# Malawi Government

## National Health Communication Strategy

2015-2020

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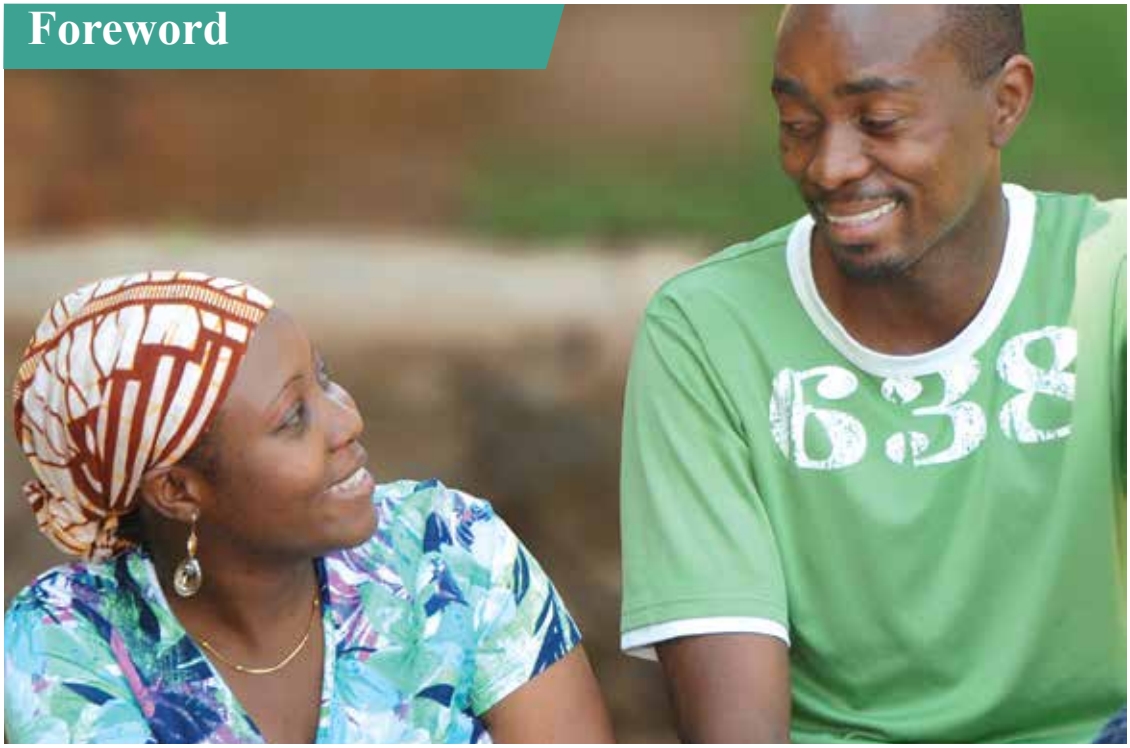
## List of Acronyms and Abbreviations

| | |
|---|---|
| ACT | Artemisinin based Combination Therapy |
| ADC | Area Development Committee |
| AIDS | Acquired Immunodeficiency Syndrome |
| ANC | Antenatal Clinic |
| ARI | Acute Respiratory Infections |
| ART | Antiretroviral Therapy /Treatment |
| BCC | Behaviour Change Communication |
| BCI | Behaviour Change Intervention |
| CBO | Community Based Organization |
| CDC | Centres for Disease Control and Prevention |
| CHAI | Clinton Health Access Initiative |
| CHAM | Christian Health Association of Malawi |
| CSP | Concurrent Sexual Partnerships |
| DA | District Authority |
| DFID | Department for International Development |
| DHEO | District Health Education Officers |
| DHMT | District Health Management Team |
| DHPO | District Health Promotion Officer |
| DIP | District Implementation Plan |
| EHP | Essential Health Package |
| EPI | Expanded Programme on Immunization |
| FAO | Food and Agricultural Organization |
| FBO | Faith Based Organization |
| FP | Family Planning |
| GAVI | Global Alliance for Vaccine Initiative |
| HES | Health Education Services |
| HEU | Health Education Unit |
| HIV | Human Immunodeficiency Virus |
| HMIS | Health Management Information System |
| HP | Health Promotion |
| HPV | Human Papillomavirus |
| HSA | Health Surveillance Assistant |
| HSSP | Health Sector Strategic Plan |
| IPTP | Intermittent Preventive Treatment for Malaria in pregnancy |
| ITN | Insecticide Treated Nets |
| JHCCP | Johns Hopkins Center for Communication Programs |
| LLITN/ LLIN | Long Lasting Insecticide Treated Net |
| M&E | Monitoring and Evaluation |
| MCH | Maternal and Child Health |
| MDA | Mass Drug Administration |
| MDG | Millennium Development Goals |

| | |
|---|---|
| MDHS | Malawi Demographic and Health Survey |
| MGDS | Malawi Growth and Development Strategy |
| MICS | Malawi Multiple Indicator Cluster Survey |
| MIS | Malaria Indicator Survey |
| MoH | Ministry of Health |
| MTHUO | Malawi Traditional Healers Umbrella Organization |
| MWK | Malawi Kwacha |
| NCDs | Non-Communicable Diseases |
| NGO | Non-Governmental Organization |
| NHCS | National Health Communication Strategy |
| NSO | National Statistical Office |
| NTDs | Neglected Tropical Diseases |
| ORS | Oral Rehydration Solution |
| PAHO | Pan American Health Organization |
| PC | Paramount Chief |
| PHC | Primary Health Care |
| PMTCT | Prevention of Mother To Child Transmission |
| POW | Programme of Work |
| PR | Public Relations |
| PRSP | Poverty Reduction Strategy Paper |
| PSI | Population Services International |
| RHU | Reproductive Health Unit |
| RTA | Road Traffic Accident |
| SBCC | Social and Behaviour Change Communication |
| SC | Senior Chief |
| SDH | Social Determinants of Health |
| SINTEF | The Foundation for Scientific and Industrial Research, Norwegian Institute of Technology |
| SRH | Sexual and Reproductive Health |
| SSDI | Support for Service Delivery Integration |
| STI | Sexually Transmitted Infections |
| TA | Traditional Authority |
| TFR | Total Fertility Rate |
| TWG | Technical Working Group |
| UK | United Kingdom |
| UNFPA | United Nations Population Fund |
| UNICEF | United National Children's Fund |
| USAID | United States Agency for International Development |
| VDC | Village Development Committee |
| VHC | Village Health Committee |
| VMMC | Voluntary Male Medical Circumcision |
| WASH | Water, Sanitation and Hygiene |
| WHO | World Health Organization |
| WFP | World Food Programme |

# Foreword



The Health Sector Strategic Plan (HSSP) 2011-2016 emphasizes the need to recognize and scale up health promotion interventions in the implementation of the Essential Health Package. This gave credence to the development of the Malawi Health Promotion Policy (HP) that was launched in February 2014. Both the HSSP and the HP policy are aligned to the Malawi Growth and Development Strategy (MGDS). All of which are aligned to the Millennium Development Goals (MDGs) covering the 2000-2015 period. The principles of the Alma Ata Declaration of 1978 lay the foundation for Health Education as the precursor to health promotion, and advocate for the primary health care (PHC) approach. Health promotion began to gain acceptance worldwide after the launching of the Ottawa Charter for Health Promotion at the first international health promotion conference held in Ottawa, Canada 1986. The World Health Organisation (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, Health Promotion Glossary, WHO/HPR/HEP/98.1) p.1.)

The purpose of the National Health Communication Strategy (NHCS) is to facilitate coordination and harmonization of health promotion and communication strategies across the Health Sector. This strategy has been developed in an interactive and participatory manner involving all stakeholders in health and is a reference and guiding document for anyone undertaking health promotion or Social and Behaviour Change Communication (SBCC) in Malawi.

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MINISTER OF HEALTH

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The development of this strategy was a highly interactive and consultative process and therefore the MoH extends its gratitude to all those who participated in its development. In this regard the ministry extends thanks to the following individuals: Mr. Fayyaz Khan, Dr. Alinafe Kasiya, Mr. Thomas Ofem, Mr. Peter Roberts, Mr. Dziko Chatata, Mr. Dennis Chimenya, Mr. Hudson Kubwalo, Mr. Henry Chimbali, Mr. Tobias Kunkumbira, Ms. Ella Chamanga, Mr. Austin Makwakwa, Ms. Angela Chitsime, Mr. Fredson Kamcira, Mr. A. Chidothi, Mr. T. Mafuleka, Mr. Sangwani Phiri, Mr. Adrian Chikumbe, Mr. Chancy Mauluka and Mr. Joel Suzi.

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SECRETARY FOR HEALTH

# About the Strategy

## *Intended Audience*

This strategy is intended for program designers, implementers, technical working groups and others who are using health communication to promote healthy behaviors and wellbeing in Malawi. This includes a wide range of stakeholders such as, but not limited to, those working for the Ministry of Health, NGOs, civil society and the private sector.

## *How the Strategy Is Organized*

The strategy begins with a stage setting introduction providing background information on the 13 priority Essential Health Package (EHP) focal areas and the current health situation in terms of disease burden and knowledge, attitude and practices. This is followed by an overview of the strategy's guiding principles, overarching strategic approaches and positioning. Here, the branding of all communication efforts under one central and unifying platform is explained. The next section provides guidance on: Behaviour Change desired for the primary audiences; Communication Objectives for the EHP focal areas; Key Messages; and, Suggested Channels, Tools and Activities. Additional information is provided for addressing strategic influencing audiences. The final sections discuss Monitoring and Evaluation, Operationalizing the Strategy and the Role of Stakeholders.

## *How to Use the Strategy*

The NHCS is designed to be the basis upon which all other 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, audiences and their needs.

## *How the Strategy Was Developed*

To allow for broad stakeholder input and consensus, the strategy was developed in stages. It started with informal discussions between SSDI-Communication and the HES. There after consultative meetings were conducted with health programme managers and stakeholders to collect information to guide the development of the strategy. A Task Team was formed which comprised representatives from HES, SSDI-Communication, WHO, UNICEF, PSI, CHAI and CHAM constituted by the Director of Preventive Health Services to facilitate strategy development process.

Data was collected using several means including a desk review of the 13 priority conditions as identified by the HSSP 2011-2016, and a baseline assessment using focus groups and key informant interviews with program managers and their staff as well as external partners. The data was validated during the stakeholder consultations.

# Executive Summary

Several health communication strategies already exist in Malawi for various health programmes including HIV and AIDS, nutrition, malaria and WASH, among others. The Government of Malawi has developed a national communication strategy to harmonise these programme specific strategies. Having multiple strategies has its own negative implications such as poor coordination and duplication of efforts. Therefore, this strategy harmonizes approaches and integrates messages across the 13 priority conditions in the Essential Health Package as spelt out in the Health Sector Strategic Plan (2011-2016).

Having a harmonized communication strategy will help to address the quadruple burden of communicable diseases, non-communicable diseases, trauma related conditions and maternal and neonatal problems. The strategy will ensure that the population is reached with essential information, skills and develop positive healthy behaviours.

The overarching theme of the NHCS is *Moyo ndi Mpamba: Usamalireni!* (Life is Precious: Take Care of it ). The NHCS is anchored in the Social Ecological Model of Communication and selected behaviour change theories. Utilizing the Life Stages Approach, it promotes healthy choices at critical junctures in life based on what is most important and meaningful to people at those times.

The ultimate aim of the National Health Communication Strategy 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. Background and Introduction

## 1.1 Country Profile

Malawi is a landlocked country in Southern Africa with a total area of 118,440 square kilometres and an estimated population of nearly 17.4 million. Malawi's population is made up of the Chewa, Nyanja, Tumbuka, Yao, Lomwe, Sena, Tonga, Ngoni, and Ngonde native ethnic groups. About 85% of the people live in rural areas with a mean age of 17.2 signifying a young population. The population growth rate is estimated at 2.3% due to the high total fertility rate estimated at 5.7% and relatively low contraceptive prevalence rate of 42% of all women in the reproductive age group.

Malawi is divided into 28 districts within three regions: Central, Northern and Southern. Major languages include Chichewa, an official language spoken by over 57% of the population, English, Chinyanja (12.8%), Chiyao (10.1%), and Chitumbuka (9.5%). The economy is based on agriculture, and more than one-third of GDP and 90% of export revenues come from this. The main agricultural products of Malawi include tobacco, sugarcane, cotton, tea, corn, potatoes, sorghum, cattle and goats. The main industries are tobacco, tea and sugar processing, sawmill products, cement and consumer goods.

## 1.2 Introduction to the Strategy

Alignment with Global and Government Priorities

The principles of the Alma Ata Declaration of 1978 lay the foundation for Health Education, the precursor to health promotion, and advocates for the primary health care (PHC) approach. The World Health Organization (WHO) defines health promotion as "aiming to strengthen the capabilities of individuals and the capacity of groups or communities to act collectively to control the determinants of health and to achieve positive change" adding that "health promotion is not something that is done on or to people; it is done by and with groups of people " or "is a process of enabling people[1] to increase control over the determinants of health and thereby improve their health[2]." The Malawi Health Sector Strategic Plan (HSSP) 2011-2016 emphasizes the need to recognize and scale up health promotion interventions in the implementation of the Essential Health Package (EHP).

This gave credence to the development of the Malawi Health Promotion Policy (HP). Both the HSSP and the HP policy are based

1 WHO, Health and Welfare Canada, Canadian Public Health Association. Ottawa Charter for Health Promotion. First International Conference on Health Promotion. 1986

2 Adapted from WHO 1998, Health Promotion Glossary, WHO/HPR/HEP/98.1.

on the Malawi Growth and Development Strategy (MGDS). The NHCS has also been aligned to the main policies for health in Malawi such as the 2011 National Health Policy and others such as the National Decentralization Policy. These are all aligned to the Millennium Development Goals (MDGs)[3] as well as the post 2015 initiatives which are guided by the Malawi Vision 2020. The National Health Communication Strategy is aligned to the current Health Promotion Policy of Malawi and covers the 13 priority Essential Health Package (EHP) conditions as spelt out in the Health Sector Strategic Plan, 2011-2016. The 13 priority conditions are:

- Malaria
- HIV and AIDS
- Perinatal conditions (comprised of Maternal and Child Health/Family Planning)
- (Mal)Nutrition
- Diarrheal diseases (addressed by: Water, Sanitation and Hygiene (WASH)
- Vaccine Preventable Diseases (addressed by Expanded Program on Immunization (EPI)
- Tuberculosis
- Non-Communicable Diseases (NCDs) including trauma
- Acute Respiratory Infections
- Cancers
- Mental Illness and Epilepsy
- Neglected Tropical Diseases (NTDs)
- Eye, Ear and Skin Infections

## 1.3 Overview of Strategic Approach

The mandate of the Ministry of Health is to ensure that the people of Malawi live a healthy and disease free life. Health promotion and communication plays a crucial role in enabling people to make informed choices that enable them to stay healthy and protect themselves and their loved ones from diseases. The NHCS takes a holistic, integrated and people centred approach by using evidence based communication models, theories and approaches.

The NHCS is anchored in the Social Ecological Model of Communication and selected behaviour change theories. The strategy has used the Life Stages audience segmentation approach which, promotes healthy choices at critical junctures in life based on what is most important and meaningful to people at those times. The NHCS has adopted the *Moyo ndi Mpamba: Usamalireni* theme with its focus on wellness, not merely the absence of disease, as the primary unifying concept. It makes use of all available communication channels—mass media, traditional media, mobile phones, social media, community mobilization and interpersonal communication.

3 The MDGs are the internationally agreed set of time-bound goals for reducing extreme poverty, extending gender equality and advancing opportunities for health and education.

# 2. Current Health Situation

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

Leading 10 risk factors & diseases and injuries in Malawi (Malawi College of Medicine, 2006)

| Top 10 risk factors | | | Top 10 diseases | | |
|---|---|---|---|---|---|
| *Risk* | *Risk factor* | *% of total* | *Rank* | *Disease* | *%of deaths* |
| 1 | Unsafe sex | 34.1 | 1 | HIV/AIDS | 33.6 |
| 2 | Childhood and maternal underweight | 16.5 | 2 | Lower Respiratory Infections | 11.3 |
| 3 | Unsafe water, sanitation and hygiene | 6.7 | 3 | Malaria | 7.8 |
| 4 | Zinc deficiency | 4.9 | 4 | Diarrhoeal diseases | 7.6 |
| 5 | Vitamin A deficiency | 4.8 | 5 | Conditions arising from perinatal conditions | 3.2 |
| 6 | Indoor smoke from solid fuels | 4.8 | 6 | Cerebrovascular disease | 2.8 |
| 7 | High blood pressure | 3.5 | 7 | Ischaemic heart disease | 2.6 |
| 8 | Alcohol consumption | 2.0 | 8 | Tuberculosis | 2.4 |
| 9 | Tobacco smoking | 1.5 | 9 | RTA | 1,3 |
| 10 | Iron deficiency | 1.3 | 10 | Protein energy malnutrition | 1.0 |

The following is the current health situation in Malawi in terms of disease burden and the known knowledge, attitude and practices for each of the 13 EHP focal areas.

## 2.1 Maternal and child health (including malnutrition, ARI, EPI and malaria)

Malawi achieved a reduction in the infant mortality rate from 76 to 66 per 1000 live births, and maternal mortality ratio from 984 to 675 per 100,000 live births between 2004 and 2010 (MDHS 2004 and 2010). The under-five mortality rate is now at 64 per 1,000 live births (2012), down from 112 in 2010 and 234 in 1992 which is ahead of the 2015 Millennium Development Goal 4 target of 78 per 1000 live births. In the last two decades, the percentage of women and their partners using contraception also rose from 7% in 1992 to 42% in 2010.

Regarding Family Planning (FP), the SSDI 2012 study found that of those surveyed, knowledge of at least one FP method was nearly universal (99%) and overall approval of FP use among married couples was 97%. Communication among couples about FP was however much lower, with only 25% of men and 22% of women reporting they had discussed FP with anyone in the past six months and only 13% of women saying they had discussed it with their partner. Similar to the MDHS findings of 2010, the survey found that current use of FP was reported at 47% for women with men higher at 60%. The most commonly used methods reported were injectables followed by condoms and female sterilization.

According to the MDHS 2010, 73% of births in Malawi are delivered in a health facility; (57% in public sector facilities, 16% in private sector facilities); compared to 57.2% in 2004. 24% of births occur at home. Women having their first baby are more likely than women with a higher birth order to deliver in a health facility; the proportion of births occurring in a facility declines as birth order increases. Women in urban areas are more likely to deliver in a health facility than their rural counterparts (86% compared with 71%). Seventy-one percentage of births in the five years preceding the survey were assisted by a skilled attendant (doctor, clinical officer, and nurse midwife), with 11% assisted by a doctor or clinical officer and 61% aided by a nurse or midwife. In the absence of a skilled attendant, a traditional birth attendant was the next most common person assisting at delivery (14 %). Nine percentage of births were assisted by a relative, friends, or other person; 3% of births were attended by no one; and 2% were assisted by a patient attendant.

According to SSDI-Communication findings from the 2012 baseline survey of 15 districts in Malawi. Baltimore, MD: Carol Underwood found that knowledge of the seven (7) danger signs associated with pregnancy was very low; approximately 20% of respondents reported they were unaware of any. In terms of health centre deliveries, the study found that 73% of births in Malawi are delivered in a health facility (57% in public sector facilities and 16% in private sector facilities); 24% of births occur at home.

According to the Malawi Multiple Indicator Cluster Survey (MICS) 2006, the Neonatal Mortality Rate (NMR) was estimated at 33 deaths per 1000 live births in 2006 (slightly higher in rural areas with 34 deaths per 1000, against 30 in urban areas). The MDHS 2010 showed a slight decline in neonatal deaths with the figure at 31 deaths per 1000 live births. The Malawi 2014 MDG Endline Survey showed further gains in neonatal survival with the NMR at 29 deaths per 1000 live births. About half (48%) of mothers did not receive any postnatal care, attributed to a lack of: emphasis on community and family care; adequate treatment for neonatal infections; and, information on danger signs, coupled with poor hygiene practices.

Overall, 7% of children in Malawi are reported to have Acute Respiratory Infection (ARI) symptoms. The proportion of children with ARIs taken to health facilities increased from 19.6% in 2004 to 70% in 2010. The data further shows that 65% of children with fever were taken to a health facility for treatment. There has also been a reduction in the pneumonia

case fatality rate from 18% in 2000 to 5.7 % in 2008.

In Malawi, diarrhoea is the third highest cause of death and illnesses among children under five years. About 224,354 under five cases of diarrhoea were reported in 2010 along with 369 deaths. The prevalence of diarrhoea overall is estimated at 17.5%, and at 33% in children aged 6-23 months. Not surprisingly, the 2010 MDHS shows a higher percentage of reported cases of diarrhoea in communities without access to improved drinking water and sanitation.

Malnutrition also remains an important public health problem in Malawi, where 47% of children under the age of 5 years have stunted growth and 1.5% experience severe wasting (acute malnutrition) and 4% experience wasting. This high rate of childhood stunting and malnutrition has been linked to higher incidences of adult obesity, diabetes, heart conditions and certain types of cancer, along with higher mortality and shorter life-spans. The good news is that the number of under-weight children has declined from about 25% in 2000 to 13% 2010. It is projected that the Millennium Development Goal of 12% will be reached by its 2015 target.

Inadequate intake in terms of quantity, quality and variety of dietary nutrients among mothers during pregnancy coupled with poor food choices from the six food groups and insufficient micro nutrient intake of vitamin A, iodine and folic acid are some of the contributing factors to malnutrition. In addition, infants who do not have proper nutrition in the first six months due to poor feeding practices such as early introduction of complementary liquids and foods are more vulnerable to diseases.

The Expanded Program on Immunization (EPI) is one of Malawi's success stories. Coverage of the third dose of DPT (DPT3) was reported at 96% in 2012 by WHO/UNICEF and 93% by the MDHS 2010. DPT3 is used as a proxy measure for overall vaccine coverage indicating that overall immunization coverage is very high. Both GAVI and WHO have recognized this excellent work. However, in 2010, Malawi experienced an outbreak of measles nationwide. The country is on track to achieve polio eradication because polio cases have not been reported since 1992.

Although significant strides have been made in children getting immunized, barriers to full uptake persist. According to a survey conducted by SSDI-Communication the two reasons for not immunizing their children were lack of knowledge about the benefits of immunization (38%) and long distances to the clinics (20%). Additionally, some communities in Malawi do not allow their children to be vaccinated due to religious or cultural beliefs.

## 2.2 Water and sanitation hygiene

Washing hands before preparing and eating food, using the toilet and changing nappies is a simple and effective way to prevent diarrhoea and other diseases in babies, young children, and their parents and siblings. According to the survey conducted by SSDI-Communication in 2012, 68% and 46% of people knew that washing hands after defecating and before eating can prevent diarrhoea respectively.

In terms of toilet/latrine usage, 53% said they use latrines without a slab/open pit, 16% use ventilated improved pit latrines, 12% use composting toilets and 10% pit latrines with slab. Only 40% said using a toilet/latrine was an effective method as a primary way to prevent diarrhoea related diseases. Knowledge on the use of zinc tablets to treat diarrhoea was reported as low, with 63% of Malawians responding they didn't know about it.

A 2010 study however found that among children under the age of five years who had diarrhoea, 74% were treated with oral rehydration therapy of increased fluids and 69% were treated with oral rehydration salt packets or pre-packaged liquid.

## 2.3 Malaria

Data from Health Management Information System (HMIS) indicates that malaria accounts for about 23% of all outpatient visits. The malaria incidence rate is reported to have declined by about 52.5%, from 484 per 1000 in 2010 to 230 per 1000 population in 2013.

Despite this, there are approximately four million episodes of malaria treated annually.

Results from the 2014 HMIS indicate that the malaria prevalence rate among children age 6-59 months is 33.3% making it the leading cause of morbidity (and mortality) in children under five years. Malaria and anaemia (attributed to malarial infection) are estimated to cause 40% of hospitalizations and 60% of hospital deaths among children under five years. It's estimated that children under five years suffer from 50% of the suspected malaria cases annually, and that children in this age group have an annual incidence rate of 1,160 episodes of malaria per 1,000 children.

The 2014 HMIS indicate that 82% of women in Malawi are aware that mosquito bites can cause malaria and about 84% of women correctly know mosquito nets are a prevention method for malaria. Additionally, 95% of men and women indicated in a survey that malaria was caused by mosquito bites. Using insecticide-treated nets (ITNs) can greatly reduce the risk of contracting malaria. According to the Malaria Indicator Survey (MIS) 2014, 70% of Malawian households own at least one ITN, and 30% of households had at least one ITN for every two people in the household. 62% of pregnant women aged 15-49 reported sleeping under a mosquito net the night before the survey. This rate was 67% for children under the age of 5 years.

According to the 2014 HMIS, 63% of pregnant women received intermittent preventive treatment (IPTp) for malaria, that is, at least two doses of SP/Fansidar

with at least one dose received during an antenatal care visit which occurred during the most recent pregnancy.

The 2014 MIS indicate that 39% of those with fever took artemisinin-based combination therapies (ACTs), the recommended treatment for malaria in Malawi. Of those children with fever, 31% were given ACT within 24 hours of onset of fever, or during the recommended timeframe.

## 2.4 HIV and AIDS

The national response to the HIV epidemic has resulted in the reduction of HIV prevalence from 16.2% in 1999 to 10.6% in 2010, according to the MDHS. However, Malawi's rate of HIV prevalence is still among the highest in the world. The highest concentration of HIV infection in Malawi is among adults ages 15-49: in 2010, 12.9% of women and 8.1% of men in this age category were estimated to be living with HIV. An estimated 47% of young men and 19% of young women (15-24 years old) in Malawi have never been tested for HIV.

UNICEF estimated that as of 2012, 180,000 children are living with HIV in Malawi and 770,000 Malawian children have lost their parents due to AIDS.

The co-epidemic of HIV and Tuberculosis (TB) has contributed to high morbidity and mortality in the country. The National Tuberculosis Control Program reported that about 68% of TB cases are co-infected with HIV. This contributed to the high TB case fatality rate of 20%. However, this was reduced to 7%.

According to a study by UNICEF in 2013, only 44.7% of men and 41.8% of women aged 15-24 have comprehensive knowledge of HIV, and only 40.5% of men and 31.4% of women aged 15- 24 use condoms if they have multiple sexual partners. The NSO in 2009 found that only 50% of men and 81% of women aged 15-24 have ever been tested for HIV. SSDI's study in 2012 found that among the larger population of adults 36.5% of men and 43% of women (16-59) reported being tested for HIV in the past 6 months. Fear was cited as the main inhibitor among men for going for HCT, while for women distance to a testing facility was cited as the main barrier. Despite low comprehensive knowledge about HIV among young people, SSDI found that about 93% of Malawians overall know about Prevention of Mother to Child Transmission of HIV. Clinic data indicates that between July 2010 and March 2011, among new pregnant women who registered for antenatal services, 7% had already tested for HIV and 71% were newly tested for HIV. Out of the 31,529 women that were HIV positive, 82% received ARVs. By June 2011 a total of 328,032 pregnant women attending ANC had been counselled and tested for HIV, representing 73% of the target and 54% coverage of the estimated pregnancies in the population. A total of 24,258 HIV positive pregnant women (representing 45%) received ARV prophylaxis and 11% of HIV pregnant women received ARVs in the July 2010 – June 2011 financial year.

Condom use, particularly among young people, is low in Malawi. In 2010, the government reported that the percentage

of young females (15-24) who used a condom at last sexual intercourse was 48.8% and the corresponding proportion among young males was at 51.4%. Findings from the SSDI survey found that among people aged 16-59, of those who reported having more than one sexual partner in the previous 12 months (22% men and 3% women), only 32% reported using a condom every time they had sex (35% men and 8% women). Trust (43%) was cited as the main reason for non-use of condoms with regular partners.

Male circumcision is seen as efficacious with the majority of those surveyed by SSDI (70%) in 2012 indicating they believe it can prevent HIV.

Key behavioural drivers of the HIV and AIDS epidemic have been identified as follows: multiple and concurrent sexual partnerships; discordancy (where one partner is HIV negative and the other is HIV positive) among couples in long term relationships, combined with insufficient protection to prevent passing HIV to the negative partner; low prevalence of male circumcision; and, low and inconsistent condom use resulting from lack of condom availability and demand. Underlying gender norms and practices that may encourage men to have multiple partners and limit women's negotiating power to insist on condom use and couple testing needs to be addressed to increase protective practices and uptake of services.

## 2.5 Non-communicable diseases including cancer

Non-Communicable Diseases (NCDs) such as hypertension, diabetes, cancers and chronic respiratory infections are also becoming a major problem in Malawi and throughout Africa. The WHO in 2011 estimated that NCDs were responsible for 28% of deaths in Malawi: 13% from cardiovascular diseases, 3% from cancer, 3% from respiratory diseases, 2% from diabetes and 7% from other NCDs.

Cardiovascular diseases were found in 33% of adults aged 25 to 64 years old during the 2009 STEPS Survey. The survey found that 37.2% of men had high blood pressure compared to 29.2% of women. Furthermore, the survey found that 94.9% of the people with high blood pressure were not on medication and/or were not aware that they were hypertensive.

The same study estimated the prevalence of diabetes be 5.6% in Malawi with no significant differences between men (6.5%) and women (4.7%).

According to a 2012 study, a total of 18,946 new cases of cancer were registered in Malawi from 2007-2010. Of these new cases, over half (55.9%) were females; 7.2% were children aged less than 15 years; 76.5% were adults aged 15-59 years; and, close to a fifth (16.4%) were aged 60 years and above. Cancer of the cervix was the most common form of cancer among women accounting for 45% of all cases followed by Kaposi Sarcoma (21.1%). High rates of cervical cancer are likely impacted by high prevalence of human papillomavirus (34%) among women in

Malawi. Over half of the cases among men were from Kaposi Sarcoma, followed by cancer of the oesophagus (16.9%). Prostate cancer is the fourth (4%).

Comprehensive data on the burden of NCDs and trends in knowledge, attitudes, and behaviours is insufficient in Malawi and is an area requiring further inquiry.

Available evidence on smoking and drinking practices indicate that 20.1% of men in Malawi smoke. Only 2.1% of women report smoking. Among those that smoke, approximately 12.4% smoke on a daily basis. Additionally, an estimated 16.9% of the population drinks alcohol on a regular basis, and reported consuming alcohol in the last 30 days.

Malawians in general engage in physical activity. The STEPS study found that only an estimated 9.8% of the population is physically inactive. Physical inactivity is more common among women, with an estimated 12.6% of women being physically inactive, while an estimated 6.8% of men are physically inactive. The diet of the majority of Malawians is lacking in adequate fruits and vegetables, with 97.5% of the population eating fewer than 0.5 servings of fruits and/or vegetables on the average day. Malawians report eating 0.5 servings of fruit and 1.6 servings of vegetables on an average day.

A study in 2011 indicates that women's risk for cancer and other NCDs is related to high prevalence of human papillomavirus (34%) and being overweight (28% or more).

## 2.6 Trauma

Nearly a tenth (8.9%) of the population in Malawi are affected by injuries and traffic accidents each year.

According to the WHO, 20 road traffic accidents take place each day in Malawi, with two fatalities and two serious injuries occurring each day. Overall, approximately 1,000 people are killed in traffic accidents each year in Malawi. The incidence of trauma in Malawi due to road traffic accidents is 3.5%, which is responsible for an estimated 1.3% of deaths. Trends in the rest of the region provide further insight into the need for further road safety measures; the majority of fatalities due to road traffic accidents in the African Region occur among car occupants (48%) and pedestrians (35%), with cyclists (8%) and individuals riding motorized two-wheelers (5%). Road traffic accidents are the 4th leading cause of death in the African Region among individuals aged 5 to 44 years. The major risk factors for road traffic accidents are careless driving due to alcohol consumption and/or poor driving skills. Lack of access to rapid treatment including First Aid and lack of emergency transport and referral systems worsens the problem of trauma in the country.

The WHO reports that individuals involved in road traffic accidents in the African region are often not utilizing the proper restraints or protective gear, such as seatbelts, helmets, and/or child car seats, leading to increased injury and more likelihood of death. Additionally, speeding, alcohol use prior to driving, and walking in roadways due to a lack of pedestrian infrastructure were all cited by the WHO as contributing to traffic

accident injuries and deaths. The WHO also reported that car passengers often do not use seatbelts or child car seats due to lack of access, especially when using public transportation (which can include riding in the back of cargo vehicles such as pick-up trucks). However, it should also be noted that the 48% of traffic accident fatalities that were car occupants most likely had access to seatbelts in their vehicles. Malawi's current laws mandate seatbelt use for front-seat passengers only.

Women and children experience violence and abuse at high rates in Malawi. According to a 2011 Malawi Demographic and Health Survey, among children 65% of girls and 35% of boys have reported experiencing violence, and 24% of children have, reported being raped. Among women, 48% reported experiencing intimate partner violence, with 3.1 million children witnessing and experiencing that violence and its impact. Women in Malawi also experience sexual violence at high rates, with 25.3% of women between the ages of 15-49 reporting that they've experienced sexual violence in their lifetime. Additionally, 6.2% of women report that they have experienced violence while pregnant. Men experience much lower rates of violence perpetuated by their wives/partners, with 1.8% reporting that they have ever experienced it.

While information on knowledge, attitudes, and behaviours around violence and abuse between adult partners is available, data on knowledge and attitudes regarding child physical and sexual abuse is more difficult to find. According to the 2010 Malawi Demographic and Health Survey, 12.6% of women and men in Malawi find domestic violence ("wife beating") acceptable in one of the five following situations: if she burns the food, if she argues with him, if she goes out without telling him, if she neglects the children, and if she refuses to have sexual intercourse. According to the same survey, 66.3% of women that report emotional, physical, and/or sexual violence by their husbands/partners also report that their husbands/partners "get drunk very often". 35.9% of women who reported ever experiencing violence also reported never telling anyone about it, and 48.1% never sought help. Among those that did tell someone, 16.9% sought help from their family, and 17.9% sought help from their in-laws.

## 2.7 Mental illness & epilepsy

Mental illness accounts for 4.3% of the total burden of disease in Malawi according to a 2011 report from the Department of Mental Health and Substance Abuse. Other studies indicate that an estimated 28.8% of the patients attending primary care have common mental health problems such as feeling low and anxiety. A study by Leonard Cheshire Disability and Development Centre found that 2.8% experience epilepsy, amounting to 463,800 people. Of those that experience epilepsy, 55% are men, 17% are between the ages of 0 and 5, 48% between 6 and 18, and 24% between 19 and 40. One study in 2008 found that maternal mental health issues are associated with child growth stunting: infants' length-for-age was found to be associated with mothers' suffering from "maternal common mental health disorders" in rural Malawi.

In a 2012 study, Crabb et al found that most Malawians surveyed attributed mental health issues to alcohol and drug use (95.7%), followed by "brain disease"

(92.8%), possession by "spirits" (82.8%) and psychological trauma (76.1%). The same study found that within its sample, having direct personal experience of mental illness did not reduce stigmatizing beliefs.

According to the World Health Organization, about half of the world's population resides in a country where there is one psychiatrist or less to serve 200,000 people on average. In Malawi, there are only two psychiatrists and two psychologists who are registered with the Medical Council of Malawi and serving a country of over 13 million people.

On epilepsy, there is a strong belief that it is not a biological disease or condition, but instead is linked to witchcraft and spirits. This misunderstanding not only contributes to stigmatization of people who have it, but also leads Malawians to seek the care and advice of traditional healers rather than going to a medical clinic for treatment. Thus they may live for years with epilepsy without the benefit of medication or treatment.

## 2.8 Neglected tropical diseases (NTDs)

The prevalence of Schistosomiasis in children of school going age ranges from 0% to 43%. It is more common in the community around rivers and lakes such as Mangochi, Salima and Nkhatabay. Trypanosomiasis (Sleeping Sickness) is linked to game reserves and the tsetse fly vector that transmits the disease. The prevalence of Lymphatic Filariasis (elephantiasis) ranges from 0% to 35.9%. It is found around shores of Lake Malawi and Lake Chilwa and in the north in Karonga.

Additional information is needed regarding knowledge, attitudes, and behaviours related to the above NTDs. In general, there is low knowledge levels and misconceptions about the causes of elephantiasis. Incorrect knowledge about elephantiasis has been shown to be associated with poor compliance in mass drug administration (MDA) programmes.

## 2.9 Eye, Ear and Skin Infections

The estimated blindness prevalence rate of 1% in Malawi represents about 136,000 blind people due to preventable or treatable eye conditions. Approximately, 1.3 million people in Malawi are at risk for trachoma, and 33,400 people are known to be living with Trichiasis. Trachoma is endemic in two districts of Malawi, and it's suspected that trachoma is endemic in five additional districts. A 2010 study on prevalence and risk factors for trachoma in Central and Southern Malawi found that trachoma follicles were found among 13.6% of children aged 1-9 years. Face dirtiness was significantly associated with the presence of trachoma follicles. The study found that the prevalence of follicles in Central and Southern Malawi exceeded WHO guidelines for intervention with mass treatment.

Ear infections have been found to be a significant cause of hearing loss in Nigeria. The prevalence of chronic suppurative otitis media has been estimated at 4% in Nigeria and Kenya and 2-3% in Tanzania. Though data on the prevalence of hearing loss in Malawi as well as Southern/Sub-Saharan Africa is limited, it's clear from what is available that the prevalence of hearing impairment and loss in developing countries such as those in Southern Africa

are higher than in developed nations. The SINTEF survey in 2004 of Disability Living Conditions in Malawi estimates there are about 4.2% of people with hearing disability in the country.

Onchocerciasis not only impacts the eyes and sight, it can also infect the skin. More than 99% of those infected with Onchocerciasis live in Sub-Saharan Africa, including Malawi. Malawi is considered to be hyper endemic, with prevalence greater than 20%. Onchocerciasis can be found in the southern part of Malawi. The total population in hyper-endemic areas (as of 2006) was 1,774,315 according to WHO.

It is difficult to find data on eye, ear and skin infections in Malawi in relation to behavioural practices and the knowledge and attitudes that impact them.

# 3. Guiding Principles

The following principles guide the National Health Communication Strategy 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 Health Promotion Policy and the Health Sector Strategic Plan.

### 1. Communication as a process.

Health Communication is an on-going process of working with the population to ensure they have the relevant information and live in an enabling environment so they can take actions that sustain and improve their health. It builds on what has been done in the past and serves as the foundation for future efforts.

### 2. Focus on quality of life and wellness and not just the absence of disease.

In line with WHO's definition of wellness, strategic communication and health promotion efforts work to enable all Malawians to have the knowledge, skills and access to services to ensure they live a full life in a "state of complete physical, mental, and social well-being, and not merely the absence of disease or infirmity."

### 3. Evidence-based decision making.

Strategic communication and health promotion efforts will be based on theoretical models, international and national research and tested innovations and best practices. This includes making the most productive use of appropriate technologies based on the audiences' needs and resources available to them.

### 4. Effective collaboration, coordination and partnership.

Households, communities, health facilities, international development partners, the Government of Malawi, local NGOs and the private sector have to work together to ensure a healthy Malawi. Social and behaviour change communication efforts will be undertaken within the context of demand creation for existing health services and improved linkages between all sectors and stakeholders.

### 5. No missed opportunity for integration and promotion of services.

To achieve wellness, people must have access to adequate and complete information to proactively protect themselves from illness and make positive

healthy decisions for themselves and their families. Recognizing this, every opportunity will be taken to integrate the most essential health information for each Lifestage including within vertical health programs. Prevention and curative services will be promoted throughout.

## 6. Gender equity and social inclusion

Many gender related norms, expectations and beliefs serve as barriers to both women and men accessing services and achieving wellness. Health communication efforts therefore should foster critical examination of gender norms that negatively impact health outcomes and promote those that positively influence actions. At a minimum, all health communication efforts will be gender sensitive and never gender exploitative. The health benefits households and communities can enjoy when men and women work together as equal partners will be actively promoted. In addition, health communication efforts will address the needs of the poor and most vulnerable who are too often ignored.

## 7. Voices of ordinary people and community participation should be prominent.

Communities often have realistic tested solutions for mobilizing and addressing common health challenges. Channels should be provided (e.g. radio, town hall meetings) for people to debate and discuss what is happening in their communities and how they can work together to achieve better health. This will help lead to better localized, home-grown, sustainable solutions.

# 4. Strategic Statement and Objectives

## Vision

Envisions a population that values, adopts and maintains health behaviors in a supportive environment.

## Goal

To reduce preventable morbidity, mortality and disability through effective health promotion interventions.

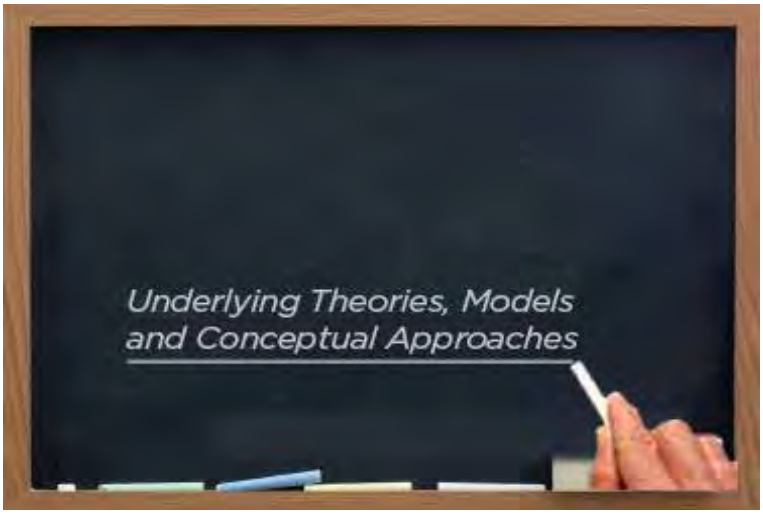
## Mission

The HP mission is ' to create public awareness, facilitate community involvement and participation, and promote activities which will foster health behaviors and encourage people to want to be healthy, stay healthy and do what they can individually and collectively do to maintain sound health and access client-friendly health services in a timely manner'.

## Objectives

- To provide effective leadership and coordination and to advocate for development of health promotion based on national priorities.
- To strengthen national, district and community capacity in planning, coordination, implementation, monitoring and evaluation of HP interventions.
- To support initiatives which enable all individuals and communities to lead healthy life- styles.

# 5. Underlying Theories, Models and Conceptual Approaches




Health is more than just an absence of illness or disease, it is a state of wellbeing that enables people to reach their full potential and meaningfully contribute to the welfare of their family, community and nation. Good health is the result of many choices and decisions made throughout life; these choices are influenced by several factors at various levels. Thus interventions must incorporate a multilevel approach in order to bring about sustainable change. Given that behaviour is influenced at multiple levels, including the individual, as well as broader societal influences, and, that notions of health and wellbeing cannot be conceptualized as merely individual-level phenomena, the NHCS uses the Socio-Ecological Model (see figure 1) as its primary foundational approach. The premise of this model is that life conditions (including poverty and lack of access to education) and diseases (HIV/AIDS, malaria, and TB) that take their toll on Malawians will only be tackled successfully through simultaneous action at the household, community, societal, and policy levels.


***Figure 1: Social - Ecological Model***

Theories of behaviour and social change further inform the strategy. At the individual level, the approach is based on the Extended Parallel Process Model (Witte, 1992). This model conceptualizes individual behaviour change as being (a) motivated by people's desires to reduce their risk and (b) facilitated by enhancement of personal efficacy to bring about change. At the interpersonal level, principles from the Theory of Normative Social Behaviour (Rimal, 2008), which

conceptualizes behaviour change as being determined by interpersonal and social network influences have been incorporated. Finally, at the socio-cultural level, principles from Social Epidemiology (Lisa F. Berkman and Ichiro Kawachi, 2000), in which individuals' choices, decisions, and behaviours depend not only on their own characteristics, but also on group or community characteristics have been integrated.

The NHCS has two other conceptual approaches that provide a framework for the overall design of interventions and harmonization of messages.

**• Segmenting Audiences by Life Stages:**

Takes the perspective that people's own definitions of health and well-being change according to their particular stage in life. This enables health communication and promotion efforts to be targeted and prioritized around what is most relevant to people. Audiences are categorized in 4 major life stages:

- Young Married Couples
- Parents of Children Under 5
- Parents of older Children
- Adolescents.

This approach provides another exciting opportunity: significant changes in people's lives, marked by pivotal events such as birth, graduation, marriage, and first employment, among others, serve as teachable moments when people become open to adopting new behaviours or changing harmful practices.

**• Central Organizing Platform:**

Communication programs are most effective when they are organized around a central theme that ties together the key components of each program and the various health packages, interventions and messages. The NHCS will adapt the *Moyo Ndi Mpamba: Usamalireni* unifying theme (Life is precious: Take care of it) to address all 13 health priority areas given its comprehensive focus on well-being, ability to encompass any health topic and current acceptance and popularity.

# 6.Overarching Campaign Positioning


The central socio-ecological approach helps ensure a comprehensive understanding of the contexts in which health choices are made so the barriers and facilitators that prevent/enable positive choices can be addressed through communication. It also indicates how and where everyone (including women, men, adolescents, health workers, religious and community leaders, teachers, business leaders, politicians etc.) can play an active role in creating an enabling environment for wellness. The model inspires key players to come together and actively discuss health issues, identify solutions and take actions by recognizing that family, community and national health, strength and wellbeing can only come about if everyone is working for a common goal.

To give expression to this approach, the NHCS has adopted and will expand the *Moyo ndi Mpamba: Usamalireni* central platform. The *Moyo ndi Mpamba* campaign is already being implemented by the Ministry of Health in collaboration with the Support for Service Delivery Integration (SSDI) project across Malawi and is widely recognized and accepted in all communities. The positioning for this campaign reflects the audiences' understanding and aspirations for health and wellbeing based on extensive formative research. Packaging messages and images under a healthy lifestyle approach, using positive images of audience representatives living out the aspirations of the people (small healthy families doing simple things to keep healthy e.g. sleeping under nets, washing their hands/drinking clean water, using modern contraceptives etc.) and accessing services at the appropriate times, enables a wide variety of health issues to be addressed in an integrated harmonized manner. The campaign offers audiences hope, and confidence that they can improve their health, just like other people are doing. It acknowledges and celebrates the changes that people are already making. This positioning will inform and guide messages and interventions targeted at primary audiences as well as key stakeholders and influencers such as health workers, and traditional and religious leaders and media partners.

The benefits of this approach and branding are two-fold: the campaign platform provides the opportunity to address audiences holistically while simultaneously delivering messages about specific diseases and actions that need to be taken to prevent and/or treat them. As target audiences and key stakeholders recognize and make positive associations with the campaign symbols, their tendency to trust and believe campaign messages and promises increases, as does the tendency to act on these messages. All health communication program implementers in

Malawi are therefore strongly encouraged to apply the *Moyo ndi Mpamba* platform principles as well as make the logo part of all health communication materials produced.

## 6.1 Designing and implementing Health promotion programs

Using the strategic approaches and overarching platform described above, the following sections provide guidance for designing tools, materials and activities to address key audiences. The Behaviour Change Matrix identifies the common current behaviours, the desired behaviours that should be practiced to minimize the burden of disease, and the barriers that must be overcome in order to make this happen. The Matrix is organized according to the four primary LifeStages:

- Adolescents
- Young Married Couples
- Parents of Children Under 5
- Parents of Children older than 5

The Key Communication Objectives are based on the Behaviour Change Matrix and provide guidance on what the overall focus of any communication materials/ interventions should include in order to bring about changes in behaviour and ultimately disease burden. The objectives are organized according to the 13 priority health areas.

- Malaria
- HIV/AIDS
- Perinatal conditions (comprised of Maternal and Child Health and Family Planning)
- (Mal)nutrition
- Diarrhoeal Disease (addressed through Water, Sanitation and Hygiene (WASH).
- Vaccine Preventable Diseases (addressed through Expanded Program on Immunization [EPI])
- Tuberculosis
- Non-Communicable Diseases (Including diabetes, cardiovascular disease and trauma)
- Tuberculosis
- Cancers
- Mental Illness and Epilepsy
- Neglected Tropical Diseases (NTDs)
- Eye, Ear and Skin Infections.

The Key Messages table builds on the Communication Objectives and provides guidance on specific messages that need to be communicated to bring about behaviour change.

## 6.2 Primary audience behaviour change matrix

Note: While many of the behaviours, desired behaviours and barriers are similar for certain health areas in several of the life stages, the tables are organized in this way so those working with specific audience life stages can have a comprehensive reference list.

## Primary Audience Behaviour Change Matrices

| | |
|---|---|
| Adolescents | Young Married Couples |
| Parents with under 5 Children | Parents with Children Older than 5 |

## Adolescents

| Current behaviour | Desired behaviour | Barriers |
|---|---|---|
| HIV and AIDS | | |
| • Multiple and concurrent sexual partnerships coupled with low and inconsistent condom use<br>• Transactional and trans- generational sex especially among girls<br>• Low acceptance of voluntary male medical circumcision. | • Adolescents have and use essential life skills including analytical decision making, good communication, assertiveness and effective negotiation and are able to negotiate safer sex<br>• Sexual debut is delayed, ideally planned and condoms are used.<br>• Sexually active adolescents practice safer sex, mutual fidelity, correct and consistent condom use, reduction in sexual partners.<br>• Adolescents know their HIV status and get tested as needed based on realistic risk perception.<br>• Male adolescents seek voluntary medical circumcision | • Lack of life skills including safer sex negotiation.<br>• Lack of comprehensive knowledge about HIV<br>• Sex is often unplanned protection is not used<br>• Adolescence is a time of risk taking including sexual risk taking.<br>• Low risk perception among adolescents<br>• Condoms may be used initially but this practice stops after "trust" has been developed<br>• Male economic dominance coupled with gender and social norms that make it difficult for young women to refuse sex with older men and demand condom use (with all partners)<br>• Desire for symbols of status may encourage young women to seek out transactional sex<br>• Cultural practices- initiation rites into womanhood and manhood that put young people at risk; example Jando<br>• Cultural and religious teachings/beliefs against voluntary male circumcision<br>• Stigma surrounding HIV and AIDS |
| **Malaria** | | |
| • Most adolescents do not sleep under mosquito net<br>• Adolescents do not report malaria signs promptly and do not adhere to treatment regimes<br>• Health workers treating for malaria presumptively, without testing first | • Adolescents sleep under a mosquito net every night<br>• Adolescents and guardians of young adolescents report early signs of fever to a facility promptly and adhere to treatment regimes<br>• Test before malaria treatment | • Priority for mosquito nets given to groups considered most vulnerable i.e. children and pregnant women<br>• High resilience-they endure pain and do not want to report fever (until the case is severe)<br>• Low risk perception among adolescents<br>• Health workers treat for malaria presumptively, without testing first |

| Current behaviour | Desired behaviour | Barriers |
|---|---|---|
| **Maternal and Child Health: Family Planning** | | |
| • Do not use contraceptives leading to high incidences of teenage pregnancies and unsafe abortions | • Sexually active adolescents use contraceptives to prevent teenage pregnancies<br>• Unwanted pregnancies do not occur and unsafe abortions are eliminated | • Adolescents do not fully access and/or understand their risk of getting pregnant/ impregnating<br>• Low knowledge regarding family planning, contraceptives and where to get them<br>• Family Planning primarily considered the responsibility of girls/women, so young men do not take an active role in preventing pregnancy<br>• Lack of sufficient youth friendly services/negative attitudes of health workers in providing FP services to adolescents<br>• Parents do not discuss issues of sex with their children and how they should protect themselves; most not willing to have their adolescents access FP methods<br>• Religious teachings that consider pre-marital sex immoral |
| **Diarrhoeal diseases (WASH)** | | |
| • Do not wash their hands with soap and clean water as frequently as required: after using the toilet and changing nappies of younger siblings, before eating and before preparing food.<br>• Do not understand the consequences of indiscriminate disposal of feces in their communities | • Adolescents wash their hands with soap and water before preparing and/or eating meals, after using the toilet and after changing nappies<br>• Adolescents become advocates for proper feces and other waste disposal in their communities<br>• Take ORS for severe diarrhoea | • Low knowledge of the link between hand washing and disease prevention<br>• Low knowledge of the link between proper disposal of feces and health<br>• Lack of sufficient access to clean water, soap, latrines |

| | | |
|---|---|---|
| **(Mal)nutrition** | | |
| • Do not eat healthy, balanced meals<br>• Those who live in urban centres patronize junk food from fast food sellers | • Eat meals prepared from the six food groups<br>• Use iodized salt to prepare meals | • Low knowledge about six food groups and their importance to health<br>• Little control over quantity and quality of food available in the home<br>• Beliefs (urban youth) that patronizing fast food joints improves one's social status |
| **Tuberculosis (TB)** | | |
| • Data not available | • Go to the clinic when you experience cough for more than two weeks<br>• Cover mouth while coughing or sneezing to prevent spread<br>• Adhere to medication at all times | Presumed:<br>• Low knowledge about TB (spread and available treatment)<br>• Low risk perception |
| **Non-communicable diseases (including cancers, mental illness and epilepsy, and trauma)** | | |
| • Experiment with alcohol, tobacco and drugs (marijuana)<br>• Stigmatize and discriminate against the mentally ill and the epileptic<br>• Do not seek help for psychological and mental health problems | • Avoid alcohol, tobacco and illicit drugs including Chamba (marijuana)<br>• Empathize with family and community members with mental health problems<br>• Accept that mental health issues can happen to anyone and seek out support from trusted family members as soon as they experience mental health problems | • Low knowledge regarding the harmful effects of alcohol, tobacco and illicit drug use<br>• Adolescence is a time of risk taking and trying things out<br>• Alcohol and drugs can feel good and enable young people to overcome inhibitions<br>• Adolescents don't think about future impact (of smoking, drinking etc.) but live more in the moment<br>• Adolescents often feel peer pressure to experience and use alcohol, drugs.<br>• Poor understanding of mental illness and when feelings are severe enough to seek out care.<br>• Poor understanding of epilepsy<br>• Cultural attribution of mental illness and epilepsy to witchcraft and evil spirits<br>• Male norms that make it difficult for young men to admit they are vulnerable, depressed etc.<br>• Lack of sufficient mental health care and poor attitudes of health workers regarding mental health issues |

| Current behaviour | Desired behaviour | Barriers |
|---|---|---|
| **Neglected tropical diseases (NTDs)- Schistosomiasis** | | |
| • Swim in stagnant water<br>• Urinate and defecate in, and around water sources<br>• Drink unclean water<br>• Do not seek medical attention promptly | • Do not swim or play in stagnant pools<br>• Do not urinate or defecate in or around water sources<br>• Seek medical help as soon as symptoms are noticed | • Low knowledge about schistosomiasis (transmission, symptoms, available treatment)<br>• Lack of access to clean water |
| **Neglected tropical diseases (NTDs)- Lymphatic Filariasis (Elephantiasis)** | | |
| • Do not prevent mosquito bites<br>• Do not seek medical attention promptly | • Prevent mosquito bites (sleep under a net)<br>• Seek medical help as soon as symptoms are noticed such as swelling and redness and pain and later elephantiasis (abnormal enlargement of any part of the body usually affecting legs, arms or external genitalia) | • Not prioritized for bed net use if limited number in the family<br>• Low knowledge about Elephantiasis (transmission, symptoms, available treatment)<br>• Lack of risk perception |
| **Neglected tropical diseases (NTDs) (Trypanosomiasis (Sleeping sickness)** | | |
| • Do not prevent tsetse fly bites<br>• Do not seek medical attention promptly | • Prevent tsetse bites by covering arms and legs for those near game reserve areas when they are out in the bush<br>• Seek medical help as soon as symptoms are noticed | • Low knowledge about Trypanosomiasis (transmission, symptoms, available treatment)<br>• Lack of risk perception |
| **Acute Respiratory Infections (ARI)** | | |
| • Poor personal hygiene and not hand washing<br>• Use wood fuel indoors<br>• Keep windows and doors closed (does not allow for ventilation) | • Wash hands with water and soap<br>• Open windows and doors<br>• Seek medical assistance for cough and difficulty breathing | • Low knowledge regarding the dangers of respiratory infections and what to do to prevent them<br>• Limited control over ventilation and cooking set-up in their homes<br>• May need parents' approval to go to the clinic |
| **Eye, Ear and Skin Infections** | | |
| • Poor personal hygiene and insufficient face and hand washing<br>• Do not keep surroundings sufficiently clean | • Wash hands and face with soap and water<br>• Get prompt treatment for sore eyes or blurred vision, pain or discharge from the ear, and itching or rashes on the skin<br>• Keep surroundings clean | • Low knowledge about dangers of infections to the eye, ear and skin<br>• Insufficient access to clean water and soap |

## Young couples

| Current behaviour | Desired behaviour | Barriers |
|---|---|---|
| **HIV and AIDS** | | |
| • Multiple and concurrent sexual partnerships coupled with low and inconsistent condom use<br>• Weak couple communication around sex, pleasure, HIV/AIDS, PMTCT and VMMC<br>• Low adherence to medication among those with HIV<br>• Insufficient utilization of HIV services including testing (especially by men) and PMTCT | • Couples practice open communication including around their sexual needs and desires<br>• Couples discuss HIV and AIDS concerns including safer sex and testing before and during marriage<br>• Husbands support wives to utilize PMTCT services<br>• Wives support husbands to utilize voluntary medical circumcision (VMMC)<br>• Couples stay mutually faithful<br>• Couples know each other's HIV status and help each other stay negative or live positively, including using condoms consistently and correctly<br>• Positive couples help each other adhere to medication | • Gender and social norms that make it difficult to discuss intimate topics among couples including testing for HIV<br>• Insufficient Risk Assessment<br>• Male economic dominance and gender norms that make it more difficult for women to negotiate for safer sex<br>• PMTCT/ANC seen as women's domain<br>• Men often resist testing due to fear of results; distance to testing sites cited as a barrier by women<br>• Cultural and religious teachings/beliefs against VMMC |
| **Malaria** | | |
| • Men and women (couples) do not sleep under insecticide- treated mosquito nets (ITN) regularly<br>• Men and women (couples) do not report malaria signs promptly to the clinic and do not adhere to treatment regimes | • Couples sleep under a mosquito net every night<br>• Couples seek medical care at the clinic within 24 hours of symptoms and adhere to treatment regimes<br>• Women take at least three doses of SP during pregnancy | • Fear that bed nets are not safe (e.g. they cause infertility)<br>• Misuse of available nets (e.g. for fishing)<br>• Poor understanding of the health and economic disadvantages of malaria |

| Current behaviour | Desired behaviour | Barriers |
|---|---|---|
| **Perinatal conditions (Maternal Child Health and Family Planning)** | | |
| • Pregnant women do not attend ANC as required<br>• Couples do not recognize danger signs or have a birth plan<br>• Poor couple communication around family planning and related issues<br>• Less than half of all women of reproductive age use FP | • Pregnant women attend ANC at least 4 times before delivery<br>• Couples know danger signs during pregnancy and seek prompt medical care<br>• Couples make and use a birth plan<br>• Couples discuss family planning<br>• Use contraception to prevent unwanted pregnancy | • Negative perceptions regarding modern contraceptives and fear of side effects<br>• Religious teachings that prohibit use of contraception or that people perceive prohibit use of them<br>• Beliefs that pregnancy is normal and needs no special attention<br>• Poor knowledge of danger signs during pregnancy and their severity<br>• Pregnancy and child birth considered a woman's domain<br>• Insufficient knowledge about importance of and how to make a birth plan<br>• Insufficient communication among couples regarding plans for children, often coupled with family pressure to reproduce soon after marriage |
| **Diarrhoeal diseases** | | |
| • Do not wash their hands with soap and clean water as frequently as required: after using the toilet, before eating and before preparing food<br>• Do not see importance of proper disposal of feces in their communities<br>• Do not properly store cooked food | • Wash hands with soap and water before preparing and eating meals and after using the toilet<br>• Dispose of feces and waste properly and advocate for others to do the same in the community<br>• Cover food and re-heat before eating<br>• Take ORS to reduce the effects of severe diarrhoea | • Insufficient knowledge of the link between hand washing and disease prevention<br>• Low knowledge of the link between proper disposal of feces and health<br>• Insufficient access to clean water and latrine |
| **(Mal)nutrition** | | |
| • Do not eat healthy and balanced meals from the six food groups<br>• Those who live in urban centres patronize junk food from fast food sellers<br>• Pregnant women do not get supplemental iron, folic acid and vitamin A | • Eat meals prepared from the six food groups<br>• Use iodized salt to prepare meals<br>• Request iron, folic acid and vitamin A at ANC | • Low knowledge about the six food groups and their importance to health<br>• Insufficient knowledge about how to access locally available foods from the 6 food groups<br>• Cultural norms around diet and lack of diversity |

| | | |
|---|---|---|
| | | • Beliefs that patronizing fast food joints improves one's social status (urban)<br>• Irregular attendance at ANC; insufficient support from husbands/partners to attend |
| **Tuberculosis (TB)** | | |
| • Insufficient data available | • Go to the clinic when you experience cough for more than two weeks<br>• Cover mouth while coughing or sneezing to prevent spread.<br>• Adhere to medication at all times | • Low knowledge about TB (spread and available treatment)<br>• Low risk perception |
| **Non-communicable diseases (including cancers, diabetes, cardiovascular diseases, mental illness and epilepsy, and trauma)** | | |
| • Men and women (couples) drink alcohol and may drink and drive<br>• (See (Mal)nutrition for additional behaviours related to risk cardiovascular and diabetes risk factors)<br>• Men (are more likely to) smoke tobacco and use drugs (marijuana)<br>• Stigmatize and discriminate against the mentally ill and the epileptic<br>• Do not seek help for psychological and mental problems<br>• Couples do not utilize cancer screening services<br>• Do not do exercises | • Avoid or take alcohol in moderation<br>• Do not drive while intoxicated<br>• Quit tobacco and illicit drugs including Chamba (marijuana)<br>• Empathize with family and community members with mental health problems<br>• Seek medical care as soon as any signs of epilepsy are experienced<br>• Accept that mental health issues can happen to anyone and seek out support from trusted family members as soon as they experience mental health problems<br>• Seek screening for cancer (cervical, breast, and prostate)<br>• People do exercises | • Low knowledge regarding the (long term) harmful effects of alcohol, tobacco and illicit drug use<br>• Are not concerned about long term effects as they are still young<br>• Feel they can drive while drunk and underestimate the compromising effects of alcohol<br>• Poor understanding of mental illness and when it is important to seek care<br>• Poor understanding of adult onset of epilepsy<br>• Gender norms that make it difficult for men to express vulnerability and seek counselling<br>• Cultural attribution of mental illness and epilepsy to witchcraft and evil spirits<br>• Access to drugs to treat epilepsy and lack of confidence in the efficacy of the medication<br>• Insufficient counselling available<br>• Poor knowledge about cancers and available cancer screening; insufficient treatment options available<br>• Lack of amenities for exercises<br>• Shortage of time or laziness |

| Current behaviour | Desired behaviour | Barriers |
|---|---|---|
| **Neglected tropical diseases (NTDs) - Schistosomiasis** | | |
| • Swimming and bathing in stagnant water<br>• Urinating and defecating in, and around water sources<br>• Drinking unclean water<br>• Poor health seeking behaviour | • Do not swim or bathe in stagnant pools<br>• Do not urinate or defecate in or around water sources<br>• Seek medical help as soon as symptoms are noticed | • Low knowledge about schistosomiasis (transmission, symptoms, available treatment) |
| **Eye, Ear and Skin Infections** | | |
| • Poor personal hygiene and insufficient face and hand washing<br>• Do not keep surroundings sufficiently clean | • Keep surroundings clean<br>• Wash hands and face with soap and water<br>• Get prompt treatment for sore eyes or blurred vision, pain or discharge from the ear, and itching or rashes on the skin | • Low knowledge about dangers of infections to the eye, ear and skin<br>• Insufficient access to clean water and soap |
| **Neglected tropical diseases (NTDs)- Lymphatic Filariasis (Elephantiasis)** | | |
| • Do not prevent mosquito bites<br>• Do not seek medical attention promptly | • Prevent mosquito bites (sleep under a net)<br>• Seek medical help as soon as symptoms are noticed such as swelling and redness and pain and later elephantiasis (abnormal swelling of legs, arms or genitals) | • Low knowledge about Elephantiasis (transmission, symptoms, available treatment)<br>• Low risk perception |
| **Neglected tropical diseases (NTDs)- Trypanosomiasis (Sleeping sickness)** | | |
| • Do not prevent tsetse fly bites<br>• Do not seek medical attention promptly | • Prevent tsetse bites by covering arms and legs for those near game reserve areas<br>• Seek medical help as soon as symptoms are noticed | • Low knowledge about Trypanosomiasis (transmission, symptoms, available treatment)<br>• Low risk perception |
| **Acute Respiratory Infections (ARI** | | |
| • Insufficient proper hygiene and hand washing practices<br>• Use of wood fuel indoors<br>• Doors and windows kept closed; does not allow for proper ventilation | • Keep surrounding clean<br>• Wash hands with soap and water<br>• Seek medical help for cough and difficulty breathing | • Low knowledge regarding the dangers of respiratory infections<br>• Practice of using wood fuel indoor/ not having separate room for cooking<br>• Lack of alternatives to using indoor fuel and resources to build a separate room |

## Parents of children Under 5

| Current behaviour | Desired behaviour | Barriers |
|---|---|---|
| **HIV and AIDS** | | |
| • Unprotected extra-marital sex<br>• Weak couple communication around sex, pleasure, HIV/AIDS, PMTCT and VMMC<br>• Low utilization of HIV services including testing (particularly among men) and PMTCT<br>• Low adherence to medication among those with HIV | • Couples stay mutually faithful or use condoms consistently and correctly if they have sex outside the marriage<br>• Couples practice open communication including around their sexual needs and desires<br>• Couples discuss HIV/ AIDS protective practices including safer sex and going for testing<br>• Couples know each other's HIV status and help each other stay negative or live positively<br>• Husbands support wives to utilize PMTCT services<br>• Wives support husbands to utilize VMMC<br>• Positive couples help each other adhere to medication | • Gender and social norms that make it difficult to discuss intimate topics among couples including around HIV testing<br>• Low risk perception that HIV is transmitted in stable long term relationships<br>• Men often resist testing due to fear of results; distance to testing sites cited as a barrier by women<br>• Cultural and religious teachings/beliefs against voluntary male circumcision<br>• Male economic dominance makes it more difficult for women to discuss/negotiate safer sex<br>• PMTCT /ANC seen as women's domain<br>• Stigma surrounding HIV and AIDS |
| **Malaria** | | |
| • Parents and children do not sleep under insecticide treated mosquito nets (ITN) every night<br>• Parents do not report malaria signs in their children (and themselves) promptly and do not adhere to treatment regimes<br>• Health workers treating presumptively | • Parents and children sleep under a mosquito net every night<br>• Parents seek medical care for themselves and their children within 24 hours of symptoms and adhere to treatment regimens.<br>• Women take at least three doses of SP during pregnancy<br>• Test before malaria treatment | • Fear that bed nets are not safe (e.g. they cause infertility)<br>• Misuse of available nets (e.g. for fishing)<br>• Poor understanding of the health and economic disadvantages of malaria<br>• Traditional healers are sought out as more accessible and cost effective alternative to health clinics<br>• Health workers treating presumptively |

| Current behaviour | Desired behaviour | Barriers |
|---|---|---|
| **Perinatal conditions (Maternal Child Health and Family Planning)** | | |
| • Poor couple communication around family planning and related issues<br>• Pregnant women do not attend ANC as required<br>• Couples do not recognize danger signs or have a birth plan<br>• Not all women exclusively breastfeed for first six months | • Couples discuss family planning and use contraception to space and limit children<br>• Pregnant women attend ANC at least 4 times before delivery<br>• Couples know danger signs during pregnancy and seek prompt medical care<br>• Couples make and use a birth plan<br>• Ensure all deliveries happen at the health centre<br>• Breastfeed babies for six months exclusively and introduce complementary liquids and food thereafter | • Negative perceptions regarding modern contraceptives and fear of side effects<br>• Religious teachings that prohibit use of contraception or that people perceive prohibit use of them<br>• Beliefs that pregnancy is normal and needs no special attention<br>• Poor knowledge of danger signs during pregnancy and their severity<br>• Pregnancy and child birth considered a woman's domain<br>• Poor knowledge regarding importance of exclusive breastfeeding and when to introduce complementary feeding |
| **Diarrhoeal diseases (WASH)** | | |
| • Do not wash their hands with soap and clean water as frequently as required: after using the toilet, before eating and before preparing food, after changing baby nappies<br>• Careless about the disposal of feces and other human waste in their communities<br>• Do not properly store cooked food<br>• Do not continue breastfeeding and giving ORS when child has diarrhoea<br>• Do not teach children proper hygiene including the benefits of washing hands with soap regularly and proper waste disposal | • Wash hands with soap and water before preparing and eating meals, after using the toilet and after changing nappies<br>• Dispose of feces and waste properly and advocate others do the same in the community<br>• Cover food properly and re- heat before eating<br>• Take ORS to reduce the effects of diarrhoea<br>• Continue to feed child breast milk when child has diarrhoea and give them ORS<br>• Take child to health centre if diarrhoea persists<br>• Teach children about proper hygiene practices and demonstrate them | • Low knowledge of the link between hand washing and disease prevention<br>• Low knowledge of the link between proper disposal of feces and health<br>• Insufficient access to clean water and latrines<br>• Misconceptions about the need to continue fluids/ feeding when child has diarrhoea<br>• Insufficient access to clean water and toilets |

| Current behaviour | Desired behaviour | Barriers |
|---|---|---|
| **(Mal)nutrition** | | |
| • Do not eat food from six food groups (healthy, balanced meals)<br>• Some who live in urban centres patronize junk food from fast food sellers<br>• Pregnant women do not get supplemental iron, folic acid and vitamin A<br>• Pregnant women do not eat an additional meal and/or sufficient healthy food; Breastfeeding mothers do not eat an additional two meals and/or get sufficient healthy food<br>• Mothers do not breastfeed exclusively for the first six months<br>• Mothers do not commence complementary feeding at the proper time | • Eat meals prepared from the six food groups<br>• Use iodized salt to prepare meals<br>• Request iron, folic acid and vitamin A at the ANC<br>• Mothers exclusively breastfeed their children for the first six months<br>• Mothers start feeding their children meals prepared from the six food groups after six months | • Low knowledge about the six food groups and their importance to health<br>• Insufficient knowledge about how to access locally available foods from the 6 food groups<br>• Cultural norms around diet and lack of diversity<br>• Poverty and limited income reduce food options<br>• Beliefs that patronizing fast food joints improves one's social status (urban setting); may also find it easier if both parents are working<br>• Delayed attendance at ANC; women often wait for the pregnancy to be showing before the first visit<br>• Misconceptions about exclusive breastfeeding and complementary feeding |
| **Tuberculosis (TB)** | | |
| • Data not available | • Go to the clinic when you or your children experience cough for more than two weeks<br>• Cover mouth while coughing or sneezing to prevent spread and make sure children do as well<br>• Adhere to medication at all times and children as well | • Low knowledge about TB (spread and available treatment)<br>• Low risk perception |

| Current behaviour | Desired behaviour | Barriers |
|---|---|---|
| **Non-communicable diseases (including cancers, diabetes, cardiovascular diseases, mental illness and epilepsy, and trauma)** | | |
| • Parents may abuse alcohol (particularly men) and may also drink and drive<br>• Men smoke tobacco and use drugs (marijuana)<br>• (See (Mal)nutrition for additional behaviours related to risk cardiovascular and diabetes risk factors)<br>• Stigmatize and discriminate against the mentally ill and the epileptic<br>• Lack of exercise (for elite)<br>• Do not seek help for psychological and mental problems<br>• Parents do not utilize cancer screening services | • Avoid or take alcohol in moderation<br>• Do not drive while intoxicated<br>• Quit tobacco and illicit drugs including Chamba (marijuana)<br>• Empathize with family and community members with mental health problems<br>• Accept that mental health issues can happen to anyone and seek out support from trusted family members as soon as they experience mental health<br>• Seek medical care as soon as any signs of epilepsy are experienced by any family member<br>• Seek screening for cancer (cervical, breast and prostate) | • Low knowledge regarding the harmful effects of alcohol, tobacco and illicit drug use<br>• Feel they can drive while drunk and underestimate the compromising effects of alcohol<br>• Poor understanding of mental illness and when it is important to seek care<br>• Gender norms that make it difficult for men to express vulnerability and seek counselling<br>• Cultural attribution of mental illness and epilepsy to witchcraft and evil spirit<br>• Access to drugs to treat epilepsy and lack of confidence in the efficacy of the medication<br>• Poor knowledge about cancers and available cancer screening; insufficient treatment options available |
| **Neglected tropical diseases (NTDs)- Schistosomiasis** | | |
| • Swimming and bathing in stagnant water and allowing children do the same<br>• Urinating and defecating in, and around water sources<br>• Parents do not properly dispose of children's feces<br>• Drinking unclean water<br>• Poor health seeking behaviour | • Do not swim or bath in stagnant pools<br>• Do not let children swim in stagnant pools<br>• Do not urinate or defecate in or around water sources<br>• Ensure feces and other wastes are properly disposed of<br>• Seek medical help as soon as symptoms are noticed | • Low knowledge about schistosomiasis (transmission, symptoms, available treatment) |

| | | |
|---|---|---|
| **Eye, Ear and Skin Infections** | | |
| • Insufficient personal hygiene and hand/face washing with soap<br>• Surroundings not kept sufficiently clean<br>• Children put dirty hands in their eyes | • Keep surroundings clean and wash hands and face with soap and water<br>• Make sure children wash hands and face with soap<br>• Teach children not to put dirty hands in their eyes (and mouth)<br>• Get prompt treatment for sore eyes or blurred vision, pain or discharge from the ear, and itch or rash on the skin | • Low knowledge about dangers of infections to the eye, ear and skin<br>• Insufficient access to clean water and soap |
| **Vaccine Preventable Diseases (EPI)** | | |
| • Not all parents take their children to receive all available immunizations | • Ensure children receive all required immunizations at the right time | • Insufficient knowledge about the benefits of immunization<br>• Distance to clinics<br>• Religious and/or cultural beliefs |
| **Acute Respiratory Infections (ARI)** | | |
| • Insufficient hygiene and hand washing practices<br>• Use of solid fuel indoors with poor ventilation<br>• Not taking child to health facility promptly | • Keep surroundings clean<br>• Wash hands with soap<br>• Have a separate place for cooking<br>• Keep windows and doors open for air flow<br>• Recognize danger signs of fast and difficult breathing (in the child)<br>• Take child to health facility within 24 hours of onset of symptoms | • Low knowledge regarding the dangers and severity of respiratory infections<br>• Practice of using wood fuel indoor/not having separate room for cooking<br>• Lack of alternatives to using indoor fuel and resources to build a separate room |

## Parents of older children (6-12 years)

| Current behaviour | Desired behaviour | Barriers |
|---|---|---|
| **HIV and AIDS** | | |
| • Unprotected extra-marital sex<br>• Weak couple communication around sex, pleasure, HIV/AIDS, PMTCT and VMMC<br>• Low adherence to medication among those with HIV<br>• Low utilization of HIV services including VMMC and testing<br>• Weak parent-child communication generally and including around relationships and sex | • Couples stay mutually faithful or use condoms correctly and consistently if having sex outside the marriage<br>• Couples practice open communication including around their sexual needs and desires<br>• Couples discuss HIV and AIDS concerns including safer sex and going for testing<br>• Couples know each other's HIV status and help each other stay negative or live positively<br>• Wives support husbands to utilize VMMC<br>• Positive couples help each other adhere to medication<br>• Parents openly communicate with their older children in general and particularly about sex, relationships and protecting themselves from HIV, STIs (and unwanted pregnancies)<br>• Parents enable their older children to access FP and RH services | • Gender and social norms that make it difficult to discuss intimate topics among couples including HIV testing<br>• Low risk perception that HIV is transmitted in stable long term relationships<br>• Men often resist testing due to fear of results; distance to testing sites cited as a barrier by women<br>• Cultural and religious teachings/beliefs against VMMC<br>• Lack of acceptance to use condoms in marriage or long term relationships<br>• Male economic dominance that makes it difficult for women to discuss/negotiate for safer sex or leave husband if she fears he may be putting her at risk of infection<br>• Stigma surrounding HIV/AIDS<br>• Parents lack sufficient skills in communicating openly with children especially around issues related to relationships and sex<br>• Misconceptions that if parents talk about sex, it will be seen as acceptance for children to engage in it<br>• Religious and cultural inhibitions towards sexuality communication with children |

| Current behaviour | Desired behaviour | Barriers |
|---|---|---|
| **Malaria** | | |
| • Everyone in the household does not sleep under an insecticide treated mosquito nets (LLIN) every night<br>• Insufficient reporting of malaria signs (parents and for children) and do not always adhere to treatment regimes<br>• Health workers treating for malaria presumptively without testing first | • Everyone in the family sleeps under a mosquito net every night<br>• Parents seek medical care for themselves and their children within 24 hours of symptoms and adhere to treatment regimens<br>• Test before malaria treatment | • Fear that bed nets are not safe (e.g. they cause infertility)<br>• Misuse of available nets (e.g. for fishing)<br>• Poor understanding of the health and economic disadvantages of malaria<br>• Health workers treating for malaria presumptively without testing first |
| **Perinatal conditions (Family Planning)** | | |
| • Women getting pregnant after age 40 without full understanding of risks to her health | • Wives and husbands discuss risk of getting pregnant at a later age and use FP to avoid getting pregnant | • Low knowledge about dangers of pregnancy after 40 years of age |
| **Diarrheal diseases (WASH)** | | |
| • Do not wash their hands with soap and clean water as frequently as required: after using the toilet, before eating and preparing food<br>• Careless about the disposal of feces and other human waste in their communities<br>• Do not properly store cooked food<br>• Do not make sure children continue to eat when they have diarrhoea<br>• Do not teach children proper hygiene including the benefits of washing hands with soap regularly and proper waste disposal | • Wash hands with soap and water before preparing and eating meals and after using the toilet<br>• Dispose of feces and waste properly and advocate for same in the community<br>• Cover food and re-heat before eating<br>• Take ORS to reduce the effects of diarrhoea<br>• Make sure children continue to eat even when they have diarrhoea and that they take ORS<br>• Teach children proper hygiene practices including regular hand washing with soap, and proper disposal of feces and other waste<br>• Take child to health centre if diarrhoea persists | • Low knowledge of the link between hand washing and disease prevention<br>• Low knowledge of the link between proper disposal of feces and health<br>• Lack of sufficient access to clean water and toilets |

| Current behaviour | Desired behaviour | Barriers |
|---|---|---|
| **(Mal)nutrition** | | |
| • Do not eat healthy, balanced meals from the six food groups<br>• Parents may not recognize nutritional needs of children and adolescents, particularly young girls<br>• Some who live in urban centres patronize junk food from fast food sellers and also feed this to their children | • Eat meals prepared from the six food groups<br>• Use iodized salt to prepare meals<br>• Make sure children and adolescents get sufficient food | • Low knowledge about six food groups and their importance to health<br>• Insufficient knowledge about how to access locally available foods from the 6 food groups<br>• Cultural norms around diet and lack of diversity<br>• Poverty and limited income reduce food options<br>• Beliefs that patronizing fast food joints improves one's social status (urban setting); may also find it easier to feed children fast food if both parents are working |
| **Tuberculosis (TB)** | | |
| • Data not available | • Go to the clinic when you or your children experience cough for more than two weeks<br>• Cover mouth – and make sure children do as well - while coughing or sneezing to prevent spread<br>• Adhere to medication at all times | • Low knowledge about TB (spread and available treatment)<br>• Low risk perception |
| **Non-communicable diseases (including cancers, diabetes, cardiovascular diseases, mental illness and epilepsy, and trauma)** | | |
| • Parents may abuse alcohol and drive while intoxicated<br>• Men smoke tobacco and use drugs (marijuana)<br>• (See (Mal)nutrition for additional behaviours related to risk cardiovascular and diabetes risk factors)<br>• Stigmatize and discriminate against the mentally ill and the epileptic<br>• Lack of exercise | • Avoid or take alcohol in moderation<br>• Do not drive while intoxicated<br>• Quit tobacco and illicit drugs including Chamba<br>• Empathize with family and community members with mental health problems<br>• Accept that mental health issues can happen to anyone and seek out support from trusted family members as soon as they experience mental health issues | • Low knowledge regarding the harmful effects of alcohol, tobacco and illicit drug use<br>• Feel they can drive while drunk and underestimate the compromising effects of alcohol<br>• Poor understanding of mental illness and when it is important to seek care<br>• Insufficient knowledge about epilepsy<br>• Cultural attribution of mental illness and epilepsy to witchcraft and evil spirits |

| | | |
|---|---|---|
| • Do not seek help for psychological and mental problems<br>• Parents do not utilize cancer screening services | • Seek medical care as soon as any signs of epilepsy are experienced by any family member<br>• Seek screening for cancer (cervical, breast, and prostate) | • Access to drugs to treat epilepsy and lack of confidence in the efficacy of the medication<br>• Poor health facilities<br>• Poor knowledge about cancers and available cancer screening; insufficient treatment options available |
| **Neglected tropical diseases (NTDs)- Schistosomiasis** | | |
| • Swimming and bathing in stagnant water and allowing children to do the same<br>• Urinating and defecating in and around water sources<br>• Lack of proper disposal of feces (parents and children)<br>• Drinking unclean water<br>• Poor health seeking behaviour | • Do not swim or bathe in stagnant pools or allow children to do so<br>• Do not urinate or defecate in or around water sources<br>• Ensure feces and other wastes are properly disposed of<br>• Seek medical help as soon as symptoms are noticedy | • Low knowledge about schistosomiasis (transmission, symptoms, available treatment) |
| **Eye, Ear and Skin Infections** | | |
| • Insufficient personal hygiene practices including not washing hands and face regularly and not ensuring children so the same<br>• Surroundings not kept sufficiently clean | • Wash face and hands regularly<br>• Keep surroundings clean<br>• Get prompt treatment for sore eyes, blurred vision, pain or discharge from the ear and itchy, or rash on the skin<br>• Teach children and adolescents about proper hygiene practices and demonstrate them | • Low knowledge regarding dangers of the symptoms |
| **Neglected tropical diseases (NTDs)- Lymphatic Filiariasis (Elephantiasis** | | |
| • Do not prevent mosquito bites and ensure children do the same<br>• Do not seek medical attention promptly for themselves and their children | • Prevent mosquito bites (sleep under a net)<br>• Seek medical help as soon as symptoms are noticed such as swelling and redness and pain and later elephantiasis | • Low knowledge about Elephantiasis (transmission, symptoms, available treatment) |

| | | |
|---|---|---|
| **Neglected tropical diseases (NTDs)- Trypanosomiasis (Sleeping sickness)** | | |
| • Do not prevent mosquito bites and ensure children do the same<br>• Do not seek medical attention promptly for themselves and their children | • Prevent mosquito bites (sleep under a net)<br>• Seek medical help as soon as symptoms are noticed such as swelling and redness and pain and later elephantiasis | • Low knowledge about Trypanosomiasis (transmission, symptoms, available treatment) |
| **Acute Respiratory Infections (ARI)** | | |
| • Insufficient hygiene and hand washing practices<br>• Use of wood fuel indoor with poor ventilation<br>• Late health seeking behaviour | • Wash hands with soap and water<br>• Avoid wood fuel indoor for air flow<br>• Seek prompt care for ARI | • Low knowledge regardless the dangers of respiratory infections<br>• Practice of using wood fuel indoor/not having seperate room for cooking<br>• Lack of alternatives to using indoor fuel and resources to build a seperate room<br>• Delay in seeking medical help |

# 7. Key Communication Objectives per EHP

Based on the information in the above tables, Communication Objectives should be developed for each priority health area. The table below provides guidance on cross cutting objectives that apply to all of the lifestages wherever the health topic is mentioned (unless otherwise noted).This guidance should be used when developing health communication/promotion materials and interventions aiming to bring about social and behaviour change.

The communication objectives provide guidance on what should be included in the health promotion interventions and messages so the objectives can be met.

| Priority Health Areas | Communication Objectives |
|---|---|
| HIV and AIDS | • Address social and gender norms that: encourage multiple and concurrent sexual partnerships; may make it difficult for women to negotiate for safer sex; and, discourage use of service (testing, PMTCT, VMMC)<br>• Normalize testing for HIV (make it a social norm)<br>• Increase couple communication on intimate topics including sexual satisfaction, protecting themselves from HIV and support for care seeking behaviour<br>• Reduce misconceptions around condom use not being appropriate for married couples<br>• Normalize condom use in risky sexual relationships and among young people engaging in sex<br>• Increase knowledge about existing HIV and AIDS services and promote uptake<br>• Increase personal risk perception of HIV and increase efficacy to take action to prevent it and/or mitigate its effects |
| Malaria | • Dispel myths, misconceptions and fears regarding LLIN use<br>• Promote LLIN use every night, all year for the entire family<br>• Increase malaria risk perception and on the severity of the disease<br>• Increase knowledge about available malaria treatment and the benefits of testing before prompt treatment<br>• Increase knowledge about the extra danger malaria poses to pregnant women and children under 5 |
| Perinatal Conditions (Maternal and Child Health: Family Planning) | • Sustain knowledge on the benefits of ANC attendance and clinic delivery<br>• Increase male involvement/support in family health including safe motherhood and infant care<br>• Increase knowledge on danger signs during pregnancy and their severity<br>• Encourage the development of birth plans, what they should include and their use<br>• Increase couple communication around planning families<br>• Address social norms around family size and spacing<br>• Motivate couples to use family planning<br>• Motivate longer acting and permanent method use (for older couples)<br>• Increase understanding on the side effects of contraceptive use and how to handle them<br>• Normalize contraceptive use<br>• Increase young people's knowledge about and access to contraception<br>• Remove barriers to young people accessing contraception |

| Priority Health Areas | Communication Objectives |
|---|---|
| Diarrhoeal diseases (WASH) | • Increase diarrheal diseases risk perception and the severity of these diseases<br>• Increase knowledge on how hand washing with soap prevents diarrheal diseases<br>• Emphasize the junctures at which hand washing with soap is crucial<br>• Increase knowledge on proper disposal of feces and other waste prevents diarrhoea and other diseases<br>• De-normalize open defecation<br>• Increase knowledge and practice around ORS use and proper feeding practices<br>• Improve prompt care seeking behaviour |
| (Mal)nutrition | • Increase knowledge on the negative health effects of malnutrition including stunting, and actions that can be taken during pregnancy and the first year two years of life to prevent it<br>• Dispel misconceptions that equate healthy food to expensive food<br>• Increase and sustain knowledge regarding commonly available foods that represent the six food groups<br>• Increase knowledge on the additional nutritional needs of pregnant and breastfeeding women<br>• Sustain knowledge on the benefits of exclusive breastfeeding for first six months, and complementary feeding afterwards<br>• Increase families' efficacy to practice proper feeding practices for infants and young children |
| Non-communicable diseases- NCDs | • Increase knowledge on NCDs and available services<br>• Increase knowledge on risk factors and signs/symptoms for NCDs (e.g. obesity, excessive drinking, lack of exercise, poor eating habits, smoking)<br>• Discourage drinking and driving<br>• Improve health care seeking behaviour including counselling, screening and early treatment<br>• Increase knowledge about available screening and treatment services |
| Mental Health and Epilepsy | • Dispel misconceptions and beliefs that link mental illness and epilepsy to evil spirits or witchcraft and other factors that facilitate stigma and delay proper treatment<br>• Improve health care seeking behaviour including counselling, screening and early treatment |

| Priority Health Areas | Communication Objectives |
|---|---|
| Cancers | • Increase knowledge about cancers and available services<br>• Increase knowledge on risk factors and signs/symptoms for cancers including smoking<br>• Increase knowledge about available cancer screening and treatment services<br>• Improve health care seeking behaviour including counselling, screening and early treatment |
| Neglected tropical diseases (NTD) | • Increase knowledge on NTDs and available services<br>• Increase knowledge, signs and symptoms of NTDs<br>• Dispel misconceptions and beliefs that link NTDs to evil spirits or witchcraft and other factors that facilitate stigma<br>• Improve health care seeking behaviour including counselling, screening and early treatment |
| Acute Respiratory Infections (ARI) | • Increase parental knowledge of ARI and danger signs to look out for in children<br>• Increase knowledge on factors that dispose children to ARI<br>• Encourage families to seek alternatives to indoor cooking and improve ventilation<br>• Improve health care seeking behaviours |
| Eye, Ear and Skin Infections | • Build knowledge on known eye, ear and skin infections and where to go for help<br>• Increase knowledge about signs and symptoms around eye, ear and skin infections<br>• Increase proper hand and face washing practices |
| Vaccine preventable diseases (EPI) | • Sustain knowledge about required immunizations and their benefits<br>• Dispel any emerging rumours and misconceptions regarding immunizations<br>• Motivate families and communities to make sure every child is vaccinated |
| Tuberculosis (TB) | • Sustain TB knowledge including risk of co-infection with HIV<br>• Increase TB risk perception<br>• Improve health care seeking behaviour including prompt TB screening and adhering to medications<br>• Increase practices to prevent transmission |

# 8. Key Messages

The messages below are based on available research regarding current knowledge, attitudes and practices. Several of the topics have been studied to a greater extent than others and more research is required to add to the existing data base as well as to be able to nuance the messages. Everyone using this strategy is encouraged to contribute to this body of knowledge and disseminate the information widely to ensure health promotion and communication messages are as targeted as possible. It is also acknowledged that biomedical research often brings about changes in protocols especially concerning treatment regiments. Users of this document are encouraged to seek out the latest scientific data and adhere to any new guidelines released by the Ministry of Health.

The table below, similar to the one above, has been organized by priority health areas. This is in keeping with the underlying principle of this strategy of harmonization and integration. People face various health challenges at the same time and therefore need access to health information and motivation to practice positive behaviours on a variety of topics. The messages below are the overarching and minimum set of messages that should be communicated around each health topic. Health promoters and communicators are encouraged to develop additional messages based on their program objectives, local context and available research.

Most of the messages are crosscutting and apply to all audiences, except where noted.

## Key Messages for Each Health Priority

| | Priority Health Area | Key messages |
|---|---|---|
| 1 | HIV/AIDS | • Knowing your HIV status helps you stay healthy:<br>- If you test negative, you will receive information on how to remain negative.<br>- If you test positive, you will get treatment at an appropriate time.<br>• Unprotected sex puts you at risk of HIV infection. Use condoms correctly each time, every time.<br>• Partners who stay faithful to each other greatly reduce their risk of HIV infection.<br>• Talk to your partner about HIV and your options to protect each other. Get tested together.<br>• Adhering to your ARV medication will enable you to stay healthy and lead a full productive life.<br>• Support your partner to live positively and adhere to their medications. |

| Priority Health Areas | | Key messages |
|---|---|---|
| | | • Parents: Talk to your children openly and honestly about the consequences of unprotected sex and how they can protect themselves from HIV (and unwanted pregnancy). |
| 2 | Malaria | • Anyone can get malaria.<br>• Sleep under a long lasting insecticide treated net every night, all year round to protect yourself.<br>• Everyone in the family should sleep under the LLIN.<br>• LLINs are safe for everyone in the family.<br>• Visit the nearest health centre within 24 hours of fever in any family member.<br>• Test for malaria before treatment.<br>• Make sure to take all your malaria drugs as prescribed at the health centre.<br>• Keep surroundings clean and dry to prevent mosquitoes from breeding.<br>• Protect your unborn child: pregnant women should get preventive malaria medicine when they go for ANC visits. |
| 3 | Perinatal conditions (Maternal and Child Health) | • Visit the hospital as soon as you know – or suspect – that you are pregnant<br>• Attend antenatal clinic at least 4 times during pregnancy, starting with as soon as you know or suspect you may be pregnant<br>• Visit the hospital as soon as you experience any of the following "danger signs" while pregnant. Responding quickly can mean the difference between life and death for the mother and the baby.<br>- Headache, fever, difficulty in breathing, pale hands or eyes, fatigue, vaginal discharge, swollen arms, feet or face<br>• A healthy pregnancy and delivery is the responsibility of both the mother and the father; discuss together as a couple the roles you each can play to ensure this.<br>• Prepare together as a couple for pregnancy and birth by doing the following:<br>- Knowing the above danger signs and labour signs (e.g. uterine contraction, labour pains, break in birth water)<br>- Having and using a birth plan<br>• Your birth plan should include what to do if you notice danger signs, how you will get to the clinic and the resources to get there, care for the other children in your home.<br>• Go to the clinic at the first indication of labour pains or break in birth water.<br>• Delivering at the clinic is the best way to ensure a safe delivery for you/your spouse and your baby. |

| Priority Health Areas | | Key messages |
|---|---|---|
| 4 | Perinatal Conditions (Family Planning) | • Planning the family is the responsibility of both men and women.<br>• Getting pregnant when you are too young (younger than 18) puts your health and that of the baby in danger.<br>• Discuss family planning as a couple and go to the nearest health clinic to find out the method that is right for you.<br>• Family planning methods are safe.<br>• Sometimes there are side effects when starting a method - If you have any side effects, go to the clinic.<br>• Use long-acting family planning methods to conveniently space pregnancies.<br>• Long-term and permanent family planning methods provide a safe and healthy way to temporarily or permanently stop having children.<br>• There are family planning methods available at the clinic for everybody. Choose one that is suitable for you.<br>• Husbands and wives should use family planning for the health of the entire family.<br>• Becoming pregnant after 40 years of age can be dangerous to the health of the woman.<br>• Ask for family planning methods that are suitable for young people at the clinic<br>• Parents: Talk to your children openly and honestly about the consequences of unprotected sex and how they can protect themselves from unwanted pregnancies (and HIV) |
| 5 | Diarrheal diseases (WASH) | • Wash hands with soap and water after visiting the toilet, after changing baby nappies, before and after handling food.<br>• Use toilets or latrines for disposal of feces. Do not defecate or urinate in the open especially in and around water sources. This can cause diseases that affect you, your family and the entire community.<br>• Encourage everyone in the family and community to use toilets or latrines for the wellbeing of the entire community.<br>• Cover left-over food and re-heat before eating.<br>• Drink only safe water (boiled or treated).<br>• Take ORS when you have diarrhoea and make sure your children take it as well. Visit the clinic if diarrhoea persists<br>• Continue to breast feed babies and ensure all children get plenty of liquids even when they have diarrhoea.<br>• Parents should take their under 5 children to the health clinic as soon as they observe the following signs:<br>- Fast or noisy breathing<br>- Loose and watery stool that lasts more than 3 days<br>- Severe body weakness and a lack of appetite |

| Priority Health Areas | | Key messages |
|---|---|---|
| 6 | (Mal)nutrition | • Eat balanced meals from the six food groups.<br>• Eating healthy meals does not have to cost a lot of money; learn how you access the foods from the six groups in your community. Talk to those in the community who can help such as the Health and Agricultural Extension Workers.<br>• Get supplemental iron, folic acid and vitamin A at the ANC.<br>• Use iodized salt when preparing food.<br>• Only give your baby breast milk – and nothing else – for the first 6 months to ensure they have a healthy start in life.<br>• After 6 months, introduce other age appropriate healthy foods, but continue breastfeeding for at least two years.<br>• If you are pregnant, eat one additional meal per day to maintain your health and that of the baby.<br>• If you are breastfeeding, eat two additional meals per day to maintain your health and so you can provide the best milk to your baby.<br>• Talk to the Health Surveillance Assistant/health extension worker about how you can ensure a healthy pregnancy and the health of your baby.<br>• Adolescents need additional food as their bodies are developing, make sure they eat healthy balanced meals.<br>• Avoid fast food (urban/elite) which can have negative effects on your health. |
| 7 | Non communicable diseases | • Ask about diabetes and blood pressure screening at the health facility.<br>• Smoking destroys your health: don't start, quit if you already started.<br>• Alcohol is bad for health and drinking too much can have negative effects on your family. Drink in moderation or quit if you can't.<br>• Drinking while driving is dangerous, you may hurt yourself or cause death of others. Do not drink and drive.<br>• Exercise regulary to stay fit and healthy (urban elite) |
| 8 | Mental illness and epilepsy | • Epilepsy and mental illness are not caused by evil spirits or witchcraft.<br>• Both can be treated by accessing services at the health clinic.<br>• Seek counselling and medical attention promptly. |

| Priority Health Areas | | Key messages |
|---|---|---|
| 9 | Neglected tropical diseases | • Do not bathe, play or swim in stagnant water and do not allow your children to as well.<br>• Visit the clinic the moment you experience symptoms of schistosomiasis (passing blood in urine), Lymphatic filariasis (swelling and pain in arms feet or genitals) and Trypanosomiasis (weakness, dizziness and feeling sleepy).<br>• Take all prescribed medication as directed. |
| 10 | Cancers | • Ask about cervical, prostate and breast cancers screening at the health facility.<br>• Smoking destroys your health and can cause lung cancer, don't start, quit if you already smoke. |
| 11 | Acute respiratory infections (ARI) | • Take children to hospital when you see the following signs:<br>- Difficult, fast or noisy breathing, coughing, refusal to eat or breastfeed, fatigue.<br>• Keep children warm all the time.<br>• Keep children away from smoke especially wood fire.<br>• Keep surroundings dry and clean.<br>• Seek alternatives to indoor cooking and make sure the house is ventilated (keep doors and windows open as appropriate). |
| 12 | Eye, Ear and Skin Infections | • Wash your face and hands–and make sure children do the same–to avoid eye infections and other diseases.<br>• Eye infections can lead to blindness; go to the clinic to get treatment.<br>• Go to the clinic as soon as you experience sore eyes or burred vision, pain or discharge from your ears or severe itching/rash on the skin. |
| 13 | Vaccine preventable diseases (EPI) | • Learn about all immunizations available for you and your children at the clinic.<br>Every child in the home -and community-should be vaccinated.<br>• Childhood immunizations help protect babies from diseases.<br>• Parents should ensure the baby recieves all immunizations that are available at the health clinic. *(Note: Health promoters should provide audiences with the schedule of immunizations)*<br>• Vaccines are safe and effective |

| Priority Health Areas | | Key messages |
|---|---|---|
| 14 | Tuberculosis (TB) | • Anyone can get TB, it is a serious disease but can be teated.<br>• If your enough lasts for more than two weeks, seek TB screening at the clinic.<br>• Adhence to all TB medication.<br>• Cover your mouth and nose with while coughing or sneezing.<br>• If your are HIV+, you are more vulnerable to TB infection. Talk to your provider if you may have been exposed or your have a cough that lasts for more than two weeks. |

# 9.Channels, Tools/Activity Matrix

To implement this strategy, several channels, tools and activities are available for use at different levels. At the national level, the Health Education Section (HES) is currently piloting a Media4Life initiative that is expected to make mass media channels more readily available for health promotion. All health promotion campaigns happening within the duration of this strategy are expected to adopt the *Moyo ndi Mpamba: Usamalireni* brand and coordinate with the HES to leverage and harness available resources and ensure approaches are synergistic and not duplicative. The table below provides a list of available channels, tools and activities that health promoters can choose from; bearing in mind that the best results are achieved when health promotion efforts combine interventions and use a variety of channels including using mass media, community mobilization, interpersonal communication, mobile phones and social media (as appropriate). This table is not exhaustive and users of this strategy should include other tools and activities available to them or have the resources to develop. Some of the suggested channels (e.g. mobile phones and social media) are nascent in their use in health promotion in Malawi. It is anticipated that during the timeframe of this strategy, these technologies may become more widely used. It is important however to always consider which channel is most appropriate for the audience you are trying to reach and the topic and objective of your communication. It is also noted that currently, there is no telephone hotline service for health in Malawi. It has been included here as a potential channel for disseminating correct and appropriate health information as it has proven invaluable, especially for providing on-demand and sensitive health information, in countries where it is available.

While extensive research has not been carried out, some data is available that provides insight into selection of channels. Health promoters however should consider the local context in which they are working in order to determine the best channels to disseminate their programs and messages. According to a 2012 survey conducted by SSDI-Communication on mass media use, radio has the widest reach and appeal as most stations use both official languages of English and Chewa that are also widely spoken. It was reported that over 78% of respondents listen to the radio at least once a week and that Malawi Broadcasting Corporation (MBC) radio 1 and 2 and Zodiac Broadcasting Services (ZBS) are the most popular stations. Interestingly, 58% of respondents said they listen to health programs at least once a week. The MDHS 2010 reported that 12% of women and 26% of men read a newspaper once a week. About 34% of men and 16% of women watch TV once a week. Further, 14% of men and 5% of women have access to all three (newspaper, TV and Radio) information sources. Considering gender and age, younger women are twice as likely as older women to read a newspaper. Interpersonal communication as a source of credible health information was mentioned by a majority of respondents (SSDI, 2012) who preferred to receive this from health providers. Over 78% indicated that doctors were the most relied and trusted source of health information followed by nurses/midwives at 70%.

| LEVEL | CHANNEL | ACTIVITY/TOOL |
|---|---|---|
| NATIONAL | CENTRAL CAMPAIGN PLATFORM | • *Moyo ndi Mpamba* Campaign with ties to all national, community and other activities |
| | MASS MEDIA: TV, Radio, Print | • TV and Radio Spots<br>• Radio and TV "Wellness" Dialogues<br>• Entertainment-Education Radio and TV drama and reality programs<br>• Print media including: posters, pamphlets, Family Health Booklet, calendars, newspaper adverts |
| | MASS MEDIA: Out-door Advertising | • Billboards<br>• Branding of inter-city and mini buses<br>• Flexi banners in banking halls, shopping malls, and other high human traffic public buildings |
| | TELEPHONE HOTLINE SERVICE | • Accessible phone and SMS service with primary focus on providing Malawians health information on demand and where to get services |
| | MOBILE PHONES | • SMS appointment and treatment reminders<br>• SMS with behaviour change messages<br>• Audience input on mass media programming to feed into future programming |
| | SOCIAL MEDIA/FACEBOOK | • Prompts to stimulate social dialogue on key health issues and prevention/ adherence strategies<br>• Builds communities to support testing, adherence<br>• Disseminate key information on health topics |
| COMMUNITY | COMMUNITY MOBILIZATION & MEDIA | • Community entertainment-education theatre, song, dance, storytelling etc.<br>• Community Radio: radio spots, interactive discussion programs, entertainment-education drama and reality programs<br>• Open days, sports competitions<br>• Religious (health related) sermons and outreach<br>• Healthy village competitions<br>• Video on wheels<br>• Identification and promotion of Health Champions<br>• Travelling radio shows<br>• Mobile clinics/community outreach<br>• Street rallies |

| LEVEL | CHANNEL | ACTIVITY/TOOL |
|---|---|---|
| INTERPERSONAL | FAMILY/INDIVIDUAL | • Distribution of printed support materials- posters, fliers, booklets, leaflets<br>• Interactive, Toolkit<br>• Radio listening and discussion groups<br>• Couple Communication Counselling<br>• Marriage counselling |

# 10.Influencing Audiences

To ensure an enabling environment for the adoption of healthy behaviours, as stated in the socio-ecological model, key influencing audiences also need to be addressed. Depending on the health topic, these may include family members such as mothers-in-law, women's groups, traditional healers and others. Users of this strategy are encouraged to address the key influencing audiences as appropriate based on the local context and available research.

Several groups have been shown to directly and indirectly influence behaviour change on a multitude of topics in nearly every context and are therefore essential to include in health promotion and communication efforts. These are: facility-based and community-based health workers, faith leaders and traditional leaders, media owners and managers, as well as journalists. Their role vis-à-vis the primary audience and how it can be capitalized on is described below.

## Health workers

Frontline health workers who interface with community members at the facility and community level are the strength of any country's health system. In addition to providing clinical services, health workers provide primary audiences with timely and relevant information on all aspects of health and wellbeing. However, there are not enough community health workers in Malawi to meet demand and they are too often over-burdened with clients. This can be demotivating and discouraging, leading to poor attitudes towards clients which in turn affects community members' use of available services. Health promotion designers and implementers should ensure that interpersonal communication training for frontline health workers is factored into health promotion activities to improve provider-client interactions, as well as provide health workers with job aids and take away materials for clients to help them provide quality services.

## Faith (religious) leaders

Malawians are religious people who hold their faith leaders in high esteem and respect. Faith leaders greatly influence the attitudes, practices and behaviours of their followers and congregations through their actions and what they say in and out of the pulpit. This strategy encourages implementers to leverage this advantageous position by identifying and working with faith leaders as partners. One of the most important interventions faith leaders can perform is the integration of health topics and campaign messages into religious sermons, as well as during counselling before and after weddings. Eminent and popular faith leaders can also be used as "voices of reason" in campaign materials and products. Working closely with these faith leaders, toolkits including sermon packs can be developed and distributed. Faith leaders can also serve as channels for the distribution of support materials developed in the project and promote local services.

## Traditional leaders

Side by side with government institutions, there is the Malawian traditional ruling system from national to village level. Paramount Chiefs (PC) oversee whole ethnic groups and are supported by Senior Chiefs (SC), who inturn supervise Traditional Authorities (TA) who operate at the district level. Next in heirachy and closer to the community are Group Village Heads (GVH) who supervise individual Village Heads (VH). Paramount chiefs have great authority over their people. They are highly feared and revered by the TAs and GVHs; when they step in the village, there is emotion in the air. Implementers can partner with this strong traditional ruling system to mobilize communities, as well as increase participation in project activities and ownership of the project. Specifically, traditional rulers can be facilitated to meet regularly to discuss health issues and make pronouncements that support healthy behaviours in their communities and foster new norms, e.g. around bed-net and latrine use, male involvement in safe motherhood, HIV testing etc. Strategies to work with Traditional Leaders include holding orientation workshops where relevant health information about their communities is presented, along with how wellbeing can be improved and the important role they can play to making this a reality. Other methods include sponsoring Traditional Leaders Forums, Healthy Village competitions and working with Traditional Leaders to identify Community Health Champions.

## Media owners, managers and journalists

Mass media is a crucial avenue for challenging norms and cultures that prevent people from attaining their full health potential, introducing new ways of thinking and doing things, and normalizing these new ways. This strategy recognizes this and so anchors the central platform of this strategy in mass media. To fully leverage the opportunities mass media provides, health promoters should actively engage media owners and managers as partners in efforts to improve the health of Malawians. Journalists should be encouraged to do accurate, engaging reporting that helps people better understand the relevant health issues and inspires them to take action to protect their health. The Ministry of Health will

convene high level meetings where media owners/managers will rub minds with key stakeholders in the health/development sector and make commitments on what the media can contribute to ongoing efforts, including but not limited to free air time and space on national media. At a second level, SSDI in support of the MoH will build the capacity of journalists in effective coverage and reporting of health related issues. Trained journalists will be mentored and provided with incentives to produce high quality health content for the mass media.

# 11.Monitoring and Evaluation

Health promotion interventions should be based on available evidence. Accordingly, sufficient resources should be allocated to allow for the development of evidence-based activities and inter-sectoral initiatives. Formative research is integral to developing programs as well as improving existing and on-going programmes. It helps health promoters identify and understand the characteristics (interests, behaviours, needs and competencies) of target populations. Monitoring is essential to understand if programs are being implemented as planned and if mid-course adjustments are needed, and evaluation is essential to measure the success of programs in reaching Malawi's health outcome goals.

The HSSP lists a number of core performance indicators. Health promotion and communication contributes to reaching those indicators by addressing knowledge, attitudes and efficacy, driving people to services, encouraging positive health behaviours and removing barriers to practicing them.

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 core performance indicators. These indicators are not exhaustive and should be adapted and supplemented based on program objectives, audiences, resources and outputs. The list includes both general indicators that can be adapted for any health area and ones specific to a particular disease. Users of the strategy are encouraged to review the HSSP core performance indicators and develop additional appropriate behaviour change indicators.

## Sample behaviour change indicators for the primary audiences:

**Exposure Related:**

- Percentage of people who recall hearing or seeing any (EHP) message within the last 6 months
- Percentage of people who can recall the *Moyo ndi Mpamba* campaign
- Percentage of people who participated in a call in dialogue program
- Percentage of people who took part in interactive community sessions

**Knowledge related:**

- 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:**

- Percentage of people who appropriately perceive their risk for malaria, HIV, NTDs, ARI, cancer, etc.

- Percentage of people who feel efficacious that they can take actions to prevent malaria, HIV, diarrhoea, safe motherhood, NTDs, ARI, cancer, 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 that they can exclusively breastfeed their infants for the first six months
- 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

**Practices:**

- 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 (with ITN) who slept under an ITN the previous night.
- Percentage of reproductive age women who are using modern family planning methods
- Percentage of children receiving ORS at appropriate times

## Sample indicators for influencing audiences

**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 towards free or subsidized airtime and space for health issues

**Journalists:**

- Proportion of journalists who are knowledgeable about issues around the EHPs
- Number of journalists who are correctly reporting on health-related issues

# 12.Operational and Implementation Plan

## Organizational Arrangement

This document should be used at national level by the MoH and all government departments, TWGs and other coordinating bodies to strategically plan and provide oversight to national and district implementation. This document is a guide that can and should be adapted as necessary based on local health priorities, resources and relevant behavioural information. Program planners can also use this document to define program specific strategies based on specific areas of focus, primary audiences and communities that they work with.

It is expected all implementing partners will contribute towards achieving this strategic plan and provide data to the District Health Management Information System, based on HES core indicators on the quarterly reporting form to track success.

There are currently national, zonal, district, health facility and community levels in the provision of health services in the country as follows:

## National level- role of HES

The Government of Malawi recognizes the Health Education Section (HES) as the apex institution in the country to lead and coordinate health promotion services. The HES, with counsel from the Health Promotion TWG, will guide and coordinate partners in implementing health promotion activities across the 13 EHP conditions. It is increasingly recognized however that many of the key determinants of health lie outside the direct control of the health sector and the participation of non-health actors is important to the success of these efforts. Health promotion in Malawi goes even further by recognizing the contributions of the private sector, civil society and international partners in working together to promote health, while removing barriers and promoting facilitators to practicing positive health behaviours and achieving wellness. The success of this strategy therefore will rely on the joint and synergistic efforts of many stakeholders, each playing their essential role, with leadership from the HES. Its mandate includes:

- Policy formulation
- Leadership and coordination of Health Promotion programs
- Convening Health Promotion TWGs at both national and district levels
- Setting standards for health communication programs and interventions

The HES, with counsel from the Health Promotion TWG, will guide and coordinate partners implementing health promotion activities across the 13 EHP conditions using the NHCS. They will also guide the planning and development of disease or condition specific communication strategies and /or programs that reflect the strategic direction of the HP policy.

## Zonal level

At zonal level, the function of health promotion falls under the Zonal Health Officer. Activities such as zonal health promotion campaigns are coordinated from the Health Promotion office in liaison with the District Health Officers through their District Health Education Officers in the districts in which the zone is situated. The zonal office will interpret the NHCS and guide the district in its implementation in the district and communities. Thus the zonal office works as the link between the Central level and District Level.

## District level

The Ministry of Health will deploy a trained District Health Promotion officer in each district, who shall work in collaboration with the District Health Office and liaise with the Zonal Health Officer. District Health Promotion Officers (DHPO) with guidance from the District HP TWG will provide leadership in the interpretation, implementation and monitoring and evaluation of the NHCS at the district and community level.

## Community level

Community based organizations shall identify priority health promotion needs in the community and using the NHCS undertake to develop health promotion activities under the guidance of the DHPO. The DHPO with support from the District Directorate of Health will identify and designate a coordinator from among Health Surveillance Officers (HSAs) for community health promotion activities by CBOs and community volunteers.

## Health facility

The DHPO, using the NHCS, shall identify and orient health facility staff to provide effective Behaviour Change Communication interventions including participating in community outreach sessions. The following are some of the health promotion activities that the health facility staff will undertake:

- Provide group and individual health promotion and lay counselling
- Establish, develop and maintain community based integrated health promotion support groups
- Conduct thematic health promotion group sessions at community venues within the health facility catchment area
- Organise health awareness events and manage supply, distribution, and use of behaviour change communication materials in the health facility catchment area (for full list of activities and costs please see annex 1)

# 13.Role of Key Stakeholders

As mentioned above, the NHCS is envisioned as being inclusive of a wide range of stakeholders including government, donors, local NGOs and the private sector. The role of these varied stakeholders is three-fold: to ensure the use and implementation of the NHCS; to contribute resources for its undertaking; and, to advocate for health promotion and participate in health promotion activities. The sections below outline their various roles.

## Relevant ministries and government programs

While the Ministry of Health provides both policy and strategic direction in Health Promotion, its implementation at the district level is through the decentralized government system for all government programs at district and lower levels. Other ministries and departments that provide health services include the Department of Forestry, the Army, Police and Prisons. In addition Ministries such as Agriculture and Food Security contribute to health by reaching out to vulnerable groups including the poor, women and children with food. It is anticipated that all of the ministries engaged in promoting health will use the NHCS to guide the development and implementation of activities and messages.

## Donors, development agencies and implementing partners

Bilateral, multi-lateral and other donor organizations will play a significant role in the implementation of the NHCS. They provide financial resources and oversight to many implementing partners that work on health promotion and therefore are expected to use the NHCS to guide their work and those of the organizations they fund.There are several stakeholders involved in health promotion and communication activities in Malawi. The United Nations Agencies under the leadership of the World Health Organization through their global mandate provides strategic guidance and quality control and standards in Health Promotion. UNICEF provides professional direction through their Communication for Development approach. Other international organizations include the World Bank, UNFPA, FAO and WFP. Among the bilateral donors, the prominent ones include the USG through USAID and CDC, and the UK through DFID.

Implementing partners include many international and some local NGOs working throughout the health sector. These include the JHU.CCP, CHAI, PSI, CHAM, JHPIEGO, ITECH and Society, Banja Lamtsogolo and PAKACHERE among others. The USAID funded Support for Service Delivery Integration (SSDI) has developed a researched holistic and sustained multi-disease Social Behaviour Change Communication program that played an important role in informing the development of this strategy.

## Local NGOs and civil society

The implementation of the NHCS will use existing structures at the community level such as local leaders, Village Development Committees and Village Health Committees. The Ministry of Health works with Community Based Organizations (CBO) that work directly with individuals, families and the

community. There are also Faith Based Organizations (FBO) that are coordinated by umbrella organizations, namely the Muslim Association of Malawi and the Christian Health Association of Malawi (CHAM). It is estimated that CHAM provides about 40% of health services in the country including preventive services. The Government of Malawi works with traditional medical practitioners through their coordination mechanism the Malawi Traditional Healers Umbrella Organization (MTHUO) and with traditional birth attendants. The Health Promotion Policy guides all these in their work and the National Health Communication Strategy will provide much needed guidance in developing local specific health promotion activities.

## Private sector

Partners in the private sector include small-scale business as well as large plantations, tea estates, factories and wholesalers. Commercial enterprises have a vested interest in maintaining the nation's health as they need strong workers to produce and consumers to buy their products. Health promoters can leverage this interest in a variety of ways. Industries that employ large number of workers should be encouraged to use the NHCS in the development of on-site health programs, set aside time for workers to engage in health promotion and education activities and incorporate proven behaviour change tools and approaches in their efforts. Small and large businesses should be encouraged to contribute resources to health promotion efforts through contributions to and sponsorship of events, awards/ prizes, building toilets and pit latrines in communities, among other activities.

# 14.Capacity Building

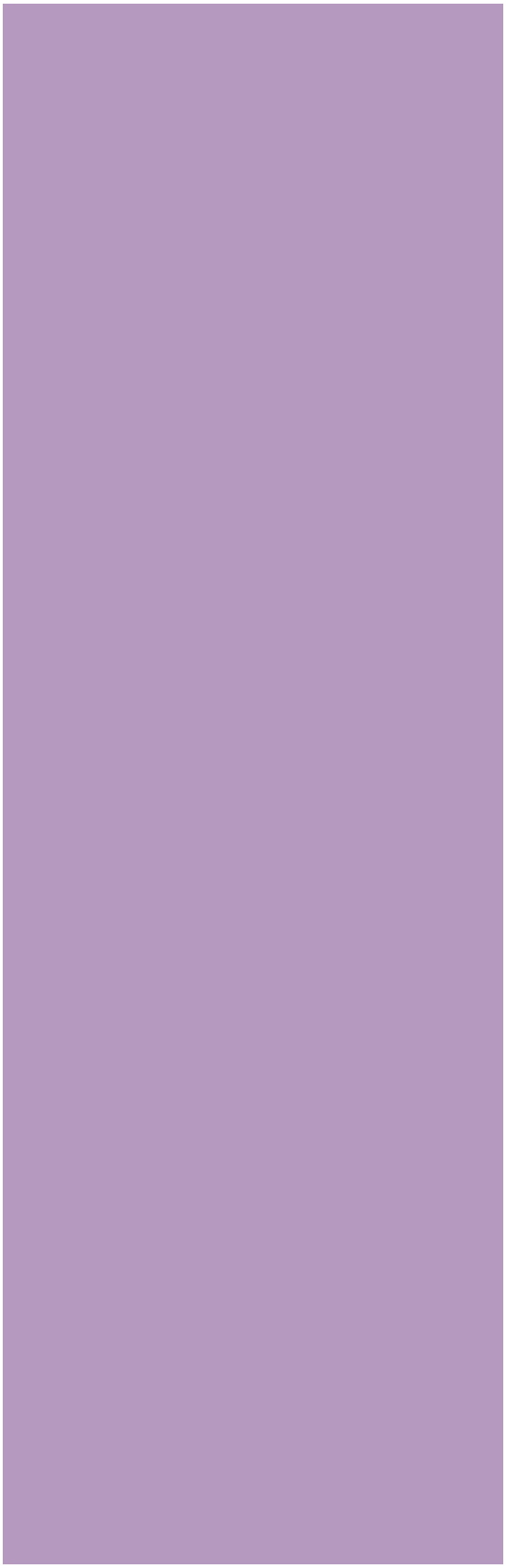
The Health Promotion Policy and the HSSP allude to the need to strengthen the position of the HES to effectively manage their significant roles, which includes coordinating and overseeing the rollout of the NHCS. Without adequate and scientific capacity building efforts, effective implementation of this strategy will be difficult.

In a recent capacity mapping exercise SSDI-Communication identified opportunities and challenges for strengthening HES' capacity. These include addressing the human resource gaps, advocating for more funds, especially for district level health promotion activities; and monitoring the quality of health promotion campaigns with regular post-mortem of all organized efforts with cost benefit analysis and lessons learnt. These initiatives will pave the way for a vibrant and well-resourced HES as well as the design and implementation of high quality strategic campaigns aimed at improving the health and wellbeing of the people.

In addition to focusing on enhancing the capacity HES for the successful implementation of this strategy, the Ministry of Health with assistance from other health sector partners should also endeavour to strengthen the discipline of health promotion in universities and colleges by integrating health promotion in the curriculum to ensure the next generation of health promoters and communicators are highly skilled and capable.

Many partners in the private sector and among the NGOs also suffer from acute capacity gaps. USAID through SSDI has conducted several capacity assessments of communication NGOs and are putting in place plans to strengthen their capacity, but more work needs to be done. There is also an opportunity to further harness the power of the media by building upon the partnership initiated by various public and private sector initiatives including SSDI-Communication, UNICEF, WHO, UNFPA, PSI, CHAI, Banja la Mtsogolo and PAKACHERE as well as orienting and training journalists. These capacity building initiatives should remain the cornerstone of all health communication efforts by MOH and its partners to ensure investments in health promotion yield the

best possible results through evidence based and effective interventions at national, district and community level.



## Annexes

### Annex 1 Activity timelines & costs

| YOUNG MARRIED COUPLES | | | | | | | |
|---|---|---|---|---|---|---|---|
| **THEMATIC AREA** | **ACTIVITIES** | **IMPLEMENTATION YEAR** | | | | | **TOTAL COST (Malawi Kwacha)** |
| | | 1 | 2 | 3 | 4 | 5 | |
| HIV/AIDS | Conduct health education band performances on VMMC & PMTCT | | | | | | 57,064,000.00 |
| | Conduct interactive radio programs on HIV/AIDS issues | | | | | | 60,750,000.00 |
| | Develop, produce & disseminate HIV communication materials | | | | | | 101,701,200.00 |
| | Media orientation on HIV/AIDS issues | | | | | | 13,654,500.00 |
| | Produce & air HIV/AIDS radio spots | | | | | | 98,625,000.00 |
| | Produce & air HIV/AIDS TV spots | | | | | | 61,416,000.00 |
| | Conduct community filming on ART | | | | | | 101,707,200.00 |
| | Support community based artists to conduct interactive drama sessions in communities around ART, PMTCT, VMMC and couple counseling & testing | | | | | | 103,161,000.00 |
| | Train community based artists in interactive drama & HIV/AIDS issues | | | | | | 66,420,000.00 |
| Malaria | Support community based artists to conduct interactive drama sessions in communities around net use/misuse, care-seeking and malaria in pregnancy | | | | | | 107,346,00.00 |
| | Train community based artists (traditional dancers, drama actors, poets in malaria focused theatre for development) | | | | | | 66,420,000.00 |
| | Conduct lobbying meetings for by-laws on LLINs misuse with district assemblies & traditional leaders (TAs, GVHs) | | | | | | 19,664,400.00 |
| | Conduct malaria community filming in hard to reach communities | | | | | | 79,934,400.00 |
| | Conduct health education band | | | | | | 119,168,000.00 |

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| | performances | | | | | | |
| | Conduct interactive radio programs | | | | | | 61,020,000.00 |
| | Develop, produce & disseminate malaria communication materials | | | | | | 108,701,200.00 |
| | Produce & air malaria radio spots | | | | | | 16,380,000.00 |
| Peri-natal Condition (Maternal & Child Health: Family Planning) | Conduct sensitization meetings with traditional. leaders on issues of safe motherhood including family planning | | | | | | 52,057,600.00 |
| | Train community based artists (traditional dancers groups, drama actors, poets in safe motherhood focused theatre for development) | | | | | | 66,420,000.00 |
| | Support community based artists to conduct interactive drama sessions in communities around antenatal care, family planning, male partner involvement, birth planning & safe deliveries | | | | | | 98,690,400.00 |
| | Develop, produce & disseminate maternal health (ANC, safe delivery, family planning, male partner involvement & birth planning) communication materials | | | | | | 108,701,200.00 |
| | Conduct community filming on maternal health in hard to reach communities | | | | | | 89,208,000.00 |
| | Lobby for mainstreaming of maternal health with community level groups (CBOs, VDCs, agriculture committees, counsellors, ADCs & faith based leaders | | | | | | 19,664,400.00 |
| | Produce & air maternal health focused radio spots | | | | | | 16,380,000.00 |
| | Orient faith based leaders (marriage counsellors, women's guilds, etc) in maternal health including family planning promotion | | | | | | 52,057,600.00 |
| | Conduct interactive radio programs | | | | | | 120,690,000.00 |

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| | Conduct media orientation on maternal health including family planning | | | | | | 18,206,000.00 |
| Diarrhoea | Develop print & disseminate participatory hygiene and sanitation for transformation(PHAST)tools | | | | | | 101,701,200.00 |
| | Orient community health workers in PHAST approach to hygiene and sanitation promotion & tools | | | | | | 54,532,800.00 |
| | Support districts to conduct hygiene & sanitation promotion sessions in communities using PHAST approach | | | | | | 68,774,000.00 |
| | Produce & air radio programs on hygiene & sanitation | | | | | | 61,020,000.00 |
| | Produce & air TV spots on diarrhea | | | | | | 61,416,000.00 |
| | Orient community based artists (traditional dancers, drama actors, poets in hygiene & sanitation focused theatre for development) | | | | | | 49,089,600.00 |
| | Conduct community filming on hygiene & sanitation | | | | | | 67,804,800.00 |
| | Support community based artists to conduct interactive drama sessions on hygiene & sanitation | | | | | | 74,174,000.00 |
| Malnutrition | Produce & air TV programs on nutrition | | | | | | 60,966,000.00 |
| | Develop print & disseminate nutrition communication materials | | | | | | 108,701,200.00 |
| | Produce & air radio programs on nutrition | | | | | | 61,020,000.00 |
| | Produce & air radio spots on nutrition | | | | | | 16,380,000.00 |
| | Post nutrition messages on mobile adverts (minibuses, buses) | | | | | | 13,000,000.00 |
| | Conduct health education band performances on nutrition in urban & peri-urban areas | | | | | | 44,780,400.00 |
| | Conduct media orientation on nutrition | | | | | | 18,206,000.00 |
| Tuberculosis (TB) | Produce & air TV spots on TB | | | | | | 60,966,000.00 |

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| | Develop print & disseminate TB communication materials | | | | | | 108,701,200.00 |
| | Produce & air radio spots on TB | | | | | | 16,380,000.00 |
| | Produce & air radio programs on TB | | | | | | 101,700,000.00 |
| | Place TB messages on social media (face book, nyasa times etc) | | | | | | 20,000,000.00 |
| | Place TB messages on mobile adverts (minibuses, buses) | | | | | | 13,000,000.00 |
| | Conduct community filming on TB in hard to reach areas | | | | | | 53,289,600.00 |
| | Conduct health education band performances in TB high prevalence districts | | | | | | 57,064,000.00 |
| Non-communicable diseases (including cancers, mental illness and epilepsy | Conduct media orientation sessions on harmful alcohol & substance use | | | | | | 18,206,000.00 |
| | Place messages on NCDs in social media | | | | | | 20,000,000.00 |
| | Produce & air TV programs on NCDs (including cancers, mental illness & epilepsy | | | | | | 61,416,000.00 |
| | Develop, print & disseminate communication materials on NCDs (including cancers, mental illness & epilepsy) | | | | | | 101,701,200.00 |
| | Produce & air radio spots on cancers, mental illness & epilepsy | | | | | | 61,170,000.00 |
| | Post NCDs messages on mobile adverts (minibuses, buses) | | | | | | 13,000,000.00 |
| | Produce & air radio programs on NCDs | | | | | | 61,020,000.00 |
| | Conduct community filming on NCDs | | | | | | 59,472,000.00 |
| Neglected tropical diseases (NTDs)-Schistosomiasis | Develop, print & disseminate communication materials on schistosomiasis | | | | | | 108,701,200.00 |
| | Produce & air radio spots on schistosomiasis | | | | | | 28,770,000.00 |

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| | Place schistosomiasis messages in social media (face book, nyasa times etc) | | | | | | 20,000,000.00 |
| | Produce & air radio programs on schistosomiasis | | | | | | 61,020,000.00 |
| | Conduct media orientation sessions on schistosomiasis | | | | | | 18,206,000.00 |
| | Produce & air TV spots on schistosomiasis | | | | | | 61,416,000.00 |
| Eye, Ear and Skin Infections | Produce & air TV spots on eye, ear & skin infections | | | | | | 90,324,000.00 |
| | Develop, print & disseminate communication materials on eye, ear & skin infections | | | | | | 109,264,000.00 |
| | Produce & air radio spots on eye, ear & skin infections | | | | | | 47,950,000.00 |
| | Place messages on eye, ear & skin infections on the social media (facebook, nyasa times, sms) | | | | | | 20,000,000.00 |
| | Produce & air radio programs on eye, ear & skin infections | | | | | | 60,750,000.00 |
| | Conduct media orientation sessions on eye, ear & skin infections | | | | | | 18,206,000.00 |
| Neglected tropical diseases (NTDs)-Lymphatic Filariasis (Elephantiasis) | Produce & air TV spots on Filariasis | | | | | | 102,360,000.00 |
| | Develop, print & disseminate communication materials on Lymphatic Filariasis (Elephantiasis) | | | | | | 51,757,200.00 |
| | Produce & air radio spots on Lymphatic Filariasis (Elephantiasis) | | | | | | 44,625,000.00 |
| | Place Filariasis messages on social media | | | | | | 20,000,000.00 |
| | Produce & air radio programs on Lymphatic Filariasis (Elephantiasis) | | | | | | 101,700,000.00 |
| | Conduct media orientation sessions on Lymphatic Filariasis (Elephantiasis) | | | | | | 20,570,000.00 |
| Neglected tropical diseases (NTDs)-Trypanosomiasis (Sleeping sickness) | Develop, print & disseminate communication materials on trypanosomiasis (Sleeping sickness) | | | | | | 32,753,600.00 |

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| | Produce & air radio spots on trypanosomiasis (Sleeping sickness) on community radio stations in tsetse fly infested areas | | | | | | 28,770,000.00 |
| | Conduct interface meetings with young married couples on issues of trypanosomiasis | | | | | | 43,008,000.00 |
| | Produce & air radio programs on trypanosomiasis (Sleeping sickness) on community radio stations in tsetse fly infested areas | | | | | | 60,480,000.00 |
| | Conduct media orientation sessions on trypanosomiasis (Sleeping sickness) | | | | | | 20,570,000.00 |
| | Orient faith based leaders including marriage counsellors on trypanosomiasis in tsetse fly infested areas | | | | | | 17,286,600.00 |
| Acute Respiratory Infections (ARI) | Produce & air TV spots on ARI | | | | | | 60,966,000.00 |
| | Develop, print & disseminate communication materials on ARI | | | | | | 130,701,200.00 |
| | Produce & air radio spots on ARI | | | | | | 66,600,000.00 |
| | Place ARI messages on social media | | | | | | 20,000,000.00 |
| | Produce & air radio programs on ARI | | | | | | 61,020,000.00 |
| | Conduct media orientation sessions on ARI | | | | | | 18,206,000.00 |
| **PARENTS OF OLDER CHILDREN(6-12 YEARS)** | | | | | | | |
| HIV and AIDS | Conduct community meetings with faith, teachers, chiefs, and other groups of people on safe sex, adherence to ART and other medicines, weak couple communication around sex, low utilization of HIV services and weak parent-child communication around sex | | | | | | 140,000,000.00 |
| | Develop messages on safe sex, adherence to ART and other | | | | | | 9,543,000.00 |

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| | medicines, weak couple communication around sex, low utilization of HIV services and weak parent-child communication around sex | | | | | | |
| | Produce radio programmes on safe sex, adherence to ART and other medicines, Weak couple communication around sex, Low utilization of HIV services and Weak parent-child communication around sex | | | | | | 2,250,000.00 |
| | Air radio programmes on safe sex, adherence to ART and other medicines, Weak couple communication around sex, Low utilization of HIV services and Weak parent-child communication around sex | | | | | | 26,700,000.00 |
| | Produce TV programmes on safe sex, adherence to ART and other medicines, Weak couple communication around sex, Low utilization of HIV services and Weak parent-child communication around sex | | | | | | 12,450,000.00 |
| | Air TV programmes on safe sex, adherence to ART and other medicines, Weak couple communication around sex, Low utilization of HIV services and Weak parent-child communication around sex | | | | | | 26,700,000.00 |
| | Develop various print materials on safe sex, adherence to ART and other medicines, Weak couple communication around sex, Low utilization of HIV services and Weak parent-child communication around sex | | | | | | 9,000,000.00 |
| | Print various materials on safe sex, adherence to ART and other medicines, Weak couple communication around sex, Low utilization of HIV services and Weak parent-child communication around sex | | | | | | 16,800,000.00 |

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| | Distribute various print materials to all districts and sectors on safe sex, adherence to ART and other medicines, Weak couple communication around sex, Low utilization of HIV services and Weak parent-child communication around sex | | | | | | 3,300,000.00 |
| Malaria | Conduct community meetings with local leaders (faith, chiefs, councillors, CBOs) on the importance of sleeping under a mosquito net, proper usage of LLINs , seeking medical care within 24hours of symptoms and adhere to treatment . | | | | | | 140,000,000.00 |
| | Develop promotional messages and materials on the importance of sleeping under a mosquito net, proper usage of available nets , seeking medical care within 24hours of symptoms and adhere to treatment | | | | | | 9,543,000.00 |
| | Produce radio programmes on the importance of sleeping under LITNs, proper usage of LITNs &, seeking medical care within 24hours of symptoms and adhere to treatment | | | | | | 450,000.00 |
| | Air radio programmes on the importance of sleeping under a mosquito net, proper usage of available nets ,seeking medical care within 24hours of symptoms and adhere to treatment | | | | | | 26,700,000.00 |
| | Produce TV programmes on the importance of sleeping under a mosquito net, proper usage of available nets ,seeking medical care within 24hours of symptoms and adhere to treatment | | | | | | 6,000,000.00<br>450,000.00 |
| | Disseminate TV programmes on the importance of sleeping under a mosquito net, proper usage of available nets ,seeking medical care within 24hours of symptoms and adhere to treatment | | | | | | 26,700,000.00 |

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| | Print promotional products on the importance of sleeping under a mosquito net, proper usage of available nets ,seeking medical care within 24hours of symptoms and adhere to treatment | | | | | | 16,800,000.00 |
| | Distribute the printed promotional products on importance of sleeping under a mosquito net, proper usage of available nets , seeking medical care within 24hours of symptoms and adhere to treatment | | | | | | 3,300,000.00 |
| Peri-natal conditions and Family Planning | Conduct briefing sessions with all community based groups, chiefs, women groups, men forums, and work place on dangers of getting unwanted pregnancy including after age 40 without understanding risks to her health | | | | | | 140,000,000.00 |
| | Develop briefing packages on FP | | | | | | 5,343,000.00 |
| | Develop messages and materials on dangers of getting unwanted pregnancy including after age 40 (and risks to health) | | | | | | 9,543,000.00 |
| | Produce Radio programmes on dangers of getting unwanted pregnancy including after age 40 (and risks to health) | | | | | | 450,000.00 |
| | Air radio programmes on dangers of getting unwanted pregnancy including after age 40 (and risks to health) | | | | | | 26,700,000.00 |
| | Produce TV programmes on dangers of getting unwanted pregnancy including after age 40 (and risks to health) | | | | | | 6,000,000.00<br>450,000.00 |
| | Air TV programmes on dangers of getting unwanted pregnancy including after age 40 (and risks to health) | | | | | | 26,700,000.00 |
| | Develop promotional materials on dangers of getting unwanted | | | | | | 2,000,000.00 |

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| | pregnancy including after age 40 (and risks to health) | | | | | | |
| | Print promotional materials on dangers of getting unwanted pregnancy including after age 40 (and risks to health) | | | | | | 16,800,000.00 |
| | Distribute promotional materials on dangers of getting unwanted pregnancy including after age 40 (and risks to health) | | | | | | 3,300,000.00 |
| Diarrhea diseases (WASH) | Develop messages and promotional materials on washing hands with soap and clean water, proper disposal of faeces and other human waste , proper storage of cooked food, Importance of children continue to eat when they have diarrhea, and teaching children proper hygiene | | | | | | 9,543,000.00 |
| | Develop promotional materials on washing hands with soap and clean water, proper disposal of faeces and other human waste ,proper storage of cooked food, Importance of children continue to eat when they have diarrhea, and teaching children proper hygiene | | | | | | 2,000,000.00 |
| | Print promotional materials on washing hands with soap and clean water, proper disposal of faeces and other human waste ,proper storage of cooked food, Importance of children continue to eat when they have diarrhea, and teaching children proper hygiene | | | | | | 16,800,000.00 |
| | Distribute promotional materials on washing hands with soap and clean water, proper disposal of faeces and other human waste ,proper storage of cooked food, Importance of children continue to eat when they have diarrhea, and teaching children proper hygiene | | | | | | 3,300,000.00 |
| | Produce TV programmes on washing hands with soap and clean water, proper disposal of faeces and other human waste ,proper storage of | | | | | | 6,000,000.00<br><br>450,000.00 |

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| | cooked food, Importance of children continue to eat when they have diarrhea, and teaching children proper hygiene | | | | | | |
| | Air TV programmes on washing hands with soap and clean water, proper disposal of faeces and other human waste ,proper storage of cooked food, Importance of children continue to eat when they have diarrhea, and teaching children proper hygiene | | | | | | 26,700,000.00 |
| | Produce Radio programmes on washing hands with soap and clean water, proper disposal of faeces and other human waste ,proper storage of cooked food, Importance of children continue to eat when they have diarrhea, and teaching children proper hygiene | | | | | | 450,000.00 |
| | Air radio programmes on washing hands with soap and clean water, proper disposal of faeces and other human waste ,proper storage of cooked food, Importance of children continue to eat when they have diarrhea, and teaching children proper hygiene | | | | | | 26,700,000.00 |
| | Conduct open days on washing hands with soap and clean water, proper disposal of faeces and other human waste, proper storage of cooked food, Importance of children continue to eat when they have diarrhea, and teaching children proper hygiene | | | | | | 48,000,000.00 |
| | Conduct interactive drama performances on washing hands with soap and clean water, proper disposal of faeces and other human waste, proper storage of cooked food, Importance of children continue to eat when they have diarrhea, and teaching children proper hygiene. | | | | | | 84,000,000.00 |
| | Conduct village meetings on washing hands with soap and clean water, proper disposal of faeces and other | | | | | | 48,000,000.00 |

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| | human waste ,proper storage of cooked food, Importance of children continue to eat when they have diarrhea, and teaching children proper hygiene | | | | | | |
| | Conduct school teaching sessions on washing hands with soap and clean water, proper disposal of faeces and other human waste ,proper storage of cooked food, Importance of children continue to eat when they have diarrhea, and teaching children proper hygiene | | | | | | 48,000,000.00 |
| Malnutrition | Conduct community meetings on the importance of eating meals from the six food groups and recognition nutritional needs of children particularly young girls, and dangers of junk food from fast food sellers | | | | | | 140,000,000.00 |
| | Orient drama groups on importance of eating meals from the six food groups, and recognition of nutritional needs of children particularly young girls, and dangers of junk food from fast food sellers | | | | | | 20,000,000.00 |
| | Conduct drama performances on the importance of eating meals from the six food groups, and recognition of nutritional needs of children particularly young girls, and dangers of junk food from fast food sellers | | | | | | 84,000,000.00 |
| | Develop messages and materials on the importance of eating meals from the six food groups, recognition of nutritional needs of children particularly young girls, and dangers of junk food from fast food sellers | | | | | | 9,543,000.00 |
| | Develop promotional materials on the importance of eating meals from the six food groups, recognition of nutritional needs of children particularly young girls, and dangers of junk food from fast food sellers | | | | | | 9,000,000.00 |
| | Print promotional materials on the importance of eating meals from | | | | | | 16,800,000.00 |

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| | the six food groups, recognition of nutritional needs of children particularly young girls, and dangers of junk food from fast food sellers | | | | | | |
| | Distribute promotional materials on the importance of eating meals from the six food groups, and recognition of nutritional needs of children particularly young girls, and dangers of junk food from fast food sellers | | | | | | 3,300,000.00 |
| | Produce radio programmes on the importance of eating meals from the six food groups, and recognition of nutritional needs of children particularly young girls, and dangers of junk food from fast food sellers | | | | | | 450,000.00 |
| | Air radio programmes on the importance of eating meals from the six food groups, and recognition of nutritional needs of children particularly young girls, and dangers of junk food from fast food sellers | | | | | | 26,700,000.00 |
| | Produce TV programmes on the importance of eating meals from the six food groups, and recognition of nutritional needs of children particularly young girls, and dangers of junk food from fast food sellers | | | | | | 6,000,000.00<br>450,000.00 |
| | Air TV programmes on the importance of eating meals from the six food groups, and recognition of nutritional needs of children particularly young girls, and dangers of junk food from fast food sellers | | | | | | 26,700,000.00 |
| | Conduct band performances on the importance of eating meals from the six food groups, and recognition of nutritional needs of children particularly young girls, and dangers of junk food from fast food sellers | | | | | | 364,000,000.00 |
| Tuberculosis (TB) | Develop messages and materials on the importance of testing for TB if having a cough of more than one week, covering mouth when coughing or sneezing and adhere to medication. | | | | | | 9,543,000.00 |

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| | Develop materials on the importance of testing for TB if having a cough of more than one week, covering mouth when coughing or sneezing and adhere to medication. | | | | | | 2,000,000.00 |
| | Print materials on the importance of testing for TB if having a cough of more than one week, covering mouth when coughing or sneezing and adhere to medication. | | | | | | 16,800,000.00 |
| | Produce radio programmes on the importance of testing for TB if having a cough of more than one week, covering mouth when coughing or sneezing and adhere to medication. | | | | | | 450,000.00 |
| | Air radio programmes on the importance of testing for TB if having a cough of more than one week, covering mouth when coughing or sneezing and adhere to medication. | | | | | | 26,700,000.00 |
| | Produce TV programme on the importance of testing for TB if having a cough of more than one week, covering mouth when coughing or sneezing and adhere to medication. | | | | | | 450,000.00 |
| | Air TV programmes on the importance of testing for TB if having a cough of more than one week, covering mouth when coughing or sneezing and adhere to medication. | | | | | | 26,700,000.00 |
| | Orient drama groups on the importance of testing for TB if having a cough of more than one week, covering mouth when coughing or sneezing and adhere to medication. | | | | | | 20,000,000.00 |
| | Conduct drama performances on the importance of testing for TB if having a cough of more than one week, covering mouth when coughing or | | | | | | 84,000,000.00 |

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| | sneezing and adhere to medication. | | | | | | |
| | Conduct open days on the importance of testing for TB if having a cough of more than one week, covering mouth when coughing or sneezing and adhere to medication. | | | | | | 448,000,000.00 |
| | Conduct community meetings with various community leaders and groups on the importance of testing for TB if having a cough of more than one week, covering mouth when coughing or sneezing and adhere to medication. | | | | | | 140,000,000.00 |
| Non-communicable diseases (including cancers, mental illness and epilepsy) | Develop messages and materials on dangers of parents abusing alcohol, driving while intoxicated, smoking and using drugs (marijuana); promote healthy exercises; promote care seeking for psychological and mental problems while discouraging stigma and discrimination against the mentally ill and the epileptic; and promote care seeking for cancer screening services | | | | | | 9,543,000.00 |
| | Develop materials on dangers of parents abusing alcohol, driving while intoxicated, smoking and using drugs (marijuana); promote healthy exercises; promote care seeking for psychological and mental problems while discouraging stigma and discrimination against the mentally ill and the epileptic; and promote care seeking for cancer screening services | | | | | | 9,000,000.00 |
| | Print promotional materials on dangers of parents abusing alcohol, driving while intoxicated, smoking and using drugs (marijuana); promote healthy exercises; promote care seeking for psychological and mental problems while discouraging stigma and discrimination against the mentally ill and the epileptic; and promote care seeking for cancer screening services | | | | | | 16,800,000.00 |

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| | Distribute promotional materials on dangers of parents abusing alcohol, driving while intoxicated, smoking and using drugs (marijuana); promote healthy exercises; promote care seeking for psychological and mental problems while discouraging stigma and discrimination against the mentally ill and the epileptic; and promote care seeking for cancer screening services | | | | | | 3,300,000.00 |
| | Produce radio programmes on dangers of parents abusing alcohol, driving while intoxicated, smoking and using drugs (marijuana); promote healthy exercises; promote care seeking for psychological and mental problems while discouraging stigma and discrimination against the mentally ill and the epileptic; and promote care seeking for cancer screening services | | | | | | 450,000.00 |
| | Air radio programmes on dangers of parents abusing alcohol, driving while intoxicated, smoking and using drugs (marijuana); promote healthy exercises; promote care seeking for psychological and mental problems while discouraging stigma and discrimination against the mentally ill and the epileptic; and promote care seeking for cancer screening services | | | | | | 26,700,000.00 |
| | Produce TV programmes on dangers of parents abusing alcohol, driving while intoxicated, smoking and using drugs (marijuana); promote healthy exercises; promote care seeking for psychological and mental problems while discouraging stigma and discrimination against the mentally ill and the epileptic; and promote care seeking for cancer screening services | | | | | | 450,000.00 |
| | Air TV programmes on dangers of parents abusing alcohol, driving while intoxicated, smoking and using drugs (marijuana); promote healthy | | | | | | 26,700,000.00 |

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| | exercises; promote care seeking for psychological and mental problems while discouraging stigma and discrimination against the mentally ill and the epileptic; and promote care seeking for cancer screening services | | | | | | |
| Neglected tropical diseases (NTDs)-Schistosomiasis | Develop messages and materials on dangers of swimming and bathing in stagnant water and allowing children to do the same, urinating and defecating in and around water sources, improper disposal of faeces (parents and children), drinking unclean water and poor health seeking behaviour | | | | | | 9,543,000.00 |
| | Develop materials on dangers of swimming and bathing in stagnant water and allowing children to do the same, urinating and defecating in and around water sources, improper disposal of faeces (parents and children), drinking unclean water and poor health seeking behaviour | | | | | | 9,000,000.00 |
| | Print promotional materials on dangers of swimming and bathing in stagnant water and allowing children to do the same, urinating and defecating in and around water source improper disposal of faeces (parents and children), drinking unclean water and poor health seeking behaviour | | | | | | 16,800,000.00 |
| | Distribute promotional materials on dangers of swimming and bathing in stagnant water and allowing children to do the same, urinating and defecating in and around water sources, improper disposal of faeces (parents and children), drinking unclean water and poor health seeking behaviour | | | | | | 3,300,000.00 |
| | Produce radio programmes on dangers of swimming and bathing in stagnant water and allowing children to do the same, urinating and defecating in and around water | | | | | | 450,000.00 |

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| | sources improper disposal of faeces (parents and children), drinking unclean water and poor health seeking behaviour | | | | | | |
| | Air radio programmes on dangers of swimming and bathing in stagnant water and allowing children to do the same, urinating and defecating in and around water sources, improper disposal of faeces (parents and children), drinking unclean water and poor health seeking behaviour | | | | | | 26,700,000.00 |
| | Produce TV programmes on dangers of swimming and bathing in stagnant water and allowing children to do the same, urinating and defecating in and around water sources, improper disposal of faeces (parents and children), drinking unclean water and poor health seeking behaviour | | | | | | 450,000.00 |
| | Air TV programmes on dangers of swimming and bathing in stagnant water and allowing children to do the same, urinating and defecating in and around water so, improper disposal of faeces (parents and children), drinking unclean water and poor health seeking behavior | | | | | | 26,700,000.00 |
| Eye, Ear and Skin Infections | Develop messages and materials on dangers of insufficient personal hygiene practices including not washing hands and face regularly, keeping surroundings not sufficiently clean; and benefits of getting prompt treatment for sore eyes, blurred vision, pain or discharge from the ear and itchy, or rash on the skin. | | | | | | 9,543,000.00 |
| | Develop materials on dangers of insufficient personal hygiene practices including not washing hands and face regularly, keeping surroundings not sufficiently clean; and benefits of getting prompt treatment for sore eyes, blurred vision, pain or discharge from the ear and itchy, or rash on the skin. | | | | | | 9,000,000.00 |

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| | Print materials on dangers of insufficient personal hygiene practices including not washing hands and face regularly , keeping surroundings not sufficiently clean; and benefits of getting prompt treatment for sore eyes, blurred vision, pain or discharge from the ear and itchy, or rash on the skin. | | | | | | 16,800,000.00 |
| | Distribute materials on dangers of insufficient personal hygiene practices including not washing hands and face regularly, keeping surroundings not sufficiently clean; and benefits of getting prompt treatment for sore eyes, blurred vision, pain or discharge from the ear and itchy, or rash on the skin. | | | | | | 3,300,000.00 |
| | Produce radio programmes on dangers of insufficient personal hygiene practices including not washing hands and face regularly, keeping surroundings not sufficiently clean; and benefits of getting prompt treatment for sore eyes, blurred vision, pain or discharge from the ear and itchy, or rash on the skin. | | | | | | 450,000.00 |
| | Air radio programmes on dangers of insufficient personal hygiene practices including not washing hands and face regularly, keeping surroundings not sufficiently clean; and benefits of getting prompt treatment for sore eyes, blurred vision, pain or discharge from the ear and itchy, or rash on the skin. | | | | | | 26,700,000.00 |
| | Produce TV programmes on dangers of insufficient personal hygiene practices including not washing hands and face regularly, keeping surroundings not sufficiently clean; and benefits of getting prompt treatment for sore eyes, blurred vision, pain or discharge from the ear and itchy, or rash on the skin. | | | | | | 450,000.00 |
| | Air TV programmes on dangers of | | | | | | 26,700,000.00 |

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| | insufficient personal hygiene practices including not washing hands and face regularly, keeping surroundings not sufficiently clean; and benefits of getting prompt treatment for sore eyes, blurred vision, pain or discharge from the ear and itchy, or rash on the skin. | | | | | | |
| Neglected tropical diseases (NTDs)- Lymphatic Filariasis (Elephantiasis) | Develop messages and materials on consequences of not preventing mosquito bites and not seeking medical attention promptly | | | | | | 9543,000.00 |
| | Develop materials on consequences of not preventing mosquito bites and not seeking medical attention promptly | | | | | | 2,000,000.00 |
| | Print materials on consequences of not preventing mosquito bites and not seeking medical attention promptly | | | | | | 16,800,000.00 |
| | Distribute materials on consequences of not preventing mosquito bites and not seeking medical attention promptly | | | | | | 3,300,000.00 |
| | Produce radio programmes on consequences of not preventing mosquito bites as well as children, and not seeking medical attention promptly | | | | | | 450,000.00 |
| | Air radio programmes on consequences of not preventing mosquito bites and not seeking medical attention promptly | | | | | | 26,700,000.00 |
| | Produce TV programmes on consequences of not preventing mosquito bites and not seeking attention promptly medical | | | | | | 450,000.00 |
| | Air TV programmes on consequences of not preventing medical mosquito bites and not seeking attention diseasespromptly | | | | | | 26,700,000.00 |

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| | Sensitize local leaders on consequences of not preventing mosquito bites and not seeking medical attention promptly | | | | | | 140,000,000.00 |
| | Conduct drama performances on consequences of not preventing mosquito bites and not seeking medical attention promptly | | | | | | 84,000,000.00 |
| Neglected tropical Trypanosomiasis (Sleeping sickness) | Develop messages and materials on the dangers of not preventing tsetse bites (for adults and children), and of not seeking medical attention promptly for parents and their children | | | | | | 3,000,000.00 |
| | Develop materials on the dangers of not preventing tsetse bites (for adults and children; and benefits of seeking medical attention promptly for parents and their children | | | | | | 9,000,000.00 |
| | Print materials on dangers of not preventing tsetse bites (for adults and children); and benefits seeking medical attention promptly for parents and their children | | | | | | 16,800,000.00 |
| | Distribute materials on dangers of not preventing tsetse bites (for adults and children) and benefits of seeking medical attention promptly for parents and their children | | | | | | 3,300,000.00 |
| | Produce radio programmes on the dangers of not preventing tsetse bites (for adults and children); and benefits of seeking medical attention promptly for parents and their children | | | | | | 450,000.00 |
| | Air radio programmes on dangers of not preventing tsetse bites for adults and children); and benefits of seeking medical attention promptly for parents and their children | | | | | | 26,700,000.00 |
| | Produce TV programmes on the dangers of not preventing tsetse bites for adults and children); | | | | | | 450,000.00 |

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| | and benefits of seeking medical attention promptly for parents and their children | | | | | | |
| | Air TV programmes on the dangers of not preventing tsetse bites for adults and children); and benefits of seeking medical attention promptly for parents and their children | | | | | | 26,700,000.00 |
| | Sensitize local leaders and communities on the dangers of not preventing tsetse bites for adults and children); and benefits of seeking medical attention promptly for parents and their children | | | | | | 140,000,000.00 |
| Acute Respiratory Infections (ARI) | Develop messages and materials on dangers of insufficient hygiene and hand washing practices, using wood fuel indoor with poor ventilation, and late health seeking behaviour | | | | | | 9,543,000.00 |
| | Develop materials on dangers of insufficient hygiene and hand washing practices, using wood fuel indoor with poor ventilation, and late health seeking behaviour | | | | | | 2,000,000.00 |
| | Print materials on dangers of insufficient hygiene and hand washing practices, using wood fuel indoor with poor ventilation, and late health seeking behaviour | | | | | | 16,800,000.00 |
| | Distribute print materials on dangers of insufficient hygiene and hand washing practices, using wood fuel indoor with poor ventilation, and late health seeking behaviour | | | | | | 3,300,000.00 |
| | Conduct open days on dangers of insufficient hygiene and hand washing practices, using wood fuel indoor with poor ventilation, and late health seeking behaviour | | | | | | 448,000,000.00 |
| | Orient drama groups on the dangers of insufficient hygiene and hand washing practices, using wood fuel indoor with poor ventilation, and late | | | | | | 20,000,000.00 |

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| | health seeking behaviour | | | | | | |
| | Conduct drama performances on the dangers of insufficient hygiene and hand washing practices, using wood fuel indoor with poor ventilation, and late health seeking behaviour | | | | | | 84,000,000.00 |
| **ADOLESCENTS** | | | | | | | |
| HIV & AIDS | Develop /adapt life skills training materials | | | | | | 4,151,500.00 |
| | Print life skills training materials | | | | | | 2,000,000.00 |
| | Conduct TOT training for community life skills trainer | | | | | | 174,300,000.00 |
| | Conduct adolescent life skills training | | | | | | 781,550,482.00 |
| | Develop health promotion materials for adolescents | | | | | | 42,066,900.00 |
| | Collect/develop adolescent materials for television and radio | | | | | | 84,698,494.34 |
| | Feature TV and radio programmes for adolescents | | | | | | 48,840,800.00 |
| | Orientation of traditional leaders on rites that may put adolescents at risk of HIV and AIDS | | | | | | 38,987,779.11 |
| | Conduct meetings with religious leaders on protecting adolescents from HIV and AIDS | | | | | | 38,987,779.11 |
| | Conduct community open days | | | | | | 201,468,300.00 |
| | Conduct supportive supervision | | | | | | 52,711,433.40 |
| Malaria | Develop/collect materials for television and radio on malaria | | | | | | 84,698,494.34 |
| | Feature TV and radio malaria programmes for adolescents | | | | | | 48,840,800.00 |
| | Promote malaria dialogue for adolescents on social media. | | | | | | 1,465,224.00 |

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| | Train HSAs on malaria issues for adolescents | | | | | | 451,997,183.60 |
| | Conduct community meetings with adolescents | | | | | | 27,219,588.35 |
| Peri-natal conditions and Family Planning | Develop /adapt life skills training materials | | | | | | 4,000,000.00 |
| | Conduct adolescent life skills training | | | | | | 60,000,000.00 |
| | Conduct TOT training for community life skills trainers | | | | | | 35,000,000.00 |
| | Develop health promotion materials for adolescents | | | | | | 17,086,400.00 |
| | Conduct meetings with parents to promote sex discussions between parents and children. | | | | | | 72,821,632.80 |
| | Collect/develop adolescent materials for TV and radio | | | | | | 84,698,494.34 |
| | Feature TV and radio programmes for adolescents | | | | | | 48,840,800.00 |
| | Advocate for youth friendly services in health facilities | | | | | | 64,518,696.80 |
| Diarrhoeal diseases (WASH) | Conduct TV and radio campaign on importance of hand washing | | | | | | 18,555,250.00 |
| | Conduct community campaign on hand washing through drama & band performances | | | | | | 187,302,360.00 |
| Malnutrition | Collect/develop TV and radio materials on healthy diet | | | | | | 55,564,354.34 |
| | Feature TV and radio programmes on healthy diet. | | | | | | 32,040,800.00 |
| Tuberculosis (TB) | Collect/develop TV and radio materials on TB | | | | | | 55,564,354.34 |
| | Feature TB TV and radio programmes. | | | | | | 32,040,800.00 |
| | Conduct community meetings with adolescents on TB | | | | | | 142,525,488.60 |

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| | Orient teachers on TB | | | | | | 122,580,090.60 |
| | Conduct TB education to adolescents in schools | | | | | | 67,509,965.60 |
| | Develop promotional materials for adolescents | | | | | | 9,625,852.50 |
| | Conduct community drama performances | | | | | | 29,845,200.00 |
| | Conduct band performances | | | | | | 143,085,600.00 |
| Non-communicable diseases (including cancers, mental illness and epilepsy | Conduct TOT training for community life skills trainers | | | | | | 35,000,000.00 |
| | Develop life skills training materials | | | | | | 4,000,000.00 |
| | Conduct adolescent life skills training | | | | | | 60,000,000.00 |
| | Develop adolescent materials for television and radio | | | | | | 84,698,494.34 |
| | Feature television and radio programmes for adolescents | | | | | | 48,840,800.00 |
| | Develop health promotion materials for adolescents on NCDs | | | | | | 42,066,900.00 |
| | Orient teachers on NCDs | | | | | | 186,852,690.60 |
| Neglected tropical diseases (NTDs)-Schistosomiasis | Conduct community awareness campaigns in affected areas through drama and band performances | | | | | | 226,635,855.60 |
| | Produce Schistosomiasis health promotion materials | | | | | | 9,625,852.50 |
| | Advocate for clean water through TV and radio programmes | | | | | | 32,040,800.00 |
| Neglected tropical diseases (NTDs)-Lymphatic Filariasis (Elephantiasis | Conduct community awareness campaigns in affected areas through drama and band performances | | | | | | 226,635,855.60 |
| | Produce Elephantiasis health promotion materials | | | | | | 9,625,852.50 |
| | Conduct TV and radio programmes | | | | | | 32,040,800.00 |

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| | Conduct video shows in communities | | | | | | 255,013,362.72 |
| Neglected tropical diseases (NTDs)- Trypanosomiasis (Sleeping sickness) | Conduct community awareness campaigns in affected areas through drama and band performances | | | | | | 226,635,855.60 |
| | Produce Trypanosomiasis health promotion materials | | | | | | 9,625,852.50 |
| | Conduct TV and radio programmes | | | | | | 20,328,000.00 |
| | Conduct video shows in communities | | | | | | 161,790,955.20 |
| Acute Respiratory Infections (ARI) | Conduct community awareness campaigns in affected areas through drama and band performances | | | | | | 226,635,855.60 |
| | Produce Trypanosomiasis health promotion materials | | | | | | 9,625,852.50 |
| | Conduct TV and radio programmes | | | | | | 20,328,000.00 |
| | Conduct video shows in communities | | | | | | 161,790,955.20 |
| Eye, Ear and Skin Infections | Conduct community awareness campaigns in affected areas through drama and band performances | | | | | | 226,635,855.60 |
| | Produce Eye, Ear and skin infections health promotion materials | | | | | | 9,625,852.50 |
| | Conduct TV and radio programmes | | | | | | 20,328,000.00 |
| **PARENTS OF YOUNGER CHILDREN (UNDER FIVE CHILDREN)** | | | | | | | |
| HIV/AIDS | Conduct dialogue sessions to couples on sex communication and male championship | | | | | | 36,691,200.00 |
| | Organize sporting activities and incorporate messages on comprehensive HIV package | | | | | | 8,072,000.00 |
| | Conduct orientation of Extension workers in couple communication messages & comprehensive HIV package | | | | | | 4, 884,800.00 |
| | Conduct sensitization meetings with opinion leaders in male involvement | | | | | | 4,930,800.00 |
| | Air messages on male involvement, ART adherence and couple communication | | | | | | 6,600,000.00 |

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| | Conduct demand creation on comprehensive HIV package through band shows | | | | | | 18,027,000.00 |
| | Conduct demand creation on comprehensive HIV package through Video shows | | | | | | 22,269,600.00 |
| | Message and material development workshop(Video, Posters & leaflets) in Male participation ,ART adherence | | | | | | 11,946,000.00 |
| Malaria | Develop messages on consistent use of bed nets by parents & early health seeking in case of malaria. | | | | | | 5,630,500.00 |
| | Air messages on consistent use of bed nets by parents & early health seeking in case of malaria. | | | | | | 3,490,000.00 |
| | Conduct BCC village level meetings in malaria signs and other cultural beliefs | | | | | | 41,049,200.00 |
| | Develop a video clip in malaria especially early health seeking | | | | | | 4,924,800.00 |
| | Conduct community filming using the developed Video clip on early health seeking, adherence and consistent net usage | | | | | | 14,436,800.00 |
| | Conduct road shows using live band on early health seeking, adherence and consistent net usage | | | | | | 13,977,600.00 |
| Peri-natal conditions and Family Planning | Conduct dialogue sessions to couples on FP, sex communication and male championship | | | | | | 20,899,200.00 |
| | Form and orient secret mothers to track first trimester pregnancies | | | | | | 16, 350,000.00 |
| | Conduct village meetings to orient them on the roles of secret mothers | | | | | | 2 ,775,200.00 |
| | Conduct sensitization meetings with opinion leaders in male involvement FP | | | | | | 14,938,000.00 |
| | Air messages on male involvement, FP and couple communication | | | | | | 16,600 000.00 |

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| | Conduct demand creation on FP package through band shows | | | | | | 17,847,000.00 |
| | Conduct demand creation on FP& MCH package through Video shows | | | | | | 25,142,400.00 |
| | Message and material development workshop (Video, Posters & leaflets) | | | | | | 11,946,000.00 |
| Diarrhoea/WASH | Conduct village level meetings on hand washing | | | | | | 6,608,000.00 |
| | Develop and reprint WASH materials and then distribute | | | | | | 14,664,000.00 |
| | Develop and air messages (print &electronic) in hand washing & diarrhea (Cholera) | | | | | | 16,524,500.00 |
| | Conduct dialogue sessions with parents on need to teach and monitor children for hand washing | | | | | | 4,930,800.00 |
| Malnutrition | Develop, reprint messages on six food groups, complementary feeds | | | | | | 4,524,500.00 |
| | Conduct nutrition open days to demonstrate six food group | | | | | | 53,064,000.00 |
| | Sensitize communities on junk food to children through band (road)show | | | | | | 12,476,200.00 |
| Tuberculosis (TB) | Conduct interactive drama performances involving local artists (Drama, music bands, Poets) in TB | | | | | | 16,884,800.00 |
| | Air messages on TB and available treatment, adherence | | | | | | 16,600,000.00 |
| Non-Communicable diseases (Including cancers, mental illness & Epilepsy) | Conduct sensitization meetings on dangers of abusing alcohol, drink & drive | | | | | | 9,508,800.00 |
| | Conduct dialogue session with the elite | | | | | | 16,432,000.00 |
| | Develop messages on psychological and mental problems | | | | | | 6,516,000.00 |
| | Produce and pre-test materials | | | | | | 1,410,000.00 |

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| | Air messages on psychological and mental problems | | | | | | 40,466,800.00 |
| Acute Respiratory Infections (ARI) | Develop messages in ARI | | | | | | 3,228,000.00 |
| | Produce and air ARI messages | | | | | | 16,400,000.00 |
| | Write a script and produce video clip in ARI | | | | | | 1,317,200.00 |
| | Train local theatre groups in ARI messages | | | | | | 21,455,000.00 |
| | Perform drama shows | | | | | | 30,072,000.00 |
| | Monitor and supervise drama performances. | | | | | | 7,526,400.00 |
| COMMUNICATION EQUIPMENT | | | | | | | |
| Procurement of equipment | Purchase laptops (34) | | | | | | 13,600,000.00 |
| | Purchase desktop computers (28) | | | | | | 12,600,000.00 |
| | Purchase motor-cycles (29) | | | | | | 203,000,000.00 |
| | Purchase printers (2) | | | | | | 600,000.00 |
| | Purchase vehicles (3) | | | | | | 75,000,000.00 |
| TOTAL BUDGET | | | | | | | |
| Total in Kwacha: | | | | | | | 15,007,904,097 |
| Total in USD: | | | | | | | 21,877,41.22 |

## Annex 2: Consultative Meeting participant list

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|---|---|
| S. Kabuluzi | Director (Preventive Health Services) |
| Fayyaz Khan | SSDI-Communication |
| Hector Kamkwamba | Deputy Director PHS (Health Education Services) |
| Thomas Ofem | SSDI-Communication |
| Dennis Chimenya | UNICEF |
| Humphrey Masuku | Deputy Director PHS (Environmental Health) |
| Triza Hara | BRIDGE II |
| Gavelet Mzembe | SSDI-Communication |
| Rhoda Banda | MOH-TB Program |
| Ben Chirwa | HES/SSDI |
| Alinafe Kasiya | SSDI-Communication |
| Jane Brown | JHU·CCP |
| Fredson Kamcira | HES |
| Ella Chamanga | HES |
| Adrian Chikumbe | HES |
| M. Mbang'ombe | Epidemiologist |

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| Tobias Kunkumbira | HES |
| Chancy Mauluka | SSDI-Communication |
| S. Mkwanda | NTDs |
| Shadreck Mulenga | Malaria |
| Grace T. Soko | CHAM |
| Dziko Chatata | SSDI-Communication |
| Chris Teleka | NAC |

## Annex 3: References

### Policies and Strategies


Government of Malawi, *Health Promotion Policy, June 2013.*

Government of Malawi, *Malawi Growth and Development Strategy, 2006.*

Government of Malawi, *Malawi Decentralisation Policy, No date.*

Government of Malawi, *National Hand Washing Campaign 2011-2012, 2011.*

Government of Malawi, *National Nutrition and Education Communication Strategy, 2011.*

Ministry of Health, *The Joint Programme of Work (POW) 2004-2010 Communication Strategy for Health Sector Reform, Malawi, April 2004.*

Ministry of Health, *Malawi Health Sector Strategic Plan 2011-2016, 2011.*

Millennium Development Goals 2000-2015. http://www.un.org/millenniumgoals/

Ministry of Health, *National Malaria Communication Strategy for Malawi 2009-2014, 2009.*

Support for Service Delivery Integration-Communication, *Social and Behavior Change Strategy, 2013.*

WHO, Health and Welfare Canada, Canadian Public Health Association, *Ottawa Charter for Health Promotion, First International Conference on Health Promotion, 1986.*
WHO Africa Regional Office, Health Promotion: *Strategy for the African Region, 2012.*


### Health Behavior and Promotion Theory and Research


Berkman LF, Kawachi I. *A historical framework for social epidemiology.* In: Berkman LF, Kawachi I, eds. Social epidemiology. New York: Oxford University press, 2000: 3–12.

Kreiger, N. *Theories for Social Epidemiology in the 21rst Century: an Ecological Perspective.* International Journal of Epidemiology, 2001: 30, 668-677.

Rimal, R. *Modeling the Relationship Between Descriptive Norms and Behaviors: A Test and Extension of the Theory of Normative Social Behavior* (TNSB) 2008

Witte, K. Putting the fear back into fear appeals: The extended parallel process model. Communication Monographs, Volume 59, Issue 4, 1992.

**Malawi General Demographic and Health Information**

Central Intelligence Agency, The World Factbook: Malawi. Washington, DC, 2013.
https://www.cia.gov/library/publications/the-world-factbook/geos/mi.html

Government of Malawi, Health Management Information System (HMIS), 2011

Government of Malawi, MDG Endline survey, 2014

Government of Malawi, National Economic Council, Malawi Vision 2020, 1998.
http://wwwsdnp.org.mw/malawi/vision-2020

Johns Hopkins Center for Communication Programs (JHU-CCP). (2013a).
*Support for Service Delivery Integration-communication (SSDI-Communication): Findings from the 2012 baseline survey of 15 districts in Malawi.*
Baltimore, MD: Carol Underwood.

Johns Hopkins Center for Communication Programs (JHU-CCP). (2013b).
*Perceptions regarding healthy and unhealthy families: Formative research findings from selected districts in Malawi. Baltimore,* MD: Carol Underwood.

Malawi College of Medicine, Burden of Disease Study, 2006.

Malawi National Statistics Office, ICF Macro. 2011. Malawi Demographic and Health Survey 2011.
http://dhsprogram.com/pubs/pdf/FR247/FR247.pdf

Malawi National Statistics Office, Malawi Population Data Sheet, 2012.
http://www.nsomalawi.mw/images/stories/data_on_line/demography/census_2008/Malawi%20Population%20Data%20Sheet%202012.pdf

Malawi National Statistics Office, *Population and Housing Census,* 2009.

Ministry of Health, *Malawi Health Management Information Bulletin*, 2013.

Ministry of Health, Department of Planning. A Joint Programme of Work for a Health Sector Wide Approach (2004-2010), Republic of Malawi. December 2004.

UNICEF, Malawi Statistics, 2013.
http://www.unicef.org/infobycountry/malawi_statistics.html#114

World Health Organization, Malawi: Health Profile.
http://www.who.int/gho/countries/mwi.pdf?ua=1

World Health Organization, Malawi Factsheets of Health Statistics, 2010.
Http://aho.afro.who.int/profiles_information/images/d/d8/Malawi-statistical_factsheet.pdf?ua=1

World Health Organization, WHO African Region, Malawi Statistics Summary (2002-present), 2013.
http://apps.who.int/gho/data/node.country.country-MWI

**Malaria**

Chibwana, A.I., Mathanga, D.P., Chinkhumba, J., & Campbell, C.H. (2009). Socio-cultural predictors of health-seeking behavior for febrile under-five children in Mwanza-Neno district, Malawi. *Malaria Journal,* 8: 219-227.

Menaca, A., Pell, C., Manda-Taylor, L., Chatio, S., Afrah, N.A., Were, F.,... Pool, R. (2013). Local illness concepts and their relevance for the prevention and control of malaria during pregnancy in Ghana, Kenya and Malawi: findings from a comparative qualitative study. *Malaria Journal, 12,* 257- 271.

National Malaria Control Programme (NMCP) [Malawi] and ICF International. (2012). *Malawi Malaria Indicator Survey (MIS)* 2012. Lilongwe, Malawi, and Calverton, Maryland, USA: NMCP and ICF International.

Pell, C., Menaca, A., Afrah, N.A., Manda-Taylor, L., Chatio, S., Were, F., ... Pool, R. (2013). Prevention and management of malaria during pregnancy: Findings from a comparative qualitative study in Ghana, Kenya, and Malawi. *Malaria Journal,* 12, 427-440.;
President's Malaria Initiative. 2013. Malawi Malaria Operational Plan FY 2013.
http://www.pmi.gov/countries/mops/fy13/malawi_mop_fy13.pdf

Rosato, M., Mwansambo, C.W., Kazembe, P.N., Phiri, T., Soko, Q.S., Lewycka, S., ... de L Costello, A.M. (2006). *Lancet*, 386, 1189-1188.

**HIV/AIDS**

Government of Malawi, 2012 Global AIDS Response Progress Report: Malawi Country Report for 2010 and 2011, 2012
http://www.unaids.org/en/dataanalysis/knowyourresponsecountryprogressreports/2012countries/ce_MW_Narrative_Report[1].pdf

Malawi Government, Global AIDS Response Progress Report: Malawi Country Report for 2010 and 2011. 2012.
http://www.unaids.org/en/dataanalysis/knowyourresponsecountryprogressreports/2012countries/ce_MW_Narrative_Report[1].pdf

National AIDS Commission & Reproductive Health Unit, National *Behaviour Change Interventions Strategy for HIV/AIDS and Sexual Reproductive Health,* April 2003.

Office of the President and Cabinet, National AIDS Commission. *A Call to Renewed Action: National HIV/AIDS Policy.* October 2003.

UNAIDS. 2012. HIV and AIDS Estimates (2012), Malawi.
http://www.unaids.org/en/regionscountries/countries/malawi/

UNAIDS. 2009. Epidemiological Fact Sheet on HIV and AIDS, 2009, Malawi.
http://www.unaids.org/en/regionscountries/countries/malawi/

UNAIDS, UNICEF and USAID, *Children on the Brink,* 2002.

**Maternal and Child Health**

UN Inter-agency Group for Child Mortality Estimation, *Levels and Trends in Child Mortality Report,* 2013.
http://www.childinfo.org/files/Child_Mortality_Report_2013.pdf

**Hygiene, Sanitation, and Diarrhea**

Munthali, Alister, *Knowledge, Attitudes and Perceptions Study on Immunisations and Diarrhoea,* 2012.

**Vaccine-Preventable Diseases**

GAVI Alliance, *Malawi to Protect Thousands of Children's Lives with Rotavirus Vaccines,* 2012.

http://gavialliance.org/library/news/press-releases/2012/malawi-protect-thousands-children-lives-rotavirus-vaccines

Government of Malawi, *Annual Progress Report submitted to the GAVI Alliance*, 2012
http://www.gavialliance.org/Country/Malawi/Documents/APRs/Annual-progress-report-Malawi-2012

WHO, Integrated Disease Surveillance and Response (IDSR) Report, 2009.
http://www.afro.who.int/en/downloads/doc_download/5796-idsr-epidemiological-report-july-2010.html

WHO, Analytical Summary, Immunization and Vaccines Development, 2014.
http://www.aho.afro.who.int/profiles_information/index.php/Malawi:Analytical_summary_-_Immunization_and_vaccines_development

**Non-Communicable Diseases (Cancer, Diabetes, Cardiovascular Diseases, Trauma)**

Dalal S, Beunza JJ, Volmink J, Adebamowo C, Bajunirwe F, Njelekela M, Mozaffarian D, Fawzi W, Willett W, Adami HO, Holmes MD: Non-communicable diseases in sub-Saharan Africa: what we know now. 2011.

Department for International Development, London, Via the World Health Organization Regional Office for Africa. Malawi Country Profile, Non-Communicable Diseases and conditions, 2005.
http://www.aho.afro.who.int/profiles_information/index.php/Malawi:Analytical_summary_-_Non-communicable_diseases_and_conditions

Malawi Ministry of Health, World Health Organization. 2010. Malawi National STEPS Survey for Chronic Non-Communicable Diseases and their Risk Factors.

Msyamboza KP, Ngwira B, Dzowela T, Mvula C, Kathyola D, et al. (2011) The Burden of Selected Chronic Non-Communicable Diseases and Their Risk Factors in Malawi: Nationwide STEPS Survey. PLoS ONE 6(5): e20316. doi:10.1371/journal.pone.0020316

Msyamboza K.P.; Burden of cancer in Malawi; common types: National Population –based cancer registry, 2012.

United Nations Children's Fund, Via the World Health Organization Regional Office for Africa. Nd. *Malawi Country Profile, Non-Communicable Diseases and conditions (2010)*

United Nations Children's Fund. 2010. Via the World Health Organization Regional Office for Africa. Nd. Malawi Country Profile, Non-Communicable Diseases and conditions.

World Health Organization. 2011. Malawi NCD Country Profile.
http://www.who.int/nmh/countries/mwi_en.pdf?ua=1

World Health Organization. 2014. WHO Supported Road Safety Activities in Malawi.
http://www.who.int/violence_injury_prevention/road_traffic/countrywork/mwi/en/

World Health Organization Regional Office for Africa. 2009. Status Report on Road Safety in Countries of the WHO African Region.

**Mental Health and Epilepsy**

Crabb, J., Stewart, R.C., Kokota, D., Masson, N., Chabunya, S., Krishnadas, R. (2012), Attitudes toward mental illness in Malawi: a cross-sectional survey. BMC Public Health, 12:541.
http://www.biomedcentral.com/1471-2458/12/541

Department of Mental Health and Substance Abuse, World Health Organization. 2011. Mental Health Atlas 2011.
http://www.who.int/mental_health/evidence/atlas/profiles/mwi_mh_profile.pdf?ua=1&ua=1

Eide, A. and Loeb, M. ed.:The SINTEF survey 2004 of Disability Living Condition in Malawi, 2004
WHO *The role of WHO in the International Health Systems Agenda,* 2007

Leonard Cheshire Disability and Inclusive Development Centre. 2011. Research: Epilepsy in Malawi.
http://www.ucl.ac.uk/lc-ccr/centrepublications/workingpapers/WP15_Epilepsy_in_Malawi_research_report.pdf

Stewart, R. C., Umar, E., Kauye, F., Bunn, J., Vokhiwa, M., Fitzgerald, M., Tomenson, B., Rahman, A. and Creed, F. (2008), Maternal common mental disorder and infant growth – a cross-sectional study from Malawi. Maternal & Child Nutrition, 4: 209–219.
http://onlinelibrary.wiley.com/doi/10.1111/j.1740-8709.2008.00147.x/full

Silvestri, M. Growing mental health awareness in Malawi calls for more trained medical professionals. Journalists for Human Rights. 2012.
http://www.jhr.ca/blog/2012/02/growing-mental-health-awareness-in-malawi-calls-for-more-trained-medical-professionals/

**Neglected Tropical Diseases**

Kelias Msyamboza, Bagrey Ngwira, Richard Banda, Square Mkwanda, Bernard Brabin: Sentinel surveillance of Lymphatic filariasis, Schistosomiasis, Soil transmitted helminths and Malaria in rural southern Malawi, 2010

http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3345679/pdf/MMJ2201-0012.pdf

WHO/PAHO *Prevention, Control and Elimination of Neglected Diseases in the Americas: Pathways to integrated, Interprogrammatic, Intersectoral Action for Health and Development. 2000*

**Eye, Ear and Skin Infections**

A.D. Olusesi. Otitis media as a cause of significant hearing loss among Nigerians, International Journal of Pediatric Otorhinolaryngology, Volume 72, Issue 6, June 2008, Pages 787-792.
http://www.sciencedirect.com/science/article/pii/S0165587608000761

C. North-Matthiassen, S.A. Singh. The hearing profile among learners in schools in the Western Cape, South Africa, International Journal of Pediatric Otorhinolaryngology, Volume 71, Issue 1, January 2007, Pages 113-118.
http://www.sciencedirect.com/science/article/pii/S0165587606004010

Charles D Bluestone. Epidemiology and pathogenesis of chronic suppurative otitis media: implications for prevention and treatment, International Journal of Pediatric Otorhinolaryngology, Volume 42, Issue 3, January 1998, Pages 207-223.
http://www.sciencedirect.com/science/article/pii/S016558769700147X

International Coalition for Trachoma Control. 2011. The End In Sight: 2020 INSight.
http://trachoma.org/sites/default/files/guidesandmanuals/2020INSight_EnglishLR.pdf

Kalua, K., Chirwa, T., Kalilani, L., Abbenyi, S., Mukaka, M., Bailey, R. (2010), Prevalence and risk factors for trachoma in central and southern Malawi. PLoS ONE, 5(2): e9067.
http://www.plosone.org/article/info%3Adoi%2F10.1371%2Fjournal.pone.0009067

Sentinel surveillance of Lymphatic filariasis, Schistosomiasis, Soil transmitted helminths and Malaria in rural southern Malawi, March 2012.
http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3345679/pdf/MMJ2201-0012.pdf

World Health Organization. Nd. African Programme for Onchocerciasis Control, Country Profiles: Malawi.

World Health Organization Regional Office for Africa, World Health Organization Programme for the Prevention of Blindness and Deafness. 1995. Prevention of Hearing Impairment in Africa, Report of a Workshop.
http://apps.who.int/iris/bitstream/10665/68739/1/WHO_PDH_96.3.pdf?ua=1

World Health Organization. 2014. Media Centre: Onchocerciasis.

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