MALAWI GOVERNMENT

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ACRONYMS AND ABBREVIATIONS

ACT	Artemisinin-Based Combination Therapy
ANC	Antenatal Care
BCC	Behaviour Change Communication
CBOs	Community Based Organizations
CCP	Johns Hopkins Center for Communication Programs
CIMCI	Community Integrated Management of Childhood Illness
DEC	District Executive Committee
DHMT	District Health Management Team
DHPO	District Health Promotion Officer
EHP	Essential Health Package
FBO	Faith Based Organization
GoM	Government of Malawi
HES/ HEU	Health Education Section/ Health Education Unit
HH	Household
HSA	Health Surveillance Assistant
IEC	Information, Education and Communication
IMCI	Integrated Management of Childhood Illnesses
IPC	Interpersonal Communication
IPTp	Intermittent Presumptive Treatment for malaria in pregnancy
IRS	Indoor Residual Spraying
KAP	Knowledge, Attitudes and Practices
LA	Artemether Lumefantrine
LLIN	Long Lasting Insecticide-treated Nets
MCS	Malaria Communication Strategy
MIECWG	Malaria IEC Sub Working Group
MIP	Malaria in Pregnancy
MMIS	Malawi Malaria Indicator Survey
MNCH	Maternal, Neonatal and Child Health
MoH	Ministry of Health
MSP	Malaria Strategic Plan

MTR	Midterm Review
NGOs	Non-Governmental Organizations
NHCS	National Health Communication Strategy
NMA	National Malaria Ambassador
NMCP	National Malaria Control Program
OPR	Operations Research
PMI	President's Malaria Initiative
RHD	Reproductive Health Directorate
RDT(mRDT)	Rapid Diagnostic Test
SADC	South African Development Community
SBCC	Social and Behaviour Change Communication
SP	Sulfadoxine/pyrimethamine
SSDI	Support for Service Delivery Integration
STEPS	Supporting the Efforts of Partners
SWOT	Strength, Weakness, Opportunity and Threat
TA	Technical Assistance
ToR	Terms of Reference
ToT	Training of Trainers
TWG	Technical Working Group
USAID	United States Agency for International Development
VDC	Village Development Committee
VHC	Village Health Committee
WG	Working Group
W.H.O.	World Health Organization

FOREWORD

Malaria remains a leading cause of morbidity and mortality in Malawi majorly affecting children below five years of age and pregnant women. While this remains the case, the Government of Malawi is scaling up interventions aimed at controlling this situation through increasing access to malaria control intervention that include: the distribution of Long Lasting Insecticide treated Nets (LLINs), scaling up indoor residual house spraying (IRS) in selected districts, promoting the prevention of malaria during pregnancy through Intermittent Presumptive Treatment of malaria in pregnancy (IPTp) and increasing access to prompt diagnosis and effective malaria treatment at facility level.

Recent studies have gathered evidence that despite the provision of these services, utilization of the same has not been optimum hence malaria continues to remain a problem in the country. It is in recognition of this that the Malawi's Ministry of Health through the National Malaria Control Program has continued to invest in public information and education through the development of the Malaria Communication Strategy. The first generation of the communication strategy ended in 2014 giving rise to the review and re-writing of this second generation of the communication strategy for the period 2015 – 2020.

The communication strategy is a guiding document for all partners to implement a unified and cohesive communication plan and allow for complementing programs among partners. The main focus of the strategy is to create social and behaviour change by examining barriers as to why individuals and communities are not adopting actions and behaviour that contribute to the prevention and treatment of malaria. Through this approach, we are able to devise innovative communication approaches to tackle the barriers.

I am honoured that the Ministry of Health through the National Malaria Control Program recognized the need for consistency and coordination among partners implementing malaria behaviour change communication programs and involved them in the process of review and re-writing of this communication strategy. It is my belief that the strategy will play a critical role in increasing knowledge, attitude and practices towards malaria prevention and treatment and supporting our vision where "All people in Malawi are free from the burden of malaria".

Macphail Magwira, PhD.
SECRETARY FOR HEALTH

ACKNOWLEDGEMENT

The Ministry of Health is grateful for those who contributed towards the review, development and completion of the Malaria Communication Strategy for Malawi. The process commenced with a review of the existing literature relevant on malaria knowledge, attitudes and practices followed by consultative meetings among malaria implementing partners where communication efforts, needs and gaps were identified. The communication gaps and needs were then discussed during the 1st consultative stakeholders workshop held on 11th and 12th November 2014 in Salima. After the Salima meeting a draft "0" of the communication strategy was developed and shared among core members for initial feedback. The draft "0" communication strategy was then subjected to a 2nd stakeholders consultative meeting in Lilongwe on 19th November 2014 where under thematic sections of the draft "0" was reviewed in a participatory group process hence building consensus on the key and thematic sections of the strategy.

The draft "0" was then revised taking into account the comments and feedback received from the core members and the 2nd stakeholder's workshop and a draft "1" of the communication strategy developed. This was circulated widely to implementing partners and participants of the consultative process and comments received to finalize this communication strategy

In this regard we particularly thank the National Malaria Control Program in conjunction with the Health Education Services for overseeing and guiding this process of revising and developing the 2nd generation of the malaria communication strategy. Special thanks go to the John Hopkins Center for Communication Programs (CCP), through the Support for Service Delivery Integration (SSDI) – Communication Program in Malawi for the technical support. We also thank the generosity of the United States Agency for International Development / US President's Malaria Initiative for the financial support in the development and printing of the communication strategy.

Special thanks are extended to Doreen Ali (Deputy Director of Preventive Services – Malaria), Hector Kamkwamba (Deputy Director Preventive Health Services – Health Education Services), John Zoya and John Chiphwanya (National Malaria Control Program), Gome Jenda (USAID/PMI), Wilfred Dodoli (National Professional Officer, WHO), Dennis Chimenya (Communication for Development Officer, UNICEF), Fayyaz A. Khan (SSDI-Communication), Alinafe Kasiya (SSDI-Communication), Thomas Ofem (SSDI-Communication), Jane Brown (Johns Hopkins Center for Communication Programs), Chancy Mauluka (SSDI-Communication), Vitima Ndovi (SSDI-Communication), Charles Yuma (Population Services International, Malawi). Appreciations also go to Ben Adika (Independent Consultant) for coordinating and compiling the document as per all the stakeholders' inputs.

EXECUTIVE SUMMARY

Malaria remains a critical public health challenge for the Government and People of Malawi. While awareness about malaria among the general population is as high as 92.8%, statistics regarding prevention and control behaviours are less promising. For instance, only 52.2% of the population use long lasting insecticide treated nets, 63.3% of pregnant women take two doses or more of Intermittent Presumptive Treatment for malaria in pregnancy (IPTp), while only 32.2% of Malawians take action to treat malaria within 24 hours of the onset of a fever. It is not surprising there that 34% of all outpatient visits and 40% of all hospital deaths in Malawi are attributable to Malaria. Several barriers to the uptake of key preventive measures have been identified to include beliefs among the populace that every fever is malaria and that malaria is a normal occurrence that should not be worried about. Other key barriers are safety concerns regarding sleeping under Long Lasting Insecticide-treated Nets (LLINs), Indoor Residual Spraying (IRS) and use of Sulfadoxine/pyrimethamine (SP) during pregnancy. Pilferage of malaria commodities such as Artemether Lumefantrine (LA), LLINs, insecticides and Malaria Rapid Diagnostic Tests (mRDTs) also make it impossible for individuals and families to practice the essential practices to deal with malaria.

This communication strategy targets these barriers and seeks to address or remove them for the purpose of increasing LLIN use, IPTp and prompt malaria treatment to 80% from the current baseline. The primary audiences focused on are 1) heads of household (HH), 2) women of childbearing age, 3) adult patients and 4) caretakers of sick children. Secondary and tertiary audiences include husbands and other men in the community, older women in HHs, community leaders, health workers and relevant government departments. The strategy employs a socioecological model that recognizes that behaviour change happens within the context of the interrelatedness of the individual, family, community and the wider societal environment. For this reason, a three-level strategic approach is recommended: advocacy to create an enabling environment for preventive behaviours, community mobilization to increase participation and community ownership and behaviour change communication (BCC) to promote individual preventive behaviours and discourage negative community norms. This strategy also links strongly to the newly developed National Health Community Strategy (NHCS) - building upon the malaria component of the NHCS and adopting Moyo ndi Mpamba, Usamalireni (Life is precious, take care of it) as an umbrella brand from which to promote Malungo Zii (Malaria free).

The Malaria Communication Strategy recommends that its implementation be coordinated at two distinct but connected levels. At the national level, a rejuvenated Malaria Social and Behaviour Change Communication (SBCC) working group (formerly Malaria Information, Education, and Communication [IEC] working group), that is headed by the Health Education Section (HES) through its Malaria Desk Officer will continue to serve as a meeting point for all partners working in malaria, monitor progress in the implementation of the strategy, ensure standards are created and met as well as

provide guidance to district level coordination and implementation of activities. At the district level, this role will be taken up by the District Health Promotion Working Group as envisaged in the National Health Communication Strategy (NHCS).

This strategy also recognizes the importance of strengthening partnerships at all levels and building the capacities of all relevant personnel in an ongoing basis. The HES is expected to determine the SBCC capacity needs of relevant personnel within government and among community based organizations and work with the relevant development agencies, government departments and tertiary institutions of learning to provide such capacity.

1.0 INTRODUCTION AND BACKGROUND

Malaria remains one of Malawi's most intractable public health issues, accounting for about 34% of all outpatient visits and about 40% of all hospitalization among children under five years of age (HMIS, 2012). It is estimated that malaria accounts for 40% of all hospital deaths (HMIS, 2013).

In 2005, the National Malaria Control Programme (NMCP) and its partners developed the draft malaria communication strategy in alignment with the Government of Malawi (GoM) Malaria Strategic Plan 2005 – 2010 and for the purpose of coordinating malaria prevention and control communication efforts. Between January and May 2009, the NMCP coordinated stakeholder reviews of the draft communication strategy and this led to the development of the Malaria Communication Strategy 2009 – 2014.

In November 2014, the NCMP led the process of reviewing the Malaria Communication Strategy (MCS) 2009 – 2014 after five years of its implementation, as well as the review of the current malaria situation in Malawi. Both reviews were conducted through desk reviews of available literature, in-depth interviews with key stakeholders and programme implementers, as well as through two stakeholder consultative workshops. The review of the MCS 2009 – 2014 highlighted gaps in the strategy itself and in its implementation process as follows: While the strategy highlighted behavioural objectives and barriers to the adoption of desired behaviours, the communication objectives were less clear and there was no clear fit among these key components of the communication strategy. The 2009 – 2014 strategy lacked a comprehensive implementation and M&E plan, and was not budgeted; lacked adequate funds for the envisaged national rollout of coordinated community mobilization, advocacy and behaviour change communication (BCC) activities. Also, there was no fulltime program officer dedicated to malaria BCC. On a related note, when the Malaria Strategic Plan (MSP) 2005 - 2010 was reviewed and updated to become the MSP 2011 – 2016, there was no such update of the MCS 2009 – 2014. The new approaches in the MSP 2011 – 2016- mass LLIN distribution, rapid diagnostic test for malaria and IRS did not therefore have a communication component.

Despite these lapses, which may have contributed to the strategy's less than optimal implementation, the NMCP and its partners reviewed, revised, and also produced new BCC and advocacy support materials that were deployed during the annual World Malaria Day and South African Development Community (SADC) Malaria Week. Such materials were also used during the public enlightenment activities that accompany mass LLIN distribution campaigns. The high malaria awareness among Malawians estimated at 92.8% (MMIS, 2014) is an indication of the success of these awareness creation campaigns. However, this success did not translate into corresponding increases in malaria prevention and control behaviours. For example, LLIN use and the receipt of 2+ IPTp doses stand at 52.2% of the population and 63.3% of pregnant women respectively (MMIS, 2014). Also, only 31.2% of respondents took action to treat malaria within 24 hours of the onset of fever (2012).

The above gaps and the findings from the review of available literature are the basis for the development of this successor Malaria Communication Strategy 2015 – 2020. This is coming at a time when Malawi has a National Health Communication Strategy (NHCS) 2015 – 2020 that integrates all 13 essential health priorities (EHPs) and provides the harmonizing framework from which respective programs can develop their EHP-specific communication strategies. The Malaria program is the first to do this. The MCS 2015 – 2020 is an expanded and deepened version of the Malaria component of the NHCS. Fortunately, the Malungo Zii, (Malaria Free) slogan developed earlier by NMCP and its partners fits within the Moyo ndi Mpamba, Usamalireni (Life is Precious, Take Care of It) central campaign platform that is at the core of the NHCS. Bringing both together will increase brand equity, and ensure that while different programs can have their EHP-specific communication strategies, opportunities for integration and resource leveraging are not missed.

2.0 CURRENT SITUATION

2.1 LLIN USE FOR MALARIA PREVENTION

According to the Malawi Malaria Indicator Survey (MMIS) 2014, 70.2% of all households (HHs) owned at least 1 LLIN, and in 30% of these HHs, there is at least 1 net for every 2 persons; the study further reports that 51.8% of Malawians have access to LLIN, and this corresponds with 52.2% of the population who reported sleeping under an LLIN on the night before the survey. This data might suggest that those who have nets use them as required, but the same study reveals that only 66.8% and 62.4% of vulnerable children and pregnant women slept under an LLIN on the night before the survey- an improvement on the 2012 figure of 39% for pregnant women. Since the Government of Malawi distributes free LLINs to pregnant women during antenatal care (ANC) visits, these findings confirm that not everyone that has an LLIN sleeps under one. The SSDI-Communication baseline survey of 2012 confirms this as respondents cited the following reasons why they do not sleep under LLINs:

- Total lack of mosquito nets in the HH.
- Heat discomfort when sleeping under the net.
- Worn out or poor condition of the mosquito net.
- Misconceptions that LLINs are unsafe or cause infertility (33% of respondents in the SSDI baseline report felt mosquito nets are unsafe).

The NHCS also cites use of LLIN for unintended use as an area of concern such as nets being used for fishing than for the prevention of malaria.

The GoM has adopted free LLIN distribution as a strategy for increasing their use for malaria prevention. Initially free LLIN distribution was undertaken at health facilities for children born there and among pregnant women attending ANC services but in order to achieve universal coverage (defined as 1 LLIN for every 2 people) and increase usage to at least 80% the GoM has adapted time limited mass distribution campaigns. Public health facilities distribution will continue so as to maintain LLIN coverage.

This strategy will sustain knowledge about LLIN use and address, where necessary, beliefs and misconceptions that prevent people who have nets from sleeping under them. The strategy also notes that very little is known about actual net use in Malawi (who uses nets, who does not and why) and recommends that research in this area be carried out.

2.2 INTERMITTENT PRESUMPTIVE TREATMENT OF MALARIA IN PREGNANCY (IPTP)

The MMIS 2014 results showed that 63.3% of pregnant women took at least 2 or more doses of IPT during their last pregnancy, while 88.7% reported having taken at least one dose of IPT. This corresponds with the SSDI-Communication survey of 2012 finding that 90% of pregnant women took IPT. As provided for in the MSP

2011 – 2016, Intermittent Presumptive Treatment of Malaria in Pregnancy (IPTp) is provided free to pregnant women attending ANC and each woman is expected to receive three doses during the second and third trimesters of pregnancy. While there is a lack of research information on why recommended IPTp uptake is still low, there is agreement among implementers that the main barrier to IPTp uptake is the delay by pregnant women to start ANC services. This is attributed to many factors – pregnant women only access ANC when the pregnancy is fully developed (appear obviously pregnant due to many reasons including the fear of losing one's child to witchcraft if you let others know too soon that you are pregnant), fear that Sulfadoxine/pyrimethamine (SP) administration will affect the child and even lead to miscarriage.

The current strategy will integrate messages and activities that motivate women to attend ANC as soon as they discover they are pregnant and continue to attend for at least 4 times before delivery. It will also tackle beliefs that one could lose a pregnancy to witchcraft.

2.3 MALARIA CASE MANAGEMENT

The MMIS 2014 results show that 30.4% of children below 5 years of age were reported to have suffered from fever, a proxy indicator sign for malaria. According to the MMIS 2012 reports, 32.4% of the respondents had a finger or a heel prick denoting that a rapid diagnostic test (RDT) for parasitological confirmation had been performed while the SSDI-Communication baseline reported 75% were tested of which 70% tested positive. On the recognition of the recommended malaria treatment, the SSDI-Communication baseline report indicated that 84% of the respondent identified LA as the best treatment for malaria, 11% Quinine and 4% Fansidar. The MMIS 2014 showed that 92.2% of the respondents reported having taken LA, the recommended treatment for malaria. The MMIS 2012 reports that 31.2% of the respondents took action to treat malaria within 24 hours from the onset of fever. Again, while knowledge regarding the availability of testing and proper treatment for malaria is high, utilization of both remains low.

According to a study to assess the socio-cultural factors associated with delayed treatment of children with fever in Mwanza district in Malawi, the following were established as factors that lead to delay in seeking treatment:

- Traditional beliefs about the cause of fever (e.g. eating of immature sugar cane, witchcraft, etc.).
- Unavailability of anti-malaria drugs.
- Barriers to accessing formal health care system.
- Trust in traditional medicine.

The MSP highlights that despite the availability of diagnostic facilities at health facilities, health workers continue treating patients routinely and presumptively for malaria without subjecting them to malaria testing as an area of concern.

The GoM aims at strengthening and increasing access to prompt diagnosis and effective malaria treatment among the population. The government adapted a new drug policy with a shift from mono-therapy to Artemesinin Based Combination Therapy (ACT) in 2007. Artemether Lumefantrine (LA) is the nationally recommended treatment for malaria and in line with the global malaria treatment guidelines, which require parasitological diagnosis before treatment using LA, the GoM introduced RDT in 2011.

This strategy will promote prompt health seeking at clinics and hospitals especially as it relates to Malaria. It will also put in place reminders that will prompt health workers to test before treating for malaria.

2.4 INDOOR RESIDUAL SPRAY (IRS) FOR MALARIA PREVENTION

The GoM began the IRS program in 2007 covering one district and has since expanded to include 7 other districts in 2010. It is projected that as part of universal coverage, 12 highly endemic districts will be reached as part of malaria vector reduction. MMIS 2014 results showed that out of the 7 highly endemic districts where IRS had been implemented only 9% of the HHs had been sprayed during 12 month period before the survey. Generally, IRS is a widely accepted intervention where it has been implemented; the refusal rate is between 2 – 5%. The End of Spray Performance Report by Chemonics (March 2012) noted that the refusal (2-5%) was associated with previous LLIN distribution – some refused to get their houses sprayed because they did not receive free LLIN while some of those who received LLIN saw no benefit for their houses to be sprayed. Other reasons thought for IRS refusal include:

- Safety / fear of the insecticides possible effect on human and domestic animals.
- Misconceptions that IRS can cause infertility.

This strategy will promote the need for joint use of both LLIN and IRS, on one hand, and address safety concerns regarding IRS on the other.

2.5 MEDICINES AND COMMODITIES

In the past few years the country has witnessed the pilferage of commodities such as LLINs and IRS insecticides while recently the rate of pilferage of LA and RDTs has escalated to daunting levels. According to a study done by the Government of Malawi with support from the Government of Norway malaria commodities; ACTs, malaria Rapid Diagnostic Test (mRDT) kits and LLINs had the highest levels of leakage. To deal with this challenge there is need for a holistic approach of behavioural, legal and logistical interventions. From a social and behaviour change perspective, individuals and communities can play a big role in addressing this problem through reporting any suspected cases of drug theft/misuse to the right channels. Whilst this area needs more research, some of the possible behavioural reasons for the pilferage could be:

- Lack of ownership of medicines and commodities by communities: This induces diminished interest to report suspected cases.
- Inavailability and ignorance of reporting channels: There are no support communication mechanisms to contribute to crime reporting.
- Fear of repercussions after reporting may also force some individuals and communities to stay away from reporting any suspected cases of crime.

The strategy will work towards strengthening collective ownership of health products at public health facilities by community members. It will also promote the role of communities as duty bearers to report on any suspected cases through safe/confidential channels.

2.6 MALARIA KNOWLEDGE AND SOURCES OF INFORMATION

Knowledge about malaria is high in Malawi, as mentioned previously in this strategy. Over 90% of respondents have heard of malaria, 72.1% cited fever as the main sign for malaria, and 82% cited mosquito as the cause of malaria (MMIS, 2014). Knowledge regarding prevention is also high with 87% citing sleeping under a mosquito net as vital for malaria prevention (MMIS, 2012); a percentage that corresponds with the 90% reported in the SSDI-Communication baseline survey.

On the most common sources of malaria information: the MMIS 2014 indicates that 40.3% of those surveyed cited Government clinics/hospitals, 42.6% radio, and 11.3% Community Health Workers while the SSDI-Communication reports 78%, 36% and 37% respectively. Men are more likely to have access to and control of the radio at the HH level. The most preferred radio stations are Zodiak Broadcasting Station, and Malawi Broadcasting Station 1 and 2.

On radio and TV ownership, the MMIS 2012 indicated that 49% and 9% of the population own a radio and TV respectively. The access to electricity is 7% hence this implies that most radios / TV would be battery power sourced.

This strategy will utilize the popular channels of clinics/hospitals, radio and community health workers, as well as others, to reach community members with timely, and comprehensive malaria information.

[1]Observation data from districts report government nets and IRS insecticides being sold while an NMCP Rapid Survey (2015) revealed major discrepancies in reported cases of malaria vs. the number of treatments procured.
[2]Government of Malawi health commodity leakage study (2015)

3.0 MALARIA COMMUNICATION STRATEGY 2015 – 2020

3.1 GUIDING PRINCIPLES

The Malaria Communication Strategy 2015 – 2020 is guided by the following general principles:

1. Implement Malaria SBCC activities all year round: Given that malaria is endemic to Malawi, its transmission occurring all year round and that everyone is at risk, malaria SBCC activities should be implemented all year round and like all the other malaria interventions – there should be "NO STOCK OUT" of malaria information and education.

2. Align strategy with MSP: This strategy responds directly to objective #3 of the Malaria Strategic Plan 2011 – 2016: "by 2016, at least 80% of the population will be practicing positive behaviours to prevent and control malaria."

3. Build on existing campaign and implementation structures: The Ministry of Health has been implementing the Moyo ndi Mpamba, Usamalireni ("Life Is Precious, Take Care of It") campaign since 2012. This campaign originally covered six EHP areas: malaria, nutrition, MNCH, family planning, WASH, and HIV/AIDS. The campaign has become quite popular among Malawians and has been adopted as the central platform for health promotion activities for all 13 EHPs (NHCS 2015 – 2020). The campaign platform provides the harmony needed by all program areas to leverage on each other and reach Malawians effectively. This strategy takes advantage of this and integrates the Malaria slogan *Malungo Zii* into the central Moyo ndi Mpamba platform. This strategy will also ride on the implementation structure of the NHCS as outlined from the national to the community level through District Health Promotion Officers (DHPOs), Health Surveillance Assistants (HSAs), Village Health Committees (VHCs) and Village Development Committees (VDCs).

4. Sustain gains on malaria knowledge: This strategy recognizes that the 92.8% malaria awareness levels realized by implementing the last strategy need to be sustained and transformed into positive actions.

5. Focus on increased uptake and utilization of malaria interventions: Beyond awareness creation, this strategy will use SBCC to motivate community members and all stakeholders to take the actions needed to prevent and control malaria.

6. Strengthen the coordination mechanism: While the IEC/Advocacy working group exists at national level to provide oversight in implementation of malaria SBCC activities, it has been holding only ad hoc reviews and planning meetings, which has been identified as a key weakness. This communication strategy will emphasize the strengthening of the coordination mechanism so as to guarantee the implementation and monitoring of the communication strategy. It will also rename the Working Group (WG) from the "IEC/Advocacy" WG to the "Social and

Behaviour Change Communication (SBCC)" WG to focus on its new mandate of targeting behaviour change on malaria and moving beyond awareness creation of malaria.

7. Generate more Knowledge, Attitudes, and Practices (KAP) data: The review process revealed that there is a limited number of malaria KAP study reports. The implementers of this communication strategy will aim to conduct more KAP studies and develop a mechanism whereby partners can share any available information through the malaria sub-WG.

8. Target health workers as key change agents: Health workers are important and trusted sources of malaria information, but despite this and their knowledge on the national guidelines for malaria diagnosis and treatment they do not practice the guidelines as they continue to treat malaria presumptively even with the availability of malaria tests. This communication strategy will target health workers and promote them as being capable of confirming malaria through a simple test while creating demand for diagnostic tests at community level. The health workers will also be supported to effectively continue disseminating malaria information at the facility level.

9. Mobilize resources and support partners: With little investment in malaria SBCC, this communication strategy will advocate for and devise innovative resource mobilization and attract more partners for increased coverage of malaria SBCC activities in the country.

3.2 PURPOSE OF THE STRATEGY

The purpose of the strategy is to provide the framework, guiding principles and key elements of malaria SBCC interventions. It also defines the implementation, coordination and monitoring of malaria SBCC programs in Malawi and emphasizes the effective involvement of District Health Management Teams (DHMTs) and other key stakeholders at all stages including the mobilization of needed resources.

3.3 OVERALL OBJECTIVE

To sustain malaria awareness and knowledge at 92.8% of the population and increase the proportion of people who take malaria prevention and control actions to 80% by the end of 2020.

3.4 BEHAVIOUR CHANGE OBJECTIVES

1. To increase by 20% the number of Malawians who consistently sleep under, and care for their LLIN by 2020.

2. To increase from 31.2% to 75% the number of Malawians who take action to treat malaria within the onset of fever by 2020.

3. To reduce the refusal rate of indoor residual spray to less than 1% by 2020.

4. To increase to 100% the number of pregnant women who took three doses of SP during their last pregnancy by 2020.

3.5 COMMUNICATION OBJECTIVES

1. To motivate the consistent use and care of LLIN at HH level while discouraging its use for unintended purposes.

2. To promote prompt diagnosis and effective malaria treatment at the nearest health facilities within 24 hours of the onset of fever.

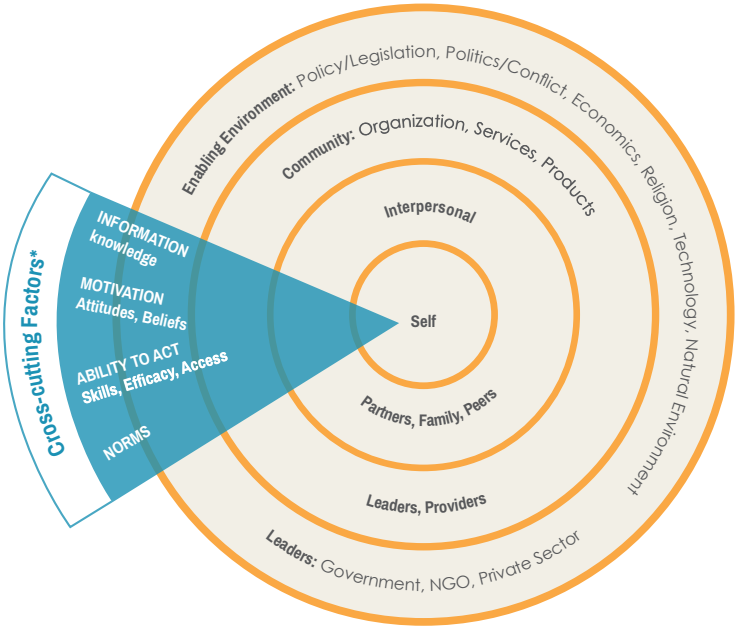
3. To promote the acceptance of, and adherence to post-IRS spray operations.

4. To promote the prevention of malaria during pregnancy.

5. To promote communities' sense of ownership of malaria commodities.

3.6 STRATEGIC APPROACH

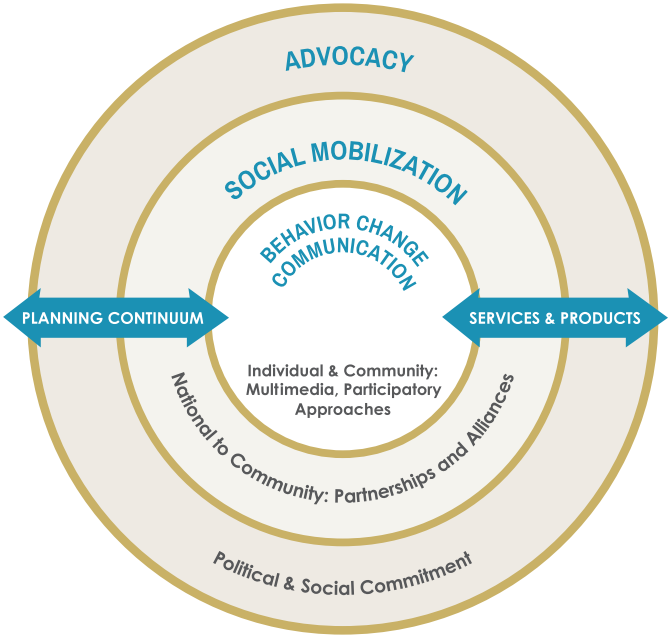
The Malaria Communication Strategy (MCS) draws its overall strategic approach from the National Health Communication Strategy (NHCS). The foundation for this approach is the socio-ecological model, which recognizes that behaviour is influenced by knowledge at the personal level, by the actions of close individuals like family and friends, by community norms and actions and at the wider society by environmental structures and factors. Based on this model, the MCS will employ three key social and behaviour change communication (SBCC) strategies to achieve its purpose and objective. These strategies include:



*These concepts apply to all levels (people and institutions), but originated at the self level.

SOURCE: Adapted from McKee, Manoncount, Chin and Carnegie (2000)

• **Advocacy:**
To strengthen policy, systems and mobilize resources through the engagement of political, social leadership, donor and policy makers. Advocacy will help create an environment conducive for the adoption/maintenance of positive behaviours. Advocacy will target government and donor agencies for policy and resource mobilization, private sector for increased participation and support, religious and community leaders for public pronouncements that educate and motivate community members to take action.



SOURCE: Adapted from McKee, Manoncount, Chin and Carnegie (2000)

• **Social/Community Mobilization:**
To increase participation and ownership among community members by engaging social groups like women, youth and other organized groups, CBOs, and events such as agricultural events, HH visits, community events, meetings, and dialogues. Social/community mobilization will tackle entrenched belief systems and community norms that are barriers to malaria prevention and control, but deepen and normalize positive individual and community actions.

• **Behaviour Change Communication (BCC):**
To change individual behaviours by targeting them through interactive and participatory communication activities including entertainment education using

clinic/hospitals, radio, community health workers and volunteers. BCC activities will be supported through the production and distribution of materials including job aids for health workers, booklets for households, posters, leaflets, radio spots and jingles and other below the line items: T-shirts, zitenje (cloth), face caps, calendars, and armbands.

3.7 CHANNEL AND ACTIVITY MIX FOR SPECIFIC OBJECTIVES

1. To motivate the consistent use and care of LLIN at HH level while discouraging its use for unintended purposes.

TABLE 1A: AUDIENCE SEGMENTS

Primary: (Directly affected)	Head of the HH
Secondary: (Directly influencing)	Women in the HH
Tertiary: (Indirectly influencing)	Community leaders, Government departments: Fisheries and the Local Government, Councillors, DECs

TABLE 1B: PRIMARY AUDIENCE

Primary audience	Head of the HH.
Desired change	Head of the HH should ensure that LLINs are hanged up and that everyone in the HH should sleep under an LLIN every night all year round.
Key barriers	• Heat discomfort when sleeping under an LLIN. • Misconceptions that LLIN are unsafe and cause infertility.
Communication objective	• To dispel misconceptions and motivate everyone in the HH to sleep under an LLIN every night.
Communication channel, activities and materials	**Interpersonal communication:** • Use community volunteers to reach HH that have received LLINs and provide support in consistent use. • Use community volunteers to provide support in Hanging up LLIN at the HH level. • Use the community volunteers to demonstrate LLIN hang up during community meetings, dialogue and malaria open days. • Use satisfied users as advocates of LLIN use. • Use of health workers (clinicians) to counsel confirmed malaria cases at the facility and LLIN beneficiaries to sleep under LLIN to prevent future malaria infections. **Community mobilization:** •Use community chiefs, VHCs, VDCs and elders to organize and hold community pre-mass LLIN distribution consultative meeting to seek the communities' commitment and support in LLIN use, identify and address any barriers to increased use before distribution. **Mass media:** • To maintain the level of awareness on the importance of LLIN for malaria prevention. • Promote testimonies of satisfied LLIN users.

TABLE 1C: SECONDARY AUDIENCE

Secondary audience	Women in the HH.
Desired change	HH members should be motivated to ensure the proper use and care of LLINs.
Key barriers	• When an LLIN is torn and worn out HH members considers it as being ineffective. • Putting worn out LLINs to alternative use rather than repairing them.
Communication objectives	• To promote the care of LLINs through regular washing. • To promote the repair of LLINs in case of tear.
Communication channel, activities and materials	**Interpersonal communication:** • Use of community volunteers to conduct HH visits and provide support in the care of LLINs. **Mass Media:** • To support the care of LLINs at HH.

TABLE 1D: TERTIARY AUDIENCE

Tertiary audience	Community leadership (chiefs, religious leaders) Government departments: Fisheries and Local Government.
Desired change	Provide support that will ensure the regulation and use of LLIN for malaria prevention other than alternative uses related within their functions.
Key barriers	Lack of regulation on the netting materials used for fishing.
Communication objectives	To engage relevant government sector especially fisheries and local government in the regulation of LLIN for use in malaria prevention only at HH level.
Communication channel, activities and materials	**Advocacy:** • Engage the relevant government sector in consultative meetings and present a position paper on LLIN use for malaria prevention and seek their commitment in guaranteeing the provision of and enforcement of relevant regulations that will mitigate the use of LLIN for unintended purposes. • Engage community leadership (Chiefs, religious leaders) in district advocacy meetings to provide support through educating communities on use of LLINs and create awareness on the relevant regulations provided at national level.

TABLE 1E: KEY MESSAGES

What	Who	Why/Benefits
Everyone in the HH should sleep under LLINs every night of the year.	All family members	Sleeping under LLINs is the most effective prevention method against malaria for you and your family.
Take care of your LLIN by repairing / stitching holes or tears, washing it regularly.	Husband/wife	Repair and washing of the LLIN will help to maintain the effectiveness of the insecticide.
Everyone in the village should sleep under an LLIN every night for the whole year.	Village chief	Ensure that every HH in your village uses the LLINs to protect against Malaria.
Support in the promotion / regulation of LLIN for malaria prevention only.	Fisheries department & the local government	LLINs should only be used for malaria prevention.

2. To promote prompt diagnosis and effective malaria treatment within 24 hours of the onset of fever at the nearest at the nearest health facilities.

TABLE 2A: AUDIENCE SEGMENTS

Primary: (Directly affected)	Individual adult patient, parent/caretaker of a sick child.
Secondary: (Directly influencing)	Parent or caretaker of a sick child.
Tertiary: (Indirectly influencing)	Health worker.

TABLE 2B: PRIMARY AUDIENCE

Primary audience	Individual adult patient, parent/caretaker of a sick child.
Desired change	• All suspected malaria cases should take prompt action and demand for malaria testing. • Only confirmed positive malaria cases receive recommended malaria treatment within 24 hours of onset and complete the prescribed dosage.
Key barriers	• Community members consider malaria as a normal occurrence and hence delay to take action. • Community members continue to consider every fever as malaria. • Self-diagnosis and treatment from sources other than health facilities by community members.
Communication objectives	• To promote early care seeking at the nearest health facilities. • To create a demand for malaria testing before treatment. • To promote the use of the nationally recommended treatment for positive malaria cases. • To motivate individuals to complete the dosage as prescribed.

Communication channel, activities and materials	**Community dialogue:** • Use HSAs and community volunteers to conduct community dialogues to identify and address barriers for prompt diagnosis and effective malaria treatment. **Interpersonal communication:** • Use of community volunteers to refer any case of fever they encounter during their HH visits to the nearest health facility. • Use the community volunteers to educate HH members that "NOT EVERY FEVER IS MALARIA" and that a quick malaria test can be done to confirm malaria. • Use of health workers to effectively communicate the results of a malaria test and the action to take depending on the result during patient consultations. • Use health workers to remind the positive malaria cases to complete the dosage as prescribed. **Health facility talks:** • Reinforce malaria diagnosis and effective treatment as a topic during health facility talks through a standardized malaria facilitative tools and materials. **Mass media:** • Promote health workers as having the capacity to conduct a quick test to confirm if you have malaria or not and that malaria testing can be done at the nearest health facility.

TABLE 2C: SECONDARY AUDIENCE

Secondary audience	Parents and caretaker of sick children, adults.
Desired change	Take or provide support to suspected malaria patients so that they can access diagnosis and treatment within 24 hours of the onset of FEVER at the nearest facility.
Key barriers	• Perceptions that under-estimate the severity of malaria. • Over-estimate the efficacy of self-medicating and subsequent failure to take prompt action.
Communication objectives	To educate the parents/caretaker/individuals/heads of HH on the importance of taking suspected malaria cases to the nearest health facility for prompt diagnosis and treatment of FEVER within 24 hours of onset.
Communication channel, activities and materials	**Interpersonal communication** • Use of community volunteers to reach HH to identify and refer sick individuals to health facilities. **Health facility talks** • Reinforce malaria diagnosis and effective treatment as a topic during health facility talks through standardized malaria facilitation tools and materials. **Mass media** • Promote malaria testing and effective malaria treatment through multimedia campaigns.

TABLE 2D: TERTIARY AUDIENCE

Tertiary audience	Health workers.
Desired change	Health workers should treat malaria as per the malaria diagnosis and treatment guidelines.
Key barriers	Health workers continue to treat malaria presumptively due to operational challenges arising from inadequate staffing.
Communication objectives	To motivate health workers to comply with the national guidelines for malaria diagnosis and treatment.
Communication channel, activities and materials	**Training:** • Integrate communication and counselling skills on malaria diagnosis and treatment in service case management training of health workers. **Mass media:** • Promote the health care worker as having the capacity to test and treat malaria appropriately: "Think you have malaria? Your health worker can now confirm if you have malaria or not through a simple test."

TABLE 1E: KEY MESSAGES

What	Who	Why/Benefits
Whenever a family member has FEVER take him/her to the nearest health facility within 24 hours of onset for a test and treatment.	Parents/caregivers	Early diagnosis will ensure confirmation of what the cause of FEVER is to enable its correct treatment.
Treat confirmed malaria cases using the nationally recommended treatment (LA).	Caregivers/care seekers/health workers	The nationally recommended treatment (LA) is the most effective treatment for malaria.
Complete the full dose of anti-malarial medicine as prescribed by a health worker.	Patients/parents/ caregivers	It is important to complete all your prescribed malaria medicine according to instructions to be completely cured from malaria.
Perform RDT before prescribing malaria treatment.	Health workers	Not every fever is malaria. Test your patients before prescribing anti-malarial medicines.

3. To promote the acceptance of, and adherence to post IRS spray operations.

TABLE 3A: AUDIENCE SEGMENTS

Primary: (Directly affected)	Heads of HH
Secondary: (Directly influencing)	Family members
Tertiary: (Indirectly influencing)	Community leaders (Chiefs, Village Elders, political leaders)

TABLE 3B: PRIMARY AUDIENCE

Primary audience	Heads of HH
Desired change	Heads of HH should allow their HH to be sprayed.
Key barriers	• Safety concerns: Fear of the effects of insecticide on human and domestic animals. • Misconceptions that the insecticide causes infertility. • Inconvenience: HHs feel inconvenienced during the process of IRS since they have to remove and rearrange their HH goods to allow for spraying. They are also required to stay out of the sprayed house before getting back to the house and feel their well painted walls will be stained after spraying. • Perceived ineffectiveness of IRS: more mosquitoes are seen in the room after spraying.
Communication objectives	• To motivate HH heads to allow for their houses to be sprayed. • To dispel the misconceptions that IRS causes infertility. • To assure HH members of the safety and effectiveness of IRS.
Communication channel, activities and materials	**Community dialogues:** • To identify and address any barriers to IRS acceptability before IRS operations. **Community mobilization:** • Use the community leaders (Chiefs, Village Elders, Political leaders) to sensitize the community on IRS as part of pre-IRS community mobilization.

TABLE 3C: SECONDARY AUDIENCE

Secondary audience	Everyone in the HH.
Desired change	Comply with post IRS requirements.
Key barriers	HH members paint, plaster or cover the sprayed surfaces thereby rendering IRS ineffective after spraying.
Communication objectives	To motivate HH members to comply with IRS requirement (do not paint, plaster or cover the sprayed surface).
Communication channel, activities and materials	**Inter-personal communication** • Use of community volunteers to visit HHs and motivate HH members to ensure compliance with the IRS requirement.

TABLE 3D: KEY MESSAGES

What	Who	Why/Benefits
ALLOW your house to be sprayed during indoor residual spraying period by cooperating with the spray team.	HH and HH members	IRS helps families keep their houses free from malaria-transmitting mosquitoes.
COMPLY with post-spraying instructions—do not wash, smear, paint or put posters/pictures on walls of your house after it has been sprayed.	Head of HH and HH members	Washing, smearing, re-plastering, painting or putting posters/pictures on walls after spraying reduces the effectiveness of IRS.

Continue using an LLIN even if the house has been sprayed.	HH members.	Even if the HH has been sprayed, everyone in the HH should sleep under an LLIN every night since LLINs offers additional protection against malaria.

4. To promote the prevention of malaria during pregnancy.

TABLE 4A: AUDIENCE SEGMENTS

Primary: (Directly affected)	Women of childbearing age.
Secondary: (Directly influencing)	Husbands and other men in the community.

TABLE 4B: PRIMARY AUDIENCE

Primary audience	Women of childbearing age.
Desired change	Women of childbearing age should start attending ANC services during the first 3 months of pregnancy and attend at least 4 focused visits so that they can receive at least 3 doses of SP during pregnancy.
Key barriers	• Pregnant women delay to start ANC services early due to cultural belief that they should not disclose pregnancy at the early stage for fear of it being "fished" out. • There are also concerns that SP may negatively affect the foetus. • Health workers due the inability to palpate a foetus in the early stage of pregnancy discourage the pregnant women seeking ANC at that stage.
Communication objectives	• To motivate women of child bearing age to start ANC services as soon as they know they are pregnant. • To dispel the cultural beliefs on early disclosure of pregnancy. • To assure pregnant women on the safety of SP to the foetus when administered during the right period. • To motivate health workers to effectively communicate with pregnant women seeking ANC services early. • To promote the consistent use of LLINs during and after pregnancy.
Communication channel, activities and materials	**Interpersonal communication:** • Use community volunteers to reach women of childbearing age at the HH level. • Use of health workers to counsel, congratulate and encourage pregnant women seeking ANC services during the first 3 months of pregnancy. **Community mobilization:** • Conduct community dialogue with women of child bearing age to identify and address cultural barriers linked to early disclosure pregnancy and assure the safety of SP. **Mass media** • To promote early ANC attendance.

TABLE 4C: SECONDARY AUDIENCE

Secondary audience	Husbands and other men in the community.
Desired change	Encourage and support pregnant women to attend ANC at least 4 times before delivery.
Key barriers	Misconception that pregnancy is strictly a woman's affair.
Communication objectives	• To motivate men to pay more attention to pregnant women and their unborn babies.
Communication channel, activities and materials	**Inter-personal communication** • Use of community dialogues to increase male involvement in pregnancy-related issues including malaria prevention for pregnant women. **Mass-media:** • Incorporate male-involvement messages into all malaria prevention and control media materials.

TABLE 4D: KEY MESSAGES

What	Who	Why/Benefits
Pregnant women should attend ANC services early so that they receive an LLIN.	Pregnant women /husband	Sleeping under an LLIN reduces the risk of getting malaria during pregnancy.
Pregnant women should receive at least 3 doses of SP during pregnancy.	Pregnant women	Administration of at least 3 doses of SP reduces the risk of getting malaria during pregnancy hence prevent low birth weight and possible miscarriage.

5. To promote communities' sense of ownership of malaria commodities (LLINs, LA, IRS insecticides, RDTs), and reporting on pilferage of these commodities

TABLE 5A: AUDIENCE SEGMENTS

Primary: (Directly affected)	Heads of HH.
Secondary: (Directly influencing)	Chiefs, Blackmarketers/Pilferers, Religious Leaders

TABLE 5B: PRIMARY AUDIENCE

Primary audience	Heads of HH.
Desired change	Heads of HHs to report suspected cases of health products (LA, nets and insecticides) being sold.
Key barriers	• Little or lack of ownership of health products as right-holders. • Unavailability of or little knowledge of reporting channels for pilferage. • Fear of repercussions from reporting.

Communication objectives	• To educate heads of HHs on negative effects of pilferage on their family and community. • To motivate heads of HHs to report pilferage. • To assure heads of HHs of their safety when they report suspected cases of pilferage.
Communication channel, activities and materials	**Interpersonal communication:** • Use community health workers and volunteers to reach heads of HHs at the HH level. **Community mobilization:** • Conduct community dialogue with heads of HHs on causes, effects, identification and reporting of pilferage. **Mass media** • Promote knowledge of causes, effects, identification and reporting of pilferage.

TABLE 5C: SECONDARY AUDIENCE

Secondary audience	Chiefs/Religious leaders
Desired change	Encourage and support heads of HHs to prevent and report suspected cases of health products (LA, nets and insecticides) being sold.
Key barriers	Chiefs can be easily influenced by bribes.
Communication objectives	• To educate chiefs and religious leaders on the negative effects of pilferage on village development. • Encourage chiefs and religious leaders to motivate heads of HHs to prevent and report cases or suspected cases of health products being sold.
Communication channel, activities and materials	**Inter-personal communication** • Use of community dialogues to increase participation of chiefs. • Integration of messages into services at churches/mosques. **Mass-media:** • Highlight the roles of community leaders (chiefs, religious leaders) in stopping pilferage.

TABLE 5D: SECONDARY AUDIENCE

Secondary audience	Blackmarketers.
Desired change	Stop pilfering health products (LA, nets and insecticides).
Key barriers	Motivated by economic benefits of pilferage.
Communication objectives	• To educate pilferers to see effects of their behaviour on a larger community. • To motivate the pilferers/blackmarkerers to stop leaking and/or selling health products.
Communication channel, activities and materials	**Mass-media:** • Communicate effects of pilferage. • Increase fear of legal results on pilferers and their families.

TABLE 5E: KEY MESSAGES

What	Who	Why/Benefits
Report suspected cases of net/LA/ insecticide pilferage to save medicines/ nets/insecticides and save lives.	Heads of HH	Products (drugs) poorly stocked lose efficacy which affects recovery from malaria. Commodities such as LLINs, LA and RDTs are meant for our health and wellbeing. When products are misused or stolen, we and our families suffer the consequences. These commodities belong to us. It is our duty to report any suspected cases of pilferage of commodities (LA, LLINs, RDTs, insecticides).
Support case identification and reporting of pilferage and avoid corruption.	Pilferers	Product misuse negatively affects service delivery and prevents health workers from serving families and communities in time of need. Legal repercussions affect one's and one's family's reputation and wellbeing.

4.0 IMPLEMENTING THE STRATEGY

1. ADVOCACY

1A. DEVELOP AND DEPLOY ADVOCACY TOOLS.

Who to target	What do we want to achieve?	How to engage them?	Materials & activities
Donors & Partners	Mobilize resources and seek technical assistance (TA) to implement the strategy.	Hold a donors consultative meeting and present the communication strategy.	Power point presention, resource envelope required to implement the strategy, short film on malaria, malaria advocacy kit.
Private Sector – Tobacco, Sugar, Electricity, Energy Generating, Mobile Telephone Companies	Resource mobilization and participation in implementation of malaria control activities.	CEOs consultative meetings - fundraising ball, dinner.	Power point presentations, short malaria film or documentary, malaria advocacy kit.
Media	Tell malaria success stories through the media (print, mass media)	Hold a malaria media workshop, Media briefing around important events like WMD and media field visits to identified programs.	Active malaria programs where positive deviants have been identified and are willing to share their success stories.
Public Sector	**Agriculture:** Seek the integration of malaria into agricultural activities since 85% of the affected populations are farmers.	Develop a blue print of strategic malaria prevention activities that the public sector departments can support. Hold an inter-sectorial malaria advocacy meeting to mobilize their support and seek commitment for the malaria prevention initiatives.	Power point presentation and briefing paper on malaria burden and its effects on various sectors. List of strategic collaborative actions required/possible. Short malaria film and malaria advocacy kits.
	Tourism: • Promote Malawi as a malaria safe destination. • Policy ensuring LLIN use in all hotels.		
	Education: • Advocate for inclusion of malaria education in the school curriculum. • Policy ensuring LLIN use in all boarding houses and student hostels.		

1B. COMMEMORATE WORLD MALARIA DAYS AND SADC WEEK

World Malaria Day (WMD): The WMD provides an excellent opportunity for advocacy events at the highest level. While the GoM has commemorated WMDs in the past, it is difficult to say what benefits have accrued to the people of Malawi considering the resources that have been invested. This strategy recommends that for WMDs to be commemorated, they should be planned well in advance, with very clear objectives and expected outcomes. The table below shows an example of a typical WMD plan.

Target	What do we want them to do?	How to engage them
The State President & members of parliament; Ministers & heads of key government institutions and departments; CEOs of key private sector organizations and media houses; heads of foreign missions and donor agencies; CSOs.	• Say what they have done regarding malaria prevention and control in the past year. • Make commitments towards malaria prevention and control in the coming year.	Annual Malaria control and prevention summit to be held on World Malaria Day.

SADC Week: This annual weeklong event is another opportunity to take stock, intensify communication activities and renew commitments. Like the WMDs, if the SADC week is not efficiently planned beforehand, resources would be wasted on activities that do not contribute to the realization of the Malaria Strategic Plan. This strategy recommends that SADC week be seen as, and implemented at the district level. A typical district level SADC week should look as shown on the table below.

Days	Activity	Expected outcomes
1	District-level annual malaria summit (attended by DHO, DHMT, Traditional Chiefs, Religious Leaders, Community based organizations, opinion leaders and other community groupings.	Malaria updates: • District Infections, transmission statistics. • Actions DHO, DHMT took in previous year. • Actions traditional chiefs, religious leaders and other relevant groups took. Stated commitments for subsequent year from all stakeholders.
2	Malaria open days in all clinics and hospitals in the district.	• BCC materials distributed. • Malaria education provided to community members. • Test conducted on those with fever, those positive treated.
3	Community outreach through street rallies, drama presentations using local drama groups, song and dance.	• Increased community ownership and participation in Malaria prevention/control efforts. • Sustained malaria awareness and knowledge.
4	HH visits by Community Health Volunteers.	• Ensure nets are properly hung. • HHs reminded of key malaria prevention and control actions.
5	Thanksgiving sermons in churches and in mosques to mark end of malaria week.	• Congregations reminded of key malaria prevention and control actions by their priests, pastors or imams. (Faith-based approach).

1C. IDENTIFY AND ENGAGE A NATIONAL MALARIA AMBASSADOR (NMA)

The process of selecting a malaria ambassador was not concluded in the past and is proposed in this strategy. In order to achieve this, the malaria SBCC sub-working group will review the terms of reference for the malaria ambassador (see Annex 2) and set out criteria for the selection or appointment of a national malaria ambassador. This will be shared with the relevant authorities to decide on this further including the placement of advertisement in the media for interested persons to apply. Once selected and appointed the malaria ambassador will provide support in advocacy of malaria at international, national and local level with a view of raising the profile, influencing change and mobilizing resources for malaria.

2. BEHAVIOUR CHANGE COMMUNICATION

2A. BRAND CAMPAIGN

As has been discussed under Guiding Principles, this strategy aligns with the National Health Communication Strategy 2015 – 2020, and will leverage on the already popular campaign and brand, Moyo ndi Mpamba: Usamalireni (Life is Precious: Take Care of it). The Malaria Communication Strategy 2015 – 2020 recommends that the sub-brand for the malaria campaign be Malungo Zii (Malaria No More!) supported by the overarching platform Moyo ndi Mpamba-Usamalireni. By doing this, the Malungo Zii and the Moyo ndi Mpamba: Usamalireni brands would have been integrated without loss of brand equity.

2B. DEVELOP AND DEPLOY BCC MATERIALS

NMCP in collaboration with the Health Education Services/Unit will organize a one-week Malaria Campaign and support materials development workshop. During this workshop, available materials will be reviewed or revised and where necessary, new ones developed. Drafts from this campaign will then be handed over to relevant production agencies to finalize for pre-testing and subsequent production and dissemination.

While in the past much emphasis was on developing materials for increased public information mainly through print materials; posters, brochures and t-shirts, the priority in this strategy is to develop materials that contain a set of messages (flip chart) that address essential malaria actions at HH level. The material will be designed so that it can help community volunteers who are expected to reach HHs to facilitate the delivery of the essential malaria action during interpersonal communication through HH visits. Once the material is developed, pre-tested and printed, next steps will be to:

- Develop an orientation curriculum for the community volunteers at national level.
- Orient the DHPO on the training curriculum and materials at the national level.
- Orient HSAs on the training materials, a process which will be led by the DHPO.
- Orient community volunteers on Interpersonal Communication (IPC) skills and the use of the materials, led by the DHPO working with HSAs.

- Develop a brochure that addresses the essential malaria actions at HH level for distribution by community volunteers to HHs after each HH visit. This brochure will act as a reminder to HH members after their HH visit. (During monitoring of malaria SBCC activities at HH level, one of the indicators will be the number of HHs reached with a brochure with essential malaria action.)

In order to support the community volunteers to conduct HH visits, the community volunteers will be given an SBCC toolkit that contains a flip chart to facilitate IPC, an LLIN (for demonstration) and brochures that are left in the HH after the HH visit. They will also have a simplified reporting tool to capture basic information like number of HH visited, those with/without LLIN, those with pregnant women and children below 5 years and to record the action/advice given. The structure will also require the HSAs to hold monthly feedback meetings with the community volunteers where monthly reports are submitted, experiences and constraints are shared and solutions agreed upon.

At health facility level: With the recognition that health facilities are a key source of trusted malaria information, BCC will support and strengthen this channel of malaria message dissemination by developing, distributing and disseminating a tool (a flip chart) to all health facilities so that when health workers are conducting health talks they will use the same standardized messaging being used at the HH level and at all other health facilities.

3. SOCIAL/COMMUNITY MOBILIZATION

3A. NATIONAL LEVEL

At this level, key national institutions will be identified and mobilized to take appropriate malaria prevention and control actions. These actions include spraying the inside and surroundings of hotels, boarding houses and student hostels, and hospitals; and ensuring that LLINs are appropriately hung over beds in all hotel rooms, student hostels and hospitals.

Who to target?	What malaria action do we want them to take?	How do we engage?
Public Sector	**Education:** • To increase the utilization of LLINs at boarding schools and campus hostels. • To apply IRS in boarding schools. • To promote malaria diagnosis and treatment through school nurses.	Make it a policy for every school to adopt the stated malaria interventions. Issue and implement a ban on the use of LLINs for unintended use within their control.
	Fisheries and the local government: • Support in limiting the use of LLIN for malaria prevention only hence increase LLIN usage.	Issue and implement a ban on the use of LLINs for unintended use within their control.
	Tourism: • To increase the utilization of LLIN at all the hotels and lodges in Malawi. • To apply IRS in and around hotels.	Advocate for the inclusion of malaria intervention (LLIN) as a requirement to licensing of hotels and lodges.
Private Sector – Tobacco, Sugar, Electricity, Energy generating, Mobile telephone companies	Increase the uptake of malaria interventions within the work environment: • Increase LLIN use among the employees and families. • Increase access to prompt diagnosis and effective treatment at staff clinics. • Apply IRS to staff quarters.	Implement employer based malaria control interventions.

3B. DISTRICT LEVEL

At the district level, the DHPO will use local community structures where they exist or form them where they do not exist to mobilize the community to take action on malaria prevention and control. This will include use of HSAs working with VDCs and VHCs to identify and select community volunteers who will be given an orientation on malaria SBCC and provided with a malaria SBCC toolkit so as to facilitate IPC during HH visits to motivate and provide support in increasing use of malaria interventions at HH level. The support will include: demonstration and actual hanging of LLINs, identification and referral of pregnant women to attend ANC, and in the case that they encounter a sick HH member during the visit they will also provide referrals to the nearest health facility. Others to target will include but not be limited to the following:

Who to target?	What malaria action do we want them to take?	How do we engage?
VDCs and VHCs	To work with HSAs and support in the selection of community volunteers, provide oversight to the community volunteers.	Orient the VDCs and VHCs on their role in promoting malaria SBCC at community level, hold periodic feedback meetings.
Women's groups	Promote malaria free HHs by ensuring each member adopts the essential malaria actions at HH level. • Encourage all members to sleep under an LLIN. • Ensure members seek prompt diagnosis and effective malaria treatment. • Ensure every member accepts IRS where applicable.	Include the women groups as members of the district malaria advocacy group and sensitize them on this role while seeking their commitment for follow up action.
Youth groups	Promote the adoption of key essential malaria action among their members at HH level: • Active participation in community mobilization during mass LLIN distribution, IRS activities.	Include the youth groups as members of the district malaria advocacy groups and sensitize them on their role while seeking their commitment.

5.0 COORDINATING THE IMPLEMENTATION OF THE STRATEGY

5.1 National Level Coordination:

There is a malaria IEC sub working group (MIECWG)at the national level. The MIECWG will be renamed the MSBCCWG to reflect international terminology and emphasize the shift in focus from IEC to SBCC. The HES will continue to chair the WG through the desk officer assigned to the malaria program while the NMCP will continue to be the secretariat through a dedicated SBCC focal program officer. In order to activate the sub WG, the sub WG will be mandated to keep track of the implementation of the communication strategy on a quarterly basis while coordinating partner's activities on malaria SBCC. Malaria implementing partners will be asked to host the quarterly meetings on a rotation basis. The ToR and membership of the malaria SBCC the sub WG can be found under Annex 1.

5.2 District Level Coordination:

In accordance with the NHCS, District Health Promotion WGs are expected to be in place so as to interpret, implement and monitor health promotion activities. The district HP WG will derive its ToR from the national ToR but will reflect more on implementation and experience sharing. Malaria SBCC activities will ride on the HES structure and strengthen its coordination mechanism to guarantee the delivery of key messages to the HH level. The DHPOs will work closely with the District Malaria Control Coordinators who are expected to provide technical support and advice on any on-going and planned interventions like mass LLIN distribution or IRS in the district for SBCC to support through the DHPO. NMCP working with HEU will support the districts to develop communication plans and mobilize resources to implement the plans. Districts will map out the existing community structures by listing out all the CBOs, FBOs, NGOs operating in their locality, use the local leadership – Village Development Committee and Village Health Committee and engage them in malaria control activities for increased HH reach.

5.3 Partnerships:

As a contribution to universal coverage, the malaria SBCC sub-working group will map out all partners' availability with respect to the geographical area where they are present and implementing activities so that gap areas can be identified. The role and participation of NGOs, private sector and the civil society is important in ensuring wide coverage of malaria SBCC activities throughout the country. A key strategy to filling the identified gap in coverage will include the dissemination of the communication strategy to potential stakeholder and partners. The partners once identified will receive all the technical support and materials to implement the malaria SBCC program so that there is national standardization while opening room for new and innovative approach that will be documented over time for future scale up.

5.4 Capacity Building:

While it is appreciated that DHPO are trained to carry out health promotion activities and that the HES is mandated to orient and continuously build the capacity on emerging issues, NMCP will work with HES to organize a training for the DHPO on basic malaria knowledge and skills so that they are equipped with the relevant information to tackle and clarify any myths and misconceptions on malaria. The malaria orientation materials and plans will include – malaria prevention through LLIN, IRS and IPTp, malaria diagnosis and treatment. Practical IRS and malaria testing will also be undertaken during the orientation. Similar cascade trainings will be extended to HSAs and community volunteers so that they understand and interpret the same at local levels. A training plan will be developed starting with a national level Training of Trainers (ToT) drawn from HES and relevant departments – NMCP, Reproductive Health Directorate (RHD) Integrated Management of Childhood Illnesses (IMCI), and Laboratory through to ToT at the district level who will in turn train HSAs and community volunteers. A key output of the planning and orientation meeting will be the development of malaria communication plans by the DHPOs, on which they will orient the HSAs. Community volunteers will be oriented on malaria SBCC communication techniques and essential malaria messages and actions for households.

6.0 RESEARCH, MONITORING AND EVALUATION

6.1 Monitoring:

NMCP Program Officers do conduct regular visits in the districts to provide support supervision and so do Program Officers from the HES both using different supervisory tools. The NMCP supervisory tool captures a section on IEC activities within the broader form. On the reporting aspect the HES has developed a health promotion quarterly reporting form that captures malaria indicators on SBCC as part of the 13 health priorities which districts have to report on and submit to HES. While this will remain the case, the communication strategy plans to strengthen the health promotion services by having the malaria SBCC sub WG review all the supervisory and reporting tools available at NMCP and HES then consolidate them to ensure they capture the necessary indicators for this strategy. District support supervisory visits between NMCP and HES are also proposed and a mechanism shall be developed for HES to capture the malaria indicators from the quarterly district reports and share the same with NMCP and partners during the quarterly malaria SBCC sub-Technical Working Group (TWG) meetings.

6.2 Evaluation/Research:

In developing this strategy, it was observed that there is a gap of information on malaria KAP and hence difficulty in setting up baseline indicators. In order to generate the required malaria KAP information for this strategy a baseline KAP is planned in the early term of the strategy. A Midterm Review (MTR) of the strategy is also suggested in 2017 so as to align it to the planning of the next MSP. In this way the next malaria communication strategy will support the direction the of the next MSP. Similarly, when the next Malawi Malaria Indicator Survey is scheduled in 2016 consideration will be put in place to review the malaria SBCC questions so that where gaps in data collection can be identified and addressed. For example: While the MIS identifies that 58% of respondents sought treatment from health facilities it does not further identify where this other significant 42% go to? If such information is available malaria SBCC can address this other source. Anecdotal information suggests it could be self-diagnosis and prescription from private pharmacies, which may warrant working with the private sector to address self-diagnosis and treatment. It is thus proposed that a special malaria KAP study be conducted.

In addition to this KAP study to be done in 2016, NMCP and HES will develop a robust research agenda to study issues and behaviors related to both health care providers and community members. An SBCC Research Working Group will be put in place to develop this research agenda and subsequently drive research priorities to guide implementing partners. The research agenda will be aimed at informing future iterations of the strategy as well as development of malaria focused annual campaigns. Research dissemination will be conducted through existing platforms, that include the Annual Malaria Research Dissemination Conferences, as well as other new platform like a web-based portal hosted by the Health Education Services.

The research agenda will also incorporate ongoing and new operations research. Some of the ongoing/planned operations research activities include the following.

- **Pilot program on monitoring community level IEC/BCC activities:** During the development of this strategy, it was established that WHO is planning to pilot this program. A consultant has been identified and undertook an in-country field visit. The malaria sub-WG will follow up on this with WHO and be part of the pilot. Lessons learnt from this pilot program will inform future programs.

- **Malaria school health program:** Engagement of schools in malaria SBCC featured during the development of this strategy but no clear direction was proposed. Counterpart International through a program - Supporting the Efforts of Partners (STEPS) will implement a malaria school health in 2 districts – Machinga and Mchinji through a partner yet to be identified. This strategy proposes that the malaria sub WG work with Counterpart International to identify a clear strategy for working through schools and come up with a model malaria school health program to inform future programs.

- **Community Integrated Management of Childhood Illnesses pilot program** NMCP through its partners is currently piloting a CIMCI program in Mchinji district and Save the Children International is supporting the SBCC component. Save the Children will share its experience on this integrated SBCC approach for future scale up of CIMCI in Malawi.

SUGGESTED OPERATIONS RESEARCH (OPR):

Male involvement in malaria control activities: It was observed during the development of this strategy that women are the main recipients of LLINs but men are expected to play a key role in hanging the LLIN. Men are the main decision makers if IRS is to be undertaken, likewise they can directly influence their spouse to attend ANC to access prevention of malaria services during pregnancy or take prompt care seeking among the family. In one instance, the NMCP team encountered a female headed HH that had benefited from mass LLIN distribution but had not hanged up the LLIN because the husband had migrated out of the country. This triggered the suggested OPR question.

7.0 RESOURCE MOBILIZATION

One of the main weaknesses of the 1st generation communication strategy was that it did not include a budget, and did not include a resource mobilization plan. To implement this communication strategy for the recommended five year period, it is estimated that USD2,781,875.00 will be required (See annex 2 below). Various activities have been outlined under the program advocacy section and include engaging donors in the dissemination of the strategy and meeting with the private sector stakeholders. Other avenues will be to include it in the next annual Malaria Operation Planning for USAID/PMI, and submission during the next Global Fund call for proposals period. Other in-country bilateral partners – WHO and UNICEF – will also be approached for support. NGOs and implementing partners are requested to identify specific areas of interest and provide support.

8.0 DISSEMINATION

Upon finalization, validation and endorsement of the communication strategy, 1,000 copies will be printed for distribution. The communication strategy will also be posted on the MoH/HES website www.healthpromotion.gov.mw. A power point presentation will be created and a simplified version of the communication strategy will be created so that participants will also have a quick reference when dissemination sessions are undertaken Dissemination sessions will target: donors, private sector partners and implementing partners such as DHMTs and NGOs.

ANNEXES

ANNEX 1: IMPLEMENTATION PLAN

Strategic Area	Activities	2015				2016				2017				2018				2019				2020			
	SBCC Reaearch and Dissemination	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
	Finalization and printing of 1000 copies of the malaria communication strategy.	X																							
Coordination, monitoring and evaluation	Hold quarterly Malaria IEC TWG meeting.	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
	Undertake quarterly district supervisory & monitoring visits.	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
	Support DHPOs to conduct quarterly onsite supervision and monitoring of malaria SBCC activities.																								
	Review, develop and finalize the malaria SBCC orientation curriculum.				X																				
	Plan and conduct a national ToT on malaria SBCC.				X																				
	Conduct the orientation of DHPO and develop district malaria communication plans.					X																			

	Support districts to orient HSAs on malaria SBCC.					X																			
	Support districts to orient community volunteers on malaria SBCC.						X																		
	Conduct a baseline malaria KAP study.			X																					
	Conduct a MTR of the malaria communication strategy during the next MMIS 2016.								X																
	Organize official launch through the dissemination of strategy in a donor's and private sector roundtable meeting.	X	X																						
	Hold planning meetings, agree on specific targets and commemoration of the WMD and the SADC malaria week.		X		X	X	X		X	X	X		X	X	X		X	X	X		X	X	X		X
	Identify and support national malaria ambassador.				X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
	Hold a media workshop on malaria and conduct media visit to document malaria success stories.					X																			

	Hold inter-sector meeting with key department to seek support on malaria SBCC (Fisheries, Tourism, Local Government, and Agriculture) and develop work plans based on agreed joint activities.			X	X																				
	Support districts to hold malaria advocacy consultative meetings and develop action plans to promote malaria.		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Advocacy and BCC	Establish an inventory of existing malaria BCC materials.		X	X																					
	Hold a national malaria BCC material and messages review/ development workshop including development of a flip chart for community volunteers and health facility micro-teaching and agree on the slogan.		X								X								X						
	Reproduce, pre-test, print and record the malaria BCC messages and materials.			X																					

	Distribute the malaria BCC materials to the districts/partners including the flip charts for community volunteers and health facility micro-teaching.			X																					
	Based on the key priorities of the malaria communication strategy, design and implement mass media campaigns.			X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
	Develop a malaria advocacy video/film.			X																					
	Develop a resource mobilization advocacy package for Malaria Communication Strategy including a briefing paper, PPT presentation and a budgeted activities package.	X																							
	Design a package (briefing paper, presentation) for public sector partners to support identified malaria BCC activities.	X	X	X	X																				

	Support districts to hold malaria information dissemination sessions (malaria open days and community dialogues).		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Social and Community Mobilization	Hold inter-sector meetings with key departments to seek support on malaria SBCC (Fisheries, Tourism, Local Government, and Agriculture).		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
	Support districts to sensitize/orient community malaria advocacy on malaria. (VDCs, VHCs, women and youth groups).		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X

ANNEX 2: MONITORING & EVALUATION PLAN

Strategy	Input	Process	Output	Outcome
Strengthen program coordination, monitoring and evaluation.	Amount of funds available, printed copies of the Malaria Communication Strategy available, malaria SBCC orientation package available, national level trainers available, malaria SBCC supervisory tools available.	Number of malaria communication strategy printed.	Number of partners reached during the dissemination and distribution of the malaria communication strategy.	Number or Proportion of partners using the malaria communication strategy to plan and implement malaria SBCC activities.
		Number of quarterly Malaria sub WG meeting planned, held and minutes are available.	Quarterly review of the implementation of the malaria communication strategy is undertaken.	Implementation of the Malaria communication strategy is on track.
		Number of quarterly district supervisory & monitoring visits planned and held.	Number of districts monitored and supervised per quarter by the national team and reports available.	Proportion of districts supervised and monitored implementing malaria SBCC activities per plan.
		Number of districts supported to conduct quarterly onsite supervision and monitoring of malaria SBCC activities.	Number of districts supported to conduct quarterly supervision and monitoring visits and reports available	Proportion of districts supported with active malaria SBCC program.
		Malaria SBCC orientation package reviewed and available.	Malaria SBCC orientation package used in the orientation of national ToT.	Malaria SBCC orientation package used in the orientation of national ToT
		Orientation of national malaria SBCC trainers held	Number of national ToT on malaria SBCC available.	Number of national malaria SBCC ToT participating in orientation of DHPOs.

		Training of DHPO on malaria SBCC and development of district malaria communication plans held	Number of DHPOs oriented on malaria SBCC and development of district communication plans	Number/proportion of districts oriented on malaria SBCC and have district communication plans in place.
		Number of districts supported to orient HSAs on malaria SBCC.	Number of HSAs oriented on the malaria SBCC and the district communication plans.	Proportion of districts implementing the district communication plans through HSAs
		Number of districts supported to train community volunteers on malaria SBCC	Number of community volunteers oriented on malaria SBCC	Number of HH reached by community volunteers oriented on malaria SBCC.
		Baseline survey on malaria KAP study planned.	Baseline survey on malaria KAP conducted and report is available.	Results of the malaria KAP baseline survey used to establish baseline indicators for the strategy.
		MTR of the malaria communication strategy planned	MTR of the Malaria Communication Strategy conducted	Results of the MTR used to align the Communication Strategy to the MSP
Strengthen malaria advocacy activities at all levels.	Resources for the launch of the strategy and for WMD and SADC Malaria Week, copies of the strategy, power point presentation of the strategy, terms of reference for national Malaria Ambassador, financial resources to support various meetings at inter-sectoral and district levels.	Dissemination launch and resource mobilization for the malaria communication strategy with donors planned and held.	Number of donors round reached.	Amount of resources mobilized and commitment received.

		Dissemination of and resource mobilization for the malaria communication strategy to/from private sector	Number of private sector partners reached.	Amount of resources mobilized and commitment received.
		Planning meetings for the commemoration of the WMD and the SADC malaria week held.	Activities to mark the WMD and SADC malaria week are conducted.	The objective of observing the day/week is achieved through firm commitments or pledges.
		National malaria ambassador identified and supported.	Number of advocacy meetings and events held by the national malaria ambassador.	Amount of resources mobilized and commitment received.
		Planning meetings for media workshop on malaria held and workshop conducted.	Number of media houses reached with malaria SBCC.	Number of malaria success stories documented and the level of malaria reporting and visibility achieved.
		Planning meetings for inter-sector meeting with key department to seek support on malaria SBCC (Fisheries, Tourism, Local Government, and Agriculture) held and minutes available.	Number of sectors/departments reached during the inter sector malaria advocacy meetings.	Inter-sector action plan and firm commitment/ pledges for malaria advocacy available.
		Number of districts supported to hold malaria advocacy consultative meetings and minutes available.	Number of districts supported to hold malaria advocacy meetings, minutes of the meetings are available	Proportion of districts supported with malaria advocacy plans available.
Strengthen malaria program communication for increased utilization of malaria interventions.	Financial resources for the national BCC workshop; copies of existing materials collected, resource persons identified for national workshop, financial resouces mobilized for materials (re) production	Inventory of the existing malaria IEC materials and messages is established.	Gaps and needs in malaria IEC materials and messages identified.	Number and type of required materials to be developed identified.

		National workshop to review malaria IEC material and messages planned and held: workshop report available.	Number of malaria IEC materials and messages reviewed as per strategic intervention and gaps identified.	Gap and need for malaria IEC materials and messages defined
		Number of malaria IEC materials and messages reproduced, developed, pre-tested, printed and recorded as per the malaria strategic interventions.	Number of malaria IEC materials and messages available per strategic intervention.	Number of malaria IEC materials and messages available for distribution and dissemination.
		Number of malaria IEC materials distributed to the districts/ partners including the flip charts for community volunteers and health facility micro-teaching	Proportion of districts reached with malaria IEC materials and messages	
		Number of malaria IEC materials and messages available per strategic intervention.	Percentage of the community reached with a malaria messages on LLIN, IRS, prevention of malaria in pregnancy or prompt diagnosis or treatment.	
		Proportion of districts reached with malaria IEC materials and messages		
		Number of radio and TV messages aired.		
		Contract awarded and Malaria advocacy video/film developed	Malaria advocacy video available and used during advocacy meetings.	Number of partners reached using the malaria advocacy video during malaria advocacy meetings.
		Malaria advocacy kit developed	Malaria advocacy kit available	Number of partners reached with a malaria advocacy kit during distribution and dissemination.

		Number of districts supported to hold malaria information dissemination sessions (malaria open days and community dialogues)	Number of dissemination sessions held at the district level.	Proportion of the population reached with a mix of malaria messages.
Strengthen social mobilization.	Financial resources for meetings with stakeholders	Number of inter-sector meetings with key departments to seek support on malaria SBCC (Fisheries, Tourism, Local Government, and Agriculture) held at national level.	Numbers of partners reached at national level	Number of partners reached and actively participating in malaria control activity.
		Number of districts supported to sensitize/ orient communities on malaria.	Number of partners, CBOs, VHCs and groups reached at districts level	Number of the partners, CBOs, VHCs and groups actively participating in malaria control activities

ANNEX 3: FINANCIAL REQUIREMENTS

Strategic Area	Activities	Unit	Qty.	Unit Cost (malawi kwacha)	Total Cost (malawi kwacha)
Strengthen program coordination, monitoring and evaluation.	Malaria SBCC Research and Dissemination	1	2	50,000,000.00	100,000,000.00
	Finalization and printing of 1000 copies of the malaria communication strategy.	1	1,000	500.00	500,000.00
	Hold quarterly Malaria SBCC TWG meeting.	1	20	100,000.00	2,000,000.00
	Undertake quarterly district supervisory & monitoring visits.	1	20	1,800,000.00	36,000,000.00
	Support DHPOs to conduct quarterly onsite supervision and monitoring of malaria SBCC activities.	12	145	50,000.00	87,000,000.00
	Review, develop and finalize the malaria SBCC training curriculum-Consultancy fees).	1	1	3,000,000.00	3,000,000.00
	Review, develop and finalize the malaria SBCC training curriculum (Stakeholder workshops).	1	4	2,500,000.00	10,000,000.00
	Plan and conduct a national ToT on malaria SBCC-Planning and Review Workshops.	1	2	1,500,000.00	3,000,000.00
	Plan and conduct a national ToT on malaria SBCC-Consultancy Fees.	1	10	150,000.00	1,500,000.00
	Conduct training of DHPO and develop district malaria communication plans.	1	2	4,000,000.00	8,000,000.00
	Support districts to orient HSAs (Senior HSAs and their Assistants) on malaria SBCC.	1	58	500,000.00	29,000,000.00
	Support districts to orient community volunteers on malaria SBCC-Done as an on-going mentoring by HSAs.	-	-	-	-

Strengthen malaria advocacy activities at all levels (national & district).	Official launch through the dissemination of strategy in a donors and private sector roundtable meeting.	1	1	3,500,000.00	3,500,000.00
	Hold planning meetings and commemorate the WMD and the SADC malaria week.	1	100	15,000.00	1,500,000.00
	Identify and support national malaria ambassador.	1	20	300,000.00	6,000,000.00
	Hold a media workshop on malaria.	1	2	3,500,000.00	7,000,000.00
	Hold inter-sector meeting with key department to seek support on malaria SBCC (Fisheries, Tourism, Local Government, Agriculture).	1	2	1,000,000.00	2,000,000.00
	Support districts to hold malaria advocacy consultative meetings.	1	10	100,000.00	1,000,000.00
	Conduct media visit to document and tell the malaria SBCC success stories.	1	5	2,000,000.00	10,000,000.00
Strengthen malaria program communication for increased utilization of malaria intervention	Establish an inventory of existing malaria IEC materials.				-
	Hold a national malaria IEC material and messages review, development workshop including a flip chart for community volunteers and health facility micro teaching and agree on the slogan.	1	2	8,400,000.00	16,800,000.00
	Reproduce, pre-test, print and record the malaria IEC messages and materials.	1	4	6,875,000.00	27,500,000.00

	Distribute the malaria IEC materials to the districts/ partners including the flip charts for community volunteers and health facility micro-teaching.	1	4	2,500,000.00	10,000,000.00
	Air radio messages.	1	9,000	5,000.00	45,000,000.00
	Air TV messages.	1	2,400	15,000.00	36,000,000.00
	Develop a malaria advocacy video/film.	1	1	4,000,000.00	4,000,000.00
	Develop a malaria advocacy kit.	1	15,000	500.00	7,500,000.00
	Support districts to hold malaria information dissemination sessions (malaria open days and community dialogues).	1	140	3,000,000.00	420,000,000.00
	Support community volunteers to conduct HH visits.				-
Strengthen social mobilization and community based Malaria SBCC for all the malaria interventions	Hold inter-sector meeting with key department to seek support on malaria SBCC (Fisheries, Tourism, Local Government, and Agriculture).	1	25	1,500,000.00	37,500,000.00
	Support districts to sensitize/ orient communities on malaria through SBCC activities.	1	140	3,000,000.00	420,000,000.00
			Total	**Kwacha**	**1,335,300,000.00**
				USD equivalent	**$ 2,781,875.00**

ANNEX 4: MALARIA SBCC SUB WG MEMBERSHIP AND TERMS OF REFERENCE

Purpose	Terms of Reference	Chair	Secretariat	Membership
To advise on the overall implementation of the malaria communication strategy and coordinate partners activities on malaria SBCC in Malawi.	• Meet on a quarterly basis • To review progress on the implementation of national malaria communication strategy and address delays and bottlenecks. • Advise on all aspects of the malaria communication strategy including research, design, and quality of production, dissemination, monitoring and evaluation of SBCC activities. • Advise on resource mobilization for the implementation of communication strategy SBCC activities • Contribute to and support the establishment of a network linking all the major stakeholders in malaria SBCC activities • Work with other Government agencies, private sector and partners to promote intra- and inter-sector collaboration for increased malaria advocacy • Report regularly to the National Malaria Control TWG and the Health Promotion WG. • Provide support to the other sub WG (Vector control, case management) on a regular basis. • Facilitate the establishment of district level coordination teams • Report regular progress to the national health promotion Sub TWG	HES	NMCP	HES NMCP Reproductive Health Directorate (RHD), because of malaria in pregnancy (MIP) links Community Health Services Unit (CHSU)

ANNEX 5: TERMS OF REFERENCE FOR THE MALARIA AMBASSADOR

Definition: Malaria Ambassador is a nationally renowned personality or celebrity who has volunteered and is endorsed by the Ministry of Health to advocate and campaign for malaria prevention, treatment and control activities in Malawi.

It may be a politician that cuts across the board, or a model, beauty pageant, musician, comedian, or athlete.

Qualities:
- Cuts across all social and cultural barriers.
- Commands respect among all.
- Dynamic: adaptable to different situations.
- Able to communicate effectively with strong oratory skills.
- An outgoing personality.

He/she should be willing to:
- Volunteer and sacrifice resources including time and money to participate in malaria control campaigns whenever and wherever required.
- Appear in malaria control related promotion activities to pass key malaria messages such include – billboards, radio and TV spots, print materials and media.
- Visit and console malaria victims.
- Use any opportunity available to represent the interest of malaria control in the country.
- Travel around the country whenever there is need.
- Support fundraising for malaria control activities.

ANNEX 6: DEFINITION OF KEY TERMS

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

Barrier Analysis is a rapid assessment tool used to identify determinants associated with a particular behaviour so that an effective behaviour change strategy, including communication and support activities, can be developed.

Behaviour Change Communication (BCC)/Program Communication is a research based consultative process of addressing knowledge, attitude and practices through identifying, analysing and segmenting audiences and participants in programs by providing them with relevant information and motivations through well-defined strategies, using an appropriate mix of interpersonal, group and mass media channels, including participatory methods.

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

Strategic Communication is understood as an evidence-based result oriented process, undertaken in consultation with the participant group, intrinsically linked to other program elements, cognizant of the local context and favouring a multiplicity of communication approaches, to stimulate positive and measurable behaviour and social change.

Social and Behaviour Change Communication (SBCC) is the systematic application of interactive, theory based, and research-driven process and strategies to effect change at individual, community and social levels. SBCC examines challenges from multiple sides by analyzing personal, societal, and environmental factors in order to find an effective way to achieve sustainable change. SBCC also employs strategies that influence physical, socioeconomic and cultural environment to facilitate healthy norms and choices and removes barriers to them.

Tipping point is the critical point in a situation, process, or system beyond which a significant and often unstoppable effect or change to take place. It can result from a naturally occurring events or a strong determinant, such as political will, that provides a final push to move barriers to change or provide the energy needed for change

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