BEHAVIOUR CHANGE COMMUNICATION STRATEGY GUIDE

For Reproductive Health Programmes in Sri Lanka

Booklet 2 – The Programme on Gender Based Violence/Intimate Partner Violence Prevention and Response

Ministry of Health Sri Lanka
Health Education Bureau
Family Health Bureau
UNFPA, United Nations Population Fund Sri Lanka

Prepared by Lakshman Wickramasinghe, National Consultant
Thusitha Malalasekera, Assistant to the National Consultant

Edited by Najib Assifi, International Consultant

Based on
Findings of the Focus Group Discussions
Output of the Stakeholder Workshop
Suggestions of a Panel of Stakeholders on the Penultimate Draft

BEHAVIOUR CHANGE COMMUNICATION STRATEGY GUIDE

FOR

THE PROGRAMME ON GENDER BASED VIOLENCE/INTIMATE PARTNER VIOLENCE PREVENTION AND RESPONSE

January 2014

Foreword by Chairman BCC Core Group

It is with great pleasure that I send this message for inclusion in the Behaviour Change Communication Strategy Guide Booklet series for Reproductive Health. These booklets reflect the successful work undertaken by many stakeholders and institutions for a period of two years beginning from November 2011. As the Chairperson of the BCC Core Group, I have witnessed the many and varied type of work planned and implemented to achieve the outcome reflected in these booklets. The Core Group has been closely involved from the conceptualization stage of the BCC strategy development process to the final discussions to develop and finalize communication strategies for each RH programme. The Core Group with the logistical and technical assistance of the Health Education Bureau, and the Family Health Bureau monitored the BCC strategy development process. In this regard I am much thankful to the two Directors and the staff of HEB and the FHB for their important contribution in making the process a success. I also thank the members of the Core Group for their active contribution. I must mention that the members from outside of the government health sector, including those members from NGOs also contributed positively to the work of the Core Group as well as at the two stakeholder workshops.

The representatives of the College of Obstetricians and Gynecologists participated very actively and creatively in developing these strategies. The representatives from the Ministry of Education and Women's Affairs too were involved in the discussions. I must also mention the contributions made by the district health administrators, especially the Regional Directors, the MOHs and their teams in the seven selected districts in which the formative research activities were conducted. The focus group discussion team moderated the group discussions effectively and compiled the results well. UNFPA played a key role in this initiative providing technical and financial support to this key initiative. The National Health Programme Officer coordinated UNFPA assistance very effectively. The national consultant helped in technical coordination of the initiative, and compiling the Strategy Guide Booklets whilst the international consultant from the Asia-Pacific Development Communication Institute helped in moderating the Stakeholder workshops and editing the booklets. I also thank the assistant to the national consultant and the research analysts who assisted in the above process. Finally I wish to mention that the most important contribution to the BCC strategy development process was made by our clients. They participated actively and without inhibitions in the focus group discussions.

May I conclude by emphasizing that the BCC Strategy Guide Booklets for Reproductive Health is only the beginning of a long journey. The efforts made during the last two years will succeed when these strategies are converted into a set of effectively orchestrated activities at policy, programme, mass media, community, and family levels. The collaboration and cooperation of all the above mentioned persons and institutions, as well as many more would be needed to make the BCC Strategy Guides a real success. The commitment and the effectiveness of the partnership between the Health Education Bureau, and the Family Health Bureau, and their capacity to orchestrate the varied activities efficiently will hold the key to future success. I am confident that we will succeed.

DR. R.R.M.L.R. Siyabalagoda
DDG (Public Health Services II)
Ministry of Health
Sri Lanka

Preface by UNFPA Representative

It has been a pleasure to extend our support to this important initiative in developing Behaviour Change Communication Strategy Guide on selected reproductive health programmes in Sri Lanka.

Since the International Conference on Population and Development (ICPD) in 1994, UNFPA, the United Nations Population Fund began to align communication and advocacy initiatives within reproductive health programmes in paving the way for attitudinal and behaviour change and in enlisting the support of key decision-makers. Empirical evidence, research and programmmes have all shown the importance of incorporating behaviour change approaches into reproductive health programmes in achieving reproductive health goals swiftly and efficiently. We are proud to say that the Behaviour Change Communication Strategy Guide for Reproductive Health Programmes in Sri Lanka is the result of these decisions and related action.

We congratulate the Health Education Bureau and the Family Health Bureau of the Ministry of Health for their commitment, dedication and partnership in developing of these documents. UNFPA is happy to have provided technical support through International and National consultants and to have facilitated stakeholder workshops.

We sincerely hope the activities identified in the strategy documents will be integrated into existing programme delivery and create the behaviour changes required to further improve the reproductive health outcomes in Sri Lanka.

Mr. Alain Sibenaler

UNFPA Representative Sri Lanka

Message by Secretary Health

The integration of Behaviour Change Communication (BCC) strategies into reproductive health programmes in Sri Lanka is very timely. The new national maternal and child health policy of 2012 which also covers most of the reproductive health initiatives recognized the importance of BCC. A key strategy in the new MCH policy is “strengthening of BCC interventions”.

There are varied challenges confronting the reproductive health programmes. The majority of these challenges are linked to people’s behaviour; some behaviours which are positive should be sustained; many behaviours which are undesirable need to be changed. A well designed, strategically sound behavior change communication approach will positively contribute to overcome these challenges.

The series of five BCC Strategy Guide booklets contain some of the optimal BCC strategies for each of the reproductive health programmes. The application of BCC approaches require specific technical skills as well as a commitment to change in work procedures. The magnitude of success of these BCC strategies will be dependent on the quality of planning, implementation and monitoring. I firmly believe that the Health Education Bureau working in partnership with the Family Health Bureau would provide effective technical support for application of BCC strategies successfully in the field. I also wish to acknowledge the contribution of UNFPA, Sri Lanka Office in this important endeavor.

Dr Y.D Nihal Jayathilake
Secretary of Health
Ministry of Health
Sri Lanka

Message by Director General Health

Health education in Sri Lanka is at the cross-roads. I believe this is true for most developing countries. With the spread of new social media including the internet, and the increasing educational achievements of our citizens, Sri Lanka would need to move to a more client-friendly, client-focussed method of health education than the traditional health education methods based on the well- known IEC approach. IEC or information, education and communication approach has stood us in good stead. But it would not be fruitful any longer as the social, educational and economic environment has changed and with that the behaviours and attitudes of our clients have become more complex. Our clients themselves are becoming more sophisticated and adopt a questioning attitude, before they accept concepts, ideas and new methods.

The behaviour change communication model approach that is being increasingly advocated by the United Nations agencies and is gradually being taken up by both developed and developing nations is an appropriate model for Sri Lanka at this stage of our progress in health programme development. We need to adopt this approach not purely because of external agency advocacy. We need to accept an approach such as BCC, as from time immemorial our society has been used to view life based on a course-effect approach. BCC is mainly a cause-effect based approach to health education. Under BCC, the health education planners need to understand the current health behaviours of clients, the reasons for such behaviours and develop health education messages and methods,taking into consideration client's knowledge, attitudes, skills, perceptions, misconceptions as well as family, community, and cultural influences.

Under this approach health education transforms itself into an interactive activity, and less a prescriptive activity. The health education planners would need to 'unlearn' as well as develop new capacities and attitudes in order to facilitate clients to accept desirable health practices and behaviours. Message design has to be based on client consultations; communication methods need to be interactive and dialogical, and above all health education has to respond and as much as possible help to resolve the problems clients are confronted with in using advocated desirable health behaviours. Under BCC approach, health education not only disseminates knowledge, but actively supports the client in resolving problems. It is a partnership of sorts.

To plan and implement a BCC strategy, the HEB and FHB would also need to work in partnership.

I wish HEB and FHB success as they embark on this joint venture for the benefit of women, children, adolescents and young people of Sri Lanka.

Dr. P.G. Mahipala
Director General of Health Services
Ministry of Health
Sri Lanka

Message by Director HEB

I am humbled to have the opportunity of releasing this series of booklets on Behavior Change Communication Strategy for Reproductive Health for the first time in Sri Lanka.

Gender Based Violence is widely seen all over developing countries. However in most countries, its consequences go unspoken and what is reported is only the tip of the ice berg.

The aim of the booklet is to educate medical as well as non-medical personnel mainly in the community level in order to implement change in the behaviors of the general population to reduce Gender Based violence in Sri Lanka.

I greatly appreciate the Behavior Change Communication Unit (BCC) of the Health Education Bureau for making this series of booklets a reality by conducting extensive field research representing all ethnic communities covering the main localities of the Island. I extend my heartfelt gratitude to the BCC Unit and other staff of the Health Education Bureau for their dedicated hard work throughout the period, the Family Health Bureau staff for their valuable technical inputs and the UNFPA for their financial support.

I would also thank Dr Chandani Galwaduge, National Programme Officer UNFPA and National Consultant Mr Lakshman Wickramasinghe, and International Consultant Mr Najib Assifi for their tireless involvement and editorial work.

I strongly believe that this booklet will provide necessary inputs to reduce gender Based Violence in Sri Lanka and I wish all the very best to all those who use this booklet to implement behavior change in the community.

Dr Neelamani S Rajapaksa Hewageegana

Consultant Medical Administrator

Director - Health Education Bureau

Sri Lanka

Message by Director FHB

Behavior Change Communication Strategy for RH programmes booklet two was developed with a view to improve gender-based violence prevention and response services in the country. This communication strategy utilized by the specific target groups would mainly contribute towards prevention of intimate partner violence in society. It would also contribute to improving community mobilization for prevention of intimate partner violence and policy support to enhance health sector participation in prevention and response to gender based violence.

The research findings of the focus group discussions done with the relevant target groups provided valuable thought provoking information for development of a need based BCC strategy.

We wish to place on record our deep appreciation to UNFPA country office for providing the financial and technical support especially to Dr. Chandani Galwaduge the national programme officer for the guidance and support provided throughout the study: to Dr. Neththanjali Mapitigama Consultant Community Physician, Gender and Women's Health for the technical inputs provided, the National Consultant Mr. Lakshman Wickramasinghe, Mr. Najib Assifi the International Consultant, for the data collectors and analyzers, all staff of Health Education Bureau and Family Health Bureau for particularly going through the recommended process, helping the national and international consultants to document the process of the stakeholder workshop and for all those who helped in numerous ways to finalize this document.

Dr. Deepthi Perera
Director - Maternal and Child Health
Family Health Bureau
Sri Lanka

LIST OF ACRONYMS

ASP	Assistant Superintendent of Police
BCC	Behaviour Change Communication
CBO	Community Based Organization
CP	Country Programme
CST	Country Support Team
DV	Domestic Violence
FGD	Focus Group Discussion
FHB	Family Health Bureau
GBV	Gender-Based Violence
HEB	Health Education Bureau
HEO	Health Education Officer
HQI	Head Quarters Inspector of Police
IEC	Information Education Communication
IPV	Intimate Partner Violence
M&E	Monitoring and Evaluation
MO	Medical Officer
MOH	Medical Officer of Health
MoH	Ministry of Health
NGO	Non-Government Organization
NIE	National Institute of Education
NYSC	National Youth Service Council
PHM	Public Health Midwife
PHNS	Public Health Nursing Sister
PHI	Public Health Inspector
Q&A	Question and Answer
RH	Reproductive Health
SPHM	Supervising Public Health Midwife
SPHI	Supervising Public Health Inspector
UNICEF	United Nations Children's Fund
UNFPA	United Nations Population Fund
WHO	World Health Organization

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4. Annexures

PART I

1. INTRODUCTION

Behaviour Change Communication (BCC) is an important supportive strategy in the 2013-2017 Sri Lanka-UNFPA Country Programme Action Plan and is expected to contribute to the achievement of goals and targets in maternal and newborn health; gender equity; reproductive rights; adolescents and young people's sexual and reproductive health. Overall, the BCC strategy is expected to support RH programmes in reducing morbidity and mortality due to reproductive health causes.

The planning and preparatory work for designing the BCC strategy for the new country programme (CP) began in 2011, during the seventh CP2008-2012. Even earlier, during the sixth country programme, UNFPA provided assistance to the Government of Sri Lanka in training key officials in the National Youth Service Council, the Ministry of Labour, the Sri Lanka Army, and the Health Education Bureau on planning and implementing BCC strategies in support of reproductive health and HIV/AIDS prevention. However, it was during the seventh CP that action was initiated to amalgamate BCC strategies and interventions into reproductive health programmes. UNFPA provided facilitation and support to the Family Health Bureau (FHB) and the Health Education Bureau (HEB) of the Ministry of Health in this task. The basis of this action was the recommendations of the External Review of the Sri Lankan Maternal and Newborn Health Programme held under the auspices of the Government of Sri Lanka, WHO, UNICEF, and UNFPA in 2007. The review recommendations[1] provided impetus to the amalgamation of previous fledgling work undertaken by UNFPA and MoH in the area of BCC strategy formulation, into the current programme.

Since the International Conference on Population and Development (ICPD) in 1994, UNFPA had begun a distinct shift, globally, towards aligning communication and advocacy initiatives with the reproductive health programmes to pave the way for attitudinal and behaviour change and to enlist support of key decision makers and leaders. Empirical evidence, global programmatic experiences within the UN system, and research have shown the importance of incorporating behaviour change approaches into country programmes in order to support achievement of the reproductive health goals rapidly and efficiently.

In 2005, the UNFPA country support team (CST) Bangkok conducted a desk review and a regional consultation on the understanding and applications of the work undertaken by various country offices under advocacy, BCC and IEC interventions. Subsequent to the review, a Global BCC Technical Meeting of UNFPA communication specialists held in December 2006, came to the understanding that result-oriented programmes at country level would profit substantially by integrating BCC strategies. The UNFPA CST Bangkok released a handbook for implementing BCC

[1] Recommendations: (1) Include behavior change communication as a strategy in the new MCH policy. (2) Develop national BCC Strategy for MNH jointly between FHB and HEB. Pg.85, Report of the External Review of Maternal and Newborn Health, Sri Lanka, Ministry of Health, UNFPA, UNICEF, WHO, Oct 2007

interventions entitled “Planning BCC Interventions: A Practical Handbook”, to provide a working methodology for integrating BCC strategies into reproductive health programmes in countries of the region. The handbook which was written by Peter Chen, the former CST BCC Advisor, also included ideas and practices discussed at the Regional Consultation and the Global Technical Meeting. It has been translated into Sinhalese language. A Tamil language version is being planned.

Although the above-mentioned handbook could be used with profit to guide planning of BCC strategies as well as training health sector officers in BCC in Sri Lanka, the UNFPA office in Colombo and the Sri Lankan Ministry of Health’s FHB and HEB, while exploring the feasibility of introducing BCC interventions into reproductive health programmes came to a joint decision that the development of a BCC strategy for each of the RH programmes, based on Sri Lankan situation analysis would be vital to start the process of integrating BCC into RH programmes.

The BCC Strategy Guide for Reproductive Health Programmes in Sri Lanka is the result of this decision and related action. This document is the synergistic outcome of the efforts of the Health Education Bureau and the Family Health Bureau of the Ministry of Health, the UNFPA Sri Lanka country office, staff of MoH and health staff of selected districts, participants of the BCC strategy development stakeholder workshop, the national and international consultants, assistant to the national consultant, and national research analyst. The consultants were commissioned by UNFPA, Sri Lanka with the concurrence of the Ministry of Health. The basic information for the development of the BCC strategy was provided by current and prospective clients (groups) of the respective reproductive health programmes in selected districts. This information was obtained through a formative research initiative coordinated by the Deputy Director and selected staff of the Health Education Bureau with technical assistance from the national consultant, national research analyst and the assistant to the consultant.

The national coordination of the overall BCC strategy development and implementation initiative for reproductive health was the responsibility of the Core Group on BCC Strategy Development established for this initiative. The membership of the Core Group included the Directors and Deputy Directors of Family Health Bureau and Health Education Bureau respectively, programme managers of the five reproductive health programmes, national programme officer of UNFPA, and other key stakeholders (please see annexure 1). The Core Group was chaired by the Deputy Director General of Health Services (Public Health II).

2. THE WAY FORWARD - IEC TO BCC: BASIC DIFFERENCES AND KEY CONCEPTS

Behaviour Change Communication, as the term implies attempts to change the existing undesirable behaviour of clients into desired set of behaviours to help a particular development programme achieve its objectives. The BCC approach will also reinforce and sustain existing positive behaviours of clients, as development of existing desirable behaviours is a key function of the strategy. Therefore, BCC could be described as a set of communication processes and techniques that is applied to programming aimed at affecting social change and individual behaviours.

People generally do not change their behaviours just because the staff of a development programme prescribes them to do so, even though the suggested behaviour is technically correct and feasible and would clearly benefit the family and the community. There are, of course, some people who would initially try out the suggested change, due to their inherent psychological tendency to try out new things and/or due to their specific socio-economic situation which could comfortably absorb any risks in relation to experimentation with the proposed new behaviour. But the vast majority would be apprehensive about changing their existing behaviours with which they have been comfortable with, without apparent disadvantages.

The information, education and communication (IEC) approach which is the dominant method currently used by health education institutions in Sri Lanka as well as in many countries in the region, is conceptually and methodologically not designed to actively assist clients to change from existing undesirable health behaviours into desired health behaviours, especially if the suggested desired behaviour is complex or entails many perceived costs. Under the IEC approach people are generally given universal facts about a practice and the technical reasons for accepting such a practice. The IEC approach mainly influenced by models such as Shannon-Weaver[2] and the Berlo[3] models of communication use one way influence approaches to attempt to change behaviour. Under an IEC dictated health education initiative, the Programme is considered supreme as it is the entity that identifies the recommended practice; owns the key communication messages in the guise of universal facts and technical knowledge about the practice, and possesses key communication resources to pass on the 'message' to prospective clients. In this approach the client is secondary in that she/he is for the most part a passive receiver of health messages, and is expected to automatically change to the recommended behaviour, as the sender stipulates. The IEC planners believe that once the basic facts and technical knowledge are sent down to the clients clearly, behaviour-change would occur, as it is the rational thing to do. However, in reality, this happens only in a small number of clients as explained above. The vast majority of clients are not in a position to respond positively to knowledge inputs sent down by the programme, especially if the recommended behaviours are

[2] Shannon, C.E., & Weaver, W (1949) The mathematical theory of communication Urbana, Illinois: University of Illinois Press

[3] Berlo, D.K. (1960) The process of communication New York: Holt, Rinehart, & Winston

complex in nature or perceived by the client to have familial, social, economic, and cultural implications.

People normally do not act only on facts and technical knowledge to change behaviour. They need a clear understanding of the behaviour, the principle behind it and how to practice it (i.e. skills); they need to understand the benefits and costs of change of behaviour-benefits and costs are not only financial but social and cultural; they need to discuss new behaviour with their families - for some practices they would need family support and assistance; they would try to find out if the local community would accept such a practice or not; they would want to know if the new practice is safe and reliable, and easy to access; that the practice is culturally acceptable, and would not cause community censure; so on and so forth.

The BCC approach, however, is specifically geared to respond to these client concerns, and to accept the premise that the client is the primary resource in planning communication approaches for facilitating desired reproductive health behaviours.

Therefore, the BCC approach in a sense turns the health education planning process upside – down. Once a programme identifies a behaviour that is technically viable, and need to be promoted widely among a particular cohort of a population (to resolve a public health problem), under the BCC approach, planning should start at the grassroots, i.e. with the clients. Through formative research exercises (these can be for the most part done rapidly once capacity is established) the programme and the health education team should find out from clients some basic information that includes the following:-

- The existing desirable and undesirable behaviours (relating to the particular heath problem or issue,) and the reasons for the two categories of behaviours.
- The existing knowledge of clients regarding the recommended (or promoted) desired behaviour. Here generally four types of knowledge would be looked into: (i) technical and factual knowledge; (ii) knowledge about the principles behind the practice; (iii) knowledge about benefits or advantages accruing to the client and family; and (iv) 'how-to-knowledge', i.e. knowledge on skills necessary to practice the particular behaviour.
- Factors[4] that facilitate (make it easy for) clients to practice such behaviours, and the factors that constrain (makes it difficult for) clients to practice or change-over to the recommended behaviour; and who or what causes these constraints, and how these constraints could be reduced.
- Communication exposure of clients, most used communication channels and their perceived credibility.

[4] These could be favourable or unfavourable beliefs, attitudes, and perceptions; myths and misconceptions; community or family resistance or household-related barriers; strengths and weaknesses in service delivery or negative experiences with service delivery system or staff; strengths and weaknesses in health education approaches and style etc.

- Other persons who influence clients' attitudes, perceptions, decisions and behaviours from within the family, as well as among peers, the local community, and the workplace etc. on reproductive health matters.
- Feedback on appropriateness of relevant rules regulations and policies (this latter may be a difficult area for clients to respond to and may need information from other stakeholders).

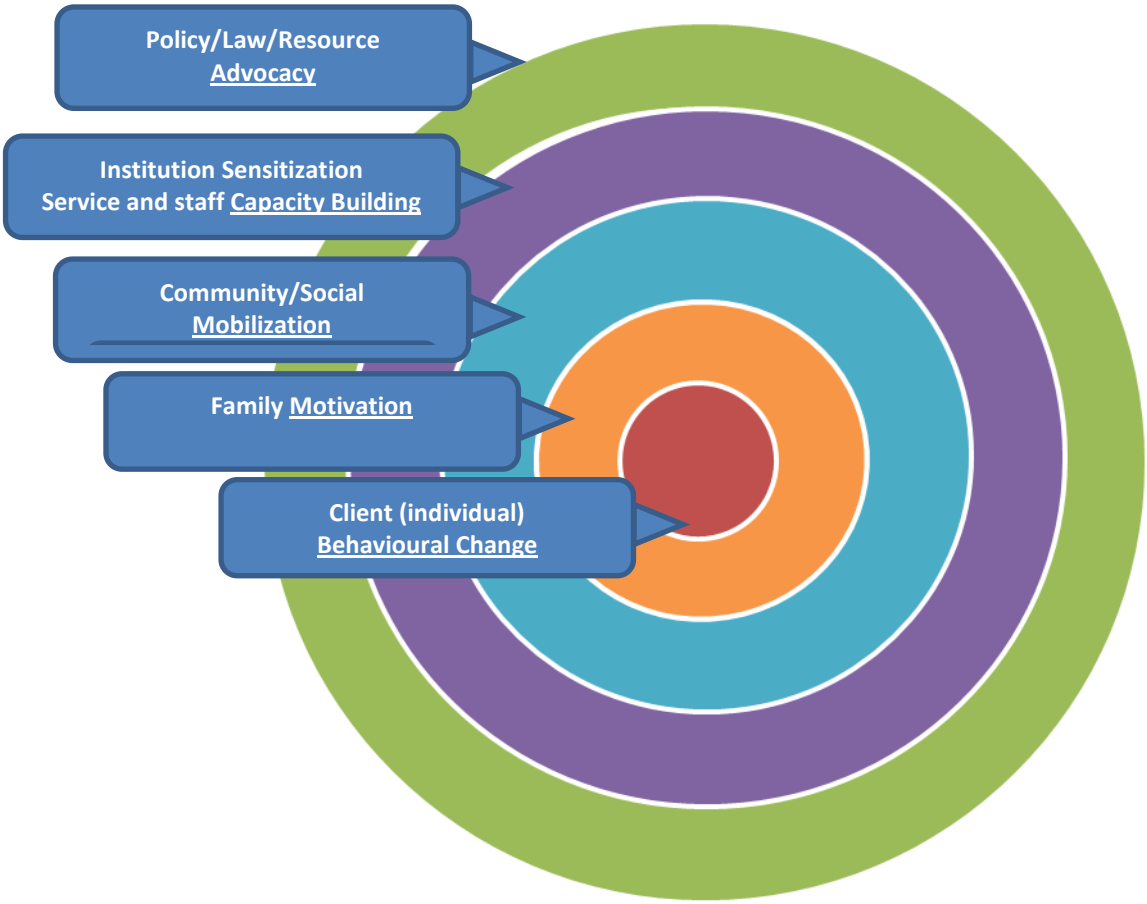
The rationale for attempting to obtain the above information is due to the understanding arrived by BCC planners and researchers that a person who wishes to undertake or change to new desired health behaviour should:

- Have a distinct reason(s) for practicing the behaviour, i.e. should perceive and internalize benefits to self and/or family;
- Know what to do, where to go, whom to meet;
- Know how to do it, i.e. have required skills to undertake the behaviour;
- Have positive ideas about the behaviour;
- Have required resources(availability of time, money, and people support) to undertake the behaviour;
- Have social acceptance and legitimacy for such a move;
- Have access to service-delivery system that ensure privacy and confidentiality, polite and courteous service providers, adequate physical infrastructure and facilities, minimal waiting time etc.; and
- Have benefit of supportive policies, programme protocols and service infrastructure, equipment and human resources.

KEY ELEMENTS OF A BEHAVIOUR CHANGE COMMUNICATION INTERVENTION

- Client (individual) **Behaviour Change**
- Family **Motivation**
- Community/Social **Mobilization**
- Institution sensitization/Service and staff **Capacity Building**
- Policy/Law/Resources **Advocacy**

LEVELS OF IMPLEMENTATION OF BCC STRATEGY

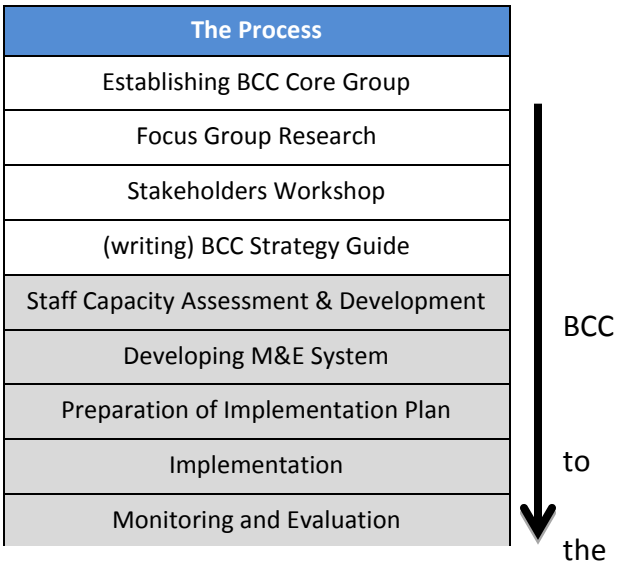


Thus a behaviour change communication strategy would ideally include the following communication elements at different implementation levels, beginning from the client, the central focus of BCC, to the policymaker as shown in the diagram of increasing concentric circles. At each of these levels, the behaviour-change in key actors is crucial for the success of the particular communication element at each level; as well as for overall success of behaviour change of the client. The main focus of the BCC activities is on the centre circle, i.e. around the client (who receives the service); however, the main activities at each of the levels shown in the concentric circles should also be implemented as planned in a coordinated manner as it is the synergistic effect of results of activities at each of the different levels that will help to accelerate client behaviour change.

3. BCC STRATEGY DEVELOPMENT FOR RH PROGRAMMES IN SRI LANKA: THE PROCESS AND METHODOLOGY

BCC Core Group and Technical Assistance

The BCC strategy development process began in 2011 with the establishment of a BCC core group, and the appointment of a national consultant. The BCC core group chaired by the Deputy Director General of Health (Public Health II) provided overall guidance and direction to the BCC strategy development process, and ensured policy and administrative recognition. At the first meeting the concept, purpose, the process and the methodology of strategy development for RH Programmes was presented to the full core group by the national consultant and approval was obtained begin implementation of the methodology. Subsequently at each key stage of the process, main categories of planned activities were presented to the core group for concurrence and on completion, the main outputs of the approved activities were also presented to the core group for information and feedback.



The national consultant provided technical leadership to the strategy development process and provided technical assistance to the Health Education Bureau and UNFPA Country Office in BCC strategy formulation.

Planning Data and Information

The main information required for planning and developing formative research was collected in three ways. The basic planning data for focus group discussions was obtained through Key Informant Interviews. The Programme Mangers of Maternal and Newborn Health, Well Woman Clinic, Family Planning, Adolescent and Young Person's Sexual and Reproductive Health, and Prevention and response to Gender based Violence Programmes were interviewed by the assistant to the consultant to obtain an understanding of programme policies, objectives, strategies, main activities, health education approaches and service delivery mechanisms which helped identify strengths and weaknesses of the respective programmes.

A literature review of available key documents pertaining to each of the above mentioned programmes was also undertaken. Further, a search for reproductive health related IEC materials developed over the last ten years was also undertaken. Two copies of each available IEC materials were collected and an inventory was prepared including a summary description of all collected IEC materials, also by the assistant to the consultant.

Focus Group Discussions

Focus Group Discussion (FGD) was the main formative research method used to generate data and information for the formulation of behaviour change communication strategies for the five RH programmes. FGDs were conducted in seven selected MOH areas. The following types of information pertaining to each programme were collected through focus group discussions.

- Existing knowledge, attitudes, skills and behaviours
- Attitudes and perceptions towards key desired behaviours
- Facilitating and constraining factors affecting adoption of desired behaviour
- Opinions, perceptions on service delivery and interaction with staff
- Sources of information on programme related knowledge, skills, and behaviours
- General communication networks and media exposure

A summary of key FGD findings for the Gender-based Violence Prevention Programme/Intimate Partner Violence Prevention is given below.

FGD Findings – Gender-Based Violence Prevention

Knowledge and Attitude of women, men and community - Women (W) and Men (M)

	W	M
- Understanding of GBV	Weak	Weak
- Understanding that GBV prevention is a fundamental right	Weak	Weak
- Understanding of root causes of GBV	Weak	Weak
- Community acceptance of male dominance	Strongly Positive	
- Community perception that violence is acceptable in married life	Strongly Positive	

Behaviours

- Gender-based violence occurs at homes mainly against wives by husbands including against pregnant women
- Gender-based violence occurs in workplaces mainly against working women by males in authority and in some instances by male co-workers and customers

Key reasons for behaviour

- Poor knowledge among community of 'what is GBV'
- Poor knowledge on the rights of every person (man and woman) to be free of violence
- Low knowledge/non recognition that violence against women is a key element of GBV
- Community/family perception that GBV is common and acceptable in marriages.
- Poor law enforcement in GBV related acts.
- Mass media: Unacceptable focus on sex and violence and gender insensitive reporting and programming.

The Focus Group Discussion methodology is described in Annexure - 2

FGD Report Presentation and Concurrence

The final FGD analysis report for the maternal and newborn health (MNH) Programme was written in English in a typical research report style format. This was initially presented to the Director, Deputy Director and selected staff of the Health Education Bureau and the National Programme Officer of UNFPA as a test case. The analytical methods and approaches used and the final research findings were deemed to be excellent. However, the narrative format used was observed to be limiting the graphic presentation of comparative data and the visualization of key issues (including facilitating and constraining factors for uptake of particular behaviours) that needed to be brought out strongly in the succeeding phase, i.e. the BCC strategy development through the stakeholder workshop phase. The MNH analysis report was redone using a power point format, which was found to be useful for prioritization and visualization of key results. Based on this experience the power point presentation format was used for all final FGD reports. All final FGD finding reports were presented to the Director, Deputy Director of HEB and to the Director of FHB, and its Deputy Director and the relevant programme managers, for information and concurrence. The Director and Deputy Director of HEB and the Director, Deputy Director and programme managers of FHB provided concurrence for using all FGD reports as the base documents for developing the BCC strategy guide document for each of the reproductive health programmes.

The BCC Strategy Development/Stakeholder Workshop

The BCC strategy development stakeholder workshop was held in June 2013, with UNFPA support. The purpose of the workshop was to bring various stakeholders in the area of reproductive health together to present and share their knowledge, experience and insights and jointly draft key elements of a behaviour change communication strategy for the selected reproductive health programmes, in line with the FGD findings. Given the amount of work and

the time required to develop the BCC strategy for five selected RH programmes, it was decided to address three out of five reproductive health programmes namely; Well Woman Clinic, Family Planning and Prevention and Response to Gender-Based Violence in the first stakeholder workshop. The two remaining programmes were addressed in a separate workshop in October 2013.

The workshop participants were divided into three programme groups and were requested to develop the key elements of the BCC strategy based on workshop presentations and FGD findings. The Workshop was co-coordinated by an international consultant from the Asia-Pacific Development and Communication Center (ADCC) of the Durakpundit University, Bangkok and the national consultant. Each programme group presented their proposed BCC strategy related to the topic assigned to them in the plenary session which was followed by Q&A and presentation of comments and suggestions by the stakeholders.

Immediately prior to the stakeholder workshop, the Secretary of Health offered his blessings and wishes for the success of the workshop. In the opening session of the workshop, the Director-General of Health gave the keynote address followed by the opening address by the UNFPA Representative. (for detailed workshop agenda and list of participants please see Annexures 5&6)

Writing of the BCC Strategy Guide for Reproductive Health Programmes in Sri Lanka

The outputs of the stakeholder workshop were molded into the final document titled BCC Strategy Guide for Reproductive Health Programmes in Sri Lanka by the national consultant, the international consultant, and the assistant to the consultant. A stakeholder panel including Directors of FHB and HEB, the Deputy Directors, representatives of College of Obstetricians and Gynecologists, selected NGOs, consultant community physicians, medical officers, and health education officers provided technical clarifications and valuable comments to enhance the quality of the final document. Dr. Lakshman Senanayaka representing the College of Obstetricians and Gynaecologists provided invaluable advice in finalizing the BCC strategy on GBV/IPV prevention and response.

4. THE BEHAVIOUR CHANGE COMMUNICATION STRATEGY GUIDE DOCUMENT- A COLLECTIVE ACHIEVEMENT FOR COLLECTIVE USE

The Behaviour Change Communication Strategy Guide for Reproductive Health is a collective achievement of the stakeholders working in reproductive health area. It is not the product of experts or a technical group; nor is it a product of UNFPA Sri Lanka or the Ministry of Health alone. As a national strategy, it belongs to all stakeholders working in the area of reproductive health in Sri Lanka. Undoubtedly, the Ministry of Health is the lead agency that would give life to it, through policy advocacy, resource mobilization, capacity building, advice and guidance during implementation as well as regular monitoring and evaluation of the whole initiative. The district

health administrations have the responsibility to ensure its implementation at MOH area levels, and as relevant, through base or district hospitals.

The other partners and stakeholders such as the Ministries of Child Development & Women's Affairs, Youth Affairs & Skills Development, Education, Labour&Labour Relations, Plantations Industries, Defense & Urban Development, etc. are equally important and should be engaged to learn the aims and approaches of the strategy and to use appropriate and relevant section of the strategy in their own programme activities. It is also expected that NGOs such as the Family Planning Association of Sri Lanka, Women-in-Need, and others, as well as UN Agencies such as WHO, UNICEF, and UNFPA would take interest in the BCC Strategy and utilize it in their assisted programmes.

5. THE BEHAVIOUR CHANGE COMMUNICATION STRATEGY GUIDE DOCUMENT – FIVE BOOKLETS

As mentioned in the introduction section, the aim of the behaviour change communication strategy guide initiative is to develop BCC strategy guides for each of the five reproductive health programmes. As inclusion of BCC strategies for all programme areas in one publication would make it voluminous and bulky, it was decided to publish the strategy guides in five separate booklets, especially as the potential readership would be different for each strategy guide. The current Booklet (Booklet 2) is on the BCC strategy guide specifically for the Programme on GBV/IPV prevention and response.

6. SUGGESTIONS FOR IMPLEMENTATION

The BCC Strategy Guide for Reproductive Health Programmes in Sri Lanka would form the stage 1 of a phased implementation plan for integrating BCC strategies to support reproductive health programmes in Sri Lanka. The BCC strategy guide alone would not be sufficient to integrate BCC strategies into RH programmes at the implementation level. A rational and doable implementation plan including a monitoring and evaluation plan, staff capacity assessment and development plan, and a resource mobilization plan would be crucial to support and add value to the BCC strategy guide document.

It is proposed that the implementation of the BCC strategy for reproductive health be undertaken using a two track approach.

The first and the slow track approach should aim to institutionalize the adoption of BCC in reproductive health programmes in Sri Lanka. This would first and foremost involve creating political and administrative will at the highest levels of the Ministry of Health for the adoption of the BCC strategy into RH programmes. In practical terms, the next steps would be to undertake an institutional and staff capacity assessment and capacity building on BCC at identified levels in the health sector. Simultaneously, policy advocacy recommendations identified in the BCC strategy guide document could be undertaken. The subsequent (follow-up) implementation

steps should be identified jointly by various stakeholders at a future implementation planning workshop.

The second and the fast track approach should be to implement selected key activities included in the BCC strategy guide for reproductive programmes in Sri Lanka in selected MOH areas as a pilot. This will allow opportunities to learn from the implementation of the strategy at the field level with the aim of further refining and fine-tuning the RH BCC strategy development initiative. For the pilot area, the FGD locations plus the adjacent MOH areas could be ideal sites. Parallel to the local pilots, selected nationwide policy advocacy activities could also start as soon as possible as these would take a fairly long time to show results. A planning team comprising key officers of FHB, HEB, selected health officers of the respective districts, and UNFPA could be established to plan and agree on objectives, training needs, implementation methodologies, M&E methods and management procedures for the pilots and learning laboratory initiative. The lessons learned from the pilot exercise will be useful to the work being undertaken to institutionalize use of BCC approaches through the slow track approach.

There are some concerns that during the implementation, the BCC programme component may evolve into a parallel and separate programme without linkages with the main RH programme. However, it should be noted that conceptually and methodologically the BCC must be an integral component of the main reproductive health service Programme. It should neither be planned nor implemented as a parallel or separate programme. The main service programme and the BCC component must be planned and carried out in a concerted and coordinated manner to ensure a cohesive and well integrated programme. The main purpose of the BCC component is to increase client participation in the main programme and as such, joint planning and implementation of the BCC and RH service delivery components is the ONLY approach for effective results.

PART II

1. THE PROGRAMME ON GENDER-BASED VIOLENCE/INTIMATE PARTNER VIOLENCE PREVENTION AND RESPONSE

In the introduction to this document it is mentioned that the objective of the Behavior Change Communication Guide initiative is to develop BCC Strategy Guides for each of the five reproductive health programmes. This booklet contains the Behaviour Change Communication Strategy for the Programme on Prevention and Response to Gender-Based Violence/Intimate Partner Violence.

The definition of Gender-Based Violence as stated at the United Nations General Assembly in 1993 is "any act of gender based violence that results in, or is likely to result in, physical, sexual, psychological or economic harm or suffering for women including threats of such acts, coercion, or arbitrary deprivation of liberty, whether occurring in public or private life".[5]

Since the BCC Strategy outlined in this document deals mainly on Intimate Partner Violence, which is an important aspect of domestic violence, it is appropriate to consider a definition on Domestic Violence as well. Domestic Violence, broadly speaking is violence largely between family members and intimate partners, usually though not exclusively taking place at home.

There are various arguments used to justify the occurrence of GBV. One is the exertion of authority similar to "paternal authority" which demands obedience and compliance to that authority person. Even among the women who were subjected to GBV/IPV, there were misconceptions: they believed that they experienced domestic violence due to the perpetrator being under the influence of alcohol.

In the Ministry of Health of Sri Lanka, Family Health Bureau is the directorate responsible for women's health inclusive of GBV issues.

Since the commencement of GBV prevention programme, the Family Health Bureau (FHB) has conducted several activities with the involvement of Health Care Workers.

One such activity is the empowerment of preventive health staff on prevention and management. To achieve this objective FHB has already developed a module for primary health care workers on prevention and management of GBV.

It has incorporated the module into the basic training curriculum of public health midwives.

FHB has already commenced an intensive training of Primary Health Care Workers on prevention and management of GBV.

Family Health Bureau has also taken action for the empowerment of curative health workers, through,

[5] United Nations General Assembly - 1993

- Empowering curative health staff to identify, refer, and manage GBV cases
- Establishing GBV care centres at hospital level
  These centres are named as “Mithuru Piyasa” in Sinhala and “Natpu Nilayam” in Tamil. It is a friendly shelter for GBV victims, operated by the hospital staff (mainly by MOs and nurses attached to out-patient department). It offers befriending/counseling services and refer required few clients for appropriate services.

  By September 2013 there were 17 such centres.

- FHB has also taken steps for these centres to establish a link with the peripheral health system and also with a network of stakeholders.

At present Gender-Based Violence is recognized as one of the significant threat to women’s health. Similarly Domestic Violence is also accepted as a major public health issue affecting mostly women causing multiple negative health outcomes in the area of Reproductive Health. Gender Based Violence is also regarded as a major barrier to development.

The Behavior Change Communication Strategy on prevention of GBV/IPV was developed to prevent and to respond to this unhealthy situation. HEB working in collaboration with FHB and other partners in health envisages that the proposed BCC strategy would be utilized to strengthen the ongoing programme on prevention and response to GBV, especially the intimate partner violence (prevention/response) component. The aim of the BCC strategy is to contribute to reduction of occurrence of GBV/IPV by enhancing knowledge and skills; changing community and family perceptions and promoting adoption of desired behaviours within families, especially among husbands and intimate male partners. The BCC Strategy also aims at providing usable information to survivors to enable them to access basic and life-saving services, as well as contributing to enhancement of quality of such services, as well as more wide-spread availability of such services through advocacy.

This BCC Strategy for the programme of Gender-Based Violence prevention/Intimate Partner Violence prevention was developed through Focus Group discussion conducted in 7 selected Medical Officer of Health Areas in 7 districts (Please see Annexure 2 for more details)

2. KEY SECTIONS OF BEHAVIOUR CHANGE COMMUNICATION STRATEGY

The Behavior Change Communication Strategy for Reproductive Health Booklet 2, BCC Strategy Guide on Prevention and Response to Gender-based Violence Programme/Intimate Partner Violence consists of 5 Sections as follows.

Section 1

Behaviour change communication strategy activities designed to motivate,

(a) Husbands and wives, especially husbands
to address the following negative behaviours
(i) One spouse inflicting violence on the other, mostly men inflicting violence on their wives.
(ii) Inadequate communication between husbands and wives on sharing household responsibilities.
(iii) Husbands having sex and sexual acts without due consideration to the feelings of their wives.

(b) Adolescents, particularly boys
To address the negative attitudes and behaviours of adolescents, mostly boys who are not adequately educated and socialized to consider that males and females have equal rights and that, boys should respect girls.

Section 2

Activities designed to enhance the capacity of Health Staff in GBV/IPV prevention and management.

The objective of this component is to motivate the health staff to consider that prevention and management of GBV/IPV are an important and integrated part of their work.

Section 3

Activities to sensitize the main-stream of both Print and Electronic media that it is their responsibility to, (i) educate public on the importance of preventing and management of GBV/IPV (ii) to develop capacity of staff to write and produce features with an in-depth and accurate understanding of gender issues and human rights (so as not to perpetuate and promote GBV/IPV unwittingly in society) (iii) to publish information on existing MoH and other programmes directed at preventing and management of GBV/IPV, including the services of 'Mithuru Piyasa' and "Natpu Nilayam", and other similar institutions.

Section 4

Activities designed to mobilize the community leaders to resist and reject GBV/IPV and to promote prevention of GBV/IPV.

Section 5

Activities designed to advocate through following responsible and influential groups for enhancement of GBV/IPV prevention programmes.

(a) Policy makers – health and other sectoral policy makers at national level
(b) Religious leaders
(c) Senior justice/law enforcement officers
(d) Senior officers of provincial and district levels
(e) Media – senior media personnel including administrators of media institutions

Under each of the above Sections (1 to 5), information and suggestions useful for planning and implementing appropriate communication activities are given. They are:

- main target audience,
- the behaviour expected of them (called the "Desired Behaviour") or the 'practice' they are called upon to perform
- the support they would get (called the Facilitating Factors) and the obstacles they would face (called the Constraining Factors) when trying to perform the 'desiredbehaviour/practice'
- the primary messages, knowledge, and skills that the communication programme should give to the target audience to motivate the target audience members to perform the 'desired behaviour/practice'. These primary messages and skills will help the target audience to increase the facilitating factors and reduce the constraining factors and thus help to perform the 'desiredbehaviour/practice'
- the communication media and or method that should be used to disseminate the primary messages and skills etc. to the target audience. This could be an interpersonal channel (PHM, MOH, or the village monk or priest, or a Women Development Officer), a group communication channel (small group discussion, special class organized by the church, a 'dayakasabha' or meeting of laypersons group of the local temple, kovil or the mosque, mothers' group etc.) it could be a mass media channel (radio, a newspaper, TV channel etc.), or a traditional media channel (street-drama etc.).
- the communication material or tool (leaflet, flip chart, multimedia presentation, anatomical model of the reproductive system, video or DVD filmlet etc.) that incorporates the key messages, knowledge, skills, service information etc.)

3. HOW TO USE THE BCC STRATEGY GUIDE DOCUMENT

The BCC strategy guide document is essentially a behaviour change communication planning guide for persons/officers responsible for motivating clients to continue with existing positive (desirable) behaviours and change existing undesirable behaviours, so that the clients and the programme would mutually benefit. The BCC strategy guide document can be used by officers at any level of the health administration. However the BCC strategy guide document would be especially useful to planners and implementers at the MOH area level and the district level. The activities under sections *3 & 5* should essentially be implemented at the national level.

The suggestions/information given in the Guide was based on the analysis of information and data obtained from clients through focus group discussions. These were reconfirmed and

sometimes added onto at the strategy development stakeholder workshop and the compilation of the final text. All suggested elements in the Guide would be directly useful to motivate a client to change from an undesirable behaviour to a desiredbehaviour. Thus this BCC Strategy Guide on the Gender-Based Violence Prevention Programme is an evidence based document and can be used strategically to prevent and manage Gender-Based Violence particularly IPV.

It must also be emphasized that the information in the Guide must be put into practice in a strategic and informed manner. When implementing the suggestions in the Guide, it must be done with a clear understanding of the purpose, and at least an elementary understanding of the BCC concepts and methods. It is therefore suggested that before a unit such as a MOH area office, or a district attempts to implement the Guide, a short training (minimum 2 days) on BCC concepts, methods and strategy planning be arranged. This training could be jointly organized by the Health Education Bureau and the Family Health Bureau, (after the two organizations receive basic training on BCC strategy planning).

The BCC Strategy Guide is akin to a menu card. It is upto the MOH and the Team to include in prevention of GBV/BCC Implementation Plan at least minimum number of key activities that are strategic and appropriate to the area. It should be mentioned that a minimum number of strategically important activities from the Guide should be selected and implemented in an orchestrated manner to produce positive effect on acceptance of desiredbehaviour. It is the combined or synergistic effect of a set of key activities implemented in a planned and timely manner that would produce rapid and positive results with regard to the acceptance of desired behaviour. A short training on BCC,and the preparation of an implementation plan that would include a strategic set of behaviour change communication activities are vital to profit from this Guide.

THE BEHAVIOUR CHANGE COMMUNICATION STRATEGY GUIDE

FOR

GENDER-BASED VIOLENCE

INTIMATE PARTNER VIOLENCE

PREVENTION AND RESPONSE PROGRAMME

SECTION 1: **BEHAVIOUR CHANGE COMMUNICATION INTERVENTIONS DESIGNED TO MOTIVATE MALES IN PREVENTING DOMESTIC VIOLENCE**

Issue 1 : **Prevention of Intimate partner violence**

Problem Behaviour : One spouse inflicting violence on the other, mostly men inflicting violence on their wives

1. **Desired Behaviours and Facilitating/Constraining Factors**

Target Groups	Desired Behaviours	Facilitating Factors	Constraining Factors
Husband and Wife	Spouses do not inflict violence in any form on each other, particularly, husbands against their wives. Husbands do not resort to any form of violence against wives under any excuse whatsoever such as being drunk. Husbands understand and respect the fact that inflicting violence against wives/women is against the Sri Lankan culture and violates country's penal code as well as the accepted international conventions on human rights. Husbands understand that inflicting violence against wives/women affects the happiness of the family.	Strong cultural and religious practices that respect motherhood and the status and role of women in the family and society. At the time of registration of marriage both partners make a declaration and commitment to respect and to look after each other throughout their married life.	Male dominance is perceived as a norm and accepted by the society. Most of the women do not have an option to challenge male dominance or patriarchal concepts due to old traditional values and norms and their acceptance and internalization. Misconception that the alcohol consumption by husband is responsible for inflicting violence on wife. Husbands and wives are not aware of human rights/women rights, penal code and Prevention of Domestic Violence Act and penalties for violating them.

2. Behaviour Change Communication Strategy

Target Group and Role in BCC	Primary Message, Knowledge and Skills	Communication Media/Methods	Communication Materials/Tools
Husbands and other men To motivate men to have the highest level of respect for his wife and refrain from abuse and inflicting violence against her.	Main Theme : No place for violence in the family. Main Focus : Statements on prevention of Domestic Violence should strongly focus on – (a) Family Values (b) Health of the family (c) Family Wellbeing (d) Welfare of the children (e) Consequences of IPV (f) Legal consequences of perpetrating IPV (g) Human Rights and Women's Rights "Family without violence is a Happy Family" Your wife is your partner for life. Relationships should be based on mutual respect and understanding. Disagreements should be resolved by discussion without resorting to violence. Under no circumstances should use of alcohol be given as an excuse to inflict violence against wives/women.	**Interpersonal communication** with husband and wife by PHM and PHI during their home visits. **Group Meetings - Interactive** To be organized and facilitated by PHI, PHM and MOH on prevention of domestic violence. Special meetings to be convened by community leaders, religious leaders, Samurdhi officers as well as sermons at temples, churches, kovils and mosques strongly opposing domestic/gender based violence and illustrating the adverse effects and unethical basis of such violence. **Mass Media** Reinforcing messages through ▪ Feature articles ▪ Interviews ▪ Panel Discussions Note : PHI & PHM should assemble husbands for meetings/discussions led by MOH with help from Samurdhi Officers, etc.	▪ Presentations/Discussions supported by Flip Charts and illustrations to make interpersonal group communication more effective. ▪ Handout materials (leaflets, booklets) on family values and women's rights addressing different aspects as: ▪ Health of the family ▪ Welfare of children ▪ Extracts from penal code, and Prevention of Domestic Violence Act 2005 ▪ Human Rights, Women's Rights and Child Rights declarations.

SECTION 1: (Contd.)

Issue 2 : **Promoting mutual respect between spouses and reinforcing the value of sharing household burden.**

Problem Behaviour : Inadequate communication between husbands and wives on sharing household responsibilities.

1. **Desired Behaviours and Facilitating/Constraining Factors**

Target Groups	Desired Behaviours	Facilitating Factors	Constraining Factors
Husbands Wives	▪ Husbands and wives should respect each other and each other's wishes. ▪ Husbands and wives must understand the roles they play in their homes must be based on sharing household responsibilities and burdens. ▪ The relationship of husbands and wives within household is based on understanding rather than on gender stereotyping. ▪ Husbands and wives should understand that their behavior would affect the future of their children.	In some families husbands willingly share family responsibilities and burdens.	Belief among most husbands that burden of household work and nurturing of children are the sole responsibility of wives.

2. Behaviour Change Communication Strategy

Target Group and Role in BCC	Primary Message, Knowledge and Skills	Communication Media/Methods	Communication Materials/Tools
Husbands and wives Couples made to understand his/her role in the family and the importance of sharing chores and responsibilities of the household.	Main Theme: Husband-wife communication and sharing of family chores and burdens are important for better understanding and family harmony. Share the burden, Bear the Fruits Importance of modifying gender roles objectively and harmoniously which in turn will help to build a peaceful and harmonious family life. Husbands and wives need to regularly communicate with each other concerning their family and the wellbeing of their children. Men need to become actively involved in chores as family wellbeing is the responsibility of both husband and wife.	**Interpersonal communication**with husband and wife by PHM and PHI during their home visits. **Group Meetings - interactive** PHM and PHI to convene husband-wife meetings at the clinics to encourage husbands and wives to discuss issues and understand the importance of communication and sharing family responsibilities and chores. A presentation by MOH/PHNS/PHI followed by interactive discussion session including answering written questions forwarded by participants. PHI to organize and mobilize **community groups** such as NGOs, CBOs and religious leaders to actively promote husband and wife communication and respect to each other. **Mass Media** to be engaged in promotion and reinforcement of husband and wife communication through broadcasting/publishing materials such as features, panel discussions, interviews etc.	▪ Presentations/ Discussions supported by visual materials such as flip charts and illustrations. ▪ Leaflet on value of good communication between husband and wife. ▪ Press kits for media such as newspapers, magazines, radio and television. ▪ Articles on the value of good communication between husband and wife. ▪ Identification of role models to promote husband and wife communication through interviews and statements in mass media. ▪ Role play/playlets on importance of husband-wife communication, mutual respect and sharing of family chores and responsibilities.

Target Group and Role in BCC	Primary Message, Knowledge and Skills	Communication Media/Methods	Communication Materials/Tools
			Prototype scripts to be written by HEB or Regional HEOs/PHIs/PHMS. These could be enacted during village based events, group meetings etc. ▪ Videoed playlets for projection

SECTION 1 : (Contd.)

Issue 3: **Lack of communication and understanding between husbands and wives regarding matters on sexual relationship**

Problem Behaviour : Husbands having sexual acts without due consideration to the concerns and feelings of their wives.

1. **Desired Behaviours and Facilitating/Constraining Factors**

Target Groups	Desired Behaviours	Facilitating Factors	Constraining Factors
Husbands and Wives	Husbands and wives /Couples communicate effectively with each other on the expectations, needs, desires, and preferences etc. in order to have a satisfying and enjoyable sexual relationship. Couples communicate with each other about the number, timing and spacing of the children they wish to have. Similarly, couples discuss with each other about the prevention of unwanted pregnancies as well as spacing of their children; using suitable and mutually agreed types of contraception, as planned.	Materials available on husband and wife communication and the value of harmonious and satisfying family relationship. Materials available on the types of contraceptive available for prevention of unwanted pregnancies and spacing between pregnancies.	▪ Cultural and local misconception that husband should always take decisions on sexual matters. ▪ Incorrect perceptions that wives are to satisfy the sexual needs of their husbands and that wives do not have needs/desires in regards to sexual matters. ▪ Inadequate and ineffective communication between husband and wife on sexual and reproductive health matters; Concerns of wives on getting pregnant or reproductive health complications are often left un-communicated /ignored.

2. Behaviour Change Communication Strategy

Target Group and Role in BCC	Primary Message, Knowledge and Skills	Communication Media/Methods	Communication Materials/Tools
Husbands/Wives Facilitating effective husband and wife communication with each other to help achieve a mutually enjoyable sexual relationship.	Main Theme: Mutually enjoyable and consensual sexual relationship contributes to family harmony and happiness. Husbands and wives need to recognize that the **sexual relationship** is an important part of family life and **should be enjoyable to both partners.** **Both partners should communicate with each other** on their needs, feelings, likes and dislikes so that sexual relationships would be satisfying to both. **Sexual relationships would be mutually enjoyable when,** both partners jointly discuss about timing and other aspects of sex. Both will be able to enjoy sexual relationship free of fear of unwanted pregnancies and disease. Skills for husbands and wives to communicate with each other on sexual matters without embarrassment and feeling of guilt.	**Interpersonal communication** with husband and wife by PHI and PHM during their home visits. **Further face to face communication and counseling** by MOH/MO with husband and wife referred by PHI and PHM on husband and wife communication, joint decision making on sexual and reproductive health matters, desired number, timing and spacing of their children and use of contraception for prevention of unwanted pregnancies and spacing. **Group communication** with women attending antenatal and post natal clinics by MOH, PHI, PHN and PHM. ▪ Quarterly meetings organized by PHI, Samurdhi officials, NGOs/CBOs e.g. Sarvodaya, etc and FPA. The meetings to be addressed by MOH or MO. **Mass Media** ▪ Articles in Women's papers, etc. ▪ TV/Radio Discussions	▪ Presentations/ Discussions supported by multimedia presentations, flip charts etc. ▪ Handbooks Family Life for newly-weds (FHB publication). ▪ Presentations and group discussions supported by multimedia presentations and handout materials such as leaflets etc. ▪ Press Kit for journalists ▪ Use of role models promoting husband and wife communication.

SECTION 1: (Contd.)

Issue 4 : **To inculcate the understanding of equality between girls and boys and the value of mutual respect shown by both groups.**

Problem Behaviour: Young persons, mostly boys do not consider that males and females have equal rights and should respect girls.

1. **<u>Desired Behaviours and Facilitating/Constraining Factors</u>**

Target Groups	Desired Behaviours	Facilitating Factors	Constraining Factors
Young persons particularly boys	Mutual respect for the rights of women and girls by males and females Adolescents particularly boys showing respect and do not harass or inflict violence on girls.	There is no discrimination in accessing education and health services for both sexes. Most parents do not discriminate against their children whether they are boys or girls. Adolescents of both sexes engaging in education, sports and other social activities together.	Education system having separate schools for girls and boys, provide less opportunities for interaction. Misconceptions of some young persons that males are superior to females. Socialization processes of young children within families still tend to reinforce traditional gender roles of males and females.

2. Behaviour Change Communication Strategy

Target Group and Role in BCC	Primary Message, Knowledge and Skills	Communication Media/Methods	Communication Materials/Tools
Boys, girls, young males and females would be given appropriate knowledge and understanding of the equal rights of each other and skills to respect each other's rights, and dignity. Adolescent boys and young males would be motivated to act as "change agents" for nurturing inculcation of values of treating girls and young women with respect and dignity.	Main Focus: Gender equality and mutual respect among boys and girls are accepted phenomenon universally. In universal human rights context, every person born, whether they are girls or boys, men or women have equal rights in every aspect of life. Therefore boys and males have no right to harass or inflict any kind of violence against girls. Young males should be made to understand that girls, young women and women are not to be treated as 'sex objects', or to be ridiculed. Girls and women are to be respected as they have the same human rights as boys and men. All religious leaders required followers to (i) respect the dignity of each and every human being; (ii) desist from harassing or inflicting violence on fellow human beings.	**Interpersonal communication** by PHM and PHI during their home visits. **Group communication** by MOH, PHI, teachers through workshops, seminars, at: ▪ Schools, (School health clubs) ▪ Youth Clubs (Yovun Samajaya), Youth Corps (Yovun Senanka) ▪ Debates at youth parliament ▪ NIE/NYSC/NGO/CBO, sponsored events. Events ▪ Debates ▪ Quiz Programmes ▪ Essay Competitions ▪ Shramadana ▪ Sports events ▪ (Encourage sports events such as Table Tennis, Tennis, Volleyball, Badminton, Carom, Chess, etc. where there are opportunities to play and interact with the opposite sex, e.g. mixed doubles.)	▪ Training Module; Develop training module on protecting rights of adolescent boys and girls and the importance of boys respecting the dignity and person of girls based on rights concept, religious teachings and cultural values, utilizing a life skills development approach. ▪ Multimedia ▪ Presentation ▪ Flip charts ▪ Panel Discussions ▪ Booklet/Leaflets Information on Human Rights, Women's Rights, Child Rights, Penal Code and religious teachings. ▪ Sports Equipment for School Health Clubs ▪ e.g: Chess and carom boards ▪ Table tennis

Target Group and Role in BCC	Primary Message, Knowledge and Skills	Communication Media/Methods	Communication Materials/Tools
		These events may be organized through establishment of local teams comprising health, education, administrative, law enforcement sector staff and clergy to inculcate value of adolescent boys and girls respecting each other, especially boys and young males respecting the dignity and person of girls and young females. Orientate the team on concepts of treating boys and girls, men and women equally. Train adolescent and young person peer-leaders to organize appropriate local community based events in partnership with the abovementioned adult team to inculcate value of adolescent boys and girls respecting each other especially boys respecting the dignity and person of girls.	▪ Social Media Diffusion of messages to youth through SMS and Face Book. ▪ Street Drama To be staged at events where adolescents gather. ▪ Role plays for use in schools, youth clubs and interactive discussion sessions.

SECTION 2: **ENHANCEMENT OF STAFF CAPACITY TO SUPPORT GENDER BASED VIOLENCE PREVENTION ESPECIALLY PREVENTION AND MANAGEMENT OF INTIMATE PARTNER VIOLENCE**

Issue 5: **Motivated Health Care Providers to promote the value of family harmony and prevention of intimate partner violence.**

Problem Behaviour : Health Care providers do not consider intimate partner violence as an important part of their work.

1. Desired Behaviours and Facilitating/Constraining Factors

Target Groups	Desired Behaviours	Facilitating Factors	Constraining Factors
Medical Officer of Health (MOH) Supervising Public Health Inspector (SPHI) Public Health Inspector (PHI) Public Health Nursing Sister (PHNS) Supervising Public Health Mid Wife (SPHM) Public Health Midwife (PHM) The health care providers to be given skills and competencies to promote prevention/elimination of intimate partner violence.	All health care providers actively promote elimination of intimate partner violence. All health care providers actively participate in prevention of intimate partner violence and extend their assistance to the survivors. All health care providers sensitize public on the services available at 'MITHURU PIYASA'/'NATPU NILAYAM' in health institutions and other available means of assistance. All health care providers develop required skills and competencies needed to successfully conduct BCC programmes addressing the prevention of IPV.	Community trusts the health care providers. Health care providers are committed to help the community to achieve good health and wellbeing. Women trust the health care providers and are used to discuss and share personal and confidential information. Most health care providers have good skills in some aspects of communication.	Health care providers are not oriented about the importance of contributing to elimination of domestic violence in their daily activities. Low involvement by male health care providers in RH related activities. Currently, PHM's engagement with husbands on dialogue on RH matters is limited. PHM has time constraints due to her workload and normally does not allocate time for activities related to prevention of intimate partner violence.Health care providers lack updated knowledge on communication specifically BCC Interventions including problem solving and conflict resolution techniques.

2. <u>Staff Capacity Building</u>

Target Group and Role in BCC	Primary Message, Knowledge and Skills	Communication Media/Methods	Communication Materials/Tools
Medical Officer of Health (MOH) Supervising Public Health Inspector (SPHI) Public Health Inspector (PHI) Public Health Nursing Sister (PHNS) Supervising Public Health Midwife (SPHM) Public Health Midwife (PHM) All health care providers should be able to recognize possibility of occurrence of IPV/DV in areas under their care. Health care providers to promote measures to prevent IPV and direct survivors to appropriate points of assistance including 'MithuruPiyasa'/'NatpuNilayam'and other service delivery points.	<u>Key Knowledge</u> ▪ Ability to recognize the occurrence of IPV/DV. ▪ Myths and misconceptions associated with IPV. ▪ Human rights and Women's rights issues ▪ Good and accurate knowledge on human sexuality and sexual relationships. <u>Communication/Counselling/Process Skills</u> ▪ Family counselling skills ▪ Interactive communication skills ▪ Problem solving skills ▪ Conflict resolution skills ▪ Coordinating with other key government/NGO officers ▪ Use of new social media skills ▪ Use of **'Mood Calendar' method** ▪ Skills for effective interaction with clients, e.g. husbands and wives, on human sexuality and sexual relationships without feeling embarrassed or guilty.	**Training Workshop** ▪ Presentations ▪ Lecture/Discussions ▪ Documentation ▪ Practical activities ▪ Role Plays ▪ Use of new media (SMS etc.)	▪ Training Module on providing knowledge and skills outlined in column 2. ▪ Multimedia presentation ▪ Flip Charts ▪ Handouts on FGD findings ▪ Manual on sex and sexuality for health workers (FHB publications) ▪ Leaflet on '**Mood Calendar' method.** <u>Note</u> : Above FHB publications to be reviewed and if necessary amended to reflect the importance of husband and wife communication on sexual relationships and the practice of agreeable and mutually enjoyable sexual relationship within marriage.

Target Group and Role in BCC	Primary Message, Knowledge and Skills	Communication Media/Methods	Communication Materials/Tools
Health care providers should have skills and competencies to guide married couples on the value and means of mutual enjoyment of sexual relationship. (They may use the materials developed by FHB for this purpose.)	<u>Supporting information</u> Importance and value of sexuality and mutually satisfying sexual relationship in promoting family harmony and welfare. Key Information on the need of sharing work and responsibilities in family. <u>Orientation on</u> FGD findings on GBV. Key elements of: ▪ Friendly service delivery ▪ Time management ▪ Providing information regarding assistance available and appropriate referrals.		

SECTION 2: (Contd.)

2 Staff Capacity Building

Target Group and Role in BCC	Primary Message, Knowledge and Skills	Communication Media/Methods	Communication Materials/Tools
MOH SPHI, PHNS, SPHM PHI, PHM To further develop skills and competencies in planning and implementing BCC strategies. (This activity can be integrated with other RH related programmes)	BCC Concepts and Methods; Practical Application of BCC in support of Reproductive Health Programmes at MOH/PHM area levels ▪ Main goals in RH programmes and importance of client behavior change in achieving RH programme goals/targets. ▪ What is behavior change? (a few bahaviour models). Why and how do people change behaviour?, What are stages of behavior change? What support should the field health staff provide for people/clients to change to desired bahaviour? Understand the National BCC strategy for GBV/IPV PreventionProgramme and developing a suitable programme in relation to the local circumstances. ▪ Key elements of National BCC strategy for GBV ▪ Developing a draft local GBV/IPV prevention strategy.	**Training Workshops** ▪ Presentations ▪ Group Work ▪ Role Plays ▪ Practical Exercises ▪ Field Practice/Exercises These workshops should be conducted by national level trainers/resource persons with the assistance of district/provincial officers)	▪ Multimedia Presentation ▪ Flip Charts ▪ Instructional Video ▪ Publications ▪ Relevant sections of the BCC guideline Book ▪ Handouts ▪ Manual prepared for the training programme.

Target Group and Role in BCC	Primary Message, Knowledge and Skills	Communication Media/Methods	Communication Materials/Tools
	<u>Technical Competencies in using BCC effectively in</u> ▪ Interpersonal communication/home visits ▪ Lecture/Presentations ▪ Group communication sessions ▪ Demonstrations ▪ Public meetings/community level meetings/meetings at religious places ▪ Use of Audio Visuals, multimedia and other tools. ▪ Problem solving techniques ▪ Conflict resolution techniques ▪ Interactive Communication Vs. One-way communication ▪ Counseling ▪ Use of new media to give relevant messages		

SECTION 3: ORIENTATE AND MOBILIZE MASS MEDIA PRACTITIONERS TO SUPPORT PREVENTION AND MANAGEMENT OF GBV/DV THROUGH RESPONSIBLE REPORTING AND ACCURATE AND EFFECTIVE MEDIA PROGRAMMES

Issue 6 : Media's handling, style and coverage on issue of domestic violence tend to create a negative perception in society which indirectly contributes towards public apathy towards GBV/IPV and at times social acceptance of intimate partner violence.

Problem Behaviour : Media does not provide sufficient space and time to educate public on adverse effects of intimate partner violence; at times, unwittingly media promotes violent behavior of men towards their wives, as well as women.

1. **<u>Desired Behaviours and Facilitating/Constraining Factors</u>**

Target Groups	Desired Behaviours	Facilitating Factors	Constraining Factors
Journalists and other media personnel working at national, regional and district levels such as: ▪ Staff Reporters ▪ Reporters ▪ Feature writers ▪ Sub editors ▪ Presenters ▪ Moderators ▪ Producers ▪ Directors	Media facilitate prevention of GBV/IPV by mobilizing public support to address the impunity with which GBV is treated. Media correctly recognize underlying factors of GBV/IPV and provide appropriate coverage in a responsible manner to facilitate the society to denounce and prevent IPV. Media enhance the awareness on Human Rights, Women's Rights, Children's Rights and the related laws that address DV/IPV. Media do not directly/indirectly portray perpetrators of DV/IPV as heroes in their presentations/programmes (including teledramas).	Media enjoys a wide coverage in the country and influences public opinion. Rural and urban people patronize both print and electronic media widely.	With the changing times, the quality of reporting in media shows a downward trend. Media in some of their presentations portray perpetrators of violence as heroes. e.g. in Teledramas and other such programmes. Media tend to sensationalize and use violence to popularize/ market themselves.

Target Groups	Desired Behaviours	Facilitating Factors	Constraining Factors
	Media educate the public on issues and problems of DV/IPV so that society could adopt preventive measures.		Media for the most part fail to study/portray human sexual relationships deeply; fail to understand or consider how media's portrayal of sexual relationships impact on community/family attitudes and behaviours, especially reinforcement of existing negative perceptions and behaviours that are biased against young girls, women and wives.

2. <u>Orientating and Sensitizing the Media Practitioners</u>

Target Group and Role in BCC	Primary Message, Knowledge and Skills	Communication Media/Methods	Communication Materials/Tools
Journalists and media personnel working at the national, regional and district levels. Media personnel act as the bridge between people and the authorities. The editors, copy writers, journalists and others in media will be sensitized and motivated to develop a comprehensive understanding of GBV/IPV and contribute towards the prevention of GBV/IPV.	<u>Main Focus:</u> Media could be used as an instrument for change. Media personnel who report on GBV/IPV should be committed and equipped to study the subject indepth. Media personnel should have a clear understanding of domestic violence; methods and approaches through which they could change the attitudes of the public to denounce and prevent domestic violence. Media should highlight the Sri Lankan cultural values that condemn violence and respect women. Media practitioners should understand myths and misconceptions surrounding the IPV menace. Media should provide information and messages highlighting a happy and fulfilling family life based on mutual understanding and respect without violence.	**Organize workshops/seminars** for feature writers, reporters, photographers,freelance journalists to enhance understanding of IPV and to discuss how media can effectively raise awareness and influence communities to address prevention of IPV. ▪ Workshops to be based on Guide Book on GBV/IPV for media including the presentation of findings of focus groups discussions on GBV/IPV. ▪ Possible strategies and programmes that media could employ to educate public, especially husband, on desisting from inflicting violence on wives. <u>Note</u>: A Media Working Group on GBV/IPV comprising medical, media, NGO, and government officers including a sociologist to be established to develop a **Guide Book on GBV/IPV for Media** (approximately 8 persons).	▪ Presentations on GBV/DV using the findings of the focus discussions groups using multimedia, handout materials, charts, illustrations etc. ▪ Media kits on prevention of IPV; ▪ Case studies on adverse effects of IPV; ▪ Mini exhibitions during workshops; ▪ Presentations by GBV/IPV survivors. ▪ Guide book on GBV/IPV prevention for media.

Target Group and Role in BCC	Primary Message, Knowledge and Skills	Communication Media/Methods	Communication Materials/Tools
	Media should make the public aware about the services available at 'Mithuru Piyasa'/'Natpu Nilayam' and other service points for the survivors so that communities, local leaders and authorities support and patronize them.	- Group discussion to highlight the role and responsibility of media in facilitating prevention of GBV/IPV. - Field Visits arranged to 'Mithuru Piyasa' and 'Natpu Nilayam'. - Periodic interactive meetings with media personnel and health care providers to discuss the problems associated with IPV and solutions that can be implemented through media interventions.	

SECTION 4 : SOCIAL MOBILIZATION TO PREVENT DOMESTIC VIOLENCE IN LOCAL COMMUNITIES

Target Group and Role in BCC	Primary Message, Knowledge and Skills	Communication Media/Methods	Communication Materials/Tools
▪ Clergy ▪ Community leaders ▪ School Principals ▪ Elected members of the local authorities. ▪ Leaders of the area NGO and CBO ▪ Rotary/Lions Leaders Clergy and Community Leaders are empowered to organize activities to prevent and manage GBV/IPV in their areas.	Main Focus: Community leaders and clergy should act positively and decisively to prevent domestic violence in their village/area. Main Theme: Domestic violence/intimate partner violence should not be tolerated in our village. Community leaders with the guidance of local clergy should do something about domestic violence. 1. Intimate partner violence is inflicted mostly on women by men. Perpetrating Violence against women is contrary to the Sri Lankan cultural norms and the accepted international rights declarations. 2. The religious teachings of all religions also endorse this message. 3. No person has the right to inflict violence on their partner under any circumstances such as being under the influence of alcohol or substance abuse. 4. Clergy and community leaders should not allow IPV to be treated with impunity and should condemn such	**Lobbying** Consistent lobbying (by MOH, SPHI and other health workers) of religious and community leaders to enlist their support for efforts to prevent/eliminate GBV/IPV. **Interactive Meetings** SPHI or PHI to convene a series of meetings with Groups of Community Leaders on how to develop awareness of the community GBV/IPV and to engage them in efforts to prevent GBV/IPV. **Religious Congregations** Clergy to use religious events to advice against IPV. **Seminars** ▪ Seminars for community leaders to raise their awareness and knowledge regarding GBV/IPV ▪ To disseminate information on services provided by 'Mithuru Piyasa'and 'Natpu Nilayam'. ▪ Engage community leaders to plan actions on prevention of GBV/IPV.	▪ Presentations on the key findings of the GBV focus group discussions through multimedia, handout materials, exhibitions. ▪ Lectures/Presentations supported by booklets, leaflets on GBV, IPV, human rights, women's rights, child rights and the laws enacted in the penal code. ▪ Recordings and presentations of interviews with victims of GBV/IPV. ▪ Exhibitions/Models ▪ Street Dramas

Target Group and Role in BCC	Primary Message, Knowledge and Skills	Communication Media/Methods	Communication Materials/Tools
	violence. They should play a positive role in preventing domestic violence. Clergy and community leaders have a responsibility to proactively undertake campaigns on prevention of GBV/IPV. **The myths and misconceptions about Domestic Violence are:** ▪ Intimate partner violence is a private matter, community members can not intervene. ▪ Intimate partner violence happens due to the fault of the wife. She is late with food; the food she prepares is not tasty; she goes out to village meetings; she does not do the house-work properly. ▪ Husband is the leader in the family. If wife makes a mistake husband has a right to punish the wife. ▪ In a marriage a little bit of violence against the wife is acceptable. ▪ Husbands assault wives when they are drunk. There is nothing that can be done about it.		

Target Group and Role in BCC	Primary Message, Knowledge and Skills	Communication Media/Methods	Communication Materials/Tools
	All the above are misconceptions. These are against all religious teachings. Are against fairness and justice. Are against Sri Lankan laws. Are against Sri Lankan culture. Are against universal human rights. A man who assaults a wife should be ashamed of his actions. No reason can justify a husband beating a wife. **Please note:** Some of the above messages and religious reasons can be used to launch a campaign against intimate partner violence in the community.		

SECTION 5: ADVOCACY FOR IMPROVEMENT OF POLICIES PROGRAMME PROCEDURES AND RESOURCES AND STAKEHOLDER SUPPORT TO MORE EFFECTIVELY PROMOTE AND IMPLEMENT GBV PROGRAMMES WITH SPECIAL EMPHASIS ON INTIMATE PARTNER VIOLENCE PREVENTION

ADVOCACY FOR SENIOR POLICY MAKERS

Target Group and Role in BCC	Primary Message, Knowledge and Skills	Communication Media/Methods	Communication Materials/Tools
▪ Higher Officials of the Ministry of Health ▪ Representatives from Professional Colleges. ▪ Medical Administrators. ▪ Selected P.D's, R.D's, Hospital Directors and M.O.Hs. ▪ Higher Officials of the Ministry of Education	Main findings of FGD research with focus on findings related to service delivery and limited capacity of the staff to assist the survivors. Description of the proposed programme highlighting the potential benefits to (i) the Ministry by way of reducing the expenditure for services and (ii) to main beneficiaries such as women and children. Human rights and women rights as well as the national policies and codes protecting the rights of women.	**Lobbying** Directors and Programme Managers of FHB and HEB with higher officials of the MOH. **Meetings** Regular follow up meetings with the above officials to obtain policy, procedure, resource related advocacy decisions/approvals and recommendations. **Advocacy through media** Regular advocacy on prevention of GBV/IPV for agenda setting and to create further understanding among policy makers and the public on the urgency of addressing GBV/IPV through promulgation of policies, strengthening enforcement measures, general awareness raising and mobilization of activists.	▪ Presentations on the key findings of the GBV focus group discussions through multimedia, handout materials, exhibitions. ▪ Statements and testimonials of the survivors/victims of GBV/IPV. ▪ Statements by the lawmakers on the women's right and national policies and codes on prevention of GBV/IPV. ▪ Press kits for the media containing information on the extent of GBV/IPV in the country.

Target Group and Role in BCC	Primary Message, Knowledge and Skills	Communication Media/Methods	Communication Materials/Tools
To advocate for policy/programme decisions required for the implementation of the GBV/IPV preventionprogramme and for the development of required human resource and generation of financial and other resources. To obtain support of policy makers to review and amend the existing national policies and codes on gender based violence and domestic violence and promulgation of new policies if required.			▪ Research reports on Domestic Violence, IPV and impact on family, community and country.

SECTION 5 : (Contd.)

ADVOCACY FOR RELIGIOUS LEADERS

Target Group and Role in BCC	Primary Message, Knowledge and Skills	Communication Media/Methods	Communication Materials/Tools
Religious Leaders Clergy To solicit the support of religious leaders for the successful implementation of the programme.	Main Theme: The teachings of all religions strongly condemn violence and endorse the message that no person has the right to inflict violence on any other person under any circumstances. Under no circumstances that violence should be excused on the pretext of perpetrators being drunk, or due to any other reason. Emphasize the fact that all religions recognize women as equal partners in the society that contribute for the development of humanity. The role of women as mothers is highly praised and respected in all religions.	**Lobbying** Concerted and consistent lobbying of highly respected religious leaders to enlist their support and assist with efforts for prevention of GBV/DV. **High level forum of religious leaders/scholars** Organizing a high-level forum of religious leaders and scholars to identify relevant messages in the religious texts that denounce violence specially GBV, DV and IPV and articulate the value of women, and publish the messages as a Booklet. Wide dissemination of religious messages denouncing violence against women and IPV through media, leaflets and exhibitions. Use the booklets containing key messages in local level seminars/ workshops organized by local clergy and community leaders for prevention of GBV/IPV. (Pls. see pg.39)	▪ Presentations on the key findings of the GBV focus group discussions through multimedia, and leaflets. ▪ Booklets containing selected religious texts/messages (as prepared at the Forum of Religious Leaders). ▪ Distribute the Booklet to clergy at local level who are involved in social mobilization initiatives to prevent GBV/IPV.

SECTION 5: ADVOCACY FOR JUSTICE AND LAW ENFORCEMENT OFFICERS

Target Group and Role in BCC	Primary Message, Knowledge and Skills	Communication Media/Methods	Communication Materials/Tools
Senior officials of the Ministry of Justice. Senior Officials of the Police Department including key officials of Women & Children's Units. To facilitate implementation of policies and enforcement of laws with regard to GBV and intimate partner violence in a woman and child friendly manner.	Main Theme: Justice and Law Enforcement Officers relate to GBV/IPV survivors/victims in a friendly and respectful manner, protecting their dignity. Main findings of FGD research with focus on findings related to service delivery and limited capacity of the staff to assist the survivors. Description of the proposed programme highlighting the potential benefits to (i) the country by way of reducing the expenditure for services and (ii) to main beneficiaries such as women and children. Human rights and women rights as well as the national policies and codes protecting the rights of women. Description of potential negative/adverse effects to women and child survivors in enforcement of laws on GBV and DV and an outline of women and child friendly approaches, procedures that can be adopted. (continued on pg. 46)	Luncheon meetings with senior officials to present focus group research findings and discuss future action. **Establish a team** comprising officers of Justice Ministry; Police Department; Health Ministry; Child Development & Women's Affairs Ministry; Child Probation Department; Attorney General's Department and Social Services Department **to draft Guidelines for Law Enforcement Officers to Respond to IPV in a survivor/victim friendly manner, as well as prevention of IPV.** Train all police officers of Women and Children's Units on the application and operationalizing of Guidelines. **Training/Orientation Workshops.**	▪ Fact File on GBV/IPV ▪ Multimedia presentation on FGD findings ▪ Training Module based on Finalized Guidelines referred to in columns 2 & 3. ▪ Pocket Reference Booklet on key provisions of the Guidelines for distribution to all Police Officers attached to Women and Children's Unit.

Target Group and Role in BCC	Primary Message, Knowledge and Skills	Communication Media/Methods	Communication Materials/Tools
	Preparation of Guidelines for Law Enforcement Officers to respond to intimate partner violence in a survivor/victim friendly manner.		

SECTION 5: (Contd.)

ADVOCACY FOR DISTRICT/DIVISIONAL LEVEL POLITICAL LEADERS AND ADMINISTRATORS

Target Group and Role in BCC	Primary Message, Knowledge and Skills	Communication Media/Methods	Communication Materials/Tools
▪ Regional Directors ▪ Hospital Directors ▪ VOG and other relevant medical personnel. ▪ Directors of Education Department. ▪ Divisional Secretary ▪ Chairmen and Opposition Leaders of local authorities ▪ ASP/HQIs To facilitate key political and administrative persons to organize district/division based events to educate public on GBV/IPV and its prevention. To provide required approval, guidance, resources and political and administrative facilitation to conduct GBV/IPVprogramme in their respective areas.	Main Theme: Coordinate District/Divisional level empowerment activities for prevention and management of GBV/IPV Main Focus: ▪ Ensure you understand the concepts and scope of human rights and women rights issues. ▪ Familiarize yourself with the GBV/IPV situation in the country. ▪ Devote special attention to measures for prevention/elimination of Gender-based Violence and intimate partner violence in your area. ▪ Facilitate linkages among different stakeholders and partners so that collective efforts of all stakeholders create stronger impact on prevention of GBV/IPV. ▪ Provide knowledge and strengthen skills of district/division/community level staff on GBV/IPV and prevention through special events, workshops and training programmes.	**Lobbying** MoH to carryout concerted and consistent lobbying aimed at the Divisional Secretaries, Police, Education Officials, and Hospital Staff to draw their attention to the GBV/IPV in the country and to persuade them to take decisive action to prevent GBV/IPV. **Meetings** Meetings with key officials and managers at various levels to draw their attention to the issues of GBV/IPV based on the findings of focus group discussions on GBV. **Workshops** Workshops involving directors, managers and service providers to discuss and develop concrete action plans on prevention of GBV/IPV. **Special Events** To publicize action against GBV/IPV and empower officers, political personnel in organizing such activities	▪ Presentations on the key findings of the GBV/IPV focus group discussions through multimedia, and handouts. ▪ Recordings of policy advocacy outcomes, decisions by high-level authorities and proposed plans for prevention of GBV/IPV. ▪ Media coverage for GBV/IPV prevention activities organized by district/divisional level officers and politicians. ▪ Orientation Guide for orientating District/Divisional Officers and Politicians on prevention of GBV/IPV and organizing of appropriate GBV/IPV prevention events.

SECTION 5 : (Contd.)

ADVOCACY FOR SENIOR MEDIA PRACTITIONERS/OFFICIALS

Target Group and Role in BCC	Primary Message, Knowledge and Skills	Communication Media/Methods	Communication Materials/Tools
Senior Editors, Senior Journalists and Producers. Directors of Electronic Media (National and Regional media as appropriate). To motivate senior media practitioners to give space and time for programmes and features for effective education of the public on GBV/IPV prevention. To facilitate media practitioners and organizations to adopt an enhanced ethical and a non-sensationalizing approach to reporting and coverage of materials pertaining to GBV/IPV.	**Main Focus**: Gravity of the problem, particularly because of the denial and the impunity with which the society treats the issue of GBV/IPV. FGD research findings on GBV/IPV and other relevant data. Negative and harmful influence of IPV impeding the happiness of the family and the education and wellbeing of the children. Harmful and negative impact of IPV on children and their education. Suffering of innocent persons mainly women within a relationship. Steps taken by Health Ministry and other authorities to address IPV and support the survivors (e.g. Training of Health workers, establishment of 'Mithuru Piyasa'and 'Natpu Nilayam'.)	**Advocacy meetings** Luncheon meetings with senior journalists, producers and Directors with the aim of engaging mass media channels in prevention of GBV/IPV. - Present focus group findings and discuss future action. - Request senior editors and media decision makers to appoint responsible focal points with capacity to re-learn and write analytically to cover GBV/IPV related themes. Appointment of a Media Working Group to develop Guide Book on GBV/IPV for Media (please see pg.37 for details).	Presentations on the key findings of the focus group research on GBV through multimedia, handout materials, and exhibitions. Presentations on the proposed plans for prevention management of GBV/IPV. Booklets on research findings of GBV focus group discussion and other data for wide dissemination. Leaflet on 'MithuruPiyasa'/'NatpuNilayam', its concepts and key activities. Guide Book on GBV/IPV for Media. To be used for orientating selected media personnel on GBV/IPV thematic area.

Target Group and Role in BCC	Primary Message, Knowledge and Skills	Communication Media/Methods	Communication Materials/Tools
	Ethical Principles: Media should minimize portraying situations that normalize or glorify violence, desist from even indirectly providing social approval to IPV through unbalanced, reporting and features that subject survivors/victims to embarrassment. Media has social and ethical responsibility for accurate and factual reporting in order to avoid harm and negative impact on the survivors of GBV/IPV and their children. They also have the responsibility of propagating positive social and cultural values which contribute to the reduction of GBV and IPV. Importance of Harm Reduction by desisting from victimizing survivors of intimate partner violence and their children, even unwittingly through media reportage, photographs, teledramas, and feature programmes.		

ANNEXURES-1:

ANNEXURES 1:

Names of members of National Core Group on BCC for Reproductive Health

Dr. R.R.M.L.R. Siyambalagoda - DDG(PHS) II - Chairman ,BCC Co re-Group
Dr. Neelamani Rajapaksa Hewageegana - Director, (H.E. & P.) Health Education Bureau (HEB)
Dr. R.D.F.C. Kanthi - Head of the BCC Unit, - Deputy Director , Health Education Bureau
Dr. Gamini Samarawickrama - National Coordinator of Reproductive Health,BCC Unit
Mr. Anura Gamini Wijesekara - HEO /Programme Assistant,BCC Unit
Dr. Deepthi Perera - Director ,MCH , Family Health Bureau (FHB)
Dr Chithramalee De Silva - Deputy Director , Family Health Bureau
Dr. Chandani Galwaduge - National Programme Officer/UNFPA
Mr. Lakshman Wickramasinghe - UNFPA/National Consultant
Mr. Thusitha Malalasekara - UNFPA/Assistant to Consultant
Dr. A.L.A.L. Padmasiri RDHS - Gampaha
Dr. R. Hettiarachchi - DD/NIHS
Dr. Ayesha Lokubalasooriya - CCP/FHB
Dr. Neththanjalee Mapitigama - CCP/FHB
Dr. Shiromi Madawage - CCP/YEDD
Dr. Dilum Perera - CCP/HEB
Dr. Dhammika Rovel - CCP/FHB
Dr. Nilmini Hemachandra - CCP/FHB
Dr. Prashantha De Silva - CCP/HEB
Mrs. Thushara Agues - Executive Director/Family Planning Association of Sri Lanka
Dr. M.A.A.P. Alagiyawanna - AC/CCP
Dr. Ramya De Silva - MO/FHB
Dr. S. Shasheela - Registrar/FHB
Dr. H.L.P. Vinod - MO/HEB
Dr. P.Y.S. Jayasinghe - MO/FHB
Dr. H.M.P. Perera - MO/FHB
Dr. Surani Fernando - SR/HEB
Dr. T. Sharmila - MO/HEB
Dr. Samantha - MO/FHB
Dr. Krishantha Peiris - MO/FHB
Dr. P.L. Gunasekera - MO-MCH - Kalutara

ANNEXURE 1:

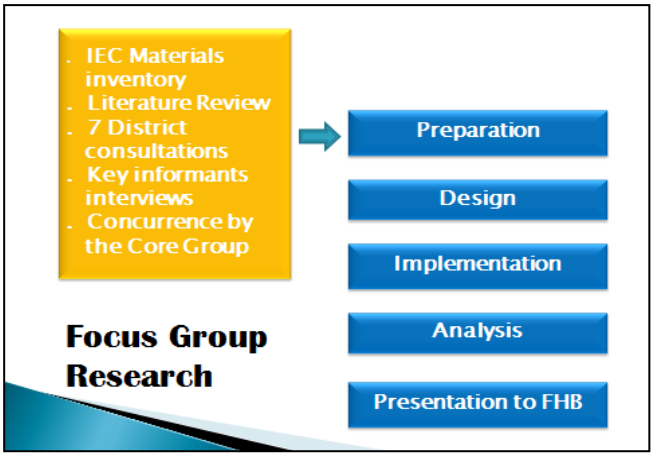
Names of members of National Core Group on BCC for Reproductive Health(contd)

Dr. S.T.A.P. Serasinghe - MO/MCH-Ampara
Ms. Kumuduni Rajapaksa - NYSC/Maharagama
Mr. K.G.P. Bandara DD/CHEO/HEB
Mr. N. Mudannayaka - ACHEO/HEB
Mr. P.G.P.K.N. Wijewickrama - HEO-Nuwara Eliya
Mr. Kosala Lakmal - HEO/HEB
Mrs. Janaki Kodikara - HEO/HEB
Mr. Aruna Athukorala - DA/HEB

Annexure – 2 : Focus Group Discussion – The Process and Methodology

Preparation

FGD was planned and implemented in 5 steps. At the preparation stage, the main activities undertaken were - selection of FGD locations; selection of a FGD Team; and organization of a Consultative Meeting for the district health staff of the selected FGD locations.



The main criteria for selection of FGD location were that each location should reflect the inherent diversity of the country and that the number of locations should match available human, financial, and time resources. The following FGD locations were selected in consultation with the Family Health Bureau, and with concurrence of the Core Group.

- Bogawantalawa MOH area, Nuwara-Eliya district
- Dimbulagala MOH area, Polonnaruwa district
- Eravur MOH area, Batticaloa district
- Karachchi MOH area, Kilinochchi district
- Suriyawewa MOH area, Hambantota district
- Telippalai MOH area, Jaffna district
- Wattala MOH area, Gampaha district

The FGD Team was selected on three main criteria: (*a)*Team members should have a working background in health; (*b)* Members should include both Sinhalese and Tamil speakers; and (*c)* Members should not be deployed to conduct FGDs in their own service areas. The FGD Team comprised of SPHMs, PHNS, HEOs, and Medical Officers and few NGO staff. The majority was HEOs including some retired officers.

The selected field health and district health staff in the selected locations were invited to a two-day Consultative Workshop. The main purpose was to obtain feedback on issues and constraints relating to the five RH programmes in the respective areas. The information obtained from the workshop was also used in preparing FGD Guides.

Designing

The designing stage for conducting focus group discussions comprised three main activities: (*a)* preparing and finalizing focus group Discussion Guides; (*b)* identification of groups for focus group discussions; and (*c)* training of FGD Team. Based on the literature review, key informant interview data, and district consultative workshop data, the first draft of the FGD Guide was compiled. The initial draft was discussed with key staff of HEB, Programme Managers and key staff of FHB. The draft was also shared with relevant members of the Core Group. Based on comments and suggestions the FGD Guides were amended. The finalized Guides were shared with the Programme Managers and the two Directors of FHB and HEB respectively.

In consultation with Programme Managers and other key staff attached to the respective programmes, the following categories of groups were identified as focus group discussants. These were also endorsed by the Director, Deputy Director, Programme Managers and key staff of FHB, and the Acting Director, Deputy Director/Chief Health Education Officer and key staff of HEB.

Maternal and Newborn Health:	(i) Young mothers, consisting 6 pregnant mothers and 6 mothers having babies below 03 months of age. (ii) 6 Young husbands whose wives are pregnant and 6 fathers of babies less than 03 months of age.
Well Woman Clinic:	(i) Women 35 years of age, ideally comprising few working mothers. (ii) Women above 36 years of age, with a few above 55 years of age. (iii) Husbands of women 35 years and above.
Family Planning:	(i) Women18-30 years of age, including a few married women. (ii) Men 18-30years of age, including a few married men. (iii) Women 30-40 years of age, with women having 2 or less children, and a few women having more than 2 children. (iv) Married men above 30 years of age. (v) Women 30-55 years of age who are unmarried, widowed, and divorced (to be selected as feasible.)

Adolescent and Young Persons Sexual and Reproductive Health:

(i) Girls 16-19 years of age.
(ii) Boys 16-19 years of age.
(iii) Parents of 16-19 years old girls and boys.
(iv) Young women 20-25 years of age, with a few married women.
(v) Young men 20-25 years of age, with a few married men (if feasible).

Prevention of and Response to Gender Based Violence:

(i) Women 20-30 years of age, comprising unmarried, married, and working women.
(ii) Men 20-30 years of age, including some married men.
(iii) women 30-55 years of age with some married, working, divorced, widowed women (as feasible)
(iv) Men 30-55 years of age mostly married.

The five-day training programme for the FGD Team began with an introduction to concepts and techniques of BCC strategy planning, and technical subject knowledge relating to the five reproductive health programmes. The main training was on techniques of facilitating focus group discussions and writing focus group discussion reports. The training included both theoretical and practical training on facilitation and report writing. The practical training comprised the conducting of focus group discussions in selected locations in communities in and around Colombo both in Sinhalese and Tamil languages.

Planning meetings were held in each of the research locations to brief all health staff on the planned focus group activity, the criteria for selecting group participants for the focus groups; and to discuss logistics.

Just prior to conducting focus group discussions in actual locations, a two day refresher training for the FGD Team was also organized. The main task was to orient team members on the FGD discussion guides, refresher training on report writing, and a discussion on anticipated constraints.

FGD Implementation

The third stage was the actual implementation of focus group activity. The Focus Group Team for each discussion comprised a Facilitator, Report Writer and an Observer. The Observer was also requested to assist the report writer by taking notes of discussions to ensure that no important information would be lost. The decision to use a third person to help the report writer was taken as the discussions were not audio- recorded due to feedback received from the districts that such recording may affect the quality of focus group discussions. A few focus group discussions were conducted by a two member team due to logistical constraints. The duration of each focus group discussion on an average was about 2 hours. Over 95% of focus group discussion reports were written at the location on the same day or within two days after the discussions to preclude loss of information due to possible lapses of memory.

FGD Data Analysis

The Analysis of FGD reports was guided by FGD Report Analysis Framework developed for the purpose. A team of seven research analysts including the national consultant and the assistant to the consultant were assigned the task of analysis. The analysis was done in three stages, namely preparation of analysis report for each focus group report; composite report for each programme for each district; final report for each programme incorporating comparative data for all research districts.

Annexure – 3:

Focus Group Discussion – Name List of Team Members

Dr.(Mrs.) Neelamani Hewageegana - Director (H.E. & P.)
Dr(Mrs.) R.D.F.C. Kanthi - Deputy Director /HEB - Head of the BCC Unit
Dr. Gamini Samarawickrama - National Coordinator of RH Programme in BCC Unit
Mr. Anura Gamini Wijesekera - HEO/HEB - Programme Assistant/ BCC Unit
Mr. Lakshman Wickramasinghe - UNFPA/National Consultant
Mr. Thusitha Malalasekara - UNFPA/A.Consultant
Mr. B.A. Ranaweera - UNFPA A.Consultant
Dr. T. Sharmila - MO/HEB
Dr. Ruvini Hettiarachchi - MO/HEB
Dr. S. Saseela - MO/FHB
Dr. P. Alagiyawanna - MOH Kaduwela
Dr. J.T. Sivashankar - MO/MCH - Jaffna
Dr. Maithily - MOH/Palai
Mr. K.G.P. Bandara - DD/CHEO/HEB
Mr. N. Mudannayaka - ACHEO/HEB
Mrs. Janaki Kodikara - HEO/HEB
Mr. Kosala Lakmal - HEO/HEB
Mr. A.I. Buhardeen - HEO/Batticoloa
Mrs. Sriyani Jayasundara - HEO/Kandy
Mrs. I.L.A.C.T. Liyanarachchi/HEO - Kandy
Mr. S. Japalan - HEO-Mannar
Mr. K.T. Thayalan - HEO/Kilinochchi
Mr. Senaka Bandara - HEO/Polonnaruwa
Mrs. M.G. Premalatha - HEO/A'pura
Mr. T. Thajeeharan - HEO/Batticoloa
Mrs. R.M.P. Senevirathne - HEO/Badulla
Mrs. R.M.P. Rathnayaka - HEO/Kurunegala
Mr. S. Beranawan - HEO/Jaffna
Mr. N. Kethiswaran - HEO/Vavunia
Mr. J.A.W. Jayakody - HEO/Gampaha
Mrs. Manel Jayalatharachchi -HEO/Gampaha
Mr. S. Sivakumary - HEO/Jaffna
Ms. Nayani Wijewickrama - HEO/N'eliya

Annexure – 3 :

Focus Group Discussion – Name List of Team Members (contd)

Mr. H.A. Desabandu - HEO/Hambantota
Mr. K.G.A.C. Thushara- HEO/Hambantota
Mrs. I.M.S.K. Iluppitiya - HEO/Hambantota
Mrs. M.M.M. Jayathilaka - HEO /Kurunegala
Mrs. K. Thiyagaraja - HEO/ Kalmunari
Mrs. R. Nawarathnajothi - PHNS/Jaffna
Mrs. K.M. Maheswaran - PHNS/Jaffna
Mr. M. Jayakumar - PHNS/Vavuniya
Mrs. Chandrawathini - Manager-OX fam
Miss. S. Thusanthiny - PPO/Batticoloa

Focus Group Discussion Organization Team
Dr. H.L.P. Vinod - MO/HEB/BCC Unit
Dr. A.D.H.S. Weerakkody - MOH/Wattala
Dr. C. Liyanage MOH - Dimbulagala
Dr. Suranga Paranagama - MOH - Sooriyawewa
Dr. K.M. Senevirathne - MOH - Bogawanthalawa -
Dr. Mohamed Hanipa Fari - MOH Eravur
Dr.S. Murali - MO-MCH Kolinochchi
Dr. K.B.C.P.K. Dissanayaka - MOH - Kilinochchi
Dr.P. Nandakumar - MOH - Tellippalai
Mr. Aruna Athukorala - DA/HEB
Mrs. Nilmini Pushpakanthi - PMA/HEB
Mr. K.A. Nimal Senevirathne - PHI/Hambantota

Annexure – 4 : Agenda of Stakeholder Workshop

SRI LANKA MINISTRY OF HEALTH AND UNFPA

BEHAVIOUR CHANGE COMMUNICATION STRATEGY DEVELOPMENT WORKSHOP FOR REPRODUCTIVE HEALTH PROGRAMMES

10-12 JUNE 2013 at Pegasus Reef Hotel , Hendala

AGENDA

DAY 1

08.15-0900	Registration of Participants
0900-10.15	**INAUGURAL SESSION 1** **National Anthem** **Lighting of the Traditional Oil Lamp** **Chair person: Dr. P.G. Mahipala ; Director General of Health Services** Welcome address and Purpose of Workshop : Dr Neelamani Hewageegana , Director HEB Opening Remarks : Dr. Deepthi Perera, Director MCH/FHB Keynote address : Principles and key components of BCC Experience in Asia : Mr. Najib Assifi, International Consultant , Asia – Pacific Development Communication Center , Bangkok Opening Remarks: Ms. Lene.K. Chistiansen, Representative , UNFPA , Sri Lanaka Address from the Chair : Dr. P.G. Mahipala, Director General of Health Services
10.15-10.35	TEA
10.35-13.00	**INAGURAL SESSION 2 : PRESENTATION OF FGD FINDINGS** Introduction of Participants (Self- Introduction) **Chair Person : Dr Deepthi Perera, Director MCH/Family Health Bureau** Background and Methodology and FGD findings report on well woman clinic programme - Presentation and discussion : Mr. Lakshman Wickramasinghe, National Consultant, UNFPA FDG findings report – Gender Based Violance Prevention Programme : Presentation and Discussion : Dr. RDFC Kanthi , Deputy Director, HEB.

FDG Findings report – Family Planning Programme : Presentation and Discussion : Mr. Lakshman Wickramasinghe, National Consultant, UNFPA.

13.00-14.15 LUNCH

14.15-15.00 **PLENARY:** Introduction to group work; forming into 3 groups - Mr. Najib Assifi and Mr. Lakshman Wickramasinghe (Group 1 - WWC. Group 2 - GBV Group 3 - FP)

15.00-16.30 Group work 1
Identification of priority desired behaviours, facilitating and constraining factors - Introduction by Mr. Lakshman Wickramasinghe
Work in groups

16.30-16.45 TEA

16.45-17.45 **Plenary** : **Chairperson - Dr. Neelamani Rajapaksha Hewageegana, Director/HEB**
Group presentations and discussions - moderated by Mr. Najib Assifi

DAY 2

09.00-10.00 Plenary : Review of day 1 activities; introduction to group work - moderated by Mr. Najib Assifi and Dr. R.D.F.C. Kanthi.

10.00-10.15 Tea

10.15-12.00 Group work 2:
Identification of potential audiences for BCC and advocacy interventions relevant to the priority desired behaviours - introduction by Mr. Najib Assifi

Work in groups.

12.00-13.15 **Plenary** : Group presentations and discussion - moderated by Mr. Najib Assifi and Mr. Lakshman Wickramasinghe

13.15-14.15 Lunch

14.15-16.15 **Plenary:** Introduction to group work - introduction by Mr. Lakshman Wickramasinghe

Group work 3 :

Identification of appropriate primary knowledge (messages) and types of skills for respective target groups.

Work in groups

16.15-16.30 Tea

16.30-17.30 Work in groups

Day 3

08.30-09.45 **Plenary** : Group presentations and discussions - moderated by Mr. Najib Assifi

09.45-10.15 **Plenary** : Introduction to group work - Mr. Lakshman Wickramasinghe

Group work 4 :

Identification of communication channel /method materials/technologies for each of the selected behaviours/audiences

10.15-12.15 Work in groups. Tea served in groups.

12.15-13.15 **Plenary 1**: Group presentations and discussions - moderated by Mr. Lakshman Wickramasinghe

Plenary 2: Introduction to group work on preparing consolidated group report - moderated by Mr. Najib Assifi

13.15-14.00 Lunch

14.00-15.45 Group work 5 :

Preparation of consolidated group reports on key elements of behaiour change communication strategy for (i) Well Woman Clinic (ii) Prevention of Gender Based Violence (iii) Family Planning Programmes.

15.45-16.00 Tea

16.00-17.00 **Plenary** : Presentation of group reports and discussion - moderated by Mr. Najib Assifi and Mr. Lakshman Wickramasinghe

17.00-17.30 Closing address

- Mr. Najib Assifi, ADCC, Bangkok
- Dr. Neelamani Rajapaksa Hewageegana, Director/HEB
- Dr. Chithramalee De Silva, Deputy Director, FHB.

Annexure – 5 : Name List of Participants of Stakeholder Workshop

Dr. Neelamani Rajapaksa Hewageegana - Director - Health Education Bureau
Dr. R.D.F.C. Kanthi - Head of the BCC Unit , Deputy Director - Health Education Bureau
Dr. Gamini Samarawickrama - National Coordinator of Reproductive Health- BCC Unit.
Mr. Anura Gamini Wijesekara - HEO /Programme Assistant/BCC Unit
Dr. Sathya Herath - Consultant Reproductive Health –BCC Unit

Dr. P.G.Mahipala	Director General of Health Services Ministry of Health
Ms. Lene Christiansen	UNFPA Country Representative
Dr. Deepthi Perera	Director(MCH)/Family Health Bureau
Dr. Chiththramalee de Silva	Deputy Director/ Family Health Bureau
Dr. Chandani Galwaduge	National Programme Officer/UNFPA
Mr. Thusitha Malalasekara	Assistant to National Consultant/UNFPA
Dr. W.A.K.Wijesinghe	RDHS -Kandy
Dr. A.L.A.L. Padmasiri	RDHS-Gampaha
Dr.S. Sathuramugam	RDHS-Batticaloa
Dr. Surange Do lamula	RDHS - Hambantota
Dr. Palitha Bandara	RDHS -Anuradhapura
Dr. M. Mahendran	Act.RDHS-Vavuniya
Dr. Nihal Wirasooriya	MS/Bogawanthalawa
Dr. Harsha Seneviratne	Professor of Obstetrics and Gynaecology/Retired VOG
Dr. Saddha Hemapriya	VOG - Kandy Hospital
Dr. Harsha Athapattu	VOG/Kalutara Hospital
Dr. Samanthi Premarathna	VOG - Cancer Hospital - Maharagama
Dr. N. Mapitigama	CCP/FHB
Dr. Ayesha Lokubalasooriya	CCP/FHB
Dr. Prasantha de Silva	CCP/HEB
Dr. Dilum Perera	CCP/HEB
Dr. Manjula Danansooriya	CCP/FHB
Dr. Kapila Sooriyaarachchi	MO/HEB
Dr. Komala Arunagiri	MO/HEB
Dr. S.Saseela	MO-FHB
Dr.Ramya de Silva	MO- FHB
Dr. Eranga Rajapaksha	MO/FHB
Dr. Kamal Perera	MO/FHB
Dr. Anura Rajapaksha	MOH-Gangawatakorale
Dr. P.Cooray	MO[MCH]-Kandy
Dr. Sumithra Tissera	Medical Director/Family Planning Association of Sri Lanka
Dr. A.D.H.S. Weerakkodi	MOH-Wattala
Dr Achchudhan	MO(MCH)-Batticoloa
Dr. J.T. Shivashankar	MO(MCH)-Jaffna
Dr. Thyaseelan	MO/MCH-Mulativu

Dr. Thilak Udayasiri	MO/MCH - Gampaha
Dr. N.B. Gamini	MO/MCH - Ratnapura
Dr. Suranga Paranagama	MOH-Sooriyawewa
Dr. S.Murali	MOH-Kilinochchi
Dr. S.Mithily	MOH-Palai
Mr. K.G.P. Bandara	DD/CHEO/HEB
Mr. N. Mudannayake	ACHO/HEB
Mrs. Janaki Kodikara	HEO/HEB
Mr. Kosala Lakmal	HEO/HEB
Mr. Janaka Suneth Bandara	Actg.PO/PHI/HEB
Mr. A. Athukorala	DA/HEB
Mr. B.A.Ranaweera	Former DD/CHEO/HEB
M. Nizar	Former Communication Officer/Unicef
Mr. Percy Jayamanna	Senior Journalist/Editor
Mrs. Sriyani Jayasundara	HEO-Kandy
Dr.T. Ganeshan	HEO-Mathale
Mr. T. Thajeeharan	HEO-Batticoloa
Mrs. M. Chandrawathini	Manager-Oxfam , Batticaloa.
Mr. Buhardeen	HEO-Batticaloa
Mr. A. Deshabandu	HEO-Hambantota
Mrs. M.G.Premalatha	HEO-Anuradhapura
Mr. S.Beranvan	HEO-Jaffna
Mr. N.Kethishwaran	HEO-Vavuniya
Mr. K.D.Thaleyan	HEO-Kilinochchi
Mrs. Nayani Wijewikrama	HEO-Nuwara Eliya
Mrs.Mercy Gayantha	PHM-Moratuwa
Mrs.Theja de silva	PHM-Kaduwela
Mrs. T Priya Janaki	PHM-Nugegoda
Mrs. M.D.Botheju	RSPHNO- Colombo
Mrs. K.S Sunethra	PHNS-Thihagoda
Mrs. B.G.W. Daya Amarasinghe	PHNS-Matara
Ms. D.M.K. Menike	RSPHNO - Gampaha
Mr. Dhammika Samarawickrama	AV Officer /HEB- Support Staff
Mrs. W.P. Nilmini Pushpakanthi	PMA/HEB- Support Staff
Mr. Vipula Kumara	SKS/HEB- Support Staff
Mr. S. Logeswaran	SKS/HEB- Support Staff
Mr. Prasanga Napawala	SKS/HEB- Support Staff
Mr. Manilka Kahatapitiya	SKS/HEB- Support Staff

Annexure – 6 : Name List of Stakeholder Panel who reviewed penultimate draft of BCC Strategy Guide for WWC

1. Dr. Neelamani Rajapaksa Hewageegana - Director - HEB
2. Dr. Deepthi Perera - Director(MCH) - FHB
3. Dr. R.D.F.C. Kanthi - Deputy Director/HEB and Head of the BCC Unit
4. Prof. Lakshman Senanayaka – Consultant Gynaecologist & Obstetrician
5. Dr. Harsha Athapaththu - Consultant Gynaecologist & Obstetrician
6. Dr. Chithramalee De Silva - Deputy Director /FHB
7. Dr. Chandani Galwaduge - Programme Officer - UNFPA
8. Dr. N. Mapitigama – Consultant Community Physician /Programme Manager Gender & Women Health FHB
9. Dr. Sumithra Thisera - Medical Director/Family Planning Association of Sri Lanka
10. Dr. Sathya Herath - Consultant Community Physician /HEB
11. Dr. Gamini Samarawickrama - National Coordinator for Reproductive Health/HEB
12. Mr. Thusitha Malalasekara - UNFPA/Assistant to National Consultant
13. Mr. B. A Ranaweera - UNFPA/Research Analyst
14. Mr. K.G.P. Bandara - Deputy Director /CHEO/HEB
15. Mr. M.A.D.N. Mudannayake - ACHEO/HEB
16. Mr. Anura Gamini Wijesekera - HEO /Programme Assistant-BCC Unit
17. Mr. Aruna Athukorala – Development Assistant /HEB

Annexure – 7:

Name List of Participants who attended the District FGD planning Meetings

Wattala- MOH Office - Date: 29.06.2012

Dr.A.L.A.L.Padmasiri	RDHS-Gampaha
Dr.A.D.H.S.Weerakkody	MOH-Wattala
Dr. D.P.A.R.N Jayasekara	AMOH
Mr.J.A.W.Jayakody	HEO-Gampaha
Mrs .Manel Jayalatharachchi	HEO-Gampaha
Mr.B.P.Chandrasena	SPHI
Mrs.P.P.S. Priyanthi Ediriweera	PHNS
Mr.B.P..Fernando	PHI
Mr.P.M.Piyamwardana	PHI
Mr.D.F.de Wijesinghe	PHI
Mr.Waruna Amarasekara	PHI
Mr.M.J.I. Mendis	PHI
Mrs.L.T.N.Shyamali	PHM
Mrs.H.P.G.N.Ranaweera	PHM
Mrs.G.G.I.Subashini	PHM
Mrs.G.W.L.Dharmaselie	PHM
Mrs.T.D.S.G.Piyarathna	PHM
Mrs.D.P.C.Bandara Menike	PHM
Mrs.P.T.Nayana	PHM
Mrs .W.A.M.H. Wickramarachchi	PHM
Mrs.K.A.A.Indumathie	PHM
Mrs. K.D. Leelawathie	PHM
Mrs.W.A.Priyanga	PHM
Mrs.K.G.P. Priyadarshani	PHM
Mrs.N.A.I.Udayangani	PHM

Annexure – 7: (Contd.)

Wattala- MOH Office - Date: 29.06.2012

Mrs.G.A.D.A. Sudarshani	PHM
Mrs.M.D,Kusumalatha	PHM
Mrs.W.D.S.Chandrathilaka	PHM
Mrs.K.A.S.S.Jayathilaka	PHM
Mrs.E.A.P.S.Edirisinghe	PHM
Mrs.M.K.A.Menikdiwela	PHM
Mrs.I.M.W.Malkanthi	PHM
Mrs.B.P.J.M.Kulathilake	PHM
Mrs.L.A.Siriyalatha	PHM
Mrs.G.G.Seelawathie	PHM
Mrs C.N.J.Jayamanne	PHM
Mrs N.L.R.Sandanei	PHM
Mrs. K.R.M.D.J.P. Nirmala	PHM
Mrs.K.K.A,D.Kithalawalana	PHM
Mrs.D.M.S. Priyadarshani	PPA

Annexure – 7: (Contd).

Dimbulagala- MOH office - Date: 25.07.2012

District Level

Dr.Chanaka Liyanage	MOH-Dimbulagala
Dr.D.P.M.A.Senavirathna	AMOH
Mr.K.M.Senaka Bandara	HEO-Polonnaruwa
Miss.P.P.G.R.S.Samarashinghe	PHNS
Mrs.G.L.A.P.Siriwardana	S PHM
Mr.H.M.A.K.Hearath	PHI
Mr.B.G.C.N.Bandara	PHI
Mr.R.M.S.W.Ranasinghe	PHI
Mr.R.M.B.N.Rathnayake	PHI
Mr. K.P.Nimal Palitha	PHI
Mr.H.M.Sajitha	PHI
Mrs.W.M.S.Menike	PHM
Mrs.P.S.Nandawathie	PHM
Mrs.S.K.N.S.Wipulasena	PHM
Mrs.K.W.N.S.Madurangani	PHM
Mrs.P.D.L.Padmini	PHM
Mrs.K.K.Dasanayaka	PHM
Miss.E.K.G.Jayamenike	PHM
Mrs.L.K.I.D.Kumari	PHM
Mrs.R.P.N.P.Kumari	PHM
Mrs.J.P.S.C.Jayalath	PHM
Mrs.K.P.de.Silva	PHM
Mrs.H.M.R.Chandralatha	PHM
Mrs.D.R.Siriyawathe	PHM
Miss.A.M.P.P.Alahakoon	PHM
Mrs Sujitha Wickramasinghe	PHM
Miss. D.A.C.P.Kumari	PHM
Mrs. R.A.Jayanthi	PHM

Annexure – 7: (Contd).

Sooriyawewa- MOH Office - Date: 09.08.2012

Dr.S.Dolamlulla	RDHS- Hambanthota
Dr.Suranga Paranagama	MOH-Sooriyawewa
Dr.U.P.Malakasiri	Mo- Planning
Mr.H.A.Deshabandu	HEO-Hambanthota
Mr.K.G.A.C.Thusara	HEO-Hambanthota
Mrs.I.M.S.E.IIuppitiya	HEO-Hambanthota
Mrs.G.B.Champika	PHNS
Mr.K.L.Gunapala	SPHI
Mr.M.M.M.Imamuddeen	PHI
Mr.M.M.A.C.H.Kumara	PHI
Mr.K.A. Nimal Senarathne	PHI
Mr.T.A.S. Thilakarathne	PHI
Mrs. T.A Shalika Prasadani	DA
Mrs.M.A.S.Jayanthi	PHM
Mrs.J.K.Kusumawathie	PHM
Mrs.R.Leelawathie	PHM
Mrs.K.Gnanaseli	PHM
Mrs.S.S.Yapa	PHM
Mrs.W.A.Piyasilie	PHM
Mrs.A.J.Y.Madunawatte	PHM
Mrs.A.P.N.Niroshani	PHM
Mrs.P.B.Weerabaddana	PHM
Mrs.B.G.Kusumawathie	PHM
Mrs.D.A.Rajaphaksha	PHM
Mrs.M.L.M.Madarasinghe	PHM
Mrs.J.R.A.S.Nanayakkara	PHM

Annexure – 7: (Contd).

Bogawanthalawa - MOH Office - Date: 29.08.2012

Dr.M.N.Weerasooriya	A-RDHS- Nuwara Eliya
Dr.K.M.Senavirathna	MOH- Bogawanthalawa
Dr .L.D.U.H. Gunawardana	A-MOH
Dr.Wijethunga	Mo
Miss.N.Wijewickrama	HEO- Nuwara Eliya
Mrs. L.U.G.R.S.K. Dayananda	PHNS
Mr.D.Wardharaja	PHI
Mr.P.K.L.Wasantha	PHI
Mrs.K.Shamali	PHM
Mrs.S.Nishanthini	PHM
Mrs.Y.Yogeshvari	PHM
Mrs.P.Nirmaladevi	PHM
Mrs.B.G.Dilani	PHM
Mrs.K.Raamesh	PHM
Mrs.R.Mageswarey	PHM
Mrs.K.Rajeswary	PHM
Mrs.P.Krishanakumar	PHM
Mrs.H.D.M.Francisca	PHM
Mrs.L.I.Dissanayaka	PHM
Mrs.L.G.D.Damayanthi	PHM
Mrs.A.Thanuja	PHM
Mrs.V.J.N.Navaratne	PHM
Mrs.P. Kalachelvi	PHM
Mrs.K.Saraswathi	Health Volunteer Worker
Mrs.K.Pradeepa	Health Volunteer Worker
Mrs.R.Vijayarani	Health Volunteer Worker
Mrs.G.Esther	Health Volunteer Worker
Mrs.P.Nithyakala	Health Volunteer Worker
Mrs.B.R.Mala	Health Volunteer Worker
Mrs.M.Pushparani	Health Volunteer Worker

Annexure – 7: (Contd).

Eravur - MOH Office -Date : 23.10.2012

Dr.M.H.N.Thuriq	MOH-Eravur
Dr .E. Srinath	MO/MCH
Mr Buhardeen	HEO-Baticoloa
Mr.T.Thajeeharan	HEO-Baticoloa
Mrs.R. Raveenthiran	PHNS
Mrs.Shanmuganalhan	SPHM
Mr.H.M.Feleel	SPHI
Mr.R.Inparajah	PHI
Mr.A.L.Nawfar	PHI
Mr.U.L.M.Jinnah	PHI
Mr.S.Maheshwaran	
Mr.A.I Moshideer	PHFA
Mrs.Riswuani	PHM
Mrs.T.Vijendrarajah	PHM
Mrs.K.Eswarj	PHM
Mrs.C.Theivendiram	PHM
Mrs.R.Edward	PHM
Mrs.P.Kanarathan	PHM
Miss.A.R.F.Farwin	PHM
Mrs.R.Niruthythanayagam	PHM
Mrs.K.B.M.Nazar	PHM
Mrs.Y. Tamilselvi	PHM

Annexure – 7: (Contd).

Kilinochchi - MOH Office - Date: 05.11.2012

Dr.P. Karthikayan	RDHS – Kilinochchi
Dr.S.Muraliharan	MOMCH – Kilinochchi
Dr.T.Maithily	MOH –Pallai
Dr.K.P.C.P.K.Disanayake	AMOH/Kilinochchi
Mr.T.Thayalan	HEO - Kilinochchi
Mrs.V.E Swaranathan	SPHM – Karachchi
Mrs.U.Ganeshanaathan	SPHM
Mr.B.Baladera	SPHI
Mr.S.Puveenthiran	PHI
Mr.K. Nishanthan	PHI
Mr.S.Piratheepan	DA
Mrs.A.Ketheswari	PHM
Mrs.Chandrakala	PHM
Mrs.P.Sutharsana	PHM
Mrs.S.Valarmathy	PHM
Mrs.N.Pugalini	PHM
Mrs.T.Kalaivani	PHM
Mrs.J.Jeyagowry	PHM
Mrs.K.Sukanthini	PHM
Mrs.S.Usannthini	PHM
Mrs.S.Vijayakanthi	PHM
Mrs.P.Jasikala	PHM
Mrs.V.Sivanthini	PHM
Miss.P.Miverna	PHM
Mrs.R.Kirithna	PHM
Miss.S.Suwarna	PHM
Miss.K.Janarththani	PHM
Miss.T.Sasitha	PHM
Mrs.R.Shandrakala	PHM
Miss.R.Sumangali	PHM
Miss.S.Sakthi	PHM
Mrs.R.Suseela	PHM
Miss.P.Ithayarany	PHM

Annexure – 7: (Contd).

Telipalai- MOH Office -Date: 06.11.2012

Dr.J.T.Sivashankar	RDHS
Dr.Nanthnakumar	MOH
Mrs. S.Sivakumari	HEO-Jaffna
Mr.J.C.Rajasooriya	SPHM
Mr.V.Rajendran	PHI-MOH
Mr.R.Thayaparam	PHI-MOH
Mr.N.Sachitharathnam	SPHI
Mr.M.Rajamenakam	PHI
Mrs.U.Udayakanthi	PHM
Mrs.S.Sivatharshini	PHM
Mrs.U.Usha	PHM
Mrs.K.A.Muthani	PHM
Mrs.A.Tharashani	PHM
Mrs.K.Pirathista	PHM
Mrs.K.Soukalya	PHM
Mrs.T.Dajitha	PHM
Mrs.G.Jatheepa	PHM
Mrs.S.Nirosha	PHM
Mrs.S.Beranavan	PHM

Annexure – 8 : Mood Calendar Method

‘MOOD CALENDAR’ METHOD

HEB is in the process of developing health promoting villages at the level of the PHM areas around the country.

A tool called “Mood Calendar” which had been developed by the Rajarata University Health Promotion – Master of Science Degree is being used to promote happiness and harmony in the families. The mood of the family members is marked in a calendar format by the youngest school going child in the family. A weekly dialogue on the calendar is promoted. Many success stories of decreasing of GBV as well as decreasing alcohol consumption had been documented.

ACKNOWLEDGEMENTS

The burden of coordinating the BCC strategy, organization of related activities, and logistics fell on two agencies of the Ministry of Health, the Health Education Bureau and the Family Health Bureau. HEB handled the bigger share of responsibility as the agency responsible for health communication. Dr. Sarath Amunugama, the outgoing Director of HEB was instrumental in including the BCC strategy Development Initiative in HEB's future programme of work. Dr. Neelamani Rajapaksa Hewageegana, the new Director accepted the ownership of the Initiative willingly, displaying her professionalism and is providing effective leadership to the Initiative. Dr. R D F C Kanthi, the Deputy Director of HEB and Master Trainer on BCC provided guidance in the interim period (of change of Directors) and helped to resolve implementation and logistical problems in the teething phase. She continues to support in technical aspects of BCC. Dr. Gamini Samarawickrama, National Coordinator of Reproductive Health in BCC Unit and Mr. Anura Gamini Wijesekera the HEO attached to the BCC section along with Mr. Aruna Athukorala and a few support staff handled coordination of many activities including field research logistics and the arrangements of the stakeholder workshop admirably. Dr. Prashantha de Silva provided useful insights informally on request and at the first stakeholder workshop. Dr. Sathya Herath who joined the BCC Unit midway through the Initiative participated actively in consultative meetings. Mrs. Nilmini Pushpakanthi with a few other staff helped in preparation of a variety of documents.

Under the leadership of Dr. Deepthi Perera, the Director FHB, Dr. Chitramalee de Silva, the Deputy Director, Dr. Nethanjali Mapitigama, Dr. Nilmini Hemachandra, Dr. Dhammica Rowell, Dr. Ayesha Lokubalasuriya, Dr. Sanjeewa Godakandage, Dr. Manjula Dhanansuriya, the Programme Managers and relevant Medical Officers responded enthusiastically and professionally to the demands of the BCC Strategy Development Initiative. While knowing that the focus group discussions would subject the reproductive health programmes to scrutiny, the FHB management demonstrated professionalism in supporting the formative research and discussing its findings. FHB assisted in the formulation of focus group discussion Guides by providing insights into technical aspect of each Programme, as well as contributing to the training of the FGD team. The FHB team also provided valuable suggestions on penultimate draft of the BCC Strategy Guide and overall contributed strongly to the BCC Strategy Development Initiative. The FHB team is commended for the collegial and professional manner in which they supported the Initiative.

Dr. R R M L R Siyambalagoda, the Deputy Director General of Health (Public Health II) provided policy guidance and direction to the BCC Strategy Initiative in his substantive role and also as the Chairperson of the National Core Group on BCC Strategy for Reproductive Health. The DDG continues to resolve many constraints that confront the Initiative with quick and practical decisions and solutions.

The members of the National Core Group on BCC Strategy played a key role in providing guidance at key stages of the initiative such as conceptualization, planning and implementation. Representation from agencies outside of the health sector was found to be very useful as new ideas and different perspectives helped in making the initiative more inclusive.

The Regional Directors of Health, other district health staff such as MO-MCH and HEOs of FGD implementation districts, and the MOHs and staff of selected locations (name lists in Annexures) helped the process in many ways. MOHs in the seven selected districts and staff played a vital role in organizing logistics for the focus group discussions, despite unexpected constraints. They were ready to find practical but technically acceptable solutions to ensure that more than 90 % of planned FGDs were undertaken. In this respect the role of the HEB team (especially Dr. Gamini Samarawickrama and HEO of the BCC unit) from Colombo was vital as their genial and committed approach helped in this effort.

Deep appreciation and commendations are also due to:

- The Focus Group Team (name list in Annexures) who worked in difficult areas under difficult logistical conditions, and was professionally disciplined to complete the vast majority of FGD reports at the location itself. Mr. K G P Bandara, Deputy Director/Chief Health Education Officer, and
  Mr. N Mudannayaka, Senior Health Education Officer for assistance in training, team selection and FGD report analysis.
- The community members who were members of the Focus Groups, whose ideas, attitudes, and perceptions provided the real impetus for analysis of FGD reports and the development of the BCC Strategy.
- The Research Analysts (Messrs B A Ranaweera, Siriml Peiris, Dr. T. Shirmila, Dr. Saseela Subash) helped in analyzing FGD Group Reports; it was a challenging task from an academic and professional point of view, as they were called upon to synthesize data from a varied number of focus groups across districts.
- The stakeholders and experts of the BCC Strategy Development Workshop (name lists in Annexures) for dedicated, active, and full-time work during three days of mentally absorbing, and at times mentally exhausting work.
- The representatives of the College of Obstetricians and Gynecologists especially Dr. Lakshman Senanayake and Dr. Harsha Atapattu who provided invaluable suggestions to enhance the quality of the final version of the BCC strategy Guides. The representative of the Family Planning Association of Sri Lanka, Dr. Sumithra Tissera also provided insightful comments on the penultimate drafts. The representatives of the NGO, Women-in-Need, also contributed in this regard.
- Dr. Najib Assifi, the International Consultant from Asia- pacific Development and Communication Centre (ADCC) who co-coordinated the BCC Strategy Development/Stakeholder Workshop and provided comments on the penultimate versions of the BCC Strategy Guide; The effort made in placing the BCC Strategy Development Initiative in an important position in the national health advocacy agenda is commendable.
- Mr. Lakshman Wickramasinghe, the national consultant and Mr. Thusitha Malalasekera, the assistant to the consultant who steered the BCC Strategy Development process from conceptualization to implementation, alongside UNFPA, HEB and FHB and prepared the final BCC Strategy Guide based on inputs and valuable comments received during all stages of the process.
- The outgoing UNFPA Representative, Ms. Lene Christiansen who had faith in the BCC Strategy Development Initiative and provided policy and financial support through the UNFPA system.
  Mr. Alain Sibenaler the incoming UNFPA Representative who participated in the second BCC stakeholder strategy development workshop within days of his taking over the new assignment and who since then has been taking a keen interest in the initiative.
- Dr. Chandani Galwaduge, the UNFPA National Programme Officer was the energizer and the live-wire behind the BCC Strategy Initiative. Using her characteristic frank and forthright communication and the strong professional contacts across all stakeholders, she resolved many problems, that arose along the challenging but immensely satisfying road traversed.
- To many others in HEB, FHB, UNFPA, and the districts who helped the initiative in many ways often behind the scene. We are grateful to their invisible but important contributions.

HOWEVER, THE MORE DIFFICULT PATH OF IMPLEMENTATION STILL LIES AHEAD. THE DEDICATED AND ACTIVE COOPERATION OF ALL ABOVE AND MANY MORE PROFESSIONALS WOULD BE VITAL FOR THAT JOURNEY.