



Republic of Malawi
Ministry of Health

National Health Communication Strategy 2021 – 2026



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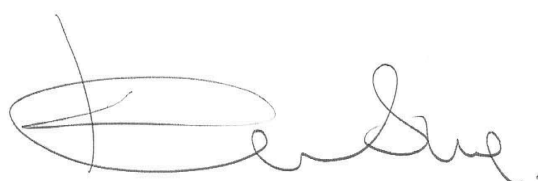
Foreword

The Malawi National Health Communication Strategy (NHCS) (2021–2026) is guided by the Malawi Health Sector Strategic Plan II 2017-2022, Sustainable Development Goals, and Health Promotion Policy that emphasise implementing health promotion and disease prevention activities to address social risk factors before they affect individual and population health.

The principles of the Alma-Ata Declaration of 1978 laid the foundation for health education as the precursor to health promotion and advocated for the primary health care approach. Health promotion began to gain acceptance worldwide after the launch of the Ottawa Charter for Health Promotion at the first International Health Promotion Conference in Ottawa, Canada, in 1986.

The World Health Organization (WHO) defines health promotion as “a process of enabling people to increase control over the determinants of health and thereby improve their health” (WHO 1998). The purpose of the NHCS is to facilitate coordination and harmonization of health promotion and communication strategies across the health sector.

This NHCS seeks to engage audiences in the design and implementation of social and behaviour change communication (SBCC) and addresses people not only as recipients but as knowledgeable subjects to achieve a deeper awareness of the socio-historical reality that shapes their lives and their capacity to transform that reality. The NHCS was developed in an interactive and participatory manner involving many health stakeholders, and it is a reference and guiding document for anyone implementing health promotion or SBCC interventions.



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MINISTER OF HEALTH

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The strategy was developed through a consultative process conducted through a task team led by the MOH-HES, and composed of the Ministry of Health - Community Health Services Section (MOH-CHSS), HC4L, Malawi University of Business and Applied Sciences, Pakachere Institute of Health and Development Communication, Malawi Broadcasting Corporation–Development Broadcasting Unit, Breakthrough Action, WHO, United Nations Children’s Fund (UNICEF), and Parent and Child Health Initiative. The MOH would especially like to thank the following individuals for their involvement in the task team: Mr. Mavuto Thomas, Ms. Ella Chamanga, Mr. Tobias Kunkumbira, Mr. Alvin Phiri, Mr. Austin Makwakwa, Mr. Taonga Mafuleka, Mr. Bowen Kapondera, Ms. Salome Kalua, Mr. Precious Phiri, Ms. Brenda Bwanali, Mr. Adrian Chikumbe, Mr. Joel Suzi, Mr. Clifton Kawanga, Mr. Christopher Teleka, Mr. Simon Sikwese, Mr. Kent Mphepo, Ms. Lusizi Kambalame, Dr. Flemmings Ngwira, Mr. Mike Nazombe, Mr. Joshua Chirwa, and Mr. Alfred Mang’ando.



.....
Dr. Charles Mwansambo
SECRETARY FOR HEALTH

List of Acronyms

| | |
|----------|--|
| ANC | Antenatal Care |
| ARI | Acute Respiratory Infection |
| ART | Antiretroviral Therapy |
| COVID-19 | Coronavirus Disease 2019 |
| CSO | Civil Society Organization |
| DAC | District AIDS Coordinator |
| DALY | Disability Adjusted Life Year |
| DHIS2 | District Health Information System 2 |
| DHPO | District Health Promotion Office |
| DHPTT | District Health Promotion Technical Team |
| DIO | District Information Officer |
| EHP | Essential Health Package |
| EPI | Expanded Programme on Immunization |
| FP | Family Planning |
| FSW | Female Sex Worker |
| GBD | Global Burden of Disease |
| GDP | Gross Domestic Product |
| HBP | High Blood Pressure |
| HC4L | Health Communication for Life |
| HP-TWG | Health Promotion Technical Working Group |
| HPO | Health Promotion Officers |
| HPP | Health Promotion Policy |
| HSA | Health Surveillance Assistant |
| HSSP | Health Sector Strategic Plan |
| HTS | HIV Testing Services |
| IPV | Injectable Polio Vaccine |
| IRS | Indoor Residual Spraying |
| KMC | Kangaroo Mother Care |
| LBW | Low Birth Weight |
| LF | Lymphatic Filariasis |
| LLIN | Long-Lasting Insecticidal Net |
| MBTS | Malawi Blood Transfusion Service |
| M&E | Monitoring and Evaluation |
| MCM | Modern Contraceptive Methods |
| MDA | Mass Drug Administration |
| MDHS | Malawi Demographic Health Survey |
| MIS | Malaria Indicator Survey |
| MNCH | Maternal, Newborn, and Child Health |
| MOH | Ministry of Health |
| MOH-CHSS | Ministry of Health - Community Health Services Section |
| MOH-HES | Ministry of Health – Health Education Section |

| | |
|--------|--|
| MSM | Men Who Have Sex with Men |
| NCD | Noncommunicable Disease |
| NCDI | Noncommunicable Disease Index |
| NGO | Nongovernmental Organization |
| NHCS | National Health Communication Strategy |
| NMCP | National Malaria Control Program |
| NTD | Neglected Tropical Disease |
| PEP | Post-Exposure Prophylaxis |
| PLHIV | People Living with HIV |
| PMTCT | Prevention of Mother-To-Child Transmission |
| PNC | Postnatal Care |
| PrEP | Pre-Exposure Prophylaxis |
| QA/QI | Quality Assurance / Quality Improvement |
| REC | Reaching Every Child |
| SBCC | Social and Behaviour Change Communication |
| SDG | Sustainable Development Goal |
| SEM | Social-Ecological Model |
| SRH | Sexual and Reproductive Health |
| STH | Soil-Transmitted Helminths |
| STI | Sexually Transmitted Infection |
| TB | Tuberculosis |
| TOC | Theory of Change |
| TWG | Technical Working Group |
| U=U | Undetectable = Untransmissible |
| UNICEF | United Nations Children's Fund |
| WASH | Water, Sanitation, And Hygiene |
| WHO | World Health Organization |
| VMMC | Voluntary Medical Male Circumcision |

About the Strategy

Intended Audience

This strategy is intended for programme designers, implementers, technical working groups, and others who are using health communication to promote health behaviours and well-being in Malawi. This includes a range of stakeholders such as those working for the Ministry of Health (MOH), nongovernmental organizations (NGOs), civil society organizations (CSOs), and the private sector.

How to Use the Strategy

The National Health Communication Strategy (NHCS) is designed to be the foundation upon which all other disease-specific health communication strategies will be developed and implemented. The strategy should be used as the basis for developing national and district level strategic plans and can be adapted to respond to local health priorities and audiences and their needs.

How the Strategy was Developed

To allow for broader stakeholder input and consensus, the strategy was developed in stages. The process began with discussions between the Health Communication for Life (HC4L) project and the Ministry of Health - Health Education Section (MOH-HES). Consultative meetings were conducted with programme managers for the various health sectors and other stakeholders to gather the information that guided the review and update of the previous communication strategy. A task team was formed that comprised representatives from the MOH-HES, HC4L, Malawi University of Business and Applied Science, Malawi Broadcasting Corporation–Development Broadcasting Unit, Palladium Health Policy Plus, Pakachere Institute of Health and Development Communication, and the Story Workshop Educational Trust.

A literature review was conducted on health communication strategies for specific health issues. A series of meetings was conducted to draft, review, and validate the strategy with task force members and other stakeholders. A validation meeting of key stakeholders was conducted to comprehensively review the strategy.

Executive Summary

Malawi has health communication strategies for several health programmes, including HIV and AIDS, nutrition, malaria, and water, sanitation, and hygiene (WASH), among others. The Government of Malawi developed the National Health Communication Strategy (NHCS) (2015–2020) to unify and guide all programme-specific strategies. This revised NHCS (2021–2026) will continue to guide national strategy for all health promotion and social and behaviour change communications (SBCC) interventions. Development of an SBCC strategy for any health-sector-specific disease area, including implementation of any health promotion and SBCC interventions for health, will be guided by this strategy.

This communication strategy will help to address the quadruple burden of communicable diseases, noncommunicable diseases, trauma-related conditions, and maternal and neonatal problems facing Malawians. One shift in the strategy has been to include emerging issues related to the Coronavirus Disease 2019 (COVID-19) pandemic. The COVID-19 pandemic affected the health delivery system and eroded some of the gains made in other areas of health. The strategy will guide how SBCC and health promotion activities must deal with emergencies, such as the COVID-19 pandemic, now and in the future.

The overarching theme of this strategy is *Moyo ndi Mpamba: Usamalireni!* (Life is precious: Take care of it). The NHCS is anchored in a social-ecological model and selected behaviour change theories. Audience targeting will be based on the life stages approach, which promotes healthy choices at critical junctures in life based on what is most important and meaningful to people at those times.

The aim of the NHCS is not only to reduce mortality and morbidity rates but also to build a nation of individuals who have the knowledge, skills, and motivation to make healthy choices and strengthen the health and well-being of communities across the country.

1.0 Background and Introduction

1.1 Country Context

Malawi is a landlocked country with a surface area of 118,484 square kilometres. The country has 28 districts, which are further divided into traditional authorities ruled by chiefs. Politically, each district is divided into constituencies that are represented by members of Parliament in the National Assembly for legislation purposes. Constituencies are further divided into wards, which are represented by a ward councillor at district assembly.

Demographically, the country had an estimated population of 17,563,749 people in 2018 (National Statistical Office, 2019), with a sex ratio of 94.2 males per 100 females and an average annual growth rate of 2.9 percent. By 2025, the population is estimated to reach 22,358,192 people. An estimated 84 percent of the population lives in rural areas. According to the National Statistical Office (2019), 15 percent of the population is children ages 0–59 months, 29 percent is ages 5–15, 52 percent is ages 15–64, and four percent is ages 65 and older.

The country has made significant improvements in social services, such as health, housing, education, water, sanitation, and hygiene. There is a strong drive by the government to provide social services and health free at the point of use, and to reduce financial barriers to services. According to the 2016 Malawi Demographic Health Survey (MDHS), life expectancy at birth is 63.7 years, and the total fertility rate in 2015–16 was 4.4 children per woman, down from 6.7 in 1992 (National Statistical Office and ICF 2017). However, there are still many barriers to the uptake of social services, mainly on the demand side, including lack of decision-making, especially among women due to culture and financial dependence on spouses, and lack of transportation.

The national poverty rate for Malawi was 51.5 percent in 2016, which decreased from 65.3 percent in 1997. Extreme poverty decreased from 24.5 percent in 2010–11 to 20.1 percent in 2016–17 (World Bank, 2017). Malawi's economy remains predominately agricultural, with agriculture accounting for 35 percent of the gross domestic product (GDP) and more than 80 percent of export earnings (primarily from tobacco sales) and supporting more than 80 percent of the population.

Malawi has a decentralized system for public health. The Local Government Act of 1998 is the legal framework for the decentralization of the system. The decentralization policy seeks to delegate authority, functions, and funds from the central government, including the Ministry of Health (MOH), to district councils. District councils are mandated to guide the decision-making process in the public health sector, including planning, budgeting, procurement, and expenditures; and to ensure efficiency, effectiveness, and equity in the delivery of health services, including the general provision of the essential health package (EHP).

Although the health sector in Malawi has been decentralized, the central government has not fully devolved its power to levels below it. The challenges affecting health services

decentralization in Malawi include shortage of human, financial, and material resources, and lack of administrative/management skills among staff. The Government of Malawi is the major provider of health services, contributing up to 52 percent of health facilities, with the Christian Health Association of Malawi contributing 15 percent of health facilities (Makwero M. T. (2018). The rest are provided by the private for-profit sector, nongovernmental organizations (NGOs), and others.

The village health committees work with Health Surveillance Assistants (HSAs) on health issues at the community level. HSAs are the lowest cadre of health workers employed by the MOH. They work in the community and are attached to health facilities. Their work is mainly preventive and promotive health service provision, though recently they have been more involved in case management of malaria, pneumonia, and diarrhoea at the community level.

1.2 Rationale for the NHCS Strategy

The field of social and behaviour change communication (SBCC) continues to evolve, creating the need for policymakers, SBCC professionals, and health promotion professionals, including programme staff, to continuously receive guidance that will help them apply their communication expertise in strategic and innovative ways. The National Health Communication Strategy (NHCS) (2015-2020) guided SBCC professionals and programme officers to effectively develop, implement, and coordinate SBCC and health promotion activities. The strategy advocated for creating a dynamic synergy between theories and models of communication and coordinating among SBCC implementers and programme providers to improve health outcomes for specific diseases and audiences.

This strategy has been revised to build on what the NHCS (2015–2020) began to implement in a bid to improve delivery of SBCC and health promotion interventions in Malawi. The strategy has been developed as a follow-up to the previous strategy to provide broad steps and guidance that SBCC and health promotion implementers should follow to help ensure SBCC efforts are developed with participation from all stakeholders. It has clear goals, segmented audiences, anticipated barriers, and proposed areas of messaging that are evidence-based.

Guided by the Malawi Health Sector Strategic Plan II 2017-2022 (HSSP II), Sustainable Development Goals (SDGs), and Health Promotion Policy (HPP), the strategy will contribute to HSSP II as its objective is to ensure healthy lives and promote well-being for all ages, which is relevant to the United Nations SDGs for 2030.

There is global recognition of the key role of health in achieving international development goals. SDG 3, *“ensure healthy lives and promote well-being for all ages,”* is directly related to health. Steps called for under SDG 3 include:

- By 2030, reduce the global maternal mortality ratio to less than 70 per 100,000 live births.
- By 2030, end preventable deaths of newborns and children younger than five.

- By 2030, end the epidemics of AIDS, tuberculosis (TB), malaria, and neglected tropical diseases (NTDs), and combat hepatitis, water-borne diseases, and other communicable diseases.
- By 2030, reduce by one-third premature mortality from noncommunicable diseases (NCDs) through prevention and treatment, and promote mental health and well-being.
- Strengthen prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol.
- By 2030, halve deaths and injuries from road traffic accidents.
- By 2030, achieve universal access to sexual and reproductive health (SRH) care services, including family planning (FP), information and education, and the integration of reproductive health into national strategies and programmes.
- Achieve universal health coverage, including financial risk protection, access to quality essential health care services, and access to safe, effective, high-quality, and affordable essential medicines and vaccines for all.
- By 2030, substantially reduce the number of deaths and illnesses from hazardous chemicals and air, water, and soil pollution and contamination.

Due to the life stage approach the strategy has adopted, health issues will be positioned more as part of everyday life and less as an expression of traditional health-wellness concepts. The strategy is oriented toward life values (on a continuum of security/safety, wealth/survival, and strength/beauty). This strategy encourages the shifting of SBCC activities from promoting health knowledge and awareness to increasing motivation, building skills, addressing social and gender norms, and creating a supportive environment for the adoption of key behaviours.

This strategy covers the following priority EHP conditions:

- Malaria
- HIV / AIDS
- Perinatal conditions (comprising maternal and child health/FP)
- (Mal)nutrition
- Diarrheal diseases (addressed by water, sanitation, and hygiene [WASH])
- Vaccine-preventable diseases (addressed by the Expanded Programme on Immunization [EPI])
- TB
- NCDs, including trauma and cancer
- Mental illness and epilepsy
- Acute respiratory infections (ARIs)
- NTDs
- Eye, ear, dental, and skin infections
- Emerging diseases, such as the Coronavirus Disease 2019 (COVID-19) and Ebola, along with blood donation

2.0 Landscape Analysis of the EHP

While Malawi has made considerable progress in improving outcomes measured by health and development indicators, many Malawians still confront serious health challenges. Malawians face the burden of communicable diseases, NCDs, trauma-related conditions, maternal and neonatal problems, and NTDs. This is reflected in the burden of disease table below.

According to the estimates in the Global Burden of Disease (GBD) Report 2013 (Institute for Health Metrics and Evaluation 2015), communicable diseases remain the leading cause of disability adjusted life years (DALYs) in Malawi. **Table 1** provides the leading causes of DALYs in Malawi.

Table 1: Leading Causes of DALYs in Malawi, 2011

| Condition | | Total DALYS (percent) |
|-----------|--|--------------------------|
| 1 | HIV/AIDS | 34.9 |
| 2 | Lower respiratory tract infections | 9.1 |
| 3 | Malaria | 7.7 |
| 4 | Diarrheal diseases | 6.4 |
| 5 | Conditions arising during the perinatal period | 3.3 |
| 6 | TB | 1.9 |
| 7 | Protein energy malnutrition | 1.6 |
| 8 | Road traffic accidents | 1.5 |
| 9 | Abortions | 1.4 |
| 10 | Hypertensive heart diseases | 1.2 |

The following section provides an overview of the current disease burden and the known knowledge, attitude, and practices for each of the 13 EHP focal areas and other emerging public health conditions in Malawi.

2.1 Reproductive, Maternal, Neonatal, and Child Health

There has been tremendous progress in reproductive health indicators, although some indicators are not improving. Approximately 95 percent of pregnant women attend antenatal care (ANC) at least once during their pregnancies. While it is recommended that pregnant women have eight ANC visits, only 51 percent completed four or more ANC visits in 2015–2016. Most pregnant women have their first ANC visit during the fifth or sixth month (National Statistical Office and ICF 2017). In 2019, 24 percent of women had their first ANC visit in the first half of their pregnancy, and 20 percent had their first ANC visit in their first trimester (MTR HSSP II).

A qualitative study conducted in Malawi found that patient-provider relationships, clinic waiting times, family and friend support, distance from home to the clinic, transportation costs, and number of visits affect adherence to ANC (Roberts et al, 2015). Failure to have at least four ANC visits increases the risk of adverse health

outcomes for the mother and baby, including maternal, infant, and child morbidity and mortality. An increasing percentage of women are delivering at health facilities with the assistance of skilled birth attendants, with the rate at 90 percent in 2016. Postnatal check-ups for mothers and newborns are still low, with only 42 percent of women completing a postnatal visit within 48 hours of birth (MTR HSSP II). Data on institutional neonatal mortality show a rate of 9 per 1,000 live births in 2019–2020. The 2015–2016 MDHS showed maternal mortality was still high at 439 per 100,000 live births, and perinatal mortality was 35 per 100,000 live births (National Statistical Office and ICF 2017).

2.2 Adolescent Health

2.2.1 Early and Unprotected Sex

In Malawi, nearly two in 10 adolescents have engaged in sex by age 15 (14.7 percent of girls and 18.2 percent of boys), sometimes leading to unplanned pregnancies and/or early marriage. Many adolescents lack access to condoms to protect themselves from pregnancy and sexually transmitted infections (STIs), including HIV (Ministry of Health, 2015b). A 2020 report by Girls Not Brides¹ shows that 42 percent of girls are married before the age of 18, and almost one in 10 are married before they turn 15 (2020). Malawi has the 12th highest prevalence of child marriage globally. The report indicates that 7 percent of boys in Malawi are married before they turn 18, which puts Malawi in the top 20 countries for prevalence of child marriage among boys.

Among girls ages 15–19, 30 percent of unmarried adolescents and 25 percent of married adolescents use contraceptives. Thus, early childbearing is high (National Statistical Office and ICF, 2017). There are approximately 154 pregnancies per 1,000 females ages 15–19, and an estimated 14 percent of these pregnancies end in abortion. According to the 2015–16 MDHS, the rate of pregnancy among adolescent girls in Malawi increased from 25 percent to 29 percent. Complications from pregnancy and childbirth are among the leading causes of death among girls ages 15–19 and are responsible for 20 percent of maternal mortality in Malawi (MTR Malawi HSSP II).

Knowledge, beliefs, and perceptions about contraceptives and condom use are critical to SRH, especially among adolescents. A study by Chipeta et al. (2010) showed that modern contraceptive methods (MCM) were perceived to have side effects such as prolonged menstruation, concerns about impotence and genital sores among men, weight gain or loss, and subsequent infertility.

The 2015–2020 National Youth Friendly Service Strategy reported that inadequate information and limited access to condoms contribute to early pregnancy and increased STIs, including HIV, among adolescents. Alcohol and substance abuse in adolescents also contribute to increased risks of sexual risk-taking. In some cases,

¹ A global partnership of Civil Society Organizations committed to ending child marriages and enabling them to fulfil their potential.

cultural practices can be harnessed to be protective for adolescents and help them deal with the adjustments of puberty and growing up while guarding them against HIV (Ministry of Health, 2015b). However, unfavourable cultural practices concerning rites of passage and marriage predispose adolescents and young people to early sexual debut, unprotected sex, unplanned pregnancy, early marriage, and STIs, including HIV (Chipeta et.al, 2010). During and after these rites, young women or men may be asked to have sex, often without protection, with partners who in most cases are older and whose status regarding HIV and other STIs is unknown.

2.3 Expanded Programme on Immunization

EPI was established in Malawi in 1979, and after 10 years, Malawi attained the universal immunization goal of more than 80 percent coverage for all childhood immunizations (e.g., Bacillus Calmette–Guérin (TB), oral polio vaccine, diphtheria, tetanus, pertussis, and measles and rubella). In 2010, the MDHS found that 84 percent of children ages 12–23 months were fully immunized; this dropped to 71 percent in 2015–2016 (National Statistical Office, 2017).

Since 2017, immunization coverage has generally improved. This has been due to several interventions that include consistent information and promotion of benefits of vaccines and immunizations, periodic intensified routine immunization, and the Reach Every Child strategy², among others. However, due to the COVID-19 pandemic, immunization coverage declined 1–4 percent in 2020. Most antigens declined by 1 percent, and measles-rubella II coverage was stable at 89 percent and 75 percent, respectively, in 2020 compared to 2019, despite the pandemic. This can be attributed to the use of micro-plans by health facilities, remote supportive supervision using phones and WhatsApp, the provision of immunization guidelines and personal protective equipment to vaccinators, and assigning national staff to specific zones and districts to track implementation of immunization services. By 2022, the HSSP II aims to have 99 percent of children age <1 year immunized with Penta III, 4 percent of children ages 12–23 months immunized against measles, and 92 percent of 1-year old children fully immunized.

Vaccine introductions usually start with low coverage due to low community awareness and mobilisation, which build over time. For example, after the introduction of injectable polio vaccine (IPV) in 2018, coverage was 13 percent; however, by 2020, coverage was 91 percent. IPV, like many other vaccines, was introduced through a campaign. Campaigns lead to higher coverage in the first round due to good mobilisation and targeted audience delivery. For instance, the cervical cancer vaccine

² Reaching Every Child (REC) is a strategy used to achieve the goal of 80 percent immunization coverage at district level and 90 percent at national level in the WHO members' states. REC aims to fully immunize every infant with all vaccines included in the national immunization schedule. To achieve this goal, the strategy focuses on building capacity from health facility level upwards to maximize access to all vaccines

achieved 83 percent coverage in its first round due to effective mobilisation during the campaign and the targeting of schools. Geographically, urban areas perform slightly better than rural areas in vaccine coverage (National Statistical Office and ICF Macro, 2011).

With the introduction of COVID-19 vaccines, the country is again experiencing vaccine hesitancy due to misinformation that has led people to doubt the effectiveness and safety of vaccines.

2.4 Blood Donation

Access to sufficient, safe supplies of blood and blood products and transfusion services is an essential part of any strong health delivery system and an important component to achieve universal health coverage goals (World Health Organization (WHO), 2017). Chronic inadequate blood and blood product supplies in Malawi hospitals are still a major challenge. The Malawi Blood Transfusion Service (MBTS) has a mandate to supply hospitals with sufficient blood and blood products to transfuse patients.

The WHO stipulates the national blood requirement for a country should be enough for 1 percent of the population. The most recent census conducted by the National Statistical Office indicated Malawi has a population of 19.5 million (National Statistical Office, 2019). According to the MBTS, Malawi requires 120,000 units of whole blood annually. Currently, MBTS collects about 70,000 units of whole blood, which is 58 percent of the 120,000 units needed. Blood donation faces several challenges. These include financial and cultural factors, lack of grassroots support to mobilise blood donors in communities, and lack of donors ages 26–65. Studies show the foundation of having sufficient blood supply is the retention of voluntary regular blood donors. WHO advocates for at least 80 percent of the blood supply to come from voluntary regular donors.

Malawi had a goal to screen 99 percent of donated blood for infectious diseases, especially HIV, Hepatitis B, and syphilis, by 2020, and Malawi was able to screen 99 percent of donated blood for these infectious diseases (National AIDS Commission, 2020).

2.5 Water, Sanitation, and Hygiene

WASH is essential to population health, welfare, and development. Poor sanitation and hygiene practices lead to increased cases of cholera, diarrhoea, and trachoma that can be spread through ingestion of contaminated water and food (United Nations Children's Fund (UNICEF) and WHO, 2019).

COVID-19, which can be spread through poor hygiene, has renewed calls for improved access to WASH. Despite significant investments in Malawi's WASH sector, access to safe drinking water (63 percent) and improved sanitation (58 percent) remains a challenge. Malawi reports that cases of preventable WASH-related diseases account

for 52.3 percent of all outpatient visits and 25 percent of mortality in children younger than five (UNICEF and WHO, 2019b).

According to the Joint Monitoring Programme for Water Supply and Sanitation (UNICEF and WHO, 2019b), 63 percent of households use an improved source of drinking water, but 68 percent of households do not treat their water before drinking even when it comes from unsafe sources. Household water treatment was less common in urban areas than in rural areas. The MDHS (National Statistical Office and ICF 2017) showed 87 percent of households use improved sources of drinking water, and 69 percent do not treat their water before drinking. The Malaria Indicator Survey (MIS) 2017 reported that 11 percent of households use an improved toilet facility, and 8 percent have a facility that would be classified as improved if not shared with other households, while 75 percent use unimproved toilet facilities, and 7 percent practice open defecation (National Malaria Control Program (NMCP) and ICF, 2018).

Handwashing with soap is still a challenge in the country, although several handwashing campaigns have been implemented. The MDHS observed handwashing facilities in 83 percent of households that were visited. Soap and water were observed in only 11 percent of the handwashing facilities, and 26 percent of the facilities had water only. Water, soap, and other cleaning agents were not observed in 58 percent of handwashing locations (National Statistical Office and ICF 2017). Although Malawi has made tremendous progress in construction of water and sanitation facilities, hygiene practices are still poor among adults due to resistance to change.

2.6 Malaria

Malaria continues to be a major public health problem, accounting for 36 percent (DHIS2, 2020) of outpatient visits in all age groups. In 2019, the country reported 5.2 million cases of malaria in health facilities and village health clinics. This represents a 38 percent reduction from 2018 levels. About 43 percent of these reported cases were in children younger than five, a reduction from 45 percent in 2018. Despite the country recording a reduction in malaria cases in children younger than five, the burden is still unacceptably high as 70 percent of the population of children younger than five in Malawi is estimated to be infected with malaria each year.

According to the Malaria Indicator Survey (MIS) 2017, women's knowledge about malaria, including causes, symptoms, and prevention, has not improved in the past five years. This has negatively affected early treatment-seeking behaviour after the onset of fever. According to the 2017 MIS, 54 percent of caregivers sought treatment for their children within 24 hours of the onset of fever (NMCP and ICF, 2018). Most delays were due to self-medication, as caretakers got antibiotics from drug stores. Many communities have poor perceptions, beliefs, and attitudes toward malaria prevention measures because they underestimate its severity. The MIS 2017 notes that perceptions, beliefs, and attitudes about the causes of malaria, how to identify symptoms, and ways to prevent the illness are often overlooked in malaria control

efforts. Yet such understanding is necessary to identify and target vulnerable populations and ensure the success of malaria control.

2.7 HIV/AIDS

HIV continues to be a major public health problem in Malawi. Tremendous efforts have been made, with support from developmental partners, to reduce the prevalence of HIV. Prevalence of HIV among adults ages 15–64 is 10.6 percent, with 12.8 percent among females and 8.2 percent among males. This corresponds to approximately 900,000 people living with HIV (PLHIV) ages 15–64 years in Malawi (Ministry of Health, 2018). Interventions to reduce the prevalence of HIV include SBCC aimed at creating awareness about the disease, incorporating HIV issues into the school curriculum, implementing HIV prevention measures, including condom programming and voluntary medical male circumcision (VMMC), implementing prevention of mother-to-child transmission of HIV (PMTCT Option B+), providing post-exposure prophylaxis (PEP), and providing antiretroviral therapy (ART) to PLHIV.

New HIV infections in Malawi vary according to socio-demographic factors. HIV prevalence is higher among women (10.8 percent) than among men (6.4 percent), and in young people (ages 15–24), prevalence is higher among women (4.9 percent) than among men (1 percent) (National Statistical Office and ICF, 2017). Moreover, the HIV incidence among adolescent girls and young women is eight times that among adolescent boys and young men (National AIDS Commission, 2020). Knowledge about HIV is still low in Malawi. For instance, 47 percent of young women and 54 percent of young men in urban areas have comprehensive knowledge about HIV, and 40 percent of young women and 42 percent of young men in rural areas do (National Statistical Office and ICF, 2017). HIV knowledge increases with increasing education. Data show that 68 percent of young women with more than secondary education have comprehensive knowledge about HIV, compared with 27 percent of young women with no education, and 72 percent of young men with more than secondary education have comprehensive knowledge about HIV, compared with 18 percent of those with no education (National Statistical Office and ICF, 2017).

HIV testing services (HTS) are an entry point for HIV care and treatment. The target was for 3 million HIV tests to be conducted by 2020, and Malawi achieved this by 2017. While more than 4 million HIV tests were conducted in 2018–2019, more than 75 percent were repeat testers (National AIDS Commission, 2020). In 2011, Malawi introduced the PMTCT strategy to reduce transmission of HIV. The target for PMTCT was to reduce HIV transmission through mother to child transmission to less than 5 percent by 2020. In 2018, the HIV transmission rate through mother to child transmission was 4.9 percent at six weeks postpartum (MTR HSSP2, April 2021). The country has made progress in treating people living with HIV such that by 2020, 97 percent of people initiated on ART and returned to care.

The MOH promotes the distribution and utilization of condoms to prevent the transmission of HIV and other STIs. In 2015–2016, 70 percent of men and women knew that using condoms and limiting sexual intercourse to one uninfected partner reduces HIV risk, compared to 63 percent of men and 47 percent of women in 2004. Reported condom use among men paying for sex increased from 61 percent in 2010 to 75 percent in 2015–2016 (National Statistical Office and ICF, 2017). A total of 50 percent of females and 75 percent of males reported using condoms during their last high-risk sexual encounter. The reported use of condoms among men who have sex with men (MSM) and female sex workers (FSWs) was 44 percent and 65 percent, respectively, which was low in relation to targets (National AIDS Commission, 2020b). Condom use at last sex with an unmarried, non-cohabiting partner was estimated at 54 percent among young women and 76 percent among young men. Misconceptions and women’s lack of negotiating power have contributed to this low and inconsistent condom use.

Community members have a high level of awareness about VMMC. However, coverage of most biomedical interventions is suboptimal in Malawi. For example, in 2016, only 28 percent of Malawian men were reported to be medically circumcised. The key challenges in promoting uptake of VMMC include inadequate demand creation activities, cultural and biological misperceptions about the procedure including the link between male circumcision and cultural identity, and perceived complications and inconveniences associated with the procedure (National AIDS Commission, 2019).

Key populations are groups of people with very high incidence and prevalence of HIV.³ These population groups experience barriers to HIV and AIDS services due to factors such as gender, stigma, and discrimination. These factors are aggravated by an unconducive legal environment and lack of awareness of the rights of key populations by service providers, which affects the provision of responsive services (National AIDS Commission, 2020b).

The number of people receiving PEP after being exposed to HIV has been increasing. In 2017, 9,648 people received PEP, and by 2019–2020, this had increased to 14,315 people, surpassing the annual target of 9,000 people. The National AIDS Commission in 2018 launched the Revised HIV Prevention Strategy (2018-2020), which included pre-exposure prophylaxis (PrEP) as an additional primary HIV prevention intervention. The aim is to promote use of PrEP among groups at higher risk, such as MSM and FSWs, as an additional primary HIV prevention method.

³ For Malawi, key population groups include FSW and their clients, transgender people, men who have sex with men, prisoners, fishermen, estate workers, discordant couples in high prevalence geographic hotspots, family members of known PLHIV, young women aged 10-24 years and children.

2.8 Sexually Transmitted Infections

STIs are a challenge in Malawi as they facilitate HIV acquisition, transmission, and progression. The prevalence of STIs in Malawi is high. Programme data have shown an increasing demand for STI services. The recorded number of STIs increased by 48 percent from 2016 to 2018. The rate of HIV status ascertainment among STI clients increased from 69 percent in 2016 to approximately 87 percent in 2018, nearly meeting the then-target of 90 percent. HIV yield among STI clients halved between 2016 (6 percent) and 2018 (3 percent).

Early health-seeking behaviours among STI clients are poor, and only 42 percent of people with STIs reported seeking recommended treatment services. The MDHS 2015-16 reported that 15 percent of women and 10 percent of men ages 15–49 who responded that they ever had sex, reported having an STI or symptoms of an STI 12 months before the survey (National Statistical Office and ICF, 2017).

2.9 Noncommunicable Diseases

NCDs constitute one of the leading causes of death in Malawi, accounting for 29 percent of deaths (Ministry of Health, 2018b). NCDs are diseases such as mental illness, hypertension, diabetes, chronic respiratory infections, and cancers. Malawi has high levels of hypertension, at 32.9 percent in adults ages 35 and above, which is much higher than many countries in the region. Asthma prevalence is estimated at 5 percent, and epilepsy contributes to 1.95 percent of the noncommunicable disease index (NCDI) DALY burden in Malawi (Ministry of Health, 2017).

According to the African Cancer Registry Network (AFCRN), Malawi has a very high cancer burden. For men, Kaposi's sarcoma is the leading cancer, followed by oesophageal. For women, it is cervical cancer. There are about 4,163 cervical cancer cases and 2,879 deaths every year, which accounts for 9,000 DALYS per year among women (AFCRN registry, 2020).

In Malawi, 6 percent of the population has diabetes. Diabetes, obesity, high blood pressure, and some infections can lead to kidney disease. GBD estimates that chronic kidney diseases have a 2.3 percent prevalence in Malawi and contributed 0.41 percent of total deaths in 2015 (Institute for Health Metrics and Evaluation, 2015).

In Malawi, mental health and substance use disorders are estimated to affect 12.85 percent of the population and contribute to 11.6 percent of the NCDI DALY burden. Depressive disorders contribute to the highest NCDI DALY burden, 4 percent, with a prevalence of 4.1 percent. These mental disorders may lead to suicide; 9 out of 100,000 people commit suicide in Malawi annually (Msiska, M. 2019). Most mental health cases are not reported at health facilities. Depression in women is most often attributed to family matters, whereas depression in young men is most often attributed to substance use.

Some of the common risk factors for NCDs are unhealthy diets, physical inactivity, excessive alcohol consumption, tobacco use, peer pressure, and religious beliefs. The STEPS survey for Malawi showed that 14.1 percent of adults currently smoke and 16.9 percent consume alcohol, with 1 in 5 men engaging in heavy episodic drinking (five or more drinks at one sitting in the previous 30 days). More women than men were estimated to be overweight, with a prevalence of 28.1 percent and 16.1 percent, respectively. Almost 17 percent of the adult population had three or more NCD risk factors. (World Health Organization, 2009).

Road traffic trauma and injuries, including violence-related trauma, contribute significantly to Malawi's public health concerns. The estimated road traffic fatalities prevalence was 31 per 100,000 inhabitants in 2016, with 50 percent of fatalities among pedestrians, 19 percent were cyclists or riders of motorized 2 and 3-wheelers, 25 percent were passengers of all vehicles, and 6 percent were drivers of all vehicles (World Health Organization, 2018). The MOH and Road Traffic Directorate are working to reduce collisions and deaths by training first aid responders and paramedics and providing ambulances along Route M1 (Ministry of Health, 2018b).

2.10 Nutrition

Overall, progress has been made in reducing the country's malnutrition rate according to the MDHS 2015-16. The rate of stunting has been reduced from 47 percent in 2010 to 37 percent in 2015-16; vitamin A deficiency from 59 percent in 2001 to 4 percent in 2015-2016, underweight in children younger than 5 from 13 percent in 2010 to 11.7 percent in 2015-16, and wasting in children younger than 5 from 4 percent to 2.7 percent. However, there has been an increase in iron deficiency anaemia in children younger than 5, from 59 percent in 2001 to 63 percent in 2015-2016, and in pregnant women, from 29 percent in 2010 to 33 percent in 2015-2016. The prevalence of undernutrition is high among adolescent girls, with 12.9 percent of adolescent girls 15-19 years having a body mass index < 18.5, compared to 5.7 percent of women ages 20-49. (National Statistical Office and ICF, 2017).

Despite efforts to reduce the burden of malnutrition, Malawi faces challenges to improving infant and young child feeding practices. Though it is recommended that women exclusively breastfeed their infants the first 6 months, the proportion of infants 0-6 months who are exclusively breastfed declined from 71.4 percent in 2010 to 60.1 percent in 2015-2016 (National Statistical Office and ICF, 2017).

Complementary feeding practices for children older than 6 months are very low in Malawi. Only 8.1 percent of children ages 6-23 months meet the minimum acceptable diet. For instance, 25 percent of breastfed children had an adequately diverse diet and had been given foods from the appropriate number of food groups, while 29.2 percent had been fed the minimum number of times appropriate for their age. (National Statistical Office and ICF, 2017).

Despite improvements in the nutrition indicators, the prevalence of malnutrition remains high according to global standards. Some of the immediate causes of malnutrition are repeated infections including ARIs, diarrhoea, and malaria; suboptimal breastfeeding; and infant feeding practices resulting in inadequate dietary intake. The underlying causes include food insecurity, gender inequality, poor hygiene practices, and lack of safe water and sanitation. Social-cultural causes include inadequate frequency and quantities of complementary feeding, low prioritisation of undernutrition, poor hygiene and sanitation at the household and community levels, and traditional beliefs. These increase the risks of childhood illnesses, poor health-seeking behaviours, and insufficient feeding of children during illness. (National Statistical Office and ICF, 2017).

2.11 Tuberculosis

Malawi is making progress in the fight against TB. The incidence of TB has decreased recently, from 162 per 100,000 in 2017 to 146 per 100,000 in 2019. In the National TB and Leprosy Control Programme Strategic Plan 2021-2025, the TB mortality rate has also decreased, from 46 per 100,000 in 2017 to 37 per 100,000 in 2019. New and relapse notifications also declined, from 129 per 100,000 in 2012 to 88 per 100,000 in 2018. The highest notification rate was among those ages 65 and older in 2018. (Ministry of Health, 2021).

In 2013, the drug resistance survey indicated a prevalence of 4.8 percent among retreated patients and 0.48 percent among new patients. Of the districts, Lilongwe (26.2 percent) had the highest prevalence of multidrug resistant cases, followed by Blantyre (15.9 percent). The overall treatment success rate for new and relapse cases in 2019 was 86 percent, which was 4 percent higher than the previous year. The TB/HIV co-infection incidence showed a remarkable decline from 70 percent in 2006 to 48.5 percent in 2018. (Ministry of Health, 2021).

Demographically, in 2018, the majority of new and relapse TB cases were among men, at 62 percent, as has been the case in previous years. TB in children contributed about 9 percent of new and relapse cases; Lilongwe and Blantyre contributed 26 percent and 15 percent, respectively, accounting for almost half of childhood TB cases reported in 2018. Regarding health zones, TB distribution for all TB forms indicated that in 2018, the Southwest (165 cases per 100,000 population) and the Central West (90 cases per 100,000 population) zones were far above the national average. The Southeast and Northern zones reported 66 cases per 100,000 population each, and the Central East zone reported 44 cases per 100,000 population. (Ministry of Health, 2021).

Tremendous strides have been made to prevent TB infections, and factors that still affect the rate of TB include:

- a) Limited access to TB treatment and care services among key populations due to social-economic barriers such as stigma and discrimination, gender

disparities, differences in economic status, and social-cultural barriers such as negative beliefs and myths

- b) Inadequate TB awareness among key populations resulting in low health-seeking behaviour among clients
- c) Inadequate knowledge on isoniazid preventive therapy benefits among providers and clients

2.12 Neglected Tropical Diseases

Eight NTDs are known to be endemic in Malawi. These are Schistosomiasis (Bilharzia), soil-transmitted Helminthiasis (STH), Lymphatic Filariasis (LF) (Elephantiasis), Trachoma, Human African Trypanosomiasis (Sleeping Sickness), Leprosy, skin diseases, and Onchocerciasis (River Blindness). NTDs cause disfigurement and disability, leading to stigma and social discrimination (Ministry of Health, 2015). NTDs have an enormous impact in terms of disease burden, loss of productivity, aggravation of poverty, and the high cost of long-term care.

Mass drug administration (MDA) campaigns are the key strategy used to reduce the prevalence of these NTDs in the country. SBCC interventions for NTDs have not been implemented at scale. SBCC materials and activities are only conducted to create demand during MDA, and no communication activities take place beyond those efforts. Further, anecdotal qualitative evidence and interviews with NTD programme managers and district NTD focal people show that SBCC materials on NTDs are unavailable in most of the districts. Consequently, knowledge on the cause, transmission, and prevention of most NTDs is very low.

The diseases and conditions that are targeted for MDA are Onchocerciasis, Lymphatic filariasis, soil-transmitted Helminths, Schistosomiasis, and Trachoma. Malawi has reached elimination levels in LF, Trachoma, and Onchocerciasis. There is a need to increase knowledge and strengthen behaviour change to maintain prevention of NTDs as well as management of LF and Trachoma.

2.12.1 Schistosomiasis (Bilharzia)

Schistosomiasis is a parasitic disease caused by the waterborne flatworm or black flukes called schistosomes. It is transmitted through contact with infected surface water. According to Makaula, P. et al., 2014, the prevalence of Bilharzia is about 23.7 percent among children living in the lakeshore areas, with reinfection rates of about 30 percent to 40 percent. School-age children are the most infected group and represent the most intensely affected. Mild cases of Schistosomiasis may result in long-term side effects that manifest in adulthood, and severe cases in children may lead to immediate morbidity. Poor sanitation and defecation in water sources such as lakes and rivers are among the prevalent practices in the disease-prone areas.

2.12.2 Soil-transmitted Helminths

STH, also known as intestinal worms, are the most common infections in Malawi. The overall age- and cluster-weighted STH prevalence was 7.7 percent, predominantly driven by hookworm infections (7.4 percent), while *Ascaris* (0.1 percent) and *Trichuris* (0.3 percent) infections were rare. The groups at highest risk of STH are children and pregnant women (Akullian, 2020).

STH are passed from the human host through faecal-oral route, penetration of the skin by the larvae hookworm, and spread due to poor sanitation and hygiene practices. Intestinal worm infection can lead to anaemia. School-age children are more likely to be infected than adults (Malawi NTD Masterplan 2015–2020).

MDA is the major strategy in treating STH, with annual deworming campaigns targeted at children ages 1 to 14.

Challenges faced during MDA

- In communities where all age groups are targeted, HSAs have a high workload during the administration of drugs.
- Children ages 5–14 do not get the deworming tablets because they do not come for the deworming exercise.
- Some children do not come for the deworming exercise because their caregivers do not go with them to the growth monitoring sessions.
- There are inadequate funds for social mobilisation in district-specific planned activities.
- There are inadequate SBCC materials, and some registers have not been updated.

2.12.3 Trachoma

Trachoma is the second leading cause of preventable blindness after cataracts. Prevalence surveys conducted between 2008 and 2014 in 24 districts showed that trachoma is endemic, with greater than 5 percent prevalence in 15 districts. About 1.3 million people in Malawi are at risk of trachoma, and 33,400 people are known to be living with Trichiasis. Among children ages 1–9 in Central and Southern Malawi, 13.6 percent had Trachoma follicles. Face dirtiness was significantly associated with the presence of trachoma follicles. Malawi eliminated blinding Trachoma in 2018, but preventive measures need to be sustained to stop a resurgence. (Malawi NTD Masterplan 2015–2020).

2.12.4 Lymphatic Filariasis

LF is transmitted by the anopheles mosquito. LF disrupts normal lymphatic vessel function and leads to chronic disabling consequences, which can manifest as hydrocele and lymphoedema (elephantiasis).

In 2008, Malawi embarked on MDA, and over 10 years, managed to reach the Filariasis elimination criteria established by WHO. The Filariasis Elimination Programme was

established to manage the process. The Filariasis Elimination Programme is now focusing on mapping Lymphatic Filariasis cases (hydrocele and lymphoedema), Hydrocele surgery campaigns, home-based management of lymphoedema cases, active surveillance, and entomological monitoring in mosquitoes.

2.12.5 Onchocerciasis (River Blindness)

Onchocerciasis, also called river blindness, is caused by *Onchocera volvulus*, which is transmitted by black fly, and is endemic in southern Malawi, particularly in Phalombe, Mulanje, Thyolo, Blantyre, Chikwawa, Neno, Chiradzulu, and Mwanza districts. The disease affects eyes and vision and impacts the skin by causing severe itching, skin thickening, and nodules leading to depigmentation (leopard skin). MDA is used as a strategy for onchocerciasis elimination, and this is done annually. Recent results demonstrate that the country is progressing toward the elimination of onchocerciasis. The main challenge is the seasonal movement of people within and outside the districts during MDA. The other challenge is the refusal to take drugs, which affects treatment coverage.

2.12.6 Human African Trypanosomiasis (Sleeping Sickness)

Sleeping sickness is a zoonotic disease caused by trypanosome (Brun et al., 2010). The disease has two clinical versions – early or first stage and late or second stage. It is endemic in five Malawi districts – Nkhotakota, Kasungu, Ntchisi, Mzimba, and Rumphi. In recent years, most cases of sleeping sickness have been reported in Kasungu, Nkhotakota, and Rumphi districts. It is estimated that about 3.5 million people are at risk of the disease (Makaula, P. et al., 2014)

2.12.7 Leprosy

Leprosy is a mycobacterial infection that affects skin and nerves, leading to muscle weakness, particularly around the face, hands, and feet. Prolonged infection, if untreated or poorly managed, can lead to the shortening of fingers and toes, mobility problems, and even blindness caused by damage of the cornea. According to the Ministry of Health, National Tuberculosis and Leprosy Control Strategic Plan (2021-2025) Malawi attained the WHO-defined leprosy elimination goal of less than one case per 10,000 inhabitants in 1994 and has since maintained that rate. To guard against the resurgence of the disease, the country continues its active surveillance efforts to ensure early detection and treatment of any suspected cases.

Active surveillance in 2011–2012 in Machinga, Mangochi, Salima, and Nkhotakota showed there was a resurgence of leprosy cases. The exercise identified 60 cases per 10,000 (Msyamboza et al., 2012). This showed that with active case-finding approaches, the country could identify more cases. Stigma and discrimination are high with this disease. This has a huge bearing on the country's surveillance efforts as some people may not be willing to report their condition to health workers for fear of being the target of social stigma and isolation in their communities. There is need to increase

awareness of early symptoms and signs of leprosy and to encourage people to report early to avoid disabilities.

2.13 Skin, Eye, and Dental Diseases

2.13.1 Skin Diseases

Many skin conditions are considered NTDs; however, scabies is the most prominent and prevalent in Malawi. The prevalence of scabies is very high, although data is not currently available. Recurrent infestations are common. The most vulnerable groups to scabies are young children and the elderly in resource-poor communities. Some of the risk factors for scabies are poor personal hygiene, overcrowding, lack of access to safe water and soap, and late healthcare-seeking behaviours to get treatment.

2.13.2 Eye Diseases

According to Kalua et al. 2011, about 136,000 people in Malawi are blind due to preventable or treatable eye conditions. Cataract, trachoma, and conjunctivitis have been identified as serious eye conditions as they cause pain and can result in blindness. Despite the seriousness of eye conditions, 22.2 percent reported they would use self-treatment first, whereas 22.6 percent would prefer treatment from a traditional healer, and 55.3 percent would go to the district hospital. Furthermore, those reporting pain as a primary condition were more likely to seek care at a district hospital rather than rely on self-treatment. Most of the respondents who opted for self-treatment were those who reported trachoma and conjunctivitis as being severe (47.7 percent and 45.9 percent, respectively). Only 6 percent of those who mentioned cataract chose self-treatment (Kalua et al. 2011).

2.13.3 Dental Diseases

Oral health problems are a major public health challenge in Malawi. A national dental and oral health survey conducted by WHO and MOH in 2016 showed that 21 percent of adolescents ages 12-15 and 49 percent of adults ages 35-44 had dental caries, and the prevalence was 49.2 percent in those 65–74 years, while 48 percent and 80 percent of the population ages 35–44 and 65–74 had missing teeth, respectively. Further, 50 percent of school children (6–9 years) had tooth decay, and the prevalence of tooth decay among those 12–17 was about 78 percent (Msyamboza et al., 2016). Evidence also showed that women were affected more than men, and many people did not practice tooth brushing, with prevalence of tooth brushing higher in urban areas than rural areas. Oral hygiene was poor, with less than 40 percent of the population brushing their teeth twice a day.

In Malawi, data on dental behavioural practices, knowledge, and attitudes is scarce. However, a few studies show that some of the factors that increase the prevalence of dental caries in Malawi include poor oral hygiene, gender, low level of oral health awareness, scarcity of dental centres, and changes in way of life and eating habits (Msyamboza et al., 2016).

2.14 Other Emerging Public Health Conditions

2.14.1 COVID-19

In Malawi, the first case of COVID-19 was reported on 2nd April, 2020. COVID-19 has spread fast and affected all districts. As of June 2021, Malawi had registered a total of 34,914 confirmed Covid-19 cases and 1,171 deaths representing a case fatality ration of 3.4% (National COVID-19 Preparedness and Response Strategy and Plan (July 2021-June 2022)). The disease is mostly spread through community transmission. The elderly and people with pre-existing chronic conditions such as diabetes, hypertension, and lung diseases have increased vulnerability to severe illness.

The COVID-19 pandemic negatively affected the implementation of most health services and interventions. There are misconceptions and myths associated with the disease and vaccine, which affect prevention efforts.

2.14.2 Ebola

In 2019, WHO declared the Ebola outbreak a Public Health Emergency of International Concern (WHO, 2019). While there have been no cases of Ebola, Malawi is a migration destination for people from Democratic Republic of the Congo and western African countries where Ebola outbreaks have occurred in recent years. There is Ebola surveillance in the border districts of Chitipa and Karonga. As such, Malawi aims to mobilise and pre-position Ebola response materials, strengthen capacity, raise public awareness and community engagement among workers at points of entry, and increase screening activities for prevention, preparedness, and readiness to respond to the outbreak (Ministry of Health, 2019).

3.0 Review of Health Communication and Promotion Gaps

Discussions with sector heads and Health Promotion Officers (HPOs) and analyses of health promotion and communication interventions were conducted to identify communication implementation gaps. The landscape analysis for disease areas in Malawi provided insights into some of the critical gaps in SBCC. One critical emerging finding is that SBCC activities and materials focused more on information dissemination and increasing knowledge and less on promoting behaviour change and audience ability to act on information. Knowledge and awareness regarding some health issues were high, while behaviour change was considerably lower. In addition, implementation of SBCC interventions did not attempt to identify upstream factors hampering behaviour change among different groups.

Some disease areas such as NTDs and NCDs were reportedly lacking in SBCC materials, affecting awareness and knowledge regarding cause, effect, and prevention of the diseases among target audiences. Implementation coordination gaps and inadequate funding are some of the identified issues affecting health communication. **Table 2** provides a summary of some gaps in health communication and promotion.

Table 2: Communication Gap Analysis

| Behaviour issue | Communication gap | Communication gap filling |
|--|--|---|
| Lack of comprehensive knowledge on cause, effect, and prevention of health issues | <ul style="list-style-type: none"> • Lack of SBCC materials for some health issues • Inability to use appropriate channel mix accessible to the target audience | <ul style="list-style-type: none"> • Identify all disease areas that have inadequate communication materials (e.g., NTDs) • Advocate for improved funding for NTD and NCD communication campaigns |
| Low health-seeking behaviour among audiences in most disease areas | <ul style="list-style-type: none"> • SBCC interventions focusing more on awareness than action. • SBCC interventions do not effectively engage influencers • Strategies not effectively addressing myths, misconceptions, religious and cultural norms, and beliefs • Structural issues such as distance, unavailability of services | <ul style="list-style-type: none"> • Develop strategies to address beliefs, myths, and misconceptions that affect health-seeking behaviours. • Strategic targeting of audiences to ensure that audiences will influence change. • Establish and utilize crisis communication teams to counter misinformation and rumours • Promote correct use of herbals based on policy • Advocate for universal health coverage to address issues of distance and cost of accessing health facilities |

| Behaviour issue | Communication gap | Communication gap filling |
|--|---|---|
| Adherence to treatment and services | Inadequate treatment literacy across the EHP | Increase knowledge regarding treatment through treatment literacy campaigns across all disease areas |
| Low risk perception that leads to poor lifestyle and health practices | <ul style="list-style-type: none"> • Inadequate knowledge on severity of some diseases (e.g., diarrhoea diseases, pandemics) • Relapse in low-risk perception during times of low disease prevalence | <ul style="list-style-type: none"> • Continuously use messages that will increase and sustain risk perceptions • Advocate for availability of handwashing facilities in all public places |
| Stigma and discrimination | <ul style="list-style-type: none"> • Lack of awareness of effects of stigma and discrimination on service uptake and adherence. • Continued use of stigmatizing language among different sections of society | <ul style="list-style-type: none"> • Use messages that are not stigmatizing • Emphasise the effects of use of stigmatizing messages and behaviours • Destigmatize health issues and services that are prone to stigmatizing language |
| Disempowered community members | Inadequate knowledge on rights, responsibility, and accountability mechanisms | <ul style="list-style-type: none"> • Increase knowledge on rights, responsibility, and how to hold duty bearers accountable. • Build community skills to hold office bearers accountable • Patient's charter • Hospital ombudsman and health advisory committee |
| Lack of coordination in the implementation of SBCC interventions | <ul style="list-style-type: none"> • Limited coordination of SBCC interventions at national and district levels • Weak SBCC structures at district level • Lack of guidance on SBCC implementation at district level • Conflicting role definition between District Health Promotion Officer (DHPO), District AIDS Coordinator (DAC), and District Information Officers (DIO) | <ul style="list-style-type: none"> • Strengthen SBCC technical working groups (TWGs) at district level. • Define roles of DHPO, DAC, and DIOs • Explore opportunities for funding for SBCC-TWG meetings through partners implementing SBCC interventions |
| SBCC funding | Limited funding for SBCC interventions | Advocate for increased funding and inclusion of SBCC interventions in projects |
| Minimal involvement of SBCC experts in national task forces | SBCC expertise is not prioritised by policy- and decision-makers | Advocate for inclusion of SBCC experts in task forces such as the COVID-19 Presidential Task Force |

4.0 Guiding Principles

The following principles guide the NHCS 2021 - 2026 and serve as the foundational tenets upon which it rests. They are drawn from and are in keeping with the principles outlined in the National HPP 2013 and the HSSP II.

4.1 Effective Communication

The strategy is founded on the principle of effective communication, which identifies and embraces all key factors that make communication effective. This includes implementing communication as a continuous two-way process between the communication teams and the target groups; understanding the target groups in terms of their values, age, gender, education, cultural and religious beliefs, and other relevant demographics; collecting and organizing information into meaningful and clear messages; consideration of potential barriers that may affect adoption and practice of desired behaviours; choosing appropriate communication channels, tactics, and activities; ensuring that messages are well understood or interpreted by the receiver and that the desired feedback is provided.

4.2 Quality of Life and Wellness

This strategy aims at improving the quality of life and wellness of Malawians through implementation of health promotion interventions that improve knowledge, skills, and access to services to ensure they lead a healthy lifestyle, which is a state of complete physical, mental, and social well-being, and not merely the absence of disease or infirmity in line with the requirements of the WHO.

4.3 Health Promotion

This strategy is based on the health promotion principle which enables people to increase their control and improve their health as guided by the Ottawa Charter for Health Promotion of 1986. Health is seen as a resource for everyday life, not the objective of living. The following approaches for health promotion will be used:

- **Advocate** – Political, economic, social, cultural, environmental, behavioural, and biological factors can all favour health. The strategy will complement health promotion, which aims to make these conditions favourable, through the support of policies for health.
- **Enable** – As health promotion focuses on achieving equity in health, women, men, boys, and girls cannot achieve their fullest health potential unless they can control factors that determine their health.
- **Mediate** – Health promotion demands coordinated action by all concerned, including governments, health and other social and economic sectors, NGOs, civil society organizations (CSOs), local authorities, the private sector, and the media.

4.4 Integrated Health Promotion Approaches and Services

Health problems have multiple determinants that need to be addressed through integrated health promotion approaches and services. Integration of health services at all levels is one of the key principles in a comprehensive primary health care approach. This strategy will promote the integration of health promotion approaches and services for health issues.

4.5 Effective Collaboration, Coordination, and Partnership

The strategy promotes collaboration among partners implementing health communication activities. All health communication partners should attend health TWG meetings where plans and reports will be shared. The strategy will promote joint supervision for monitoring of activities implemented by partners. Biannual conferences will be conducted where success stories and lessons will be shared.

4.6 Formative Assessments

The strategy is grounded in the principle of strategic SBCC, which calls for identification of the problem through a formative assessment that guides audience segmentation, barrier analysis, and selection of appropriate and relevant communication tactics, channels, and activities.

4.7 Equity and Social Inclusion

Health communication efforts shall foster critical examinations of gender, norms, customs, beliefs, and practices that negatively impact health outcomes for all. This strategy, therefore, will use communication to promote practices that positively influence health behaviours for vulnerable groups including the elderly, adolescents, women, children, people living with physical disabilities and albinism, key populations⁴, and minority groups. Communities can enjoy full health benefits when all these groups work together as equal partners. In addition, health promotion efforts shall address the needs of these groups, who are often ignored.

4.8 Community Empowerment and Participation

Communities often have realistic solutions for mobilising and addressing common health challenges. This strategy aims to empower and promote community participation in problem identification, production, and dissemination of messages, and carrying out strategic actions to achieve health outcomes. Community members shall have access to platforms such as radio, forums, and community meetings through which they can disseminate information, debate and discuss community problems, and decide how they can work together to achieve better health. This will help build a sense of ownership and lead to localized, home-grown, and sustainable solutions.

⁴ MSM and FSWs as stated in the *Malawi National Strategic Plan for HIV and AIDS, 2020 - 2025*

4.9 Rights-Based Approach

This strategy recognises all individuals have the right to health information and services. Communities include groups such as children, people with disabilities, youth, and key and vulnerable populations. Communities have a right to receive health care services and information, and the duty bearers must fulfil these rights. Communication interventions will aim to empower and motivate community members including special groups to convert the knowledge they have into action.

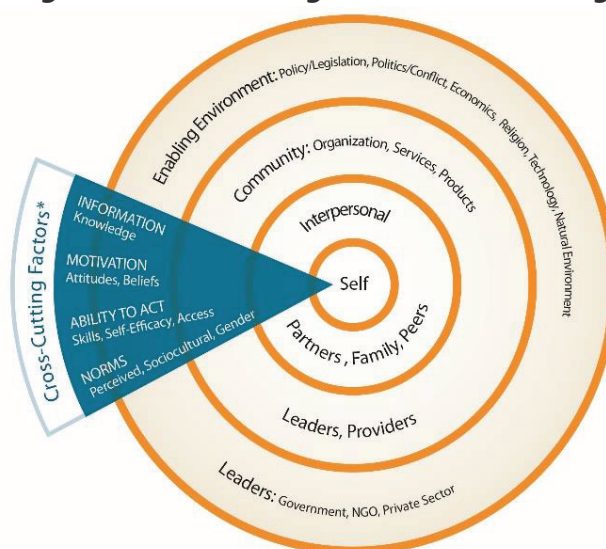
The strategy is sensitive to the different country contexts and unique communication needs of different target groups. It provides direction on contextualization and adaption of the NHCS to fit the district and community level contexts, which include geographical considerations, literacy levels, and other factors. To respond to the rights-based programme communication needs of people with disabilities, SBCC materials should be available in sign language or Braille. The strategy will be delivered in a phased approach that sensitizes policymakers, decision-makers, and programme planners to this approach so the programme can reflect the rights-based design.

5.0 Guiding Theoretical Model

The Socio-Ecological Model (SEM) of behaviour change has been used to guide the development of this strategy. The SEM (**Figure 1**) supports the theory that individual behaviour is a product of multiple overlapping individual, interpersonal, social and environmental influences and factors and combines individual change to influence the social context in which the individual operates. The SEM is based on a synthesis of theories and approaches from disciplines such as psychology, sociology, communication, and political science. The model allows practitioners to examine and address several levels of influence to find effective opportunities for change.

For interventions to succeed at achieving behavioural change for specific health issues, they must include a comprehensive approach to improve knowledge, attitudes, beliefs, and behaviours related to the health issue. Household members need to adjust their practices and habits and optimize their health behaviours. Such changes are often difficult and require more than providing the correct information about the prevention of disease. For individuals to change behaviour, key factors affecting the individuals themselves and those directly or indirectly influencing them need to be addressed. These factors include motivation, the ability to act, including self-efficacy, and social and gender norms.

According to Glanz et al. (2015), **Figure 1: Socio-Ecological Model for Change** adequately addressing societal and cultural barriers that influence behaviours, including social norms, may require application of more than one behaviour change theory. This is why the strategy applies a SEM (McKee et al., 2000) that combines individual, interpersonal, and community-level theories⁵ to analyse determinants of behaviour change across four domains: (1) individual, (2) interpersonal, (3) community, and (4) enabling environment, to identify and define barriers and facilitators of information/knowledge, motivation, ability-to-act, and social norms affecting social and behavioural change around health. By addressing not only the individual, but also the relationships, systems, and structures that influence the adoption of new behaviours and practices, individuals and



⁵ Social Learning Theory, Behavioural Economics, Positive Deviance Approach, Health Belief Model, Theory of Planned Behaviour, and the Diffusion of Innovation Theory

households are empowered with the knowledge, skills, motivation, and self-efficacy to practice new behaviours and build a supportive environment in which to practice them.

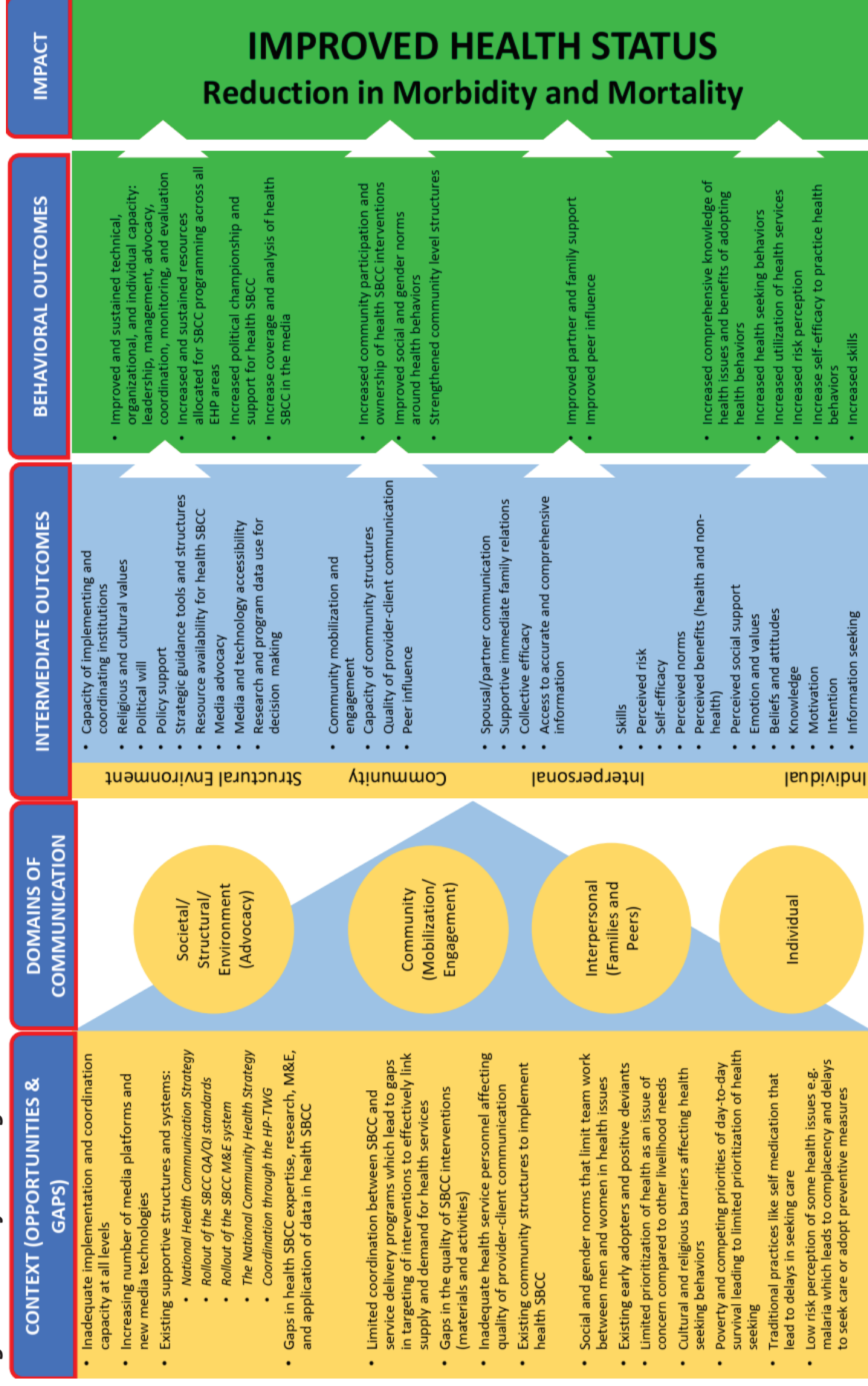
5.1 Theory of Change (TOC)

Based on the understanding of health communication gaps at the individual, community, social, and environmental levels, including enforcement of public health laws, a TOC (**Figure 2**) for the NHCS 2021 - 2026 was developed to identify pathways for health communication interventions. The purpose of the pathways is to simplify the understanding of the general context and the interplay of determinants affecting health. The framework illustrates how expected outcomes corresponding to each domain of communication contribute to health status improvement when the right mix of audiences, channels of communication, and messages is applied. Moreover, the pathway clearly delineates areas for designing SBCC, social mobilisation, and advocacy strategies with envisioned outcomes at initial stages of strategy implementation and in the long term.

The Theory of Change (TOC) for this strategy assumes that a combination of the following will result in “tipping points” for change:

- Prioritisation of SBCC interventions by policymakers, donors, and development partners resulting in increased resources for effective SBCC design, implementation, monitoring, evaluation, and coordination
- Increased individual knowledge, skills, and self-efficacy to adopt/negotiate positive health behaviours, including an understanding of the human cost of misused and stolen government resources
- Increased motivation and ability to seek and demand health information and services available through health facilities, village clinics, outreach clinics, HSAs, care groups, and other community structures
- Reduction in societal and cultural barriers, as well as a positive shifts in social and gender norms among peers, family, and community members to foster a more supportive social environment for key health behaviours (e.g., positive gender roles and responsibilities among men, women, boys, and girls; male partner support; and empowerment of women, among others)
- Reduction in stigma and use of stigmatizing language, which are barriers that affect some people’s ability to seek health care services
- Emphasise treatment literacy to enable audiences to understand how treatment works across all disease areas, promoting adherence and treatment-seeking behaviours
- Prioritisation of universal health coverage to ensure marginalised populations can access health care services within acceptable distances, particularly as efforts are made to increase demand for services

Figure 2: Theory of Change



5.2 Strategic Approaches

Carefully designed SBCC interventions can ignite change at the community, household, and individual levels as well as build support for an enabling environment for positive health behaviours. SBCC operates through three key strategies, which are:

- **Advocacy** to increase resources and political/social commitment for change goals
- **Social Mobilisation** for wider participation, collective action, and ownership, including community mobilisation
- **Behaviour Change Communication** for changes in knowledge, skills, motivation, self-efficacy, and behaviours of specific audiences



SOURCE: Adapted from McKee, N. Social Mobilization and Social Marketing in Developing Communities (1992)

This strategy focuses on communication as the vehicle for achieving behaviour change at all levels within the SEM. To be able to affect health status, the three broad strategies of advocacy, social mobilisation, and behaviour change communication will be strategically linked at all levels. The successes of the interventions are directly linked to the availability of services and products and to proper planning.

5.3 Overarching Campaign Position

The strategy maintains *Moyo ndi Mpamba: Usamalireni!* as its overarching theme, guiding positioning and creative considerations of all health SBCC interventions. Evidence from implementation of the preceding National Health Communication Strategy (2015–2020) shows that *Moyo ndi Mpamba: Usamalireni!* is widely recognised and accepted in all communities in Malawi (FHI 360, 2019; FHI 360, 2020). This positioning will inform and guide interventions and messages targeted at primary audiences as well as key stakeholders and influencers such as health workers, traditional and religious leaders, and media partners.

Health SBCC interventions shall balance the emphasis on health and non-health benefits, demonstrating relatable, doable actions and self-efficacy, and fostering individual and family aspirations to motivate and empower critical thinking and the confidence to make informed choices that improve their health and well-being.

6.0 Vision, Goal, Mission, and Objectives

Vision

A population that values, adopts, and maintains health behaviours in a supportive environment

Goal

This strategy aims to reduce preventable morbidity, mortality, and disability through effective health promotion interventions.

Mission

The Health Promotion mission is to empower people to have control over their health.

Objectives

1. Guide and unify health promotion interventions
2. Provide a framework for the coordination of health communication interventions to increase the proportion of organizations collaborating in planning, implementation, and monitoring and evaluation (M&E) at the national, district, and community level
3. Enhance community empowerment through capacity building of frontline health workers, community health workers, and community leaders to effectively implement health promotion interventions
4. Promote and advocate for multi-sectoral involvement, including influencing policy and providing legal support, to address social determinants that affect health and mainstream health promotion
5. Guide effective engagement and wide use of public, institutional, social, and community media and other new technologies for health communication programming to strengthen audience-specific and need-based SBCC programmes
6. Ensure effective implementation of the strategy through continuous monitoring, evaluation, and dissemination of best practices at different levels

Through the objectives above, the NHCS will endeavour to:

- **Impart correct knowledge** on disease prevention, treatment, and care
- Promote health-seeking behaviour, health practices, and adherence
- **Promote social inclusion, gender, and health rights** of vulnerable and minority groups to improve their health and well-being
- **Strengthen advocacy** for capacity building, resource mobilisation, and management of social media communications

7.0 Priority Audiences, Behaviours, and Channels

7.1 Segmentation of Audiences

7.1.1 Life Stage Audiences

The strategy utilizes a life stage approach, which promotes healthy choices at critical junctures in life based on what is most important and meaningful to people at those times. It takes the perspective that people's definitions of health and well-being change according to their stage in life. This enables health communication and promotion efforts to be targeted and prioritised around what is most relevant to people. Audiences are categorized into five major life stages:

- Pregnant women
- Parents/caretakers of children younger than 5
- Parents/caretakers of children ages 6–12
- Adolescents ages 13–19
- People ages 20–49

See sample behaviour matrix for life stage audiences in **Table 4** shows illustrative desired behaviours, barriers/challenges, communication objectives and messages guides to guide in tailoring SBCC strategy and interventions to the unique needs of life stage audiences.

Using the strategic approaches and the overarching platform described above, the following sections provide guidance for designing tools, materials, and activities to address key audiences.

7.1.2 Life Stage Packages and Priority Behaviours

This communication strategy has accommodated packages of priority behaviours per life stage audience. For each package, illustrative areas of content integration across health and development focus areas are provided, and primary and key secondary audiences are presented. Other secondary and tertiary audiences will be addressed across prioritised behaviours as appropriate.

7.2 Target Audience Analysis and Intervention Areas of Focus

During implementation of disease-specific SBCC interventions, special attention must be paid to the different life stages regarding:

- a. Who is most affected by the problem? (Primary)
- b. Who directly influences those who are most affected? (Secondary)
- c. Who indirectly affects those who are most affected? (Tertiary)

Analysing the primary, secondary, and tertiary target audiences related to each life stage will help us understand how they influence each other within the SEM. According to the SEM, the individual is directly influenced by family, friends, peers, and community members, who in turn operate in a complex environment of indirect

influencers such as policymakers, religious and traditional leaders, and other decision-makers. People in each stage of life must be looked at as a primary audience affected by secondary and tertiary audiences. Such audiences must be identified and targeted to achieve behaviour change.

The intervention focus must recognise that influencer (secondary and tertiary) audiences could cause barriers, but if strategically targeted with appropriate interventions and messages, these same influencers could help lead to behaviour change. **Table 3** below provides a summary of each target audience, level of influence, and intervention focus area.

Table 3: Intervention focus area based on target audience and level of influence

| Target audience | Level of influence | Intervention focus |
|------------------|--|---|
| Primary | At the level of people most affected | <ul style="list-style-type: none"> • Continue to provide correct information to increase and sustain awareness levels about the health issue • Support people to move from knowledge to action by providing skills, motivation, nudges and a supportive environment for sustained adoption of health seeking and preventive behaviours • Focus on self-management and ability to manage the health situation/condition by building skills • Use early adopters and positive deviants to accelerate adoption of health seeking and preventive behaviours • Motivate audience to demand/request provision of quality services • Increase risk perception, understanding of severity of the health issues • Promote advantages of early health-seeking behaviours |
| Secondary | At the level of people directly influencing people most affected | <ul style="list-style-type: none"> • Provide information and testimonies on the social, economic and health benefits of adopting recommended health behaviours e.g. saving money, time and relationships • Motivate and mobilise the community, family members, and peers to support people most affected (primary audience) in their quest to access health services • Address gender norms at all levels of the SBCC process, looking at how men, women, boys and girls are affected by the health issues and tailoring communication strategies, interventions and approaches accordingly • Address religious, social, and cultural barriers to accessing services • Address normative barriers |
| Tertiary | At the level of people indirectly influencing people most affected | <ul style="list-style-type: none"> • Advocate for increased investments in SBCC at all levels • Advocate for service access and availability • Document and share evidence on the role of SBCC in improving health and development outcomes at all levels • Advocate and support efforts for higher level cultural and religious leaders' involvement in addressing religious and social-cultural barriers • Address structural barriers |

Table 4: Behaviour matrix for the primary audience

Pregnant Women

| Desired behaviour | Challenges and barriers | Communication objectives | Message areas to focus on |
|--|---|--|--|
| 1. Maternal, Newborn, and Child Health (MNCH): Antenatal care (ANC) | | | |
| <ul style="list-style-type: none"> Pregnant women start ANC within 3 months of pregnancy Male partners support spouse/partner in ANC Pregnant women deliver at health facility, use MCM as soon as they deliver, and complete all recommended ANC visits | <ul style="list-style-type: none"> Limited knowledge of the recommended number of ANC visits Myths and misconceptions related to miscarriage and early disclosure of pregnancy Low risk perception of possible pregnancy complications Cultural and religious beliefs Shyness and stigma affecting teenage, older, and single pregnant women Pregnancy among women with physical disabilities is not socially accepted Inadequate knowledge of expected day of delivery Attitude of health care providers Inadequate preparedness for ANC Childcare responsibilities Beliefs and practices affecting male involvement in ANC | <ul style="list-style-type: none"> To increase knowledge on completing 8 ANC visits To increase self-efficacy regarding ANC attendance To correct misconceptions on beliefs related to ANC To increase the proportion of women who have the confidence to go for ANC in the first 12 weeks of pregnancy and complete the recommended visit To encourage experienced mothers to go for ANC | <ul style="list-style-type: none"> Promoting the importance of ANC attendance within 3 months Addressing the cultural and social norms affecting ANC attendance Addressing myths and misconceptions affecting ANC attendance Sustaining knowledge levels concerning ANC attendance Motivating mothers to attend ANC as a lifestyle choice that is good for their health Addressing discrimination and segregation of the marginalised and the disabled Providing accurate information on signs of pregnancy and expected date of delivery Promoting provision of accurate information on conception, becoming pregnant, and childbearing |

| Desired behaviour | | Challenges and barriers | | Communication objectives | Message areas to focus on |
|---|---|--|--|--------------------------|---------------------------|
| 2. Malaria | | | | | |
| <ul style="list-style-type: none">Pregnant women demand and accept anti-malaria drugs (fansidar) during ANCPregnant women sleep under a mosquito net all night every night during pregnancyPrompt care-seekingPregnant women allow indoor residual spraying (IRS) intervention | <ul style="list-style-type: none">Fear of side effects of fansidarMyths and misconceptions (that fansidar needs to be taken with food, chemicals in mosquito nets are not effective to kill mosquitoes and bed bugs, nets inhibit men's sexual ability and desire, nets bring bed bugs, etc.)Belief that drugs are not needed if a woman is feeling wellSome pregnant mothers report that they get malaria even if they sleep under a mosquito netLow risk perception towards malariaSome pregnant women find it difficult to breathe when they use a mosquito net | <ul style="list-style-type: none">To encourage pregnant women to adhere to fansidar 3 dosesTo motivate pregnant women to sleep under a mosquito net all night to prevent malariaTo impart knowledge that there is no connection between the use of nets and presence of bed bugs, sexual desire, and difficulty breathing | <ul style="list-style-type: none">Reducing fear of side effects of fansidarPromoting adherence to malaria prevention during pregnancyPromoting knowledge on the use of the malaria preventive medicineMotivating mothers to seek medical care when sickDemystifying myths and misconceptionsPromoting the health and non-health benefits of sleeping under a mosquito net, taking fansidar, and IRS | | |
| 3. Nutrition | | | | | |
| <ul style="list-style-type: none">Pregnant women eat foods from six food groups and take iron tablets daily to increase chances of having a successful pregnancy and healthy babyMen/partners buy nutritious foods and provide support to pregnant woman | <ul style="list-style-type: none">Low knowledge that a diverse diet supports foetal healthLow knowledge on the importance of iron, iodine, vitamin A, and their dietary sourcesCravings for non-healthy items (soil)Chronic diseases like HIV and TB may affect pregnant women's appetite and nutrient absorptionMyths and misconceptions around certain types of foods during pregnancy such as eggs, bananas, and sugarcane complicate dietary decision-making | <ul style="list-style-type: none">To increase knowledge on dietary diversification and supplements during pregnancyTo increase knowledge of alternative locally available animal proteinsTo build skill and knowledge among health care workers to deliver nutrition information to pregnant womenTo promote a male-friendly environment in ANC | <ul style="list-style-type: none">Promoting adherence to the uptake of six food groups during pregnancyMotivating men to support pregnant women by buying nutritious foodAddressing the cultural and social norms affecting uptake of six food groupsProviding information on the benefits of iron, Vitamin C, and iodine | | |

| Desired behaviour | Challenges and barriers | Communication objectives | Message areas to focus on |
|--|---|---|---|
| | <ul style="list-style-type: none"> ANC is not male friendly to access nutrition information during pregnancy Some males perceive pregnancy as an excuse for women to eat better foods and don't believe in the need for a diverse diet | <ul style="list-style-type: none"> To encourage partners to provide nutritious foods during pregnancy | |
| 4. HIV and AIDS | | | |
| <ul style="list-style-type: none"> Women test for HIV within 3 months of becoming pregnant to prevent transmitting the virus to the baby Pregnant women take ART to prevent transmitting the virus to the baby | <ul style="list-style-type: none"> Fear of HIV testing Pregnant women unaccompanied by partners may be delayed in getting HTS Stigma and discrimination relating to HIV and AIDS Fear of being put on ART after testing positive | <ul style="list-style-type: none"> To motivate pregnant women to go for ANC to test for HIV within 3 months To sensitize pregnant women living with HIV on the importance of adherence to treatment | <ul style="list-style-type: none"> Promoting benefits of early HIV testing and PMTCT Providing knowledge on benefits of starting treatment early and adherence to ART treatment Addressing stigma and fear of starting ART |
| 5. WASH | | | |
| <ul style="list-style-type: none"> Pregnant women prevent water and foodborne diseases by practising personal, food, and water hygiene Pregnant women use a latrine | <ul style="list-style-type: none"> Inadequate knowledge on water treatment and food hygiene practices Unavailability of chlorine/water guard to treat water Smell of chlorine Unavailability of safe water, soap, and handwashing facilities. Myths and cultural norms related to use of latrine | <ul style="list-style-type: none"> To increase knowledge on prevention of food and water-borne diseases To provide knowledge on water treatment using chlorine to reduce smell To encourage pregnant women to use soap, safe water, hand-washing facilities, and toilets | <ul style="list-style-type: none"> Promoting personal, food, and water hygiene Promoting access to water treatment chemicals Promoting proper disposal of solid and liquid waste |

Caretakers of under-five children

| Desired behaviour | Challenges and barriers | Communication objectives | Message areas to focus on |
|--|---|--|--|
| 1. Care for preterm and low birth weight (LBW) babies | | | |
| <ul style="list-style-type: none"> Caretakers provide kangaroo mother care (KMC) for LBW and preterm babies Community supporting families practicing KMC Males provide KMC for LBW and preterm babies | <ul style="list-style-type: none"> Inadequate knowledge about KMC and caring for preterm and LBW babies Myths and misconceptions regarding LBW babies Caretakers not comfortable with KMC and fear of hurting LBW baby Limited support from family/ community members on KMC Norm of carrying baby on the front runs counter to KMC Shyness, stigma, and discrimination towards mothers of LBW babies | <ul style="list-style-type: none"> To increase knowledge of mothers/caretakers to start believing that KMC can help the baby thrive To encourage partners/ family to support mothers/ caretakers in practicing KMC To encourage mothers/caretakers to feel confident in their ability to provide consistent KMC as directed by their health care provider after birth | <ul style="list-style-type: none"> Providing awareness that an LBW and preterm baby survives if taken care of Promoting understanding that LBW and preterm babies are normal human beings Promoting rights of the newborn Demystifying myths around KMC Providing information on benefits of taking care of babies on KMC Promoting community support to families with babies on KMC |
| 2. Postpartum check-ups | | | |
| <ul style="list-style-type: none"> Postpartum women attend postnatal visits at 2 days, 7 days, and 6 weeks after delivery | <ul style="list-style-type: none"> Limited prioritization of PNC especially when the mother and baby are well Busy schedules by health care workers that sometimes lead to poor customer care/negative experiences by some clients Feeling that PNC is not prioritised by facilities Low risk perception | <ul style="list-style-type: none"> To encourage mothers to go for PNC at 2 days, 7 days, and 6 weeks after delivery | <ul style="list-style-type: none"> Promoting the importance and benefits of adhering to the recommended postpartum visits |
| 3. MCM | | | |
| <ul style="list-style-type: none"> Mothers of newborn babies or their partners use an MCM to avoid pregnancy for at least 24 months | <ul style="list-style-type: none"> Fear of side effects (bleeding, weight gain, reduced libido, cancer, etc.) and negative experience Low couple dialogue on the use of contraceptives and child spacing MCM not available | <ul style="list-style-type: none"> To promote use of MCM among couples of child-bearing age | <ul style="list-style-type: none"> Promoting social, economic, and health benefits of MCM Demystifying myths and misconceptions on MCM Promoting male partner support for the uptake of MCM |

| Desired behaviour | Challenges and barriers | Communication objectives | Message areas to focus on |
|---|--|--|---|
| | <ul style="list-style-type: none"> Partner refusal Religious beliefs prevent use of MCM Limited knowledge on how MCM works and benefits among males Bearing children as security for marriage Myths and misconceptions related to MCM | | <ul style="list-style-type: none"> Increasing knowledge on the benefits of MCM among males Promoting couple communication on MCM and child spacing Promoting safety of MCM |
| 4. Nutrition | | | |
| <ul style="list-style-type: none"> Mothers initiate breastfeeding within 30 minutes of delivery and exclusively breastfeed their babies up to 6 months Mothers introduce complementary foods at 6 months while breastfeeding the baby Caretakers feed adequate amounts of nutritious, age-appropriate foods to children ages 6-9, 9-12, and 12-24 months of age, while continuing breastfeeding | <ul style="list-style-type: none"> Inadequate knowledge on the benefits of colostrum Inadequate support from nurses and guardians immediately after birth for early initiation of breastfeeding Myths and misconceptions surrounding colostrum and expressed milk Inadequate knowledge on how to manage low milk production Belief that babies need other food to be satisfied Inadequate support from family and community members to breastfeeding mothers Leaving the baby for work or business Inadequate knowledge and skills on optimal complementary feeding practices and food preparation Inadequate access to a diverse diet/all six food groups Poor harvests affect agricultural output Limited female control of household resources | <ul style="list-style-type: none"> To promote breastfeeding within 30 minutes of delivery To promote exclusive breastfeeding up to 6 months To promote introduction of complementary foods at 6 months while breastfeeding the baby To encourage caretakers to feed their children nutritious foods from six food groups | <ul style="list-style-type: none"> Increasing awareness on the importance of adherence to breastfeeding guidelines Promoting guardian and partner support to postpartum mothers Addressing myths and misconceptions related to breastfeeding and expressed milk Promoting six food groups including introduction of complementary foods after 6 months Providing knowledge and skills on optimal complementary feeding practices and food preparation Promoting continued breastfeeding and provision of six food groups to children ages 6-9, 9-12 and 12-24 months Promoting guardian and partner support to mothers to provide age-appropriate food Promoting benefits of good nutrition |

| Desired behaviour | Challenges and barriers | Communication objectives | Message areas to focus on |
|---|---|--|--|
| | <ul style="list-style-type: none"> Limited support from grandmothers, partners, and community members for optimal feeding practices Low perceived threat of nutrition-related illness Seasonal availability of certain food | | <ul style="list-style-type: none"> Providing education on the risks of poor nutrition Promoting backyard gardens and rearing of livestock |
| 5. Immunization | | | |
| <ul style="list-style-type: none"> Caretakers of under-five children take their children for timely routine immunizations and complete them as indicated on the schedule | <ul style="list-style-type: none"> Inadequate knowledge on benefits of immunization Mothers' workload Times that immunization sessions are provided Cultural and religious beliefs Dis-information and misinformation Fear of side effects after immunization | <ul style="list-style-type: none"> To promote timely uptake of vaccines for under-five children | <ul style="list-style-type: none"> Promoting awareness on the importance of adherence to immunization schedule Promoting benefits of immunization Demystifying myths and misconceptions related to immunization Providing accurate information on how vaccines work |
| 6. Malaria | | | |
| <ul style="list-style-type: none"> Caretakers seek prompt and appropriate care for signs and symptoms of malaria for the newborn Children under five years sleep under a long- lasting insecticidal net (LLIN) all night year-round | <ul style="list-style-type: none"> Self-diagnosis and self-treatment Religious and traditional beliefs and practices not supporting health- seeking at the facility Belief that health care does not need to be sought until the illness is severe Myths and misconceptions Delayed care-seeking due to financial and opportunity cost | <ul style="list-style-type: none"> To promote early health-seeking behaviour among caretakers of newborn babies | <ul style="list-style-type: none"> Promoting the comprehensive knowledge on danger signs of illness for newborn babies Providing accurate information on detecting signs and symptoms of malaria in newborn and under-five children Promoting prompt health-seeking behaviour for under-five children |

| Desired behaviour | Challenges and barriers | Communication objectives | Message areas to focus on |
|---|--|--|--|
| <ul style="list-style-type: none"> Households in targeted areas prepare for and accept IRS in their homes Households clear all possible breeding grounds for mosquitoes Caretakers ensure that under-five children take only prescribed malaria medicine and finish the prescription | <ul style="list-style-type: none"> Gender norms do not encourage male support for child health Concerns that the baby will still get malaria even if sleeping under LLIN Low risk perception on severity of malaria Low knowledge of IRS, including correct timing, location, and process for spraying campaigns Perceived low efficacy of the insecticide used in IRS Mistrust of spray operators from outside the community accessing private spaces in the home | | <ul style="list-style-type: none"> Promoting guardian and partner support to mothers of under-five children when the child is sick Demystify myths and misconceptions related to malaria illness, use of nets, and IRS Promoting awareness on benefits of sleeping under a LLIN for under-five children Promoting adherence to malaria prevention in under-five children Providing accurate information on malaria treatment and adherence Promoting awareness on social, economic, and health benefits of sleeping under a mosquito net |
| 7. WASH | | | |
| <ul style="list-style-type: none"> Family members wash hands with soap at four critical times (after defecation, after changing diapers/nappies, before food preparation, and before eating food/feeding a child) Family members safely dispose of human faeces | <ul style="list-style-type: none"> Inadequate knowledge about causes and transmission of diseases and impact of recurrent diarrhoea on health Caretakers do not view infant faeces as dangerous Limited access to soap and safe water Low risk perception of dangers and health risks associated with not washing hands | <ul style="list-style-type: none"> To promote personal, food, and water hygiene practices among caretakers of under-five children | <ul style="list-style-type: none"> Promoting awareness of benefits (social, economic, and health) of good hygiene in prevention of diarrhoea and other waterborne diseases in under-five children Providing accurate information on handling and treatment of water Providing accurate information on causes (transmission pathway) of diarrhoeal and other waterborne diseases for under-five children Promoting the use of latrines for disposal of under-five children's faeces |

| Desired behaviour | Challenges and barriers | Communication objectives | Message areas to focus on |
|---|---|---|---|
| <ul style="list-style-type: none"> Family members practice water, food, and personal hygiene Proper disposal of solid and liquid waste | | | <ul style="list-style-type: none"> Promoting recommended disposal of solid and liquid waste Promoting construction of tippy taps Providing accurate information on the effects of improper disposal of waste |
| 8. HIV and AIDS | | | |
| <ul style="list-style-type: none"> Mothers living with HIV exclusively breastfeed up to 6 months and thereafter introduce complementary foods and continue breastfeeding up to 18 months Breastfeeding mothers adhere to ART treatment Partners and families support breastfeeding mothers living with HIV | <ul style="list-style-type: none"> Mother may be sickly and weak and have blisters on breasts Fear of transmitting HIV to the baby Low treatment literacy Fear of stigma and discrimination against breastfeeding mothers living with HIV Traditional belief that no child can grow up without supplemental milk Inadequate family/peer support | <ul style="list-style-type: none"> To encourage mothers living with HIV to breastfeed their children up to 18 months | <ul style="list-style-type: none"> Promoting benefits of exclusive breastfeeding up to 6 months Promoting introduction of complementary foods and continuing breastfeeding from 6 months to 18 months Promoting adherence to ART among breastfeeding mothers living with HIV Promoting partner and family support to mothers living with HIV Providing accurate information on PMTCT Increasing treatment literacy (undetected=untransmissible [U=U]) |

Caregivers of Children ages 6-12 years

| Desired behaviour | Challenges and barriers | Communication objectives | Message areas to focus on |
|---|--|---|---|
| 1. Bilharzia | | | |
| <ul style="list-style-type: none"> • Parents provide safe water to children and ensure children do not bathe or defecate in water sources • Households properly dispose of their solid and liquid wastes | <ul style="list-style-type: none"> • Poor access to safe water • Open defecation and urination • Children playing or swimming in unsafe water sources • Inadequate knowledge about transmission, symptoms, and available treatment of bilharzia • Myths and misconceptions related to MDA campaigns and causes of bilharzia • Inconsistent use of latrines | <ul style="list-style-type: none"> • To promote use of safe water for bathing • To promote use of the toilet for defecation | <ul style="list-style-type: none"> • Promoting consistent use of latrines for urinating and defecating by children • Using of bath shelters • Using safe water sources for domestic chores • Providing accurate information about the transmission of and symptoms of bilharzia • Promoting early treatment-seeking |
| 2. Trachoma | | | |
| <ul style="list-style-type: none"> • Parents ensure their children wash faces with soap every morning and regularly to prevent eye infections like trachoma • Parents seek early medical care when a child has an eye infection | <ul style="list-style-type: none"> • Low knowledge about the dangers of eye infections • Poor access to clean water and soap • Poor personal hygiene, specifically facial and handwashing • Poor environmental hygiene, for example, disposal of solid and liquid waste • Belief in traditional healers • Myths and misconceptions related to trachoma | <ul style="list-style-type: none"> • To promote face and body washing with soap among children ages 6–12 | <ul style="list-style-type: none"> • Keeping the surroundings clean to avoid breeding flies • Promoting personal hygiene, especially facial and handwashing • Promoting early treatment for eye infections and diseases • Prioritising buying soap for personal hygiene • Providing accurate information on cause, effect, and transmission of trachoma • Demystify myths and misconceptions surrounding trachoma |

| Desired behaviour | Challenges and barriers | Communication objectives | Message areas to focus on |
|---|---|--|--|
| 3. ARI | | | |
| <ul style="list-style-type: none"> Caretakers of children ages 6–12 follow preventive measures for ARI | <ul style="list-style-type: none"> Inadequate knowledge regarding the causes, transmission, prevention, and dangers of respiratory infections The practice of using wood fuel indoors/having a separate room for cooking Lack of alternatives to using indoor fuel and resources to build a separate room Poor hygiene practices, for example handwashing Poor ventilation | <ul style="list-style-type: none"> To increase knowledge on the prevention of ARI | <ul style="list-style-type: none"> Increasing knowledge regarding causes, transmission, prevention, and dangers of respiratory infections Increasing knowledge on preventing ARI through house ventilation, washing hands with soap, having a separate room for cooking Promoting health-seeking behaviour for ARI when a child is coughing or struggles to breathe |
| 4. Oral health | | | |
| <ul style="list-style-type: none"> Parents ensure that children practice oral hygiene consistently Parents provide children with toothpaste daily and toothbrushes every three months | <ul style="list-style-type: none"> Inadequate toothbrush and toothpaste Inadequate knowledge on dental care Low risk perception Negligence by both parents and children | <ul style="list-style-type: none"> To encourage children to brush teeth at least twice a day with recommended toothbrush and toothpaste To enhance oral health-seeking behaviour | <ul style="list-style-type: none"> Providing accurate information on dental care and diseases Promoting oral health practices Providing awareness of recommended oral hygiene practices Providing frequent reminders to children to brush teeth after every meal |
| 5. SRH | | | |
| <ul style="list-style-type: none"> Parents of children ages 6–12 discuss with children comprehensive sexuality information | <ul style="list-style-type: none"> Culture and traditions preventing parents from discussing sexuality and reproductive health issues with their children Beliefs that parents should be discussing issues of sexual and reproductive when a child is old enough Inadequate knowledge and skills on how to discuss SRH with children | <ul style="list-style-type: none"> To promote discussion of age appropriate SRH between parents and children | <ul style="list-style-type: none"> Promoting provision of age-specific information on SRH and comprehensive sex education Increasing knowledge and skills of parents on provision of SRH and comprehensive sex education information to their children Demystifying taboos on SRH and comprehensive sex education with their children |

| Desired behaviour | Challenges and barriers | Communication objectives | Message areas to focus on |
|--|--|---|---|
| 6. HIV and AIDS | | | |
| <ul style="list-style-type: none"> Caregivers ensure children ages 6–12 years living with HIV adhere to ART | <ul style="list-style-type: none"> Misinformation that ART will affect the child's health Parents feel that the child should have a break because of the pill burden Stigma and discrimination resulting in nondisclosure of HIV status to the children Religious beliefs inhibiting adherence to ART Low treatment literacy Inadequate knowledge on the link between ART adherence and viral load suppression Traditional healers discourage ART | <ul style="list-style-type: none"> To motivate parents to give ART to children as prescribed To promote community support for children living with HIV and AIDS To encourage health-seeking behaviour to address side effects of HIV To diffuse religious and traditional beliefs and misinformation related to HIV and ART | <ul style="list-style-type: none"> Increasing knowledge on benefits of ART adherence (U=U) Providing correct information about ART Addressing myths and misconceptions about ART Addressing stigma and discrimination related to ART Promoting community support for children living with HIV and on ART |
| 7. Nutrition | | | |
| <ul style="list-style-type: none"> Caregivers of children ages 6–12 ensure children have adequate dietary intake of foods from six food groups to support healthy growth and development and avoid malnutrition | <ul style="list-style-type: none"> Low knowledge of six food groups and importance to health Perception that fast foods improve growth of the children Poor knowledge on nutritional needs of children ages 6–12 Cultural norms affect diverse food preparation and utilization | <ul style="list-style-type: none"> To promote sustained knowledge about the six food groups and their importance to health | <ul style="list-style-type: none"> Promoting uptake of locally available foods from the six food groups Promoting diverse food preparation and utilisation Increasing and sustaining knowledge of the six food groups |

Adolescents

| Desired behaviour | Challenges and barriers | Communication objectives | Message areas to focus on |
|--|--|--|--|
| 1. SRH and HIV <ul style="list-style-type: none"> • Adolescents delay sexual debut • Adolescents use condoms correctly and consistently to prevent unwanted pregnancies, HIV, and STIs • Adolescents take steps to reduce their risk of acquiring HIV • Adolescents at risk of HIV go for HTS and receive their test result | <ul style="list-style-type: none"> • Inadequate knowledge on physical and growth changes • Uneven exposure to messages • Low knowledge of the fertile period • Cultural and traditional norms that encourage early sexual debut and childbearing • Myths, misconceptions, and fear around condom use • Inaccessibility and cost of buying condoms • Parents do not allow adolescents to get condoms from service points • Inadequate HIV knowledge • Low risk perception, including trust among partners • Inability to negotiate safer sex and need for money • Peer pressure to have sexual partners and lead a perceived high-class lifestyle • Fear of being thought promiscuous • Concerns over provider confidentiality | <ul style="list-style-type: none"> • To increase knowledge of physical and growth changes • To modify cultural norms and beliefs that promote early sexual activities • To promote correct and consistent condom use among adolescents if they fail to delay sex • To promote discussion of SRH among parents, adolescents, and service providers • To increase comprehensive knowledge of HIV among adolescents • To empower adolescents with appropriate skills on HIV prevention • To motivate adolescent boys to go for VMMC • To encourage adolescents at risk of HIV to go for HIV testing | <ul style="list-style-type: none"> • Increasing knowledge on adolescents' sex and sexuality and growing up • Addressing negative cultural practices that promote early sexual activities • Increasing knowledge of negative consequences of early sexual debut among adolescents • Promoting parent-child communication • Addressing fears, myths, and misconceptions around condoms • Encouraging dialogues on condom use among parents, adolescents, and service providers • Increasing knowledge on dual protection for condoms • Increasing HIV risk perception among adolescents • Promoting life skills such as condom use and safer sex negotiation • Promoting VMMC among adolescent boys • Promoting school retention among adolescents • Promoting the importance of HTS among adolescents • Promoting HIV treatment literacy |

| 2. WASH – Menstrual hygiene | | | |
|--|---|--|--|
| <ul style="list-style-type: none"> Girls practice menstrual hygiene | <ul style="list-style-type: none"> Inadequate knowledge of menstrual hygiene Disposable sanitary pads are costly Inadequate soap to support menstrual hygiene Secrecy and negative cultural norms surrounding menstruation | <ul style="list-style-type: none"> To promote menstrual hygiene among adolescent girls | <ul style="list-style-type: none"> Promoting personal hygiene during menstruation Promoting the use of clean sanitary pads, which are dry Promoting awareness of infections that can arise due to the use of unclean sanitary pads |
| 3. Nutrition | | | |
| <ul style="list-style-type: none"> Adolescents eat adequate nutritious foods for healthy growth and development | <ul style="list-style-type: none"> Low knowledge of six food groups and importance to health Perception that fast/junk foods improve growth of the adolescent Cultural norms that affect food diversification and consumption Inadequate knowledge on the effects of undernutrition | <ul style="list-style-type: none"> To promote sustained knowledge about the six food groups and their importance to health To motivate adolescents to prepare nutritious and diverse foods | <ul style="list-style-type: none"> Promoting sustained knowledge of eating the six food groups Encouraging adolescents to eat three nutritious meals per day Providing information on effects of eating junky foods as main diet Providing accurate information on the effects of undernutrition |
| 4. Malaria | | | |
| <ul style="list-style-type: none"> Adolescents to seek prompt and appropriate care when they feel symptoms of malaria Adolescents sleep under an LLIN all night year-round | <ul style="list-style-type: none"> Delay in seeking medical care (self-medication, home treatment, and from traditional healers) Inadequate knowledge on malaria signs, symptoms, and effects Low risk perception Concerns they will still get malaria even if they sleep under LLIN Myths and misconceptions Unavailability of free nets for adolescents | <ul style="list-style-type: none"> Promote early health-seeking behaviour among adolescents when they have malaria-like signs Promote sleeping under LLIN all night year-round among adolescents | <ul style="list-style-type: none"> Increasing knowledge on malaria symptoms, signs, and effects Promoting early health-seeking behaviour by adolescents Promoting benefits of malaria prevention through use of LLINs Dispelling myths and misconceptions about sleeping under LLIN |

People Ages 20–49

| Desired behaviour | Challenges and barriers | Communication objectives | Message areas to focus on |
|--|--|--|--|
| 1. NCDs (high blood pressure [HBP], diabetes, asthma, heart disease, cancer) | | | |
| <ul style="list-style-type: none"> • People practice behaviours that prevent high blood pressure (HBP), asthma, diabetes, and cardiovascular disease • People with underlying health conditions (e.g. HBP, diabetes, asthma) adhere to the recommended treatment | <ul style="list-style-type: none"> • Low knowledge of the harmful effects of alcohol, tobacco, and illicit drug abuse • Poor health-seeking behaviour • Poor dietary habits • Poor community support • Physical exercises are tiresome, and people do not have time for exercise • Low risk perception of NCD • Positive attitude toward gaining weight • Poor knowledge about cancers and available cancer screening • Use of herbs and traditional medicine for treatment of NCDs | <ul style="list-style-type: none"> • To promote knowledge, prevention, and treatment of NCDs and available services | <ul style="list-style-type: none"> • Discouraging excessive alcohol use and tobacco use • Promoting healthy diets and adherence to treatment for HBP, cancer, diabetes, etc. • Providing accurate information on the dangers of NCDs • Demystifying misconceptions associated with body weight and uptake of an unhealthy diet • Promoting partner, family, and social support for the affected and those on treatment • Promoting physical exercise |
| 2. Mental illness | | | |
| <ul style="list-style-type: none"> • Increase knowledge, care seeking, and adherence to manage mental health conditions | <ul style="list-style-type: none"> • Limited knowledge and skills on how to manage mental illnesses • Poor partner, family, and society support • Myths and misconceptions on mental illnesses • Cultural and traditional belief regarding mental illness and epilepsy (attributing to witchcraft and evil spirits) | <ul style="list-style-type: none"> • To promote knowledge about mental illness and epilepsy • To promote health care-seeking behaviour for epilepsy and mental health patients | <ul style="list-style-type: none"> • Increasing knowledge of and skills on mental illnesses and capacity to manage conditions • Providing accurate information on mental health (depression, epilepsy, and addiction) • Promoting family and community support for the affected and those on treatment • Demystifying myths and misconceptions about mental illnesses • Promoting access to health services and adherence to treatment |

| Desired behaviour | Challenges and barriers | Communication objectives | Message areas to focus on |
|--|---|--|--|
| 3. TB | | | |
| <ul style="list-style-type: none"> People follow preventive measures and seek early treatment for TB | <ul style="list-style-type: none"> Inadequate knowledge on prevention, causes, signs, and symptoms Inadequate knowledge of TB treatment Fear of stigma related to TB and TB treatment (e.g. association of TB and HIV) Myths and misconceptions on causes, signs, and symptoms | <ul style="list-style-type: none"> To promote early health care-seeking behaviours and treatment adherence among TB patients To promote preventive measures for TB | <ul style="list-style-type: none"> Increasing knowledge on prevention, causes, signs, and symptoms, including treatment of TB Addressing stigma and discrimination related to TB, including its association with HIV Promoting the benefits of adherence to TB treatment Promoting early diagnosis and benefits of early treatment of TB |
| 4. HIV and AIDS | | | |
| <ul style="list-style-type: none"> People practice HIV prevention methods, access, and utilize HTS, and access and adhere to treatment Family and community support to people affected and infected with HIV Communities support and understand the needs of key populations in HIV prevention | <ul style="list-style-type: none"> Fear of HIV test Fear of stigma related to being HIV + Inadequate treatment literacy Low risk perception Lack of partner support Religious and cultural beliefs associated with HIV and AIDS Inadequate knowledge on the availability of PrEP and PEP Myths and misconceptions on VMMC and other HIV prevention measures Inadequate support of and discrimination against key populations | <ul style="list-style-type: none"> To increase comprehensive knowledge about HIV and its prevention methods To motivate men to go for VMMC To promote adherence to HIV treatment and uptake of HIV counselling and testing services To promote support for key populations in HIV prevention | <ul style="list-style-type: none"> Promoting treatment literacy on HIV and AIDS Promoting awareness on viral suppression and HIV prevention (U=U) Promoting awareness and uptake of PrEP and PEP among eligible populations Addressing myths and misconceptions affecting PrEP uptake Promoting HTS and preventive measures (condom use, having only one partner, abstinence, etc.) Promoting awareness on HIV prevention initiatives for key populations Promoting benefits of VMCC and demystifying myths and misconceptions related VMCC and condom use Promoting benefits of early HIV test among the untested Addressing stigma and discrimination |
| 5. Scabies | | | |

| Desired behaviour | Challenges and barriers | Communication objectives | Message areas to focus on |
|--|--|---|---|
| <ul style="list-style-type: none"> • People practice good personal hygiene to prevent scabies, and those with scabies seek early treatment | <ul style="list-style-type: none"> • Inadequate knowledge regarding transmission and prevention of scabies • Poor hygiene • Shyness to present the ailment for treatment • Stigma against infected and affected • Low risk perception of the infection • Inadequate knowledge on preventive measures | <ul style="list-style-type: none"> • To promote awareness on causes and prevention of scabies | <ul style="list-style-type: none"> • Promoting personal hygiene • Promoting family and community support • Promoting awareness on the causes, effects, and prevention of scabies • Providing awareness messages on the benefits of adhering to treatment • Promoting early health-seeking behaviours |
| 6. Eye infections | | | |
| <ul style="list-style-type: none"> • People prevent the contracting of eye illnesses and seek early treatment when infected | <ul style="list-style-type: none"> • Inadequate knowledge on causes and prevention of eye infection • Cultural and traditional beliefs related to eye infection and use of traditional medicine • Myths and misconceptions | <ul style="list-style-type: none"> • To promote awareness on causes and prevention of eye infections | <ul style="list-style-type: none"> • Promoting awareness on causes, effects, and prevention of eye infections • Promoting early treatment-seeking behaviours • Demystifying myths and misconceptions • Addressing cultural and traditional beliefs associated with eye infections |
| 7. Ear infections | | | |
| <ul style="list-style-type: none"> • People prevent contracting of ear infections and seek early treatment when infected | <ul style="list-style-type: none"> • Inadequate knowledge on signs, symptoms, and prevention of ear infection • Use of traditional medicine • Myths and misconceptions | <ul style="list-style-type: none"> • To promote awareness on causes and prevention of ear infections | <ul style="list-style-type: none"> • Promoting awareness on signs, symptoms, causes, effects, and prevention of ear infections • Promoting benefits of adhering to treatment • Promoting early health-seeking behaviour • Demystify myths and misconceptions |
| 8. Oral hygiene | | | |

| Desired behaviour | Challenges and barriers | Communication objectives | Message areas to focus on |
|--|--|---|--|
| <ul style="list-style-type: none"> People practice proper oral hygiene and seek early treatment in cases of oral health problems | <ul style="list-style-type: none"> Low risk perception Inadequate knowledge and skills regarding oral health Intake of perceived prestigious food types | <ul style="list-style-type: none"> To promote awareness on oral hygiene and prevention of oral health problems | <ul style="list-style-type: none"> Promoting awareness on oral hygiene Promoting benefits of early health-seeking behaviour and adhering to treatment Providing accurate information on the type of food that can put people at risk or dental-related challenges |
| 9. MCM | | | |
| <ul style="list-style-type: none"> Men and women of reproductive age use modern contraceptive methods | <ul style="list-style-type: none"> Concerns over side effects (bleeding, weight gain, reduced libido, cancer, etc.) Past negative experience Low couple dialogue Limited decision-making among women regarding use of FP methods Use of traditional methods Myths and misconceptions | <ul style="list-style-type: none"> To promote use of modern FP methods among men and women of reproductive age | <ul style="list-style-type: none"> Promoting awareness on benefits of MCM Demystifying myths and misconceptions on MCM Promoting male involvement on issues of MCM Promoting right to health for women Providing accurate information on modern FP methods Promoting male partner support for the uptake of MCM |
| 10. STIs | | | |
| <ul style="list-style-type: none"> People engage in practices that prevent contracting STIs and seek early treatment when they have STIs | <ul style="list-style-type: none"> Inadequate knowledge on transmission, causes, signs, and symptoms of STIs Trust of traditional medicine and herbs Inability to notify partners if one has STIs | <ul style="list-style-type: none"> To promote awareness on the prevention and treatment of STIs | <ul style="list-style-type: none"> Increasing knowledge and awareness on STI transmission Promoting prevention through correct and consistent condom use Promoting partner notification Promoting benefits of early STI diagnosis, treatment, and adherence to treatment Providing accurate information on signs and symptoms |

Cross-cutting health areas

| Desired behaviour | Challenges and barriers | Communication objectives | Message areas to focus on |
|--|--|---|---|
| 1. Blood Donation | | | |
| <ul style="list-style-type: none"> • People ages 16–65 donate blood regularly | <ul style="list-style-type: none"> • Perception that blood is sold in hospitals • Parents, guardians, and peers discouraging regular blood donation • Cultural and religious beliefs associated with regular blood donation • Myths and misconceptions surrounding blood donation | <ul style="list-style-type: none"> • To promote regular blood donation for people ages 16–65 | <ul style="list-style-type: none"> • Promoting benefits of regular blood donation • Addressing myths, misconceptions, beliefs, and rumours surrounding blood donation • Positioning blood donation as a duty to save lives |
| 2. Emerging issue: COVID-19 | | | |
| <ul style="list-style-type: none"> • People adhere to preventive measures of COVID-19 | <ul style="list-style-type: none"> • Low risk perception among general public, especially in rural areas • Relapse in risk perception during low-infection times • Unavailability of masks in rural areas and of handwashing facilities in strategic points and public places • Perceived cost of procuring a mask • Prolonged wearing of masks is uncomfortable and leads to headaches, rash, and difficulty breathing • Religious beliefs, myths and misconceptions, misinformation, and disinformation about COVID-19 • Religious and social gatherings disregarding social distancing | <ul style="list-style-type: none"> • To continue promoting adherence to COVID-19 prevention measures • To clarify misconceptions and beliefs surrounding COVID-19 transmission and prevention • To enhance uptake of COVID-19 vaccination among eligible populations | <ul style="list-style-type: none"> • Reinforcing preventive measures for COVID-19, e.g., handwashing with soap, wearing of face masks, physical distancing, etc. • Clarifying myths and misconceptions about COVID-19 (transmission, prevention, treatment) • Motivating the public to get vaccinated against COVID-19 • Addressing relapse in low risk perception during low-infection times |

7.3 Influencing Audiences

Secondary and tertiary audiences play a critical role in influencing primary audiences. The influencing audiences are people who influence primary audiences either directly or indirectly. These can include family members, friends, service providers, community leaders, and teachers. This can also include people who shape social norms and influence policies or how people think about an issue. Influencing audiences should be prioritised because of the role they play in creating desired change. For example, grandmothers are likely to influence audiences of young mothers. However, the level of influence (low, moderate, strong) may depend on context and behaviours, and some of these behaviours may be targets of change.

To ensure an enabling environment for the adoption of healthy behaviours, as stated in the SEM, key influencing audiences should be identified and targeted with appropriate messages. Users of this strategy must identify the key influencing audiences based on the local context and available research.

Messages for every target audience should be designed with a purpose in terms of what the message aims to achieve. Messages must take target audiences through a continuum of change, which includes knowing, feeling, thinking, and doing. **Table 5** provides a summary of expected actions and area of messaging.

Table 5: Continuum of Change

| Action | Messaging Areas |
|--------------|---|
| Know | <ul style="list-style-type: none">• Health, economic, and physical (personal) benefits of adopting and practicing the health behaviour being promoted (<i>What's in it for her/him/the family?</i>)• Cause and effect of disease and health issues• Prevention measures• Risk of potential effects or complications if they do not adopt the behaviour being promoted• Available services even during pandemics like COVID-19 |
| Feel | <ul style="list-style-type: none">• Safe and confident to access health care services as and when required• Confident to take action• Urgency to seek health care advice and services when they feel unwell• At risk of potential adverse effects and complications if they do not seek proper health care services• Empowered to act |
| Think | <ul style="list-style-type: none">• Early health-seeking behaviour is good for them and their family• Reflect on whether they have a disease and need treatment• Take action early to take the best care of themselves and to remain attractive |
| Do | <ul style="list-style-type: none">• Go to a health facility any time they suspect they are unwell, and avoid procrastination• Follow the provided medical advice• Follow preventive measures as appropriate• Adopt healthy behaviours and lifestyles |

7.4 Communication Channels

It is important to think creatively about how the communication strategies will be implemented through communication channels, activities, or interventions. This should help to determine the effect the strategies will have. A combination of interpersonal, community-based, and mass media interventions should be used to reinforce the strategies. **Table 6** will help to prioritise activities, channels, and materials based on their advantages and audience preferences and lifestyles.

Table 6: Guide to Channel and Activity Mix

| Channel Type | Examples of Planned Activities and Supporting Materials |
|---|--|
| Interpersonal <ul style="list-style-type: none"> • Peer education • Client-provider communication • Counselling, telephone hotlines • Home visits | <ul style="list-style-type: none"> • Series of site visits with leaders and politicians • Coalition-building meetings • Peer education • Peer education guide |
| Community based <ul style="list-style-type: none"> • Community dialogues • Rallies • Participatory drama performances • Risk mapping • Community radio programming | <ul style="list-style-type: none"> • Rallies in front of the Parliament • Community dialogue sessions with selected groups • Radio or road shows |
| Mass and Social Media <ul style="list-style-type: none"> • Radio and television spots and jingles • Role modelling/celebrity testimonials • Serial drama • Newspaper articles • Posters, brochures, booklets • Digital, online and mobile: websites, Facebook, blogs, WhatsApp, short message service, YouTube videos • Outdoor media: billboards | <ul style="list-style-type: none"> • Emails and letters to the Minister of Health • Newspaper placements and inserts • Radio soap opera with call-in programme • Brochures, posters, leaflets, booklets • Facebook page with question-and-answer sessions • Blog for urban men and women on social norms |

Tips on Channel and Activity Selection

- Use a combination of channels that are linked and mutually supportive. For example, use mass media to highlight effective community dialogue.
- Build in repetition of messages throughout various media and create opportunities for audience members to ask questions or state what they think of the activities (feedback loop).
- Make sure all activities are recognisable as originating from the strategic design and tied together by a logo.
- Invest wisely for sufficient repetition. Make sure activities are disseminated as many times as possible but avoid audience fatigue.

- Make sure a workshop that trains trainers are longer than three days and participants apply the learning before they train others.
- Don't automatically choose peer education programmes. They are often seen as quick and inexpensive interventions, but experience has shown volunteers need to be continuously trained, motivated, and supervised.
- Remember, less is more, and quality pays off. It is better to do one thing well than to have many different activities that people will not remember because of poor implementation.

Adopted from C-Change Module 2: <https://www.fhi360.org/sites/default/files/media/documents/Module2-Practitioner.pdf>

8.0 Risk and Crisis Communication Management

Risk communication is a national public health priority that encourages people, organizations, and governments to share life-saving information and knowledge to take preventive and protective actions against disease or threat. When an emerging disease or threat occurs, this communication strategy shall guide well-planned and effective implementation of crisis communication activities to mitigate rumours and misinformation and promptly address other communication issues that arise.

The following steps will be conducted:

1. The risk and crisis communication team at national and district levels shall be activated to quickly mobilise resources to develop communication materials to be shared with the general public using all means of communication.
2. The team will engage with religious groups, traditional leaders, teachers, media, and other influential leaders to give the right information and update them on the status of the emerging disease or threat.
3. The risk and crisis communication team will monitor and evaluate the situation through audience feedback and snapshot surveys so that data guide the design of communication activities and materials, and engagement meetings are held with relevant people.
4. Information shall be frequently shared through all relevant communication channels, including mass media, print media, Facebook, Twitter, and WhatsApp.

8.1 Audience, Messages, and Channels

Crises will be handled on a case-by-case basis. The geographical location, level of spread, and magnitude of the crisis will determine the audience to be addressed, strategies to be applied, messages to be disseminated, and channels to be used to convey messages. Local or geographically limited crises will be dealt with through local means of communication.

8.2 Produce/Update Crisis Communication Materials, Tools, and Guides

The following materials will be developed:

- Key messages for risk communication
- Fact sheets
- Public service announcements
- Question-and-answer documents on anticipated issues and rumours
- Guidelines for public relations officers on how to prepare for and respond to rumours or questions
- A draft press release and holding statements

8.3 Media Engagement

The following activities will be used to engage the media:

- Hold media briefings to provide updated information

- Update media contact lists (especially journalists who focus on health issues) and agree on whom to contact within each media house in case of a crisis
- Develop a media kit on the role of media during a widespread crisis

8.4 Enhance Capacity of National and District Spokespeople

The following activities will be conducted to enhance the capacity of national and district spokespeople:

- Hold orientation sessions on risk and crisis communication for all district public relations officers
- Provide all district health officers with crisis communication materials including the guide, question-and-answers, and fact sheets.
- Conduct orientation for religious leaders in collaboration with various faith based groups and associations

9.0 Organizational Arrangement

9.1 Coordination and Implementation Mechanism

The NHCS is a strategic tool for use at all levels in the planning, implementation, monitoring, and evaluation of health promotion interventions in the country. Under the leadership of the MOH, all government ministries and departments, donors, NGOs, implementing partners, and TWGs must focus their efforts, resources, and interventions on this national strategy. Implementation of this strategy strengthens the existing systems and structures in the provision of health promotion services at the national, district, health facility, and community levels as outlined below.

9.1.1 National level coordination

At the national level, coordination and implementation of the strategy rely on the following systems and structures:

Ministry of Health - Health Education Section (MOH-HES)

The Government of Malawi recognises the MOH as the lead institution in the coordination and implementation of health promotion services in the country. This mandate by the MOH is fulfilled by the MOH-HES, a department with technical expertise in health promotion initiatives. The MOH-HES plays the leading role in the coordination, planning, implementation, monitoring, and evaluation of all health promotion interventions, as envisioned in this strategy. In collaboration with the Health Promotion – Technical Working Group (HP-TWG), the MOH-HES provides leadership in resource mobilisation, guidance on prioritised health promotion interventions, and any other support that may be needed by implementing partners.

Health Promotion Technical Working Group (HP-TWG)

All stakeholders implementing health promotion activities at the national level must be members of the HP-TWG. Implementing partners at the national level provide both technical and financial support to the HP-TWG to ensure it remains operational and provides needed guidance to stakeholders in line with this strategy. To align with the priorities, goals, and objectives of this strategy, the HP-TWG remains the entry point for guidance to all partners at the national level on proposed interventions, priority geographical locations, and implementation modalities of health promotion activities in the country.

Quality Assurance Sub-Technical Committee

The HP-TWG has a sub-technical committee responsible for quality assurance and quality improvement (QA/QI) in the design, production, and implementation of various health promotion initiatives in print, broadcast, and electronic media formats. All Health SBCC materials should be submitted to the committee for review and approval before implementation. To achieve its objectives, the committee works in collaboration with the Malawi Communications Regulatory Authority to track all health

communications materials being disseminated to the public without prior approval by the HP-TWG.

Stakeholders and Implementing Partners

The NHCS envisions inclusive participation of a range of stakeholders and implementing partners. These include government, development partners, local and international NGOs, the formal sector, the informal sector, and the private sector. These stakeholders must ensure that implementation of all health promotion initiatives is in line with the priorities, goals, and objectives of the NHCS. In all their interventions, they should advocate to advance implementation of health promotion activities and ensure they remain prioritised.

Donors and Development Partners

Development partners support implementation of the strategy through technical and financial support, capacity building, and resource mobilisation. In line with the aspirations of the NHCS, development partners and donors work with the MOH-HES in all approval processes of resource mobilisation proposals submitted by implementing partners. This is important because it will help to ensure proposed interventions and intended implementation locations are aligned with strategy priorities.

9.1.2 District level coordination

At the district level, coordination and implementation of the strategy relies on the following systems and structures:

District Health Promotion Officers (DHPOs)

At the district level, the DHPO provides leadership and oversight in the planning, implementation, monitoring, and evaluation of all health promotion interventions. In collaboration with the membership of the District Health Promotion Technical Team (DHPTT), the district MOH-HES office provides leadership in resource mobilisation, guidance on prioritised health promotion interventions, and other support needed by implementing partners.

District Health Promotion Technical Working Group (DHP-TWG)

All stakeholders implementing health promotion activities at the district level must be members of the DHP-TWG. Implementing partners at the district level provide technical and financial support to the DHP-TWG to ensure it remains operational and provides needed guidance to stakeholders. To align with the priorities, goals, and objectives of this strategy, the DHP-TWG remains the entry point for guidance to all partners at the district level on proposed interventions, priority implementing geographical locations, and implementation modalities. Rather than creating new structures, the DHP-TWG continues to work with existing community structures at all levels.

9.1.3 Stakeholders and implementing partners

The NHCS envisions inclusive participation of a wide range of stakeholders and implementing partners. At the district level, these include district-based government departments, local and international NGOs, the formal sector, the informal sector, and the private sector. These stakeholders will ensure that implementation of all health promotion activities is in line with the priorities, goals, and objectives of the NHCS. In all their initiatives, they should advocate for implementation of health promotion activities at the grassroots level in communities.

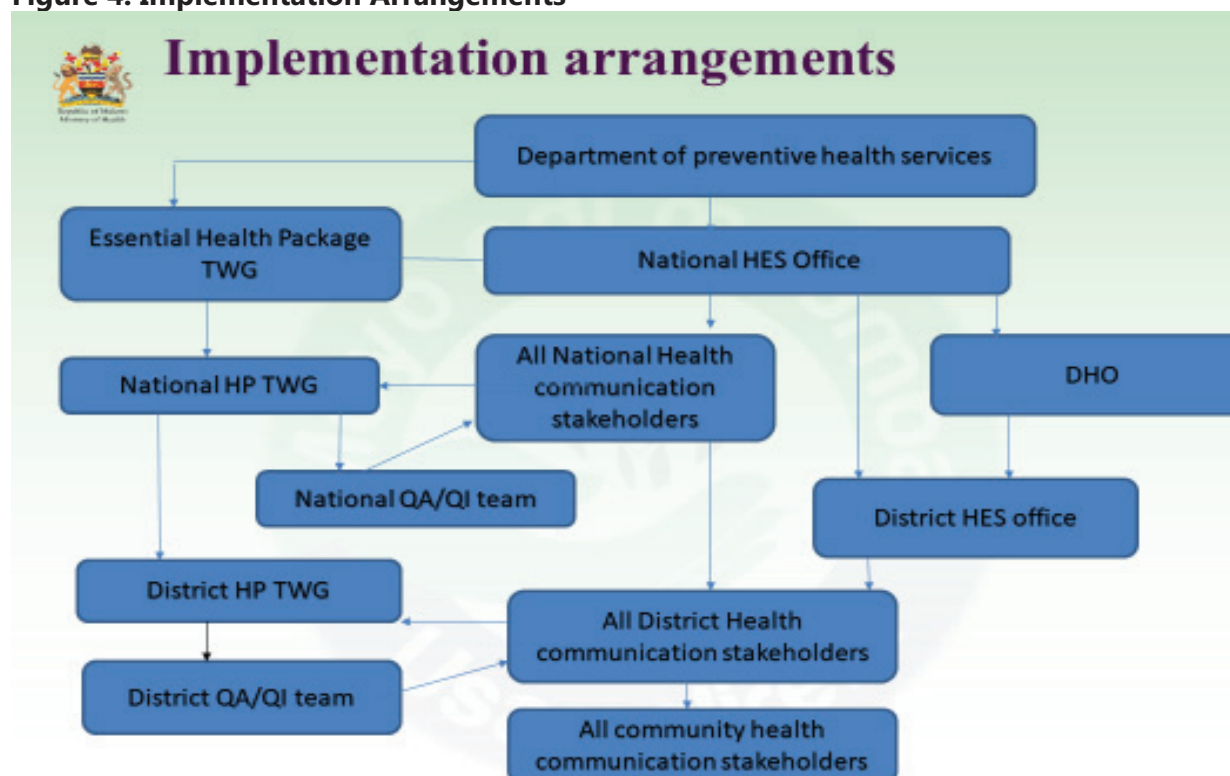
9.1.4 District level resource mobilisation

At the district level, the DHPO provides leadership in resource mobilisation for health promotion initiatives. In line with the goals of the NHCS, donors and implementing partners at the district level work with the DHPO in all approval processes of resource mobilisation proposals submitted to support health promotion activities. This helps to ensure that proposed initiatives are aligned to strategy priorities.

9.1.5 Facility-Based Health Promotion Office

At the facility level, health promotion personnel continue to work with grassroots structures to provide technical support for the implementation of health promotion activities. These grassroots structures include the Area Development Committee, Area Executive Committee, Village Development Committee, community health action group, Village Health Committee, care groups, support groups, and village level drama groups. To ensure the quality of interventions, facility-based health promotion personnel work under direct supervision of the DHPO.

Figure 4: Implementation Arrangements



10.0 Monitoring and Evaluation

NHCS health promotion interventions should be based on available evidence. M&E shall be conducted throughout the implementation of the strategy at the national, district, and community levels.

10.1 Monitoring

Monitoring shall involve routinely collecting process and outcome indicators to track progress. The strategy shall use Demographic Health Information System 2 (DHIS2) to manage programme implementation data. DHIS2 captures data on SBCC at the health facility and district levels.

An SBCC monthly report form shall be used to collect quantitative data at the facility and district levels. All implementing partners shall use the SBCC form to report their activities and submit to the District Health Office. Client exit interviews and a health promotion checklist shall be used quarterly to monitor health promotion activities.

10.2 Evaluation

Evaluation of this strategy shall be based on theories of change and findings of formative studies, which shall provide an understanding of the local context, facilitating factors, and barriers to the desired social and behaviour change to assess the effectiveness of the approaches being implemented. Baseline, midline and end line evaluation surveys quantitative and qualitative surveys shall be used to collect data for evaluation. The behaviour change indicators below can be used by health promoters to measure the success of their interventions as well as their contribution to the HSSP II core performance indicators. These indicators are not exhaustive and should be adapted and supplemented based on programme objectives, audiences, resources, and outputs. The list includes general indicators that can be adapted for any health area and disease-specific indicators. After reviewing the indicators, strategy evaluators may need to develop additional social and behaviour change indicators.

Exposure Related Indicators:

- Percentage of people who recall hearing or seeing any EHP message in the past 6 months
- Percentage of people who can recall the *Moyo ndi Mpamba* campaign
- Percentage of people who participated in a call-in dialogue programme
- Percentage of people who took part in knowledge-related interactive community sessions
- Percentage of people who know the main symptoms of malaria, NTDs, epilepsy, ARI, diarrheal disease, TB, etc.
- Percentage of people who know preventive measures for malaria, HIV, NTDs, epilepsy, ARI, diarrhoea, TB, etc.

- Percentage of people who know critical times to wash hands and face with soap and water
- Percentage of people who know the importance of a birth plan

Attitudes, Risk Perception, and Efficacy Indicators:

- Percentage of people who appropriately perceive their risk for malaria, HIV, NTDs, ARI, cancer, etc.
- Percentage of people who feel efficacy to prevent malaria, HIV, diarrhoea, NTDs, ARI, cancer, maternal morbidity, etc.
- Percentage of men who believe they should take a role in FP, HIV prevention, safe motherhood, PMTCT, etc.
- Percentage of mothers who are confident they can exclusively breastfeed their infants for the first six months

Practices Indicators:

- Percentage of men and women who agree couples should go for HIV testing together
- Percentage of women who believe that not immunizing their children puts them at high risk of disease and death
- Percentage of people who access services in a timely manner
- Percentage of people who adhere to all medications (for malaria, HIV, NTDs, etc.)
- Percentage of pregnant women who attend ANC during the first trimester
- Percentage of men who go for VMMC
- Percentage of households with an improved toilet facility
- Percentage of pregnant women who slept under an LLIN the previous night
- Percentage of reproductive age women who are using MCM
- Percentage of children receiving oral rehydration solution at appropriate times

Sample Influencing Audiences Indicators

Health workers:

- Proportion of health workers who have received training on interpersonal communication and counselling (disaggregated by type of facility)
- Proportion of health workers who have job aids to remind them of treatment and care guidelines (compare between baseline and final)

Faith leaders:

- Proportion of faith leaders who have the skills required to integrate EHP messages in sermons and other religious activities
- Proportion of faith leaders who speak out against risky behaviours and norms
- Proportion of faith leaders who promote health services

Traditional leaders:

- Number of traditional leaders who are working together to tackle negative (unhealthy) community norms and practices, e.g., open defecation

Media owners and managers:

- Number of media owners and managers who make commitments toward free or subsidized airtime and space for health issues

11.0 References

- Akullian, A. (2020). Baseline patterns of infection in regions of Benin, Malawi and India seeking to interrupt transmission of soil transmitted helminths (STH) in the DeWorm3 trial. *PLOS Neglected Tropical Diseases*, November 2020.
- Brun, R., Blum, J., Chappuis, F., Burri, C. (2010). Human African trypanosomiasis. *The Lancet*, 379(9709).
- Chipeta, E. Phiri, Kalilani, L. and Chimwaza, W. "Contraceptive knowledge, beliefs, and attitudes in rural Malawi: Misinformation, Misbeliefs and Misperceptions". *Malawi Medical Journal*, June 2010.
- District Health Information System 2 (DHIS2). (2020). Unpublished data.
- FHI 360. (2019). *Moyo ndi Mpamba Campaign Audience Feedback Survey, Health Communication for Life (HC4L) Project, 2019*. FHI 360: Lilongwe, Malawi.
- FHI 360. (2020). *Moyo ndi Mpamba Campaign Audience Feedback Survey, Health Communication for Life (HC4L) Project, 2020*. FHI 360: Lilongwe, Malawi.
- Girls Not Brides: The Global Partnership to End Child Marriages. (2020). *Impact Report 2020: Girls Not Brides*. The Global Partnership to End Child Marriages: London, United Kingdom.
- Glanz, Karen, Barbara K. Rimer, and Sharyn M. Su. (2005). *Theory at a Glance: A guide for Health Promotion Practice*. 2nd ed. National Cancer Institute: DC, US
- Institute for Health Metrics and Evaluation. (2015) *Global Burden of Disease Collaborative Network. Global Burden of Disease Study 2013 (GBD 2013) Incidence, Prevalence, and Years Lived with Disability 1990-2013*. IHME: Seattle, USA.
- Kalua K, Lindfield R, Mtupanyama M, Mtumodzi D, Msiska V. (2011) Findings from a Rapid Assessment of Avoidable Blindness (RAAB) in Southern Malawi. *PLoS ONE*, 6(4).
- Makaula, P., Sadalaki, J.R., Muula, A.S. *et al.* Schistosomiasis in Malawi: a systematic review. *Parasites Vectors* **7**, 570 (2014). <https://doi.org/10.1186/s13071-014-0570-y>
- Makwero M. T. (2018). Delivery of primary health care in Malawi. *African journal of primary health care & family medicine*, 10(1), e1–e3.
<https://doi.org/10.4102/phcfm.v10i1.1799>
- Malawi National Communication and Advocacy Strategy for Pre-Exposure Prophylaxis (PrEP) 2020 – 2023

McKee, N., Manoncourt, E., Chin, S.Y. & Carnegie, R. (2002). *Involving People, Evolving Behaviour: The UNICEF experience*. In: SERVAES, J. (ed.), *Approaches to Development Communication*, Paris: UNESCO.

Mid-Term Review (MTR) HSSP2, April 2021 Ministry of Health, Lilongwe, Malawi

Ministry of Health (2019):

https://m.facebook.com/malawigovernment/photos/update-on-malawis-preparedness-against-ebola-outbreak-the-ministry-of-health-and/1220458431473982/?locale=zh_CN

Ministry of Health (2021): *National Tuberculosis and Leprosy Control Strategic Plan (2021-2025)*, Lilongwe, Malawi

Ministry of Health. (2015). *Malawi NTD Master 2015-2020*. Ministry of Health: Lilongwe, Malawi.

Ministry of Health. (2015b) *National Youth Friendly Health Services Strategy 2015–2020*. Ministry of Health: Lilongwe, Malawi.

Ministry of Health. (2017). *National Action Plan for Prevention and Management of Non-Communicable Diseases and Mental Health in Malawi*. Ministry of Health: Lilongwe, Malawi.

Ministry of Health. (2018). *Malawi Population-Based HIV Impact Assessment (MPHIA) 2015-2016: Final Report*. Ministry of Health: Lilongwe, Malawi.

Ministry of Health. (2018b). *The Malawi non-communicable diseases and injuries poverty commission report*. Lilongwe: Ministry of Health.

Ministry of Health. (2021) *National TB and Leprosy Control Programme Strategic Plan 2021-2025*. Ministry of Health: Lilongwe, Malawi.

Msiska, M. 2019. Rate of psychiatric readmissions and associated factors at Saint John of God Psychiatric Hospital in Mzuzu, Malawi.

Msyamboza, K.P., Mawaya, L.R., Kubwalo, H.W. *et al.* Burden of leprosy in Malawi: community camp-based cross-sectional study. *BMC Int Health Hum Rights* **12**, 12 (2012). <https://doi.org/10.1186/1472-698X-12-12>

Msyamboza, K.P., Phale, E., Namalika, J.M. *et al.* (2016). Magnitude of dental caries, missing and filled teeth in Malawi: National Oral Health Survey. *BMC Oral Health* **16**, 29 (2016).

Msyamboza, K.P., Phale, E., Namalika, J.M. *et al.* Magnitude of dental caries, missing and filled teeth in Malawi: National Oral Health Survey. *BMC Oral Health* **16**, 29 (2016). <https://doi.org/10.1186/s12903-016-0190-3>

National AIDS Commission. (2015). *Malawi AIDS Response Progress Report: 2015*. National AIDS Commission: Malawi.

National AIDS Commission. (2019) *Malawi Voluntary Medical Male Circumcision Communication Strategy 2019-2023*. National AIDS Commission: Lilongwe, Malawi.

National AIDS Commission. (2020). *Malawi National Strategic Plan for HIV and AIDS 2020-2025: Sustaining gains and accelerating progress towards epidemic control*. National AIDS Commission: Lilongwe, Malawi.

National AIDS Commission. (2020b) *Malawi National Communication and Advocacy Strategy for Pre-Exposure Prophylaxis (PrEP) 2020-2023*. Ministry of Health: Lilongwe, Malawi.

National Malaria Control Programme (NMCP) and ICF. (2018). *Malawi Malaria Indicator Survey 2017*. NMCP and ICF: Lilongwe, Malawi, and Rockville, Maryland, USA.

National Statistical Office and ICF Macro. (2011). *Malawi Demographic and Health Survey 2010*. NSO and ICF Macro: Zomba, Malawi, and Calverton, Maryland, USA.

National Statistical Office and ICF. (2017) *Malawi Demographic and Health Survey 2015-16*. NSO and ICF: Zomba, Malawi, and Rockville, Maryland, USA.

National Statistical Office. (2019) *2018 Malawi Population and Housing Census Report*. National Statistical Office: Zomba, Malawi.

Roberts, J. Sealy, D., Marshak, H.H., Manda-Taylor, L., Gleason, P., and Mataya, R. (2015) "The patient-provider relationship and antenatal care uptake at two referral hospitals in Malawi: A qualitative study." *Malawi Med J.* 27(4):145–150.

The African Cancer Registry Network (AFCRN)
<https://afcrn.org/index.php/membership/membership-list/82-blantyre-malawi>

The Republic of Malawi Department of Disaster Management Affairs National COVID-19 Office (2021): *National COVID-19 Preparedness and Response Strategy and Plan (July 2021-June 2022)*:

United Nations Children's Fund (UNICEF) and World Health Organization (WHO). (2019). *Progress on household drinking water, sanitation and hygiene 2000-2017. Special focus on inequalities*. UNICEF and WHO: New York, USA.

United Nations Children's Fund (UNICEF) and World Health Organization (WHO). (2019b). *Malawi Household Data*. <https://washdata.org/data/household#!/mwi>

World Bank. (2017). *World Bank Poverty Data. World Bank Global Poverty Working Group. World Bank: Washington, DC, USA.*

World Health Organization. (1998) *Health Promotion Glossary*. WHO: Geneva, Switzerland.

World Health Organization. (2009). *Malawi STEPS Survey 2009: Fact Sheet*. WHO STEPS. WHO: Malawi.

World Health Organization. (2017). *Global Status Report on Blood Safety and Availability 2016*. WHO: Geneva, Switzerland

World Health Organization. (2018) *Global Status Report on Road Safety 2018*. WHO: Geneva, Switzerland

ANNEX: Costed Implementation Plan

| Life Stage: Pregnant Mothers | | | | | | | | |
|--|---|-------------------------------|---|---|---|---|------------------|------------------|
| Health Focus Areas | Activities | Implementation Period (Years) | | | | | Total Cost (MWK) | Total Cost (USD) |
| | | 1 | 2 | 3 | 4 | 5 | | |
| ANC; Hospital delivery; malaria prevention in pregnancy; LLINs; Nutrition; Iron supplements uptake; Men/partners support; PMTCT; WASH and food safety. | Conduct message development for Pregnant mothers | | | | | | 36,000,000 | 44,887 |
| | Conduct creative sessions for communication materials for pregnant mothers | | | | | | 21,064,000.00 | 26,264 |
| | Production of communication materials | | | | | | 125,800,000.00 | 155,860 |
| | Printing of communication materials | | | | | | 500,000,000.00 | 623,442 |
| | Broad cast of communication materials on national and community radios | | | | | | 400,000,000.00 | 498,753.11 |
| | Broadcast of TV spots | | | | | | 100,000,000.00 | 124,688 |
| | Conduct interpersonal communication with pregnant mothers using care groups, HSAs and other volunteers | | | | | | 600,416,000.00 | 748,129.66 |
| | Conduct community filming on pregnant related issues | | | | | | 235,707,200.00 | 293,899.25 |
| | Support community groups, radio listening clubs, drama groups in interactive health education sessions on issues related to pregnancy | | | | | | 450,161,000.00 | 561,298 |
| | Brief celebrities to give information on pregnancy on social media | | | | | | 60,000,000.00 | 74,812.97 |
| | Sending SMS and IVR on pregnant related issues | | | | | | 75,000,000.00 | 93,516.21 |
| | Collection of radio materials | | | | | | 48,000,000.00 | 59,850.38 |

| Life Stage: Pregnant Mothers | | | | | | | | | |
|------------------------------|------------|-------------------------------|---|---|---|---|------------------|------------------|--|
| Health Focus Areas | Activities | Implementation Period (Years) | | | | | Total Cost (MWK) | Total Cost (USD) | |
| | | 1 | 2 | 3 | 4 | 5 | | | |
| Sub-Total | | | | | | | 2,652,148,200.00 | 3,305,401.00 | |

| Life Stage: Care Takers Of Under Five Children | | | | | | | | |
|--|--|-------------------------------|---|---|---|---|------------------|------------------|
| Health Focus Areas | Activities | Implementation Period (Years) | | | | | Total Cost (MWK) | Total Cost (USD) |
| | | 1 | 2 | 3 | 4 | 5 | | |
| Breastfeeding, KMC for LBW babies; post-partum care; Immunization; Family Planning (Modern Contraceptive Methods); Infant and Young Child Feeding (IYCF); Management of Child illnesses; Malaria prevention and treatment. Dental Health; Albendazole and Vitamin A uptake | Conduct message development for care takers of under five children | | | | | | 54,000,000 | 67,331.67 |
| | Conduct creative sessions for communication materials children under 5 years | | | | | | 34,064,000.00 | 42,473.81 |
| | Production of communication materials | | | | | | 200,800,000.00 | 250,374.06 |
| | Printing of communication materials | | | | | | 700,000,000.00 | 672,817.96 |
| | Broadcast communication materials on national and community radios | | | | | | 500,000,000.00 | 623,441.40 |
| | Broadcast of TV spots | | | | | | 100,000,000.00 | 124,688 |
| | Conduct interpersonal communication with care takers of children ages 6-12 using care groups, HSAs and other volunteers | | | | | | 800,416,000.00 | 998,024.94 |
| | Conduct community filming and band shows issues related to children under five years | | | | | | 100,707,200.00 | 125,570.08 |
| | Support community groups radio listening clubs, drama groups in interactive health education sessions on issues related to pregnancy | | | | | | 450,161,000.00 | 561,865.34 |
| | Brief celebrities to give information on related to children under five years | | | | | | 60,000,000.00 | 74,812.96 |
| | Sending SMS and IVR to care takers of children under five years | | | | | | 100,000,000.00 | 124,688.28 |

| Life Stage: Care Takers Of Under Five Children | | | | | | | | |
|--|------------|--|---|---|---|---|------------------|------------------|
| Health Focus Areas | Activities | Implementation Period (Years) | | | | | Total Cost (MWK) | Total Cost (USD) |
| | | 1 | 2 | 3 | 4 | 5 | | |
| | | Collection of radio materials for programmes related to children under five children | | | | | | 75,000,000.00 |
| Sub-Total | | | | | | | 3,175,148,200.00 | 3,759,604.71 |

| Life Stage: Care Takers of Children Ages 6 – 12 | | | | | | | | |
|--|--|-------------------------------|---|---|---|---|------------------|------------------|
| Health Focus Areas | Activities | Implementation Period (Years) | | | | | Total Cost (MWK) | Total Cost (USD) |
| | | 1 | 2 | 3 | 4 | 5 | | |
| Bilharzia; Scabies; Trachoma; ARI; Dental Health; SRH; Nutrition; Malaria; LLIN; IRS; WASH and food safety ART; VMMC | Conduct message development for care takers of children ages 6-12 | | | | | | 54,000,000 | 67,331.67 |
| | Conduct creative sessions for communication materials for care takers children ages 6-12 | | | | | | 200,800,000.00 | 250,374.06 |
| | Production of communication materials for children ages 6-12 | | | | | | 700,000,000.00 | 672,817.96 |
| | Printing of communication materials children ages 6-12 | | | | | | 500,000,000.00 | 623,441.40 |
| | Broadcast communication materials on national and community radios for children ages 6-12 | | | | | | 100,000,000.00 | 124,688 |
| | Broadcast of TV spots for issues related to children ages 6-12 | | | | | | 800,416,000.00 | 998,024.94 |
| | Conduct interpersonal communication with children ages 6-12 using care groups, HSAs and other volunteers | | | | | | 100,707,200.00 | 125,570.08 |
| | Conduct community filming and band shows issues related to children ages 6-12 | | | | | | 450,161,000.00 | 561,865.34 |

| Life Stage: Care Takers Of Under Five Children | | | | | | | | |
|--|--|-------------------------------|---|---|---|---|------------------|------------------|
| Health Focus Areas | Activities | Implementation Period (Years) | | | | | Total Cost (MWK) | Total Cost (USD) |
| | | 1 | 2 | 3 | 4 | 5 | | |
| | Support community groups, radio listening clubs, drama groups in interactive health education sessions on issues related to children ages 6-12 | | | | | | 60,000,000.00 | 74,812.96 |
| | Brief celebrities to give information on related to children ages 6-12 | | | | | | 100,000,000.00 | 124,688.28 |
| | Sending SMS and IVR to caretakers of children ages 6-12 | | | | | | 75,000,000.00 | 93,516.21 |
| | Collection of radio materials for programmes related to children ages 6-12 | | | | | | 54,000,000 | 67,331.67 |
| Sub-total | | | | | | | 3,195,084,200.00 | 3,784,462.57 |

| Life Stage: Adolescents (Ages 13 – 19 Years) | | | | | | | | |
|--|--|-------------------------------|---|---|---|---|------------------|------------------|
| Health Focus Areas | Activities | Implementation Period (Years) | | | | | Total Cost (MWK) | Total Cost (USD) |
| | | 1 | 2 | 3 | 4 | 5 | | |
| Adolescents delay sexual debut; Prevention of unplanned pregnancies, HIV, STIs, Menstrual hygiene management; Malaria prevention and treatment; Early healthcare seeking behaviour; WASH and food safety; Dental caries; | Conduct message development on issues related to adolescents | | | | | | 54,000,000 | 67,331.67 |
| | Conduct creative sessions to produce communication targeting issues related to adolescents | | | | | | 200,800,000.00 | 250,374.06 |
| | Production of communication materials for issues related to adolescents | | | | | | 700,000,000.00 | 672,817.96 |
| | Printing of communication materials for issues related to adolescents | | | | | | 500,000,000.00 | 623,441.40 |
| | Broadcast of communication materials on national and community | | | | | | 100,000,000.00 | 124,688 |

| Life Stage: Care Takers Of Under Five Children | | | | | | | | |
|--|---|-------------------------------|---|---|---|---|------------------|------------------|
| Health Focus Areas | Activities | Implementation Period (Years) | | | | | Total Cost (MWK) | Total Cost (USD) |
| | | 1 | 2 | 3 | 4 | 5 | | |
| Bilharzia; Nutrition | radios for issues related to adolescents | | | | | | | |
| | Broadcast TV spots of issues related to adolescents | | | | | | 800,416,000.00 | 998,024.94 |
| | Conduct interpersonal communication with adolescents on issues related to adolescents | | | | | | 100,707,200.00 | 125,570.08 |
| | Conduct community filming and band shows addressing issues related to adolescents | | | | | | 450,161,000.00 | 561,865.34 |
| | Support community groups, radio listening clubs, drama groups in interactive health education sessions on issues related to adolescents | | | | | | 60,000,000.00 | 74,812.96 |
| | Brief celebrities to give them information on issues related to adolescents | | | | | | 100,000,000.00 | 124,688.28 |
| | Collection of radio materials for programmes on issues related to adolescents | | | | | | 54,000,000 | 67,331.67 |
| | Sending SMS and IVR of issues related to adolescents 2 | | | | | | 75,000,000.00 | 93,516.21 |
| | Sub-total | | | | | | 3,195,084,200 | 3,784,462.57 |

| Life Stage: People Ages 20 + | | | | | | | | |
|--|---|-------------------------------|---|---|---|---|------------------|------------------|
| Health Focus Areas | Activities | Implementation Period (Years) | | | | | Total Cost (MWK) | Total Cost (USD) |
| | | 1 | 2 | 3 | 4 | 5 | | |
| Prevent BP; Diabetes; Cardiovascular diseases; Mental health; TB; Family | Conduct message development on issues related to people ages 20 and above | | | | | | 54,000,000 | 67,331.67 |
| | Conduct creative sessions for communication | | | | | | 200,800,000.00 | 250,374.06 |

| Life Stage: Care Takers Of Under Five Children | | | | | | | | | |
|---|--|-------------------------------|---|---|---|---|------------------|------------------|--|
| Health Focus Areas | Activities | Implementation Period (Years) | | | | | Total Cost (MWK) | Total Cost (USD) | |
| | | 1 | 2 | 3 | 4 | 5 | | | |
| planning (Modern contraceptive methods); HIV; Malaria prevention and treatment; WASH and Food safety; Onchocerciasis; SRH; Dental Health; Nutrition | materials on issues related to people ages 20 and above | | | | | | | | |
| | Production of communication materials for issues related to people ages 20 and above | | | | | | 700,000,000.00 | 672,817.96 | |
| | Printing of communication materials of issues related to people ages 20 and above | | | | | | 500,000,000.00 | 623,441.40 | |
| | Broadcast communication materials on national and community radios on issues related to people ages 20 and above | | | | | | 100,000,000.00 | 124,688 | |
| | Broadcast of TV spots on issues related to people ages 20 and above | | | | | | 800,416,000.00 | 998,024.94 | |
| | Conduct interpersonal communication with people ages 20 and above on issues related to people ages 20 and above | | | | | | 100,707,200.00 | 125,570.08 | |
| | Conduct community filming and band shows on issues related to people ages 20 and above | | | | | | 450,161,000.00 | 561,865.34 | |
| | Support community groups, radio listening clubs, drama groups in interactive health education sessions on issues related to people ages 20 and above | | | | | | 60,000,000.00 | 74,812.96 | |
| | Brief celebrities to provide information on issues related to people ages 20 and above | | | | | | 100,000,000.00 | 124,688.28 | |
| | Collection of radio materials for programmes | | | | | | 54,000,000 | 67,331.67 | |

| Life Stage: Care Takers Of Under Five Children | | | | | | | | |
|--|---|-------------------------------|---|---|---|---|------------------|------------------|
| Health Focus Areas | Activities | Implementation Period (Years) | | | | | Total Cost (MWK) | Total Cost (USD) |
| | | 1 | 2 | 3 | 4 | 5 | | |
| | on issues related to people ages 20 and above | | | | | | | |
| | Sending SMS and IVR on issues related to people ages 20 and above | | | | | | 75,000,000.00 | 93,516.21 |
| Sub-total | | | | | | | 3,195,084,200 | 3,784,462.57 |
| Emerging Issues | | | | | | | | |
| Health Focus Areas | Activities | Implementation Period (Years) | | | | | Total Cost (MWK) | Total Cost (USD) |
| | | 1 | 2 | 3 | 4 | 5 | | |
| People adhere to preventive measures of COVID-19 | Conduct creative sessions to produce communication materials | | | | | | 54,000,000 | 67,331.67 |
| | Printing of communication materials | | | | | | 500,000,000.00 | 623,441.40 |
| | Broadcast communication materials on national and community radios | | | | | | 100,000,000.00 | 124,688 |
| | Conduct media briefing with media personnel | | | | | | 100,707,200.00 | 125,570.08 |
| | Support community groups, radio listening clubs, drama groups in interactive health education sessions on issues related emerging health issues | | | | | | 60,000,000.00 | 74,812.96 |
| | Brief celebrities to give information on related to emerging issues | | | | | | 100,000,000.00 | 124,688.28 |
| | Collection of radio materials for programmes related to emerging health issues | | | | | | 54,000,000 | 67,331.67 |
| Sub Total | | | | | | | 968,707,200.00 | 1,207,864.06 |

| Coordination and Capacity Building | | | | | | | | |
|------------------------------------|---|-------------------------------|---|---|---|---|------------------|------------------|
| Focus Areas | Activities | Implementation Period (Years) | | | | | Total Cost (MWK) | Total Cost (USD) |
| | | 1 | 2 | 3 | 4 | 5 | | |
| Coordination | HP-TWG at district level | | | | | | 15,000,000.00 | 18,703.25 |
| | HP at national level | | | | | | 40,000,000.00 | 49,875.31 |
| | Review meetings with DHPO on progress on Health promotion activities | | | | | | 80,000,000.00 | 99,750.62 |
| | Meetings with district programme managers | | | | | | 30,000,000.00 | 37,406.49 |
| | Meetings with IEC focal persons | | | | | | 75,000,000.00 | 83,516.21 |
| | National supervisions | | | | | | 120,000,000.00 | 149,625.94 |
| | District supervision | | | | | | 60,000,000.00 | 74,812.96 |
| | Health promotion national dissemination conference | | | | | | 60,000,000.00 | 74,812.96 |
| | Procurement of office equipment at district level | | | | | | 200,000,000.00 | 249,376.56 |
| | Procurement of office equipment at national level | | | | | | 400,000,000.00 | 498,753.12 |
| | | | | | | | | |
| Capacity building | Training of HPOS on SBBC approaches | | | | | | 75,000,000.00 | 93,516.21 |
| | Training of HPOS on M&E | | | | | | 75,000,000.00 | 93,516.21 |
| | Training of HPOs on adaption of evidence-based interventions/approaches to Health promotion | | | | | | 75,000,000.00 | 93,516.21 |
| Sub-Total | | | | | | | 1,305,000,000 | 1,542,369.09 |

