Final Draft

NATIONAL STRATEGIC COMMUNICATION PLAN FOR NUTRITION: 2007-2011

GOVERNMENT OF SRI LANKA, UNICEF AND IMPLEMENTING PARTNERS

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ACHRONYMS

ADB: Asian Development Bank
ARH: Adolescent Reproductive Health
CBO: Community Based Organization
CFS: Child friendly school; child friendly space
CRC: Convention on the Rights of Children
DPDHS: Deputy Provincial Director of Health Services
ECCD: Early Childhood Care & Development
EPI: Expanded Programmes on Immunization
IDP: Internally Displaced People
IPC: Inter Personal Communication
IR: Immediate Result
FAO: Food and Agriculture Organization
FBO: Faith Based Organization
FHB: Family Health Bureau
FW: Field Worker
GA: Government Agent
HEB: Health Education Bureau
JICA: Japanese International Corporation Agency
LTTE: Liberation of Tamil Tigers Elam
MDG: Millennium Development Goals
MOE: Ministry of Education
MOF&P: Ministry of Finance and Planning
MOH: Ministry of Health
MOI: Ministry of Information
MOL: Ministry of Labour
MOPA: Ministry of Public Administration
MOPI: Ministry of Plan Implementation
MOTC: Ministry of Tele Communication
MOSW: Ministry of social Welfare
MRE: Mine Risk Education
MWSAD: Ministry of Water Supply and Drainage
NGO: Non Government Organization
PD: Provincial Director
PDHS: Provincial Director of Health Services
PHI: Public Health Inspector
PHM: Public Health Midwife
PTA: Parents’, Teachers’ Association
SDC: School Development Committee
UNICEF: United Nations Children’s Fund
TOT: Training of Trainers
WASH: Water, Sanitation And Hygiene
WHO: World Health Organization
USAID: United States Agency for International Development
ZDE: Zonal Director of Education

EXECUTIVE SUMMARY

In October 2006, the outlines of a communication strategy, to prevent malnutrition, was developed at a participatory group event attended by representatives of Ministry of Health, UNICEF, other UN agencies, and partners from the NGO sector. The key principle of this strategy is to address the nutrition related problems of the most marginalized and vulnerable segments of the population. The draft of the strategy has been reviewed, and modified accordingly. Strategic Communication or Behaviour Change Communication (BCC) has been identified as an integral part of all efforts to enhance the nutritional status of the people of Sri Lanka.

It is expected that this strategy document/ strategic communication plan will be used as a guideline or a reference point to develop specific interventions and initiatives at the field level.

This communication plan includes a thorough situation analysis based on available data and tries to portray to the best of abilities, the existing situation of malnutrition among the communities in Sri Lanka, followed by a strategic communication approach that synergistically links advocacy efforts, mass media with local media, school based, out of school initiatives, interpersonal and participatory methodologies, entertainment-education and interactive behaviour change/ behaviour development tools, to create an effective and dynamic movement for behaviour and social change related to prevention and reduction of malnutrition. Its objective is to raise awareness, increase knowledge, improve attitudes and skills, leading to individual behaviour change as well as creating the foundation for social change through the development of an enabling environment to empower the target population.

Under the leadership of MOH, and the technical guidance of UNICEF, the partners will take responsibilities for implementing innovative and participatory “bottom” up or community based initiatives that directly addresses the problems related to prevention and reduction of malnutrition. The key target groups are children, adolescents and youth, pregnant and lactating mothers as well as the general population including the advocates and influentials who can spear head the processes of change. The strategies out lined in this document aim to empower the population to take sustained actions- not to make them passive recipients of messages. It also emphasizes on the roles of the communities as key agents of change and strongly advocates for inter-ministerial, inter-agency collaboration and involvement of the private sector, and enhanced roles of media journalists as well as that of local influentials in supporting the change processes.

Part A includes the background;
Part B details out the key communication strategies, audiences, communication contents, proposed interventions and monitoring indicators by national objectives;
Part C includes the preliminary situation analysis, causal analysis;
Part D includes the strategic communication planning and approach, expounding on the theories and applications of strategic communication models for behaviour change.

PART A: INTRODUCTION

1. BACKGROUND

The broad aim of the health policy in Sri Lanka is to increase life expectancy and improve the quality of life of the people. With its strong commitment to the well being of mothers and children, during the past few decades, the country has made considerable progress in lowering levels of infant and maternal mortality, increasing life expectancy and reducing fertility. (NPA for the children of Sri Lanka, 2004-2008).

The Sri Lankan Health Master Plan addresses the policy and strategic framework for an innovative health system over the next decade, targeting the year 2015. The overarching aim of improving health status and reducing inequalities will be achieved by the five strategies, namely:

1. Ensuring delivery of comprehensive health services, which reduce the disease burden and promote health;
2. Empowering communities towards more active participation in managing their health;
3. Improving human resources for health development and management;
4. Improving health financing, mobilization, allocation and utilization of resources;
5. Strengthening the stewardship and management functions of the health system.

(Health Master Plan Sri Lanka-Healthy & Shining Island in The 21st Century. November, 2003).

While significant progress has been made in child survival, …the incidences of low birth weight is also relatively high varying from 11.6 percent to 29.4 percent across districts. Inadequate weight gain in pregnancy, anaemia and maternal under-nutrition are probable causes…Anaemia and malnutrition are common among pregnant women, but anaemia due to iron deficiency has declined from 60-65 percent in the early nineties to 30 percent at present. Although low child mortality and morbidity levels and high coverage of MCH services have been reached in the country, significant differences exist between districts and the underserved populations or disadvantaged groups. Morbidity and mortality is also high among children living on estates, in urban slums, in migrant families, in single parent families and on the streets. (NPA for the children of Sri Lanka, 2004-2008).

The National Plan of Action for the children of Sri Lanka, 2004-2008 is guided by some core principles to improve the nutritional status of the target population:

Unborn and new born children:

i).Reduce high maternal morbidity and mortality and improve nutritional status of mothers.

ii) Reduce teenage and unwanted pregnancies by 25 percent.

iii) Prevent mother/parent to child transmission of HIV and STDs.

Infant and pre-school children:

ii).Reduce morbidity and mortality among newborns, infants and preschoolers.

iii) Improve nutritional status of infants and pre-school children, prevent micronutrient deficiencies and promote growth and development of all children.

iii) Reduce morbidity and mortality due to diarrhoea, acute respiratory infections (mortality by 25 percent), worm infestations and mosquito borne infections.

iv). Attain 100 percent age appropriate immunization status in respect of vaccines used in the EPI.
v) Provide better quality care at clinics and during home visits.
School children:
i).Improve the health and nutritional status of school children.
ii) Provide a healthy and safe environment in school, encourage healthy behaviours, ensure access to dental services in schools and improve children's mental health.
iii) Provide support services for adolescent health problems.
iv). Improve collaboration and sharing of responsibilities for school health activities by the MOE.

This communication plan proposes in a comprehensive way, how the communication strategies will contribute to a meaningful awareness raising and sustained behavioural development among children and adolescents and behavioural changes among the communities in 2007- 2011. The plan synergistically builds linkages with advocacy efforts, mass media with local media, interpersonal communication and participatory/interactive behaviour change tools and approaches, school based and out of school initiatives, peer education, Child-to-Child and human resources development to create a powerful and innovative movement to address the nutritional problems in Sri Lanka. Its objectives are to increase knowledge, skills and promote positive attitudes leading to individual behaviour change as well as influence traditional norms and facilitate the creation of an enabling environment that ensures equitable benefits to all sectors of the community. This plan prioritizes immediate actions which need to be designed and implemented in the years that follow.

2. SRI LANKA'S COMMITMENT TO CHILDREN

CRC (Convention on the Rights of the Child) recognizes that every child has inherent right to life (Article 6); to the enjoyment of the highest attainable standard of health and to facilities for the treatment and rehabilitation of health, to combat diseases and malnutrition… provision of adequate nutritious foods and clean water and access to pollution free environment…(Article 24); a standard of living adequate for the child's physical, mental, spiritual and social development (Article 27); …The operational strategies as indicated in the Master Plan of Operations are based on the human rights and humanitarian principles as indicated in the CRC and CEDAW (Convention on the Elimination of all forms of Discrimination against Women) documents and draw upon UNICEF's experience in emergency to respond to needs of children and women in unsteady situations.

Sri Lanka signed the Global Plan of Action for Children in April 1991. The Convention on the Rights of the Child, adopted in July 1991 contained a comprehensive set of legal standards for the protection and well being of children and also helped accord political priority to children. Based on the Convention, a Children's Charter was developed for Sri Lanka in 1992, which provided the framework for modifications introduced into Sri Lankan law subsequently. Sri Lanka, together with other countries, reaffirmed commitment to complete the unfinished agenda of the World Summit for Children and to

address other emerging issues, within the framework of the Millennium Declaration, through national actions and international cooperation (UNICEF 2004).

Children (under 18 years) constitute about 36 percent of the total population, and 8.8 percent comprise the under five years old population. Infants comprise 1.6 percent and those under four years 7.2 percent, making a total of 8.8 percent for the under five age group. The school going population is about 21 percent of the total population (NPA for the children of Sri Lanka, 2004-2008). Adolescents account for 3.7 million Sri Lankans, or 19.7% of the population (DCS, 2002). Of those, approximately 2.7 million (72.9%) are reported to attend school (MOHECA, 2002). Approximately, 91.4% and 56.2% of Sri Lankan adolescents complete primary and secondary education, respectively (National Survey on Emergency Issues Among Adolescents in Sri Lanka, UNICEF. 2004)
The government has repeatedly reconfirmed its commitment to the overall well being, development and protection of children and adolescents by supporting policies and interventions to:

- Improve nutritional status of children and pregnant mothers.
- Ensure education for all; support quality ensured education as well as reconstruction of education in the conflict affected areas.
- Maximize efforts on immunization; improve health conditions of children by reducing incidences of infectious diseases, parasitic diseases, intestinal infections, diseases of the respiratory and circulatory systems; and prevention of incidences of injuries at home.
- Eradicate child labour and all kinds of exploitation and sexual abuse of children including prevention of under age recruitment of children by LTTE; ensure that juvenile justice system conforms to the requirement of the CRC; rehabilitate children living in extremely difficult circumstances; integrate disabled children into normal schools/life.
- Ensure provision of safe drinking water, sanitation and hygiene education for all.

3. OVERALL PROGRAMME DIRECTION

This communication strategic communication plan on nutrition (2007-2011) is geared to support the gradual improvement of the nutritional status of children and women across districts and in the Estates by establishing a consistent, focused and research-based strategic set of approaches which will lead to an agreed long-term vision for improved health and dignity for the entire population.

In line with The National Plan of Action (2004-2008) and Master Plan of Operations (2002-2006), this document is designed to contribute to the following Key Intermediate Results (IR) for **improved nutritional status of all Sri Lankans** with special focus on 0-5 years old, children and adolescents, children with disabilities and children with special needs, pregnant women and lactating mothers:

- **IR1: Awareness increased and desired behaviours practiced among marginalized and disadvantaged parents, pregnant and lactating women, children/adolescents and communities to improve their nutritional status.**
- **IR2: An enabling environment created through the implementation of**

gender sensitive and improved policy and regulations, stronger decentralized accountable systems in place and appropriate collaboration with key policy makers, partnerships with community and religious leaders, FBOs, CBOs, and active participation of adolescents and children in the design and implementation of nutrition focused initiatives.

- **IR3: Improved quality of services and greater access of disadvantaged groups to correct information, care and support ensured and mechanisms in place to enable target groups' full engagements in designing and implementing interactive behaviour change/behaviour development tools and initiatives.**
- **IR4: Responsible psycho-social environment at school levels as well as out of school initiatives created to promote health status and emotional and intellectual development and growth of children and adolescents of all categories.**

The communication plan will focus its efforts on a number of key programme strategies that will include:

- **Advocating for improved implementation of existing policies and approaches to address the underserved and the marginalized communities, especially focusing on pregnant women, 0-5 year olds, children and adolescents, lactating mothers and children living with disabilities and children with special needs:** the key principles proposed to be adopted for this are:
  i). Forge a sustained, decentralized and stronger convergence with other development sectors by reviewing existing policies and communication approaches and on the basis of lessons learnt. For example, for school based nutrition programmes Child Friendly Schools (CFS) supported by the MOE need to be taken into account as well as the "guidance teacher" approach as adopted by MOE for supporting psychosocial wellbeing of children and adolescents;
  ii) Advocacy in favour of launching research based community communication programmes or approaches to reach the pregnant and lactating mothers in addition to the other members of the communities including the fathers, teachers, service providers and opinion leaders as well as out of school children, in school children and out of school youth. To be effective the efforts must address the regional variations and the philosophy of community participation in designing and implementation of all interventions;
  iii) Advocacy in favour of effective implementation of policy towards inclusive communication efforts/programmes for children living with disabilities by building partnerships with agencies who have specialized experience in this area (for example: Handicap International, Motivation, White Pigeon, etc.);
  iv) Advocacy for meaningful and sustained implementation of policy for involvement of private sectors: to support community based communication efforts. For example feeding programmes for "in school" and out of school children, providing soap for hand washing in schools, sponsoring deworming efforts (MOE's current exploration findings is indicating that children have changed schools in many areas only to access provision of meals as provided in some schools);

v) Policy to establish behavioural indicators and participatory monitoring mechanisms to measure the effects of communication efforts.

- **Focus on nutrition promotion as an essential component in the overall development of children, and a health benefit for their families:** participation of children, adolescents, parents and communities are essential:
  i). Reach "in school" children through various venues such as out of class time, children's clubs (operational in Galle, Ampara, Batticaola, etc.); build/strengthen the capacity of peer educators from the existing/functioning children's clubs (e.g. boy scouts and girl guides can be peer educators) and adult facilitators on life skills education to empower young people with acquisition of life skills so that they are able to participate in issues related to nutrition and other associated factors that affect their well being and growth as well as motivate them to share learnt information with others. These life skills are: communication skills (e.g. seeking correct information on nutrition, discussing relevant issues to promote health), critical thinking (e.g. how to promote nutrition related activities in school), creative thinking (what alternatives can be operationalized to motivate all school mates to follow correct practices that influence nutritional status- for example use of sanitary latrines, hand washing after defecation, before eating to prevent incidences of diarrhoeal diseases and parasitic infestations), decision making (choice to follow positive behaviour), etc. as well as technical skills (how to wash hands correctly, how to store water in a safe manner, etc.).
  ii) Promote Child-to-Child approaches among younger children (7-9/10 years old) through the clubs or other school based mechanisms, for example library class? Sports class?; child friendly spaces (currently being implemented in partnership with NGOs in Trinchomele, Batticaola, Amapara) can also be considered as a possible venue to engage children and adolescents affected by conflict;
  iii) Include children living with disabilities in all "in school" and "out of school" communication efforts on nutrition and life skills building (partnership at local level with NGOs and agencies working in this field);
  iv) Reach pregnant and lactating mothers through mothers' associations (exists in Trinchomele dist/Mutur, Galle) other existing women's groups/gatherings in the communities, lactation centres, parents' groups;
  v) Reach parents through PTAs (parents and teachers associations), school development committees/societies(SDCs);
  vi) Reach the general communities and opinion leaders through religious associations (mosque committees, church committees, etc??) to be promoters of positive nutrition related behaviours.

- Strengthen/build capacity of health providers and teachers on interpersonal communication skills and participatory approaches:
  i) Build capacity of school systems to effectively communicate promotion of information on nutrition (for example healthy eating habits and practices among students, benefits of consumption of leafy and green vegetables; correct hygiene practices and connection with diseases- diarrhea and worm infestations; use of iodized salt – teachers should have correct information regarding the role iodine

plays in a child's development, the reason to choose powdered form of salt, etc.; nutritional needs of adolescent girls as they menstruate at puberty; importance of exercising and playing, etc.). They should be able to engage students through participatory discussions and encourage children to support activities on nutrition initiated by themselves within the school and at community levels. Health professionals/ domiciliary workers (PHMs, PHIs, etc) and teachers require increased knowledge and communication skills to be effective and respond to community's/students' needs. Orientation and training for service providers require to be designed and implemented by the help of professional participatory trainers in local languages.

- **Creating community capacities and responsibilities:**
  i). Orientation of community/local and religious leaders on issues related to nutrition and healthy living- this can be done by district level Govt. authorities (MOE, MOH) with the assistance of (local) NGOs like Sarvodaya, Save the Children, CCF, etc.);
  ii) By initiating discussions on community participation and capacity building for effective and sustained communication approaches lead by communities with active support from local leaders for reduction of incidences of diarrhoeal and other gastro-intestinal diseases, malnutrition among children, etc. PHI/PHMs with assistance of teachers and SDCs can launch this effort. Scouts and girl guide leaders can be mobilized to either support or lead this community activity.

- **Development of sustained regional community communication campaigns:**
  i) Community based activities to be launched to create a "noise" and initiate discussions at the community level drawing attention on the need to unite for positive behaviours that contribute to reduction of diseases, the economic and health benefits of positive practices. The campaigns should focus on involvement of children/adolescents and communities as key actors to high light the best practices in Sri Lanka.

- **Audience segmented approach and implementation and expansion of proven programme strategies (evidence based) and interactive materials:**
  i). This can be done through the replication/adaptation of selected, proven communication materials, approaches that have worked in other countries as well as in Sri Lanka to empower young people as children's and adolescents' needs are different from that of adults. Priority must be given to entertainment-education (EE) approaches that have proven to be effective in harnessing children's participation and engagement in many development programmes;
  ii) Development of new life skills based information and EE materials needs to be considered. The culture of "giving information or messages" or "telling' should be totally avoided as this has not worked well so far. The materials should be designed and developed through scientific formative research. Posters have not provided "evidence based" results of efficacy. Proper assessment needs to be done before producing more posters. Mass media, IPC and other interactive local methods work well with adults.

Strategic Communication

This plan illustrates the need for and elements of ***strategic communication***, a cross-cutting programme area using a three-step strategic communication approach including ***Advocacy*, *Social Mobilization*** and ***Behavior Change Communication***. In this framework, ***strategic communication*** is comprised of advocacy for political commitment and policy change, behavior change communication (BCC), as well as details of social mobilization – cross-cutting strategies supporting alliance building and collaboration, and participation with key partners. **This approach is elaborated in full in Part C** of this document.

PART B: COMMUNICAITON STRATEGIES BY NATIONAL OBJECTIVES- 2007-2011

1. OVERALL OBJECTIVES

The overall objectives for 2007-2011 are to improve the nutritional status of the most vulnerable population in Sri Lanka:

1) To advocate for mobilization of bureaucratic and political commitment for improved and supportive/ inclusive policies and resources and their effective implementation for infant and young child feeding and care, children with special needs and children living with disabilities including increased food subsidy to targeted schools catering the disadvantaged population and deployment of adequate and trained human resources at all levels.

2) To advocate with top level decision makers to give priority to the finalization of the National Plan of Action for Nutrition by 2007.

3) To advocate for stronger inter-ministerial collaboration and effective convergence with other development programme sectors and forging meaningful partnership with the private sector.

3) To influence policy makers for greater commitment towards prioritizing the implementation of strategic communication/behaviour change interventions at community levels with special focus on 0-5 years old, children and adolescents, children living with disabilities and children in special needs, pre-pregnant women, pregnant women and lactating mothers.

4) To influence policy and decision makers to strengthen the school curriculum to address nutritional issues relevant for children and adolescents.

5) To raise awareness, knowledge, understanding and skills and promote positive behaviours among children, adolescents, pregnant and lactating women, their husbands and the community (general population – youth, adults) at large on issues concerning prevention of malnutrition.

6) To increase the quality of interpersonal communication on prevention of malnutrition between service providers and the target population through proper training of service providers and by implementing participatory interventions at household/community levels.

2. PROGRAMME STRATEGIES

The key elements of the nutrition communication plan are as follows:

a. Advocacy and network building **i)** Improved and supportive/ inclusive policies and their effective implementation to prevent malnutrition **ii)** Forging meaningful inter-ministerial collaboration and partnership with private sectors **iii)** Development/finalization of the National Plan of Action for Nutrition by 2007
b. Behaviour change communication **i)** Reaching "in school" and "out of school" children and adolescents and children living with disabilities and children with special needs through various venues (youth groups, school clubs, CFS, sports groups, scouts, guides, etc.) **ii)** Strengthening school curriculum to address nutrition issues and its implementation **iii)** Reaching pregnant and lactating mothers and care givers through community based associations, clinics and through IPC at household levels (special focus on 0-5 years old children); reaching youth and general population **iv)** Capacity strengthening of service providers (teachers, peer leaders and health staff) **v)** Nutrition communication strategy linked to accessible and client friendly services
c. Social mobilization i) Participation of civil society, community based key stake holders for reduction of malnutrition among the target groups ii) Mobilizing new partners??
d. Monitoring and evaluation

3. SUMMARIES OF KEY STRATEGIES AND ACTIVITIES -AUDIENCES, COMMUNICAITON CONTENTS AND PROPOSED INTERVENTIONS

Five key principles derived from the preliminary situation analysis (see Part C of this document) are central to this communication plan:

1. Political commitment to reduce malnutrition
2. Involvement or meaningful participation of children and adolescents (disabilities, special needs), pregnant women and lactating mothers and the community at large (adults, youth including pre-pregnant women) in designing and implementing interventions.
3. Audience segmented approach and use of evidence based effective efforts such as entertainment-education (EE) initiatives for life skills building (to combat malnutrition) especially among children and adolescents
4. Convergence with other programme sectors (Education, WASH, Social Protection)
5. Partnership with the private sector

Advocacy: i) Improved and supportive/ inclusive policies and their effective implementation

Key audience	Strategies/strategic approach	Proposed Interventions/ activities	Key Communication content	Monitoring indicators
* Minister, Secretary, additional Secretary, MOH, MOE, * MWSAD, UNICEF, WFP, WB, Directors of key INGOs (Save the Children, Oxfam?) and NGOs (Sarvodaya?). * Celebrities and other influentials (advocate in favour of inclusive policies) * Chair of Journalists' (as a pressure group) association at National level * Rotary and Lions Club chairs * Scouts/girl guide commissioners	* Qualitative explorations/KAP on nutritional status of children, living with disabilities, children in special needs (slum, affected by conflict, estates, institutions, prisons), adolescents *Promote dialogue with top policy makers, donors/influentials & within various Departments of MOH to review existing policies, amend them to improve if required; effective implementation of improved policies. *Work with the above stakeholders to sensitize them regarding the impact of malnutrition on general population so that through their actions they support to create an enabling environment to shape positive social norms *Tap into existing local and regional information networks and strengthen collaboration with journalists and media for media coverage on impact of malnutrition including iodine and Vitamin A deficiency among the most marginalized pregnant and lactating mothers * Mainstream entertainment-education approach, messages materials on nutritional issues into curricula and programmes for youth and adolescents (in school and out of schools) to empower them with life skills and correct information participatory EE initiatives (using drama, folk songs, films/videos, pictorial booklets, comic books, etc) for communities (special focus on pregnant, lactating mothers)	* Conduct Qualitative KAP on nutritional status of children adolescents, children in special needs (slum, affected by conflict, estates, institutions, prisons) living with disabilities *Mass dissemination of data available of Unicef surveys to mobilize political commitment & actions to reduce malnutrition. * Develop fact sheets, power point presentations, guidebook; orientation for journalists for sensitive & accurate reporting. *Panel discussions in Mass media on the emerging issues regarding the nutritional status of the marginalized & its impact & role of civil society, top policy makers *Advocacy meetings to foster inter-ministerial collaborations * Mobilize MOH, MOE to integrate EE in school curriculum & community interventions. * Develop tools based on research and design initiatives with participation of target audiences. *Organize district based awareness programmes for Zone office Govt. authorities, local influentials. * TOT in networking building and advocacy.	* Long term effects of malnutrition and how it impacts the national health and intelligence level of children. * Existing statistics on malnutrition and sectoral experiences including best practices. * How supportive policies can influence behaviour at the service providers level, community levels. *Roles and responsibility of media, leaders & communities for investment in preventive approaches. *Need for improved policies & their effective implementation. * High level Advocacy-understanding concept and how to implement.	* KAP conducted on time *Data available & disseminated *Number of meetings held with stakeholders * Number of journalists sensitized * Number of materials developed & implemented * Curriculum development in process * Capacity building for advocacy taking place

ii) Forging meaningful inter-ministerial collaboration and partnership with private sectors

Key audience	Strategies/strategic approach	Proposed Interventions/ activities	Key Communication content	Monitoring indicators
*Minister, Secretary, additional Secretary, MOH, MOE, UNICEF, MM&I, the *Private sector (multinational companies- Lever Brothers, Johnson & Johnson- other pharmaceutical industries, Shell, Private Banks, Private Insurance Companies, Food manufacturers, national & private television and radio, DHL, International cosmetic companies working on women's issues such as Body Shop, Ponds, etc)	* Identification of most effective potential partners & agreement on who to involve *Multi-lateral meetings with MOH, MOE & donors (WFP, WB, ADB, ILO) for collaboration, including partnership building with the private sector. *Sharing statistics, documents on the existing nutrition status in Sri Lanka & best practices. *Consultations/brainstorming on roles of private sectors and how to forge meaningful collaboration. *Plan of action for involvement (long term & short term). *Creating a credible & accessible data base on nutritional status at various regions, best practices, lessons learnt, etc.	*Regular briefings, Orientation on key issues *Develop a national network or Task Force with multi-sectoral & private sector partners *Plan of Action on collaboration development & implementation *Field visits (especially to highly affected districts/population, estates, etc.) to instill greater understanding of the issue	* Information on roles & responsibilities of stakeholders * Evidence based experiences from other countries on collaboration *"Take aways" of private sectors from collaborative efforts (association with Ministries, UNICEF, etc.)	* Number of briefing meetings taking place, minutes documented & circulated * National Task force functioning * Plan of Action in place * Number of Field visits taking place

iii) Development/finalization of the National Plan of Action for Nutrition by 2007

Key audience	Strategies/strategic approach	Proposed Interventions/ activities	Key Communication content	Monitoring indicators
*MOH, Secretary, Additional Secretary, * UNICEF	* Work with policy makers to get the National plan finalized by 2007.	*Meeting with top level policy makers to hasten process of finalization * Identify & agree on dissemination efforts of the Plan of Action * Identify mechanisms to ensure "buy ins" of the Action Plan, implementation by other ministries and stakeholders	* Current nutrition statistics * Need for harnessing collaborative efforts.	* National plan finalization in process

b. Behaviour change communication

i) Reaching "in school" and "out of school" children and adolescents and children living with disabilities and children with special needs through various venues (youth groups, school clubs, CFS, sports groups, scouts, guides, etc.)

Key audience	Strategies/strategic approach	Proposed Interventions/ activities	Key Communication content	Monitoring indicators
* Children and adolescents * Teachers * Service providers (health staff, NGO field workers, peer leaders, scouts and girl guides) * Care givers/ grand parents * Older siblings	* Audience segmented approach. * Development of Entertainment-Education (EE) materials based on qualitative research * Separate materials to be produced on specific topics (iodine, Vitamin A, etc.) * Use of existing EE materials (**Meena** materials: comic books, users' guides, videos on health & nutrition, hygiene education, diarrhea prevention, worm infestation, iodine deficiency, Vitamin A, etc.) for life skills building. * Expansion and implementation of evidence based efforts. * Supporting peer education & introducing Child-to-Child approaches. * Capacity strengthening of service providers. * Use of school and non school venues to implement behaviour development initiatives. * Integrating nutrition in ongoing other activities * Identify potential interventions & monitor schools & non schools venues for base line.	* Implementation of EE materials with support from children and adolescents and key target groups in designing initiatives and implementing them- in school, out of school venues (CFS, child friendly spaces, Children's clubs). * Regular training of service providers on participatory approaches, inter personal communication, Life skills and on key contents. These TOTs **must** be outsourced and conducted with the help of professional trainers. *Pilot testing of the community initiatives and expansion in phases. * Workshops/training on Nutrition activities in the initiatives of Girl guides (currently it is integrated. Unicef has trained master trainers on life skills and nutrition related issues).	* Micronutrients – how benefits & why needed ; how to prevent deficiency * Positive behaviours and practices on nutrition aspects (healthy eating, taking micronutrients, sanitary practices and hygiene education, positive attitude, adolescents' needs, gender sensitive approach, etc.)	* Audience segmented efforts & EE materials development in process * Evidence based approach introduced * Number of workshops, & TOT on Life skills run by professional trainers; duration & frequency

ii) Strengthening school curriculum to address nutrition issues, and its implementation

Key audience	Strategies/strategic approach	Proposed Interventions/activities	Key Communication content	Monitoring indicators
* Curriculum board *Teachers *Children and adolescents	* Integrate nutrition in existing curriculum. The contents should be decided & designed based on scientific/qualitative research & through the involvement of children, adolescents, teachers & content specialists. * Plan for implementation of curriculum.	* Consultative meetings with Curriculum board * Drafting of content to incorporate into existing curriculum * Pretest and finalize * Print and implement- in phases through schools * Organize training of teachers on the contents	* Malnutrition and prevention (eating habits, micronutrient deficiencies & impact, hygiene education, etc.)- how affects well being & health * Role of micro-nutrients in preventing malnutrition * Role of teachers and students in prevention of malnutrition	* Number of meetings held with curriculum board * Number of teachers training held

iii). Reaching pregnant and lactating mothers and care givers through community based associations, clinics and through IPC at household levels (special focus on 0-5 years old); reaching youth (including pre-pregnant women) and general population

Key audience	Strategies/strategic approach	Proposed Interventions/ activities	Key Communication content	Monitoring indicators
*Pregnant women (teenage, younger and older women) *Lactating mothers (teenage, younger and older women) *Elders (mothers, grandmothers, mothers-in-law) * Friends (neighbours- general adult population) * Service providers (health staff, NGO workers)	*Audience segmented approach (regional variations, ethnic differences, educational attainment, estate population). * Expansion of evidence based initiatives (folk songs; radio & TV programmes- jingles, drama; street/community theatre; IPC;). * Development of inter-active and EE behaviour change tools (pictorial booklets, flip charts, flash cards, etc.) based on scientific research and full involvement of target groups. Outsourcing of materials development for quality product. * Reaching the key audiences through community mechanisms (lactation centres, mothers associations/clubs, festivals, etc.). *Capacity strengthening of service providers on contents, IPC and interactive methods.	* Implement EE materials at household levels & community based associations, private & public gatherings & venues. * Train service providers in IPC & interactive methods. * Organize courtyard meetings with key target groups * Orient SDCs, PTAS on nutrition related issues and discuss at SDC, PTA meetings. * Regular IPC with key target groups	*Micronutrients: deficiencies & benefits (helps develop baby's brain, makes her intelligent, ensures higher memory & child can perform better in school, etc.) * Anti natal check ups & care during pregnancy *Weight gain and rest during pregnancy *Breastfeeding: importance of exclusive breastfeeding, care and rest of mother, breastfeeding administration, infant feeding, weaning food. *Child care (Diarrhoea prevention and management- ORS administration; ARI, completion of immunization, understanding the importance of growth charts). * Hygiene education, sanitary practices- how contributes to health, eating habits & healthy life styles *Importance of accessing correct information *Male involvement in pregnancy, breastfeeding & child care	* Number of districts covered with EE approach * Number of service providers trained * Number of courtyard meetings held & SDCs, PTAs oriented

iv) Capacity strengthening of service providers (teachers, peer leaders and health staff).

Key audience	Strategies/strategic approach	Proposed Intervention/ activities	Key Communication content	Monitoring indicators
* Government health workers: PHI, PHMs, nurses * NGO field workers *Teachers *Peer educators/ leaders	*Review existing training programmes of health workers *Development of participatory modules focusing on contents and facilitation techniques (out sourced and engage professionals) on the basis of scientific research and involvement of service providers. Adaptations may be considered. *Integration of the newly developed modules and training into the existing system: on the job training and in service training for new recruits (both for Govt. health workers and teachers) *Provision for refreshers' training for NGO workers, implement newly developed module as necessary based on training need assessments- encourage adaptations as required. *Provision for training of NGO workers and peer educators. *Addressing motivational aspects of health workers and positive attitudes.	*Regular training for health staff, NGO workers on interactive methods, how to effectively use communication materials, IPC, courtyard meetings, orientation, positive attitude building, etc. (training should be provided by professional trainers). *Refreshers' training once a year to address their problems, lessons learnt *Orientation and training of peer leaders on life skills and on interactive methods, how to effectively use communication materials, IPC.	*Micronutrients: deficiencies benefits *Antenatal check ups care , weight gain & rest during pregnancy * Low birth weight baby (based on qualitative exploration) *Breastfeeding: importance of exclusive breastfeeding, care rest of mother, breastfeeding administration, infant feeding, weaning food. * Child care (Diarrhoea prevention and management- ORS administration; ARI, completion of immunization, understanding the importance of growth charts), importance of completing all dosage of immunization. * Hygiene education/practices, eating habits & healthy life styles *Birth spacing * How to talk to mothers & respond to their needs *Importance of male involvement in pregnancy , breastfeeding & child care. * Importance of involvement of other family members during pregnancy, breastfeeding & child care.	* Number of training held for service providers, peer leaders on IPC * Types of methods used in training * Frequency & duration of training * Evaluation of each training course

v) Nutrition communication strategy linked to accessible and client friendly services

Key audience	Strategies/strategic approach	Proposed Intervention/ activities	Key Communication content	Monitoring indicators
*Children & adolescents (living with disabilities, in special needs, urban, rural, slum, affected by conflict, in school & out of school). *Pregnant women, lactating mothers & their husbands *Elders *Friends, neighbours *Service providers & programmers	*National & regional communication campaigns * Community mobilization group events- integration of nutrition related issues in cultural activities	*Develop TV and radio programmes (interviews, brief drama, songs) micronutrient deficiencies, male involvement, improved spousal communication roles & responsibilities of elders, neighbours, friends *Develop radio & TV jingles on breastfeeding, child care infant feeding & weaning food. *Develop radio & TV folk songs, jingle on adolescents' nutritional needs, needs of the adolescent girl. *Develop radio programmes (interview, jingles, Q/A or letter writing programme on nutrition) on roles of health workers *Serialize **Meena** comic books on nutrition issues on popular news paper *Broadcast **Meena** videos on nutrition issues on national & private channels, NGO mobile units, at CFS & other potential venues.	*Micronutrient deficiencies, male involvement, improved spousal communication roles & responsibilities of elders, neighbours, friends *Breastfeeding, child care infant feeding & weaning food. *Adolescents' nutritional needs, especially needs of the adolescent girl. *Role of health workers	* Number of TV, radio programmes developed *Number of broadcast of AV programmes, time, frequency * Number of national dailies serializing Meena comic books * Number of CFS using Meena videos followed by discussions, frequency

c. Social mobilization

i) Participation of civil society, community based key stake holders for reduction of malnutrition among the target groups

Key audience	Strategies/strategic approach	Proposed Intervention/ activities	Key Communication content	Monitoring indicators
* Mosque Committees * Church Committees * Buddhist religious Committees * Faith based organizations * Community based organizations *Religious/community/opinion leaders (formal/informal) *Rotarians, Leos and scouts/girl guides leaders	* Capacity strengthening of the civil society on issues related to nutrition, participation of the community on these issues. * Comprehensive use of folk and local media to create awareness among religious and local leaders * Dialogues between various groups on nutrition related issues, especially on child care and feeding, breast feeding by estate mothers, negative effects of powder milk, care of children of migrating mothers, children with disabilities, etc. and to identify community mechanisms to provide support to the above mentioned groups. * Pilot interventions in phases & replicate successful experiences.	* Meetings * Religious groups deliberations (Friday prayers, Sunday sermons, Poya days, etc) * Seminars and symposiums * Develop fact sheets & leaflets/pamphlets, for religious leaders	* Information on micronutrients * Roles of civil society * Religious views & instructions on child care, breast feeding, etc.	* Number of meetings taking place * Number of religious institutions promoting nutrition * Number of symposiums, seminars organized * Number of communication materials developed

ii). Mobilizing new partners

Key audience	Strategies/strategic approach	Proposed Intervention/ activities	Key Communication content	Monitoring indicators
Management of Estates Garments owners (to involve adolescent workers: females and males?)	* Dialogue with management on nutritional needs of workers, especially of pregnant, lactating mothers, under five children, children above five years & adolescents * Consultative meetings with management on what requires to be done to improve the nutritional status in their estate/factory.	* Share current statistics and documentation * Develop fact sheets and leaflets/pamphlets * Orientation of Estate and factory management * Partnerships with managements * Creation of an Advocacy group or a Task Force to promote networking among estates and factories.	* Relevant information on malnutrition & its impact *	* Number of meetings held with Estate management * Number of orientations organized * Advocacy group functioning

(See Annex I for a one year activity chart)

4. MONITORING AND EVALUATION

Monitoring and evaluation
A comprehensive monitoring and evaluation (M&E) plan is an important element for all nutrition initiatives M & E plans for all nutrition related initiatives will include three components that guide programme development and assess its effectiveness in achieving the programme's objectives. These are:

- **Formative research** to identify the underlying factors that facilitate or obstruct the use of positive health behaviors and provide meaningful, audience-centered input to the design of a programme.
- **Ongoing monitoring** of programme implementation to ensure that any essential adjustments or modifications to the programme are made in a timely manner.
- **Evaluation research** to assess the effect or impact of the programme activities on the use of positive health behaviors and the intermediate factors that influence the use of these behaviors.

PART C: PRELIMINARY SITUATION ANALYSIS

AN OVERVIEW

a) Introduction
Under nutrition among children continues to be a major health problem and it is high in the estate sectors and lower in the urban sectors. Nearly 24 percent of the children under five years and 55 percent in the 6-10 year age group are anaemic. In children (under six years) vitamin A deficiency varied from 22 percent in the Central Province to 57 percent in the North Central Province. Iodine deficiency is also prevalent in certain areas. The provision of preventive health care has been considerably affected by the conflict in the North-East and a large number of health institutions have been destroyed or damaged and are currently not functioning….Also immunization coverage of children under five years appears to be low-74.5 percent (NPA for the children of Sri Lanka, 2004-2008).

Preliminary results from the national Demographic and Health Survey 2000, which included the North and East, indicated that malnutrition in those areas is much more widespread than the rest of the country. Although no hard data is available, micronutrients deficiencies are likely to be high. Women and children are undernourished and stunted. Although the coverage of school health programme has increased over the last few years…., in the areas most affected by the conflict absenteeism is common among children who are enrolled in school, with children often missing as much as 30 percent of their schooling. (Government of Sri Lanka- UNICEF Programme of Co-operation, 2002-2006, Master Plan of Operations).

Surveys undertaken in seven districts (Matale, Nuwara Eliya, Hambantota, Anuradhapura, Badulla, Moneragala, Ratnapura) in 2003, and in 2004 in selected Northern and Eastern districts (Jaffna, Mannar, Vavuniya, Batticaloa, Ampara,

Trincomalee) provide some good insight regarding child health and welfare status in certain regions in Sri Lanka. Behavioural interventions should be designed keeping these information in mind. The total sample population of the surveys were 5,472 and 4,525 households, respectively.

In the 2003 survey, majority of the women accounted by 88% have reported that their first pregnancy had occurred in the age interval of 18-35 years but 11% of females (women) have become pregnant while they were still teenagers. According to survey information, over 50 percent of mothers in all seven districts are aware of food items rich in Vitamin A and iron but few mothers are aware about the health benefits of iron supplementation. A relatively large number of mothers are not aware of health benefits of Vitamin A- only 26 percent of mothers have reported adequate knowledge in this regard.

Virtually all districts have reached a high 90% target in receiving the first dose of DPT but apparently over 85 percent of children have received the second and third doses in all districts with the exception of Anuradhapura where the corresponding rates are 80 percent and 77 percent, respectively. The average immunization coverage of measles is 86 percent, and polio is over 91 percent being immunized with the first dose, the second and third doses have been received by 89 and 87 percent, respectively. (Estimates are based on the recordings in the health cards of the children in the target group. As such 8.6% of children whose health cards were unavailable, were not included in the analysis as reliable information could only be obtained from the card- this includes 19.3% from Nuwara Eliya and 10.6% from Badulla).

According to survey results, the practice of exclusive breast-feeding has been carried out in respect of 50.1 percent of children for four months, while 27 percent have been exclusively breastfed for at least 3 months. The lowest proportion of 33.6 percent has been reported from Nuwara Eliya district. In the Estates, only 23 percent babies have had exclusive breast feeding for four months. Regarding weaning food, the survey reports that one fourth of infants are not introduced to weaning food up to 9 months of age although instruction to mothers by the primary health care system is to introduce weaning food between 4 to 6 months of age. The non breast feeding group which accounts for one fourth of the infants in the 6 to 9 months age cohort, appear to consume less complementary food types than their counterparts who are being breast fed. While a relatively higher proportion of infants who are not breast fed receive powdered milk lag behind in receiving other liquid food such as juice and soup; essential solid food such as rice, wheat products, cereal preparations, pulses, vegetables, fruits and food items of animal origin, mainly egg, fish or meat.

Overall 18 percent children have been born as low birth weight (less than 2.5 kg) babies in these seven districts. There are some variations of data in the districts. This means that every fifth newborn is under weight at birth in Moneregala (22%), Nuwara Eliya (22%), Anuradhapura (20%). The other districts are also far from being satisfactory, Ratnapura (17%), Badulla (17%), Matale (16%) and Hambantota (14%). According to the survey results, weight gain among infants in the first year of life shows that every other infant reports to have reached the required growth level as per the growth curve. However, in

the second year of life this progress is reduced with only one out of four toddlers being able to maintain weight gain. Weight gain progress or growth faltering is seen higher among children in estates.

Over two thirds of expecting women have been attended by health personnel more than 12 times during pregnancy in all the seven districts. However some variations in data have been noted – 10 percent of pregnant women in the estates have had at most six antenatal check ups. It is 9 percent in Anuradhapura district. About 70 percent of the mothers obtain information from the health workers. (**The other sources are TV 28%, radio 12.9%, printed media 18%, elders 17%).**

Diarrheal diseases contribute to growth faltering of children. An average of 10 percent of children in the target group have suffered from at least one episode of diarrhea during the reference period. Desegregation by sector suggests that children in rural areas are prone to diarrhoeal diseases more than the others.

On an average 18 percent or nearly one fourth of children under the age of 5 years in the seven districts reviewed, are shorter than the average standard. The prevalence is highest in Nuwara Eliya district (31%) with one out of three children stunted. In Badulla one out of every four preschool children are stunted. Stunting of children in the estates is 33 percent. The prevalence of wasting among the children is highest in Hambantota (23%) and Anuradhapura districts. Genderwise, boys (20%) show a higher vulnerability to wasting than girls (15%). The affected proportion of wasting is as high as 44 percent in the estates whereas, it is 37 percent in rural households, and 27 percent in urban dwellings. On the whole, a proportion of 37 percent of children in the age interval of 3-59 months are found to be underweight.

Even though it appears that iodized salt is extensively used for cooking purposes across sectors and districts, the concern is that a majority of the households (nearly 80%) uses iodized salt crystals. There are two issues that arise out of use of salt crystals: one relates to household habit of washing the salt before use which washes off most of the iodine as it is water soluble. The second issue is that iodization of salt crystals does not permit the required uniformity of iodization in terms of the requisite iodine parts per million (PPM) as recommended by WHO and can lead to differing concentration of iodine in iodized salt crystals. Iodization of salt is not meant for salt crystals but for washed powdered salt to avoid both the above issues. Therefore, this concern needs to be addressed at both policy and programme levels. (Survey of Child health and welfare in Seven Districts in Sri Lanka. UNICEF, 2003).

In a similar survey of child health and welfare in selected Northern and Eastern Districts undertaken in 2004 where UNICEF supported interventions are implemented, information have been collected on some key issues.

Nearly one out of six women in these selected districts reported that their first pregnancy had occurred while they were still teenagers. It's higher in the rural areas (17%) as compared to the urban areas (11%). Trincomele district has the highest rate of teen age

pregnancies (19%) as compared to other sample districts. Over 87 percent women were aware of the need of consuming extra food and considered receiving requisite vaccination is essential (82%). Only 26 percent or one out of every four pregnant women have gone for health checks more than 12 times during prenatal care period. Overall 30 percent pregnant mothers have had seven to nine antenatal check ups while another 25 percent have been attended by a health personnel. However, on an average only 18 percent of mothers have been subjected to less than seven antenatal check ups during their last pregnancies, in the five year period preceding the survey. Overall one out of every three mothers received a mega dose of Vitamin A after delivery. Non recipients are very high in Batticaola (81%) and Jaffna (74%).

Generally among mothers, awareness about food items that contain iron is higher (75%) than on items rich in Vitamin A (56%). Teenage mothers and elderly mothers over 50 years of age lag behind in their knowledge about nutrient requirements of their children as compared to the rest of the interviewed mothers. However, it is noted that only 31 percent of the interviewed mothers have been able to identify the benefits of Vitamin A supplementation. 66 percent of the mothers obtain health information from health workers (77% in Batticaola, 43% in Vavunya). 22 percent on an average depend on the advice of elders. Other sources as reported are printed media (20%) and friends (11 %).

On an average DPT vaccine, first, second and third doses have been received by 93 percent, 92 percent and 89 percent, respectively, whereas the fourth dose has been received by only 42 percent. It should be noted that 5.8% children for whom health cards were unavailable were not included in the analysis.

Exclusive breastfeeding for four months from the time of birth was carried out in respect of 55 percent on an average, while another 27 percent have been fed with breast milk for up to three months. 13 percent of children were exclusively breastfed for more than four months. It has been noted in the survey that two out of three infants receive complimentary food in addition to breast milk during the transition period when the infant moves away from exclusive breast feeding. Among sectors rural mothers (69%) are more inclined towards giving food supplement to their breast fed babies than mothers is urban areas (52%). Apparently younger mothers 30 years old or below show a greater likelihood (70%) in this practice than older mothers (60%). On an average, 11 percent babies born during the five year period prior to survey (verified through health card) were of low birth weight.

6.8 percent children under five years of age reported to have suffered form diarrhea at least once during the two period preceding to the survey. Overall 38 percent mothers did not change the amount of solid food offered to children when sick with diarrhea. 24 percent reduced the quantity slightly and another 24 percent made a substantial reduction in solid food.

On an average 18 percent or one in every five children below five years of age in the six districts surveyed are stunted. Gender wise stunting appears to be marginally higher among girls (19%) as compared to boys (17.6%). On an average 15.5 percent children in

the target group have recorded lower weight against the standard that should be maintained for their height. Wasting is highest in Mannar and Ampara districts (17%) followed by Trincomele (16%).On the whole a proportion of 36 percent of children in the age interval of 3-59 months are under weight. Sectoral differences are significant (rural: 38.7% and 26.3% in urban sector).

Use of iodized salt is over 84 percent by the population with children in these districts. The variation among districts is significant: Jaffna 70 percent, Ampara 94 percent, one tenth of the house holds use salt powder whereas the rest use salt crystals. As found in the 2003 survey, the population in the 2004 survey have similar behavioral pattern of washing the salt before using and the required iodization in the salt crystal is not uniform in terms of requisite PPM. However, awareness among mothers is relatively high in respect of iodine supplementation (over 58%) in six districts as compared to Jaffna (46%).

Both surveys (UNICEF. 2003, 2004) indicate that on the whole in the households surveyed in seven districts over 90 percent of households usually consume 3 meals a day. Nearly 4.2 percent of the households have access to only two meals a day. In the Northern and Eastern selected districts 91 percent are in the habit of taking three meals per day. Over 15 percent households in these particular districts indicate that they usually enjoy two meals. The number of meals consumed a day was ascertained as a proxy indicator for poverty and household food resource availability for children. In the 2003 survey, over 40 percent of household heads consider themselves to be poor and 9.3 percent as very poor (poor constitute 64% in estates- as perceived by households). In the 2004 survey, 35% of households viewed themselves as poor and another 9% as very poor, 42 % perceived themselves as belonging to the lower middle class.

Both surveys highlight that educational attainment of mothers in most cases influenced practice of positive behaviours. The 2003 survey indicates that overall one tenth of the household population has never attended school. It's even higher in certain districts. One out of every seven persons or 13.5 percent in Nuwara Eliya and 14.0 percent in Badulla districts have had no access to any schooling. On an average females with no schooling is nearly two to three fold higher than that of males (19 % Badulla, 14.9% Nuwara Eliya). The 2004 survey indicates that on average, 5 percent of household members over 30 years of age have never attended school. Between districts it ranged from 1.1 percent to 8.5 percent. The women cohort is double the size of that of men in all districts surveyed except in Mannar. Overall, 38 percent of the adult household members have gone only upto primary level of schooling while another 38 percent have completed secondary education.

The 2003 survey indicates that 9.7 percent of the population (over 10 years of age) claims no regular exposure to mass media. 38.5 percent reads the newspaper at least once a week, 76.2 percent listen to the radio at least once a week and 70.5 percent watch television at least once a week. While a higher preference for the electronic media is reported from all districts, the radio appears to be accessible to the majority. In the 2004 survey, sector wise 40 percent of the urban dwellers have affirmed regular use of both

print and electronic media as against 23 percent of their rural counterparts. Electronic media is more popular among the population of the six districts than news papers. Regular TV viewers stand at 75 percent, radio listeners 60 percent as against 37 percent of news paper readers. The habit of reading news paper is higher in Jaffna district (51%, and urban sector 52%). In Trinchomele district it is 25 percent (16% with those with primary education, 4% with no formal educational background).

The provision of safe water, access to sanitary latrines, migrating populations (internal and external) also play a vital role in influencing behaviours that affect the nutritional status of the population as indicated in the two surveys.

Both surveys (2003, 2004) draw attention to the existence of children living with disabilities. The disabled constitute a higher proportion of the household population in the three districts of Anurdhapura, Badulla and Hambantota. Anuradhapura reports 18 disabled persons in every thousand population, while it is 15 and 13 per thousand in Badulla and Hambantota. Disability by age reveals that nearly one third of the disabled belong to the youngest cohort, below 18 years of age and is significantly high in certain districts (mental disability 32 % is noted for Badulla. With the exception of Anurdahpura all districts indicate that every fourth disability among the disabled is due to mental disability). In the Northern and Eastern districts one out of sixty people in the target households or 16 per every thousand people are reported to be suffering from some type of disability. While physical disabilities are highest in Ampara district, mental problems are highest in Jaffna district and account for 36 percent of the disabled cases. Children account for 33 percent of the total reported cases while another 31 percent is claimed by young adults between the age of 18 years, and 40 years of age.

All these factors need to be scientifically scrutinized and specific, relevant, research based and audience segmented behavioural interventions designed and implemented with full participation/engagement of various groups of target population in order to make a difference in the nutritional status of women, children and adolescents in Sri Lanka.

b) Policy and environment

The government faces a number of challenges in effective implementation of the strategies as outlined in the Health Master Plan, November 2003 (Health Master Plan Sri Lanka - Healthy & Shining Island in The 21st Century. November, 2003). It indicates:

- Nutritional status has improved but remain a serious problem among the poorest and vulnerable communities and even on an average is unsatisfactory….One of the recurrent constraints for improving the effectiveness of human resource policy and planning in the health sector is lack of a comprehensive human resource strategy and lack of coordination among all units concerned in Ministry of health and Ministry of Education.

- The current major problems are imbalance in production of staff, geographic inequity in distribution, lack of a fit between expected job performance and

training. …Specifically, the number and the rate of health personnel in the Northern Province is extremely low while districts such as Colombo, Kandy and Galle have a significantly higher concentration.

- The insufficient quality and competency of health staff too have been identified as a challenge for correction. Lack of technical competency and absence of positive human attitudes have affected the responsiveness of the services.

There are additional challenges as well:

- Strategic communication approaches are not well coordinated or grounded in research. As a result, behavioural aspects are lagging behind.

- Lack of /limited? Public- private cooperation such as not meaningful dialogues established to identify how the private sector can contribute in improving the nutritional status of the disadvantaged population and emerge as an important ally.

- Limited number of experienced social scientists in the resource pool of the government?

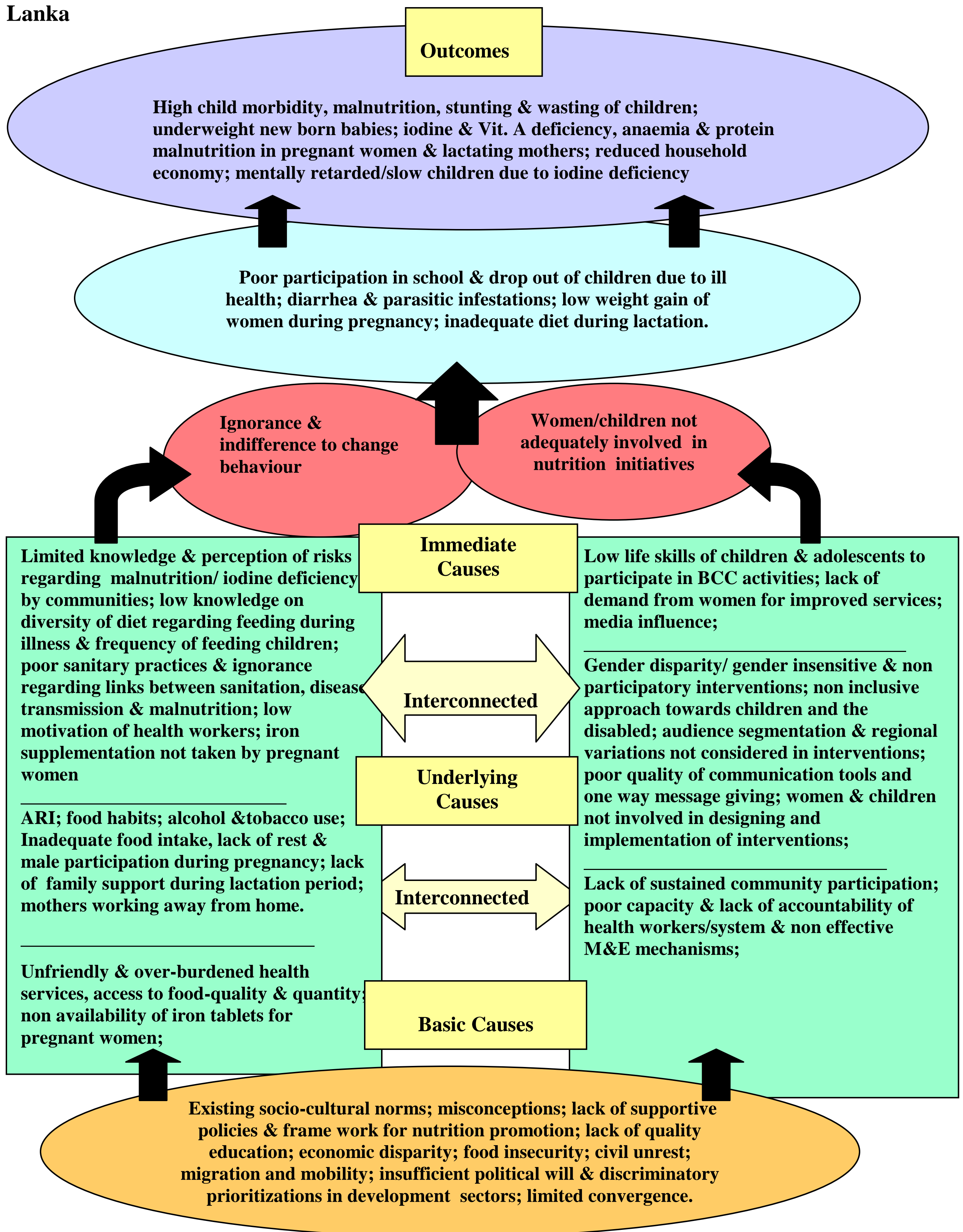
c) Causal analysis

Each step of the causal analysis is interlinked with the subsequent outcomes: **basic causes** that stem out of socio-cultural, religious, political and economic factors which are deep-rooted and hard to change in the short term; **underlying causes** that are factors at the infrastructural and organisational level, originating from basic causes; and **immediate causes,** directly responsible for outcomes, that is waterborne diseases, resulting in stunting, ill health and malnutrition.

This analysis has been done in order to understand where the communication interventions being designed expect to play a part in changing the existing situation. It is, probably less difficult to address immediate causes. However, social change and sustainable behaviour change may not be possible without also attempting to address underlying behavioural and structural causes, as well as basic causes. While communication has a role to play at these lower levels, changes in services, infrastructure, laws and policies are also required. Strategic Communication is essential to make such changes happen.

The diagram below represents the general direction of causality for programme design.

Figure 1: Preliminary Causal Analysis for problems related to malnutrition in Sri Lanka

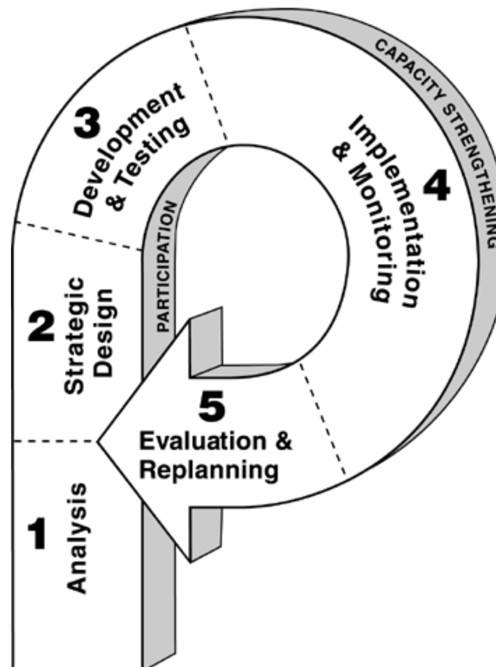


PART D: STRATEGIC COMMUNICAITON APPROACH

1. INTRODUCTION

The preliminary situation analysis detailed above spells out the first step in the planning process for reducing the level of malnutrition in Sri Lanka. The next strategic steps are a combination of actions which involve: 1) detailed communication analysis and needs assessment of specific audiences, 2) strategic design, 3) development and testing of communication materials and approaches, 4) development of implementation plans and the monitoring of all actions, and, 5) evaluation and replanning, as necessary. Formative research occurs during the communication analysis, design and development process, and monitoring takes place through the development process, as well as throughout the implementation of action plans. Figure 2, below, represents an overall view of the whole process being applied to nutrition communication in Sri Lanka.

Figure 2: P-Process for Communication Planning



Source: Health Communication Partnership – Johns Hopkins Bloomberg School of Public Health, 2003

2. STRATEGIC DESIGN

a) <u>Three- Tier Approach</u>

A detailed, integrated, advocacy and communication plan for raising awareness about benefits of nutrition and harmful effects of malnutrition on the survival, growth and overall development of children is crucial. In ***strategic communication*** there are three distinct and essential terms which represent three broad, inter-related strategic

approaches. These are ***Advocacy, Social Mobilization*** and ***Behavior Change Communication (BCC).***

Advocacy is an important strategy used in various programmes to gain required political commitment where it is lacking or weak. The definition of Advocacy in international development work is as follows:

> **Advocacy** is a continuous and adaptive process of gathering, organizing, and formulating information into argument to be communicated through various interpersonal and media channels with a view to raising resources or gaining political and social leadership acceptance and commitment for a development program, thereby preparing a society for its acceptance (McKee et al. 2000).

Advocacy is used to generate political commitment and policy change, to mobilize human and financial resources and to accelerate the implementation of programmes. Many countries have used ***Advocacy*** to establish a multi-sectoral approach, a social movement for a development cause. The process of establishing such a movement is called ***social mobilization***. However, it has been defined more comprehensively as follows:

> **Social mobilization** is a process of bringing together all feasible and practical inter-sectoral social partners and allies to determine felt-need and raise awareness of and demand for a particular development objective. It involves enlisting the participation of such actors, including institutions, groups, networks and communities, in identifying, raising, and managing human and material resources, thereby increasing and strengthening self-reliance and sustainability of achievements (McKee et al. 2000).

Building a multi-sectoral response entails the involvement of all levels of government, NGOs and Community-Based Organizations (CBOs), faith-based organizations, foundations, service clubs, the private sector (including retail and manufacturing), the informal sector, and financial services. It also means collaboration between public sectors that are often vertically organized: health, nutrition, agriculture and fisheries, education, social services, law, sports, media, culture, children and youth, gender, media, communications and transportation, uniformed services, and others. This is not to say that each and every member of these categories, levels, and sectors must work together from the start. Inter-sectoral collaboration is not the norm in most countries. Networking and coalition building takes time (McKee, Bertrand, and Becker-Benton 2004).

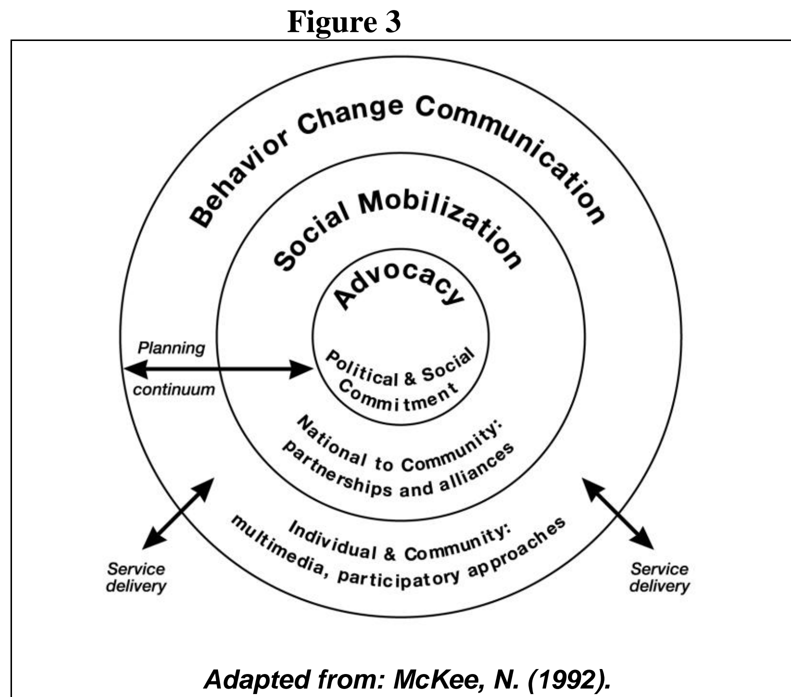
Social mobilization, together with ***advocacy***, are not sufficient for strategic communication for social and individual behavior change. There is a third component, ***behavior change communication (BCC)***. It is also called ***communication for behavior development and behavior change*** as for children and adolescents we are normally trying to develop new, positive behaviors, not changing old, unhealthy ones as in adults. BCC can be defined as follows:

> **Behavior change communication** is a research-based, consultative process of addressing knowledge, attitudes, and practices through identifying, analyzing, and

segmenting audiences and participants in programs and by providing them with relevant information and motivation through well-defined strategies, using an appropriate mix of interpersonal, group and mass-media channels, including participatory methods. (adapted from McKee et al. 2000).

Figure 3, below, elaborates the relationship between these various components of strategic communication and how they should be increasingly connected to service delivery such as educational institutions, community based organized clubs, treatment, and access to correct information, and psycho-social support where it exists, and overall effective and friendly (health) facilities.

Figure 3



Adapted from: McKee, N. (1992).

The planning continuum arrow on the three principal components of strategic communication indicates that there is no automatic starting point. Rather, it depends on the existing situation of the problem (malnutrition in this case) in each country. Leadership may be ready for advocacy on one issue to address malnutrition but not another (in this case may be not so much for influencing policies for involvement of women and children in designing and implementing interventions, etc.). Sometimes, instead of direct advocacy on difficult issues it may be more effective to try to build network for a process of social mobilization, selecting a set of partners who can influence the people in leadership positions. Alternatively, in the absence of or in case of "luke-warm" political support, communication programmers may begin by building demand in the population through wide-scale BCC approaches and thereby initiate a gradual change in the perception of leadership on the issues.

b) Participation analysis: key participants and their communication profiles

A **participation analysis** given below is an outcome of this workshop which laid down the basis for audience segmentation for an effective nutrition communication strategy.

The definitions of all possible participants are given below:

Advocacy:

Partner: An institution, association, ministry, corporation or group that serves as a resource (financial, technical, human or material) for collaboration with the core partners in achieving the overall objectives of a designated programme area, usually for the full length of the programme.

Ally: An institution, association, corporation, group, celebrity, spokesperson or politician that serves as a resource (financial, technical, human or material) for collaboration with the core partners in achieving at least one of the objectives in a designated programme area, often being engaged for a specifically defined time.

Gatekeeper: An authority, powerful individual, institution or association at the national, regional or district level, that influences the policy or legal environment (social, cultural, religious, political or economic) that either facilitates or inhibits behaviour and social change. Gatekeepers may allow or inhibit programme interventions to take place through various national, regional or district channels. They can be brought on board as partners and allies through advocacy, or may be "mobilization".

Behaviour Change Communication (BCC):

Primary Audience: The core group of people around whom the strategic communication objectives are focused and within whom the primary behaviour change is to take place. Example: the primary audience of 'Youth Behaviour Change Communication' is 'all youth' (street children, college youth, rural, urban, in-school and out of school); or rather, all youth between the ages of 10 and 24.

Secondary Audience: People who directly relate to the primary audience through frequent contact and who may support or inhibit behaviour change in the primary audience through their influence. The strategic communication objectives often must focus on them directly for changes to take place in the primary audience. Example, for youth the secondary audience includes parents and immediate family members. In some cases teachers may be in this category.

Tertiary Audience (community-level gatekeepers): Local community groups, institutions or individuals who may support or inhibit behaviour and social change in a community by allowing or disallowing an intervention to take place. These people control the local social environment, communication channels and decision making processes and have a great influence on local social norms.

Field Worker: A natural agent of change in a community, usually representing an institution or organization that may have similar goals for behaviour and social change and who may be brought on board for communication programme purposes through involvement in training and planning.

The participants in the advocacy programme may be “targets” or audiences who need to be motivated to support a cause and advocate in its favour or become “social mobilisers” for the cause. Some of the people belonging to this category may be “gatekeepers” who we need to convince in order to communicate to the general population (e.g. media gatekeepers) or to a specific group of people (e.g. public health officials for children and adolescents in school). Strategic advocacy efforts can lead to the involvement of a wide range of operational partners and shorter-term allies in a multi-sector response – “social mobilization” for a sustained, democratic and effective system to carry forward initiatives to reduce malnutrition. Some may be spontaneous partners or allies, already committed to the cause. Some are “potential allies” who need to be convinced to join the cause. The strategy formulation group voiced that targets for advocacy should include: ministries (MOH, MOE, MWSAD) and key departments operating under the ministries: FHB, HEB, PDHS, DPDHS, Presidential Secretariat, local authorities, etc.

A participation analysis as indicated in this plan for behaviour change communication which is focused to address specific communities and groups of people whose behaviour change is a must to achieve the programme goals. It has been often observed that more emphasis is given to change the behaviour of these groups in comparison to the groups that can support policies and regulations that can enhance the creation of an enabling environment needed for social change to take place and for individual behaviour change to be reinforced and sustained.

The section below concentrates on the participation analysis for reduction of malnutrition and the communication profiles of the target participants:

Figure 4: Overall Participation Analysis: Advocates

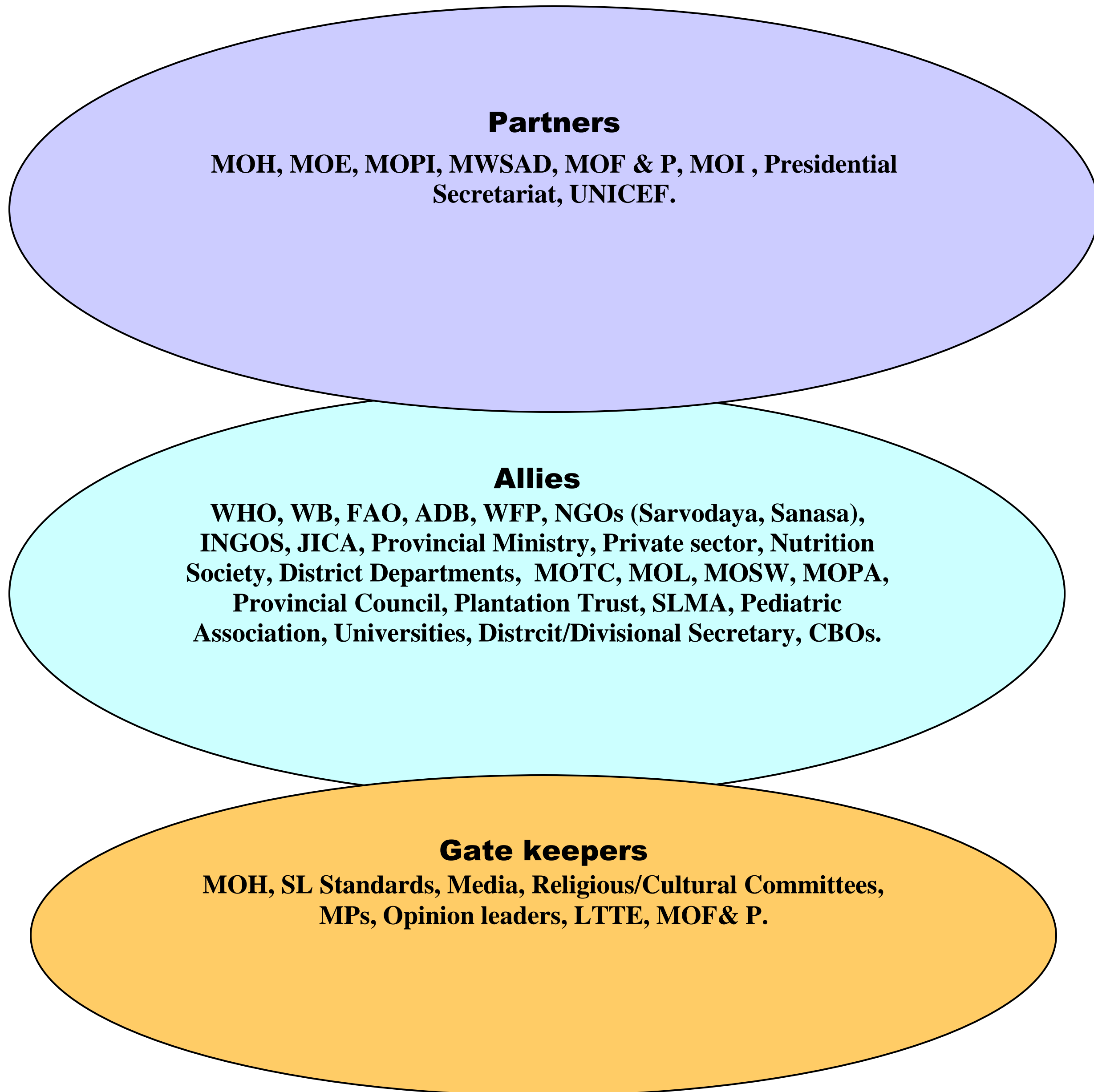
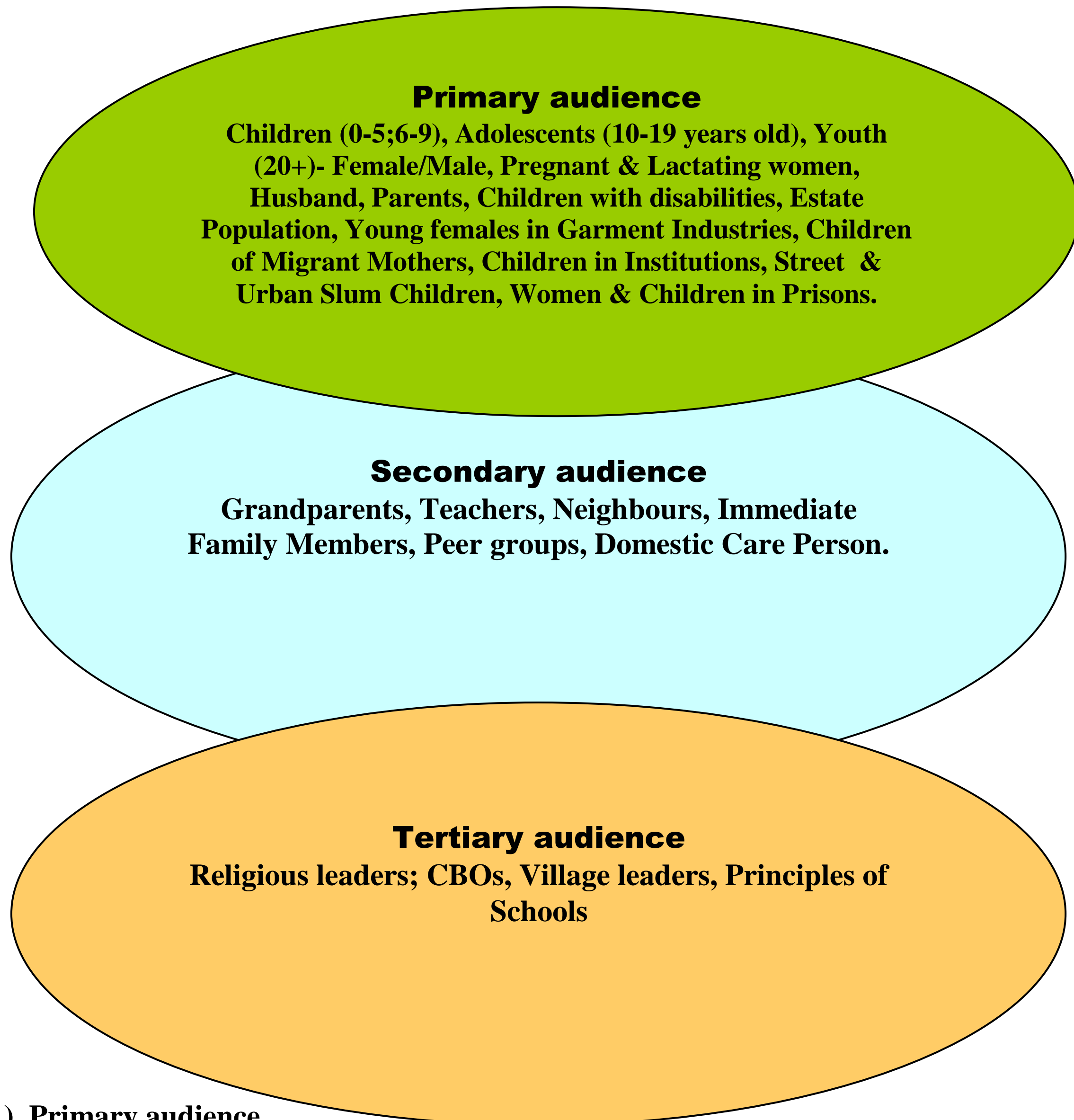


Figure 5: Overall Participation Analysis for BCC audience



1). Primary audience

Children 0-5 years old:

These are children living in urban and rural areas as well as in IDP camps and possibly in slums. Some (3-5 years old) may be attending pre-schools in some locations. As indicated in the situation analysis nearly 24 percent children under five years are anaemic. In children (under 6 years) vitamin A deficiency varied from 22 percent in the Central Province to 57 percent in the North Central Province. Iodine deficiency is

prevalent in some areas and can affect children's physical and mental development. (National Plan of Action, 2004-2008)

Communication profile:

Care givers and parents of these children are mainly responsible for their nutritional status. As indicated in the situation analysis the nutritional status of these children is influenced by the behaviour of the mothers/care givers. Breast feeding practices, administration of weaning food and maintenance of hygiene practices by mothers/ care givers need to change to improve the health status of this group of children. Behaviour change can happen by engaging the care givers/ mothers in interventions that create awareness, address norms and behavioural issues.

Children and adolescents

Six to nine years old children: these are children living in urban and rural areas as well as in IDP camps and possibly in slums. Some may be attending schools in some locations. Care givers and parents of these children are mainly responsible for their nutritional status. 55 percent of children in the 6-10 year age group are anaemic (National Plan of Action, 2004-2008).

Adolescents (10-18 plus or 19 years old): This older group may have some understanding of hygienic and healthy behaviours as well as positive food habits but may or may not practice what they know. They're at risk of water borne, helminthic diseases which increases possibilities of morbidity resulting in malnutrition. The data from the 2003 and 2004 surveys indicate that a substantial percentage of children (0-9 year old) begin their early lives with stunting, wasting, iodine deficiency and malnutrition As a result, it can easily be inferred that these conditions persist as they enter adolescence followed by gradual move towards adulthood. For females this has very strong implications during their pregnancies.

At the community level in most cases children may not be perceived as initiators of behaviour change though they have the potential to play a vital role in designing, implementing and managing interventions on nutrition and hygiene related issues at house hold levels; promotion of nutrition initiatives at school and community levels; Policies and strategies are needed to invest in this vast population and empower them (3.7 million adolescents, approx.) through life skills based education so that they can turn into effective nutrition promoters as well as sanitation mangers.

Children out of school: about 10% of the children in the age bracket of 5-14 years drop out and a further 6% drop out at the end of grade IX (National Plan of Action for the children of Sri Lanka. 2004). According to the adolescent survey (UNICEF. 2004) out of 3.7 million adolescents (19.7% of the population) approximately 2.7 million (72.9%) are reported to attend school. So there is a considerable group of adolescents who are out of school. They need to be brought within the fold of nutrition promotion efforts.

War/tsunami affected children: 500,000 people have been affected by Tsunami and out of that roughly 30% are children. 900,000 children are affected by armed conflict and internally displaced (Annual Report- Central Bank of Sri Lanka 2002)-many families are still housed in welfare centres.

Many of the adolescents are in situations with minimum or no recreational options and not being able to contribute constructively to their own well being and development. Many of these children have been subjected to various kinds of cruelty, neglect, exploitation including sexual abuse. Many are at present living in extremely difficult situations or in IDP camps or in the conflict zones with limited access to basic requirements.

Communication profile:

Not much detail information is available about 6-9 year old group. They're at risk of ARI, water borne, helminthic diseases which increase possibilities of morbidity, in some cases mortality in younger children and malnutrition due to repeated occurrences of such diseases. This group can be engaged through "in school" activities and for out of school population child friendly spaces or children's clubs could be used to implement interventions. Entertainment- education tools such as **Meena** comic books and animated video films can be used for life skills building and to promote positive healthy behaviours.

The adolescent population may or may not receive targeted communication campaigns or may not have been engaged in interventions specifically related to nutrition with an audience segmentation approach. Urban, rural (and slum) children/adolescents living in the IDP camps received IEC materials (including Meena on education, gender, psychosocial healing and hygiene promotion issues through schools and the camps). They are being actively engaged in the child friendly spaces spear headed by Unicef and implemented by NGOs in Tricomele, Amapra and Batticaola. In Galle, similar efforts are being undertaken through Children's clubs. Evidences (MRE survey, Unicef 2004) show that children have access to radio, television, street theatre, hoardings, posters, miking and leaflets. The surveys of 2003 and 2004 also indicate that children above 10 years of age have access to various media- electronic and print. This population usually favour media with dramatic and interactive elements, education through entertainment (**Meena**).

Not enough information is available about children out of school. Studies (Amarsinghe, S 2002; SAP International 2003) undertaken among children living in beach towns/cities have shown that they have very limited recreational or career options once they drop out of the schools mainly due to the humiliation they face there in addition to poor quality of education and other factors. Their access to media is also not very clear. Some references have been made in various studies about their exposure to local and mass media as well as videos. Multi-media communication interventions would be needed to create awareness among this group which may include street drama, folk music, **Meena** films, etc. Print media will possibly be less effective as many of these young people may not have full literacy competency.

No detail data is available specifically on the media habits of children affected by conflict or tsunami and the efficacy of any particular medium for this population. However, street theatre, bill boards and **Meena** materials used so far in IDP camps on MRE have proven to have some effects in changing behaviours (MRE Survey, Unicef 2004). Child Friendly Spaces using inter-active tools and **Meena** materials are also claiming some success.

Children with special needs: A rough estimation claims 50, 000 children have some kind of special needs in Sri Lanka. Another 25,000 are institutionalized, including 2000

offenders (UNICEF report, unpublished 2002). In Unicef surveys undertaken in 2003 and 2004 references are being made about the number of children living with disabilities in seven selected districts and Northern and some Eastern districts (UNICEF, 2003, 2004).

Communication profile: Not much data available. Entertainment-education materials, specifically focusing on inclusion of such children in nutrition and hygiene promotion initiatives should be strongly considered.

Pregnant women: as indicated in the surveys undertaken in 2003, 2004 (Unicef) and other available data sources, the percentage of teenage pregnancy is an issue to be addressed by raising awareness among adolescents, families, women and the communities. There are also gaps identified in the knowledge levels of pregnant women regarding benefits of micro-nutrients and healthy practices. Educational attainment of women and their age as well as regional variations need to be considered when designing interventions for this segment of population. Low weight gain by pregnant women and poor male involvement are issues of concern.

Lactating women: the 2003, 2004 surveys (Unicef) as well as other data available indicate that lactating women have low knowledge on exclusive breastfeeding as well as weaning issues. They are also burdened by cultural practices, norms and are malnourished themselves. Many poor mothers have to work outside of home and leave their babies with care givers at home. Poor hygiene practices lead to water borne and parasitic diseases and also impact the health of their children. The condition is much worse in the estates.

Communication profile: the available data indicates that a high percentage of mothers obtain health related information from health workers. But the capacity of these health workers need to be improved as indicated in the Health Master Plan, Sri Lanka, Volume 1, November, 2003: "The insufficient quality and competency of health staff has been identified as a challenge for correction. Lack of technical competency and absence of positive humane attitudes have affected the responsiveness of the services." They are also exposed to electronic media- television viewing followed by listening to radio. Print media habit is comparatively lower. A large number of mothers depend on the advice of the elders as well as their friends.

c) Information, Motivation, Skills and an Enabling Environment

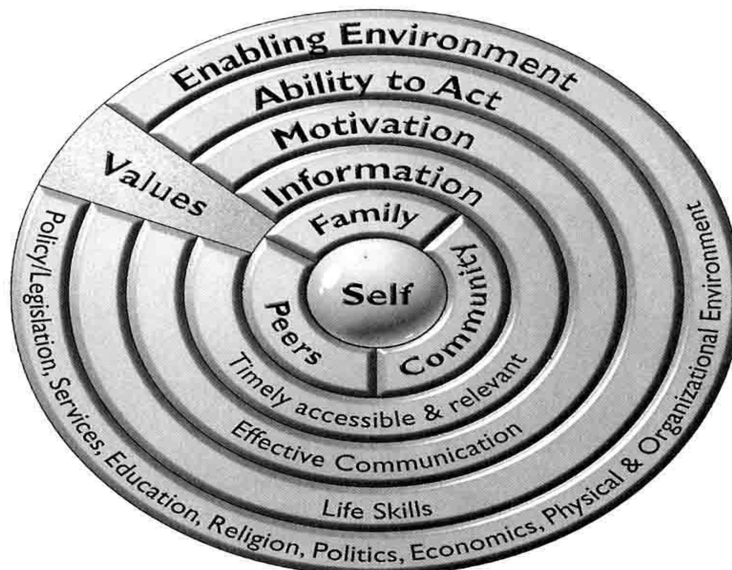
Social and behavior change is often a difficult challenge. For example, communities/audiences need accurate and timely **information** about what malnutrition exactly means, how is it affecting the lives of the children, adolescent, pregnant and lactating women as well as the community at large, what is the connection between gastro-intestinal diseases and parasitic infestations or iodine deficiency in the overall growth, survival and development of children as well as morbidity and mortality of pregnant women. With such information some young people, groups or communities may be empowered to act. These are, usually, the people who are already motivated or empowered through education. Information alone may not be enough for most people,

especially the youth/adolescents. **Motivation** must be provided through appropriate communication, such as effective interpersonal communication, peer education or appealing print materials, or radio or TV programmes with an entertainment-education (EE) focus which the audiences find engaging, relevant and easy to understand. If properly researched, produced and strategically implemented and brought to scale, such communication will promote individual attitudinal and behavior change, as well as influence social norm change.

However, in addition to information and motivation, people, especially children and adolescents/youth may also need the **ability to act** in particular circumstances that may threat their health, well being and survival. Such skills are called psychosocial **life skills**. These are problem solving (in social relationships), decision making, critical and creative thinking, interpersonal communication and other relationship skills such as empathy, and coping with stress and emotions. (See details in the Overall Programme Direction section of this document).

Lastly, continued actions must be taken on creating an overall, **enabling environment** that is needed to sustain primary behavioral change. An enabling environment consists of organizational infra-structures that facilitate required change, access to services, supportive policies and other factors such as supportive educational, cultural/media, religious and socio-economic and socio-political systems that allow sustained change and the growth of human potential. The model below (see Figure 6) demonstrates how all of these elements fit together in a synergistic way.

Figure 6



Behaviour Development and Social Change Model

Appendix 1: sample activity chart for one year

Activity Charts: Advocacy: year 1

Strategy/Activity	J	F	M	A	M	Ju	Jy	A	S	O	N	D
Improved/supportive policies & their implementation												
KAP: children & adolescents living with disabilities; in special needs(affected by conflict, estates, institutions, prisons)		X	X	X	X	X						
Dialogue with top policymakers, Unicef, donors/influentials, Deprt. Of MOHt review existing policies, improve if required & implement		X	X	X	X							
Work with above stakeholders & sensitize them on impact of malnutrition to create an enabling environment	X	X		X	X	X	X	X		X	X	X
Strengthen collaboration with journalists: orientations, meetings	X			X				X			X	
Mainstream EE messages, materials							X	X	X			
Mass dissemination of unicef data (surveys 2003, 2004)	X	X	X									
Panel discussion with mass media, emerging issues, impact of malnutrition, role of civil society & top policy makers		X				X			X			X
Develop materials for journalists (Power point, facts sheets, etc.)	X	X										X
Advocacy meetings to forge inter-ministerial collaboration ; mobilize MOH, MOE to integrate EE approach in school curriculum	X	X		X	X	X	X					X
Organize district based awareness raising programmes							X	X	X	X	X	
Training of trainers in network building & advocacy		X	X	X								
Forging meaningful inter-ministerial collaboration &partnership with the private sector												
Identification of most effective partners for involvement			X	X	X							
Multi-lateral meetings with MOH, MOE, donors & partnership building with the private sector					X	X	X	X				

Sharing statistics, documentation, best practices with ministries/private sector/donors			**X**	**X**	**X**	**X**						
Consultations on role of private sectors to forge collaboration				**X**	**X**	**X**	**X**					
Plan of action for involvement of private sector: long term/short term							**X**	**X**	**X**	**X**		
Development/finalization of national Plan of Action for nutrition												
Work with policy makers to get the National Plan of Action finalized		**X**	**X**	**X**	**X**							
Identify & agree on dissemination efforts of Action Plan						**X**	**X**	**X**	**X**			
Identify mechanisms to ensure "buy ins" of Action Plan implementation by other ministries & stakeholders							**X**	**X**	**X**			

Activity Charts: Behaviour Change Communication : year 1

Strategy/Activity	J	F	M	A	M	J	J	A	S	O	N	D
Reaching "in school," "out of school" children & adolescents & children living with disabilities, children with special needs thru various venues (youth & sports groups,CFS, scouts, guides, etc.)												
Audience segmented approach in developing research based comm. tools with involvement of children/adolescents on specific topics				**X**	**X**	**X**	**X**	**X**	**X**			
Use of existing EE Meena materials on relevant topics for life skills building of children & adolescents (pilot & in phases)			**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**
Expansion & implementation of evidence based efforts (pilot & in phases)						**X**	**X**	**X**	**X**	**X**	**X**	**X**
Supporting peer education & C-T-C approaches			**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**
Capacity strengthening of service providers with regular training	**X**	**X**	**X**	**X**					**X**	**X**		
Use of school & non school venues for behaviour development initiatives		**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**
Integrating nutrition in other ongoing activities focused on children & adolescents	**X**	**X**	**X**						**X**	**X**		**X**
Identify potential interventions	**X**	**X**										
Monitor schools & non school venues for base line				**X**				**X**			**X**	
Pilot testing of the community initiatives & expansion in phases					**X**	**X**	**X**				**X**	**X**
Strengthen nutrition activities in girl guide initiatives			**X**	**X**	**X**							
Strengthening school curriculum to address nutrition issues & its implementation												
Integrate nutrition into existing curriculum-contents to be decided based on research & consultation with children/adolescents, teachers, content specialists		**X**	**X**	**X**	**X**							
Plan for implementation of curriculum					**X**	**X**						
Consultative meeting with curriculum board		**X**	**X**	**X**								
Drafting of content to incorporate into existing curriculum		**X**	**X**									
Pretest & finalize				**X**	**X**	**X**						
Print curriculum							**X**	**X**				
Implement curriculum in phases (some pilot schools in accessible regions									**X**	**X**	**X**	**X**

Activity Charts: Behaviour Change Communication : year 1 contd.

Strategy/Activity	J	F	M	A	M	J	J	A	S	O	N	D
Reaching pregnant & lactating mothers & care givers thru community based associations, clinics, & thru IPC at house hold levels (special focus 0-5 year olds); youth & general population												
Expansion of evidence based initiatives (folk songs, radio & TV programs; jingles, drama, street/community theatre; IPC)			X	X	X	X	X	X	X	X	X	X
Audience segmented approach in development of inter-active & EE behaviour change comm. tools (pictorial booklets; flip charts; flash cards, etc.) based on scientific research & full involvement of target groups-outsourced to ensure quality.			X	X	X	X	X					
Reaching key audiences thru community mechanisms (lactation centres, mothers associations, clubs, festivals)						X	X	X	X	X	X	X
Supporting peer education & C-T-C approaches			X	X	X	X	X	X	X	X	X	X
Capacity strengthening of service providers with regular training	X	X	X	X					X	X		
Implement EE materials at household levels & thru community based associations, private gatherings, venue		X	X	X	X	X	X	X	X	X	X	X
Organize courtyard meetings with key target groups	X	X	X	X	X	X	X	X	X	X		X
Orient SDCs, PTAs on nutrition related issues & discuss at SDC, PTA meetings		X			X			X			X	
Capacity strengthening of service providers (teachers, peer leaders, health staff)												
Reviewing existing training programmes of HWs	X	X	X									
Development participatory modules focusing on contents & facilitation techniques on the basis of scientific research & involvement of service providers - out sourced; adaptations as required			X	X	X	X	X					
Integrate the newly developed module & training into existing system: on the job & in service training (govt, HWs, teachers) & keep provisions fro refreshers' training								X	X	X		
For NGO workers- implement new module as necessary-encourage adaptations as required								X	X			
Train peer educators, Govt. health workers, NGO workers on IPC, interactive methods, how to use comm., materials, courtyard meetings, orientation. Positive attitude building, etc.										X	X	
Address motivational aspects of health workers		X	X	X								
Orientation & training of peer leaders on life skills & inter active methods, use of comm. materials, IPC, etc.												

Activity Charts: Behaviour Change Communication : year 1 contd.

Strategy/Activity	J	F	M	A	M	J	J	A	S	O	N	D
Nutrition communication strategy linked to accessible & client friendly services												
Develop TV &radio programmes (interviews, short drama, songs) on micronutrient deficiencies, male involvement, improved spousal communication, roles/responsibilities of elders, neighbours, friends			**X**	**X**	**X**	**X**	**X**					
Develop radio & TV jingles on breastfeeding, child & care infant care & weaning food			**X**	**X**	**X**	**X**	**X**					
Develop folk songs & jingles for radio& TV on adolescents' nutritional needs, needs of adolescent girls					**X**	**X**	**X**					
Develop radio programmes (interviews, jingles, questions & answers or letter writing programmes on nutrition)			**X**	**X**	**X**	**X**						
Implement the TV & radio programmes							**X**	**X**	X	X	**X**	**X**
Serialize **Meena** comic books on nutrition issues on popular news papers		**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**
Broadcast **Meena** videos on nutrition issues on national & private channels, & NGO mobile units, at Child Friendly (CFS) Spaces & other potential avenues	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**		**X**

Activity Charts: Social Mobilization: year 1 contd.

Strategy/Activity	J	F	M	A	M	J	J	A	S	O	N	D
Participation of civil society, community based stakeholders for reduction of malnutrition among target groups												
Capacity strengthening of civil society on issues related to nutrition, encourage participation of communities on these issues		**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**
Comprehensive use of folk & local media to create awareness among religious leaders								**X**	**X**	**X**	**X**	**X**
Dialogues between various groups on child care & feeding, breastfeeding by mothers living in estates, negative effects of powder milk, care of children of migrating mothers, children with disabilities & their nutritional needs, etc., & to identify community mechanisms to provide support to these issues				**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**
Meetings, deliberations by religious groups (Friday prayer, Sunday at Church, Poya days)- *Pilot interventions in phases & replicate successful experiences*			**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**
Seminars & symposiums		**X**					**X**					**X**
Develop facts sheets & leaflets for religious leaders & implement					**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**

Activity Charts: Social Mobilization : year 1 cont.

Strategy/Activity	J	F	M	A	M	J	J	A	S	O	N	D
Mobilizing new partners												
Dialogue with management of estates & garments factories re nutritional needs of their workers, especially pregnant & lactating mothers, under five children, and above five children & adolescents		X	X	X								
Consultative meetings with management to develop mechanisms to improve nutritional status among key target groups in their estates & factories			X	X	X	X						
Share current statistics & documentation with management			X	X	X							
Develop facts sheets/pamphlets & implements							X	X	X	X	X	X
Orientation of Estate & factory management							X	X				X
Partnership building with managements & media					X	X	X					
Creation of Advocacy group or a task Force to promote networking among estate & factory owners/ managements					X							

<u>* For 2008-2011: based on the activities on chart year one (2007) the activities of following years need to be modified, implemented or incorporated as required. Some activities need to continue till 2011 and some will end earlier based on needs. Activities chart for year 1 can be used as a sample for developing future activities.</u>

Indicator Chart

Advocacy:

Objectives: i) To mobilize bureaucratic & political commitment for improved & supportive/inclusive policies & resources & their effective implementation, & deployment of adequate & trained human resources at all levels to reduce malnutrition;
ii) To advocate for stronger inter-ministerial collaboration & partnership with private sectors
iii) To advocate for the finalization of the national Plan of action on Nutrition

Programme Activities	Output Indicators 2008	Outcome Indicators 2010
Improved/supportive policies & their implementation • KAP: Children & adolescents living with disabilities, in special needs • Dialogue with top policy makers, Unicef, donors/influentials, Depts. Of MOH & review existing policies, improve if required & implement • Advocacy to mainstream EE messages/initiatives	• Research report completed • Number of stakeholders participating in dialogue, by type of stakeholders • Number of master trainers receiving training on advocacy & networking • Number of EE initiatives implemented	• Number of new/improved policies or documented implementation of existing policies
Inter-ministerial collaboration & partnership with private sectors • Identification of effective partners & consultations held • Multi-lateral meetings with MOH, MOE, donors/Unicef (WFP, WB, ADB, ILO)	• Number of partners identified & participated in consultations • Number of participatory meetings with stakeholders	• Number of plans that promote prevention of nutrition for all target groups • Plan of action for collaboration developed
Development/finalization of national Plan of Action on nutrition Work with policy makers	Action plan completed	

Indicators Chart: Behavour Change Communication

Objectives: i) To raise awareness, knowledge, understanding and skills and promote positive behaviours among children, adolescents, pregnant and lactating women, their husbands and the community at large on issues concerning prevention of malnutrition.
ii) To increase the quality of interpersonal communication on prevention of malnutrition between service providers and the target population through proper training of service providers and by implementing participatory interventions at household/community levels.

Programme Activities	Output Indicators 2008	Outcome Indicators 2010
Reaching "in school," "out of school" children & adolescents & children living with disabilities, children with special needs thru various venues (youth & sports groups, CFS, scouts, guides, etc.) • Development of EE materials • Use of existing EE Materials (Meena) • Expansion & implementation of evidence based initiatives	• Number of new EE materials developed • Number of existing EE materials implemented • Evidence based initiatives implemented	• Correct knowledge on malnutrition among children & adolescents
Strengthening school curriculum to address nutrition issues & its implementation • Develop & pretest curriculum • Implement curriculum: TOT for master trainers	• School based curriculum completed & approved by MOE • Number of master trainers receiving training in school based curriculum	• Number of adolescents * children engaged in positive behaviour & acquired life skills
Capacity strengthening of service providers (teachers, peer leaders, health staff) • Development participatory modules focusing on contents & facilitation techniques- adaptations if required • Train peer educators, Govt. health workers, NGO workers on IPC, interactive methods, how to use comm., materials, courtyard meetings, orientation, positive attitude building, etc.	• Number of modules distributed. • Number of service providers received training on module	• Number of service providers with improved capacity & positive attitudes

BCC contd.

Programme Activities	Output Indicators 2008	Outcome Indicators 2010
Nutrition communication strategy linked to accessible & client friendly services		
• Develop TV &radio programmes (interviews, short drama, songs) on micronutrient deficiencies, male involvement, improved spousal communication, roles/responsibilities of elders, neighbours, friends	• Number of electronic materials developed	• Number of target population has correct knowledge on malnutriton & its impact.
• Develop radio & TV jingles on breastfeeding, child & care infant care & weaning food		
• Develop radio programmes (interviews, jingles, questions & answers or letter writing programmes on nutrition) for children & adolescents		
• Implement the materials	• Number of materials implemented	• Percentage of target population having access to Meena comic books & videos
• Serialize **Meena** comic books on nutrition issues on popular news papers	• Number of Meena comic books serialized in number of news papers	
• Broadcast **Meena** videos on nutrition issues on national & private channels, & NGO mobile units, at Child Friendly (CFS) Spaces & other potential avenues	• Number of Meena videos broadcast	
Reaching pregnant & lactating mothers & care givers thru community based associations, clinics, & thru IPC at house hold levels (special focus 0-5 years old infants/children)		
• Reaching key audiences thru community mechanisms (lactation centres, mothers associations, clubs, festivals)	• Number of women reached	• Number of pregnant & lactating mothers having correct knowledge
• Implement EE materials at household levels & thru community based associations, private gatherings, venue		

Indicators Chart

Social Mobilization

Objectives: To build greater alliance with operational partners

Programme Activities	Output Indicators 2008	Outcome Indicators 2010
Participation of civil society, community based stakeholders for reduction of malnutrition among target groups • Capacity strengthening of civil society • Dialogue between various groups	• Number of stakeholders participating in seminars/symposiums	• Number of civil society partners contributing to reduction/prevention of malnutrition
Mobilizing new partners • Develop partnership with owners/ management of estates & garments factories • Develop media partnership	• Number of partnerships finalized with estates, garments factories • Number of journalists trained	• Number of private sector partners contributing to promotion of nutrition efforts

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