USAID
FROM THE AMERICAN PEOPLE

PRIMARY HEALTH
CARE PROJECT

وزارة الصحة
دائـــرة الصحـــة العامـــة

BEHAVIOR CHANGE COMMUNICATION STRATEGY

FOR PRIMARY HEALTH CARE SERVICES IN IRAQ

DISCLAIMER
This guideline has made possible through support provided by the U.S. Agency for International Development (USAID) under Primary Health Care Project in Iraq (PHCPI) implemented by University Research Co,. LLC. This guideline has been developed in Iraq in close collaboration with the Ministry of Health (MoH) in November, 2013

CONTENTS

Introduction 7

Situational Analysis: Challenges and Opportunities 8

Challenges 8

Opportunities 11

Priority Approaches 13

The Strategy 14

Overall Goal 15

Strategy Objectives 15

Strategic Approach 15

Strategic Framework 15

Guiding Principles 17

Strategic Intervention 19

Implementation 28

Monitoring and Evaluation 30

Appendix 1 36

Interview Guide: BCC stakeholders 36

Acronyms

ANC	Ante-Natal Care
BCC	Behavior Change Communication
BCC TWG	behavior Change Communication Technical Working Group
BHSP	Basic Health Service Package of the Iraq MOH
CHW	Community Health Worker
CPR	Contraceptive Prevalence Rate (% adults using modern contraceptives)
CPI	Client-Provider Interaction
DoH	Director of Health
EPI	Expanded Program on Immunization
FGDs	Focus Group Discussions
FP	Family Planning
GOI	Government of Iraq
HCW	Health Care Worker
HPPI	Health Promotion Program in Iraq (USAID- sponsored)
HPD/U	Health Promotion Department/ Unit
HSS	Health System Strengthening
IDP	Internally Displaced Person
IEC	Information, Education and Communication
IMCI	Integrated Management for Childhood Illness
IPC	Inter-Personal Communications
KABP	Knowledge, Attitude, Behavior and Practice
LHCs	Local Health Committees
MDG	Millennium Development Goal

MOH	Ministry of Health
M&E	Monitoring and Evaluation
MCH	Maternal and Child Health
MCRH	Maternal, Child and Reproductive Health
MIL	Mother-in-Law
NGOs	Non-Government Organizations
OD	Organizational Development
PDD	Planning Department Directors
PHC	Primary Health Care
PHCPI	Primary Health Care Program in Iraq
PMP	Performance Management Plan
TA	Technical Assistance
TOT	Training of Trainers
TFR	Total Fertility Rate
URC	University Research Company, LLC
USAID	United States Agency for International Development
VDC	Village Development Committee
WHO	World Health Organization
WRA	Women of Reproductive Age (15-49)

IN THE NAME OF ALLAH THE MOST BENEFICENT THE MOST MERCIFUL

"AS FOR THE FOAM, IT VANISHES, [BEING] CAST OFF; but as for that which benefits the people, it remains on the earth. Thus does Allah present examples"

"Believe the Great Allah

I've thoroughly read the contents and annexes of the Behavioral Change Communication (BCC) strategy for Primary Health Care in Iraq, especially the first part which illustrates a comprehensive behavior change strategic framework related to primary health care and services in Iraq. Part two of the strategy explains the relationship between the strategic framework and the operational elements related to the implementation of the strategy on the national level.

Active partnership, strategic collaboration and integrated visions and experiences that are based on concluding, eliciting and achieving the maximum benefit of the practical lessons are crucial fountains for the success of this strategy.

This strategy was developed by the Ministry of Health in coordination and collaboration with the Directorate of Public Health and PHC, specifically BCC- TWG and Health Promotion department by the technical support from USAID-Primary Health Project in Iraq (PHCPI). This collaboration BCC Strategy outcome's resulted in filling in an important programmatic to increase the utilization of and demand to the available PHC services. The BCC strategy is based on critical analysis of the challenges and available opportunities in Iraq that can help in addressing challenges in this field, solving problems, and building sustainable organizational and community participation systems for health promotion in a way that ensure that the individuals, families and communities have more control of their own health.

We realize that change in all aspects of life is not an easy process, and neither the Ministry of Health nor its departments can implement this strategy alone. The change process requires collaborated efforts among various sectors especially the organized media effort that is based on studying knowledge, attitudes and behaviors related to traditions and customs imposed and inherited by the community. Mass Media and

health education has a very important role in sustain the required behavior change, by creating awareness around the "Mass media and health promotion activities have a very important role in supporting the required behavior change, by conducting the awareness and promotion around the issue .

As we adopt and support such a tendency, we always feel confident that the modern, evidence-based thinking makes this strategy a living documented improvable to accommodate the most recent theories and updates in this field based on the standards and indicators of monitoring and evaluation. All these factors will enable us to create the required connections between local community and health service providers. We collaborate with all sectors to apply it on the ground as it directly approaches priorities of Iraq MDGs to adopt healthy, sustainable behaviors and practices, and make them a motive to establish community participation in health process. This achievement, which is made with the support of USAID through PHCPI priorities, truly represents the culmination for the effective partnership between the two parties as well as other stakeholders.

I'd like to express my thanks and appreciation to the Directorate of Public Health and PHC and its related competent staff especially BCC TWG, USAID, PHCPI management, experts and advisors, and to all those who have put their hard work and great ideas that lay the foundation for the desired health advancement on which we work in a collaborative manner, may Allah help all of us to better serve the Iraqi people and health process in Iraq.

Dr. Majeed Hamad Ameen

Minister of Health

Republic of Iraq

Date:

INTRODUCTION

The Iraqi Ministry of Health (MOH) is currently undergoing a process of health reform and moving forward with reorganizing and stabilizing its health services. Ensuring access to routine, high quality, and equitable healthcare have emerged as a critical need. The Government of Iraq (GOI) is committed to improving the quality of Primary Health Care (PHC) services.[1]

The USAID-funded Primary Health Care Project in Iraq (PHCPI), implemented by University Research Co., LLC (URC) (2011-2015) is working to strengthen health sector capacity to provide the essential PHC quality services and expand availability of such services throughout the country, with increasing coverage for vulnerable and at-risk populations, such as children under five, women, and Internally Displaced Persons (IDPs). The objectives of the PHCPI are; to strengthen management systems, improve quality and utilization of clinical services, and increase community involvement in health service delivery to increased demand for and use of PHC services, especially those that target reduction in child mortality and the improvement of maternal health, so the country can meet its 2015 Millennium Development Goals (MDGs) 4 & 5. PHCPI is supporting the MOH by assisting in capacity development for 298 clinics among 18 Iraqi governorates.

> Behavior Change Communication
> BCC is a research-based, consultative process of addressing knowledge, attitudes, and practices through identifying, analyzing, and segmenting audiences and participants in programs and by providing them with relevant information and motivation through well-defined strategies, using an appropriate mix of interpersonal, group and mass media channels, including participatory methods.
>
> **(Neill McKee, 2002)**

The following Behavior Change Communication (BCC) Strategy has been developed in collaboration between the Public Health and Primary Health Care Directorates of the MOH. The BCC Technical Working Group (TWG) which is comprised of **team from Health Promotion department, Quality improvement, PHC Department**and USAID/PHCPI provided technical support during the development of the strategy. The purpose of the PHC- BCC strategy is to promote the demand for and use of PHC services

[1] "A Basic Health Services Package for Iraq." January 2009. http://www.emro.who.int/iraq/pdf/basic_health_service_package_en.pdf

in the country through behavior change communication. The strategy provides an analysis of the challenges and opportunities to do so, as well as various ways the MOH could: (a) improve awareness about patients' rights and PHC services; (b) improve the capacity among health service providers and community partners, especially Local Health Committees (LHCs), to communicate key health messages to clients and communities; (c) increase demand for PHC services; (d) encourage the adoption of healthy behaviors among key target audiences; and (e) build sustained community involvement in health promotion. The strategy builds on past and existing MOH efforts and experiences in these areas, and other community programs, with the support of USAID and other implementing partners.

This strategy provides a national platform to guide and shape audience specific BCC operational plans and interventions with a focus on Maternal and Child Health (MCH) morbidity and mortality as an immediate priority. The strategy will work on changing PHC-related behaviors at different levels of care ranging from national to local level government counterparts, health service delivery sites, communities, families and individuals.

The first part of the strategy proposes the overall PHC BCC strategic framework, while the second part focuses on operational issues related to nationwide implementation.

This strategy is a living document and requires regular stakeholder discussions and formative research to continuously update and address current programmatic needs.

SITUATIONAL ANALYSIS: CHALLENGES AND OPPORTUNITIES

CHALLENGES

DISEASE BURDEN

During the last 25 years, three wars and a decade of sanctions have severely crippled large parts of the Iraqi infrastructure, including its health facilities and services. Iraq is currently facing a huge burden of both communicable and non-communicable diseases, with diarrheal diseases and respiratory tract infections prevalent among children and malnutrition, diabetes and cardiovascular disease becoming increasingly common non-communicable diseases.[2] The life expectancy of Iraqi's is 68 years, which is very low for the region.

[2] USAID/PHCPI. Primary Health Care Project in Iraq. Baseline Assessment Report. December 2011.

To meet Iraq's MDGs 4 & 5 by 2015 (reduction in child mortality and improvement of maternal health), maternal and child health statistics are in great need of improvement: the Total Fertility Rate (TFR) is still over 6 children per woman, with a Contraceptive Prevalence Rate (CPR) of less than 50%. . Maternal mortality rates of 25.8 per 100,000 live births are due to declined access to quality antenatal care and safe delivery services. Antenatal coverage is only 51%, with 41% of pregnant women receiving 4 or more antenatal care visits. After birth, visits and examinations are at 57%. Under-five mortality is 24.2/1,000 with the infant mortality rate equal to 19.9/1,000.

HEALTH SYSTEM

While national level PHC goals are clearly articulated in the national health strategy and communicated by the MOH, with a strong commitment from provincial stakeholders, the implementation of PHC plans is scarce at the District and PHC facility levels. The PHCPI Baseline Study found the following major PHC service delivery challenges:[3]

- Presence of training plans, but training facilities, program and materials are limited.
- Presence of staffing plans, but misallocation of human resources at the District and PHC facility level (e.g., too few female nurses and only half the lab technicians needed).
- Health workers, Health volunteers, and LHCs are used to working through expertise-based interventions, for facilitation and community leadership.
- Poor Client-Provider Communications (CPI); lack of training of staff in patient counseling skills
- Only 113 of a total 2,642 PHCCs in Iraq used the family medicine and referral mechanisms, largely due to lack of diagnostic equipment and specialist staff.
- Limited handicapped, elderly or displaced programs.

These gaps in the health services system affect not only the ability of PHC facilities to function at full performance level, but also result in low provider and client confidence in the system. Implementing BCC efforts to increase demand for and utilization of health

[3] USAID/PHCPI. Primary Health Care Project in Iraq. Baseline Assessment Report. December 2011.

MOH annual report 2013

services in a system that is not ready to receive and serve increasing numbers of clients is a challenge at best.

COMMUNITY MOBILIZATION

While collaboration between international agencies (like USAID and the United Nations), the MOH, and provincial-level health facilities is strong, the utilization rate of PHC is still low with limited community involvement within Primary Health Care services and activities. Specific challenges include: [4,5]

- Low utilization of PHC facilities.
- Local Health Committees and community mobilizers are still in formation in most locations, and many community health mobilizers work for international NGOs focused on Internally Displaced Persons only.
- Most of the community health educational programs have focused only on limited/restricted areas not always accessible by PHCCs.
- There are limited customized programs for women and youth.
- Presence of joint programs between international donors (USAID and United Nations) and MOH; however, most programs have limited community involvement
- Lack of awareness-raising programs for private sectors and community/patients on health related issues
- Several professional health associations are conducting BCC and IEC activities, but with little collaboration with PHC facilities
- Community health educators, Health Volunteers especially women, with youth and sheikhs are least involved, affecting public perception of health issues
- Limited involvement of community groups and representatives in PHC policy development

[4] "A Basic Health Services Package for Iraq." January 2009. http://www.emro.who.int/iraq/pdf/basic_health_service_package_en.pdf

[5] USAID/PHCPI. Primary Health Care Project in Iraq. Baseline Assessment Report. December 2011.

OPPORTUNITIES

Recently, the MOH has made great strides in building capacity and implementing health-related BCC efforts. From 2009-2011, the MOH gained technical assistance from the "Health Promotion Program in Iraq" to strengthen the capacity of the MOH's Health Promotion Department (HPD) to design, implement, and evaluate BCC programs. Originally conceived to help mitigate H1N1 influenza, the program shifted its focus away from this topic to focusing on non-communicable diseases, nutrition, and emergency communication protocols.

Health promotion program activities included: (1) strategic planning workshops and trainings, and reactivating the existing Inter-Ministerial Communications Committee to help plan, coordinate and implement BCC activities; (2) strengthening the research, monitoring, and evaluation systems for BCC activities; (3) conducting workshops on BCC material development and mass media – surveys and campaigns were implemented targeting childhood obesity and nutrition; (4) increasing the capacity of the HPD at national and governorate levels in BCC skills with Training-of-Trainer (TOT) programs; (5) organizing a study tour for MOH staff to learn from Jordan's experience with implementing BCC activities; (6) improving knowledge management and information sharing within the HPD and MOH and with donors and other stakeholders, including developing a basic BCC Clearinghouse; (7) improving MOH's emergency communication and crisis information management; and (8) enhancing the MOH capacity to revise, update, and implement the national H1N1 communication strategy.

While the Program encountered numerous challenges throughout, it did lay the groundwork for more coordinated and strategic BCC activities in the country. Recommendations from the Program, which this BCC strategy will build upon, include:

- Providing Technical Assistance (TA) to the HPD to promote the BCC capacity building at level of MOH, provincial, district, PHCCs, and community levels;
- Addressing BCC topics; regarding to MOH needs focusing on MDG 4&5Improving UN agencies, NGO and private sector involvement to improve the healthy life style in different health sectors especially mother and child health;
- Improving M&E systems to evaluate BCC project impact;
- Continuing to rollout the BCC TOT program.

In addition, the PHC BCC Strategy will build on and scale-up other successful partner BCC-related activities. Some past and existing activities are outlined below.

MOH's Basic Health Services Packages (BHSP) for Iraq outlines a model of promoting the primary health care activities and both secondary and tertiary services with integration between public and private sectors. The private sector is able to complement and fill gaps in care that exist in the public sector. Currently, NGOs in Iraq have only limited experience in providing health services. However, several international NGOs have implemented programs over the past decade addressing the need for greater community outreach. As an immediate priority of this national strategy, the MOH aims to use this BCC strategy to build its MCH-BCC operational plan by using the strategic approaches and guidelines identified in this strategy. [6]

In 2004, the UN Health Cluster was founded by ten UN partner organizations (WHO, UNICEF, UNFPA, WFP, UNDP, UNIDO, UNEP, IOM, UNIFEM, and UNOPS) in order to simultaneously address many of the priority health needs for Iraq. From 2005-2007, the Health Cluster's program objectives included a 50% reduction in under 5 mortality and increased access to quality health care services for IDPs and other vulnerable groups. Its program strategies included mass vaccination campaigns, particularly in conflict zones such as Fallujah, and IEC community outreach on maternal and child health services, particularly emergency obstetric services. Through its efforts, the UN Health Cluster was able to immunize more than 900,000 children.[7] [8]

The WHO has also been promoting various community-based initiatives (CBI) in Iraq since 1999 that provide important models and lessons learned on community linkages. These initiatives include the healthy village programme (HVP), the healthy city programme (HCP), the women in health and development (WHD) programme, and the basic development needs (BDN) programme. While these initiatives have focused on different areas (including emergency preparedness, infant health, healthy environments, community schools, etc.), their common objective is to build the capacity of communities to enable them to address their health needs and establish effective community institutions that can plan and carry out various interventions. WHO research showed that communities in which CBIs were implemented provided support to primary health care and had stronger partnerships with health service providers. WHO believes that next

[6] "A Basic Health Services Package for Iraq." January 2009. http://www.emro.who.int/iraq/pdf/basic_health_service_package_en.pdf

[7] "Cluster D: Health and Nutrition." United Nations Assistance Mission for Iraq. 2010. http://www.uniraq.org/operations/show_cluster.asp?Language=EN&ClusterID=D

[8] "Concept Paper on the 2006-2007 Strategic Direction and Funding Needs." UN Health and Nutrition Cluster for Iraq. http://www.who.int/hac/crises/irq/appeal/Iraq_HealthClusterConceptPaper2006-07.pdf.

steps for the CBI strategy should include advocacy efforts to encourage behavior change and policies which protect human rights.[9]

PRIORITY APPROACHES

Develop a focused audience specific BCC operationalization plan that compliments the BCC Strategic Plan and can effectively initiate and sustain positive health changes in the communities of Iraq.

Although the strategic priority areas are listed below, maternal and child morbidity and mortality (MDGs 4&5) are areas that need to be addressed immediately. . These priorities have been identified through the MOH situational and needs assessments that have been conducted with TA from USAID/PHCPI, as well as strategic stakeholder meetings with MOH officials and technical staff.

PHC Focus Areas

- Antenatal Care
- Institutional Deliveries
- Post Natal & New Born Care
- Unmet need for family planning
- Nutrition through the life cycle (infant, under three, adolescents, women)
- Routine immunization
- Hygiene and safe water practices
- Non-communicable diseases
- Communicable diseases
- Others area according to MOH needs and priorities in time

[9] "Introduction to the community-based initiatives programme in Iraq." WHO. 2007.

BCC Approach Focus Areas

- Supportive supervision of PHC clinics to improve quality and increase the competency of service providers
- Capacity building of BCC skills for service providers across Iraq to provide institutional infrastructure for sustainability
- Improving UNs agencies, NGO and private-sector involvement in BCC interventions planning and management supporting MOH
- Establish and utilize community based structures and bodies to activate and strengthen community participation and outreach activities especially for low-income and low-literacy beneficiaries through targeted customized community based interventions. This will create the supportive social norm that will facilitate and synergize the BCC interventions and impact.
- Strengthen the monitoring and evaluation systems to monitor and assess the impact of different BCC interventions

THE STRATEGY

This BCC strategy document seeks to shift the emphasis of PHC BCC programs from awareness to action, and from theories to practical operationalization. The strategy structure and components are based on a detailed analysis of the dynamics of PHC health issues in Iraq, the barriers to behavior change, and an understanding of the audience of the strategy and other participants in the program.

This document outlines how the MOH should use ***strategic*** communication to enhance PHC service delivery and demand creation among targeted audiences in Iraq. The strategy builds on the understanding that encouraging individuals or couples to change behaviors is a continuous process, involving distinct audiences that need different messages in the designing process is important to maximize the impact of the behavior change intervention, market positioning and synchronized approaches are essential for any effective BCC activity. Information alone is not enough to bring about behavior change among any audience. Instead, the strategy is based on multi-level, synchronized, interpersonal, community and mass media levels of communication.

Detailed consultations were held with stakeholders to delineate the overall goal and objectives of the strategy; present a conceptual framework that illustrates how program approaches are expected to contribute to objectives; and chose the priority target audiences and communication channels that the strategy focuses on. Based on this design, implementation and monitoring and evaluation plans are being proposed for putting the strategy into action on national and local levels.

OVERALL GOAL

To encourage the adoption of healthy behaviors and health seeking practices among the Iraqi population, ultimately resulting in better health outcomes.

STRATEGY OBJECTIVES

The following overarching objectives of this strategy are:

- To raise **awareness** of the rights to, importance of and services offered for primary health care in Iraq among the primary target audiences.
- To improve the **capacity** of health service providers and community partners to communicate key health messages and to promote patient's rights to PHC.
- To increase the **demand** for utilization of PHC services as they become available, especially among the primary target audiences
- To engender **sustained** PHC practices among the target populations over time: adoption of healthy behaviors and health seeking practices among the target audiences, and building community involvement in health.

STRATEGIC APPROACH

STRATEGIC FRAMEWORK

This BCC strategy is based on the following conceptual framework. The model shows that the PHC BCC interventions will impact behavior through 4 different approaches:

1. **Creating enabling environments at the national, provincial, and district levels:** This involves, among others: Development of national and provincial/district level BCC frameworks for PHC. Improving health system strengthening, organizational development, and monitoring and evaluation (M&E) efforts.
2. **Creating supportive community norms:** Establish local partnerships and community mobilization activities, including public advocacy for PHC services and patients' rights through the use of Local Health Committees (LHCs), Village Development Committees (VDCs), NGOs, community organizations, opinion

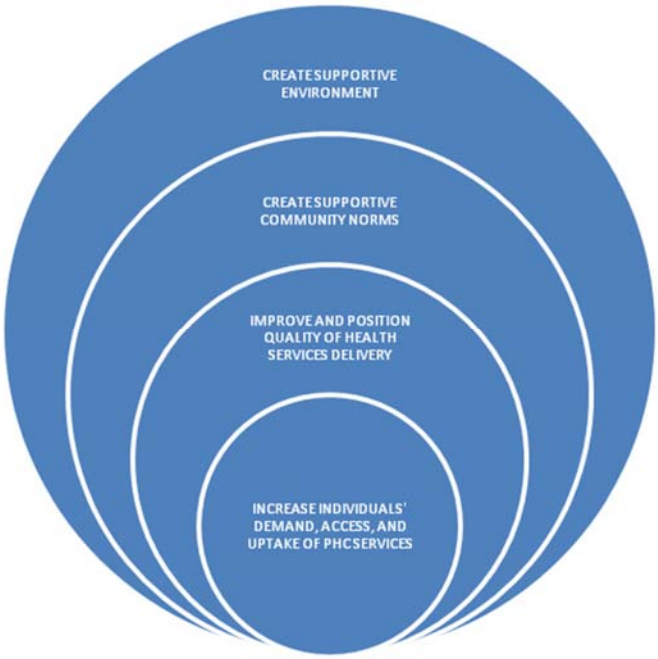
leaders, committees of primary health care, councils of parents and local government councils.

3. **Improving and positioning quality of health services delivery:** Increase the effectiveness of client/provider interaction; increase clients' access to accurate, consistent and tailored information; increase clients' awareness of patients' rights.

4. Increase individuals' demand, access, and uptake of PHC services: Through creating awareness of patient's rights; creating positive attitudes towards PHC services and confidence in the PHC system; and decreasing barriers to accessing PHC services.

Capacity building and skills transfer are the overarching strategies for achieving these approaches.

Diagram 1: PHC BCC Strategic Framework



GUIDING PRINCIPLES

The following principles will guide the BCC Strategy in design and implementation. These Principles are based on research from the global health community,[10] the PHCPI Baseline Assessment and feedback from local partners in 2011 in addition to the MOH field surveys and studies.

Table 1: Guiding Principles

Results-oriented	The effectiveness of a communication effort should be ultimately determined by the health outcomes, output and impact. Clear targets and indicators for increased knowledge and adoption of healthy behaviors should be established and verified by monitoring and data collection efforts.
Evidence-based on the scientific and pragmatic practices toward behavior and attitude change	Communication planning should utilize accurate formative research on local issues and clients as well as communication theory and tested mechanisms to inform and guide the activities.
Client-centered	Representatives from both clients of this strategy—those who will deliver the messages such as Community Health Workers (CHWs) and community mobilizers and those who will receive them (potential health clients) should be involved in the process of shaping messages to address identified needs.
Participation	Client involvement should be throughout the communication process including program design, implementation and evaluation.
Benefit-oriented	The benefit of the change and the support for the change to the client must be clear and the center of all BCC efforts.

[10] Many principles here are based on USAID-funded Reproductive Health Communications Strategies' BCC components, such as that used in Kenya 2010-12.

Service-linked	This Principle has two aspects: (1) health promotion efforts should be directed towards promotion of specific services to ensure uptake and measurable results; and (2) the readiness of the supply-side of these services must be ensured before and promotion efforts take place to avoid non-scientific analysis with the services that are being promoted.
Multi-channeled	Multiple channels that are complimentary and tailored to specific audiences (e.g., clinicians vs adolescents vs IDP's) should be used with a view to enhance effectiveness of communication and reach the target audiences.
Advocacy-related	Strategic communication should be advocacy-related, targeting policy makers and opinion leaders to engender an enabling environment for the changes being promoted.
Cost-effective	Communication resources should be focused towards the most effective channels to increase the probability of sustaining the efforts over time.

STRATEGIC INTERVENTION

TARGET AUDIENCES

While primary health care is the right and need of all people, recent assessments and documentation of the primary health situation in Iraq by the MOH, WHO, USAID and others have outlined groups with particularly urgent health burdens and barriers to health care access. These include: women of reproductive age (WRA) (especially pregnant and post-natal mothers and mothers of children under five); youth (under age 25, especially married girls under age 18); and Iraqis still in the process of post-conflict re-settlement (generally referred to as internally-displaced persons (IDPs)).

For purposes of this strategy, target populations are broken down into primary and secondary audiences.

- *Primary* audiences (mainly WRA, mothers, pregnant women and husbands) will be addressed through direct and tailored messaging to encourage demand for and uptake of the available PHC services.

- *Secondary* audiences include those who directly and indirectly influence the primary audiences knowledge, attitudes and behaviors that influence their access and demand for services either on the individual/community level, through the health care delivery system, and/or through a socio-political context. The secondary audiences who can directly influence behaviors include immediate influentials (e.g., health service providers, husbands/partners, mothers/mother-in-laws, community members) as well as local champions (e.g., satisfied clients, key media personalities, community health mobilizers, local health committees, Village Development Committees, local community groups and NGOs, etc.). Those who indirectly influence clients' behaviors include the MOH, key national and local level stakeholders, professional associations, private-sector partners, among others.

The addressed audiences are identified in Table 1 are subject to modification through finalization of the BCC strategy with national and local-level stakeholders and partners.

Table 1: Target Audiences

<table>
<tr><th>Primary Audiences</th><th>Secondary Audiences</th></tr>
<tr><td>WRA, especially pregnant and post-natal mothers, mothers of children < 5 years</td><td rowspan="3">Immediate influential
• Public and private-sector health care providers (Doctors, health care workers)
• Husbands/partners
• Mothers/mother-in-laws
Community influential/Local Champions
• IDP leaders
• Religious leaders
• Local community groups (e.g., Women and youth organizations, men’s groups)
• NGOs
• Schools
• Traditional healers
• Birth attendants
• Client satisfaction
• Key media personalities
• Local health committees
• Village Development Committees
• Employers
• Prof. associations
• Government/Partners
• MOH
• Key national, provincial and district-level stakeholders
• Professional associations
• Private-sector
• Partner council
• Councils of PHC</td></tr>
<tr><td>Youth (under age 25, especially married girls under age 18)</td></tr>
<tr><td>Internally Displaced Persons</td></tr>
</table>

POSITIONING

Positioning creates "a specific image or market niche for a health issue, service, or product that will be memorable and influential to the intended target audience."[11] Formative research will be conducted to decide how best to develop and promote an Iraqi appropriate branding (theme/image) to cement together all the different activities and material that are related to this strategy and position the messages and promoted practices as a priority of action for the addressed audience/s.

Together with stakeholders, a unique label/image will be designed to position this identify so that it will easily be remembered in the minds of the audiences with clear call to action. Positioning all PHC BCC program activities under this comprehensive theme/image will better integrate different programmatic interventions, behaviors, and stakeholders at both national and local levels.

CHANNELS

This is often referred to as the "channel mix," and includes mechanisms as varied as inter-personal communications (IPC) to mass media. Discussions with the Iraq MOH revealed the preference to use a combination of methods in a BCC PHC Strategy, including IPC, one-to-one counseling, group education, print materials, TV, and radio.[12] Special consideration and attention will be given to the materials that are appropriate for low literate beneficiaries during both the development and field-testing stages.

KEY IMPLEMENTERS OF BCC ACTIVITIES

Key implementers of BCC activities will include: the HPD, PHC services, PHC cub-centers, Community health houses, local health committees and community partnership networks, community groups, NGOs as well as other community influential and partners listed in Table 2. BCC activities should fold into existing mechanisms of these agents as much as possible, such as any current HPD BCC activities, LHC awareness campaigns,

[11] Piotrow et al. Health Communication. Lessons from Family Planning and Reproductive Health. Johns Hopkins School of Public Health. Center for Communication Programs. 1997.

[12] STTA Trip Report for the PHCPI, December 2011

VDC's and women's groups health activities, etc., to increase efficiency and promote sustainability.

INTERPERSONAL COMMUNICATION AND COUNSELING

- Improve IPC/C skills of health service providers: Strengthen the capacity of health service providers (doctors, and health workers) in interpersonal communication and counseling (IPC/C) and outreach through IPC/C trainings and workshops; provision of easy to read job aids, and knowledge updates.

- Provide IPC/C supportive supervision and mentoring of health service providers: Reinforce and strengthen health service providers' skills in IPC/C through supportive supervision. Advocate for use of quality improvement approaches such as rewards/recognition for performance for enhancing use of IPC and providing quality services.

COMMUNITY MOBILIZATION

- Health Events: Work with local NGOs, community groups, private-sector partners, health professional associations, LHCs, and VDCs, and local media to organize and conduct regular health events to maximize reach and visibility of PHC-related messages.
- Health classes and group counseling: Conduct health classes, including group counseling, on key health messages as part of existing community outreach done by PHC facilities.
- Advocacy: Conduct provincial/district/community-level advocacy with local chief executives and health officers on the importance and need for advocacy to use of PHC services; develop and support PHC BCC frameworks, strategies, and activities; and allocating resources to do so. Hold workshops with community influentials – e.g., IDP leaders, religious leaders, provincial/district council committee members, women and youth organizations' members, schools (especially primary schools), traditional healers and birth attendants on their important role in providing basic health messages and to encourage people to visit PHC facilities for appropriate care, treatment, and information.
- Material development and dissemination: Develop and disseminate innovative targeted messages and materials that can be used by policymakers, PHC facilities, hospitals, public plazas, community groups, NGOs, the private sector, and for local transit vehicles. Materials include advocacy materials (for policy

makers, community influentials) to highlight the importance and benefits of using PHC services; materials on patient rights, job aids, and knowledge updates (for both health service providers and patients); outdoor materials such as streamers, backdrops (for health events), give-away promotional materials (i.e., T-shirts, bags), pamphlets, posters, and materials to post on transit vehicles that highlight key health messages for community mobilizers. During the operationalization of the strategy, localized formative researches will guide the development process of targeted messages and materials as well identifying the appropriate communication channel/s for different program's beneficiaries including low literate and poor communities. All developed materials and messages will be tested on the addressed audiences to ensure the appropriateness and comprehension of the designed messages and materials.

MEDIA

- National media: Use national media (e.g., national TV, radio, and newspaper placements) to reach target audiences with PHC messages.
- Local media: Use local conventional media (e.g., local TV, radio, and newspaper placements) to reach target audiences with PHC messages. Train local media on how to report on and cover PHC BCC topics' messages and activities.

Table 3: Audiences, Communication Approaches, Activities, and Key Message Topics

Audience	Approaches	Activities	Key Message Topics
Women of Reproductive Age	IPC/C	• Provider counseling during PHC services • Support groups/peer discussion groups	• Awareness of patients' rights • Location, hours, and services of nearest PHC • Know importance of PHC for major health issues and priorities • Feel safe and confident to

Youth **IDPs**			practice healthy and health-seeking behaviors • Review and Sustain the integration between the behavior and it's continuously and the into long-term practices
	Community mobilization	• IPC by community influentials and local champions (e.g., through home visits, schools, women's groups, etc.)	• Key health messages on high impact health interventions • Messages on patient's rights to PHC • Location, hours, and services of nearest PHC • Encourage all target audiences to go to PHC facilities to get care
	Materials	• Information dissemination by community influentials and local champions • National and local media to reinforce messages	• Key health messages on high impact health interventions • Messages on patient's rights to PHC
Health service providers	IPC/C	• IPC/C Training of Trainers • IPC/C roll-out	• Awareness of patients' rights • Location, hours,

(Doctors, Health workers)		trainings • Job aids • Knowledge updates (service delivery & patient rights) • Monitor compliance to IPC/C and service delivery national standards and performance improvement	and services of nearest PHC • Communicate regularly and effectively to target audience • Aware and train about Counseling skills
Community Influentials		• Identify, train, and mobilize local community groups to reach out to communities through information dissemination and health events and encourage them to access PHC services • Community meetings • Develop advocacy briefers • Conduct public advocacy for PHC services by LHCs, VDCs, and other civic and opinion leaders • Identify local media partners and provide media kits on how to report on PHC BCC topics and activities	• Community influentials have an important role in ensuring the health of their communities • Awareness of patients' rights • Location, hours, and services of nearest PHC • Encourage all target audiences to go to PHC facilities to get appropriate care • Communicate regularly and effectively to target audiences
MOH/DoH/Health Districts, LHC,	BCC planning	• Finalize BCC Strategy	

VDCs	• Develop provincial/district level BCC operational frameworks for PHC • Conduct formative research • Finalize target audiences, locations, message development and testing • Conduct M&E

IMPLEMENTATION

The MOH will proceed with the implementation of this strategy over its life span through different stages: identifying the immediate, midterm and long term priorities, identify the technical assistance requirements to start immediately in developing a well-defined operational plan to address MDG 4-5 as immediate priorities and develop a capacity building to strengthen the institutional infrastructure and resources for evidence-based and action oriented BCC planning and implementation on the long term.

As explained below, the MOH will start by establishing national and provincial bodies to oversee and guide the strategy prioritization and operationalization process and at the same time guide the technical aspects required for proper implementation and evaluation.

STEP 1: NATIONAL BCC STAKEHOLDER COMMITTEE FORMATION

As a first step in carrying out the BCC strategy, a National PHC BCC Stakeholder Committee will be established. The committee will be coordinated by MOH counterparts (especially from the HPD), representatives from the Inter-Ministerial Communications Committee, representatives of relevant ministries and syndicates, members of the UN Health Cluster, members of professional associations, the private sector, and international NGOs. PHCPI will provide the required TA to this national body. The major tasks of this group will be delineated during the first stakeholder meeting, the major tasks of this committee will include:

- Finalization and dissemination of the PHC-BCC strategy and its operational plan.
- Providing technical leadership in implementing and evaluating the BCC Strategy.
- Designing and conducting quality assurance related to BCC activities.
- Facilitating the information sharing among stakeholders.
- Ensuring sustainability and scaling-up of interventions through resource mobilization.
- Advocacy for relevant policy changes.
- Supervising implementation of BCC operational plans in the provinces.

Step 2: Provincial BCC Committees

Second, provincial-level BCC Committees will be established. The groups will be coordinated by the MOH Provincial-level Directorates, representatives from Provincial Councils, representatives from District Health Offices, Community Partnership Networks, and NGOs. The major tasks of these groups will include:

- Developing local operational plans, indicators, and M&E Plans for BCC implementation.
- Finalizing priority target audiences, messages, and channels.
- Supervising implementation of local-level BCC plans.
- Mobilizing resources for BCC implementation.

Step 3: Formative Research

While some data is already available on the major health challenges and factors affecting PHC access and service delivery in Iraq[13], PHCPI will conduct additional local-level, participatory, community-level and targeted field-testing and formative studies activities to ensure appropriateness of the developed messages, materials and communication channel/s. This will enhance the engagement of the addressed audiences and maximize the impact of the promoted behaviors.

Step 4: Message Development and testing

Once the PHC BCC formative research and strategic designs are complete, the PHCPI will assist the MOH and its relevant department to develop audience specific operational plans and to develop and test specific messages and materials to support the strategy. It is likely that messaging will be designed around the nine main PHC health services listed in the BHSP.

While developing messages, it is useful to remember that persuasive communication follows the Seven Cs of Effective Communication:[14]

- *Command attention* – be daring enough to command attention, but stay sensitive to cultural context
- *Cater to the heart and head* – provide messages that arouse emotion (often best delivered through songs, drama, etc.)
- *Clarify the message* – convey the message in a single, important point

[13] Secondary data sources include: *PHCPI Baseline Assessment* Sept 2011; the *MCRH Strategy for Iraq, 2005-08*; the *Basic Health Service Package for Iraq*, WHO, 2009; the *Community-Based Initiatives Programme in Iraq*, WHO, 2007

[14] Piotrow et al. Health Communication. Lessons from Family Planning and Reproductive Health. Johns Hopkins School of Public Health. Center for Communication Programs. 1997.

- *Communicate a benefit* – position messages such that they create an important personal benefit to the target audience
- *Create trust* – have messages come from sources they trust
- *Call for action* - Provide clear cue to action after the message
- *Consistency counts* – Repeat the message as often as possible, with variations but basic consistency.

All messages will need to be translated and back-translated to ensure accuracy. Messages and materials will be pre-tested with representatives of both primary and secondary audiences. Messages and materials will need to be revised based on the audiences' reactions to the pretest.

Step 5: Roll-Out and Dissemination

MOH will start with the PHCPI TA to set immediate priorities for the strategy, strengthen the MOH institutional communication infrastructure and develop audience specific operationalization plans to roll out the campaign activities.

Monitoring and Evaluation

While the BCC Strategy efforts and activities will be monitored by the MOH relevant departments, a specific BCC M &E framework will be developed by the MOH with TA from PHCPI based on the available studies results and BCC goals, objectives, and targets set forth by the BCC Stakeholder Committee. In general, the overall effectiveness of the HPC BCC strategy will be assessed through both process and impact evaluation. Preliminary proposed indicators are found in Table (4).

MOH will be vigilant in monitoring data quality of the BCC activities, as it does with the project as a whole. Training and technical assistance will be provided to all counterpart staff who collect data that is used in the M&E system. Data quality will be checked by carefully reviewing incoming data for anomalies and outliers, as well as formal data quality audits (data collection tool audits, provider-patient interaction observations, as well as interviews with clients and providers).

Process Evaluation

Process evaluation, or monitoring, will be conducted throughout the implementation of the project activities and will actively involve key stakeholders on national and local levels. The purpose of the process evaluation will be to determine whether activities and outputs are proceeding and produced according to plan, and if not where necessary changes need to be made.

In addition, it will examine the strengths and weaknesses of the program activities. The key indicators will cover: implementation of planned project activities such as BCC training initiatives; number of people trained; number of provinces, districts, villages, PHC service delivery facilities covered; number of health events sponsored; number of people who attend health events, community outreach and other activities by type; numbers of materials produced and distributed; number of people reached through mass media (e.g., radio, television), etc.. Specific activity indicators will be finalized through the National and Provincial Stakeholder Committees. PHCPI will assist the MOH on institutionalizing monitoring and evaluation methodologies and systems that can assess the outcomes and impacts of BCC interventions.

Impact Evaluation

Impact evaluation will be used to assess whether the right messages are coming across to the target audiences and the net effect of the strategy on the target audiences' behaviors. To track these changes USAID/PHCPI proposes the use of the following assessments:

Quality of IPC/C: Will be assessed through supportive supervision monitoring tools including client-exit interviews and observation of provider-patient interactions

Facility-based surveys: To link exposure to BCC campaigns and messages to service utilization. To assess knowledge, attitudes, and behavior regarding PHC; change in access to PHC services and to measure client satisfaction

Stakeholder surveys: To assess national and local commitment to BCC

Table 4: Proposed Indicators

Indicators		
BCC Implementation	Materials	IPC/C manual and participant handbook developed
		Number and types of outreach materials developed (are these the same as IPC/C materials or are these flags, posters for outreach? Not sure I understand what these are?)
	Trainings	Number and types of outreach materials distributed
		Number of trainers trained in IPC/C

	Supportive Supervision	% of participating health clinic staff trained in IPC/C
	Community Mobilization	Number of community volunteers trained in IPC/C (What about use of the training in daily practice? Applicable to all of the #/% of people trained.)
		% of provincial MOH and participating clinic supervisors trained in IPC/C supportive supervision
		Number of local NGOs or community groups who have potential for community mobilization identified
		Number of people and community groups trained in community mobilization
Reach	IPC/C	Number of people reached through IPC/C by trained health service providers and community volunteers (How will these be tracked?)
	ACSM	Number of advocacy, communication, social mobilization activities (ACSM) conducted by type of activity (e.g., health events, support groups, school outreach, etc.) by target group and topic
		Numbers of people reached with ACSM activities, by target group and topic (May be difficult to track and keep good records.)
	Community mobilization	% of PHC clients citing health behavior change, by health topic
		Number of NGOs/community groups mobilized to support PHC BCC activities
	Patient Rights	% of PHC clients, health care workers, community members, program managers citing awareness of patient rights (This may be tricky to measure and we will need to be consistent on what exactly will be measured. E.G. aided, unaided, can articulate,
	Supportive	

	Supervision	etc.) Percent facilities actively using patients rights charter as part of their service delivery process % of participating districts with a functional supportive supervision of IPC/C of PHC providers and PHC centers
Systems Strengthened	Patient rights BCC planning, budgeting and monitoring	Patient's rights charter adopted by MOH Number of provinces implementing a PHC BCC operational plan and allocating adequate budgets for implementing activities Number of LHCs and VDs adopting plans and budgets for PHC BCC Number of PHC facility budgets that include budgets for BCC outreach materials, staff, and community mobilize trainings Number of LHCs and Community Partnership networks engaged in PHC District and sub-District level planning and monitoring process with MOH

Table 5: Illustrative Implementation Timeline

Strategy Step	Major Activities	Y 1	Y 2	Y 3	Y 4
1. National BCC Stakeholder Committee Formation and Activities	Selection of National BCC Stakeholder Committee members	X			
	National BCC Stakeholder Committee meetings	X	X	X	X
	Finalize PHC BCC Strategy and disseminate to Provinces and Districts		X		
	Provide technical leadership in implementing and evaluating BCC Strategy	X	X	X	X
	Design and conduct quality assurance activities	X	X	X	X
	Promote information sharing among stakeholders	X	X	X	X
	Work to ensure sustainability and scale-up of interventions through resource mobilization		X	X	X
2. Provincial BCC Committee Formation and Activities	Provide TA in developing operational plans, indicators, and M&E plans for BCC implementation		X	X	X
	Finalize priority audiences, messages, and channels		X		
	Provide TA for mobilizing resources for BCC implementation		X	X	X
3. Formative Research	Design research survey instruments	X			
	Hire and train data collectors		X		
	Data collection and analysis		X		
	Results presentation to stakeholders		X		

4. Message Development and Testing	Engage BCC design specialists		X		
	Develop, pre-test, and finalize messages, tools and channels based on research results, MOH priorities, and audience contexts and capacities		X		
5.Roll-out	TOT of health service providers		X		
	Training of health service providers		X	X	
	Communication campaigns targeting target audiences		X	X	X
6. Monitoring, and Evaluation	Establish BCC targets and goals with BCS, incorporating Formative Research results for baselines and indicators		X		
	Align with M&E systems of the PHCPI PMP, MOH, HIMS, USAID and other relevant indicators and assessment mechanisms salient to BCC and health-seeking behaviors		X		
	Conduct data collection activities		X	X	X
	Incorporate periodic reports into regular management meetings and quality control mechanisms of the PHCPI PMP, MOH, HIMS, USAID		X	X	X
	Perform mid-term evaluation			X	
	Revise strategy as needed			X	
	Conduct final evaluation, disseminate results				X

Appendix 1

Interview Guide: BCC stakeholders

Province _____
Position of the respondent----------
Name of the respondent----------
Name of the organization----------
Date of Interview _____

We would like to request about 45minutes to 1 hour of your time to discuss the development of a BCC strategy document in the context of MoH in Iraq. The need for developing a BCC strategy has been stated in the primary health care strategy. Your experience and expertise in developing and implementing health policies and programs will be crucial to making this strategy document feasible and amenable to effective implementation.

I. Health Priorities

1. In your opinion, which are the 3 biggest health problems in your (province/district)? And why?

2. MoH data indicate that maternal care coverage indicators are still low. What are the reasons for low maternal care coverage in your (province/district)?

3. From all the national health programs, Immunization, HVP, FP, RCH, TB, etc., which do you think are most effectively implemented? What makes these programs so effective?

4. What are some of the key programs implementation challenges / issues under the PHC program?

II. Audience Priorities

1. Given the major health problems you just described, who do you think should be the primary audiences for being given information on how to change their behaviors?

    a. What are their knowledge, attitudes, and beliefs about that particular health issue?

    b. What barriers do they have for accessing PHC services?

    c. How do they best access information? (i.e., through community groups, radio, TV, etc.?)

2. Which audiences do you think influence the health behaviors of those primary audiences?

BCC Priorities

1. What do you understand by the term "Behavior Change Communication"? Does it have an important role in achieving the goals of PHC strategy?

2. What are the weaknesses of existing BCC efforts in Iraq?

3. What are the strengths of existing BCC efforts in Iraq?

4. What is your vision of a BCC strategy in your province?

5. What is the scope of using mass media campaigns in your province? What channels are available? Which ones are most effective in reaching the audiences we just talked about?

6. Would local media need to be trained in certain ways to better provide BCC messages; if so, what type of training do you suggest?)

7. What is the scope of using community based BCC approaches such as home visits, group meetings, local committees, youth groups etc? Please give us your views in detail.

III. Operational Issues

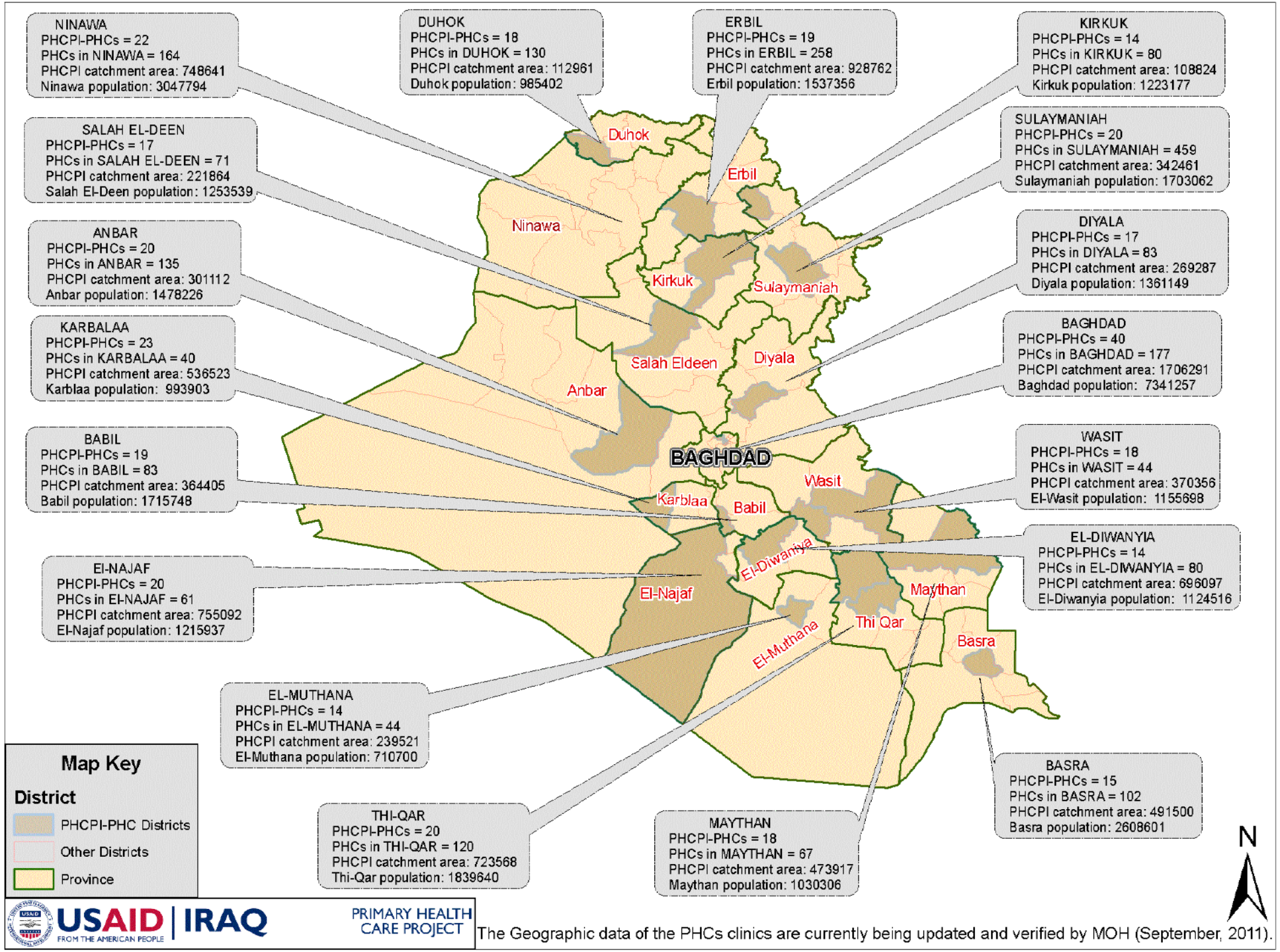
1. What is the infrastructure you currently have in place for implementing BCC activities?
2. Do you have a provincial-level BCC plan?
3. Do you have specific budgets allocated for BCC activities?
4. What types of BCC activities has your province/district carried out so far?
5. What types of technical assistance would your office need to help implement BCC activities in your province/district?
6. If a national BCC strategy were developed to promote PHC services, what can be done to ensure that it is implemented in UP as planned?

Committee members involved in behavior change communication strategy for PHCs:-

- **Dr. Aseel Ayad Naji / Director of Health Department**
- **Dr. Alia'a Hussein Ali / Health Education Section Manager Dr./MOH -Iraq**
- **Mun'em Jawad Dawood / Quality Management Section Manager/MOH-Iraq**

- **Dr. Maysoon Rabia Amer / Studies and evaluation Department Manager/MOH-Iraq.**
- **Dr. Kefa'a Munawar Hashim / Community Initiatives Section Manager./MOH-Iraq**
- **Dr. Ikhlas Yunus Mohammad / PHCC Section Manager/MOH-Iraq**
- **Dr. Einas Bassim / PHCPI**

PHCPI-PHCs population mapped to IRAQ population



USAID | IRAQ
FROM THE AMERICAN PEOPLE

PRIMARY HEALTH CARE PROJECT

The Geographic data of the PHCs clinics are currently being updated and verified by MOH (September, 2011).

U.S. Agency for International Development
Primary Health Care Project In Iraq
http://phciraq.org/
www.usaid.gov