be evaluated?
9. Issues—e.g., discontinuation, lack of adherence, informed choice, moving from oral to medium- or long-acting methods, continued unmet need (is the project addressing this; who are and are not users)

EQ I-Component Two

10. Community mobilization—Define it and clarify its differences between partner vs. SMC. Explore advocacy, courtyard meetings, gatherings for mobile film and audio.
11. Targeted BCC, segmented marketing using total marketing approach—What BCC strategies are available, being used (probe for LARC, adolescent reproductive health, safe delivery)?
12. MIH BCC—Value added in project areas and with channels, products developed, being used, probe for perceptions of the TV spots, mobile film and audio shows, marketing done, innovations by MIH, EngenderHealth or others, e.g., use of role models
13. Initiatives by others to address same behaviors related to family planning, nutrition, safe pregnancy, MCH services, adolescent health, school health in the division (describe)
14. Workplace initiatives, what, when and for whom
15. School Health—What is the main aim, how curriculum is developed, results, any lessons learned
16. Barriers to engaging males, other influencers, e.g., mothers-in-law, to utilizing methods
17. Door-to-door work by CSAs, probe if any other home visiting programs are in the area

EQ I-Component Three

18. Training program development for BSP, PHCP, CSA, other such as TBA; process
19. Training models used (formal to on-the-job)
20. Monitoring and follow-up/mentoring after training—Involvement of OGSB, of government with monitoring, mentoring
21. Quality assurance/improvement—Quality-of-service concerns (BSP, pilot injections by PHCP, provision of supplies by CSA, and LARC by physicians), quality of care/service, decision by MIH to contract out
22. Performance of providers (BSP, PHCP, and LARC) after training; BSP performance (from the perspective of the partner)
23. Work by MIH to develop referral system, barriers to accessing LARC
24. Provider attitudes toward contraceptives
25. Ideas to improve this component

EQ2 and EQ 3

26. Reproductive health/family planning community, coordination, tasks forces, etc. Burning issues, work on next national strategy or guidelines, probe for women health, reasons for unmet contraceptive need
27. New innovations in country, promising or best practices, lessons learned, e.g., fistula work

28. Availability of supplies–Note systems, forecasting, donors and stability of supply chain
29. Availability and accessibility of services/providers, probe for development of private sector–Note presentation, “The Importance and Feasibility of Providing Permanent Methods in Low-Resource Countries and How FIGO Members Can Help SK Nazmul Huda” (IUDs, implants, permanent measures, also post-abortion, menstrual regulation, community-based provision of misoprostol, adolescent reproductive health)
30. Capacity-building for the private sector
31. Quality assurance/improvement
32. Policies and guidelines being developed or needed
33. BCC for delay (noting work to address adolescent reproductive health and to delay marriage, spacing, work to increase injectables, and limiting–creating demand for LARC, safe pregnancy, MCH, nutrition–addressing anemia, etc. Barriers to contraceptives, reasons for unmet need)
34. Financing to ensure equity to health, schemes being used, e.g., vouchers
35. Challenges, barriers, including attitudes of providers, sustainability of social marketing
36. Critical public health needs in the country relating to reproductive health and ideas to address them

Note: Explore with them who at the central or field level would be our best informants about the above

C-3 Guides to Focus Group Discussions with Community Members

Married women of reproductive age; users of modern contraceptives in Sylhet and Chittagong. (Maximum group of 8)

1. Awareness, availability, acceptability, accessibility, and affordability

- a) Please tell us about small and large health services in this community for women and children. *Whether or not Blue Star Providers were mentioned, ask about them: What do you know about them, what do they do, where and when do you see them working? What do people say about them and their service, noting availability accessibility, affordability or products and perceived quality? Probe for how the participants view their services and how they could be improved to better meet the needs of the participants.*
- b) Please tell us about family planning methods that are available in this community, probe for type of method (and brands of condoms and pills) and where each is provided (awareness and availability). If not mentioned, probe for the emergency contraceptive pill, Norix. If not mentioned, ask about community workers as providers.

2. Let’s talk about the family planning methods.

2.1 Oral contraceptives or pills

- a) Who is likely to use this method, why and why not?
- b) What brands are the most popular and why?
- c) What about the place where you get them? Do you do the purchasing (if bought), or does someone else? Do you find it easy to purchase? Which providers are preferred, why? *Probe for why other potential sources not preferred.*
- d) Are they available each time you go to purchase them?
- e) What do you think about the prices (high, medium low)?

2.2 Injectables

- a) Who is likely to use this method, why and why not?
- b) Which providers are preferred, why? *Probe for why other potential sources not preferred (particularly BSP).*
- c) Are injections available each time?
- d) Are you or your friends who are using injectables satisfied with the privacy of the space, and the counseling and education that is provided, linking this with type and location of provider?

- e) What do you think about the prices (high, medium low)?

2.3 IUDs

- a) Have you heard about it? If so, what have you heard about IUD and where did you heard about this method? What do you know about the advantages?
- b) Has anyone promoted this method for you; if so, who?
- c) Do you know any of the providers that provide IUDs?
- d) If you want to use this method, where would you/could you go? *Probe for: known potential providers; barriers—cost, distance; where they would prefer to go. Whom do you talk to about what methods to use if you want to space your children or limit your number of children? What would your family members think about using the IUD?*

2.4 Implant

- a) Have you heard about this? If so, what have you heard about IUD and where did you heard about this method? What do you know about the advantages?
- b) Has anyone promoted this method for you, if so, who?
- c) If you were interested in getting one, where could you go (known potential providers)? *Probe for where they would prefer to go; any barriers like cost, distance.*
- d) Whom do you or could you talk to about the methods to use if you decide to wait to have a children or to limit the number of children?

2.5 Sterilization

What do they know about permanent methods?

- a) Has anyone promoted this method for you or your husband; if so, who?
- b) If you were interested in getting one, where could you go (known potential providers)? *Probe for where they would prefer to go; any barriers like, cost, distance.*
- c) Who do you or could you talk to about the methods to use if you decide to wait to have a children or to limit the number of children?
- d) What women and why are not using modern family methods? *Probe for how they are preventing getting pregnant.*

2.6 Safety Kits

- a) Where did you deliver your last child? *If most say at home: Did you deliver with a TBA present?*
- b) Have you ever heard of Safety Kits? *(If that is not the SMC brand name, mention brand. Then describe brand and what it contains.)*
- c) Where are the Safety Kits available? Is the cost affordable for most people?

3. Communication and exposure to MIH/SMC messages

- a) From where do you get your information about family planning methods, their brands and providers? How have you learned about these methods, brands and the providers that offer these services? Are there other places where you have heard about family planning and methods? *Probe for home visitors, BSP, PCHP or other pharmacies, community health workers such as CSAs/SK or SS, doctors, paramedics or others (by type and location).*
- b) Have you ever participated in group discussions about family planning at a community gathering? What was talked about in the discussion? *Probe for information about family planning methods, infant and child, and pregnant/breastfeeding child. Who organized the meeting? How often are these sessions held?*
- c) Have there been any special events that focused on health? If so, what, where and by whom? What do you remember about this?
- d) Have you seen any messages on TV about family planning methods? What do you remember seeing?
- Radio?
 - Newspaper? Magazines? Brochure, flip chart, other?

- Have you ever watched a video about family planning; if so, where?
 - (Show some brands' promotional materials—one at a time.) Have any of you ever seen this ad? What is the overall message? What do you think this message is asking you to do?
- e) In this community, where is best place or person to talk to get good information about keeping you and your family healthy or about using any of the products discussed earlier (FP and child health)?

Married women of reproductive age (15-49), non-users of modern contraceptives in Sylhet and Chittagong

Guiding questions

I. Awareness, availability, acceptability, accessibility, and affordability

- a) Please tell us about health services in this community for women and children. *Whether or not Blue Star Providers were mentioned, ask about them: What do you know about them, is there a provider near to you, what do they do, where and when do you see them working? What do people say about them and their service, noting availability accessibility and perceived quality? Probe for how the participants view their services and how they could be improved to better meet the needs of the participants.*

I.2 Awareness of family planning services and methods

- a) As we want to learn more about this community, we are talking to women who use and who do not use modern methods and family planning services. Please tell us about the family planning methods that are available in this community; *probe for type of method (different brands of condoms and pills) and where each is provided (awareness and availability). If not mentioned, probe for the emergency contraceptive pill Norix, and also for providers: probe as needed to see if aware of CSAs and BSPs as providers.*
- b) If you were wanting to limit the number of children or would want to space your children, whom would you talk to about possible methods? *(Discuss different people they talk to (Husbands? Other family members? Religious leader? Medical provider?) Whom could your husband talk to if he had questions?*
- c) Do you know of other women who use contraceptives to avoid pregnancy? What do you hear from them?
- d) What women are not using modern family methods, and why not? *Probe for how they are preventing getting pregnant.*

2. Communication and exposure to MIH/SMC messages

We're interested in hearing about your sources of information about family planning:

- a) Have you ever participated in group discussions about family planning at a community gathering? *Probe for where and organized by whom.*
- b) Have you ever attended a special event that focused on family planning and child health? *Probe for information on ORS, zinc and micronutrients; information channels, such as the mobile film show, audio show, drama or song/dance.*
- c) Have you seen any messages on TV about family planning methods? What do you remember seeing?
- Radio?
 - Newspaper? Magazines? Other?
 - Have you ever reviewed messages by your mobile phone?
 - Signs, brochures, bill board, poster?

3. Child Health (may drop this if too long)

- a) We are going to change the subject somewhat. How many of you have children in your home that are under 5 years of age? (If a majority of hands are raised, then continue. If not, then go to concluding question.)

3.1 ORS/Zinc

- a) How many of you are familiar with ORS when your child suffers from diarrhea? And how many of you are familiar with using zinc in combination with ORS?
- b) If someone is aware of using zinc, ask her to describe its benefits.
- c) How did you learn of using zinc? Where can you buy it?
- d) *If no one is aware of using zinc, please explain its benefits. Why would mothers not use zinc?*
- e) *(Name the SMC brand.) Have you ever heard of (brand)? Do you know where you could purchase this brand?*

3.2 Micronutrient supplements

- a) Do you know about adding supplements to your child's food for a more nutritious meal?
- b) Can you name any food supplement that would be sold or distributed in your area?
- c) Have you heard of Monimix? (or BRAC brand name in Chittagong)
- d) Can anyone describe the benefits of using Monimix with your child's food?
- e) What would be the advantages of using Monimix?
- f) What do you see as the disadvantages of using it?
- g) Where do you suppose you could purchase it?
- h) If it were sold at (price in Taka) would you consider using? Why? Why not?

3.3 Safety Kits

- a) Where did you deliver your last child? *If most say at home: Did you deliver with a TBA present?*
- b) Have you ever heard of Safety Kits? *(If that is not the SMC brand name, mention brand. Then describe brand and what it contains.)*
- c) Where are the Safety Kits available? Is the cost affordable for most people who are delivering at home?
- d) Did you use it or have any plan to use it future delivery?

Concluding question

Of all the things we've discussed today, what are topics that you would like to further discuss or learn more about?

Conclusion

1. Thank you for participating. This has been a very successful discussion.
2. Your opinions will be a valuable asset to the study.
3. We hope you have found the discussion interesting.
4. If there is anything you are unhappy with or wish to complain about, please speak to me later.
5. I would like to remind you that any comments featuring in this report will be anonymous.

Please, write your report based on the results of the focus group. Please remember to maintain confidentiality of the participating individuals by not disclosing their names. This will only be used for report purposes and will not be used in any public document.

Married men of reproductive age (15-49) whose wives are either non-users or users of modern contraceptives in Sylhet and Chittagong

Guiding questions

I. Awareness, availability, acceptability, accessibility and affordability

- a) Mapping: Please tell us about health services in this community for women and children. *Whether or not Blue Star Providers were mentioned, ask about them: What do you know about them, is there a provider near to you, what do they do, where and when do you see them working? What do people say about them and their service, noting availability accessibility, affordability and perceived quality? Probe for how the participants view their services and how they could be improved to better meet the needs of the participants.*

1.1 Awareness of family planning services and methods

- a) As we want to learn more about this community, we are talking to women who use and who do not use modern methods and family planning services as well as men who are your age. Please tell us about the family planning methods that are available in this community. *Probe for type of method (different brands of condoms and pills) and where each is provided (awareness and availability). If not mentioned, probe for awareness of injectables, IUDs, implants, the emergency contraceptive pill Norix, and also for providers—probe as needed to see if aware of CSAs and BSPs as providers.*

1.2 Attitudes and perceptions about family planning

- a) What do you think of practicing family planning? Why do you think that way?
b) What kinds of issues do you discuss with your wife about family matters? Do you discuss the number of children you have or would like to have? Have you ever spoken to your wife about delaying, spacing or limiting the number of children you have?
c) Have you ever considered using or your wife using family planning? Why (or why not)?
d) About which of the family planning methods that were mentioned would you need more information?
e) If you were wanting to limit the number of children or would want to space your children, whom would you talk to about possible methods? *(Discuss different people they talk to: Wives? Other family members? Religious leader? Medical provider?) Whom could your wife talk to if she had questions?*
f) What would your friends, family members, other members of the community say if they knew you were practicing family planning?

2. Communication and exposure to family planning messages

- a) Have you ever participated in group discussions about family planning at a community gathering? *Probe for where and organized by whom.*
b) Have you ever attended a special event that focused on family planning and child health? *Probe for information on ORS, zinc and micronutrients; information channels such as the mobile film show, audio show, drama or song/dance.*
c) Have you seen any messages on TV about family planning methods? What do you remember seeing?
 - Radio?
 - Newspaper? Magazines? Other?
 - Have you ever reviewed messages by your mobile phone?
 - Signs, brochures

d) *(Show some brands' promotional materials—one at a time.)* Have any of you ever seen this ad? What is the overall message? What do you think this message is asking you to do?

3. Safe delivery (3 minutes)

- a) Has anyone ever heard of safe delivery kits? *(If not, explain)*
b) Would you be interested in enabling your wife to ensure a safe delivery by purchasing a safe delivery kit?
c) Discuss accessibility of kit *(mention where located).*
d) Affordability of kit *(mention prices).*

4. Communication with your wife (7 minutes)

Concluding question (5 minutes)

Of all the things we've discussed today, what would you like to further discuss, and in what setting?

Older women who may be mothers-in-law of married women 15-49 in Sylhet and Chittagong

Guiding questions

1. Awareness, availability, acceptability, accessibility, and affordability

- a) Mapping-Please tell us about health services in this community for women and children. *Whether or not Blue Star Providers were mentioned, ask about them: What do you know about them, is there a provider near to you, what do they do, where and when do you see them working? What do people say about them and their service, noting availability accessibility, affordability and perceived quality? Probe for how the participants view their services and how they could be improved to better meet the needs of the participants.*

1.1 Awareness of family planning services and methods

- a) As we want to learn more about this community, we are talking to women who use and who do not use modern methods and family planning services as well as men who are your age. Please tell us about the family planning methods that are available in this community. *Probe for type of method (different brands of condoms and pills) and where each is provided (awareness and availability). If not mentioned, probe for awareness of injectables, IUD, implants, the emergency contraceptive pill Norix, and also for providers—probe as needed to see if aware of CSAs and BSPs as providers.*

2. Communication and exposure to family planning messages

- a) Have you ever participated in group discussions about family planning at a community gathering? *Probe for where and organized by whom.*
- b) Have you ever attended a special event that focused on family planning and child health? *Probe for information on ORS, zinc and micronutrients; information channels, such as the mobile film show, audio show, drama or song/dance.*
- c) Have you seen any messages on TV about family planning methods? What do you remember seeing?
- Radio?
 - Newspaper? Magazines? Other?
 - Have you ever reviewed messages by your mobile phone?
 - Signs, brochures?
- d) *(Show some brands' promotional materials—one at a time.)* Have any of you ever seen this ad? What is the overall message? What do you think this message is asking you to do?

3. Safe delivery

- a) Has anyone ever heard of safe delivery kits? *(If not, explain)*
- b) Would you be interested in enabling your family to ensure a safe delivery by purchasing a safe delivery kit?
- c) Discuss accessibility of kit *(mention where located).*
- d) Affordability of kit *(mention prices).*

4. Communication with son, daughter or daughter-in-law

- a) What would you say if you found that your son and his wife didn't want to have another child right away? Or if newly married to wait to have a child? Or to limit the number of children?
- b) If you were to learn that there are easy, affordable, longer-term methods that could still allow for fertility if desired, with side effects that are temporary and don't last, at an affordable price with a trained provider, what would you do/think—would you discuss it, encourage it and help your daughters, daughters-in-law to get it? *(Really probe and discuss.)*

- c) How could you encourage the use of safe delivery kits when your family members or friends are delivering their children at home?

Concluding question:

If you would like to have more information or discussion about family planning methods and providers or other issues discussed today, where would you like this to be provided and with or by whom?

C-4 Focus Group Discussion with Community Sales Agents

1. Their work: probe for what they do, specifics of services provided, mode of delivery, and for whom
2. Note any incentives they receive
3. Products that they provide (look at bag contents), ask if they are missing any products
4. Ask about product prices and if affordable for their customers
5. Ask about sales, with focus on safe delivery kits, family planning methods, zinc with ORS, and micronutrient sprinkles. Probe for reasons that some of these products are not selling well, also any change in buying practices.
6. Supplies: probe for system for resupplying, satisfaction with products and supply chain
7. IEC/BCC messages and aids
8. Training received, what and by whom, satisfaction
9. Referral system: how, when, where to, and how this is working
10. Supervision and coordination within MIH and with others' processes: probe for relationship with other community field workers, e.g., Family Welfare Assistants
11. Monitoring and reporting
12. Their successes and their challenges
13. Their needs: probe for training needs
14. Their customer needs for services or products: who's using what, who is not, and why
15. Their ideas for improved marketing of products or for expanded role

C-5 Focus Group Discussion Guide: CBAs (due to lack of time with this group in two places, questions 1, 3, 5 were covered, touched on 9)

1. Their work: probe for what they do, specifics of services provided, mode of delivery, and for whom
2. How busy they are: are more women delivering at facilities or using medical attendants at home? If home births with TBAs are still high, ask about reasons why women do not go to facilities, or why they prefer home births and TBAs.
3. Are more of their mothers going for ANC care; if so, where? Postpartum/newborn care, if so, where, if not to either, why not?
4. Note any incentives they receive, reason and from whom.
5. Supplies commonly used: probe for awareness, availability, accessibility, affordability, and utilization of Safety Kits; products that they provide
6. Referral system (where, when): probe for if they accompany women, any incentive program
7. Their successes, challenges and needs: probe for training needs
8. The needs of expectant or new mothers and newborns, probing for both services and products
9. Their concerns about safe pregnancy: ask about experience with misoprostol

C-6 Schoolteachers

1. Their role
2. Aim and objectives of the activity, results
3. Training provided by MIH or others
4. Satisfaction with MIH support and teaching materials and aids, what they like most, what they like least, how they think the lessons could be improved

5. Products that are marketed or sold at the school
6. Value of products, e.g., Joya—explore if this has affected school attendance, also what kind of disposal systems are provided at the school for the napkins.
7. Needs of females, probe for reproductive health needs, and also male youth, referral system
8. Ideas for sustaining, expanding the school health program

C-7 Workplace (observation)

1. Name and type of company, number of employees, male/female
2. Description of activity, topics, materials and aids used
3. Venue, participants
4. Questions raised
5. Note if included marketing and selling of products
6. If possible, interview company person organizing the event, to learn if the company has a health plan for their employees, if so what? Also if any health services or other education/promotion activities are provided on site, if so, what and by whom?

C-8 Youth

1. Activities that they are involved in (relating to the site visited)
2. Needs of youth, female and male
3. Ideas for reaching youth out of school

C-7 Consultative Meeting Agenda

Purpose: This is to be a consultative meeting to learn more about specific aspects of MIH as implemented by PSTC and CWFD, and then, with other partners, to brainstorm ideas for improving community mobilization and behavior change interventions.

9:00 am

1. Context—project area. Allow for 15 minutes for each of the two organizations to present on their project area, covering the following:
 - Sociocultural, physical environment and health statistics: how these have challenged and shaped community mobilization activities?
 - Availability of resources and services, linkages and referral system
2. Questions from evaluation team

10:00 tea break

10:30

3. Community Mobilization/BCC
 - Challenges and successes in advocacy efforts and reaching targeted populations
 - Materials and/or channels used for BCC
4. Questions from evaluation team

11:30

5. Future programming ideas⁹⁵
 - CSA desire for increased scope: more products, potential services

⁹⁵ Invite two members from Shimanitak and BRAC MIH head office.

- Greater coverage and depth of community mobilization/BCC
- Improved coordination and referral

1:00 Lunch

ANNEX D. PERSONS INTERVIEWED OR PARTICIPANTS IN DISCUSSIONS

Organization	Person met	Designation
USAID	Melissa Jones	Director OPHNE
USAID	Marietou Satin	Deputy Director
USAID	Dr. Sukumar Sarker	Senior Technical and Policy Advisor, OPHNE
USAID	Dr. Ferdousi Begum	Clinical Service Lead, OPHNE
USAID	Brenda Doe	Family Planning Advisor, OPNE/USAID
USAID	Dr. Niaz Chowdhury	Project Management Specialist
USAID	Dr. Samina Chowdhury	Project Management Specialist
SMC	Muhammed Ali	Chairman, Board of Directors
SMC	Ashfaq Rahman	Managing Director
SMC	Md. Ali Raza Khan	Managing Director, SMC-EL
SMC	Toslim Uddin Khan	General Manager, Program
SMC	Shafi Uddin Ahmed (Selim)	Secretary to the Board of Directors and Chief Financial Officer
SMC	Dr. Md. Salah Uddin Ahmed	Head, Training & Service Delivery
SMC	Dr. A Z M Zahidur Rahman	Head of BCC
SMC	Abul Bashir Khan	Head of Grants, C&A
SMC	Md. Moshir Rahman	Manager, R, M&E
SMC	Md. Anwar Morsalin	Manager, Program and Health Network Marketing
SMC	Md. Motahar Hossain	Program Manager, Community Mobilization
SMC	Md. Ziaul Mawla	Program Coordinator Blue Star Network
SMC	Laila Tabassum	Deputy Manager, M&E
SMC	ASM Habibur Rahaman	Chief of Pharma Project
SMC location	Khan Ashraful Alam	SPE SMC EL
SMC location	Abul Hayat Md. Kamal	SMC, EL
SMC	Kh. Shamim Rahaman	H-CM&D

SMC	Sayedur Rahman	DGM, Sales and Family Planning
SMC	Sekander H. Khan	Human Resources and Administration
SMC Comilla	C.N. Mandal	Area Office Manager
SMC Comilla	Md. Akhter Habib	Senior Sales Manager
SMC Comilla	Md. Nazrul Islam Talukder	Program Coordinator Community Mobilization
SMC Sylhet	Md. Akhter Habib	Senior Sales Manager
SMC Sylhet	Md. Ziaul Mawla	Program Coordinator, BSN
SMC Sylhet	Md. Anamul Hoque	Program Coordinator, CM
SMC Sylhet	Duiwan Bhoumik	So, Sylhet EI
SMC Sylhet	Khandaker Mostakim	So. Sylhet EL
SMC Sylhet	Ferdous Ahmed Bakht	PO-Tr-ESD, SMC, Sylhet
SMC Sylhet	Md. Tofazzal Hossain khan	So. Sylhet EL
BRAC	Dr. Abbas Uddin Khan	Sr. Program Manager
BRAC	Dr. Md. Ariful Islam	Program Coordinator
BRAC	Mostafizur Rahman	Program Coordinator
BRAC Comilla	Md. Jafar Iqbal	Upazila Manager, Sadar Dakkhin
BRAC Comilla	Md. Tahiduzzaman	Upazila Manager, Daudkandi
DGFP Comilla	Mst. Nurunnahar	FWA
DGFP Comilla	Amirun Nesha	FWV
DGHS Comilla	Aunjumanara Rumi	Assistant Health Inspector
DGHS Sylhet	Priyanka Sinha	CHCP
DGHS Sylhet	Dr. Padma Mohan Sinha	UH&FPO
DGHS Sylhet	Dr. Mamun	Resident Medical Officer
Shimantik	Dr. Ahmed Al-Kabir	President
Shimantik	Kazi Hodayun Kabir	Director (Program and Research)
Shimantik	Kazi Moksedur Rahman	Executive Director
Shimantik	Md. Emdad Hossain	Project Manager, Shimantik
Shimantik	Tariqul Alam	District Team Leader, Moulvibazar
Shimantik	Suprio Das	Program Officer, Community Mobilization, Kamalgonj
Shimantik	Abdus Sakur	

Shimantik	Md. Mahbubur Rahman	Program Officer, Community Mobilization, Chatok, Sunamgonj
Shimantik	Md. SaydulHaque	Program Officer MIS and Documentation, Sylhet
Shimantik	Parvez Alam	Program Officer, BCC, Sylhet
		Director, Training and Capacity Building
Sylhet	Dr. Satto Cum Chakrabarty	Civil Surgeon, Moulvibazar
DGHS Sylhet	Dr. Md Yeahia	UH&FPO
DGHS Sylhet	Dr. Habibur Rahman	Civil Surgeon, Sylhet
DGHS Sylhet	Gorango Mandol	Deputy Civil Surgeon, Sylhet
Balagonj	A T M Ajharul Islam	UNO
Balagonj	Abdul Hye Moshahid	Chairman Upazila
Balagonj	M A Motin	UP Chairman, Balagonj
CWFD	Rokeya Sultan	Project Director, MIH
CWFD	Md. Aktar Hossain	Program Officer, BCC and Advocacy
CWFD	Zahirul Alam	PM, CWFD
CWFD	Md. Shahin Alam	DTL, CWFD, Barisal
CWFD	Md. Monir Hossain	PO-CM, CWFD, Faridpur
PSTC	Nabakumar Dutta	Program Officer BCC & Advocacy
PSTC	Eheteshamul Haque	Program Officer MIS & Doc
PSTC	Rezwana Howlader	CM-PSTC-Sreenagar
PSTC	Sabbrena Akter	PO-CM-PSTC Sreenagar
PSTC	Md. Shadequr Rahman	DTL, PSTC, Narshingdi
PSI	Manuela Tolmino	PSI Advisor to SMC
EngenderHealth	Dr. A J Faisel	COP, Mayer Hashi & CR, EH BCO
EngenderHealth	Dr. Sanjida Hassan	Senior Program Officer
EngenderHealth	Dr. Didarul Islam	Senior Quality Assurance Officer
MEASURE	Mizanur Rahman, Ph.D.	Senior Research Advisor
OGSB	Prof. Rowshaon Ara Begum	President, LARC Network
AITAM	Dr. Zahed Md. Masud	ED

AITAM	Dr. Khurshida Jahan	Program Director
Sylhet Diabetic Hospital	Lalit Mohon Nath	RMO
Sylhet Diabetic Hospital	Dr. Syeda Tyuba Begum	Consultant, LARC Network
DGFP	Md. Abdus Salam Sarker	JS, Director Logistics
DGFP	Zakia Sultana	PM, IEM
DGFP	Dr. Md. Moinuddin Ahmed	LD CCSDP
Ukaid / DFID	Dr. Shehlina Ahmed	Health and Population Advisor
RTM International	Ahmed Al-Kabir, Ph.D.	President
PH Consultant	Dr. Abdus Sobur	Development Consultant, UN and INGOs, and PH Professor
BRAC University	Dr. Jahir Uddin Ahmed	Interim Chairperson, Midwifery Program, SMC Member
D-net	Ananya Raihan	CEO
GAIN	Dr. Rudaba Khondker	Country Manager
Bangladesh Center for Communications	Md. Shajahan	CEO
BKMI	Rebecca Arnold	Project Director
SIAPS	Zahedul Islam	Country Project Director
SIAPS	Golam Kibria	Senior Technical Advisor, Quantification
SIAPS	Mohammad Abdullah	Senior Technical Advisor, Logistics
Population Council	Obaidur Rob	Country Director, EVIDENCE
Save the Children	Imteaz Mannan	Senior Advisor, Advocacy and Communications
CARE Bangladesh	Dr. Mohammad Zahangir	Program Director, Health
CARE Bangladesh	Dr. Ahsanul Islam	Coordinator, Health Unit
CARE Bangladesh	Rina Rani Paul	Program Coordinator
Surjer Hashi Clinic Comilla	Kazi Ikram Hossain	Clinic Manager
Surjer Hashi Clinic	Md. Mafizur Rahman Babul	Project Director, NHSDP Project, SSKS

ANNEX E. DOCUMENTS REVIEWED

1. USAID/SMC. MIH Award. July 2012.
2. MEASURE. Bangladesh Marketing Innovation for Health Baseline Survey 2013-2014. January 2015.
3. MIH project documents: annual reports and work plans, advertising and BCC materials, including audio/visual dramas, BCC strategy, Blue Star and PCHP training guides, ledgers and monitoring tools, MIS data (SMC), data report from Shimantik Sylhet
4. SMC Five-Year Strategic Plan 2015-2020
5. RTM, PSI, SMC. (TRAC Report) Household-Level Tracking Survey on Critical Program Indicators. October 2014.
6. RTM, PSI, SMC. (FoQus Report) Reproductive, Antenatal, and Early Childhood Health—Understanding Behaviors and Decision-Making in Bangladesh. 2014.
7. Eminence, SMC. Knowledge and Effectiveness of CSA Activities in Selected Study Areas. September 2014.
8. RTM International, SMC. Evaluating the Knowledge, Attitude and Practice of Trained Private Community Health Providers. June 2014.
9. Research and Computing Services Private Limited (RCS), SMC. Brand Awareness, Trial and Usages Study on Monimix, Norix and Zinc Tablet. August 2014.
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ANNEX F. CONFLICT OF INTEREST STATEMENTS

The authors declare that they have no conflicts of interest.

U.S. Agency for International Development
1300 Pennsylvania Avenue, NW
Washington, DC 20523