

**BEHAVIOUR CHANGE
COMMUNICATION STRATEGY GUIDE**
For Reproductive Health Programmes in Sri Lanka

Booklet 1 – The Well Woman Clinic Programme

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

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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 WELL WOMAN CLINIC PROGRAMME**

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 programmes 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 cause-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



It is a great honour to have the opportunity to release a series of booklets on Behaviors Change Communication for Reproductive Health for the first time in Sri Lanka.

Well Women Clinic (WWC) is an important strategy in the island which developed over the decades to detect and screen cancers and other non communicable diseases in women. However since its commencement the WWC had been under utilized by the community women and its value undermined by their families.

The aim of the booklet is to educate medical as well as non medical personnel mainly at the community level in order to implement change in the behaviors of the general population in order to encourage women to improve their attendance to the WWC to reduce the prevalence of targeted diseases.

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 dedication and hard work throughout the period, the Family Health Bureau staff for their valuable technical inputs and the UNFPA for their financial support.

I wish to thank Dr Chandani Galwaduge, National Programme Officer UNFPA, 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 enhance utilization of WWC services in Sri Lanka and I hope it will inspire the reader to implement behaviour 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

BC	Breast Cancer
BCC	Behaviour Change Communication
CC	Cervical Cancer
CP	Country Programme
CST	Country Support Team
FGD	Focus Group Discussion
FHB	Family Health Bureau
HEB	Health Education Bureau
IEC	Information Education Communication
M&E	Monitoring and Evaluation
MNH	Maternal and Newborn Health
MO	Medical Officer
MOH	Medical Officer of Health
MoH	Ministry of Health
MLT	Medical Laboratory Technologist
NGO	Non-Government Organization
PHI	Public Health Inspector
PHM	Public Health Midwife
PHNS	Public Health Nursing Sister
Q&A	Question and Answer
RH	Reproductive Health
SBE	Self Breast Examination
SCC	Specialized Centre/Clinic
STD	Sexually Transmitted Disease
STI	Sexually Transmitted Infection
SPHI	Supervising Public Health Inspector
SPHM	Supervising Public Health Midwife
UNICEF	United Nations Children's Fund
UNFPA	United Nations Population Fund
WDO	Women Development Officer
WHO	World Health Organization
WWC	Well Woman Clinic

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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 recommendations¹ 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,

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

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 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-Weaver² and the Berlo³ 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

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

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

recommended behaviours are 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 health 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.
- Factors⁴ 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).

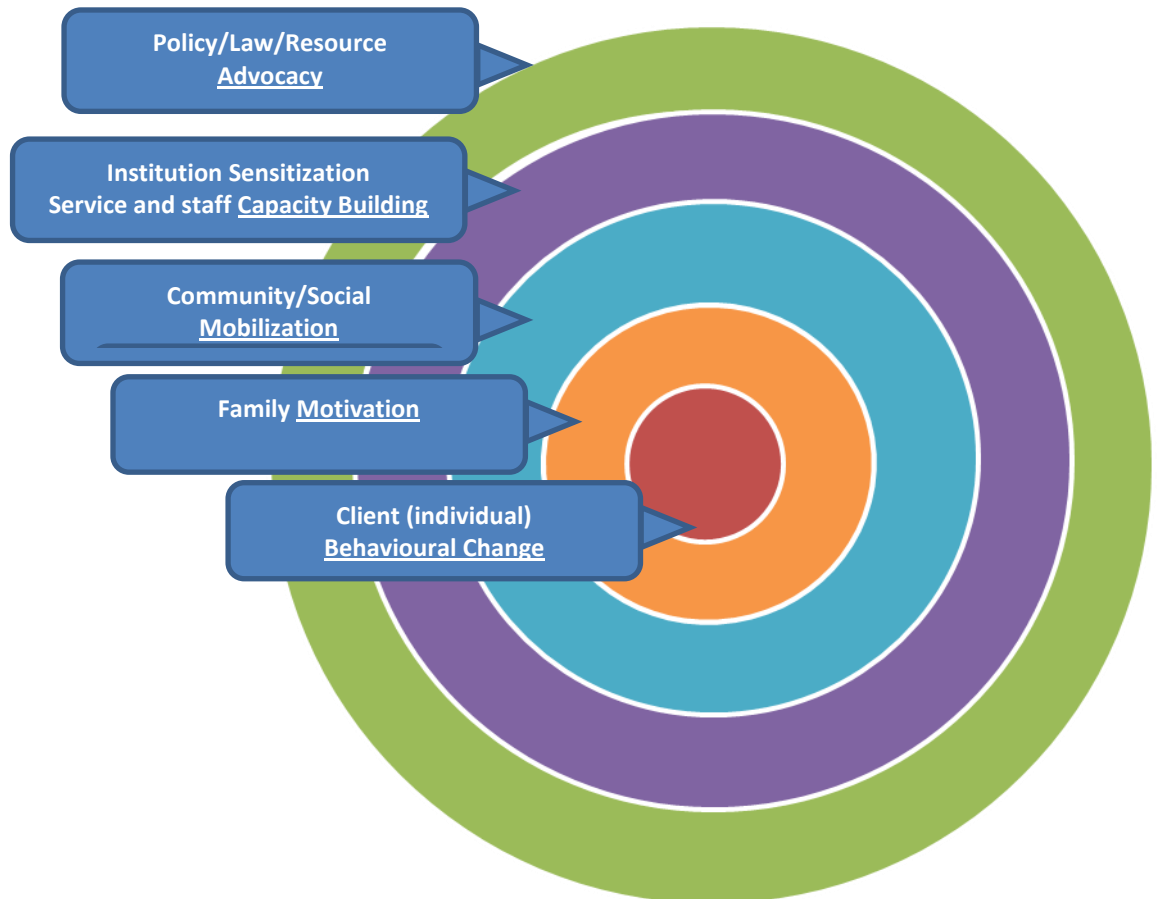
The rationale for attempting to obtain the above information is due to the understanding arrived by BCC planners and researchers that a person who wishes to undertake or change to new desired health behaviour should:

- 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

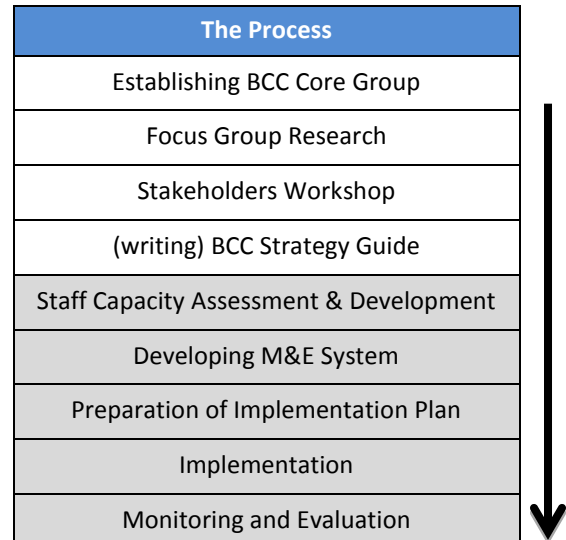


Thus a behaviour change communication strategy would ideally include the following communication elements at different implementation levels, beginning from the client, the central focus of BCC, to the policymaker as shown in the diagram of increasing concentric circles. At each of these levels, the 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 BCC strategy development for RH Programmes was presented to the full core group by the national consultant and approval was obtained to begin implementation of the methodology. Subsequently at each key stage of the process, the 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 Managers 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 Well Woman Clinic Programme is given below.

FGD Summary Findings – WWC Programme

Knowledge of – 35 year old Women (W) and Men (M)

	<u>W</u>	<u>M</u>
- Understand Prevention	L	L
- Knowledge of Breast Cancer (BC) and Cervical Cancer (CC)	VH	L
- Knowledge of Diabetes	L	L
- Signs of BC	H	L
- How to do Breast Self-Examination (BSE)	L	-
- Signs of CC	L	L
- Knows of Pap Smear (PAP) test	H	L

Code : VH – Very High; H – High; L - Low

Behaviours/Practices reported by 35 year old women

- About one half of FGD members had attended WWC
- Regular BSE was not carried out by them
- PAP test: very small number of FGD members had done the test
- No husbands had accompanied their wives to WWC

Key reasons why women do not attend WWC

- Inadequate knowledge of prevention concept and benefits; negligence, no time.
- BSE not done; referrals not followed-up: so embarrassed to attend again.
- Household chores; husband, older sons, mother-in-law not assisting/resisting.
- Test results not communicated to clients; inadequate advice about what to do next; no feedback to attend again; low trust in WWCs confidentiality; some staff rough/abrasive; inadequate toilet facilities/privacy to take test samples; prefer women MOs.
- Women shy/ashamed to attend; embarrassed on returning home.

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. Harsha Atapattu representing the College of Obstetricians and Gynaecologists provided invaluable advice in finalizing the BCC strategy on WWC.

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 1) is on the BCC strategy guide specifically for the Well Woman Clinic Programme.

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 WELL WOMAN CLINIC PROGRAMME-AN INTRODUCTION

The Well Woman Clinic Programme (WWC) was established in 1996 in Sri Lanka to provide following services to women over 35 years of age:

(a) general physical examination (b) screening for hypertension (c) screening for diabetes (d) breast examination and education on conducting self-breast examination for screening and prevention of breast cancer (e) visual examination of the cervix and taking Pap smear for screening and prevention of cervical cancer (f) family planning services on request and (g) health education on menopause, STD and HIV/AIDS, and nutrition. The aim of the programme is to reduce morbidity and mortality associated with the diseases mentioned above and improve quality of life of women attending the Well Woman Clinics.

WWCs are conducted at the Medical Officer of Health area level, and are normally linked to family planning clinics. The majority of WWCs are operated under the management and supervision of the Medical Officer of Health. Public Health Nursing Sisters (PHNS), Supervisory Public Health Midwives (SPHM), and Public Health Midwives (PHM) assist the MOH in conducting WWCs. While PHNS assist the MOH in physical examinations of clients, health education and other services such as record keeping are generally conducted by PHNSs, SPHMs, and PHMs. PHMs also play a key role in motivating clients to attend WWCs as well as provision of health education at the field level including at household level.

The Pap smear slides are sent to the nearest designated hospital with a pathological laboratory for testing and reporting back. Women with abnormal test results are referred to a Gynecologist at a specialist clinic for referral and follow-up. Women with abnormal indications on blood pressure and blood sugar are also referred to specialized clinics and care centres available in the district. All women who attend WWCs are requested to do self breast examinations every month at home after a health education session conducted at the WWC. (For a detailed description of services and a flow-chart of activities in WWCs, please refer to the Guidelines for implementation of the Well Woman Clinic Programme, No.FHB/FE/05/98 dated 14 July 1999.)

By the end of 2012 there were 939 Well Woman Clinics in the country. In 2010, a change was made regarding priority target clients in WWCs. From 2010, the priority target group for Pap Smear Screening was considered to be women completing the 35th year. The PHM could conveniently identify the one year age cohort of women completing 35 years using the eligible family register. However, all women over 35 years of age who voluntarily request for WWC services will be provided WWC services, along with the priority target group who would be actively motivated to obtain WWC services. In 2012 28% percent of women in the 35 year age cohort obtained WWC services.

2. KEY SECTIONS INCLUDED IN BEHAVIOUR CHANGE COMMUNICATION STRATEGY GUIDE DOCUMENT – BOOKLET 1, WWC PROGRAMME

The BCC Strategy for Reproductive Health Booklet 1, BCC Strategy Guide for the Well Woman Clinic (WWC) Programme includes seven sections as follows:

Section 1- Behaviour change communication interventions designed for the clients of the Well Woman Clinics, their spouses and other family members:

- (i) 35 year old women (clients) – to motivate to attend WWCs (Pg.18)
- (ii) Husbands and other family members of 35 year old women - to actively support wives/women to attend WWCs(Pg.25)
- (iii) 35 year old women attendees to - agree to a PAP smear to be taken for testing (Pg.28)
- (iv) Women attendees with abnormal test results– to motivate to seek specialized medical care as advised (Pg.30)
- (v) 35 + women with positive family histories – to motivate to attend WWCs (Pg.34)
- (vi) All women – to motivate to practice breast self examination regularly at home (Pg.37)

Section 2 – Social mobilization activities to offer social legitimacy and encouragement to family members and 35 year old women to attend WWC. The targets of social mobilization would include:

- (i) Divisional Secretary and field officers in the Divisional Secretary area (Pg.39)
- (ii) Leaders of community based organizations in the area (Pg.40)

Section 3 –Mobilization of mass media practitioners to educate 35 year old women and their families on the importance of attending WWCs.

- (i) Senior Editors and Programme Directors of print and electronic media (Pg.41)
- (ii) Feature Editors, Programme Producers, Feature Writers, Script Writers (Pg.42)

Section 4 – Enhancement of staff capacity to increase attendance and to follow-up clients with positive test results at WWCs through education and motivation of clients

- (i) Key staff attached to MOH offices /areas (P.44)

Section 5 – Advocacy for improvement of policies, programme procedures and resources to increase attendance at WWCs

- (i) Senior policy makers at national, provincial, district levels; representatives of colleges of obstetricians and gynecologists and pathologists; and trade union representatives as applicable (Pg.47)

Section 6 – Sensitization of institutions/staff to support advocacy aimed at increasing attendance and improving follow-up services at WWCs.

- (i) National Committee on Family Health, Technical Advisory Committee on Family Health and Management Development Planning Unit (MDPU) of Ministry of Health, Provincial and Regional Directors of Health, Colleges of Obstetricians and Gynecologists and Pathologists, representatives of trade unions as appropriate (Pg.49)
- (ii) Directors of hospitals, Pathologists, Medical Laboratory Technologists, College of Pathologists, representatives of trade unions as applicable (Pg.51)
- (iii) National Committee on Family Health, Colleges of Obstetricians and Gynecologists and Pathologists, and other appropriate organizations (Pg.52)

Section 7 – Advocacy for mobilization of service clubs and private sector to support WWC infrastructure improvement and service expansion.

- (I) President and Exco of service clubs such as Rotary, Lions, etc. (Pg.53)
- (II) President and Exco of Ceylon Chamber of Commerce, and National Chamber of Commerce etc (Pg.54)

Under each of the above Sections(1 to 7), information and suggestions useful for planning and implementing appropriate communication activities are given. They are:

- main target audience,
- the behaviour expected of them or the 'practice' they are called upon to perform (called the 'Desired Behaviour')
- the support they would get (called the Facilitating Factors) and the obstacles they would face (called the Constraining Factors) when trying to perform the 'desired behaviour'.
- the primary messages, knowledge, and skills that the communication programme should pass on to the target audience to motivate the target audience members to perform the 'desired behaviour'. 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 'desired behaviour'
- the communication media and or method that could be used to disseminate the primary messages and skills etc to the target audience. This could be an interpersonal channel (PHM, MOH, or a Women Development Officer), a group communication channel (small group meeting, support group, mothers' group etc.), 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 5,6&7 should essentially be implemented at the national level.

The key elements contained in the BCC Strategy Guide are designed on the basis of information and data received from clients through focus group discussions. The key elements were reconfirmed and sometimes added on to at the Strategy Development Stakeholder Workshop as well as at compilation stage of the final text to further enhance the communication impact. All suggested elements in the Guide are directly useful to motivate a client to change from an undesirable behaviour to a desired behaviour. Thus this BCC Strategy Guide on the Well Woman Clinic Programme is an evidence based document and can be used to increase attendance at WWC clinics, and increase the use of recommended practices.

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 objectives, 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 BCC Strategy Guide, a short training (of 2 days duration) on BCC concepts, methods and communication strategy planning be organized for all staff. 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 up to the MOH and the team of officers to include in the local WWC/BCC implementation plan at least a 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 desirable behaviour. 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 behavior (please see pg. 6). Therefore 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 THE WELL WOMAN CLINIC

PROGRAMME

SECTION 1: BEHAVIOUR CHANGE COMMUNICATION INTERVENTIONS DESIGNED FOR THE CLIENTS, THEIR SPOUSES AND OTHER FAMILY MEMBERS.

Issue: Inadequate demand for WWC Services

Problem Behaviour: The majority of 35 year old women do not attend Well Women Clinics (WWC)

1. Desired Behaviours and Facilitating/Constraining Factors

Target Group	Desired Behaviour	Facilitating Factors	Constraining Factors
35 year old women	35 year old women attend WWC voluntarily.	<p><u>In All Areas</u></p> <ul style="list-style-type: none"> ▪ Strong awareness of existence and location of Well Woman Clinics. ▪ Good knowledge that breast and cervical cancer prevention services are available in WWCs. ▪ Good knowledge of signs of breast cancer (BC). ▪ WWC services are free. ▪ Good rapport with/ trust in PHMs. <p><u>In Few Areas</u></p> <ul style="list-style-type: none"> ▪ Trust in quality of WWC services and safety of instruments used. ▪ Belief that BC can be cured/controlled. ▪ Support of CBOs, religious institutions. ▪ PHM informs about test results. ▪ Close distance to WWCs. 	<p><u>Knowledge</u></p> <ul style="list-style-type: none"> ▪ Low understanding of and priority for preventive health. ▪ Moderate knowledge of signs of cervical cancer. ▪ Very low knowledge on how to do breast self-examination (BSE). ▪ Poor knowledge on WWC services and benefits other than on cancer prevention. <p><u>Household/Family</u></p> <ul style="list-style-type: none"> ▪ Heavy household chores. ▪ Lack of cooperation of husbands and other family members. <p><u>Skills</u></p> <ul style="list-style-type: none"> ▪ BSE not practiced as women do not have how-to-do skills.

Target Group	Desired Behaviour	Facilitating Factors	Constraining Factors
35 year old women (contd.)			<p data-bbox="1444 240 1566 264"><u>Attitudes</u></p> <ul data-bbox="1444 277 1898 423" style="list-style-type: none"> <li data-bbox="1444 277 1898 423">▪ Poor attitudes of women, e.g. BC cannot be cured; referrals not followed-up; negligence; no time to attend WWC. <p data-bbox="1444 475 1623 500"><u>Socio-cultural</u></p> <ul data-bbox="1444 513 1892 773" style="list-style-type: none"> <li data-bbox="1444 513 1892 578">▪ Feelings of embarrassment and shame at WWC. <li data-bbox="1444 591 1892 737">▪ Feeling ashamed on returning home as family members may ask about the type of services received. <li data-bbox="1444 750 1787 773">▪ Female MOs preferred. <p data-bbox="1444 824 1707 849"><u>WWC Services/Staff</u></p> <ul data-bbox="1444 862 1906 1203" style="list-style-type: none"> <li data-bbox="1444 862 1885 885">▪ Some staff rough and abrasive. <li data-bbox="1444 898 1871 963">▪ Inadequate toilet facilities for taking samples in privacy. <li data-bbox="1444 976 1738 1040">▪ Low trust in WWC's confidentiality. <li data-bbox="1444 1053 1787 1118">▪ Medical test results not communicated <li data-bbox="1444 1131 1906 1203">▪ Inadequate feedback and advice on what follow-up steps to take.

2. Behaviour Change Communication Strategy

Target Group and Role in BCC	Primary Message, Knowledge and Skills	Communication Media/Methods	Communication Materials/Tools
<p>35 year old women</p> <p>Reached directly to motivate to attend WWCs voluntarily.</p>	<p>1. Good health is your right. Learn about prevention. Prevention is better than cure. - WWCs help women to stay healthy. Learn how WWCs can help you and your family.</p> <p>2. Services provided by WWCs. Screening for breast cancer and cervical cancer; high blood pressure; diabetes; obesity; family planning services. Health education on menopause and gynecological problems. Counseling for any of above and follow-up.</p> <p>3. Who should attend WWC (i) All women who are 35 years of age MUST attend WWCs.</p>	<p>Interpersonal PHM/PHNS/MOH Home visits</p> <p>Group meetings - interactive</p> <ul style="list-style-type: none"> ▪ Monthly meetings at WWCs/MCH clinics ▪ Special quarterly meetings for invited 35 year old women in each PHM area. ▪ Other relevant fora/groups in the area. ▪ Presentation followed by interactive discussion session including answering written questions forwarded by participants. 	<ul style="list-style-type: none"> ▪ Multimedia Presentation on the concept of prevention and WWC. ▪ Flip Chart (on above theme). ▪ Written testimonials or direct presentation by satisfied users of WWC. ▪ Q&A Leaflet on services provided by WWCs for distribution to women and families. The leaflet would cover in Q&A format information about WWC services on breast cancer, cervical cancer, Gynaecological and menstrual problems, high blood pressure, diabetes, and FP services.

Target Group and Role in BCC	Primary Message, Knowledge and Skills	Communication Media/Methods	Communication Materials/Tools
<p>35 year old women</p> <p>Reached directly to motivate to attend WWCs voluntarily. (contd.)</p>	<p>ii) Any woman with a risk factor, i.e. who have positive family history should attend WWCs for advice irrespective of age.</p> <p>iii) All women who had abnormal test results should contact WWC again to receive further information about what follow-up action to take.</p> <p><i>(When explaining about target women categories (ii) & (iii), please be very sensitive about possible stigma, fear, and embarrassment that can be caused. Please be empathetic; and reassure them that it is really a blessing in disguise, as in both these categories, cancer can be prevented; High blood pressure and diabetes managed without any harm to self.)</i></p> <p>Explain that all who have positive family history will not get the disease. There is a tendency only. When they attend WWCs any such possibility can be prevented or managed and treated.</p>	<p>(interactive discussions should be used to clarify doubts and resolve problems raised by participants)</p>	

Target Group and Role in BCC	Primary Message, Knowledge and Skills	Communication Media/Methods	Communication Materials/Tools
<p>35 year old women</p> <p>Reached directly to motivate to attend WWCs voluntarily. (contd.)</p>	<p>In respect of abnormal medical test result too, it is only an early indicator which will help the woman to prevent getting cancer. When a PAP smear test is positive it does not say that the person has cancer. In most cases, it just shows the person has pre-cancerous cells only.</p> <p>And when that person attends specialized clinic or care center in hospital (as referred to by WWC) pre-cancer cells can be prevented from developing into cancer.</p> <p>4. Benefits of WWC services Early identification of pre-cancer cells will prevent cervical cancer; when identified early breast cancer can be cured; high blood pressure and diabetes can be prevented and controlled.</p>		

Target Group and Role in BCC	Primary Message, Knowledge and Skills	Communication Media/Methods	Communication Materials/Tools
<p>35 year old women</p> <p>Reached directly to motivate to attend WWCs voluntarily. (contd.)</p>	<p>5. Gravity of the problem with a convenient doubly safe solution Cancer is a dangerous disease; but in most cases it can be totally prevented or cured. With safe and early screening provided by WWC, cancer can be prevented or cured. Give statistics related to the problem and probability of prevention/cure due to early intervention.</p> <p>6. WWCs help women to prevent and manage high blood pressure, diabetes, gynaecological problems and menstrual problems. When left untreated these diseases and problems would badly affect your health; they could even be life-threatening. At WWC every woman 35 years and above will be screened and treatment given or referred to other clinics.</p>		

Target Group and Role in BCC	Primary Message, Knowledge and Skills	Communication Media/Methods	Communication Materials/Tools
	<p>7. Family Planning services are very important for women 35 years and above. WWC provide FP services confidentially and efficiently.</p> <p>Practice of FP will help you to avoid an unwanted pregnancy, and even an induced abortion which some women and families resort to in desperation. Staff in WWCs will discuss your FP needs in private and confidentially and offer you advise and required services.</p>		

SECTION 1 CONTINUED

Issue: Husbands and other family members do not understand/appreciate the importance of wives/mothers attending Well Woman Clinics.

Problem Behaviour: The majority of husbands and some grown-up sons, mothers-in-law and sisters-in-law resist or do not consider it a priority for wives, mothers, and daughters-in-law attending WWCs.

1. Desired Behaviour and Facilitating/Constraining Factors

Target Group	Desired Behaviour	Facilitating Factors	Constraining Factors
Husbands and Family Members	Husbands or grown-up sons/daughters accompany wives/mothers to WWCs or actively support in ensuring that wives/mothers attend WWCs as required on specified dates.	Strong cultural practice of caring for women and mothers.	<p><u>Knowledge</u></p> <ul style="list-style-type: none"> ▪ Low understanding among husbands about concept of preventive health. ▪ Lack of knowledge on services provided and benefits accruing to women and family through WWCs. <p><u>Attitude</u></p> <ul style="list-style-type: none"> ▪ Poor attitude of husbands/grown-up sons towards preventive health of wives/mothers. <p><u>Household</u></p> <ul style="list-style-type: none"> ▪ Husbands and sons do not actively contribute in reducing household chores of wives/mothers.

2. Behaviour Change Communication Strategy

Target Group and Role in BCC	Primary Message, knowledge and skills	Communication Media/Methods	Communication Materials/Tools
<p>Husbands and Family Members</p> <p>To motivate to support their 35 year old wives to attend WWCs by educating family members about WWCs; by making joint advance plans for wife to attend WWCs on the specified date by adjusting household chores/facilitating transport etc.</p>	<p>Husbands/Family Members – Learn why prevention is important to your family. Learn of WWC. It helps your wife to lead a healthy life. It is also a boon to husbands/fathers/children as it helps to keep wife/mother healthy.</p> <p>Preventing illness is a way of keeping your family happy and economically strong. When your children were very small you helped to take them to the clinic for immunization. WWC is a clinic for women. It helps your wife to stay healthy. WWC helps to prevent breast and cervical cancer. Diabetes and high blood pressure can also be prevented or treated at WWCs.</p> <p>It is run by MOH, PHM and PHNSs – same officers who help pregnant mothers during pregnancy; who immunize small children. It is free. It is important</p>	<p>Interpersonal PHMs, PHNSs, PHIs, and MOHs</p> <ul style="list-style-type: none"> ▪ Home visits <p>Group meetings – interactive</p> <ul style="list-style-type: none"> ▪ Farmers Group Meetings ▪ Convene special meetings of ‘Husbands’ at Community Centers in cooperation with CBO leadership. ▪ Meetings at work places <p>(Select appropriate activity to suit area).</p>	<ul style="list-style-type: none"> ▪ Multimedia Presentation on the concept of prevention and WWC ▪ Flip chart (on above theme) ▪ Leaflet for husbands/ family members on WWCs and services it offer for women. ▪ Identify a well-known male in the community to speak in support of WWC and role of husbands/ family members. ▪ Drama/Role Play HEB or District HEOs produce prototype drama/role play scripts with local talented persons. ▪ Video clips of Role Plays. ▪ Traditional Media.

Target Group and Role in BCC	Primary Message, knowledge and skills	Communication Media/Methods	Communication Materials/Tools
<p>Husbands and Family Members (contd.)</p>	<p>for all 35 year old women to attend WWC clinic.</p> <p>Please accompany your 35 year old wife to WWC clinic without fail; or please make necessary arrangements for her to go to WWC. If your wife is over 35 years of age and still has not attended WWC, take her to WWC.</p> <p>Happy family through healthy wife/mum. A healthy wife/mother keeps the family happy. Children can be helped to study well. A healthy mother is a great strength to husband/children. If mother falls sick it is a disadvantage to the family in many ways. If the mother stays healthy the family will prosper. Money will be saved in the long run (bus fare now vs. treatment costs later) and family happiness may not be affected.</p>		<ul style="list-style-type: none"> ▪ Leaflet on why it is important for women to attend WWC and avail of services provided. ▪ Q&A leaflet on difficulties faced by women at household level in attending WWCs; and how husbands and family members can help wives/mothers to attend WWCs.

SECTION 1 CONTINUED

Issue: 35 year old women (who attend WWCs as well as others) do not appreciate the importance of secondary prevention in protecting from cancer.

Problem Behaviour: 35 year old women miss-out on the PAP smear test (due to shyness or other cultural factors or due to perceived difficulties/dislikes in service delivery/staff aspects).

1. Desired Behaviour and Facilitating/Constraining Factors

Target Group	Desired Behaviour	Facilitating Factors	Constraining Factors
35 year old women WWC attendees who avoid/miss-out on PAP smear test.	All 35 year old women who attend WWCs undergo a PAP smear test voluntarily.	<ul style="list-style-type: none"> ▪ WWCs provide PAP smear facilities. ▪ Majority of women have heard of PAP smear test and have a basic knowledge, on the reason for doing a PAP. 	<ul style="list-style-type: none"> ▪ Feeling of embarrassment and shyness at WWC. ▪ Feeling ashamed on returning home as family may ask the type of services received. ▪ Fearful at the clinic (WWC). ▪ Non-availability of female medical officers in WWC. ▪ Pathology laboratory delay in processing/PAP smear tests on samples sent by WWC. ▪ Delay in communicating of test-results to women by WWCs.(some women who test negative do not receive test results at all)

2. Behaviour Change Communication Strategy

Target Group and Role in BCC	Primary Message, knowledge and skills	Communication Media/Methods	Communication Materials/Tools
<p>35 year old women WWC attendees who avoid/miss-out on PAP smear test.</p> <p>Reached directly, to motivate to take PAP smear test.</p>	<p>1. Correcting negative perceptions about WWCs and reducing feelings of shame and embarrassment in women.</p> <ul style="list-style-type: none"> - Clinic for all women of 35 years. - Painless and harmless procedures. - Privacy and confidentiality ensured. - Explain about clinic procedures. - Benefits of clinic procedures and tests including PAP smear test. - Also repeat primary knowledge 4&5.(on pgs.22&23) 	<p>Interpersonal PHM/PHNS/Female Medical Officer Satisfied clients.</p> <ul style="list-style-type: none"> - Home visits - Counseling <p>Formation of Support Group on PAP smear</p> <ul style="list-style-type: none"> - Meetings of support group with women of 35 years in the community <p>Group Meetings - Interactive</p> <p>Presentation on PAP smear test followed by interactive discussion session, including answering written questions forwarded by participants.</p> <p><i>(The main objective of above methods is to clarify doubts, remove apprehension and embarrassment regarding PAP smear test and discuss solutions to problems)</i></p>	<ul style="list-style-type: none"> ▪ Multimedia Presentation on concept of prevention and WWC. ▪ Flip Chart (on above theme). ▪ Leaflet on PAP smear test, what it is, how it is carried out and how often it should be carried out. ▪ Flash Cards on PAP smear test for use in counseling.

SECTION 1 CONTINUED

Issue: Women who need specialized care on the basis of abnormal test results conducted by WWCs are not covered by specialized care services as medically required, although such facilities of variable quality and service capacities are available in districts.

Problem Behaviour: Some women with abnormal medical test results do not seek or do not regularly follow-up on specialized care recommended by WWCs and specialized clinics.

1. Desired Behaviour and Facilitating/Constraining Factors

Target Group	Desired Behaviour	Facilitating Factors	Constraining Factors
WWC attendee women with abnormal medical test results.	All WWC attendee women with abnormal medical test results seek specialized care and follow-up as indicated.	Specialized care services are available in Government health care sector institutions in districts (please also see constraining factor analysis on services)	<p><u>Knowledge/Culture</u></p> <ul style="list-style-type: none"> ▪ Women and family knowledge on follow-up and specialized care services inadequate. ▪ Women’s feelings of embarrassment, shyness and fear at/after WWC. <p><u>Services/Staff</u></p> <ul style="list-style-type: none"> ▪ Some impolite/rough staff at WWCs. ▪ Some women do not get test results. ▪ Some women indicate that advice on follow-up action and referrals given by WWC staff are inadequate or unclear. ▪ Delay in processing PAP tests.

Target Group	Desired Behaviour	Facilitating Factors	Constraining Factors
WWC attendee women with abnormal medical test results (contd.)	All WWC attendee women with abnormal medical test results seek specialized care and follow-up as indicated (contd.)		<p data-bbox="1444 240 1835 305"><u>Specialized Care Centre/Clinic Services</u></p> <ul data-bbox="1444 318 1881 813" style="list-style-type: none"> <li data-bbox="1444 318 1881 423">▪ Less priority given to WWC referrals in specialized clinics and centres. <li data-bbox="1444 435 1881 540">▪ Variable quality of service across district specialized clinics and centres. <li data-bbox="1444 552 1881 813">▪ Inadequacy of trained human resources, facilities and equipment at specialized clinics and centres, e.g. all specialized clinics and centres do not have colposcopy facilities. <p data-bbox="1444 862 1751 894"><u>Household/Community</u></p> <ul data-bbox="1444 902 1881 1395" style="list-style-type: none"> <li data-bbox="1444 902 1881 967">▪ Lack of husband/family support. <li data-bbox="1444 979 1881 1011">▪ Heavy household chores. <li data-bbox="1444 1023 1881 1128">▪ Weak attitudes of women, husbands and family towards referrals and follow-up. <li data-bbox="1444 1140 1881 1245">▪ Low community priority to maintaining and protecting health of elderly women. <li data-bbox="1444 1256 1881 1289">▪ Women fear to find-out. <li data-bbox="1444 1300 1881 1395">▪ If diagnosed with cancer, very little can be done 'as we are poor' (few areas).

2. Behaviour Change Communication Strategy

Target Group and Role in BCC	Primary Message, knowledge and skills	Communication Media/Methods	Communication Materials/Tools
<p>WWC attendee women with abnormal medical test results Reached directly to motivate women who need specialized care to attend specialized clinics and centers regularly as advised.</p> <p>Husband, older son or near relative of women with abnormal test results Engaged to actively support and motivate</p>	<p>An abnormal test result does not mean that a person has cancer. Explain the implication of an abnormal test result (i) It does not mean that a person has cancer (ii) Most abnormal test results will automatically become normal (i.e. abnormal cells will turn normal) in a few years time (iii) However, some of the abnormal cells can sometimes become cancerous after 5-10 years. (iv) That is why it is important to visit clinics as requested. With simple treatment, these bad cells can be prevented from developing into cancer. <i>(when explaining about abnormal test results, please be very sensitive about possible stigma, fear, and embarrassment that can be caused. Please be empathetic; reassure them that abnormal test result is really a blessing in disguise. If it is an abnormal PAP</i></p>	<p>Interpersonal PHM/PHNS/Female M.O/MOH</p> <ul style="list-style-type: none"> ▪ Home visits ▪ Counseling <p>Formation of support groups for women with abnormal test results</p> <ul style="list-style-type: none"> • Inviting women diagnosed with abnormalities to attend the support group meetings <p>Each MOH area staff should decide the most appropriate interpersonal communication event. e.g. invitation to attend MOH office/home visit/mobile phone discussion.</p> <p>Talk to husbands/family members or jointly to wife and husband, depending on individual situation. An empathetic face to face talk with husband and wife; grown-up child and mother, would be the best approach.</p>	<ul style="list-style-type: none"> ▪ Leaflet on how husband, mother or older child can support the wife/mother who received abnormal test results. ▪ Flash Cards on abnormal test results, and what steps women and family members should take to protect women with abnormal test results from cancer. ▪ Multimedia Presentation on abnormal test results and follow-up activities for use in support groups.

Target Group and Role in BCC	Primary Message, knowledge and skills	Communication Media/Methods	Communication Materials/Tools
<p>WWC attendee women with abnormal medical test results (contd.)</p> <p>Husband, older son or near relative of women with abnormal test results (contd.)</p>	<p><i>smear, cancer can be prevented by following medical advice faithfully. If it is about diabetes and high blood pressure – both can be managed with medical advice and treatment, without any harm to oneself)</i></p> <ul style="list-style-type: none"> ▪ Please attend specialized clinics and centres as soon as possible; if in doubt or not clear about what to do ask the WWC doctor, PHNS or PHM again; it is the duty of the WWC staff to explain clearly what you should do as a follow-up. Ask for a Leaflet on follow-up advice. ▪ For each main type of abnormal test result, lay down the follow-up and referral procedure in writing to ensure that the referral advice given by all staff is consistent. 	<p>Orientate MOH office staff, WWC staff on written abnormal test result referral procedure!</p>	

SECTION 1 CONTINUED

Issue: Women with risk factors are screened for prevention, early detection, and treatment.

Problem Behaviour: Majority of women with risk factors (i.e. 35 year old women as well as 36+ year old women with positive family history) do not attend WWC clinics.

1. Desired Behaviour and Facilitating/Constraining Factors

Target Group	Desired Behaviour	Facilitating Factors	Constraining Factors
Women with risk factors. (35 years old and 36+ years old i.e. women with positive family history)	All women with risk factors voluntarily attend WWC clinics All women with risk factors receive services at WWC.	Availability of early screening services free of charge at WWCs.	<u>Services/Resources</u> <ul style="list-style-type: none"> ▪ WWC’s focus on 35 year old women tends to dissuade 36+ women with positive family history from attending WWC clinics. ▪ Absence of a specific socially and culturally appropriate health communication approach for women with positive family history. ▪ Lack of a dedicated WWC service delivery for women with positive family history. ▪ Inadequate pathology laboratory facilities/ staff to conduct and communicate medical test results processed through WWCs without undue delay.

2. Behaviour Change Communication Strategy

Target Group and Role in BCC	Primary Message, Knowledge and Skills	Communication Media/Methods	Communication Materials/Tools
<p>Women with risk factors. (35 years old and 36+ years old i.e. women with positive family history)</p> <p>Engaged to motivate them to attend WWCs</p>	<p>Having a positive family history is a blessing in disguise.</p> <ul style="list-style-type: none"> ▪ If you are wise you can turn it into a big advantage. ▪ Do not be afraid; do not feel embarrassed. Come directly to a WWC clinic. Get yourself tested and prevent the disease. Be smart; use the knowledge of family history to prevent disease. ▪ WWC services will help you to be safe and healthy even if you have a positive family history about cancer, diabetes or high blood pressure. <p><i>(When explaining about positive family history, please be very sensitive about possible stigma, fear and embarrassment that can be caused. Please be empathetic and sensitive to their feelings).</i></p>	<p>Interpersonal PHM</p> <ul style="list-style-type: none"> ▪ Home visits ▪ Counseling <p>Group Meetings - Interactive PHM, SPHM, PHNS, MOH</p> <ul style="list-style-type: none"> ▪ Meetings at MOH office ▪ Community Based Women’s Group meetings e.g. Mothers Groups’, Micro-Credit Groups, etc. organized with assistance of relevant community leaders. ▪ Community support group for women with positive family history. 	<ul style="list-style-type: none"> ▪ Leaflets for women with risk factors (with positive family history), on what it means to have a positive family history; how WWCs can help such women to stay healthy. ▪ Multimedia presentation on above theme. ▪ Prototype mini-drama scripts written by HEB on promoting visits of women with positive family history to WWCs, with focus on countering stigmatization. (scripts to be distributed to interested MOH areas).

Target Group and Role in BCC	Primary Message, Knowledge and Skills	Communication Media/Methods	Communication Materials/Tools
<p>Women with risk factors. (35 years old and 36+ years old i.e. women with positive family history)</p>			<ul style="list-style-type: none"> ▪ Mini videos of dramas produced based on prototype scripts distributed to interested MOH areas for use in interactive group meetings. ▪ Traditional media plays and dramas produced and staged at village level with relevant CBOs. Message inputs should ideally be provided by SPHM, PHM, PHNS, PHI, MOH. Alternatively prototype scripts developed by HEO can be used to produce mini-dramas. The staging of mini-dramas may be followed by interactive discussion.

SECGTION 1 CONTINUED

Issue: 35 year old women (who attend WWCs as well as others) do not appreciate the importance or practicing secondary prevention.

Problem Behaviour: Women do not practice regular self-breast examination (SBE)

1. Desired Behaviour and Facilitating/Constraining Factors

Target Group	Desired Behaviour	Facilitating Factors	Constraining Factors
All women (even below or above 35 years)	Women practice SBE monthly.	WWC programme includes advice on SBE.	<ul style="list-style-type: none">▪ Low knowledge and lack of skills in doing self-breast examination (SBE).▪ Few mothers who have skills and also practice, do not do SBE on a regular basis.

2. Behaviour Change Communication Strategy

Target Group and Role in BCC	Primary Message, knowledge and skills	Communication Media/Methods	Communication Materials/Tools
<p>All women</p> <p>Reached directly to motivate to do breast self - examination (SBE) monthly at home.</p>	<p>Practice SBE monthly; it is a life saver simple and effective. Take time to learn seriously and practice.</p> <ul style="list-style-type: none"> ▪ SBE explained in simple language; step by step. (Repeating as necessary) ▪ Opportunity provided for clients themselves to explain. Correct if/when wrong. ▪ Possible venues, and times to do (SBE) at home discussed; specific problems encountered, and solutions also discussed. ▪ If you feel a lump you do not have to get excited or fearful. All lumps are not cancerous. But any lump should not be neglected either. Any one feeling a breast lump should consult a doctor. If you feel so, you could discuss with your PHM confidentially and arrange for a consultation with a doctor too. It is important to get medical advice quickly. 	<p>Interpersonal PHM/PHN</p> <ul style="list-style-type: none"> ▪ Home visits ▪ Counseling <p>Group Meetings Demonstration PHM, PHNS and Female Medical Officers</p> <p>Interactive sessions including presentations, demonstration on BSE using anatomical models, instructional video or other appropriate A/V materials. Discussions, question/ answers including answering written questions. (To be held in WWCs or MOH office quarterly.)</p>	<ul style="list-style-type: none"> ▪ Anatomical model if available/ appropriate. ▪ Instructional video on SBE ▪ Flip Chart and Flash Cards on SBE. ▪ Leaflets for reference at home (illustrations only as a teaching aide; should not be too graphic as it is for reference at home and should not have a boomerang effect). Leaflet should be pre-tested to ensure community acceptance.

SECTION 2: SOCIAL MOBILIZATION ACTIVITIES TO OFFER LEGITIMACY AND ENCOURAGEMENT TO FAMILY MEMBERS OF 35 YEAR OLD WOMEN TO ATTEND WWC.

Target Group and Role in BCC	Primary Message, Knowledge and Skills	Communication Media/Methods	Communication Materials/Tools
<p>Divisional Secretary and Key Officers including field officers of the Division, e.g. Samurdhi Officers, Agricultural Officers, Women Development Officers, Social Service Officers.</p> <p>To seek assistance for motivating family members/35 year old women to attend WWCs.</p>	<p>Same Messages as 1,2 &3 (i) on pg.20</p> <p>Request Divisional Secretary if and when relevant to include information on importance of prevention of disease in women and mothers through WWCs during appropriate meetings organized by Divisional Secretary and staff.</p>	<p>Face to face meeting of MOH with Divisional Secretary to discuss modalities and plans for participation in appropriate fora.</p> <p>Also request for MOH or appropriate officer be invited to appropriate fora to present and lead a discussion on WWCs.</p> <p>There are two possible approaches as follows to disseminate Primary Messages, Knowledge and Skills.</p> <p>(i) MOH or a health sector staff to conduct sessions at meetings identified by Divisional Secretary.</p> <p>(ii) MOH to train selected Divisional Officers on WWC and services and request trained officers to conduct information giving sessions during appropriate meetings.</p>	<ul style="list-style-type: none"> ▪ Multimedia Presentation on concept of prevention, and WWC services; and how prevention can benefit the family community, the local areas, and the country as a whole. ▪ Leaflet specially prepared for mobilizing public officers on WWC services. ▪ Leaflet for women and family members on WWC services for distribution at meetings.

Target Group and Role in BCC	Primary Message, Knowledge and Skills	Communication Media/Methods	Communication Materials/Tools
<p>Leaders of Community Based Organizations (as appropriate)</p> <p>School Principals (as appropriate)</p> <p>To seek assistance for motivating family members/35 year old women to attend WWCs.</p>	<p>Same Message as 1,2& 3 (i) on pg.20</p>	<p>MOH or health officers to meet with CBO leaders to discuss possible modalities for participation in community fora.</p> <p>Requesting CBO leaders to provide an opportunity for MOH or appropriate health/staff to moderate a discussion on WWCs at appropriate meetings.</p> <p>MOH or health officers to discuss with School Principals, as above. Request Principals to provide an opportunity to moderate a discussion on WWCs and its services at schools or at Parent Teachers Association/ School Development Society Meetings.</p>	<ul style="list-style-type: none"> ▪ Multimedia presentation on concept of prevention, and WWC services; and how prevention can benefit the family, community, local areas and the country as a whole. ▪ Flip Chart (on above theme) ▪ Leaflet for community leaders and school principals (on above theme) ▪ Leaflet for women and families on WWC services for distribution at meetings.

SECTION 3: MOBILIZATION OF MASS MEDIA PRACTITIONERS TO EDUCATE 35 YEAR OLD WOMEN AND THEIR FAMILIES ON THE IMPORTANCE OF ATTENDING WWCs

Target Group and Role in BCC	Primary Message, Data/Information	Communication Media/Methods	Communication Materials/Tools
<p>Senior Editors/ Programme Directors of Print and Electronic Media (National and Regional)</p> <p>To request media to create public awareness on (i) the need for 35 year old women to attend WWCs (ii) husbands and family members of 35 year old women to encourage such attendance. (iii) services provided by WWCs. (iv) prevention of breast cancers and cervical cancers.</p>	<ol style="list-style-type: none"> 1. Sustained information dissemination, interview with experts etc. on the concept of prevention including cost benefits of prevention Vs. providing curative services. 2. Gravity of the problem related to breast cancer, cervical cancer, high blood pressure, diabetes, etc. in women of 35 years and beyond. 3. Services provided by WWC and benefits for women and families. 4. Rationale for currently targeting on 35 year old women due to epidemiological evidence and cost-effectiveness. 5. Current statistics of WWC attendance and planned target for future. 6. Request publication and broadcasting of motivational features to empower 35 year old women to attend WWC clinics. 	<p>Organize two high-level sensitization meetings/seminars for (i) Senior Editors of Print Media and (ii) CEOs of Electronic Media under the auspices of a respected media organization or a professional medical organization.</p> <p>After the two sensitization meetings, liaise with focal person/s nominated by media organization to plan future features/programmes such as visits to WWCs; interview with experts; interview with satisfied clients; photo features on WWCs.</p>	<ul style="list-style-type: none"> ▪ Multimedia presentation on concept of prevention; WWC services; and how prevention can benefit the community and the country as a whole. ▪ Media Kit (on same theme as above) ▪ Research Reports on connected topics ▪ Annual Reports on the progress and activities of WWC, number of attendees etc. ▪ Statistics on incidence of breast and cervical cancer in Sri Lanka and the world. ▪ Press release to update knowledge and information.

Target Group and Role in BCC	Primary Message, Data/Information	Communication Media/Methods	Communication Materials/Tools
<p>Feature Editors. Programme Managers Feature Writers Reporters, Script Writers Programme Producers in selected Print and Electronic media.</p> <p>To create public awareness on, (i) the need for 35 year old women to attend WWCs (ii) husbands and family members of 35 year old women to encourage such attendance.</p>	<p>Similar data and information (1-5) as for Senior Editors Meeting. (pg 41)</p> <p>Request to write/broadcast creative feature programmes designed to encourage 35 year old women to use WWC services.</p>	<ul style="list-style-type: none"> ▪ Seminar/Workshop for feature editors, writers, reporter, script writers and others on the concept of prevention and the WWCs ▪ Facilitate Media Visits; interview with experts and satisfied clients; provide interesting information to produce feature programmes/ articles, on a regular basis without creating media fatigue among the audience groups. ▪ Emails 	<ul style="list-style-type: none"> ▪ Multimedia presentation on concept of prevention; WWC services and how prevention can benefit the family, community and the country as a whole. ▪ Media Kit (on above theme) ▪ Research Reports on relevant subject areas. ▪ Annual Reports on the progress and activities of WWC. ▪ Statistics on incidence of breast and cervical cancer in Sri Lanka and the world. ▪ Periodic Media Information Sheets on WWCs and services.

Target Group and Role in BCC	Primary Message, Data/Information	Communication Media/Methods	Communication Materials/Tools
<p>(iii) services provided by WWCs.</p> <p>(iv) prevention of breast cancers and cervical cancers.</p>		<p><i>Programme Manager or designated officer or organization should maintain regular contact with designated media practitioners to enable media to present creative, informed, and accurate features on WWC and its services.</i></p>	

SECTION 4: ENHANCEMENT OF STAFF CAPACITY TO INCREASE ATTENDANCE AT WWC CLINICS THROUGH EDUCATION AND MOTIVATION OF CLIENTS

Target Group and Role in BCC	Primary Message, Data/Information Training Themes	Communication Media/Methods	Communication Materials/Tools
<p>MOH, SPHI, SPHM, PHNS, PHI, PHM (select officers as per job function for technical skill training)</p> <p>Relevant hospital staff</p> <p>To further develop capacity of WWC staff in technical and communication components.</p>	<p>FGD Findings on WWC Programmes.</p> <ul style="list-style-type: none"> - Identify gaps and weaknesses in WWC service delivery and staff capacities and attitudes as indicated in FGD findings. - Analyze weaknesses and suggest what improvements are needed and how improvements can be made. - The clients of WWC should be treated with dignity and respect - It is essential that instructions given to patients are adequate, clear and accurate. - Develop check list for providing client friendly services. 	<p>Training Workshop</p> <ul style="list-style-type: none"> - Presentations - Group work - Demonstrations - Practical Exercises - Role Plays - Case studies 	<ul style="list-style-type: none"> - Multimedia presentation on FGD findings - Flip Chart on technical competencies - Anatomical models for demonstrations - Instructional Video on technical competencies - Check Lists

Target Group and Role in BCC	Primary Message, Data/Information Training Themes	Communication Media/Methods	Communication Materials/Tools
MOH, SPHI, ,SPHM, PHI, PHM,PHNS, (contd.)	<p>Technical Skills/Competencies</p> <ul style="list-style-type: none"> - Breast self-examination education - Taking PAP smears and related logistics. - Communicating PAP smear test results. - Procedure for referrals and follow-up. - Monitoring/advising clients with abnormal test results. - Other technical skills as required. <p>Communication Competencies in applying BCC strategy effectively.</p> <ul style="list-style-type: none"> - Concept and principles of client oriented communication and communication methods. - Interactive Communication Vs. one-way communication in BCC. - Public Relation. - Interpersonal Communication/ Home Visits. 	<p>Training Workshop</p> <ul style="list-style-type: none"> - Presentations - Group Work - Role Play - Practical Exercises - Case Study Analysis 	<p>Training Module on,</p> <ul style="list-style-type: none"> - Principles of client oriented communication - Public Relation - Interpersonal Communication - Interactive Group Communication - Demonstrations - Use of Audio Visuals - Problem solving techniques - Conflict Resolution methods - Counseling

Target Group and Role in BCC	Primary Message, Data/Information Training Themes	Communication Media/Methods	Communication Materials/Tools
MOH, SPHI, ,SPHM, PHI, PHM,PHNS, (contd.)	<ul style="list-style-type: none"> - Lecture/Presentations; Public speaking. - Conduct effective interactive group communication sessions. - Demonstrations. - Use of audio-visuals; Multimedia and other tools, including instructional video. - Preparation of communication materials locally. - Problem solving techniques/methods, conflict resolution techniques/methods. - General counseling. 		

SECTION 5: ADVOCACY FOR IMPROVING POLICIES, PROGRAMME PROCEDURES AND RESOURCES TO INCREASE ATTENDANCE AT WWCs

Issue: Strengthening policies and programme guidelines to ensure client-friendly culture and service delivery methods as well as adequate and high-quality human resources to enhance demand for WWC services.

Problem Practices: Clients concerned about male doctors conducting physical examinations; feel shy and embarrassed at WWCs and on returning home. PAP smear samples sent by WWCs to Pathology Laboratories for testing are delayed; Lack of colposcopy services at some specialized clinics and care centres. Women over 36 years are not encouraged to attend WWCs due to human resource constraints.

Target Group	Desired Behaviour	Facilitating Factors	Constraining Factors
<p>Senior Policy Makers at National/ Provincial/District level, at (i) political and (ii) administrative levels</p> <p>Colleges of Obstetricians and Gynecologists and Pathologists.</p> <p>Trade Unions (as appropriate)</p>	<p>Advocate for,</p> <p>(i) Appointment of female MOs and/or</p> <p>(ii) Adequate Public Health Nursing Sisters to MOH offices (i.e. fill all PHNS cadre position vacancies).</p> <p>(iii) Appointment of adequate number of Pathologists and</p> <p>(iv) Appointment of adequate number of MLTs to hospital laboratories in districts to expedite testing of PAP smear samples sent by WWCs to hospital laboratories.</p>	<p>Overall government commitment for provision of quality health services to citizens.</p> <p>WWC have been established and operating satisfactorily.</p>	<p><u>Policy and Resources</u></p> <ul style="list-style-type: none"> ▪ Reviewing of policies on and increasing resources to WWC services is not a high priority within the current health services. ▪ Male doctor examining/ Inadequacy of female doctors in WWCs. ▪ Vacancies in PHNS positions in MOH offices. <p><u>Clients</u></p> <ul style="list-style-type: none"> ▪ Shy to attend ▪ Felt embarrassed/ ashamed ▪ Felt afraid/fearful ▪ Felt ashamed after returning from WWCs.

Target Group	Desired Behaviour	Facilitating Factors	Constraining Factors
Senior Policy Makers at National/ Provincial and District levels.(contd.)	<p>(v) Completion of PAP smear tests on samples sent by the Well Woman Clinic to Pathology Laboratories of hospitals within a one month period; so that WWCs are enabled to hold the trust of their clients.</p> <p>(vi) Include one more cohort of women above 35 years of age as an additional target population for WWC services. Preparation of Feasibility Report for including one more cohort of women (above 35 years of age) to receive WWC services.</p>		<p><u>WWC Service/Staff</u> Constraining factors as given on Page 19.</p>

SECTION 6: SENSITIZATION OF INSTITUTION AND STAFF TO SUPPORT ADVOCACY AIMED AT INCREASING ATTENDANCE AT WWCs

Issue: Strengthening policies and programme guidelines to ensure client-friendly culture and service delivery methods and adequate and high-quality human resources to enhance demand for WWC services.

Problem Practices: Clients concerned about male doctors conducting physical examinations; feel shy and embarrassed at WWCs and on returning home. PAP smear samples sent by WWCs to Pathology Laboratories for testing are delayed; Lack of colposcopy services at some specialized clinics and care centres. Women over 36 years are not encouraged to attend WWCs due to human resource constraints.

Target Group and Role in BCC	Primary Message, knowledge and skills	Communication Media/Methods	Communication Materials/Tools
<ul style="list-style-type: none"> - National Committee of Family Health - Technical Advisory Committee on Family Health - Management Development and Planning Unit (MDPU) of MoH - Provincial Directors of Health Services - Regional Directors of Health Services - College of Pathologists - Trade union representatives 	<p>Feasibility Reports on (i) Appointing female MOs to cadre positions of Medical Officers of Health. The Feasibility Report may contain a review of recruitment and staff deployment policy; legal aspects including fundamental rights and gender discrimination, and recommendations with regard to meeting client request or other possible ways of minimizing clients' embarrassment with regard to physical examinations</p>	<p>Ministry of Health, the National Committee on Family Health, and Family Health Bureau in collaboration with PDHS, RDHSs and other stakeholders convene Technical Advisory Committees to prepare feasibility reports and plans to give effect to advocacy requests. (i),(ii),(iii),(iv)(v), (vi) on pg.47 & 48.</p>	<ul style="list-style-type: none"> ▪ Multimedia presentations on themes (i) (ii) (iii) (iv) and (v). ▪ Concept Papers on above themes including relevant statistics. ▪ Field Visits to observe field situation/conditions in representatively selected field locations.

Target Group and Role in BCC	Primary Message, knowledge and skills	Communication Media/Methods	Communication Materials/Tools
<p>To prepare feasibility reports and plans to give effect to Advocacy requests on Pg.47&48, including identification of required resources, suggested time-lines for plan implementation, and solutions for anticipated constraints.</p>	<p>and taking PAP smears by males.</p> <p style="text-align: center;">OR</p> <p>Feasibility Reports on,</p> <ul style="list-style-type: none"> (ii) Filling all and PHNS vacancies at MOH Offices. (iii) Filling all Pathologist vacancies at hospitals. (iv) Filling all MLT vacancies at hospitals. <p>Each Feasibility Report may include following analysis (i) approved cadre position and current vacancies by districts (ii) currently available personnel for deployment to fill vacancies (iii) Availability for future deployment based on a projection of outputs from training colleges/ professional institutions (iv) resource mobilization plan.</p>		

Target Group and Role in BCC	Primary Message, knowledge and skills	Communication Media/Methods	Communication Materials/Tools
<ul style="list-style-type: none"> - National Committee on Family Health - Technical Advisory Committee on Family Health - Management Development and planning Unit (MDPU) of MOH - Provincial Directors of Health Services - Regional Directors of Health Services - College of Pathologists - Trade union representatives 	<p>Feasibility Reports on (v) Completing PAP tests on samples forwarded by WWCs and communicating results back to WWCs within one month of receipt of samples.</p> <p>The Feasibility Report may contain</p> <ul style="list-style-type: none"> (i) Review of existing procedures (ii) analysis of time taken to complete PAP tests of samples forwarded by WWC over a period of for example 06 months (iii) identifying bottlenecks (iv) propose procedures and guidelines to complete testing and communicate results to WWCs within one month of receipt of samples. 	<p>FHB in collaboration with National Committee on Family Health, DDG Laboratory Services and DDG PHS II convene district based sub-committees to give effect to prepare Feasibility Report and Plan.</p>	

SECTION 6 CONTINUED

Issue: **Elder women who may be vulnerable to breast cancer, cervical cancer, diabetes, high blood pressure, etc. have less opportunities to use WWC services**

Problem Practice/
Behaviour: The WWC programme as presently planned and implemented do not actively mobilize women over 36 years of age to attend WWC clinics due to human resource and other constraints.

Target Group and Role in BCC	Primary Message, Key Output	Communication Media/Methods	Communication Materials/Tools
<ul style="list-style-type: none"> - National Committee on Family Health. - Technical Advisory Committee on Family Health. - College of Gynecologists and Pathologists - Other appropriate organizations. <p>To prepare Feasibility Report and plan for including one more cohort of women above 35 years of age as target population for WWC services.</p>	<p>Feasibility Report on (v) Including one more cohort of women over 35 years as additional target for WWC services.</p> <p>The Feasibility Report may include a rationale based on epidemiological data including incidence and prevalence of breast and cervical cancer by age groups; an analysis of socio-economic impact of women being struck down by BC and CC on families; and an analysis on the burdens of prevention vs. treatment of BC and CC on the health services delivery system; an analysis of required human, financial and other resources for such a policy change.</p>	<p>Family Health Bureau in consultation with and guided by the Ministry of Health, National Committee on Family Health, Colleges of Obstetricians and Gynecologists and Pathologists convene sub-committee as appropriate to prepare Feasibility Report and Plan.</p>	

SECTION 7:

**ADVOCACY FOR MOBILIZATION OF SERVICE CLUBS AND PRIVATE SECTOR TO SUPPORT WWC
INFRASTRUCTURE IMPROVEMENT AND SERVICE EXPANSION**

Target Group and Role in BCC	Primary Message Data/ Information	Communication Media/Methods	Communication Materials/Tools
<p>President and the Executive Committee of service clubs, e.g. Lions, Rotary, etc.</p> <p>To motivate service clubs to include support to WWCs in their annual service programme.</p>	<ol style="list-style-type: none"> 1. Similar data and information as for Senior Editors meeting sections 1-5 Pg 41) 2. Analysis of gaps and needs in the WWC Programme for potential support by Service Clubs. 3. Suggested Ideas for potential initiatives by service clubs to cater to identified needs. 4. The potential benefits that would accrue to the WWC programme and women by implementing suggested ideas. 	<p>Information sharing meeting.</p> <ul style="list-style-type: none"> ▪ Lobbying ▪ Organizing visits to WWCs. ▪ Relationship Maintenance ▪ E-mails 	<ul style="list-style-type: none"> ▪ Multimedia presentation on the concept of prevention and WWC services offered to women ▪ Statistical analysis on prevalence of Cervical Cancer and Breast Cancer in Sri Lanka ▪ Information Kit for service clubs/private sector on WWC, its services, and contributions to prevention of cancers in women. ▪ Research Reports on relevant topics ▪ Annual Reports of WWC Programme

SECTION 7 CONTINUED.

Target Group and Role in BCC	Primary Message Date/ Information	Communication Media/Methods	Communication Materials/Tools
<p>President and Executive Committee of Ceylon Chamber of Commerce.</p> <p>National Chamber of Commerce.</p> <p>To motivate member private sector companies to include assistance to WWCs through their corporate social responsibility initiatives.</p>	<ol style="list-style-type: none"> 1. Similar data and information as for Senior Editors meeting (section 1-5 Pg.41) 2. Analysis of gaps and needs in the WWC Programme for potential support by Private Sector. 3. Suggested Ideas for potential initiatives by the private sector to cater to identified needs. 4. The potential benefits that would accrue to the WWC programme and women by implementing suggested ideas. 	<ul style="list-style-type: none"> ▪ Information sharing meeting ▪ Lobbying ▪ Meeting with CEOs ▪ Organizing visits to WWCs ▪ Relationship Maintenance ▪ E-mail 	<ul style="list-style-type: none"> ▪ Multimedia presentation on the concept of prevention and WWC services offered to women ▪ Statistical analysis on prevalence of Cervical Cancer and Breast Cancer in Sri Lanka ▪ Information Kit for service clubs/private sector on WWC, its services, and contributions to prevention of cancers in women. ▪ Research Reports on relevant topics ▪ Annual Reports of WWC Programme.

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 Core-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)

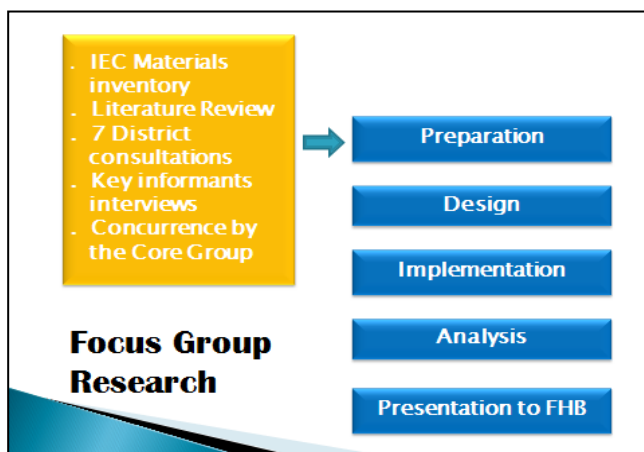
Dr. S.T.A.P. Serasinghe - MO/MCH-Ampara
Ms. Kumuduni Rajapaksha - NYSC/Maharagama
Mr. K.G.P. Bandara DD/CHEO/HEB
Mr. N. Mudannayaka - ACHEO/HEB
Mr. P.G.P.K.N. Wijewickrama - HEO-Nuwara Eliya
Mr. Kosala Lakmal - HEO/HEB
Mrs. Janaki Kodikara - HEO/HEB
Mr. Aruna Athukorala - DA/HEB

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) Women 18-30 years of age, including a few married women.
 - (ii) Men 18-30 years 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-Oxfam
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 - Kolinochchi
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 Lanka
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 Violence 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 behaviour 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. Chithtramalee 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 Dolamula	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 Lokubalasoorya	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)-Batticaloa
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-Batticaloa
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.Dharmaseli	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.Malkanathi	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.Samarasinghe	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.Iluppitiya	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.Rajapaksha	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-Baticoloo
Mr.T.Thajeeharan	HEO-Baticoloo
Mrs.R. Raveenthiran	PHNS
Mrs.Shanmuganalhan	SPHM
Mr.H.M.Feeel	SPHI
Mr.R.Inparajah	PHI
Mr.A.L.Nawfar	PHI
Mr.U.L.M.Jinnah	PHI
Mr.S.Maheshwaran	PHI
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.Usanthini	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	MO/MCH - Jaffna
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

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 Lokubalasureya, Dr. Sanjeewa Godakandage, Dr. Manjula Dhanasureya, 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.

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- 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.
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- 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.