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Visual Storytelling for Knowledge Translation: A Study on BRAC's Novel Health Loans in Protecting the Poor Against Health and Asset Vulnerability In Bangladesh

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Knowledge Translation (KT) is a dynamic and iterative process that includes synthesizing, disseminating, exchanging, and ethically sound application of knowledge to improve health and strengthen the health care system. It facilitates sharing the information generated through research outcomes with the public, the policymakers, or others for further scaling up or continuation of the interventions. Literature suggests a substantial gap exists in communicating with the decision-makers. BRAC JPGSPH produced a documentary/video that iterates how BRAC's revised medical treatment loan program (MTL+) works with its microcredit clients and modalities. After reviewing all possible options for communication, the video was chosen as the best knowledge translation tool. The video creation and dissemination process are comprised of four phases: pre-production, production, post-production, and exhibition. The video production team reviewed documents and articles and conducted multiple interviews before developing the script. Later, a series of interviews were taken with the beneficiaries who receive medical treatment loans, mid-level, senior managers at BRAC, and researchers. After the production, the director, with a professional editor, edited the video. Over three hours of footage was viewed and ultimately compiled into a six-minute-long video documentary. The audience for the video was more expansive than narrow; from potential beneficiaries to policymakers and every group of stakeholders in between, the video was well-understood. The new MTL+ was integrated into the main program and would be scaled up soon.

Keywords: medical treatment loan, Bangladesh, BRAC, health cost, video

INTRODUCTION

Broadly, knowledge translation (KT) is communicating what has been found through research. Findings of research, even revolutionary, do not hold any meaning at all unless communicated and shared through the right channel and to the right audience. According to the Canadian Institutes of Health Research, KT is a dynamic and iterative process that includes synthesizing, disseminating, exchanging, and ethically sound application of knowledge to improve health and strengthen the health care system (1). Substantial evidence has revealed that often there remains a gap between transferring knowledge into action (2). Frequently, research conducted tends to stay within the close network of academic institutions and people. So, just as conducting the research, it is equally essential for researchers to share what they have learned in lucid and intelligible ways to all different kinds of audiences. KT finds ways to share that information with the public, the policymakers, or others who will execute practical steps towards what has been suggested by the research outcome (3).

Sharing information with the support of audio-visual material can be a particularly effective medium for increasing the reactivity of the audience because it puts "images to work" while sharing knowledge on matters with which some participants may be less familiar (4). It is not difficult for a film connoisseur to understand that films or visual storytelling are the most accessible communication methods. It is engaging, emotional, empathetic, and educational (5). It is the closest to being there in the field in person. Videos leap over the barriers of language or literacy. So, particularly, narrative documentary films can play a vital role in how researchers communicate their knowledge. They are more effective when sharing knowledge from public health research (6). Health and the issues related to it are hard to be understood through text for a non-technical audience. Alongside graphs, charts, and other visual aids being helpful in a technical medium, videos can be the most effective way to understand concerns related to health for a non-technical purpose.

While Bangladesh strives to progress towards Universal Health Coverage (UHC), the country suffers a lack of financial protection (7). The Ministry of Health and Family Welfare (MOHFW) has identified several reforms within the health care system to tackle the issue. The poor and vulnerable remain largely underserved. Owing to the absence of a widely rolled out financial safety net in the form of loans and insurance schemes for health services, marginal households reportedly have to put up with poor access to health care (8). In Bangladesh, 67% of total health expenditure is out-of-pocket (9), accounting for 74% of household expenditure (10). As a result, about 13% (five million Bangladeshi) of the households in the country are trapped in poverty (11).

In this light, the novel and innovative loan scheme of our research project should contribute to ensuring UHC and meeting Sustainable Development Goals (SDGs) across Bangladesh. In the absence of affordable health insurance schemes, the low-income households of Bangladesh rely on mutual lending among friends and relatives. Self-sourcing protects them from repayment with hefty interest rates and minimal payback time, and these informal methods often fail in providing sufficient financial protection. (12). On the other hand, for those who have access to microcredit, a health emergency forces them to draw on the finances that would otherwise have been utilized to invest in income-generating activities. Moreover, 87% of BRAC's microcredit clients are women, so the extra burden of gender discrimination must be considered (13).

Medical Treatment Loan (MTL), an innovative strategy, was introduced in 2013 by BRAC's Microfinance Program to provide a solution. MTL offers loans to BRAC's microcredit clients and their family members, the poorest in the community, to seek proper health care in case of a health shock. The MTL program currently covers 26 regions (25 out of 64 districts), protecting low-income communities in the event of medical emergencies and providing a shield from the blow of unprecedented medical expenditures. As a Leaving No One Behind (LNOB) risk-mitigation strategy (Kharas, McArthur, and Ohno 2020), the MTL program serves three objectives: a. to facilitate access to healthcare, otherwise foregone due to high costs; b. to limit asset sale in case of illness; c. to increase micro-finance loan repayment (13). An existing borrower can take this loan with a payback period of 6, 12, 18, or 24 months. The loanable amount ranges from BDT 3,000 – 50,000.

Despite trying to solve the haunting issue of lack of access to health care for all, MTL could not succeed in scaling up beyond a handful of clients. BRAC recognized its exceptional potential to examine why such a program would fail to reach a broader clientele. With the support from the Inequality Challenge Project, BRAC James P. Grant School of Public Health (BRAC JPGSPH), BRAC University with support from consultants at Heidelberg Institute of Global Health, Germany, and the University of Dhaka, Bangladesh sought to address the challenge. The aim was to improve the existing MTL program through decentralization, digitalization adaptation, and innovations in product design (13).

In the face of such challenges, BRAC JPGSPH proposed remodeling the MTL program: a. Propose a shift of the verification procedure from the district to the village level and b. integrate enrollment and disbursement procedures in the existing BRAC digital information system by implementing pre-enrolment strategies based on current BRAC client data. Incorporating these proposed revisions, BRAC MTL saw a significant increase in the number of its borrowers, which has been the ultimate goal of the study conducted by BRAC JPGSPH all along. The new and improved version of the innovative MTL program came to be known as MTL+.

Upon presenting the findings from the study, it was imperative that the knowledge acquired be translated to inform and make all the stakeholders directly or remotely associated with the program. As has already been claimed initially in this article, videos are effective tools that help bridge the gap and accelerate the process of implementing the knowledge acquired into practical applications (6). They are also a popular source of entertainment for all age groups from all walks of life; however,

up until recent times, the significance of videos in engaging the audience emotionally and intellectually to make a real-life impact was scarcely acknowledged (14). With this view, BRAC JPGSPH produced a documentary/video that iterates the whole process of how MTL+ works and its modalities.

METHODOLOGY

Before disseminating information gathered from the research, we drew on multiple KT tools to examine and assess what works best. We understood that KT is not a linear instead of a very dynamic process, and borrow definition as a dynamic process of exchange, synthesis, and ethically sound application of knowledge within a complex system of relationships among researchers and users" (15). Our audience was versatile-covering a range from formal to informal educational, technical to non-technical backgrounds, and also traditional to liberal-minded people. Considering these prerequisites, the effective KT we chose must involve sharing knowledge between the researchers and participants. In this regard, a documentary/video was deemed as our best option. Later, it instigated dialogues among policymakers, researchers, and participants as it played a massive role in disseminating information to all the stakeholders.

The video production was in alignment with the research comprising two phases - formative and evaluation. In the first phase, the existing female clients eligible to take this loan, field-level workers, branch managers, and policymakers at the top level were interviewed. It pinned down the core causes of why MTL has not been as attractive to those who needed it as expected. The second phase was about disseminating the study outcomes and proposing to revise the program, altering its mechanism to address the identified issues.

To create and disseminate a video documentary, one must go through four essential parts: pre-production, production, post-production, and exhibition. In the pre-production stage, ideas were generated regarding the topic. Later a video production team (director, cinematographer, production coordinator, and editor) was assembled according to the requirements of the video. The budget was also finalized during this stage. To better understand the topic and develop the script, the video production team did multiple interviews with the research team of BRAC JPGSPH. They also reviewed documents and articles relevant to this project. After familiarizing myself with the project, the video production team interviewed MTL and MTL + beneficiaries, branch, and regional managers of the program in Rangpur, Bangladesh. After the interviews, a communication expert created a script approved by the research team of BRAC JPGSPH. Rangpur was chosen as the site where the video would be shot as the related research project was conducted there and the pilot site for BRAC MTL project implementation.

After the finalization of the script, the video production team went for the shooting of the documentary. The production part was divided into two phases; Phase 1 in Rangpur and Phase 2 in Dhaka. During Phase 1, The video production team again interviewed the MTL and MTL+ beneficiaries, branch managers, and regional managers. Consent was received from each participant, and interviews were recorded to be used in the video documentary. The interviews were in-depth, with the video production team probing the respondents regarding the MTL/MTL+ program and its benefits, scopes of improvement, and implementation process. After completing Phase 1 in Rangpur, the team moved to Dhaka to start Phase 2. In Phase 2, Key Informant Interviews (KIIs) were conducted with the Co- and Principal Investigator of this project, "Assessing BRAC's Innovative Health Loans in Protecting the Poor Against Health and Asset Vulnerability in Bangladesh." Next, the team moved on to conducting KIIs with the program and policy implementors of the BRAC Microfinance team, who were in charge of implementing the Medical Treatment Loan program on the ground. For this, the director, manager, and head of operations of BRAC Microfinance were included in video interviews. All the Key informants spoke about how MTL came to be and the reasons why MTL+ was introduced after the initial research done by BRAC JPGSPH. The post-production part of the documentary consisted of the editor going through the video footage with the director and editing the clips into one complete documentary following the script. Over three hours of footage was viewed and ultimately compiled into a six-minute-long video documentary.

RESULTS

The journey of success of the program from MTL to MTL+ was depicted in the video documentary. It was an effective knowledge transfer tool as it grabbed the attention of the researchers, policymakers, implementers, and beneficiaries and brought them under the same umbrella. The aim was to understand the implementation process better, identifying the bottlenecks and positive outcomes of the revised program for future nationwide scale-up.

The video explains how the MTL program was first introduced by BRAC microfinance as voiced by a key informant:

"They have been observing the health-seeking behavior of their clients and looking at how they can improve the health outcome of the clients. It was not usual for BRAC to consider an insurance program. However, BRAC understood that it requires robust assessment to introduce an insurance product for the beneficiaries. Therefore, after different discussions and planning, BRAC decided to pilot a loan product for their existing clients, once they got ill they could quickly access the loan and be able to pay for their health-related costs" - Senior Director, Microfinance, Ultra poor graduation, BRAC and BRAC International.

The MTL program was first launched as a pilot program in Rangpur, Bangladesh. After a year, it was successfully rolled out in other regions of Bangladesh. Understanding the clients' pattern or behavior of seeking healthcare was crucial to understanding why the program, when first launched, did not

expand beyond only a particular client pool. So, BRAC Microfinance decided to utilize its partnership with BRAC James P Grant School of Public Health to understand better what had gone well and what had not. The ultimate vision was to scale up the program nationwide. Another objective was to determine if the whole idea of a medical treatment loan is as beneficial for the clientele as the data suggested. In this regard, the Senior Manager of Product Development Unit in BRAC Microfinance says, *"Once we are convinced through this pilot that we are indeed finding the right solutions for the challenges that our clients face, we shall be able to help them with the right solutions."* -Senior Manager, Product Development Unit, BRAC Microfinance.

The principal investigator of the project said,

"*Since BRAC is implementing the Medical Treatment Loan, we spoke to their top-level policymakers, researchers at Heidelberg University and BRAC University and arranged a workshop where we discussed if we could relaunch the Medical Treatment Program as a new product introducing changes to make the product more attractive to the clients. We brought a few changes to the program and named this new program Medical Treatment Loan Plus (MTL+)."* - PI, 'Assessing BRAC's Innovative Health Loans in Protecting the Poor Against Health and Asset Vulnerability in Bangladesh' project, BRAC JPGSPH BRAC University.

The video portrays the procedure to obtain the Medical Treatment Loan in place- to receive a loan, a referral slip is required from a designated BRAC doctor. The client must visit the designated doctor. Upon the doctor's prescription and advice, she can take the loan. The client has to go to the BRAC office with the prescription, one copy of their photograph, and a photocopy of their voter ID card to fill out the application and apply for the loan. The MTL loan can be taken for any amount ranging from three thousand taka to fifty thousand taka (US $ 625). In the video, the female client mentioned that she took the Medical Treatment Loan because she had pain in her backbone. She said, *"I took a loan of 10 thousand taka. With this ten thousand taka (the US $ 125) loan, I got treatment and could also buy all my medicines. Now I am healthy."* -IDI, Beneficiary of MTL loan.

Initially, as mentioned in the video by the co-investigator, 12 branches were selected. This new MTL+ program would be rolled out, and there were 12 others where the existing traditional MTL program continued. In the branches where MTL+ was rolled out, it was found out that the new loan product compared to MTL had almost four to five times the demand. Within the capacity of MTL+, there was a provision of giving out loans to any clients for any of their family members. Also, no referral slip from a designated doctor was required anymore. A client seeking the loan could see any certified doctor, get a prescription for the illness, and obtain the loan.

The video thoroughly grips on to sheer lucidity when portraying the implementation process. All involved stakeholders could understand better how the program worked from the field to the policy level. The video sought to ensure complete unambiguity from the beginning to the very end. The seemingly complex procedure to obtain the loan is explained through iterations of the content for the beneficiaries, field officers, and policymakers. After completion of the post-production, the video documentary was ready for exhibition. The video documentary premiered at a dissemination session. It was shown to the policymakers at BRAC Microfinance and 'the partners of BRAC JPGSPH.

The video was also sent to GIZ, Germany (the donor of Inequality Challenge), for uploading the video on their website. As a part of the dissemination, BRAC JPGSPH also uploaded the video on YouTube and disseminated it on their newsletters, social media, and website.

DISCUSSION

Why Was the MTL Program Introduced?

Among the existing formal services, microcredit loans mainly aim to finance income-generating activities and not health shocks. However, the lenders or service providers are aware that many a time, some of the standard microcredit loans are used to fund health care needs. In such absence of affordable, formal health insurance, poor and vulnerable people seek refuge in the informal, self-insurance mechanisms, where they secure a loan from their close relatives. These help each other out in the event of illnesses. Such informal loan schemes involve connecting one or more lenders accumulating assets of the borrower that are less productive but easy to liquidate and an agreement of paying back the borrowed money with exorbitant interest rates. Moreover, liquidating assets that could have been used as an income-generating instrument is lost in the process, exposing the borrowers to even more financial threats and instabilities. On the other hand, self-insurance mechanisms often do not have the financial capacity to cover the health catastrophe, for reduced income-generating, risk coping abilities of the borrowers due to asset depletion or over-indebtedness.

Understanding the health-care-financing needs, BRAC initiated a Medical Treatment Loan (MTL) program in Bangladesh in 2013. Three main reasons to include MTL in the product portfolio were: i) Maintaining clients' long-term repayment capabilities, ii) Improved risk monitoring and increased loyalty of existing clients, iii) Addressing a crucial human development issue through BRAC microfinance and improving microcredit's reputation.

Despite the promising features, MTL could not expand beyond a certain pool of clientele. So, to assess the underlying reasons for its shortcomings, BRAC decided to conduct a thorough study on what works best and what does not under the current circumstances of method and procedure. Additionally, giving the MTL program an uplift with better accessibility by BRAC Microcredits clients in need was also a priority. The BRAC Microcredit program leads the implementation of the MTL program. The design of the innovations to be integrated into the existing MTL program was done jointly by BRAC School of Public Health, BRAC Microcredit program, and Heidelberg University.

What Happened in the Intervention and Research Implications

During the MTL intervention, a research grant from BMZ supported the research activities for 15 months, aiming to design an innovative product and develop a decentralized and digitized implementation protocol that allows better access for the vulnerable clients and better monitoring of impacts BRAC. BRAC JPGSPH also evaluated the performance of the modified program MLT+ in generating sufficient demand. Following the research outcomes, some suggestions were made and integrated into the program to help reshape MTL into an improved loan scheme (MTL+) with more client-centric components.

Implementation Process and Policy Implications

BRAC JPGSPH presented the video documentary to BRAC Microfinance and then in Rangpur to all the staff and beneficiaries to ensure all the stakeholders are on the same page. The video as a knowledge translation (KT) tool successfully interpreted the research findings that sparked dialogues among the policymakers, helped the field officers of MTL+ and the partners fully comprehend the new and improved version of the program. Initially, the dissemination plan did not include producing a video. Proposed later by the donor, GIZ, to make a video, the primary objective was to ensure that the information about the revised design of the loan product and the course of actions to secure a health loan is well understood by all sorts of audiences. The target group was not limited to BRAC, its stakeholders, and the donor only. A health loan for microfinance lenders in Bangladesh has never been seen before. Hence, another important aim of the video was raising awareness and starting dialogues within and outside the development sector. The film intends to share the story of this novel product to influence and positively impact the public health actors and financial institutions in Bangladesh. Through the powerful and emotional narrative style of the documentary, it was expected that the real story of the MTL and MTL+ beneficiaries, staff, and stakeholders would tell the tale of how to roll out and scale-up a product successfully that is timely and yet challenging; considering that penetrating through marginalized communities with a financial product is not easy. Witnessing lives changed and listening to the voices from the ground added value to one's understanding. The BRAC authority was convinced of the effectiveness of the MTL + and is now being offered to 54,000 microcredit borrower families. It is also expected to be scaled up eventually, despite the progress being stalled currently due to the Covid 19 Pandemic. Seeing the raw and authentic story of the journey of MTL+ from MTL unfolded before their eyes, the development actors should be inspired to design public health projects that are the right fit for these communities. However, one of the challenges of knowledge translation to keep in mind is that the language of academic literature can be hard to grasp by all. For the communities that the beneficiaries of MTL+ belong from, such language is far from anything intelligible.

Understanding the Efficacy of the Video Through Literature Review

Knowledge translation (KT) is the dynamic process of sharing and dissemination of knowledge obtained. Although experts have been able to identify specific and appropriate tools for various purposes, the umbrella term 'knowledge translation can be somewhat elusive that has led to its status as a buzzword (2). The array of words used to refer to the transference of knowledge into action generally varies, for example- knowledge transfer, knowledge translation, knowledge exchange, research utilization, dissemination, diffusion, etc. Such a wide spectrum of terms, all used interchangeably, contribute to the alienation of the audience. The same technique was applied to keep things simple to choose the right KT tool, and visual storytelling or videos were chosen, which have been demonstrated to be effective and impactful (6). In our case, the audience, who can very well not belong to the relevant field, public health, and still find the subject matter relatable easily and influenced to take necessary actions. Literature supports the argument that when they are 'shown' the real-life scenario through a video, rather than being told through a long and tedious report, the messages are better received by the audience (16). Sixty-eight percent of respondents shared that they'd like to learn about a new product or service by watching a video, according to Wyzowl's State of Video Marketing Survey (17). However, it is also crucial to remember that the relative importance of knowledge translation to different target audiences will vary depending on the research topic, and appropriate endpoints can be other across diverse stakeholder groups (18).

Research findings can only make a real-life difference, having applied them into practical use once these findings are read and understood by the policymakers, decision-makers, and other stakeholders. 'Read' and 'understood' make for two inspection areas and two grave concerns regarding ensuring research is not black ink on white papers only. To break this down further, Ridde & Degenais assert, " 'make a splash,' your policy brief must first be read" (19), and our verdict is that the same applies for all sorts of KT tools. While ensuring that the KT initiatives are effectively disseminated to the right audience is imperative to KT strategy, maneuvering them to catch the audience's attention is the primary objective. In this regard, visual storytelling plays a vital role. At the same time, it needs to be kept in mind that most of the audience, especially in the context of Bangladesh, is non-scientific. So, to influence existing practices and policymaking, the format of the KT tools needs to be kept simple and engaging. Evidence also suggests integration and execution of KT intervention into a complex project that imparts noteworthy insights about the process local government can engage in public health decision-making (20).

Moreover, findings from health science literature often remain wielded into practical use in a timely fashion despite the dedication of ample resources in the studies conducted. Dr. Ian D. Graham has identified this issue as 'KTA gap,' the gap in transferring knowledge to action. In his paper "Lost in Translation - Time for a map?", he uses some data to indicate the severity of this particular problem. For example, in the

United States, cancer treatment can be improved by 30% only by applying what is already known (2).

Strength and Limitation

It is the first kind of study that showcases the voices of researchers, study subjects (beneficiaries), implementers, and policymakers captured through the research. It also illustrates how the knowledge gathered through the research can be translated and communicated to scale up the intervention. The limitation of this study is the absence of an effectiveness trial of the video that could have created robust evidence. Therefore, the application of this study in other settings might not be possible.

CONCLUSION

Videos can evoke powerful human emotions and is ideal for explaining anything involving many steps. It is also more desirable by consumers than text-based promotions or infographics. Moreover, thinking and reflecting on the audiences that the knowledge is intended for and staying true to what message is aimed to be conveyed is vital. Hence, the process of acquiring BRAC's Medical Treatment Loan program is arguably best described through this video. In the process of doing so, it was expected to convey the lived experiences. For the BRAC JPGSPHs video on MTL+, the audience was more wide than narrow; it ranged from potential beneficiaries to policymakers and different stakeholders in between. Therefore, it was essential to ensure that the video achieved the spot where it could be well-understood by all those groups.

In conclusion, the 'show, not tell' way of storytelling through videos jumps across the complex nature of text-based knowledge sharing. In such cases, the video can help relevant stakeholders understand the "bigger picture" of public health interventions such as MTL+. It can be compelling and thought-provoking, making an ideal tool of knowledge translation where the audience is the general mass.

DATA AVAILABILITY STATEMENT

The raw data supporting the conclusions of this article will be made available by the authors, without undue reservation.

ETHICS STATEMENT

The studies involving human participants were reviewed and approved by Ethics Review Committee, BRAC JPGSPH. The patients/participants provided their written informed consent to participate in this study.

AUTHOR CONTRIBUTIONS

MS and RT conceptualized the theme of the manuscript. MaR has written the first draft. RT, MuR, and MI were engaged in the video production and contributed in the manuscript. AR provided comments on the video script and the manuscript. MS finalized the manuscript and incorporated the comments shared by all co-authors. All authors contributed to the article and approved the submitted version.

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