

Republic of Zambia

**MINISTRY OF COMMUNITY DEVELOPMENT,
MOTHER AND CHILD HEALTH**

**COMMUNICATION AND ADVOCACY STRATEGY
FOR REPRODUCTIVE HEALTH,
MATERNAL NEWBORN,
CHILD HEALTH AND NUTRITION.**

2014 to 2016



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Acronyms

AIDS	Acquired Immune Deficiency Syndrome
ANC	Ante Natal Care
ARV	Anti Retro Viral Drugs
BCC	Behaviour Change Communication
CBO	Community Based Organisation
CHNP	Child Health and Nutrition Programme
EPI	Expanded Programme of Immunization
SBCC	Social Behaviour Change Communication
FBO	Faith Based Organisation
FP	Family Planning
GBV	Gender Based Violence
GMP	Growth Monitoring Program
HHs	Households
HMIS	Health Management Information System
HIV	Human Immuno-deficiency Virus
IEC	Information Education and Communication
IMCI	Integrated Management of Childhood Illnesses
ITN	Insecticide Treated Net
KAP	Knowledge Attitude and Practice
MCDMCH	Ministry of Community Development, Mother and Child Health
MDGs	Millennium Development Goals
MNCH	Mother, Newborn and Child Health
SCC	Social Change Communication
NAIS	National Agriculture Information Services
NMCC	National Malaria Control Centre
NHCs	Neighbourhood Health Committees
SRHS	Sexual reproductive Health Services
UNICEF	United Nations International Children Education Fund
WILSA	Women in Law in Southern Africa
PMTCT	Prevention of Mother to Child Transmission
PNC	Post Natal Care
RED	Reaching Every District
TT	Tetanus Toxoid
TV	Television
HRT	Hormone Replacement Therapy
PCR	Polymerase Chain Reaction
SIAs	Supplemental Immunization Activities



SMAGS	Safe Motherhood Action Groups
SRH	Sexual and Reproductive Health
STIs	Sexually Transmitted Infections
TB	Tuberculosis
UCI	Universal Childhood Immunization
USAID	United States Agency for International Development
ZANIS	Zambia News and Information Service
ZDHS	Zambia Demographic Health Survey

Foreword

The Government of the Republic of Zambia, through the Ministry of Community Development, Mother and Child Health (MCDMCH), is committed to providing social protection and primary health care services in an integrated manner as close to communities as possible. More than a decade ago, world leaders met and adopted comprehensive and time-bound Millennium Development Goals (MDGs) to improve the state of the world by 2015. The fourth (improve child health), fifth (improve maternal health) and sixth MDGs (combat HIV/AIDS, malaria and other diseases) are critical to MCDMCH.

This Communication and Advocacy Strategy for Maternal, Newborn, Child Health and Nutrition (MNCHN) is intended to guide communication activities that are implemented at national, provincial, district and community levels. It is envisaged that this document will equip service providers and communicators with tools and approaches to provide locally tailored, appropriate and relevant information on communication.

The purpose of this strategy is to provide key communication guidance for implementing reproductive health, maternal, newborn, child health and nutrition activities. It is intended for use by policy makers, implementing partners, communication and programme officers, and health workers, and through them, Neighbourhood Health Committees (NHCs) and others working at the community level. Because these communication interventions aim to increase appropriate use of health services and promote positive behaviour change and healthy lifestyles at home, the strategy goes beyond mere dissemination of health information to provide a framework for guiding behaviour-centred communication activities. It is therefore imperative that all stakeholders, including implementing and cooperating partners, become fully involved and actively participate in the implementation of this Communication and Advocacy Strategy

Honourable Emerine Kabanshi, MP

Minister

MINISTRY OF COMMUNITY DEVELOPMENT MOTHER AND CHILD HEALTH

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1.0 Background and Introduction

The Ministry of Community Development, Mother and Child Health (MCDMCH) was established in 2012 with a mandate to ensure that social protection and primary health care services are delivered in an integrated manner as closer to the communities as possible. MCDMCH is committed to reorganize and manage its revised portfolio in an efficient and integrated manner by rationalizing available resources to significantly improve service delivery following the realignment of its functions, which came about as a result of the merger between the Ministry of Community Development and Social Services with some of the specialized functions of the Ministry of Health. The establishment and realignment of the MCDMCH was aimed at strengthening the government's commitment to improve the health and livelihood status of vulnerable populations (women, children and disabled persons).

In 2007 the Ministry of Health developed a Maternal, Newborn, Child and nutrition communication strategy whose purpose was to provide a framework to guide communication activities that were implemented by the health sector and its stakeholders. Due to the new policy direction and restructuring of the health sector, the realignment of Primary Health care to community development, the strategy needed to be reviewed to incorporate new areas of focus and emerging health trends.

From 2013 to 2014 a series of meetings were held to review the 2007 communication strategy and identify new health areas following the realignment. Subsequently, the revised communication strategy 2007 is called “Reproductive Health Maternal, Newborn, Child Health and Nutrition communication and advocacy strategy which will be implemented from 2014 to 2016. This strategy is aligned to the MCDMCH strategic plan of 2013 -2016 and the National Health Strategic Plan 2012-2015.

Vision	Pioneers in the provision of integrated social protection and primary health care service
Value Statement	In the provision of social protection and primary health care services, the Ministry shall uphold integrity, transparency, and respect for clients, confidentiality, impartiality, non-discrimination, and commitment.
Mission	To effectively and efficiently facilitate the provision of equitable social protection and quality primary health care services to communities in order to contribute to sustainable human development.
Overall Goal	Contribute to 50% reduction in the high disease burden by 2016.

2.0 Guiding Principles

The RMNCHN communication and advocacy strategy outlines the following guiding principles for planning, designing, implementing, monitoring and evaluating Social behaviour Change Communication Interventions for reproductive Maternal, Newborn, Child Health and Nutrition programs:

1. Results oriented- the effectiveness of the RMNCHN 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
2. Science based- RMNCHN strategy planning will use accurate data and theory to inform and guide activities
3. Client –Centred- a client centered approach involves audiences in determining their health needs and engages them in the process of developing messages that address those needs.
4. Participatory- Clients should be involved throughout the communication process including program design, implementation and evaluation Benefit oriented- the messages will focus on the benefits perceived by the clients for adopting the targeted behaviour.
5. Linked services- Health promotion services should be directed towards specific services and enhance self-efficiency and community empowerment.
6. Multi channelled- the use of complimentary channels or ways to reach target audiences has been shown to increase effectiveness of BCC
7. Technical quality- Social and Behaviour Change Communication (SBCC) should aim for high quality messaging and products
8. Advocacy related- Social and Behaviour Change Communication should target individual and policy makers in order to influence the adoption of healthier behaviours.
9. Expanded to scale- SBCC is effective when successful efforts can be scaled up
10. Programmatically sustainable- SBCC programs should aspire to create sustainable social change
11. Cost effective- SBCC resources should be focused towards a combination of the most cost effective channels
12. Culturally appropriateness- All programs should be in tandem with the culture of the environment in which they are being implemented
13. Gender considerations- gender issues should be considered where appropriate.
14. 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 program 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.

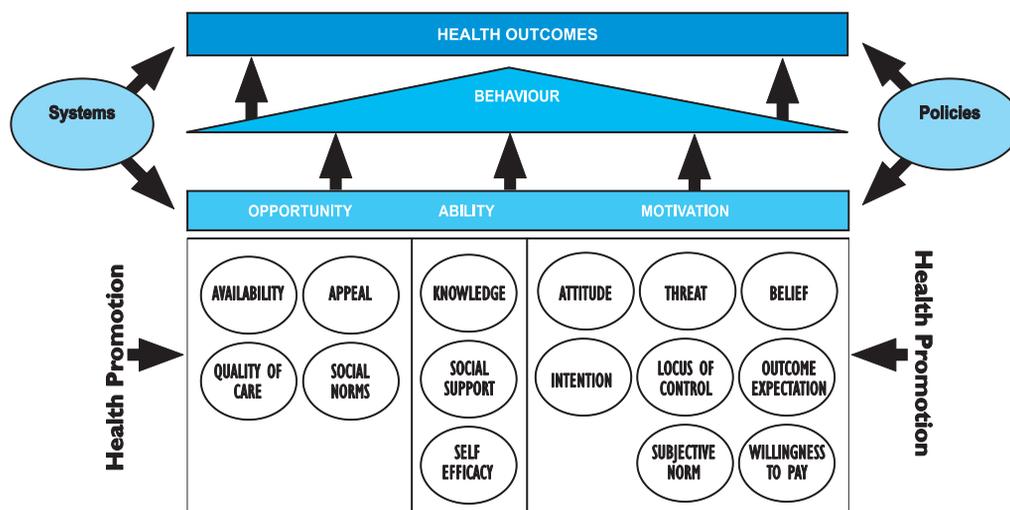
15. Health promotion staff need to devise and implement effective advocacy strategies to convince their superiors of the value of SBCC for reaching program objectives
16. The RMNCHN communication and advocacy strategy will take into consideration issues of the persons with disabilities

3.0 Strategic Approach

The choice of communication activities and key messages in this strategy targeting RMNCHN interventions are informed primarily by the BCP approach.

Determinants of Health Model

This communication strategy is based on the determinants of health model. The Determinants of Health theory is a combination of several models which include the Health Belief and the Stage of Change Models, organizes them differently, adding to them and illustrating them in a model that really emphasizes the determinants or factors that directly influences behaviour. This model provides a specific and concrete way to analyse barriers and motivations.



This model is based on the behavior change model frequently used by population services International [PSI] to develop and monitor social marketing programs, but has been modified slightly to apply to all kinds of health promotion activities. [CDC, 1993].

4.0 Social and Behaviour Change Communications

Health communication in Zambia has both immediate and long-term objectives. In the long-term, health communication aims to make Zambians more “health literate” by providing up-to-date, clear information to all Zambians, beginning with children, about why they and others are or are not healthy, and what they can do – at home, in their community, and by using health services – to protect and improve their health. The main focus of this type of communication is on the best available scientific knowledge presented in appropriate detail, language and channels for each audience.

More urgently, health communication aims to promote and facilitate people's actions that will immediately benefit their health. Doing so may not require such an intense focus on pure information, since the primary objective is to promote changes in behaviour rather than in knowledge. Thus, social and behaviour change communication (SBCC) aims more to motivate and facilitate changed behaviour than to educate for its own sake. It is critical that SBCC activities are coordinated with and complement other actions that motivate and facilitate healthful changes in behaviour; for example, improvements in the convenience and reliability of health services or the friendliness of health staff, community actions to organize emergency transport, or a policy change that facilitates access to a key health commodity. While the MCDMCH is dedicated to reaching both types of communication objectives, its first priority is on communication that supports behaviour change.

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 program 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. Advocacy by health promotion and health education staff in Zambia at national, provincial, and district levels merits much attention, since the priority and funding for SBCC outside of special donor programs are low. Health promotion staffs need to devise and implement effective advocacy strategies to convince their superiors of the value of SBCC for reaching program objectives so they will provide sufficient funding and carry out other needed actions.

Successful health communication activities require a variety of well-designed and effective

materials and activities that not only provide strategic information but that also motivate people to action and provide suggestions that enable them to take healthful actions. Every print material, video or other communication material should have a specific role in a larger strategy that addresses a specific health concern. The success and impact of communication strategies, activities and materials depend largely on the planners' understanding of their audiences. Working with audience members throughout the development process helps ensure that communication materials and activities meet the needs of the intended audiences.

Steps in Planning and Implementing Effective Strategic Health Communications

Situation analysis.

The first step is to take advantage of existing knowledge and experience. This can avoid the need to undertake unnecessary new research and also can prevent you from implementing ineffective approaches that others have already tried unsuccessfully. From collecting and examining documents and from interviewing a small number of key informants, planners can learn about:

- Relevant programs, policies, and laws
- The organizational structure and manpower available for program interventions, that do or could address the health topic or one or more of your likely audiences
- Communication and outreach networks, both within the government and NGOs
- What has worked well or not for current and recent programs that address the same health topic
- For your likely audiences, existing demographic, social (including gender), epidemiological, cultural, communication and behavioural data (factors that might facilitate or inhibit changes, influencers, access to media and media habits, literacy, access to and use of health services).

Formative research.

In many cases, new, brief, intensive, small-sample research will be needed to fill in gaps in information from your review of existing information. The MCDMCH at national or provincial levels will normally coordinate such formative research with a partner or contracted agency. Common methods include focus group discussions, in-depth interviews and observations, and trials of improved practices (TIPs). TIPs allows planners to learn what new practices are (or are not) acceptable and feasible for the main audiences to do. The method also provides an

opportunity for audience members to contribute their own suggestions to program recommendations, as well as to learn the audience's immediate felt benefits of implementing the recommended practices. These audience concepts (e.g. “my baby sleeps better after I let him empty both breasts”) are often much more effective motivators than the benefits from the public health viewpoint.

Design your behaviour change or SBCC strategy.

Based on what you have learned from the situational analysis and formative research, for each major audience (or “participant group”) that you will address, work with relevant staff or partners to draft either a comprehensive behaviour-change strategy (that includes other program actions that complement strategic communications) or a more focused BCC strategy. The BCC strategy for each audience should include a behavioural analysis (current behaviours, desired or feasible behaviours, barriers to change, enablers [existing factors that support change]), as well as your main communication goals, objectives, targets, channels, materials and activities (and their purposes, e.g. to inform, motivate, remind, etc.), and targets.

Behavioral objectives should be stated in measurable terms, meaning it will be possible to observe and measure progress towards meeting the objectives. For example, an objective may read: “Within 12 months, consistent and correct condom use among sex workers in one fishing camp will increase by 50%.” Realistic targets should be set for each objective, taking into account factors such as audience characteristics, the seriousness of the barriers to change, the extent of communication infrastructure, and access to information services (e.g. radio and TV ownership, access to education, availability of support services).

In many circumstances, communication activities *alone* will not determine the extent of behaviour change. For example, communication can be responsible for the percentage of caregivers who know when their child's next immunization is due, but it cannot, by itself, be responsible for vaccination coverage levels, since service accessibility, reliability, convenience, and friendliness may also have major impacts on coverage. In this example, it is fine to *measure* coverage but one should also measure changes in caregivers' practical knowledge about vaccination services and side effects that communication affects most directly.

Preparatory Activities

Essential preparatory activities include: developing possible partnerships and programmatic linkages, establishing coordination for essential support services, and ensuring availability of

trained manpower.

Develop linkages and strategic partnerships.

Linkages need to be established among Government, NGOs, CBOs, and traditional structures to encourage collaboration, integration and gathering of support for the communication interventions. Linkages with Government may be with the Ministries of Health, Education, Youth, Women and Child Welfare, Information and Broadcasting Services, Agriculture and other line ministries. Linkages with the private-sector are often essential also. The MCDMCH can either contract private companies or arrange for in-kind contribution e.g. when Manzi valley travel to a rural district to deliver their merchandise they can carry CHW logistics and materials .

Arrange support services.

Planning in advance for provision of health services and supplies is essential in facilitating public education and awareness. This includes physical inputs, such as medicines, supplies, and services, which can have a strong impact on reaching objectives and targets set for the overall program and for specific groups.

Build needed skills.

An effective communication program may require building the capacity of a variety of people, such as health workers, community volunteers, drama troupe members, radio DJs, and teachers. Such groups may need increased knowledge, changed attitudes, and new skills. It is important to understand that building capacity is rarely a matter of giving one brief training. For example, teaching and reinforcing effective counselling and group-facilitation skills are essential in many communication efforts. Staff or community volunteers are unlikely to gain proficiency in these skills after attending one training experience. Once on the job, they need well-designed job aids and supportive supervision with mentoring and modelling of good practice.

Prepare Communication Materials

There are basically two types of communications materials:

- (1) Passive ones that provide information (posters, brochures, SMS reminder messages, radio and television programs with no opportunity for listener/viewer feedback) and
- (2) Materials that facilitate dialogue (two-way communication).

Two-way communication (counselling, group discussions, Facebook, etc.) is essential to support behaviour change, because many people may not be able (for psychological, social or practical reasons) to change in one step from their current practice to the more healthful practice

that the MCDMCH recommends. Dialogue enables the person to find feasible small steps that she or he can take immediately and also to jointly come up with small strategies for doing so. However, there is also a very legitimate role for materials that reminds or informs people but that do not provide an immediate opportunity for discussion. Folk media – such as puppetry, drama and story-telling – can be used to draw people's attention and then stimulate interactive group discussions afterwards that both inform participants and help them apply the information to their own lives.

Consulting with target groups (to understand their needs for information, motivation, strategies, and various types of support to carry out desired behaviours) should guide your communication content, media and channels (radio, TV, posters, interpersonal approaches, traditional media, digital media, etc.). This is the culmination of the conceptualization, analysis and planning exercise. The situational assessment, supplemented as needed by new formative research, should enable planners to select and define the content, format, presentation, medium, etc. for each identified target group.

The basic steps in preparing the materials recommended in the communications strategy are: design, pretesting, revision, possibly a second pretesting, production (with good quality control), and dissemination. Effective materials depend on each step being done well.

In general, it is recommended that the MCDMCH contract out the actual materials development to appropriate professionals. Nonetheless, MCDMCH staff should be fully involved in the process. They need to prepare a detailed scope of work and description of the essential characteristics of each material, and they need to ensure a professional process and good results. MCDMCH staff should draft such a “creative brief” for each material, while allowing contracted consultants or agency working on the materials to recommend changes.

Pretesting

Pretesting refers to learning or discovering the reaction of your target audience to one or more draft materials (prototypes) prior to producing and distributing the materials. Pretesting helps identify strengths and weaknesses of a draft material so that the final version can be more effective. Pretesting can also allow you to compare which of two versions of a material is preferred.

Too often, programs either do not pre-test or do a “quick and dirty” pre-test that gives little useful feedback. Reasons given for not pretesting include: lack of time or money; the false confidence of technical people who feel that they “know their audiences”; and the false confidence of

creative people about their design. Don't accept these excuses!

Pretesting can save time and money and lower the risk that the materials will offend or give misunderstood advice to the target audience. It cannot guarantee success, but it can help reduce some of the uncertainty and risk of producing materials that may be misunderstood or misinterpreted. The more changes needed to be made to the material based on the pretesting results, the more successful the pretesting process. (A useful guide is the Ministry of Health publication, *Guidelines for Pretesting and Evaluating Communication Materials*.)

Pretesting provides information on the following five aspects of a material:

1. Comprehension

Do people understand what the material is trying to say? Is the message as clear as it needs to be in order to be understood? Which illustrations and vocabulary were understood and which weren't? How well does each image depict its relevant text? Which prototype is most clearly understood?

2. Acceptability/Believability

Is there anything in the message that is offensive? Is there anything that people perceive to be false and unrealistic? Is there any element that might irritate the audience? Which prototype is the most acceptable and believable and why?

3. Personal Relevance

Does the target audience perceive that this material is talking to people like them or to “others”?

4. Attraction

Is the message interesting enough to attract and hold the attention of the target group? Do people like it? What elements do they like and dislike? Which prototype attracts the most attention and is best liked?

5. Persuasion

Does the message convince the target audience to do the suggested action? Which prototype might best convince them? If done carefully, pretesting should tell planners not only how well target groups “like” a proposed communication material and feel that it is culturally appropriate but also how well the material communicates information and

thus the likelihood that the communication will stimulate the desired actions.

Pretesting can use either a qualitative or quantitative approach. Asking a larger sample more close-ended questions is easier to interpret, since you can set a percentage (70% or 80%) of the respondents who must like something before you will change it. However, interviews or group discussions with mostly open-ended questions for a small, but carefully chosen, sample can yield more in-depth feedback and suggestions. When you pretest a material designed to facilitate interpersonal communication, you should pretest it with both the users (health workers, community volunteers) and with the audience (mothers or other community members). A small number of the users should be trained to use the material and actually use it as you foresee it being used in the field, so they can give immediate feedback on and suggestions based on their experience.

Production

Production of communication materials is normally done by a company contracted for that purpose. Although you have already approved the look of the material, you also need to prepare a detailed description of the material (e.g. size, material, weight of paper, glossy or non-glossy paper) and build in occasions in the production process when you need to inspect and approve the product.

Advertising firms can normally negotiate good broadcast rates from radio and television stations. They can also advise on the best days, times, and frequency needed to reach your particular audiences. When you solicit proposal from them, ask them to provide a general plan for these things. You may also want to make them responsible for monitoring broadcasts to be certain that they occur at the negotiated times.

If you are working with local individuals (singers, puppeteers) or groups such as drama troupes, you (or provincial or district staff) should organize “try-outs” to pick the best performers. You then need to work with the selected persons to be certain that their performances are technically correct as well as entertaining. It is best if a health worker leads the discussion after the entertainment, but if you expect one of the entertainers to do so, you must train them on the technical issues and the best responses to the most likely questions.

The same advice goes for interactive radio or television programs that include the opportunity for viewers to comment or ask questions. The persons facilitating listener or viewer input must have both excellent technical understanding and facilitation skills.

Dissemination of Communication Materials

After all of the effort to design and produce good materials, the process can still fail in the dissemination phase. Insufficient time and money are common issues. Especially when there is a deadline to begin communication activities (e.g. for Global Hand washing Day or a Child Health Week), there is often insufficient time at the end for distribution of materials down to the district or sub-district level where they will be used. There may also not be enough funds for the personnel, vehicles, petrol, and per diem needed for the transport of bulky materials. The solution is to fully address this step during planning by preparing a comprehensive plan for dissemination and distribution of all communication materials. Leave enough time, and either allocate enough funds or make arrangements with public- or private-sector partners to assist with dissemination.

Implementation and Monitoring of Communication Activities

Monitoring of communication activities in the field – and in turn making adjustments to the program based on monitoring findings – is extremely important. In addition to routine monitoring via regular monthly or quarterly reports, special monitoring studies, particularly in the first months of a new communication effort, are recommended. Initial monitoring should look more at inputs and outcomes: Have the materials been distributed? Are the activities occurring as planned? Are they reaching people as planned? Later monitoring can begin to look at impact. Are people beginning to learn the key information, change attitudes, and change practices?

5.0 Channels of Message Delivery

In order to effectively deliver messages on the thematic areas above, the implementers of this strategy should endeavor to use a mix of communication channels with deep consideration of related cost, effectiveness and appropriateness to a given situation or target audience.

The full-fledged implementation of this strategy will require on-going commitment towards building BCC resources in the MCDMCH. The five overarching strategies are:

- ❑ Mass media;
- ❑ Mid media;
- ❑ interpersonal communication (IPC) and
- ❑ Digital channels. The purpose of presenting all these broad and overarching strategies together is to underscore the need to work with all of them instead of a singular focus on one. Below is a description for each of the channels:
- ❑ Braille
- ❑ Sign language

5.1 Mass Media:

Mass media are excellent for reaching large numbers of people to introduce and reinforce new information and promote a particular social change. Mass media includes all forms of radio, television, e-mail and any widely-distributed print media such as newspapers, magazines or even billboards that reach large masses or segments of the population. These channels are best for reaching broader (and hence less targeted) audiences with simple and concise messages. Selecting the right broadcasting channels and the right timing for airing of mass media will depend on the intended audience. Examples include television sets that are located in clinics, and community development centres.

However, most people do not readily accept new information they hear or see on media without having an opportunity to discuss it with someone they trust. It is for this reason that mass media is most appropriately used to reinforce or legitimize information or persons who can communicate directly with people, providing appropriate information and helping them make healthy behaviour changes.

a) *Radio and Television*

Many Zambian families have access to radio, particularly in rural areas. Lack of electricity in some communities requires radios to be powered either by battery or by generator. There are national radio stations as well as community radio stations that reach a limited portion of the country. An advantage of local radio is that it can broadcast in the language that the majority of local people understand, whereas some people will not understand national broadcasts in English or other languages.

Radio and television can accommodate many formats of programs types of materials). They can broadcast speeches, poems, songs, discussion programs, interviews, live broadcasts of events, dramas with embedded health messages, or some combination of these. Programs can be pre-recorded or can be broadcast live.”

b) *Films on DVDs/Monitors/Screens*

Films are expensive to make and require persons with skill and experience to write, produce, and broadcast them effectively. However, they potentially can reach many people (shown on television, or just the sound track on radio) and can be very effective as a group medium if followed up by good facilitated discussions. Films can vary in length from 30 seconds to 30 minutes (or longer, although this runs the risk of losing audience interest). They can be dramas (either with actors or documentaries) with teaching points embedded or more didactic presentations. They can teach skills such as how to build a latrine or express breast milk. They can address psychological barriers to desired practices, for example by giving testimonies of real people telling how they overcame the factors that are blocking many others from carrying out the desired practices.

Films with discussions are appropriate for community events such as health fairs or community celebrations, community meetings, or in schools. Films on television can reach a large (mostly urban) audience, but to have maximum impact, local health staff, CHWs and/or NGO staff need to organize listening groups or otherwise follow up the film by facilitating discussions and action planning.

c) Newspapers and Information Packets

These two types of print materials are most appropriate to reach local, district, and (particularly) national decision makers (with an advocacy objective). The material is likely to be most appropriate if it is based on formative research with the audience, which clarifies their current practices, feasible new practices, barriers and motivations. Every effort should be made to make newspaper stories accurate. Information packets should feature both emotional appeals (photos, words) and factual information, and should clearly lay out what they want the audience to do and how they can do it when there are barriers. These materials must be clearly written, have minimal health jargon and acronyms, and be short and succinct.

Press kits are a particular type of information packet intended to inform news personnel about some health topic, often things like a health campaign, Child Health Week, a health day (e.g. World Tuberculosis Day), or the release of an important documents, such as the latest Demographic and Health Survey for Zambia.

d) Posters

Posters are one of the most used and misused materials. They have significant limitations that are often not recognized. They can contain a limited amount of information, are quite ineffective for low-literate people, may not stay up for too long a period, particularly if placed outdoors, and, unless used as an aid in IPC, are not interactive. It may also be difficult to place posters where they will be seen by the specific intended audience.

e) Calendars

Calendars may be expensive per unit but can be cost-effective if they are located in places where many people see them and look at them frequently – such as health centers, schools, and community centers. They can contain a good amount of illustrations, photos and words, but are appropriate only for literate audiences. They can also be used as incentives or thank you gifts for people like teachers and CHWs.

Like any print material, a calendar's use can be enhanced if it is used to support IPC, al-though by itself it can serve as a reference or reminder for literate audiences. Although not required, calendars may be most effective when the health information they contain is appropriate to the

month or season where it is displayed; for example, the show information on malaria at the beginning of the high malaria season.

f) Comic Books

Comic books are difficult to design and illustrate well, but they can be quite effective, particularly for schoolchildren, when they are research-based, pretested, and contain relevant, important, and actionable information in an entertaining way using attractive characters and situations. Designing and producing comic books may be expensive per unit, unless a very large print run is made. They are most cost-effective if used both as a teaching aid and as a take-home material for literate audiences.

g) Booklets/Leaflets

Like posters, booklets and leaflets are overused in many countries. Although often targeted to the public, they commonly contain a lot of technical information that may not be appropriate for families, especially where literacy levels are low and there are many predominant languages in different parts of a country. Booklets and leaflets are most appropriate as reminders of key information for health staff, local leaders, community volunteers, and possibly students. Booklets/leaflets or single sheets may also be appropriate handouts at group talks, to remind the participants of some of the key points discussed.

h) Books

Books are generally too expensive and not appropriate for large audiences. However, they can be a useful material if intended to support persons who talk to or read to groups and individuals. Effective uses of books might include:

- Story books read to or read by community groups or students, as a stimulus to discussion.
- Literacy texts that contain important health information.
- Reference books to remind health staff or volunteers of technical information, service standards, and correct information to give to the public.
- Question and answer booklets (to help health staff, local leaders, and community volunteers) respond well to people's questions on health topics.

Signs/Banners/Billboards

Simple signs can be useful in particular situations, e.g. a sign in a well-traveled location giving the time and date of the next Child Health Week, or signs in health facilities giving the days and hours when different services are offered.

Banners may be appropriate to announce times and places of big events such as health campaigns or special health events. Billboards are could carry the same type of information as banners as well as photos and short messages for emotional impact, but they might be appropriate only for large cities and may not be cost-effective.

5.2 Mid or Group Media:

This refers to promotional activities that are aimed at large groups, such as public announcements using loud speakers, presentations, speeches, special promotional events, drama group presentations, etc. Community drama shows and presentations to large groups of 50+ people have proven to be successful, though more rigorous evaluation of these approaches is needed. Though limited in its reach, social media also fits within this category, and has promise as a channel for engaging young people in open discussions and for sharing personal experiences and thoughts about HIV with large groups of friends and family members.

Examples of other forms of mid or group media and how to use them are as follows:

a) *Health Talks*

Health talks can take place in health facilities, venues such as schools and churches, and communities or wherever people gather. If the person giving the talk uses audiovisual aids and if he or she engages well with the audience, such talks can be effective. The speaker should ask enough questions of the audience to be certain that:

- The topic is both relevant and of interest to them
- What their current beliefs and practices are in relation to the topic
- What obstacles people must overcome to change their current practices and some strategies for doing this
- What other topics are of particular interest to the group

b) Community Health Fairs/Celebrations

These take a lot of effort to organize but can be both fun and educational. Usually there needs to be a group such as a mothers club, class at the school, or health committee willing to take responsibility for organizing. It may be possible to organize a health fair in conjunction with an already-planned community event or holiday celebration.

The types of activities that can take place at a community health fair include:

- Demonstrations (e.g. of good hand washing; construction, care and use of a latrine or a child's potty, how to make nutritious complementary foods)
- Health talks, which could incorporate stories, photos, flip charts, etc. to stimulate reflection and discussion
- Films, videos, or stories followed by discussion.

c) Demonstrations

In most demonstrations, someone talks about and then actually performs a practice or shows how something like an improved latrine works, talks about the importance of always keeping the hole covered, of washing the latrine with some kind of cleansing agent frequently. When possible, the audience should actively participate in the demonstration, e.g. washing their hands with soap and then shaking them dry, or tasting or letting their young child taste the complementary food prepared in the demonstration.

d) Meetings/Seminars/Workshops

Depending on the purpose and participants, such gatherings of people may provide a good opportunity for health education and discussion. Stories, role plays, flip charts, photos or illustrations and other materials or activities can often be used effectively to stimulate discussion. (Please see “health talks” above for characteristics of effective discussions.)

e) Religious Services

Most pastors, priests, and nuns, are not health experts, but they want people to live healthy lives. Health programs can prepare some basic health information for church leaders to give during or

after services, informing people about basic health recommendations and/or giving details about health services and events such as Child Health Days, health fairs, and health campaigns.

f) Live Performances

Live performances by singers, dancers, actors (drama troupes), acrobats, and magicians attract crowds that then can be engaged in such health education activities as films, discussions, and question and answer sessions. This concept of combining entertainment with education is known as Edutainment. It can be quite effective as long as the entertainment part does not cost too much and does not overwhelm the education part, which is the real purpose of the event. It is very important to have a well-prepared and effective person to facilitate a good discussion after the entertainment part ends.

g) Flip Charts

Flip charts can be used with groups or individuals. Some flip charts are designed primarily to aid health experts' present information to an audience. While the drawings or photos on a flip chart can facilitate such communication, the activity will be much more effective if the person using the flip chart engages the audience to ask questions, talk about their current practices, and discuss the possibility of new practices.

It takes skill and effort to design a cost-effective flip chart. Besides basing the content on formative research and thoroughly pretesting the material, the designers need to consider the cost of each unit in relation to: how large it needs to be to be appropriate for the anticipated audience sizes, how heavy it will be for carrying around from place to place, and how durable the material should be.

h) Stories

Cultural wisdom and traditions are often communicated via stories. For health communication, spoken or written stories can be used to transmit information and/to stimulate reflection and discussion. Stories can also be used as a formative research approach with a small group. A facilitator can provide a scenario and instructions or begin the story and then let the group members take turns in continuing the story. People can be asked to construct a story of what is “typical” or “normal” in their community or given some other instruction, such as tell of story of how improvements are possible in their community.

i) Role Plays

Well-designed role plays are the next best thing to actually doing something in a home, community, or health facility. They are appropriate for:

- ❑ Teaching, demonstrating or assessing many types of skills, particularly ones involving interpersonal communication;
- ❑ Changing attitudes by putting people in the role play in the other person's shoes; e.g. by asking health workers to take on the role of mothers who are yelled at and not given key information by the health worker; or by showing mothers how they can ask questions to get essential information from health workers.

The “scenarios” of role plays need to be carefully planned, with the purpose of the exercise in mind, and, to be effective a role play should always be used to as a stimulus to discussion.

j) Transect Walks and Other Community Investigations

Organizing community groups to “investigate” health conditions and practices in their own community can be very educational and motivating. For example, a community group can make a map of their community, marking public health hazards such as open defecation areas and unprotected water sources. A community group can carry out a small survey in their own community – recording observations of things like hand washing stations and latrines and/or asking families questions. Such group activities can help people identify and prioritize issues needing attention and can also motivate participants to take action.

5.3 Inter-Personal Communications (IPC):

This category encompasses one-to-one and small group interactions, ideally led by one or more informed and motivated spokespersons. IPC has proven to be the single most effective method to date for generating informed use for services and encouraging healthy practices at home in Zambia. This is because of the complexity of several interventions as personalised services, as well as the opinion on benefits and risks of stigma which require longer-format and interactive community-based discussions to allow potential clients and community leaders to ask questions and receive complete information to allay fears and any misconceptions.

In cases where people cannot immediately adopt a behavioural recommendation, IPC can

support a discussion that helps those persons decide what immediate step(s) towards the ideal behaviour they are able to take at the moment. Below are examples of tools and approaches for IPC.

a) *Counseling Cards/Flip Chart*

Effective counseling is not easy to learn but has the potential of being a very effective way to promote more healthy practices. Selecting appropriate counselors, good initial training, and good supervision and on-the-job training are all important, but good counseling materials are often essential also. The material can both facilitate good communication by having drawings that the mother can react and point to and remind the counselor of the many alternative suggestions to address various situations needing improvement. Materials which are usually in the form of a series of cards or a flip chart often have illustrations or photos on one side, to show and discuss with the mother or other person being counseled, and questions and suggestions of things to say written on the back for the counselor.

b) *Photographs and Illustrations*

Either in counseling materials, flip charts, or other materials, or separately, photos and illustrations can be used to illustrate a teaching point, or stimulate reflection and discussion, either with individuals or with small groups. When used by a competent facilitator, photos or drawing are also good to stimulate group reflection on a health situation or problem.

c) *Reminder Materials*

These materials can be useful for both health staff and families. For example, a simple job aid can remind a vaccinator of the topics that he or she should cover with every caregiver – what vaccines the child got that day, the importance of getting all the recommended vaccinations, when the child's next vaccination is due, and that mild side effects are common and not a cause for concern, and how to make the child more comfortable.

Reminder materials can be very helpful to mothers who have to remember complicated instructions or to repeat a practice daily or even more often. For example, when the mother is given instructions on how to give medicine to a sick child, it may be very helpful if the provider gives her a slip of paper with how many days, how many times per day, and what dosage to give

each time. After counseling on prevention (e.g. improving hygiene or young child feeding practices), it can be very helpful if the mother has a slip of paper with reminders (drawings or words) of the new practice(s) she has agreed to try. “Hand washing stations,” simple places with a tippy tap or two plastic bowls, water, and soap near the latrine and kitchen, can both serve as good reminders to wash and make it easier to do so. SMS's can also be used to give daily reminders in some situations.

d) School children as change agents

After being taught about health topics in school, school children can be quite effective at increasing awareness and even changes practices and conditions in their homes. Teachers can give them such assignments as assessing health conditions (e.g. water quality, hand wash stations, latrines) and practices at home and encourage them to talk to their parents about making improvements.

5.4 Digital channels:

Technological advances have seen the rapid transformation of digital computers, the Internet and other forms of interactive media. Examples of these media would include cell phones, digital television and the internet-based forms (web portals, website, Twitter, Y-Tube and Facebook). Digital media have introduced new ways of communicating that diminish geographic distance, allow for a huge increase in the volume of communication, provide the possibility of increasing the speed of communication and provide opportunities for interactive communication. It also enables easy reach across security and other barriers. A good example is reaching the President of Zambia and other leading politicians through their Facebook sites.

The core strategic input for the Communication and Advocacy strategy should centre on interpersonal communication and group or community-level BCC activities. This in turn will be supported by mass media and community mobilization interventions.

The remaining sections of this strategy review communication objectives and considerations for each of the major health technical areas under MCDMCH responsibility.

5.5 Tools for implementing advocacy:

- a) Negotiation – This is direct negotiation normally between community advocates and government stakeholders to reach a common position.
- b) Lobbying – This refers to the efforts to influence the policy issues and processes by closely working and championing calls for change in policy or status quo among the policy makers and stakeholders
- c) Community Meetings – Usually as part of a lobbying strategy, meetings should be held to create a platform of information sharing and identification of areas that demand policy change or adjustment.
- d) IEC Tools – As alluded to earlier, IEC and advocacy may be difficult to separate, here we see IEC practices being applied in an advocacy strategy e.g. newsletters, drama, petitions and canvassing, radio, Television, information packs, posters etc.

Monitoring and evaluation – Like in all programmatic undertakings Advocacy needs constant feedback, monitoring, and evaluation to provide checks and balances. It is therefore important to put monitoring and evaluation check points in the advocacy plan. It is important to evaluate your activities to see if your advocacy objectives are being achieved. You need to keep monitoring your progress so that activities that are not working are revised or improved

6.0 Strategic Design

The strategic focus of the MCDMCH communication and advocacy strategy is to give communication a significant role in the implementation of the Ministry's programme activities. The thematic areas addressed in this strategy are as follows:

Adolescent Health

Family Planning

- o HIV and AIDS
- o STIs
- o Abortions

Maternal Health/Safe Motherhood

- o Maternal nutrition
- o Obstetric care and delivery
- o Cancer of the reproductive system

Ante Natal Care

- o Prevention of mother to child transmission of HIV
- o Hypertension in pregnancy
- o Diabetes mellitus in pregnancy
- o Malaria in pregnancy

Post Natal Care and New Born Care

- o Newborn Care
- o Abortion care
- o Obstetric fistula

Child Health

- o Breastfeeding
- o Immunization
- o Hygiene
- o Infant and young child nutrition
- o Integrated Management of Childhood Illnesses (IMCI)

Nutrition

Sexual and Gender-Based Violence

Persons with disabilities

6.1 Adolescent Health

Adolescents are persons between the ages of 10 and 19 years of age, which represent a significant demographic and socioeconomic force. Adolescence is a special stage in any person's life during which transformation from childhood into adulthood occurs. Adolescence is characterized by major biological, physical, psychological and behaviour changes. These changes if not properly managed can lead to significant exposure to health risks with long-term consequences to the individuals and their social contacts. Besides being exposed to many risks in Sexual and Reproductive Health (SRH), adolescents also begin to engage in other risky behaviours such as smoking and excessive alcohol consumption.

The main adolescent health problems in Zambia include the following:

1. Early, unprotected sex and sexual abuse
2. HIV, AIDS and STIs
3. Teenage pregnancies
4. Unsafe cultural practices
5. Poor nutrition
6. Drugs and alcohol abuse (substance abuse)
7. Accidents and violence
8. Mental health
9. Persons with disabilities.¹

Adolescents in Zambia account for over one quarter (27 %) of the Zambian population. According to the ZDHS 2007, 56 % of females and 51 % of males aged between 15 and 24 years reported that they had sex before the age of 18 years. The majority of youth practiced unsafe sex, with only 24 % of females and 22 % of males of this age group reported having used a condom at first sex. As a result, teenage pregnancy rates are high, with higher rates in rural areas (35 %) than in urban areas (20 %) (ZDHS,2007). It is estimated that 30 % of young women aged 15 to 19 years have either given birth or are currently pregnant. Between 2004 and 2007, about 36,000 girls dropped out of school due to pregnancies, a situation that puts young women at a disadvantage both educationally and economically. Among the adolescents 15-19 years of age, approximately 7 % of females and 4 % of males are HIV positive (ZDHS, 2007).

¹Adolescent Health Strategic Plan 2011 – 2015

Table 1: Adolescent Health

Target audience	<p>Primary Audience</p> <ul style="list-style-type: none"> • Adolescents aged 10 to 14 years • Adolescents aged 15 to 19 years <p>Secondary Audience</p> <ul style="list-style-type: none"> • Guardians, counsellors, teachers, health providers, traditional and religious leaders
Current behaviours	<ul style="list-style-type: none"> • Seeking unprofessional SRH services, e.g. getting information on reproductive health from peers and self-treatment. • Practicing risk behaviours such as: <ul style="list-style-type: none"> ○ Substance and drug abuse leading to drug dependence ○ Having unprotected sex leading to STIs and HIV infection, teenage pregnancies, and risk of unsafe abortion and school dropout.
Barriers	<ul style="list-style-type: none"> • Negative attitude of health workers • Inadequate or unavailable adolescents and youth friendly services at health facilities • Available information on reproductive health does not address adolescents needs • Strict societal/cultural norms • Lack of accessible information on sexual reproductive health and related services • 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 copying bad behaviours • Weak implementation of sanctions for alcohol abuse among the adolescents • Unavailability of income-generating and recreational activities, forcing adolescents to engage in risky activities
Facilitating factors	<ul style="list-style-type: none"> • Availability of adolescent and youth friendly services in some health facilities • Availability of policies supporting SRH Services for adolescents • Availability of trained psycho-social counsellors in health facilities
Behavioral objectives	<ul style="list-style-type: none"> • To increase the number of adolescents seeking and accessing SRHS • To reduce the % of adolescents involved in drug and substance abuse • To raise the average age of sexual initiation from a baseline to 16 years • To increase the number of guardians/parents who discuss SRH issues with adolescents
Communication Objectives	<ul style="list-style-type: none"> • To increase the % of adolescent who have adequate knowledge about SRHR services. • To increase the number of adolescents with knowledge on the benefits of delayed sexual debut • To increase the number of health workers with positive attitudes to adolescents' SRH needs.
Key messages	<ul style="list-style-type: none"> • Use adolescent and youth friendly services which are available at the nearest health facility • Protect yourself and partner from HIV-- use a condom every time you have sex • Talk to your partner about safe sex • Learn your HIV status • Go for safe Voluntary Male Circumcision (VMC) at nearest health facility • Choose and spend time with friends who do not practice risky behaviours • Find and spend your time in healthy interests such as physical activity, music, drama, reading or writing

Key communication tasks and ideas	<ul style="list-style-type: none"> • Raise awareness among adolescents of available services, including VMC, • Provide clear and accurate technical information on web sites, with links to popular adolescent sites • 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 • Arrange for health experts to go on radio programs to talk about RH/FP • Collaborate with the Ministry of Education to provide education and discussions on adolescent health issues.
Other essential actions (needed to facilitate the recommended practices)	<ul style="list-style-type: none"> • 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, friendly 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 sensitize 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 healthy RH practices for adolescents • Expand programs that address alcohol and substance abuse.

6.2 Maternal Health

Maternal Health Care

Maternal, Newborn and Child Health initiatives aim to ensure women's safe and healthy passage through the reproductive health process free of disability, complications and death, while also ensuring the health of newborns. As highlighted in the National Health Strategic Plan (NHSP 2011-2015), Maternal, Newborn and Child Health are key health priorities in Zambia.

The Zambian health system continues to improve and access to services has increased. Despite this progress however, Zambia has one of the highest maternal mortality ratios at 591/100,000 births (ZDHS 2007). The most common causes of maternal mortality include; haemorrhage, sepsis, abortion, eclampsia, and obstructed labour. This high mortality rate reflects a number of complex and interwoven factors; for example low contraceptive usage in Zambia, which has resulted in high fertility trends over the years, with a current average fertility rate per woman at 6.3.² Only about half of all pregnant women initiate antenatal care by 5.1 months of gestation,³ thereby reducing opportunities for early detection of danger signs and the adequate management of maternal complications. The GRZ has committed to reducing the maternal mortality ration by two thirds to 162/100,000 live births by 2015

²World Bank Development Indicators, 2009

³Zambia Demographic and Health Survey, 2007

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.

Family Planning

Family planning enables an individual or couple to have the number of children they want and can care for properly when they want them. Family planning is one of the most cost-effective ways to prevent maternal, infant, and child mortality. Family planning can reduce maternal mortality by reducing the number of pregnancies, the number of abortions, and the proportion of births at high risk. It offers a host of additional health, social, and economic benefits: it can help reduce infant mortality, slow the spread of HIV, promote gender equality, reduce poverty, accelerate social-economic development, and protect the environment.

Awareness of family planning among Zambians is high at 97 % in women and 99 % in men (2007 ZDHS). However, this knowledge has not always translated into the use of family planning services: the uptake of family planning methods in Zambia is relatively low compared to other African countries. The contraceptive prevalence rate is 41 % for all methods, while the unmet need for family planning is at 27 %.

Table 2: Maternal Health

Target audience	<p>Primary Audience</p> <ul style="list-style-type: none"> • Pregnant women age 15 to 49 <p>Secondary Audience</p> <ul style="list-style-type: none"> • Spouses and family members, health providers
Current behaviours	<ul style="list-style-type: none"> • Few women use modern FP methods. • Many women still use traditional FP methods. • Many families are not talking and planning when to have children thus are having unplanned pregnancies. • Many pregnant women delay accessing antenatal care (5.3 months). • Many do not attend all the four scheduled ANC visits. • Many women deliver at home with unskilled attendants. • Many girls under 18 become pregnant.

Barriers	<ul style="list-style-type: none"> • 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 family planning services • Inadequate knowledge on the importance of post-delivery care • Lack of knowledge on family planning options • Fear of partner/spousal disapproval • Myths, rumours, cultural beliefs and misinformation about modern family planning • Exaggerated fear of side effects of family planning methods • Difficulty to reach special groups due to fear of stigmatization • Negative cultural beliefs that discourage use of reproductive health services • Weak social support/involvement of families and local leaders (and a corresponding lack of willingness to allocate financial and emotional resources to maternal care - seeking)
Facilitating factors	<ul style="list-style-type: none"> • Increasing knowledge about modern FP methods • Availability of free services in health facilities and at community level
Behavioral objectives	<ul style="list-style-type: none"> • To increase the % of women who use a modern FP method i.e. Combined oral contraceptives, combined injectable and barrier methods such as IUD and condoms. • To increase the number of women and men (16 to 49 years) seeking and accessing correct information on modern FP methods • To increase number of pregnant women who access antenatal care in the first 3 months of pregnancy • To increase the % of mothers who attend antenatal care at least 4 times during their last pregnancy • To increase the % of expecting mothers who create a birth-plan. • To increase the % of pregnant mothers who have a facility delivery assisted by a skilled birth attendant. <p>To increase the % of mothers who go for post-delivery care.</p>
Communication objectives	<ul style="list-style-type: none"> • To increase awareness of men and women of childbearing age about FP methods. • To increase awareness of men and women of childbearing age about the benefits of practicing FP by men and women of childbearing age • To increase the % of mothers who have adequate knowledge on the importance post-delivery care • To increase the % of pregnant women who know the benefits of antenatal services to mothers and babies • To increase the % of pregnant women who know where to access antenatal care.
Key program recommendations	<ul style="list-style-type: none"> • Inform yourself about family planning and use it because of its many benefits, including allowing: (1) a couple to plan when to have a child and how many children to have; (2) mothers to regain their strength before the next pregnancy; (3) babies to breastfeed for at least two years before the next child; (4) the family to plan and use its available resources to meet its basic needs; (5) couple to not have to worry about unwanted pregnancies. • Go to a health facility to learn about the variety of safe and effective FP methods. • Enjoy the many health and financial benefits of eating a nutritious diet throughout childhood and teenage years, pursuing your education, and delaying pregnancy and childbirth until after 18 years of age. • Make at least four prenatal care visits to help ensure a safe and healthy pregnancy.

Key communication tasks and Ideas	<ul style="list-style-type: none"> • Build the capacity of providers to counsel more effectively on FP and during ANC; provide job aids to support this and reminder materials to facilitate adherence at home • Encourage health facility staff to hold more community discussions on MH issues and recommendations • Promote girls' health and nutrition, FP and ANC through print, electronic and interpersonal messages • Train of drama groups and service providers • Community mobilization • Promote male involvement in maternal issues
Other essential actions (needed to facilitate the recommended practices)	<ul style="list-style-type: none"> • Provide more FP services that are accessible to adolescents • Encourage health facility staff to make early postpartum home visits • Expand the Community Champions initiative

6.3 Ante Natal Care (ANC)

Every pregnancy carries a risk and 10% of pregnancies result into complications. It is important that danger signs related to obstetric emergencies are recognized promptly and treatment instituted as soon as possible. It is in this vein that women are encouraged to deliver at a health facility as opposed to deliver at home with traditional birth attendants, relatives or friends with no midwifery skills, who may not be able to respond appropriately to complications such as haemorrhage, obstructed labour, ruptured uterus, mal-presentation and stillbirth. In Zambia, 52% of all births occur at home, with rural areas recording much higher rates of home births than urban areas (66.5% as compared to 15.7%) (ZDHS 2007).

Antenatal care can reduce risks. At least 4 antenatal visits are recommended, with the first visit early in the pregnancy (during the first three months). Skilled health workers should accomplish the following: early detection of complications and prompt treatment, i.e. detection and treatment of sexually transmitted infections; prevention of diseases through immunization and micronutrient supplementation; birth preparedness and complication readiness; health promotion and disease prevention by providing health messages and counselling to pregnant women.

Zambia is among the southern African countries with a high percentage of ANC attendance. Most Zambian women rely on professionally trained providers for ANC. Previous studies show that on average 93.4 % of all pregnant women have received at least one ANC check-up. However, there are concerns that the average time for the first ANC visit in Zambia is 5.3 months of gestation (ZDHS 2007), which signifies missed opportunities for critical early ANC

interventions such as timely testing and treatment of couples with STIs and screening and/or treatment of women with anaemia. Poor ANC attendance contributes to small-for-date babies due to malaria and/or poor nutrition.

Hypertension in Pregnancy

The standard pattern of antenatal care developed in the 1920s was largely aimed at detection of pre-eclampsia. Hypertension during pregnancy (diastolic blood pressure of 90mm Hg or greater on two occasions more than 4 hours apart or a single diastolic blood pressure above 110mm Hg) occurs in women with pre-existing primary or secondary chronic hypertension, and in women who develop new-onset hypertension in the second half of pregnancy. Hypertensive disorders carry a risk for both the mother and baby, and it remains one of the leading causes of maternal death. Half of women with severe pre-eclampsia give birth prematurely to small-for-date babies. Symptoms of pre-eclampsia, arising from both chronic hypertension and gestational hypertension, include high blood pressure and protein in the urine and can lead to serious complications for both the mother and the baby if not treated quickly.

Diabetes Mellitus in Pregnancy

Gestational diabetes is a condition in which women without previously diagnosed diabetes exhibit high blood glucose levels during pregnancy (especially during third trimester). The following factors increase the risk of developing gestational diabetes during pregnancy:

- Being overweight prior to becoming pregnant
- Having sugar in your urine
- Having high blood sugar levels (but not high enough to be diabetic)
- Family history of diabetes
- Previously giving birth to a baby weighing over 3.5 kg
- Previously giving birth to a stillborn baby
- Having gestational diabetes with a previous pregnancy
- Having too much amniotic fluid

Gestational diabetes generally has few symptoms, and it is most commonly diagnosed through screening during pregnancy. Babies born to mothers with untreated gestational diabetes are at increased risk of problems such as being large for gestational age (which may lead to delivery complications), low blood sugar and jaundice. If untreated, it can also cause seizures or stillbirths. Early detection and treatment of diabetes during ANC can reduce these risks.

Prevention of Mother to Child Transmission of HIV

In Zambia, mother-to-child transmission of HIV is reported to account for about 10 per cent of all new infections (ZDHS 2007). Prevention of Mother to Child Transmission of HIV (PMTCT) is a component of ANC. PMTCT can help families have healthier children when they desire them, prevent illnesses in the baby through arresting mother-to-child transmission of HIV and other sexually transmitted Infections (STI). Every expectant mother should have access to STI screening and treatment, including information and guidance on the prevention of mother-to-child transmission of HIV and other STIs. Providers should encourage couples considering having a baby to seek voluntary counselling and testing. Pregnant women should be supported to access ARVs and STI treatment. Providers should also promote male involvement and participation in PMTCT.

Although PMTCT services are readily available country wide, uptake of ART by HIV positive pregnant women is still not high enough. In 2007, 98.9% of pregnant women were counselled and tested, but only 47% delivered at health facilities implying that 53% delivered elsewhere and did not access PMTCT services.

Malaria in pregnancy

Despite much effort to control malaria and many achievements, malaria remains the leading cause of morbidity and mortality in Zambia (National Health Strategic Plan 2011-2015,). In 2009, 3.2 million cases of malaria (confirmed and unconfirmed) were reported countrywide, with about 4,000 deaths. Malaria accounts for over 40 % of all health facility visitations in Zambia, and the disease poses a severe social and economic burden on communities living in endemic areas.

All members of the community should be protected against mosquito bites, particularly young children and pregnant women. Malaria is very dangerous in pregnant women, especially during the third trimester. This is due to changes in a woman's body that lowers resistance to malaria and could result in severe anaemia, miscarriage or even premature birth.

Babies born to mothers who have had malaria during pregnancy are often underweight, which could make them more vulnerable to infections that may lead to death during their first year. To prevent malaria in pregnancy and the resultant effects, pregnant women in Zambia are put on anti-malarial treatment during ANC visits and are advised to sleep under insecticide treated mosquito nets.

Table 3: Ante-Natal Care

Target audience	<p>Primary Audience</p> <ul style="list-style-type: none"> • Pregnant women age 15 to 49 <p>Secondary Audience</p> <ul style="list-style-type: none"> • Spouses and family members, health providers
Current behaviours	<ul style="list-style-type: none"> • Pregnant women delay in accessing ANC (5.3 months of pregnancy). • Many pregnant women attend fewer than four ANC visits. • Some do not collect HIV test results and do not access ART services. • Many pregnant women take fewer than 3 doses of malaria prevention medicine for Intermittent Presumptive Treatment (IPTp). • Many pregnant women take fewer than the recommended doses of ferrous sulphate and folic acid. • Many pregnant women give birth at home with unskilled attendants.
Barriers	<ul style="list-style-type: none"> • Limited appreciation of immediate and long-term benefit of PMTCT services • Stigma and discrimination surrounding HIV positive pregnant women • Cultural norms and negative attitudes arising mainly from the influence of family and community members • 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 • Lack of knowledge on how to recognize true signs of labour • Distance to health facility • Poor attitude of health workers • Lack of mothers' shelters • Myths, rumors and misconceptions about hypertension • Stigma around HIV, fear of partners' reactions
Facilitating factors	<ul style="list-style-type: none"> • Availability of structures in the in the country where PMTCT can be provided • Presence of peer educators and psychosocial counsellors who can orient men on PMTCT • Care and support for discordant and concordant positive couples available in the GRZ health facilities • Trained health care providers who offer PMTCT services • Availability of ANC and family planning services providers in health facilities and at the community level
Behavioural objectives	<ul style="list-style-type: none"> • To increase the % of women aged 15 to 49 initiating ANC within the first 3 months of their pregnancy • To increase the % of pregnant women who complete at least 4 ANC visits in their last pregnancy. • To increase the % of women who have created a birth plan (no baseline measured in DHS; will be measured by CSH baseline) • To increase % of local leaders who advocate for establishment of more centres which provide services for PMTCT services in their communities

Communication objectives	<ul style="list-style-type: none"> • To increase the levels among of pregnant women aged 15 to 39 and their partners of knowledge about the risk of HIV infection to babies during pregnancy, delivery and breastfeeding. • To increase knowledge of pregnant women and their partners about the benefits of HIV counselling and testing during pregnancy. • To increase knowledge levels in women about the benefits of ANC services • To increase % of pregnant women who know the true signs of labour • To increase the % of pregnant women who know the importance of having birth plan
Key program recommendations	<ul style="list-style-type: none"> • Talk with your husband/partner about your pregnancy and going for ANC . • Create a Birth Preparedness Plan with your husband/partner . • Start ANC visits early so you know how baby is growing, to receive various free services, and to learn your due date. • 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.
Key communication tasks and ideas	<ul style="list-style-type: none"> • Advocate to policy makers for increased number of centres providing PMTCT 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, mothers and their babies/children • Promote birth preparedness among couples • Promote family, friends and community involvement in ensuring that expectant mothers are taken to nearest health facility for delivery. • Arrange for health experts to go on radio programs to talk about recommendations for pregnancy and childbirth • Provide reminder materials or SMS messages to pregnant mothers 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.
Other essential actions (needed to facilitate the recommended practices)	<ul style="list-style-type: none"> • Ensure establishment of SMAGs in communities where they do not exist and ensure their functionality • Increased and improved ANC services, including capacity-building and supportive supervision of providers, job aids for providers • Expand the Community Champions initiative

6.4 Postnatal and New born Care

The postnatal period, defined as the first six weeks after birth, is critical to the health and survival of the mother and her new born. The most vulnerable time for both is during the first hours and days after birth. Lack of care during this period may result in death and is often a missed opportunity to provide the mother with important information on how to care for herself and her child. It is recommended that all women and babies receive check-ups of their health at six hours, two days six days, at six weeks.

According to ZDHS 2007, 51 % of the women did not receive any postnatal care; 39 % received a postnatal check-up within two days of delivery. Young mothers who gave birth to their first child are more likely to go for postnatal care within the first two days after giving birth than older mothers.

The peri-natal mortality rate for Zambia is 38 deaths per 1,000 pregnancies (ZDHS, 2007). It tends to decrease with increasing length of birth intervals and is higher among children of mothers younger than age 20 years.

New born Care

Immediate new-born care

Immediately after birth the baby must be kept dry and warm. The baby should not be bathed immediately, and breastfeeding should be initiated within the first hour of birth. Avoid sepsis by keeping the umbilicus dry and clean. All new-borns need: **air** (stimulates or resuscitates infants who do not breathe immediately at birth), Do not perform suctioning of the mouth and nose in new-borns that start breathing on their own after birth. Ensure a set of measures to keep the new-born warm. This is also called a warm chain and it involves: training of health workers; warm delivery room; immediate drying and skin-to-skin contact after birth; breastfeeding; postpone bathing and weighing for at least 6 hours after birth; keep mother and new-born together; warm resuscitation and transportation if needed; appropriate clothes for the new-born.

The infant's clothes should be dry and clean. Change nappies whenever they are wet. The infant should not be tightly swaddled, because this may result in breathing disorders, feeding problems and quick cooling.

Umbilical Cord care

Clamp and cut the cord within 1-3 minutes after birth. Keep cord clean. The cord stump is the major means of entry for infections after birth. The most effective principles of cord stump care that apply at home as well as in the health facility are: keep it dry, do not apply anything on it. The stump will dry and mummify in the air without any dressing, binding or bandages. It will remain clean if it is protected with clean and dry clothes, and is kept away from urine and soiling. If soiled, the cord should be washed with clean water and dried with clean cotton or gauze. No antiseptics are needed for routine care. If the umbilical stump becomes infected, it will be red or will drain pus.

Early initiation and exclusive breastfeeding

Initiate breastfeeding within the first hour for all new-borns, including low birth weight babies. Babies who are able to breastfeed should be put to the breast as soon as possible after birth, when they are clinically stable and the mother and baby are ready. Babies, who are unable to breastfeed soon after birth, should be fed breast milk by cup or nasogastric tube, as appropriate.

Danger signs in the new-born

The new-born should be treated or referred for further evaluation if any of the following signs are present regardless of whether the new-born is in the health facility, or the mother and new-born are at home:

- Stops feeding well or not sucking well;
- Crying excessively/irritable;
- History of convulsions;
- Fast breathing (more than 60 breaths per minute);
- Severe chest in-drawing;
- Temperature $>37.5^{\circ}\text{C}$ or $<35.5^{\circ}\text{C}$;
- No spontaneous movement/lethargy;
- Bulging or depressed fontanel

Abortion Care

Unsafe abortion is the termination of an unwanted pregnancy by persons lacking the necessary skills or in an environment lacking minimal medical standards or both. Self-induced abortions can be an extremely dangerous, life-threatening procedure. An abortion performed by a medical practitioner who does not provide appropriate post-abortion attention is also considered to be unsafe.

Unsafe abortion in Zambia is among the top 5 causes of maternal death and accounts for 30% of national maternal mortality. According to ZDHS, 2007 unsafe abortion in Zambia is related to the low modern contraceptive prevalence rate of 32.7% and the high (27%) unmet need for family planning methods. Thus, many women of reproductive age group are unable to access family planning, which contributes to a high fertility rate of 6.2 % and the high maternal mortality rate. Women of childbearing age have a reproductive health right to contraception, which would allow them to avoid unwanted pregnancies.

Obstetric Fistula

This is an opening that develops between the bladder and vagina or between the bladder and the rectum following obstructed labour that is allowed to proceed without adequate medical intervention (Caesarean section). Over the course of three to five days of labour, the unborn child presses against the mother's vagina very tightly, cutting off blood flow to the surrounding tissues between the vagina and rectum and between the vagina and bladder, causing the tissues to disintegrate or rot away. Obstetric fistula has far-reaching physical, social, economic and psychological consequences.

Obstetric fistula can also be caused by poorly performed abortions, pelvic fractures; cancer or radiation therapy targeted at the pelvic area, or infected episiotomies after childbirth. Other potential causes are sexual abuse and rape or other trauma.

In sub Saharan Africa, many girls enter into arranged marriages (usually between the ages of 9 and 15). Early marriages lead to early childbirth, which increases the risk of obstructed labour, since young mothers who are poor and undernourished may have underdeveloped pelvises.

Fistula is considered a condition of poverty because of its tendency to occur in women in poor countries who do not have adequate health resources during childbirth. Symptoms of obstetric fistula include urinary and faecal incontinence, foul smelling vaginal discharge, repeated vaginal and urinary infections, irritation and pain in the vagina or surrounding area, and pain during sexual activity. Other effects include stillborn babies due to prolonged labour, which happens of the time; severe ulceration of the vaginal tract; foot drop (paralysis of the lower limbs caused by nerve damage making it impossible for women to walk); and infection of the fistula forming an abscess. Most of the women stop having their periods.

Prevention comes in form of access to obstetrical care, support from trained health care professionals throughout pregnancy and after delivery, providing access to family planning, promoting the practice of spacing between births, and supporting women to continue their education and postpone early marriages. Other strategies include organizing community awareness campaigns to educate women about prevention methods such as good hygiene and

care during pregnancy and labour. Education on prevention of prolonged labour which can lead to fistula should begin as early as possible in each woman's life.

It is also important to ensure access to timely and safe delivery during childbirth, including emergency obstetric care as well as quick and safe Caesarean section for women in labour.

Table 4: Postnatal and New born Care

Target audience	<ul style="list-style-type: none"> • Postnatal mothers • Women in the 15–49 age group, health providers
Current behaviours	<ul style="list-style-type: none"> • Only a minority of women go for recommended postnatal care. • Many women seek traditional services for termination of pregnancy. • Only some of the women wanting to use family planning services do use them.
Barriers	<ul style="list-style-type: none"> • Inadequate knowledge on the benefits of post natal care services • Inadequate knowledge on the how to recognise obstructed labour • Cultural beliefs, e.g. not exposing new born babies to the public • Negative attitude of health workers towards postnatal mothers • Long distance and/or difficult travel to health facilities • Shortage of skilled health workers • Health providers not emphasizing the importance of postnatal care • Inadequate information about postnatal care services • Lack of mothers' shelters at or near health facilities • Current policy on abortion requiring three medical doctors to endorse an abortion • Many women feel shy to seek abortion services • Non-availability of comprehensive sexual reproductive health services in most health facilities
Facilitating factors	<ul style="list-style-type: none"> • Availability of free FP services at all government health facilities • Availability of guideline for postnatal services • Presence SMAGs in the communities
Behavioural objectives	<ul style="list-style-type: none"> • To increase number of pregnant women who deliver at health facilities assisted by a skilled birth attendant. • To increase the number of women accessing postnatal care (at 6 days, 6 weeks and 6 months). • To increase the number of women accessing safe abortion care at health facilities
Communication objectives	<ul style="list-style-type: none"> • To increase the number of women who know the importance of attending postnatal care at 6 hours, 6 days and 6 weeks • To increase awareness among pregnant women on the importance of health centre delivery assisted by skilled birth attendant. • To increase knowledge levels among health care providers on the signs of obstructed labour
Key program recommendations	<ul style="list-style-type: none"> • Share your concerns and talk with your health care provider about your health and well-being • Eat a well-balanced, nutritious diet rich in proteins after delivery • Sleep under an ITN after delivery to protect yourself and your new born against malaria • Ensure a hygienic environment for mother and baby • Use modern FP methods to prevent an unwanted pregnancy • Go to the health facility for safe abortion care • Access sexual and reproductive health services at your nearest health facility • Initiate breastfeeding within the first hour after delivery • Before delivery, talk with your husband about going for postnatal care at the nearest health facility

Key communication tasks and ideas	<ul style="list-style-type: none"> • Advocate for increased and improved postnatal services • Advocate for increased and accessible FP services as close to the family as possible • Promote attendance to postnatal clinics among mothers • Promote sleeping under ITNs by mothers and their babies • Promote family, friends and community involvement in ensuring that all women who have given birth go to nearest health facility for postnatal care • Create awareness on the country's abortion policy • Promote usage of existing FP methods among the rural semi illiterate and young women • Promote usage of FP methods among sexually active adolescents • 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	<ul style="list-style-type: none"> • Encourage community leaders and groups to organize emergency transportation • Establish SMAGs in communities where they do not exist and ensure they are functional

6.5 Child Health

In Zambia the causes of under-five morbidity and mortality are a list of preventable diseases which include: pneumonia, malaria, diarrhoea, measles, anaemia and malnutrition. In recent years HIV has become a significant cause of deaths in children under the age of five years. While the neonatal mortality rate has remained stagnated at around 40 deaths per 1000 live births over the past two decades, there is need for concerted efforts to address this situation. At least 50% of the deaths in the first one year of life occur in the first month of life, many of them at home and without access to essential health services and basic commodities that could save their lives. In up to half of under-five deaths an underlying cause is under-nutrition. Unsafe water, poor sanitation and inadequate hygiene also contribute to childhood diseases and deaths.

Deaths occurring in children under the age of five years is known to be the result of a wide variety of factors such as the nutritional status and the health knowledge of mothers; the level of immunization and oral rehydration therapy; the availability of maternal and child health services (including prenatal care); income and food availability in the family; the availability of safe drinking water and basic sanitation; and the overall safety of the child's environment, among other factors.

The survival of children through their early years depends on the adults who care for them. Children need to eat well in order to grow, be healthy and strong. They need protection from illness and injury as they explore the world around them. When they are sick, they need good medical care. Adults must meet many needs of a growing child.

Children also need adults who give them love, affection, and appreciation. They need adults who spend time playing and communicating with them. Adults help children from birth to learn the skills that will make it possible for them, too, to become competent, happy, and caring adults. Families should be counselled to breastfeed young children and give their children nutritious complementary foods; Play and communicate with their children to help them learn, and to strengthen their relationship with their children; Prevent childhood illnesses and injury; Recognize signs of illness and take their sick children to a health facility for care. It should also be noted that at community level, Community health workers support the efforts of families and other caregivers as they raise their children⁴.

⁴IMCI – Caring for child's healthy growth and development 2012

Integrated Management of Childhood Illnesses (IMCI)

Integrated Management of Childhood Illnesses (IMCI) is an approach that integrates technical guidelines for management of specific diseases of sick children under the age of 5 years. It is a step by step process that allows health workers to manage the sick child not just for one problem presented to them by caretaker, but for those illnesses that are most likely to cause death in children. It contributes to the reduction of under-five morbidity and mortality due to common causes of childhood illness like Pneumonia, diarrhoea, malaria, measles, malnutrition and HIV/AIDs. It is important to adopt positive and sustainable health seeking behaviours by individuals and communities that promote a rapid response for the treatment of major childhood diseases and improve child survival. The communication objective is to increase awareness on the signs of childhood illnesses which indicate a need for URGENT treatment. The signs of childhood illnesses which indicate a need for URGENT treatment in a sick child include the following general danger signs: Not able to drink or breastfeed, vomiting everything, has history convulsions in the present illness or convulsions now and is lethargic or unconscious, this child should be taken immediately to the clinic. In the sick young infant (age up to 2months) the signs that suggest severe illness that need URGENT treatment include the any of the following: Not feeding well or Convulsions or Fast breathing (60 breaths per minute or more) or Severe chest indrawing or Fever (37.5°C* or above) or Low body temperature (less than 35.5°C*) or Movement only when stimulated or no movement at all.

Any sick child on initial treatment regardless of follow up or review date, should be taken back immediately to the clinic if he/she become sicker, not able to drink or breastfeed, develop fever if he/she had no fever, if he/she start breathing fast or develop difficulty in breathing if he/she had cough or cold and if he/she develop blood in stool and start drinking poorly if he/she have diarrhoea. Any sick child should be given more fluid and more food or breast milk than usual. A child should be taken to the clinic if he/she has fever, measles rash, respiratory infection (cough or difficulty breathing), diarrhoea, ear problems or swelling of both feet or losing weight or failing to gain weight in one month

Immunizations

Zambia adopted the goal of Universal Childhood Immunization (UCI), meaning that all children aged from zero to five years should receive among others, BCG, measles, OPV and DPT-HepB-Hib (pentavalent) vaccines according to or near the schedule. The priority is for all children to

receive all doses before their second birthday. All children who drop out according to the schedule should be identified and followed up. To achieve this goal, Zambia has introduced the Reaching Every District (RED) strategy approach. Pneumococcal vaccine and rotavirus vaccines have recently been introduced, meaning that high vaccination coverage now has the potential of preventing severe forms of pneumonias (PCV) and diarrhoea caused by Rota virus (Rotavirus vaccines) among young children in Zambia.

Vaccination services should be integrated with other aspects of growth promotion e.g. health education and counselling, micronutrient supplementation, family planning, early antenatal attendance and breastfeeding. The national target for child immunizations is to have at least 90% of the districts attaining 80% coverage of DPT3. The proportion of districts attaining coverage above 80% for DPT3 declined from 79% in 2011 and 73% in 2012 (HMIS).

Every child should receive one dose of BCG, four doses of oral polio vaccine (OPV), three doses of DPT-HepB-Hib, three dose of Pneumococcal Conjugate Vaccine (PCV), two doses of Rotavirus vaccine and two doses of measles by the age of 18 months. If a child is seen at a health facility before 13 days old, OPV-0 should be given at the same time as BCG. OPV-0 should not be given after 13 days. If OPV-0 is missed, OPV-4 should be given at the same time as the measles vaccine. Missed doses should be given at the next contact. The minimum interval between doses of the same antigen is four weeks.

All children enrolling for Grade 1 should present their children's clinic cards to the school administration/health authority to have their immunization status checked and be immunized if missing any immunizations, to maximize protection of school-age children. It is recommended that both boys and girls receive one TT dose upon enrolment. Additional TT doses will be given to school girls of childbearing age. A dose of BCG should be given if there is no scar.

During pregnancy, women should receive at least two doses of tetanus toxoid to protect their unborn child against neonatal tetanus and five doses during their reproductive health life. National immunization objectives include attaining 60% coverage of TT2 among pregnant women, and improving the quality of immunization services, especially in terms of injection safety.

Hygiene

Young children are more vulnerable than other age group to the ill effects of unsafe water, poor sanitation and lack of hygiene. These contribute significantly to deaths due to diarrhoeal diseases. Children under 5 years old account for nearly 90 per cent of deaths from diarrhoea.

The simple habit of hand washing with soap can reduce the incidence of diarrhoea by nearly half. It also greatly reduces the risk of respiratory infections such as pneumonia and other diseases, including eye infections, especially trachoma.

It is important for parents and caregivers to always ensure that they wash their hands:

1. After cleaning the infant or young child who has defecated.
2. After helping the child use the toilet or latrine.
3. After going to the latrine or toilet themselves.
4. Before touching food and feeding young children and
5. After dealing with refuse.

Parents and caregivers need to help their children develop the habit of washing their hands with soap or ash before eating and after using the latrine or toilet.

There is emerging evidence that a phenomenon called environmental enteropathy is a major cause of stunting. This occurs when a baby or toddler sits or plays in dirt where chickens or other animals have defecated. E. coli and other micro-organisms from animal faeces are in the dirt and enter the children when they eat the dirt directly or put their dirty hand in their mouths. The micro-organisms then harm the lining of the child's stomach so that s/he cannot absorb the nutrient in food normally, contributing to malnutrition. Keeping young children and animals separated has thus become an important practice to promote, either by creating protected play areas or by keeping animals penned so they don't defecate where children play.

⁵UNICEF, et al. Facts for Life, 4th Edition

Table 5: Child Health

Target audience	<ul style="list-style-type: none"> • Mothers and caretakers of children under two years of age • Fathers of children under five
Current behaviours	<ul style="list-style-type: none"> • Not washing hands after using the toilet, after changing the baby and before touching food preparation. • Not using toilets and indiscriminately disposing used dippers • Not boiling or chlorinated drinking water • Not covering food and heating left over food before feeding children
Barriers	<ul style="list-style-type: none"> • No running water for hand water for hand washing near the toilet • No soap • Belief that baby faeces are harmless • Inadequate information on the importance and benefits of hand washing
Facilitating factors	<ul style="list-style-type: none"> • Availability of ash in the communities • Desire to have health children with less episodes of diarrhoea. • Availability of free Chlorine at the health centre. • Chlorine is affordable in the retail shops in the community • Availability of health centre staff and community volunteers counselling the community members on safe water and sanitation
Behavioural objectives	<ul style="list-style-type: none"> • To increase percentage of children <2 fully immunized (BCG, measles, OPV3, DPT3, Rotavirus, PCV) to 90% • To increase percentage of children <1 completely immunized (BCG, measles, OPV3, DPT3) to 90% • To increase the proportion of mothers who exclusively breastfeed up to six months • To increase the proportion of pregnant women receiving TT2 to 60% • To increase the proportion of children under 5 years of age who take them for growth monitoring every two months to 90%.
Communication objectives	<ul style="list-style-type: none"> • To increase the knowledge of mothers and caregivers of children under 5 years about neonatal tetanus. • To increase the knowledge of mothers and caregivers of children under 5 years of importance of being vaccinated during pregnancy • To increase the knowledge of mothers and caregivers of children under 5 years of the benefits of child immunizations • To increase the knowledge of mothers of children under 5 years on the benefits of exclusive breastfeeding. • To enhance mothers' positive attitudes towards completing their children's immunizations before the first birthday • To increase knowledge of fathers of children under 5 years who know the importance of complete immunization for children before first birthday
Key program recommendations	<ul style="list-style-type: none"> • Advocate for the sinking of boreholes in the community • Advocate for the construction of pit latrines for every family • Advocate for placement of hand washing stands and soap near the pit latrine • Advocate for use of pit latrines • Advocate for construction or provision of safe play spaces for children • Advocate for penning of animals to keep them away from play spaces for children
Key communication tasks and ideas	<ul style="list-style-type: none"> • Have CHWs, SMAGs, TBAs, etc. hold community meeting to discuss safe water and diarrhoeal diseases • Use radio programmes to reach community with information on diarrhoea and the importance of sanitation and good hygiene • Hold meetings with chiefs and indunas(traditional elders) to encourage community member to pen their animals and create safe play spaces for children
Other essential actions (needed to facilitate the recommended practices)	<ul style="list-style-type: none"> • Encourage community leaders and groups to water and sanitation days • Establish water and sanitation committees in the community

6.6 Nutrition

Food and nutrition security is widely recognized as a human right and a critical ingredient for economic, social and human development. In Zambia, ensuring adequate nutrition, especially among mothers and children, low income groups, and other vulnerable populations, is a serious challenge. Currently, 40% of the children under-five years of age are chronically under-nourished (short for age: stunted). This represents about 1.2 million children, while an additional 5% are wasted. Close to 52,000 babies are born with low birth weight, which is often related to maternal under-nutrition. Every year almost half (42%) of the deaths of Zambian children are as a result of under-nutrition being the underlying cause. Children who survive under-nutrition carry lifelong limitations in their intellectual and physical development and health.

It is important to note that under-nutrition results from both poor food intake as well as from a variety of infections and other processes that either reduce a person's ability to properly digest and utilize food consumed or that actually *rob* a person of food consumed. These latter factors include intestinal parasites; illnesses such as diarrhea; measles, pneumonia, malaria, and other infections. micro-organisms ingested from the soil (a phenomenon known as environmental enteropathy) account for reduced nutrients.

Poverty and inequality sit at the heart of hunger. The poor often cannot afford to grow or buy food, and the resources needed to get access to food are inequitably distributed. In addition, beliefs and perceptions sometimes lead to poor practices, which negatively impact nutrition.

The Millennium Development Goals (MDGs) – particularly MDG 1 (eradicate extreme poverty and hunger), MDG 4 (reduce child mortality) and MDG 5 (improve maternal health) – will not be reached unless the nutrition of vulnerable groups such as women and children is given high priority at global, regional, and national levels through development programmes and strategies that are developed to address these goals.

Stunting if not addressed among children aged less than 24 months of age will negatively and permanently affect the health, learning and potential productivity of individuals and ultimately the nation. The impact of stunting is such that it has negative implications across the full life cycle. Stunting prevalence among children under five years of age in Zambia is high at 40% and need to be reduced further. The problem of stunting has been seen to rapidly increase among Zambian children after six months of age in the absence of good quality nutritious food. The moderate and severe stunting rates for children aged 6-18 months increase dramatically and then reaches a peak between 18–23 months. Stunting declines slightly for children 24-59 months, but much damage will have been done in terms of physical and cognitive development.

The prevalence of underweight among children under five years of age in Zambia decreased from 25% in 1992 to 15% in 2007. The prevalence is slightly higher among children in rural areas (15.3%) than those in urban areas (12.8%). In Zambia about 5% of children under five are wasted, and the prevalence peaks among children aged 9-11 months (12%).

In Zambia, malnutrition is a major factor that contributes to ill-health of people, especially in children during their first two critical years (i.e. the first 730 days after child's birth)⁶. The period from birth to 24 months is a critical development stage of the child. If the baby is not fed adequately during this period, its growth and health easily gets compromised. The baby usually becomes stunted and has ill-health. This is common among babies born from mothers with little knowledge about nutrition or insufficient access to food Young and inexperienced mothers.

Various other factors besides young children's food consumption contribute to stunting. Two of the most important ones are infections, including worms, and harm to children's stomachs from ingesting micro-organisms found in animal faeces. Thus safe play areas, hand washing with soap, and other hygiene practices can directly and indirectly affect stunting, which is chronic malnutrition that results in reduced size and intelligence.

According to the 2007 Zambia Demographic Health Survey, 45% of children under 5 are stunted or too short for their age. Stunting in Zambia is more common in rural areas (48% vs. 39% in urban areas). Stunting is least common among children of more educated mothers and those from wealthier families. Wasting (too thin for height), which is also a sign of acute malnutrition, is far less common (5%). Fifteen percent of Zambian children are under-weight, or too thin for their age.

Breastfeeding

Breast milk is normally a baby's first food. Breast milk is the perfect and complete food for young babies. It has all necessary vitamins and minerals. Babies who are breastfed are generally healthier and achieve optimal growth and development compared to those who are fed formula milk. However, in situations where the mother is not available to breastfeed, infant formula is usually recommended and can provide adequate nutrition, although it increases the risk of diarrhoea and other infections. Breastfeeding is very common in Zambia, with 98% of children ever breastfed.

Most mothers in Zambia are advised to breastfeed their babies exclusively (no other liquids or solids, not even water) in their first six months of life. Almost two-thirds (61%) of children under

⁶National Food and Nutrition Commission, 1000 Critical Days Brochure

⁷2007 ZDHS Page 160

six months of age are being exclusively breastfed. This has contributed to greatly improve children's health and development. Breast milk provides the energy and nutrients that babies need to be healthy.

Delaying the introduction of complementary foods until a child reaches six months reduces the risk of malnutrition. The chart (Appendix I) provides the recommended feeding of young children by Ministry of Health in Zambia⁸. Sufficient water is also essential for health and development. Breast milk provides nutrients sufficient for the first six months. When separate water is introduced to a baby at six months, it is important to ensure that it is safe through boiling or filtering it.

In terms of maternal nutrition, data from 2007 ZDHS show that 71% of women have a normal BMI, 10% are undernourished or thin. Young women, (age 15-19) are more likely to be undernourished than women in older age groups. During the period 1992-2007 the prevalence of underweight women (BMI less than 8.5) decreased from 15% to 10%. Low BMI in women is related to low birth weight of children, which correlates with stunting of the same children..

The most nutritionally vulnerable women are those with the additional nutritional stress of pregnancy and lactation. Too often women do not see the need for, or cannot afford, additional and high quality diets and micronutrient supplements during these periods. Few women are encouraged to consume various foods by their spouses and other influential family members due to various factors including food insecurity resulting in poor nutritional status that threatens not only the health and a safe birth for the woman but also for the baby.

Micronutrient deficiencies are highly prevalent in Zambia, mostly affecting infants and young children aged 6-24 months and pregnant and lactating women due to the increased need for these nutrients at these times. Micronutrient deficiencies also affect adolescent girls. . Well known deficiencies in infants and young children include vitamin A, iron, and zinc. The prevalence of vitamin A deficiency in children was 65.7% (1997) and 53% in 2003. For women in child-bearing age, vitamin A deficiencies was 21.5% in 1997 and 13.4 % in 2003. Iron deficiency anemia remains a major public health concern affecting 53% among under-five children and 22.5% among pregnant women (NFNC 2003). While significant progress has been reported in reducing the prevalence of iodine through iodation programs and vitamin A deficiencies through vitamin A fortification of sugar and bi-annual mass supplementation with vitamin A capsules, there has been limited success in reducing the burden of iron deficiency anemia and other micronutrient deficiencies. There is need for reliable data to evaluate the effectiveness of these interventions at national and household levels.

MOH, Integrated Technical Guidelines for Frontline Health Workers, June 2009, page 56

Nutrition and HIV and AIDS in Children

HIV affects the nutritional status and health of children just as it does to adults. Children living with HIV usually:

- Have stunted growth and fail to thrive
- Experience more frequently the common childhood infections such as diarrhoea, ear infections, pneumonia, fever, chronic gastroenteritis and tuberculosis (TB)
- Have a poor appetite
- Fail to suckle properly
- Have difficulties in swallowing
- Experience nausea

All the infections mentioned above, in addition to poor appetite, failure to suckle properly, having difficulty in swallowing and experiencing nausea, affect nutrient intake and increase risk of malnutrition in HIV-positive children. Appropriate nutrition care should therefore be part of HIV-positive children's comprehensive care and support, including:

- Regular assessment of all children of mothers with HIV and AIDS for feeding problems and signs of malnutrition
- Support for all HIV-infected children to consume adequate energy and nutrients.

HIV infected children require increased energy-giving foods, protein and micronutrients

Table 6: Nutrition

Target audience	<p>Primary Audience</p> <ul style="list-style-type: none"> • Mothers of children <2 years old • Pregnant and lactating women <p>Secondary Audience</p> <ul style="list-style-type: none"> • Fathers, grandmothers and family members
Current behaviours	<ul style="list-style-type: none"> • Majority of mothers breastfeed babies <6 months old exclusively or fully, but some begin to supplement with water &/or food, before 6 months, • Mothers tend to give many short breastfeeds rather than emptying both breasts each time as recommended • Complementary feeding practices vary; common problems include feeding insufficient quantity, variety, and animal-source foods; feeding watery (not calorie-dense) cereal and soup; and poor food hygiene. • Pregnant women tend not to eat enough, due mainly to nausea, food cravings, and fear of having a big baby/difficult delivery. • Lactating mothers tend not to eat and drink enough, mainly due to limited availability and low awareness of recommendations.

Barriers	<ul style="list-style-type: none"> • Various beliefs and perceptions affect breastfeeding practices: that babies on breast milk also need water; that a crying baby means not satisfied with breast milk only • Lack of understanding of need for longer breastfeeds for more nutrition and more milk production • Some mothers must return to work outside the home soon after giving birth. • Mothers have a very strong desire to do what they perceive baby is “asking” for, but they commonly misinterpret the baby. • Many fathers show little interest in young child feeding and feel it is the mothers’ responsibility. • Limited variety of food available, especially for poor families and in certain seasons. • Most mothers have partial, incomplete understanding and knowledge of main recommendations for complementary feeding. • Mothers are very busy, so grandmothers and older children sometimes have feeding and caring responsibilities. • Fear of eating too much will lead to a big baby/difficult delivery. • Lack of appreciation of maternal nutrition needs among fathers and other families members.
Facilitating factors	<ul style="list-style-type: none"> • Mothers have some level of understanding of young child feeding recommendations. • Many NGO and government efforts to improve IYCF. • Improving rates of ANC attendance provide opportunities for counselling. • NHCs, CHWs, SMAGs provide opportunities for education, counselling, demonstrations. • Presence of other community structures to use as channels of service delivery
Behavioural objectives	<ul style="list-style-type: none"> • To increase % of infants < 6 months EBF until 6 months. • To increase prevalence of women emptying both breasts each time rather than using the breast as a pacifier in short feeds. • To increase the % of families feeding babies <6 months with recommended breastfeeding, food variety, animal-source foods, serving size, number of meals and snacks, calorie density. • To increase % of pregnant and lactating women eating 3 or more meals or snacks with a variety of foods and more healthy and safe drink (diverse diet).
Communication Objectives	<ul style="list-style-type: none"> • To increase the % of mothers with improved correct understanding of IYCF and maternal nutrition recommendations • To increase the % of fathers and other families members with improved correct understanding of IYCF and maternal nutrition recommendations • To increase mothers’ awareness of unused but available healthy foods • To increase mothers’ knowledge of healthy combinations of available foods • To increase mothers’ awareness of strategies to grow and preserve foods for babies and themselves.
Key program recommendations	<p><i>First 3 days after birth:</i></p> <ul style="list-style-type: none"> • Let the baby begin sucking on the breasts in the first 30 minutes after birth to enable Baby take in the first the thick, yellow milk called colostrum which is rich in nutrients. • Give breast milk only (and later the thinner white milk). • Give no other food or drink to the baby. • No need to wait for the breasts to be washed with herbs before breastfeeding can commence

Key program recommendations

<6 months:

- Give breast milk only: give no other food or drink to the baby.
- Give 10 or more breastfeeds each day, including some at night, during the first three months.
- Give 8 or more breastfeeds each day, including some at night, during months 3, 4, and 5.
- Each time, put the baby on both breasts until they are empty.
- Position the baby so it can feed well: hold the baby close to you and support her/his whole body with your hand; the baby should face the breast directly without needing to turn his/her head to the side.
- The baby should have his/her mouth wide open and have most of the dark area of the mother's breast in his mouth and his chin touching the breast.
- The mother should eat and drink more during the period when she is breastfeeding.
- Do not use the bottle to feed the baby anything not even breast milk.

6-11 months:

- Continue to breastfeed often, day and night.
- Each time, put the baby on both breasts until they are empty.
- As soon as the baby reaches 6 months of age, give two meals per day besides breast milk.
- At 6 months, the baby should eat only thick, soft foods, but as the child gets closer to one year, s/he should also eat chopped foods and meat, fish or other animal products. Thick but soft means that when you turn a spoon of the porridge or other food sideways, the food should fall out in clumps, not run off like water.
- Give no other liquids besides breast milk until the baby is 8 months or older.
- As the baby grows older from 6 through 11 months s/he should gradually be eating: (1) more meals and snacks each day, (2) more food at each meal, and (3) a larger variety of foods.
- At each meal, give the baby as much food as s/he is willing to eat. Stop
- Use the child feeding bowl to ensure that your child is eating the correct amount of food for his /her age.
- Beginning at 6 months of age, the child should receive vitamin A and deworming every 6 months; the family should use only iodated salt.
- Do not feed anything, not even breast milk, from a baby bottle.
- Practice good food hygiene (actions that keep food clean and protect the baby from illness): Food hygiene refers to the cleanliness with which food is prepared.
 - -Wash hands with soap before cooking or feeding.
 - -Protect food from flies – cover it with a clean cloth.
 - -Use only boiled water – water should be boiled, then cooled, stored in a covered container, and retrieved from a spigot or by using a clean cup without touching the water.

If you feed food that was cooked earlier in the day, reheat then cool the food first.

12-23 months: Recommended Practices

- Continue to breastfeed often, day and night.
- Give them 3 meals/day plus 2 snacks/ day plus breastfeeding each day.
- Give one-year-olds the same foods the rest of the family is eating, mashed or chopped if necessary – such things as soft rice with meat/fish (no bones)/ eggs/beans/other vegetables and fruit.

	<ul style="list-style-type: none"> • Feed as many different foods as possible, including some with bright colours and some meat or other animal products. • At each meal, give the baby as much food as s/he is willing to eat. • When using the feeding bowl, stop only when the baby has eaten all the food he requires for his age. • Supervise the baby eating and encourage him or her to eat.
Key communication tasks and ideas	<ul style="list-style-type: none"> • More use of radio to educate on nutrition especially on IYCF information. • Improve education and counselling at ANC and well -baby visits (Under-five Clinic). • More support and tools for NHCs, SMAGs, CHWs Women groups and other community groupings to provide education, counselling and cooking demonstrations. • Make available communication materials, including child feeding mats, child feeding bowls, home-based reminder materials • Improve availability of existing communication materials and make necessary innovations.
Other essential actions (needed to facilitate the recommended practices)	<ul style="list-style-type: none"> • Training for NHCs, SMAGs, CHWs, ANC and other community groupings as providers on IYCN education and counselling • Collaboration with NGOs, Ministry of Agriculture, and private sector to promote and facilitate home gardens, raising small animals, safe play areas for young children, and local production and preservation of healthy local foods. • Complementary efforts to improve availability of essential water and sanitation technologies and good hygiene practices.

6.7. Cancer of Reproductive System

The objective of cancer management in Zambia is to create suitable conditions for screening, early diagnosis and treatment of cancers of the reproductive system. The government's integrated approach to the delivery of reproductive health care is meant to address all cancers related to the reproductive health system such as cervical, breast and prostate cancers.

Cervical Cancer

Cervical cancer continues to be a major public health problem for women. It is a silent disease that affects the mouth of a woman's uterus/womb. The disease can develop without pain and with minor symptoms, so one cannot feel anything until it has advanced. Since cancer of the cervix is

silent, early detection requires that women go for periodic check-ups. Signs and symptoms include: bleeding between periods, pain during and after having sex, bleeding after having sex and excessive vaginal discharge.

Women who are at a higher risk of developing cancer of the cervix are: those who initiate sex before the age of 16 years, because the skin around the vagina and cervix is not yet developed and can easily tear to allow germs; women with multiple sexual partners (unprotected sex); women who smoke; those who lack of essential vitamins and minerals; and the HIV infected. By examining the cervix, a trained health worker using special techniques can notice the early changes caused by cervical cancer. Treatment is available when detected early.

Breast Cancer

Breast cancer is one of the most common cancers. Around one in nine women develop breast cancer at some stage in their life. Most cancers develop in women over the age of 50 but younger women are sometimes affected. Breast cancer can also develop in men, although this is rare. Breast cancer grows from one abnormal cell that develops in the lining of the duct or lobule in one breast. The exact reason why a cell becomes cancerous is unclear. It is thought that something damages or alters certain genes in the cell.

A lump in a breast and armpit is a common sign of breast cancer and a signal that a woman needs to have a doctor's examination.

Table 7: Cancers of the Reproductive Health

Target Audience	<ul style="list-style-type: none"> • Women of childbearing age (15 to 49 years)
Current behaviours	<ul style="list-style-type: none"> • Most women check breasts for lumps rarely or never. • Few women who notice something unusual on their breasts go to health facility.
Barriers	<ul style="list-style-type: none"> • Non-availability of services • Inadequate information on the importance and benefits of breast and cervical cancer screening • Inadequate information on dangers of breast cancer • Inadequate information on dangers of cervical cancer • Lack of support from partners and family members • Low risk perception of getting cancer

Facilitating Factors	<ul style="list-style-type: none"> • Women feel they are taking good care of themselves and prolonging their health when they go for regular breast and cervical cancer screening
Behavioural Objectives	<ul style="list-style-type: none"> • To increase the number of women who go for breast and cervix cancer screening. • Increase number of women who actively seek information on breast and cervical cancer
Communication Objectives	<ul style="list-style-type: none"> • To increase the number of women of child bearing age who know the importance and benefits of screening for cancer of the breast • To increase number of women of child bearing age who know the early signs and symptoms of breast and cervical cancer
Key messages	<ul style="list-style-type: none"> • Go for regular screening for breast cancer once a year • Go for regular screening for cervical cancer every year • The signs and symptoms of breast cancer include breast lumps, changes in the size or shape of the breast, dimpling or thickening of the skin on the part of the breast, discharge from the nipple, which maybe blood stained, and rash around the nipple • The signs and symptoms of cervical cancer include bleeding in between periods, pain during and after having sex, bleeding after having sex and excessive vaginal discharge • Avoid sexual activity before the age of 16 years or older • Avoid multiple sexual partners • Male circumcision helps protect women from HPV virus
Key Communication Tasks and Ideas	<ul style="list-style-type: none"> • Create breast cancer awareness in communities • Promote regular breast cancer check-ups among women of childbearing age. • Create cervical cancer awareness in communities. • Promote regular cervical cancer check-ups among women of childbearing age and in menopause
Other Essential Actions (needed to facilitate the recommended practices)	Advocate for more comprehensive cancer facilities and related resources as close to people as possible, especially in rural communities.

6.8 Sexual & Gender Based Violence

Gender-based violence (GBV) is abuse against a person that occurs in private or public life because of that person's gender. It is an act that harms or is likely to cause harm to the safety, health or well-being of the person. The term GBV is used to encompass violence against women, men, girls and boys who have experienced such violence. A UNICEF study in 2008 found that children and women are most likely to experience extreme poverty, livelihood failure, chronic and transitory food insecurity and high incidences of diseases especially in remote areas. The study also indicated that women and children are subjected to levels of physical, psychological and sexual violence that far exceeds any traditionally acceptable practices, and have little access to protection. Patriarchal systems enable men to have more access to, control over, and authority over resources than women in most African countries.

GBV can be physical or nonphysical. Nonphysical GBV include economic abuse i.e. refusing to provide necessities, barring a person from seeking employment, destroying or damaging property. Emotional

abuse includes insults, threats and possessiveness, segregating orphans or dependants. Physical abuse is the use of physical force such as spouse battery, property grabbing and sexual abuse. The WILSA study indicated that women's and girls' powerlessness, especially in the area of sexual and reproductive matters, which are influenced by cultural values and norms, has increased their exposure to HIV. Early and forced marriages, rape, abduction and defilement predispose women and girls to STIs, including HIV infection. Women and girls are physiologically more vulnerable to HIV infection. Forced sex tends to tear female membranes, particularly in girls whose bodies have not developed fully for the sexual act. Women who are pregnant at the time of GBV are susceptible to miscarriage, hypertension and premature delivery. Such women need counselling and encouragement and information on the benefit of them attending ANC services regularly.

It is the responsibility of the health care provider to identify abuse when the victim tries to conceal it. During history taking, the health care provider should take note of inconsistencies in the woman's story and indicators of abuse.

Table 8: Sexual & Gender Based Violence

Target Audience	<ul style="list-style-type: none"> • Girls, boys and women of childbearing age • Men , traditional and religious leaders
Current behaviours	<ul style="list-style-type: none"> • Victims of Sexual and Gender Based Violence (SGBV) not report abuse to relevant authorities. • Some women transmit traditions and cultural norms and values that perpetuate gender abuse • Persistent silence around gender and sexual abuse issues by civic, community leaders such as churches, CBOs and opinion leaders
Barriers	<ul style="list-style-type: none"> • Ignorance and misconceptions on issues related to GBV • Fear of disgracing the family • Fear of being stigmatized by the community • Fear of divorce • Fear of more gender violence towards the victim by the perpetrator and supporters • Lack of adequate information on services available to victims of GBV • Negative socialization of boys and girls leading to Social norms that condone male supremacy • Inadequate discussion opportunities on gender issue by men • Inadequate user friendly communication channels on GBV • Conflicting view points between church teachings/counseling and requirements by law especially in cases of GBV • Not enough role models amongst traditional leaders to influence their subjects to change their negative attitudes

Facilitating Factors	<ul style="list-style-type: none"> • Establishment of Places of Safety for survivors of GBV • Availability of the National Gender Policy • Availability of victim support systems within the police service • Availability of NGOs that support women who have been abused • Education for women that enables them to support themselves
Behavioural Objectives	<ul style="list-style-type: none"> • To increase number of girls aged below 16 and women of child bearing age who report acts of GBV to responsible authorities • To increase number of men, traditional and church leader who are to describe the meaning of GBV correctly • To increase number of men, traditional leaders and church leaders who talk about dangers of GBV • To decrease number of traditional marriage counsellors who encourage traditions and cultural norm that perpetuate gender imbalance
Communication Objectives	<ul style="list-style-type: none"> • To increase awareness of the dangers GBV among men, traditional and church leaders. • Raise awareness of community members on the effect of GBV on individuals' sexual reproductive health.
Key messages	<ul style="list-style-type: none"> • Talk about GBV to your partner and children about GBV and what they should do to avoid being abused. • A real man does not abuse his family and loved ones. • Abuse of any kind is against the law. • Parents apportion roles equally to children and show them that boys and girls are equal. • Seek prompt medical treatment if you have been abused. • Report GBV to the nearest police station or relevant authorities. • Discuss issues of GBV in your communities. • Socialize boys and girls positively on issues of gender. • Traditional leaders talk about GBV with your subjects. • Church leaders talk to your congregation about GBV.
Key Communication Tasks and Ideas	<ul style="list-style-type: none"> • Create awareness on GBV and types • Create awareness on available GBV service for the victims • Promote positive socialization of both boys and girls • Create role models among traditional leaders to champion GBV issues in their communities.
Other Essential Actions (needed to facilitate the recommended practices)	<ul style="list-style-type: none"> • Involvement of key stakeholders (including traditional leaders) in all strategies addressing GBV and health

6.9 Persons with Disabilities

Persons with disabilities (PWDs) are one of the most vulnerable groups in society, and the impact of poverty on this group of citizens is worse when compared to the rest of the population. According to the 2014 WHO/World Bank World report on disability, about 15% of the world's population lives with some form of disability, of whom 2-4% experience significant difficulties in functioning. The global disability prevalence is higher than previous WHO estimates, which date from the 1970s and suggested a figure of around 10%. This global estimate for disability is on the rise due to population ageing and the rapid spread of chronic diseases, as well as improvements in the methodologies used to measure disability. While the laws and policies of Zambia declare persons with disabilities to be equal to others, there are still a number of factors that promote inequality. Myths and misconceptions about disability also contribute to persons with disabilities being disadvantaged in our society.

The MCDMCH recognizes the potential of persons with disabilities to make a positive contribution to their individual lives, their families, communities and the nation at large, if given an opportunity and the right support and resources.

Health communication has not done much to accommodate persons with disabilities. The deaf and the blind, for example, do not have communication materials in sign language and braille respectively, neither have health communication efforts been very successful in reaching other groups with physical disabilities. This communication strategy will endeavour to better reach the disabled through increased use of personal communication channels and use of both braille and sign language. The strategy will also advocate for mobile health services that will reach more people at community level, including persons with disabilities.

Table 9: Persons With Disabilities

Target Audience	<ul style="list-style-type: none"> Persons With Disabilities
Current behaviours	<ul style="list-style-type: none"> Few PWDs access the health services they need. Families and community leaders tend to hide PWDs rather than support them in using the abilities they have and in accessing services. Health communicators not producing IEC/BCC materials for persons with disabilities Persons with disabilities left out in mainstream activities Persons with disabilities not participating in key national issues
Barriers	<ul style="list-style-type: none"> Limited access to health care services Lack of specialized services for persons with disabilities Stigmatization by the community, family and health workers Lack of support from family members, partners and community Lack of accessible facilities and services Inadequate resources put in implementation of policies on PWDs Lack of information on what services are available for them PWDs are not empowered economically

Facilitating Factors	<ul style="list-style-type: none"> • The Persons With Disabilities Act No. 6 of 2012 in place • National Disability Policy in place • National disability survey • Social Cash Transfer targeting persons with disabilities in urban districts
Behavioural Objectives	<ul style="list-style-type: none"> • To increase the number of PWDs seeking and using IEC/BCC materials produced for this target audience. • To increase the number of PWDs accessing health services • To increase number of Persons with disabilities who participate in national events
Communication Objectives	<ul style="list-style-type: none"> • To increase awareness among health communicators about the importance producing communication materials for persons with disabilities • To increase awareness among persons with disabilities about availability of health care services. • To increase knowledge among service providers on how to make services and facilities accessible to persons with disabilities.
Key messages	<ul style="list-style-type: none"> • Every person has some weaknesses and some abilities; one must use those abilities to the fullest. • Seek sexual and reproductive health services at any health facility • Use family planning services of your choice • Go for Focused Antenatal care (FANC) • Deliver at the health facility with a skilled health worker • Proud family members are supportive of their disabled relatives • Service providers serve all persons in need of health services
Key Communication Tasks and Ideas	<ul style="list-style-type: none"> • Carter for disability needs in health communication • Advocate for health services that are more accessible to persons with disabilities.
Other Essential Actions (needed to facilitate the recommended practices)	<ul style="list-style-type: none"> • Government and other stakeholders to provide resources to support full implementation of disability policies

7.0 Implementation framework

This strategy will build on on-going activities, and will be implemented at three levels: national, provincial and district. At district and provincial levels, the choice and focus of specific communication activities will depend on what else is happening in that specific context. For instance, some provinces and districts may choose to implement social mobilization, to complement on-going IEC activities. The implementation approach will use capacity building, coordination and programme partnerships/integration.

- 1. Capacity building for Advocacy, Communication, and Social Mobilization:** To implement this strategy, the MDCMCH will seek to build the capacity of local partners and communities in RMNCHM communication. For instance, health workers may need training in community mobilization, client counselling and on how to communicate the right information using targeted key messages to community and individuals and to conduct follow up for action. Technical assistance will be provided to organizations and groups implementing RMNCHN programmes, local community groups and DCMO on how to plan and conduct ACSM activities. The MCDMCH will also support health educators in the districts to effectively coordinate and mobilize support for RMNCHM communication within their areas. As a first step in the implementation of this strategy, the MDCMCH will support provinces and districts to plan and set priorities on their specific communication activities. MDCMCH will also provide standardized IEC materials which can be adapted for local use by the partners and local groups.
- 2. Coordination:** To make the best use of the available resources for RMNCHM communication and behaviour change activities in implementing this strategy, the MCDMCH will coordinate the different partners through the. The is a good platform for MCDMCH to share information and to promote its priorities as well as gain the support of the partners on RMNCHM diseases. In the districts, the coordination role will be conducted by the DCMO. PHO will be responsible of making sure that districts understand this role and carry it out. MDCMCH, HQ will also work in coordination with other stakeholders and other government ministries, leveraging other health promotion and communication activities as much as possible and creating a strong multi-sectoral approach.

Coordination roles for MCDMCH.

- Define priority areas for ACSM interventions
- Maintain inventory of ACSM partners, activities and materials and identify gaps
- Set up and maintain information and knowledge sharing platforms and tools for the RMNCHM diseases
- Identify, document and share best practices
- Oversee the development of consistent and standardized messages.
- Coordinate joint planning with stakeholders where possible to reduce overlaps and encourage scale up

Mobilize resources by leading advocacy efforts to policy and decision makers.

- Undertake advocacy, capacity and technical skills building at all levels to ensure successful implementation of ACSM activities.
- Ensure quality of ACSM activities.
- Monitor and evaluate implementation progress.
- Conduct media outreach and advocacy to improve information dissemination through press

Roles of Partners:

- Provide technical and resource support, and advice to MCDMCH on ACSM
- Assist the implementation of ACSM strategy
- Assist the development of consistent and standardized messages.
- Support qualitative and quantitative research for the development of ACSM interventions and messages and for measuring effectiveness of various program interventions.
- Assist in building partnership with the media and local communities

3. Integration/programme partnerships:

To increase the impact of the communication activities outlined in this strategy, they will be integrated into other health programmes as much as possible: For instance, health providers will be trained to integrate RMNCHM with other programs delivered at facilities and during client counseling. Providers will also be trained and encouraged to distribute information leaflets, or show videos as the clients wait for services at health facilities. The MDCMCH will also collaborate with other government departments to ensure that RMNCHM messages are included into schools and community health



education activities implemented by the MOE, and other partners. MCDMCH will also use partnership with other organizations to incorporate RMNCHM messages in workplace health programmes and private sector health education initiatives in the districts. MCDMCH will provide technical guidance, support and materials in implementing the interventions.

8.0 Monitoring and Evaluation (M&E) Framework

The main objective of this M&E Framework is to broadly outline how progress toward the set communication and behavioural objectives across the nine key health intervention areas outlined in this strategy will be assessed and tracked over time. This 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. A more detailed M&E plan will need to be developed to accompany this framework and layout the specifics of how each of the communication and advocacy activities and interventions across these health areas will be monitored and evaluated.

This framework includes a set of proposed performance indicators for monitoring the implementation of communication and advocacy activities over time to track progress and inform programmatic decision-making, and for evaluating the effect of those activities to see whether the set communication and behavioural objectives outlined in this strategy have been achieved. Monitoring indicators include those that track progress of inputs, processes and outputs of the implemented activities or interventions, while evaluation level indicators include both intermediate and behavioural level outcome indicators.

A set of proposed indicators for monitoring communication and advocacy activities are outlined below, by the specific type of indicator – inputs, processes and outputs. These indicators are broadly defined and will require tailoring to the specific communication and advocacy activities across the different health intervention areas.

Inputs

- Amount of financial resources spent on mass media activities by communication channel
- Amount of financial resources spent on materials production by type of material
- Amount of financial resources spent on interpersonal communication activities by type of activity (individual, small-group, community-based activities)

Processes

- Communications activity developed based on existing evidence and/or formative research
- Communications activity materials pilot-tested with the target audience
- Communications activity developed according to minimum GRZ standards/guidelines

- Communications activity reviewed by the MCDMCH IEC/BCC Technical Working Group
- Number of provinces using the RMNCHM communication and advocacy strategy
- Number of districts using the RMNCHM communication and advocacy strategy
- Number of communities using the RMNCHM communication and advocacy strategy
- Number of communication channels used by campaign or activities
- Number of trainings held
- Number of IEC/BCC materials developed and produced by type (radio, television, braille, or print)
- Number of community events held

Outputs

- Number of people trained
- Number of IEC/BCC materials distributed to the target audience
- Number of people participating in individual, small group or community events
- Number or percentage of the target audience reached with a specific communication channel (e.g., radio, television)
- Number or percentage of the target audience who are able to recall a specific message or topic from the communication activity.

The proposed set of key evaluation level indicators are outlined in Tables 1 – 9 below by each of the key intervention areas: adolescent health, maternal health, antenatal care, postnatal and newborn care, child health and hygiene, nutrition, reproductive health cancers, sexual and gender-based violence, and persons with disabilities. They include a set of both intermediate and behavioural outcome level indicators.

Adolescent Health Intermediate and Behavioural Outcome Indicators

Communication and Behavioural Objectives	Intermediate and Behavioural Outcome Indicators
<p>Communication Objectives:</p> <ul style="list-style-type: none"> • To increase the % of adolescent who have adequate knowledge about SRHR services. • To increase the number of adolescents with knowledge on the benefits of delayed sexual debut • To increase the number of health workers with positive attitudes to adolescents’ SRH needs. <p>Behavioural Objectives:</p> <ul style="list-style-type: none"> • To increase the number of adolescents seeking and accessing SRHS • To reduce the % of adolescents involved in drug and substance abuse • To raise the average age of sexual initiation from a baseline to 16years • To increase the number of guardians/parents who discuss SRH issues with adolescents 	<p>Intermediate Outcome Indicators:</p> <ul style="list-style-type: none"> • Percentage of adolescents that know where to access SHR services. • Percentage of adolescents who understand the benefits of delaying sexual intercourse. • Percentage of health workers reporting having a positive attitude to providing adolescent SRH services. <p>Behavioural Outcome Indicators:</p> <ul style="list-style-type: none"> • Percentage of adolescents that accessed sexual and reproductive health services in the past year. • Percentage of adolescents that report having abused drugs or other substances in the past year. • Median age at first sex intercourse. • Percentage of guardians/parents reporting discussing sexual and reproductive health issues with adolescents.

Maternal Health Intermediate and Behavioural Outcome Indicators

Communication and Behavioural Objectives	Intermediate and Behavioural Outcome Indicators
<p>Communication Objectives:</p> <ul style="list-style-type: none"> To increase awareness of men and women of childbearing age about FP methods. To increase awareness of men and women of childbearing age about the benefits of practicing FP by men and women of childbearing age To increase the % of mothers who have adequate knowledge on the importance post-delivery care To increase the % of pregnant women who know the benefits of antenatal services to mothers and babies To increase the % of pregnant women who know where to access antenatal care. <p>Behavioural Objectives:</p> <ul style="list-style-type: none"> To increase the % of women who use a modern FP method i.e. Combined oral contraceptives, combined injectable and barrier methods such as IUD and condoms. To increase the number of women and men (16 to 49 years) seeking and accessing correct information on modern FP methods To increase number of pregnant women who access antenatal care in the first 3 months of pregnancy To increase the % of mothers who attend antenatal care at least 4 times during their last pregnancy To increase the % of expecting mothers who create a birth-plan. To increase the % of pregnant mothers who have a facility delivery assisted by a skilled birth attendant. To increase the % of mothers who go for post- delivery care. 	<p>Intermediate Outcome Indicators:</p> <ul style="list-style-type: none"> Percentage of men and women of child bearing age who know the different FP method. Percentage of men and women of child bearing age who understand the benefits of practising FB. Percentage of mothers who know the importance of post-delivery care. Percentage of pregnant women who know the importance of antenatal care for mothers and babies Percentage of pregnant women who know where to access antenatal care. <p>Behavioural Outcome Indicators:</p> <ul style="list-style-type: none"> Percentage of women reporting using modern FP methods (i.e. Combined oral contraceptives, combined injectable and barrier methods such as IUD and condoms). Percentage of women and men, ages 16 to 49 years, who accessed information on modern FP methods in the last 12 months. Percentage of pregnant women who accessed antenatal care service in the first 3 months of pregnancy. Percentage of mothers who accessed antenatal care services at least 4 times during their last pregnancy. Percentage of pregnant women who created a birth plan. Percentage of mothers who delivered at health facility assisted by a skilled birth attendant. Percentage of mothers who access post-delivery care.

Antenatal Care Intermediate and Behavioural Outcome Indicators

Communication and Behavioural Objectives	Intermediate and Behavioural Outcome Indicators
<p>Communication Objectives:</p> <ul style="list-style-type: none"> • To increase the levels among of pregnant women aged 15 to 39 and their partners of knowledge about the risk of HIV infection to babies during pregnancy, delivery and breastfeeding. • To increase knowledge of pregnant women and their partners about the benefits of HIV counselling and testing during pregnancy. • To increase knowledge levels in women about the benefits of ANC services • To increase % of pregnant women who know the true signs of labour • To increase the % of pregnant women who know the importance of having birth plan <p>Behavioural Objectives:</p> <ul style="list-style-type: none"> • To increase the % of women aged 15 to 49 initiating ANC within the first 3 months of their pregnancy • To increase the % of pregnant women who complete at least 4 ANC visits in their last pregnancy. • To increase the % of women who have created a birth plan (no baseline measured in DHS; will be measured by CSH baseline) • To increase % of local leaders who advocate for establishment of more centres which provide services for PMTCT services in their communities 	<p>Intermediate Outcome Indicators:</p> <ul style="list-style-type: none"> • Percentage of among pregnant women and their partners who know the risks of transmitting HIV infection to babies during pregnancy, delivery, and breastfeeding. • Percentage of pregnant women and their partners who know the benefits of HIV counselling and testing during pregnancy. • Percentage of women who know the benefits of antenatal services. • Percentage of pregnant women who recognize the true signs of labour. • Percentage of women who understand the importance of a birth plan. <p>Behavioural Outcome Indicators:</p> <ul style="list-style-type: none"> • Percentage of pregnant women aged 15 to 49 who access ANC within first 3 months of their pregnancy. • Percentage of pregnant women who accessed ANC at least 4 times during their last pregnancy. • Percentage of women who created a birth plan. • Percentage of local leaders who advocate for the establishment of PMTCT services in their communities.

Postnatal and Newborn Care Intermediate and Behavioural Outcome Indicators

Communication and Behavioural Objectives	Intermediate and Behavioural Outcome Indicators
<p>Communication Objectives:</p> <ul style="list-style-type: none"> • To increase the number of women who know the importance of attending postnatal care at 6 hours, 6 days and 6 weeks • To increase awareness among women of child bearing age on the importance of health centre delivery assisted by skilled birth attendant. • Increase knowledge levels among health care providers on the signs of obstructed labour <p>Behavioural Objectives:</p> <ul style="list-style-type: none"> • To increase number of pregnant women who deliver at health facilities assisted by a skilled birth attendant. • To increase the number of mothers accessing postnatal care (at 6 days, 6 weeks and 6 months). • To increase the number of women accessing safe abortion care at health facilities 	<p>Intermediate Outcome Indicators:</p> <ul style="list-style-type: none"> • Percentage of women who know the importance of attending postnatal care at 6 hours, 6 days, and 6 weeks after delivery • Percentage of women of child bearing age who know the importance of health center delivery assisted by a skilled birth attendant. • Percentage of health care providers who able to recognize the signs of obstructed labour. <p>Behavioural Outcome Indicators:</p> <ul style="list-style-type: none"> • Percentage of pregnant women who delivered at a health facility assisted by a skilled birth attendant. • Percentage of mothers who access postnatal care at 6 days, 6 weeks, and 6 months after delivery. • Percentage of women who accessed safe abortion care at health facilities. • Percentage of women who reported using modern FP methods.

Child Health Care Intermediate and Behavioural Outcome Indicators

Communication and Behavioural Objectives	Intermediate and Behavioural Outcome Indicators
<p>Communication Objectives:</p> <ul style="list-style-type: none"> • Increase the knowledge of mothers and caregivers of children less than 5 years about neonatal tetanus. • Increase the knowledge of mothers and caregivers of children under 5 years of importance of being vaccinated during pregnancy • Increase the knowledge of mothers and caregivers of children under 5 years of the benefits of child immunizations • Increase the knowledge of mothers of children under 5 years on the benefits of exclusive breastfeeding. • Enhance mothers' positive attitudes towards completing their children's immunizations before the first birthday • Increase knowledge of fathers of children under 5 years who know the importance of complete immunization for children before first birthday <p>Behavioural Objectives:</p> <ul style="list-style-type: none"> • Increase percentage of children <2 fully immunized (BCG, measles, OPV3, DPT3, Rotavirus, PCV) to 90% • Increase percentage of children <1 completely immunized (BCG, measles, OPV3, DPT3) to 90% • Increase the proportion of mothers who exclusively breastfeed up to six months • Increase the proportion of pregnant women receiving TT2 to 60% • Increase the proportion of children under 5 years of age who take them for growth monitoring every two months to 90%. 	<p>Intermediate Outcome Indicators:</p> <ul style="list-style-type: none"> • Percentage of mothers and caregivers of children under 5 years who know about neonatal tetanus. • Percentage of mothers and caregivers of children under 5 years who know the importance of being vaccinated during pregnancy • Percentage of mothers and caregivers of children under 5 years who know the benefits of child immunizations. • Percentage of mothers of children under 5 years who know the benefits of exclusive breastfeeding. • Percentage of mothers who believe in the need for completing their children's immunizations before their first birthday. • Percentage of fathers who know the importance of completing their children's immunizations before their first birthday. <p>Behavioural Outcome Indicators:</p> <ul style="list-style-type: none"> • Percentage of children under 2 years that have been immunized against BCG, measles, OPV3, DPT3, Rotavirus, and PCV. • Percentage of children under 1 year that have been immunized against BCG, measles, OPV3, and DPT3. • Percentage of mothers who report exclusively breastfeeding up to six months after birth. • Percentage of pregnant women receiving TT2. • Percentage of children under 5 years who have been taken for growth monitoring every two months.

Nutrition Intermediate and Behavioural Outcome Indicators

Communication and Behavioural Objectives	Intermediate and Behavioural Outcome Indicators
<p>Communication Objectives:</p> <ul style="list-style-type: none"> • To increase the percentage of mothers of children under 2 years with correct knowledge of IYCF and maternal nutrition recommendations • To increase the % of fathers and caretakers of children under 2 years with correct knowledge of IYCF and maternal nutrition recommendations • To increase the knowledge of mothers with children under 2 years of unused but available healthy foods • To increase knowledge of mothers with children under 2 years on combinations of available healthy foods • To increase knowledge mothers of children under 2 years on strategies to grow and preserve healthy foods for babies and themselves. <p>Behavioural Objectives:</p> <ul style="list-style-type: none"> • To increase % of nursing mothers who EBF their infants until 6 months. • To increase percentage of nursing mothers emptying both breasts at each. • To increase the % of mothers and caretakers feeding babies >6 months with recommended breastfeeding, food variety, animal-source foods, serving size, number of meals and snacks, calorie density. • To increase % of pregnant and lactating women eating 3 of main meals or 2 snacks with a variety of foods and safe drink. 	<p>Intermediate Outcome Indicators:</p> <ul style="list-style-type: none"> • Percentage of mothers of children under 2 years who know IYCF and maternal nutrition recommendations. • Percentage of fathers and caretakers of children under 2 years who know IYCF and maternal nutrition recommendations. • Percentage of mothers with children under 2 years who know commonly used locally available healthy foods. • Percentage of mothers of children under 2 years who know how to combine healthy locally available foods. • Percentage of mothers of children under 2 years who know how to grow and preserve healthy foods for babies and themselves. <p>Behavioural Outcome Indicators:</p> <ul style="list-style-type: none"> • Percentage of mothers of children under 6 months reporting exclusive breastfeeding their children. • Percentage of nursing mothers reporting emptying both breasts during each feeding. • Percentage of pregnant women and nursing mothers reporting eating 3 of main meals and 2 snacks including a variety of foods, and drinking safe drink.

Reproductive Health Cancer Intermediate and Behavioural Outcome Indicators

Communication and Behavioural Objectives	Intermediate and Behavioural Outcome Indicators
<p>Communication Objectives:</p> <ul style="list-style-type: none"> • To increase the number of women of child bearing age who know the importance and benefits of screening for cancer of the breast • To increase number of women of child bearing age who know the early signs and symptoms of breast and cervical cancer <p>Behavioural Objectives:</p> <ul style="list-style-type: none"> • To increase the number of women who go for breast and cervix cancer screening. • Increase number of women who actively seek information on breast and cervical cancer 	<p>Intermediate Outcome Indicators:</p> <ul style="list-style-type: none"> • Percentage of women of child bearing age who know the importance and benefits of screening for breast cancer. • Percentage of women of children bearing age who know the early signs and symptoms of breast and cervical cancer. <p>Behavioural Outcome Indicators:</p> <ul style="list-style-type: none"> • Percentage of women of child bearing age who access services that screen for breast and cervical cancer. • Percentage of women of child bearing age who access information on breast and cervical cancer.

Sexual and Gender-Based Violence Intermediate and Behavioural Outcome Indicators

Communication and Behavioural Objectives	Intermediate and Behavioural Outcome Indicators
<p>Communication Objectives:</p> <ul style="list-style-type: none"> • To increase awareness of the dangers GBV among men, traditional and church leaders. • Raise awareness of community members on the effect of GBV on individuals' sexual reproductive health. <p>Behavioural Objectives:</p> <ul style="list-style-type: none"> • To increase number of girls aged below 16 and women of child bearing age who report acts of GBV to responsible authorities 	<p>Intermediate Outcome Indicators:</p> <ul style="list-style-type: none"> • Percentage of men and traditional and church leaders who know the dangers of GBV. • Percentage of community members who understand the effects of GBV on individuals' sexual reproductive health. <p>Behavioural Outcome Indicators:</p> <ul style="list-style-type: none"> • Percentage of girls aged below 16 years and women of child bearing age reporting acts of GBV to responsible authorities.

<ul style="list-style-type: none"> • To increase number of men, traditional and church leader who are to describe the meaning of GBV correctly • To increase number of men, traditional leaders and church leaders who talk about dangers of GBV • To reduce number of traditional marriage counsellors who encourage traditions and cultural norm that perpetuate gender imbalance 	<ul style="list-style-type: none"> • Percentage of men, traditional and church leaders describing GBV correctly • Percentage of men, traditional leaders and church leaders who share the information with others on the dangers of GBV. • Percentage of women encouraging traditions and cultural norms that perpetuate gender imbalance
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Disability Intermediate and Behavioural Outcome Indicators

Communication and Behavioural Objectives	Intermediate and Behavioural Outcome Indicators
<p>Communication Objectives:</p> <ul style="list-style-type: none"> • To increase awareness among health communicators about the importance producing communication materials for persons with disabilities • To increase awareness about availability of health care services among persons with disabilities • To increase knowledge among service providers on how to make services and facilities accessible to persons with disabilities. <p>Behavioural Objectives:</p> <ul style="list-style-type: none"> • To increase the number of PWDs seeking and using IEC/BCC materials produced for this target audience. To increase the number of PWDs accessing health services 	<p>Intermediate Outcome Indicators:</p> <ul style="list-style-type: none"> • Percentage of communicators indicating the importance producing communication materials for persons with disabilities. • Percentage of persons with disabilities who know where to access health care services for their disabilities. • Percentage of service provider who know how to make services and facilities accessible to persons with disabilities. <p>Behavioural Outcome Indicators:</p> <ul style="list-style-type: none"> • Percentage of persons with disabilities who access health care services for their disabilities.

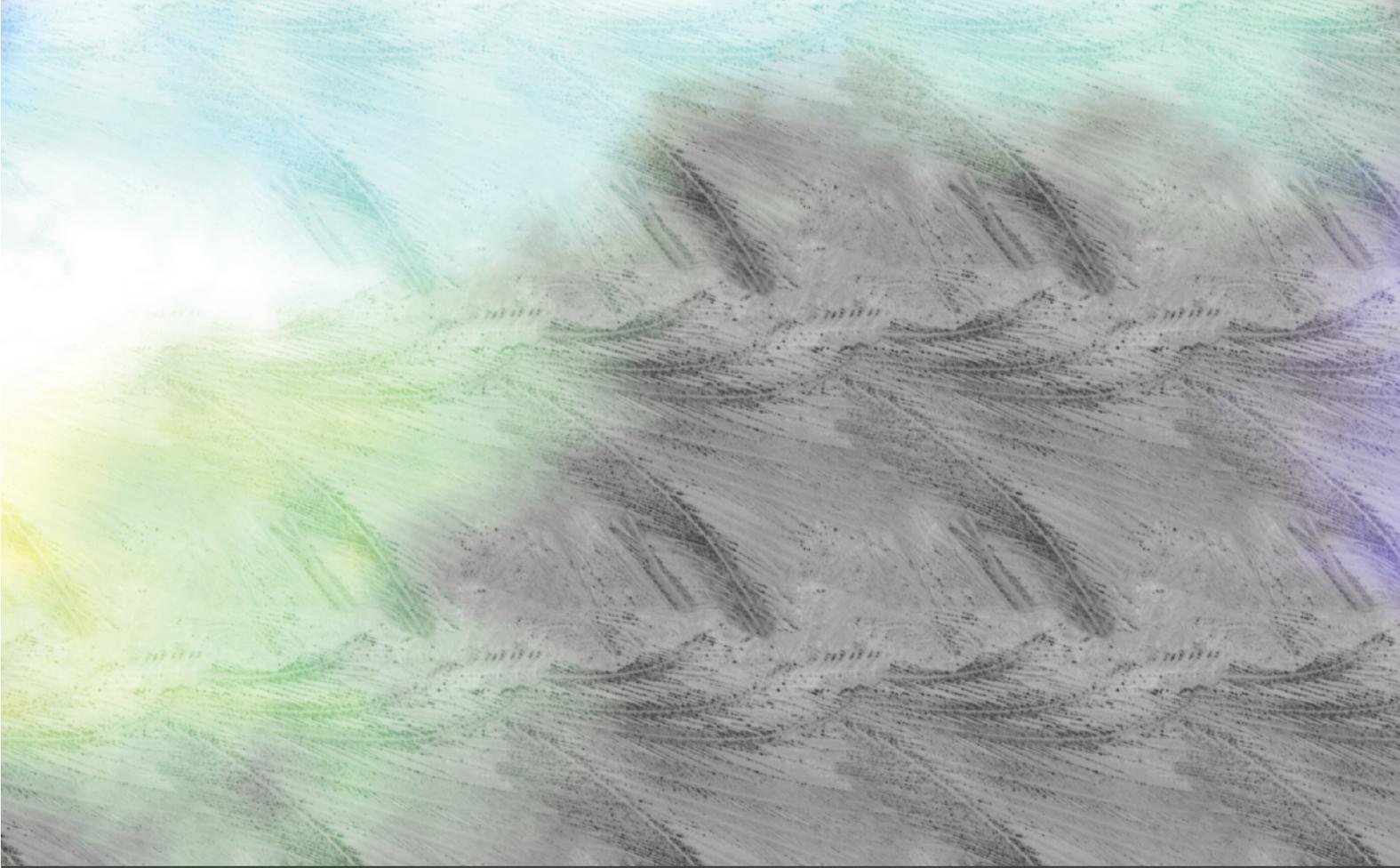
Appendices

Appendix I – Recommended feed for a child

Age in Months	Types of Feed
0 – 6 Months	<ul style="list-style-type: none"> ▪ Breastfeed exclusively at least 8 times within 24 hours. ▪ Do not give water, traditional medicines, glucose, gripe water, other milks, porridge or any other liquids or foods unless medically indicated. ▪ If the child is not gaining weight and is being breastfed properly, <i>refer for medical check up for any underlying illnesses.</i>
6 – 12 Months	<ul style="list-style-type: none"> ▪ Continue breastfeeding 8-10 times within 24 hours. ▪ Feed at least three times a day if breastfed, five times with 1-2 cups of milk per day if not breastfed. ▪ Introduce a variety of locally available foods. Give about half to three quarters cup of food (150-180ml) per feeding of: <ul style="list-style-type: none"> - <i>Thick</i> porridge enriched with sugar, oil, pounded groundnuts or Kapenta, mashed beans or avocado, soya flour, oil, pounded dried caterpillars or green leafy vegetables, or - Nshima with <i>mashed</i> relish of green leafy vegetables, beans, fish, or <i>pounded</i> Kapenta, caterpillar or meat cooked in oil or pounded groundnuts. ▪ Between main meals, give other foods, such as fruits (banana, pawpaw, avocado, mango or orange juice) chikanda, <i>mashed</i> pumpkin, beans, groundnuts, cassava, boiled sweet potatoes and pumpkins with pounded groundnuts, sugar, milk or oil, whenever possible. Mash these foods and feed to the child. ▪ Serve and feed child separately in own dish.
12 – 24 Months	<ul style="list-style-type: none"> ▪ Continue breastfeeding as much as child wants. ▪ Feed at least five to six times a day about one to one and half cups (200-250ml) of the following per feeding: <ul style="list-style-type: none"> - Nshima with <i>mashed</i> or <i>pounded</i> relish. Do not feed only the gravy - <i>Thick</i> porridge enriched with one or more of the following: sugar, oil, <i>pounded</i> Kapenta, groundnuts, dried caterpillars, mashed beans, egg and milk. ▪ In between main meals, give other foods such as fruit, samp, boiled cassava, mashed beans or groundnuts, porridge, bread, pumpkin, sweet potato or rice with sugar or oil. ▪ Serve the child separately and <i>supervise</i> the eating.
24 Months or more	<ul style="list-style-type: none"> ▪ Milk remains important in the child's diet. ▪ Feed the child from the family meals at least three times a day. ▪ Two times a day between family meals give fruit (such as banana, orange, mango, pawpaw and guava), samp, sweet potato, bread, rice with sugar or oil, eggs or beans. ▪ Portion size should be increased with age of the child.

References

1. Ministry of Community Development, Mother and Child Health Strategic Plan 2013 - 2016
2. Adolescent Health Strategic Plan 2011 to 2015
3. National HIV and AIDS Communication and Advocacy Strategy (2011 – 2015)
4. National Malaria Communication Strategy 2011 - 2014
5. MNCH Strategy and New Born Care strategy 20 13; Child Health strategies
6. National Food and Nutrition Strategic Plan 2011-2015
7. WILSA Study on Page – 55



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