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 accomplishing this task. The basis of this action was the recommendations of the External Review of the Sri Lankan Maternal and Newborn Health Programme held under the auspices of the Government of Sri Lanka, WHO, UNICEF, and UNFPA in 2007. The review recommendations[1] provided impetus to the amalgamation of previous fledgling work undertaken by UNFPA and MoH in the area of BCC strategy formulation, into the current programme.

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

In 2005, the UNFPA country support team (CST) Bangkok conducted a desk review and a regional consultation on the understanding and applications of the work undertaken by various country offices under advocacy, BCC and IEC interventions. Subsequent to the

[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

Review, a Global BCC Technical Meeting of UNFPA communication specialists held in December 2006, came to the understanding that result-oriented programmes at country level would profit substantially by integrating BCC strategies. The UNFPA CST Bangkok released a handbook for implementing BCC interventions entitled "Planning BCC Interventions: A Practical Handbook", to provide a working methodology for integrating BCC strategies into reproductive health programmes in countries of the region. The handbook which was written by Peter Chen, the former CST BCC Advisor, also included ideas and practices discussed at the Regional Consultation and the Global Technical Meeting. It has been translated into Sinhalese language. A Tamil language version is being planned.

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

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

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

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

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

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

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

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

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

behavioursare 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 behavior i.e. benefits and costs are not only financial but social and cultural; they need to discuss new behaviour with their families - for some practices they would need family support and assistance; they would try to find out if the local community would accept such a practice or not; they would want to know if the new practice is safe and reliable, and easy to access; that the practice is culturally acceptable, and would not cause community censure; so on and so forth.

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

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

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

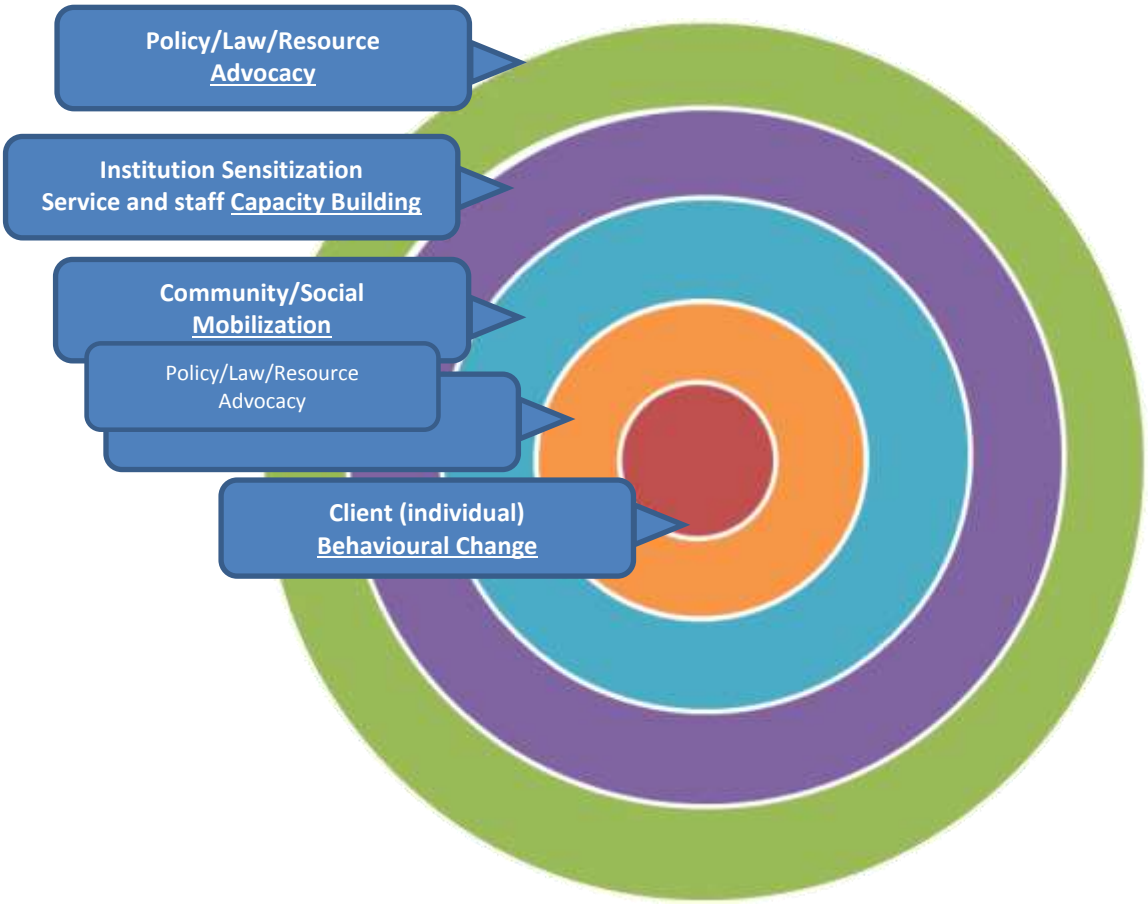
The rationale for attempting to obtain the above information is due to the understanding arrived at by BCC planners and researchers that a person who wishes to undertake or change to new desired health behaviour should:

- 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

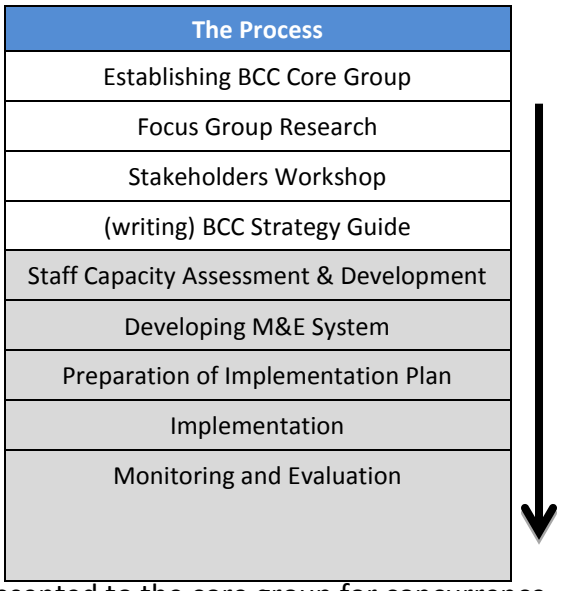


Thus a behaviour change communication strategy would ideally include the following communication elements at different implementation levels, beginning from the client, the central focus of BCC, to the policymaker as shown in the diagram of increasing concentric circles. At each of these levels, the 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 research was obtained through Key Informant Interviews. The Programme Managers of Maternal and Newborn Health, Women's Health, 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 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 Maternal and Newborn Health Programme is given below.

FGD Summary Findings – MNHProgramme

Knowledge of pregnant mothers and mothers of infants (M) husbands and fathers (F)

	M	**F**
- Understand term and concept of newborn health	M	L
- Immediate newborn care package	VH	L
- Skin to skin contact	H	L
- Thermal protection	VH	L
- List of items to be taken to hospital on admission for delivery	VH	L
- Colostrum	VH	M
- Exclusive breastfeeding	VH	M
- Danger signs in pregnant women	VH	H
- ANC clinic frequency/benefits	VH	H
- Anaemia and iron supplementation	M	M
- Attitude to thermal protection	P	SN
- Attitude towards use of caps, socks, wrappers	P	SN

Code : VH – Very High; H – High; M – Moderate; L – Low; P – Positive; SN - Strongly Negative

Behaviours/Practices

- All main practices of essential newborn care accepted by all mothers
- All mothers practice skin to skin contact
- All pregnant mothers take items on list to hospital on admission for delivery
- All mothers initiate breastfeeding within 01 hour
- Majority of mothers practice EBF
- Some mothers give a little water while practicing EBF
- Following categories of mothers do not practice EBF (which is a minority)
    - Feel breast milk to be inadequate
    - Feel sick
    - Working mothers
    - Mothers overworked at home
- Most houses with infants have feeding bottles
- Vast majority of mothers attend ANC clinics as recommended
- All mothers attend ANC in 3rd trimester
- All mothers take folic acid
- Majority of mothers do not take iron tablets as recommended.

Key reasons for some mothers not practicing EBF

- 'Little bit of water' is given
- 'Ratha-kalka' is given
- Breast milk is not complete food (after 3 months of age)
- Powdered formula milk makes child's brain to develop better (child becomes more intelligent)

Key reasons for majority of mothers not taking iron tablets

- Low knowledge on adverse consequences of anaemia.
- Do not know the benefits of taking iron tablets.
- Low knowledge on anaemia.
- Consume large quantity of green leafy vegetables.
- Side effects or difficulty : bad smell, nausea, vomiting, constipation (majority)

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 programmesthe Maternal and Newborn Health and Adolescent Sexual and Reproductive Health Programmeswere 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 Durakjit Pundit 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. (Fordetailed 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, and the international 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.

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. They should be encouraged to learn of 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 4) is on the BCC strategy guide specifically for the Maternal and Newborn Health.

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 Maternaland Newborn (and Child) Health Programme.

Background: Maternal and child health began as an organized activity in the mid 1920's with the setting up of the Health Unit System in selected areas. Gradually the Health Unit System was extended throughout the country. In 1965 family planning services were linked to the MCH programme. In 1968 the MCH Bureau was established to plan and supervise MCH/FP programmes in all areas of the country. In 1973 MCH Bureau was re-designated the Family Health Bureau to highlight the integrated nature of the MCH/FP services. FHB is responsible for planning, coordination, monitoring and evaluation of the MCH/FP services, now commonly referred to as The Family Health Pragramme. The MCH programme which is the core programme of the Family Health Programmewas influenced and nurtured by a number of international health initiatives such as the Safe Motherhood Initiative,the Baby Friendly Hospital Initiative, the Expanded Programme of Immunization Initiative and the Reproductive Health Initiatives recommended by the ICPD of 1994.

The Government of Sri Lanka unveiled a National Health Policy in 1992 in which MCH was identified as apriority component. A Population and Reproductive Health Policy was formulated in 1998, the majority of components being linked to MCH/FP services. In 2000 Sri Lanka became a signatory to achieve Millennium Development Goals (MDGs) by end 2015. The latest National Maternal and Child Health Policy was formulated in 2012 comprising of goals, with the stated mission of "contribute to the attainment of highest possible levels of health of all women, children and families through provision of comprehensive, sustainable, equitable and quality Maternal and Child Health services in a supportive, culturally acceptable and family friendly setting". One of the goals and related strategies of the 2012 MCH policy is to strengthen BCC interventions to improve the MCH programme.

Although affected by a protracted conflict, and the devastation of the 2004 tsunami, Sri Lanka while being a low-income country up till about 2009, and a lower middle-income country for about the last 04 years or so, has achieved tremendous progress in human development which includes advances in maternal and child health, education, and life expectancy.

The maternalmortality ratio declined from 340 per 100,000 live births in 1960 to 43/100,000 in 2005 and to 39/100,000 in 2008. Skilled attendance at birth and antenatal care (at least one visit to ANC) was at 99 percent in 2006-2007. Infant mortality rate declined from 57 in 1960 to 14 in 2010.Neonatal mortality rate was 10 per 1,000 live births in 2010. Early initiation of breastfeeding (within 1 hour of birth %) was 80 in 2006. Primary school net enrollment ratio for girls and boys respectively was 96 and 95 per cent respectively (2009). There is a positive correlation between education,maternal and child survival and development. The results indicate that the social welfare focused policies, infusion of resources and political will of

successive governments in Sri Lanka since independence resulted in achieving synergies in health, education and social welfare.

Despite the devastation of a thirty year conflict, the gains in human development achieved by Sri Lanka, while being a low-middle income country is a testimony for the people-focused policies adopted by Sri Lanka since independence.

The new National Maternal and Child Health Policy of 2012,while recognizing the commendable progress achieved, recognizes that the changing scenarios in the MCH area call for new policies and approaches to address the broader needs of mother, child and adolescents. It also recognizes new challenges that are directed at clients and the programme due to suchfactors as devolution of MCH functions to the provinces, rapid demographic transition that has resulted in new demands for services; rising expectations of people; increasing unhealthy lifestyles andbehaviour changes of young adults.

The Behaviour Change Communication (BCC) Strategy Initiative seeks to use planned strategic communication, mobilization, and advocacy approaches to facilitate behavior sustenance (development) or change to support achievement of the key MCH goals of the programme. In the maternal and newborn health programme, behavior development i.e. sustaining of existing desirable behaviours assume importance as many desirable behaviours are currently being practiced by pregnant mothers, mothers of infants and their families. The BCC initiative would seek to reinforce and sustain these desirable behaviourswhile attempting to change behaviours that are not conducive for good health, growth and development of babies and health of mothers.

2. KEY SECTIONS INCLUDED IN BEHAVIOUR CHANGE COMMUNICATION STRATEGY GUIDE – BOOKLET 4, MATERNAL AND NEWBORN HEALTH (MNH) PROGRAMME

The BCC strategy for Reproductive Health Booklet 4, BCC Strategy Guide for Maternal and Newborn Health (MNH) Programme includes eleven sections as follows:

Section 1 : Behaviour change interventions designed for pregnant mothers and spouses.

(i) Pregnant mothers - to motivate pregnant mothers to sustain the current good practice of high attendance at ANC clinics (pgs.20-22).

(ii) Pregnant mothers - to continue with the good practice of high rates of folic acid consumption and to resolve problems relating to intake of iron tablets, so as to increase rates of consumption of iron tablets (pgs.23-37).

(iii) Husbands of pregnant mothers - to motivate husbands to support their pregnant wives to take iron tablets daily (pgs.38-40).

(iv) Pregnant mothers and husbands of pregnant mothers – to empower husbands and wives to plan pregnancy together; providing key knowledge to and fostering positive attitudes of husbands to enable them to assist their pregnant wives throughout pregnancy including responding to danger signs in pregnancy. (pgs.41-44).

Section 2 : Behaviour change communication intervention designed for pregnant mothers and spouses and mothers of infants and spouses (fathers) and family members.

(i) Pregnant mothers and husbands of pregnant mothers, mothers of newborns, fathers of newborns – to improve understanding of technical term newborn health and concepts; to further motivate to sustain current high levels of adoption of ENCP; to reduce possible spousal apathy and resistance towards ENCP (pgs.45-49).

(ii) Pregnant mothers,husbands of pregnant mothers, and other family members – to motivate husbands and other family members to support mothers to practice essential newborn care practices at home including responding to danger signs; reinforce knowledge of pregnant mothers in newborn care practices. (pgs.50-54).

Section 3 : Behaviour change interventions designed for pregnant mothers in hospital for childbirth.

(i) Pregnant mothers on admission to hospital for child-birth - to equip pregnant mothers with knowledge and skills to assist in ENCP; and practice EBF and essential newborn care practices at home (pgs.55-56).

(ii) Post natal mother before leaving hospital with the new baby - to equip new mother with knowledge and skills on essential newborn practices at home, and exclusive breastfeeding (pgs.57-58).

Section 4 :Behaviour change interventions designed for pregnant mothers; post natal mothers and husbands (fathers) on post natal interventions benefitting baby.

(i) Pregnant mothers and husbands of pregnant mothers -to motivate and provide skills tocontinue exclusive breastfeeding of their infants from birth upto six months. (pgs.59-70)

(ii) Post natal mother,father and family members - to reinforce knowledge and skills of mothers on newborn practices, exclusive breastfeeding, and monitoring of danger signs in infant; to motivate father and other family members to support post natal mother in maintaining new born care practices and exclusive breastfeeding. (pgs.71-72)

(iii) Post natal mothers attending post-natal clinics - to reinforce knowledge and resolve any practical problems relating to essential newborn care practices and exclusive breastfeeding. (pgs.73-75)

Section 5 : Social mobilization activities to offer community and social support to encourage pregnant mothers to take iron tablets daily.

(i) Clergy in MOH areas – to seek assistance to include iron supplementation and anaemia as a theme during religious discussions/events. (pg.76)

(ii) Leaders of women's NGOs, CBOs, Women's groups, mothers' groups – to seek assistance to use these groups as appropriate channels to promote iron supplementation and exclusive breastfeeding. (pg.77)

Section 6:Mobilizing mass media to educate pregnant mothers, husbands, family members, and lactating mothers on iron supplementation, newborn care practices and exclusive breastfeeding.

(i) Chief Editors/CEOs –to request that they accord priority to the abovementioned themes in editorial decision-making on health themes. (pgs.78-79)

(ii) Journalists, programme producers – to be dedicated to provide regular media coverage for iron supplementation, newborn care practices, and exclusivebreastfeeding. (pg.80).

Section 7 :Sensitization of Government Institutions to actively promote iron supplementation and exclusive breastfeeding in their own areas.

(i) Secretary, Ministry of Child Development and Women's Affairs, Divisional Secretaries – to advocate to WDOs on importance of implementation of above activities in their (duty) areas. (pg.81)

Section 8: Enhancement of staff capacity on behaviour change communication strategy planning to implement MNH Programme.

(i) All relevant health staff in districts and MOH areas – to develop capacity to plan and implement BCC strategies in support of MNH activities, especially promotion of iron supplementation,ENCP and EBF. (pgs.82-84)

Section 9 : Advocacy for strengthening intersectoral support to promote iron supplementation among pregnant mothers and exclusive breastfeeding among lactating mothers.

(i) National Nutritional Council – to advocate for intersectoral collaboration to promote iron supplementation, and exclusive breastfeeding (pgs.85-86)

Section 10:Advocacy for mobilizing of service clubs to support promotion of iron supplementation among pregnant mothers.

(i) Service clubs (such as Rotary, Lions, etc.) – to motivate inclusion of 'promotion of iron supplementation' in annual programmes and/or campaigns. (pgs.87-88)

Section 11: Advocacy within the health sector to strengthen implementation of existing Guidelines on exclusive breastfeeding and associated circulars.

(i) College of Paediatricians and General Practitioners – to decisively support the implementation of existing Health Ministry Guidelines and Circulars on EBF. (pgs.89-90)

Section 12: Political advocacy to support further strengthening of exclusive breastfeeding and complementary feeding programmes.

(i) To seek assistance of Sri Lanka Parliamentarians for strengthening EBF among lactating mothers by being active promoters of EBF. (pg.91)

(ii) To seek assistance of Provincial Council members for strengthening EBF programme among lactating mothers by being active promoters of EBF while desisting from supporting contrary, even unwittingly. (pgs.92)

THE BEHAVIOUR CHANGE COMMUNICATION STRATEGY GUIDE

FOR

MATERNAL AND NEWBORN HEALTH PROGRAMME

THE MATERNAL HEALTH COMPONENT

SECTION 1: BEHAVIOR CHANGE COMMUNICATION INERVENTIONS DESIGNED FOR PREGNANT MOTHERS AND SPOUSES

Issue : Pregnant mothers have 'excellent to good' knowledge of services on offer at antenatal clinics (ANC) and the benefits of attending ANCs.

Fathers have 'good to medium' knowledge of services on offer at ANCs and benefits to mothers in attending ANCs.

Pregnant mothers have excellent knowledge of recommended frequency of clinic visits; pregnant mothers' rate of attendance at ANCs is very high especially in the 3rd trimester.

Problem Behaviour: There is no problem behavior with regard to mothers' attendance at ANCs.

The aim of behavior change communication strategy in such a situation is to actively continue BCC activities to sustain and reinforce such behaviours without health educators falling into a state of complacency; and to provide knowledge and motivation to new cohorts of pregnant mothers to adopt and sustain desiredbehaviours.

Desired Behaviours and Facilitating/Constraining Factors

Target Group	Desired Behaviour	Facilitating Factors	Constraining Factors
Pregnant mothers	All pregnant mothers attend ANC according to the recommended clinic schedule.	▪ Excellent antenatal care package which is accepted by mothers. ▪ Mothers' possess excellent knowledge of services offered at ANC and of benefits. ▪ High credibility enjoyed byfield health care staff especially the PHM.	▪ Household work; no help to look after the elder child. ▪ Overcrowded ANCs. ▪ Inadequate service provision facilities at some ANCs. ▪ Some mothers concerned about long time taken at ANCs which curtails time for domestic activities.

Target Group	Desired Behaviour	Facilitating Factors	Constraining Factors
Pregnant mothers (contd.)		▪ Strong rapport and interaction between PHM and the mother. ▪ Mothers and husbands are keen to avert any risks to baby and mother. ▪ Family's trust and credibility in the ANC system. ▪ To get the card marked to facilitate mothers' admission to hospital for child-birth. ▪ MOH very strict on attendance (one location).	

2. Behaviour Change Communication Strategy

Target Group and Role in BCC	Primary Message, Knowledge and Skills	Communication Media/Methods	Communication Materials/Tools
Pregnant mothers To motivate pregnant mothers to continue with current good practices especially of attending ANCs as recommended.	1. Critical importance of registering with PHM as soon as mother knows she is pregnant. 2. Description of services offered at ANC and its benefits to pregnant mothers and baby. 3. Recommended ANC visit frequency and the importance of regular attendance. 4. Encouraging words to support continuation of behaviour.	**Interpersonal communication** PHM – Home visits MOH – counselling at ANC **Group communication** SPHM, PHM, PHNS, MOH (small group health education sessions at ANC, during clinic hours). The main tactics should be to use interactive communication approaches to help in resolving any problems faced by mothers in attending antenatal clinics.	▪ Multimedia presentation on ANC services, benefits, visit frequency and the importance of regular attendance. ▪ Leaflets for pregnant mothers, spouses and family members on abovementioned themes.

SECTION 1: (CONTD.)

Issue : Knowledge and practice relating to vitamins, folic acid, and iron supplementation among pregnant mothers are variable. Almost all pregnant mothers take vitamins and folic acid tablets as recommended. Substantial numbers of mothers do not take iron tablets regularly as recommended. Knowledge of iron supplementation and anaemiais variable among pregnant mothers with three FGD locations registering high knowledge on iron tablet and anaemia while four FGD locations register low levels of knowledge.

Problem Behaviour: Substantial numbers of mothers do not take iron tablets regularly (although almost all mothers take vitamins and folic acid tablets), as recommended.

Desired Behaviours and Facilitating/Constraining Factors

Target Group	Desired Behaviour	Facilitating Factors	Constraining Factors
Pregnant mothers	All pregnant mothers take iron tablets as recommended. All pregnant mothers take folic acid tablets as recommended.	**<u>Iron Tablets</u>** ▪ Iron tablets are given free at ANC. ▪ Good knowledge of anaemia and effects on (foetus) baby (two FGD locations). ▪ Good knowledge about the link between anaemia and iron supplementation (two FGD locations). ▪ Most mothers take iron tablets (two FGD locations); some buy iron tablets from pharmacy as commercial brands appear to give less side-effects; some mothers take iron tablets	**<u>Iron Tablets</u>** ▪ Substantial numbers of pregnant mothers have inadequate knowledge and a weak understanding of anaemia, such as: - Adverse effects of anaemia to mother,foetus and baby. - Link between anaemia and iron tablets.(four FGD locations) However, some mothers know the importance of taking iron tablets; but do not take iron tablets due to, - Bad smell - Nausea, vomiting

Target Group	Desired Behaviour	Facilitating Factors	Constraining Factors
Pregnant mothers (contd.)		distributed through ANC, with food, to reduce side-effects. **<u>Folic acid tablets</u>** ▪ All mothers generally have a good knowledge on the benefits of folic acid to baby. ▪ Almost all mothers take folic acid. ▪ Mothers do not complain of side-effects.	- Constipation - Other side-effects ▪ Some mothers believe that as they consume green leafy vegetables in sufficient quantity, they do not need to take iron tablets (one FGD location). **<u>Folic acid tablets</u>** ▪ No constraining factors recorded during FGDs.

2. **Behaviour Change Communication Strategy**

Target Group and Role in BCC	Primary Message, Knowledge and Skills	Communication Media/Methods	Communication Materials/Tools
Pregnant mothers Reached directly to, (i) Improve knowledge on iron supplementation and anaemia. (ii) Motivate all mothers to take iron tablets daily as recommended. (iii) Sustain the current desirable practice of taking folic acid tablets daily as recommended.	**IRON SUPPLEMENTATION AND ANAEMIA** **1. Iron Supplementation is essential for ALL PREGNANT MOTHERS** ▪ Irrespective of whether a pregnant mother has good Hb levels or low Hb levels, every pregnant mother should take iron tablets daily as recommended. In other words, pregnant mothers who have high Hb levels, as well as low Hb levels (i.e. mothers who are not anaemic as well as mothers who are anaemic) should take iron tablets daily as recommended.	**Interpersonal communication -** PHM – Home visits **Group communication –** MOH and health staff - Health education sessions at ANC. (Please note: use interactive communication approaches, including allowing time for questions and answer sessions). The main approach should be to discuss difficulties experienced by pregnant mothers in taking iron tablets and jointly arrive at appropriate solutions. It is ideal if pregnant mothers who have successfully overcome the difficulties of taking iron tablets are mobilized to talk to pregnant mothers about their personal experience.	▪ Multimedia presentation on iron supplementation and anaemiacovering themes included in sections 1-13 in column 2, pgs. 25-34. ▪ Booklet on iron supplementation and anaemiafor mothers covering themes in sections 1-13 in column 2, pgs.25-34. ▪ Leafletfor mothers in the form of frequently asked questions on difficulties and side-effects experienced by mothers in taking iron tablets and how to resolve them. ▪ Leaflet on iron supplementation and anaemia for mothers who have low Hb levels.

Target Group and Role in BCC	Primary Message, Knowledge and Skills	Communication Media/Methods	Communication Materials/Tools
Pregnant mothers (contd.)	▪ **Why is this so?** WHEN A PREGNANT MOTHER TAKES IRON TABLETS AS RECOMMENDED IT IS THE BABY THAT BENEFITS MOST. During the first six months of life the quantity of iron a baby has in the body is dependent on the iron the foetus had absorbed from the mother in the womb. In other words, during the first six months of life the baby's iron reserves are built by the iron, the foetus receives from the mother during pregnancy. If a mother does not take iron tablets during pregnancy, then the baby invariably would have low iron reserves in the body, during first six months of life. This will reduce the immunity of the baby thus exposing the baby to infections. In the first six months an iron deficient baby will also be less active. This may also adversely affect baby's cognitive development.	**Individual counseling – PHNS/PHM** **Group Communication –** MOH,PHNS, PHM ▪ Mothers Group meetings. ▪ Women's Group meetings. ▪ In collaboration with Women Development Officer, and community leaders organize a health education session on iron supplementation and anaemiaat above meetings, if feasible. **Mass Media –** Articles in newspapers, tabloids, magazines that are mostly read by women especially pregnant women. Feature programmes, panel discussions, health advice programmes broadcast over FM radio and TV stations.	▪ Video clip on iron supplementation and anaemia based on key information included in sections 1 to 13 in column 2, pgs.25-34. Also for use in Husband-wife ANC classes/sessions in trimester 1 & 2. ▪ Media Kit on iron supplementation and anaemia based on key information included in sections 1-13 in column 2, pgs. 25-34. ▪ Poster on iron supplementation for pregnant mothers.

Target Group and Role in BCC	Primary Message, Knowledge and Skills	Communication Media/Methods	Communication Materials/Tools
Pregnant mothers (contd.)	▪ During the first six months of life, a baby is not able to produce all of the iron requirements of his/her body. It is the iron stocks that the baby builds-up at foetus stage that the baby uses after birth, as an iron reserve upto six months of life. **In short if a mother does not take iron supplementation (tablets) as recommended, she deprives the baby of needed iron during the first six months of life.** **2.** Anaemic pregnant mothers (i.e. mothers with low Hb levels) should take iron supplementation as this is vital for mother's health and the baby's health as well. The MOH or her/his staff will recommend the number of iron tablets that a pregnant mother with low Hb levels (i.e. anaemic) should take.		

Target Group and Role in BCC	Primary Message, Knowledge and Skills	Communication Media/Methods	Communication Materials/Tools
Pregnant mothers (contd.)	These pregnant mothers should take the iron tablets as recommended daily, without fail. If anaemic or low Hb level mothers do not take iron tablets during pregnancy (and for six months thereafter) the (i) health and development of the baby and (ii) health of the mother will be badly affected. **3. What is anaemia? How does one get anaemia?** ▪ A person gets anaemia (becomes anaemic) when (i) her/his blood has a lower than normal number of red blood cells, and (ii) when the red blood cells do not contain enough haemoglobin. Haemoglolobin helps the red blood cells to carry oxygen from a person's lungs to all parts of the body. ▪ About half of all pregnant mothers in developing countries are anaemic.		

Target Group and Role in BCC	Primary Message, Knowledge and Skills	Communication Media/Methods	Communication Materials/Tools
Pregnant mothers (contd.)	In Sri Lanka, about one third of pregnant mothers are anaemic. **4. What causes anaemia?** The most common cause of anaemia is lack of iron in the body. This is called iron deficiency anaemia. When the quantity of iron in a person's body is inadequate, the haemoglobin level in the blood goes down; the number of red cells in blood also goes down. - **In Thalesaemia prevalent areas, the pregnant mothers should be requested to do a blood test for "blood picture" and results shown to MOH for further advice.** **5. What are the bad effects of anaemia?** ▪ A person with anaemia feels tired often; cannot cope with the normal work; some may also feel short of breath and feel momentarily dizzy; headaches are also common.		

Target Group and Role in BCC	Primary Message, Knowledge and Skills	Communication Media/Methods	Communication Materials/Tools
Pregnant mothers (contd.)	▪ Anaemia can make one prone to infections. Severe anaemia can even lead to heart problems. Anaemia is not at all good when one gets pregnant. It is bad for the mother and the growth of the baby. It is also a risk for mother and baby. **6. Anaemia however is very easy to treat.** Taking iron tablets is the answer. This is why ANCs give free iron tablets. Follow advice of MOH, PHNS and PHM. Take the iron tables given at ANC as advised. **7. Benefits of taking iron tablets as recommended.** ▪ Reduce chances of pre-term labour. ▪ Less complication during delivery.		

Target Group and Role in BCC	Primary Message, Knowledge and Skills	Communication Media/Methods	Communication Materials/Tools
Pregnant mothers (contd.)	▪ Helps in preventing post-partum hemorrhage. ▪ Baby will be healthy and have an adequate birth weight. ▪ Baby would have sufficient iron reserves for first six months of life. ▪ Baby will be protected from infections and other complications during first 3 months of life. ▪ Child will have good cognitive development. **8. How and when to take iron tablets** ▪ Take one or two (for anaemic mothers) tablets daily as recommendedat the ANC clinic, preferably one or two hours after dinner. ▪ Avoid taking tea or coffee two hours before or after taking iron tablets. Tea and coffee obstructs absorption of iron.		

Target Group and Role in BCC	Primary Message, Knowledge and Skills	Communication Media/Methods	Communication Materials/Tools
Pregnant mothers (contd.)	**9. How does one store iron tablets at home?** ▪ Store tablets away from light and moisture in an airtight dark coloured bottle,(e.g. brown colour bottle). Keep out of reach of small children. **10. What are the possible difficulties in taking iron tablets? What are the possible side-effects? How does one overcome these?** - Bad smell: Can be reduced by storing in dark airtight bottles. - Nausea, vomiting: Can be managed by taking iron tablets, immediately after a meal or before going to sleep. - Constipation: Can be reduced by eating increased quantity of fruits and vegetables.		

Target Group and Role in BCC	Primary Message, Knowledge and Skills	Communication Media/Methods	Communication Materials/Tools
Pregnant mothers (contd.)	**10(a).** Dark coloured stools are normal when taking iron tablets. Mothers need not worry about dark coloured stools. **11. Please note food alone cannot give you the quantity of iron that is needed** during pregnancy. Pregnant women need additional quantity of iron that can NOT be obtained through food. This is called iron supplementation. Therefore all pregnant mothers should take iron tablets daily as prescribed by MOH and advised by PHM/PHNS. This will ensure the health of the baby and the mother.		

Target Group and Role in BCC	Primary Message, Knowledge and Skills	Communication Media/Methods	Communication Materials/Tools
Pregnant mothers (contd.)	**12. If you experience any difficulties in taking iron tablets or experience side-effects, do not just stop taking iron tablets.** It is VERY IMPORTANT that you discuss with your PHM or MOH and with their advice continue to take iron tablets. **13. How long should iron tablets be taken?** It is necessary to continue to take iron tablets for a period of 06 months after the birth of the baby. This will ensure that the mother will build up the iron reserves she lost during pregnancy. This will help the mother to look after and care for the baby energetically.		

Target Group and Role in BCC	Primary Message, Knowledge and Skills	Communication Media/Methods	Communication Materials/Tools
Pregnant mothers (contd.)	**<u>FOLIC ACID SUPPLEMENTATION</u>** **1. What is folic acid** It is a type of vitamin B. The intake of folic acid through food is inadequate for needs during pregnancy. Therefore, it is essential to take folic acid tablets. **2. What are the benefits? Why is it important to take folic acid during pregnancy?** Folic acid is needed for proper development of the brain and spine of the foetus. If there is a deficiency in folic acid, some mothers may give birth to babies with weak brains and weak spines. - Folic Acid helps in improving baby's cognitive function		▪ Multimedia presentation on Folic Acid Supplementation based on key information in sections 1-3 in column 2, pgs.35-37. ▪ Leaflet on Folic Acid Supplementation based on key information in sections 1-3 in column 2, pgs. 35-37. ▪ Media Kit on Folic Acid Supplementation based on key information in section 1-3 in column 2, pgs.35-37.

Target Group and Role in BCC	Primary Message, Knowledge and Skills	Communication Media/Methods	Communication Materials/Tools
Pregnant mothers (contd.)	- Reduce birth of low-birth weight babies. - Reduces spontaneous abortion **3. When and how should folic acid tabletsbe taken.** The ideal situation is to take folic acid at the time of planning a pregnancy. At the time of conception, pregnant mothers need to maintain adequate folate levels (i.e. levels of folic acid) in the body; This could be achieved when women begin to take folic acid tablets at least 03 months before conception. All women who are planning a pregnancy should ensure that they take folic acid tablets at least 03 months before they plan to be pregnant.		

Target Group and Role in BCC	Primary Message, Knowledge and Skills	Communication Media/Methods	Communication Materials/Tools
Pregnant mothers (contd.)	A woman, who did not take folic acid prior to pregnancy, MUST begin to take folic acid tablets immediately on knowing that she is pregnant. Folic acid tablets are given free at ANCs.		

2. Behaviour Change Communication Strategy

Target Group and Role in BCC	Primary Message, Knowledge and Skills	Communication Media/Methods	Communication Materials/Tools
Husbands of pregnant mothers. To be reached (i) directly to motivate husbands to support their pregnant wives to take iron tablets daily as recommended. (ii) and also through husband/wife ANC classes/sessions especially the two classes/sessions during trimester 1 and trimester 2 organized by MOH and staff.	**Husbands! It is your duty and responsibility to support your wife when she faces difficult situations during pregnancy.** This way you will not only be helping your wife, but also your unborn child. **One area of difficulty that your wife faces in pregnancy is taking iron tablets.** **Some pregnant women find it unpalatable to take iron tablets due to side-effects.** If you can provide moral and practical support to your wife, she may be motivated to take iron tablets regularly.	**Interpersonal communication** PHM – Home visits. If feasible short discussion with both husband and wife during home visits. **Group communication** Husband/wife ANC classes/sessions during trimesters 1 & 2 organized by MOH and his/her staff. **Please note**: At FGDs, fathers said they feel left out of ANC activities especially with regard to health education. Some suggested that health education sessions be organized for fathers while they hang-out outside the ANC building. **Testimonial communication**: Identifying a male role model and working through him to spread the message among husbands.	▪ Multimedia presentation on anaemia and importance of taking iron tablets – A summary version of presentation prepared for pregnant women. (Column4, Pg.25). ▪ Q & A leaflets on difficulties and side-effects experienced by mothers in taking iron tablets. (Same leaflet as in column 4,pg.25).

Target Group and Role in BCC	Primary Message, Knowledge and Skills	Communication Media/Methods	Communication Materials/Tools
Husbands of pregnant mothers. (contd.)	**As a loving husband your role should be to gently and kindly motivate your wife to take iron tablets.** Not to blame or force her to take iron tablets. If you force her into taking iron tablets it may make it more difficult for her. Use moral support and a gentle approach to help her to take iron tablets. Explain the benefits of taking iron for both the baby and mother. **Husbands please discuss with your wife if she has real problems of taking iron tablets.** If so, accompany her to ANC and obtain advice from MOH. With this in mind please learn about the importance of taking iron tablets. For PHMS/PHNS/Health Educators etc. – Please use key knowledge on iron supplementation given in Section 1 – 13 in column2, pgs.25-34, to educate husbands.		

Target Group and Role in BCC	Primary Message, Knowledge and Skills	Communication Media/Methods	Communication Materials/Tools
Husband of pregnant mothers. (contd.)	**Please emphasize that in iron supplementation, the husbands' primary task is to gently motivate and provide moral support to their pregnant wives** to take iron tablets as recommended by MOH/PHM. Husbands can develop their own doable support activities in this regard.		

2. Behaviour Change Communication Strategy

Target Group and Role in BCC	Primary Message, Knowledge and Skills	Communication Media/Methods	Communication Materials/Tools
Pregnant mothers. **Husbands of pregnant mothers** - To empower husband and wife to plan together to have a successful pregnancy. - To provide key knowledge and skills to husbands on how to be of assistance to spouse during pregnancy. - To help husbands internalize the idea that during pregnancy husbands should as much as possible actively help the wife to have a successful pregnancy.	**For husband-wife group class No.1 during trimester 1** (i) Role and responsibility of husband during pregnancy including behaviour of husband towards pregnant spouse. (ii) Clinic attendance,services,and benefits. (Sections 1 - 3 in column 2, pg.22) (iii) Iron supplementation (Section 1-13 in column 2, pgs.25-34) (iv) Vitamins and folic acid tablets (Section 1-3,in column 2, pgs.35-37) (v) Danger signs during trimester 1 and role of husband/family members in responding to danger sign; what action to be taken in response to danger signs.	▪ 03 Nos. Husband-wife group classes to be organized one each, during (i) first trimester (ii) second trimester and (iii) third trimester. ▪ Venue: ANC or appropriate location such as a school, communitycentre etc. ▪ Participation: pregnant mothers and husbands. If it is the first baby it is highly appropriate for both the pregnant mother and husband to attend all 03 group classes. ▪ Sponsorship: A CBO, an appropriate NGO or a local business entity may be requested to provide sponsorship to strengthen publicity and encourage participation.	**For husband-wife groupclass No.1 :** ▪ Multimedia presentation on ANC services (use same presentation in column 4, pg.22.*)* ▪ Multimedia presentation on iron supplementation and anaemia(use same presentation as in column 4, pg.25) ▪ Booklet on iron supplementation and anaemia (distribute same booklet as in column 4, pg.25) ▪ Leaflet on vitamins and micro-nutrient especially the importance of folic-acid for use by pregnant women and husbands. **For group class No.2:** ▪ Multimedia presentation on difficulties in taking iron tablets, associated side-effects, suggested solutions.

Target Group and Role in BCC	Primary Message, Knowledge and Skills	Communication Media/Methods	Communication Materials/Tools
Pregnant mothers. Husbands of pregnant mothers (contd.)	- Vaginal bleeding - High temperature (fever) - Pain in lower abdomen **<u>For Husband-wife group class No.2</u>** (i) During trimester 2, iron supplementation and anaemia– Discussion on problems and solutions for continuing iron supplementation by pregnant mothers. Summary of sections 1-13, column 2, pgs.25-34. (ii) Danger signs in pregnant mother and response action. (iii) List each danger sign and describe clearly and in simple language what happens and how the pregnant mother should monitor and assess. (iv) Explain the response action that should be taken by husband/family members.	▪ Rationale: Some participants at a few FGD locations suggested that the MOH/Department of Health organize 'Parent' classes or 'Group' classes. **Mass Media** ▪ Article in newspapers, tabloids, magazines that are read by men, especially young men. ▪ Feature programmes, panel discussions, health related programmes, broadcast over FM radio and TV station. **Main themes for Mass Media: Role and support of husbands towards their pregnant wives.** ▪ Husbands should take special care to protect their health, including desisting as much as possible from risky activities	▪ Q & A booklet for mothers on difficulties of taking iron tablets, side-effects, and possible solutions (use same booklet as in column 4, pg.25) ▪ Multimedia presentation on danger signs in pregnant mother and response action. ▪ Leaflets on danger signs and response action for use by pregnant mothers, husbands and family members. ▪ Video clip on danger signs and response action for mothers, husbands and family members: - One video clip each for danger signs in each trimester. - Flash card sets on danger signs as above.

Target Group and Role in BCC	Primary Message, Knowledge and Skills	Communication Media/Methods	Communication Materials/Tools
Pregnant mothers. Husbands of pregnant mothers (contd.)	(v) Danger signs during trimester 2. - Vaginal bleeding - Hightemperature (fever) - Lessening of fetal movements - Severe headache - Difficulty in breathing - Changes in vision (eye-sight) - Chest pain **For Husband-wife group class No.3 during trimester 3** (i) Role and responsibility of husband during pregnancy including behaviour/practices of husband towards pregnant mothers. (ii) Danger signs in trimester 3 and response action to be taken by husband and/or family members. (iii) Danger signs in trimester 3 - Increased stomach pains. - Vaginal bleeding with or without pain.	andbehaviours such as smoking, alcohol consumption, etc. ▪ Assist pregnant wife in every possible way. Ensure she takes adequate nutritious food; take vitamins, folic acid, calcium and iron tablets as recommended by ANC staff. Actively assist pregnant wives to take iron tablets. ▪ Maintain a very calm and peaceful atmosphere at home. Husband should especially avoid quarrels with pregnant wives; desist from inflicting physical or emotional harm on pregnant wives. ▪ Engage as much as possible in religious/spiritual activities that provide calmness of mind.	

Target Group and Role in BCC	Primary Message, Knowledge and Skills	Communication Media/Methods	Communication Materials/Tools
Pregnant mothers. Husbands of pregnant mothers (contd.)	- High fever (temperature). - Lessening of baby's movements or no movements. - Change in vision (eye-sight) - Chest pain or smarting sensation in chest. - Difficulty in breathing. - Severe headache. - Signs of jaundice (in pregnant mother) such as lack of appetite, vomiting, yellow colouration in eyes, yellowish urine.	▪ Husbands should plan for emergencies during pregnancy; learn of danger signs during pregnancy and appropriate response action; keep some monies to be used only in emergencies etc.	

THE NEWBORN HEALTH COMPONENT

SECTION 2: **BEHAVIOUR CHANGE COMMUNICATION INTERVENTIONS DESIGNED FOR PREGNANT MOTHERS AND SPOUSES AND MOTHERS OF INFANTS AND SPOUSES (FATHERS)**

Issue : Weak understanding among almost all husbands of pregnant mothers and fathers of infants; majority of pregnant mothers and mothers of infants about the term Newborn Health - in Sinhalese 'Nava JanmaSaukya' and in Tamil 'Thai SeeiNalam'. However, the low knowledge levels had not affected adoption of applicable essential newborn care practices and behaviours. A strong understanding of the term and concept would facilitate continuing adoption and sustenance of essential newborn care practices and behaviours.

Problem Behaviour: Most fathers/husbands and majority of mothers/pregnant mothers do not possess an adequate knowledge and understanding of the term and concepts of newborn health.

Desired Behaviours and Facilitating/Constraining Factors

Target Group	Desired Behaviour	Facilitating Factors	Constraining Factors
Pregnant mothers **Husbands of pregnant mothers** **Mothers of newborn babies** **Fathers of newborn babies**	All pregnant mothers and mothers of newborn babies understand the term 'Nava JanmaSaukya' and 'Thai SeeiNalam' (newborn health in mother tongue) and concepts of newborn health. All husbands of pregnant mothers and fathers of newborn babies understand the term 'Nava JanmaSaukya' and 'Thai SeeiNalam' (newborn health in mother tongue) and concepts of newborn health.	▪ Overwhelming majority of mothers and fathers received at least a (completed cycle of) primary education. Majority have had a secondary education. ▪ High rates of adoption of essential newborn care practices (ENCP) by mothers in hospitals. ▪ Very positive attitudes towards ENCP by the vast majority of mothers of newborns.	▪ The term 'newborn health' is comparatively new – the term traditionally used being 'child health'. ▪ The equivalent terms for newborn health in Sinhalese and Tamil are in semi-classical language ▪ Health staff more keen and committed to promote ENCP than explain terms, concepts and principles.

Target Group	Desired Behaviour	Facilitating Factors	Constraining Factors
Pregnant mothers Husbands of pregnant mothers Mothers of newborn babies Fathers of newborn babies (contd.)		▪ The vast majority of mothers and fathers possess the educational background to understand technical terms, concepts whenexplained using interactive communication methods.	▪ Husbands and Fathers are normally not considered important target audience groups for health education on MNH.

SECTION 2: (CONTD.)

Issue : Weak understanding among husbands/fathers about the importance of thermal protection of baby especially the use of items such as caps, socks, wrapping cloth or blankets.

Problem Behaviour: Currently there is no problem behavior regarding ENCP, even with regard to thermal protection and purchase/use of baby clothes for keeping baby warm. However, some husbands questioned the recommendation for use of caps, socks, wrapping cloth for baby in a tropical climate. Yet, currently they do not prevent wives from taking these items to hospital. But if this doubt is allowed to spread among husbands there could be a possibility of increased domestic tension and pressure being applied against the use of caps, socks, etc. for keeping baby warm.

Desired Behaviour and Facilitating/Constraining factors

Target Group	Desired Behaviour	Facilitating Factors	Constraining Factors
Pregnant mothers **Husbands of pregnant mothers**	All husbands of pregnant mothers understand the principle of thermal protection for newborn babies. All husbands understand the reason for use of caps, socks, wrapping sheets to keep newborns warm. All husbands support the use of caps, socks, wrapping sheets to keep newborn babies warm.	All pregnant mothers take items in the list including caps, socks, and wrappers to hospital on admission for child-birth. Most mothers understand the reason for use of caps, socks, wrappers in newborn babies.	Some fathers question the need for the use of caps, socks, wrappers to keep the baby warm in warm parts of the country. The above group of fathers passively accedes to the use of these clothes on newborn babies.

2. Behaviour Change Communication Strategy

Target Group and Role in BCC	Primary Message, Knowledge and Skills	Communication Media/Methods	Communication Materials/Tools
Pregnant mothers **Husbands of pregnant mothers** Reached directly to improve understanding of term newborn health and concept so that the current high level of adoption of ENCP would be sustained; a strong positive attitude towards ENCP developed; and male spousal apathy and a potential resistance towards ENCP neutralized.	(i) Explain the official terminology in Sinhala and/or Tamil for newborn health and key concepts of newborn health. Sinhala – 'Nava JanmaSaukhya'. Tamil – 'Thai SeeiNalam' (ii) **Present the list of items required to be taken by mother on admission to hospital for child-birth.** ▪ Explain the rationale and reason for each item or categories of items. ▪ Explain why the items required to keep the newborn warm are essential even if our country is a tropical country. (iii) **Present the ENCP list of practices.** Explain rationale and reason for each main practice with special focus on:	▪ **Interpersonal communication PHM/Home visits**. ▪ **Group communication** Group health education at ANC, by MOH, PHI, PHNS, SPHM, PHM. **Husband-wife ANC class No.3 during trimester 3 organized by MOH & staff.** Use interactive communication approaches (as FGD members have identified this as a key requirement) for improving impact of health education activities. ▪ **Mass media** – regular columns and programmes in print and electronic media to explain concept of newborn health and ENCP.	**<u>For husband-wife ANCgroup class No.3</u>** ▪ Instructional video on ENCP and early breastfeeding. ▪ Booklet on newborn health and ENCP for pregnant mothers and husbands. ▪ Multimedia presentation on EBF. (same as item 1, column 4, pg.63) ▪ Written Guideline on how to explain the terminology of newborn health in Sinhalese and Tamil languages, and key concepts and principles of newborn health and practices. The purpose is to ensure dissemination of accurate and identical messages at all health administration levels and geographic areas.

Target Group and Role in BCC	Primary Message, Knowledge and Skills	Communication Media/Methods	Communication Materials/Tools
Pregnant mothers Husbands of pregnant mothers (contd.)	- **Thermal protection,** benefit to baby and how it is done. - **Skin to skin contact**, its importance to the newborn and to the mother. Alleviate myths on skin to skin contact. - **Breastfeeding baby within the first hour of birth.** It helps to establish mother-baby bonding, longer duration of breastfeeding. It is a real investment for baby, mother and family. (iv) **Exclusive breast feeding.**Explain - what is really meant by exclusive breastfeeding and its benefits to baby, mother and family.		▪ Leaflet on newborn health and ENCP for parents. Key contents are: - Concept of newborn health based on 'Guidelines'in column 4, pg.48. - ENCP in hospital - List of items required to be taken by pregnant mothers on admission for child-birth to hospital. - Rationale and reasons for including each item on the list. (The rationale referred to above should be designed to meet the resistance or non-acceptance of items required to keep the baby warm, e.g. caps, socks, blanket, by fathers).

2.Behaviour Change Communication Strategy

Target Group and Role in BCC	Primary Message, Knowledge and Skills	Communication Media/Methods	Communication Materials/Tools
Pregnant mothers **Husband of pregnant mothers and family members.** To motivate husbands to encourage and support mothers to practice essential newborn care practices at home. To increase knowledge and skills of pregnant mothers in essential newborn care practices at home. To motivate joint-planning with husband and/or other family members to practice essential newborn care practices at home.	1. **Husband's support is vital** to ensure that all essential newborn care practices are practiced well at home (after bringing baby home). Husband and wife should plan for this in advance with the help of other family members. 2. **Husband and other family members must prepare to receive mother and baby home by,** ▪ Dusting and cleaning the house ▪ Cleaning the designated room/space for the baby ▪ Select room/space for baby that is warm and with medium light. ▪ Select a place for the baby that provides protection from direct draft, rain-spray, etc.	**Interpersonal communication. PHM/home visit.** If feasible short discussion with both husband and wife during home visits. Also with other family members when feasible. **Group communication at ANC, MOH and staff.** Organize short meeting for accompanying husbands on a specified day of the month on essential newborn care practices at home. (The above activity is proposed, as the husbands who accompany mothers are a captive audience that can be tapped for improving MNH practices. At FGDs, fathers said they felt 'left-out' and suggested that it may be useful to organize health education sessions for fathers too)	▪ **Multimedia presentations**on essential newborn care practices at home titled 'Looking after the newborn and mother at home'. ▪ **Leaflet** titled **'Looking after the newborn and mother at home'** for husbands and family members. The themes for the above two items are : (i) The positive and important role husbands could play in ensuring healthy growth of the new born. (ii) List of newborn care practices at home and how husbands and family members can help, mother to practice them. (iii) Monitoring of danger signs in a baby and including required response action.

Target Group and Role in BCC	Primary Message, Knowledge and Skills	Communication Media/Methods	Communication Materials/Tools
Pregnant mothers Husband of pregnant mothers and family members (contd.)	**3.** For the first six months, baby should be given breast milk only. Husband should help in routine household work to give breastfeeding mother adequate physical and mental rest. (Please discuss how this could be done). **4.** Husband must ensure that breastfeeding mother has adequate nutrition (Please discuss about appropriate foods taking the local situation into context). **5.** Family must be given appropriate knowledge and skills on 'how to manage visitors during the newborn period' to protect baby from infections. **6.** Essential newborn care practices after taking newborn home. ▪ Keeping the baby warm	**Husband-wife ANC class No.3 during trimester 3. – MOH and staff**	(iv) Monitoring of danger signs in a mother (after mother comes home with baby) and required response action.

Target Group and Role in BCC	Primary Message, Knowledge and Skills	Communication Media/Methods	Communication Materials/Tools
Pregnant mothers Husband of pregnant mothers and family members (contd.)	▪ Exclusive breastfeeding (please see separate section on EBF) ▪ Prevention and control of infection ▪ Routine care of newborn: bathing and cleaning, skincare, putting to sleep; appropriate clothing; managing the umbilicus. Please use the 'Handbook on Postpartum Care Guide' to disseminate knowledge and skills on above essential newborn care practices. **7.** Danger signs in the newborn and appropriate referral. ▪ Poor feeding/refusal of feeding ▪ Rapid respiration ▪ Grunting ▪ Fever – temperature above 38°C		

Target Group and Role in BCC	Primary Message, Knowledge and Skills	Communication Media/Methods	Communication Materials/Tools
Pregnant mothers Husband of pregnant mothers and family members (contd.)	▪ Redness around the umbilicus/pus draining from the umbilicus ▪ Yellow discolouration of the body ▪ Three or more pustules in the body ▪ Fits (Please discuss how to identify each of the above danger signs and what quick response action should be taken for baby's protection). 8. **Appropriate family planning methods after 1½ months of baby's birth.** Please instil a positive attitude towards family planning with an explanation of benefits of FP to family economy, mother's health, baby's wellbeing and risks of induced abortions.		

Target Group and Role in BCC	Primary Message, Knowledge and Skills	Communication Media/Methods	Communication Materials/Tools
Pregnant mothers Husband/Fathers of pregnant mothers (contd.)	**9. Danger signs in post-natal mother and response action.** ▪ Increasing vaginal bleeding ▪ Fever ▪ Pain in legs especially in the calf-area ▪ Strong pain in lower-abdomen ▪ Offensive smelling vaginal discharge ▪ Festering of wounds related to child birth ▪ Changes in behaviour, e.g. frequent crying or laughing; neglecting baby; fear; lack of interest in dress, personal hygiene, cleanliness, etc. Please explain clearly what response action the husband and or other family members should take in case of onset of above danger signs.		

SECTION 3 : BEHAVIOUR CHANGE INTERVENTIONS DESIGNED FOR PREGNANT MOTHERS ADMITTED TO HOSPITAL FOR CHILD BIRTH

2. Behaviour Change Communication Strategy

Target Group and Role in BCC	Primary Message, Knowledge and Skills	Communication Media/Methods	Communication Materials/Tools
Pregnant mother on admission to hospital for child-birth. To equip mothers with requisite knowledge and skills to assist in the practice of, (i) ENCP at hospital (ii) Essential newborn care practices at home (iii) Exclusive breastfeeding (iv) Monitoring and responding to danger signs in newborn if any.	**Welcome to ward, put mother at ease, short introduction on,** 1.**ENCP** (i) thermal protection and the use of items brought by mothers for thermal protection (ii) skin to skin contact, how to practice and how the mother can be helpful in supporting the practice (iii) breastfeeding within one hour of birth and how mother can help to initiate breastfeeding. 2. **Essential newborn care** practices to be done at home during the first 03 months (a simple and short introduction). 3. **Lactation Management Centre** and how it can help if/when mother's experience problems in breastfeeding at hospital or at home after taking baby home.	**Interpersonal communication ward staff** (On admission to ward – welcome, make mother feel at ease, and short talk on main aspects of ENCP and how mother can help). If time is available a short introduction to essential newborn care at home and exclusive breastfeeding. Handing over of **welcome leaflet** to mother, which would include a simple short description of ENCP especially thermal protection, skin to skin contact and breastfeeding. It is suggested that each obstetrics and gynaecology ward in all hospitals train two or three female staff on communication and health education to welcome and receive pregnant mothers on admission and subsequently explain about	▪ **Welcome leaflet** for pregnant mothers admitted to the ward. After a short paragraph designed to welcome the mother to the ward, include simple and short descriptions of ENCP especially thermal protection, skin to skin contact and breastfeeding.

Target Group and Role in BCC	Primary Message, Knowledge and Skills	Communication Media/Methods	Communication Materials/Tools
Pregnant mother on admission to hospital for child-birth. (contd.)		items 1, 2 & 3 in column 2 briefly and in a genial and friendly manner. They can also brief them before leaving hospital.	

2. Behaviour Change Communication Strategy

Target Group and Role in BCC	Primary Message, Knowledge and Skills	Communication Media/Methods	Communication Materials/Tools
Post natal mother before leaving hospital with the newborn. To equip the mother with requisite knowledge and information on, (i) Essential newborn practices at home (ii) Practice of exclusive breastfeeding at home (iii) How to monitor danger signs in baby at home and take appropriate action. (iv) How to monitor danger signs in post-natal mother at home and take required response action.	1. Essential newborn care practices at home on taking the newborn home. (Same messages as in item 6, column 2, pg.51) 2. Danger signs in a newborn. (Same messages as in item 7 column 2, pg.52) 3. How to continue breastfeeding. Please reinforce basic skills of breastfeeding. (select appropriate information from sections 1-13, column 2, pgs.63-70) 4. In case of problems how to obtain advice from the Lactation Management Centre at hospital.	**Interpersonal communication** ward(before mother leaves hospital with baby). **Individual counselling on EBF** – by Lactation Management Centre staff. **Group communication**(if feasible to organize group meeting of mothers before leaving the ward). Handing over of leaflet on **'Looking after the newborn and the mother at home'.** (Same leaflet as in column 4, pg.50). Handing over of leaflet on '**Exclusive Breastfeeding',** referred to in column 4, top of this page.	▪ **Leaflet on Exclusive Breastfeeding.** ▪ Importance of breastfeeding to baby, mother and family economy. ▪ Appropriate breastfeeding positions. ▪ Importance of EBF for 06 months. ▪ Breast milk contains adequate quantity of water even adequate on hot days. ▪ DHA which is essential for baby's brain development occurs naturally and in very high quantities in breast milk. ▪ How to breastfeed correctly ▪ How to assess if the baby had adequate breast milk during a feed.

Target Group and Role in BCC	Primary Message, Knowledge and Skills	Communication Media/Methods	Communication Materials/Tools
Post natal mother before leaving hospital with the newborn. (contd.)	5. Danger signs in a post-natal mother (Same message as in item 9, column 2, pg.54)		▪ How to express breast milk and store safely. ▪ Commonly experienced as well as perceived problems in breast feeding and how to overcome them. ▪ Lactation Management Centre, its services and how to receive its services in case of a breast feeding problem even after leaving hospital.

SECTION 4: **BEHAVIOUR CHANGE COMMUNICATION INTERVENTIONSDESIGNED FOR PREGNANT MOTHERS, POST NATAL MOTHERS ANDHUSBANDS- TO GIVE SKILLS TO SUSTAIN EBF AND MAINTAIN ESSENTIAL NEWBORN CARE PRACTICES INCLUDING MONITORING OF DANGER SIGNS**

Issue : Vast majority of mothers have an excellent knowledge on exclusive breastfeeding including benefits of EBF; Majority of mothers with infants practice EBF as recommended.

Problem Behaviour: Some mothers who believe that they practice EBF give "a little bit of water" to infants; these mothers do not think that they are doing something wrong or are breaking the practice of EBF. Some mothers who perceive/feel that they do not have adequate breast milk give substitute powdered milk, in addition to breast milk. Some mothers who feel they are sick also give substitute powdered milk. Some working mothers give some feeds of powdered milk in addition to breast milk. Some mothers who have older child/children give some feeds of powdered milk due to 'overwork'.

Desired Behaviours and Facilitating/Constraining Factors

Target Group	Desired Behaviour	Facilitating Factors	Constraining Factors
Pregnant mothers preparing for motherhood and exclusive breastfeeding **Husbands of pregnant mothers**	All mothers with infants feed their infants upto 6 months of age solely on breast milk.	▪ Vast majority of mothers have excellent knowledge of early initiation of breastfeeding and colostrum. ▪ Vast majority of mothers have excellent knowledge of EBF, benefits and timing. ▪ Effective health education on EBF for mothers. ▪ Mothers trust field health staff, especially PHM. ▪ Opportunity for mothers to consult PHM, if a problem (on EBF) arises. ▪ Capacity of some families to view advertisements on powdered milk critically.	▪ Nearly half of husbands/ fathers have poor knowledge on early initiation of breastfeeding and colostrum. ▪ Most of husbands/fathers have poor knowledge on timing of EBF. Most believe EBF is for 03 months or less than 03months. (except in 02 FGD locations). ▪ Mothers start work in 03 months.

Target Group	Desired Behaviour	Facilitating Factors	Constraining Factors
Pregnant mothers preparing for motherhood and exclusive breastfeeding Husbands of pregnant mothers (contd.)			▪ Although some mothers know of expressing breast milk, they do not do so. ▪ Difficult for working mothers to breastfeed, regularly. ▪ Mothers and mothers-in-lawinstructparentsabout inadequacy of breast milk for baby's growth. Fathers believe through TV advertisements on follow-up formula that formula milk will give "better brain development". ▪ Some mothers believe that it is appropriate to give 'a little water' while exclusively breastfeeding; some also give 'rathakalka'. ▪ Private sector leaveis inadequate, for working mothers. ▪ Poor knowledge and skills in expressing breast milk; (some consider it a chore) and storing.

Target Group	Desired Behaviour	Facilitating Factors	Constraining Factors
Pregnant mothers preparing for motherhood and exclusive breastfeeding Husbands of pregnant mothers (contd.)			▪ Some mothers with older children feel overburdened with household work. ▪ Influence of follow-up formula milk advertisements. ▪ When baby "cries often" or due to poor physical growth of baby some doctors prescribe formula milk. ▪ Some mothers feel they do not have adequate supply of breast milk to satisfy baby. ▪ Some mothers and fathers believe formula milk is more nutritious. ▪ Some families introduce kanji water, fruit juice and formula milk after 3 to 4 months. ▪ At 3months the traditional 'SoruOdduthal' (weaning ceremony) takes place after which Cerelac, Golden Cow

Target Group	Desired Behaviour	Facilitating Factors	Constraining Factors
Pregnant mothers preparing for motherhood and exclusive breastfeeding Husbands of pregnant mothers (contd.)			rusks, coriander water and fruit juices are added (Kilinochchi only) ▪ Some doctors prescribe formula milk (substitutes) ▪ Mother anxious that prolonged breastfeeding will adversely affect physical beauty. ▪ Mothers feel that they do not get adequate nutrition.

2. Behaviour Change Communication Strategy

Target Group and Role in BCC	Primary Message, Knowledge and Skills	Communication Media/Methods	Communication Materials/Tools
Pregnant mothers To empower pregnant mothers with knowledge, skills and positive attitudes on exclusive breastfeeding, on birth of baby and thereafter. **Husband of pregnant mothers** To empower husbands (i) on the vital importance of exclusive breastfeeding. (ii) with accurate knowledge; and (iii) to support mothers to exclusively breastfeed upto 6 months.	1. **Exclusive breastfeeding (EBF) Breast milk (BM) is the best for your baby. Breast feed exclusively for 06 months.** A breastfed child is healthier and more intelligent. EXCLUSIVE BREAST FEEDING MEANS FEEDING YOUR BABY **ONLY BREAST MILK** FOR FIRST 6 MONTHS OF LIFE. 2. **Colostrum**: Early initiation of breast feeding helps the newborn to take in colostrum. Colostrum protects baby from infections by giving immunity during first crucial months of life. - Colostrum comes in small quantities. This small quantity is quite adequate to meet baby's requirements. In the early days as colostrum occurs in small quantities, many mothers feel that they do not produce enough breastmilk.	**Interpersonal communication PHM/Home visits.** **Group communication** Breastfeeding class at ANC, PHNS, SPHM, PHM. Breastfeeding classes may be organized during antenatal clinics especially for mothers in 2nd and 3rd trimester. Husband-wife/career mother etc. ANC class No.3 during trimester 3.	▪ Multimedia presentation on EBF, Key contents as described in sections 1-13, column 2, pgs.63-70. ▪ Booklet on EBF, Key contents as in sections 1-13, column2, pgs. 63-70. ▪ Q&A booklet on inaccurate perceptions, misconceptions and negative attitudes regarding EBF. ▪ Instructional video on breastfeeding, demonstrating skills in breastfeeding.

Target Group and Role in BCC	Primary Message, Knowledge and Skills	Communication Media/Methods	Communication Materials/Tools
Pregnant mothers and husbands (contd.)	As the baby begins to suckle and take in colostrum, gradually the quantity of breastmilk will increase. 3. **All mothers can breastfeed**: Almost every mother can breastfeed successfully. Breastfeeding the baby frequently causes increased production of more milk. 4. **The many advantages of breastfeeding are:** ▪ **Breast Milk is a complete food**: Total nutritional requirements of baby are adequately supplied through breast milk in the first 6 months. ▪ Breastmilk is the most easily digested food for the baby.		

Target Group and Role in BCC	Primary Message, Knowledge and Skills	Communication Media/Methods	Communication Materials/Tools
Pregnant mothers and husbands (contd.)	▪ The composition of breastmilk changes almost day to day to suit baby's increasing needs. ▪ Breastmilk contains adequate amounts of water to cater to baby's daily water requirements; so you do not have to give water again to baby even on a very hot day. ▪ Breastmilk builds baby's immunity. It is like an immunization against diseases and infections. ▪ You do not have to purchase breastmilk from a shop; you do not have to prepare breastmilk; Mother Nature prepares it for the baby. 5. **Do not give - water, powdered milk, ratha-kalka**: Do not give water, even a "little bit of water". Do not give powdered milk, even a few feeds of powdered milk during the first 6 months.		

Target Group and Role in BCC	Primary Message, Knowledge and Skills	Communication Media/Methods	Communication Materials/Tools
Pregnant mothers and husbands (contd.)	Giving your baby anything else other than breast milk within the first six months will cause him/her suckle less and reduce the amount of breast milk that your body produces. 6. **Breast feeding helps in baby's brain development:** (i) The process of breastfeeding helps in baby's brain development. The mother-child bonding that occurs during breastfeeding through stroking, talking, etc. is the greatest influencer and facilitator of baby's brain development. This path to brain development is unique to breastfeeding and cannot be obtained through any other means. (ii) Breast milk contains very high quantities of DHA – one substance that helps to develop your baby's brain.		

Target Group and Role in BCC	Primary Message, Knowledge and Skills	Communication Media/Methods	Communication Materials/Tools
Pregnant mothers and husbands (contd.)	Breastmilk in Sri Lankan mothers contains high amounts of DHA. Even mothers in hill areas have adequate quantities of DHA in their breastmilk. Therefore breastfeed your baby to enhance your baby's brain development. DHA in breastmilk is natural. 7. **Breast feed on demand**: Breastfeed your baby on demand both day and night (about 8-12 times). The more suckling the baby is allowed to do, the more breast milk is produced. This is why it is important to breastfeed on demand. 8. **Let your baby finish one breast completely before switching:** Baby should be allowed to finish one breast before starting on the other. Avoid switching back and forth.		

Target Group and Role in BCC	Primary Message, Knowledge and Skills	Communication Media/Methods	Communication Materials/Tools
Pregnant mothers and husbands (contd.)	Switching back and forth from one breast to the other prevents the baby from getting nutritious 'hind' milk. The 'fore' milk has more water and satisfies baby's thirst. The 'hind' milk has more fat and satisfies your baby's hunger. 9. **How do you know if baby is hungry:** Signs of hunger: Crying is a late sign of hunger. Early signs that baby wants to breastfeed include: ▪ Turning head and searching ▪ Opening mouth and turning head from side to side ▪ Putting tongue in and out ▪ Suckling on finger and fists If you observe any of these signs breastfeed baby. 10. **Bottles and teats are bad**: When a mother feeds a baby with bottle and teats, babies		

Target Group and Role in BCC	Primary Message, Knowledge and Skills	Communication Media/Methods	Communication Materials/Tools
Pregnant mothers and husbands (contd.)	refuse suckling through nipples. This is why mothers should not use bottles and teats to feed a baby. Secondly a baby can catch infections through unclean bottles, teats and spouted cups. 11. **Breastfeeding positions**: Good positioning helps to ensure that baby suckles well and helps you to produce a good supply of breast milk. Good attachment helps to ensure that your baby suckles well. **Note to PHM/PHNS:** Explain key position and good attachment in simple and clear manner using demonstrations if feasible, anatomical models or instructional videos. 12. **Develop following skills in working mothers.** ▪ How to express breast milk. ▪ Correct storing of breast milk.		

Target Group and Role in BCC	Primary Message, Knowledge and Skills	Communication Media/Methods	Communication Materials/Tools
Pregnant mothers and husbands (contd.)	▪ Cup feeding skills for the carers. ▪ Start expression of breast milk and cup feeding from first month. **Note to PHM/PHNS:** This key message and skill should be given to all working mothers at clinic and/or at home. 13. **Breast milk is the best for a low birth weight baby:** Breast milk is especially needed and the BEST for low birth weight babies. **Note to PHNS, PHM and relevant staff:** This key message and skill should be given to mothers, during pregnancy as wellas later at home, if the baby is of low birth weight.		

2. Behaviour Change Communication Strategy

Target Group and Role in BCC	Primary Message, Knowledge and Skills	Communication Media/Methods	Communication Materials/Tools
Post natal mother (after taking baby home from hospital) **Husband and/or family member** To reinforce knowledge and skills of mother, on (i) Essential newborn practices (ii) Exclusive breastfeeding (iii) Monitoring of danger signs and response To motivate husband and family members to support mother on (i), (ii) and (iii) above.	1. Essential newborn care practices on taking the baby home (Pls. refer item 6, column 2, pg.52) 2. Practice of exclusive breastfeeding (Pls. refer sections 1-13, column 2, pgs.63-70) 3. Danger signs in a newborn baby and response (Pls. refer item 7, column 2,Pgs.52) 4. How husbands and other family members can support mother to implement 1, 2, and 3 above. 5. Provide knowledge and skills to respond to practical problems that arise in practicing 1,2 and 3.	**Interpersonal communication** **PHM** – Home visits **PHN, MOH** – consultation at clinic **GP** – consultation (i) PHM during her first visit after baby is brought home to reinforce knowledge and skills to mother on a one-to-one basis. (ii) During the second visit, talk with both wife and husband to reinforce knowledge and discuss ways for the household to support mother in EBF and other essential newborn care practices. (iii) PHM to visit mother and baby at least one more time around the 6th week to provide psychological and practical support to mother in sustaining essential	▪ Flashcards on EBF ▪ Leaflet on EBF (same leaflet as in column 4, pg.57) ▪ Leaflet on 'Looking after the newborn and mother at home' (same leaflet as in column 4, pg.50)

Target Group and Role in BCC	Primary Message, Knowledge and Skills	Communication Media/Methods	Communication Materials/Tools
Post natal mother (after taking baby home from hospital) Husband and/or family member (contd.)		newborn care practices as well as exclusive breastfeeding for 06 months. During these visits discuss with mother the progress of the baby, and any concerns regarding growth, EBF and monitoring of danger signs. PHM should utilize interactive communication approaches (including use of audio-visuals such as flash cards, photographs, brochures, or booklets) to help resolve the problems that mother identifies. Reinforce the importance of practicing EBF as recommended, i.e. the inappropriateness of giving even a 'little bit of water'; 'ratha-kalka'; and other liquids. If the situation or problems regarding EBF are complex, PHM should request mother to attend clinic for a special consultation with MOH.	

Target Group and Role in BCC	Primary Message, Knowledge and Skills	Communication Media/Methods	Communication Materials/Tools
Post natal mothers i.e. mothers with infants who are attending/should attend post natal clinics. Reinforce knowledge and skills on newborn care practices in order to sustain practice of newborn care initiatives mainly exclusive breastfeeding.	1. Exclusive breastfeeding – Sections 1-13, column 2, pgs.63-70. **Background information:** FGDs in 07 districts indicated that some mothers do not practice (substantial majority do practice) EBF due to a variety of reasons ranging from mother's perceptions, fathers and family influence, having to go back to work, belief that a little water should be given; influence of commercial advertisements; experiencing difficulty in expressing milk; mothers' perceived inadequacy of breast milk and or sickness and cultural reasons. (For complete list of constraining factors, please refer column 4, pgs.59-62. Please prepare in advance to respond to these constraints when organizing EBF classes or similar health education initiatives)	**If necessary refer to the Lactating Management Centre in hospitals.** **Interpersonal communication PHM** – Home visits. **Interactive group communication**: Breastfeeding classes at MCH clinic –PHN/ PHM/SPHM/ MOH. (i) Presentations followed by discussion, Q&A sessions (ii) Problem-solving sessions based on real problems identified by mother (iii) Demonstrations (iv) Use of satisfied clients as presenters and discussants. **Individual counseling – PHNS,SPHM, PHM** **Refer to Lactation Management Centre in hospital if required.**	▪ Multimedia presentation on EBF. (Same as in item 1, column 4, pg.63.) ▪ Flash cards on EBF (same as in item 1, column 4, pg.71). ▪ Anatomical models ▪ **Written Guide on a methodology and tips to respond to often cited constraints for EBF such as,** (i) Inadequate breast milk (ii) Mother feels sick (iii) Breast milk is not complete food after 3months (iv) Need to give 'a little bit of water' to baby (v) Kilinochchi, 'SoruOdduthal' weaning ceremony at 3 months. (vi) Formula – milk will make child more intelligent

Target Group and Role in BCC	Primary Message, Knowledge and Skills	Communication Media/Methods	Communication Materials/Tools
Post natal mothers (contd.)	2. Monitoring for 'Danger Signs' and taking prompt action can protect your baby from avoidable emergencies. 3. If you notice any of the following danger signs in your infant immediately request for PHM assistance and/or take to hospital or to a GP. For danger signs in baby, please refer item 7, column 2, pgs.52-53.	Mothers often need support in the way of targeted communication, for their specific problems and concerns of EBF and essential newborn care practices. For these mothers, problem solving ideas on their real problems using discussions or even personal counselling would be useful.General presentation on EBF etc. would not be sufficient. Research has shown that counselling, problem solving, education and support could increase EBF rates among children less than 06 months old upto 90 per cent[5]. ▪ PHM to monitor EBF and assist with problems during home visits.	(vii) Deceptive commercial advertisements. (viii) Fear of feeding from a cup for baby's safety. (ix) Working mothers/non-working mothers too busy with household chores. (x) Difficulty in expressing breast milk. ▪ Video clip on exclusive breastfeeding methods and benefits and associated personal hygiene practices.

[5] The Lancet, Evidence-based interventions for improvement of maternal and child nutrition, pg.7 www.thelancet.com/journals/lancet article/PIIS0140-6736(13)60937-X/fulltext

Target Group and Role in BCC	Primary Message, Knowledge and Skills	Communication Media/Methods	Communication Materials/Tools
Post natal mothers (contd.)		The MOH and team should use interactive communication approaches and counselling to respond to evolving problems experienced by mothers in breastfeeding and essential newborn care practices.	

SECTION 5: SOCIAL MOBILIZATION ACTIVITIES TO OFFER SOCIAL LEGITIMACY AND ENCOURAGEMENT TO PREGNANT MOTHERS TO TAKE IRON TABLETS TO COMBAT ANAEMIA

Target Group and Role in BCC	Primary Message, Knowledge and Skills	Communication Media/Methods	Communication Materials/Tools
Clergy in MOH areas To seek assistance of clergy to provide social and cultural legitimacy for iron supplementation in pregnant mothers.	Request clergy to include in religious discussions as appropriate the importance of taking iron tablets duringpregnancy. Key knowledge on iron supplementation Sections 1-13, Column 2, pgs.25-34.	**Interpersonal communication** MOH, PHI, PHNS, PHM MOH to meet with relevant clergy (as and if appropriate) to discuss the possibility of including key messages on iron supplementation and anaemiain religious discussions and related religious activities. MOH, PHI, PHNS, PHM to arrange short orientation session on ironsupplementation and anaemia to clergy.	▪ Special multimedia presentation for clergy on (i) Iron supplementation and anaemiafor inclusion in religious sermons and discussions. ▪ Leaflet for clergy on iron supplementation and anaemia.

SECTION 5: (CONTD.)

Target Group and Role in BCC	Primary Message, Knowledge and Skills	Communication Media/Methods	Communication Materials/Tools
Office bearers/leaders of women's NGOs/CBOs, e.g. women's groups mothers' groups To disseminate information on and nurture positive attitudes towards (i) consumption of iron tablets during pregnancy (ii) practicing exclusive breastfeeding of babies'upto 06 months.	Request that in coordination with Women Development Officer in the area to organize orientation sessions on (i) iron supplementation and anaemia and (ii) exclusive breastfeeding of babies till 06 months of age. Key knowledge on iron supplementation and anaemia (Sections 1-13, column 2, pgs.25-34) Key knowledge on EBF (Sections 1-13, column 2, pgs.63-70)	▪ **Group communication** MOH, PHNS, SPHM, PHM, WDO ▪ Interactive communication sessions on (i) importance of iron supplementation during pregnancy (ii) EBF (iii)difficulties experienced by mothers on themes (i) and (ii).A participatory discussion on ways and means of resolving difficulties of mothers in (i) and (ii). Please Note : Mothers who are already taking iron tablets as recommended as well as mothers who are already strictly practicing EBF may be used as resource persons.	▪ Multimedia presentation on iron supplementation and anaemia. (same as item 1, column4, pg.25) ▪ Multimedia presentation on EBF. (same as item 1, column 4, pg.63) ▪ Role-play on practical situations pertaining to iron supplementation and EBF. ▪ Q & A leaflet on difficulties and side-effects experienced by mothers in taking iron tablets (same leaflet as item3, column 4, pg.25).

SECTION 6: MASS MEDIA (MOBILIZATION) TO REINFORCE THE MNH KNOWLEDGE ALREADY DISSEMINATED BY HEATH SECTOR TO PREGNANT MOTHERS, HUSBANDS AND FAMILY MEMBERS.

Target Group and Role in BCC	Primary Message, Knowledge and Skills	Communication Media/Methods	Communication Materials/Tools
Editors Guild and other senior editors of print media. **CEO's of main electronic media.** To request decision-makers in media organizations to publish/broadcast articles, features, programmes on MNH, especially iron supplementation, INCP and EBF.	**A.** Request decision makers of mass media to allocate space and time for articles and programmes designed to educate pregnant mothers, husbands and family members on three important areas in the MNH programme. 1. Iron supplementationand anaemia. 2. Essential newborn care package(ENCP). 3. Exclusive breastfeeding (EBF). **B.** Summary of core knowledge on above themes and associated problems. 1. Key programmatic information and constraints regarding - ▪ Iron supplementation and anaemia.	Luncheon meetings at a hotel in Colombo for, (i) Print media (ii) Electric media Method and process: - Presentations - Discussions/dialogue - Decisions	▪ Multimedia presentation on programmatic approaches and constraints regarding, (i) Iron supplementation and anaemia. (ii) Essential newborn care package (ENCP). (iii) Exclusive breastfeeding (EBF) ▪ Multimedia presentation on Focus Group Discussion findings on, (i) Iron tablets and anaemia (ii) ENCP (iii) EBF ▪ Media kit on above three themes.

Target Group and Role in BCC	Primary Message, Knowledge and Skills	Communication Media/Methods	Communication Materials/Tools
Editors Guild and other senior editors of print media. CEO's of main electronic media. (contd.)	▪ Immediate newborn care package. ▪ Exclusive breastfeeding. 2. FGD findings on, ▪ Iron supplementation and anaemia. ▪ Immediate newborn care package. ▪ Exclusive breastfeeding. **C.** Request identification of key media person/s from each main mass media organization to coordinate writing/production of articles, features, panel discussions, interviews, etc. 1. Decision: Agreement to organize two orientation workshops for identified media personnel.		

Target Group and Role in BCC	Primary Message, Knowledge and Skills	Communication Media/Methods	Communication Materials/Tools
Selected journalists from print media. **Selected script writers and programme producers in electronic media.**	**Main Themes A and B as on column 2, Pg.78 (Iron supplementation, ENCP and EBF).**	**02 Workshops** organized by FHB and HEB on iron supplementation, ENCP and EBF. **Designated officers to maintain regular contacts** with media personnel; organize field activities; provide raw materials to write/produce articles and programmes.	

SECTION 7: SENSITIZATION OF GOVERNMENT INSTITUTIONS AND STAFF TO SUPPORT ADVOCACY AIMED AT PROMOTING IRON SUPPLEMENTATION AMONG PREGNANT MOTHERS AND PROMOTING EXCLUSIVE BREASEFEEDING AMONG MOTHERS HAVING BABIES UNDER 06 MONTHS OF AGE.

Target Group and Role in BCC	Primary Message, Knowledge and Skills	Communication Media/Methods	Communication Materials/Tools
Secretary, Ministry of Child Development and Women's Affairs. **Divisional Secretaries** To motivate Women Development Officers (WDOs) to promote (i) intake of iron tablets by pregnant mothers and (ii) promote exclusive breastfeeding among mothers having babies under 06 months of age, in their local areas of work.	1. The positive role that WDOs could play in the local areas of operation (Divisional Secretariat Area) in promoting two interventions that are crucial for health of mothers and infants. (i) Iron supplementation and anaemia (ii) Exclusive breastfeeding (EBF) <u>Anaemia</u> Please refer Sections 1-13, Column 2, pgs.25-34 <u>EBF</u> Please refer Sections 1-13, Column 2, pgs 63-70.	▪ **Interpersonal Communication** ▪ Meeting with Secretary of Ministry of Women's Affairs and key senior officers – FHB, HEB. ▪ **Group communication** – FHB ▪ Seminars for WDOs on iron supplementation &anaemiaand EBF organized by FHB and provincial/district health administrations. ▪ **Interpersonal communication** ▪ Meeting with Divisional Secretary (DS) – MOH to request assistance of DS for the WDO to disseminate knowledge on iron supplementation &anaemiaand EBF through women's groups, CBOs and other appropriate events.	▪ Multimedia presentation on iron supplementation and anaemia(same as Item 1, column 4, pg.25) ▪ Multimedia presentation on EBF(same as item 1, column 4, pg.63) ▪ Booklet on iron supplementation and anaemia(same as item 2, column 4, pg. 25) ▪ Booklet on EBF(same as item 2, column 4, pg.63)

SECTION 8: ENHANCEMENT OF STAFF CAPACITY TO APPLY BEHAVIOUR CHANGE COMMUNICATION APPROACHES IN SUSTAINING HIGH LEVELS OF APPROPRIATE CLIENT BEHAVIOUR IN MNH PROGRAMME WHILE IMPROVING ON GAPS.

Target Group and Role in BCC	Primary Message, Knowledge and Skills	Communication Media/Methods	Communication Materials/Tools
Medical Officer - Maternal and Child Health (MO-MCH) **Medical Officer of Health (MOH)** **Senior Public Health Inspector (SPHI)** **Senior Public Health Midwife (SPHM)** **Public Health Inspector (PHI)** **Public Health Nursing Sister (PHNS)** **Public Health Midwife (PHM)** **All relevant health care providers** To enhance skills on BCC approaches to sustain high client behaviours, and further improve on gaps in client behaviours.	**Communication Competencies in applying BCC strategy effectively.** - Concept and principles of Behaviour Change Communication - Interactive Communication Vs. one-way communication in BCC. - Media and Public Relation. - Interpersonal Communication/Home Visits. - 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.	**Training Workshop** - Lecture/Presentations - Group Work - Role Play - Practical Exercises - Case Study Analysis - Interactive communication sessions for problem solving on iron supplementation and exclusive breastfeeding: Practical communication exercise.	▪ **Training Modules on,** - Principles and techniques of Behaviour Change Communication - Communication Planning - Interpersonal Communication - Interactive Group Communication - Conducting Lectures and Demonstrations - Use of Audio Visuals - Problem solving techniques - Conflict Resolution methods - Media and Public relations - Counseling

Target Group and Role in BCC	Primary Message, Knowledge and Skills	Communication Media/Methods	Communication Materials/Tools
Medical Officer - Maternal and Child Health (MO-MCH) Medical Officer of Health (MOH) Senior Public Health Inspector (SPHI) Senior Public Health Midwife (SPHM) Public Health Inspector (PHI) Public Health Nursing Sister (PHNS) Public Health Midwife (PHM) (contd.)	- How to use the "Behaviour Change Communication Strategy Guide for Maternal and Newborn Health Programme" especially at MOH area level. **Technical Skills/Competencies** <u>Iron supplementation and anaemia.</u> - Key knowledge on iron supplementation and anaemia (Based on Sections 1-13, column 2, pgs.25-34 - FGD findings – presentation on anaemia and iron supplementation. - Problem solving approaches with regard to side-effects and difficulties experienced by pregnant women in taking iron tablets.		▪ **Training module on**, - Iron supplementation and anaemia. - exclusive breastfeeding. ▪ Multimedia presentation on iron supplementation and anaemia. (same as item 1, column 4, pg.25) ▪ Multimedia presentation on EBF.(same as item 1, column 4, pg.63) ▪ Guide booklet or Note on how to respond to constraints experienced by mothers regarding EBF.

Target Group and Role in BCC	Primary Message, Knowledge and Skills	Communication Media/Methods	Communication Materials/Tools
Medical Officer - Maternal and Child Health (MO-MCH) Medical Officer of Health (MOH) Senior Public Health Inspector (SPHI) Senior Public Health Midwife (SPHM) Public Health Inspector (PHI) Public Health Nursing Sister (PHNS) Public Health Midwife (PHM) (contd.)	<u>Exclusive Breastfeeding</u> - Key knowledge and skills on EBF (Based on Sections1-13,column 2, pgs.63-70) - FGD findings – presentation on EBF		- Guide booklet or Note on how to respond to difficulties experienced by mothers in taking iron tablets.

SECTION 9: ADVOCACY FOR MOBILIZATION OF INTERSECTORALCOLLABORATION THROUGH NATIONALNUTRITION COUNCIL TO PROMOTE IRON SUPPLEMENTATION IN PREGNANTMOTHERS,AND EXCLUSIVEBREASTFEEDING AMONG MOTHERS HAVING BABIES UNDER 06 MONTHS OF AGE

Target Group and Role in BCC	Primary Message, Knowledge and Skills	Communication Media/Methods	Communication Materials/Tools
National Nutrition Council (NNC) **National Nutrition Secretariat (NNS)**	FGD findings on. (i) Iron supplementation and anaemia (ii) Exclusive breastfeeding Please note: Use research findings from other sources such as DHS, UNICEF, WHO, Universities, etc. to present a situation analysis on the above two themes.	**Group communication** ▪ MoH, FHB, HEB to organize a meeting with NNC and NNS to appraise the situation with regard to anaemia and iron supplementation and EBF. ▪ **Expected output:** NNC to appoint two sub-committees (which include members from the NNS, Technical Advisory Committee on Family Health of the Ministry of Health; and other experts) to suggest ways and means of - (i) Increasing intake of iron tablets by pregnant mothers and (ii) Sustaining high rates of EBF and further increasing rates of real EBF among mothers having babies below 06 months of age.	▪ Multimedia presentation on FGD findings on (i) iron supplementation and anaemia (ii) EBF ▪ Other research reports on anaemia and EBF ▪ Draft terms of reference (TOR) of the two sub-committees on iron supplementation &anaemia and EBF respectively.

Target Group and Role in BCC	Primary Message, Knowledge and Skills	Communication Media/Methods	Communication Materials/Tools
National Nutrition Council (NNC) National Nutrition Secretariat (NNS)		▪ Expected Outcome: Report on iron supplementation andanaemia (i) suggestions for substantially reducing side-effects or difficulties of taking iron tablets or (ii) introducing iron tablets with required dosage and potency but minimal side-effects, into the ANC programme, cost and benefits of such action, and recommendations. Report on (i) Monitoring advertisements related to follow-up formula milk and their effect on EBF and (ii) Based on findings, prepare terms of reference and an advertising brief to plan and implement a social marketing campaign on EBF.	

ADVOCACY

SECTION 10: ADVOCACY FOR MOBILIZATION OF SERVICE CLUBS TO SUPPORT POPULARIZATION OF IRON SUPPLEMENTATION TO PREVENT ANAEMIA IN PREGNANT WOMEN

Target Group and Role in BCC	Primary Message, Knowledge and Skills	Communication Media/Methods	Communication Materials/Tools
President and the Executive Committee of service clubs, e.g. Lions, Rotary, etc. To motivate service clubs to include a local or national campaign to increase intake of iron tablets by pregnant mothers.	1. The impact of iron deficiency and anaemia on pregnant mothers, foetus and the newborn. ▪ health impact for baby and mother ▪ Public health impact ▪ Social/household impact ▪ Economic impact tofamily and the health care system in Sri Lanka. 2. Basic knowledge on iron supplementation, anaemia, and problems associated with intake of iron tablets by pregnant mothers. (Based on sections 1-13, column 2, pgs. 25-34).	▪ **Interpersonal communication** – FHB, HEB, District Health Administration key officials. ▪ Meeting with President and Excoof selected service clubs to propose the idea that iron supplementation and anaemia in pregnant women be included as a component in the annual service programme of either Lions or Rotarians. ▪ Information sharing meeting or seminar for Presidents and Exco members. ▪ Organization of field visits ▪ Negotiation and discussion of follow-up activities	▪ FGD findings on iron supplementation and anaemia. ▪ Multimedia presentation on impactof iron deficiency anaemia on (i) pregnantmothers,foetus, and the newborn baby; (ii) public health system of the country. ▪ Multimedia presentation on anaemia and iron supplementation. (Same multimedia presentation referred to in column 2, pg.25). ▪ Multimedia presentation on suggested ideas for joint future initiatives. ▪ Research reports on relevant topics.

Target Group and Role in BCC	Primary Message, Knowledge and Skills	Communication Media/Methods	Communication Materials/Tools
President and the Executive Committee of service clubs, e.g. Lions, Rotary, etc. (contd.)	3. Analysis of gaps and needs in iron supplementation and anaemia control for pregnant mothers. 4. Suggested ideas for future initiatives by service club either nationally or locally.	▪ Relationship maintenance ▪ Email ▪ Regular meetings	

SECTION 11: ADVOCACY WITHIN HEALTH SECTOR FOR FURTHER ENHANCEMENT OF EXCLUSIVE BREAST FEEDING AND STRENGTHENING IMPLEMENTATION OF THE EXISTING BREAST FEEDING GUIDELINES AND ASSOCIATED CIRCULARS.

Target Group and Role in BCC	Primary Message, Knowledge and Skills	Communication Media/Methods	Communication Materials/Tools
Paediatricians **General Practitioners in Private Sector** **General Practitioners from Government Sector** **The College of Paediatricians** **The College of General Practitioners** To further improve the implementation of existing BF Guidelines and associated circulars. To discuss/suggest solutions for constraints to EBF identified through Focus Group discussion findings.	▪ FGD findings on exclusive breastfeeding ▪ Revisit existing breastfeeding guidelines and circulars ▪ Problem scenarios on constraints identified by lactating mothers on EBF as revealed through Focus Group discussion findings (for discussions and agreement on optimum responses by paediatricians and private and government sector general practitioners). **The constraints to EBF identified through Focus Group discussion findings are :**	Family Health Bureau and Health Education Bureau in collaboration with the College of Paediatricians and the College of General Practitioners to organize a series of advocacy sessions on EBF for (i) Paediatricians, SRs, HOs (ii) General Practitioners using appropriate fora for each of the categories. For orientating the provincial and district hospital staff, the suggested EBF advocacy sessions could be introduced through clinical society meetings.	▪ Multimedia presentation on FGD findings on Breastfeeding. ▪ Presentation of existing BF guidelines and circulars. ▪ Case studies on problems/solutions identified through FGDs and other research.

Target Group and Role in BCC	Primary Message, Knowledge and Skills	Communication Media/Methods	Communication Materials/Tools
Paediatricians General Practitioners in Private Sector General Practitioners from Government Sector The College of Pediatricians The College of General Practitioners (contd.)	- Mother 'feels' that she does not have adequate breast milk. - When mothers complain that baby "cries often" or physical growth is not adequate, doctors prescribe formula milk. - Fathers/mothers believe that formula milk will give "better brain development". - Some doctors prescribe formula milk (substitutes) - Mothers feel that they do not have adequate nutrition (to breastfeed). - Mothers start work in 3 months. - Difficult for working mothers to breastfeed regularly - Some mothers believe that it is appropriate to give a "little bit of water" while exclusively breastfeeding; some also give 'ratha-kalka'.	▪ Discussion on strengthening implementation of EBF Guidelines and circulars. **Outcome:** ▪ Consensus statement on full implementation of EBF Guidelines and circulars (especially with regard to constraints to EBF identified through Focus Group Discussion findings conducted by FHB/HEB/UNFPA with the assistance of 07 district health administrations).	

SECTION 12: POLITICAL ADVOCACY FOR FURTHER STRENGTHENING EXCLUSIVE BREASTFEEDING AND COMPLEMENTARY FEEDING PRACTICES.

Target Group and Role in BCC	Primary Message, Knowledge and Skills	Communication Media/Methods	Communication Materials/Tools
Hon. Members of Sri Lanka Parliament To provide knowledge and information for decision-making on further strengthening exclusive breastfeeding in Sri Lanka by Hon. Members of the Sri Lanka Parliament.	1. EBF and complementary feeding. 2. Breastfeeding code. 3. Existing Ministry of Health Guidelines on breastfeeding and associated circulars. 4. Focus Group Discussion findings on breastfeeding and other research. 5. Inventory of practices subscribed to by politicians and political organizations that unwittingly or unknowingly negatively affect practice of exclusive breastfeeding. **Outcome -** Consensus statement by the Parliament of Sri Lanka on the need to strengthen EBF in Sri Lanka.	▪ Family Health Bureau and the Health Education Bureau to advocate to the Hon. Minister of Health to propose the holding of a Advocacy Seminar on EBF to all members of parliament in consultation withandapproval of the Hon. Speaker of the Sri Lanka Parliament. ▪ Advocacy seminar on EBF and complimentary feeding for members of the Sri Lanka Parliament organized by the Ministry of Health (Family Health Bureau and the Health Education Bureau) under the guidance of the Secretary-General of Parliament on approval by the Hon. Speaker of the Parliament of Sri Lanka.	▪ Multimedia presentation on EBF and complementary feeding. ▪ Multimedia presentations (summary) on breast milk marketing code and a few case studies on current contraventions. ▪ Ministry of Health Guidelines and Circulars on EBF and implementation constraints. ▪ Focus Group Discussion findings on exclusive breastfeeding. ▪ Short presentation on Inventory of practices subscribed to by politicians and political organizations that unwittingly or unknowingly negatively affect practice of exclusive breastfeeding. ▪ Advocacy booklet on EBF for Members of Parliament.

Target Group and Role in BCC	Primary Message, Knowledge and Skills	Communication Media/Methods	Communication Materials/Tools
Members of Nine Provincial Councils To provide knowledge and information for decision-making on further strengthening exclusive breastfeeding in Sri Lanka by Provincial Councillors in 09 provinces.	1. EBF and complementary feeding. 2. Breastfeeding code. 3. Existing Ministry of Health guidelines on breastfeeding and associated circulars. 4. Focus Group discussion findings on breastfeeding and other research. 5. Inventory of practices subscribed to by politicians and political organizations that unwittingly or unknowingly negatively affect practice of exclusive breastfeeding. 6. Consensus statement by all Provincial Councils in Sri Lanka on the need to strengthen EBF	▪ Family Health Bureau and Health Education Bureau to advocate to the respective Ministers of Health in the provinces to propose the holding of Advocacy seminars on EBF in their respective Provincial Councils in consultation with and approvals of the respective chairpersons. ▪ Advocacy seminars on EBF and complimentary feeding for members of Provincial Councils in Sri Lanka by each Province, organized by the Provincial Ministry of Health, Family Health Bureau and Health Education Bureau.	▪ Multimedia presentation on EBF and complementary feeding. ▪ Multimedia presentations (summary) on breast milk marketing code and a few studies on current contraventions. ▪ Ministry of Health Guidelines and Circulars on EBF, and implementation constraints. ▪ Focus Group Discussion findings on exclusive breastfeeding. ▪ Short presentation on types of practices/campaigns which are implemented with the involvement of politicians with good intensions but unknowingly to them would negatively affect EBF. ▪ Advocacy booklet on EBF for Members of Provincial Councils.

	in Sri Lanka.		

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 Rajapaksha 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:

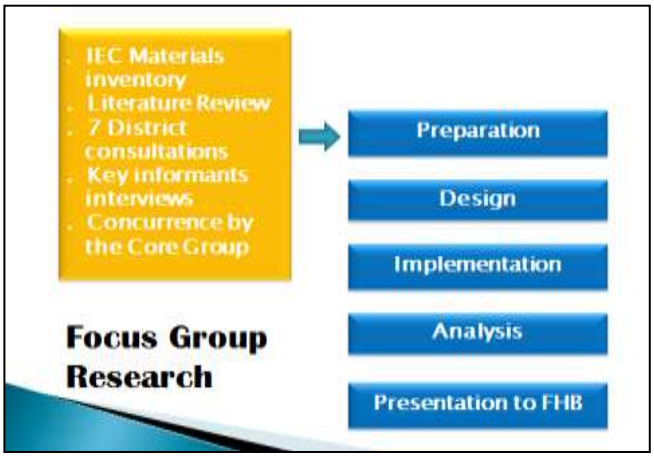
Names of members of National Core Group on BCC for Reproductive Health(contd)

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-Eliyadistrict
- 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: 18-30years of age, including a few married men. (iii) Women 30-40 years of age, with women having 2 or less children, and a few women having more than 2 children. (iv) Married men above 30 years of age. (v) Women 30-55 years of age who are unmarried, widowed, and divorced (to be selected as feasible.)

Adolescent and Young Persons Sexual and Reproductive Health:

(i) Girls 16-19 years of age.
(ii) Boys 16-19 years of age.
(iii) Parents of 16-19 years old girls and boys.

(iv) Young women 20-25 years of age, with a few married women.
(v) Young men 20-25 years of age, with a few married men (if feasible).

Prevention of and Response to Gender Based Violence:

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

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

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

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

FGD Implementation

The third stage was the actual implementation of focus group activity. The Focus Group Team for each discussion comprised a Facilitator, Report Writer and an Observer. The Observer was also requested to assist the report writer by taking notes of discussions to ensure that no important information would be lost. The decision to use a third person to help the report writer was taken as the discussions were not audio- recorded due to feedback received from the districts that such recording may affect the quality of focus

group discussions. A few focus group discussions were conducted by a two member team due to logistical constraints. The duration of each focus group discussion on an average was about 2 hours. Over 95%of focus group discussion reports were written at the location on the same day or within two days after the discussions to preclude loss of information due to possible lapses of memory.

FGD Data Analysis

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

Annexure – 3:

Focus Group Discussion – Name List of Team Members

Dr.(Mrs.) Neelamani Hewageegana - Director (H.E. & P.)
Dr(Mrs.) R.D.F.C. Kanthi - Deputy Director /HEB - Head of the BCC Unit
Dr. Gamini Samarawickrama - National Coordinator of RH Programme in BCC Unit
Mr. Anura Gamini Wijesekera - HEO/HEB - Programme Assistant/ BCC Unit
Mr. Lakshman Wickramasinghe - UNFPA/National Consultant
Mr. Thusitha Malalasekara - UNFPA/Assistant to Consultant
Mr. B.A. Ranaweera – UNFPA Research Analyst
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. Jeyabalan - 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
Mr. Chandrawathini - Manager-Oxfam, Batticaloa
Miss. S. Thusanthiny - PPO/Batticoloa

Focus Group Discussion Liaison/Logistics Team

Dr. Gamini Samarawickrama - National Coordinator of RH Programme in BCC Unit
Mr. Anura Gamini Wijesekera - HEO/HEB - Programme Assistant/ BCC Unit
Dr. A.D.H.S. Weerakkody - MOH/Wattala
Dr. C. Liyanage MOH - Dimbulagala
Dr. Suranga Paranagama - MOH - Sooriyawewa
Dr. K.M. Senevirathne - MOH - Bogawanthalawa -
Dr. Mohamed Hanipa Fari - MOH Eravur
Dr.S. Murali - MO-MCH Kolinochchi
Dr. K.B.C.P.K. Dissanayaka - MOH - Kilinochchi
Dr.P. Nandakumar - MOH - Tellippalai
Mr. 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		
Date: 14-15 Oct.2013	Time:8.00 am – 6.30 pm	Workshop venue: Pegasus Reef Hotel, Hendala, Wattala

AGENDA				
Item	Description	Presenter	Time allotted	
	DAY 1:Monday Oct. 14, 2013			
	Registration of participants		8.00 am	8.45 am
	Inaugural Session 1 National Anthem Lighting of traditional oil lamp		8.45 am	10.15 am
	Welcome address and purpose of L/C workshop	Dr Neelamani Hewageegana, Director, Health Education Bureau		
	Opening remarks	Dr Deepthi Perera, Director MCH, Family Health Bureau		
	Opening remarks	Mr Alain Sibenaler UNFPA Representative Sri Lanka		
	Address from the Chair	Dr P.G.Mahipala Director General of Health Services, Ministry of Health		
	Introduction of participants (self-introduction)			
	Principles and key components of behavior change communication strategy	Mr Najib Assifi Chairman of the Board of Directors, Asia-Pacific Development and Communication Centre, Thailand		
	TEA		10.15 am	10.35 am
	Inaugural Session 11 Presentation of FGD research findings FGD findings report on Maternal and Newborn Health programme FGD findings report on Adolescent Sexual and Reproductive Health Programme	Chairperson : Dr R R M L R Siyabalagoda, DDG, PHS 11, Ministry of Health Mr Lakshman Wickramasinghe National Consultant, UNFPA	10.35 am	11.30 am

AGENDA				
Item	Description	Presenter	Time allotted	
	Group Work 1: Identification of target audiences; priority desired behaviours relevant to target audiences; and, facilitating and constraining factors		12.15 pm	1.30 pm
	LUNCH		1.30 pm	2.30 pm
	Group Work 1 (contd.)		2.30 pm	4.15 pm
	TEA		4.15 pm	4.30 pm
	Group Work 1 (contd.)		4.30 pm	5.15 pm
	Plenary: Group presentations and discussions	Mr Najib Assifi	5.15 pm	6.30 pm
	DAY 2: Tuesday Oct. 15, 2013			
	Plenary: Review of day 1 activities and Introduction to Group Work 2	Dr R D F Kanthi Mr Najib Assifi Mr Lakshman Wickramasinghe	8.30 am	8.45 am
	Group Work 2: Identification of appropriate primary knowledge (messages) and types of skills for the respective target groups		9.45 am	10.45 am
	TEA		10.45 am	11.00 am
	Group Work 2 (contd.)		11.00 am	12.15pm
	Plenary: Quick feedback on Group Work 2 and introduction to Group Work 3	Mr Najib Assifi	12.15 pm	12.30pm
	Group Work 3 Identification of communication channels/methods/materials/technologies for each of the selected behaviors/audiences		12.30 pm	1.30 pm
	LUNCH		1.30 pm	2.30 pm
	Group Work 3 (contd.)		2.30 pm	3.30 pm
	Plenary: Presentation of Group Work 2 & 3 and discussion	Mr Najib Assifi Mr Lakshman Wickramasinghe	3.30 pm	4.45 pm
	TEA		4.45 pm	5.00 pm
	Closing	Dr Neelamani Hewageegana Dr Deepthi Perera Dr Chandani Galwaduge	5.00 pm	5.30 pm

Annexure – 5 : Name List of Participants of Stakeholder Workshop

Dr. Neelamani Rajapaksha 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. Nadeeja Herath	Reg/HEB
Dr. Chinthaka Abeynayaka	MO/HEB
Dr. Buddhika Sudasinghe	MO/HEB
Dr. Uthpala Amarasinghe	ACCP/HEB
Dr. Nethmini Thenuwara	SR/HEB
Dr. Harsha Gamage	MO/HEB
Dr. Nihal Jayathilaka	Secretary/Ministry of Health
Dr. K.A.S. Keeragala	Addl. Secretary (M.S.)/(P.H.)/Ministry of Health
Dr. P.G.Mahipala	Director General of Health Services Ministry of Health
Dr. Sarath Amunugama	DDG(PHS) I /Ministry of Health
Dr. R.R.M.L.R. Siyambalagoda	DDG(PHS) II/Ministry of Health
Dr. Amal Harsha De Silva	PDHS/Addl.Sec.(MS) /Ministry of Health
Ms. Lene Christiansen	UNFPA Country Representative
Mr. Najib Assifi	International Consultant
Mr. Alan Sivenaler	Representative of Sri Lanka/UNFPA
Mr. Gamini Wansekera	Asst. Representative of Sri Lanka /UNFPA
Dr. Chandani Galwaduge	National Programme Officer/UNFPA
Mr. Jayan Abeywickrama	National Programme Officer/UNFPA
Mr. L. Wickramasinghe	UNFPA/National Consultant
Mr. Thusitha Malalasekara	Assistant to National Consultant/UNFPA
Dr. Deepthi Perera	Director(MCH)/Family Health Bureau
Dr. Chithtramalee de Silva	Deputy Director/ Family Health Bureau
Dr. Dhammika Rowel	CCP/FHB
Dr. Manjula Danansooriya	CCP/ FHB
Dr. Sapumal Dhanapala	CCP/ FHB
Dr. Samantha Jayasinghe	MO/ FHB
Dr. Ayesha Lokubalasooriya	CCP/ FHB
Dr. Harsha Atapattu	VOG/Kalutara
Dr. M.A.C. Perera	VOG/FHB
Dr. M. Achchuthan	MO/MCH - Batticoloa
Dr. N.B. Gamini	MO/MCH - Ratnapura
Dr. Ganga Rathnayaka	MO/MCH - Matale
Dr. Nayana Dhanapala	MO/MCH - Kandy
Dr. Wasantha Priyadharshani	MO/MCH - Kurunegala
Dr. Suranga Obeysekera	MO/MCH - Matara
Dr.(Mrs.) Thirumagal	MO/MCH - Jaffna

Dr. Sandaya Herath	MOH-Chillaw
Dr. Aruna Rajapaksa	MOH -Gangawata Korale
Dr. S.J. Senanayake	MOH - Maharagama
Dr. Niranda Fernando	MO/Y.F.H.S. - Kalubovila
Dr. Nishantha Wickramasinghe	MO FP Unit - Gampaha
Dr. Lalith Madurapperuma	MO/Y.F.H.S. - Gampaha
Dr. Thilak Udayasiri	MO/MCH - Gampaha
Dr. Chaminda De Silva	AMOH/MO/HI
Dr. Malathie Thanthirimalage	Kurunegala MO/Health Promotion
Dr. Umanga Sooriyarachchi	CCP/ET & R/Ministry of Health
Mr. K.GP. Bandara	DD/CHEO/HEB
Mr. N. Mudannayaka	ACHEO/HEB
Mr. P.B. Herath	HEO/Kurunegala
Mr. S. Benaravan	HEO/Jaffna
Dr. Anoma Jayathilaka	Consultant/WHO
Dr. Sumithra Tissera	Medical Director/FPA
Mr. B.A. Ranaweera	Former DD/HEB
Mr. M. Nizar	Former Comm. Officer/UNFPA
Dr. A.L.A.L. Padmasiri	RDHS-Gampaha
Mr. S. Mohamed Zhaafihu	Minister/Youth Parliament - Ampara
Ms. Rasa Jemsi	Senator/Youth Parliament - Nuwaraeliya
Ms. Kaveesha Madushani	Minister/Yough Parliament - Kalutara
Mrs. H.M.A. Kumarihamy	Nursing Officer/CSHW
Mrs. B.m. Mangalika Kumarihamy	Nursing Officer/CSHW
Dr. S.P. Mandalawatta	MOH/Kolonnawa
Mrs. Badra Gunathilaka	Principal/Udupila Primary School
Miss. Sudharshani	National Institute of Education
Mrs. P.R. Weththasinghe	National Institute of Education

Annexure – 6 :

Name List of Stakeholder Panel who reviewed penultimate draft of

BCC strategy Guide for MNH

1. Dr. Neelamani Rajapaksha Hewageegana - Director - HEB
2. Dr. Deepthi Perera - Director - 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. Mr. Jayan Abeywickrama - Programme Officer - UNFPA
9. Dr. Dhammica Rowell – Consultant Community Physician /Programme Manager Maternal & Neonatal Health/ FHB
10. Dr. Nilmini Hemachandra - Consultant Community Physician /Programme Manager Maternal & Neo-natal Health/ FHB
11. Dr. Hiranya Jayawickrama - Consultant Community Physician /Programme Manager Maternal & Neo-natal Health/ FHB
12. Dr. Sathya Herath - Consultant Community Physician /HEB
13. Dr. Gamini Samarawickrama - National Coordinator for Reproductive Health/HEB
14. Mr. Lakshman Wickramasinghe - National Consultant /UNFPA
15. Mr. Thusitha Malalasekara - Assistant Consultant/UNFPA
16. Mr. B. A Ranaweera –Research Analyst/UNFPA
17. Mr. K.G.P. Bandara - Deputy Director /CHEO/HEB
18. Mr. M.A.D.N. Mudannayake - ACHEO/HEB
19. Mr. Anura Gamini Wijesekera - HEO /Programme Assistant-BCC Unit

Annexure 7:

Name List of Staff who provided administrative, logistics and secretarial, to BCC Strategy development for RH activities

Mr. Aruna Athukorala	DA/HEB
Ms. Sudarshani Priyangika Kumari	DO/HEB
Mr. Dhammika Samarawickrama	AV Officer/HEB
Mrs. Nilmini Pushpakanthi	PMA/HEB
Mr. Vipula Kumara	SKS/HEB
Mr. S. Logeswaran	SKS/HEB
Mr. Prasanga Napawala	SKS/HEB
Mr. Manilka Kahatapitiya	SKS/HEB

Annexure – 8:

Name List of Participants who attended the District FGD Planning Meetings
Wattala- MOH Office - Date: 29.06.2012

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

Annexure – 8: (Contd.)

Wattala- MOH Office -Date: 29.06.2012

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

Annexure – 8: (Contd).

Dimbulagala- MOH office -Date: 25.07.2012

District Level

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

Annexure – 8:(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.Rajaphaksha	PHM
Mrs.M.L.M.Madarasinghe	PHM
Mrs.J.R.A.S.Nanayakkara	PHM

Annexure – 8: (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 – 8: (Contd).

Eravur - MOH Office-Date : 23.10.2012

Dr.M.H.N.Thuriq	MOH-Eravur
Dr .E. Srinath	MO/(MCH)
Mr Buhardeen	HEO-Baticaloa
Mr.T.Thajeeharan	HEO-Baticaloa
Mrs.R.Raveenthiran	PHNS
Mrs.Shanmuganalhan	SPHM
Mr.H.M.Feleel	SPHI
Mr.R.Inparajah	PHI
Mr.A.L.Nawfar	PHI
Mr.U.L.M.Jinnah	PHI
Mr.S.Maheshwaran	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 – 8: (Contd).

Kilinochchi - MOH Office- Date: 05.11.2012

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

Annexure – 8: (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

Annexure 9:

How to use the BCC Strategy Guide Document

The BCC strategy guide document is essentially a behavior 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 Stakeholders 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 behavior to a desired behavior. Thus this BCC Strategy Guide on the Maternal and Newborn Health Programme is an evidence based document and can be used to increase attendance at ANC 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 MNH/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 behavior. 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 behavior change communication activities are vital to profit from this Guide.

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 Rajapaksha Hewageegana, the new Director accepted the ownership of the Initiative willingly, displaying her professionalism and is providing enthusiastic and very effective leadership to the Initiative. Dr. R D F C Kanthi, the Deputy Director of HEB and a Master Trainer in BCC provided administrative guidance in the interim period (of change of Directors) and helped to resolve implementation and logistical problems. She was a moderator at the stakeholder workshops and continues to support in technical aspects of BCC. Dr. Gamini Samarawickrama,as the National Coordinator Reproductive Health in BCC Unit handled coordination of many activities including field research, logistic and the arrangements of the stakeholder workshop admirably with the support by Mr. Anura Gamini Wijesekera the HEO attached to the BCC Unit, Mr. Aruna Athukorala, Development Assistant, and a few support staff. 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 and provided useful input on RH. Mrs. Nilmini Pushpakanthi with a few other staff helped in preparation of a variety of documents.

Under the leadership of Dr. Deepthi Perera, the Director FHB, Dr. Chitramalee de Silva, the Deputy Director, Dr. Nethanjali Mapitigama, Dr. Nilmini Hemachandra, Dr. Dhammica Rowell, Dr. Ayesha Lokubalasuriya, Dr. Sanjeewa Godakandage, Dr. Manjula Dhanansuriya, the Programme Managers and relevant Medical Officers responded enthusiastically and professionally to the demands of the BCC Strategy Development Initiative. While knowing that the focus group discussions would subject the reproductive health programmes to scrutiny, the FHB management demonstrated professionalism in supporting the formative research and discussing its findings. FHB assisted 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 very valuable suggestions on penultimate drafts of the BCC Strategy Guide Booklets 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, though it was not strictly and traditionally in their main line of work.

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 services, 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 from Colombo, especially that of Dr. Gamini Samarawickrama, National Coordinator, Reproductive Health was vital as their genial and committed approach helped in resolving field-level problems in partnership with the MOHs and the field teams.

Deep appreciation and commendations are also due to:

- The Focus Group Team (name list in Annexures) who worked in difficult areas under difficult logistical conditions, and was professionally disciplined to complete the vast majority of FGD reports at the location itself. Mr. K G P Bandara, Deputy Director/Chief Health Education Officer, and
  Mr. N Mudannayaka, Senior Health Education Officer for assistance in training, team selection and FGD report analysis.
- The community members who were members of the Focus Groups, whose ideas, attitudes, and perceptions provided the real impetus for analysis of FGD reports and the development of the BCC Strategy.
- The Research Analysts (Messrs B A Ranaweera, Sirimal Peiris, Dr.T. Shirmila, Dr. Saseela Subash) helped in analyzing FGD Group Reports; it was a challenging task from an academic and professional point of view, as they were called upon to synthesize data from a varied number of focus groups across districts.
- The stakeholders and experts of the BCC Strategy Development Workshop (name lists in Annexures) for dedicated, active, and full-time work during three days of mentally absorbing, and at times mentally exhausting work.
- The representatives of the College of Obstetricians and Gynecologists especially Dr. Lakshman Senanayake and Dr. Harsha Atapattu who provided invaluable suggestions to enhance the quality of the final version of the BCC strategy Guides. The representative of the Family Planning Association of Sri Lanka, Dr. Sumithra Tissera also provided insightful comments on the penultimate drafts. The representatives of the NGO, Women-in-Need, also contributed in this regard.
- Dr. Najib Assifi, the International Consultant from Asia- pacific Development and Communication Centre (ADCC) who co-coordinated the BCC Strategy Development/Stakeholder Workshop and provided comments on the penultimate versions of the BCC Strategy Guide; The effort made in placing the BCC Strategy Development Initiative in an important position in the national health advocacy agenda is commendable.
- Mr. Lakshman Wickramasinghe, the national consultant and Mr. Thusitha Malalasekera, the assistant to the consultant who steered the BCC Strategy Development process from conceptualization to implementation, alongside UNFPA, HEB and FHB and prepared the final BCC Strategy Guide based on inputs and valuable comments received during all stages of the process.

- The outgoing UNFPA Representative, Ms. Lene Christiansen who had faith in the BCC Strategy Development Initiative and provided policy and financial support through the UNFPA system.

  Mr. Alain Sibenaler the incoming UNFPA Representative who participated in the second BCC stakeholder strategy development workshop within days of his taking over the new assignment and who since then has been taking a keen interest in the initiative.
- Dr. Chandani Galwaduge, the UNFPA National Programme Officer was the energizer and the live-wire behind the BCC Strategy Initiative. Using her characteristic frank and forthright communication and the strong professional contacts across all stakeholders, she resolved many problems, that arose along the challenging but immensely satisfying road traversed.
- To many others in HEB, FHB, UNFPA, and the districts who helped the initiative in many ways often behind the scene. We are grateful to their invisible but important contributions.

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