REPUBLIC OF ZAMBIA

MINISTRY OF HEALTH

REPRODUCTIVE, MATERNAL, NEWBORN, CHILD AND ADOLESCENT HEALTH AND NUTRITION COMMUNICATION AND ADVOCACY STRATEGY 2018-2021

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FOREWORD

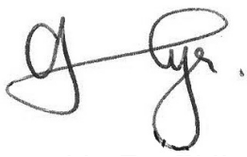
Communication is essential in overcoming hindrances to access or generating demand for services. Within the context of Reproductive Maternal Newborn Child Adolescent Health and Nutrition (RMNCAH-N), communication is an important input into tackling sexual and reproductive health issues including deteriorating indicators, unmet need for RMNCAH-N, poor utilisation of available services as well as weak dissemination of existing policies and guidelines to the lower levels. These have led to a high Maternal Mortality Ratio (MMR) of 398/100,000 live births, neonatal mortality of 24 per 1,000 live births, under-five mortality of 168 per 1,000 live births, 141 adolescent births per 1,000 and 40% stunting rates in under-five children to mention a few.

This Communication Strategy seeks to increase awareness and the level of knowledge in the community on RMNCAH-N continuum of care which includes promotive, preventive, curative, rehabilitative and palliative care. The Strategy also seeks to increase the proportion of national level policy makers' knowledge on the socio-economic significance of RMNCAH-N and allocating adequate resources to meet the needs of Zambians.

The vision of my Ministry is to make Zambia "a nation of healthy and productive people", through primary health care with a focus on community health. The Communication Strategy is in line with the National Health Strategic Plan 2017-2021, the 7th National Development Plan 2017-2021 and the Vision 2030. The plan has been developed through the collaborative efforts of various health sector partners and line ministries. It builds on the achievements and challenges of the 6th National Health Strategic Plan 2011-2016. The strategy will also help us to attain universal health coverage and sustainable development goals.

This Communication Strategy is a milestone in the history of Zambia, as it is specific to Social and Behaviour Change Communication Interventions for RMNCAH-N. Priority will be given to scaling up the implementation of SBCC interventions and activities aimed at enhancing equitable access to RMNCAH- N services. Such measures will include increasing coverage and access to family planning services, reducing morbidity and mortality from pregnancy related conditions, ensuring that most deliveries are conducted under the care of skilled health attendants, improving immunisation coverage for children and strengthening provision of high impact nutrition interventions during the 1000 critical days.

Government will invest substantial resources in building the capacity of communities to take charge of their health. Successful implementation of this plan will require the concerted efforts of all stakeholders involved with RMNCAH-N SBCC within the health sector. I am confident that this strategy, I therefore urge all the stakeholders involved in the implementation of this strategy to fully dedicate themselves to this important cause well implemented, will impact positively on the RMNCAH-N indicators and complement government's vision of achieving a nation of healthy and productive people empowered with knowledge to make informed decisions on RMNCAH-N issues. I therefore urge all the stakeholders involved in the implementation of this strategy to fully dedicate themselves to this important cause.



Honourable Dr. Chitalu Chilufya, MP
MINISTER OF HEALTH

ACKNOWLEDGEMENT

The Communication and Advocacy Strategy for RMNCAH-N is a product of concerted efforts of many organisations. The Ministry of Health would therefore, like to acknowledge all those who were involved, in one way or the other, in the development of this Strategy that will guide the implementation of identified SBCC interventions and activities in order to create demand and improve access to reproductive, maternal, newborn, child health, adolescent and nutrition in Zambia.

We also wish to recognise and thank the various stakeholders in this sector, for their insight and technical assistance that has given reality to the vision of elaborating this document through a highly consultative process.

The development of this Strategy was made possible with financial and technical support from UNFPA.

Dr. Jabbin Mulwanda
Permanent Secretary- Health Services
MINISTRY OF HEALTH

DEFINITION OF TERMS

Advocacy: An organised effort to inform and motivate leadership to create an enabling environment for achieving programme objectives and development goals (to promote the development of new policies, change existing governmental or organisational laws, policies or rules, and/or ensure the adequate implementation of existing policies, to influence funding decisions for specific initiatives).

Advocacy for health: A combination of individual and social actions designed to gain political commitment, policy support, social acceptance and systems support for a particular health goal programme

Behaviour change: Any transformation or modification of human behaviour.

Behaviour Change Communication: Behaviour change communication (BCC) involves the development of tailored messages and approaches to develop, promote and sustain individual, community and societal behavior change. Cognisance is given to cultural diversity and audience reception and a multi-channel approach is employed. BCC can improve and promote dialogue at community and national level on a range of health issues.

Community empowerment: The process of enabling communities to increase control over their lives.

Enabling: In health promotion, enabling means acting in partnership with individuals or groups to empower them, through the mobilisation of human and material resources, to promote and protect their health. The emphasis in this definition on empowerment through partnership and on the mobilisation of resources draws attention to the important role of health workers and other health activists acting as a catalyst for health promotion action, for example by providing access to information on health; by facilitating skills development and supporting access to the political processes which shape public policies affecting health.

Health behaviour: Any activity undertaken by an individual, regardless of actual or perceived health status, for the purpose of promoting, protecting or maintaining health, whether or not such behavior is objectively effective towards that end.

Health communication: The study and practice of communicating promotional health information, such as in public health campaigns, health education and communication between doctor and patient to influence personal health choices by improving health literacy. Health communication is a key strategy to inform the public about health concerns and to maintain important health issues on the public agenda. The use of the mass and multimedia and other technological innovations to disseminate useful health information to the public, increases awareness of specific aspects of individual and collective health as well as importance of health in development. Health communication encompasses several areas including edutainment or entertainment-education, health journalism, interpersonal communication, media advocacy, organisational communication, risk communication, social communication and social marketing

Health development: Health development is the process of continuous, progressive improvement of the health status of individuals and groups in a population

Health gain: Health gain is a way to express improved health outcomes. It can be used to reflect the relative advantage of one form of health intervention over another in producing the greatest health gain. The Jakarta Declaration indicates that health promotion "acts on the determinants of health to create the greatest health gain for people.

Health indicator: A health indicator is a characteristic of an individual, population, or environment which is subject to measurement (directly or indirectly) and can be used to describe one or more aspects of the health of an individual or population (quality, quantity and time).

Health outcomes: A change in the health status of an individual, group or population which is attributable to a planned intervention or series of interventions, regardless of whether such an intervention was intended to change health status.

Health policy: A formal statement or procedure within institutions (notably government) which defines priorities and the parameters for action in response to health needs, available resources and other political pressures. Health policy is often enacted through legislation or other forms of rule-making which define regulations and incentives which enable the provision of health services and programmes, and access to those services and programmes.

Health promotion evaluation: Health promotion evaluation is an assessment of the extent to which health promotion actions achieve a "valued" outcome. The extent to which health promotion actions enable individuals or communities to exert control over their health represents a central element of health promotion evaluation. In many cases it is difficult to trace the pathway which links particular health promotion activities to health outcomes.

Health promotion outcomes: Health promotion outcomes are changes to personal characteristics and skills, and/ or social norms and actions, and/or organisational practices and public policies which are attributable to a health promotion activity. Health promotion outcomes represent the most immediate results of health promotion activities and are generally directed towards changing modifiable determinants of health. Health promotion outcomes include health literacy, healthy public policy, and community action for health. See also health outcomes and intermediate health outcomes.

Health Promotion: Health promotion enables people to increase their control over, and improve their health. It is an approach that involves the population as a whole in the context of their everyday lives, rather than focusing on people at risk of specific diseases, and one that is directed towards action on the determinants or causes of health and well-being.

Health literacy: The degree to which individuals have the capacity to obtain, process and understand basic health information and services needed to make appropriate health decisions

Health system literacy: The ability of people and care providers to navigate the health system for effective utilisation and improvement of health care services

Health promotion: The process of enabling people to increase control over their health and its determinants, and thereby improving their health

Policy Advocacy: Policy advocacy is a strategy to influence policy makers through persuasive communication when they make laws and regulations, distribute resources, and make other decisions that affect peoples' lives. The principal aims of advocacy are to create policies, reform policies and ensure policies are implemented. There are a variety of advocacy strategies, such as discussing problems directly with policy makers, delivering messages through the media, or strengthening the ability of local organisations to advocate.

Public health emergency: An occurrence or imminent threat of an illness or health condition caused by bioterrorism, epidemic or pandemic disease, or a novel and highly fatal infectious agent or biological toxin that poses a substantial risk of a significant number of human facilities or incidents or permanent or long-term disability

Socio-ecological model: A theory-based framework for understanding the multifaceted and interactive effects of personal and environmental factors that determine behaviours, and for identifying behavioural and organisational leverage points and intermediaries for health promotion within organisations

Social and Behavioural Change Communication (SBCC): The systematic application of interactive, theory-based, and research-driven communication processes and strategies to address tipping points for change at the individual, community and social levels. A tipping point refers to the dynamics of social change, where trends rapidly evolve into permanent changes. It can be driven by a naturally occurring event or a strong determinant for change, such as political will that provides the final push to tip over barriers to change. Tipping points describe how momentum builds up to a point where change gains strength and becomes unstoppable

Social mobilisation: A continuous process that engages and motivates various intersectoral partners at national and local levels to raise awareness of, and demand for, a particular development objective. These partners may include government policy makers and decision makers, community opinion leaders, bureaucrats and technocrats, professional groups, religious associations, non-governmental organisations, private sector entities, communities, and individuals. This communication approach focuses on people and communities as agents of their own change, emphasises community empowerment, and creates an enabling environment for change and helps build the capacity of the groups in the process, so that they are able to mobilise resources and plan, implement and monitor activities with the community

ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
ANC	Ante Natal Care
ARVs	Anti Retro Viral Drugs
CBO	Community Based Organisation
CHNP	Child Health and Nutrition Programme
CSO	Central Statistical Office
DHD	District Health Director
DHPESD	Department of Health Promotion Environmental and Socio Determinants
eMTCT	Elimination of Mother to Child Transmission
EPI	Expanded Programme of Immunisation
FBO	Faith Based Organisation
FP	Family Planning
GBV	Gender Based Violence
GMP	Growth Monitoring Programme
HHs	Households
HMIS	Health Management Information System
HIV	Human Immuno-deficiency Virus
ICCM	Integrated Community Case Management
IEC	Information Education and Communication
IMCI	Integrated Management of Childhood illnesses
ITN	Insecticide Treated Net
IUD	Intra-uterine Device
KAP	Knowledge Attitude and Practice
LAM	Lactational Amenorrhea Method
LARC	Long Acting Reversible Contraceptives
MDGs	Millennium Development Goals
MNCH	Mother, Newborn and Child Health
NAIS	National Agriculture Information Services
NHCs	Neighbourhood Health Committees
NHSP	National Health Strategic Plan
NMCC	National Malaria Control Centre
PMTCT	Prevention of Mother to Child Transmission
PHD	Provincial Health Director
PNC	Post Natal Care
RED	Reaching Every District
TT	Tetanus Toxoid
TV	Television
HRT	Hormone Replacement Therapy
PCR	Polymerase Chain Reaction
RMNCAH-N	Reproductive Maternal Newborn Child Adolescent Health and Nutrition
SRHS	Sexual Reproductive Health Services
SBCC	Social Behaviour Change Communication
SCC	Social Change Communication
SIAs	Supplementary Immunisation Activities
SMAGs	Safe Motherhood Action Groups
SRH	Sexual and Reproductive Health
STIs	Sexually Transmitted Infections
TB	Tuberculosis
UCI	Universal Childhood Immunisation
UNFPA	United Nations Population Fund

UNICEF	United Nations International Children's Emergency Fund
USAID	United States Agency for International Development
WHO	World Health Organisation
WILSA	Women in Law in Southern Africa
ZANIS	Zambia National Information Services
ZDHS	Zambia Demographic Health Survey

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GUIDING PRINCIPLES OF THE COMMUNICATION STRATEGY

The RMNCAH-N communication and advocacy strategy outlines the following guiding principles for planning, designing, implementing, monitoring and evaluating social and behaviour change communication interventions for Reproductive Maternal, Newborn, Child, Adolescent Health and Nutrition programme.

1. **Advocacy related** – Social and Behaviour Change Communication should target individual and policy makers in order to influence the adoption of healthier behaviour.
2. **Advocacy is a type of SBCC** whose target audience is policy makers or decision makers. The objective is usually to encourage these people to provide more resources and support for a programme or policy that will benefit people. Although the communication materials and activities are likely to differ from those used with different audiences, the planning steps should be the same.
3. **Benefit Oriented** - The client must perceive the benefit of adopting the targeted behaviour
4. **Client–centered** - A client centered approach involves audiences in determining their health needs and engages them in the process of developing messages that address those needs.
5. **Cost effective** -SBCC resources should be focused towards a combination of the most effective channels.
6. **Culturally appropriate** - all programmes should be in tandem with the culture of the environment in which they are being implemented.
7. **Expanded to scale-** SBCC is effective when successful efforts can be scaled up.
8. **Gender considerations** – gender issues should be considered where appropriate.
9. **Linked services** – Health Promotion Services should be directed towards specific services and enhance self-efficiency and community empowerment.
10. **Multi channeled** – the use of complimentary channels or ways to reach target audiences has been shown to increase effectiveness of BCC.
11. **Participatory**-clients should be involved throughout the communication process including programme design, implementation and evaluation.
12. **Benefit oriented**- the messages will focus on the benefits perceived by the clients for adopting the targeted behaviour.
13. **Programmatically sustainable**- SBCC programmes should aspire to create sustainable social change.
14. **Results oriented**- the effectiveness of the RMNCAH-N communication and advocacy strategy will be determined by the outcomes of increased knowledge, approval, and adoption of healthy norms or behaviours and these should be verified by research.
15. **Science based**-RMNCAH-N strategy planning will use accurate data and theory to inform and guide activities.
16. **Technical quality** – Social and Behaviour Change Communication (SBCC) should aim for high quality messaging and products.

SECTION 1: SITUATION ANALYSIS

Overview of Reproductive Health in Zambia

Remarkable improvements have been achieved in reducing Maternal Mortality Ratio (MMR) from 591/100,000 live births in 2007 to 398/100,000 in 2014(DHIS). Despite the decrease, maternal mortality is still high in absolute terms, and Zambia was not able to achieve the MDG target of 162 per 100,000 live births at the end of 2015. (Refer to the MDG report 2015).

About 59% of adolescent girls become pregnant by the age of 19. Teenage pregnancies reported among girls in grades 1-12 increased 5 times (from 3,663 to 14,849) between 2002 and 2012 and in 2007 adolescent births accounted for nearly 11.8% of births nationally according to Ministry of Education. However, according to ZDHS, the adolescent fertility rate has slowly been declining from 146 births in 2007 to 141 births per 1,000 adolescent girls in 2014, with teenage pregnancies in rural areas standing at 36 % and urban areas at 20% of all pregnancies (2014 ZDHS). A related fact is that 42% of women aged 20-24 in Zambia report to have been married by 18 years.

There has been significant progress in the provision of family planning services, with the contraceptive prevalence rate for modern family planning methods having been estimated to have increased from 33% to 45% and unmet need reducing from 27% to 21% in 2007 and 2013 respectively. Despite the nearly universal knowledge of family planning, the total fertility rate is still high at 5.3%, with the rural urban disparity reporting at 6.6% and 3.7% respectively.

The ZDHS 2013-14 statistics show that although 96% of the pregnant women attend ante-natal care (**ANC**) services at least once during pregnancy, only 24% initiated ANC in the first trimester and 25% made a minimum of 4 visits during their pregnancy.

According to the 2013-14 ZDHS, the deliveries in health facilities stood at 67% while 64% were attended to by skilled birth attendants.

A National Emergency Obstetric and Newborn Care (EmONC) Assessment conducted in 2013/2014 revealed that only 18% of the designated EmONC facilities were fully functional with all the seven signal functions available. This contributed to the unmet need for EmONC services, caesarean section rate, which was estimated at 3.6% and is below the globally acceptable standard of 5.5%.

According to ZDHS 2013 -14 the uptake of post-natal services within 48hrs stood at 63% and uptake within six days was estimated at 65.7%, which both fall below the World Health Organisation acceptable levels where all post-natal mothers (100%) are supposed to receive post-natal care (WHO, 2014).

Zambia has made substantial improvement in institutionalisation of Maternal Death Surveillance Reviews(MDSRs) using the WHO Guidelines, with all provinces and districts having started to conduct maternal death reviews. The 2014 MDSR report indicates that 84% of maternal deaths occur in health facilities and most of them being in first level and tertiary level hospitals. The report also revealed that maternal death was less likely to occur if referral was made from lower to higher level facilities as opposed to referral to a facility of the same level (MoH, UNFPA, and 2014 MDSR Report).

Nevertheless, there are weaknesses in surveillance and response mechanisms to address the identified challenges. Additionally, there is weak perinatal death surveillance despite high numbers of fresh still births being reported.

Obstetric fistula remains to be among the major health challenges. In the past 10 years, the Ministry of Health has surgically repaired close to 2000 fistula clients.

Another major contributing factor to maternal morbidity and mortality is Sexual and Gender Based Violence (SGBV). According to the 2013-2014 ZDHS, 47% of all married women aged 15-49 reported experiencing physical, sexual and emotional violence from their current or most recent partner.

1.1 Family Planning: Zambian Context

Family planning continues to be a priority for the Government of the Republic of Zambia (MoFNP 2014). Zambia has a total population of 14.5 million with a fertility rate of 5.3 births per woman and a 2.8% population growth rate. Family planning is one of the most cost-effective ways to prevent maternal, infant and child mortality by reducing the number of pregnancies, the number of abortions and the proportion of births at high risk. ZDHS 2013-14, estimated that meeting women's need for modern contraceptives would save about 140,000 to 150,000 lives a year (CSO, 2014).

The Government of the Republic of Zambia has committed to increasing the contraceptive prevalence rate (CPR) for modern methods from 33% in 2007 to 58% by 2020. Family planning offers a host of additional health, social and economic benefits: it can help reduce infant mortality, slow the spread of HIV/AIDS, promote gender equality, reduce poverty, accelerate socio-economic development and protect the environment. The development and implementation of the Eight-Year Integrated Family Planning Scale-Up Plan 2013-2020 has initiated a variety of efforts to increase FP uptake. With support from partners, some notable achievements have been attained successfully and these include increasing access to long acting FP methods; enlarging programmes of community-based distribution of condoms, pills and provision of injectable contraceptive (Depo- Provera). Substantial work on the standardisation of training materials has also been implemented. The contraceptive prevalence rate (CPR) is at 49% for all methods (45% for modern FP methods) and the unmet need for FP is 21.1%. (CSO, 2014). Zambia's FP 2020 priorities to help meet the set objectives include:

a) **FP demand generation and behaviour change communication**: To strengthen demand for family planning services by repositioning FP as a key driver in development and providing targeted, easily-accessible and accurate information to the population;
b) **Adolescents and youth**: To more effectively target and serve adolescents and youth with quality accessible sexual and reproductive health information and services in and out of school;
c) **Staff and training**: To build capabilities of providers and increase capacity to deliver high quality contraceptive services, including long-acting reversible contraceptives;
d) **Rural and underserved access to FP services**: To increase coverage and access to quality integrated FP services available to those living in rural and underserved areas;
e) **Stock outs at service delivery points**: To improve the distribution, availability and security of family planning commodities from the central level to service delivery points, including both contraceptives and consumables;
f) **FP governance structure and programme coordination**: To strengthen the central, provincial and district-level FP structures to better coordinate and monitor government and partner activities, in order to deliver services efficiently.

Knowledge of contraceptive methods is an important precursor to women's contraceptive use. However, ability to recognise a family planning method when it is described does not always translate into use of FP services. More information is needed if one is to make an informed choice. According to the 2013-14 ZDHS, knowledge of contraception is nearly universal in Zambia. The survey reported that modern methods are more widely known than traditional methods; almost all women know of a modern method, while 75% know of a traditional method. Male condoms 97%, the pill 96%, and injectable 95% are the most commonly known modern methods among women, with 90% mentioning female condoms and implants at 87%.

Among all men the most common methods of contraception known are the male condom 99%, pill 92%, and injectable 87% and female condoms 86%. Knowledge of the IUD, Standard Days Method, female and male sterilisation, Lactational Amenorrhea Method (LAM), and emergency contraception are known by smaller percentages of women and men (CS0, 2014). One in two currently married women uses a method of contraception, with most women using a modern method (45 %). Forty-nine percent (49%) of currently married women are using a method of family planning; 45% a modern method and 4% a traditional method. Use of any method is higher among women who are currently married (49%) than among sexually active unmarried women (39 %). A similar pattern is seen in use of modern methods for currently married women (45 %) and sexually active women (38 %).

Injectable contraceptives are the most widely used modern method (19%) among currently married women, followed by the pill (12 %), implants (6 %), and the male condom (4 %). Modern contraceptive use varies by age. Use of any modern method is lower among the youngest (36 %) and oldest (28 %) cohorts of women compared with those aged 20-44. Use of any modern method is highest among those aged 25-34 (49%). 21% of currently married women have an unmet need for family planning services, with 14 % having an unmet need for spacing births and 7% having an unmet need for limiting them. 7% of contraceptive users discontinued using a method within 12 months of starting its use because of side effects, health concerns, or both (CSO,2014). The government sector remains the major provider of contraceptive methods, serving more than four in five users (82 %).

1.1.1 Demand Awareness of FP among Zambians

Demand-side obstacles that prevent adoption of FP among those who know about it include actual or feared partner/spousal disapproval, myths, rumours, religious beliefs, large desired family size, misinformation about FP, including fears of side effects and health concerns.

Women in rural areas, youth, men, and or persons with special needs can be difficult to reach with accurate information to generate demand for family planning.

Lack of knowledge and accurate information is a barrier for long-acting reversible contraceptives. In addition, representatives from MoH and NGOs in Zambia report that various negative myths and false beliefs about LARC exist in communities; for example, implants and IUDs can move around the body, becoming lodged in the brain, the heart or a growing foetus; and that fertility will not return after LARC removal. Some Zambian health care providers also have negative beliefs about IUDs such as they cannot be used by women who have never had children (MoH, 2013.) Exposure to FP messages through different media can increase awareness of contraceptive methods, access and availability for non-users.

Programme managers and planners can effectively use different media platforms to communicate with their target population subgroups for information, education and communication campaigns.

1.2 Maternal Health

The Zambian health system continues to improve access to maternal health services in order to improve the health of women and reduce mortality ratio. Maternal mortality has declined from 591/100,000 in 2007 (ZDHS 2007) live births to the current ratio of 398/100, 000 live births in 2014 (ZDHS 2013 - 14). The proportion of deliveries by skilled health attendants is at 64% while facilities deliveries are at 67% (ZDHS 2013-14).

Zambia has one of the highest maternal mortality ratios whose common causes of maternal deaths include; hemorrhage (34%), sepsis (13%), abortion complications (4%), hypertensive disorders - eclampsia (5%) and obstructed labour (8%).

Although 95% of the pregnant women attend ANC services at least once during pregnancy, only 24% initiate ANC in the first trimester and 56% make a minimum of 4 visits during their pregnancy (ZDHS, 2013/14).

On average pregnant women initiate antenatal care by 4.8 months of gestation, thereby reducing opportunities for early detection of danger signs and the adequate management of maternal complications. The Government of Zambia has committed to reducing the maternal mortality to less than 000,000 live births by 2021.

Over 90% of health facilities provide EMTCT services; currently 89% of HIV positive pregnant women are initiated on ART contributing to a reduction of the transmission to infants at six weeks from 9% in 2013 to 4% in 2015 (MOH 2015 HMIS Report).

1.2.1 Safe Motherhood

Safe motherhood addresses service delivery for improvement of the health of the mother and the new-born baby. It means ensuring affordable, quality care for the mother and the new-born as close to the family as possible. Factors contributing to poor quality of safe motherhood services include inadequate infrastructure, insufficient skilled health personnel, an inefficient referral system, inadequate supplies of drugs, inadequate family planning services and information, lack of knowledge of danger signs and complications, young maternal age at first pregnancy and harmful traditional practices during labour and delivery.

1.2.1.1 Ante Natal Care (ANC)

Zambia is among the Southern African countries with a high percentage of ANC attendance and previous studies show that on average 96% of pregnant women have received at least one ANC checkup. However, there are concerns that the average time for the first ANC visit in Zambia is at about

4.8 months of gestation (ZDHS 2014), which signifies missed opportunities for critical early ANC interventions. Every pregnancy carries a risk and 10% of pregnancies result into complications and it is important that danger signs related to obstetric emergencies are recognised promptly and treatment instituted as soon as possible. Antenatal care can reduce risks and at least eight (8) contacts are recommended, with the first visit early in the pregnancy (during the first three months). Therefore, women are encouraged to deliver at health facilities where they will be attended to by trained health personnel as opposed to delivering at home.

1.2.1.2 eMTCT

In Zambia, mother to child transmission of HIV is reported to account for about 10 % of all new infections, and contributes to the high morbidity and mortality among under five children (ZAMPHIA, 2016). Uptake of ART by HIV positive pregnant women to reduce Mother to Child transmission has increased from 67% in 2007 to 89% in 2014 (ZDHS, 2014). Zambia is working to eliminate transmission of mother to child from 5% in 2016 to 1% by 2021 (NHSP 2017-2021).

1.2.1.3 Postnatal

The postnatal period is the first six weeks after delivery and crucial to the health and survival of the mother and new born. According to the Zambia Demographic and Health Survey, 28% of women did not receive any postnatal care, however, there has been a notable increase in women who received postnatal care at 48 hours from 39% in 2007 to 63.4% in 2014. The perinatal mortality rate for Zambia is 31 deaths per 1,000 pregnancies (ZDHS 2014). It tends to decrease with increasing length of birth intervals and is higher among mothers younger than 20 years old.

1.2.1.4 Obstetric Fistula

Obstetric Fistula is caused by prolonged labour and or poorly performed abortions, pelvic fractures; cancer or radiation therapy targeted at the pelvic area, sexual abuse, rape, trauma and infected episiotomies after childbirth. The recent fistula tracking report for 638 women treated revealed that 64.9% were completely healed at the time of the study (MoH & UNFPA, 2015). Most of the surgical operations are done through “fistula repair camps” because there is limited institutional capacity in all provinces for conducting routine fistula repair. Additionally, there is limited data on the magnitude of Obstetric Fistula cases in Zambia making it difficult to design interventions.

1.3 Newborn Health

The first 28 days of life (the newborn period) represents the most vulnerable time for a child’s survival. In 2016, 2.6 million deaths, or roughly 46% of all under-five deaths, occurred during this period. This translates to 7000 newborn deaths every day. The majority of the neonatal deaths are concentrated in the first day and week, with about 1 million dying on the first day and close to one million dying within the next six days (WHO, 2017).

Reducing neonatal mortality is important not only because the proportions of under-five deaths that occur during the newborn period is increasing as under-five mortality declines, but also because the health interventions needed to address the major causes of newborn deaths generally differ from those needed to address other under-five deaths. While efforts to reduce maternal and child mortality rates over the past 20 years have had a striking impact, stillbirths and newborn deaths have over the same period missed out on the attention they need (WHO, 2017).

The vast majority of newborn deaths take place in developing countries where access to health care is low. Most of these newborns die at home, without skilled care that could greatly increase their chances for survival. Nearly half of all newborns do not receive skilled care during and immediately after birth and up to two thirds of deaths can be prevented by skilled health care during pregnancy, childbirth and in the postnatal period. In addition, WHO and UNICEF now recommend home visits by a skilled health worker during a baby's first week of life to improve newborn survival. Newborns in special

circumstances, such as low-birth-weight babies, babies born to HIV-positive mothers, or sick babies, require additional care and should be referred to a hospital. Early initiation of breastfeeding within one hour of birth can protect the newborn from acquiring infections and significantly reduces infant mortality.

In the African region, 1.12 million newborn deaths occur annually. The main causes include prematurity and low-birth-weight, infections, lack of oxygen at birth, and birth trauma. These causes account for nearly 80% of the deaths in this age group. Many newborns that are born prematurely are more susceptible to infections such as HIV. Preventative antiretroviral therapy (ART) can help prevent otherwise high transmission rates (WHO, 2015).

The Zambia Demographic and Health Survey has reported a significant decline in overall child mortality rates. The neonatal mortality rate (NMR) however, decreased minimally from 34 per 1000 live births in 2007 to 24 per 1000 live births in 2014 (CSO,2014). Currently, the high impact RMNCAH-N interventions are not universally accessible and implementation has omitted some of the proven effective interventions such as social behavioural change communication. The family and community package tends not to be effectively linked with the health system. These omissions in implementing effective RMNCAH-N interventions result in uneven achievements of impacts outcomes. There is an urgent need to concentrate on adequately linking the community initiatives to the facility based interventions if the gaps in the continuum of care model are to be reduced. The global Every Newborn Action Plan (ENAP), launched in 2014, provides a road map of strategic actions for ending preventable newborn mortality that include community interventions, but these have not been adapted to the Zambia context.

1.3.1 Paediatric HIV

Zambia is among the 25 countries with highest estimated numbers of pregnant women living with HIV who are in need of antiretroviral treatment to prevent mother-to-child transmission of HIV and the corresponding number of children who are in need of ART. Prevention of mother-to-child transmission of HIV (PMTCT) is a key strategy to reducing Paediatric HIV infections. According to a recently released report on Towards Universal Access on HIV and AIDS, Zambia has made good progress (ZAMPHIA, 2015).

According to the ZDHS 2014, 40% proportion of pregnant women living with HIV are on antiretroviral therapy (ART), 96 % of pregnant women attend antenatal care (ANC) services at least once during their pregnancy, but only 56% of women reported visiting ANC clinics at least four times during pregnancy. Therefore, numerous missed opportunities exist for identifying HIV positive pregnant women and to initiate treatment. Many women also report late for antenatal care, with only 24% of pregnant women having their first antenatal visit in the first trimester of pregnancy. With 67% of pregnant women delivering at health facilities, there are immense challenges to ensure that eligible pregnant women receive treatment to prevent transmission of HIV to their babies. However, while prevention and treatment services have rapidly expanded, access to treatment and use of more efficacious EMTCT regimens in rural areas has not kept pace with urban and peri-urban centres.

1.4 Child Health

Steady progress has been made in child health in Zambia and this is illustrated by the reduction in the morbidity and mortality rates. Mortality under age five and infant mortality reduced from 168 to 75 per 1,000 live births respectively, between 2002 and 2014. The ZDHS 2013-2014 report, estimated neonatal mortality rate at 24 per 1,000 live births, constituting approximately half the number of all infant deaths. Although the Neonatal Mortality Rate has declined from 34 per 1,000 live births in 2007, it

remains unacceptably high at 24 per 1,000 live births in 2013-2014. Children under five are also affected by high rates of chronic malnutrition at 40% (ZDHS 2013/14) and limited Early Childhood Development (ECD) interventions. While the trends have been declining, there is need to strengthen interventions that can foster child development beyond survival, as children need to survive and thrive.

1.5 Adolescent Health

Zambia has the fifth highest birth rates among adolescents in sub-Saharan Africa, which in turn places it among the highest in the world. About 29% of adolescent girls become pregnant by the age of 19 years (ZDHS 2013-2014). Teenage pregnancies reported among girls in grade 1-12 increased five times from 3, 663 in 2002 to 15,125 in 2015 according to the Ministry of General Education (MOGE Statistical Bulletin, 2015). However, the ZDHS 2013-2014 statistics show that the adolescent fertility rate has slowly been declining from 146 births in 2007 to 141 births in 2014 per 1,000 adolescent girls in 2014, with teenage pregnancies in rural areas standing at 36% and urban areas at 20% of all pregnancies. About 32% of adolescents aged 15-17 years and 60% of those aged 18-19 years are sexually active in Zambia, and therefore face the risk to HIV and other STIs, especially as only 40% of them report regular condom use (ZDHS 2013-20-14). A related fact is that 42% of women aged 20-24 in Zambia report having been married by the age of 18.

According to the ZDHS, 2013-2014, contraceptive prevalence rate for modern family planning methods among adolescent girls aged 15-19 was 10.2%, despite the rate having been estimated to have increased from 33% to 45% in the general population. Adolescents also experience other problems that include mental health, trauma, physical and sexual violence, non-communicable diseases, alcohol and substance abuse.

Key challenges are the following:

- Inadequate implementation of ADH strategies at lower levels
- Inadequate knowledge among adolescents of existing health services
- Inadequate knowledge among health care workers of key adolescent health issues
- Inadequate HIV/SRH outreach services for adolescents
- Lack of ADH –specific indicators in the current HMIS

1.6 Nutrition

Good nutrition is a prerequisite for wellbeing of individuals and national development. Zambia has experienced under-nutrition which depicts deficiencies of either or both macro and micronutrients in an individual or populations for decades. These nutritional deficiencies manifest in conditions such as; stunting, wasting, underweight and micronutrient deficiencies, which if not addressed have irreversible damaging effects on cognitive and intellectual capabilities of children. Common micronutrient deficiencies in children below the age of five and women of reproductive age include; Vitamin A deficiency, iron deficiency, Iodine Deficiency Disorders (IDD) and low birth weight babies. In addition to under nutrition, over-weight trends have begun to rise among the Zambian population, posing a threat to increase in non- communicable diseases.

The 2014 Zambia Demographic Health Survey statistics on under five malnutrition were: stunting 40%; underweight 15%; wasting 6% and low birth weight at 9%. Overweight among the under-fives was 5.6% and 23% among women of child bearing age. Out of 40% stunting rates, 17% was severe stunting and the age group of 18-23 months was most affected at 54%. Similarly, the higher percentage of under - weight children was among those aged 18-23 months. This signifies a major problem associated to chronic inadequate feeding practices during either infancy or early childhood periods. Minimum acceptable diet among the 6-23 months children was very low at 11%. Out of the 6% wasting, 2% was severe wasting; and severe underweight was at 3% out of 15%. The poor nutritional status among children under two years, calls for more attention in this age group.

Trends in Child Nutrition Status show persistent under nutrition problems with moderate reduction in levels of stunting in 2013-14 compared to levels in 1992. This situation can be attributed to poor nutrition during 1000 days covering the period from pregnancy to the first 2 years of a child's life.

Zambia faces a double disease burden of both communicable and non-communicable diseases; mostly due to exposure to malnutrition across the life cycle. Malnutrition is characterised by the prevalence of under nutrition, but over-nutrition is present in the same population. While under nutrition makes people prone to communicable diseases, over-nutrition is a key driver of non-communicable diseases such as obesity, hypertension, diabetes and cardiovascular diseases. Other issues are lifestyle factors, lowered energy expenditure and changes in dietary habits (excessive consumption of fast foods) have a tendency to promote obesity and degenerative disorders. Response to nutrition problems is now through a multisectoral approach given the multifaceted causal factors (UNICEF, 1990). Addressing malnutrition issues effectively requires participation of other sectors such as Agriculture, Social Development and Welfare, Sanitation and Water Development, Education, Gender and Traditional Affairs. These are all party to the Scaling up Nutrition and the 1st 1000 Most Critical Days Programme addressing malnutrition in Zambia. In addition, all continuum of care interventions should ensure nutrition is well embedded.

1.7 Cancers of The Reproductive Organs

1.7.1 Cervical Cancer

Cervical Cancer is one of the emerging health problems in Zambia. The estimated age standardised incidence and mortality rates from cervical cancer are 58.0 and 36.2 per 100,000 women respectively. Cervical Cancer is the most common cancer seen at Cancer Diseases Hospital in Lusaka, comprising approximately 35% of all cancers. Cancer of the cervix is preventable, easily detectable, and curable in its early stages, but lack of awareness and limited screening programmes result in the majority of women presenting at late stages with invasive and advanced disease when it is very difficult and expensive to treat.

1.7.2 Breast Cancer

In Zambia, breast cancer is second to cervical cancer in incidence rates among women (22.4 per 100,000). It is estimated that breast cancer in Zambia kills approximately 400 women each year (Globocan, 2012). According to data from CDH, breast cancer cases make up 9% of all cases seen at CDH. Screening and surgical treatment along with general prevention efforts can be implemented commensurate with the scale up of capacity for laboratory diagnostics and surgical, chemotherapy, and radiotherapy capacity. Introduction of community breast self -awareness and encouraging women to seek out care when symptoms or signs are initially detected is critical to improving treatment and survival rates in the country. Zambia should scale up early diagnosis activities with breast ultrasound and ultrasound guided core biopsies. To facilitate breast cancer screening and early diagnosis, the Zambian government has installed ten analogue mammography units placed in nine provincial hospitals

1.7.3 Prostate Cancer

Prostate cancer is the most common cancer seen amongst men at Cancer Diseases Hospital in Lusaka, representing 5% of all cancers. Zambia is estimated to have a slightly above average incidence of prostate cancer, but has one of the world's highest estimated mortality rates from prostate

cancer. Zambia's incidence and mortality rates from prostate cancer are at 21.9 and 18.2 per 100,000 men respectively. The average age of a man diagnosed with cancer at CDH is 71 years of age.

1.8 Infertility

The rates of infertility in Zambia are not known but gauging from the prevalence of STIs alone, it is estimated that both primary and secondary infertility rates are of concern. Impaired fertility, variously described as infertility or sub-fertility, may be due to a relative or absolute inability to conceive, or to repeated pregnancy wastage. It affects both men and women in approximately equal proportions, causing considerable personal suffering and disruption of family life. As in many other societies, in Zambia the inability to conceive and bear a healthy child is considered to be the fault of the female partner rather than a problem of the couple. The lack of access to effective treatment, or to counselling causes much personal suffering and family and social dysfunction. Most infertility is preventable, through measures to reduce reproductive tract infections and improve their management. In contrast, infertility is generally difficult and costly to treat. It is cost-effective to focus on prevention, especially in resource-poor settings.

1.9 Menopause

Menopause, the permanent cessation of menstruation generally occurs between the ages of 45-55. The median age of menopause is 50-52 in industrialised countries and about one to two years younger in developing countries. The menopausal transition lasts about four years. Specific diseases associated with the hormonal changes accompanying menopause include circulatory diseases and osteoporosis.

In the 2013-14 ZDHS, women were considered menopausal if they were neither pregnant nor postpartum amenorrhoeic and had not had a menstrual period for at least six months preceding the survey. The proportion of women who were menopausal increased with age; from 2 percent among women aged 30-34 to 50 percent among those aged 48-49. Overall, 8 percent of women aged 30-49 were menopausal. The proportion of currently married women aged 48-49 who were menopausal increased from 47 percent in 2007 to 50 percent in 2013-14. In addition to irregular bleeding patterns and eventual cessation of menses, pre-menopausal and menopausal women may experience vasomotor symptoms (hot flushes, night sweat), urogenital problems and psychological symptoms. Not all women experience or report all these symptoms; some symptoms are experienced more commonly before and during menopause and others after.

Declining estrogen levels which lead to urogenital atrophy (decreased vaginal and bladder muscle tone), a thinner vaginal epithelium and vaginal dryness, making intercourse painful is another post-menopausal problem. Urinary problems - urgency of urination, pain on urinating, and incontinence (leaking urine) - are reported to affect 25-50 percent of postmenopausal women. Pelvic floor muscles that have been damaged from repeated pregnancies further compound the problem or urinary incontinence. Certain health risks, including cardiovascular disease and osteoporosis, increase after menopause.

Postmenopausal women have higher cholesterol levels than premenopausal women. Menopause also triggers a process of reduction in bone mass that can result in pain, disability and increased risk of fractures in women aged 60-80.

1.10 Gender Based Violence

Zambia has in the recent past seen an increase in the number of Gender Based Violence especially against women. GBV takes many forms including physical, sexual, psychological and economic violence. The patterns and prevalence of violence vary from place to place and may take many forms,

but mainly disproportionately impacts women and girls because of their subordinate status. The prevalence rates for some form of violence are better documented than others. For instance, physical violence is more documented in statistics than psychological violence. Violence against Women (VAW) is understood to encompass, but not limited to physical, sexual and psychological violence occurring in the family and general community. The Zambia Demographic and Health survey 2014 shows that the common types of violence against women include emotional, physical and sexual violence. The results show that more than 54% of Zambian women aged 15-49 years have suffered from spousal or partner violence at some point in time either physical, sexual, psychological or emotional violence.

Statistics from the Victim Support Unit (VSU) indicated that from 2007 to 2009, cases of child defilement had been on the increase from 696 to 1,676 (CSO, 2010).

The VSU also indicate that in 2009, there were 8,261 cases of GBV reported countrywide (VSU Annual Report, 2009). It is important to note that these statistics may not reflect the exact magnitude of the problem countrywide because many cases of GBV go unreported. The results from the ZDHS 2007 show that 46.8 % of women 15-49 years who had ever experienced physical or sexual violence never sought any help. According to the ZDHS 2013/14, 47% of married women aged 15-49 report having experienced physical, sexual, and /or emotional violence from their current partner / husband.

1.11 Water and Sanitation

According to the ZDHS 2013/14, the proportion of the population with access to safe drinking water in rural areas is 47% and in urban 89%, while access to improved sanitation (urban, rural) stands at 39% and 20% respectively. Most of the peri-urban and rural areas continue to experience inadequate water supply which has led to endemic infectious enteric diseases in the country. Infectious Enteric Disease affects mostly women and children, especially those with inadequate and inappropriate sanitary/ facilities compounded by long distances to water sources. There is need to increase advocacy with policy makers on the importance of clean and safe water and improved sanitation so that they can start lobbying for more resource allocation to the water and sanitation programme.

1.12 The Policy Environment

Ministry of Health has well-defined health policies and an overall health sector reform agenda which are expected to positively influence RMNCAH-N SBCC interventions. Emphasis on changing the entry point of health services from the hospital to the community setting has led to more investment in health promotive oriented services. Different policies, guidelines, standards and strategies have been developed and adopted to operationalise the transformation agenda.

The aim of these policies is to address RMNCAH-N concerns and promote and protect reproductive rights. The policy environment focuses on improving health care delivery services and systems through a transformation agenda by prioritising SBCC/IEC needs.

1.13 Programmatic Environment and the Status of Communication

Communication is recognised as an essential input into programmes. The role of the Directorate of Health Promotion Environment and Social Determinants is mainly to create demand for RMNCAH-N services and boost interventions that sensitise and mobilise communities to achieve RMNCAH-N goals and objectives. Despite the existing communication interventions, there is inadequate inter and intra-sectoral coordination between government agencies and NGOs/ key partners for a coordinated and

technically sound communication strategy implementation. Strategies are often formulated at the central level and dispersed to the field without district and community level input.

Gaps are also evident in many facets of Behaviour Change Communication (BCC) planning and implementations, suggesting that many interventions are not tactical and targetted. The donor dependence for implementation of many communication programmes is not sustainable. .

1.14 Theoretical Framework for the Communication Strategy

A socio-ecological model is applied to this strategy in order to further understand the context of population groups most affected. This model allows an analysis of how an individual is influenced by peers, family, and community, and by the overall enabling environment. Individuals health behaviours are also influenced by the information they receive, their motivation, their ability to act, and prevailing social and gender norms.

The socio-ecological model helps to define audiences who are most affected by an issue or problem and their direct and indirect influencers (also known as primary, secondary, and tertiary audiences). It helps analyse their context, and enables programme designers to choose appropriate strategies to ignite change at different levels. SBCC interventions and activities should target a segmented audience. Segmentation is a process of identifying unique groups of people within a larger population.

These groups share similar interests and needs relative to the behaviour to be promoted, and are likely to respond similarly to a given communication. Segmentation requires going beyond the traditional demographics (age, education, location) to personalisation, including giving each of the audience profiles a name. Target groups include people directly affected, people directly influencing them, and people indirectly influencing them.

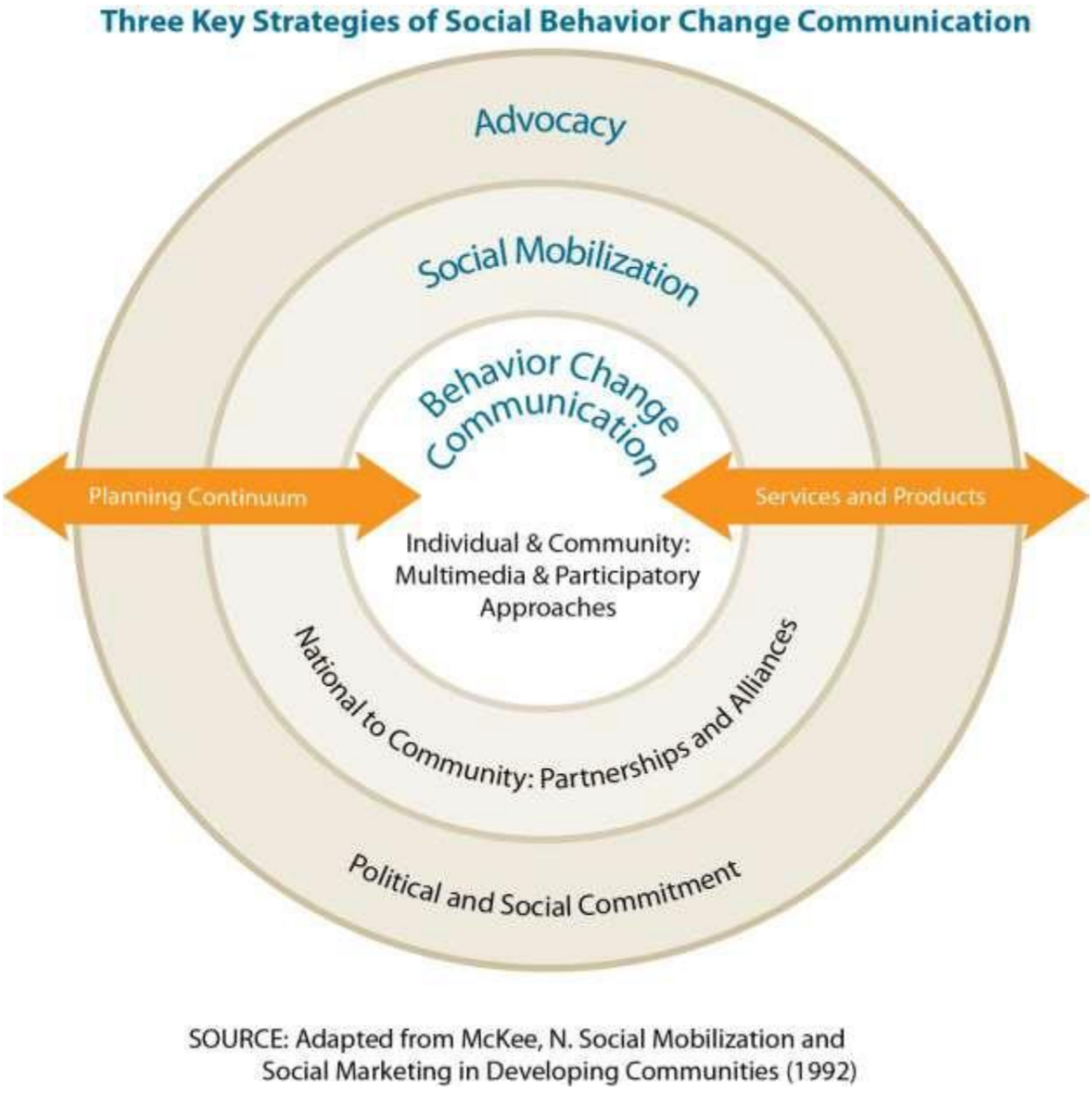

Figure 1: The Three Strategies of Social Behaviour Change Communication

According to Sallis et al (2016), Ecological models of health behaviour emphasise the environmental and policy contexts of behaviour, while incorporating social and psychological influences. Sallis indicates that ecological models lead to the explicit consideration of multiple levels of influence, thereby guiding the development of more comprehensive interventions. In the past two decades, there has been a dramatic increase in interest in, and application of, ecological models in research and practice. This is due partly to the models guidance on comprehensive population-wide approaches to changing behaviours that will reduce serious and prevalent health problems. The combination of environmental, policy, social, and individual intervention strategies is credited with the major reductions in tobacco use in the United States since the 1960s (Institute of Medicine, 2001), and this experience has stimulated the application of multi-level models and interventions to many health problems. The core concept of an ecological model is that behaviour has multiple levels of influences, often including intrapersonal

(biological, psychological), interpersonal (social, cultural), organisational, community, physical environmental, and policy. Ecological models are believed to provide comprehensive frameworks for understanding the multiple and interacting determinants of health behaviours. More importantly, ecological models can be used to develop comprehensive intervention approaches that systematically target mechanisms of change at each level of influence. Ecological models of health behaviour recognise the influence of the environment on a person's health behaviours.

Ecological models include the following multiple levels of influence:

Figure 2: Social Ecological Model

- **Intrapersonal/individual factors,** which influence behaviour such as knowledge, attitudes, beliefs, and personality.
- **Interpersonal factors,** such as interactions with other people, which can provide social support or create barriers to interpersonal growth that promotes healthy behaviour.
- **Institutional and organisational factors,** including the rules, regulations, policies, and informal structures that constrain or promote healthy behaviours.
- **Community factors,** such as formal or informal social norms that exist among individuals, groups, or organisations, can limit or enhance healthy behaviours.
- **Public policy,** including local, state, and policies and laws that regulate or support health actions and practices for disease prevention including early detection, control, and management.

There are many factors that influence a person's engagement with community activities and programmes. Understanding the factors allows programmers to develop programmes that better "fit" the individual. The underlying core principles of the socio-ecological model concern the interrelationships between the different levels of influence on the individual.

1.16 SWOT Analysis

The SWOT analysis is a strategic planning technique used to identify the strengths, weaknesses, opportunities and threats that will affect the success of the RMNCAH&-N Communication Strategy. The components of SWOT are:

- **Strengths** are the existing means or experiences within the reproductive health segment that the Strategy will build on. These include the presence of up to date robust and supportive policies and legislation, evidence of achievements by DPH and stakeholders in advocating for supplementary funds for RMNCAH-N.

- **Opportunities** are affirmative factors peripheral to the programme that will favourably affect its success. In this context, such factors include the recent policy shift among key partners on areas of interest in RMNCAH-N.

- **Weaknesses** encompass the internal undesirable forces that will hamper the success of programmes.

- **Threats** are the external factors or conditions that will also unfavourably affect the programme's achievements.

The objective of the Communication Strategy is to take full advantage of the strengths and opportunities and reduce or avoid the effects of weaknesses and threats to the programmes. The framework below analyses the strengths, weaknesses, opportunities and threats that will affect the success of the communication strategy.

Strengths	Weaknesses
• Supportive legal/policy framework in place around issues related to RMNCAH-N. These RMNCAH-N policies, guidelines and plans are a positive foundation on which to build strategic Social and Behaviour Change communication interventions. • Strong institutional structure with DHPE&SD and Health Communication partners: presence of the ICC-RMNCAH-N Steering Committee National Health Promotion Technical Working Group, Safe Motherhood Technical Working Group, Family Planning Technical Working Group, Adolescent Health Technical Working Group, Child Health Technical Working Group, Nutrition Technical Working Group and Taskforces and committees and their ability to coordinate efforts among Government ministries, donor agencies, and NGOs. • Success in recent changes in institutional structure which resulted in making Health Promotion as a department in the Ministry of Health which will result in strengthened coordination of Social and Behaviour Change Communication Interventions at all levels of service delivery • Integration of Health Promotion and Social Determinants services gaining ground. • Prioritisation of Health Promotion on the health agenda of the government because of its cost effectiveness in disease management and prevention	• Inadequate dissemination and operationalisation • Inadequate linkages and coordination among the RMNCAH-N programmes /interventions • Communication materials not aligning to SBCC approaches that focus on programme outcomes e.g. piece meal untargeted messages. • Within government establishments, communication activities are minimal, often not well articulated in the project designs. • Inadequate skilled communicators on health communication with cross cutting issues such as gender and human rights. • Poor data quality on most RMNCAH-N interventions including communications • Lack of data on ADH • Weak supply chain especially the last mile. • Inadequate IEC materials for RMNCAH-N
Opportunities	**Threats**
• Political will to utilisation of the Primary Health Care Model in delivery of health services • Services are demand–driven: Uptake of curative and preventive health services • Stated government commitment in the 7th NDP on issues related to RMNCAH-N • The history of good collaboration between Government and NGOs provide a strong foundation for the success of RMNCAH-N programme. • Unmet need for RMNCAH-N • Existence of RMNCAH-N champions • There are documented cases of successful communication programmes that can provide evidence based lessons for improving/scaling up communication activities	• Socio-cultural factors such as gender issues knowledge/ignorance, poverty, which hinder use of services • Global financial crises and change in foreign policy • Competing national needs versus limited resources; situation will likely negatively impact the country to provide RMNCAH-N services • Poor appreciation of how communication can be applied in programmes; communication often gets low budget /not factored when budgeting (both human and financial). Programmes have limited IEC/BCC experts. • Programmes too dependent on donor funds

Figure 3: SWOT Analysis for the Communication Strategy

2: THE COMMUNICATION STRATEGY

2.1 Vision

A Nation of Healthy and Productive people empowered with knowledge to make informed decisions on Reproductive, Maternal, Neonatal, Child, Adolescent and Nutrition Health (RMNCAH-N) issues.

2.2 Mission Statement

To provide equitable access to cost effective quality RMNCAH-N services as close to the family as possible.

2.3 Purpose

This communication strategy is aligned to the objectives of the National Health Strategic Plan 2017-2021 and supports its achievement through the following approaches:

i. Communication, to build on current levels of knowledge about RMNCAH-N programme; and create RMNCAH-N Services awareness about appropriate Social and Behaviour Change Communication and health care seeking behaviour, while addressing barriers to change in attitudes and practices identified in the situation analysis.

ii. The strategy defines the approaches that will be used to reach the targeted audiences for maximum benefit and participation in the RMNCAH-N programme through advocacy, social mobilisation, behaviour change communication and capacity building of BCC practitioners. This includes:

- Advocacy, to secure leadership and commitment of stakeholders at all levels and to strengthen the multi-sectoral response to RMNCAH-N programme;
- Social mobilisation, to ensure local communities participation in RMNCAH-N programme and social and behaviour change initiatives and continued public education;
- To build capacity of Behaviour Change Communication practitioners

2.4 Strategic Objectives

Below are the strategic objectives at the policy, institutional and programmatic levels.

Strategic Objective 2.4.1- Policy: Increase the proportion of national level policy makers knowledgeable on the socio-economic consequences of Reproductive Health, Maternal and Newborn, Child and Adolescent Health and Nutrition including cancers of the reproductive organs, Gender Based Violence, Infertility and Water Sanitation and Hygiene and devoting more resources to the promotive, preventive, and utilisation of reproductive health services through SBCC and IEC.

Strategic Objective 2.4.2- Institutional: Strengthen the capacity of DHPESDs and DPH to plan and coordinate communication as a core component to support its programme goals at the national, provincial, district and community level.

Strategic Objective 2.4.3- Programmatic: Increase awareness and the level of knowledge in the community about RMNCAH-N issues and available health solutions.

2.5 Anticipated Outcomes

2.5.1 Increased demand, uptake and use of RMNCAH-N services among all target audiences for adoption of safer health practices

2.5.2 Increased involvement of local communities in RMNCAH-N Programme.

2.5.3 Improved health outcomes among women, adolescents and children

2.5.4 Reduction in maternal, newborn, child and adolescent morbidity and mortality

SECTION 3: THEMATIC AREAS FOR STRATEGIC INTERVENTIONS

Thematic Area 3.1: Family Planning

Audience 1: National Policy Makers

1.1 **Specific Objective**

- Increase number of national policy makers that are knowledgeable on the benefits of family planning to women of the reproductive age and are allocating more resources to the Family Planning Services

Table 1: National Policy Makers

Target Audience	National Policy Makers
Current Behaviours	• Most national policy makers, who are the gate keepers of all communities, do not advocate/ talk about the benefits of family planning services to women of the reproductive age. • Most national policy makers have inadequate knowledge and are unappreciative of modern contraceptives. • Most national policy makers do not understand the components of effective RH/FP programmes and how to support them in their communities. • Most national policy makers do not advocate for usage of modern contraceptive among the young people.
Barriers	• Lack of confidence about the benefits of RH/FP services for communities, especially young people who are expected to abstain instead • Myths and misconceptions about the link between infertility and modern contraceptives. • Religious and traditional beliefs. • Competing issues for resources with the communities
Facilitating Factors	• Availability of RH/FP services in health facilities within the communities. • Availability of policies supporting RH/FP Services. Availability of trained health workers and CBVs in health facilities and communities. • Increased number of community leaders that support their communities to seek modern FP services.
Desired Behaviour Change	• Increased number of national policy makers that are supporting women of the reproductive age to seek Family Planning Services. • Increased number of national policy makers allocating more resources to Family Planning

Communication Objective	• Increase number of national policy makers that are knowledgeable on the benefits of family planning to women of the reproductive age and are allocating more resources to the Family Planning Services
Key Messages	• It is okay to learn about various modern methods of contraception in order to assist the men and women of the reproductive age take control of their lives and prevent them from having unwanted pregnancies, subsequently; their quality of life will improve. • Several modern methods of contraception exist, and each has its own benefits and limitations. • It is important to request service providers to provide more information on appropriate methods of modern contraceptives as a national policy maker. • Only condoms can protect sexually active people from Sexually Transmitted Diseases and HIV/AIDS. • It is important to advise the men and women of reproductive age on the benefits of delaying child bearing so that they pursue their dreams and have a higher quality of life especially young girls • It is important to come up with polices that will allow utilisation of family planning services among school going girls to prevent them from getting teenage pregnancies • It is important for national policy makers to talk to the public about safe sex and Family Planning services. • It is important to advise the public on the importance of knowing their HIV status by advising them to test with their sexual partners. • It is important to advise communities to protect themselves and partners from HIV by using a condom every time they have sex.
Message Delivery Strategies	• Consultative meetings, presentations, Indaba with national policy makers, Leaflets, brochures etc
Key communication tasks and ideas	• Raise awareness among national policy makers of available services on RH/FP. • Provide clear and simplified Social and Behaviour Change Communication on RH/FP in strategic places were the national policy makers will find it easier to access. • Train national policy makers RH/FP interventions and services.
Other essential actions (needed to facilitate the recommended practice)	• Designing of executive booklets for parliamentarians which will provide details on Family Planning Services in the country

Audience 2: Women of Reproductive Age

2.1 Specific objective

- To increase the number of women of the reproductive age group with knowledge about available family planning services
- To increase the number of women in the reproductive age group utilising available family planning services.

Table 2: Women of Reproductive Age

Target Audience	Women of Reproductive Age
Current behaviours	• 51% of the women are not using any FP method • Contraceptive Prevalence Rate (CPR) at 49%. • 4% of women still use traditional FP methods. • Unplanned pregnancies. • 21% unmet FP needs. • Some religions prohibiting use of modern contraception methods.
Barriers	• Many women still use traditional FP methods. • Many families are not planning when to have children thus are having unplanned pregnancies. • Health concerns and fear of side effects of modern methods. • Lack of knowledge on family planning options. • Misconceptions and myths about effectiveness of methods. • Fear of criticism for women discussing FP with their partners. • Perception that FP leads to increased promiscuity. • Desire to prove ability to have children. • Practice of achieving a family size equal to that of their parents. • Desire for a son if family has only daughters. • Perception of negative attitudes of health workers. • Inadequate knowledge on the benefits of child spacing or limiting the number of children. • Lack of accessibility of FP methods. • Religious and traditional beliefs about modern family planning.
Facilitating factors	• Increasing knowledge about modern FP methods. • Availability of free services in health facilities and at community level. • Availability of skilled family planning providers in health facilities and at the community level.
Desired behaviour Changes	• Increased number of women of the reproductive age group who understand modern RH/ FP methods. • Increased number of women of the reproductive age group seeking RH/ FP services.
Communication objectives	• To increase the number of women of the reproductive age group with knowledge about modern FP methods i.e. combined oral, contraceptive, combined injected and barrier methods such as IUD and condoms. • To increase the number of women in the reproductive age group utilising available family planning services.
Key Messages	• Spacing your children at least two years apart is key for a healthy and prosperous family. • Modern family planning methods are safe and reliable.

	• Use a modern family planning method to delay pregnancy or space births. • Talk to your partner about a modern family planning method of your choice. • Visit a health facility for more information and family planning services.
Message Delivery Strategies	• **Multi-media**(brochures and posters placed at ANC,PNC, community meetings , peers , workplaces/churches, TV, /Radio, community listening groups, SMS, billboards, Facebook/twitter, interpersonal communication)
Key communication tasks and ideas	• Implement multimedia behaviour change communication, social mobilisation, and advocacy interventions reaching urban, peri-urban, and rural women of reproductive age to promote use of FP services and contraceptive choice and increase the use of LARC. • Implement Social, Behaviour Change and Communication (SBCC) capacity strengthening activities among health providers to address health-provider barriers to uptake of FP services, especially LARC. • Build the capacity of providers to effectively counsel clients on FP and provide job aids and reminder materials to facilitate adherence at home. • Encourage health facility staff to hold more community discussions on FP issues and make recommendations. • Promote FP through print, electronic and interpersonal messages. • Training of drama groups and service providers. • Community mobilisation. • Promote male involvement in FP
Other essential actions (needed to facilitate the recommended practice	• Provide more FP services that are accessible to all clients including the physically challenged and persons with learning disabilities • Expand the Community Champions Initiative.

Audience 3: Men of Reproductive Age

3.1 Specific Objectives

- To increase the number of men of the reproductive age who are knowledgeable about FP services and are utilising the services
- To increase the number of men of the reproductive age who support their partners in the uptake of modern contraceptive methods to prevent unplanned pregnancies or space children at least 2 years apart.

Table 3: Men of Reproductive Age Audience

Target Audience	Men of Reproductive Age
Current behaviours	• Low uptake of condoms among men of Reproductive Age • Low male involvement in family planning services
Barriers	• Open sex talk is a taboo • Belief that it is a woman's responsibility to prevent pregnancy.

	• Perception that FP leads to increased promiscuity • Misconceptions and myths about effectiveness of modern methods. • Negative attitudes of health workers. • Lack of confidence about the benefits of child spacing or limiting the number of children. • Distance to a health facility/accessibility of FP methods. • Desire for a son if family has only daughters. • Religious and traditional beliefs. • Limited FP targeted for Men
Facilitating factors	• Increasing knowledge about modern FP methods. • Availability of free services in health facilities and at community level. • Availability of skilled family planning providers in health facilities and at the community level.
Desired Behaviour Changes	• Increased number of men of the reproductive age group that understand modern RH/ FP methods. • Increased number of men of the reproductive age group seeking RH/ FP services. • Increased number of men of reproductive age who support their partners in the uptake of modern contraceptive methods to delay birth of first child or space children at least 2 years apart.
Communication objectives	• To increase the number of men of reproductive age who are knowledgeable about FP services and are utilising the services. • To increase the number of men of reproductive age who support their partners in the uptake of modern contraceptive methods to delay birth of first child or space children at least 2 years apart.
Key Messages	• Spacing your children at least two years apart is key for a healthy and prosperous family. • Modern family planning methods are safe and reliable. • Use a modern family planning method to delay pregnancy or space births. • Talk to your partner about a modern family planning method of your choice. • Visit a health facility for more information and family planning services.
Message Delivery Strategies	• **Multi-media** (brochures and posters placed at ANC,PNC, workplaces/churches, TV, /Radio, community listening groups, SMS, billboards, Facebook/twitter, interpersonal communication, community meetings , Peer to Peer)
Key communication tasks and ideas	• Implement multimedia behaviour change communication, social mobilisation, and advocacy interventions reaching urban, peri-urban, and rural women of reproductive age to promote use of FP services and contraceptive choice and increase the use of LARC. • Implement Social and Behaviour Change and Communication (SBCC) capacity strengthening activities among health providers to address health-provider barriers to uptake of FP services, especially LARC. • Build the capacity of providers to effectively counsel clients on FP and provide job aids to support this and reminder materials to facilitate adherence at home. • Encourage health facility staff to hold more community discussions on FP issues and recommendations. • Promote FP through print, electronic and interpersonal messages • Training of drama groups and service providers • Community mobilisation • Promote male involvement in maternal issues.
Other essential actions (needed to facilitate the recommended practice	• Provide more services that are accessible to all clients including the physically challenged and persons with learning disabilities. • Expand the Community Champions Initiative.

Audience 4: Adolescent and Youth

4.1 Specific Objective

- Increase the number of health facilities with functional youth friendly services addressing the family planning needs of the adolescents and youth.
- Increase the number of adolescents and youth knowledgeable about FP services.
- Increase number of adolescents that are aware about RH/FP services.

Table 4: Adolescent and Youth Audience

Target Audience	Adolescents and Youth
Current behaviours	• HIV burden and prevalence, high among the adolescent girls (4.8%) compared to (4.1%) among boys of the same age (ZDHS 2013-2014). • Limited availability and accessibility of commodities e.g. condoms & modern contraceptives. • Low uptake of condom use among sexually active young people more than 50%, (ZDHS 2013-2014). • Higher cost of condoms (ZDHS 2013-2014). • Limited availability and accessibility, and negative perceptions of condoms have created a gap between the number of condoms distributed and the amount needed for the population to protect themselves from HIV, STIs and to prevent unplanned pregnancies (MOT, 2009). • Alcohol and substance abuse among the young people. • Seeking unprofessional RH/FP services, e.g. getting information on reproductive health from peers and self-treatment. • Having unprotected sex leading to STIs and HIV infection, teenage pregnancies, and risk of unsafe abortion and school dropout.
Barriers	• Inadequate adolescents and youth-friendly services and clinics for RH/FP. • FP methods not accessible among the adolescents and youth. • Negative attitude of health workers towards the adolescents and youth who seek RH/FP services. • Available information on reproductive health does not address the needs of the adolescents and youth. • Strict societal/cultural norms. • Inadequate access to information on RH/FP and related services for the adolescent and youth. • Parents' discomfort and inability to talk to adolescents on sexual and reproductive health issues. • Peer pressure from friends and fear of alienation. • Misuse of social media, leading to replication of bad behaviours among the adolescent and youth. • Weak implementation of sanctions for alcohol abuse among the adolescents and youth. • Unavailability of income-generating and recreational activities, forcing adolescents and youth to engage in risky activities.
Facilitating factors	• Availability of adolescent and youth friendly services in some health facilities • Availability of policies supporting RH/FP Services for adolescents and Youth • Availability of trained psycho-social counsellors in health facilities
Desired behaviour	• Increased number of health facilities with functional youth friendly services

Change	addressing the family planning needs of the adolescents and youth • Increased number of adolescents and youth that are accessing RH/ FP services. • Increased number of adolescents and youth seeking RH/FP services
Communication objectives	• Increase the number of health facilities with functional youth friendly services addressing the family planning needs of the adolescents and youth • Increase the number of adolescents and youth knowledgeable about RH/FP services • Increase number of adolescents and youth that aware about RH/FP services
Key message	• It is okay to learn about various modern methods of contraception to take control of your life and prevent unwanted and teenage pregnancies. • Several modern methods of contraception exist, and each has its own benefits and limitations. • It is important to visit a health provider for counselling on appropriate methods. • Only condoms can protect you from sexually transmitted diseases. • It is important to delay child bearing so that you pursue your dreams and have a higher quality of life • It is important to delay sexual debut. • Talk to your partner about safe sex • Learn your HIV status • Protect yourself and partner from HIV – use a condom every time you have sex
Message Delivery Strategies	• Multi-media(brochures and posters placed at adolescent and youth friendly, schools/churches youth groups, TV, /Radio, community listening groups, SMS, billboards, Facebook/twitter, interpersonal communication)
Key communication tasks and ideas	• Raise awareness among adolescents of available services on RH/FP • Provide clear and simplified Social and Behaviour Change Communication on RH/FP in strategic places where the adolescents and youth will find it easier to access • Provide capacity building and simple job aids to providers to facilitate counselling of adolescents on RH/FP issues • Prepare and distribute a simple guide to help parents talk to adolescents about FP/RH services • Routinely put radio spots for the adolescents and youth on /about RH/FP services • Collaborate with the all stakeholders concerned on scaling up adolescents and youth RH/FP services to all parts of the country rural and urban as close to the family as possible
Other essential actions (needed to facilitate the recommended practices)	• Advocacy with Government and NGOs to provide more adolescents and youth friendly services/corners with standard package of health services, possibly with special hours, assured privacy, and competent counselling • Implement more effective RH classes/discussions and activities in schools and communities • Train health providers and peer educators in counselling skills and skills and sensitise them to adolescents perspectives and empathetic attitudes • NGOs to expand peer to peer education and counselling on FP/RH issues • Explore collaboration with churches to promote health RH practices for adolescents • Expand programmes that address alcohol and substance abuse

Audience 5: Service Providers

5.1 Specific Objectives

- To increase the number of health facilities with service providers trained in interpersonal communication skills resulting in positive provider-client attitude

Table 5: Service Providers Audience

Target Audience	Service Providers
Current behaviours	• Few service providers with interpersonal communication skills on RH/FP issues. • Few providers who practice positive interpersonal communication skills during FP services. • Few providers report counselling clients on RH/FP services and modern methods of contraception.
Barriers	• Too many patients and not enough time to counsel each one properly • Biases regarding RH/FP services • Low pay and lack of motivation
Facilitating factors	• Availability of infrastructure to provide RH/FP services. • Availability of policies supporting RH/FP Services for the eligible clients. • Availability of trained health workers and CBVs in RH/FP in health facilities
Desired Behaviour Change	• Increased number of health facilities with service providers skilled in interpersonal communication skills, resulting in positive provider-client encounter.
Communication objectives	• To increase the number of health facilities with positive providers trained in interpersonal communication skills resulting in positive provider-client attitude
Key message	• Treat each and every client/patient with dignity • Every client has the right to information on RH/FP • Communication issues of RH/FP to all clients/patients in an effective and efficient manner without prejudice due to age, sex, race, tribe, culture, status etc.
Message Delivery Strategies	• Interpersonal Communication, Leaflets, Booklets, Training, Updates, Mentorship, Posters etc
Key communication tasks and ideas	• Raise awareness among providers on the need to adhere to the code of practice when handling clients/patients • Provide update training on Client/ Customer Care to all health workers implementing RH/FP services.
Other essential actions (needed to facilitate the recommended practices)	• Recruit and post more qualified health workers • Motivate health workers by introducing systems which recognise hard workers

Audience 6: Community Leaders

6.1 Specific Objective

- Increase number of community leaders who are knowledgeable on RH/FP services

Table 6: Community Leaders Audience

Target Audience	Community Leaders
Current behaviours	• Most community leaders, who are the gate keepers of most communities, do not have confidence in modern contraceptives. • Most Community Leaders have inadequate knowledge and unappreciative about modern contraceptives. • Most community Leaders do not understand the components of effective RH/FP programmes and how to support them in their communities. • Most Community Leaders still embrace cultural and traditional beliefs which impact negatively on the acceptance of modern contraceptives by women and young girls.
Barriers	• Lack of confidence about the benefits of RH/FP services for communities. • Myths and misconceptions about the link between infertility and modern contraceptives. • Religious and traditional beliefs. • Competing issues and resources with the communities.
Facilitating factors	• Availability of RH/FP services in health facilities within the communities. • Availability of policies supporting RH/FP Services. • Availability of trained health workers and CBVs in health facilities and communities.
Desired Behaviour Change	• Increased number of community leaders that support their communities to seek modern FP services.
Communication objective	• Increase number of community leaders who are knowledgeable about RH/FP services
Key message	• It is okay to learn about various modern methods of contraception in order to assist the community members take control of their lives and prevent them from having unwanted pregnancies, subsequently, their quality of life will improve. • Several modern methods of contraception exist, and each has its own benefits and limitations. • It is important to visit a health provider for counselling on appropriate methods of modern contraceptives as a Community Leader. • Only condoms can protect your communities from Sexually Transmitted Diseases and HIV/AIDS. • It is important to advise community members to delay child bearing so that they pursue their dreams and have a higher quality of life. • It is important to delay sexual debut especially among the adolescent and youths. • It is important to encourage community members to talk to their partners and families about safe sex and FP. • It is important to advise community members to know their HIV status by encouraging them to test with their sexual partners. • It is important to advise the community members to protect themselves

	and partner from HIV by using a condom every time they have sex.
Message Delivery Strategies	• **Multi-media**(brochures and posters placed at adolescent and youth friendly, communities strategic places, bus stations schools/churches youth groups, TV, /Radio, community listening groups, SMS, billboards, Facebook/twitter, interpersonal communication, community meetings, peer to peer education)
Key communication tasks and ideas	• Raise awareness among Community Leaders of available services on RH/FP. • Provide clear and simplified Social and Behaviour Change Communication on RH/FP in strategic places were the Community Leaders will find it easier to access • Train Community Leaders on RH/FP interventions and services to facilitate counselling of community members. • Prepare and distribute a simple guide for Community Leaders for usage during discussions with community members. • Develop a Toolkit for the Community Leaders on RH/FP services. • Collaborate with all stakeholders concerned with scaling up RH/FP services at community level.
Other essential actions (needed to facilitate the recommended practices)	• Establishment of NHCs/ SMAGs//CBDs in communities where they do not exist and ensure they are provided with clear TORs for them to operate effectively and efficiently.

Thematic Area 3:2: Maternal and Newborn Health

Audience 1: National Policy Makers

1.1 **Specific Objective**

- Increase number of national policy makers that are knowledgeable on the benefits of maternal and newborn services to women of reproductive age and are lobbying for more resources to the programme.

Table 7: National Policy Makers

Target Audience	National Policy Makers
Current Behaviours	• Most national policy makers, who are the gate keepers of all communities, do not advocate/ talk about the benefits of maternal and newborn health services to women of reproductive age. • Most national policy makers have inadequate knowledge on maternal and newborn health. • Most national policy makers do not understand the components of effective maternal and newborn health programme
Barriers	• Religious and traditional beliefs. • Competing issues for resources with the communities • Lack of policy to force women to start ante-natal checkups during the 3 months of pregnancy

Facilitating Factors	• Availability of Parliamentarian Committee on health
Desired Behaviour Change	• Increased number of national policy makers that are supporting women of reproductive age to seek Maternal Health Services and are allocating more resources to the programme
Communication Objective	• Increase number of national policy makers that are knowledgeable on the benefits of maternal and newborn services to women of reproductive age and are lobbying for more resources to the programme
Key Messages	• It is important to learn about maternal and newborn health programme • It is important to request service providers to provide more information on maternal and newborn health programme • It is important to come up with polices that will force women of reproductive age to utilise maternal and newborn health services • It is important as national policy makers to talk to the public about the benefits of maternal and newborn health services
Message Delivery Strategies	• Consultative meetings, presentations, Indaba with national policy makers, Leaflets, brochures etc
Key communication tasks and ideas	• Raise awareness among national policy makers.
Other essential actions (needed to facilitate the recommended practice)	• Designing of executive booklets for parliamentarians which will provide detailed information on Maternal and Newborn Health Programme

Audience 2: Women of Reproductive Age

2.1 Specific objectives

- To increase the number of women of reproductive age knowledgeable about the importance of antenatal care in the first 3 months of pregnancy.
- To increase the number of pregnant women accessing antenatal care in the first 3 months of pregnancy.
- To increase the number of pregnant women who have at least 8 antenatal care contacts during pregnancy.
- To increase the number of women of reproductive age knowledgeable about the importance of postnatal care (within 6 hours, 48 hours, 6 days, 6 weeks).
- To increase the number of postpartum women utilising postnatal services (within 6 hours, 48 hours, 6 days, 6 weeks).
- To increase the number of women accessing safe abortion care services at health facilities.

Table 8: Women of Reproductive Age Audience

Target Audience	Women of Reproductive Age
Current behaviours	• Only 24% of pregnant women attend ANC within the 1st trimester and as such only 25% of pregnant women access at least 4 ANC visits (ZDHS, 2014).

	• Only 60.8% pregnant women attending ANC clinics receive 3+ doses of IPTp (HMIS -2015). • Many pregnant women take fewer than the recommended doses of ferrous sulphate and folic acid; 50% of women of reproductive age are anaemic (ZDHS, 2014). • Only 67% of women deliver from health facilities (ZDHS, 2014). • Only 63% of women attend postnatal care within 48 hours (ZDHS, 2014) • Many women seek traditional services for termination of pregnancy • 29% teenage pregnancy rate (ZDHS2014) • Un planned pregnancies • Some women are using traditional medicines to expedite labour. • Many women are using sniffing tobacco to keep their bodies warm.
Barriers	• Perception that pregnancy should not be announced before it becomes visible. • Inadequate knowledge on birth preparedness. • Myths and misconceptions surrounding first pregnancy. • Inadequate knowledge on danger signs in pregnancy and during delivery • Inadequate information on the availability of services for safe motherhood • Inadequate skilled health personnel • Inadequate knowledge on the importance of post -delivery care • Fear of partner/spousal disapproval • Difficulty to reach special groups due to fear of stigmatisation • Negative cultural beliefs that discourage use of reproductive health services • Weak social support/involvement of families and local leaders • Poor health seeking behaviour • Limited appreciation of immediate and long-term benefit of PMTCT services • Stigma and discrimination surrounding HIV positive pregnant women • Limited male involvement due to cultural beliefs and misconceptions that maternal health and antenatal care services are strictly for women • Inadequate knowledge on the benefits of initiating early ANC • Desire to hide pregnancy as long as possible to reduce the risk of bad spells • Inadequate knowledge on how to recognise true signs of labour • Distance to health facility and the cost of transport • Poor attitude of health workers • Lack of mothers' shelters • Stigma around HIV, fear of partners' reactions • Cultural beliefs, e.g. not exposing new born babies to the public • Shortage of skilled health workers • Current policy on abortion requiring three medical doctors to endorse an abortion (Abortion Act – 1972). • Many women feel shy to seek abortion services • Non-availability of comprehensive sexual reproductive health services in most health facilities • Long queues • Hidden costs of accessing maternal health services e.g. books, tests, fast track.
Facilitating factors	• Knowledge about danger signs in pregnancy and delivery.

	• Availability of free maternal health services in health facilities and at community level. • Availability of Pregnancy, Childbirth, Postnatal, Neonatal and Child health (PCPNC) guidelines • Presence of SMAGs in the communities
Desired Behavior Changes	• Increased women of reproductive age that are seeking antenatal care in the first 3 months of pregnancy • Increased number of pregnant women accessing antenatal care in the first 3 months of pregnancy • Increased number of pregnant women who have at least 8 antenatal care contacts during pregnancy. • Increased number of women of reproductive age that are seeking postnatal care (within 48 hours, 6 days, and 6 weeks). • Increased number of postpartum women utilising postnatal services (within 48 hours, 6 days, 6 weeks) • Increased number of women accessing safe abortion care services at health facilities
Communication objectives	• To increase the number of women of reproductive age knowledgeable about the importance of antenatal care in the first 3 months of pregnancy. • To increase the number of pregnant women accessing antenatal care in the first 3 months of pregnancy. • To increase the number of pregnant women who have at least 8 antenatal care contacts during pregnancy. • To increase the number of women of the reproductive age knowledgeable about the importance of postnatal care (within 48 hours, 6 days, 6 weeks). • To increase the number of postpartum women utilising postnatal services (within 48 hours, 6 days, 6 weeks). • To increase the number of women accessing safe abortion care services at health facilities.
Key Messages	• Girls who are educated and healthy and who have a nutritious diet throughout their childhood and teenage years are more likely to have healthy babies and go through pregnancy and childbirth safely if childbearing begins after they are 18 years old. • Pursue your education, and delay pregnancy and childbirth until after 18 years of age. • Visit a health facility as soon as you know you are pregnant • Talk with your husband/partner about your pregnancy and going for ANC. • Start ANC visits early within the 1st three months of pregnancy so you know how the baby is growing, to receive various free maternal services, and to learn your due date. • Make at least eight (8) antenatal care contacts during your pregnancy. • Create a Birth Preparedness Plan with your husband/partner. • Plan to deliver your baby at a health facility • Talk about your pregnancy concerns with your health care provider. • Take de-worming tablets to protect yourself against worms ; daily iron, folic supplements; malaria medicine; tetanus vaccinations; vitamins are also important for you and the unborn baby • Share your concerns and talk with your health care provider about your health and well-being • In case you deliver at home, visit a health facility within 48 hours

	after delivery • Keep the baby warm after delivery • Wash your hands before handling the baby • Ensure the cord is not bleeding • Eat a well-balanced, nutritious diet rich in proteins after delivery to prevent anaemia • Breastfeed the baby within 60 minutes after delivery • Breastfeed your baby exclusively for six months and thereafter introduce other complementary feeding • Before delivery, talk with your husband about going for postnatal care at the nearest health facility • Sleep under an ITN before and after delivery to protect yourself and your newborn against malaria • Ensure a hygienic environment for mother and baby • Use modern FP methods to prevent unwanted pregnancy • Go to the health facility for safe abortion care • Access sexual and reproductive health services at your nearest health facility.
Message Delivery Strategies	• **Multi-media**(brochures and posters placed at Maternal and Child Health (MCH) Department, workplaces/churches, TV, /Radio, community listening groups, SMS, billboards, social media Facebook/twitter/Whatsapp , interpersonal communication, T-Shirts with key messages, peer to peer, community meetings)
Key communication tasks and ideas	• Advocate to policy makers for increased number of centres providing PMTCT and delivery services Promote attendance to ANC services and facility deliveries among pregnant women via mass media and community meetings and events • Promote sleeping under ITNs by pregnant mothers and their babies • Promote birth preparedness among couples • Promote family, friends and community involvement in ensuring that pregnant women are taken to nearest health facility for delivery. • Arrange for health experts to go on radio programmes to talk about recommendations for pregnancy and childbirth • Provide reminder materials or SMS messages to pregnant women for actions they need to take at home (daily iron, folic supplements, sleep under LLIN, malaria medicine) and for ANC visits • Have CHWs, SMAGs, TBAs, etc. teach pregnancy and delivery danger signs. • Build the capacity of providers to counsel more effectively on eMTCT; provide job aids. • Encourage health facility staff to hold more community discussions on maternal health issues and recommendations • Promote girls' health and nutrition, ANC, and PNC through print (including local languages), electronic and interpersonal messages • Training of drama groups on maternal health issues • Community mobilisation • Promote male involvement in maternal health • Advocate for increased and improved postnatal services • Promote attendance to postnatal clinics among mothers • Create awareness on the country's abortion policy • Promote involvement of male spouses and family members in planning and enforcing uptake of postnatal care services • Have CHWs, SMAGs, TBAs, etc. teach postpartum danger signs

Other essential actions (needed to facilitate the recommended practice	• Ensure establishment of SMAGs in communities where they do not exist and ensure their functionality • Increase and improve ANC services, including capacity-building and supportive supervision, mentorship of providers, job aids for providers • Expand the Community Champions initiative • Encourage community leaders and groups to organise emergency transportation

Audience 3: Men of the Reproductive Age

3.1 Specific Objective

- Increase the number of men of the reproductive age who are knowledgeable about the importance of antenatal and postnatal services.

Table 9: Men of the Reproductive Age

Target Audience	Men of Reproductive Age
Current behaviours	• Many men do not encourage pregnant women to access ANC early; only 24% of pregnant women attend ANC within the 1st trimester and as such only 25% of pregnant women access at least 4 ANC visits; only few partners are tested for HIV during ANC (ZDHS, 2014). • Many men do not escort their women to health facilities for delivery; hence they deliver at home with unskilled attendants; only 67% of women deliver from health facilities (ZDHS, 2014). • Many men do not encourage their spouses/partners to attend postnatal care; only 63% of women attend postnatal care within 48 hours; • Many families are not planning when to have children, thus they have many children. • Only 63% of women attend postnatal care within 48 hours; men do not encourage their wives to attend PNC • Many women and their spouses/partners seek traditional services for termination of pregnancy • Many prefer male to female children
Barriers	• Limited male involvement due to cultural beliefs and misconceptions that maternal health and antenatal care services are strictly for women. • Lack of knowledge on the benefits of initiating early ANC. • Desire to hide pregnancy as long as possible to reduce the risk of bad spells. • Distance to health facility and inadequate transport. • Poor attitude of health workers towards men who get involved in maternal health issues (Men are not allowed in labour ward). • Religious and traditional beliefs associated with HIV infection and treatment. • Lack of knowledge on the benefits of initiating early ANC. • Cultural beliefs associated with obstructed labour (inchila).
Facilitating factors	• Knowledge about danger signs in pregnancy and delivery. • Availability of free maternal health services in health facilities and

	at community level. • Availability of PCPNC guidelines • Presence SMAGs in the communities.
Desired Behavior Changes	• Increased number of men of the reproductive age that accompany their partners for antenatal and postnatal services.
Communication objectives	• Increase the number of men of the reproductive age who are knowledgeable about the importance of antenatal and postnatal services.
Key Messages	• Accompany your spouse/partner for ANC within the 1st three months of pregnancy. • ARVs use in pregnancy and during breastfeeding is safe both to the mother and her unborn baby • Talk to your partner about a birth plan • Visit a health facility/service delivery point for more information on maternal health services.
Message Delivery Strategies	• **Multi-media**(brochures and posters placed at MCH, workplaces/churches, TV, /Radio, community listening groups, SMS, billboards, Facebook/twitter, interpersonal communication, insaka, T-Shirts with key messages, Peer to Peer)
Key communication tasks and ideas	• Implement multimedia behaviour change communication, social mobilisation, and advocacy interventions reaching urban, peri-urban, and rural men of reproductive age to promote use of maternal health services. • Implement Social and Behaviour Change and Communication (SBCC) capacity strengthening activities among health providers to address health-provider barriers to utilisation of maternal health services. • Build the capacity of providers to effectively counsel clients on eMTCT and provide job aids to support this and reminder materials to facilitate ART adherence at home. • Encourage health facility staff to hold more community discussions on maternal health issues and recommendations. • Promote access to ANC, facility delivery and PNC through print, electronic and interpersonal messages • Training of drama groups and service providers • Community mobilisation • Promote male involvement in maternal issues.
Other essential actions (needed to facilitate the recommended practice	• Provide more maternal health services that are accessible to all clients including the physically challenged and persons with learning disabilities. • Expand the Community Champions Initiative.

Audience 4: Service Providers

4.1 Specific Objective

- Increase the number of facilities with trained service providers with good interpersonal communication skills during maternal and newborn health service delivery.

Table 10: Service Providers Audience

Target Audience	Service Providers
Current behaviours	• Few providers with interpersonal communication skills on maternal and newborn health issues. • Few providers who practice positive interpersonal communication skills during the provision of maternal and newborn health services. • Few providers report counselling clients on eMTCT and the need to access ANC services early, importance of facility deliveries, and postnatal care within 48 hours. • Few health providers are supervised and mentored on maternal and newborn health issues.
Barriers	• Too many clients and not enough time to counsel • Poor staff attitude • Low pay and lack of motivation • Poor infrastructure and lack of privacy • Inadequate equipment • Insufficient and ineffective referral system
Facilitating factors	• Availability of infrastructure to provide maternal and newborn health services. • Availability of policies supporting maternal and newborn health services for the eligible clients. • Availability of trained health workers and CBVs trained in maternal and newborn health in health facilities • Availability of a road map on RMNCH and PCPNC
Desired Behaviour Change	• Increased number of health facilities with skilled services providers in interpersonal communication resulting in positive provider-client relationship
Communication objectives	• Increase the number of health facilities with trained service providers with good interpersonal communication skills
Key message	• Treat each and every client/patient with dignity • Every client has the right to information on maternal and newborn health services. • Every client has a right to privacy • Communicate issues of maternal and newborn health services to all clients/patients in an effective and efficient manner without prejudice due to age, sex, race, tribe, culture, status etc.
Message Delivery Strategies	• Trainings, presentations, peer to peer, mentorship, leaflets, booklets, posters, updates etc
Key communication tasks and ideas	• Raise awareness among providers on the need to adhere to the code of practice when handling clients/patients • Provide update training on Client/ Customer Care to all health workers implementing maternal and newborn health services.
Other essential actions (needed to facilitate the recommended practices)	• Recruit and post more qualified health workers • Motivate health workers by introducing systems which recognise hard work and awarding them • Advocacy for improved infrastructure and procure tools for service providers to utilise during their work.

Audience 5: Community Leaders

5.1 Specific Objective

- Increase the number of community leaders who are knowledgeable about the importance of maternal and newborn health services.

Table 11: Community Leaders Audience

Target Audience	Community Leaders
Current behaviours	• Most community leaders have inadequate knowledge about the importance and benefits of maternal and newborn health services. • Most community leaders still embrace cultural and traditional beliefs which impact negatively on the acceptance and utilisation of maternal and newborn health services by women of the reproductive age.
Barriers	• Myths and misconceptions about early disclosure of pregnancy, and factors related to obstructed labour. • Religious and traditional beliefs. • Low literacy levels
Facilitating factors	• Availability of maternal and newborn health services in health facilities within the communities. • Availability of policies supporting maternal and newborn health services. • Availability of trained health workers and CBVs in health facilities and communities. • Availability of traditional leaders training handbook.
Desired Behaviour Change	• Increased number of community leaders that are supporting their communities to seek maternal and newborn health.
Communication objectives	• Increase the number of community leaders who are knowledgeable about the importance of maternal and newborn health services
Key message	• It is okay to learn about available maternal and newborn services in order to assist the community members to utilise them and increase chances of survival for mothers and their babies. • It is important to visit a health provider for counselling on HIV and other reproductive health issues as a Community Leader. • It is important to advise community members to know their HIV status by encouraging them to test with their sexual partners. • Only ARVs can prevent the transmission of HIV from the mother to her baby. • It is important to advise community members to delay child bearing so that they pursue their dreams and have a higher quality of life. • It is important to delay sexual debut especially among the adolescent and youths. • It is important to encourage community members to talk to their partners and families about safe sex especially during pregnancy and breastfeeding. • It is important to advise the community members to protect themselves and partner from HIV by using a condom every time they have sex.
Message Delivery Strategies	• **Multi-media**(brochures and posters placed at MCH, adolescent and youth friendly corners, communities strategic places, bus stations schools/churches youth groups, TV, /Radio, community listening groups,

	SMS, billboards, Facebook/twitter, interpersonal communication, T-Shirts with key messages, community meetings)
Key communication tasks and ideas	• Raise awareness among Community Leaders of available services on maternal and newborn health. • Provide clear and simplified Social and Behaviour Change Communication on maternal and newborn health in strategic places where the Community Leaders will find it easier to access • Train Community Leaders on maternal and newborn health interventions and services to facilitate counselling of community members. • Prepare and distribute a simple guide for Community Leaders for use during discussions with community members. • Develop a Toolkit for the Community Leaders on maternal and newborn health services. • Collaborate with all stakeholders concerned with scaling up maternal and newborn health services at community level.
Other essential actions (needed to facilitate the recommended practices)	• Establishment of SMAGs in communities where they do not exist and ensure they are provided with clear TORs for them to operate effectively and efficiently. • Provide tool kits for SMAGs to use during community meetings

Thematic Area 3.3: Paediatric HIV

Audience 1: National Policy Makers

1.1 **Specific Objective**

- Increase number of national policy makers that are knowledgeable on the benefits of Paediatric HIV Services to the public and are allocating more resources to the programme.

Table 12: National Policy Makers

Target Audience	National Policy Makers
Current Behaviours	• Most national policy makers, who are the gate keepers of all communities, do not advocate/ talk about the benefits of Paediatric HIV Services to the public • Most national policy makers have inadequate knowledge and unappreciative of Paediatric HIV Services. • Most national policy makers do not understand the components of effective Paediatric HIV Services • Most national policy makers do not advocate for usage of Paediatric HIV Services
Barriers	• Inadequate information on Paediatric HIV Programme • Myths and misconceptions • Religious and traditional beliefs. • Competing issues for resources with the communities
Facilitating Factors	• Availability of RH/FP services in health facilities within the communities. • Availability of policies supporting RH/FP Services. Availability of trained health workers and CBVs in health facilities and communities.

	• Increased number of community leaders that support their communities to seek modern FP services.
Desired Behaviour Change	• Increased number of national policy makers that are supporting the public to seek Paediatric HIV Services and are allocating more resources to programme.
Communication Objective	• Increase number of national policy makers that are knowledgeable on the benefits of Paediatric HIV Services to the public and are allocating more resources to the programme
Key Messages	• It is okay to learn about Paediatric HIV Services. • It is important to request service providers to provide more information on Paediatric HIV services as a national policy maker. • It is important to come up with polices that will allow utilisation of Paediatric HIV Services by the public. • It is important for national policy makers to talk to the public about benefits of Paediatric HIV Services. • It is important to advise the public on the importance of knowing their HIV status by advising them to test with their sexual partners. If found HIV positive, to test their children as well. • It is important to advise communities to protect themselves and partners from HIV by using a condom every time they have sex.
Message Delivery Strategies	• Consultative meetings, presentations, Indaba with national policy makers, Leaflets, brochures etc
Key communication tasks and ideas	• Raise awareness among the national policy makers on the available options for Paediatric HIV Services. • Provide clear and simplified Social and Behaviour Change Communication on Paediatric HIV Services in strategic places where the national policy makers will find it easier to access
Other essential actions (needed to facilitate the recommended practice)	• Designing of executive booklets for parliamentarians which will provide detailed information on Paediatric HIV Services.

Audience 2: General Public

2.1 Specific Objectives

- Increase the number of communities that are knowledgeable about the benefits of Paediatric HIV Services.
- Increase the number of service providers trained in interpersonal communication skills for Paediatric HIV Services.
- Increase number of community leaders that are knowledgeable about the benefits of Paediatric HIV Services.
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Table 13: General Public Audience

Target Audience	General Public
Current behaviours	• Inadequate ART centres for Paediatric HIV care • Limited number of health facilities offering Early Infant Diagnosis • Inadequate resource allocation for scale up of Paediatric ART

	• Inadequate social welfare services for Paediatric • HIV Clients • Inadequate stocks of ARVs and other related commodities for Paediatric HIV care • Poor case management due to inadequate Paediatric ART Specialists in some parts of the country • Some challenges in data or record keeping • Poor communication skills • Inadequate health workers in some health facilities • Lack of diagnostics equipment and supplies for Paediatric HIV in most Health Facilities • Many households have little understanding about Paediatric HIV • Reluctance of parents/caregivers to test all their children for HIV • Parents/ Caregiver do not start their children on ART due to the perceived side effects • Mothers give incorrect information to avoid follow-up due to stigma • Continued HIV related discrimination by the community • Health workers have poor communication skills and do not communicate clearly to expecting and postnatal mothers on Paediatric HIV • Religious beliefs which discourage taking of ARVs but believe that HIV can be healed with prayers • Parents/Caregivers not disclosing the HIV status of their children for fear of discrimination • Non-compliance of taking ARVs among the adolescent for fear of discrimination e.g. Boarding schools
Barriers	• Lack of tailored social mobilisation tools for Paediatric HIV • Limited resources which are allocated for Paediatric HIV programme • Limited knowledge among policy makers on Paediatric HIV • Misleading information on ART and healthy living which impacts negatively on Paediatric HIV care • High poverty levels affecting most communities • Inadequate trained health workers to provide Paediatric ART services • Inadequate health facilities providing Paediatric ART services • Inadequate transport for the Paediatric HIV Programme • Inadequate diagnostic supplies • Poor record management for the programme • Negative attitude by health workers towards parents/caregiver with Paediatric HIV clients • High work load among the health workers which leads to compromise in quality of work • Stigma associated with Paediatric HIV • Lack of tailored social mobilisation for Paediatric HIV • Religious beliefs which discourage parents/ caregivers to allow their children to take ARVs • Some gate keepers disseminate misleading information on HIV which impact negatively on Paediatric HIV programme
Facilitating factors	• Availability of the National HIV/AIDS Strategic Framework 2017-2021 • Willingness of traditional leaders to act as champions for Paediatric HIV programme • Political will to implement Paediatric HIV programme • Good will from the co-operating partners and the Government towards the Paediatric HIV programme • Availability of skilled health personnel • Availability of national mentors on Paediatric HIV programme

	• Availability of drugs (ARVs) and logistics • Availability of community structures e.g. CHAs, NHCs, CBVs, SMAGs and Peer Educators • Availability of the youths and adolescents living with HIV who are role models • Willingness of mothers to take their children for under-five clinic • Availability of a Support system for pregnant and lactating women who are found HIV positive in the community
Desired Behaviour Changes	• Increased number of communities that are seeking Paediatric HIV Services. • Increased number of service providers skilled in interpersonal communication resulting in positive provider/ client encounter for Paediatric HIV services. • Increased number of community leaders that support their communities in seeking Paediatric HIV Services.
Communication objectives	• .Increase the number of communities that are knowledgeable on the benefits of Paediatric HIV Services. • Increase the number of service providers trained in interpersonal communication skills for Paediatric HIV services • Increase the number of community leaders that are knowledgeable about the benefits of Paediatric HIV Services.
Key Messages	• HIV positive mothers can infect their babies during pregnancy, delivery and breastfeeding • Get your baby tested to know their status if you are HIV positive • Make sure your child takes his/her ART medication everyday • ARV's prolong life • When you start ART do not stop • Exclusively breastfeed your baby in the first six months • Babies born with HIV can still grow into adulthood if consistently taking ARVs
Message Delivery Strategies/Channels	• **Multi-media**(brochures and posters placed at MCH, adolescent and youth friendly corners, communities strategic places, bus stations schools/churches youth groups, TV, /Radio, community listening groups, SMS, billboards, Facebook/twitter, interpersonal communication, T-Shirts with key messages, community meetings)
Key communication tasks and ideas	• Implement multimedia Social behavior change communication, social mobilisation, and advocacy interventions reaching urban, peri-urban, and rural to the public in order to promote utilisation of Paediatric HIV services. • Implement Social and Behaviour Change and Communication (SBCC) capacity strengthening activities among health providers to address health-provider barriers to utilisation of Paediatric HIV services. • Build the capacity of providers to effectively counsel clients on eMTCT and provide job aids to support this and reminder materials to facilitate ART adherence at home. • Encourage health facility staff to hold more community meetings on Paediatric HIV issues and make recommendations. • Promote access to ANC, facility delivery and PNC through print, electronic and interpersonal messages • Training of CBVs, drama groups and service providers on Paediatric HIV Services
Other essential actions (needed to facilitate the recommended practice	• Establishment of Paediatric HIV Services in communities where they do not exist and ensure they are provided with clear TORs for them to operate effectively and efficiently. They can be useful in tracking and following up cases of Paediatric HIV especially in rural areas.

Thematic Area 3.4: Child Health

Audience 1: National Policy Makers

1.1 Specific Objective

- Increase number of national policy makers that are knowledgeable on the benefits of Child Health Services to caretakers/ parents with under five children and are lobbying for more resources to the programme.

Table 14: National Policy Makers

Target Audience	National Policy Makers
Current Behaviours	• Most national policy makers, who are the gate keepers of all communities, do not advocate/ talk about the benefits of Child Health Services to caretakers/ parents with under five children. • Most national policy makers have inadequate knowledge and appreciative of Child Health Services. • Most national policy makers do not understand the components of effective Child Health Services to caretakers/ parents with under five Children. • Most national policy makers do not advocate for usage of Child Health Services to caretakers/ parents with under five children
Barriers	• Inadequate information on Child Health Services • Myths and misconceptions • Religious and traditional beliefs. • Competing issues for resources with the communities
Facilitating Factors	• Availability of Child Health Services in all health facilities. Availability of partners supporting Child Health Services. • Availability of trained health workers.
Desired Behaviour Change	• Increased number of national policy makers that are supporting caretakers/parents with under five children to seek Child Health Services and are allocating more resources to programme.
Communication Objective	• Increase number of national policy makers that are knowledgeable on the benefits of Child Health Services to caretakers/parents with under five children and are lobbying for more resources to the programme
Key Messages	• It is okay to learn about Child Health Services • It is important to request service providers to provide more information on Child Health Services as a national policy maker. • It is important to come up with polices that will reinforce utilisation of Child Health Services by the caretakers/ parents with under five children. • It is important for national policy makers to talk to the public about benefits of Child Health Services. • It is important to advise the caretakers/parents with under five

	children on the importance of knowing their HIV status by advising them to test with their sexual partners. If found HIV positive, to test their children as well. • It is important to advise caretakers/parents with under five children to protect themselves and partners from HIV
Message Delivery Strategies	• Consultative meetings, presentations, Indaba with national policy makers, Leaflets, brochures etc
Key communication tasks and ideas	• Raise awareness among the national policy makers on the available options for Child Health Services. • Provide clear and simplified Social and Behaviour Change Communication on Child Health Services in strategic places where the national policy makers will find it easier to access. • Train national policy makers on Child Health Services interventions and services.
Other essential actions (needed to facilitate the recommended practice)	• Designing of executive booklets for parliamentarians which will provide detailed information on Child Health Services.

Audience 2: Caretakers/ Parents with under five Children

2.1 Specific Objectives

- To increase the number of caretakers/parents with under five children that are knowledgeable on child health services.
- To increase the number of service providers that are trained on interpersonal communication skills for child health services.
- To increase the number of community leaders who are knowledgeable on the benefits of child health services.

Table 15: Caretakers/ Parents with under Five Children Audience

Target Audience	Caretakers with Under Five Children
Current behaviours	• Immunisation • Fathers rarely take children for vaccination. • Mothers/caretakers sometimes develop an attitude of not taking children for vaccinations routinely due to vaccine stock-outs. • Some health workers attitudes towards mothers/caretakers are not good. • Mothers/caretakers do not take their children for immunisation when they have lost or misplaced the under five cards. • Cultural/religious and traditional beliefs on the use of traditional medicines as opposed to vaccination. • Mothers/caretakers shun vaccination due to side effects like rising of temperatures and in situations where there was a past swelling on the injection site. **Integrated Management of Childhood Illnesses (IMCI)**

	• Cultural/religious and traditional beliefs on the use of traditional medicines as opposed to seeking health care interventions • Late health seeking behaviour on sick children • Sharing treatment meant for one child and low compliance to treatment advice • Giving alcohol for prevention of epilepsy and rickets in children • Mother/Caregivers not giving appropriate amounts of food and fluids when children are sick • Inadequate attention in child care by some hired Caregivers (maids) leading to home accidents • Pregnant and lactating mother abusing drugs/substance (cocaine, Alcohol, Tobacco) affecting children's growth and development. • Improper disposal of baby's faeces. • Not practicing hand washing with soap after changing nappies, use of toilet, before preparing baby's food and feeding. • Negligence in letting children sleep under ITNs • Some mothers/care givers ignoring to know the HIV/AIDS status of their children • Negligence in letting children access drugs/substances of abuse • Child abuse/negligence (sexual, physical, emotional) **Essential Newborn Care (ENC)** • Cultural/religious and traditional beliefs on the use of traditional medicines as opposed to vaccination • Inadequate care of the umbilical cords • Failure for mothers and newborn babies being together for bonding • Pregnant and lactating mother abusing drugs/substance (cocaine, Alcohol, Tobacco) affecting children 's growth and development **Early Childhood Development (ECD)** • Concentration mostly on growth monitoring and promotion • Failure to feed children appropriately for proper child's development • Failure to appropriately play and communicate with children to stimulate the child's physical, cognitive, social, and emotional development • Failure to appropriately prevent disease that affects child's development • Failure to appropriately respond to illness that affects child's development • Negligence in letting children access drugs/substances of abuse
Barriers	**Immunisation, IMCI, Newborn Care & ECD** • Inadequate knowledge on the importance of vaccinations among mothers • Long distance to health facility • Long waiting time at clinics • Lack of confidence in health services • Religious beliefs that God will protect the child or that the child's health

	is in God's hands • Overwhelmed mother/caregivers with home chores • Working mothers may be denied leave by employers • Understaffing at health facilities • Inadequate transport for outreach activities • Bad health workers' attitude towards mothers /caregivers • Availability of traditional doctors • High illiteracy levels • Cultural/religious and traditional beliefs on care of the newborn • Inadequate knowledge on ECD • Non availability of ECD services
Facilitating factors	**Immunisation, IMCI, Newborn Care & ECD** • Availability of immunisation services at both static and outreach levels • Availability of community based volunteers for creation of awareness on immunisations and provision of community promotive, preventive and curative services • Availability of policy and guidelines supporting immunisations, newborn care, ECD and good political will • Availability of vaccines, medicines and supplies • Availability of adequate staff and community based volunteers to provide immunisation, IMCI, newborn care and ECD services • Availability of health workers with good attitude towards mothers/caretakers
Desired Behaviour Changes	**Immunisation, IMCI, Newborn Care & ECD** • Increased number of caretakers/parents with under five children that seek Child Health Services. • Increased number of service providers that are skilled in interpersonal communication for the child health services. • Increased number of community leaders that support their communities to seek child health services
Communication objectives	**Immunisation, IMCI, Newborn Care & ECD** • To increase the number of caretakers/parents with under five children that are knowledgeable on child health services • To increase the number of service providers that are trained on interpersonal communication skills for child health services. • To increase the number of community leaders who are knowledgeable on the benefits of child health services.
Keys Messages	**Immunisation, IMCI, Newborn Care & ECD** • As caretakers/parents take your children for routine checks-up whilst they are under five to ensure they take all vaccinations they are eligible for. • Caretakers/parents take your children for under-five for vaccinations routinely before their first birthday • Use health facility vaccines to prevent childhood diseases • Use conventional prescribed medicines to treat sick children and newborns • Comply to treatment dosage and schedule for sick children to avoid treatment failure and disease resistance to treatment

	• Give appropriate amounts of food and fluids when children are sick • Care for children to prevent home accidents • Avoid drug abuse and substances like cocaine, Alcohol, Tobacco that can affect child's growth and development. • Dispose baby's faeces in toilets. • Wash your hands with soap/ashes after changing nappies, use of toilet, before preparing baby's food and before feeding the child. • Children should sleep under ITNs • Mothers/caregivers to take their children for HIV testing if status not known • Prevent and protect children from accessing drugs/substances of abuse • Mothers/caregivers, community members to stop abusing (sexually, physically, emotionally) and neglecting children • Clean umbilical cord stump of the newborns with boiled cooled clean water and keep the umbilical cord dry as advised by the health worker • Keep the newborn warm by using kangaroo method
Message Delivery Strategies	• **Multi-media** (brochures and posters placed at ANC,PNC, public places, workplaces/churches, TV, /Radio, community listening groups, SMS, billboards, Facebook/twitter, intrapersonal communication), community meetings , Peer to Peer)
Key communication tasks and ideas	**Immunisation, IMCI, Newborn Care & ECD** • Promote group education and community meetings on immunisation • Promote group education and community meetings on key family and community practices, such as hand washing, recognise when child needs treatment outside home and take to HW, etc. • Advocate for increased outreach services • Promote education on newborn care • Create awareness for ECD services
Other essential actions (needed to facilitate the recommended practice)	**Immunisation, IMCI, Newborn Care & ECD** • Initiate and increase reliable mobile immunisation services, especially in rural areas where health facilities are not easily accessible • Capacity building of health workers, particularly on counselling supported by job aids and supportive supervision • Collaboration with Ministry of Education and private sectors to promote and facilitate for safe play areas and other ECD activities. • Collaboration with Drug Enforcement commission on educating pregnant and lactating mothers on the dangers of use and abuse of drugs and other harmful substances • Collaboration with Red Cross and other stakeholders in capacity building in basic CPR and other lifesaving skills for mothers and community members to recognise illnesses or emergencies early and take appropriate action.

Thematic Area 3.5: Adolescent Health

Audience 1: National Policy Makers

1.1 Specific Objective

- Increase number of national policy makers that are knowledgeable on the benefits of Adolescent Health Services and are lobbying for more resources to the programme.

Table 16: National Policy Makers

Target Audience	National Policy Makers
Current Behaviours	• Most national policy makers, who are the gate keepers of all communities, do not advocate/ talk about the benefits of Adolescent Health Services to the adolescent and youth. • Most national policy makers have inadequate knowledge and appreciative of Adolescent health Services. • Most national policy makers do not understand the components of Adolescent Health Services. • Most national policy makers do not advocate/talk about sexual rights of the adolescent and youth.
Barriers	• Inadequate information on Adolescent Health Services. • Myths and misconceptions • Religious and traditional beliefs. • Competing issues for resources. • Lack of policies on sexual health and the adolescent.
Facilitating Factors	• Availability of the Adolescent Health Strategic Plan. • Availability of partners supporting Adolescent Health Services.
Desired Behaviour Change	• Increased number of national policy makers that are supporting the adolescent and youth to seek Adolescent Health Services and are allocating more resources to programme.
Communication Objective	• Increase number of national policy makers that are knowledgeable on the benefits of Adolescent Health Services to the adolescent and youth and are lobbying for more resource allocation to the programme
Key Messages	• It is okay to learn about Adolescent Health Services . • It is important to request service providers to provide more information on Adolescent Health Services as a national policy maker. • It is important to come up with policies that will allow utilisation of Adolescent Health Services for the young people especially the adolescent and youth. • It is important for national policy makers to talk to the adolescent and youth about benefits of utilizing professional Adolescent

	Health Services. • It is important to advise the adolescent and youth on the importance of knowing their HIV status by advising them to test with their sexual partners. If found HIV positive, to start treatment immediately • It is important to advise the adolescent and youth on the importance of protecting themselves and partners from HIV by using a condom every time they have sex.
Message Delivery Strategies	• Consultative meetings, presentations, Indaba with national policy makers, Leaflets, brochures etc
Key communication tasks and ideas	• Raise awareness among the national policy makers on the available options for Adolescent and youth. • Provide clear and simplified Social and Behaviour Change Communication on Adolescent Health Services in strategic places where the national policy makers will find it easier to access. • Train national policy makers on Adolescent Health Services interventions and services.
Other essential actions (needed to facilitate the recommended practice)	• Designing of executive booklets for parliamentarians which will provide detailed information on Adolescent Health Services.

Audience 2: Adolescents and Youth

2.1 Specific Objectives:

- Increase the number of adolescents and youth knowledgeable on the benefits of utilising professional Adolescent Health services
- Increase the number of service providers trained on interpersonal communication skills for the Adolescent Health

Table 17: Adolescent and Youth Audience

Target Audience	Adolescents and Youth
Current Behaviours	• Seeking information on Sexual Reproductive Health (SRH) and services from unprofessional people and peers • HIV burden and prevalence, high among the adolescent girls (4.8%) compared to (4.1%) among boys of the same age (ZDHS 2013-2014). • Limited availability and accessibility of commodities e.g. condoms and modern contraceptives. • Sexually active young people do not use condoms (more than 50%), (ZDHS 2013-2014). • Higher cost of condoms, most adolescents and youth engaging in unprotected sex (ZDHS 2013-2014). • Negative perceptions of condoms have created a gap between the number of condoms distributed and the amount needed for the

	adolescent and youth to protect themselves from HIV, STIs and to prevent unplanned pregnancies (MOT, 2009). • Alcohol and substance abuse among the adolescent and youth. • Seeking unprofessional RH services, e.g. getting information on reproductive health from peers and self-treatment. • Misusing alcohol, drug and other harmful substances leading to addiction • Engaging in early and unprotected sex leading to unwanted pregnancies (29% adolescents aged 15-19 (ZDHS 2013-2014) • Engaging in an early and unprotected sex leading to STIs, HIV infections (4.8%) adolescents aged 15-19 –(ZDHS 2013-2014) • Engaging in early marriages, 31% of adolescents aged below 18years (ZDHS 2013-2014) • Using risky and criminal abortions resulting into death and school drop-outs (16378 adolescents aged 10-19 ESB ,2014) • Opting to deliver out of health facilities arising from indulgence into early and unprotected sex • Copying inappropriate foreign cultures e. g. dress codes and abusing Information and Communication Technology (ICT) gadgets such as phones, computers, and magazines by watching pornographic materials leading to rampant rape cases, HIV and STIs infections as well as early teenage pregnancies and marriages. • Engaging in poor eating habits leading to Non-Communicable Diseases (NCDs).
Barriers	• Inadequate health workers to provide information on SRH and Rights as well as inaccessibility to affordable SRH services. • High Illiteracy levels and negative attitudes. • Long distance to SRH health facilities. • Inaccessibility to appropriate information on sexual reproductive health and related services. • Negative peer pressure from friends and fear of alienation. • Weak enforcement of policies and guidelines as well as unstiffened punitive measures on alcohol, drug and other harmful substance offenders. • Inadequate income-generating ventures and unavailability of recreational facilities forcing adolescents to engage in risky behaviours.
Facilitating Factors	• Availability and accessibility of adolescents and youth friendly services in all public health facilities and designated community places. • Availability of policies supporting SRH for adolescents and youth. • Availability of trained psycho-social counsellors in health facilities.
Desired Behaviour Changes	• Increased number of adolescents and youth seeking professional Adolescent Health Services. • Increased number of service providers trained in interpersonal communication skills resulting in positive Provider/ Client encounter for the Adolescent health services.
Communication Objectives	• Increase the number of adolescents and youth knowledgeable on the benefits of utilising professional Adolescent Health services • Increase the number of service providers trained in interpersonal communication skills for Adolescent Health
Key Messages	• Seek all adolescents and youth SRH information and services from designated health facilities. • Use condoms every time you have sex. • Do not indulge in alcohol, drug and substance abuse; these are harmful to your health.

	• Teenage pregnancies result into severe life threatening complications. • Early marriages lead to increased school dropouts and unproductive to an individual's, community and national social and economic development.
Message Delivery Strategies	• **Multi-media** (brochures and posters placed at schools, Youth Friendly Corners, workplaces/churches, TV, /Radio, community listening groups, SMS, billboards, Facebook/twitter, interpersonal communication, community meetings, Peer to Peer)
Key Communication task and Ideas	• Implement multimedia behaviour change communication, social mobilisation, and advocacy interventions reaching urban, peri-urban, and rural adolescents and youth to promote use of all reproductive health services. • Implement Social and Behaviour Change and Communication (SBCC) capacity strengthening activities among health providers to address service -provider barriers to uptake of reproductive health services among the adolescents and youth. • Build the capacity of service providers to effectively counsel adolescents and youth • Promote adolescents and youth reproductive health services through print and interpersonal messages. • Training of drama groups and service providers on SBCC for the adolescents and youth
Other Essential Actions Needed To Facilitate The Recommended Practice	• Implement more effective and qualify Adolescent/ Youth Friendly Corners on Reproductive Health (RH) in communities • Expand and scale up educative programmes/interventions that address SRH issues, affecting the adolescents and youth.

Audience 3: Community Leaders

3.1 Specific Objectives

1. To increase the number of community leaders that are knowledgeable on the benefits of Adolescent Health Services

Table 18: Community Leaders Audience

Target	Community Leaders

Current Behaviours	• Most community leaders have inadequate knowledge and appreciative about RH issues of the adolescent and youths.
	• Most community leaders do not understand the components of adolescent health programs and how to support them in their communities.
	• Most community leaders still embrace cultural and traditional beliefs which impact negatively on the acceptance of modern contraceptives by women and young girls.
	• Engaging in an early and unprotected sex leading to STIs, HIV infections
	• Engaging in criminal activities e.g. GBV, trafficking and thefts
	• Opting to deliver out of health facilities arising from indulgence into early and unprotected sex
	• Exposing adolescents to cultural practices such as:
	  • Sexual cleansing
	  • Forced teenage marriages

	• Unsafe traditional male circumcision • Engaging in poor eating habits leading to Non-Communicable Diseases (NCDs). • Parents/Caregivers discomfort and inability to talk to adolescents on sexual and reproductive health issues
Barriers	• Lack of confidence about the benefits of SRH needs and services for the adolescent communities. • Myths and misconceptions • Religious and traditional beliefs. • Competing issues and resources with the communities. • Negative attitude of health care providers • Strict societal/Cultural norms
Facilitating Factors	• Education and health programmes at community level • Availability of trained community workers • Appropriate information on Sexual Reproductive Health • Drugs and substance consumption should be in accordance to the prescribed laws and regulations of the country and to be administered by professionals and legalised cadres. • Availability of policies supporting SRH for community members and leadership • Availability of trained community Psycho - social Counsellors
Desired Behaviour Changes	• Increased number of community leaders that support the youths and adolescents within their communities to seek professional Adolescent Health Services
Communication Objectives	• To increase the number of community leaders that are knowledgeable on the benefits of Adolescent Health Services
Key Messages	• Seek SRH information and services from the experts/professionals • Alcohol, drug and substance abuse/dependence is dangerous to health and one must immediately seek medical intervention/counselling services • Teenage pregnancy may often result into serious complications during delivery including death • Abortion without medical advice is a criminal offence • Early marriages lead to increased school dropouts and unproductive to an individual's, community and national social and economic development
Message Delivery Strategies	• Presentations, Peer to Peer Education, Leaflets, Booklets, Meetings, Workshops)
Key Communication task and Ideas	• Raise awareness among community members and leadership on available Adolescent Health services • Provide clear and accurate technical information related SRH/ Adolescent Health Services through community mobilisation
Other Essential Actions Needed To Facilitate The Recommended Practice	• Implement more effective Reproductive Health (RH) classes/discussions and activities in and communities • Expand and scale up educative programmes that address cultural, SRH, alcohol and drug/substance abuse

Audience 4: Service Providers

4.1 Specific Objectives

To increase number of health facilities with trained service providers on interpersonal communication skills for the Adolescent health services.

Table 19: Service Providers Audience

Target Audience	Service Providers
Current Behaviors	• Health Care Providers not providing Family Planning methods to adolescents • Health Care Providers not accommodating adolescents who go to seek reproductive health services
Barriers	• Inadequate Health providers with interpersonal communication skills on adolescent health issues. • Inadequate providers who handle adolescents with the required attention. • Lack of availability, accessible, affordable professional Adolescent Health Services. • Negative attitude of health care providers towards adolescents. • Inadequate use of information on adolescent reproductive health. • Strict societal/Cultural norms. • Inadequate health education materials for appropriate information on adolescent sexual reproductive health and related services. • Health /Caregivers discomfort and inability to talk to adolescents on sexual and reproductive health issues. • Too many clients and not enough time to counsel adolescents. • Poor staff attitude towards adolescents. • Low pay and lack of motivation. • Poor infrastructure and lack of privacy. • Inadequate equipment. • Insufficient referral system.
Facilitating Factors	• Availability of adolescents and youth friendly services in some health facilities. • Availability of policies supporting SRH for adolescents. • Availability of trained Psycho - social Counselors in health facilities. • Availability of infrastructure to provide adolescent health services (Youth friendly corners). • Availability of trained health workers in adolescent reproductive health.
Desired Behavior Changes	• Increased number of health facilities with skilled service providers on interpersonal communication resulting in positive Provider/Client encounter for adolescent health Services
Communication Objectives	• To increase the number of health facilities with trained service providers on interpersonal communication skills for the adolescent health services
Key Messages	• Seek knowledge and access RH services • Teaching adolescents on the dangers of early sex, unprotected sex and sexual abuse is our passion • Health workers with positive attitudes to adolescents SRH. • Psychosocial Counselors available for adolescent health • Health Policies support Adolescent Reproductive Health • Youth Friendly Conner available in every health Care Facility.

	• Treat each and every adolescent client/patient with dignity. • Every adolescent client has the right to information on sexual reproductive health services.
Message Delivery Strategies	• Training, Booklets, Meetings, Leaflets, Brochures, Posters etc
Key Communication task and Ideas	• Raise awareness among service provide on the need to adhere to the code of practice when handling adolescent clients/patients. • Provide update training on Adolescent Client/ Customer Care to all health workers implementing adolescent health services.
Other Essential Actions Needed To Facilitate The Recommended Practice	• Improve infrastructure and provide equipment • Recruit and post more qualified Health Workers

Thematic Area 3.6: Nutrition

Audience 1: National Policy Makers

1.1 **Specific Objective**

- Increase number of national policy makers that are knowledgeable on the benefits of Nutritional Services to the public and are lobbying for more resources to the programme.

Table 20: National Policy Makers

Target Audience	National Policy Makers
Current Behaviours	• Most national policy makers, who are the gate keepers of all communities, do not advocate/ talk about the benefits of Nutritional Services to the public • Most national policy makers have inadequate knowledge and appreciative of Nutritional Services • Most national policy makers do not understand the components of effective Nutritional Services • Most national policy makers do not advocate for Nutritional Services
Barriers	• Inadequate information Nutritional Services. • Myths and misconceptions. • Religious and traditional beliefs. • Competing issues for resources with the communities.
Facilitating Factors	• Availability of nutritional services in the health facilities Availability of partners supporting Nutritional programme. • Availability of trained health workers on nutritional services
Desired Behaviour Change	• Increased number of national policy makers that are supporting the public to seek Nutritional Services and are allocating more resources to programme.
Communication Objective	• Increase number of national policy makers that are knowledgeable on the benefits of Nutritional Services to the public and are lobbying for more resources to the programme

Key Messages	• It is okay to learn about nutritional services. • It is important to request service providers to provide more information on nutritional services as a national policy maker. • It is important to come up with polices that will support nutritional programme. • It is important for national policy makers to talk to the public about benefits of nutritional services.
Message Delivery Strategies	• Consultative meetings, presentations, Indaba with national policy makers, Leaflets, brochures etc
Key communication tasks and ideas	• Raise awareness among the national policy makers on the available options for nutritional services. • Provide clear and simplified Social and Behaviour Change Communication on nutritional services in strategic places were the national policy makers will find it easier to access. • Train national policy makers on nutritional Services interventions and services.
Other essential actions (needed to facilitate the recommended practice)	• Designing of executive booklets for parliamentarians which will provide detailed information on nutritional Services.

NUTRITION FOR PRE-PREGNANT WOMEN

Audience 2: Women of Reproductive Age

2.1 Specific Objectives

- Increase in the number of women of reproductive age that are knowledgeable on nutritional health services
- Increase in the number of service providers that are trained in interpersonal communication skills for nutritional health services

Table 21: Women of Reproductive Age Audience

Target Audience	Women of Reproductive Age
Current behaviours	• Most women of reproductive age have inadequate knowledge on the benefits of nutritious foods during pre-pregnancy period • Most women of reproductive age have inadequate intake of a variety of foods rich in essential nutrients during pre-pregnancy (macro and micronutrients) • Most women of reproductive age live in extreme poverty levels and cannot afford to balance their meals. • Most women of reproductive age who do not have knowledge on the acceptable methods of food preparations and end up preparing meals which do not have any nutritional values
Barriers	• Cultural orientation of mono diets • Poverty • Low self-esteem among women of reproductive age • Inadequate skills among health care providers • High illiteracy levels among women of reproductive age • High work load among health care providers to provide adequate counselling to women of reproductive age on good nutrition

Facilitating factors	• Availability of community groups • Availability of NGOs mandated to improve nutrition at household level • Availability of counselling materials • Availability of services in health facilities • Availability of trained health care providers in health facilities and at the community level.
Desired Behaviour Changes	• Increased number of women of reproductive age seeking nutritional health services • Increased number of service providers with skills in interpersonal communication for nutritional health services
Communication objectives	• Increase in the number of women of reproductive age that are knowledgeable on nutritional health services • Increase in the number of service providers that are trained on interpersonal communication skills for nutritional health services
Key Messages	• Eat a well-balanced diet on a daily basis • Know how to prepare your meals • Consume a variety of foods, including leafy green vegetables and salads • Consume lots of fruits, preferably five portions in a day if you can afford • Learn how to preserve fruits during rainy season when they are plentiful, for future consumption • Take iron and folic acid tablets pre and during pregnancy period and beyond if required • Drink 2500-3000litres of water divided doses in 24 hours
Message Delivery Strategies	• **Multi-media**(brochures and posters placed at ANC,PNC, workplaces/churches, TV, /Radio, community listening groups, SMS, billboards, Facebook/twitter, interpersonal communication)
Key communication tasks and ideas	• Promote nutrition through print, electronic and interpersonal messages. • Training of drama groups and service providers • Community mobilisation on good nutrition at household level utilising readily available commodities • Promote male involvement in nutritional issues.
Other essential actions (needed to facilitate the recommended practice	• Provide more nutrition information that is accessible to all clients including the physically challenged and persons with learning disabilities.

NUTRITION FOR CHILDREN 0-5 MONTHS

Audience 3: Men and Women of the Reproductive Age Group

3.1 Specific Objective

- To increase the number of men and women of reproductive age that are knowledgeable on the nutritional needs for children 0-5 months.

Table 22: Men and women of Reproductive Age

Target Audience	Men and Women of Reproductive Age
Current behaviours	• Delay initiation of breastfeeding • Breastfeed frequently but not long enough (to empty both breasts each

	time) • Prematurely introduce complementary foods and mixed feeding before six months (formula & breast milk)
Barriers	• Cultural and religious beliefs, myths and misconceptions • Fashion and fads of modernisation (exclusive replacement feeding) • Career women/peasant farmers • Conflicting messages about nutrition
Facilitating factors	• Availability of community groups • Availability of NGOs mandated to improve nutrition at household level • Availability of counselling materials • Availability of services in health facilities • Availability of trained health care providers in health facilities and at the community level
Desired Behaviour Changes	• Increased number of men and women of reproductive age that are seeking nutritional health services for children 0-5 months
Communication objectives	• To increase the number of men and women of reproductive age that are knowledgeable on the nutritional needs for children 0-5 months
Key Messages	**Promotion of exclusive breastfeeding** • Breastfeed your baby within the first hour of birth to safeguard their life. • First milk (colostrum) provides the first immunisation for the baby; • Breastfeed exclusively for the first six months because breast milk is by far the best way of feeding for babies health, growth and development of intelligence. • Eat fortified foods to increase your intake of vitamins and minerals which make you a healthy mother • Take vitamin 'A' within eight weeks of delivery to improve vitamin 'A' in breast milk; • Eat enough of variety of foods to improve on your health and production of breast milk.
Message Delivery Strategies	• **Multi-media** (brochures and posters placed at ANC, PNC, workplaces/churches, TV, /Radio, community listening groups, SMS, billboards, Facebook/twitter, interpersonal communication)
Key communication tasks and ideas	• Implement multimedia behaviour change communication, social mobilisation, and advocacy interventions reaching urban, peri-urban, and rural women of reproductive age particularly lactating women to promote the practice of exclusive breastfeeding. • Implement Social and Behaviour Change and Communication (SBCC) capacity strengthening activities among health providers to address health-provider barriers to uptake of exclusive breastfeeding. • Build the capacity of providers to effectively counsel clients on exclusive breastfeeding. • Encourage health facility staff to hold more community discussions on exclusive breastfeeding. • Promote exclusive breastfeeding through print, electronic and interpersonal messages. • Training of drama groups and service providers • Community mobilisation.
Other essential actions (needed to facilitate the recommended practice	• Provide more information and personalised counsel to mothers of children. • Use volunteers to promote nutrition services that are accessible to all clients including the physically challenged and persons with learning disabilities. • Expand the Community Champions Initiative.

NUTRITION FOR THE LACTATING MOTHER

Audience 4: Men and women of Reproductive Age

4.1 Specific Objective

- Increase in number of men and women of reproductive age that are knowledgeable about the nutritional needs of a lactating mother.

Table 23: Men and women of Reproductive Age

Target Audience	Men and women of Reproductive Age
Current behaviours	• Exclusive breastfeeding not practiced accordingly for fear of HIV transmission • Cultural beliefs associated with initiation of breastfeeding • Health care providers knowledge and counselling skills limited
Barriers	• Inadequate staff and volunteers. • Inadequate knowledge and skills among staff and volunteers to follow up counselling on breastfeeding. • Community pressure to follow cultural beliefs and practices (Strict societal/cultural norms). • Teenage mothers not ready to be mothers and not adhering to counsel on child care including breastfeeding. • Negative attitude of health workers towards support to lactating mothers. • Inadequate family and community support or exclusive breastfeeding. • Inadequate maternity protection for exclusive breastfeeding. • Economic pressure to return to work before exclusive breastfeeding. • Inadequate literacy levels to read and understand literature
Facilitating factors	• Availability of community volunteers within communities • Availability of guidelines and counselling tools that can be used to support lactating women • IEC materials on breastfeeding from time to time in health facilities. • Availability of trained psycho-social counsellors in health facilities.
Desired Behaviour Change	• Increased number of men and women of reproductive age seeking nutritional health services of a lactating mother
Communication objectives	• Increase in number of men and women of reproductive age that are knowledgeable about the nutritional needs of a lactating mother
Key message	**Promotion of exclusive breastfeeding** • Breastfeed your baby within the first hour of birth to safeguard their life. • First milk (colostrum) provides the first immunisation for the baby. • Breastfeed exclusively for the first six months because breast milk is by far the best way of feeding for babies health, growth, and development of intelligence. • Eat fortified foods to increase your intake of vitamins and minerals which make you a healthy mother • Take vitamin 'A' within eight weeks of delivery to improve vitamin 'A' in breast milk • Eat enough of variety of foods to improve on your health and production of breast milk. • Exclusively breastfeed babies from 0 months to 6 months completed months of age; • Mothers eat variety of nutrient-dense foods
Message Delivery Strategies	• **Multi-media**(brochures and posters placed at adolescent and youth friendly, schools/churches youth groups, TV, /Radio, community listening groups, SMS,

	billboards, Facebook/twitter, interpersonal communication)
Key communication tasks and ideas	• Increase in number of private health facilities with staff trained • Initiate partnerships with various partners
Other essential actions (needed to facilitate the recommended practices)	• Integrate nutritional SBCC into all the community structures • Train CBVs on Nutrition SBCC

Audience 5: Service Providers

5.1 Specific Objective

- Increase in number of health facilities with trained service providers on interpersonal communication skills for Nutritional Health Services.

Table 24: Service Providers Audience

Target Audience	Service Providers
Current behaviours	• Few providers with interpersonal communication skills on MIYCN issues. • Few providers conduct counselling clients on MIYCN
Barriers	• Too many clients and inadequate time to counsel each one properly • Inadequate skill on SBCC • Poor attitude towards clients • Inadequate evidence based information for informed decision making
Facilitating factors	• Availability of infrastructure to provide counselling • Availability of policies supporting MIYCN to guide appropriate nutrition • Availability of trained health workers and CBVs in MIYCN
Desired Behaviour Change	• Increased number of health facilities with trained service providers in interpersonal communication skills resulting in positive Provider/ Client encounter for Nutritional Health Services
Communication objectives	• Increase in number of health facilities with trained service providers on interpersonal communication skills for Nutritional Health Services.
Key messages	• Treat each and every client/patient with dignity • Every client has the right to information on MIYCN • Communicate issues of MIYCN to all clients/patients in an effective and efficient manner without prejudice due to age, sex, race, tribe, culture, status etc.
Message Delivery Strategies	• Interpersonal Communication • Leaflets • Booklets • Training • Updates • Mentorship • Posters
Key communication tasks and ideas	• Raise awareness among service providers on the need to adhere to MIYCN guidelines. • Provide update training on Client/ Customer Care to all health workers implementing MIYCN
Other Essential Actions (Needed To Facilitate The Recommended Practices)	• Recruit and post more qualified Health Workers • Motivate community based volunteers • Train community volunteers in MIYCN from community zones (ensure adequate numbers in zones)

Audience 6: Community Leaders

6.1 Specific Objective

- Increase in the number of community leaders that are knowledgeable on the importance of nutritional health services

Table 25: Community Leaders Audience

Target Audience	Community Leaders
Current behaviours	• Most community leaders who are the gate keepers of most communities have inadequate knowledge recommended practices for MIYCN. • Most Community Leaders believe and preserve religious, cultural and traditional beliefs on MIYCN.
Barriers	• Inadequate knowledge on MIYCN • Myths and misconceptions on foods and feeding practices for maternal and MIYCN • Religious and traditional beliefs. • Competing issues and resources within communities. • Inadequate information on food contains(lack of food labeling)
Facilitating factors	• Availability of MIYCN services in health facilities within the communities. • Availability of policies supporting MIYCN • Availability of NHCs willing to be trained to conduct various activities • Availability and commitment of trained health workers and CBVs in health facilities and communities.
Desired Behaviour Change	• Increased number of community leaders that support their communities to seek nutritional health services
Communication objectives	• Increase in the number of community leaders that are knowledgeable on the importance of nutritional health services
Key message	• Several benefits and limitations can affect MIYCN. • It is important to visit a health provider for counseling on appropriate MIYCN.
Message Delivery Strategies	• Presentations, Consultative Meetings, Leaflets, Brochures, Community meetings, Peer to Peer
Key communication tasks and ideas	• Raise awareness among Community Leaders on MIYCN • Provide clear and simplified Social and Behaviour Change Communication on MIYCN in strategic places were the Community Leaders will find it easier to access • Train Community Leaders on MIYCN interventions and actions to support other community members. • Prepare and distribute simplified guidelines on MIYCN principles for Community Leaders reference • Develop a Toolkit for the Community Leaders on MIYCN; • Mobilise partners and resources
Other essential actions (needed to facilitate the recommended practices)	• Advocate for more support to the programme • Work with CBVs to dispel the myths and misconceptions around such nutritious foods at community level

Thematic Area 3.7: Cancers of The Reproductive Organs

Audience 1: National Policy Makers

1.1 Specific Objective

- Increase number of national policy makers that are knowledgeable on the benefits of Cancer Services to the public and are lobbying more resources to the programme.

Table 26: National Policy Makers

Target Audience	National Policy Makers
Current Behaviours	• Most national policy makers, who are the gate keepers of all communities, do not advocate/ talk about the benefits of Cancer Services to the public • Most national policy makers have inadequate knowledge and appreciative of Cancer Services. • Most national policy makers do not understand the components of effective Cancer Services • Most national policy makers do not advocate for usage of cancer Services
Barriers	• Inadequate information on Cancer Programme • Myths and misconceptions • Religious and traditional beliefs. • Competing issues for resources with the communities
Facilitating Factors	• Availability of cancer services in some health facilities. • Availability of partners supporting cancer services. • Availability of trained health workers on cancer services
Desired Behaviour Change	• Increased number of national policy makers that are supporting the public to seek cancer services and are allocating more resources to programme.
Communication Objective	• Increase number of national policy makers that are knowledgeable on the benefits of cancer services to the public and are lobbying more resources to the programme
Key Messages	• It is okay to learn about cancers services. • It is important to request service providers to provide more information on cancer services as a national policy maker. • It is important to come up with policies that will reinforce utilisation of cancer services by the public. • It is important for national policy makers to talk to the public about benefits of cancer services. • It is important to advise the public on the importance of knowing their HIV status by advising them to test with their sexual partners. If found HIV positive, to start treatment immediately.

Message Delivery Strategies	• Consultative meetings, presentations, Indaba with national policy makers, Leaflets, brochures etc
Key communication tasks and ideas	• Raise awareness among the national policy makers on the available Cancer Services. • Provide clear and simplified Social and Behaviour Change Communication on cancer programme in strategic places where the national policy makers will find it easier to access.
Other essential actions (needed to facilitate the recommended practice)	• Designing of executive booklets for parliamentarians which will provide detailed information on Cancer Services.

1.6.1 Cervical Cancer

Audience 1: Women of Reproductive Age

1.1 Specific Objectives

- Increase in the number of women of reproductive age that are knowledgeable on the benefits of cervical cancer screening services.

Table 27: Women of Reproductive Age Audience

Target Audience	Women of the Reproductive Age
Current behaviours	• Some women are still hesitant to go for cervical cancer screening • Some women have inadequate knowledge on the screening modalities on cervical cancer • Some women still think cervical cancer can only affect HIV positive women • Some women present late to the hospital with cervical cancer • Cervical cancer is the number one cancer affecting women in Zambia (CDH 2016)
Barriers	• Inadequate information on the availability of cervical cancer screening services • Inadequate information on the benefits of cervical cancer screening • Inadequate information on the complications of cervical cancer • Low risk perception of getting cancer • Multiple concurrent sexual partners
Facilitating factors	• Availability of services for cervical cancer screening • Trained health workers who offer cervical cancer screening services • Availability of awareness programmes on cervical cancer programme.
Desired Behaviour Changes	• Increased number of women of reproductive age that are seeking cervical cancer screening services
Communication objectives	• Increase in the number of women of reproductive age that are knowledgeable on the benefits of cervical cancer screening services
Key Messages	• Go for regular cervical cancer screening • Avoid concurrent multiple sexual partners • Take young girls between the ages of 9 and 15 for HPV vaccination

	• Talk to your friends about cervical cancer screening modalities available • Avoid alcohol and cigarettes • Signs and symptoms of cervical cancer include bleeding between periods, pain during and after sex, bleeding after sex, foul smelling vaginal discharge, lower abdominal pain and postmenopausal bleeding at times • Encourage the male partners to go for voluntary male circumcision
Message Delivery Strategies	• Multi-media(*brochures and posters placed at markets,, churches, taverns, workplaces, schools)* • TV, /Radio, community listening groups, SMS, billboards, Facebook/twitter, interpersonal communication)
Key communication tasks and ideas	• Implement multimedia behaviour change communication, social mobilisation, and advocacy interventions reaching urban, peri-urban, and rural women of reproductive age to promote cervical cancer screening and treatment services. • Implement Social and Behaviour Change and Communication (SBCC) capacity strengthening activities among health providers to address health-provider barriers to uptake of cervical cancer screening and treatment services. • Build the capacity of providers to effectively counsel clients on the importance of screening, signs and symptoms, and available treatment options. • Encourage health facility staff to conduct more awareness and sensitisation activities at community level. • Promote cancer awareness activities through print, electronic and interpersonal messages. • Training of drama groups and service providers
Other essential actions (needed to facilitate the recommended practice)	• Advocate for more comprehensive cervical cancer facilities and related resources as close to the people as possible, especially in rural areas.

3.6.2 Breast Cancer

Audience 1: Men and Women of Reproductive Age

1.1 Specific Objective

- Increase the number of men and women of reproductive age that are knowledgeable on the benefits of breast cancer screening services.

Table 28: Women of the Reproductive Age Audience

Target Audience	Men and Women of Reproductive Age
Current behaviours	• Breast cancer is the second most common cancer affecting women in Zambia (CDH 2016) • Some women are still hesitant to go for breast cancer screening • Some women have inadequate knowledge on the screening modalities about breast cancer • Some women still think breast cancer is the disease of the elderly • Some women present late to the hospital with breast cancer
Barriers	• Inadequate information on the availability of breast cancer screening services

	• Inadequate information on the benefits of breast cancer screening • Inadequate information on the disease process and complications of breast cancer • Low risk perception of getting cancer
Facilitating factors	• Availability of services at provincial level health facilities (mammography) and at community level (Clinical Breast Examination) for breast screening • Trained health workers who offer breast cancer screening services • Availability of awareness programmes on breast cancer programme.
Desired Behaviour Changes	• Increased number of men and women of the reproductive age that are seeking breast cancer screening services
Communication objectives	• Increase in the number of men and women of the reproductive age that are knowledgeable on the benefits of breast cancer screening services
Key Messages	• Go for regular breast cancer screening • Do self-breast examination at least once a month • Do exercise on a regular basis and avoid fatty foods • Talk to your friends about breast cancer screening modalities available • Avoid alcohol and cigarettes • Breast feed regularly • Signs and symptoms of breast cancer include hard lump in the breast, nipple retraction, pain in the breast, swelling of the breast, nipple discharge and breast skin changes with ulceration at times • Breast cancer can also affect males
Message Delivery Strategies	• **Multi-media**(brochures and posters placed at markets,, churches, taverns, workplaces, schools, TV, /Radio, community listening groups, SMS, billboards, Facebook/twitter, interpersonal communication)
Key communication tasks and ideas	• Implement multimedia behaviour change communication, social mobilisation, and advocacy interventions reaching urban, peri-urban, and rural women of reproductive age to promote breast cancer screening and treatment services. • Implement Social and Behaviour Change and Communication (SBCC) capacity strengthening activities among health providers to address health-provider barriers to uptake of breast cancer screening and treatment services. • Build the capacity of providers to effectively counsel clients on the importance of screening, signs and symptoms, and available treatment options. • Encourage health facility staff to conduct more awareness and sensitisation activities at community level. • Promote cancer awareness activities through print, electronic and interpersonal messages. • Training of drama groups and service providers
Other essential actions (needed to facilitate the recommended practice)	• Advocate for more comprehensive breast cancer screening facilities and related resources as close to the people as possible, especially in rural areas.

3.6.3 PROSTATE CANCER

Audience 1: Men of Reproductive Age

1.1 Specific Objectives

- Increase the number of men that are knowledgeable on the benefits of prostate cancer screening services

Table 29: Men of Reproductive Age Audience

Target Audience	Men of Reproductive Age
Current behaviours	• Most men are still hesitant to go for prostate cancer screening. • Most men have inadequate knowledge on the screening modalities of prostate cancer. • Most men still think prostate cancer is a disease of the elderly. • Most men present late at the hospital with prostate cancer
Barriers	• Inadequate financial support for prostate cancer as a programme • Inadequate information on the available screening services for prostate cancer • Inadequate health workers trained on prostate cancer • Myths and misconceptions surrounding prostate cancer
Facilitating factors	• Availability of services for cancer screening • Trained health workers who offer cancer screening services • Availability of awareness programmes on cancer programme.
Desired Behaviour Changes	• Increased number of men that are seeking prostate cancer screening services
Communication objectives	• Increase the number of men that are knowledgeable on the benefits of prostate cancer screening services
Key Messages	• Exercise regularly and avoid fatty foods • Avoid concurrent multiple sexual partners • Talk to your friends about cancer screening modalities available • Avoid alcohol and cigarettes
Message Delivery Strategies	• Multi-media(*brochures and posters placed at markets,, churches, taverns, workplaces, schools,* TV, /Radio, community listening groups, SMS, billboards, Facebook/twitter, interpersonal communication)
Key communication tasks and ideas	• Implement multimedia behaviour change communication, social mobilisation, and advocacy interventions reaching urban, peri-urban, and rural women of reproductive age to promote cancer screening and treatment services. • Implement Social and Behaviour Change and Communication (SBCC) capacity strengthening activities among health providers to address health-provider barriers to uptake of cancer screening and treatment services. • Build the capacity of providers to effectively counsel clients on the importance of screening, signs and symptoms, and available treatment options. • Encourage health facility staff to conduct more awareness and sensitisation activities at community level.

	• Promote cancer awareness activities through print, electronic and interpersonal messages. • Training of drama groups and service providers.
Other essential actions (needed to facilitate the recommended practice)	• Advocate for more comprehensive cancer facilities and related resources as close to the people as possible, especially in rural areas.

Audience 2: Community Leaders

2.1 Specific Objectives

- Increase the number of community leaders that are knowledgeable on the benefits of cervical, breast and prostate cancers screening services.

Table 30: Community Leaders Audience

Target Audience	Community Leaders
Current behaviours	• Most community leaders have inadequate knowledge on cancers • Most community leaders do not understand the importance of cancer screenings
Barriers	• Low risk perception of getting cancers • Conflict of interests • Competing issues and resources at national level
Facilitating factors	• Availability of cancer services in health facilities • Availability of trained health workers and in health facilities
Desired Behaviour Change	• Increased number of community leaders that support their communities in seeking cervical , breast and prostate cancers screening services
Communication objectives	• Increase number of community leaders that are knowledgeable on the benefits of cervical , breast and prostate cancers screening services
Key messages	• Learn about the basics of the different types of cancer • There are screening modalities available for particular cancers • Visit a health provider and institutions for information on cancer • Cancer is not communicable • Advise the nation to go for cancer screening • Frame policies that delay sexual debut for young girls • Encourage the nation to stop smoking and avoid excessive alcohol intake • Advise the nation to exercise regularly and maintain a normal diet
Message Delivery Strategies	• Multi-media(brochures and posters placed at adolescent and youth friendly, communities strategic places, bus stations schools/churches youth groups, TV, /Radio, community listening groups, SMS, billboards, Facebook/twitter, interpersonal communication)
Key communication tasks and ideas	• Raise awareness among policy makers on available cancer services • Train policy makers on cancer services to facilitate awareness across the nation • Prepare and distribute a simple guide on cancer to leaders to use during discussions, meetings and interactions with the members of the public • Develop a Toolkit for the policy makers on cancer services.

	• Collaborate with the all stakeholders concerned with scaling up cancer services in most health centres
Other essential actions (needed to facilitate the recommended practices)	• Establishment of SMAGs in communities where they do not exist and ensure they are provided with clear TORs for them to operate effectively and efficiently.

Audience 3: Service Providers

3.1 Specific Objectives

- Increase in the number of health facilities with service providers that are trained in interpersonal communication skills on cervical, breast and prostate cancer screening services.

Table 31: Service Providers Audience

Target Audience	Service Providers
Current behaviours	• Few providers with interpersonal communication skills on cancer issues. • Few providers who practice positive interpersonal communication skills during cancer services. • Few providers report counselling clients on cancers of the reproductive organs
Barriers	• Too many patients and not enough human resource to cater for all clients/patients • Treatment services only centralised in Lusaka
Facilitating factors	• Availability of infrastructure to provide cancer services. • Availability of trained health workers and health facilities
Desired Behaviour Change	• Increased number of health facilities, with service providers trained in interpersonal communication skills, resulting in positive provider-client encounter for Cancer Screening Services
Communication objectives	• Increase in the number of health facilities with service providers that are trained in interpersonal communication skills on cervical, breast and prostate Cancer Screening Services.
Key message	• Treat each and every client/patient with dignity • Every client has the right to information on cancer • Communication issues on cancer to all clients/patients in an effective and efficient manner without prejudice due to age, sex, race, tribe, culture, status etc.
Message Delivery Strategies	• Interpersonal Communication • Leaflets • Booklets • Training • Updates • Mentorship • Posters
Key communication tasks and ideas	• Raise awareness among service providers on the need to adhere to the code of practice when handling clients/patients • Provide update training on Client/ Customer Care to all service providers on cancer services.
Other essential actions (needed to facilitate the recommended practices)	• Recruit and post more qualified Health Workers • Motivate health workers by introducing a system that awards hard working service providers

Thematic Area 3.8: Infertility

Audience 1: National Policy Makers

1.1 **Specific Objective**

- Increase number of national policy makers that are knowledgeable on the benefits of Fertility Services to men and women of the reproductive age and are allocating more resources to the programme.

Table 32: National Policy Makers

Target Audience	National Policy Makers
Current Behaviours	• Most national policy makers, who are the gate keepers of all communities, do not advocate/ talk about the benefits of Fertility Services to men and women of the reproductive age. • Most national policy makers have inadequate knowledge on Fertility Services. • Most national policy makers do not understand the components of effective Fertility Services • Most national policy makers do not advocate for usage of Fertility Services
Barriers	• Inadequate information on Fertility Services • Myths and misconceptions • Religious and traditional beliefs. • Competing issues for resources with the communities
Facilitating Factors	• Availability of partners supporting RH Services. • Availability of trained health workers and CBVs in health facilities and communities
Desired Behaviour Change	• Increased number of national policy makers that are supporting men and women of reproductive age to seek Fertility Services and are allocating more resources to programme.
Communication Objective	• Increase number of national policy makers that are knowledgeable on the benefits of Fertility Services to men and women of reproductive age and are lobbying for more resources to the programme.
Key Messages	• It is okay to learn about Fertility Services. • It is important to request service providers to provide more information on Fertility Services as a national policy maker. • It is important to come up with policies that will allow utilisation of Fertility Services by men and women of the reproductive age. • It is important to advise the public on the importance of knowing their HIV status by advising them to test with their sexual partners. If found HIV positive, to start treatment immediately.
Message Delivery Strategies	• Consultative meetings, presentations, Indaba with national policy

	makers, Leaflets, brochures etc
Key communication tasks and ideas	• Raise awareness among the national policy makers on the available options for Fertility Services. • Provide clear and simplified Social and Behaviour Change Communication on Fertility Services in strategic places where the national policy makers will find it easier to access.
Other essential actions (needed to facilitate the recommended practice)	• Designing of executive booklets for parliamentarians which will provide detailed information on Fertility Services.

Audience 2: Men and Women of Reproductive Age

2.1 Specific Objective

- Increased number of men and women in the reproductive age group who are knowledgeable on the benefits of fertility health services

Table 33: Men and Women of Reproductive Age

Target Audience	Men and Women Of Reproductive Age
Current behaviours	• Couples resort to traditional medicines • Couples having multiple sexual partners • Arranged sexual partners • Society believes only women are infertile • Couples resort to traditional medicines • Substance abuse such as alcohol due to frustration • Divorces due to not having children
Barriers	• Inadequate knowledge on where to seek help on infertility • Inadequate knowledge on causes of infertility • Inadequate knowledge among health care providers on infertility • Stigma attached to infertility • Services not mostly provided in public health facilities • Private clinics quite expensive • Expensive laboratory tests • Lack of equipment to diagnose and treat infertility
Facilitating factors	• Increasing knowledge about infertility. • Low self-esteem in women • Availability of fertility services in health facilities • Availability of skilled health care providers in health facilities and at the community level.
Desired Behavior Changes	• Increased number of men and women of the reproductive age that seek Fertility Health Services
Communication objectives	• Increase in the number of men and women of the reproductive age that are knowledgeable on the benefits of Fertility Health Services
Key Messages	• Infertility is not being pregnant despite having frequent, unprotected sex for at least a year for most couples. • Infertility causes in men are as a result of sperm disorder. • Infertility causes in women can be an ovulation disorder, blockage of the fallopian tubes, and hormonal defects

	• Infertility may be treated with medicine, surgery, artificial insemination, or assisted reproductive technology, based on the couples test results and other factors
Message Delivery Strategies	• **Multi-media** (brochures and posters placed at ANC,PNC, workplaces/churches, TV, /Radio, community listening groups, SMS, billboards, Facebook/twitter, interpersonal communication)
Key communication tasks and ideas	• Implement multimedia behavior change communication, social mobilisation, and advocacy interventions reaching urban, peri-urban, and rural women of reproductive age to promote use of infertility services. • Implement Social and Behaviour Change and Communication (SBCC) capacity strengthening activities among health providers to address health-provider barriers to uptake of infertility services. • Build the capacity of providers to effectively counsel couples with infertility. • Encourage health facility staff to hold more community discussions on infertility issues. • Promote infertility messages through print, electronic and interpersonal messages. • Training of drama groups and service providers. • Community mobilisation. • Promote male involvement in issues of infertility.
Other essential actions (needed to facilitate the recommended practice	• Provide more infertility services that are accessible to all couples. • Expand the Community Champions Initiative.

Audience 3: Service Providers

3.1 Specific Objectives

- To increase the number of health facilities, with service providers trained in interpersonal communication skills, resulting in positive provider-client attitude for Fertility Services

Table 34: Service Providers Audience

Target Audience	Service Providers
Current behaviours	• Poor communication skills by health workers. • Bad attitudes and poor interpersonal communication by health care providers. • Poor counselling skills on infertility
Barriers	• Inadequate knowledge among health care providers on infertility • Too many patients and not enough time to counsel couples/individuals on infertility • Biases against infertility • Low pay and lack of motivation • Services not mostly provided in public health facilities • Expensive laboratory tests • Lack of equipment to diagnose and treat infertility
Facilitating factors	• Availability of infrastructure to provide infertility services. • Availability of policies supporting infertility Services for the eligible

	clients. • Availability of trained health workers and infertility in health facilities
Desired Behaviour Change	• Increased number of health facilities, with service providers skilled in interpersonal communication skills, resulting in positive provider-client encounter for the Fertility Health Services
Communication objectives	• To increase the number of health facilities, with service providers trained in interpersonal communication skills, resulting in positive provider-client attitude for Fertility Health Services
Key message	• Treat each and every client/patient with dignity • Every client has the right to information on infertility • Communicate issues of infertility to all clients in an effective and efficient manner without prejudice due to age, sex, race, tribe, culture, status etc.
Message Delivery Strategies	• Interpersonal Communication, Leaflets, Booklets, Training, Updates Mentorship, Posters, Mass Media.
Key communication tasks and ideas	• Raise awareness among provider on the need to adhere to the code of practice when handling clients. • Provide update training on Client/ Customer Care to all health workers implementing infertile services.
Other essential actions (needed to facilitate the recommended practices)	• Recruit and post more qualified Health Workers • Motivate health workers by awarding hard workers • Intensify the use of mass media

Audience 4: Community Leaders

4.1 Specific Objectives

- Increase the number of community leaders who are knowledgeable on the benefits of Fertility Services.

Table 35: Community Leaders Audience

Target Audience	Community Leaders (Gate keepers, SMAGS, NHCs)
Current behaviours	• Guide couples to access traditional medicines. • Arranged sexual encounters • Beliefs that men are never infertile
Barriers	• Inadequate knowledge on where to seek help on infertility • Inadequate knowledge on causes of infertility • Stigma attached to infertility
Facilitating factors	• Availability of fertility services in health facilities within the communities. • Availability of partners supporting RH Services. • Availability of trained health workers.
Desired Behaviour Change	• Increased number of community leaders that support their communities to seek Fertility Services.
Communication objectives	• Increase the number of community leaders that are knowledgeable on the importance Fertility Services.
Key message	• It is okay to learn about fertility options in order to assist the community

	members take control of their infertility problems. • It is important to visit a health provider to seek medical advice on fertility options. • It is important as a community leader to support your communities to seek Fertility Service where professional advice can be given. • It is important as a community leader to advise community members to discuss issues of infertility with their partners
Message Delivery Strategies	• Brochures, leaflets, presentations, peer to peer education, community meetings, Consultative meetings etc
Key communication tasks and ideas	• Raise awareness among the Community Leaders on available Fertility Services. • Provide clear and simplified Social and Behaviour Change Communication on Fertility Services. • Train Community Leaders on Fertility Services. • Prepare and distribute a simple guide on Fertility Services for Community Leaders for utilisation during discussions with community members. • Develop a Toolkit for the Community Leaders on Fertility Services. • Collaborate with the all stakeholders involved with Fertility Services.
Other essential actions (needed to facilitate the recommended practices)	• Establishment of Fertility Support Groups in communities

Thematic Area 3.9: Menopause

Audience 1: National Policy Makers

1.1 **Specific Objective**

- Increase number of national policy makers that are knowledgeable on the benefits of Menopausal Services to women of the reproductive age and are allocating more resources to the programme.

Table 36: National Policy Makers

Target Audience	National Policy Makers
Current Behaviours	• Most national policy makers, who are the gate keepers of all communities, do not advocate/ talk about the benefits of Menopausal Services to women of the reproductive age. • Most national policy makers have inadequate knowledge about Menopausal Services • Most national policy makers do not understand the components of Menopausal Services.
Barriers	• Inadequate information on Menopausal Services • Myths and misconceptions • Religious and traditional beliefs. • Competing issues for resources with the communities
Facilitating Factors	• Availability of partners supporting RH Services. • Availability of trained health workers and CBVs in health facilities

	and communities
Desired Behaviour Change	• Increased number of national policy makers that are supporting women of the reproductive age to seek Menopausal Services and are allocating more resources to programme.
Communication Objective	• Increase number of national policy makers that are knowledgeable on the benefits of Menopausal Services to women of the reproductive age and are allocating more resources to the programme
Key Messages	• It is okay to learn about Menopausal Services. • It is important to request service providers to provide more information on Menopausal Services as a national policy maker. • It is important to come up with polices that will allow utilisation of Menopausal Services by the public. • It is important for national policy makers to talk to the public about benefits of Menopausal Services. • It is important to advise the public on the importance of knowing their HIV status by advising them to test with their sexual partners. If found HIV positive, to start treatment immediately.
Message Delivery Strategies	• Consultative meetings, presentations, Indaba with national policy makers, Leaflets, brochures etc
Key communication tasks and ideas	• Raise awareness among the national policy makers on the available options for Menopausal Services. • Provide clear and simplified Social and Behaviour Change Communication on Menopausal Services in strategic places were the national policy makers will find it easier to access.
Other essential actions (needed to facilitate the recommended practice)	• Designing of executive booklets for parliamentarians which will provide detailed information on Menopausal Services

Audience 2: Men and Women of Reproductive Age/ Service Providers Audience

2.1 Specific Objectives

- Increase the number of men and women of the reproductive age who are knowledgeable on benefits of Menopausal Services
- Increase the number of service providers trained interpersonal communication skills in Menopausal Services

Table 37: Men and Women of the Reproductive Age/ Service Providers

Target Audience	Men and Women of the Reproductive Age/ Service Providers
Current behaviours	• Seeking medical attention • Buying over the counter drugs • Moody
Barriers	• Inadequate knowledge on menopause • Non-availability of menopausal counselling services
Facilitating factors	• Increasing knowledge about menopause • Availability of counselling services for menopausal women.

	• Availability of skilled health care providers in health facilities and at the community level to provide counselling on menopause.
Desired Behaviour Changes	• Increased number of men and women of the reproductive age that are seeking Menopausal Services • Increased number of service providers skilled in interpersonal communication resulting in positive Provider/client encounter for • Menopausal Health Services
Communication objectives	• Increase the number of men and women of the reproductive age who are knowledgeable on the benefits of Menopausal Services • Increase the number of service providers trained interpersonal communication skills in Menopausal Services
Key Messages	• Menopause known as the change" or "change of life," is a normal part of a woman's life. • It is a point in time—the last menstrual cycle, the last period. • Menstrual irregularities are the primary reason that women seek for medical attention. • The first thing many women notice is a change in their periods. They might start coming farther apart or closer together. They might last longer or end sooner. The flow could be heavier or lighter. • Cycles shorten as increased FSH which triggers early ovulation, and skipped cycles due to Anovulation. • Long periods of Anovulation can lead to excessive estrogen states and irregular, unexpected menses may occur.
Message Delivery Strategies	• **Multi-media**(brochures and posters placed at health facilities, workplaces/churches, TV, /Radio, community listening groups, SMS, billboards, Facebook/twitter, interpersonal communication)
Key communication tasks and ideas	• Implement multimedia behaviour change communication, social mobilisation, and advocacy interventions reaching urban, peri-urban, and rural women of reproductive age to promote awareness on menopause • Implement Social and Behaviour Change and Communication (SBCC) capacity strengthening activities among health providers to address health-provider barriers to uptake of menopausal services. • Build the capacity of providers to effectively counsel clients with menopause. • Encourage health facility staff to hold more community discussions on menopause issues. • Promote menopause messages through print, electronic and interpersonal messages. • Training of drama groups and service providers. • Community mobilisation. • Promote male involvement in issues of menopause.
Other essential actions (needed to facilitate the recommended practice)	• Provide more Menopause Services and make them accessible by women of the reproductive age

Thematic Area 3.10: Gender Based Violence

Audience 1: National Policy Makers

1.1 **Specific Objective**

- Increase number of national policy makers that are knowledgeable on the benefits of GBV Services to the public and are lobbying for more resources to the programme.

Table 38: National Policy Makers

Target Audience	National Policy Makers
Current Behaviours	• Most national policy makers, who are the gate keepers of all communities, do not advocate/ talk about the benefits of GBV Services to the public • Most national policy makers have inadequate knowledge and appreciative of GBV Services. • Most national policy makers do not advocate for GBV services.
Barriers	• Inadequate information on benefits of GBV services • Myths and misconceptions about causes GBV • Religious and traditional beliefs • Poverty • Illiteracy
Facilitating Factors	• Availability of Ministry of Gender to push the national agenda on GBV programme • Availability of partners willing to support the programme •
Desired Behaviour Change	• Increased number of national policy makers that are supporting the public to seek GBV Services and are allocating more resources to programme.
Communication Objective	• Increase number of national policy makers that are knowledgeable on the benefits of GBV Services to the public and are lobbying for more resources to the programme
Key Messages	• It is okay to learn about GBV Programme. • It is important to request service providers to provide more information on GBV services as a national policy maker. • It is important to come up with policies that will protect men and women reporting GBV • It is important for national policy makers to talk to the public about importance of reporting and prosecuting GBV
Message Delivery Strategies	• Consultative meetings, presentations, Indaba with national policy makers, Leaflets, brochures etc
Key communication tasks and ideas	• Raise awareness among the national policy makers on GBV programme. • Provide clear and simplified Social and Behaviour Change Communication on GBV Services in strategic places where the national policy makers will find it easier to access
Other essential actions (needed to facilitate the recommended practice)	• Designing of executive booklets for parliamentarians which will provide detailed information on GBV programme

Audience 2: General Public

2.1 Specific Objectives

- Increase number of community members knowledgeable about GBV
- Increase in number of service providers trained in interpersonal communication skills for GBV services

Table 39: General Public Audience

Target Audience	General Public (Women, Girls, Boys, Men, Community Leaders, Traditional Leaders, Politicians, Policy Makers)
Current Behaviours	• Silence by GBV victims at home • Men having multiple sex partners • Acceptance by women to being beaten as a sign of love • Excessive alcohol and substance abuse • Women not seeking help when they are abused • Men ashamed to report GBV cases • Early or forced marriages (42%, ZDHS :2014) • Property grabbing by a husband's family
Barriers	• Inadequate knowledge on GBV by women • Inadequate access to economic resources • Unequal power relations due to the patriarchal nature of society • Inadequate awareness on GBV cases and where to report to • Culture and traditional norms which are mostly patriarchal in nature • Inadequate education on drug and substance abuse • Medical staff not willing to testify in cases where there is GBV • Inadequate staff in the judicial and police force to handle cases of GBV
Facilitating factors	• Stiffer punishment for offenders • Effective implementation of policies • Educated boys and men on GBV • Empowered women financially and materially • Sensitised programmes for boys, girls, men and women on GBV issues and gender rights • Educational programmes on drug and substance abuse • Women accessing financial resources • Accessibility of laws on GBV • Availability of one-stop centres dealing with GBV
Desired Behaviour Change	• Increased number of community members utilising GBV services • Increased numbers of service providers skilled in interpersonal communication resulting in positive provider/client encounter for GBV
Communication Objectives	• Increase number of community members knowledgeable about GBV • Increase in number of service providers trained in interpersonal communication skills for GBV

Key Messages	• Once you educate and empower a girl and woman, you educate and empower a nation! Educate girls and women. • Stop beating women. It should not be seen as a sign of love. • Stop having multiple sexual partners. This should not be acceptable by women. • Stop alcohol and substance abuse • Women and victims of GBV should speak out about this matter. • GBV affects boys and men too! Do not remain silent! Reporting GBV as a man should not make you feel or look weak! Report all forms of GBV against boys and men! • Stop GBV against boys and men!
Message Delivery Strategies	• **Multi-media**(brochures and posters placed in public places, , bus stations, markets, schools/churches youth groups, TV, /Radio, community listening groups, SMS, billboards, Facebook/twitter, interpersonal communication, radio discussions, social marketing, community meetings, peer to peer education)
Key communication tasks and ideas	• Build the capacity of media personnel on gender based violence so that they are used to advocate against GBV • Build the capacity of traditional leaders, medical staff, law enforcers and parliamentarians on GBV matters • Introduce curricular in schools addressing GBV • Introduce workplace policy on GBV issues • Encourage health personnel to come forward and testify on GBV cases • Encourage the use of drama in conveying messages on GBV especially in the rural areas • Encourage more males in influential positions to speak out against GBV
Other essential actions (needed to facilitate the recommended practice)	• Establishment of GBV support groups in communities

Thematic Area 3.11: Water and Sanitation

Audience 1: National Policy Makers

1.1 **Specific Objective**

- Increase number of national policy makers that are knowledgeable on the benefits of clean water and improved sanitation to the public and are allocating more resources to the programme.

Table 40: National Policy Makers

Target Audience	National Policy Makers
Current Behaviours	• Most national policy makers, who are the gate keepers of all communities, do not advocate/ talk about the importance of clean water and improved sanitation services to the public • Most national policy makers have inadequate knowledge and appreciative of water and sanitation services • Most national policy makers do not understand the components of

	effective water and sanitation services • Most national policy makers do not advocate water and improved sanitation services
Barriers	• Inadequate information on water and sanitation programme • Competing issues for resources • Poverty • Illiteracy
Facilitating Factors	• Availability of adequate water bodies in the country • Availability of partners willing to support the government in scaling up the water and sanitation programme in the country
Desired Behaviour Change	• Increased number of national policy makers that are allocating more resources to water and sanitation programme.
Communication Objective	• Increase number of national policy makers that are knowledgeable on the benefits of Water and Sanitation Services to the public and are lobbying more resources to the programme
Key Messages	• It is important to learn on the benefits water and sanitation Programme. • It is important to request service providers to provide more information on the importance of water and sanitation Programme as a national policy maker. • It is important to come up with policies that will allow scaling up of clean water and improved sanitation to the public. • It is important to advise communities to protect themselves from infectious enteric disease by advising them on the benefits of boiling and treating water with chlorine at household level. • It is important for the national policy maker to advocate for policies that will ensure that every citizen has access to clean water and improved sanitation in order to prevent diarrhoeal diseases.
Message Delivery Strategies	• Consultative meetings, presentations, Indaba with national policy makers, Leaflets, brochures etc
Key communication tasks and ideas	• Raise awareness among the national policy makers on the benefits of safe and clean water and improved sanitation services to the public. • Provide clear and simplified Social and Behaviour Change Communication on safe water and improved sanitation in strategic places were the national policy makers will find it easier to access. • Train national policy makers on water and sanitation Programme.
Other essential actions (needed to facilitate the recommended practice)	• Designing of executive booklets for parliamentarians which will provide detailed information on the importance of water and improved sanitation to the public

Audience 2: General Public

2.1 Specific Objectives

- Increase in the number of communities that are knowledgeable on the benefits of drinking safe and clean water
- Increase in the number of communities that are knowledgeable on the benefits of improved sanitation in their communities
- Increase in the number of communities that are knowledgeable on the benefits of hygiene

Table 41: General Public

Target Audience	General Public
Current behaviours	• Most communities do not understand the importance of safe water and improved sanitation • Most communities living in deprived peri-urbans areas with no safe water and sanitation facilities • Most communities do not understand the benefits of drinking safe clean water. • Most communities have endemic infectious enteric diseases because of inadequate clean water facilities
Barriers	• Lack of policy on urbanisation which has led to influx of peri-urban compounds in inner cities throughout the country • Most communities live in deprived environments • Illiteracy levels
Facilitating Factors	• Availability of Public Health/Food and Drugs Laws of Zambia
Desired Behaviour Changes	• Increased number of communities that adhere to the recommended measures of treating water at household level in order to prevent diarrheoal diseases • Increased number of communities that adhere to the recommended measures of improved sanitation in their communities • Increased number of communities that are practicing recommended hygienic measures
Communication Objectives	• Increase in the number of communities that are knowledgeable on the benefits of drinking safe and clean water • Increase in the number of communities that are knowledgeable on the benefits of improved sanitation in their communities • Increase in the number of communities that are knowledgeable on the benefits of hygiene
Key Messages	• Keep your surroundings clean • Always use a toilet • Always drink clean and safe water • Always wash your hands with clean water and soap after using a toilet and before eating food • Always trade in authorised markets • Visit a health facility for more information on diarrhoeal diseases • Always use a bin to throw your waste
Message Delivery Strategies	• Multi-media(brochures and posters placed at ANC,PNC, workplaces/churches, TV, /Radio, community listening groups, SMS, billboards, Facebook/twitter, interpersonal communication)
Key Communication Tasks and Ideas	• Implement multimedia behaviour change communication interventions reaching urban, peri-urban and rural areas to facilitate adherence to Public Health/Food and Drugs Regulations • Build the capacity of trained health workers to effectively enforce Public Health Regulations • Hold meetings regularly with stakeholders at all levels to address trained health workers' barriers to enforce Public Health/Food and Drugs Regulations • Encourage trained health workers to hold quarterly review meetings on enforcement of Public Health/Food and Drugs Regulations
Other essential actions (needed to facilitate the recommended practice)	• Scale up Safe water and improved sanitation to peri-urban areas in order to ensure that every household has access in order to prevent infectious enteric diseases which have become endemic in the country

SECTION 4: IMPLEMENTATION FRAMEWORK

4.1 Implementation Approach

To implement this Strategy in a concrete and meaningful way, this guide details the steps that need to be taken at national, provincial, district and community levels.

4.1.1 National Level

The RMNCAH-N Communication and Advocacy Strategy will be implemented in synchronisation with the National Health Strategic Plan 2017–2021. The strategy will be managed and coordinated by the Directorate of Health Promotion, Environmental and Social Determinants at the national level, and by provincial and district health offices at their respective levels. The Directorate will collaborate with the Directorate of Public Health in providing oversight and supportive supervision to teams of implementing partners working at provincial, district and community levels respectively.

The National Health Promotion Technical Working Group will work closely with the RMNCAH-N Steering Committee in coordinating the existing Technical Working Groups (TWGs) namely Safe Motherhood, Family Planning, Adolescent, Child Health and Nutrition. These will provide the central level technical review of the national SBCC interventions and activities.

4.1.1.1. RMNCAH-N Communication and Advocacy Secretariat;

To promote sustainability and effectively implement the RMNCAH-N Communication and Advocacy Strategy, it is anticipated that a Secretariat will be established to coordinate the affairs of the TWGs. Among its roles and responsibilities, the Secretariat will:

- Coordinate the planning and implementation of activities in the RMNCAH-N Communication Strategy; and the reporting of these activities to the Heads of DPH and HPESDs;
- Be responsible for networking with all partners, government agencies, private providers, and FBOs involved in RMNCAH-N communication to ensure maximum support to DPH and DHPESDs in implementing the strategy;
- Record decisions of the TWGs and inform activity planning;
- Serve as editor of RMNCAH-N SBCC materials, the DPH-RH newsletter and web site, and initiate communications through other channels identified in the RMNCAH-N Communication and Advocacy Strategy;
- Take the lead in M&E of SBCC interventions and activities that are guided by the RMNCAH-N Communication and Advocacy Strategy;
- Report on the results of the strategy, in accordance with guidance from the TWGs, the Directorates of DPH-RH and HPESDs;

4.1.2 Co-ordinate and Plan

To implement a comprehensive RMNCAH-N Communication and Advocacy Strategy, a clear coordination and monitoring mechanism needs to be developed to oversee proposed activities. The DHPESD will

coordinate the national SBCC programme, messages, materials and indicators for the Communication and Advocacy Strategy in collaboration with key line ministries, government departments and cooperating partners.

Key activities to be implemented:

- Determine SBCC message priorities for national campaigns.
- Harmonise the messages and materials developed by various stakeholders implementing RMNCAH-N SBCC activities and interventions.
- Provide input on timelines and deliverables of SBCC programmes.
- Obtain input and commitment from national stakeholders on SBCC programme components.
- Coordinate the responsibilities, tasks, and contributions of stakeholders.
- Ensure that the SBCC campaign is implemented at provincial and district levels.
- Ensure that the SBCC programme is monitored and evaluated as part of partner activities in each province.
- Set standards and guidelines on RMNCAH-N SBCC.
- Conduct fundraising and research related to RMNCAH-N Communication.

4.1.3 Implement and Develop

Based on the recommendations of the NTWGs, the Directorate Health Promotion, Environmental & Social Determinants and Public Health will develop a national media campaign for RMNCAH-N SBCC and these will include messages and materials for all the segmented audiences. Key national partners and all SBCC partners will collaborate with MoH to harmonise RMNCAH-N messages and generate the campaigns accordingly.

The national campaigns on RMNCAH-N SBCC materials for men and women will include TV and radio spots, posters, billboards and general information leaflets for use by the members of the public, the health facilities, and service provider job aids. Materials for all the audiences segmented will include posters, magazine, flyers, radio and TV programmes and online components. All materials developed previously, will be subsequently distributed to partners during meetings to ensure correct understanding of the SBCC programme.

To ensure that SBCC programme activities reflect the priorities of the RMNCAH-N Communication and Advocacy Strategy, national partners will participate in TWGs and submit their tailored SBCC materials for review.

National partners implementing SBCC for RMNCAH-N Programme will also collaborate with the DHPESDS and DPH on SBCC programme components and provide technical support in areas identified by the NTWGs.

4.1.4 Provincial Level

At provincial level, the DHPESD will work with the PHD to coordinate provincial partners in the implementation of the SBCC. Key activities at the province will include:

- Implementation of the provincial RMNCAH-N SBCC interventions and activities with provincial partners.
- Gather provincial-level data for planning and implementation of SBCC for RMNCAH-N Programme.
- Convene provincial meetings to tailor RMNCAH-N SBCC activities / messages to provincial needs and localise messages and materials.
- Identify resources available to adapt, print, and distribute materials in local languages, as appropriate, in coordination with implementing partners.
- Coordinate informative research.
- Coordinate M&E and the collection of data of RMNCAH-N programme.

4.1.5 District Level

At district level, the PHD will work with the DHD to coordinate district partners in the implementation of the strategy. Key activities at the district will include:

- Plan for district and local-level activities and SBCC interventions.
- Conduct local SBCC planning meetings with Community Volunteers, such as NHCs, SMAGs, CBVs in collaboration with the health facility staff to share SBCC priorities and campaign components.
- Gather district-level data for planning and implementation of SBCC intervention and activities.
- Work with Traditional and Community Leadership to tackle the social- ecological barriers to uptake RMNCAH-N Services at Community Level.

4.1.6 Community Level

At Community level planning and implementation of SBCC interventions and activities of the RMNCAH-N Communication and Advocacy Strategy will be done by health facility staff and NHCs through all the community structures trained in RMNCAH-N SBCC in collaboration MoH partners in SBCC, operating at community level. The NHCs and all relevant community structures on RMNCAH-N Health Communication will:

- Plan for community level activities and interventions of SBCC.
- Conduct Community SBCC mapping planning meetings with Community Volunteers, such as NHCs, SMAGs, CBVs to share SBCC priorities and campaign components.
- Gather Community-level data for planning and implementation of SBCC intervention and activities at Community level.
- Work with Traditional and Community Leadership to tackle the social- ecological barriers to uptake RMNCAH-N Services at Community Level.

TABLE 31: Implementation Matrix for Advocacy for RMNCAH-N Social Behaviour Change Communication

ADVOCACY FOR RMNCAH-N SBCC										
Strategic Objective	**Communication Objective**	**Broad activities**	**Materials**	**Implementers**	**Process indicators**	**Indicative budget (ZMK)**	**2018**	**2019**	**2020**	**2021**
Increase the proportion of national level policy makers knowledgeable on the socio-economic consequences of reproductive health, Maternal and Newborn, Child and Adolescent Health and Nutrition including Cancers of the reproductive organs, Gender Based Violence, Infertility and Water Sanitation and Hygiene and devoting more resources to the promotive, preventive, and utilisation of reproductive health services through SBCC and IEC.	Increase number of national policy makers knowledgeable about RMNCAH-N SBCC and are lobbying for more resource allocation towards the programme	Hold consultative forums with political leaders to sensitise them and increase resource allocation and support for RMNCAH-N SBCC interventions at all levels of service delivery	Booklets on RMNCAH-N SBCC Programme for political leaders	DHPESD/DPH	# of consultative forums conducted	**1,800,000.00**	980,000	520,000	450,000	300,000
		Hold quarterly meetings with parliamentary committees on health to discussion the RMNCAH-N SBCC	Booklets on RMNCAH-N SBCC for parliamentary committees on health	DHPESD/ DPH	# of parliamentary committee on Health meetings conducted	**300,000**	150,000	50,000	50,000	50,000

		interventions								
			Fact Sheets for parliamentarians on RMNCAH-N SBCC Programme	DHPESD/ DPH	# of fact sheets for parliamentarians developed and disseminated	**225,000**	100,000	50,000	50,000	25,000
		Hold consultative forums with traditional leaders to advocate for support for RMNCAH-N SBCC Interventions at national, provincial, Districts & Community level	Logistics required to hold consultative meetings with traditional leaders	DHPESD/ DPH	# of consultative forums held on RMNCAH-N SBCC interventions with traditional leaders	**1,049,687**	755,010	174,000	145,567	149,110
			Fact sheet for traditional leaders for RMNCHA-N Programme	DHPESD/ DPH	# of fact sheets for RMNCAH-N developed, printed and disseminated	**1,152,000**	600,000	200,000	200,000	152,000
			presentations on RMNCAH-N Programme	DHPESD/ DPH	# of presentation done to traditional	**150,000**	100,000	25,000	25,000	10,000

			for traditional leaders		leaders					
		Hold consultative forums with Religious leaders to advocate for support for RMNCAH-N SBCC Interventions at national, provincial, Districts & Community level	Logistics required to hold consultative meetings with religious leaders	DHPESD/ DPH	# of consultative forums held on RMNCAH-N SBCC interventions with religious leaders	**390,000**	240,000	75,000	50,000	25,000
			Fact sheet for religious leaders for RMNCHA-N Programme	DHPESD/ DPH	# of fact sheets for RMNCAH-N developed, printed and disseminated	**1,152,000.00**	600,000	200,000	200,000	152,000
			presentation s on RMNCAH-N Programme for religious leaders	DHPESD/ DPH	# of presentation done to religious leaders	**150,000.00**	100,000	25,000	25,000	10,000
		Capacity building of the media to advocate for RMNCAH-N SBCC interventions	Facts sheets for the media and logistics required to hold capacity building meetings	DHPESD/ DPH	# of capacity building meetings for media on RMNCAH-N SBCC interventions held	**399,500**	150,000	99,500	95,000	55,000

		Orient Community leaders and NHCs to become activists for the RMNCAH-N SBCC programme at Community level	Advocacy toolkits for Community leaders	DHPESD/ DPH	# of advocacy toolkits developed , printed and disseminated to Community Leaders	**1,406,490**	50,400	550,205	455,675	350,210
			Logistics required to hold an orientation meeting	DHPESD/ DPH	# of districts who have orientated Community leaders and NHCs to become activists for the RMNCAH-N SBCC programme at Community level	**1,262,813**	602,140	350,110	310,563	240,093

TABLE 32: Implementation Matrix for Social Mobilisation and BCC for RMNCAH-N

SOCIAL MOBILISATION AND BEHAVIOUR CHANGE COMMUNICATION FOR RMNCAH-N SBCC										
Strategic Objective	**Communication Objective**	**Broad activities**	**Materials**	**Implementers**	**Process indicators**	**Indicative budget (ZMK)**	**2018**	**2019**	**2020**	**2021**
Increase awareness and the level of knowledge in the community about RMNCAH-N issues and available health solutions.	Social mobilisation, to ensure local communities participation in RMNCAH-N programme and social and behaviour change initiatives and continued public education	Conduct a workshop to develop standard SBCC messages for RMNCAH-N programme campaigns and interventions to be used at all levels for priority target audiences	Booklets on RMNCAH-N SBCC Programme for political leaders	DHPESD DPH, Partners in RMNCHA-N Health Communication	# of consultative forums conducted	**1,800,000.00**	980,000	520,000	450,000	300,000
		Conduct interpersonal communication activities and outreach at community level to provide RMNCAH-N comprehensive messages	RMNCAH-N SBCC Materials	DHPESD DPH, Partners in RMNCHA-N Health Communication	# of CBVs kits developed and produced	**300,000**	150,000	50,000	50,000	50,000
		Conduct RMNCAH-N mass media campaigns	Radio and TV spots addressing barriers to uptake of RMNCAH-N services	DHPESD DPH, Partners in RMNCHA-N Health Communication	# of radio and TV spots campaigns conducted	**225,000**	100,000	50,000	50,000	25,000

			TV and Radio spots encouraging desired behaviours and addressing barriers to uptake of RMNCAH-N services	DHPESD DPH, Partners in RMNCHA-N Health Communication	# of Radio & TV spots produced and aired # of Radio & TV programs produced and aired	**1,049,687**	755,010	174,000	145,567	149,110
			Newsletters on RMNCAH-N services	DHPESD DPH, Partners in RMNCHA-N Health Communication	# of newsletters developed and disseminated	**1,152,000**	600,000	200,000	200,000	152,000
			Posters on RMNCAH-N SBCC	DHPESD DPH, Partners in RMNCHA-N Health Communication	# of posters developed and disseminated	**1,460,000**	1,100,000	125,000	125,000	110,000
		Conducted targeted FBOs activities outreach	Fact sheets for FBOs	DHPESD DPH, Partners in RMNCHA-N Health Communication	# of fact sheets for FBOs developed and disseminated	**390,000**	240,000	75,000	50,000	25,000
			Presentation s on RMNCAH-N SBCC	DHPESD DPH, Partners in RMNCHA-N Health Communication	# of provinces and districts implementing outreach activities for FBOs	**1,152,000.00**	600,000	200,000	200,000	152,000

		Conduct activities on RMNCAH-N special groups and physically challenged population	SBCC materials for Special groups and Physically challenged populations	DHPESD DPH, Partners in RMNCHA-N Health Communication	# of SBCC materials developed, and disseminated for the special groups and physically challenged population	**399,500**	150,000	99,500	95,000	55,000
			Facts sheets for special needs and physically challenged populations	DHPESD DPH, Partners in RMNCHA-N Health Communication	# of facts sheets for people with special needs and physically challenged developed and disseminated	**1,406,490**	50,400	550,205	455,675	350,210
			TV and Radio spots encouraging desired behaviours and addressing barriers to uptake of RMNCAH-N services	DHPESD DPH, Partners in RMNCHA-N Health Communication	# TV and Radio spots produced and aired for the special and physically challenged population	**1,680,000**	602,140	350,110	310,563	240,093
		Conduct outdoor advertising on RMNCAH-N SBCC	Billboards	DHPESD DPH, Partners in RMNCHA-N Health Communication	# of provinces and districts with outdoor advertising on RMNCAH-N	**2,500,000**	2,000,000	1,000,000	1,000,000	500,000

					SBCC					
			Wall branding	DHPESD DPH, Partners in RMNCHA-N Health Communication	# provinces /districts with RMNCHA-N SBCC wall branding	**860,230**	500,000	150,000	110,000	100,230
		Support women's and men groups/clubs to integrate RMNCAH-N SBCC into their activities	Leaflets and facts sheets for RMNCAH-N SBCC	DHPESD DPH, Partners in RMNCHA-N Health Communication	# of leaflets and fact sheets developed and disseminated to women and men's groups/clubs	**1,132,284**	456,351	345,105	200,567	130,261
			Guidelines for integrating RMNCAH-N SCBB into groups/clubs	DHPESD DPH, Partners in RMNCHA-N Health Communication	# provinces /districts with RMNCHA-N SBCC integrated in women and men's groups/Clubs	**1,981,215**	690,010	530,220	410,726	350,259

TABLE 33: Implementation Matrix for Capacity Strengthening for Service Providers and SBCC Practitioners on RMNCAH-N SBCC

CAPACITY STRENGTHENING FOR SERVICE PROVIDERS AND SBCC PRACTITIONERS ON RMNCAH-N SBCC										
Strategic Objective	**Communication Objective**	**Broad activities**	**Materials**	**Implementers**	**Process indicators**	**Indicative budget (ZMK)**	**2018**	**2019**	**2020**	**2021**
Strengthen the capacity of DHPESDs and DPH to plan and coordinate communication as a core component to support its programme goals at the national, provincial, district and community level.	To strengthen capacity of service providers and SBCC practitioners on RMNCAH-N SBCC	Capacity strengthening of providers/health promoters on RMNCAH-N SBCC	SBCC capacity strengthening modules and tools for RMNCAH-N /SBCC practitioners	DHPESD DPH, Partners in RMNCHA-N Health Communication	# of provinces and districts with trained service providers/ health promotors on RMNCAH-N SBCC	**1,735,010.00**	690,000	420,000	350,000	275,010
		Capacity building of service providers on interpersonal communication skills	Training on interpersonal and communication skills	DHPESD DPH, Partners in RMNCHA-N Health Communication	# provinces and districts with trained service providers in interpersonal communication skills # of service providers skilled on interpersonal and communication skills	**1,193,294**	298,000	356,313	288,452	250,529
		Capacity building of community based groups e.g. SMAGs, CBVs, NHCs, Growth Promotors on RMNCAH-N SBCC	SBCC capacity strengthening modules and tools for community based groups/implementers	DHPESD DPH, Partners in RMNCHA-N Health Communication	# of provinces and districts with trained community based groups RMNCAH-N SBCC	**2,042,233**	690,752	501,980	450,290	399,211

		Conduct RMNCAH-N SBCC research to provide evidence based information to inform programming	RMNCAH-N SBCC Research Protocols on maternal and newborn issues such as barriers to maternal and newborn health services	DHPESD DPH, Partners in RMNCHA-N Health Communication	# of provinces and districts who have conducted RMNCAH-N SBCC informative research and results disseminated	**2,265,030**	755,010	755,010	755,010	755,010
		Developmaterials for service providers for RMNCAH-N SBCC	Booklets Brochures Flip charts Wall charts Reference guide on RMNCAH-N SBCC Job aids	DHPESD DPH, Partners in RMNCHA-N Health Communication	# of workshops held to develop materials on RMNCAH-N SBCC for service providers Reference guide on RMNCAH-N SBCC # Job aids developed and disseminated for service providers	**1,152,000**	600,000	200,000	200,000	152,000

SECTION 5: MONITORING AND EVALUATION

5.1 MONITORING AND EVALUATION (M&E) FRAMEWORK

The Monitoring and Evaluation Framework's main goal is to assess and track the performance of the set advocacy and social behavioural Change Communication objectives across the key health interventions outlined in the strategy. The Monitoring and Evaluation of the implementation of the Strategy will be conducted through appropriate existing and new systems, procedures and mechanisms.

The framework serves to demonstrate how results will be measured to provide a basis for accountability and evidence-based decision-making at both the programme and policy level. The implementation plan specifies how each of the advocacy and communication activities and interventions across these health domains will be monitored and evaluated.

Included in the framework are a set of proposed output and outcome indicators for the monitoring of the implementation of communication and advocacy activities over time to track progress and inform programmatic decision making, and of evaluating the effect of those activities to see whether the set communication and behavioural objectives outlined in this strategy have been achieved.

The indicators to be monitored include those that track progress of the implemented activities and interventions. The Health Management Information System, exit Interviews, surveys, field visits and other routine systems will be the major tools for data collection.

The evaluation of the strategy shall be carried out through a mid-term review after 2.5 years and a final term review after 5 years. The mid-term assessment will focus on progress made in the implementation of the strategy.

A set of proposed indicators for monitoring communication and advocacy are outlined below, by each of the key intervention areas: family planning, maternal and new born, paediatrics HIV, child health, adolescent health, nutrition during pre-pregnancy, nutrition children 0-5 months, nutrition for lactating mothers, cancers of the reproductive organs, infertility, menopause, gender based violence, water and sanitation.

TABLE 45: Monitoring and Evaluation

Thematic Area	Target Audience	Communication Objectives	Desired Behaviour Changes	Indicators	Frequency	Means of Verifications
FAMILY PLANNING	National Policy Makers	To increase the number of national policy makers knowledgeable on the benefits of FP to women of the reproductive age and are allocating more resources to the family planning services	Increased number of national policy makers that are supporting women of the reproductive age and are allocating more resources to Family Planning Services	Percentage of national policy makers that are advocating for resource allocation to the modern family planning programme.	Annually	Field Reports/ Questionnaire
	Women of the Reproductive Age Group	To increase the number of women of the reproductive age group with knowledge about modern FP methods	Increased number of women of the reproductive age group seeking RH/ FP services.	Percentage of women of reproductive age who know at least 3 modern RH/FP methods	Bi-Annual	Field Reports/ Questionnaire
		To increase the number of women in the reproductive age group accessing available Family Planning Services.	Increased number of women of the reproductive age group that are utilising Family Planning Services.	Percentage of New RH/FP acceptors.	Monthly	HMIS/DHIS2
	Men of the Reproductive Age Group	To increase the number of men of the reproductive age that are knowledgeable about FP services and are utilising the Services	Increased number of men of the reproductive age group who understand modern RH/ FP methods.	Percentage of men who know at least 3 modern RH/FP methods	To increase the number of men of the reproductive age that are knowledgeable about FP services and	Increased number of men of the reproductive age group who understand modern RH/ FP methods.

Thematic Area	Target Audience	Communication Objectives	Desired Behaviour Changes	Indicators	Frequency	Means of Verifications
					are utilising the Service	
		To increase the number of men of reproductive age who support their partners in the uptake of modern contraceptive methods to delay birth of first child or space children at least 2 years apart.	Increased number of men of the reproductive age group seeking Family Planning Services.	Proportion of men who report using modern FP methods.	To increase the number of men of the reproductive age who support their partners in the uptake of modern contraceptive methods to delay birth of first child or space children at least 2 years apart.	Increased number of men of the reproductive age group seeking Family Planning Services.
	Adolescents and Youth	To increase the number of health facilities with functional youth friendly services addressing the family planning needs of the adolescents and youth	Increased number of health facilities with functional youth friendly services addressing the family planning needs of the adolescents and youth	Percentage of health facilities with functional youth friendly services	Bi-Annual	Performance Assessment Reports/ Questionnaire
		To Increase in the number of Adolescents and youth knowledgeable about Family Planning Services.	Increased number of adolescents and youth accessing Family Planning	Percentage of adolescents and youths who know at least 3 modern	Annually	Field Reports/ Questionnaire

Thematic Area	Target Audience	Communication Objectives	Desired Behaviour Changes	Indicators	Frequency	Means of Verifications
			Services.	RH/FP methods		
		To Increase number of adolescents that are aware about Family Planning Services.	Increased number of adolescents and youth seeking Family Planning Services.	Percentage of adolescents and youths who report using modern RH/FP	Quarterly	Field Reports/ Questionnaire
	Service Providers	To increase the number of health facilities, with positive service providers trained in interpersonal communication skills, resulting in positive provider-client attitude	Increased number of health facilities with service providers skilled in interpersonal communication skills, resulting in positive provider-client encounter.	Percentage of health facilities with service providers skilled in interpersonal communication, resulting in positive provider-client attitude.	Annually	Field Reports/ Questionnaire
	Community Leaders	Increase number of community leaders who are knowledgeable on RH/FP services	Increased number of community leaders that support their communities to seek modern FP services	Percentage of community leaders who know at least 3 modern RH/FP methods	Bi-Annual	Field Reports/ Questionnaire
MATERNAL AND NEW BORN	National Policy Makers	Increase number of national policy makers that are knowledgeable on the benefits of maternal and newborn services to women of the reproductive age and are lobbying for more resources to the programme.	Increased number of national policy makers that are supporting women of the reproductive age to seek Maternal Health Services and are allocating more resources to the	Percentage of national policy makers that are advocating for resource allocation to the Maternal and Newborn Health Services	Annually	Field Reports/ Questionnaires

Thematic Area	Target Audience	Communication Objectives	Desired Behaviour Changes	Indicators	Frequency	Means of Verifications
			programme			
	Women of Reproductive Age	To increase the number of women of the reproductive age knowledgeable about the importance of antenatal care in the first 3 months of pregnancy.	Increased women of the reproductive age that are seeking antenatal care in the first 3 months of pregnancy	Percentage of women of reproductive age who report knowing at least 3 benefits of accessing antenatal care in the first 3 months	Annually	Field Reports/ Questionnaire
		To increase the number of pregnant women accessing antenatal care in the first 3 months of pregnancy.	Increased number of pregnant women accessing antenatal care in the first 3 months of pregnancy	First Antenatal Visit Coverage	Monthly	HMIS/DHIS2
		To increase the number of pregnant women who have at least 8 antenatal care contacts during pregnancy.	Increased number pregnant women who have at least 8 antenatal care contacts during pregnancy.	Average Antenatal Visits	Monthly	HMIS/DHIS2
		To increase the number of women of the reproductive age knowledgeable about the importance of postnatal care (within 6 hours, 48 hours, 6 days, 6 weeks).	Increased number of women of the reproductive age that are seeking postnatal care (within 48 hours, 6 days, and 6 weeks).	Percentage of women of reproductive age who report knowing at least 3 benefits of accessing postnatal care (within 48 hours,	Annually	Field Reports/ Questionnaire

Thematic Area	Target Audience	Communication Objectives	Desired Behaviour Changes	Indicators	Frequency	Means of Verifications
				6 days, 6 weeks)		
		To increase the number of postpartum women utilising postnatal services (within 6 hours, 48 hours, 6 days, 6 weeks).	Increased number of postpartum women utilising postnatal services (within 48 hours, 6 days, 6 weeks)	Postnatal care within 6 days, 6 weeks Coverage rate	Monthly	HMIS/DHIS2
		To increase the number of women knowledgeable about safe abortion care services at health facilities.	Increased number of women accessing safe abortion care services at health facilities	Percentage of women utilising safe abortion care services at health facilities	Annually	Field Reports/ Questionnaire
	Men of the reproductive Age	Increase the number of men of the reproductive age who are knowledgeable about the importance of antenatal and postnatal services.	Increased number of men of the reproductive age that accompany their antenatal and postnatal services	Percentage of men of reproductive age who know at least 3 benefits of antenatal and postnatal services	Annually	Field Reports/ Questionnaire
	Service Providers	Increase the number of facilities with trained service providers with good interpersonal communication skills during maternal and newborn health service delivery.	Increased number of health facilities with skilled services providers in interpersonal communication resulting in positive provider-client encounter	Percentage of health facilities with service providers trained interpersonal communication skills	Annually	Field Reports/ Questionnaire

Thematic Area	Target Audience	Communication Objectives	Desired Behaviour Changes	Indicators	Frequency	Means of Verifications
	Community Leaders	Increase the number of community leaders who are knowledgeable about the importance of maternal and newborn health services	Increased number of community leaders that are supporting their communities to seek maternal and newborn health	Percentage of community leaders who know at least 3 benefits of maternal and new born programs	Annually	Field Reports/ Questionnaire
PAEDIATRICS HIV	National Policy makers	Increase number of national policy makers that are knowledgeable on the benefits of Paediatric HIV Services to the public and are allocating more resources to the programme.	Increased number of national policy makers that are supporting the public to seek Paediatric HIV Services and are allocating more resources to programme.	Percentage of national policy makers who lobby for resource allocation for the Paediatric HIV programme.	Annually	Field Reports/ Questionnaires
	General Public	Increase the number of communities that are knowledgeable about the benefits of Paediatric HIV Services	Increased number of communities that are seeking Paediatric HIV Services.	Percentage of communities who report knowing 3 benefits of Paediatric HIV Services	Annually	Field Reports/ Questionnaires
		Increase the number of service providers trained in interpersonal communication skills for Paediatric HIV Services	Increased number of service providers skilled in interpersonal communication resulting in positive provider/ client	Percentage of health facilities with skilled service providers in interpersonal communication skills, resulting in	Annually	Field Reports/ Questionnaires

Thematic Area	Target Audience	Communication Objectives	Desired Behaviour Changes	Indicators	Frequency	Means of Verifications
			encounter for Paediatric HIV services	positive provider-client encounter		
		Increase number of community leaders that are knowledgeable about the benefits of Paediatric HIV Services	Increased number of community leaders that support their communities in seeking Paediatric HIV Services.	Percentage of community leaders that report knowing 3 or more benefits and importance of Paediatric HIV services	Annually	Field Reports/ Questionnaires
		Increase the number of service providers trained in interpersonal communication skills for Paediatric HIV Services	Increased number of service providers skilled in interpersonal communication resulting in positive provider/ client encounter for Paediatric HIV services	Percentage of health facilities with skilled service providers in interpersonal communication skills, resulting in positive provider-client encounter	Annually	Field Reports/ Questionnaires
CHILD HEALTH	National Policy Makers	Increase number of national policy makers that are knowledgeable on the benefits of Child Health Services to caretakers/ parents with under five Children and are lobbying for more resources to the programme.	Increased number of national policy makers that are supporting caretakers/parents with under five children to seek Child Health Services and are allocating more resources to	Percentage of national policy makers who lobby for resource allocation for the Child Health Services Proportion of the	Annually	Field Reports/ Questionnaires

Thematic Area	Target Audience	Communication Objectives	Desired Behaviour Changes	Indicators	Frequency	Means of Verifications
			programme.	budget allocated to Child Health Services		
	Caretakers with Under 5 Children	To increase the number of caretakers/parents with under five children that are knowledgeable on child health services	Increased number of caretakers/parents with under five children that seek Child Health Services.	Percentage of who report caretakers/parents of under five children who know 3 benefits of Child Health Services	Annually	Field Reports/ Questionnaires
		To increase the number of service providers that are trained on interpersonal communication skills for child health services.	Increased number of service providers that are skilled in interpersonal communication for the child health services.	Percentage of health facilities with skilled service providers in interpersonal communication skills, resulting in positive provider-client encounter for child health services	Annually	Field Reports/ Questionnaires
		To increase the number of caretakers/parents with under five children that are knowledgeable on child health services	Increased number of caretakers/parents with under five children that seek Child Health Services.	Percentage of who report caretakers/parents of under five children who know 3 benefits of Child Health Services	Annually	Field Reports/ Questionnaires

Thematic Area	Target Audience	Communication Objectives	Desired Behaviour Changes	Indicators	Frequency	Means of Verifications
		To increase the number of service providers that are trained on interpersonal communication skills for child health services.	Increased number of service providers that are skilled in interpersonal communication for the child health services.	Percentage of health facilities with skilled service providers in interpersonal communication skills, resulting in positive provider-client encounter for child health services	Annually	Field Reports/ Questionnaires
		To increase the number of community leaders who are knowledgeable on the benefits of child health services	Increased number of community leaders that support their communities to seek child health services	Percentage of community leaders who know at least 3 benefits of child health services	Annually	Field Reports/ Questionnaires
ADOLESCENT HEALTH	National Policy Makers	Increase number of national policy makers that are knowledgeable on the benefits of Adolescent Health Services to the adolescent and youth and are lobbying for more resource allocation to the programme	Increased number of national policy makers that are supporting the adolescent and youth to seek Adolescent Health Services and are allocating more resources to programme.	Proportion of the budget allocated to adolescent health programmes.	Annually	Field Reports/ Questionnaires
	Adolescent and Youth	Increase the number of adolescents and youth knowledgeable on the benefits of utilizing	Increased number of adolescents and youth seeking professional	Percentage of adolescents and youths accessing professional SRH	Annually	Field Reports/ Questionnaires

Thematic Area	Target Audience	Communication Objectives	Desired Behaviour Changes	Indicators	Frequency	Means of Verifications
		professional Adolescent Health services	Adolescent Health Services.	services.		
		Increase the number of service providers trained on interpersonal communication skills for the Adolescent Health	Increased number of service providers trained on interpersonal communication skill resulting in positive Provider/ Client encounter for the Adolescent health services.	Percentage of service provider with skills in SBCC for adolescent health programmes.	Annually	Field Reports/ Questionnaires
	Community Leaders	To increase the number of community leaders that are knowledgeable on the benefits of Adolescent Health Services	Increased number of community leaders that support the youths and adolescents within their communities to seek professional Adolescent Health Services	Percentage of community leaders who report positively about Adolescent SRH services.	Annually	Field Reports/ Questionnaires
	Service Providers	Increased number of community leaders that support the youths and adolescents within their communities to seek professional Adolescent Health Services	Increased number of health facilities with skilled service providers on interpersonal communication resulting in positive Provider/Client encounter for	Proportion of health facilities that have trained service providers on interpersonal communication skills for adolescents SRH.	Annually	Field Reports/ Questionnaires

Thematic Area	Target Audience	Communication Objectives	Desired Behaviour Changes	Indicators	Frequency	Means of Verifications
			adolescent health Services			
NUTRITION	National Policy Makers	Increase number of national policy makers that are knowledgeable on the benefits of Nutritional Services to the public and are lobbying for more resources to the programme	Increased number of national policy makers that are supporting the public to seek Nutritional Services and are allocating more resources to programme	Proportion of the budget allocated to nutrition programmes.	Annually	Field Reports/ Questionnaires
NUTRITION DURING PRE-PREGNANCY	Women of Reproductive Age	Increase in the number of women of the reproductive age that are knowledgeable on nutritional health services	Increased number of women of the reproductive age that seeking nutritional health services	Percentage of women of the reproductive age who report knowing at least 4 nutrient rich foods.	Annually	Field Reports/ Questionnaires
		Increase in the number of service providers that are trained on interpersonal communication skills for nutritional health services	Increased number of service providers with skills in interpersonal communication for nutritional health services	Percentage of health facilities with trained health workers in SBCC for nutrition.	Annually	Field Reports/ Questionnaires
NUTRITION (Children 0-5 Months)	Women of the Reproductive Age and men	To increase the number of Men and women of the reproductive age that are knowledgeable on the nutritional needs for children 0-5 months.	Increased number of men and women of the Reproductive Age that are seeking nutritional health services for children 0-5 months	Proportion of parents/caregivers that feed their children with the minimum acceptable diet.	Annually	Field Reports/ Questionnaires

Thematic Area	Target Audience	Communication Objectives	Desired Behaviour Changes	Indicators	Frequency	Means of Verifications
NUTRITION FOR LACTATING MOTHERS	Men and women of the Reproductive Age Groupd	Increase in number of men and women of the reproductive age that are knowledgeable about the nutritional needs of a lactating mother	Increased number of men and women of the reproductive age that seeking nutritional health services of a lactating mother	Percentage of women of the reproductive age who report knowing at least 3 nutritional needs of a lactating mother.	Annually	Field Reports/ Questionnaires
	Service Providers	Increase in number of health facilities with trained service providers on interpersonal communication skills for Nutritional Services.	Increased number of national policy makers that are supporting the public to seek Nutritional Services and are allocating more resources to programme.	Percentage of health facilities with service providers skilled in interpersonal communication, resulting in positive provider-client attitude.	Annually	Field Reports/ Questionnaire
	Community Leaders	Increase in the number of community leaders that are knowledgeable on the importance of nutritional health services	Increased number of community leaders that support their communities to seek nutritional health services	Percentage of community leaders who are lobbying for resources towards nutritional programmes.	Annually	Field Reports/ Questionnaire
CANCERS OF THE REPRODUCTIVE ORGANS	National Policy Makers	Increase number of national policy makers that are knowledgeable on the benefits of Cancer Services to the public and are lobbying more resources to	Increased number of national policy makers that are supporting the public to seek Cancer Services and are	Numbers of districts with functional cervical cancer screening clinics.	Monthly	Field Reports/ Questionnaire/ Cancer register

Thematic Area	Target Audience	Communication Objectives	Desired Behaviour Changes	Indicators	Frequency	Means of Verifications
		the programme	allocating more resources to programme.			
	Women of the Reproductive Age Group (Cervical Cancer)	Increase in the number of women of the reproductive age that are knowledgeable on the benefits of cervical cancer screening services	Increased number of women of reproductive age that are seeking cervical cancer screening services	Percentage of women of reproductive age who report knowing where to access cervical cancer screening services. Percentage of women of reproductive age who report knowing at least 3 signs or symptoms of cervical cancer.	Bi-Annual	Field Reports/ Questionnaire
	Men and Women of the Reproductive Age Group (Breast Cancer)	Increase the number of men and women of the reproductive age that are knowledgeable on the benefits of breast cancer screening services	Increased number of men and women of the reproductive age that are seeking breast cancer screening services	Percentage of men and women of reproductive age who report knowing where to access breast cancer screening services	Annually Field	Reports/ Questionnaire
	Men of Reproductive Age (Prostate Cancer)	Increase the number of men of the reproductive age who knowledgeable about prostate cancer screening	Increased number of men of the reproductive age understand prostate	Percentage of men of reproductive age who report	Annually	Field Reports/ Questionnaire

Thematic Area	Target Audience	Communication Objectives	Desired Behaviour Changes	Indicators	Frequency	Means of Verifications
		services.	cancer screening services	knowing where to access prostate cancer screening services.		
	Community Leaders	Increase the number of community leaders that are knowledgeable on the benefits of cervical, breast and prostate cancers screening services	Increased number of community leaders that support their communities in seeking cervical, breast and prostate cancers screening services	Percentage of community leaders who report knowing at least 3 signs or symptoms of breast cancer.	Annually	Field Reports/ Questionnaire
	Service Providers	Increase in the number of health facilities with service providers that are trained in interpersonal communication skills on cervical, breast and prostate Cancer Screening Services	Increased number of health facilities, with service providers skilled in interpersonal communication skills, resulting in positive provider-client attitude	Percentage of health facilities with service providers skilled in interpersonal communication, resulting in positive provider-client attitude.	Annually	Field Reports/ Questionnaire
INFERTILITY	National Policy Makers	Increase number of national policy makers that are knowledgeable on the benefits of Fertility Services to men and women of the reproductive age and are allocating more resources to the programme.	Increased number of national policy makers that are supporting men and women of the reproductive age to seek Fertility Services and are allocating more resources to programme.	Percentage of national policy makers that are advocating for more resource allocation to the Fertility Services	Annually	Field Reports/ Questionnaire

Thematic Area	Target Audience	Communication Objectives	Desired Behaviour Changes	Indicators	Frequency	Means of Verifications
	Men and Women of Reproductive Age	Increase in the number of men and women of the reproductive age that are knowledgeable on the benefits of Fertility Health Services	Increased number of men and women of the reproductive age that seek Fertility Health Services	Percentage of men and women of the reproductive age that are accessing Fertility Health Services	Annually	Field Reports/ Questionnaire
	Service Providers	To increase the number of health facilities, with service providers trained in interpersonal communication skills, resulting in positive provider-client attitude for Fertility Services	Increased number of health facilities, with service providers skilled in interpersonal communication skills, resulting in positive provider-client encounter	Percentage of health facilities with service providers skilled in interpersonal communication, resulting in positive provider-client attitude.	Annually	Field Reports/ Questionnaire
	Community Leaders	To Increase the number of community leaders who are knowledgeable on the importance fertility health services	Increased number of community leaders who understand the importance of fertility health services	Percentage of community leaders who know at least 3 fertility health services.	Annually	Field Reports/ Questionnaire
MENOPAUSE	National Policy Makers	Increase number of national policy makers that are knowledgeable on the benefits of Menopausal Services to women of the reproductive age and are allocating more resources to the programme	Increased number of national policy makers that are supporting women of the reproductive age to seek Menopausal Services and are allocating more	Proportion of the budget allocated to the Menopausal Services programme.	Annually	Field Reports/ Questionnaires

Thematic Area	Target Audience	Communication Objectives	Desired Behaviour Changes	Indicators	Frequency	Means of Verifications
			resources to programme			
	Men and Women of the Reproductive Age/ Service Providers Audience	Increase the number of men and women of the reproductive age who are knowledgeable on benefits of Menopausal Services	Increased number of men and women of the reproductive age that are seeking Menopausal Services	Percentage of men and women of the reproductive age who are accessing menopausal services	Annually	Field Reports/ Questionnaires
	Service Providers	Increase the number of service providers trained interpersonal communication skills in Menopausal Services	Increased number of service providers skilled in interpersonal communication resulting in positive Provider/client encounter for Menopausal Health Services	Percentage of health facilities with service providers skilled in interpersonal communication, resulting in positive provider-client attitude.	Annually	Field Reports/ Questionnaires
GENDER BASED VIOLENCE	National Policy Makers	Increase number of national policy makers that are knowledgeable on the benefits of GBV Services to the public and are lobbying for more resources to the programme	Increased number of national policy makers that are supporting the public to seek GBV Services and are allocating more resources to programme.	Proportion of the budget allocated to the GBV programme.	Annually	Field Reports/ Questionnaires
	General Public	Increase number of community members	Increased number of community members	Number of community	Annually	Field Reports/ Questionnaires

Thematic Area	Target Audience	Communication Objectives	Desired Behaviour Changes	Indicators	Frequency	Means of Verifications
		knowledgeable about GBV	utilising GBV services	members accessing GBV services		
	Service Providers	Increase in number of service providers trained in interpersonal communication skills for GBV	Increased numbers of service providers skilled in interpersonal communication resulting in positive provider/client encounter for GBV	Percentage of health facilities with service providers skilled in interpersonal communication, resulting in positive provider-client attitude.	Annually	Field Reports/ Questionnaires
WATER AND SANITATION	National Policy Makers	Increase number of national policy makers that are knowledgeable on the benefits of Water and Sanitation Services to the public and are allocating more resources to the programme	Increased number of national policy makers that are allocating more resources to water and sanitation programme	Proportion of the budget allocated to the Water and Sanitation programme.	Annually	Field Reports/ Questionnaires
	General Public	Increase in the number of communities that are knowledgeable on the benefits of improved sanitation in their communities	Increased number of communities that adhere to the recommended measures of treat water at household level in order to prevent diarrhoeal diseases	Percentage of communities with sanitary facilities meeting the required minimum standards	Annually	Field Reports/ Questionnaires
		Increase in the number of communities that are	Increased number of communities that are	Proportion of community	Annually	Field Reports/ Questionnaires

Thematic Area	Target Audience	Communication Objectives	Desired Behaviour Changes	Indicators	Frequency	Means of Verifications
		knowledgeable on the benefits of hygiene	practicing recommended hygienic measures	members who report knowing at least 3 benefits of hygiene		

REFERENCES

1. **Bhutta, Z.A., Das, J.K., Rizvi, A., Gaffey, M.F., Walker, N., Horton, S., Maternal and Child Nutrition Study** Group (2013). ***Evidence-based Interventions for Improvement of Maternal and Child Nutrition: What Can Be Done and at What Cost?*** Lancet, 382 (9890), 452-477.
2. Central Statistical Office(2014). ***Zambia Demographic and Health Survey*** 20-2013-2014.
3. Central Statistical Office (CSO) [Zambia]. 2011**.** ***Living Conditions Monitoring Survey Report 2006 and 2010***. Lusaka, Zambia: Central Statistical Office.
4. Central Statistical Office (CSO) [Zambia]. 2012. 2010 ***Census of Population and Housing National Analytical Report. Lusaka, Zambia***: Central Statistical Office.
5. Central Statistical Office (CSO) [Zambia]. 2013. 2010 ***Census of Population and Housing Descriptive Tables. Lusaka, Zambia:*** Central Statistical Office.
6. Central Statistical Office (CSO) [Zambia]. 2014. ***Gross Domestic Product: 2010 Benchmark Estimates Summary Report.*** Lusaka. Zambia: Central Statistical Office
7. Ministry of Health (2013) ***Integrated Family Planning Scale-Up Plan 2013-2020***, Lusaka
8. Ministry of Health (2011) ***Main Report- Mid-Term Review of the Implementation and Performance of the NHSP 2011-2016***, Lusaka
9. Ministry of Health (2014) ***Communication and Advocacy Strategy for Reproductive Health, Maternal Newborn Child Health and Nutrition 2014-2016***, Lusaka
10. Ministry of Health (2013) ***Roadmap for Accelerating Reduction of Maternal Newborn and child Mortality 2013-2016.*** Lusaka
11. Ministry of Health (2009) **Standards and Guidelines for Reducing Unsafe Abortions Morbidity and Mortality in Zambia.** Lusaka
12. Ministry of Health (2000) ***Zambia Reproductive Health Policy***, Lusaka
13. Ministry of Health (2009) ***Zambia Family Planning Guidelines***, Lusaka
14. Ministry of Health (2009)***Zambia Sexual Behaviour***, Lusaka
15. Ministry of Health (2006)***The National Food and Nutrition Policy***. Lusaka
16. Ministry of Health (2017) **Adolescent Health Strategic Plan 2017-2021,** Lusaka
17. Ministry of Health (2015). ***National Health Strategic Plan 2011-2015***. Lusaka

18. National Food and Nutrition Commission (NFNC) [Zambia]. 2006. **National Food and Nutrition Policy. Lusaka, Zambia**

19. National Food and Nutrition Commission (NFNC) [Zambia]. 2011. **National Food and Nutrition Strategic Plan 2011-2015** for Zambia. Lusaka, Zambia

20. National Food and Nutrition Commission (NFNC) [Zambia]. 2013. **The First 1,000 Most Critical Days Three Year Programme 2013-2015**. Lusaka, Zambia.

21. NFNC, & MoH. (2016). **Growth Monitoring and Promotion Implementation guidelines**. Lusaka: NFNC.

22. NFNC, (2014). **First 1000 MCD Communication Strategy and Implementation Plan, July 2014 – December 2016,** Lusaka. NFNC

23. NFNC & MOH. (2016). **Maternal, Adolescent, Infant and Young Child nutrition (MAIYCN) Guidelines Zambia**, 2016, Lusaka: NFNC.

24. UNICEF (1990) **Multi-sectoral approaches to Nutrition: Nutrition –Specific AND Nutrition Sensitive Interventions to accelerate progress**. New York

25. WHO (2015) **Maternal Death Surveillance and Response- MDSR** [viewed 3rd October, 2018] available from http://www.who.int.mdsr-country-profie

ANNEXE 1: LIST OF CONTRIBUTORS

	NAME	DESIGNATION	INSTITUTION
1.	Dr. Kennedy Malama	Permanent Secretary	MoH
2.	Dr. Francis Bwalya	Director- DHPESDs	MoH
3.	Dr. Abel Kabalo	Director- DHPESDs	MoH
4.	Dr. Tasila Tembo	Public Health Specialist	MoH
5.	Dr. Angel Mwiche	Assistant Director	MOH
6.	Dr. Mutale Nsakashalo	Assistant Director-Health Promotion	MoH
7.	Elizabeth Mulanga	Co-coordinator RMNCAH-N SBCC	MoH
8.	Dr. Chuma Njovu	Senior Registrar	CDH
9.	Dr. Kennedy Lishimpi	Consultant Oncologist	CDH
10.	Caren Chizuni	Chief Safe Motherhood Officer	MoH
11.	Dyness Kaluba	Chief Family Planning Office	MoH
12.	Dorothy Sikazwe	Chief Nutrition Officer	MoH
13.	Michael Silavwe	Chief IMCI Officer	MoH
14.	Evelyn Tembo	Assistant Director	MoG
15.	Charity Banda	School Coordinator- RH	MOE
16.	Dr. Amon Ngongola	Registrar	UTH
17.	Miyoba Dindi	Chief M&E Officer	MoH
18.	Aaron Mutinta	M&E Officer	MoH
19.	Mildred Tolosi	Senior M&E Officer	MoH
20.	Andrew Chaziya	Senior Planner	MoH
21.	Mable Mweemba	Chief Adolescent Health Officer	MoH
22.	Pauline Mbangweta	Public Relations Officer	MoH
23.	Kenneth Chanda	ICT Specialist	MoH
Partners			
1.	Dr. Stephen Mupeta	National Program Specialist (RH)	UNFPA
2.	Jenipher Mijere	Fistula Analyst	UNFPA
3.	Rita Magawa	Monitoring & Evaluation Analyst	UNFPA
4.	Dr. Sitali Maswenyeho	Health Specialist (MNCH&HIV/AIDS)	UNICEF
5.	Lois Munthali	Advisor Family Planning	USAID
Editors			
1.	Elizabeth Mulanga	Co-coordinator RMNCAH-N SBCC	MoH
2.	Kenneth Zulu	Graphic Designer	ZANIS

ANNEXE 2: HEALTH PROMOTION GLOSSARY

Health

Health is defined in the WHO constitution of 1948 as: A state of complete physical, social and mental well-being, and not merely the absence of disease or infirmity. Within the context of health promotion, health has been considered less as an abstract state and more as a means to an end which can be expressed in functional terms as a resource which permits people to lead an individually, socially and economically productive life. Health is a resource for everyday life, not the object of living. It is a positive concept emphasizing social and personal resources as well as physical capabilities. Reference: Ottawa Charter for Health Promotion. WHO, Geneva, 1986.In keeping with the concept of health as a fundamental human right, the **Ottawa Charter**. Emphasizes certain pre-requisites for health which include peace, adequate economic resources, food and shelter, and a stable eco-system and sustainable resource use. Recognition of these pre-requisites highlights the inextricable links between social and economic conditions, the physical environment, individual lifestyles and health. These links provide the key to a holistic understanding of health which is central to the definition of health promotion. Today the spiritual dimension of health is increasingly recognized. Health is regarded by WHO as a fundamental human right, and correspondingly, all people should have access to basic resources for health. A comprehensive understanding of health implies that all systems and structures which govern social and economic conditions and the physical environment should take account of the implications of their activities in relation to their impact on individual and collective health and well-being.

Health promotion

Health promotion is the process of enabling people to increase control over, and to improve their health. Reference: Ottawa Charter for Health Promotion. WHO, Geneva, 1986.Health promotion represents a comprehensive social and political process, it not only embraces actions directed at strengthening the skills and capabilities of individuals, but also action directed towards changing social, environmental and economic conditions so as to alleviate their impact on public and individual health. Health promotion is the process of enabling people to increase control over the determinants of health and thereby improve their health. Participation is essential to sustain health promotion action. The **Ottawa Charter** identifies three basic strategies for health promotion. These are advocacy for health to create the essential conditions for health indicated above; enabling all people to achieve their full health potential; and mediating between the different interests in society in the pursuit of health. These strategies are supported by five priority action areas as outlined in the **Ottawa Charter** for health promotion:

- Build healthy public policy
- Create supportive environments for health
- Strengthen community action for health

Develop personal skills, and

- Re-orient health services
- Each of these strategies and action areas is further defined in the glossary.

The **Jakarta Declaration** on Leading Health Promotion into the 21st Century from July 1997confirmed that these strategies and action areas are relevant for all countries. Furthermore, there is clear evidence that: Comprehensive approaches to health development are the most effective. Those that use combinations of the five strategies are more effective than single-track approaches;

Settings for health offer practical opportunities for the implementation of comprehensive Strategies; Participation is essential to sustain efforts. People have to be at the centre of health promotion action and decision-making processes for them to be effective;

Health literacy/ health learning fosters participation. Access to education and information is essential to achieving effective participation and the empowerment of people and communities. For health promotion in the 21st century the **Jakarta Declaration** identifies five priorities:

- Promote social responsibility for health
- Increase investments for health development
- Expand partnerships for health promotion
- Increase community capacity and empower the individual
- Secure an infrastructure for health promotion

Health for All

The attainment by all the people of the world of a level of health that will permit them to lead a socially and economically productive life. **Reference: Glossary of Terms used in Health for All series. WHO, Geneva, 1984** Health for All has served as an important focal point for health strategy for WHO and its Member States for almost twenty years. Although it has been interpreted differently by each country in the light of its social and economic characteristics, the health status and morbidity patterns of its population, and the state of development of its health system, it has provided an aspirational goal, based on the concept of equity in health. The Health for All strategy is currently being redeveloped to ensure its continued relevance into the next century. A new policy is being developed, to be adopted by the World Health Assembly in 1998.

Public health

The science and art of promoting health, preventing disease, and prolonging life through the organized efforts of society. **Reference: adapted from the "Acheson Report", London, 1988**.Public health is a social and political concept aimed at the improving health, prolonging life and improving the quality of life among whole populations through health promotion, disease Prevention and other forms of health intervention. A distinction has been made in the health promotion literature between public health and a new public health for the purposes of emphasizing significantly different approaches to the description and analysis of the determinants of health, and the methods of solving public health problems. This **new public health** is distinguished by its basis in a comprehensive understanding of the ways in which lifestyles and living conditions determine health status, and recognition of the need to mobilize resources and make sound investments in policies, programmes and services which create, maintain and protect health by supporting healthy lifestyles and creating supportive environments for health. Such a distinction between the "old" and the "new" may not be necessary in the future as the mainstream concept of public health develops and expands. The concept of **ecological public health** has also emerged in the literature. It has evolved in response to the changing nature of health issues and their interface with emerging global environmental problems. These new problems include global ecological risks such as the destruction of the ozone layer, uncontrolled and unmanageable air and water pollution, and global warming. These developments have a substantial impact on health which often eludes simple models of causality and intervention. Ecological public health emphasizes the common ground between achieving health and sustainable development. It focuses on the economic and environmental determinants of health, and on the means by which economic investment should be guided towards producing the best population health outcomes, greater equity in health, and sustainable use of resources.

Primary health care

Primary health care is essential health care made accessible at a cost a country and Community can afford, with methods that are practical, scientifically sound and socially acceptable. **Reference: Alma Ata Declaration, WHO, Geneva, 1978**.The Alma-Ata Declaration also emphasizes that everyone should have access to primary health care, and everyone should be involved in it. The primary health care approach encompasses the following key components: equity, community involvement/participation, intersectorality, appropriateness of technology and affordable costs. As a set of activities, primary health care should include at the very least health education for individuals and the whole community on the size and nature of health problems, and on methods of preventing and controlling these problems. Other essential activities include the promotion of adequate supplies of food and proper nutrition; sufficient safe water and basic sanitation; maternal and child health care, including family planning; immunization; appropriate treatment of common diseases and injuries; and the provision of essential drugs.

Primary health care as defined above will do much to address many of the pre-requisites for health indicated earlier. In addition, at a very practical level, there is great scope for both planned and opportunistic health promotion through the day to day contact between primary healthcare personnel and individuals in their community. Through health education with clients, and advocacy on behalf of their community, PHC personnel are well placed both to support individual needs and to influence the policies and programmes that affect the health of the community. The primary health care concept and themes are currently being reviewed by WHO**.**

Disease prevention

Disease prevention covers measures not only to prevent the occurrence of disease, such as risk factor reduction, but also to arrest its progress and reduce its consequences once established. **Reference: adapted from Glossary of Terms used in Health for All series. WHO, Geneva, 1984** Primary prevention is directed towards preventing the initial occurrence of a disorder. Secondary and tertiary prevention seeks to arrest or retard existing disease and its effects through early detection and appropriate treatment; or to reduce the occurrence of relapses and the establishment of chronic conditions through, for example, effective rehabilitation. Disease prevention is sometimes used as a complementary term alongside health promotion. Although there is frequent overlap between the content and strategies, disease prevention is defined separately. Disease prevention in this context is considered to be action which usually emanates from the health sector, dealing with individuals and populations identified as exhibiting identifiable risk factors often associated with different risk behaviours.

Health education

Health education comprises consciously constructed opportunities for learning involving some form of communication designed to improve health literacy, including improving knowledge and developing life skills which are conducive to individual and community health. Health education is not only concerned with the communication of information, but also with fostering the motivation, skills and confidence (self-efficacy) necessary to take action to improve health. Health education includes the communication of information concerning the underlying social, economic and environmental conditions impacting on health, as well as individual risk factors and risk behaviours, and use of the health care system. Thus, health education may involve the communication of information, and development of skills which demonstrates the political feasibility and organizational possibilities of various forms of action to address social, economic and environmental determinants of health. In the past, health education was used as a term to encompass a wider range of actions including social mobilization and advocacy. These methods are now encompassed

in the term health promotion, and a narrower definition of health education is proposed here to emphasize the distinction.

Advocacy for health

A combination of individual and social actions designed to gain political commitment, policy support, social acceptance and systems support for a particular health goal programme. **Reference: Report of the Inter-Agency Meeting on Advocacy Strategies for Health and Development: Development Communication in Action. WHO, Geneva, 1995**Such action may be taken by and/or on behalf of individuals and groups to create living conditions which are conducive to health and the achievement of healthy lifestyles. Advocacy is one of the three major strategies for health promotion and can take many forms including the use of the mass media and multi-media, direct political lobbying, and community mobilization through, for example, coalitions of interest around defined issues. Health Professionals have a major responsibility to act as advocates for health at all levels in society.

Alliance

An alliance for health promotion is a partnership between two or more parties that pursue a set of agreed upon goals in health promotion. Alliance building will often involve some form of mediation between the different partners in the definition of goals and ethical ground rules, joint action areas, and agreement on the form of cooperation which is reflected in the alliance.

Community

A specific group of people, often living in a defined geographical area, who share a common culture, values and norms, are arranged in a social structure according to relationships which the community has developed over a period of time. Members of a community gain their personal and social identity by sharing common beliefs, values and norms which have been developed by the community in the past and may be modified in the future. They exhibit some awareness of their identity as a group, and share common needs and a commitment to meeting them. In many societies, particularly those in developed countries, individuals do not belong to a single, distinct community, but rather maintain membership of a range of communities based on variables such as geography, occupation, social and leisure interests.

Community action for health

Community action for health refers to collective efforts by communities which are directed towards increasing community control over the determinants of health, and thereby improving health. The Ottawa Charter emphasizes the importance of concrete and effective community action in setting priorities for health, making decisions, planning strategies and implementing them to achieve better health. The concept of community empowerment is closely related to the Ottawa Charter definition of community action for health. In this concept an empowered community is one in which individuals and organizations apply their skills and resources in collective efforts to address health priorities and meet their respective health needs. Through such participation, individuals and organizations within an empowered community provide social support for health, address conflicts within the community, and gain increased influence and control over the determinants of health in their community.

Determinants of health

The range of personal, social, economic and environmental factors which determine the health status of individuals or populations. The factors which influence health are multiple and interactive. Health promotion

is fundamentally concerned with action and advocacy to address the full range of potentially modifiable determinants of health – not only those which are related to the actions of individuals, such as health behaviours and lifestyles, but also factors such as income and social status, education, employment and working conditions, access to appropriate health services, and the physical environments. These, in combination, create different living conditions which impact on health. Achieving change in these lifestyles and living conditions, which determine health status, are considered to be intermediate health outcomes.

Empowerment for health

In health promotion, empowerment is a process through which people gain greater control over decisions and actions affecting their health. Empowerment may be a social, cultural, psychological or political process through which individuals and social groups are able to express their needs, present their concerns, devise strategies for involvement in decision-making, and achieve political, social and cultural action to meet those needs. Through such a process people see a closer correspondence between their goals in life and a sense of how to achieve them, and a relationship between their efforts and life outcomes. Health promotion not only encompasses actions directed at strengthening the basic life skills and capacities of individuals, but also at influencing underlying social and economic conditions and physical environments which impact upon health. In this sense health promotion is directed at creating the conditions which offer a better chance of there being a relationship between the efforts of individuals and groups, and subsequent health outcomes in the way described above.

A distinction is made between individual and **community empowerment.** Individual empowerment refers primarily to the individuals' ability to make decisions and have control over their personal life. Community empowerment involves individuals acting collectively to gain greater influence and control over the determinants of health and the quality of life in their community, and is an important goal in community action for health.

Enabling

In health promotion, enabling means taking action in partnership with individuals or groups to empower them, through the mobilization of human and material resources, to promote and protect their health. The emphasis in this definition on empowerment through partnership, and on the mobilization of resources draws attention to the important role of health workers and other health activists acting as a catalyst for health promotion action, for example by providing access to information on health, by facilitating skills development, and supporting access to the political processes which shape public policies affecting health.

Epidemiology

Epidemiology is the study of the distribution and determinants of health-states or events in specified populations, and the application of this study to the control of health problems. **Reference: Last, JM. Dictionary of Epidemiology. UK, 1988**

Epidemiological information, particularly that defining individual, population and/or physical environmental risks has been at the core of public health, and provided the basis for disease prevention activities. Epidemiological studies use social classifications (such as socioeconomic status) in the study of disease in populations, but generally make less than optimal use of social sciences, including economic and public policy information, in investigating and understanding disease and health in populations.

Social epidemiology has evolved as a discipline during the past two decades. Social epidemiology is the study of health and illness in populations which is informed by a Social, psychological, economic and public

policy information, and uses that information in the definition of public health problems and proposal of solutions. As the discipline of epidemiology further develops and expands such distinctions will be less important in the future.

Equity in health

Equity means fairness. Equity in health means that people's needs guide the distribution of opportunities for well-being. **Reference: Equity in health and health care. WHO, Geneva, 1996**The WHO global strategy of achieving Health for All is fundamentally directed towards achieving greater equity in health between and within populations, and between countries. This implies that all people have an equal opportunity to develop and maintain their health, through fair and just access to resources for health. Equity in health is not the same as equality in health status. Inequalities in health status between individuals and populations are inevitable consequences of genetic differences, of different social and economic conditions, or a result of personal lifestyle choices. Inequities occur as a consequence of differences in opportunity which result, for example in unequal access to health services, to nutritious food, adequate housing and so on. In such cases, inequalities in health status arise as a consequence of inequities in opportunities in life

Health behaviour

Any activity undertaken by an individual, regardless of actual or perceived health status, for the purpose of promoting, protecting or maintaining health, whether or not such behaviour is objectively effective towards that end. **Reference: Health Promotion Glossary, 1986.**It is possible to argue that almost every behavior or activity by an individual has an impact on health status. In this context it is useful to distinguish between behaviours which are purposefully adopted to promote or protect health (as in the definition above), and those which may be adopted regardless of consequences to health. Health behaviours are distinguished from risk behaviours which are defined separately as behaviours associated with increased Susceptibility to a specific cause of ill-health. Health behaviours and risk behaviours are often related in clusters in a more complex pattern of behaviours referred to as lifestyles.

Health communication

Health communication is a key strategy to inform the public about health concerns and to maintain important health issues on the public agenda. The use of the mass and multimedia and other technological innovations to disseminate useful health information to the public, increases awareness of specific aspects of individual and collective health as well as importance of health in development. **Reference: adapted from Communication, Education and Participation: A Framework and Guide to Action. WHO (AMRO/PAHO), Washington, 1996**Health communication is directed towards improving the health status of individuals and populations. Much of modern culture is transmitted by the mass and multimedia which has both positive and negative implications for health. Research shows that theory-driven mediated health promotion programming can put health on the public agenda, reinforce health messages, stimulate people to seek further information, and in some instances, bring about sustained healthy lifestyles.

Health communication encompasses several areas including edutainment or enter-education, health journalism, interpersonal communication, media advocacy, organizational communication, risk communication, social communication and social marketing. It can take many forms from mass and multimedia communications to traditional and culture-specific communication such as storytelling, puppet shows and songs. It may take the form of discreet health messages or be incorporated into existing media for communication such as soap operas. Advances in communication media, especially in the multimedia and new information technology continue to improve access to health information. In this respect, health

communication becomes an increasingly important element to achieving greater empowerment of individuals and communities.

Health development

Health development is the process of continuous, progressive improvement of the health status of individuals and groups in a population. **Reference: Terminology Information System. WHO, Geneva, 1997**The **Jakarta Declaration** describes health promotion as an essential element of health development.

Health expectancy

Health expectancy is a population based measure of the proportion of expected life span estimated to be healthful and fulfilling, or free of illness, disease and disability according to social norms and perceptions and professional standards. Health expectancy belongs to a new generation or type of health indicator which are currently being developed. These indicators are intended to create measures which are more sensitive to the dynamics of health and determinants. Health expectancy indicators combine information from life expectancy tables and health surveys of populations. They need to be based on life expectancy at country level or a similar geographic area.

Examples of health expectancy indicators currently in use are disability free life years (**DFLY**) and quality adjusted life years (**QALY**). They focus primarily on the extent to which individuals experience a life span free of disability, disorders and/or chronic disease. Health promotion seeks to expand the understanding of health expectancy beyond the absence of disease, disorder and disability towards positive measures of health creation, maintenance and protection, emphasizing a healthy life span.

Health gain

Health gain is a way to express improved health outcomes. It can be used to reflect the relative advantage of one form of health intervention over another in producing the greatest health gain. The **Jakarta Declaration** indicates that health promotion "acts on the determinants of health to create the greatest health gain for people. "See also health outcome and intermediate health outcomes

Health goal

Health goals summarize the health outcomes which, in the light of existing knowledge and resources, a country or community might hope to achieve in a defined time period. Health goals are general statements of intent and aspiration, intended to reflect the values of the community in general, and the health sector in particular, regarding a healthy society. Many countries have adopted an approach to setting health goals and health targets as statement of direction and intent with regard to their investments for health. WHO has supported the development, and promoted the use of health goals and targets at global and regional, national and local levels.

Health indicator

A health indicator is a characteristic of an individual, population, or environment which is subject to measurement (directly or indirectly) and can be used to describe one or more aspects of the health of an individual or population (quality, quantity and time). Health indicators can be used to define public health problems at a particular point in time, to indicate change over time in the level of the health of a population or individual, to define differences in the health of populations, and to assess the extent to which the objectives of a programme are being reached. Health indicators may include measurements of illness or disease which are more commonly used to measure health outcomes, or positive aspects of health (such as quality of life, life skills, or health expectancy), and of behaviours and actions by individuals which are related to health. They may also include indicators which measure the social and economic conditions and

the physical environment as it relates to health, measures of health literacy and healthy public policy. This latter group of indicators may be used to measure intermediate health outcomes, and health promotion outcomes.

Health literacy

Health literacy represents the cognitive and social skills which determine the motivation and ability of individuals to gain access to, understand and use information in ways which promote and maintain good health. Health literacy implies the achievement of a level of knowledge, personal skills and confidence to take action to improve personal and community health by changing personal lifestyles and living conditions. Thus, health literacy means more than being able to read pamphlets and make appointments. By improving people's access to health information, and their capacity to use it effectively, health literacy is critical to empowerment. Health literacy is itself dependent upon more general levels of literacy. Poor literacy can affect people's health directly by limiting their personal, social and cultural development, as well as hindering the development of health literacy.

Health outcomes

A change in the health status of an individual, group or population which is attributable to a planned intervention or series of interventions, regardless of whether such an intervention was intended to change health status. Such a definition emphasizes the outcome of planned interventions (as opposed, for example, to incidental exposure to risk), and that outcomes may be for individuals, groups or whole populations. Interventions may include government policies and consequent programmes, laws and regulations, or health services and programmes, including health promotion programmes. It may also include the intended or unintended health outcomes of government policies in sectors other than health. Health outcomes will normally be assessed using health indicators. See also intermediate health outcomes, and health promotion outcomes.

Health policy

A formal statement or procedure within institutions (notably government) which defines priorities and the parameters for action in response to health needs available resources and other political pressures. Health policy is often enacted through legislation or other forms of rule-making which define regulations and incentives which enable the provision of health services and programmes, and access to those services and programmes. Health policy is currently distinguished from healthy public policy by its primary concern with health services and programmes. Future progress in health policies may be observed through the extent to which they may also be defined as healthy public policies. As with most policies, health policies arise from a systematic process of building support for public health action that draws upon available evidence, integrated with community preferences, political realities and resource availability.

Health promoting hospitals

A health promoting hospital does not only provide high quality comprehensive medical and nursing services, but also develops a corporate identity that embraces the aims of health promotion, develops a health promoting organizational structure and culture, including active, participatory roles for patients and all members of staff, develops itself into a health promoting physical environment and actively cooperates with its community. **Reference: based on Budapest Declaration on Health Promoting Hospitals. WHO, (EURO), Copenhagen, 1991**

Health promoting hospitals take action to promote the health of their patients, their staff, and the population in the community they are located in. Health promoting hospitals are actively attempting to become "healthy

organizations". Health Promoting Hospitals are being implemented since 1988. An international network has developed to promote the wider adoption of this concept in hospitals and other health care settings.

Health promoting schools

A health promoting school can be characterized as a school constantly strengthening its capacity as a healthy setting for living, learning and working. **Reference: Promoting health through schools. Report of a WHO Expert Committee on Comprehensive School Health Education and Promotion. WHO Technical Report Series N°870. WHO, Geneva, 1997**

Towards this goal, a health promoting school engages health and education officials, teachers, students, parents and community leaders in efforts to promote health. It fosters health and learning with all the measures at its disposal, and strives to provide supportive environments for health and a range of key school health education and promotion programs and services.

A health promoting school implements policies, practices and other measures that respect an individual's self-esteem, provide multiple opportunities for success, and acknowledge good efforts and intentions as well as personal achievements. It strives to improve the health of school personnel, families and community members as well as students, and works with community leaders to help them understand how the community contributes to health and education. WHO's Global School Health Initiative aims at helping all schools to become "health promoting" by, for example, encouraging and supporting international, national and subnational networks of health promoting schools, and helping to build national capacities to promote health through schools.

Health promotion evaluation

Health promotion evaluation is an assessment of the extent to which health promotion actions achieve a "valued" outcome. The extent to which health promotion actions enable individuals or communities to exert control over their health represents a central element of health promotion evaluation. In many cases it is difficult to trace the pathway which links particular health promotion activities to health outcomes. This may be for a number of reasons, for example, because of the technical difficulties of isolating cause and effect in complex, "real-life" situations. Therefore, most recent outcome models in health promotion distinguish between different types of outcomes and suggest a hierarchy among them. Health promotion outcomes represent the first point of assessment and reflect modifications to those personal, social and environmental factors which are a means to improve people's control over their health. Changes in the determinants of health are defined as intermediate health outcomes.

Changes in health status represent health outcomes. In most cases, there is also "value" placed on the process by which different outcomes are achieved. In terms of valued processes, evaluations of health promotion activities may be **participatory**, involving all those with a vested interest in the initiative; **interdisciplinary**, by involving a variety of disciplinary perspectives; **integrated** into all stages of the development and implementation of a health promotion initiative; and help build the capacity of individuals, communities, organizations and governments to address important health problems.

Health promotion outcomes

Health promotion outcomes are changes to personal characteristics and skills, and/ or social norms and actions, and/or organizational practices and public policies which are attributable to a health promotion activity. Health promotion outcomes represent the most immediate results of health promotion activities and are generally directed towards changing modifiable determinants of health. Health promotion outcomes

include health literacy, healthy public policy, and community action for health. See also health outcomes and intermediate health outcomes.

Health Sector
The health sector consists of organized public and private health services (including health promotion, disease prevention, diagnostic, treatment and care services), the policies and activities of health departments and ministries, health related nongovernment organizations and community groups, and professional associations. **Reference: adapted from Glossary of Terms used in Health for All Series N° 9. WHO, Geneva, 1984**

Health Status
A description and/or measurement of the health of an individual or population at a particular point in time against identifiable standards, usually by reference to health indicators. **Reference: adapted from Glossary of Terms used in Health for All Series N° 9. WHO, Geneva, 1984**

Health Target
Health targets state, for a given population, the amount of change (using a health indicator) which could be reasonably expected within a defined time period. Targets are generally based on specific and measurable changes in health outcomes, or intermediate health outcomes.

Health targets define the concrete steps which may be taken towards the achievement of health goals. Setting targets also provides one approach to the assessment of progress in relation to a defined health policy or programme by defining a benchmark against which progress can be measured. Setting targets requires the existence of a relevant health indicator and information on the distribution of that indicator within a population of interest. It also requires an estimate of current and likely future trends in relation to change in the distribution of the indicator, and an understanding of the potential to change the distribution of the indicator in the population of interest.

Healthy Cities
A healthy city is one that is continually creating and improving those physical and social environments and expanding those community resources which enable people to mutually support each other in performing all the functions of life and in developing to their maximum potential. **Reference: Terminology for the European Conference on Health, Society and Alcohol: A glossary with equivalents in French, German and Russian. WHO (EURO), Copenhagen, 1995**

The WHO Healthy Cities project is a long-term development project that seeks to place health on the agenda of cities around the world, and to build a constituency of support for public health at the local level. The healthy cities concept is evolving to encompass other forms of settlement including healthy villages and municipalities.

Healthy Islands
A healthy island is one that is committed to and involved in a process of achieving better health and quality of life for its people, and healthier physical and social environments in the context of sustainable development. **Reference: adapted from Yanuca Island Declaration. WHO (WPRO), Manila, 1995**

The **Yanuca Island Declaration** states that Healthy Islands are places where children are nurtured in body and mind; environments invite learning and leisure; people work and age in dignity; and ecological balance is a source of pride. This Declaration was ratified by the Health Ministers of fourteen Pacific Island nations in 1995 and has since become an inter-regional source of reference for Healthy Islands programmes throughout the world.

Healthy Public Policy
Healthy public policy is characterized by an explicit concern for health and equity in all areas of policy, and by accountability for health impact. The main aim of healthy public policy is to create a supportive environment to enable people to lead healthy lives. Such a policy makes healthy choices possible or easier for citizens. It makes social and physical environments health enhancing. **Reference: Adelaide Recommendations on Healthy Public Policy. WHO, Geneva, 1988**

The **Ottawa Charter** highlighted the fact that health promotion action goes beyond the health care sector, emphasizing that health should be on the policy agenda in all sectors, and at all levels of government. One important element in building healthy public policy is the notion of accountability for health. Governments are ultimately accountable to their people for the health consequences of their policies, or lack of policies. A commitment to healthy public policies means that governments must measure and report on their investments for health, and the subsequent health outcomes, and intermediate health outcomes of their investments and policies in a language that all groups in society readily understand. Closely related to the health promotion concept of healthy public policy is the strategy of investment for health. Investment for health is a strategy for optimizing the health promoting impact of public policies.

Infrastructure for Health Promotion
Those human and material resources, organizational and administrative structures, policies, regulations and incentives which facilitate an organized health promotion response to public health issues and challenges. Such infrastructures may be found through a diverse range of organizational structures, including primary health care, government, private sector and non-governmental organizations, self-help organizations, as well as dedicated health promotion agencies and foundations. Although many countries have a dedicated health promotion workforce, the greater human resource is to be found among the wider health workforce, workforces in other sectors than health (for example in education, social welfare and so on), and from the actions of lay persons within individual communities. Infrastructure for health promotion can be found not only in tangible resources and structures, but also through the extent of public and political awareness of health issues, and participation in action to address those issues.

Intermediate Health Outcomes
Intermediate health outcomes are changes in the determinants of health, notably changes in lifestyles, and living conditions which are attributable to a planned intervention or interventions, including health promotion, disease prevention and primary health care. See also determinants of health, health outcomes and intermediate health outcomes

Intersectoral Collaboration
A recognised relationship between part or parts of different sectors of society which has been formed to take action on an issue to achieve health outcomes or intermediate health outcomes in a way which is more effective, efficient or sustainable than might be achieved by the health sector acting alone. **Reference: modified from Intersectoral Action for Health: A Cornerstone for Health for all in the 21st Century. WHO, Geneva, 1997**

Intersectoral action for health is seen as central to the achievement of greater equity in health, especially where progress depends upon decisions and actions in other sectors, such as agriculture, education, and finance. A major goal in intersectoral action is to achieve greater awareness of the health consequences of policy decisions and organizational practice in different sectors, and through this, movement in the direction of healthy public policy and practice. Not all intersectoral action for health need involve the health sector. For example, in some countries the police and transport sectors might combine to take action to reduce road transport injury. Such action, although explicitly intended to reduce injury, will not always involve the health sector. Increasingly intersectoral collaboration is understood as cooperation between different sectors of society such as the public sector, civil society and the private sector.

Investment for Health

Investment for health refers to resources which are explicitly dedicated to the production of health and health gain. They may be invested by public and private agencies as well as by people as individuals and groups. Investment for health strategies are based on knowledge about the determinants of health and seek to gain political commitment to healthy public policies. Investment for health is not restricted to resources which are devoted to the provision and use of health services and may include, for example, investments made by people (individually or collectively) in education, housing, empowerment of women or child development. Greater investment for health also implies reorientation of existing resource distribution within the health sector towards health promotion and disease prevention. A significant proportion of investments for health are undertaken by people in the context of their everyday life as part of personal and family health maintenance strategies. See also healthy public policy and supportive environments for health

Life Skills

Life skills are abilities for adaptive and positive behavior that enable individuals to deal effectively with the demands and challenges of everyday life. **Reference: Life skills education in schools. WHO, Geneva, 1993**

Life skills consist of personal, inter-personal, cognitive and physical skills which enable people to control and direct their lives, and to develop the capacity to live with and produce change in their environment. Examples of individual life skills include decision making and problem solving, creative thinking and critical thinking, self-awareness and empathy, communication skills and interpersonal relationship skills, coping with emotions and managing stress. Life skills as described above are fundamental building blocks for the development of personal skills for health promotion described as one of the key action areas in the **Ottawa Charter**.

Lifestyle (lifestyles conducive to health)

Lifestyle is a way of living based on identifiable patterns of behavior which are determined by the interplay between an individual's personal characteristics, social interactions, and socioeconomic and environmental living conditions. These patterns of behavior are continually interpreted and tested out in different social situations and are therefore not fixed, but subject to change. Individual lifestyles, characterized by identifiable patterns of behaviour, can have a profound effect on an individual's health and on the health of others. If health is to be improved by enabling individuals to change their lifestyles, action must be directed not only at the individual but also at the social and living conditions which interact to produce and maintain these patterns of behaviour. It is important to recognize, however, that there is no "optimal" lifestyle to be prescribed for all people. Culture, income, family structure, age, physical ability, home and work environment will make certain ways and conditions of living more attractive, feasible and appropriate.

Living Conditions

Living conditions are the everyday environment of people, where they live, play and work. These living conditions are a product of social and economic circumstances and the physical environment – all of which can impact upon health – and are largely outside of the immediate control of the individual. The Ottawa Charter action of creating supportive environments for health is largely focused on the need to improve and change living conditions to support health.

Mediation

In health promotion, a process through which the different interests (personal, social, economic) of individuals and communities, and different sectors (public and private) are reconciled in ways that promote and protect health. Producing change in people's lifestyles and living conditions inevitably produces conflicts between the different sectors and interests in a population. Such conflicts may arise, for example, from concerns about access to, use and distribution of resources, or constraints on individual or organizational practices. Reconciling such conflicts in ways which promote health may require considerable input from health promotion practitioners, including the application of skills in advocacy for health.

Network

A grouping of individuals, organizations and agencies organized on a non-hierarchical basis around common issues or concerns, which are pursued proactively and systematically, based on commitment and trust. WHO actively initiates and maintains several health promotion networks around key settings and issues. These include, for example, the intersectoral healthy cities network, networks of health promoting schools, and WHO country networks for health promotion such as the WHO mega country initiative. Networks of networks are also being established. Examples include the WHO (EURO) initiative "Networking the networks" and global networking initiatives for health promotion in order to build a global alliance for health promotion.

Partnership for Health Promotion

A partnership for health promotion is a voluntary agreement between two or more partners to work cooperatively towards a set of shared health outcomes. Such partnerships may form a part of intersectoral collaboration for health, or be based on alliances for health promotion. Such partnerships may be limited by the pursuit of a clearly defined goal – such as the successful development and introduction of legislation; or may be on-going, covering a broad range of issues and initiatives. Increasingly health promotion is exploring partnerships between the public sector, civil society and the private sector. See also social responsibility for health and primary health care (section I)

Quality of Life

Quality of life is defined as individual's perceptions of their position in life in the context of the culture and value system where they live, and in relation to their goals, expectations, standards and concerns. It is a broad ranging concept, incorporating in a complex way a person's physical health, psychological state, level of independence, social relationships, personal beliefs and relationship to salient features of the environment. **Reference: Quality of Life Assessment. The WHOQOL Group, 1994. What Quality of Life? The WHOQOL Group. In: World Health Forum. WHO, Geneva, 1996.**

This definition highlights the views that quality of life refers to a subjective evaluation, which induces both positive and negative dimensions, and which is embedded in a cultural, social and environmental context. WHO identified six broad domains which describe core aspects of quality of life cross-culturally: a physical

domain (e.g. energy, fatigue), a psychological domain (e.g. positive feelings), level of independence (e.g. mobility), social relationships (e.g. practical social support), environment (e.g. accessibility of health care) and personal beliefs/spirituality (e.g. meaning in life).

The domains of health and quality of life are complementary and overlapping. Quality of life reflects the perception of individuals that their needs are being satisfied and that they are not being denied opportunities to achieve happiness and fulfillment, regardless of physical health status, or social and economic conditions. The goal of improving the quality of life, alongside preventing avoidable ill-health, has become of increased importance in health promotion. This is particularly important in relation to meeting the needs of older people, the chronically sick, terminally ill, and disabled populations.

Re-orienting Health Services

Health services re-orientation is characterized by a more explicit concern for the achievement of population health outcomes in the ways in which the health system is organized and funded. This must lead to a change of attitude and organization of health services, which focuses on the needs of the individual as a whole person, balanced against the needs of population groups. **Reference: adapted from Ottawa Charter for Health Promotion. WHO, Geneva, 1986**

The **Ottawa Charter** also emphasizes the importance of a health sector which contributes to the pursuit of health. Responsibility for achieving this is shared between all the health professions, health service institutions and government, alongside the contribution of individuals and communities served by the health sector. In most cases this will require an expansion in health promotion and disease prevention action to achieve an optimal balance between investments in health promotion, illness prevention, diagnosis, treatment, and care and rehabilitation services. Such an expanded role need not always be achieved through an increase in direct health system activity. Action by sectors other than the health sector may be more effective in achieving improved health outcomes. Governments need to acknowledge the key role of the health sector in supporting such inter-sectoral action for health.

Risk Behaviour

Specific forms of behaviour which are proven to be associated with increased susceptibility to a specific disease or ill-health. Risk behaviours are usually defined as “risky” on the basis of epidemiological or other social data. Changes in risk behaviour are major goals of disease prevention, and traditionally health education has been used to achieve these goals. Within the broader framework of health promotion, risk behaviour may be seen as a response, or mechanism for coping with adverse living conditions. Strategies to respond to this include the development of life skills, and creation of more supportive environments for health.

Risk Factor

Social, economic or biological status, behaviours or environments which are associated with or cause increased susceptibility to a specific disease, ill health, or injury. As is the case with risk behaviours, once risk factors have been identified, they can become the entry point or focus for health promotion strategies and actions.

Self Help

In the context of health promotion, actions taken by lay persons (i.e. non health Professionals) to mobilize the necessary resources to promote maintain or restore the health of individuals or communities. Although self-help is usually understood to mean action taken by individuals or communities who will directly benefit

those taking the action, it may also encompass mutual aid between individuals and groups. Self-help may also include self-care – such as self-medication and first aid in the normal social context of people's everyday lives.

Settings for Health

The place or social context in which people engage in daily activities in which environmental, organizational and personal factors interact to affect health and wellbeing. A setting is also where people actively use and shape the environment and thus create or solve problems relating to health. Settings can normally be identified as having physical boundaries, a range of people with defined roles, and an organizational structure. Action to promote health through different settings can take many different forms, often through some form of organizational development, including change to the physical environment, to the organizational structure, administration and management. Settings can also be used to promote health by reaching people who work in them, or using them to gain access to services, and through the interaction of different settings with the wider community. Examples of settings include schools, work sites, hospitals, villages and cities.

Social Capital

Social capital represents the degree of social cohesion which exists in communities. It refers to the processes between people which establish networks, norms, and social trust, and facilitate co-ordination and co- operation for mutual benefit. Social capital is created from the myriad of everyday interactions between people, and is embodied in such structures as civic and religious groups, family membership, informal community networks, and in norms of voluntarism, altruism and trust. The stronger these networks and bonds, the more likely it is that members of a community will co-operate for mutual benefit. In this way social capital creates health, and may enhance the benefits of investments for health.

Social Networks

Social relations and links between individuals which may provide access to or mobilization of social support for health. A stable society is far more likely to have established social networks which provide access to social support. De-stabilizing influences such as high unemployment, re- housing schemes and rapid urbanisation can lead to considerable dislocation of social networks. In such circumstances action to promote health might focus on support for reestablishing social networks.

Social Responsibility for Health

Social responsibility for health is reflected by the actions of decision makers in both public and private sector to pursue policies and practices which promote and protect Health. **Reference: The Jakarta Declaration on Leading Health Promotion into the 21st Century. WHO, Geneva, 1997**.The policies and practices pursued by the public and private sectors should avoid harming the health of individuals; protect the environment and ensure sustainable use of resources; restrict the production of and trade in inherently harmful goods and substances, as well as discourage unhealthy marketing practices; safeguard the citizen in the marketplace and the individual in the workplace, and include equity- focused health impact assessments as an integral part of policy development.

Social Support

That assistance available to individuals and groups from within communities which can provide a buffer against adverse life events and living conditions, and can provide a positive resource for enhancing the quality of life. Social support may include emotional support, information sharing and the provision of

material resources and services. Social support is now widely recognized as an important determinant of health, and an essential element of social capital.

Supportive Environments for Health

Supportive environments for health offer people protection from threats to health, and enable people to expand their capabilities and develop self-reliance in health. They encompass where people live, their local community, their home, where they work and play, including people's access to resources for health, and opportunities for empowerment. **Reference: adapted from Sundsvall Statement on Supportive Environments for Health. WHO, Geneva, 1991**Action to create supportive environments for health has many dimensions, and may include direct political action to develop and implement policies and regulations which help create supportive environments; economic action, particularly in relation to fostering sustainable economic development; and social action.

Sustainable Development

Sustainable development is defined as development that meets the needs of the present without compromising the ability of future generations to meet their own needs (WCED 1987). It incorporates many elements, and all sectors, including the health sector, which must contribute to achieve it. **Reference: Our common future: Report of the World Commission on Environment and Development (WCED), 1987. Health and Environment in Sustainable Development. Five years after the Earth Summit. WHO, Geneva, 1997**. Human beings are at the centre of sustainable development. Sustainable development refers to the use of resources, direction of investments, the orientation of technological development, and institutional development in ways which ensure that the current development and use of resources do not compromise the health and well-being of future generations. There is no single best way of organizing the complex development-environment-health relationship that reveals all the important interactions and possible entry points for public health interventions. In health promotion, sustainable development is particularly important in terms of building healthy public policy, and supportive environments for health in ways which improve living conditions, support healthy lifestyles, and achieve greater equity in health both now and in the future.

ANNEXE 3: COMMUNICATION CONCEPTS AND APPROACHES

Communication approaches or methodologies used in this strategy are those that are applied in the field of health. They range from those targeting individuals to those concerned with broad social and environmental factors for change and can be summarised as:

- Behaviour change communication
- Social marketing
- Health education
- Health promotion
- Policy advocacy
- Participatory development communication
- Social change and human rights based communication
- Social mobilisation
- Enabling health communications environments

Behaviour Change Communication

Behaviour change communication (BCC) involves the development of tailored messages and approaches to develop promote and sustain individual, community and societal behaviour change. Cognisance is given to cultural diversity and audience reception and a multi-channel approach is employed. BCC can improve and promote dialogue at community and national level on a range of health issues.

Social Marketing

Social marketing draws on the principles of commercial marketing to bring about behavior and social change. It's based on the premise that individuals and organizations are willing to exchange resources for perceived benefits, and that commercial techniques can promote healthy behavior and ideas. The basic components of social marketing include: creating an enticing product, minimizing price, and promoting the product in appropriate ways, through appropriate channels and in appropriate places. Trust Condoms have been promoted by PSI using this approach.

Health Education

Health education is designed to improve health literacy, including improving knowledge, and developing life skills conducive to individual and community health. One form of health education known as "edutainment" combines entertainment and education to disseminate information. This can take the form of soap operas, songs, cartoons, comics, theatre and other forms, which carry messages that lead to healthy behaviour. This approach can reach huge numbers and has a rapid impact. Makutano Junction a local TV programme uses this approach to disseminate health information.

Health Promotion

Health promotion enables people to increase their control over, and improve their health. It is an approach that involves the population as a whole in the context of their everyday lives, rather than focusing on people at risk of specific diseases, and one that is directed towards action on the determinants or causes of health and well-being. Interventions may be topic-focused (for example, sexual health promotion) or arena-focused (for example school based health education). Health promotion can include policy advocacy, health education and a range of other communication approaches.

Policy Advocacy

Policy advocacy is a strategy to influence policy makers through persuasive communication when they make laws and regulations, distribute resources, and make other decisions that affect peoples' lives. The principal aims of advocacy are to create policies, reform policies, and ensure policies are implemented. There are a variety of advocacy strategies, such as discussing problems directly with policy makers, delivering messages through the media, or strengthening the ability of local organizations to advocate.

Participatory Development Communication

This focuses on facilitating exchange between peers to address health issues. It has a strong capacity-building and empowering component, since the participants are responsible for informing and sensitizing their peers. Communication is the means by which the individuals within a larger group or organization coalesce around an issue. They agree that there is a problem; agree on the major causes of the problem; agree to pull their resources together in addressing these causes; and agree on the major lessons learnt in the process.

Social Mobilisation

Social mobilisation is another example of a participatory method emphasising political coalition-building and Community action. Wide community participation is necessary for members to gain ownership, so that innovations are not seen as externally imposed. Social mobilisation is closely interlinked with advocacy. It strengthens advocacy efforts and relates them to social movements and social marketing activities. There is considerable overlap between these approaches and they are best used in combination. Those aiming to develop a communication programme may want to start with the basics – the behaviour that causes risk – using approaches such as behaviour change and health education. Complementing these more clinically orientated approaches are those based on social change and participation, which empower communities to make changes for themselves. Such approaches help to create deeper-rooted change, and can avoid the entrenchment of a range of dynamics that could be unsustainable and even create dependency.