BRAC James P. Grant School of Public Health
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Dhaka, Bangladesh

"Entrepreneurs As Health-Promoting Agents: Community Engagement For Sustaining Maternal And Child Nutrition Practices Within The Healthy Village In Urban Programme"

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A thesis submitted to the BRAC James P Grant School of Public Health in partial fulfilment of the requirements for the degree of
Master of Public Health

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Declaration

I, Rohan Gurung, hereby declare that this thesis entitled "Entrepreneurs as Health-Promoting Agents: Community Engagement for Sustaining Maternal and Child Nutrition Practices Within the Healthy Village in Urban Programme " is an original work submitted in partial fulfilment of the requirements for the degree of Master of Public Health (MPH) at the James P. Grant School of Public Health (JPGSPH), BRAC University, Dhaka, Bangladesh.

I further declare that this work has not been submitted previously, in whole or in part, for any other degree or examination at this or any other university or institution.

All sources used in this thesis have been duly acknowledged and cited. Any assistance received has been mentioned in the acknowledgements section.

I have also added a separate declaration on GenAI use at the end of this work.

Rohan Gurung

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Date: 02-06-2026

Approval

The thesis/project titled “Entrepreneurs as Health-Promoting Agents: Community Engagement for Sustaining Maternal and Child Nutrition Practices Within the Healthy Village in Urban Programme” submitted by

1. Rohan Gurung (25167017)

Of 2026 has been accepted as satisfactory in partial fulfilment of the requirements for the degree of Master of Public Health.

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Ethics Statement

The Institutional Review Board (IRB) of the BRAC James P. Grant School of Public Health (BRAC JPG), BRAC University provided ethical approval for this study. All procedures relating to recruitment, consent, data collection, data security, and dissemination were specified by the approved protocol.

Non-identifiable codes were used in transcripts and reports, consent forms were securely stored and linking files were kept separately and access to data was restricted to authorized study staff only. This helped to maintain the confidentiality process. Identifying details (names, exact locations) was removed from quotations used in publications and presentations. Potential risks are minimal, primarily related to discomfort when discussing sensitive experiences (e.g., financial hardship, intra-household conflict); interviewers were trained to respond sensitively, remind participants they may skip any question, and pause or terminate the interview upon request.

Abstract

Background: Amongst the urban poor population in Bangladesh undernutrition of children and mothers remains an important public health concern where progression of care is restricted by high mobility, fragmented health services and socioeconomic constraints. Sustaining behaviour changes in these contexts relies not just on spreading of information but also on effective community-based strategies which facilitate change in the localities.

Objectives: This study aimed to understand how entrepreneurial Health-Promoting Agents engage with communities to support and sustain maternal and child nutrition practices within HVUP intervention areas. Specifically, it explored how Health Promoting Agents (HPAs) build and maintain relationships with community members and identified social, economic, and contextual factors influencing sustained engagement.

Methods: An exploratory qualitative study was conducted in selected urban and peri-urban areas of Lalmonirhat district under Max Foundation's Healthy Village in Urban Programme (HVUP). The study population included HPAs, mothers/caregivers of children under five, and ESDO program staff who are implementing the project in field. A total of 24 participants were selected using purposive sampling. In-depth interviews (IDIs) with HPAs and mothers, and key informant interviews (KIIs) were conducted with program personnel. Data were collected through semi-structured interviews, audio-recorded with consent, and complemented by a desk review of program documents. Transcripts were analysed using reflexive thematic analysis with an inductive-deductive coding approach to identify key themes related to community engagement, trust-building, and sustainability.

Results: Successful HPA involvement in the community was decided by the relationship with the community was developed slowly by establishing a sense of trust with the mothers. Regular communication, positive experience and perceived good guidance from HPA was key in development of trust. Moreover, HPAs' confidence and efficacy in community interactions were improved through training, applying knowledge and skills from prior experience, and continuous supervision by programme staff. By combining localized health education, improved service delivery through system linkage, and training for entrepreneurship, HPAs played a variety of roles that enhanced their relevance and long-term involvement. Program sustainability and motivation were particularly substantiated through the incorporation of entrepreneurship. Mothers reported

noticeable behavioural improvements that progressively emerged through trust and reinforcement, especially in hygiene and childcare routines.

Conclusions: From this study, we can see that consistent presence, self-sustaining mechanisms, trust-building, and supporting program frameworks are key components of entrepreneurial HPAs' long-term community engagement. Their strong presence promotes behaviour change within the community, while providing better access to services. These results emphasize the benefits of establishing entrepreneurial community-based models to enhance long-term maternal and child nutrition outcomes and strengthen urban primary health care methods.

Keywords: Health-Promoting Agents, Maternal and Child Nutrition, Community Engagement, Entrepreneurship, Behaviour Change

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Contents

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List of Acronyms

Acronyms	Full Form
BDO	Business Development Officer
CBP	Community Business Promoter
CHW	Community Health Worker
HPA	Health Promoting Agent
HVUP	Healthy Village in Urban Programme

Chapter 1: Introduction

1.1 Background and Rationale

Background:

Despite improvements in child survival, maternal and child undernutrition is still a major public health concern in Bangladesh. Food insecurity, informal employment, crowded living conditions, fragmented primary health care delivery, and high population mobility all contribute to urban poor populations' disproportionate nutritional vulnerability and interfere with the continuity of counseling and preventive services (Hasan et al., 2023; NIPORT & ICF, 2023). Research consistently demonstrates that improving maternal and child nutrition requires more than just information transfer. Sustained behavior change depends on social norms, trust, repeated interpersonal engagement, household decision-making power, and the messenger's perceived credibility (Glenton et al., 2013). In low- and middle-income countries (LMICs), community-based workers are therefore frequently employed to close gaps between homes and health systems, especially for nutrition counseling, cleanliness habits, and early care-seeking (Perry et al., 2014).

Many public health projects are depending more and more on frontline community-based health workers as dependable middlemen who increase the reach of the health system into homes and encourage long-term behavior change in vulnerable groups in order to solve these ongoing service delivery gaps. However, programmatic and contextual elements play a major role in the longevity and effectiveness of community health worker (CHW) platforms. Qualitative analysis also shows that uptake of maternal and child health practices is facilitated by trust, social proximity, cultural acceptability, and perceived legitimacy of frontline workers who directly engage with the community. However, the engagement can be undermined by role uncertainty, poor accountability, and concerns about confidentiality, particularly in densely populated urban areas (Glenton et al., 2013). Research on BRAC-supported volunteer and semi-incentivized CHWs in Bangladesh demonstrates that financial incentives for community health workers can lead to better performance as measured by improved community messaging uptake (Reichenbach & Shimul, 2011; Sarma et al., 2020).

The Healthy Village Urban Programme (HVUP) is implemented in Lalmonirhat district of Northern Bangladesh focusing on vulnerable urban and peri-urban population. Targeting children under five (including children with disabilities), pregnant and nursing women, and the general population, HVUP is a four-year initiative that runs from July 2022 to June 2026 and covers one municipality and six unions. HVUP is unique in that it places a strong focus on system strengthening and entrepreneurship. Local governments and healthcare facilities are assisted in incorporating healthy practices into regular services, and local business owners are trained to provide reasonably priced health, hygiene, and nutrition items, establishing a sustainable market-based supply chain. In addition, the program supports women's empowerment, disaster resilience (floods, COVID-19), and inclusive access for individuals with disabilities, guaranteeing that the most vulnerable groups are not left behind and that improvements in child development, nutrition, and health are long-lasting and scalable. The HVUP follows a Healthy Village Pathway. It focuses on behavior modification combined with supporting goods and services like handwashing stations and equipment for example. Also, communities are expected to maintain key indicators such as handwashing at critical times and villages are formally recognized as “healthy” once at least 90% of households meet agreed indicators.

The HVUP in urban Bangladesh uses entrepreneurial Health-Promoting Agents (HPAs) as their frontline workers to engage communities through social network facilitation, product linkage,

counseling, and demonstrations. Better child health by lowering undernutrition and stunting is the main goal of the HVUP strategy, which integrates WASH, nutrition and maternal and childcare practices. The change is then made sustainable through community ownership and local government adoption. Although implementation experience points to the possibility of long-term engagement, there is still a scarcity of empirical data clarifying how entrepreneurial HPAs establish and preserve relationships based on trust with community members and which social, economic, and contextual factors facilitate or stop long-term engagement in complex urban environments.

The presence of well-supported frontline community workers becomes particularly important for maintaining continuity of care, reinforcing consistent health messaging, building household trust, and sustaining behavior change in fragmented and resource-constrained urban settings—characterized by weak governance coordination, variable service quality, safety and access barriers, and high residential mobility—where formal health systems alone struggle to maintain regular engagement, according to current research on urban health systems (Hasan et al., 2023).

Rationale:

This study is significant because, even in situations where short-term gains are made through externally funded interventions, maintaining maternal and child nutrition practices in rapidly urbanizing low- and middle-income settings continues to be a persistent challenge. Understanding how entrepreneurial community engagement models can sustain behavior change once external funding and direct supervision decline is important given Bangladesh's ongoing rapid urban expansion and development partners' growing focus on sustainability and local ownership of interventions. Preventive counseling and long-term behavior change are weakened in Bangladeshi urban populations due to fragmented primary health care delivery, substantial population mobility and limited household resources. As evidenced from studies HPAs performance and sustainability has a direct link with the organizational support, incentive structures, relational trust and local social dynamics than simply only on training (Kok et al., 2015; Glenton et al., 2013). Studies also shows that when these community entrepreneurs add health promotion with small-scale income there is a chance for improving motivation among community entrepreneurs (Bjorkman Nyqvist et al., 2017; Wagner et al., 2020; Wagner et al., 2021).Although BRAC and related initiatives have shown that incentive-based community delivery platforms are feasible in Bangladesh, little is known clearly about how entrepreneurial models such as the Health-Promoting Agents in the HVUP actually establish and maintain relationships with urban communities and how social, economic, and contextual factors influence long-term engagement (Reichenbach & Shimul, 2011; Sarma et al., 2020; Hasan et al., 2023).

The study contributes to a significant evidence gap on understanding how entrepreneurial community agents maintain maternal and child nutrition practices after the intensive intervention phase. Peer-reviewed urban health and nutrition literature has not sufficiently examined the sustainability of their operations. The study will provide practical insights for program designers, legislators, and implementing organizations looking for scalable and financially sustainable community-based mechanisms for behavioral change. The investigation will focus on how Health-Promoting Agents foster trust, negotiate household decision-making, and sustain engagement under limited resources. Beneficiaries include public health planners who need evidence to maximize urban primary health-care strategies in the context of donor transition and resource constraints; urban mothers and children who depend on regular counseling and supportive environments for optimal nutrition; and community agents whose roles, incentives, and support systems can be better aligned for long-term effectiveness.

1.2 Problem Statement

In the last 30 years Bangladesh has made a serious improvement in reducing child stunting and maternal mortality. Despite this almost a quarter of under-five Bangladeshi children are affected by malnutrition (Tanvir et al., 2023; Bangladesh Bureau of Statistics [BBS], 2025). Also, there is a large implementation gap between the national nutrition policy and community-level practice (Hossain et al., 2025). Furthermore, coverage, uniformity, and quality of nutrition counseling for mothers, infants, and young children are still insufficient throughout Bangladesh's health care delivery systems, and chronic malnutrition in urban regions is falling more slowly than in rural areas (Tanvir et al., 2023). These numbers are a result of slum populations' shifting residential patterns, the structural complexity of urban primary health care governance, and various livelihood pressures that interfere with the continuity of care for the most vulnerable households (Arif et al., 2023).

Health-Promoting Agents (HPAs) and other community-based frontline workers have been positioned as essential demand-creation actors for maternal and child nutrition in urban Bangladesh. According to Perry and Zulliger (2016), Bangladesh's notable health improvements have been largely attributed to long-term experimentation with large-scale community-based approaches involving a doorstep delivery model and to contractual partnership arrangements with NGOs that build community trust and fill service gaps. Therefore, exclusive breastfeeding, complementary feeding practices, and child anthropometric outcomes have all been shown to be improved by community health worker (CHW)-mediated models; this is especially true when interpersonal counseling is combined with community mobilization during the first 1,000 days of life (Mahumud et al., 2022). However, various kinds of poorly understood interpersonal, structural, and environmental elements still influence the long-term application of these evidence-based practices, particularly for HPAs utilizing mixed entrepreneurial-promotional models in urban settings. Scaling up and sustaining CHW programs in LMICs requires effective program design, community acceptability, adequate finance and motivation, and integration with the broader health system context. In crowded, mobile urban societies, these demands are especially difficult to fulfill effectively (Pallas et al., 2013).

The Healthy Village in Urban Programme (HVUP), which employs HPAs tasked with maintaining their community engagement through entrepreneurial income generation from health commodity sales and fee-based services in addition to promoting maternal and child nutrition practices, is a recent and contextually specific solution to this implementation gap. The generous, relational concept that promotes community trust and the acceptance of health promotion messages can conflict with the commercial orientation necessary for financial self-sufficiency, creating structural conflicts that traditional CHW models have not had to deal with (Ameso, 2025). Performance-based and commodity-linked income structures can lead to poor retention, inconsistent service quality, and concerns among health system actors regarding the shifting focus of community health work away from its social mission, according to evidence from similar entrepreneurial CHW models around the world (Afsana et al., 2015; Ameso, 2025). Financial incentives based on opportunity cost and qualifications are required to maintain a high-performing urban health workforce in Bangladesh, where unpredictable, performance-based income has been found to be the main cause of CHW dropout among similar employees (Afsana et al., 2015; Alam & Oliveras, 2012).

The mechanisms by which entrepreneurial HPAs within the HVUP establish and sustain relationships with communities to promote maternal and child nutrition practices—as well as the

social, economic, and contextual factors that enable or constrain the sustainability of those relationships over time—have not been examined in any peer-reviewed study, despite the substantial body of evidence on CHW effectiveness, retention, and community engagement in LMICs, and in Bangladesh specifically. Despite occupying a unique position at the relationship of urban nutrition programming, social business, and community health promotion, the HVUP's HPA model is largely invisible in the published literature. Program designers and policymakers lack the evidence base required to improve or scale this model without a thorough understanding of how HPAs manage the relational demands of community engagement alongside entrepreneurial pressures, as well as how sociostructural factors like gender norms, household decision-making dynamics, and urban livelihood constraints shape their sustained engagement.

With impacts for the larger design of sustainable, community-based maternal and child nutrition programs in urban Bangladesh, the current qualitative study is well-positioned to directly address this gap by producing original evidence on the community engagement strategies and sustainability factors of entrepreneurial HPAs within the HVUP.

1.3 Study Objectives

1.3.1 Overall Objective

To understand how entrepreneurial health-promoting agents engage with communities to support and sustain maternal and child nutrition practices within HVUP intervention areas.

1.3.2 Specific Objectives

1. To explore how health-promoting agents build and maintain relationships with community members to promote maternal and child nutrition practices.
2. To identify social, economic, and contextual factors that enable entrepreneurial health-promoting agents to sustain community engagement.

1.4 Structure of the Thesis

This thesis is organized into six chapters. Chapter 1 provides the introduction, background, and study objectives. Chapter 2 presents a comprehensive review of existing literature. Chapter 3 outlines the methodology used in this study. Chapter 4 presents the findings. Chapter 5 provides a discussion and interpretation of the results in light of existing evidence and limitations. Chapter 6 concludes the thesis with key conclusions and recommendations.

Chapter 2: Literature Review

Global Perspective

Geographical and cultural proximity to communities serves as a basic and important bridge between formal health systems and underserved populations, according to the basic principle of community health worker (CHW)-mediated health promotion (Scott et al., 2018). This idea has a broad analytical framework provided by social capital theory: Based on a systematic analysis of prospective multilevel research, Murayama et al. (2012) claim that networks, norms, and trust enable

coordinated social action, supporting the success rate of community-based health promotion. Based on this, Scott et al. (2018) analysed 83 previous CHW program reviews and found that, along with supportive supervision, ongoing education, and sufficient logistical support, community involvement—in which community members feel ownership of the program and maintain positive relationships with the CHW—is the most consistently enabling feature of successful programs.

Wouters et al. (2017) clarified the mechanisms through which trust is built and maintained. They discovered that CHW trustworthiness is mediated by sociostructural factors such as gender, age, and social status and can be significantly weakened when institutional staff undermine the CHW's competency in the eyes of community members. Through critical evaluation, Vanden Bossche et al. (2022) strengthen this concept by showing that client-centred attitudes and coordination with primary care systems activate mental models of recognition, equality, and mutual respect, which are the foundation of trustworthy CHW-client interactions. Through their "partners in health" concept, Spencer et al. (2015) apply these relational dynamics, claiming that CHWs use social support, interpersonal communication, and cultural compatibility to reduce provider-patient social distance and facilitate long-term behaviour change.

South Asian Perspective

In South Asia, studies on CHW show how these global trends operate within the specific constraints of hierarchical household structures, crowded urban environments, and controversial gender norms. Rafique et al. (2025) came up with a social network lens that puts CHWs as providers of collective action rather than just message carriers. Kim et al. (2019) provides empirical support for this framing. Their cluster-randomized evaluation across South and Southeast Asia revealed that NSBCC interventions produced significant knowledge transfer, with 35% of non-participant mothers reporting receiving nutrition information from participating neighbours, leading to a 0.17 standard deviation increase in infant and young child feeding knowledge among non-beneficiaries.

These transmission effects highlight how HPA community engagement is strengthened through social networks, expanding the program's influence beyond direct participants. Sinha et al. (2024), whose synthesis across Bangladesh, India, and Vietnam, found that community-based support group members demonstrated improved breastfeeding and complementary feeding knowledge through peer-to-peer learning, home visits, and community meetings; consistent engagement of fathers and mothers-in-law was identified as crucial to translating knowledge into sustained practice. Intra-

household gatekeepers, especially mothers-in-law, have decisive authority over pregnancy and delivery decisions, which further complicates the CHW's engagement strategy and requires relational investment well beyond the primary beneficiary, according to qualitative data from rural South Asia provided by Akter et al. (2018). Tanvir et al. (2023) confirm that institutional incorporation of community engagement enhances individual-level HPA-client interactions by demonstrating that integrating nutrition interpersonal counselling within structured antenatal care platforms—combining provider capacity-building with community mobilization—produced measurable improvements in maternal dietary diversity and complementary feeding practices.

Evidence from Bangladesh

The most closely comparable evidence foundation for understanding the HPA model of the HVUP in Bangladesh is the BRAC Manoshi project. According to Perry and Zulliger (2016), BRAC's urban MCH engagement strategy was carefully started through community mapping, local leader engagement, MCH committee formation, and responsiveness to community feedback, with a single frontline worker in charge of about 200 households. This shows that relational infrastructure must come before, not just after, service delivery. In urban areas persistent problems like low exclusive breastfeeding rates, high home delivery proportions, and a 23%prevalence of low birth weight emphasize the need of community-based frontline workers (Hossain et al., 2025).

Even in urban primary health facilities, structural constraints like waiting times, poor facility conditions, and distance puts limits on maternal and child nutrition services (Arif et al., 2023). Also, retention of CHW was primarily driven by financial incentives (Alam et al., 2012).

Conceptual Framework

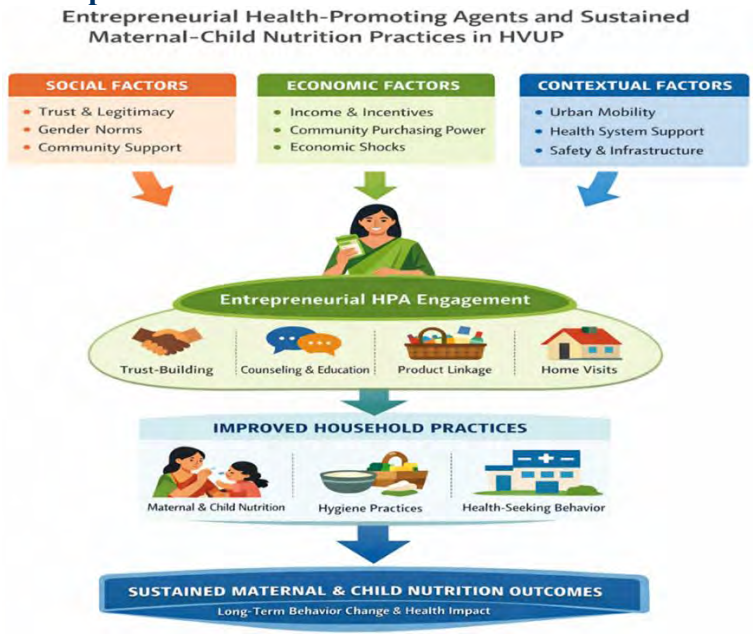

Figure 1: Conceptual Framework *Source: Generated with ChatGPT*

The framework identifies the different factors which influence HPA messaging uptake and influence health and nutrition of mothers and children. Factors like community trust, cultural norms, family support, income, financial stability, and access to healthcare or safe surroundings play a vital role in deciding how communities interact with HPAs and how easily they listen and follow health advice. Through engagement with HPAs, Mothers get improved knowledge about health and nutrition, better access to useful products and home visits for counselling and GMP. This helps them develop a better habit and with time the positive habits lead to long lasting improvements in health for both mothers and children.

Chapter 3: Methods

3.1 Study Design

This study was designed as an exploratory qualitative design to examine how HPAs engage urban communities to sustain maternal and child nutrition practice within the Healthy Village in Urban Programme (HVUP) in Lalmonirhat, Bangladesh. This approach is useful to study the mechanisms, motivations, and contextual dynamics of entrepreneurial HPAs in urban settings, which remains

largely un-explored in the existing literature. Similar study designs have been used in Bangladesh and other LMICs to examine how community-based actors build relationships.

3.2 Study Area and Setting

The study was done in purposively selected urban and peri-urban areas of Lalmonirhat district in northern Bangladesh where the HVUP program is ongoing. This district contains one municipality and six unions and has a dense population, informal settlements and minimum access to primary health care and nutrition. The HVUP program aims to provide services to at least 90% households within the area with WASH and nutrition counselling. Within a defined area HPAs acts as a local entrepreneur who provides counselling, advocates positive behaviour change and provides health, hygiene and nutrition products to households at an affordable rate. Thus, this setting provides us with good context for studying how HPAs build trust and go through social and economic constraints in urban settings. The data was collected for this study between February 28 2026 to March 8 2026.

3.3 Study Population

3.4.1 Study Population

The target population comprised of key actors directly involved in or influenced by HVUP's entrepreneurial community engagement model for maternal and child nutrition messaging. These include:

- Health-Promoting Agents (HPAs) operating within the HVUP catchment areas.
- Mothers or primary caregivers of children under five years of age (including children with disabilities) residing in HVUP intervention areas.
- Program staff responsible for HVUP design, supervision, and implementation, such as Business Development Officers (BDOs), Community Business Promoters (CBPs), and the Chairman of the HPA Association.

3.4.2 Inclusion and Exclusion Criteria

Inclusion criteria for HPAs:

- Currently working as an HPA within the HVUP program area.
- At least six months of continuous engagement in HPA activities (counseling, product distribution, and community mobilization).
- Willing and able to provide informed consent and participate in an interview.

Inclusion criteria for mothers/caregivers:

- Mother or primary caregiver of at least one child under five years of age living in an HVUP intervention community.
- Has had at least two interactions (home visits, group sessions, or product purchase encounters) with an HPA in the last 12 months.
- Resident in the area for at least six months and able to provide informed consent.

Inclusion criteria for program staff and key informants:

- Direct involvement in HVUP design, coordination, supervision, or support of HPAs (e.g., BDOs, CBPs, HPA Association leadership).
- At least one year of experience with the program or in a similar role.

Exclusion criteria (all groups):

- Individuals unable to participate due to severe illness, cognitive impairment, or communication difficulties that rule out meaningful interview participation.
- Individuals who decline or withdraw informed consent at any stage.

3.5 Sample Size

Given the exploratory qualitative design, sample size was guided by the concept of information power and data saturation. The planned sample includes approximately 24 participants.

- 6 IDIs with HPAs.
- 12 IDIs with mothers/caregivers.
- 6 KIIs with program staff and key informants (e.g., BDOs, CBPs and the HPA Association Chairman).

3.6 Sampling Technique

For the purpose of this study, we employed to ensure variation in HPAs through geography (diverse working areas), duration of involvement and performance levels where available (e.g., sales or coverage indicators). Difference in socio-economic status and level of engagement with HPAs was considered for selecting mothers/caregivers.

3.7 Data Collection

3.8.1 Data Collection Tools

In English semi-structured guides for IDIs and KIIs were developed. Then Bangla translation was done by bilingual researchers who are familiar with qualitative methods and public health terminology. Open-ended questions and suggested probes will be used to allow flexibility to explore unanticipated but relevant topics.

In-Depth Interviews (IDIs)

Semi-structured IDIs were conducted with HPAs and mothers/caregivers to explore experiences, perceptions, and relational dynamics in depth. Separate interview guides were developed for HPAs and mothers, organized around domains such as nature of HPA–household interactions, trust-building processes, perceived credibility, social and economic incentives, barriers and facilitators to sustained engagement, and perceived impact on maternal and child nutrition practices. Guides were informed by existing literature on CHWs, entrepreneurial models, and maternal nutrition behavior change, and by preliminary insights from the desk review.

Interviews were conducted in Bangla by trained qualitative researchers. Each interview was expected to last 10–15 minutes and was conducted in a private and convenient location chosen by the participant (e.g., home, community space, HPA office) to support comfort and confidentiality. With the consent from participants interviews were audio recorded and field notes were taken to capture nonverbal cues and context.

Key Informant Interviews (KIIs)

For program implementers and stakeholders which included BDOs, CBPs and HPA Association Chairman KIIs were conducted. The guides focused on program design, supervision structures,

sustainability and contextual factors that influenced HPA operations. The KII was taken for approximately 30 minutes in a quiet setting.

3.8.2 Pretesting

The research team pretested the study tools internally before implementation. The research team examined and improved the tools before it was used in data collection to make sure they were clear, appropriate, and consistent. Therefore, no field-based pretesting was done.

3.8.3 Data Collection Procedure

The participants were placed in a quiet and comfortable space for the interview. Then a consent form was given and explained to them. After this a written consent was taken from the participants. With the consent of participants audio was recorded using a recorder and to maintain the quality of the audio being recorded the interview was taken in a quiet space.

3.9 Data Management and Quality Assurance

Every day the audio recordings were transferred from digital recorders to password-protected project computers and backed up on encrypted external drives which are only accessible to authorized team members. By trained transcribers, recordings were transcribed verbatim in Bangla. The transcripts included notations for pauses, emotional emphasis, and key contextual elements where relevant. With the help of experienced bilingual staff Bangla transcripts were translated into English for analysis. For this back-translation approach was used for a subset of transcripts: an independent translator translated the English version back into Bangla. To maintain the credibility of cross-language qualitative analysis this type of iterative translation and back-translation is recommended. To discuss emerging themes, refine probes, and adjust sampling if needed for saturation regular debriefing meetings was held during data collection. Unique codes were used for all identifiable personal information. Then a separate encrypted file linking codes to identities was stored securely and separately.

3.10 Data Analysis

The data was analyzed using reflexive thematic to identify participants' narratives regarding HPAs community engagement, trust, and sustainability mechanisms. The following steps were followed:

1. Familiarization: To become familiar with the data members of the team read and reread Bangla and/or English transcripts, field notes, and relevant program documents. Also, initial notes on repeated ideas and potential codes were taken.
2. Initial Coding: Using an inductive-deductive approach, Transcripts was coded line-by-line in google spreadsheet to capture segments related to the developed codes.
3. Developing and Reviewing Themes: Codes were clustered into potential themes and sub-themes through iterative team discussions. To have coherence, distinctness and adequate representation of participants' perspective themes was reviewed against coded extracts and entire datasets.
4. Defining and Naming Themes: Keeping attention to its scope each theme will be clearly defined. Then a concise, descriptive name was assigned that shows its analytic contribution.

With support from illustrative quotations from different participant types (HPAs, mother and program staff) detailed theme summaries were developed.

5. Interpretation and Integration: Using conceptual framework, existing literature on CHWs and entrepreneurial models and the broader health system and socio-economic context of Bangladesh thematic findings was interpreted. IDIs and KIIs were triangulated to reinforce emerging explanations (e.g., alignment or divergence between HPA self-reports and program documents).

At least two researchers independently coded transcripts and compared coding to discuss and resolve disparity. This helped to maintain analytical rigor. Also, this helped support reflexivity and depth of interpretation. An analytical memo was made to document the analytic process during field workdays, and supplement understanding of the collected data.

3.11 Ethical Considerations

The Institutional Review Board (IRB) of the BRAC James P. Grant School of Public Health (BRAC JPG), BRAC University provided ethical approval for this study. All procedures relating to recruitment, consent, data collection, data security, and dissemination were specified by the approved protocol.

Non-identifiable codes were used in transcripts and reports, consent forms were securely stored and linking files were kept separately and access to data was restricted to authorized study staff only. This helped to maintain the confidentiality process. Identifying details (names, exact locations) was removed from quotations used in publications and presentations. Potential risks are minimal, primarily related to discomfort when discussing sensitive experiences (e.g., financial hardship, intra-household conflict); interviewers were trained to respond sensitively, remind participants they may skip any question, and pause or terminate the interview upon request.

Chapter 4: Findings

Establishing Presence of HPA in Community

The findings show that Health Promotion Agents (HPAs) in the community established their presence through a gradual process which began with a formal introduction, which began establishing them as trusted members of the community. Initially, HPAs were unfamiliar, however with time members of the community started to recognize their value as social assets. In the beginning community members were unwilling or unclear about their participation in the early stages, however due to repeated visits by the program employees the community started to view the HPAs as a source of knowledge and support. HPAs regularly visit their houses, have conversations and help the community people with nutritional and WASH messaging and access. Even though the Community Business Promoters (CBPs) helped them in their first introduction to the community their sustained presence depended on their efforts like regular visits and interaction.

"Initially, the program coordinators introduced us. Then, we attended courtyard meetings with the CBP sisters to get introduced. Since this is my own ward, the people living around me are already known to me." IDI_7_HPA_1

Although the formal program introduction provided a starting point, acceptance was made easier by pre-existing social ties, especially in their own communities. The mothers/caregivers also explained that the home visits that the HPAs conducted was crucial for establishing presence of HPAs in the community. As mothers started to expect and accept these visits HPAs presence in the community was normalized and became a regular to their community.

"Yes, they (Max Foundation/HPAs) contacted me. That's where I first met them." IDI_2_Mother_1

"Initially, they didn't value my words much. But when the CBP sisters introduced me as their HPA and explained that I would be providing services even when they weren't around, the community started listening." IDI_7_HPA_1

Trust Building Mechanism for HPA

Trust between HPAs and community members was established through consistent presence, demonstrated reliability, and the visible outcomes of HPAs' guidance. During the interviews, the HPAs stressed that being friendly, kind, and trustworthy was important to their position, as many maintain a personal connection with people. They showcased that through regular house visits, listening to worries and providing assistance when required they were able to maintain trust and comfort.

Moreover, as the community people found good results from their advice the HPAs had more confidence in them. When mothers saw differences in their daily habits or health by following their advice the trust in HPAs grew.

As the relationship grew better mothers felt comfortable asking questions and expressing their problems. This was important to encourage open conversation which ultimately led to increased trust, and better health outcomes as they began making bigger changes in their day to day lives. If and when the mothers felt that they understood their problems they were more motivated to listen to the advice given to them by the HPAs.

"We follow all her words. Why wouldn't we? I see that it is benefiting us a lot. Following her advice makes things easier for us." IDI_15_Mother_2

HPA Accessibility

The results show that the efficiency of Health Promoting Agents (HPAs) interaction with the members of the community is greatly impacted by accessibility. Respondents described accessibility as the ability of community members to contact, interact with and take help from HPAs when required.

To make sure that they were regularly visible in the neighborhood they made constant household visits and face to face interactions. In addition to face-to-face visits, they made themselves accessible through mobile connection. By providing their phone numbers the HPAs made it possible to be accessible in yet another way.

"I am available 24/7, except when I'm sleeping." IDI_11_HPA_2

Since HPAs frequently visit the community members in their homes there is a reduction in need for mothers to travel or seek help in other places. This was significantly important when quick advice was needed, especially for everyday care products and child health.

"Those who can, contact her by phone, and many others just go to her house. Everyone has her phone number." IDI_10_Mother_3

Training and Previous Experience of HPAs

To function effectively both training and prior experience have a great impact on Health Promoting Agents (HPAs) capacity to work. These components had an influence on how confident, skilled and prepared they were when they had to interact with the community members.

The training included both theoretical and practical parts. During home visits, HPAs learned how to interact with mothers, communicate health-related information in plain language, and deal with different situations.

One HPA described the value of training in enhancing their abilities and self-assurance:

"*I've received a lot of training, including from RDRS. They taught us how to measure children's weight and height. We were trained on business management and how to behave politely with customers—emphasizing that good behavior is essential for a successful business." IDI_18_HPA_2*

Before enrolling in this program, several HPAs had worked in comparable positions, which made it easier to adjust to their new role. They already understood the difficulties of fieldwork, basic health principles, and community involvement, which allowed them to better support the community needs.

Even after their initial training, program staff continued to actively support HPAs through supervision and counseling. Due to this continuous help HPA were able to improve their abilities, get answers to questions and deal with problems more effectively.

One member of the program team explained how they assist HPAs:

"We have provided many training regarding the project—business development, market linkage, nutrition, WASH, and sanitation. They have received extensive training on all these topics. If there is something they don't know, they contact us, and we assist them immediately." KII_2_BDO

HPA Role and Responsibility

By combining small-scale business operations, health education and service delivery, the HPAs provided advice to mothers and also, they actively participated in a wide range of activities that had a direct influence on regular lives of the community members.

Their range of work included both livelihood-related and health-related tasks, such as they checked the health of mothers and children, made regular house calls, took active part in courtyard sessions and performed business-related duties including selling healthcare products. Due to this combination of roles, they were able to maintain regular contact with the members of the community and also maintain their financial stability.

They described their dual roles as service providers and educators, where they provided suggestions on common ailments, nutrition, hygiene and child health. Also, they listened to personal needs by providing guidance outside of scheduled meetings.

This joint role was clearly explained by one HPA:

"We sell sanitary pads, baby diapers, and [birth control] pills for mothers. We sell Moni biscuits to those with young children. I've also added new products beyond their original plan, like Himsagar oil, hair oil, curry spices, meswak [tooth-cleaning twigs], and toothpaste." IDI_1_HPA_1

The mothers understood the roles of HPAs primarily based on activities they promoted especially in regard to cleanliness, feeding and general care the everyday habits of mothers changed as a consequence of HPAs advice. The community members readily accepted the advice given by the HPAs as mothers referenced the HPAs helped them in developing new habits which included better nutrition and health awareness, better child feeding habits and better hygiene practices. This shows that HPAs were not just delivering information but also were successful in affecting behaviour change.

One mother explained this shift in daily routine:
"I wash my hands before eating myself." IDI_4_Mother_3

This shows how the direction and advice provided by HPAs were seen in daily behaviour of the community people.

HPA Entrepreneurship

Entrepreneurship played a major part in the HPA model, making sure that their operation was both economically sustainable and community focused. They were encouraged to take part in small scale business that funded their livelihood and their community role instead of depending just on outside funds or fixed salary.
To ensure the program's long-term viability, entrepreneurship was looked at by program officials as an essential approach as by selling health-related goods or services this initiative reduced reliance on ongoing financial assistance. In addition to this, this strategy made sure that HPAs continued to be inspired and involved in their work.

One program staff member explained this idea clearly:
"HPA's business is a social business. It's not just about profit; it's about helping the community while gaining a small benefit" KII_1_Program Manager
This shows how the program's framework included economic sustainability.

From the HPAs perspective professionalism and entrepreneurship were closely connected, as rather than only seeing themselves as volunteers or unofficial employees HPAs viewed their work as professional obligation. In order for them to get involved in business activities, such as selling health items they have to maintain trust, responsibility and positive relationships with community members. Their reputation in the community was influenced by their professional conduct, when people thought of them as trustworthy and responsible, they would more easily buy products from them and follow their advice. In this regard professionalism enhanced their entrepreneurial efforts as well as their role in health promotion.

This sense of accountability was explained by one HPA:
"I never turn away a villager with a problem. I even take patients to the hospital" IDI_7_HPA_1

This shows that HPAs understood how essential it was to keep a professional image for them to achieve success in their role.

HPA Promoted Behavior Change

One of the most important findings of HPA operations in the community was behavior change, especially in their daily health and hygiene habits. These positive changes happened gradually rather than instantly through frequent contact, direction and hands on demonstration by the HPAs.
Behavior changes were seen in very practical and everyday ways from the mothers' point of view. Real advancements were reported by mothers in their child care, hygiene and household health behaviors. This supports the fact that HPAs were successful in both spreading knowledge and assisting in its use.
One of the major areas that saw changes was improvement in personal and household hygiene. As evidenced from the mother's handwashing, cleanliness and creating a healthier atmosphere for kids have all improved. Even though these changes were simple, they had a strong effect on day-to-day living and children's health.

One mother gave a clear explanation of this change:
"I wash my hands before eating myself. Because they told us to, I follow these strictly now. We knew about these at home before, but after hearing it from them, everyone follows it more carefully. I mean, I followed it before too, but not this well. Now I follow it more." IDI_4_Mother_3
This shows a clear and useful shift in behavior brought about by HPA recommendations

For positive behavior modification the bond and trust that HPAs developed was of great impact. Mothers were more likely to follow the advice when they trusted the HPAs. As they were consistently available and approachable HPAs advice was taken with seriousness and put into practice in day-to-day activities. In addition to this, mothers stated that these changes became part of their daily chores, as the immediate effects the HPAs had a long-term influence on behavior change.

This change was expressed by another mother:
"I followed those rules, and then I gradually started noticing the changes—I could feel it in myself and in the baby." IDI_3_Mother_2
This shows how continuous involvement resulted in long-lasting behavioral changes.

System Linkages

By enabling communication between the community and the official healthcare system, system linkages had an influential impact in the HPA program operation. When community peoples were in need these connections made sure that people in the community were directed to the right place. To improve the access to healthcare, the HPAs and program staff both highlighted the need of establishing and sustaining these relationships.
Health system linkage was seen by program workers as an organized and essential part of the program. HPAs fit into this role as a connection between the community and the healthcare system. It is part of their role to identify household needs and then show the people the right resource settings which made it possible for the community members to receive care outside their community so that health issues were not neglected.

This was clearly explained by one program staff member:
"We have linkages with companies so that we can buy products at a lower rate." KII_3_Chairman of HPA Association
This shows the attempt to include HPAs into the larger healthcare system.

HPAs perceived system connectivity as a part of their community role. They help people understand where to go, direct them to the right resources and occasionally follow up on referrals. They did their job as identifiers of more advanced care and helped make the right connection.
In addition to these HPAs helped make the process easier for community members by providing proper direction and assistance. In case of referrals to community clinics and hospitals, HPAs helped close the knowledge gap that many community peoples have in things like where to go and how to obtain services. As a direct consequence of this the community members were able to move through the health systems more easily. Continuity was another crucial factor for Ante Natal Care (ANC) and Post Natal Care (PNC). After making a referral HPAs frequently followed up the community members in order to find if the patient received care and whether additional assistance was required. This continuous process ensured that referrals were significant and successful.

This procedure was described by one HPA:
"When we see a mother having a problem that we cannot handle, we refer her to the community clinic or hospital." IDI_7_HPA_1
This shows that system linking was an ongoing, helpful activity rather than a one-time event.

HPA Motivation

Motivation played an important role in determining how actively and successfully HPAs carried out their duties in the community. Motivation was very closely linked with the sense of purpose they encountered while assisting others. When they saw positive improvements in the community HPAs reported feeling a sense of achievement. Various factors like benefits from their profession, community recognition and personal fulfillment played a role in their motivation.

It was expressed by one HPA:
"Being an HPA brings a lot of respect. Everyone in the area honors me now. Beyond the profit, the recognition is more valuable." IDI_18_HPA_2

The major source of motivation was the money they get from their activities of selling products. The steady flow of cash income motivated HPAs to stay involved over time and made their participation more sustainable.

The motivation was clearly expressed by one HPA:
"I earn an income, I improve my life, and I stay well. It's a win-win situation—I benefit, and those I advise benefit too." IDI_13_HPA_1
This demonstrates how their motivation was fueled by both financial gain and emotional fulfillment.

Maintaining motivation was also influenced by a sense of duty to the community. HPAs felt responsible for the welfare of the families they assisted. They were compelled by this obligation to maintain regularity in their travels and to keep helping locals.

Another HPA described this feeling of responsibility:
"It inspired me because of the field sessions. When we called mothers and children and did the measurements, it felt very important to me. I felt that I should do this work, help them, and work with them." IDI_1_HPA_1
This illustrates how their ongoing involvement was also influenced by a sense of obligation.

HPA / Women Empowerment

The findings demonstrate that the HPA program made a substantial contribution to women's empowerment at the communal level as well as on an individual basis for HPAs. Increased self-assurance, decision-making skills, financial independence, and social recognition were all indicators of empowerment.
HPAs emphasized that their participation in community service increased their self-assurance in decision-making and communication. They were able to connect with other households, give advice, and speak in front of others. One of the main parts of empowerment was this shift from a more limited role to a community presence.

This change was clearly stated by one HPA:
"Before, my husband didn't easily let me leave the house or mix with people. Once I explained, he became aware. Now there's no risk or problem." IDI_1_HPA_1
This shows how their role made them able to overcome both personal societal obstacles.

Empowerment was seen by the program staff as one its major results, programme officer emphasised that the programs' objective included improving health outcomes as well as giving women the opportunities to work, learn new skills and take leadership roles in the community. The program employees stated that empowered HPAs could have an influence on other women. As their visibility and confidence improved the HPAs became a sign of role models for other community members. As a consequence of this more and more women were motivated to participate in the events, apply healthier habits and take part in discussions in the community gatherings.

This broader effect was described by one program staff member:
"People see that a woman is running a business and selling various products. They think, "If she can do it, why can't I?" It creates a mindset of "I can do this too." KII_6_CBP
This shows how empowerment influenced the larger community.

Operational and Community Challenges

Although HPAs had a positive influence on the community, their work was hindered by a variety of operational and community challenges. These challenges started from both the community/mother's side and the service delivery/HPA side. When considered collectively, they highlight the program's practical implementation and sustainability challenges.
Operational challenges were regular and regularly linked to the characteristics of the fieldwork from the HPAs perspective. The HPAs stated difficulties related to time management, encompassing large areas and ensuring all households got regular visits. It was not always easy to maintain consistency across all the households because their work required consistent movement and involvement in the community.

The reluctance from community side was stated by one HPA:

"Many people didn't understand and thought the products were supposed to be free. Sometimes I even sold items at a loss just to build the habit." IDI_11_HPA_2
This shows that the community's reluctance was a hindrance to their work that had to be gradually eliminated.

From the perspective of mothers, most of the hindrance had to do with including the recommended activities into their everyday habits. Even though the mothers acknowledged the advice given by the HPAs, they sometimes found it difficult to consistently follow it due to situational, economical or personal limitations. Bringing a change in personal habits was an additional challenge. It wasn't always easy to give up old habits in order to take on new ones. Mothers needed regular direction and reminders for the new habits to become a part of their daily routines.

One of the mothers stated this difficulty as follows:
"They (HPA) come and call us. Sometimes we are busy with work and can't come on time." IDI_15_Mother_2
This shows how real-world constraints had its impact on behaviour change.

Performance and Monitoring of HPA

There is a significant connection in the program staff's ongoing monitoring and supervision of HPAs with their performance. Along with monitoring their actions, tracking was used to direct, assist and enhance their regular efficiency in the community.
As stated by the program staff, monitoring was a methodical and continuous process. Staff members regularly kept track of HPA operations to ensure that the duties were being done correctly and consistently. This required making sure that the HPAs were regularly visiting homes, providing precise health messages and continuing to interact with the community. To make sure that the program's objectives were being achieved and to help sustain quality of service monitoring was done regularly.

One of the program staff members stated this as follows:
"We monitor them daily to see if they have gone to the field and if they are facing any problems." KII_1_Program Manager
This shows the correlation between monitoring and performance.

The HPAs performance was being measured by the program staff based on their level of involvement, efficiency and reliability in the community. This included metrics like how regularly HPAs went to households, how comfortably they relayed health messages and how they engaged in active interaction with the mothers in the community.
In addition to this, regular tracking made it feasible for program staff to recognise and encourage good performance. When the HPAs performed in a good way, they got encouragement and good feedback which helped them stay motivated. To improve any problems program staff may take over early and provide positive feedback.

To emphasize on importance of supervision another member of program staff stated:
"For now, they are doing everything because we are monitoring them." KII_6_CBP
This shows how continuous monitoring made it possible for HPAs to be in line with the program objective.

Chapter 5: Discussion

HPA effectiveness was largely developed through relational processes, particularly the mechanism for building trust for HPA and the strengthening of system linkage. These findings are consistent with research on community health workers (CHWs) showing that repeated interpersonal engagement, responsiveness, and obvious benefits of advice helped bring trust. The results show that consistent face-to-face interaction and perceived credibility are crucial for community acceptance and behavior change (Glenton et al., 2013; Kok et al., 2015). At the same time, the role of HPAs as connectors facilitating referrals, follow-up, and navigation of services reflects established evidence that effective CHW programs rely on strong integration with health systems to extend impact beyond health education alone (Perry et al., 2014). When compared to previous studies, these results show that trust and system linkage are mutually supporting mechanisms, where trust improves uptake of referrals, while HPAs function in the community is further established by successful service linkage.

To maintain their legitimacy and existence in regular community life HPAs maintain strong relationships with the community by relying on face to face in person communication. Through regular home visits, informal conversations and taking active part in regular social settings the HPAs were able to transcend the initial introductions and be socially integrated into the regular community life. This finding aligns with studies showing that community health workers efficiency greatly relies on their ability to maintain regular communication with the community members and incorporate into local social networks (Lehmann & Sanders, 2007). Similarly long-term acquaintance and participation have a great influence on the gradual acceptance and possibility of positive behavior change among the community members (Scott et al., 2018).

The entrepreneurial model of the HPA program helps to improve the sustainability and functionality of HPA activities through the incorporation of revenue-generating possibilities with the community-based health service delivery. By constantly coming in contact with the community households by connecting small-scale business opportunities with health promotion the HPAs are able to be economically stable and financially motivated. This helped strengthen their role in the community. While talking about resource-limited setting this dual role of the HPAs is in line with studies that financial incentive and regular livelihood support helps to maintain the retention, motivation and performance of community health workers (Bhutta et al., 2010). Also, in addition to this merging service delivery with access to necessary goods can have a positive impact on both the reach and effectiveness of community-based interventions (Raven et al., 2015).

In this circumstance, the entrepreneurial model of the HPA program is impacted by a number of contextual elements that influences how HPAs work and keep their positions in the community. For persistent involvement, activities that generate revenue became important due to inability to maintain steady revenue, need for livelihood security and limited financial resources among the community members. At the same time the community's requirement of easily accessible and fairly priced health products allowed the HPAs an opportunity to merge business and service delivery. The success of this model was also influenced by social acceptance and trust in the community, since people in the community were more inclined to buy goods and follow advice from people, they

thought were trustworthy and approachable. Program-level assistance, such as monitoring, supply access, and training, was also essential in helping HPAs successfully handle their entrepreneurial and health-related duties.

Limitations:
The study had several limitations that should be considered while interpreting the findings. First, the small sample size(n=24) limits the generalizability of the results beyond the specific study setting. In addition, the findings were highly context-specific and may not be applicable to other programs or geographical locations. Selection bias may also have occurred, as participants who were more actively engaged in the program or who had more positive experiences may have been more willing to participate in the interviews. Furthermore, the study relied on participants' recollection of past experiences, which may have introduced recall bias.

Chapter 6: Conclusion and Recommendations

6.1 Conclusion

This study adds to the growing body of knowledge on how community health workers can sustainably promote behavior change at the community level. The major finding of this study is that Health Promoting Agents were able to encourage positive behavior change by being consistently present in the community, building trust, being accessible and engaging in regular interpersonal communication. This study also shows that integrating entrepreneurship with health promotion boosted HPA motivation, enhanced women's empowerment, raised community acceptance, and promoted the program's sustainability. To strengthen these findings, more studies on the long-term viability and scalability of the HPA entrepreneurial model in various geographical and sociocultural contexts may be carried out in the future. It was important to carry out this study because it offered valuable information about how community-based health promotion initiatives operate in actual environments and illustrated the contribution of reliable female community workers to enhancing health practices, strengthening system linkages and empowering women in the community.

6.2 Recommendations

This study corroborates previous findings which suggests that for sustainability of a CHW lead program financial incentive is vital. To strengthen the programs overall efficacy, it is absolutely essential to consider that income generation functions as a strong motivating factor as it can motivate to improve engagement, accountability and sustainability of the community driven program. To enhance visible change among the community members a reliable person from within the community itself can be recruited which helps in promoting trust and uptake of interventions. In

addition to this approaches that improves system linkages and help improve referral pathways for the better continuity of care can be used. To make sure that the HPAs remain competent, confident and efficient in their role, continued investment in their training and capacity building can be done.

Declaration of GenAI Use

I, Rohan Gurung, declare that in preparing this assignment, I used ChatGPT as a support tool to assist with brainstorming ideas, organising the structure of my writing, overcoming writer's block, and improving clarity and language in the text that I drafted myself. GenAI was not used to generate original arguments, interpret results, or produce final academic content. All substantive ideas, judgments, references, and conclusions are my own and have been independently verified in line with JPGSPH academic integrity guidelines.

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Appendices

Appendix A: Data Collection Instrument

Section 1: General Information / Background

- **Participant ID:**
- **Name:**
- **Gender:**
- **Age:**
- **Educational qualification:**
- **Occupation:**
- **Years working in this community:**
- **Interview date:**
- **Interview start time:**
- **Interview end time:**
- **Interview location:**
- **Phone number:**

- **Signature:**

Section 2: Background and Role within Healthy Village in Urban Programme

1. **What were you doing before joining Healthy Village in Urban Programme?**
2. **What training did you receive before starting?**
3. **What motivated you most to join this work? (income / service / recognition / skills / other)**

Section 3: Community Engagement and Relationship Building

4. **How do you first approach and introduce yourself to new households or mothers in the community? (Probe: who introduces you, challenges at entry)**
5. **What strategies do you use to build trust and maintain good relationships with families over time? (Probe: home visits, follow-up frequency, informal talks, demonstrations, social events)**
6. **How accessible are you to community members when they need advice or support, and how do they usually contact you? (Probe: phone calls, home visits, emergencies, outside working hours)**
7. **How do community members perceive your role — as a health worker, businessperson, volunteer, or something else — and how does this affect your relationship with them? (Probe: acceptance, credibility, effect of selling products on trust)**
8. **Can you share examples where strong relationships helped you influence health or nutrition practices — or situations where lack of trust made engagement difficult? (Probe: success stories, resistance, lessons learned)**

Section 4: Promotion of Maternal and Child Nutrition & Menstrual Hygiene

9. **How do you educate mothers and families about maternal nutrition, child feeding, and menstrual hygiene practices during your visits? (Probe: topics covered, demonstrations, materials used, home vs group sessions)**

10.What methods do you use to convince families to adopt recommended practices such as exclusive breastfeeding, complementary feeding, handwashing, or safe menstrual hygiene? (Probe: examples, persuasion techniques, repeat visits)

11. Through which platforms do you promote these practices?

- **(Probe: household visits, courtyard meetings/uthan baithak, GMP sessions, schools, clinics, word of mouth)**

12.What changes have you observed in maternal or child nutrition and menstrual hygiene practices in your community, and what challenges do you face in promoting these behaviors? (Probe: success stories, cultural barriers, myths, resistance, supply problems)

Section 5: Interaction with Health System and Community Structures

13. **Do you collaborate with community health workers, clinics, schools, or local leaders?**
    - **How do these relationships support your work?**
14. **Who do you usually interact with most (mothers, elders, leaders)?**

Section 6: Sustainability, Enablers, and Challenges

16. **What motivates you to continue working as an HPA, and what factors make it difficult to sustain your work long term? (Probe: income, incentives, community respect, workload, family support, burnout)**
17. **What kinds of support or resources from the programme or community help you perform your role effectively? (Probe: training, supervision, supplies, product availability, peer support, local leaders)**
18. **What major challenges do you face while engaging households or promoting nutrition and menstrual hygiene practices? (Probe: refusal, cultural barriers, mobility, safety, time constraints, financial limitations, trust issues)**
19. **In your opinion, what changes or improvements would make the HPA model more sustainable and effective in your community? (Probe: incentives, workload, training, recognition, system support, entrepreneurship opportunities)**

Section 7: Perceived Impact of the HPA Model

19. **What changes have you observed in mothers' and children's nutrition, hygiene, or menstrual practices since you started working as an HPA?**
20. **In what ways do you think your presence and regular engagement have contributed to these changes in the community?**
21. **From your experience, how effective do you think the HPA model is in improving community health, and why?**

Section 8: Recommendations and Scale-Up

22. **Based on your experience, what changes or improvements would make your work as an HPA more effective and easier in supporting families?**
23. **What strategies do you think could help HPAs engage more households and build stronger trust across the community?**
24. **If this HPA approach is expanded to other areas, what should be kept the same and what should be changed to ensure success?**

বিভাগ ১: সাধারণ তথ্য / পটভূমি

অংশগ্রহণকারীর আইডি:

নাম:

লিঙ্গ:

বয়স:

শিক্ষাগত যোগ্যতা:

পেশা:

এই সম্প্রদায়ে কাজের বছর:

সাক্ষাত্কারের তারিখ:

সাক্ষাত্কার শুরুর সময়:

সাক্ষাত্কার শেষের সময়:

সাক্ষাত্কারের স্থান:

ফোন নম্বর:

স্বাক্ষর:

বিভাগ ২: Healthy Village in Urban Programme-এর মধ্যে পটভূমি এবং ভূমিকা

১. Healthy Village in Urban Programme-এ যোগদানের আগে আপনি কী করছিলেন?

২. শুরু করার আগে আপনি কী প্রশিক্ষণ পেয়েছিলেন?

৩. এই কাজে যোগদানের জন্য আপনাকে সবচেয়ে বেশি কী অনুপ্রাণিত করেছিল? (আয় / সেবা / স্বীকৃতি / দক্ষতা / অন্যান্য)

বিভাগ ৩: সম্প্রদায়ের সম্পৃক্ততা এবং সম্পর্ক তৈরি

৪. সম্প্রদায়ের নতুন পরিবার বা মায়েদের কাছে আপনি প্রথম কীভাবে যান এবং নিজেকে পরিচয় করিয়ে দেন? (অনুসন্ধান: কে আপনাকে পরিচয় করিয়ে দেয়, প্রবেশে চ্যালেঞ্জ)

৫. সময়ের সাথে সাথে পরিবারগুলির সাথে বিশ্বাস তৈরি এবং ভাল সম্পর্ক বজায় রাখতে আপনি কী কৌশল ব্যবহার করেন? (অনুসন্ধান: বাড়িতে পরিদর্শন, ফলো-আপ ফ্রিকোয়েন্সি, অনানুষ্ঠানিক আলোচনা, প্রদর্শনী, সামাজিক অনুষ্ঠান)

৬. যখন সম্প্রদায়ের সদস্যদের পরামর্শ বা সহায়তার প্রয়োজন হয় তখন আপনি তাদের কাছে কতটা সহজলভ্য, এবং তারা সাধারণত কীভাবে আপনার সাথে যোগাযোগ করে? (অনুসন্ধান: ফোন কল, বাড়িতে পরিদর্শন, জরুরী অবস্থা, কাজের সময়ের বাইরে)

৭. সম্প্রদায়ের সদস্যরা আপনার ভূমিকাকে কীভাবে দেখে — স্বাস্থ্যকর্মী, ব্যবসায়ী, স্বেচ্ছাসেবক, বা অন্য কিছু — এবং এটি তাদের সাথে আপনার সম্পর্ককে কীভাবে প্রভাবিত করে? (অনুসন্ধান: গ্রহণযোগ্যতা, বিশ্বাসযোগ্যতা, পণ্য বিক্রয়ের বিশ্বাসের উপর প্রভাব)

৮. আপনি কি এমন উদাহরণ শেয়ার করতে পারেন যেখানে শক্তিশালী সম্পর্ক আপনাকে স্বাস্থ্য বা পুষ্টি অনুশীলনকে প্রভাবিত করতে সাহায্য করেছে — বা এমন পরিস্থিতি যেখানে বিশ্বাসের অভাব সম্পৃক্ততাকে কঠিন করে তুলেছে? (অনুসন্ধান: সাফল্যের গল্প, প্রতিরোধ, শিখিত পাঠ)

বিভাগ ৪: মাতৃ ও শিশু পুষ্টি এবং মাসিক স্বাস্থ্যবিধির প্রচার

৯. আপনার পরিদর্শনের সময় মায়েদের এবং পরিবারকে মাতৃ পুষ্টি, শিশু খাওয়ানো এবং মাসিক স্বাস্থ্যবিধি অনুশীলন সম্পর্কে আপনি কীভাবে শিক্ষিত করেন? (অনুসন্ধান: আলোচিত বিষয়, প্রদর্শনী, ব্যবহৃত উপকরণ, বাড়ি বনাম গ্রুপ সেশন)

১০. পরিবারগুলিকে প্রস্তাবিত অনুশীলন গ্রহণ করতে রাজি করাতে আপনি কী পদ্ধতি ব্যবহার করেন যেমন একচেটিয়া বুকের দুধ খাওয়ানো, পরিপূরক খাওয়ানো, হাত ধোয়া, বা নিরাপদ মাসিক স্বাস্থ্যবিধি? (অনুসন্ধান: উদাহরণ, রাজি করানোর কৌশল, বারবার পরিদর্শন)

১১. আপনি কোন প্ল্যাটফর্মের মাধ্যমে এই অনুশীলনগুলি প্রচার করেন?

(অনুসন্ধান: পারিবারিক পরিদর্শন, উঠান বৈঠক, GMP সেশন, স্কুল, ক্লিনিক, মুখে মুখে)

১২. আপনার সম্প্রদায়ে মাতৃ বা শিশু পুষ্টি এবং মাসিক স্বাস্থ্যবিধি অনুশীলনে আপনি কী পরিবর্তন দেখেছেন, এবং এই আচরণগুলি প্রচার করতে আপনি কী চ্যালেঞ্জের মুখোমুখি হন? (অনুসন্ধান: সাফল্যের গল্প, সাংস্কৃতিক বাধা, মিথ, প্রতিরোধ, সরবরাহ সমস্যা)

বিভাগ ৫: স্বাস্থ্য ব্যবস্থা এবং সম্প্রদায় কাঠামোর সাথে মিথস্ক্রিয়া

১৩. আপনি কি সম্প্রদায়ের স্বাস্থ্যকর্মী, ক্লিনিক, স্কুল বা স্থানীয় নেতাদের সাথে সহযোগিতা করেন?

১৪. এই সম্পর্কগুলি আপনার কাজকে কীভাবে সমর্থন করে?

১৫. আপনি সাধারণত কার সাথে সবচেয়ে বেশি যোগাযোগ করেন (মায়েরা, বয়স্করা, নেতারা)?

বিভাগ ৬: স্থায়িত্ব, সক্ষমকারী এবং চ্যালেঞ্জ

১৬. HPA হিসাবে কাজ চালিয়ে যেতে আপনাকে কী অনুপ্রাণিত করে, এবং কোন কারণগুলি আপনার কাজ দীর্ঘমেয়াদে টিকিয়ে রাখা কঠিন করে তোলে? (অনুসন্ধান: আয়, প্রণোদনা, সম্প্রদায়ের সম্মান, কাজের চাপ, পারিবারিক সহায়তা, ক্লান্তি)

১৭. প্রোগ্রাম বা সম্প্রদায় থেকে কী ধরনের সহায়তা বা সংস্থান আপনাকে আপনার ভূমিকা কার্যকরভাবে সম্পাদন করতে সাহায্য করে? (অনুসন্ধান: প্রশিক্ষণ, তত্ত্বাবধান, সরবরাহ, পণ্যের প্রাপ্যতা, সহকর্মী সহায়তা, স্থানীয় নেতারা)

১৮. পরিবারগুলির সাথে জড়িত হওয়ার সময় বা পুষ্টি এবং মাসিক স্বাস্থ্যবিধি অনুশীলন প্রচার করার সময় আপনি কী প্রধান চ্যালেঞ্জের মুখোমুখি হন? (অনুসন্ধান: প্রত্যাখ্যান, সাংস্কৃতিক বাধা, চলাচল, নিরাপত্তা, সময়ের সীমাবদ্ধতা, আর্থিক সীমাবদ্ধতা, বিশ্বাসের সমস্যা)

১৯. আপনার মতে, কী পরিবর্তন বা উন্নতি HPA মডেলকে আপনার সম্প্রদায়ে আরও টেকসই এবং কার্যকর করে তুলবে? (অনুসন্ধান: প্রণোদনা, কাজের চাপ, প্রশিক্ষণ, স্বীকৃতি, ব্যবস্থা সহায়তা, উদ্যোক্তা সুযোগ)

বিভাগ ৭: HPA মডেলের অনুভূত প্রভাব

২০. আপনি HPA হিসাবে কাজ শুরু করার পর থেকে মায়েদের এবং শিশুদের পুষ্টি, স্বাস্থ্যবিধি বা মাসিক অনুশীলনে আপনি কী পরিবর্তন দেখেছেন?

২১. আপনার উপস্থিতি এবং নিয়মিত সম্পৃক্ততা কীভাবে সম্প্রদায়ে এই পরিবর্তনগুলিতে অবদান রেখেছে বলে আপনি মনে করেন?

২২. আপনার অভিজ্ঞতা থেকে, সম্প্রদায়ের স্বাস্থ্য উন্নতিতে HPA মডেল কতটা কার্যকর বলে আপনি মনে করেন, এবং কেন?

বিভাগ ৮: সুপারিশ এবং স্কেল-আপ

২৩. আপনার অভিজ্ঞতার ভিত্তিতে, পরিবারগুলিকে সহায়তা করতে HPA হিসাবে আপনার কাজকে আরও কার্যকর এবং সহজ করার জন্য কী পরিবর্তন বা উন্নতি হওয়া উচিত?

২৪. আরও বেশি পরিবারের সাথে জড়িত হতে এবং সম্প্রদায় জুড়ে শক্তিশালী বিশ্বাস তৈরি করতে HPA-দের সাহায্য করতে পারে এমন কোন কৌশল আপনার মতে?

২৫. যদি এই HPA পদ্ধতি অন্যান্য এলাকায় সম্প্রসারিত হয়, তাহলে সাফল্য নিশ্চিত করতে কী একই রাখা উচিত এবং কী পরিবর্তন করা উচিত?

IDI GUIDE 1: BENEFICIARY MOTHERS
Objective

To understand how beneficiary mothers experience, perceive, and are influenced by entrepreneurial HPAs in adopting and sustaining maternal and child nutrition and menstrual hygiene practices, with a focus on trust, accessibility, and relationship quality.

Section 1: Background Information

- **Respondent ID:**
- **Age:**
- **Education level:**
- **Marital status:**
- **Number of children (age of youngest child):**
- **Occupation:**
- **Interview date:**
- **Interview location:**

Section 2: Awareness and Initial Contact with HPA

1. **How did you first come to know about the Health-Promoting Agent (HPA) in your area?**
2. **What was your first interaction like with the HPA?**
    - **What did she/he talk to you about?**
3. **What was your first impression of HPA, and how comfortable did you feel talking with them at the beginning?**
    - **What made you trust her/him initially?**

Section 3: Relationship, Trust, and Accessibility

4. **How would you describe your relationship with the HPA? (Probe: friendly, formal, like an outsider)**
5. **Do you trust the advice and information provided by the HPA? Why or why not?**
6. **How comfortable do you feel discussing personal or sensitive issues with the HPA?**
    - **Why?**
7. **How easy is it for you to contact or reach the HPA when you need help or have questions?**

Section 4: Nutrition and Menstrual Hygiene Practices

8. **Can you describe how you currently feed and care for yourself during pregnancy/breastfeeding and for your child? (Probe: exclusive breastfeeding, complementary feeding, handwashing before feeding)**
9. **Has the HPA given you any advice or support related to nutrition? What changes, if any, have you made because of their guidance? (Probe: specific behavior changes, demonstrations, follow-up visits, reminders, product use)**
11. **How do you usually manage menstrual hygiene for yourself or adolescent girls in your household? (Probe: type of materials used, washing/drying practices, privacy, disposal methods, challenges)**
12. **Did the HPA discuss menstrual hygiene with you or provide any products or information? How has this affected your practices or confidence?**

Section 5: Perceived Impact and Value

12. **Since interacting with the HPA, what changes have you noticed in your own health or your child's health and care practices?**
- **How helpful has the HPA been for you and your family? In what ways has their support been most useful?**
14. **If the HPA were no longer available in your community, how would it affect you and other mothers? Why?**

Section 6: Barriers and Suggestions

- **What difficulties or challenges do you face in following the nutrition or menstrual hygiene advice given by the HPA? (Probe: cost, time, family influence, cultural beliefs)**
16. **What could the HPA or the program do to support mothers like you better?**

Closing Statement: "Thank you for sharing your experiences. Your views will help improve how HPAs support mothers and children in this community."

বিভাগ ১: পটভূমির তথ্য

উত্তরদাতার আইডি:

বয়স:

শিক্ষার স্তর:

বৈবাহিক অবস্থা:

সন্তানের সংখ্যা (সর্বকনিষ্ঠ সন্তানের বয়স):

পেশা:

সাক্ষাত্কারের তারিখ:

সাক্ষাত্কারের স্থান:

বিভাগ ২: সচেতনতা এবং HPA-এর সাথে প্রথম যোগাযোগ

১. আপনি প্রথম কীভাবে আপনার এলাকার স্বাস্থ্য-প্রচার এজেন্ট (HPA) সম্পর্কে জানতে পেরেছিলেন?

২. HPA-এর সাথে আপনার প্রথম মিথস্ক্রিয়া কেমন ছিল?

৩. তিনি আপনার সাথে কী নিয়ে কথা বলেছিলেন?

৪. HPA সম্পর্কে আপনার প্রথম ধারণা কী ছিল, এবং শুরুতে তাদের সাথে কথা বলতে আপনি কতটা স্বাচ্ছন্দ্য বোধ করেছিলেন?

৫. প্রথমে তাকে বিশ্বাস করতে আপনাকে কী করেছিল?

বিভাগ ৩: সম্পর্ক, বিশ্বাস এবং সহজলভ্যতা

৬. HPA-এর সাথে আপনার সম্পর্ককে আপনি কীভাবে বর্ণনা করবেন? (অনুসন্ধান: বন্ধুত্বপূর্ণ, আনুষ্ঠানিক, বহিরাগতের মতো)

৭. HPA দ্বারা প্রদত্ত পরামর্শ এবং তথ্যে আপনি কি বিশ্বাস করেন? কেন বা কেন নয়?

৮. HPA-এর সাথে ব্যক্তিগত বা সংবেদনশীল বিষয় নিয়ে আলোচনা করতে আপনি কতটা স্বাচ্ছন্দ্য বোধ করেন?

৯. কেন?

১০. যখন আপনার সাহায্য বা প্রশ্নের প্রয়োজন হয় তখন HPA-এর সাথে যোগাযোগ করা বা পৌঁছানো আপনার জন্য কতটা সহজ?

বিভাগ ৪: পুষ্টি এবং মাসিক স্বাস্থ্যবিধি অনুশীলন

১১. গর্ভাবস্থা/বুকের দুধ খাওয়ানোর সময় নিজের জন্য এবং আপনার সন্তানের জন্য আপনি বর্তমানে কীভাবে খাবার দেন এবং যত্ন নেন তা বর্ণনা করতে পারেন? (অনুসন্ধান: একচেটিয়া বুকের দুধ খাওয়ানো, পরিপূরক খাওয়ানো, খাওয়ানোর আগে হাত ধোয়া)

১২. HPA কি আপনাকে পুষ্টি সম্পর্কিত কোনো পরামর্শ বা সহায়তা দিয়েছে? তাদের নির্দেশনার কারণে আপনি কোনো পরিবর্তন করেছেন কিনা? (অনুসন্ধান: নির্দিষ্ট আচরণগত পরিবর্তন, প্রদর্শনী, ফলো-আপ পরিদর্শন, অনুস্মারক, পণ্য ব্যবহার)

১৩. আপনি সাধারণত নিজের জন্য বা আপনার পরিবারের কিশোরী মেয়েদের জন্য মাসিক স্বাস্থ্যবিধি কীভাবে পরিচালনা করেন? (অনুসন্ধান: ব্যবহৃত উপকরণের ধরন, ধোয়া/শুকানোর অনুশীলন, গোপনীয়তা, নিষ্পত্তির পদ্ধতি, চ্যালেঞ্জ)

১৪. HPA কি আপনার সাথে মাসিক স্বাস্থ্যবিধি নিয়ে আলোচনা করেছে বা কোনো পণ্য বা তথ্য প্রদান করেছে? এটি আপনার অনুশীলন বা আত্মবিশ্বাসকে কীভাবে প্রভাবিত করেছে?

বিভাগ ৫: অনুভূত প্রভাব এবং মূল্য

১৫. HPA-এর সাথে মিথস্ক্রিয়ার পর থেকে, আপনার নিজের স্বাস্থ্য বা আপনার সন্তানের স্বাস্থ্য এবং যত্ন অনুশীলনে আপনি কী পরিবর্তন লক্ষ্য করেছেন?

১৬. আপনার এবং আপনার পরিবারের জন্য HPA কতটা সহায়ক হয়েছে? কোন উপায়ে তাদের সহায়তা সবচেয়ে উপকারী হয়েছে?

১৭. যদি আপনার সম্প্রদায়ে HPA আর উপলব্ধ না হয়, তাহলে এটি আপনাকে এবং অন্যান্য মায়েদের কীভাবে প্রভাবিত করবে? কেন?

বিভাগ ৬: বাধা এবং পরামর্শ

১৮. HPA দ্বারা প্রদত্ত পুষ্টি বা মাসিক স্বাস্থ্যবিধি পরামর্শ অনুসরণ করতে আপনি কী অসুবিধা বা চ্যালেঞ্জের মুখোমুখি হন? (অনুসন্ধান: খরচ, সময়, পারিবারিক প্রভাব, সাংস্কৃতিক বিশ্বাস)

১৯. আপনার মতো মায়েদের আরও ভালভাবে সহায়তা করতে HPA বা প্রোগ্রাম কী করতে পারে?

সমাপনী বিবৃতি: "আপনার অভিজ্ঞতা শেয়ার করার জন্য ধন্যবাদ। আপনার মতামত এই সম্প্রদায়ে HPA-রা কীভাবে মা এবং শিশুদের সহায়তা করে তা উন্নত করতে সাহায্য করবে।"

KII GUIDE: PROGRAMME STAFF / SUPERVISORS OF HPAs
Objective

To explore, through Key Informant Interviews (KII), how programme staff perceive, support, and assess the role of entrepreneurial HPAs in engaging communities and improving maternal and child nutrition and menstrual hygiene practices, including factors influencing performance, accountability, and sustainability.

Section 1: Background and Role

- **Respondent ID:**
- **Position/designation:**
- **Years working with Healthy Village in Urban Programme:**
- **Areas supervised:**
- **Interview date:**

Section 2: Oversight of HPA Activities

1. **How do you supervise and monitor the day-to-day activities of HPAs in your area?**
2. **What mechanisms are used to assess HPA performance and ensure accountability for their work? (Probe:household coverage, behavior change outcomes, product sales records, feedback from mothers)**
3. **In what ways do you provide guidance or support to HPAs when they face challenges in community engagement or service delivery?**

Section 3: Community Engagement and Trust

4. **From your observation, how do HPAs engage with households and communities to introduce themselves and promote nutrition and hygiene practices?**
5. **What factors contribute most to community trust in HPAs?**
    - **(Probe: local residency, gender, communication skills, availability)**
6. **In your experience, how does the quality of HPA–community relationships influence adoption of maternal and child nutrition or menstrual hygiene practices?**

Section 4: Contribution to Nutrition and Hygiene Outcomes

7. **Based on your experience, what changes have you observed in maternal and child nutrition and menstrual hygiene practices in areas supported by HPAs?**
8. **How effective are HPAs in promoting menstrual hygiene, particularly among adolescent girls and women?**
9. **How do you assess or measure the impact of HPA activities on nutrition and hygiene outcomes? (Probe: reports, success stories, comparison between high- and low-performing areas)**

Section 5: Enabling and Constraining Factors

10. **From your perspective, what factors or supports help HPAs perform effectively in engaging communities and promoting nutrition and menstrual hygiene practices? (Probe: training quality, supervision, incentives)**
11. **What major challenges or barriers limit HPAs' ability to carry out their responsibilities effectively?**
12. **How do programme design or system-level factors influence HPA performance and sustainability, either positively or negatively? (Probe: policies, accountability systems, coordination)**

Section 6: Women's Empowerment and System Strengthening

13. **In your view, how has the HPA model contributed to women's empowerment both for the HPAs themselves and for beneficiary mothers?**
    (Probe: income, leadership, decision-making)
14. **How do HPAs link communities with health systems and local government structures?**

Section 7: Recommendations and Scale-Up

15. **Based on your experience, what changes or improvements would strengthen the effectiveness of HPAs in delivering nutrition and menstrual hygiene support?**
16. **What measures are needed to ensure the HPA model remains sustainable and functional after external funding or intensive programme support reduces?**
17. **If this HPA approach is expanded to other districts or urban settings, what key factors should be considered to ensure successful replication?**

Closing Statement: "Thank you for your insights. Your perspectives are critical for strengthening and scaling the HPA model within Healthy Village in Urban Programme."

বিভাগ ১: পটভূমি এবং ভূমিকা

উত্তরদাতার আইডি:

পদবী/পদ:

Healthy Village in Urban Programme-এর সাথে কাজের বছর:

তত্ত্বাবধানে থাকা এলাকা:

সাক্ষাত্কারের তারিখ:

বিভাগ ২: HPA কার্যক্রমের তত্ত্বাবধান

১. আপনি আপনার এলাকায় HPA-দের দৈনন্দিন কার্যক্রম কীভাবে তত্ত্বাবধান এবং পর্যবেক্ষণ করেন?

২. HPA কর্মক্ষমতা মূল্যায়ন এবং তাদের কাজের জন্য জবাবদিহিতা নিশ্চিত করতে কী ব্যবস্থা ব্যবহার করা হয়? (অনুসন্ধান: পরিবারের কভারেজ, আচরণ পরিবর্তনের ফলাফল, পণ্য বিক্রয় রেকর্ড, মায়েদের কাছ থেকে প্রতিক্রিয়া)

৩. যখন তারা সম্প্রদায়ের সম্পৃক্ততা বা সেবা প্রদানে চ্যালেঞ্জের মুখোমুখি হয় তখন আপনি কীভাবে HPA-দের নির্দেশনা বা সহায়তা প্রদান করেন?

বিভাগ ৩: সম্প্রদায়ের সম্পৃক্ততা এবং বিশ্বাস

৪. আপনার পর্যবেক্ষণ থেকে, HPA-রা নিজেদের পরিচয় করিয়ে দিতে এবং পুষ্টি ও স্বাস্থ্যবিধি অনুশীলন প্রচার করতে কীভাবে পরিবার এবং সম্প্রদায়ের সাথে জড়িত হয়?

৫. HPA-দের প্রতি সম্প্রদায়ের বিশ্বাসে কোন কারণগুলি সবচেয়ে বেশি অবদান রাখে?
(অনুসন্ধান: স্থানীয় বাসিন্দা, লিঙ্গ, যোগাযোগ দক্ষতা, প্রাপ্যতা)

৬. আপনার অভিজ্ঞতায়, HPA–সম্প্রদায় সম্পর্কের গুণমান কীভাবে মাতৃ ও শিশু পুষ্টি বা মাসিক স্বাস্থ্যবিধি অনুশীলন গ্রহণকে প্রভাবিত করে?

বিভাগ ৪: পুষ্টি এবং স্বাস্থ্যবিধি ফলাফলে অবদান

৭. আপনার অভিজ্ঞতার ভিত্তিতে, HPA-দের দ্বারা সমর্থিত এলাকায় মাতৃ ও শিশু পুষ্টি এবং মাসিক স্বাস্থ্যবিধি অনুশীলনে আপনি কী পরিবর্তন পর্যবেক্ষণ করেছেন?

৮. বিশেষত কিশোরী মেয়েদের এবং মহিলাদের মধ্যে মাসিক স্বাস্থ্যবিধি প্রচারে HPA-রা কতটা কার্যকর?

৯. আপনি পুষ্টি এবং স্বাস্থ্যবিধি ফলাফলে HPA কার্যক্রমের প্রভাব কীভাবে মূল্যায়ন বা পরিমাপ করেন? (অনুসন্ধান: রিপোর্ট, সাফল্যের গল্প, উচ্চ এবং নিম্ন-পারফরমিং এলাকার মধ্যে তুলনা)

বিভাগ ৫: সক্ষমকারী এবং বাধাদানকারী কারণ

১০. আপনার দৃষ্টিকোণ থেকে, কোন কারণ বা সমর্থন HPA-দের সম্প্রদায়ের সাথে জড়িত হতে এবং পুষ্টি ও মাসিক স্বাস্থ্যবিধি অনুশীলন প্রচারে কার্যকরভাবে কাজ করতে সাহায্য করে? (অনুসন্ধান: প্রশিক্ষণের গুণমান, তত্ত্বাবধান, প্রণোদনা)

১১. কোন প্রধান চ্যালেঞ্জ বা বাধা HPA-দের তাদের দায়িত্ব কার্যকরভাবে পালন করার ক্ষমতা সীমাবদ্ধ করে?

১২. প্রোগ্রাম ডিজাইন বা সিস্টেম-স্তরের কারণগুলি কীভাবে HPA কর্মক্ষমতা এবং স্থায়িত্বকে ইতিবাচক বা নেতিবাচকভাবে প্রভাবিত করে? (অনুসন্ধান: নীতি, জবাবদিহিতা ব্যবস্থা, সমন্বয়)

বিভাগ ৬: নারীর ক্ষমতায়ন এবং ব্যবস্থা শক্তিশালীকরণ

১৩. আপনার দৃষ্টিতে, HPA মডেল HPA-দের নিজেদের এবং সুবিধাভোগী মায়েদের উভয়ের জন্য নারীর ক্ষমতায়নে কীভাবে অবদান রেখেছে?
(অনুসন্ধান: আয়, নেতৃত্ব, সিদ্ধান্ত গ্রহণ)

১৪. HPA-রা কীভাবে সম্প্রদায়কে স্বাস্থ্য ব্যবস্থা এবং স্থানীয় সরকারী কাঠামোর সাথে সংযুক্ত করে?

বিভাগ ৭: সুপারিশ এবং স্কেল-আপ

১৫. আপনার অভিজ্ঞতার ভিত্তিতে, পুষ্টি এবং মাসিক স্বাস্থ্যবিধি সহায়তা প্রদানে HPA-দের কার্যকারিতা শক্তিশালী করতে কী পরিবর্তন বা উন্নতি করা উচিত?

১৬. বাহ্যিক অর্থায়ন বা নিবিড় প্রোগ্রাম সহায়তা হ্রাস পাওয়ার পরে HPA মডেল টেকসই এবং কার্যকর থাকার জন্য কী ব্যবস্থা প্রয়োজন?

১৭. যদি এই HPA পদ্ধতি অন্যান্য জেলা বা শহুরে পরিবেশে সম্প্রসারিত হয়, তাহলে সফল প্রতিলিপি নিশ্চিত করতে কোন মূল কারণগুলি বিবেচনা করা উচিত?

সমাপনী বিবৃতি: "আপনার অন্তর্দৃষ্টির জন্য ধন্যবাদ। Healthy Village in Urban Programme-এর মধ্যে HPA মডেল শক্তিশালী এবং স্কেল করার জন্য আপনার দৃষ্টিভঙ্গি অত্যন্ত গুরুত্বপূর্ণ।"

Appendix B: Informed Consent Form

Information Sheet

Introduction: Hello my name is Rohan Gurung, and I come from BRAC. We are conducting a study on the Healthy Village Urban Project in collaboration with Max Foundation, funded by BRAC and Max Foundation.

Serial no.: [Protocol number]

Aim: To understand how entrepreneurial Health-Promoting Agents engage with communities to support and sustain maternal and child nutrition practices within Healthy Village in Urban Programme intervention areas.

Justification of participation: Because it provides evidence of the HPA model's efficacy.

Procedure: Procedure of data collection is a qualitative method which includes IDI and KII. The survey will take place for 9 days. The interview will be audio recorded. Photographs may be taken with consent.

Benefits of participation: There is no direct benefit but it will justify continued investment and scale-up of community-based health promotion.

Compensation: Respondent will not receive any compensation.

Risk: No risk whatsoever will fall to the respondent.

Confidentiality and anonymity: Confidentiality and anonymity will be maintained by coding the identification of the participants. Principal Investigator and Co-investigator will have access to the personal information. Data will be stored on cloud-based software. Findings will be published and shared in research journals. When findings will be shared nobody will be able to identify the participants.

Nature of participation: Participants are free to choose to participate without any pressure or coercion. Their decision will not create any problems for them. They can withdraw from participation after data collection has been concluded.

Contact information: [Provide contact details of a person from the project they can contact if they have any questions or concern] [Provide contact details of IRB]

If you have any further query about the research project, then please contact Rohan Gurung through this phone number 01939-662404.

For ethical concerns, can contact the Institutional Review Board: + 801993379512. Email: irb-jpgsph@bracu.ac.bd)

Consent Form

Title of the study: Entrepreneurs as Health-Promoting Agents: Community Engagement for Sustaining Maternal and Child Nutrition Practices within the Healthy Village in Urban Programme

If you agree to participate in this study, please confirm by putting your signature/thumbprint. Thank you for your cordial cooperation.

(Note to investigator: Please note that the items below can vary from protocol to protocol) Do you give permission for the interview to be audio recorded? *Please note that at any point during the interview, you can ask the interviewer to turn off the recording device.*	Yes	No
Do you give permission to share your findings?	Yes	No
Do you give permission to take photos?	Yes	No
Do you give permission to share the photos?	Yes	No
(If you need to contact the/collect data from the respondent again, need to state here and ask permission…)		
Do you have any questions? State the question	Yes	No

Interviewer name: Rohan Gurung
Interviewer signature:
Date:

Respondent's name:
Respondent's signature/thumbprint:
Date:

আমার নাম রোহন গুরুং এবং আমিব্র্যাক থেকেএসেছি। আমরা ব্র্যাক এবং ম্যাক্স ফাউন্ডেশনের অর্থায়নে, ম্যাক্স ফাউন্ডেশনের সহযোগিতায়স্বাস্থ্যকর গ্রাম শহুরেপ্রকল্পের উপর একটি গবেষণা পরিচালনা করছি।

Protocol Number: [প্রোটোকল নম্বর]

উদ্দেশ্য: Healthy Village in Urban Programme হস্তক্ষেপ এলাকার মধ্যেমাতৃ ও শিশু পুষ্টিঅনুশীলনকেসমর্থন ও টেকসই করার জন্য উদ্যোক্তা স্বাস্থ্য-প্রচার এজেন্টরা কীভাবেসম্প্রদায়ের সাথেজড়িত হয়তা বোঝা।

অংশগ্রহণের যৌক্তিকতা: কারণ এটি HPA মডেলের কার্যকারিতার প্রমাণ প্রদান করে।

পদ্ধতি: তথ্য সংগ্রহের পদ্ধতিহল একটি গুণগত পদ্ধতিযার মধ্যেরয়েছেIDI এবং KII। জরিপটি ৯ দিনের জন্য অনুষ্ঠিত হবে। সাক্ষাত্কার অডিও রেকর্ডকরা হবে। সম্মতিসহ ছবিতোলা হতেপারে।

অংশগ্রহণের সুবিধা: কোনোসরাসরিসুবিধা নেই তবেএটি সম্প্রদায়-ভিত্তিক স্বাস্থ্য প্রচারের ক্রমাগত বিনিয়োগ এবং স্কেল-আপকেসমর্থন করবে।

ক্ষতিপূরণ: উত্তরদাতা কোনোক্ষতিপূরণ পাবেন না।

ঝুঁকি: উত্তরদাতার জন্য কোনোধরনের ঝুঁকিনেই।

গোপনীয়তা এবং নামহীনতা: অংশগ্রহণকারীদের শনাক্তকরণ কোড করেগোপনীয়তা এবং নামহীনতা বজায়রাখা হবে। প্রধান গবেষক এবং সহ-গবেষক ব্যক্তিগত তথ্যেঅ্যাক্সেস পাবেন। তথ্য ক্লাউড-ভিত্তিক সফটওয়্যারেসংরক্ষিত থাকবে। ফলাফল প্রকাশ করা হবেএবং গবেষণা জার্নালেশেয়ার করা হবে। যখন ফলাফল শেয়ার করা হবেতখন কেউ অংশগ্রহণকারীদের চিহ্নিত করতেপারবেনা।

অংশগ্রহণের প্রকৃতি: অংশগ্রহণকারীরা কোনোচাপ বা জবরদস্তিছাড়াই অংশগ্রহণ করতেস্বাধীন। তাদের সিদ্ধান্ত তাদের জন্য কোনোসমস্যা সৃষ্টিকরবেনা। তথ্য সংগ্রহ সম্পন্ন হওয়ার পরেতারা অংশগ্রহণ থেকেপ্রত্যাহার করতেপারবেন।

যোগাযোগের তথ্য: [প্রকল্পের একজন ব্যক্তির যোগাযোগের বিবরণ প্রদান করুন যাদের সাথেতারা যোগাযোগ করতেপারেন যদিতাদের কোনোপ্রশ্ন বা উদ্বেগ থাকে] [IRB-এর যোগাযোগের বিবরণ প্রদান করুন]

গবেষণা প্রকল্প সম্পর্কেআপনার আরও কোনোপ্রশ্ন থাকলে, দয়া করেএই ফোন নম্বর ০১৯৩৯-৬৬২৪০৪ এর মাধ্যমেরোহন গুরুং-এর সাথেযোগাযোগ করুন।

নৈতিক উদ্বেগের জন্য, ইনস্টিটিউশনাল রিভিউ বোর্ডের সাথেযোগাযোগ করতেপারেন: + ৮০১৯৯৩৩৭৯৫১২। ইমেইল: *irb-jpgsph@bracu.ac.bd*

সম্মতিফর্ম

গবেষণার শিরোনাম: স্বাস্থ্য-প্রচার এজেন্ট হিসাবেউদ্যোক্তা: স্বাস্থ্যকর গ্রাম শহুরেকর্মসূচির মধ্যেমাতৃ ও শিশু পুষ্টিঅনুশীলন টেকসই করার জন্য সম্প্রদায়ের সম্পৃক্ততা

আপনিযদিএই গবেষণায়অংশগ্রহণেসম্মত হন, তাহলেদয়া করেআপনার স্বাক্ষর/টিপসই দিয়েনিশ্চিত করুন।

আপনার আন্তরিক সহযোগিতার জন্য ধন্যবাদ।

(গবেষকের জন্য নোট: দয়া করেমনেরাখবেন যেনীচের আইটেমগুলিপ্রোটোকল থেকেপ্রোটোকলেপরিবর্তিত	হ্যাঁ	না

হতেপারে*)*
আপনিকিসাক্ষাত্কার
অডিও রেকর্ডকরার
অনুমতিদেন? দয়া
করেমনেরাখবেন
যেসাক্ষাত্কারের
যেকোনোসময়ে,
আপনিসাক্ষাত্কারগ্রহণকা
রীকেরেকর্ডিং ডিভাইস বন্ধ
করতেবলতেপারেন।

আপনিকিআপনার ফলাফল শেয়ার করার অনুমতিদেন?	হ্যাঁ	না
আপনিকিছবিতোলার অনুমতিদেন?	হ্যাঁ	না
আপনিকিছবিশেয়ার করার অনুমতিদেন?	হ্যাঁ	না

*(*যদিআপনার উত্তরদাতার কাছ থেকেআবার যোগাযোগ/তথ্য সংগ্রহ করার প্রয়োজন হয়, এখানেউল্লেখ করতেহবেএবং অনুমতিচাইতেহবে...*)*

আপনার কিকোনোপ্রশ্ন আছে?	হ্যাঁ	না

প্রশ্নটি উল্লেখ করুন

সাক্ষাত্কারগ্রহণকারীর নাম: রোহন গুরুং	উত্তরদাতার নাম:
সাক্ষাত্কারগ্রহণকারীর স্বাক্ষর:	উত্তরদাতার স্বাক্ষর/টিপসই:
তারিখ:	তারিখ: