

NSDP Campaign Evaluation Survey 2006

Draft Report

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EXECUTIVE SUMMARY

The NSDP campaign Evaluation Survey, in short the Campaign Survey, was carried out to evaluate the performances and achievements of the NSDP communication campaign. The fieldwork for data collection was carried out over the period from December 6 2005 through May 12, 2006.

Exposure to campaign

ESH (Enechi Surjer Hashi) was successful in reaching remarkable proportions of the target audience. Nearly 40 percent of respondents reported having ever watched the drama, accounting for 51 percent of those who watched television and 63 percent of those who were aware of the airing of the drama. Women were more likely to watch the drama than were men—42 percent versus 37 percent. Local level BCC activities were more successful in reaching the target people than was the drama serial. When only about 40 percent of respondents reported having ever watched an episode of ESH, over a half (51 percent) of those reported having exposure to local level BCC activities, ever seeing at least one publicity or education material about the SS clinic in the past 6 months in the community. There were virtually no variations in exposure to local level BCC activities between women (51.1 percent) and men (50.6 percent).

Determinants of exposure to campaign

Multivariate logistic regression analysis was conducted of exposures to the campaign to identify the factors having independent effects on them. In the analyses, Age of respondents emerged as an important determinant of exposure to ESH, showing that both men and women in the two oldest age groups, 30-39 and 40+, were significantly less likely to watch ESH than those in the younger age group. Education, asset quintile and place of residence had also significant impact on exposure to ESH. Respondents were more likely to watch ESH if they were more educated, more if they were from richer asset quintile, and more if they lived in urban areas than in rural areas.

Age variations in exposure to BCC activities were generally not significant, except for men in the oldest age group, 40+, who had significantly less exposure to those activities than had their counterparts in the younger age groups. Variations in exposure to BCC activities were also insignificant between rural and urban women. But rural men were significantly more likely to say that they had seen BCC materials in the community than their urban counterparts. Exposure to BCC activities rose significantly among both men and women with increases in their education, as did exposure to ESH. However, variations in exposure to BCC activities by asset quintile were generally not significant.

Awareness about smiling sun clinics

One of the major objectives of the Evaluation Survey was measuring the success of the campaign in raising awareness about smiling sun (SS) clinics. Awareness was assessed in terms of the following three variables: awareness of smiling sun logo, awareness of SS clinics and the services available in them, and overall awareness of messages disseminated about the clinics. When the logo was shown, most respondents reported having seen the logo—86 percent among women and 83 percent among men. Smiling sun clinics were also found to be widely known in the community and more widely among women than men. Among female respondents 91 percent and among male respondents 81 percent reported knowing of them.

Commonly known types of services available at smiling sun clinics were Child Health related services, Maternal Health related services, Family Planning services and General Treatment services. Among women, 71-80 percent reported knowing of the availability of Maternal Health related Services (78), Child Health related services (71 percent) and Family Planning Services (75 percent). Availability of General Treatment services was relatively much less known. Only 37 percent of women said they knew of the availability of General Treatment services. Men were generally less likely to know of the services at smiling sun clinics, compared to women.

Impact of campaign on awareness

Odd-ratios for all the campaign variables—exposure to ESH, exposure to BCC activities and knowledge of availability of services at discounts/free of costs—appeared statistically significant, showing increased awareness of smiling sun clinics, increased overall awareness of messages about them and increased awareness of their services, among respondents who had exposure to the campaign. This is clear evidence that the campaign was successful in raising awareness about smiling sun clinics in the target population.

However, the campaign was more successful in raising awareness with BCC activities than with ESH. For example, awareness of smiling sun clinics was 10.5 times higher among women who had exposure to BCC activities than among those who had not, while the difference was only 3.6 times between women who had exposure to ESH and those had not. The campaign was also found to have been more successful in raising awareness more among women than among men. Interestingly, offering of services at discounts/free of costs had discernible impact in raising awareness about smiling sun clinics.

Use of smiling sun clinics

Use of smiling sun clinics was assessed in terms of the number of people visiting those clinics to seek or obtain services either for themselves or for others. Among female respondents, nearly 6 in 10 (58 percent) reported having ever visited a smiling sun clinic. Men were much less likely to visit a smiling sun clinic. Only 38 percent of men reported having ever visited a smiling sun clinic. Among women, 73 percent of those who visited a smiling sun clinic visited it in the 12 months before the survey; while among men did 71 percent. The rest, 27 percent among women and 29 percent among men, said they visited the clinic one year ago. Among those who visited in the previous 12 months, a significant proportion reported having visited the clinic more than once in the said period, accounting for 55 percent of all ever visitors among women and 37 percent among men. Home contacts by outreach workers (33%) emerged to be the most prominent factor motivating people to visit smiling sun clinics, given by 33 percent of the respondents. Next most important motivating factors were the friend's/relative's/ neighbor's recommendations (27%), spouse's recommendations (24%), depot-holder's motivation (21%), accessibility to clinics/quality of its services (15%), and other family members' recommendations (10%).

Most commonly used services from smiling sun clinics were the services supplying short-term family planning methods, accounting for 31 percent of all users of smiling sun clinic services. Next most commonly used services were general treatment services for ailment (22 percent), ANC services (14 percent), and child immunization services (13 percent). The patterns of utilization of services varied between women and men. Women were more likely to visit SS clinics than male for the services like family planning, ANC and child immunization, while men were more likely to visit them for general treatment services.

Differentials in visits to smiling sun clinics by exposure to the campaign

Surprisingly, exposure to ESH effected very little variations in visits to smiling sun clinics. The proportion of women visiting smiling sun clinics remained about unchanged between those who had watched ESH (15 percent) and those who had not (14 percent). This might be a result confounded with the results of other factors. However, local level BCC activities had remarkable effects on use of smiling sun clinics. Women who had seen BCC materials in the community were twice as likely to visit smiling sun clinics as those who had not seen those materials—19 percent compared to 10 percent. Women who were aware of the availability of services at discounts or free of costs were also found to be more likely to visit a clinic than those who were not aware of the information. The variations, however, were more pronounced in case of SS clinics than in case of other clinics—13 versus 19 percent for smiling sun clinics, compared to 12 versus 14 percent for other clinics.

Determinants of visits to clinics

Age of youngest child emerged as a significant determinant of clinic visits in the multivariate analyses. Women were likely to visit a clinic most if they had children less than one year of age, and

least if they had no children. Female respondents having children less than one year of age were three times as likely to visit a smiling sun clinic as those who had no children. Urban-rural variations were not significant in case of visits to smiling sun clinics. Age of women had also no significant effects on visits to smiling sun clinics, except for those in the oldest group, 40-49 years, appearing to be significantly less likely to visit a smiling sun clinic than those in the other age group. Educational variations in visits to smiling sun clinics were also generally insignificant. Asset quintiles had significant variations only for women in the third quintile, showing that they were less likely to visit a smiling sun clinic than those in both the poorer and richer asset quintiles.

Knowledge of services offered at discounts/free of costs had significant effects on visits to smiling sun clinics. Women who had this knowledge were 1.6 times as likely to visit a smiling sun clinic as those who did not have the knowledge. However, despite provisions of services available at discounts/free of costs and the other influences, the impact of the campaign was evident in the logistical analyses, clearly for exposure to BCC activities in the community. Exposure to BCC activities in the community appeared as a significant determinant of visits to smiling sun clinics. Women having exposure to BCC activities were 2.6 times as likely to visit a smiling sun clinic as were those having no exposure to BCC activities. The likelihood of visiting a smiling sun clinic was also found to be higher among women who had exposure to ESH than among those who had no exposure to ESH. But the variations were not large enough to be statistically significant.

Case sample versus non-case sample

The case and non-case samples were compared to ascertain directly the impact of the campaign in promoting visits to smiling sun clinics. The case and non-case samples were drawn in every round of data collection, as was the project community sample. Respondents in the case sample were chosen from among clients who visited a sample clinic on the day they were interviewed. Respondents in the case sample were randomly drawn from among individuals living in the clinic's catchment area. Only those individuals who were in need of the service promoted in the drama episode telecast immediately prior to the round, but did not visit the clinic in the three weeks prior to the interview date were eligible to be interviewed in the case sample.

Respondents in both the samples had about similar characteristics. They had their mean ages at 23-24 years, their mean years of education at 5 years, their proportions of rural people at 50-51 percent, and their proportions of every day television watchers at 30-31 percent. They varied only in their proportions having a under-1 child, being at 25 percent for those in the case sample and 38 percent in the non-case sample. This variation was due to the women with under-1 child being included as eligible respondents in the non-case sample in one round.

It was hypothesized that, if the respondents in the case and non-case sample had similar characteristics and if the campaign had any impact on clinic visits, respondents in the case sample would have greater likelihood of having exposure to the campaign than those in the non-case sample. As observed in the multivariate analyses, respondents in the case sample were significantly more likely to have watched ESH, seen BCC materials in the community and seen billboard related to smiling sun clinics, compared to those in the non-case sample. These variations were independent of the other factors influencing visits to smiling sun clinics. It thus became evident that the campaign had a significant impact upon people who visited smiling sun clinics in the three months before the survey.

Project sample versus non-project sample.

The project and non-project community samples were compared to ascertain if the drama serial had any differential impact between the NSDP project areas and non-NSDP areas.

Respondents in the non-project sample had similar background characteristics as those in the project sample, establishing their comparability in terms of both their exposure to the campaign and their visits to smiling sun clinics. It emerged from the multivariate analyses that, like those in project areas, respondents in the non-project areas were significantly more likely to visit a clinic when they had exposure to ESH/BCC activities. However, the campaign impact was less marked in non-project areas than in project areas.

Chapter 1

Introduction and Methodology

1.1 Background information

The NGO Service Delivery Program (NSDP) is a nationwide health project in Bangladesh, funded by the U.S. Agency for International Development (USAID). The project was launched in July 2002 to promote delivery and use of an Essential Services Package (ESP) of family planning and family health services in under-served areas of Bangladesh to reduce fertility and improve family health. The services are provided by a network of 33 NGOs through static and satellite clinics. The clinics have well known logo of smiling sun and are, therefore, known as “**Smiling Sun**” (SS) clinics. Pathfinder International along with seven partner organizations is managing the program. Working through 318 urban and rural clinics, nearly 8500 satellite clinics and almost 8000 female depot holders nationwide, NSDP serves approximately 17% (20 million people) of the national population. The Essential Health Services Package (ESP) package offered at Smiling Sun clinics covers child health, maternal health care, reproductive health care, clinical and non-clinical family planning services, communicable disease control, tuberculosis, safe delivery including first aid emergency obstetric care, post-abortion care, and limited curative care.

NSDP conducts communication activities to make target beneficiaries aware about the health care needs and the facilities available in the NSDP clinics. Bangladesh Center for Communication Programs (BCCP) is the lead communication organization on this project, with Johns Hopkins Bloomberg Center for Communication Programs (CCP) providing technical assistance to BCCP.

1.2 NSDP communication campaign

The NSDP communication campaign consisted of two components – Airing of a TV drama serial “**Enechhi Shurjer Hashi**” and the **Local Level BCC (Behavioral Change Communication) Activities**. The drama was telecast in 26 episodes, with each episode dealing with a specific health topic. It was an Enter-Educate TV drama serial centered on the lives of the urban and rural people of Bangladesh and reflects their joys and sorrows and their dreams for a better life. The actual playing time of each episode was 23 to 25 minutes. At the end of each episode there was a 2-3 minutes presentation of a Fact Pack containing information about Health Service Centers including Smiling Sun clinics. The Fact Pack was also used to reinforce the main health messages delivered, and to encourage everyone to make use of health services.

Local Level BCC activities, including displaying/distribution of promotional materials, were conducted in 308 selected clinics. These activities consisted of two elements, namely, Health Services Promotions and Brand Positioning. The Health Services Promotions were designed to promote 6 specific health services, which will be offered free or at 50% discount on service charges in conjunction with the airing of the TV drama episodes related to those services. The specific health services promotion offers included:

- a. Free Blood Pressure Check-up
- b. Free Child Health Check-up
- c. Free RTI/STI check-up
- d. ANC check-up at 50% discount on service charge
- e. Free PNC check-up + Vitamin A
- f. Free ARI Check-up

The health services promotions were accompanied by several promotional materials and activities including:

- a. Print materials:
 - Banners: at static and satellite clinics
 - Posters: at the community level
 - Leaflets: at the community level and for distribution
 - Danglers: at static clinics and give away at satellite clinics
 - Calendar: as a give away at static and satellite clinics
 - Stickers on maternal and child health:/ as give away at static and satellite clinics
- b. Group Meetings
- c. Miking
- d. Rickshaw Tin Plates - in 264 areas /excluding Dhaka and Chittagong city areas.

The **Brand Positioning** activities and materials were designed to promote the TV drama as well as the branding of the Smiling Sun Clinics. These were also established in the selected 308 clinics. The specific brand positioning activities and materials included:

- a. Premiere of the TV drama prior to the airing at the static clinics
- b. Badges for depot holders
- c. Signboards – directional, depot holders, static clinics, satellite clinics
- d. Banner for satellite clinics
- e. Bags for all clinic staff – depot holder, satellite team, service promotion officer at urban clinics and service promoter at rural clinic
- f. Leaflets for depot holder
- g. Live TV drama show for least advantaged populations
- h. Clinic visits by the brand ambassador - all 20 clinics promoted via posters and miking.
- i. Cinema Slides - designed to promote both services as well as the drama. In one cinema hall per catchment area of 308 clinics
- j. Billboards - In 150 key locations

1.3 The NSDP campaign Evaluation Survey

The NSDP campaign Evaluation Survey, in short the Campaign Survey, was carried out to evaluate the performances and achievements of the NSDP communication campaign. Major objectives of the evaluation were:

- To ascertain the proportion of target people who had exposure to the drama serial.
- To ascertain the proportion of target people who had exposure to local level BCC activities and materials.
- To ascertain the impact of the campaign on visits to smiling sun clinics, by exposure to BCC activities, and by exposure to the drama serial.
- To ascertain the impact of the campaign on knowledge of, and perception of, services available at smiling sun clinics.

1.4 Rounds of data collection

Data in the survey were collected in five rounds. The first round data were collected in the period following the airing of the episode promoting child health, second round data in the period following the episode promoting adolescent health, third round data following the episode promoting ANC for maternal health, fourth round data following the episode promoting PNC for maternal health, and fifth round data following the episode promoting permanent method for family planning. It was originally planned to collect data in six rounds, covering each of episodes promoting the six services.

But the survey could not undertaken earlier to cover the episode promoting the blood pressure check-up services.

1.5 Sample of clinics

In a round data were collected from a randomly selected sample of 36 smiling sun clinics, including 18 rural and 18 urban clinics (**see table 1**). In every round, the sample of clinics was drawn a new, independently of their selections in the previous rounds. Thus, a total of 161 smiling sun clinics were covered with the clinic samples in the five rounds.

Table 1: Distribution of sample by different strata according to rural and urban areas

	Rural			Urban			Total
	Static	Satellite	Total	Static	Satellite	Total	
Low levels of clinic performances	2	4	6	3	3	6	12
Medium levels of clinic performances	2	4	6	3	3	6	12
High levels of clinic performances	2	4	6	3	3	6	12
Total	6	12	18	9	9	18	36

1.6 Samples of respondents

Data were gathered in four samples of respondents. They were the project community sample, the sample of cases, the sample of non-cases, and the non-project community sample. The project community sample was comprised of both men (15-59) and women (15-49) selected in equal numbers from the project areas. The sample of cases was comprised of cases interviewed from among clients who visited a sample clinic on the day of interviewing. The sample of non-cases for a round was comprised of respondents who were in need of the service promoted in the episode telecast but did not visit a clinic in the last three weeks to obtain the service. The non-project community sample was interviewed only in the fifth round. Like the project community sample, it was comprised of both men and women, selected in equal numbers. The non-project community sample was selected from the areas outside the project areas. **Table 2** shows the number of respondents interviewed in the different samples by rounds.

Table 2: Number of respondents interviewed according to round and by different samples

Rounds	Cases	Non-cases	Target audience	
			Project	Non-project
First	641	648	864	-
Second	648	648	864	-
Third	648	648	864	-
Fourth	648	648	864	-
Fifth	644	648	864	864
Total	3229	3240	4320	864

1.7 Selection of cases

In a clinic, cases were interviewed over three consecutive days in a round, interviewing 6 cases a day. The six cases were randomly selected from among clients visiting the clinic for services on that day.

1.8 Selection of non-cases

For interviewing of non-cases for a clinic for a round, a village/mohollah from the clinic's catchment area were randomly selected. The interviewer interviewed the non-cases from the selected village/mohollah, selecting them in the following manner. Non-cases for the round were the individuals who needed the service promoted in the drama episode telecast preceding the round but did not visit a clinic to obtain the service. For example, for the round following the episode promoting ANC services, non-cases were the pregnant women resident in the village, who did not visit a clinic to obtain the service. Starting from the north-west corner of the village/mohollah, the interviewer visited as many households in a systematic fashion as needed to interview 18 non-cases from the village.

1.9 Selection of respondents for the project sample of target audience

For interviewing of respondents in the project community sample of target audience for a clinic for a round, a village/mohollah other than the one used for selection of non-cases were randomly selected from the clinic's catchment area. The interviewer interviewed the respondents from the selected village/mohollah, selecting them in the following manner. Starting from the north-west corner of the village/mohollah, the interviewer visited as many households as needed to interview 24 respondents from the village/mohollah. Out of the 24 respondents, 12 were men age 15-59 and 12 were women age 15-49. If a man was interviewed in the first household visited, then a woman was interviewed in the second household visited, then a man in the third household visited, then a woman in the fourth household visited and so. The other order was a woman interviewed in the first household, followed by a man interviewed in the second household, followed by a woman interviewed in the third household, and so. The interviewer randomly chose either of the orders was followed in a village/mohollah.

1.10 Non-project sample of target audience

As stated earlier, this sample was interviewed only in the fifth round. Like the project sample of target audience, it was comprised of 432 target people from rural areas and 432 target people from urban areas. The sample was drawn in two steps from the purposively chosen rural and urban areas not covered with the NSDP project. At the first step, 18 rural villages were randomly selected from the rural areas and 18 urban mohollas from the urban areas. At second step, respondents were selected including 24 respondents from each of the selected villages/mohollahs. The 24 respondents were selected in the same fashion as the respondents from a village/mohollah in the project sample of target audience were selected.

1.11 Evaluation Instruments

Two questionnaires were used for the collection of data –a questionnaire for cases and a questionnaire for respondents other than cases (household questionnaire). The questionnaires were used to obtain the pertinent evaluation data from the respondents included in the samples. The draft questionnaires were supplied by NSDP. The questionnaires were finalized after pretesting them, and again in consultation with NSDP.

1.12 Pre-testing and finalization of Survey Questionnaires

Pre-testing of the survey questionnaires was conducted in November 2006, in two areas, one rural and one urban. The purpose of the pretest was to see if there were any difficulties/problems in administering the questions to any of the respondents and if they had any difficulty in understanding and answering any of the questions. The interviewing team deployed to carry out the pre-testing consisted of six members including two Research Officers, and four Female Interviewers. The team members were given training on the survey instrument and methodology for 2 days at the office of Mitra and Associates.

After the pre-testing was completed, the team members shared their experiences with the senior survey-staff of Mitra and Associates and the representatives from NSDP. Thus, after the pre-testing, NSDP, in consultation with Mitra and Associates, finalized the questionnaires, incorporating only few changes.

1.13 Fieldwork for data collection

Eighteen interviewing teams were deployed to carry out the fieldwork. Each team consisted of one supervisor, and 2 female interviewers. Four quality control officers were employed to oversee the work of the interviewing teams. In addition to the quality control officers, senior professionals of Mitra and Associates and the representatives of NSDP visited the field to monitor the data collection work. The fieldwork started on December 6 2005 and was completed by May 12, 2006.

1.14 Training of field personnel

Field personnel (including interviewers, supervisors and quality control officers) were given one week training on the evaluation methodology and instruments. The training were imparted by the senior professional staff members of Mitra and Associates. Representatives from NSDP participated in the training as resource persons to guide the conduct of the training.

The training was designed to prepare the interviewers, supervisors and quality control officers for the data collection work, giving them the required knowledge and skills. The training consisted of teachings and discussions on the following topics.

- (i) Survey methodology
 - a. the purpose of the survey
 - b. the sample design
 - c. the samples and their importance in collecting representative data
 - d. how to locate a sample household
 - e. how to identify and select respondents in a household
- (ii) Techniques of interviewing
 - a. importance and techniques of rapport building with respondents
 - b. how to conduct interview with a respondent
 - c. how to interview respondents not easily available or difficult to interview
 - d. how to maintain neutrality (or avoid biases) in asking questions
- (iii) Questionnaires
 - a. purposes of the different questionnaires used in the survey
 - b. sections in a questionnaire and their purposes
 - c. types of questions included in a questionnaire and their purposes
 - d. different key terms used in a questionnaire
 - e. a thorough explanation of all questions
 - f. underlying intent of asking a question
 - g. difficulties that may arise in asking specific questions, and how they should be asked
- (iv) How to handle non-response
- (v) How to check questionnaires for avoiding non-sampling errors
- (vi) How to handle daily schedules
- (vii) Team administration
 - a. how interviewers would be supervised
 - b. how performance of interviewers/supervisors would be evaluated

Training consisted of lectures, classroom practices, group discussions and role-playing. Interviewers practiced filling in questionnaires, with one interviewer conducting a mock-interview with another interviewer. During these practice interviews, the interviewers were observed by the trainers. The trainers were sent to the field for a day to conduct practice interviews in an area close to Dhaka city. At the conclusion of the training, the trainees were tested to measure if they had achieved the desired knowledge and skills to work as interviewers. Those who could not pass the test were not employed in the survey.

1.15 Data Processing

Four data entry operators were engaged to enter data from the questionnaires into the computer. The data was entered using the ISSA (Integrated System for Survey Analysis) Program developed for the Demographic and Health Survey. This program had a built-in mechanism to guard against erroneous entry of data in the computer file. After completion of the data entry, range checks were applied to every input variable in the data file, again, using the ISSA program. Range checks were done to detect if any input variable was coded outside its declared range. The ISSA program was also used to pinpoint inaccuracies, if any, still remaining in the file, by conducting internal consistency (IC) checks between interrelated questions. The data entry commenced on 16 January 2006 and was completed by May 2006.

Chapter 2

Reach of the Campaign

This chapter presents the survey findings as to how successful the NSDP campaign was in reaching the target audience. The reach was measured in terms of the percentage of target people who had exposure to the campaign. Variations in exposures among different subgroups of population were ascertained to identify the subgroups, which were more likely or less likely to be reached with the campaign. Efforts were also made to identify the factors, which had significant bearings on the reach of the campaign.

2.1 Project community sample

The community sample was the main sample used to ascertain the reach of the campaign and its impact on the awareness and use of clinic services, specifically of smiling sun clinic services. Thus, findings presented in this chapter on the reach of the campaign and those presented in the next two chapters on the awareness and use of clinic services were all drawn from the community sample.

2.2 Characteristics of respondents

Table 2.1 contains the distributions of respondents interviewed in the community sample by their selected background characteristics. Among female respondents, 46 percent were in the 20-29 year age group and 29 percent in the 30-39 year age group. Only 15 percent of female respondents were under age 20, and 11 percent at age 40-49. Male respondents had relatively more people from older ages (35 years and above) than did female respondents. Among male respondents, nearly 50 percent were at age 35 years and above, while the proportion was only 24 percent for female respondents. On average, a male respondent was 34 years old and a female respondent 28 years old.

Most respondents were currently married-- 80 percent among male respondents and more than 90 percent among female respondents. However, nearly 20 percent of male respondents were never married, while this proportion was only 4 percent for female respondents.

About one-third (34 percent) of respondents had no education, with 32 percent among male respondents and 35 percent among female respondents. Only 5 percent of female respondents had an education at secondary level or above, with 11 percent of male respondents.

There were no variations between male and female respondents in their composition by wealth status assessed in terms of asset quintiles. Both male and female respondents were proportionately included from an asset quintile.

Twenty one percent of respondents had their youngest child aged less than 2 years. Another 11 percent had no children, while the rest 68 percent had their youngest child aged 2 years or above. There were practically no variations between male and female respondents by age of the youngest child.

Respondents had almost universal measles coverage of their children, aged 12-23 months, with measles vaccine. Among the respondents who had a child aged 12-23 months, 94 percent reported that the child had received measles vaccine. There were no variations in the reported measles vaccine coverage between male and female respondents.

Table 2.1: Percent distribution of respondents by selected background characteristics

Background characteristics	Sex		All
	Male	Female	
Age			
15-20	10.3	14.5	12.4
20-24	12.9	23.2	18.0
25-29	14.9	22.3	18.5
30-34	12.8	16.0	14.4
35-39	14.8	12.7	13.7
40-49	24.1	11.2	17.7
50-59	10.3	-	5.2
Marital status			
Currently married	80.0	94.0	86.9
Separated	0.2	0.3	0.3
Deserted	0.1	0.3	0.2
Divorced	0.2	0.5	0.3
Widowed	0.2	1.3	0.7
Never married	19.4	3.6	11.6
Educational level			
No education	32.3	35.0	33.7
Primary	26.5	30.1	28.3
Secondary	30.3	30.0	30.2
Secondary or above	10.9	4.9	7.9
Total N ¹	100.0 2180	100.0 2140	100.0 4320
Age of youngest children			
No child	11.8	10.5	11.1
0-11	11.3	11.9	11.6
12-23	9.6	9.7	9.7
24+	67.4	67.9	67.7
Total N ²	100.0 1757	100.0 2063	100.0 3820
Measles coverage among children age 12-23			
Yes	94.0	94.0	94.0
No	6.0	6.0	6.0
Total N ³	100.0 168	100.0 201	100.0 369
Asset quintile			
Lowest	19.8	21.0	20.4
Second	18.9	20.3	19.6
Middle	19.4	19.1	19.2
Fourth	21.1	20.3	20.7
Highest	20.9	19.3	20.1
Total N ¹	100.0 2180	100.0 2140	100.0 4320

¹N is the total number of interviewed respondents.

²N is the total number of ever-married respondents.

³N is the total number of respondents who had children aged between 12-23 months.

2.3 Exposure to campaign

As stated in the earlier section, the campaign consisted of two components covering the target population at the community level: airing of the drama serial, ESH and the local level BCC activities. Thus, exposure to the campaign was assessed in terms of both those who had watched ESH and those who had seen local BCC materials.

2.4 Exposure to ESH

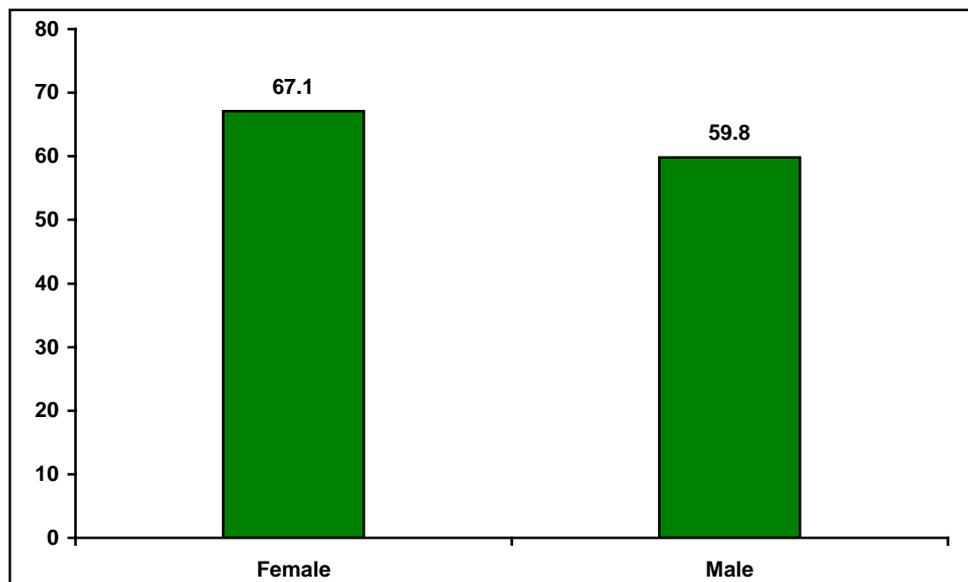
Exposure to ESH was evaluated in two steps. First step was devoted to ascertaining the extent people were aware of the airing of the drama, while second step was devoted to ascertaining the extent people watched it.

2.4.1 Awareness of airing of ESH

Major efforts were put in to publicize ESH in order to achieve its maximum coverage of the target people. Advertisements were run in different media, informing people about the airing of ESH and urging them to watch it. Success of these efforts was assessed by finding out the proportion of respondents who were aware of the airing of the drama serial.

Overall, as shown in **Figure 2.1**, nearly two-thirds of respondents reported knowing of the airing of ESH. Women were more likely to know of it than were men-- 67 percent versus 60 percent. The sources the respondents said they learnt of the airing of the drama are listed in **Table 2.1**.

Figure 2.1: Percent aware about airing of ESH



Television and neighbours/relatives/friends emerged to be the two major sources, as displayed in **Figure 2.2**. Television was however by far the largest source. About 6 in 10 (57 percent) of female respondents and more than 6 in 10 (64 percent) of male respondents reported having learnt of ESH from advertisements in television. Neighbour/relatives/friends were mentioned as a source by 42 percent among female respondents and 32 percent among male respondents. Advertisements through such media as radio, newspapers, magazines, were of very little use in publicizing the drama serial. Only a few respondents reported having learnt of the drama from the advertisements in those media – about 6 percent or less among female respondents and 5 percent or less among male respondents (**Table 2.2**).

Figure 2.2: Sources of awareness of ESH

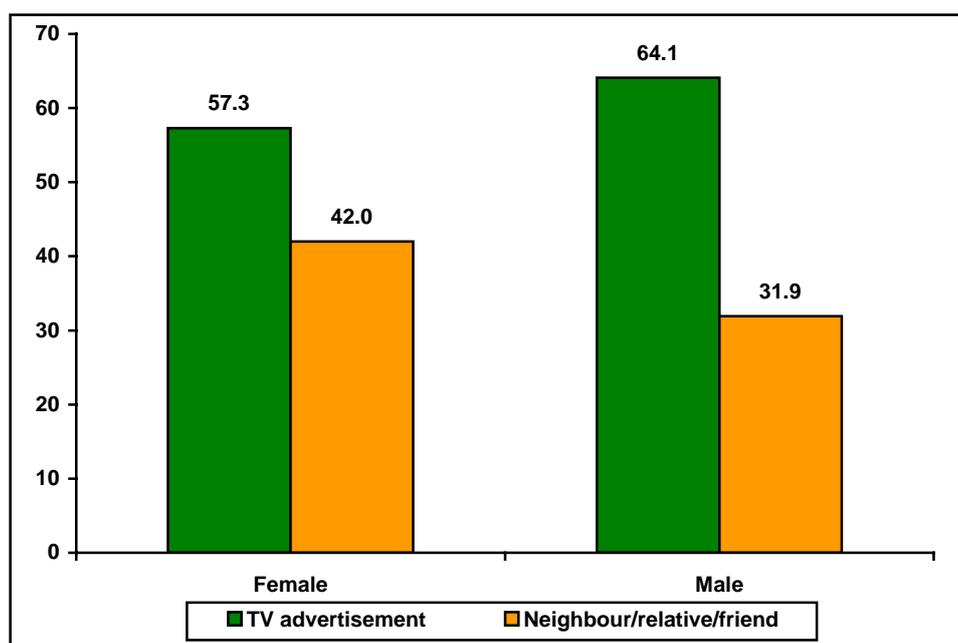


Table 2.2: Sources of awareness about airing of ESH

Sources	Female	Male	All
TV advertisement	57.3	64.1	60.5
Neighbour/relative/friend	42.0	31.9	37.2
Health worker of NGOs clinic (Smiling sun clinic)	6.4	3.7	5.1
Radio advertisement	3.7	4.5	4.1
Miking	2.9	2.6	2.7
Print material	0.8	2.8	1.8
Health worker	1.9	1.7	1.8
Newspaper/magazine	0.8	2.4	1.6
Spouse	0.4	2.2	1.3
Today (from Smiling sun clinic)	0.4	0.2	0.3
Cinema slide	0.1	0.2	0.1
Local doctor/pharmacy	-	0.2	0.1
Others	3.8	3.6	3.7
N ¹	1435	1304	2739

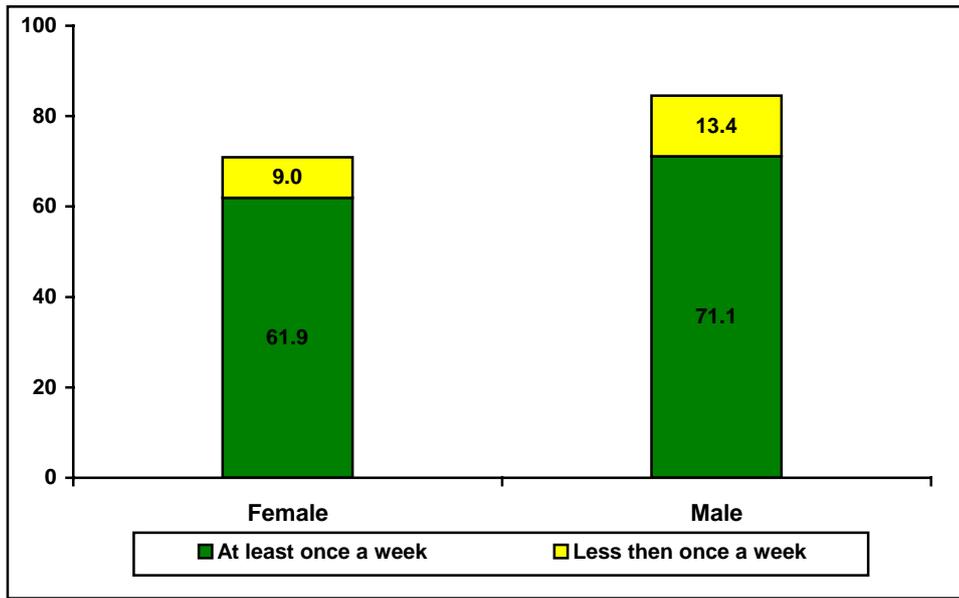
¹N is the number of respondents who are aware of ESH

Percentages do not add up to 100% because of multiple responses

2.4.2 Watching of ESH

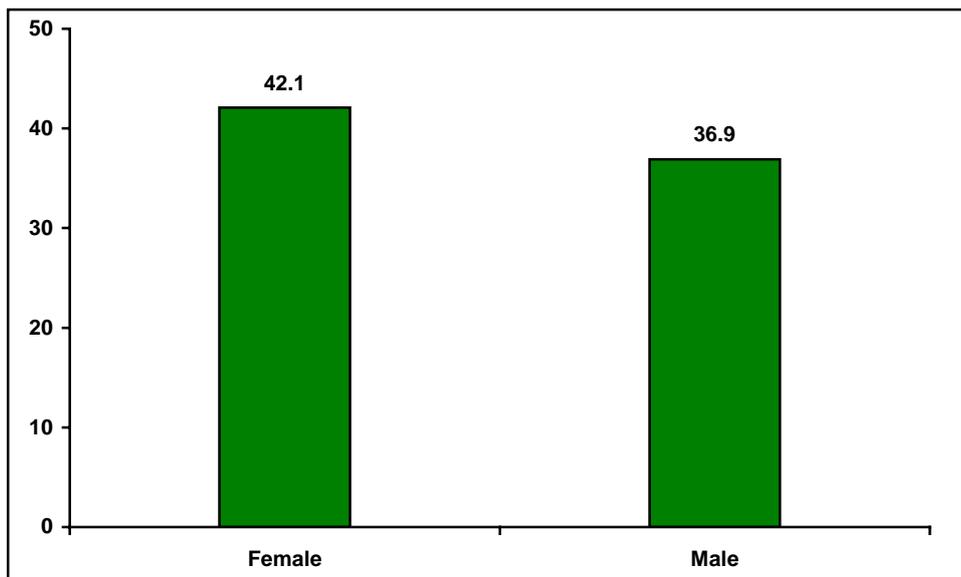
The likelihood of watching a drama on television is dependent, among others, on opportunities to watch television. As ascertained in the survey, opportunities to watch television were widespread in the target population (**Figure 2.3**). Among female respondents, more than 7 in 10 (71 percent) reported watching television, with 61 percent watching it at least once a week. The proportions were even higher for male respondents at 85 percent and 71 percent, respectively.

Figure 2.3: Frequency of watching TV



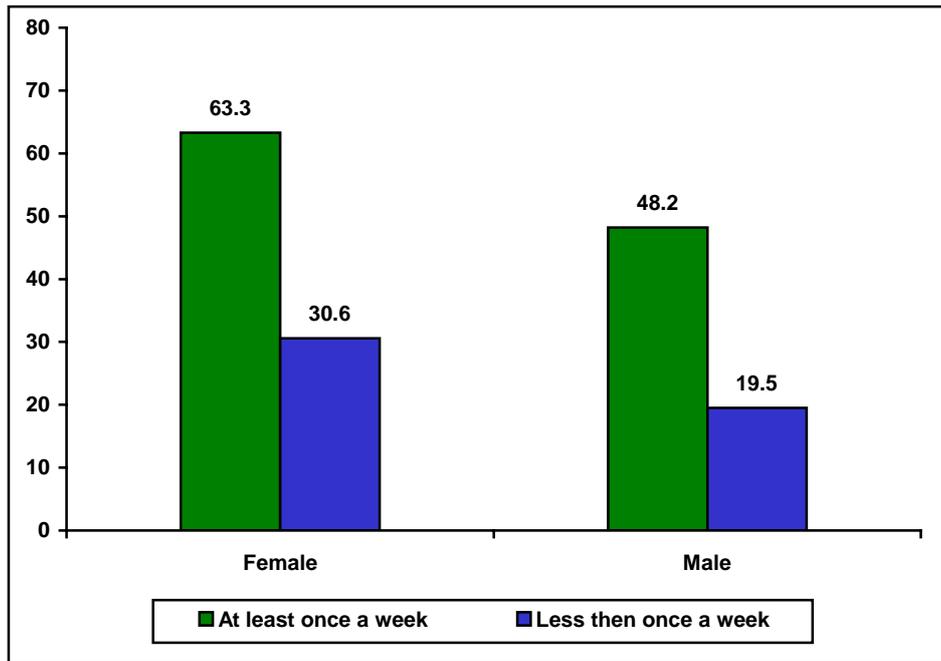
ESH (Enechi Surjer Hashi) was successful in reaching remarkable proportions of the target audience (**Figure 2.4**). Nearly 40 percent of respondents reported having ever watched the drama, accounting for 51 percent of those who watched television and 63 percent of those who were aware of the airing of the drama. Women were more likely to watch the drama than were men—42 percent versus 37 percent.

Figure 2.4: Percent having ever watched ESH on BTV



As expected, exposure to ESH was associated with the extent of television watching. Those who watched television more frequently were more likely to watch the drama (**Figure 2.5**). Among female respondents watching television at least once a week 63 percent reported having ever watched ESH, compared to only 39 percent among those watching television less than once a week. Similar variations were noticeable in the proportion watching the drama among male respondents, ranging from 20 percent for those watching television less than once a week to 48 percent for those watching television at least once a week.

Figure 2.5: Percent having ever watched ESH by frequency of watching television



2.5 Exposure to local level BCC materials

Local level BCC activities were more successful in reaching the target people than was the drama serial. When only about 40 percent of respondents reported having ever watched an episode of ESH, over a half (51 percent) of those reported having exposure to local level BCC activities, ever seeing at least one publicity or education material about the SS clinic in the past 6 months in the community (**Figure 2.6**). There were virtually no variations in exposure to local level BCC activities between women (51.1 percent) and men (50.6 percent).

Figure 2.6: Percent having seen BCC materials in the community

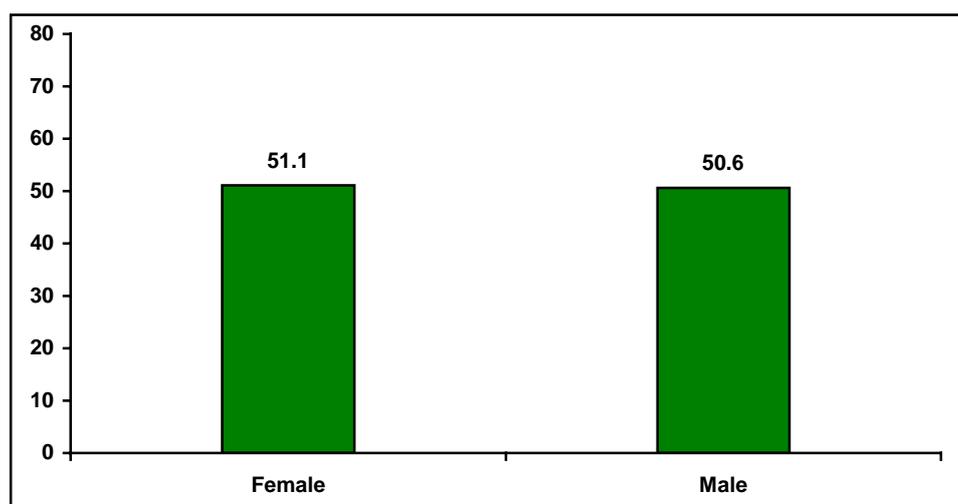


Table 2.3 shows the percentage of respondents who had seen a specific type of BCC materials. Mostly seen local level BCC materials were the Banners at satellite clinics, seen by 36 percent of respondents reporting exposure to those materials. Next mostly seen materials were directional signboards indicating directions to a clinic (33 percent), signboards of static clinics (29%), signboards of satellite clinics (28 percent), calendar (25 percent) and banners for special health care week (22 percent). Only one-fifth of the respondents who have seen education materials reported having seen poster for the TV drama (ESH).

Table 2.3: Percentage seen a specific type of BCC materials

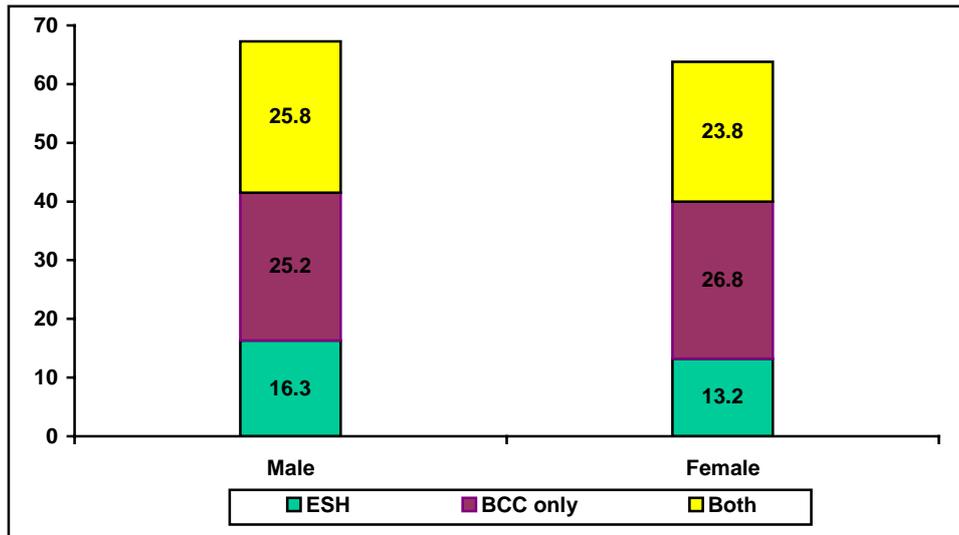
BCC materials	Female	Male	All
Banners: at satellite clinic	33.8	38.1	35.9
Directional signboard	29.5	36.8	33.1
Signboard at static clinic	21.9	37.5	29.7
Signboard-satellite clinic	23.9	31.4	27.7
Calendar	31.0	19.0	25.0
Banners: special health care week	20.9	24.0	22.5
Poster for drama	16.0	23.0	19.5
Danglers	23.1	14.8	19.0
Miking	17.6	16.6	17.1
Banners: at static clinic	12.0	19.0	15.5
Banner of drama	9.2	20.3	14.8
Leaflets: special health care week	16.4	13.1	14.7
Clinic badges	14.1	10.6	12.3
Billboard	8.6	16.1	12.3
Sticker: special health care week	14.2	10.1	12.1
Signboard-depot holder	9.5	11.4	10.5
Health benefit card	3.1	1.9	2.5
Leaflets for depot holder	1.6	1.5	1.5
Posters: depot holder	0.6	1.5	1.1
Other's health services leaflet	5.3	3.6	4.5
N ¹	1093	1102	2195

¹N is the total number of respondents who had seen any BCC material in the community about smiling sun clinics.

Percentages do not add up to 100% because of multiple responses.

Figure 2.7 presents a classification of respondents by three categories as (i) those who had exposure to (watched) ESH only, (ii) those who had exposure to (seen) to local level BCC activities only and those who had exposure to the both. Among female respondents, about a quarter had exposure to both ESH and the BCC materials, about another quarter to BCC materials only and another 16 percent to ESH only. Similar levels and patterns of exposure to ESH and the BCC materials were notable among male respondents. Thus, on overall, 67 percent among female respondents and a slightly lower 64 percent among male respondents were found to have had exposure to the campaign for ESH and the BCC materials.

Figure 2.7: Percent having seen BCC materials/ESH



2.6 Trends in exposure

Data in the survey were collected in five rounds, with a round spanning a period as long as about a month. The first round data were collected following the airing of the drama-episode promoting child health. Likewise, the second round data were collected following the episode promoting adolescent health, the third round data following the episode promoting ANC for maternal health, the fourth round data following the episode promoting PNC for maternal health, and the fifth round data following the episode promoting permanent method for family planning. The original plan was to collect the data, in six instead of five rounds, covering each of the six episodes promoting the six services. But the survey could not be undertaken earlier to cover the episode promoting the blood pressure check-up services. Respondents interviewed in different rounds were comparable, having similar background characteristics (see Table 2.4).

Table 2.4: Percentage of respondents by selected background characteristics according to rounds

	Round					All
	1	2	3	4	5	
Male						
Average age of respondents	35.6	32.8	33.8	32.5	35.2	34.0
Percentage of ever attended school	70.2	65.5	71.3	66.4	64.8	67.7
Percentage of currently married women	81.2	78.0	78.6	77.6	84.5	79.9
Percentage of having living children	92.5	88.8	86.2	85.8	87.7	88.2
Coverage of measles	89.7	95.0	92.9	100.0	92.6	94.1
Prevalence of FP method	75.3	66.1	66.3	68.2	73.0	69.8
Percentage of highest two asset quintile	43.9	39.3	48.8	36.6	41.0	41.9
Female						
Average age of respondents	28.1	27.7	28.8	28.1	28.5	28.2
Percentage of ever attended school	70.7	59.7	65.4	65.7	63.4	65.0
Percentage of currently married women	94.2	90.1	93.9	94.4	97.5	94.0
Percentage of having living children	90.3	89.9	91.0	89.7	86.9	89.5
Coverage of measles	84.2	95.6	98.0	97.4	93.6	94.0
Prevalence of FP method	62.7	55.4	63.2	63.1	64.6	61.9
Percentage of highest two asset quintile	46.3	32.3	46.1	37.0	36.1	39.6

The rates of exposure to the campaign by rounds are displayed in **Figures 2.8 and 2.9**. Exposure to the campaign rose as the campaign progressed. Among female respondents, 38 percent reported having ever watched an episode of ESH in the first round (Figure 1). The rate was higher 46 percent in the third round, reaching around 47 percent in the fourth and fifth rounds. Similar trends were seen in the percentage for male respondents, but showing smaller changes, rising from 35 percent in the first round, to reach around 39 percent in the fourth and fifth rounds. Exposure to BCC materials also rose as the campaign progressed, rising among female respondents from 40 percent in the first round to around 58 percent in the fourth and fifth rounds, and among male respondents from 43 percent to at least 60 percent. However, for reasons not known, there were drops notable in exposure rates for both ESH and BCC materials in the second round from the first round. For BCC materials, the drop was from 40 to 33 percent among female respondents and from 43 to 40 percent among male respondents. For ESH, the drop was notable only among female respondents, from 38 to 32 percent.

Figure 2.8: Percent having ever watched ESH by rounds

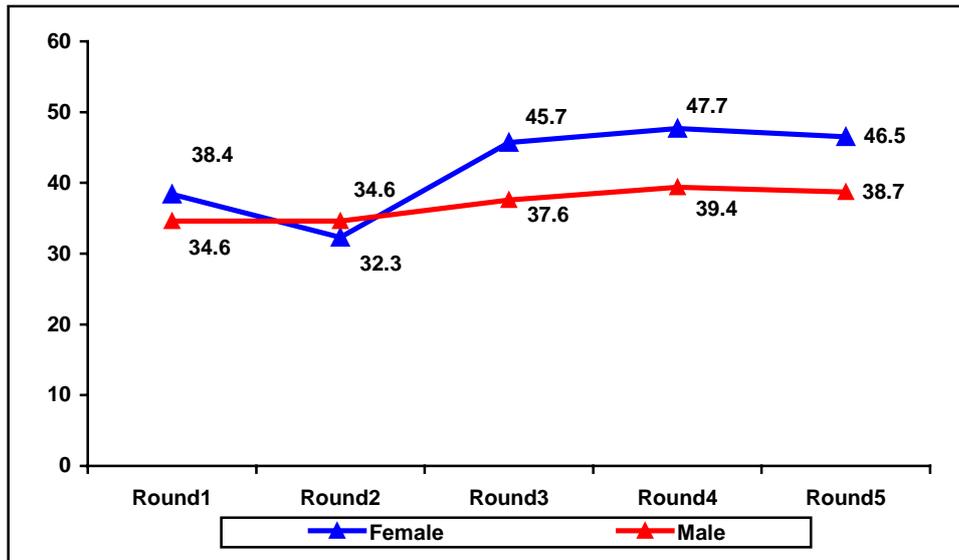
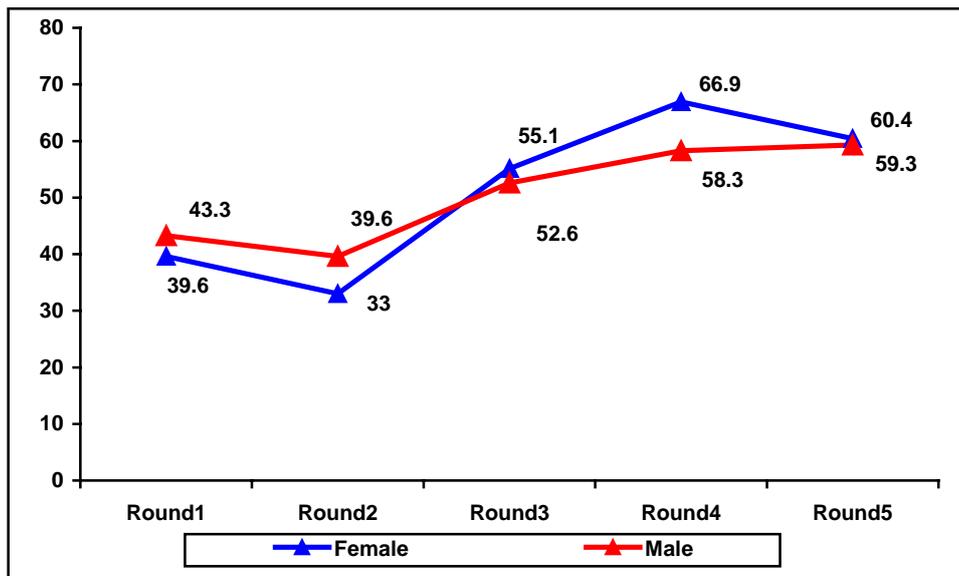


Figure 2.9: Percent having seen BCC materials in the community by rounds

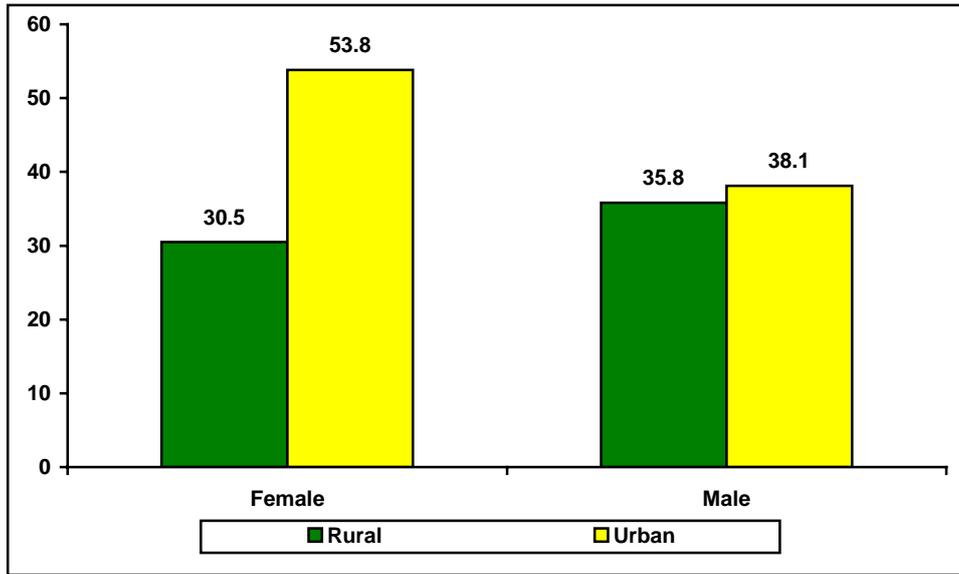


2.7 Differentials in exposure to campaign

Figures 2.10 to 2.17 display the differentials in exposure to ESH and BCC materials by the selected characteristics, namely, rural-urban residence, age, education, and asset quintile.

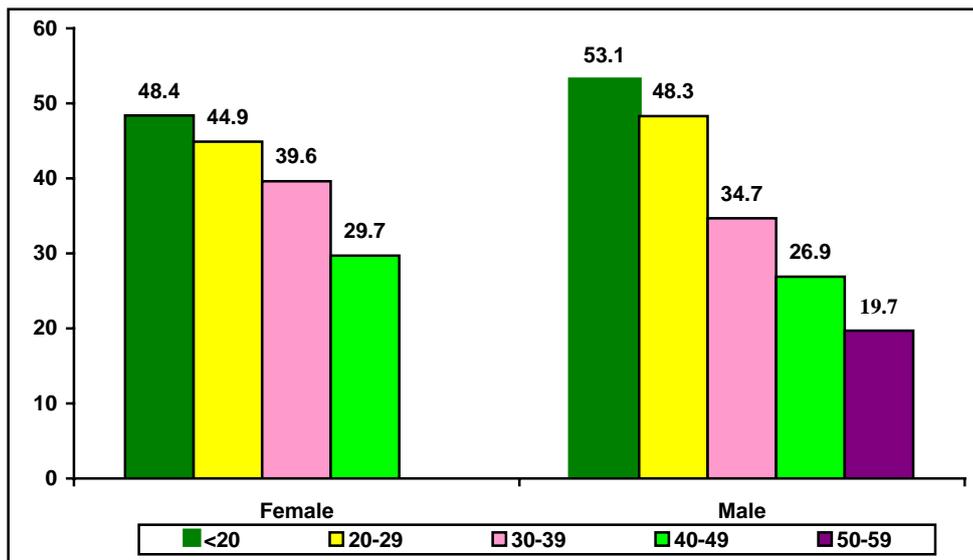
There were wide disparities in exposure to ESH among women between rural and urban areas. Urban women were much more likely to have watched ESH than were their rural counterparts, the variation being at 54 percent of female respondents in urban areas compared to 39 percent of those in rural areas. The urban-rural disparity was however less pronounced for men, the variation ranging only from 36 percent in rural areas to 38 percent in urban areas.

Figure 2.10: Percent having ever watched ESH by rural-urban areas



Exposure to ESH was negatively associated with age, showing it higher among younger people. Among female respondents in the youngest age group (under 20 years of age), 48 percent reported having ever watched ESH. The percentage drops with age reaching to only 30 percent among those ages, 45-49 years, the oldest group interviewed for women. The variations were even more striking among male respondents, dropping from 53 percent in the youngest age group to 27 percent in the age group, 45-49 years, and then to 20 percent in the age group, 50-59 years, the oldest group interviewed for men.

Figure 2.11: Percent having ever watched ESH by age group



Exposure to ESH was also positively associated with socio-economic status as determined by the level of education and the asset quintile. People were more likely to have watched the drama if they were from higher status. Only 27 percent of female respondents with no education said they had watched ESH. The proportion rose with every next level of education reaching 67 percent for those in the highest educational level, SSC or above. Likewise, exposure to the drama among female respondents rose by asset quintile from 17 percent in the lowest quintile to 68 percent in the highest quintile. Similar patterns of variations in exposure by level of education and the asset quintile were apparent among male respondents, the variations being 24-to-51 percent for education and 24-to-53 percent for asset quintile.

Figure 2.12: Percent having ever watched ESH by education

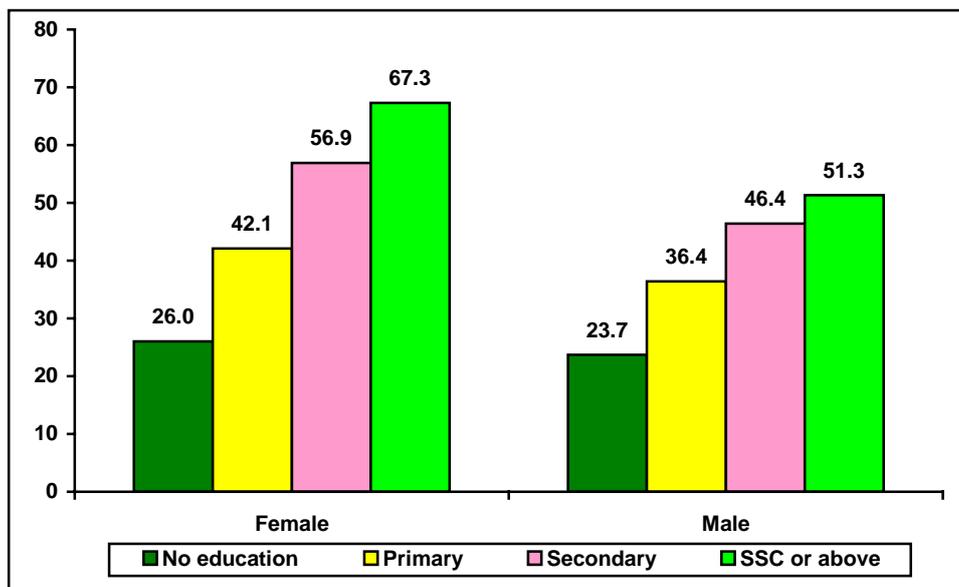
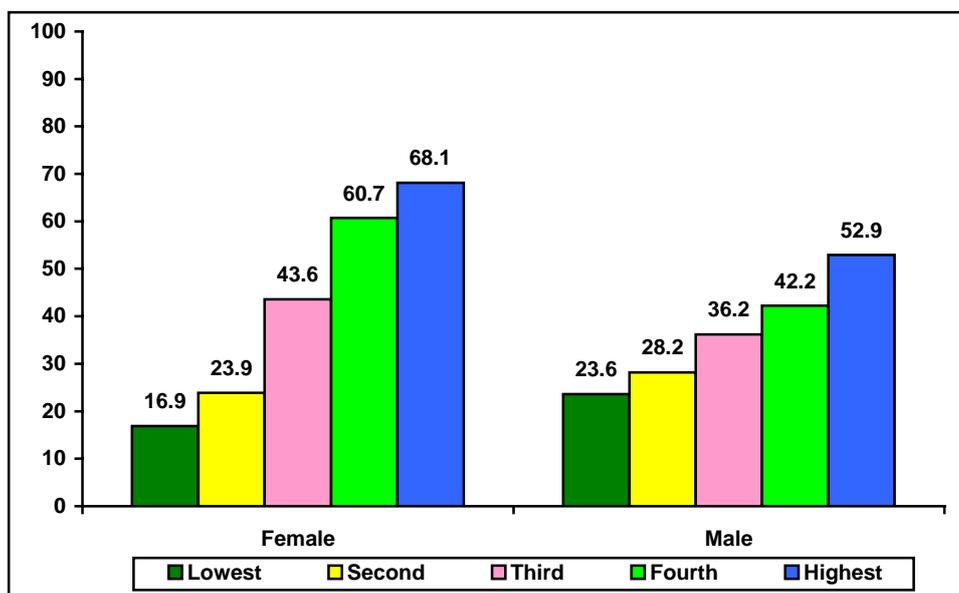
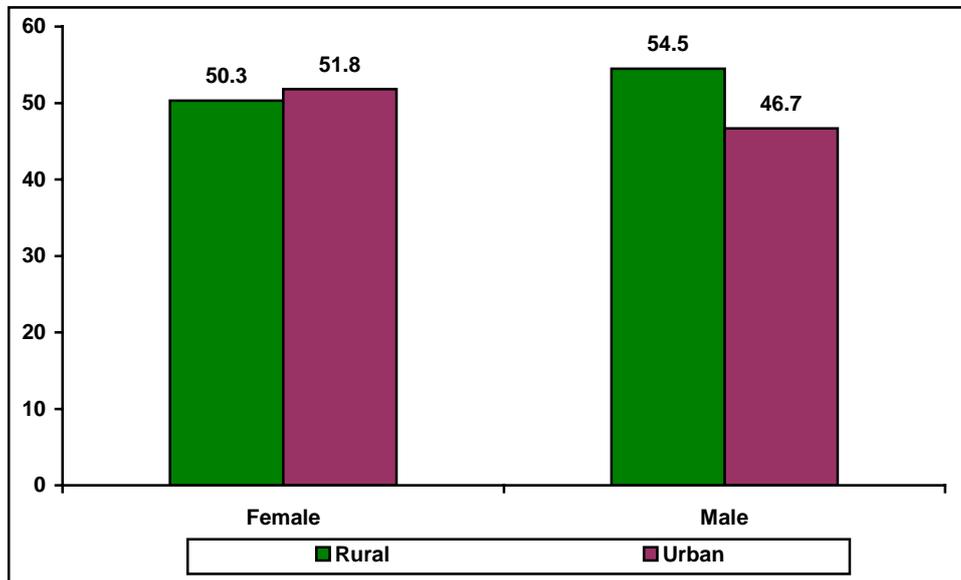


Figure 2.13: Percent having ever watched ESH by Asset quintile



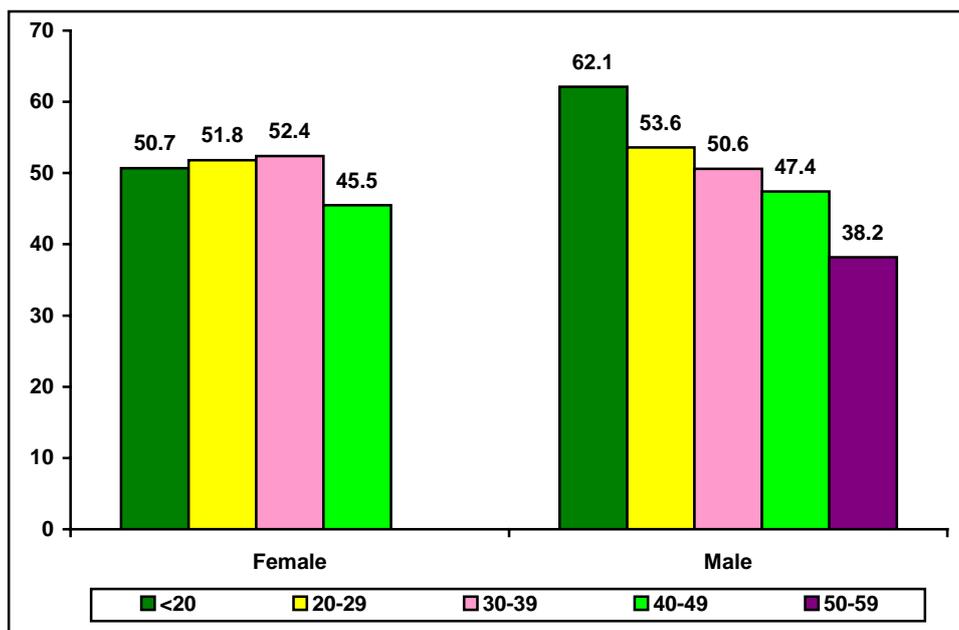
For BCC materials, there were little variations in exposure among women between rural (50 percent) and urban (52 percent) areas. But interestingly, rural men were more likely to have seen BCC materials in the community than their urban counterparts—55 percent versus 48 percent.

Figure 2.14: Percent having seen BCC materials in the community by rural-urban areas



Age was a strong determinant of exposure to BCC materials among men. Younger men were much more likely to have seen those materials. Thus, while only 38 percent of male respondents in the oldest age group, 50-59 years, reported having seen BCC materials in the community, the proportion was up at 62 percent for those in the youngest age group, under 20 years. Age variations were however less pronounced among women, ranging only from 46 percent in the oldest age group, 45-49 years to around 51 percent in the younger age groups.

Figure 2.15: Percent having seen BCC materials in the community by age group



As in the case for ESH, there were striking variations in exposure to BCC materials by level of education and the asset quintile. Among women, the variations by education were from 44 percent in the lowest educational category to 61 percent in the highest educational category, and among men from 36 percent to 61 percent. By asset quintile, the variations were from 45 percent in the lowest asset quintile to 54 percent in the highest asset quintile, among women, while for men they were from 40 percent to 57 percent.

Figure 2.16: Percent having seen BCC in the community by education

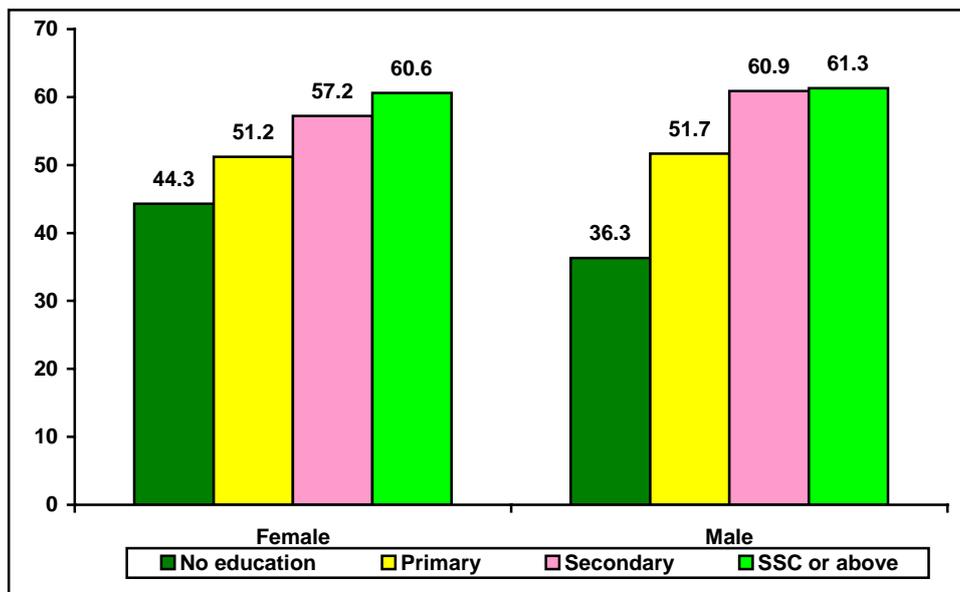
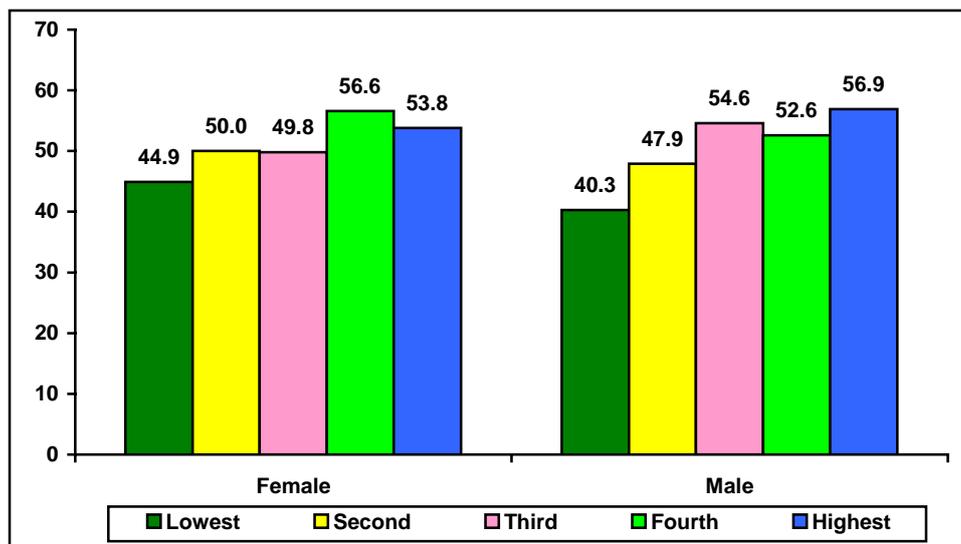


Figure 2.17: Percent having seen BCC materials in the community by asset quintile



2.8 Determinants of exposure to campaign

Multivariate logistic regression analysis was conducted of exposures to the campaign to identify the factors having independent effects on them. Two regression-models were fitted, one for exposure to ESH and one for exposure to local level BCC activities, each separately for male and female respondents. The resulting odd-ratios and their level of significance for specific subgroups are presented in **Table 2.5** for exposure to ESH and in **Table 2.6** for exposure to local level BCC activities.

Age of respondents emerged as an important determinant of exposure to ESH, showing that both men and women in the two oldest age groups, 30-39 and 40+, were significantly less likely to watch ESH than those in the younger age group. Education, asset quintile and place of residence had also significant impact on exposure to ESH. Respondents were more likely to watch ESH if they were more educated, more if they were from richer asset quintile, and more if they lived in urban areas than in rural areas.

Age variations in exposure to BCC activities were generally not significant, except for men in the oldest age group, 40+, who had significantly less exposure to those activities than had their counterparts in the younger age groups. Variations in exposure to BCC activities were also insignificant between rural and urban women. But rural men were significantly more likely to say that they had seen BCC materials in the community than their urban counterparts. Exposure to BCC activities rose significantly among both men and women with increases in their education, as did exposure to ESH. However, variations in exposure to BCC activities by asset quintile were generally not significant.

Table 2.5: Odd ratios of watching ESH

Explanatory variables	Female	Male
Age		
<20 (RC)	1.00	1.00
20-29	0.77	0.92
30-39	0.60*	0.56*
40+	0.36*	0.36*
Educational level		
No education (RC)	1.00	1.00
Primary	1.54*	1.40*
Secondary	1.71*	1.61*
Secondary or above	1.71*	1.73*
Asset quintile		
Lowest (RC)	1.00	1.00
Second	1.46*	1.17
Middle	3.46*	1.52*
Fourth	6.05*	1.87*
Highest	7.24*	2.83*
Area		
Urban (RC)	1.00	1.00
Rural	0.62*	1.23*

Table 2.6: Odd ratios for seeing BCC materials in the community

Explanatory variables	Female	Male
Age		
<20 (RC)	1.00	1.00
20-29	1.10	0.80
30-39	1.22	0.79
40+	0.94	0.65*
Educational level		
No education (RC)	1.00	1.00
Primary	1.29*	1.78*
Secondary	1.65*	2.41*
Secondary or above	1.95*	2.59*
Asset quintile		
Lowest (RC)	1.00	1.00
Second	1.16	1.22
Middle	1.08	1.45*
Fourth	1.34*	1.25
Highest	1.05	1.40*
Area		
Urban (RC)	1.00	1.00
Rural	1.02	1.61*

Chapter 3

Awareness about Smiling Sun clinics

One of the major objectives of the Evaluation Survey was measuring the success of the campaign in raising awareness about smiling sun (SS) clinics. This chapter presents the findings from the community sample, showing the extent the campaign was successful in raising awareness about smiling sun clinics.

First, awareness was assessed in terms of the following three variables: awareness of smiling sun logo, awareness of SS clinics and the services available in them, and overall awareness of messages disseminated about the clinics. Then, differentials in these variables were examined to identify the factors associated with awareness. Finally, multivariate logistic analysis was conducted to ascertain the impact of the campaign on awareness, controlling for the factors found associated with awareness.

3.1 Awareness of smiling sun logo

In assessing awareness of the logo, respondents were shown the logo and asked if they had ever seen it. As shown in **Figure 3.1**, most respondents reported having seen the logo—86 percent among women and 83 percent among men. **Figure 3.2** shows the places where the respondents commonly saw the logo. Signboards at the SS clinic emerged to be the most common source of seeing the logo. More than a half among both female (54 percent) and male (55 percent) respondents said they saw the logo on the signboard of a smiling sun clinic. Next most common sources were Television and billboard, advertising/ displaying the logo. Television was more a common source for women (34 percent) than men (29 percent), while the reverse was true for the billboard being a more common source for men (37 percent) than women (23 percent).

Figure 3.1: Percent aware of smiling sun logo

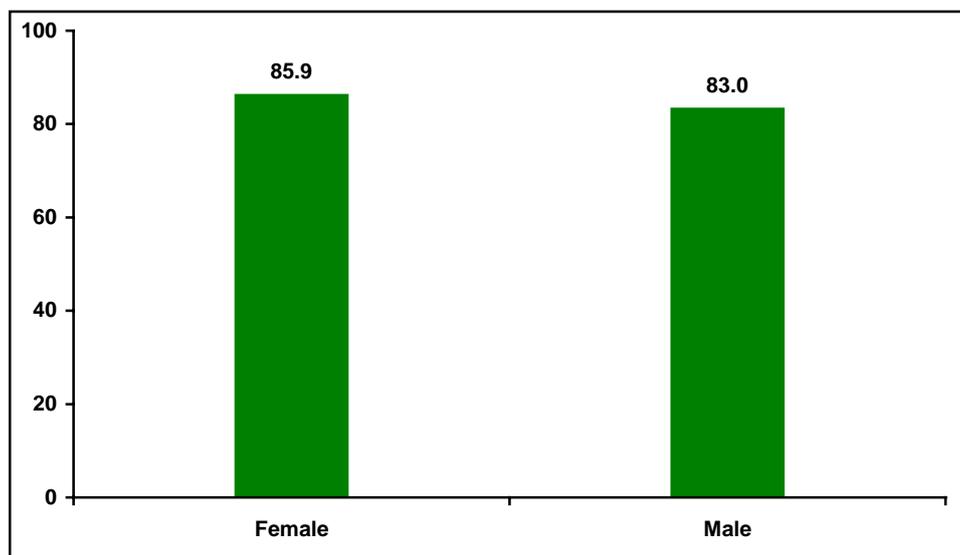
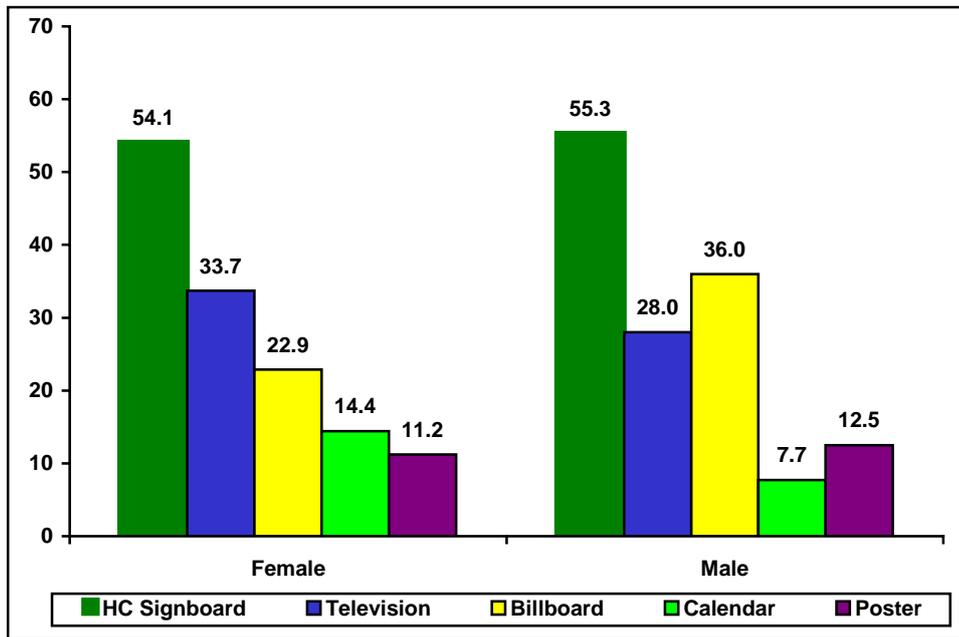


Figure 3.2: Sources of awareness of smiling sun logo



3.2 Awareness of smiling sun clinics

Smiling sun clinics were widely known in the community and more widely among women than men (**Figure 3.3**). Among female respondents 91 percent and among male respondents 81 percent reported knowing of them. As shown in **Figure 3.4**, field workers/Depot holders and friends/relatives were the two most common sources of the awareness, distantly followed by television and clinic signboards. Among female respondents, 55 percent learnt of SS clinics from Field workers/Depot holders and 51 percent from friends/relatives. Friends/relatives were equally as important source among men as among women. Men were however much less likely to know of the clinic from fieldworkers/Depot holders – only 38 percent against 55 percent for women. Television was mentioned as a source by over a quarter among both men (26 percent) and women (27 percent). Clinic signboards were a less important source for women than men, covering only 16 percent of women instead of a quarter for men.

Figure 3.3: Percent aware of smiling sun static/satellite clinics

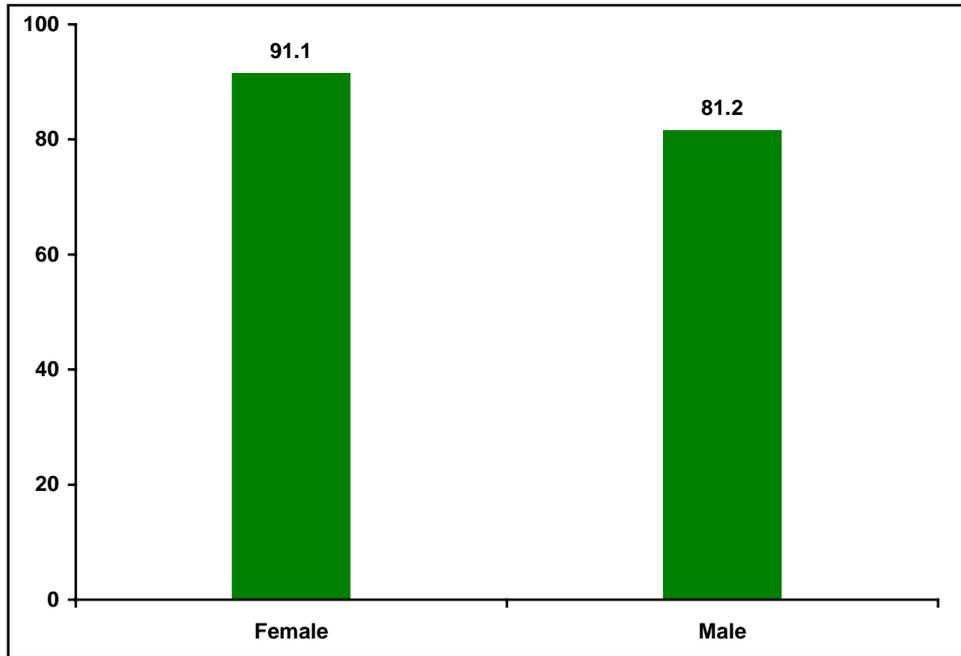
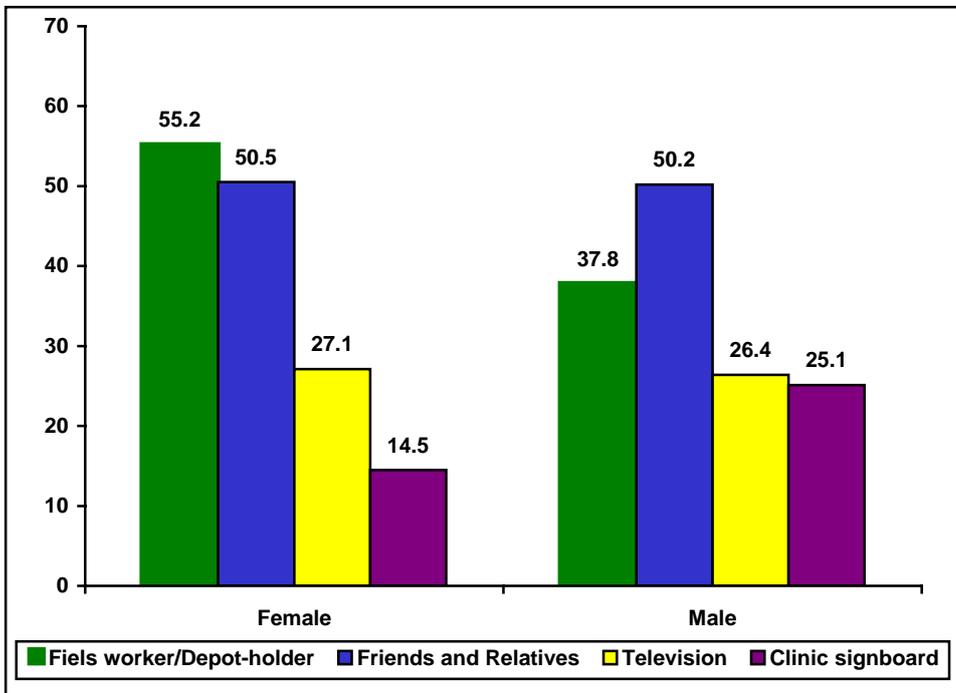


Figure 3.4: Sources of awareness of smiling sun clinics



Although awareness of smiling sun clinics was widespread, there were some notable variations by background characteristics, as shown in **Table 3.1**. People were less likely to know of smiling sun clinics if they had less education. While almost 100 percent of women with completed secondary education or above reported knowing of smiling sun clinics, the proportion was lower at 86 percent for those who had no education. For men the variations were even more remarkable, from 92 percent to 69 percent. As with education, people in poorer asset quintile were less likely to know of smiling sun clinics. Only 70 percent of men and 84 percent of women, in the poorest asset quintile, reported knowing of smiling sun clinics, while the proportions were 90 percent and 99 percent, respectively for the richest quintile. However, age differentials in awareness of clinics were almost non-existent, except for those in the age group, 40+, appearing somewhat less aware than were those in the younger age groups. There were also little variations in awareness among respondents between rural and urban areas.

Table 3.1 Percent aware of smiling sun clinics by selected background characteristics

Background characteristics	Male	Female	All
Age			
<20	84.8	90.3	88.0
20-29	83.8	92.6	89.2
30-39	83.8	91.0	87.5
40-49	77.0	86.2	80.0
50-59	74.1	-	74.1
Educational level			
No education	69.4	86.3	78.1
Primary	82.8	90.5	86.9
Secondary	88.6	96.1	92.3
Secondary or above	92.0	98.1	93.9
Asset quintile			
Lowest	69.9	84.4	77.3
Second	78.6	89.0	83.9
Middle	82.3	91.2	86.6
Fourth	84.8	93.6	89.1
Highest	89.8	97.8	93.6
Area			
Rural	81.1	88.8	84.9
Urban	81.4	93.4	87.3
Total	81.2	91.1	86.1
N	2180	2140	4320

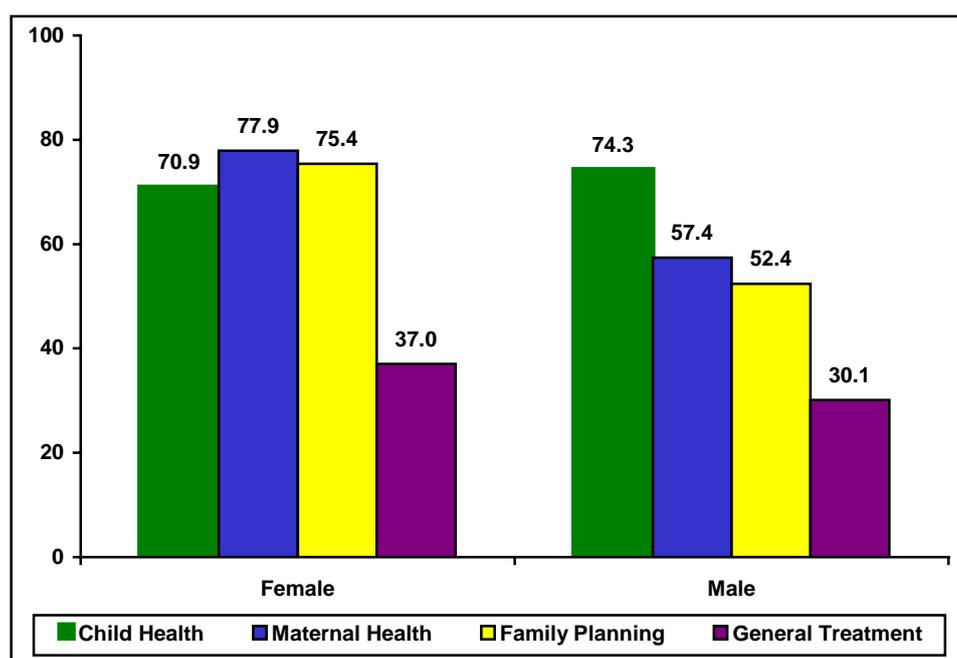
3.3 Awareness of services available at smiling sun clinics

Table 3.2 provides the percentage of respondents who were aware of specific services available at smiling sun clinics. As shown in **Figure 3.5**, commonly known types of services available at smiling sun clinics were Child Health related services, Maternal Health related services, Family Planning services and General Treatment services. Among women, 71-80 percent reported knowing of the availability of Maternal Health related Services (78), Child Health related services (71 percent) and Family Planning Services (75 percent). Availability of General Treatment services was relatively much less known. Only 37 percent of women said they knew of the availability of General Treatment services. Men were generally less likely to know of the services at smiling sun clinics, compared to women.

Table 3.2: Awareness of specific individual services available at smiling sun clinics

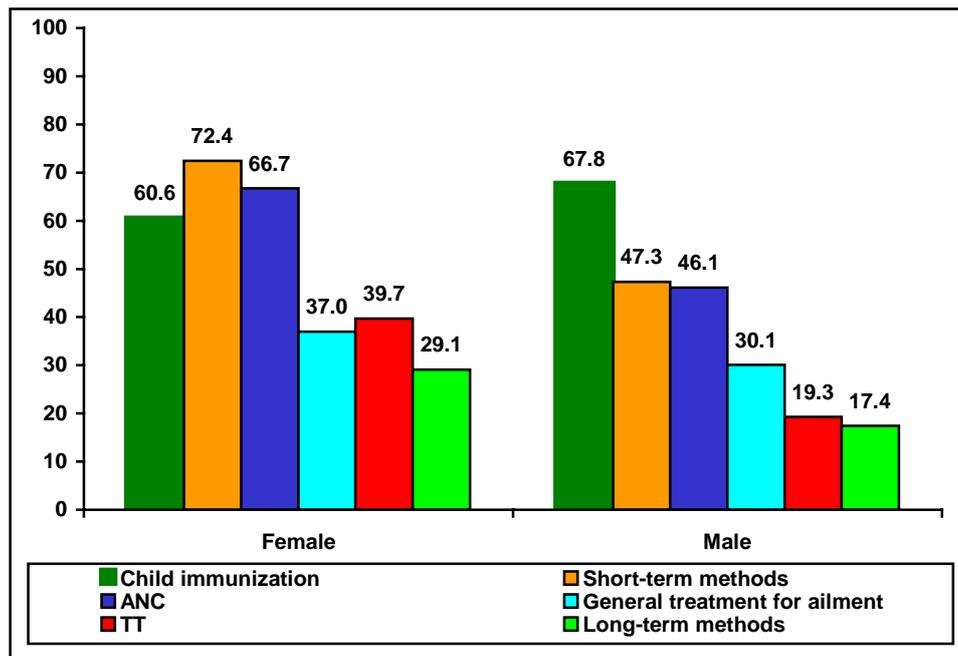
	Female	Male	All
Child Health			
Child Immunization	60.6	67.8	64.0
Child pneumonia/ARI/fever	16.0	13.9	15.0
Child diarrhoea	6.0	8.4	7.1
Vitamin 'A'	8.5	14.4	11.3
Nutrition counselling	3.8	5.6	4.7
Maternal Health			
ANC	66.7	46.1	56.9
Pregnancy care/birth preparation counselling	14.0	13.7	13.8
Child birth delivery	3.5	3.5	3.5
PNC (and vitamin A)	2.6	2.6	2.6
TT	39.7	19.3	29.9
Newborn care			
Newborn care services or counselling	1.8	2.5	2.1
Breastfeeding counselling	0.9	1.5	1.2
Family Planning			
Short-term methods	72.4	47.3	60.5
Long-term methods	29.1	17.4	23.5
Family planning/side effect counselling	13.8	9.7	11.9
Others			
STI/RTI treatment and/or counselling	2.4	2.4	2.4
Adolescent health counselling	1.4	1.4	1.4
General treatment for ailment	37.0	30.1	33.7
Treatment for TB	2.4	1.9	2.2
Blood/urine test	4.9	1.4	3.2
Can't remember/don't know	3.0	9.7	6.2
Other health	1.8	0.9	1.4
N	1949	1771	3720

Figure 3.5: Awareness of specific types of services available at smiling sun clinics



As shown in **Figure 3.6**, commonly known of specific services of smiling sun clinics were vaccination for child immunization, supplying of short-term methods for family planning, ANC services, TT vaccination, supplying of long-term methods for family planning, general treatment for ailment. Among female respondents, 61-72 percent knew of vaccination services for child immunization (61 percent), ANC services (67 percent) and the supplying of short-term methods for family planning (72 percent). Awareness of the other commonly known services was not as widespread. Only 40 percent of women or fewer knew of those services: supplying of long-term methods for family planning (29 percent), general treatment for ailment (37 percent) and TT vaccination. That men were generally less aware of clinic services than women was also evident in their proportions knowing of specific services.

Figure 3.6: Awareness of specific services available at smiling sun clinics



Differentials in awareness of clinic services by selected background characteristics are shown in **Table 3.3**, for the following mostly known type of services: child health related services, maternal health related services and family planning services. There were little variations in awareness of these three types of services among men between rural and urban areas. There were also no clear patterns between the two areas for women. Maternal health related services were about equally widely known between rural and urban women. Between the other two types, child health related services were found to be better known among urban women while family planning services were found to be better known among rural women. Both maternal and child health related services were better known among respondents who were more educated and better known among respondents who were from richer asset quintile. There were however little variations in awareness of family planning services among respondents, either by their educational status or by their wealth status.

Table 3.3 Percent aware of services available at smiling sun clinics by selected background characteristics

Background characteristics	Child health	Maternal health	Family planning
Male			
Area			
Rural	74.5	56.0	56.0
Urban	74.0	58.7	48.8
Educational level			
No education	67.3	45.0	53.2
Primary	73.8	54.6	54.0
Secondary	78.6	64.4	49.7
Secondary or above	79.0	72.1	54.3
Asset quintile			
Lowest	67.2	49.0	50.0
Second	72.1	49.2	55.4
Middle	76.1	57.2	53.4
Fourth	77.3	59.2	54.1
Highest	76.6	68.5	49.3
Total	74.3	57.4	52.4
N	1771	1771	1771
Female			
Area			
Rural	66.7	77.6	84.1
Urban	74.8	78.2	67.1
Educational level			
No education	66.6	73.8	77.1
Primary	70.5	78.0	77.0
Secondary	74.4	81.4	73.6
Secondary or above	78.4	81.4	65.7
Asset quintile			
Lowest	70.0	74.2	82.6
Second	61.5	76.2	81.4
Middle	71.2	81.7	72.3
Fourth	72.1	76.0	73.3
Highest	79.1	81.4	67.6
Total	70.9	77.9	75.4
N	1949	1949	1949

3.4 Differentials in awareness by exposure to ESH/BCC materials

Awareness about smiling sun clinics varied remarkably by exposure to ESH/BCC materials, showing the likely influences of the campaign. Among women, awareness of smiling sun clinics rose from 86 percent of those who had not watched ESH to almost universal proportions at 98 percent with those who had watched the drama (**Figure 3.7**). Among men, the variations were even more remarkable, ranging from 74 percent to 94 percent. Awareness of clinics had also similar variations by exposure to BCC materials (**Figure 3.8**). Among women, the variations were from 83 percent of those who had not seen BCC materials to almost 100 percent of those who had seen BCC materials, while for men the range was from 68 percent to 94 percent.

Figure 3.7: Awareness of smiling sun clinics by exposure to ESH

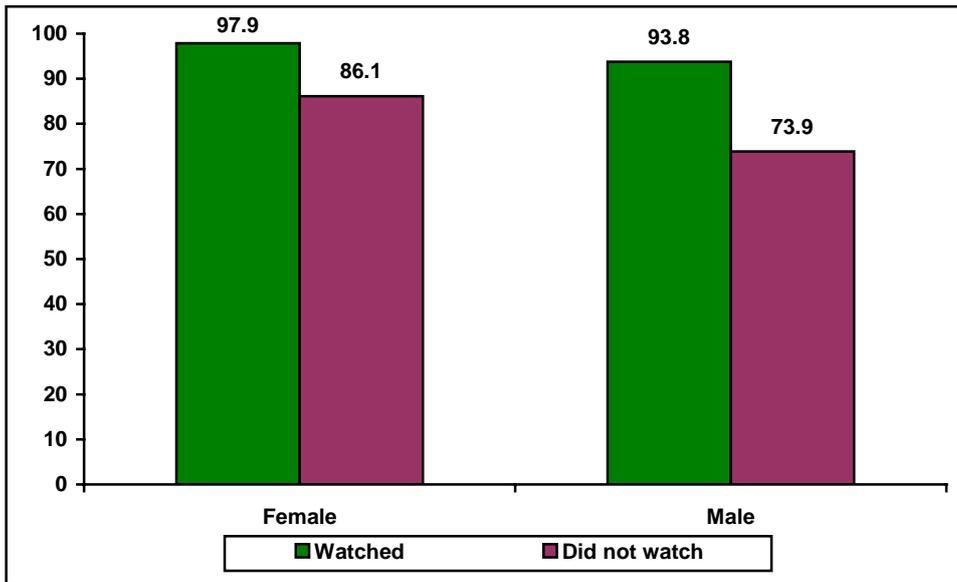
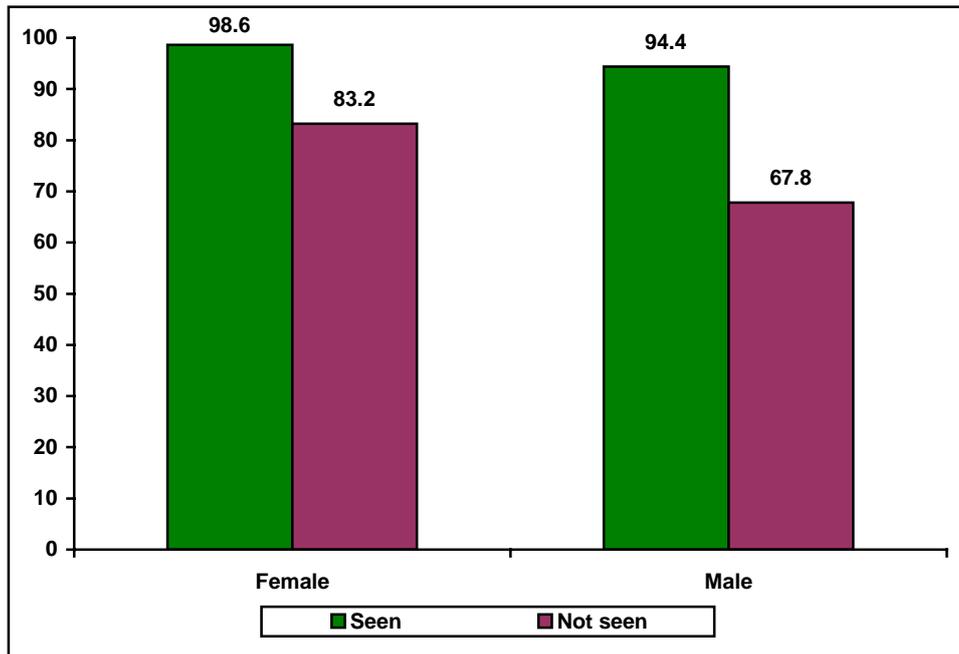


Figure 3.8: Awareness of smiling sun clinics by exposure to BCC materials in the community



Like awareness of smiling Sun clinics, awareness of their services varied with exposure to ESH/BCC materials. Awareness of any commonly known services was higher among respondents who had watched the drama than among those who had not (**Figure 3.9**). For example, only 81 percent of female respondents who had not watched ESH reported knowing of maternal health related services at smiling sun clinics, compared to only 64 percent of those who had not watched the drama. The comparable variations were 76 versus 56 percent for child health related services and 75 versus 65 percent for family planning services. Similar variations were noticeable in awareness of services by exposure to BCC materials, rising with those who had seen those materials (**Figure 3.10**). Among female respondents, awareness of maternal health related services rose from 59 percent of those

who had not seen BCC materials to 83 percent of those who had seen them, while for child health related services the rise was from 53 percent to 77 percent and for family planning services from 56 percent to 88 percent.

Figure 3.9: Awareness of specific types of services available at smiling sun clinics by exposure to ESH

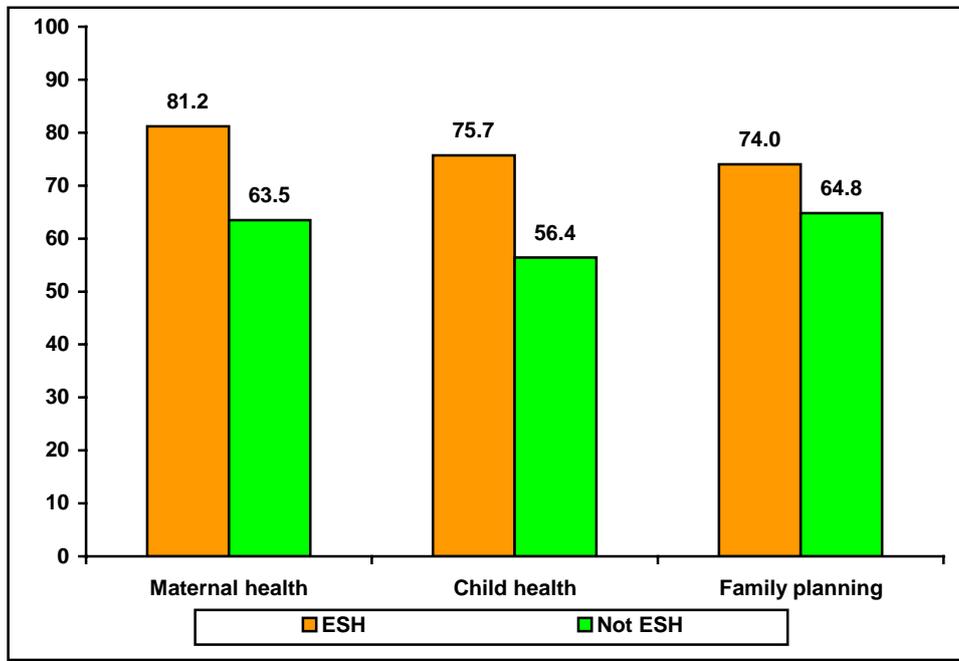
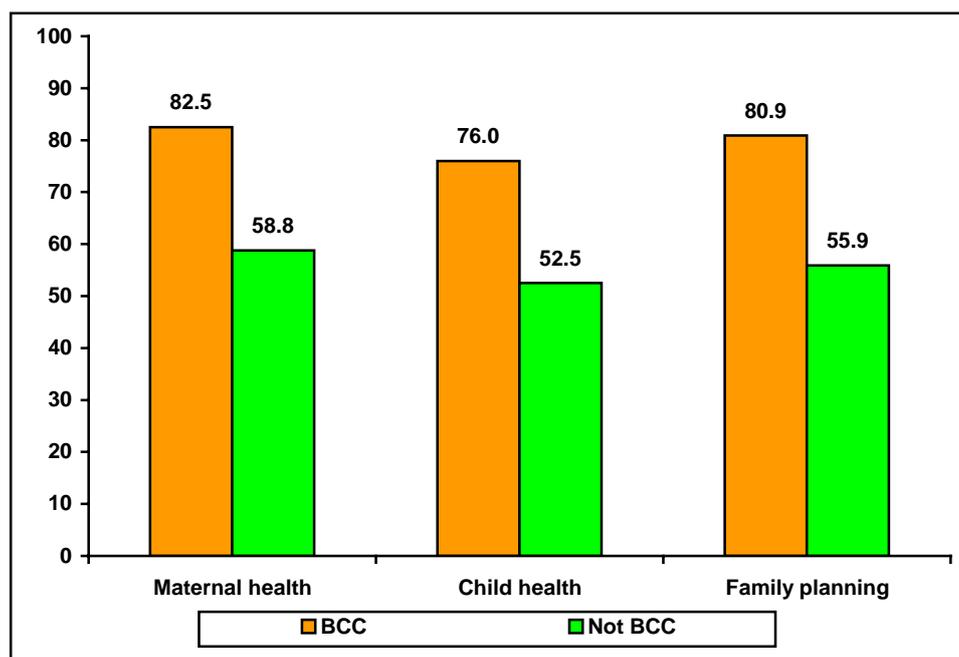


Figure 3.10: Awareness of specific types of services available at smiling sun clinics by exposure to BCC materials



Awareness of messages disseminated about smiling sun clinics was widespread among people (**Figure 3.11**). Among female respondents, nearly 9 in every 10 (89 percent) reported having ever heard of messages about smiling sun clinics and /or about the services available from them. The proportion among male respondents was lower, yet high as 68 percent. Awareness of messages seemed to have risen with the campaign. The proportion of female respondents aware of messages was almost universal (98 percent) for those who had watched ESH, compared to 83 percent for those who had not watch the drama (**Figure 3.12**). Striking variations were also notable among male respondents at 85 percent versus only 58 percent. Awareness of messages varied similarly by exposure to BCC materials, being remarkably higher among those who had seen BCC materials than among those who had not (**Figure 3.13**).

Figure 3.11: Overall awareness of messages about smiling sun clinics

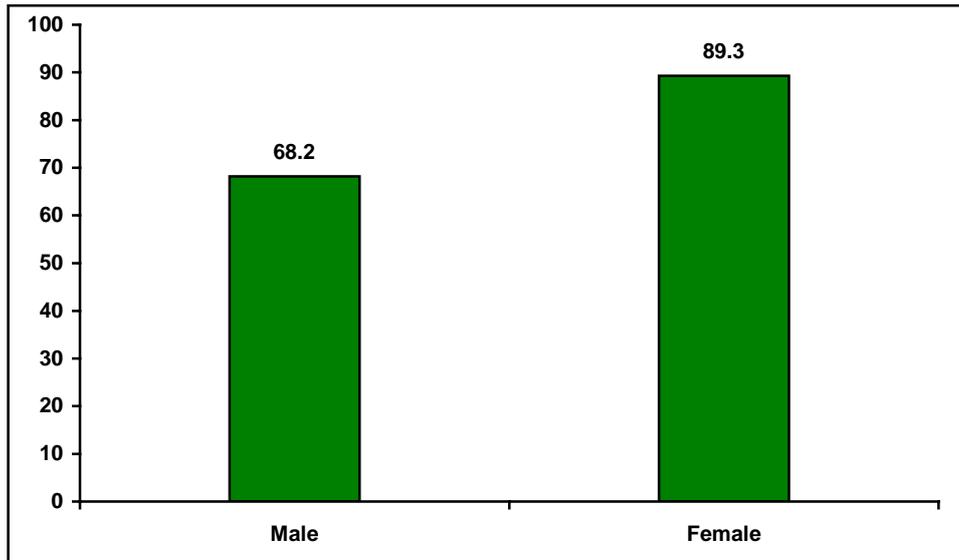


Figure 3.12: Overall awareness of messages about smiling sun clinic by exposure to ESH

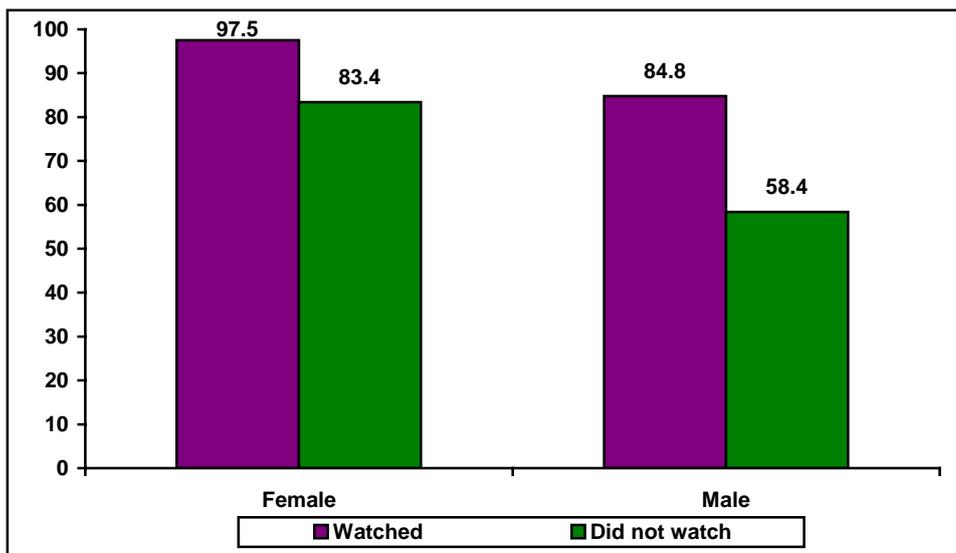
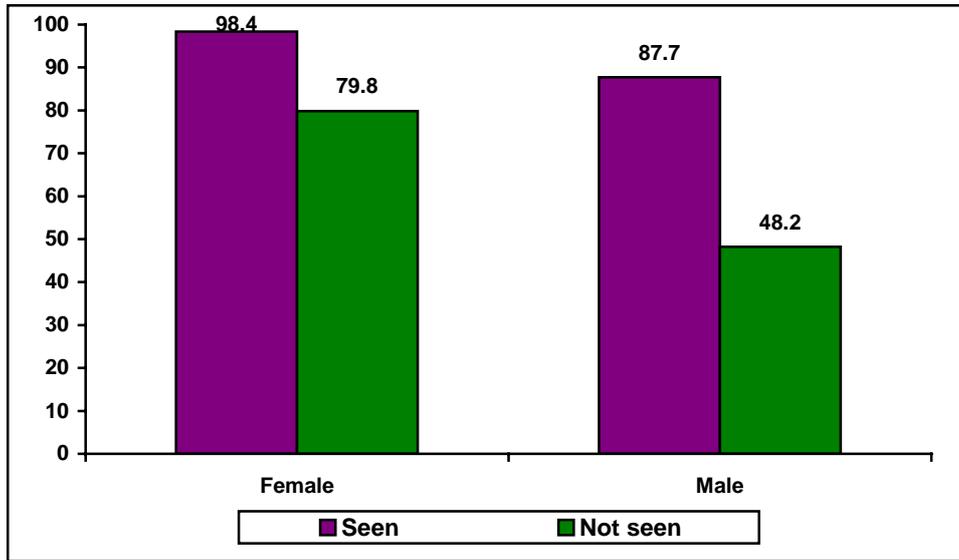


Figure 3.13: Overall awareness of messages about smiling sun clinics by exposure to BCC



Not many respondents were aware of the services offered at discounts/free of costs, in smiling sun clinics--only 15 percent among female respondents and 20 percent among male respondents (**Figure 3.14**). This awareness was also found to be higher among those who had exposure to the campaign than among those who did not, upholding the benefits of the campaign (**Figures 3.15 and 3.16**).

Figure 3.14: Awareness of services offered at discounts/free of costs

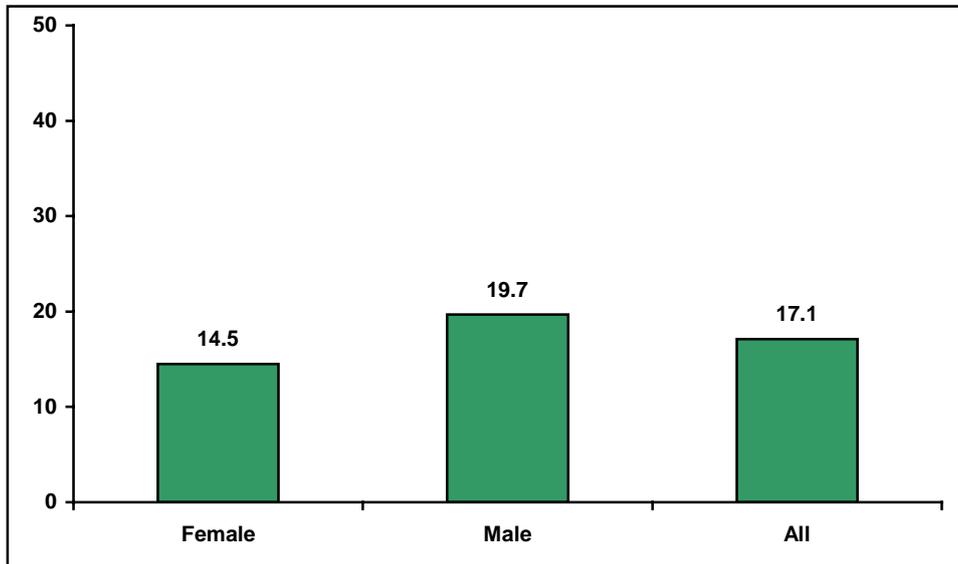


Figure 3.15: Awareness of services offered at discounts/free of costs by exposure to ESH

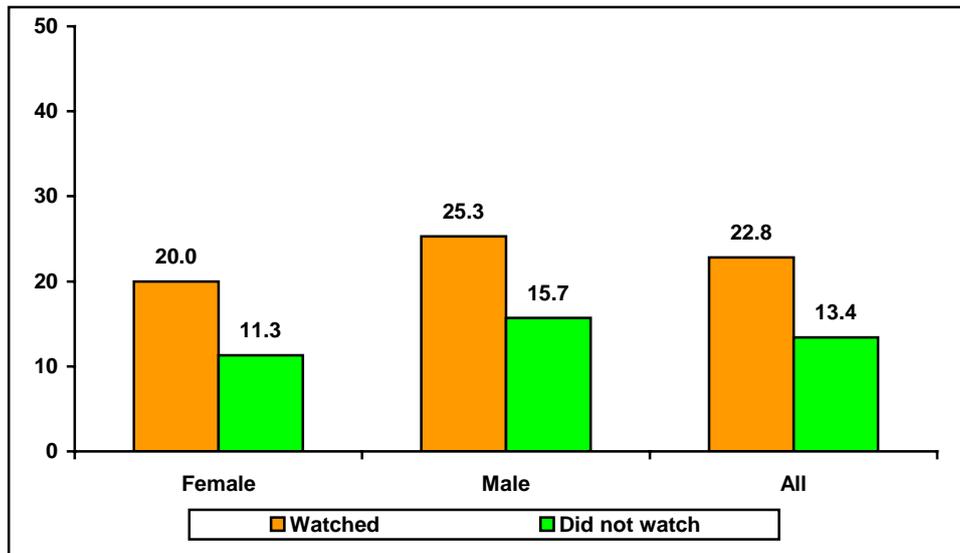
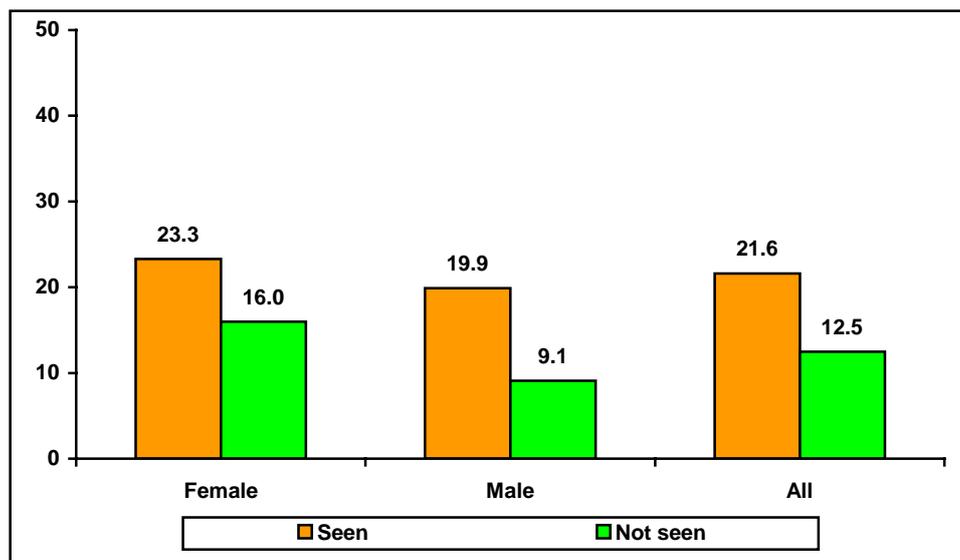


Figure 3.16: Awareness of services offered at discounts/free of costs by exposure to BCC materials



3.5 Impact of campaign on awareness

Three regression-models were fitted to examine the impact of the campaign on awareness about smiling sun clinics, controlling for the background characteristics found to be associated with awareness. One model was fitted to awareness of smiling sun clinics, one to overall awareness of messages about smiling sun clinics, and one to awareness of specific types of services. Each model was fitted for the male and female respondents separately. The campaign variables included in the models were exposure to ESH, exposure to BCC activities, and knowledge of services available at discounts/free of costs. The results showing the odd-ratios and their significant level for specific campaign variables are shown in **Figure 3.17** for awareness of smiling sun clinics, in **Figure 3.18** for overall awareness of messages about smiling sun clinics, and in **Figure 3.19** for awareness of specific types of services.

Odd-ratios for all the campaign variables—exposure to ESH, exposure to BCC activities and knowledge of availability of services at discounts/free of costs –appeared statistically significant, showing increased awareness of smiling sun clinics, increased overall awareness of messages about them and increased awareness of their services, among respondents who had exposure to the campaign. This is clear evidence that the campaign was successful full in raising awareness about smiling sun clinics in the target population.

The campaign was more successful in raising awareness with BCC activities than with ESH. For example, awareness of smiling sun clinics was 10.5 times higher among women who had exposure to BCC activities than among those who had not, while the difference was only 3.6 times between women who had exposure to ESH and those had not. The campaign was also found to have been more successful in raising awareness more among women than among men. Interestingly, offering of services at discounts/free of costs had discernible impact in raising awareness about smiling sun clinics.

Figure 3.17: Odd ratios of having awareness of smiling sun clinics for exposure to ESH, exposure to BCC materials and knowledge of services available at discounts/free of costs

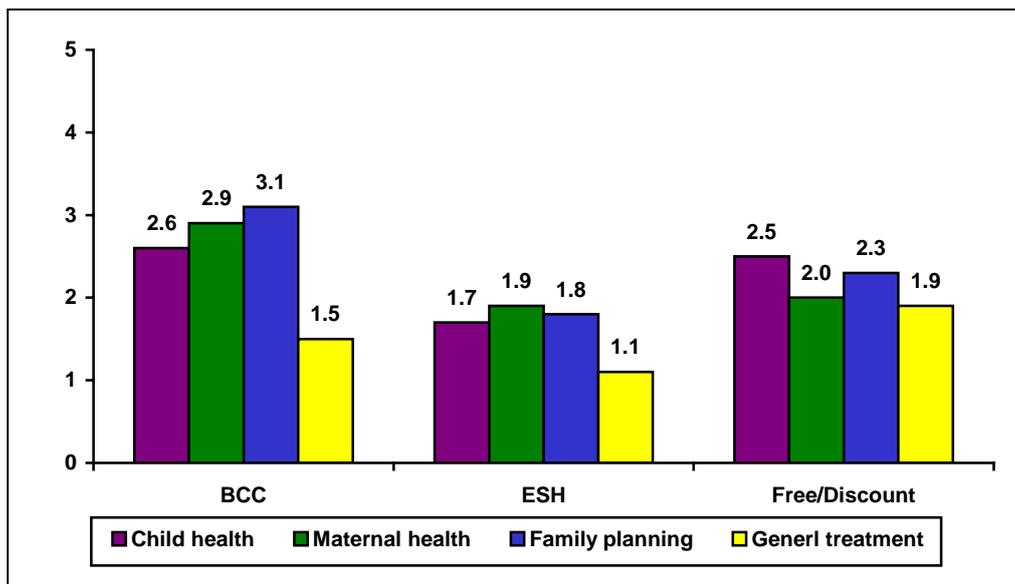


Figure 3.18: Odd ratios of having overall awareness of messages about smiling sun clinics for exposure to ESH, exposure to BCC materials and knowledge of services available at discounts/free of costs

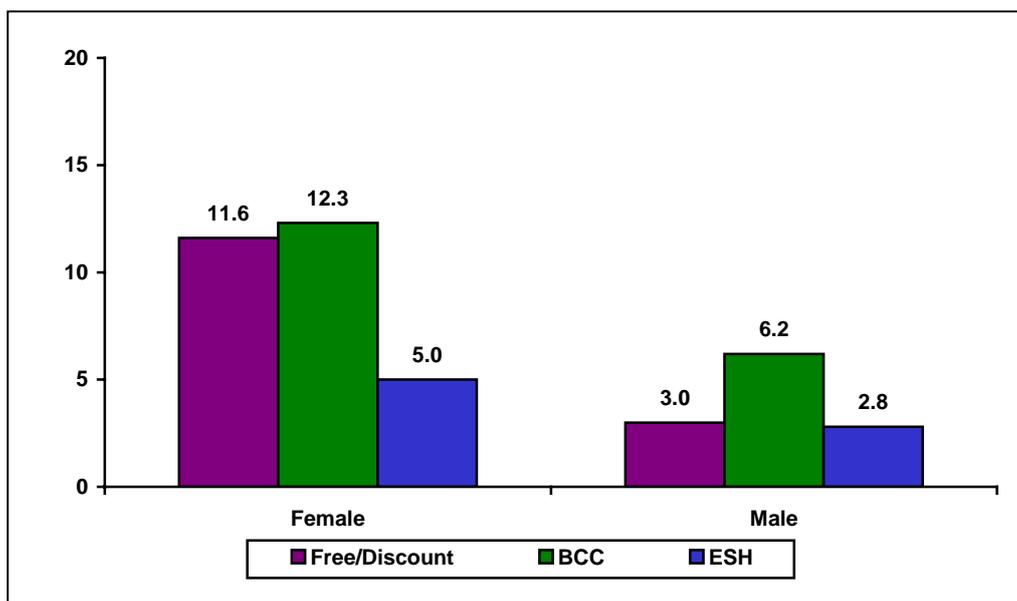
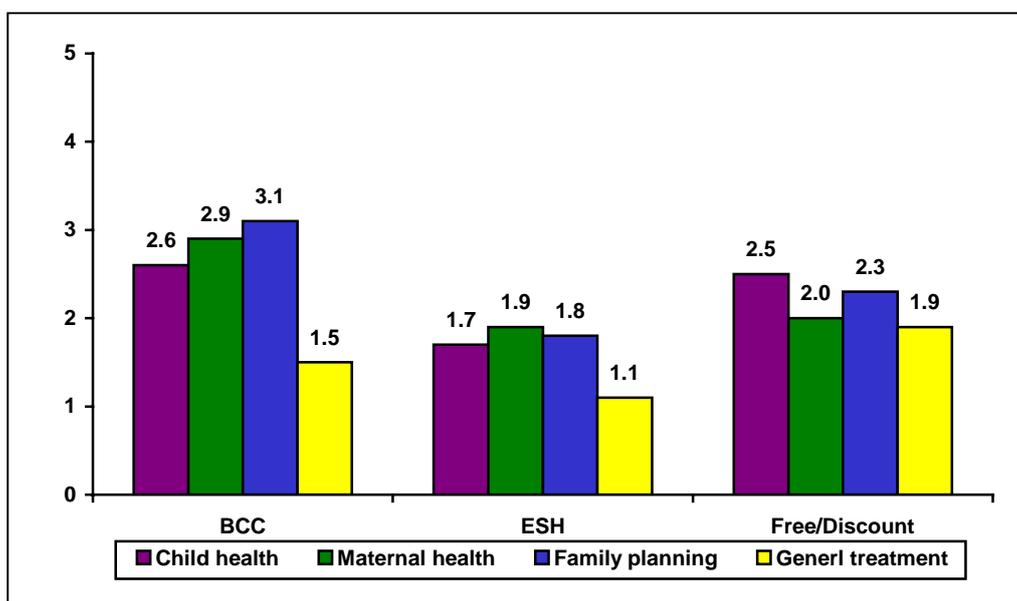


Figure 3.19: Odd ratios of having awareness of specific types of services for exposure to ESH, exposure to BCC materials and knowledge of services available at discounts/free of costs



Chapter 4

Use of Smiling Sun Clinic

The major focus of the NSDP communication campaign was on promoting the use of health care services offered at smiling sun clinics, and such other facilities run by Government, private agencies and other non-NSDP NGOs. The chapter presents the survey findings from the community samples, showing the extent the campaign was successful in promoting the use of clinics, more specifically smiling sun clinics.

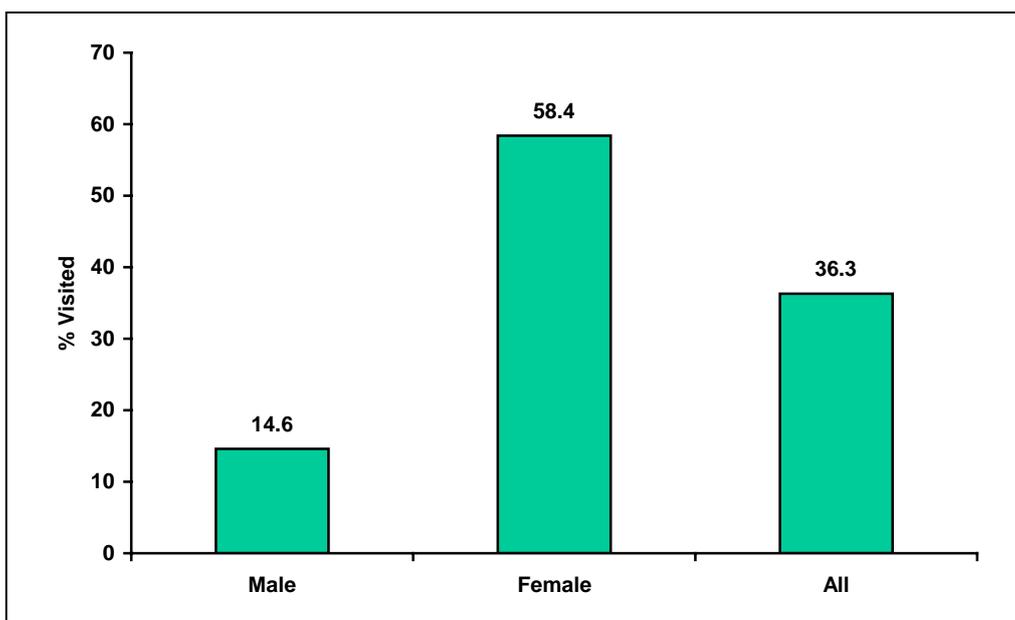
Findings are presented covering the following aspects of the use of clinics:

- Visits to clinics
- Factors motivating people to visit clinics
- Use of services from smiling clinics in last visit
- Most recent visitors who visited the clinic in the month before the survey
- Differentials in recent visits to clinics by background characteristics
- Differentials in recent visits to clinics by exposure to the campaign
- Determinants of visits to clinics and the impact of the campaign.

4.1 Use of smiling sun clinics

Use of smiling sun clinics was assessed in terms of the number of people visiting those clinics to seek or obtain services either for themselves or for others. As shown in Figure 4.1, women were found to be much more likely to use services from smiling sun clinics than were men. Among female respondents, nearly 6 in 10 (58 percent) reported having ever visited a smiling sun clinic, while among men did only 38 percent.

Figure 4.1: Percent ever visited any SS clinic



A detail pattern of visits to smiling sun clinics is presented in **Table 4.1**. Among women, 73 percent of those who visited a smiling sun clinic visited it in the 12 months before the survey; while among men did 71 percent. The rest, 27 percent among women and 29 percent among men, said they visited the clinic one year ago. Among those who visited in the previous 12 months, a significant proportion reported having visited the clinic more than once in the said period, accounting for 55 percent of all ever visitors among women and 37 percent among men. Among male visitors, 40 percent visited the clinic to seek services for their own health care; the rest 60 percent said they went to the clinic to accompany someone else. Women were more likely to visit the clinic to seek services for their own health care than to accompany someone else – 76 versus 24 percent.

Table 4.1: Pattern of visits to smiling sun clinics by sex of respondents

	Male	Female	All
Visited SS clinics			
Ever visited	14.6	58.4	36.3
Never visited	85.4	41.6	63.7
Total	100.0	100.0	100.0
N	2180	2140	4320
When visited last time			
Within last 1 month	20.5	24.8	23.9
Within last 3 months	21.4	25.2	24.4
Within last 6 months	16.0	12.5	13.2
Within last 1 year	12.9	10.2	10.7
More than 1 year ago	29.2	27.3	27.7
Total	100.0	100.0	100.0
N	318	1249	1567
Number of times visit in last 12 months			
0	28.6	26.9	27.2
1	34.0	17.8	21.1
2	17.9	14.7	15.4
3	8.2	14.3	13.0
4	4.4	14.7	12.6
5	2.5	3.6	3.4
6 +	4.3	8.0	6.9
Total	100.0	100.0	100.0
N	318	1249	1567
Mean number	1.6	2.3	2.2
Visited for self or for someone else			
For self	40.6	76.0	68.8
For someone else	59.4	24.0	31.2
Total	100.0	100.0	100.0
N	318	1249	1567

4.2 Factors motivating people to visit Smiling sun clinics

Factors motivating people to visit smiling sun clinics were ascertained by asking respondents what motivated them to visit a smiling sun clinic the last time. Responses given by those who visited smiling sun clinics in the previous 12 months are listed in **Table 4.2**. Home contacts by outreach workers (33%) emerged to be the most prominent factor motivating people to visit smiling sun clinics, given by 33 percent of the respondents. Next most important motivating factors were the friend's/relative's/ neighbor's recommendations (27%), spouse's recommendations (24%), depot-holder's motivation (21%), accessibility to clinics/quality of its services (15%), and other family members' recommendations (10%). There were however variations in importance of motivating factors between men and women. Motivating factors such as home contacts by outreach workers, friend's/relative's/neighbor's recommendations and depot-holder's motivation had relatively more influences on women than men in encouraging visits to smiling sun clinics, while the reverse was true for the factors such as spouse's recommendations, accessibility to the clinic/the quality of its services and the other family member's recommendations.

Table 4.2: Factors that motivated respondents to visit smiling sun clinics according to sex

Reasons for visit	Male	Female	All
Spouse's recommendation	34.9	21.8	24.4
Other family member's recommendation	11.0	9.7	10.0
Friend's/relatives/neighbors recommendation	26.7	27.5	27.4
Home visit by outreach worker	26.4	34.9	33.2
Miking announcements	5.0	3.2	3.6
Community meeting	0.3	-	0.1
TV Drama	3.8	1.9	2.3
Free/discounted service	2.5	1.0	1.3
Affordable Cost	3.8	1.1	1.7
Accessibility/Quality services	17.3	14.2	14.8
Rickshaw tin plate	-	-	-
Print material	1.6	0.1	0.4
TV advertisement	2.8	1.0	1.4
Directional signboard	0.9	0.5	0.6
Billboard	0.3	-	0.1
Signboard at clinic	7.9	2.9	3.9
Depot-holder	10.1	23.2	20.5
SS banner	0.6	0.9	0.8
Others	4.7	3.4	3.6
Total	100.0	100.0	100.0
N	318	1249	1567

4.3 Use of services at smiling sun clinics in last visit

Table 4.3 presents the percentage of users who used a specific service in last visit to a smiling sun clinic. Most commonly used services were the services supplying short-term family planning methods, accounting for 31 percent of all users of smiling sun clinic services. Next most commonly used services were general treatment services for ailment (22 percent), ANC services (14 percent), and child immunization services (13 percent). The patterns of utilization of services varied between women and men. Women were more likely to visit SS clinics than male for the services like family planning, ANC and child immunization, while men were more likely to visit them for general treatment services.

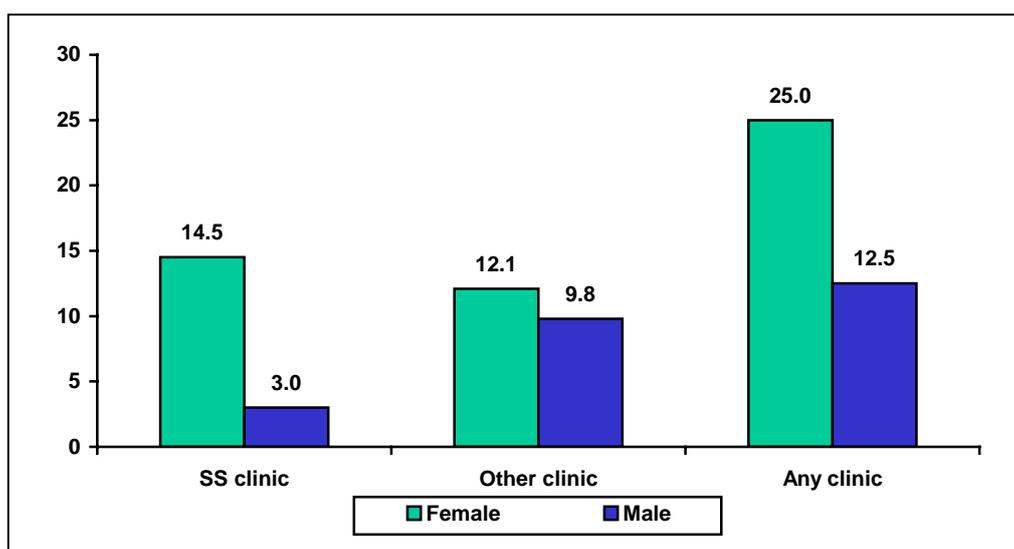
Table 4.3: Use of specific services from smiling sun clinics during most recent visit according to sex

Services	Male	Female	All
Child Health			
Child Immunization	9.5	13.9	13.1
Child pneumonia/ARI/fever	10.5	3.6	5.0
Child diarrhea	2.2	1.0	1.2
Vitamin 'A'	3.5	1.5	1.8
Nutrition counseling	0.6	1.0	0.9
Maternal Health			
ANC	10.8	14.7	13.6
Pregnancy care/birth preparation counseling	4.8	2.8	3.2
Child birth delivery	0.6	0.6	0.6
PNC (and vitamin A)	0.6	0.5	0.7
TT	3.5	10.0	8.7
Newborn care			
Newborn care services or counseling	1.0	0.2	0.4
Breastfeeding counseling	1.2	1.5	1.4
Family Planning			
Short-term methods	15.0	35.1	31.0
Long-term methods	2.6	4.6	4.1
Family planning/side effect counseling	5.7	5.2	5.4
STI/RTI services and/or counseling	2.2	1.2	1.4
Adolescent health and/or counseling	0.3	0.3	0.3
General treatment for ailment	44.8	16.7	22.2
Treatment for TB	1.2	0.7	0.8
Other health	4.8	3.1	3.4
Blood/urine test	2.5	3.2	3.1
N	315	1251	1566

4.4 Most recent visitors

The further analyses of visits to smiling sun clinics, presented in subsequent sections, were based on most recent visitors to those clinics, who visited them in the month preceding the survey. **Figure 4.2** shows the percentages of male and female respondents, who visited any clinic, smiling sun clinics only and other than smiling sun clinic only, within the last one month before the survey. The other than smiling sun clinics included the government, NGO and private healthcare facilities.

Figure 4.2: Percentages of male and female respondents who visited a clinic in the one month before the survey, by type of clinic

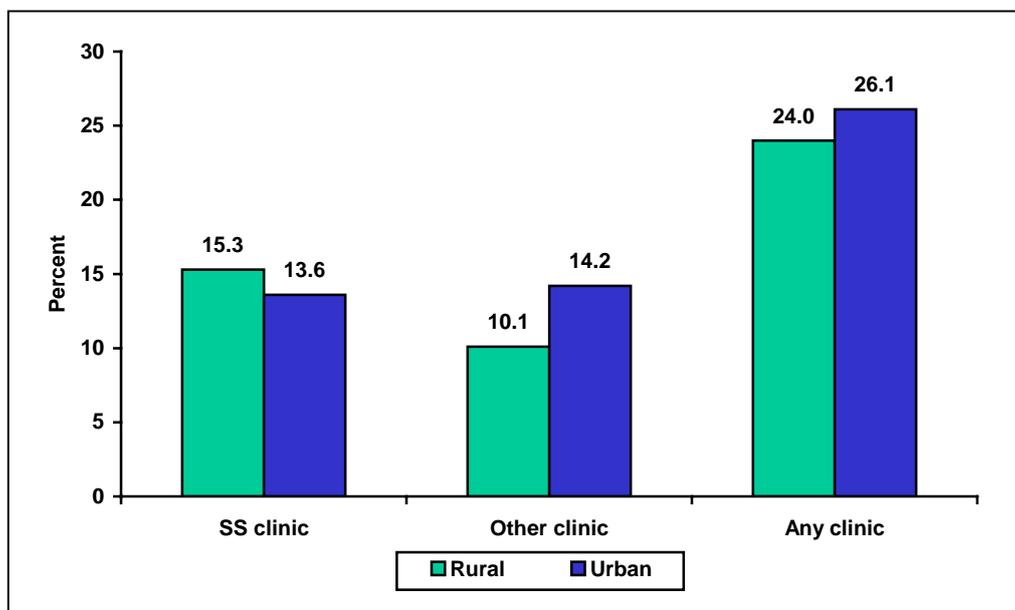


The results indicate that men were much less likely to visit a smiling sun clinic than were men. Only 3 percent of male respondents reported having visited a smiling sun clinic in the last one month, while the percentage was higher as 15 percent for female respondents. Although the differences were much less marked, men were also found to be less likely to visit other clinics than were women —10 percent compared to 12 percent. Between smiling sun and other clinics, women preferred to visit smiling sun clinics and men to visit other clinics. Men were excluded from the further analyses of visits to smiling sun clinics as they had only few (only 3 percent) of them visiting those clinics.

4.5 Differentials in most recent visits by background characteristics

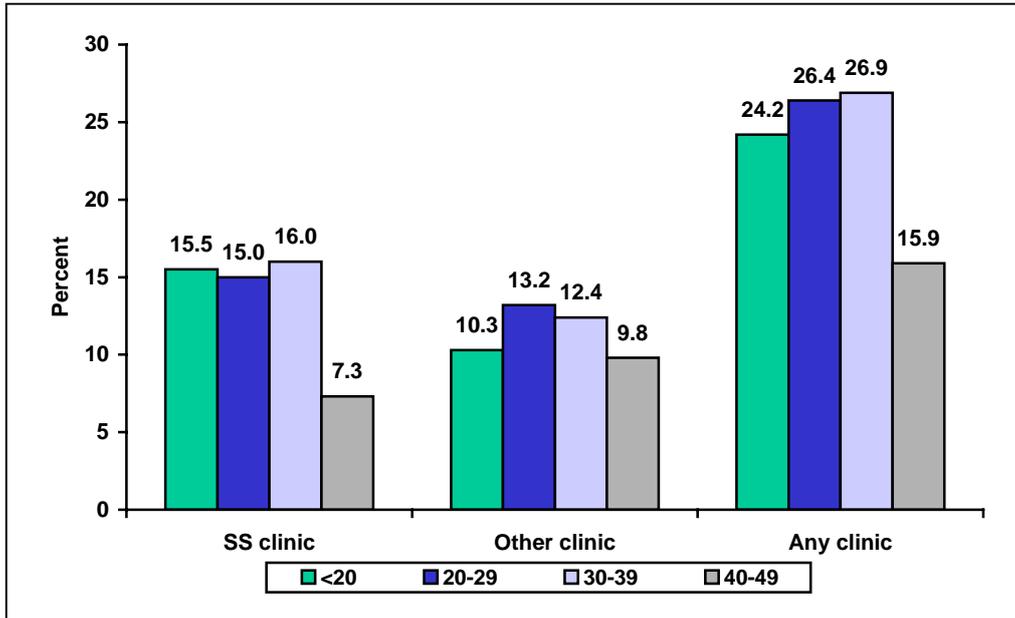
This section examines the differentials in most recent visits to clinics by the following selected background characteristics of respondents: their place of residence, age, education, wealth status, and age of their youngest child. As shown in **Figure 4.3**, on overall, women living in urban areas were more likely to visit a clinic than those living in rural areas. But these variations were due to the government and other non-smiling sun clinics being used by relatively more of urban women, 14 percent compared to 10 percent of rural women. Rural women were slightly more likely to visit smiling sun clinics than were the urban women (15 percent versus 14 percent).

Figure 4.3: Percentage of women who have visited clinics by place of residence



There was a marked variation in visits to smiling sun clinics by women's age (**Figure 4.4**). Only 7 percent of women in the oldest age group, 40-49 reported having recently visited a smiling sun clinic, compared to 15/16 percent of those in the younger age groups, below 40. Age variations were however less pronounced in case of visits to the government and other non-smiling clinics, ranging only from 10 to 13 percent.

Figure 4.4: Percentage of women who have visited smiling sun clinics and other clinics by age



Visits to clinics were associated with having children **Figure 4.5**. Women were likely to visit a clinic, least if they had no children and most if they had children age below 12 months. Only 9 percent of female respondents who had no children reported having recently visited a smiling sun clinic, compared to 20 percent of those who had children age below 12 months. The comparable variations in case of visits to the government and other non-smiling clinics were at 7 percent versus 16 percent.

Figure 4.5: Percentage of women who have visited SS clinic and other clinic by age of youngest child

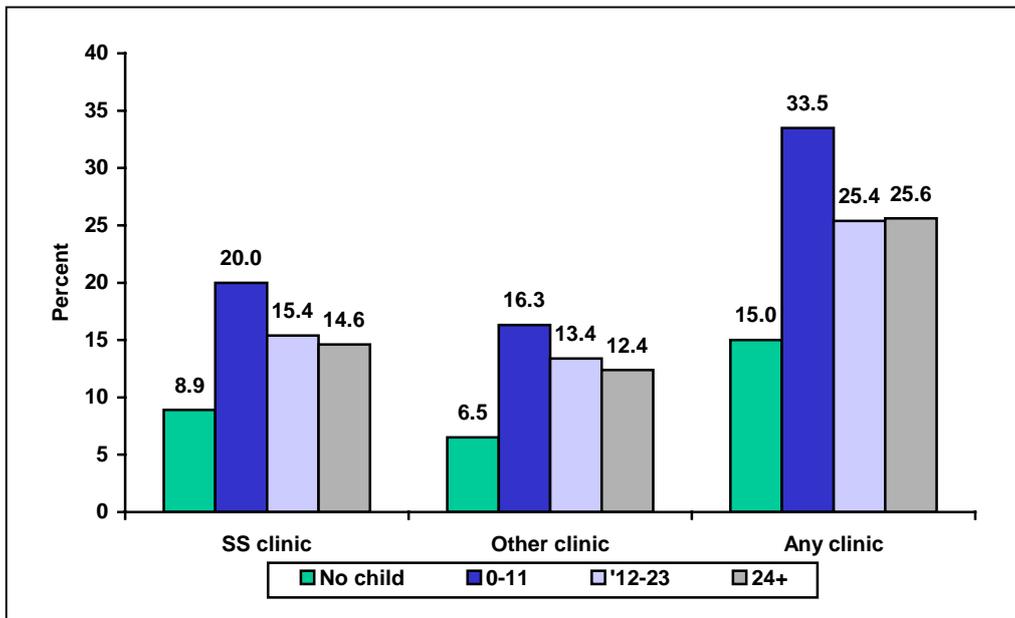
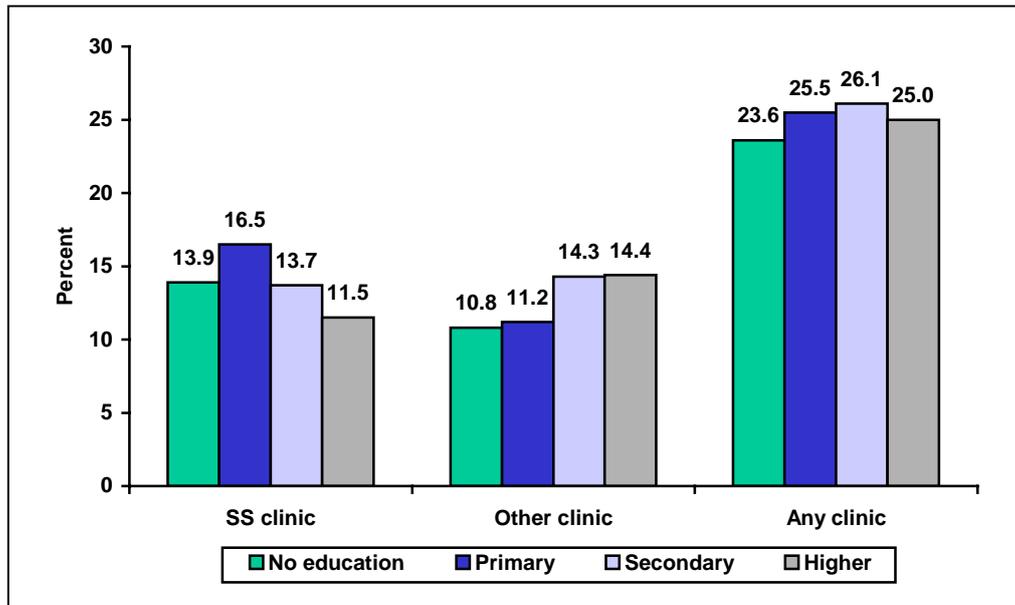


Figure 4.6 shows the differentials in visits to clinics by education of women. Visits to smiling sun clinics followed a curvilinear relation with education. Among women, 14 percent reported having recently visited a smiling sun clinic. The proportion rose to a peak at 17 percent among women having a primary education, and then dropped with women having more education, reaching 12 percent for those having an education worth complete secondary or above. Women with a secondary education or above were more likely to visit other than a smiling clinic, compared to those with no education or a primary education.

Figure 4.6: Percentage of women who have visited clinics within last one month by education



Visits to smiling sun clinics varied with the economic status of women (**Figure 4.7**). Women in the poorest asset quintile were most likely to visit a smiling sun clinic. Among women in the poorest asset quintile, 18 percent reported having recently visited a smiling sun clinic, while the proportion was 15 percent or less for those in the other quintiles. Unlike smiling sun clinics, other clinics including government facilities were relatively more used by women in the two richest quintiles.

Figure 4.7: Percentage of women who have visited clinic within last one month by asset quintile

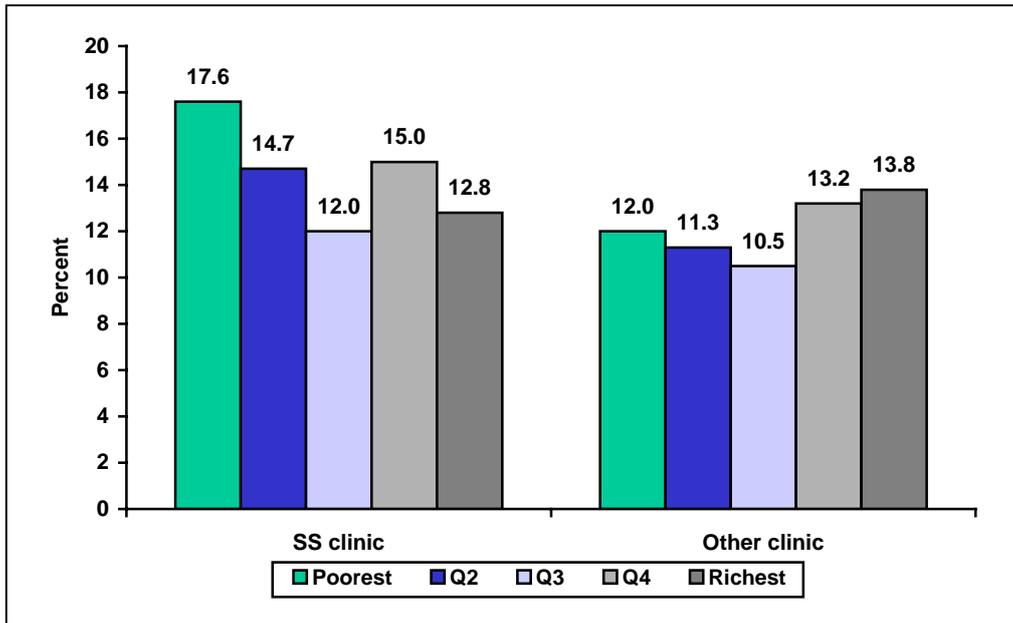
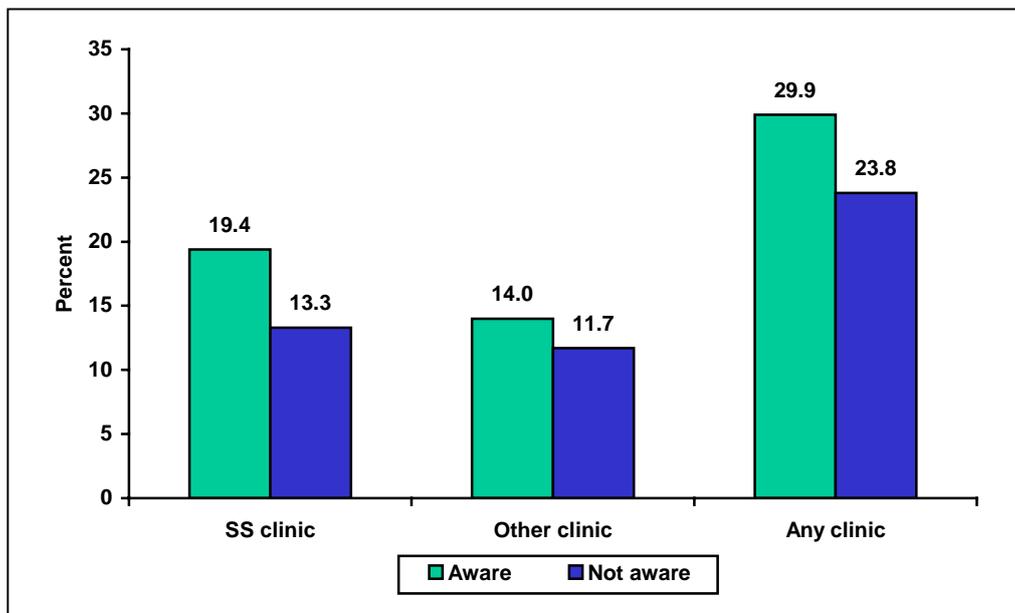


Figure 4.8 shows the relation between visits to clinics and the knowledge of services available at discount or free of cost. Women who were aware of the availability of services at discounts or free of costs were more likely to visit a clinic than those who were not aware of the information. The variations, however, were more pronounced in case of SS clinics than in case of other clinics—13 versus 19 percent for smiling sun clinics, compared to 12 versus 14 percent for other clinics.

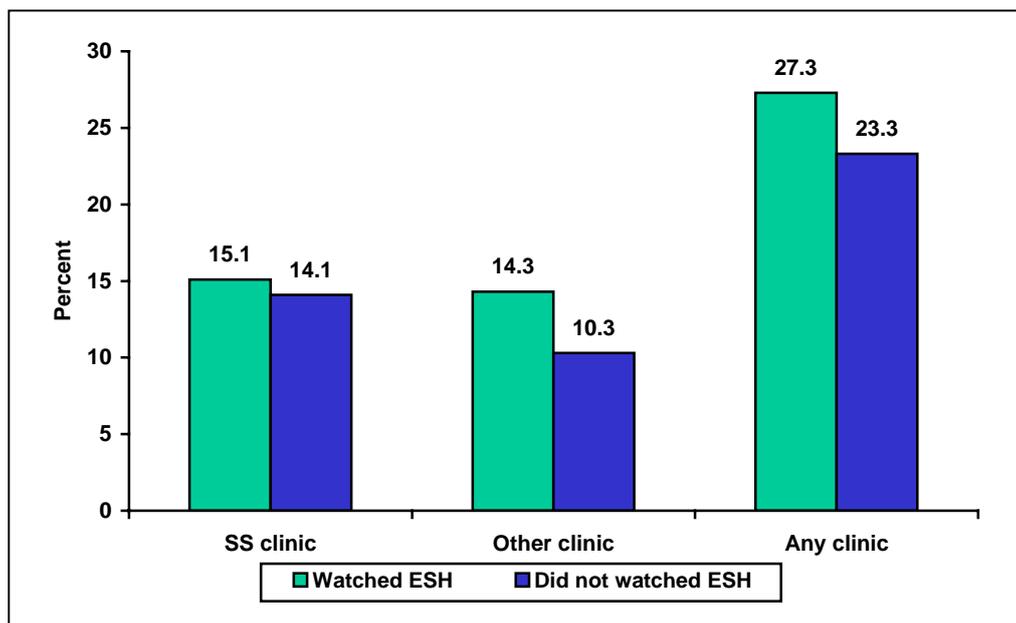
Figure 4.8: Percentage of women who have visited clinics by awareness of discount/free service at clinic



4.6 Exposure to Media Campaign and Utilization of Clinics

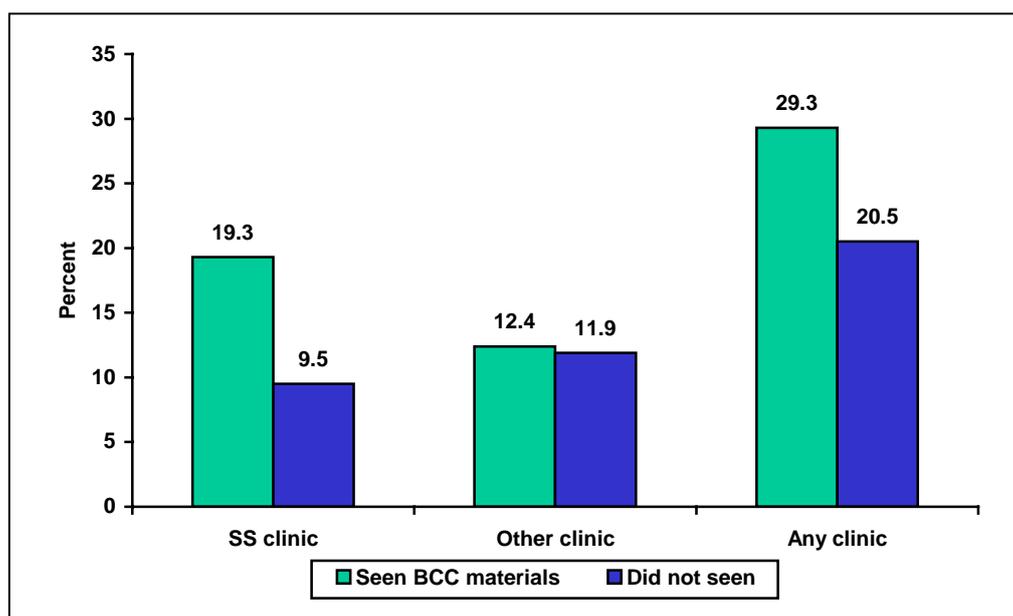
Figure 4.9 demonstrates the relationship between exposure to the drama serial ESH and visits to clinics. Women who had watched ESH were more likely to visit a clinic than those who did not watch ESH—27 percent versus 23 percent. Surprisingly, exposure to ESH had very little effects on visits to smiling sun clinics. The proportion of women visiting smiling sun clinics remained about unchanged between those who had watched ESH (15 percent) and those who had not (14 percent). However, the drama had substantial effects on use of other than SS clinics. About 14 percent of women who had watched ESH reported having recently visited other than smiling sun clinics, compared to 11 percent of those who had not watched ESH. It is worth mentioning here that the messages contained in the drama serial ESH were aimed at promoting the use of all clinics, not only of smiling sun clinics.

Figure 4.9: Percentage of women who have visited clinics by exposure to ESH



Local level BCC activities had remarkable effects on use of smiling sun clinics. As shown in **Figure 4.10**, women who had seen BCC materials in the community were twice as likely to visit smiling sun clinics as those who had not seen those materials—19 percent compared to 10 percent. Local level Bcc activities had however virtually no effects on use of other clinics.

Figure 4.10: Percentage of women who have visited clinics within last one month according to the exposure to BCC activities



4.7 Determinants of visits to clinics

Multivariate logistic regression analysis was conducted to examine the independent effects on clinic visits of the factors found associated with them (clinic visits) in the two way analyses presented in the foregoing sections. The factors (used as explanatory variables in the regression model) were respondents' place of residence, age, education, asset quintile, age of their youngest child, their exposure to ESH, exposure to local level BCC materials, and knowledge of availability of services at discounts/free of costs. The underlying intent was to find out if the campaign had any impact on clinic visits. Two regression-models were fitted, one for visit to smiling sun clinics and one for visit to other clinics, using 'visit' as a dichotomized variable. The results showing odd-ratios and their significant levels for specific subgroups are presented in **Table 4.4**.

Age of youngest child emerged as a significant determinant of clinic visits. Women were likely to visit a clinic most if they had children less than one year of age, and least if they had no children. Female respondents having children less than one year of age were three times as likely to visit a smiling sun clinic as those who had no children.

Urban-rural variations were not significant in case of visits to smiling sun clinics. But rural women were found to be significantly less likely to visit the other clinics than their rural counter parts. Age of women had no significant effects on visits to any clinics, except for those in the oldest group, 40-49 years, appearing to be significantly less likely to visit a smiling sun clinic than those in the other age group. Educational variations in visits to clinics were also generally insignificant, except for women with some secondary education showing a significantly greater propensity to visit the other clinics than those in the other educational categories. Asset quintiles had significant variations only for women in the third quintile, showing that they were less likely to visit a smiling sun clinic than those in both the poorer and richer asset quintiles.

Knowledge of services offered at discounts/free of costs had significant effects on visits to smiling sun clinics, but understandably, not on visits to the other clinics. Women who had this knowledge were 1.6 times as likely to visit a smiling sun clinic as those who did not have the knowledge.

Despite provisions of services available at discounts/free of costs and the other influences listed above, the impact of the campaign was evident in the logistical analyses, clearly for exposure to BCC activities in the community. Exposure to BCC activities in the community appeared as a significant determinant of visits to smiling sun clinics. Women having exposure to BCC activities were 2.6 times as likely to visit a smiling sun clinic as were those having no exposure to BCC activities. The likelihood of visiting a smiling sun clinic was also found to be higher among women who had exposure to ESH than among those who had no exposure to ESH. But the variations were not large enough to be statistically significant. The campaign had insignificant on visits to other than smiling sun clinics.

Table 4.4. Logistic regression analysis (showing odds ration) of visit to SS Clinic and other clinic

Explanatory variables	SS clinic	Other Clinic
Residence (rc: Urban) Rural	1.12	0.69*
Age of Child (rc: no child) 0-11 months 12-23 months 24+	3.00** 1.96* 2.20**	3.30** 2.50** 2.54**
Exposure to BCC at Community	2.59**	1.35
Exposure to ESH	1.30	0.93
Knowledge about discount service	1.59*	1.14
Age (rc: <20) 20-29 30-39 40-49	0.75 0.81 0.35*	1.04 1.03 0.84
Education (rc: no education) Primary Secondary Higher	1.20 0.93 0.86	1.01 1.50* 1.53
Asset Quintile (rc: Q1) Q2 Q3 Q4 Q5	0.77 0.61* 0.80 0.72	0.86 0.68 0.76 0.67

rc = reference category, ** p<0.001, *p<0.05

Chapter 5

Comparative Analyses of Campaign Effects

This chapter presents two comparisons—one between the case and non-case samples and one between the project and non-project community samples. The comparison between the case and non-case samples is designed to ascertain directly the impact of the campaign in promoting visits to smiling sun clinics, controlling for the other factors found to be influencing visits to clinics. The comparison between the project and non-project community samples is designed to ascertain if the drama serial had any differential impact between the NSDP project areas and non-NSDP areas.

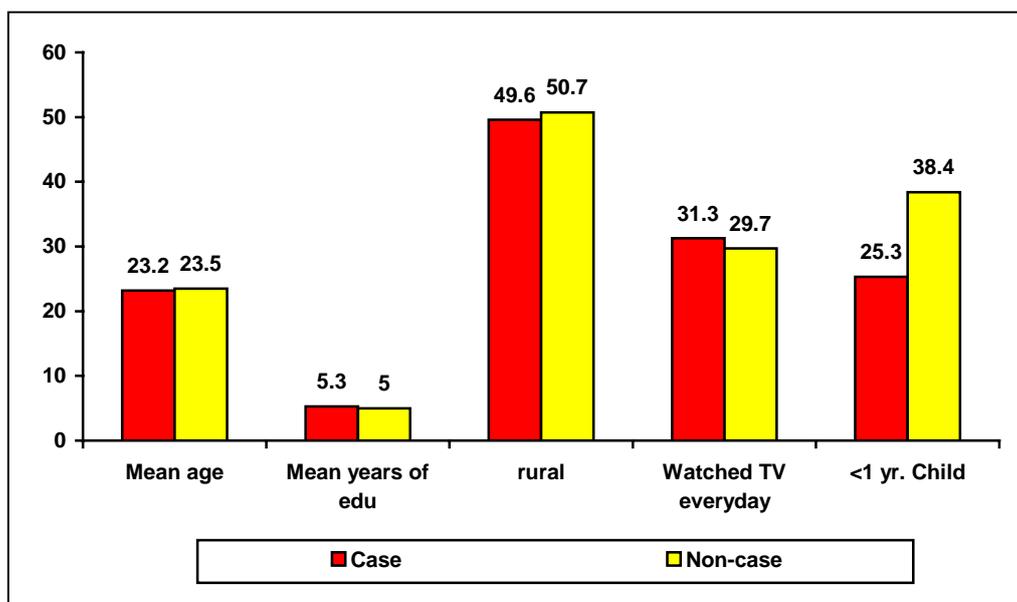
5.1 Case sample versus non-case sample

As stated in Chapter 1, the case and non-case samples were drawn in every round of data collection, as was the project community sample. Respondents in the case sample were chosen from among clients who visited a sample clinic on the day they were interviewed. Respondents in the case sample were randomly drawn from among individuals living in the clinic's catchment area. Only those individuals who were in need of the service promoted in the drama episode telecast immediately prior to the round, but did not visit the clinic in the three weeks prior to the interview date were eligible to be interviewed in the case sample.

5.1.1 Comparisons of background characteristics

Figure 5.1 displays a comparison of characteristics of respondents between the case and the non-case samples. Respondents in both the samples had about similar characteristics. They had their mean ages at 23-24 years, their mean years of education at 5 years, their proportions of rural people at 50-51 percent, and their proportions of every day television watchers at 30-31 percent. They varied only in their proportions having a under-1 child, being at 25 percent for those in the case sample and 38 percent in the case sample. This variation was due to the women with under-1 child being included as eligible respondents in the non-case sample in one round.

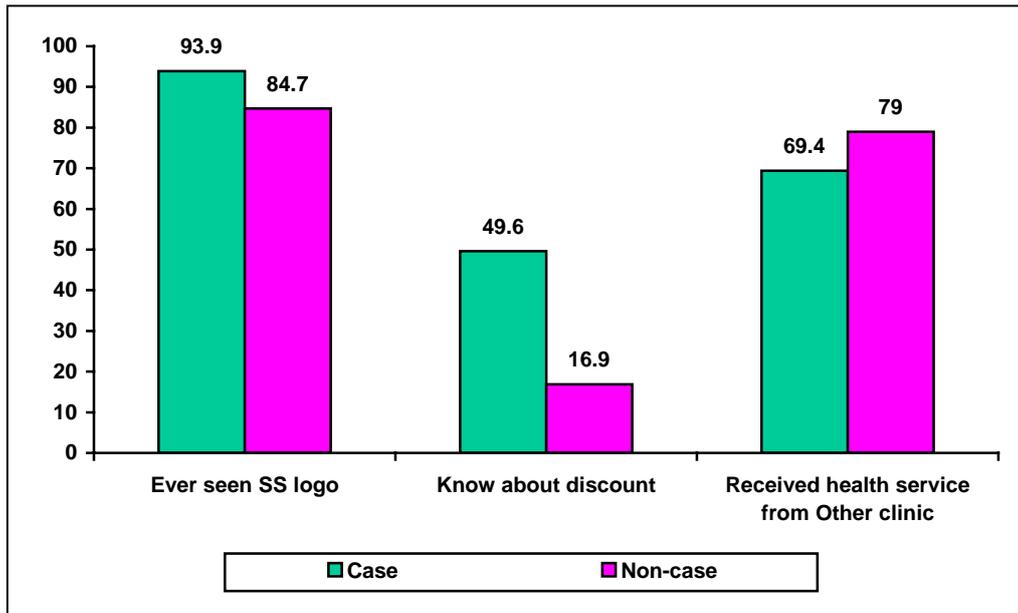
Figure 5.1: Characteristics of the case and non-case sample of female respondents



5.1.2 Comparisons of awareness about smiling sun clinics

Figure 5.2 displays a comparison of awareness of smiling sun clinics between the case and non-case samples. Respondents in the case sample were more likely to be aware about smiling sun clinics. The proportion aware of smiling sun logo was almost universal at 94 percent among respondents in the case sample, while it was a lower 85 percent for those in the non-case sample. Respondents in the case sample were also found to be much more likely to be aware of offering of services at discounts/ free of costs than were those in the non-case sample—50 percent versus only 17 percent.

Figure 5.2: Knowledge about SS clinic among female respondents



5.1.3 Variations in exposure to the campaign and other communication sources

Variations in exposure to the campaign are presented in **Figure 5.3**. Respondents in the case sample were more likely to have exposure to the campaign than those in the non-case sample. The proportion having seen BCC materials in the community was higher 63 percent among respondents in the case sample than 48 percent among those in the case sample. Similar variations were evident in the proportion for exposure to ESH, 53 percent versus 42 percent.

Respondents in the case sample were also found to have more exposure to the other communication sources about smiling sun clinics. Among respondents in the case sample, about 80 percent reported having seen messages about smiling sun clinics on television, compared to only 67 percent among those in the case sample (**Figure 5.4**). Likewise, the proportion of respondents who said they had seen billboard related to smiling sun clinics was higher 28 percent in the case sample than 18 percent in the non-case sample (**Figure 5.5**).

Figure 5.3: Percentage of Females who have seen any BCC activities about SS clinic at community and watched ESH

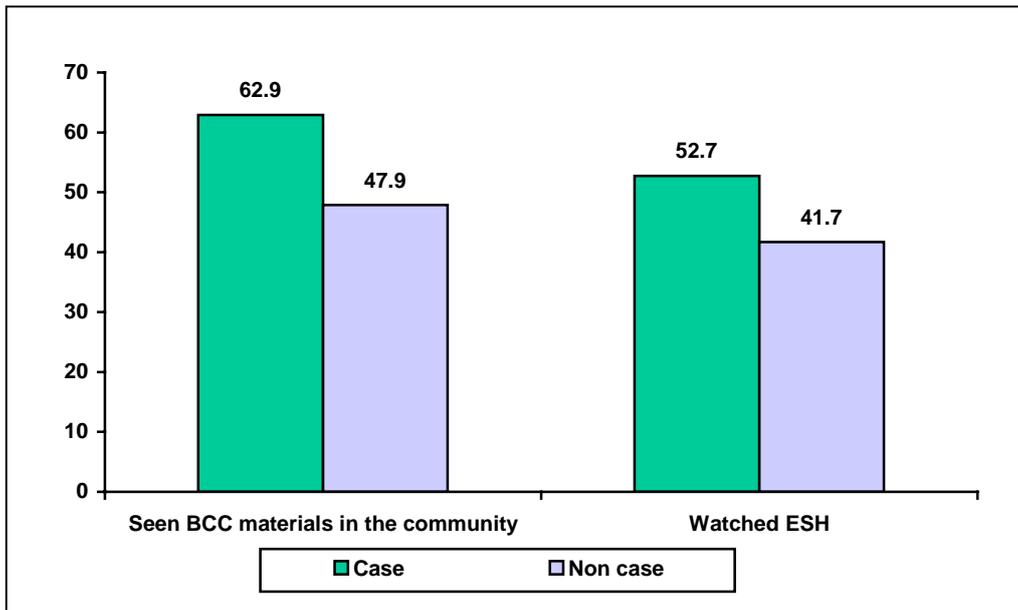


Figure 5.4: Percentage of Females who have seen about SS clinic on TV

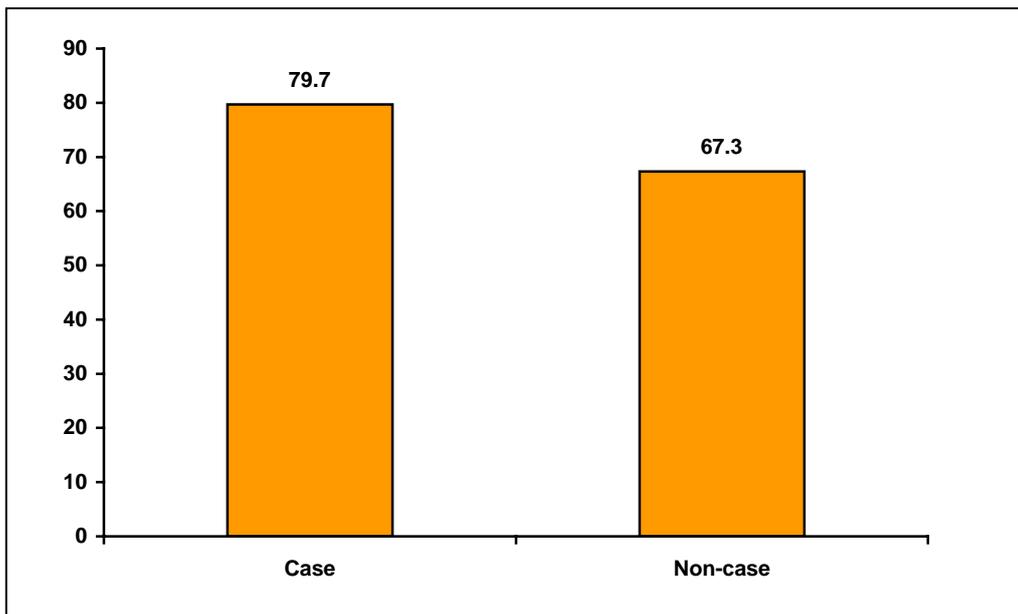
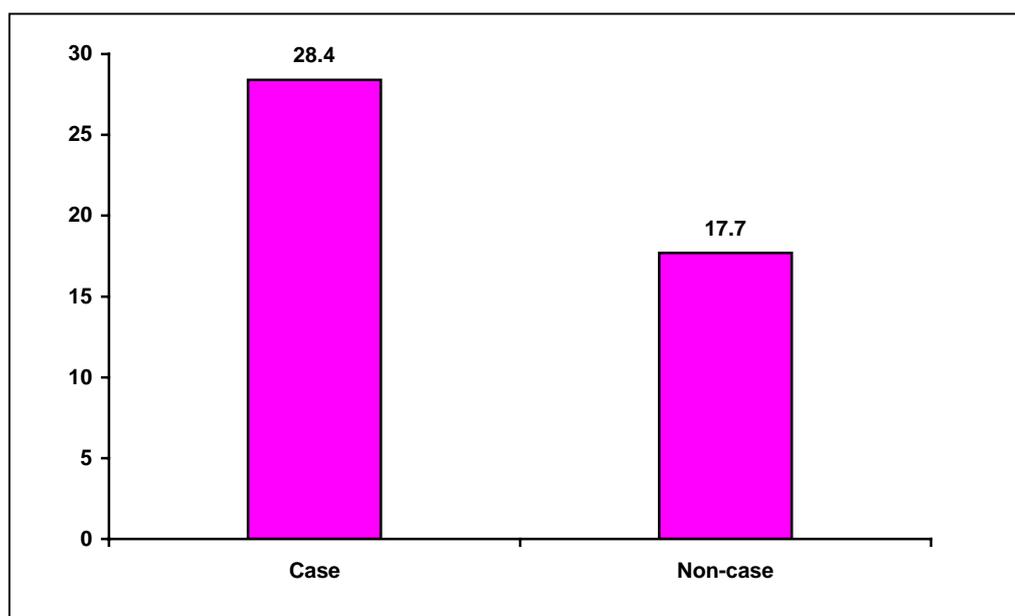


Figure 5.5: Percentage of Females Seen Billboard related to SS clinic



5.1.4 Odds ratios between cases and non-cases

Table 5.1 contains the odds ratios derived from logistic regressions, showing the relative likelihood of respondents in the case sample being different from those in the non-case sample in terms of their exposure to the campaign and the characteristics found to be associated with the exposure.

It was hypothesized that, if the respondents in the case and non-case sample had similar characteristics and if the campaign had any impact on clinic visits, respondents in the case sample would have greater likelihood of having exposure to the campaign than those in the non-case sample. Respondents in the case sample were significantly more likely to have watched ESH, seen BCC materials in the community and seen billboard related to smiling sun clinics, compared to those in the non-case sample. These variations were independent of the other factors influencing visits to smiling sun clinics. It thus became evident that the campaign had a significant impact upon people who visited smiling sun clinics in the three months before the survey.

Table 5.1: Odds ratio of visit to SS clinic

Explanatory variables	Odds ratio
Residence (rc: Urban)	NS
Age of Child (rc: no child)	
0-11 months	0.56**
12-23 months	1.42*
24+	1.06
Exposure to BCC at Community	1.48**
Exposure to ESH	1.20*
Discount service	4.75**
Exposure to Bill board	1.19*
Age (rc: <20)	NS
Education (rc: no education)	
Primary	0.78*
Secondary	0.79*
H.S.C and above	1.30
Asset Quintile (rc: Q1)	1.32*(Q3)

rc: reference category, ** p<0.001, * p<0.05

5.2 Project sample versus non-project sample.

Respondents in the non-project sample had similar background characteristics as those in the project sample (data not shown), establishing their comparability in terms of both their exposure to the campaign and their visits to smiling sun clinics.

Figure 5.6 displays a comparison of exposure to ESH between the project and non-project samples. Respondents in the non-project sample were less likely to have watched ESH, compared to those in the project sample. This was more so for female than male respondents were. Local level BCC activities were conducted only in project areas. It is therefore obvious that respondents in the project sample had little opportunity to see BCC materials (**Figure 5.7**).

There were marked variations in clinic visits between the project and non-project areas. The likelihood of visiting a clinic in the last one month was lower among respondents in the non-project areas than among those in the project areas—20 versus 25 percent for female respondents and 10 versus 13 percent for male respondents (Figure 5.8).

Figures 5.9 and 5.10 contains the odd ratios showing the relative likelihood of respondents visiting a clinic when they had exposure to the campaign, compared to when they did not have the exposure. Like those in project areas, respondents in the non-project areas were significantly more likely to visit a clinic when they had exposure to ESH/BCC activities. However, the impact was less marked in non-project areas than in project areas.

Figure 5.6: Percent ever watched ESH

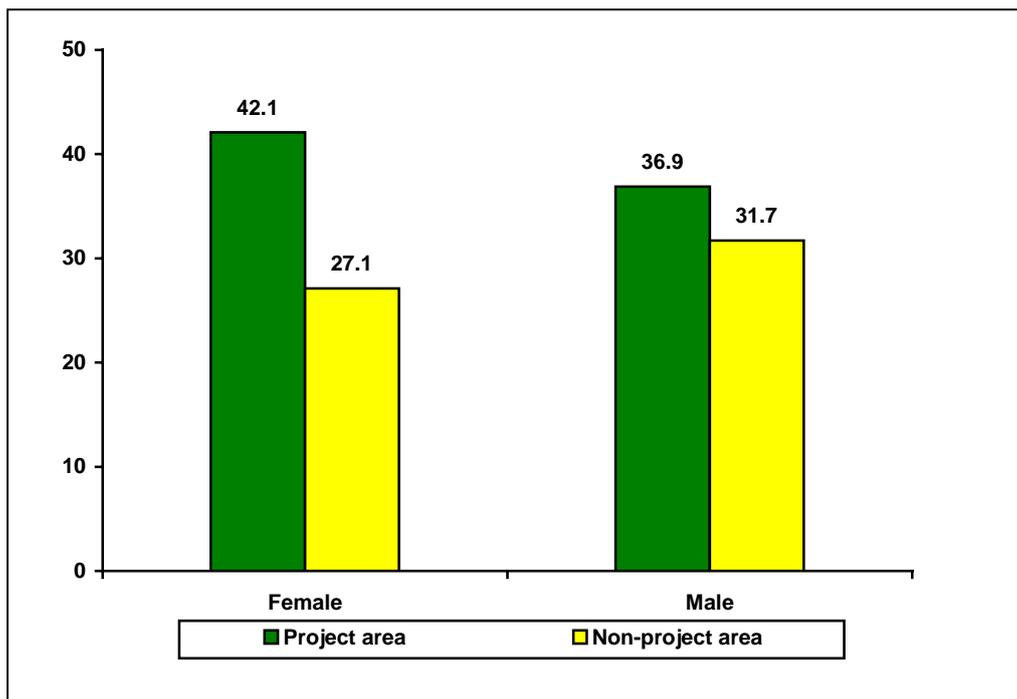


Figure 5.7: Percent seen BCC materials at community

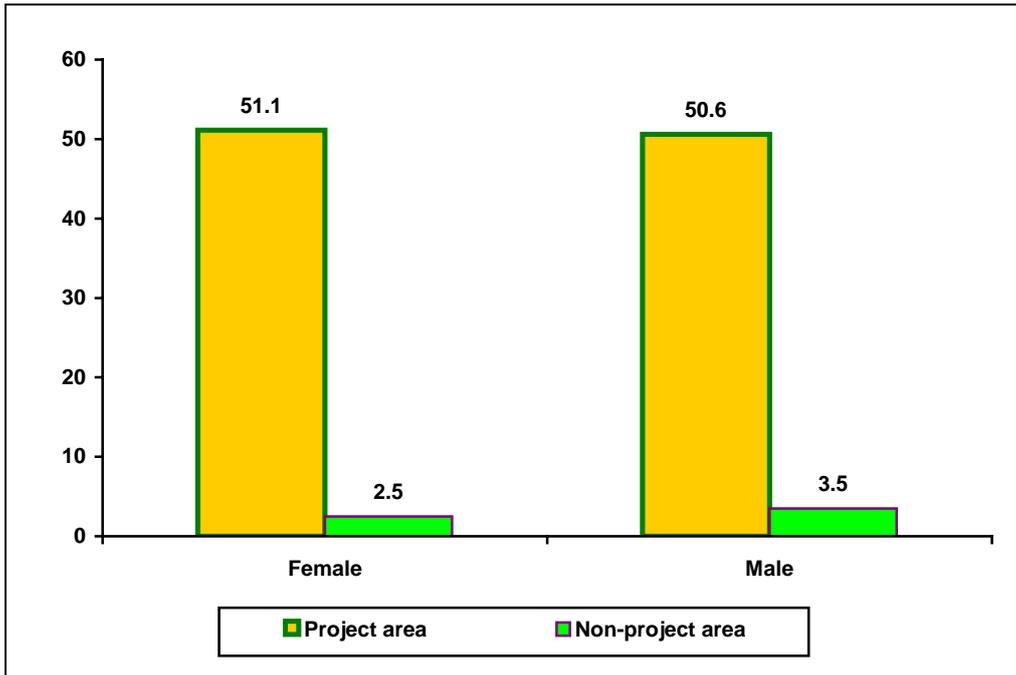


Figure 5.8: Last visit to a clinic within last one month

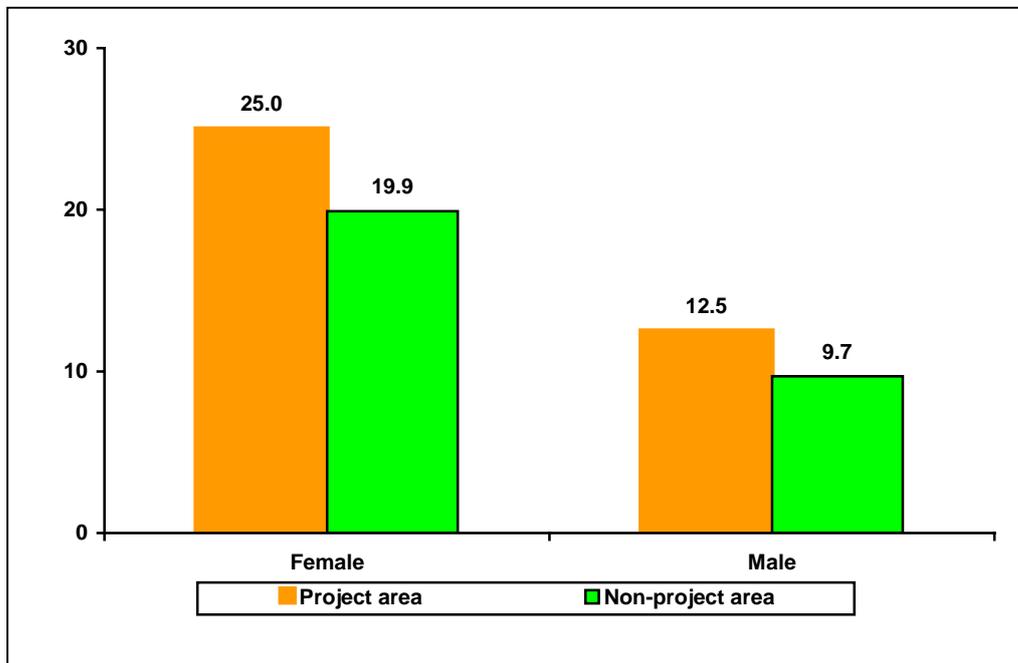


Figure 5.9: Odd ratios of visiting a clinic in the last one month for exposure to ESH and BCC

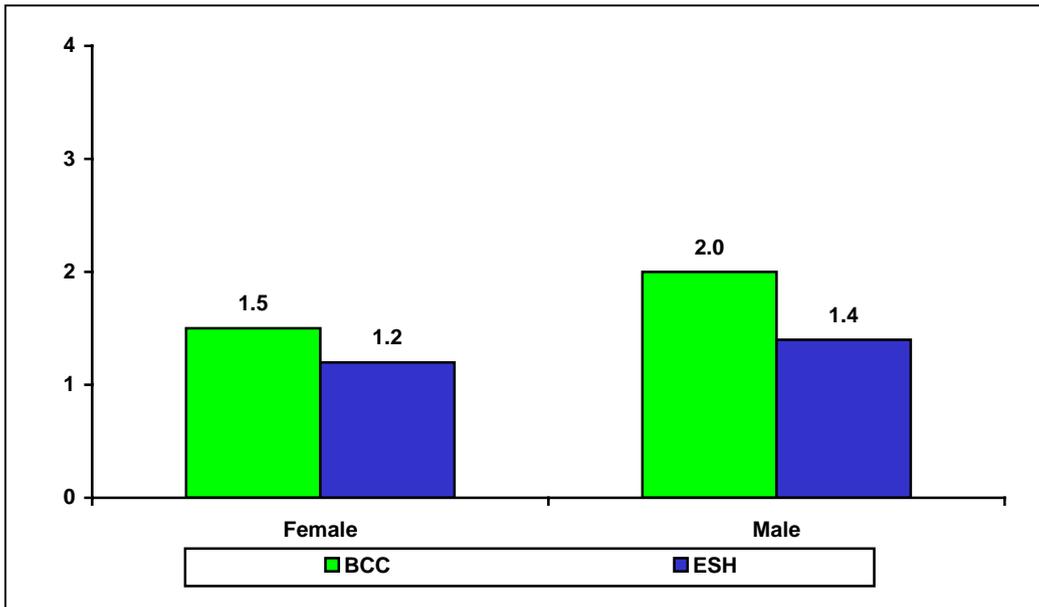


Figure 5.10: Odd ratios of visiting a clinic in the last one month for exposure to ESH and BCC

