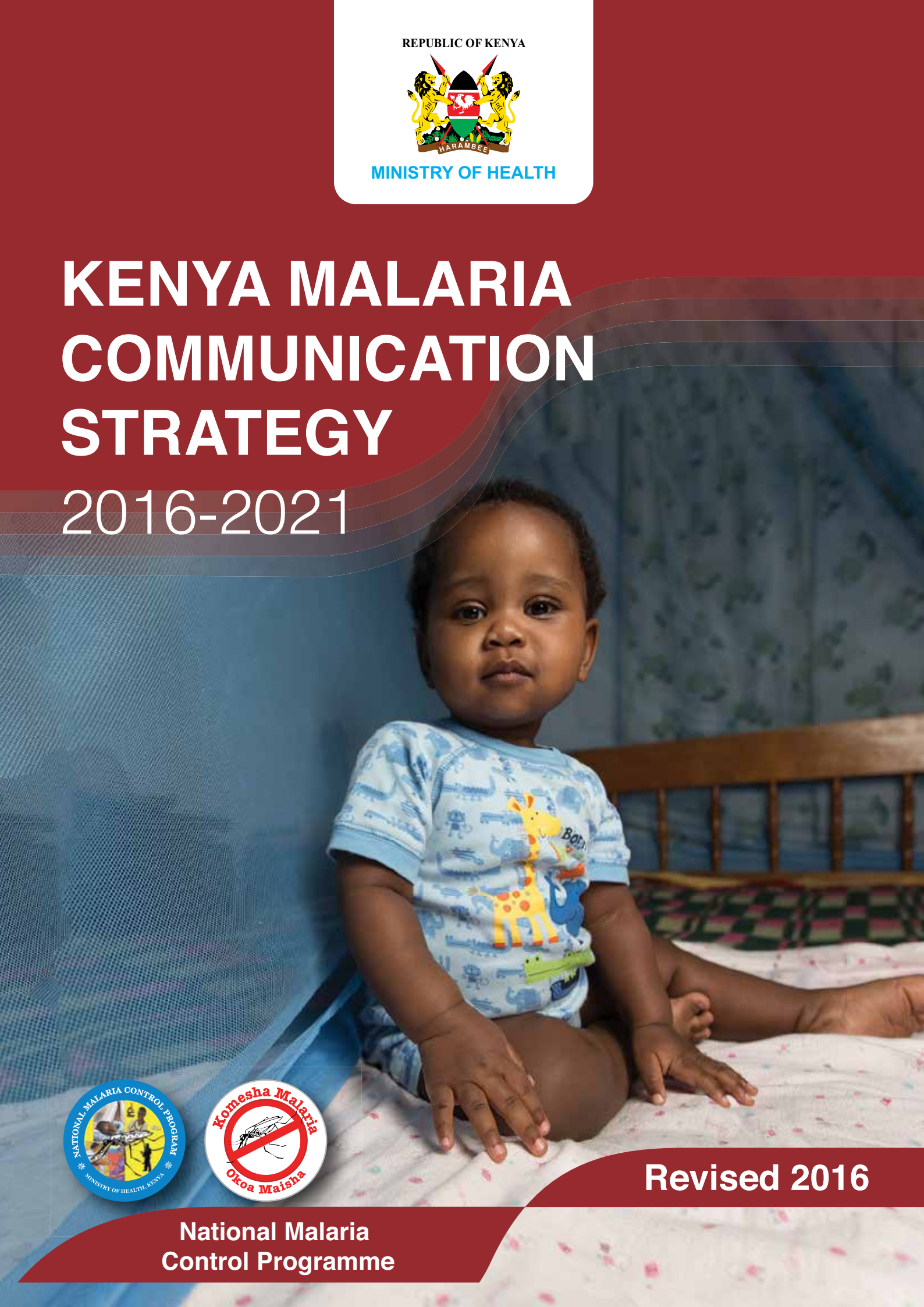
REPUBLIC OF KENYA

MINISTRY OF HEALTH

KENYA MALARIA COMMUNICATION STRATEGY 2016-2021



Revised 2016

National Malaria Control Programme

The Kenya Malaria Communication Strategy

2016–2021

National Malaria Control Programme
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Foreword

The Kenya Malaria Communication Strategy 2016 – 2021 is a product of the review of the Malaria Communication Strategy 2010-2014. This strategy is aligned to the Kenya Malaria Strategy (2009 -2018), the Global Technical Strategy for Malaria (2016 -2030), the Roll Back Malaria Partnership's Action and Investment plan to defeat Malaria (2016- 2030), The Strategic Framework for Malaria Communication at the Country Level 2012- 2017 and the Roll Back Malaria Partnership's BCC Indicators reference guide.

This document spells out the operational framework for advocacy, communication and social mobilization (ACSM) interventions in Kenya and has taken into account the achievements and gaps in the implementation of the MCS 2010-2014 and the changes of governance in the health sector. This strategy has maintained the vision, mission and goal of the KMS 2009-2018 by moving forward the spirit of objective 5 that is linked to malaria ACSM of increasing utilization of malaria control interventions by communities in Kenya to at least 80 percent by 2021. The revised strategy includes new stakeholders, articulates their roles and responsibilities and coordination mechanism.

We are confident that the strategy will play a key role in increasing uptake of malaria control interventions through the engagement and collaboration of multi-sector partners at both national and county levels. I urge all our partners to put their efforts into the implementation of this strategy as we move forward towards pre-elimination of malaria.

"Komesha Malaria Okoa Maisha"

Dr. Cleopa Mailu

Cabinet Secretary

Ministry of Health

Acknowledgement

The Malaria Communication Strategy has been developed through a series of consultative meetings involving development and implementing partners; CSO representatives and county health teams. The stewardship provided by Principal Secretary Dr. Nicholas Muraguri, the Head Department of Preventive and Promotive Health, Dr. Jackson Kioko, supported by the Head of Division of National Strategic Public Health Programmes, Dr. Joseph Sitinei and Head of National Malaria Control Program, Dr Waqo Ejersa is highly appreciated.

The members of the ACSM TWG who have participated in the discussions and giving feedback that have enriched the final product. Of special mention are our technical partners; WHO, PMI, PS Kenya, UNICEF, Malaria No More, ICF, PIMA, AMREF, CHAI, KEMRI and KeNAAM. We appreciate the participation of the Ministry of Health divisions, units and agencies including Health Promotion and Community Health. Appreciations, also go to Terry Muchoki (Independent Consultant) for coordinating and compiling the document as per all the stakeholders' inputs.

Financial support for the strategic review and drafting was provided by PMI/USAID through PS Kenya.

PS Kenya.

Dr. Nicholas Muraguri

Principal Secretary

Ministry of Health

Abbreviations

ACSM	Advocacy, communication and social mobilization
ACT	Artemisinin-based combination therapy
AL	Artemether Lumefantrine
ANC	Antenatal care
CHV	Community health volunteer
EMA	Essential Malaria Action Guide
FBO	Faith-based organization
GoK	Government of Kenya
HH	Household
HPAC	Health Promotion Advisory Committee
HPU	Health Promotion Unit
IEC	Information, Education and Communication
IPC	Interpersonal communication
IPTp	Intermittent Preventive Treatment in Pregnancy
IRS	Indoor residual spraying
KHSSP	Kenya Health Sector Strategic Plan
KMIS	Kenya Malaria Indicator Survey
KMS	Kenya Malaria Strategy
LLIN	Long-lasting insecticidal nets
LSM	Larval Source Management
M&E	Monitoring and evaluation
MOH	Ministry of Health
NMCP	National Malaria Control Program
RDT	Rapid diagnostic test
SBCC	Social behavior change communication
SP	Sulphadoxine-pyrimethamine
TWG	Technical working group
WHO	World Health Organization

Executive Summary

Malaria remains a public health problem in Kenya with about 70 percent of the population at risk of the disease. The Ministry of Health through the National Malaria Control Program has adopted the vision of achieving a malariafree Kenya. The revised Kenya malaria strategy 2009–2018 (KMS), the National malaria policy (2010) and the Kenya malaria monitoring and evaluation plan (2009–2018) provide the guiding framework for malaria control in Kenya towards accelerating the reduction of the burden of malaria and achieving the vision of a malaria-free Kenya.

The KMS 2009–2018 is hinged on six strategic objectives that lay out the key malaria control interventions: vector control (universal coverage of long lasting insecticidal nets in targeted areas; indoor residual spraying and larval source management; prevention of malaria in pregnancy), diagnosis and treatment, epidemic-preparedness and response as well as surveillance, monitoring, evaluation and operational research, advocacy, communication and social mobilization and program management. The KMS recognizes strategic communication as an integral component to achieve the vision of a malaria-free Kenya as outlined in its fifth strategic objective that seeks to increase the utilization of malaria interventions to 80 percent at household level through malaria advocacy, communication and social mobilization (ACSM) activities by 2021 through four strategic interventions:

1. Strengthen structures for the delivery of ACSM interventions at all levels.
2. Strengthen program communication for increased utilization of all malaria interventions
3. Advocate for inter-sector collaboration for malaria advocacy, communication and social mobilization:
4. Strengthen community based social and behavior change communication activities for all malaria interventions.

This Malaria communication strategy for Kenya 2016–2021 (MCS) has been developed to provide a framework within which advocacy, communication and social mobilization activities will be implemented to support the core strategies of the revised Kenya malaria strategy (2009–2018). It details in depth how the four strategic interventions above will be achieved.

The MCS 2016–2021 advocates coordinated implementation at two distinct but connected levels. At the national level, through a rejuvenated ACSM working group serving as the coordinating working group for all partners implementing malaria ACSM at the national level as well providing technical guidance to county level coordination and implementation of activities. In the counties, through health promotion advisory committees ensuring coordinated implementation, monitoring of ACSM, advocacy for resource allocation and pooling of resources.

The goal of the strategy is to implement a coordinated and effective program over the next five years, which will achieve change in behavior at different levels: political, service delivery, community and individual. Chapter 1 of the strategy provides background into the review process and development of the communication strategy. Chapters 2 and 3 outline the strategic directions, interventions and activities to address the key problems. Chapter 4 provides the implementation plan and coordination framework between national level ACSM and counties ACSM level while the Chapter 5 provides details of how ACSM activities will be monitored and evaluated towards tracking progress on the national target.

1 Review of the Malaria Communication Strategy 2010-2014

1.1 Background

The review of the Malaria communication strategy 2010–2014 (MCS) was informed by two emerging issues: the mid-term review of the Kenya malaria strategy 2009–2017; and the change in government structure that devolved power, roles and responsibilities – including the delivery of health services–to counties.

Mid-term review of the Kenya Malaria Strategy (2009–2018)

Following a mid-term review in 2014, the National malaria strategy for the period 2009–2017, has been revised into the current Kenya malaria strategy 2009–2018. This malaria strategy has been developed to guide malaria control interventions in the country with the aim to reduce malaria morbidity and mortality. The revision of the previous strategy was informed by the Kenya health sector strategic plan (2014 – 2018), the Kenya health policy (2012–2030), the new political dispensation that has devolved health some health roles and responsibilities from the national to county governments in line with the Constitution of Kenya (2010), the Global technical strategy for malaria (2016–2030) and the Roll Back Malaria Partnership's action and investment plan to defeat malaria (2016–2030).

The Kenya malaria strategy lays out the strategic framework for malaria control interventions, which hinge on six strategic Objectives:

Objective 1: To have at least 80 percent of persons in malaria risk areas using appropriate malaria preventive interventions by 2018.

Objective 2: To have all suspected malaria cases that present to a health provider managed in accord with National Malaria Treatment Guidelines by 2018.

Objective 3: To ensure that all sub counties in malaria epidemic and seasonal transmission zones have the capacity to detect and respond in a timely manner to malaria epidemics by 2018.

Objective 4: To ensure that all malaria indicators are routinely monitored, reported, and evaluated in all counties by 2018.

Objective 5: To increase utilization of all malaria control interventions by communities to at least 80 percent by 2018.

Objective 6: To improve capacity in coordination, leadership, governance, and resource mobilization at all levels towards achievement of the malaria program objectives by 2018. During the mid-term review of the Kenya malaria strategy in 2014, objective 5, which is linked to malaria advocacy, communication and social mobilization (ACSM), was reviewed and revised from

addressing knowledge of malaria control interventions (which had been achieved by over 90%) to increasing the use of malaria control interventions by communities in Kenya to at least 80 percent by 2018. This document builds on the strategic objective for ACSM in the Malaria communication strategy (2010–2014), to align it with the new strategic objective.

Devolution of government

The Constitution of Kenya (2010) mandates the devolution of power to 47 counties. Health service delivery was devolved to the counties, with limited functions remaining at the national level, making counties key actors in achievement of the vision of a malaria-free Kenya and, consequently, in achieving 80 percent utilization of malaria control interventions by 2018, as laid out in the Malaria communication strategy. These changes have also seen the Division of Malaria Control evolve into the Malaria Control Unit, and now the National Malaria Control Program.

1.2 Process

In May 2016, the National Malaria Control Program led the process of developing this malaria communication strategy that builds on the Malaria communication strategy (MCS) 2010–2014. The process entailed a desk study of available literature, in-depth interviews with key stakeholders and program implementers, as well as a stakeholder consultative workshop.

Developing this communication strategywas based on consensus among multiple stakeholders to ensure wide ownership. The review has been informed by the Kenya malaria strategy (2009–2018), the Global technical strategy for malaria (2016–2030), the Roll Back Malaria Partnership's action and investment plan to defeat malaria (2016– 2030), the Strategic framework for malaria

communication at the country level (2012– 2017), and the Roll Back Malaria Partnership's BCC indicators reference guide.

Developing this communication strategy entailed:

- Reviewing relevant malaria ACSM documents and survey reports to understand existing issues and challenges
- Undertaking key informant interviews with relevant stakeholders
- Conducting a consultative workshop in May 2016 at Naivasha with stakeholders drawn from the National Malaria Control Program, the ACSM technical working group and partners
- Drafting and circulating a zero draft of the communication strategy based on the literature review, key informant interviews and workshop report
- Convening an ACSM technical working group meeting in June 2016 with relevant partners to present the zero draft and receive comments for further review
- Revising the zero draft and developing a first draft based on comments received
- Subjecting the first draft to external peer review
- Presenting the second and third draft to stakeholders for validation
- Presenting the 3rd draft to the Malaria Interagency Committee

1.3 Literature Review Findings and Implications

The findings of the Kenya malaria indicator survey (2015) were used to develop the communication strategy. The main findings are highlighted below:

Malaria epidemiology

Kenya has four malaria epidemiological zones.

- **Highland epidemic zone:** this includes the western highlands of Kenya where malaria transmission is seasonal with considerable year-to-year variation; when climatic conditions are favorable malaria epidemics occur.
- **Endemic zone:** this zone includes areas around around Lake Victoria in western Kenya and the coastal region where malaria transmission is stable.
- **Semi-arid zone:** this zone includes the arid and semi-arid areas of the northern and south-eastern parts of the country that experience short periods of intense malaria transmission during rainy seasons.
- **Low risk zone:** this zone covers the central highlands of Kenya including Nairobi.

Implication: Malaria interventions are implemented selectively in the different epidemiological zones. This communication strategy will support targeted ACSM interventions that can be applied to each epidemiological zone.

Ownership and use of long lasting insecticidal nets (LLIN)

Ownership of LLINs has over the years been higher than use. However, between 2010 and 2015 there has been an increasing trend in LLIN use among pregnant women and children under 5 years. KMIS (2015) showed that household LLIN ownership stood at 63 percent with each household owning at least 1 LLIN; 40 percent of these households had at least

one LLIN for every two people - an indicator of universal coverage - who stayed in the house the previous night. In 2010, 39 percent of children under 5 slept under a LLIN the night before the survey compared to nearly more than half of the children in 2015. Among pregnant women, LLIN use has increased from 36 percent in 2010 to 58 percent in 2015. The overall usage of LLINs stood at 48 percent, with 56 percent of children below 5 years and 58 percent pregnant women having slept under an LLIN the previous night. Ninety percent of the respondents were confident of hanging up LLINs and knew the importance of sleeping under a LLIN. Sixty percent of the LLINs were in good condition.

Implication: The strategy advocates consistent communication around use of treated nets to address barriers hindering use of LLINs.

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Implication: The strategy advocates consistent communication around use of treated nets to address barriers hindering use of LLINs.

Prevention of malaria in pregnancy

Prevention of malaria during pregnancy targets all pregnant women in 14 malaria endemic counties. The women receive three doses of intermittent preventive treatment in pregnancy (IPTp) with Sulphadoxine-pyrimethamine (SP) during visits to antenatal clinic. KMIS (2015) showed that 94 percent of the respondents in the survey attended antenatal clinics during their last pregnancy; 56 percent of the respondents received at least two or more doses of IPTp while 38 percent receiving three or more doses. The report on knowledge, attitude, beliefs and practices on the 10 key child survival development and protective behaviour (KABP), 2016 stressed the fact that ANC coverage is lower among women who need it the most: the poor, less educated, and those living in rural areas. There is a common belief that pregnancy is often perceived as a natural process of life. This perception may make women, families and communities underestimate the importance of ANC. Studies reviewed in this report also suggested that the lack of knowledge about danger signs in pregnancy may make women and families not know how to seek care when a complication occurs during pregnancy.

Implication: The strategy aims to integrate messages that encourage pregnant women to attend antenatal clinic as soon as they discover they are pregnant to receive at least three or more doses of IPTP, as well as continue to leverage on the partnership with the department of reproductive health and other partners to increase uptake of IPTp.

Malaria Case Management

KMIS (2015) showed that 72 percent of the respondents sought advice on treatment during the onset of fever with 75 percent of these respondents visiting a public health facility while 18 percent sought treatment from a faith-based facility. Thirty-nine percent of those who sought treatment had a parasitology test carried out with 91 percent of the respondents reported having received artemisinin-based combination therapy, 60 percent received treatment on the same or the next day; 43 percent of the respondents could recognize the nationally recommended artemisinin-based combination therapy (ACT)/Artemether Lumefantrine (AL). Knowledge of ACT/AL among women declined slightly from 56 percent in 2010 to 53 percent in 2015. The National Malaria Control Program is undertaking projects aimed at increasing the use of rapid diagnostic tests in the private sector, and changing national policy to allow point-of-service testing at registered pharmacies. Pilot projects are also ongoing in the coastal counties of Kilifi, Kwale and Mombasa with the objective to increase access to use of rapid diagnostic tests through the private sector.

Implication: Because most respondents (75 percent) sought treatment from public health facilities, this communication strategy proposes the use of a two-pronged communication approach targeting both health workers and caregivers. Communication efforts for health workers as change agents will focus on ncreasing acceptance and use of malaria testing before treatment. For caregivers communication efforts will focus on prompt seeking behavior on onset of fever and request for malaria test.

Malaria and Anemia

The Kenya Population and Housing Census (2009) showed that 43 percent of the population is less than 15 years of age while KMIS (2015) results found that malaria prevalence to be high among the 5–9 year olds at 10 percent and the 10–14-years age bracket with 11 percent. Prevalence was also found to be high in the rural areas while the lake region had the highest prevalence at 27 percent and the coastal region at 8 percent.

Implication: Investing in communication in school health programs is critical in reducing high prevalence among the 5–14-years old school-going children. The NMCP has made initial efforts towards implementing school health programs in some counties. Results from these interventions will be critical in informing future school health interventions. More ACSM interventions will be concentrated in rural areas where malaria prevalence remains high.

Sources of Information

The KMIS 2015 shows that radio and television ownership stood at 70 percent and 36 percent respectively. An impressive 90 percent of the households interviewed owned a mobile phone. According to a report released by the Communication Authority of Kenya in 2015, radio, mobile phones and television are the leading sources of information in Kenya and will continue being so for communities in the coming years. In 2013 Kenya moved from analogue to digital broadcasting. Digital broadcasting saw a sharp rise in the number of TV stations. The report estimates there are 130 radio stations, 61 TV Stations on digital platform, 34 newspapers, 36.1 million mobile phone subscribers, 27.7 million mobile money subscriptions and 29.6 million internet users. Vernacular radio stations continue to shape the radio landscape with approximately 23.7 million listeners daily. The vibrant and solid media and ICT infrastructure in Kenya provide wide coverage for disseminating messages.

Implication: Radio and mobile telephony can be widely explored and continuously tracked to deliver the intended behavior change.

Literacy

The KMIS (2015) showed that 87 percent of the respondents were literate; however, literacy levels varied across different regions and counties.

Implication: Communication efforts will consider literacy levels in each region or county.

Gender

While children and pregnant women are biologically more susceptible to malaria, gender differences are compounded due to sociocultural norms and expectations that influence patterns of exposure, decision making, and economics. Neglecting the role that gender plays will undermine efforts to reach crucial milestones and improvements in the health of families and communities in Kenya. Understanding how gendered patterns of behavior influence exposure to mosquitoes, treatment decisions, and access to care can help in developing more effective recommendations for preventing malaria infection (WHO, 2007). KMIS 2015 indicated that 36 percent of households are headed by women. While this data is important in understanding decision making within the household, it does not explain the challenges female-headed homes face in accessing and using malaria control interventions.

Implication: With 36 percent of households headed by females, this communication strategy recognizes the important role women play in increasing the use of malaria interventions at household level.

1.4 Evaluation of Malaria Communication Strategy (2010–2014)

While developing this strategy, it was important to review the previous strategy in order to appreciate its achievements, challenges faced in its implementation and the lessons learnt. This section aims to leverage on the gains and make recommendations on overcoming challenges of the previous strategic period. During the mid-term review of the KMS in 2014, the ACSM objective was changed from increasing knowledge about malaria control interventions to utilizing malaria control interventions. ACSM interventions by the National Malaria Control Program and partners in the period after the review (2014– 2016) focused on utilization of malaria control interventions within the four key strategic interventions of the Kenya malaria strategy 2009–2018.

The ACSM objective in the National malaria strategy (2009–2017) aimed at "strengthening advocacy, communication and social mobilization (ACSM) capacities for malaria control to ensure that at least 80 percent of people in malarious areas had knowledge of prevention and treatment of malaria by 2014," and deployed three key strategies to achieve this objective:

- Strengthening the capacity for ACSM
- Developing appropriate advocacy
- for uptake of specific malaria
- interventions
- Conducting multi-sector IEC/BCC

Strategy 1: Strengthening the capacity for ACSM

Achievements

Working with partners, the National Malaria Control Program developed and disseminated the Malaria communication strategy (2010– 2014), the Essential malaria action (EMA) guidelines, the Community educators manual on Malaria, and the Teachers and pupils guide on malaria. Various partners have used these documents to guide delivery of content during implementation of interventions. Some partners made efforts to build the capacity of the ACSM unit and of health workers (both at the facility and in the community) through training in behavior change communication.

Gaps

- Malaria is a socioeconomic burden and requires sector wide participation. The engagement with the relevant non-health sectors was not optimally exploited.
- Counties continue to rely on central funding, with little resource mobilization being undertaken at that level.
- Where funding for ACSM activities exists, focus has primarily been on endemic zones with little support given to seasonal and low risk zones. The lack of a bare minimum ACSM package to ensure malaria infections in these seasonal and low risk areas remain low poses the risk of prevalence rising and hence, eroding the gains achieved.
- Weak coordination and reporting mechanism between the National Malaria Control Program and the county teams responsible for malaria control.
- The role of the health promotion unit in the ACSM thematic working group needs to be strengthened for malaria advocacy communication and social mobilizations to be sustainable in the country.
- The roles, responsibilities and membership of the national ACSM thematic working group have become blurred and erratic.

Strategy 2: Developing appropriate advocacy for uptake of specific malaria interventions

Achievements

Advocacy activities heightened around the World Malaria Day where stakeholders were rallied around the day's events. The office of the Malaria Goodwill Ambassador was established.

Gaps

- In the absence of an advocacy strategy to guide collaboration and resource mobilization, advocacy events have been limited and sporadic, and largely centered around World Malaria Day. This has denied the program the advantages of sustained advocacy efforts and therefore there has been no firm political will for malaria.
- The office of the Malaria Ambassador remained vacant denying the country the benefits this office could offer by lobbying for malaria action at the political level.
- Poor funding for the office of the Malaria Goodwill Ambassador led to little or no advocacy intervention within the political arena.

Strategy 3: Conducting multi-sector IEC/BCC

Achievements

The National Malarial Control Program implemented community-based malaria SBCC programs in 12 endemic and epidemic sub counties in western and Nyanza regions. The results show that household malaria indicators on use of interventions can be achieved by working through the community health strategy. NMCP through partners implemented branded behavior change communication campaigns on use of LLINs and prompt fever treatment– "Msimu wowote" and "Haraka Upesi"– at the community level in malaria endemic sub counties. These interventions were through radio and TV and interpersonal communication activities. An evaluation of SBCC interventions indicated that exposure to SBCC was strongly associated with net

use the previous night. Behaviour change interventions around indoor residual spraying and malaria in pregnancy were also undertaken. NMCP also conducted a pilot project to increase access to rapid diagnostic tests in the private sector. Innovative research interventions around the malaria vaccine and rapid diagnostic tests are on going.

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Gaps

- Uptake of the community health strategy and interpersonal communication in malaria ACSM was low; where they exist, reporting is poor with partners using varied reporting tools and channels that have no link to the national reporting mechanism.
- Limited translation into vernacular of ACSM messages to reach all target audiences.
- ACSM's focus was largely on communities (and largely women) with little or no effort or focus directed to health workers despite the constant provider– patient interface.
- ACSM funding for malaria in pregnancy was low. Low ACSM funding could lead to low uptake of IPTp doses.

1.5 Potential Challenges and Implications for Malaria Communication Strategy Implementation

Table 1 provides a summary of potential challenges (and implications) that could hinder implementation and achievement of positive outcomes of the revised Malaria communication strategy.

Table 1. Potential Challenges and Implications

Challenges	Implications
Weak links between the national and county malaria programs Inter-sector collaboration is weak nationally	• Low funding and prioritization of malaria ACSM activities • Poor delivery of ACSM interventions in counties • Poor allocation of limited resources for malaria at the community level as a result of duplication of partner activities • Over-reliance by county governments on funding from the National Malaria Control program for ACSM activities • Uncertainty in the devolution process regarding roles and responsibilities where malaria control might not be prioritized • Poor integration of health and non-health sectors resulting in low leverage of ACSM resources amongst partners that could potentially increase mileage for ACSM
The roles, responsibilities and membership of the ACSM TWG have become blurred and erratic	• Declining inter-sectoral collaboration
Low communication capacity among ACSM staff at NMCP	• Delayed ACSM technical assistance to counties
Absence of an active advocacy strategy	• Low funding and prioritization of malaria ACSM activities • Limited, inconsistent and sporadic advocacy events
Low uptake of the community health strategy in delivery of malaria interventions at household level as well as lack of understanding of interpersonal communication	• Low behaviour change at the household level—cultural barriers such as taboos and misconceptions around malaria remain challenges to prevention and care seeking in rural communities
Partners have varied monitoring and reporting tools that have no link to the national reporting mechanism. Low or no documentation of best practices.	• Difficulty in showing attribution • Apathy in funding ACSM activities • Lessons learnt cannot easily be integrated into subsequent • interventions
Low capacity and commitment of health workers on ACSM	• Poor delivery at the point of contact in the health facilities and in homes
Underutilized school health program where children can be used as change agents for malaria control	• Increasing prevalence among children age 5–14 years
Low funding for malaria in pregnancy ACSM activities	• Malaria in pregnancy ACSM outcomes may continue to lag

1.6 Problem Statement

Based on the situation analysis and review of the communication gaps and needs assessment, the core problem for malaria ACSM in Kenya that this malaria communication strategy seeks to address is captured in the statement below:

Despite increased access to malaria control interventions by communities in Kenya, use and prioritization of malaria interventions remain low at community and household s due to suboptimal implementation of malaria ACSM activities as a result of weak links administrative units between national and county levels coupled with inadequate capacity and skills in ACSM among program and health workers, in addition to low funding of ACSM activities.

2 Malaria Communication Strategy

2.1 Goal of the Communication Strategy

The goal of the communication strategy is to implement a coordinated program that will achieve behavioral change at political, service delivery, community and individual levels. Behaviour change will be achieved through providing guidance to all stakeholders and partners implementing the advocacy, communication and social mobilization agenda within strategic objective 5 of the revised KMS 2009–2018 to ensure coordination of effort, messages, activities and reporting during the implementation period. The strategy will also guide counties and sub-counties in developing social behavior change communication (SBCC) plans that address specific behavioral challenges within each county context.

Aspirational values that will guide the communication function for the NMCP include: relevance, accuracy, integrity, transparency, currency, open communications (two way including feedback mechanisms), flexibility and adaptability.

2.2 Approaches to Implementing the Communication Strategy

The communication strategy will use three approaches:

Advocacy to ensure that the national government, policymakers, donors and media i) remain engaged, ii) are strongly committed to improving laws and policies for malaria control, iii) allocate funds for malaria control and iv) malaria control remains in the public agenda.

Communication Behavior change communication is a crucial component in changing social norms; addressing myths and misconceptions; and improving knowledge, attitudes and practices around malaria control among various groups of people. Effective behavior change communication and messages need to convey more than just the medical facts because on their own these facts do not necessarily motivate people to action. The messages should explore the reasons why people do or do not take action on the information they receive, then focus on changing the actual behavior by addressing the causes identified, e.g. social norms or personal attitudes.

Behavior change communication is a set of organized communication interventions and processes aimed at influencing social and community norms and promote individual behavioral change or positive behavior maintenance for a better quality of life...it is based on proven theories and models of behavior change.

Communication for Social Change – engage & empower communities/networks to influence/ reinforce social norms: human resource & time intensive

Social Mobilization brings together community members and other stakeholders to strengthen community participation for sustainability and self-reliance. Social mobilization generates dialogue, negotiation and consensus among players. At the heart of social mobilization is the need to involve people who are most affected by malaria. Mobilizing

resources, building partnerships, networking and community participation are all key strategies for social mobilization Specific activities include group and community meetings, partnership sessions, school activities, traditional media, music, song and dance, road shows, community drama, soap operas, puppet show, karaoke songs and contests. Other activities unique to a particular county or region may provide even better opportunities to engage and motivate individuals. Communication programs generally produce the best results when they work across these multiple levels.

A single effort has less impact than collective effort. Although distinct elements, advocacy, communication and social mobilization are most effective when used together. ACSM activities should therefore be developed in parallel and not separately. Chapter 3 provides details of how the National Malaria Control Program will i) engage with the national government, decision makers and media to provide an enabling environment through supportive policies and legislation for malaria control; and ii) work with its partners such as county governments, community health services and health promotion unit to deliver key malaria interventions through community units and networks to deliver health service closer to households.

2.3 Strategic Communication Goal

To increase the use of malaria interventions at household level to 80 percent by 2018 through well-coordinated malaria ACSM activities.

2.4 Specific Objectives

1. To influence positive behavior change among target audiences with regard to malaria control behavior that will helps to reduce the incidence of malaria in Kenya.
2. To galvanize action around malaria Through advocacy aimed at increasing funding for malaria by county governments and to strengthen links between the national and county governments.
3. To strengthen coordination and linkages of ACSM interventions and improve the flow (dissemination) of information to key target audiences at national, county, community and household levels through a planned and systematic series of activities and channels.
4. To harmonize malaria ACSM activities implemented by the different partners.

The malaria communication strategy complements the revised KMS 2009–2018. The strategy covers a 5 year period 2016–2021 beyond the lifespan of the KMS 2009–2018. It is anticipated that the midterm review of this strategy will be in 2018 (which is the anticipated end term review of the current KMS 2009–2018) with an end term review in 2021.

Guiding Principles

The following principles will underpin the planning, implementation and monitoring of the communication strategy:

Epidemiology- based intervention: ACSM interventions will be implemented based on the different epidemiological zones as outlined in the National malaria policy (2010).

Local context approach: the strategy will recognize, appreciate and make use of local structures and knowledge to facilitate the desired change.

Evidencebasedinterventions: Communication planning will utilize accurate data and theory to inform and guide the activities.

Gender considerations: gender-related information is crucial in program planning, data collection, monitoring and evaluation to raise awareness of gender imbalances, advocate for change, address gender dimensions of health, and demonstrate program progress and impact.

Ownership: clear and consistent interaction with county government is critical for coordinated response.

Public private partnerships: Engaging in public private partnerships for malaria ACSM will strengthen and accelerate efforts towards increasing utilization of malaria interventions.

Sustainable interventions: The strategy envisages creating positive and sustainable behavior change by utilizing a variety of approaches that are cost effective, evidence based and appropriate within the Kenyan context

3. Key Strategic Interventions

This communication strategy has four strategic interventions that will be implemented in the strategic period 2016 –2021. The strategy will support the achievement of objective five of the KMS 2009–2018 through advocacy, behaviour and social change communication and social mobilization approach. The four strategic areas are:

1. To strengthen structures for the delivery of ACSM interventions at all levels
2. To strengthen program communication for increased utilization of malaria interventions at household level
3. To increase inter-sector advocacy and collaboration for malaria intervention
4. To strengthen community-based social and behavior change communication activities for all malaria interventions

3.1 Strengthen structures for the delivery of ACSM interventions at all levels.

Four activities will be undertaken under this strategic objective.

Strengthen national level ACSM coordination

The NMCP through the ACSM unit will be responsible for overseeing the implementation of the MCS 2016–2021. NMCP's role will be to build capacity and provide mentorship and technical assistance to counties on ACSM, formulate policy and guidelines, develop strategic plans and coordinate with all partners.

- The ACSM unit requires technical expertise on ACSM to successfully fulfill these functions. This calls for strengthening the capacity of ACSM program staff at the NMCP through training, coaching, mentoring and enhancing ACSM skills. This strategy recommends institutionalizing key skills and expertise required in the unit and drawing up a capacity-building plan for staff to ensure that they are well trained to offer technical support to county governments. Capacity building at national and county levels will be a key component to achieve the objectives laid out in this communication strategy.
- The national ACSM technical working group will provide leadership and guidance in the implementation of the communication strategy. Over the years, roles, responsibilities and membership of the working group have become blurred and erratic and this calls for rejuvenation of membership. The strategy calls for expanding the scope of the group to include new partners in the various sectors that influence malaria control. The group will continue to meet every quarter to review progress in implementation of the strategy and facilitate decision making through the development of an integrated annual work plan that captures activities implemented by the national program and partners. The terms of reference and membership of the ACSM technical working group is in Annex 1. The health promotion unit will continue to chair the quarterly ACSM technical working group meetings.

Strengthen county level Malaria ACSM

- The national ACSM TWG and partners will work closely with the Health Promotion Unit through health promotion advocacy committees (HPACs) at the county to articulate and strengthen delivery of malaria ACSM interventions. HPACs are county ACSM technical working groups that bring together actors and stakeholders across all health areas to discuss and determine the direction of the health promotion agenda. HPACs also provide a platform for lobbying and pooling of ACSM resources. The national ACSM technical working group will work with county malaria teams to ensure that the malaria agenda is well articulated and that there is adequate representation during HPAC meetings. Implementing partners will continue to play a critical in the delivery of malaria ACSM at the community levels; hence their areas of coverage need to be mapped out so that gaps and areas of need are identified for support.

The national ACSM TWG will also liaise with the Community Health Services (CHS) to provide a platform for delivering key malaria interventions at the household level through the network of community health volunteers across the counties. This will include reviewing the content of malaria training, defining the volunteers' role in supporting malaria control interventions at the community level, and ensuring that key malaria ACSM indicators captured by the district health information system (DHIS).

Support counties to develop malaria communication plans

NMCP will scale up ACSM capacity of implementers in counties and sub counties through training county health teams in SBCC. Trainers of trainers will be identified in each county to ensure sustainable and effective programming over time.

NMCP has trained county health promotion teams across 29 counties on ACSM and it is anticipated that all the 47 counties will be trained in ACSM and county SBCC plans will be developed during the training sessions. The SBCC plan will be adapted to the county malaria context as outlined in the county malaria profiles. County SBCC plans will guide county-specific malaria interventions and will be a tool for mobilizing resources in the county. The NMCP ACSM unit will continuously provide technical guidance and training to counties to ensure malaria remains a priority at the county and that new county ACSM staff are well trained on malaria ACSM.

NMCP will also continue to support counties in ACSM implementation of national policies and guidelines and in ACSM campaigns like mass distribution of nets and malaria vaccine, as and when required.

3.2 Strengthen program communications for increased use of all malaria interventions

Behaviour and social change communication is evidence based and is most effective when combinations of approaches are used, weaving together mass media, interpersonal communication and structural approaches to promote new or modified behaviors. This multimedia approach is therefore recommended in the implementation of ACSM malaria control interventions. The following activities will be undertaken to achieve this objective.

Review of existing malaria messaging and branding and establishment of an online repository

The ACSM TWG will bring together the other TWGs—case management, vector control and malaria in pregnancy—to review messages and materials to ensure they are up to date and relevant. The following activities will be undertaken:

a) Review existing information education and communication (IEC) material and development
NMCP and partners will seek to collate, review and establish an inventory of all the IEC materials and messages both print and audio related to malaria to ensure their relevance and alignment with the malaria communication strategy.

b) NMCP will also review its malaria branding and slogans used over time and adopt a national and unifying theme and slogan. The strategic objective of branding aims at strengthening NMCP's public standing. This role requires NMCP to maintain a consistent corporate image and identity in all its internal and external engagements. The key principles underpinning NMCP branding and corporate identity shall include:

i. NMCP will promote its logo and slogan (Komesha Malaria, Okoa Maisha) to all its partners and stakeholders. The NMCP brand will be projected in all its documents e.g. correspondence,, PowerPoint presentations, and advertisements and any other form of publicity.

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ii. The MOH–GoK logos will also be promoted ensuring the ministry's name is mentioned at all times as Ministry of Health, placed below the words Republic of Kenya, which also define the complete and proper use of the Coat of Arms of the Republic of Kenya.

iii. The NMCP corporate colors derived from the logo portrait are predominantly blue and red, as in the revised Kenya malaria strategy 2009–2018 and in this document. All publications, correspondence and promotional materials must be clearly identified with this image that will be placed prominently.

c) Establish an online repository The materials and messages will be maintained in an online repository on the NMCP website as per the relevant strategic interventions areas. This will ensure counties and partners easily access the materials, and avoid duplication of messaging.

Development and dissemination of tailored communication on surveillance and epidemic preparedness for highland epidemic, semi-arid and low risk zones

This strategy recommends development and dissemination of focused malaria ACSM intervention packages (targeted to health workers, community health volunteers and the community) for the four epidemiological zones, as outlined in the Kenya malaria policy 2009–2018. The ACSM package aims at providing impetus for county governments in highland epidemic, semi-arid and low zones to continuously lobby for prompt care seeking behavior, epidemic preparedness and surveillance interventions. The ACSM packages will close the gap identified in the previous strategy (where little ACSM attention was given to these areas, hence posing the risk of resurgence of malaria).County governments supported by the NMCP will support the development and dissemination of messages. Counties will be encouraged to secure resources and print their own IEC materials based on national guidelines and templates.

Scale up routine multi-media activities

NMCP will, with support from partners, conduct multi-media campaigns for interventions that cut across all malaria epidemiological zones. Multi-media activities will be targeted to various audiences addressing key malaria control challenges.

Multiple media platforms that will be used include:

Mass media. Mass media channels can reach large numbers of beneficiaries at a low to moderate cost, and are an excellent means of increasing awareness about the gravity of malaria.

NMCP with support from partners will conduct mass media campaigns for interventions that cut across all malaria epidemiological zones on promotion of effective malaria diagnosis and treatment and communicating risk preparedness as part of malaria surveillance. Focus will be on using regional media channels that offer interactive radio programs where communities can dialogue with county, sub-county and local implementing partners. The shift from analogue to digital broadcasting has seen a rise in the number of television stations in Kenya.

Talk shows and advertisement around malaria control will spur family discussions and deliver intended message through vision and sound. It is imperative though for partners to establish television viewership rates of their target audiences before ad placement and ensure they place adverts where they will reap maximum impact.

Mobile phone and social media penetration and use:

Mobile ownership and social media platform have grown rapidly in Kenya. KMIS (2015) places ownership of mobile phones at 90 percent, it is however unclear the level of social media penetration and use amongst the malaria audiences especially in the rural areas. The short messaging service (SMS) provides opportunity for sending messages to pregnant women reminding them of their next date for antenatal visit, as a way of increasing uptake of IPTp. Social media platforms such as Facebook and Twitter can explore innovative ways of engaging malaria audiences; building new online communities that can target health careworkers, women groups including pregnant mothers, and distributing content online. It is recommended that the roll out for social media be gradual, and proper surveillance be in place to ensure that issues that arise are picked up and addressed.

Outdoor advertising: can serve the purpose of increasing awareness and recall. This could include billboards, wall branding, signages, bus branding.

Print materials: serve two purposes: advocacy and educational. Newspapers and brochures can serve as advocacy materials to attain political goodwill. Comic books, posters and magazines serve an educational purpose. Use of comic books for school health programs will go a long way in creating an engaging platform for school going children to engage in issues around Malaria.

Table 2 provides a matrix that outlines key malaria control interventions, target audiences, key messages and channels.

Table 2. Key audiences, messages and channels

Intervention	Target audience	Key messages	Channels
LLIN use	Primary: Head of households and school-going children (5–14 years) Secondary: Household members	Ensure LLINs are hung up properly Ensure everyone, especially children under 5 and pregnant women sleeps under an LLIN every night	Mass media radio & TV Mobile phone Outdoor advertising IPC
Case management	Primary: Individual patient and health worker Secondary: Caretaker of a sick child	Take prompt action towards diagnosis and treatment of malaria with recommended ACT/AL Caregivers should demand for a test Complete the malaria treatment prescribed	Mass media radio & TV Mobile phone Out of home IPC
Malaria in pregnancy	Primary: Pregnant women Secondary: Spouses and mothers-inlaw	Attend antenatal care services as soon as she realizes she is pregnant early and regularly. Take at least 4 doses of SP Sleep under an LLIN every night and after delivery	IPC–women's group, health talks and household visits Mobile messaging Radio TV Posters Social Media
IRS	Primary: Household head Secondary: All household members	Household heads accept IRS in the house Household members adhere to key actions that follow IRS in the house Household head to accept to remove belongings during spraying	Mass media: radio & TV Mobile phone Outdoor advertising

Building the capacity of facility health workers on malaria communication

KMIS 2015 results showed that 75 percent of care givers of children with fever were likely to seek advice or treatment from a government health facility. This underscores the role health workers can play in communicating key messages on malaria as they come into contact with their clients. Training of health workers on interpersonal skills is critical as a way of improving the quality of service and building a health worker–client relationship. The current curriculum used for training health workers on national malaria diagnosis and treatment guidelines will be reviewed to include a strong component of interpersonal communication.

Explore integrated BCC for interventions

Some malaria control outcomes like malaria in pregnancy ACSM are lagging largely due to lack of funding. The strategy proposes exploring ways of integrating MIPACSM in interventions already funded by partners.

3.3 Increase inter-sector advocacy and collaboration for malaria ACSM interventions

The National Malaria Control Program will lead the coordination of malaria advocacy activities with the aim of fostering strong linkages between the national and county governments and across other health and non-health sectors. The NMCP will engage and collaborate with various stakeholders to ensure that malaria control secures political commitment and social acceptance by leaders and stakeholders at all levels, and strengthens multi-sectoral response to malaria control. Only then will politicians and other stakeholders allocate malaria the attention, priority and resources it requires.

Advocacy efforts will cut across all the strategies of the revised KMS 2009–2018. The priority foci for advocacy efforts are:

Table 1. Potential Challenges and Implications

Advocacy need	The ACSM program lacks an organized team for malaria advocacy at national and county levels. As a result, malaria's profile relative to other health problems is low.
Target audience	NMCP and county health teams and partners
Advocacy objective	To create a pool of members within the ACSM working group who are competent and confident to engage in advocacy work in the counties and nationally.
Activities	1. Train members of the ACSM TWG on shared understanding of advocacy 2. Train members of health promotion units in counties in advocacy
Desired outcome	Pool of ACSM TWG members who are competent and confident to engage in advocacy work for Malaria

Priority Focus 2: Secure political and financial commitment of leaders and stakeholders at all levels and to galvanize multi-sectoral response to malaria control

Advocacy need	Political and financial commitment on malaria by leaders and multi- sectoral partners is low at all levels
Target audiences	Parliamentary health select committee, Senate parliamentary committees, Politicians (governors, senators, MPs, MCAs, women representative, ministers), county executive committee members for health, community leaders, religious leaders.
Advocacy objective	To secure political commitment for malaria through allocation of resources and support to formulate relevant policies and laws that support malaria control interventions in counties and nationally.
Activities	1. Annual roundtable discussions with the private sector, NGOs, Members of parliament and senate, county executive committee members for health, private sector to take stock of malaria prevention and control achievements as a way of renewing their commitment and support, and soliciting private–public partnerships on malaria control. 2. Provide regular updates through direct mail on status of implementation, challenges and lobby for support from community and religious leaders 3. High level advocacy: Stakeholder meetings and forums
Desired outcome	• Documented work plan presented to donors and partners highlighting key aspects of the strategy that need funding. • Funding secured and allocated appropriately.

Priority focus 3: To keep malaria in the public agenda throughout the year through media advocacy.

Advocacy need:	Malaria agenda/advocacy events have been limited and sporadic, and are largely centered around World Malaria Day
Target audience	Media, malaria ambassador and non-health sectors, e.g. academia
Advocacy objective	To leverage on media to raise the profile of Malaria
Activities	1. Identify and train a pool of science/health journalists from media houses to create awareness of malaria. 2. Identify and train correspondents from counties/malaria endemic zones who will keep the issue alive in the counties. 3. Carry out a media symposium every year to sensitize the media and update them on the malaria situation so that they may convey the same through the different media houses. 4. Encourage ACSM partners to work with counties; organize media tours so that human interest stories and documentaries on malaria may be captured and disseminated.

	5. Commemorate the World Malaria Day activities with NMCP at the forefront. NMCP provide technical support to counties in planning of activities. The media breakfast was identified as a key event where updates on malaria control activities can be presented to key malaria stakeholders and media personnel, for wider dissemination through mass media (press—adverts and supplements), media interviews, TV talk 6. ACSM unit will continue to publish and distribute to partners the Malaria Information and Advocacy bulletin on a bi annual basis.
Desired outcome	• Malaria agenda consistently features in the media • General population understands the seriousness of malaria.

3.4 Strengthening community- based social and behavior change communication activities for all malaria interventions

Community-based social behavior change interventions facilitate individual and community decisions that result in positive health outcomes through mobilizing the participation of local communities in malaria control initiatives through local networks, and continued access to malaria prevention and treatment messages. Community Health Strategy will provide a critical avenue for counties to reach households with malaria control interventions in endemic and epidemic zones.

The activities below will be implemented at the community level to achieve the desired behaviour change in households.

Re-orient malaria partners on IPC and community health strategy

Review of the last strategic period indicated lack of understanding of interpersonal communication among implementers. In implementing this strategy, the National Malaria Control Program, HPU and Community Health Services teams will work jointly to reorient partners and implementers on interpersonal communication and on the community health strategy to achieve a coordinated response to malaria control. The desired outcome from this exercise is the shared understanding of what interpersonal communication entails and coordinated implementation at the community level.

Review and update the training curriculum for community health volunteers and household data collection tools

NMCP working with CHS and HPU will jointly review the CHV's malaria training curriculum, household registers and monitoring tools to ensure that key malaria information and indicators are captured. This will include reviewing and harmonizing the current Community education training manual on malaria prevention and treatment and the Essential malaria action guide for Kenyan families.

Joint training of community health volunteers to implement SBCC interventions

Community health units or local networks such as community-based organizations or faith-based organizations (in areas without community units) will be identified, trained (through clustered community unit trainings) and facilitated in undertaking community-based SBCC activities. Training will involve how to promote malaria interventions at the household level; data collection and reporting; monitoring and evaluation; conducting malaria action days; and forming malaria advocacy groups comprising of CBOs, FBOs and other representatives to lobby for malaria control.

Implementing SBCC interventions in the community

NMCP has implemented community- based malaria SBCC program in 12 endemic and epidemic sub counties in Western and Nyanza regions. The results show that household malaria indicators on use of interventions can be achieved working through the community health strategy.

Building on this, NMCP will closely collaborate with community health strategy, health promotion unit and counties to use community health volunteers to strengthen and scale up household reach with key malaria interventions.

Implementation at the community level will be through a two-pronged stepwise approach: community mobilization and interpersonal communication.

Community mobilization activities will take into account traditional and popular channels such as health action days, outreach services, songs, games, sports, caravans and market-related events. The role of community mobilization activities will be to catalyse discussions around malaria control that continue long after the activity itself has ended.

Interpersonal communication will play an integral role in embracing dialogue towards ensuring positive behaviour at the household level. This is where discussions initiated during community mobilization activities will continue with the intention of achieving uptake of malaria control interventions.

Interpersonal communication is a behaviour change communication channel that has been proven to promote behaviour change in health interventions through **engaging communities, understanding and exploring options** that work for the community. Interpersonal communication activities will take the form of **home visits** by community health volunteers, **small group discussions** (e.g. women's groups or mother-to-mother support groups) and **health talks** at the health facilities and through school health **programs.**

The highest prevalence of malaria is among the 5–9 and 10–14 year age groups at 11 percent and 10 percent respectively, and investing in school health programs is therefore critical. NMCP is currently implementing a school health program in 8 counties where teachers are trained so that they can pass key messages on malaria to pupils, who in turn are expected to act as change agents at household level. NMCP has developed a teachers and pupils guide promoting malaria prevention and control by school children in Kenya, and is working on expanding coverage to other counties.

County and sub county health promotion officers in collaboration with malaria control coordinators will support implementing partners in the different epidemiological zones plan for their specific communication behavior change activities.

Conducting monitoring and supervision of malaria control interventions

NMCP will provide technical support to counties to undertake monitoring and supervision of malaria prevention and control activities at household level. NMCP will convene a malaria monitoring and evaluation stakeholders meeting to review and harmonise monitoring and supervision tools. Currently, different partners have different tools of reporting. It is desirable for the indicators to be captured and uploaded in the district health information system as part of the community-based health management and information system.

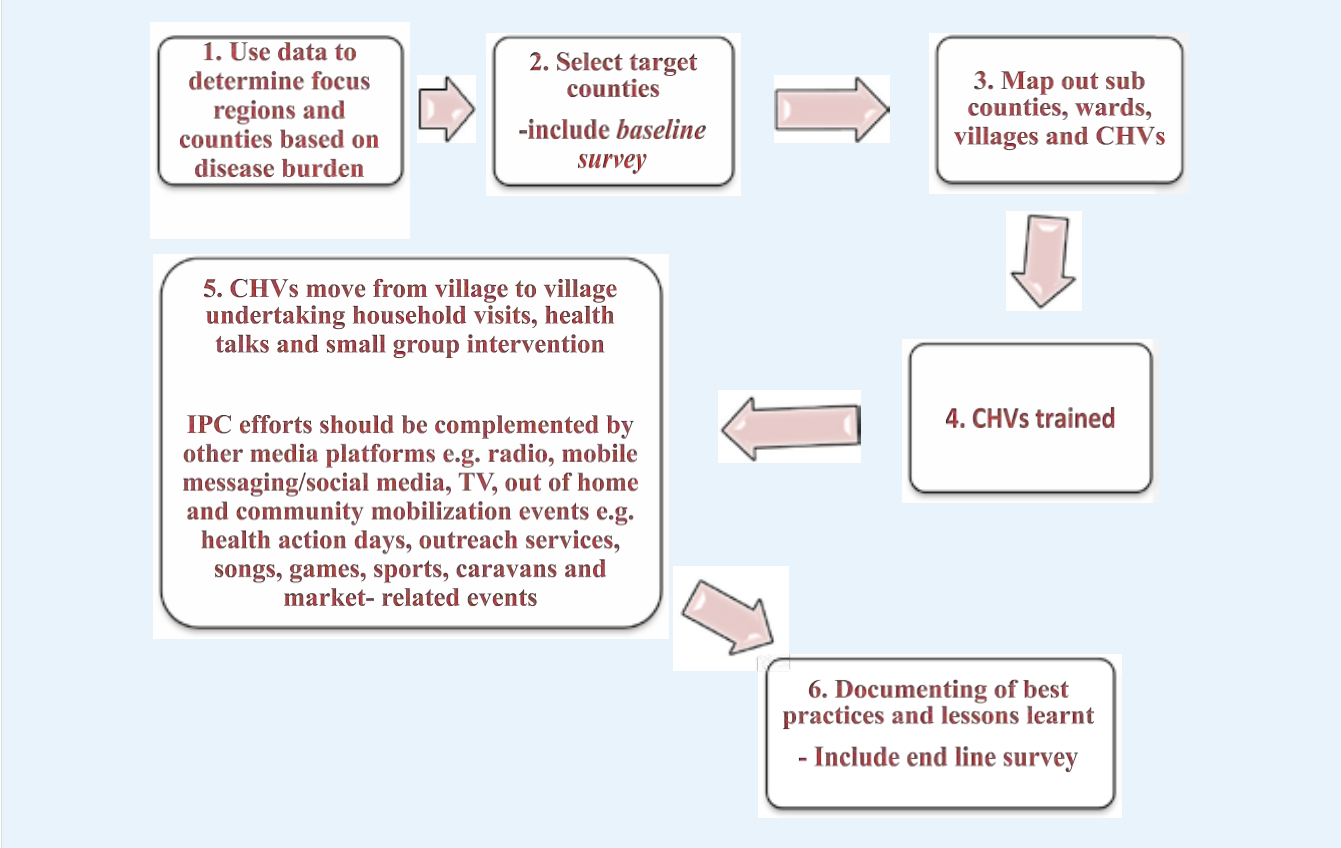
Documenting results and disseminating lessons learnt

The purpose of documenting will be to build evidence of what works that can be disseminated for wider adoption, to learn from what hasn't worked and what could be done to address the same, and to explore opportunities to make the ACSM program sustainable. By documenting and sharing ACSM lessons, NMCP and partners can review experiences and provide strategic input for future activities. Sharing ideas between partners enables "cross pollination" of experiences and prevents "reinventing the wheel". Sharing results may also prompt partners to reciprocate with similar experiences, lessons they have learnt, new ideas or potential resources. Tools like after-action reviews, written reports, articles and other ACSM updates can be shared through at community or national meetings. Targeted, well-planned field visits and websites, blogs, message boards and list servers are also form ways of widely disseminating best practices. Websites like the Communication Initiative's website (www.comminit. com) and e-magazines such as Health Communication Exchange (http://www. healthcomms.org) and Health Compass (http://www.healthcompass.org) can also be explored.

Guidance on implementing interpersonal communication interventions

The figure below provides a step down guidance for partners on implementing in- terpersonal communication interventions.

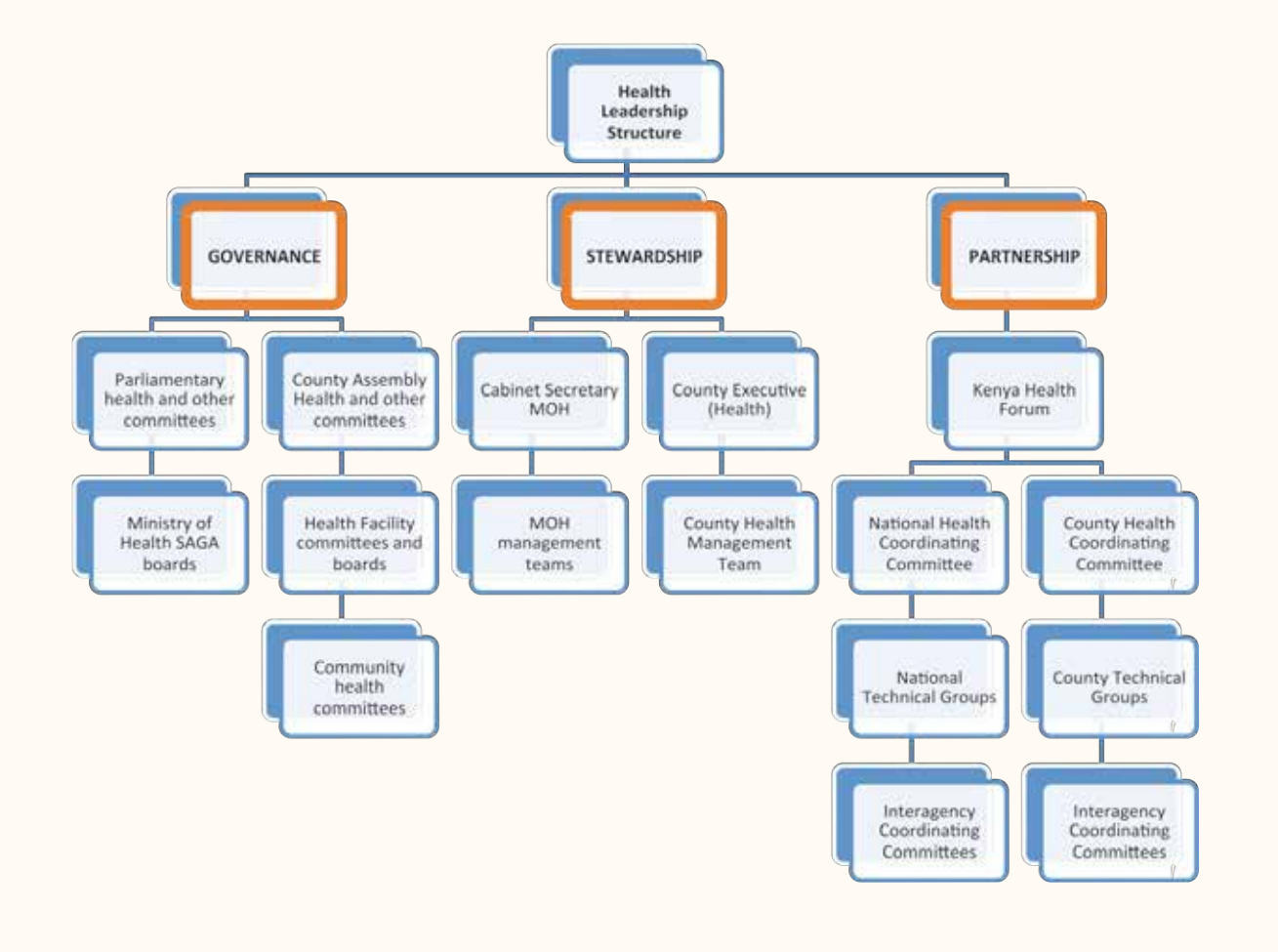
Figure 1. Guidance on implementing interpersonal communication activities



Implementation and coordination of the strategy

The NMCP through the ACSM TWG whose purpose is to ***"advise on advocacy, communication and social mobilization for malaria control interventions"*** will be the custodian of this strategy, overseeing its planning, implementation, coordination and evaluation. Under the leadership of the Cabinet Secretary and the Principal Secretary for Health, the ACSM TWG will, through the Malaria Inter-Agency Coordinating Committee, provide regular updates on the implementation of the strategy (see figure 3.2: Implementation and coordination arrangement of malaria ACSM.

Figure 2: Implementation and coordination arrangements of Malaria ACSM



4. Implementation Plan 2016–2021

Strategy/Activities	Timeline (FY July–June)						Responsible
	2016	2017	2018	2019	2020	2021	
Strategy 1: Strengthen structures for the delivery of ACSM interventions at all levels.							
Activity 1.1 Review, print and disseminate the Malaria Communication Strategy for Kenya (2016–2021)	X	X	X	X	X	X	NMCP/ Partners
Activity 1.2 Undertake the midterm review (during the review KMS 2009–2018) and end term review of the Malaria communication strategy			X			X	NMCP/ Partners
Activity 1.3 Develop and disseminate to partners annual work plans highlighting funding gaps	X	X	X	X	X	X	NMCP/ Partners
Activity 1.4 Develop an annual capacity-building plan for ACSM program staff to strengthen technical expertise on ACSM through training, coaching, mentorship and enhancement of ACSM skills	X	X	X	X	X	X	NMCP/ Partners
Activity 1.5 Scale-up the technical capacity of implementers at national, county, subcounty levels, and partners on ACSM by supporting counties to develop Malaria communication plans	X	X	X	X	X	X	NMCP/ Partners
Activity 1.6 Re-launch a rejuvenated ACSM TWG with an expanded multi-sectoral membership		X					NMCP/ Partners
Activity 1.7 Revive Health Promotion Unit participation in the ACSM TWG		X	X	X	X	X	NMCP/ Partners
Activity 1.8 Hold quarterly meetings of national malaria ACSM TWGs.	X	X	X	X	X	X	NMCP/ Partners
Activity 1.9 Hold quarterly meetings of HPACs	X	X	X	X	X	X	NMCP/ Partners
Activity 1.10 Undertake technical support and support supervision for malaria ACSM activities in counties.	X	X	X	X	X	X	NMCP/ Partners
Strategy 2: Strengthen program communication for increased utilization of all malaria interventions							
Activity 2.1 Establish an online repository of existing malaria IEC materials and messages	X	X	X	X	X	X	NMCP/ Partners
Activity 2.2 Develop and disseminate tailored communication on surveillance and epidemic-preparedness for low risk, arid and highland epidemic zones	X	X	X	X	X	X	NMCP/ Partners
Activity 2.3 Scale up routine multimedia activities (mainly interactive radio programs) to support ACSM at county / subcounty and community level	X	X	X	X	X	X	NMCP/P
Activity 2.4 Build capacity of health workers in malaria communication	X	X	X	X	X	X	NMCP/ Partners

Strategy/Activities	Timeline (FY July–June)						Responsible
	2016	2017	2018	2019	2020	2021	
Activity 2.5 Explore the use of social media for increased dissemination of malaria information	X	X	X	X	X	X	NMCP/ Partners
Strategy 3: Lobby for inter-sectoral collaboration for malaria ACSM							
Activity 3.1 Conduct training for members of the ACSM TWG on shared understanding of advocacy	X	X	X	X	X	X	NMCP/ Malaria No More/ Partners
Activity 3.2 Conduct training in advocacy to members of health promotion units in the counties	X	X	X	X	X	X	NMCP/ Malaria No More/ Partners
Activity 3.3 Hold annual roundtable discussions with council of governors, private sector, NGOs, members of parliament	X	X	X	X	X	X	NMCP/ Malaria No More/ Partners
Activity 3.4 Develop Annual Work Plan and presentations to donors and partners highlighting key aspects of the strategy that need funding.	X	X	X	X	X	X	NMCP/ Malaria No More/ Partners
Activity 3.5 Identify and train a pool of science/health journalists from media houses to create awareness of malaria.	X	X	X	X	X	X	NMCP/ Malaria No More/ Partners
Activity 3.6 Identify and train correspondents from counties/ and malaria endemic zones who will keep the issue alive at county level.	X	X	X	X	X	X	NMCP/ Malaria No More/ Partners
Activity 3.7 Hold annual media symposium and tours for journalists	X	X	X	X	X	X	NMCP/ Malaria No More/ Partners
Activity 3.8 Hold consistent bi-annual consultative meeting with relevant sector partners for malaria ACSM	X	X	X	X	X	X	NMCP/ Malaria No More/ Partners
Activity 3.9 Commemorate World Malaria Day at all levels	X	X	X	X	X	X	NMCP/ Partners
Activity 3.10 Publish bi-annual malaria information and advocacy bulletin	X	X	X	X	X	X	NMCP/ Malaria No More/ Partners
Activity 3.11 Identify and support national malaria ambassador.	X	X	X	X	X	X	NMCP/ Malaria No More/ UNICEF/ Partners

Strategy/Activities	Timeline (FY July–June)						Responsible
	2016	2017	2018	2019	2020	2021	
Activity 3.12 Support counties to identify and support malaria ambassador.	X	X	X	X	X	X	
Strategy 4: Strengthen community based Social and Behavior Change Communication activities for all malaria interventions							NMCP/ Partners
Activity 4.1 Re-orient malaria partners on IPC and community health strategy	X	X	X	X	X	X	NMCP/ Partners
Activity 4.2 Review and update CHV training curriculum and household data collection tools	X	X	X	X	X	X	NMCP/ Partners
Activity 4.3 Community units database with mapping of functional units	X	X	X	X	X	X	NMCP/ Partners
Activity 4.4 Joint training of community health volunteers to implement SBCC interventions	X	X	X	X	X	X	NMCP/ Partners
Activity 4.5 Conduct monitoring and supervision of malaria control interventions	X	X	X	X	X	X	NMCP/ Partners
Activity 4.6 Support counties to implement malaria school health programs on malara that engage learners in malaria interventions at household level	X	X	X	X	X	X	NMCP/ Partners
Activity 4.7 Support counties to use local interactive radio programs on malaria in local dialects.	X	X	X	X	X	X	NMCP/ Partners
Activity 4.8 Document and disseminate lessons learnt on innovative malaria ACSM interventions in selected counties	X	X	X	X	X	X	NMCP/ Partners

5. Monitoring and Evaluation Plan 2016 –2021

The malaria communication strategy will cover a 5-year period from July 2016 to June 2021 and will be monitored and evaluated as follows:

1. **Kenya Malaria Strategy review:** the current Kenya Malaria Strategy (2009– 2017) will be reviewed in 2017. During the review of the KMS the ACSM component of the strategy Chapter 5 will also be reviewed hence any implication on ACSM during the review will be considered.

2. **Mid-term review:** a mid-term review of the malaria communication strategy will be conducted in December 2018

3. **Kenya Malaria Indicator Survey:** the next KMIS is due in 2019 hence during the survey the progress towards achievement of the malaria ACSM indicators will also be measured and that will have an indication of the malaria communication strategy.

4. **End-term review:** towards the end of the 5 year life of the strategy in May 2021 an end term review of the strategy will be undertaken and the next communication strategy revised and re-written.

Regular tracking performance on key attitudes, practices and behaviours around malaria interventions

Findings from the review of the last strategy indicated a gap in regular monitoring and evaluation of SBCC activities by partners. There was an overreliance on KMIS to track progress. This strategy recommended for regular rapid assessments (both qualitative and quantitative) on key attitudes, practices and behaviours on malaria by NMCP and partners to track progress on ACSM indicators and bring lessons learnt to bear within a short time frame.

Operations Research

Based on the KMIS 2015, the following areas call for more research;

1. Regular rapid assessments (qualitative and quantitative) studies on malaria control interventions to track performance on knowledge, attitudes, beliefs and practices (reduce overreliance on KMIS).
2. Effectiveness of mobile telephony in influencing malaria action at home
3. Factors hindering uptake of IPTp 2 and IPTp 3
4. Accessibility and use of malaria control interventions in female- heads of households

Strategy / Indicators	Source of data	Frequency	Responsible
Strategy 1: Strengthen structures for the delivery of ACSM interventions at all levels.			
Output indicators			
Proportion of counties with ACSM plans	Activity reports	Quarterly	NMCP/ partners
National malaria ambassador supported			
Proportion of counties where malaria ambassadors have been identified and supported			
Number of counties and subcounties with communication plans developed			
Number of counties trained on SBCC			
Outcome			
Proportion of counties implementing ACSM activities as per their communication plans	Activity reports	Quarterly	NMCP/ partners
Strategy 2: Strengthen program communication for increased utilization of all malaria interventions			
Output			
Number of focused ACSM packages disseminated	Activity reports	Quarterly	NMCP/ partners
Number of media campaigns conducted			
Outcome			
Proportion of population that knows that they should seek treatment within 24 hours of fever onset	MIS	3 years	NMCP: SMEOR: KNBS
Proportion of population that cite LLIN as the best protection against malaria			
Proportion of population who correctly cite at least 3 main symptoms of malaria			
Proportion of population who recall hearing and seeing targeted messages in the last six months			

Strategy / Indicators	Source of data	Frequency	Responsible
Strategy 3: Advocate for inter-sector collaboration for malaria ACSM			
Output			
Number of non-health sectors engaged in malaria ACSM	Activity reports	Annually	NMCP/ partners
Number of IEC/BCC materials distributed through non-health sector partners			
National World Malaria Day commemorated			
Number of counties commemorating the WMD			
Number of bi-annual malaria information and advocacy bulletins distributed			
Strategy 4: Strengthen community-based social and behavior change communication for increased utilization of all malaria interventions			
Output			
Number of CORPs trained in ACSM			
Numbers of community dialogues on malaria interventions planned and conducted			
Number of malaria action days planned and conducted			
Number of regional radio programs in local dialect aired			
Number of schools promoting malaria interventions through pupils			
Proportion of HH reached by school pupils			
Outcome			
Proportion of people who received malaria ACSM messages through community channels	MIS	3 years	NMCP/ SMEOR: KNBS

Annex 1: Terms of Reference for ACSM TWG

Purpose	Terms of references	Chairperson	Secretariat	Membership
To advise on advocacy, communication and social mobilization for malaria control interventions	To advise on all aspects of the ACSM to support malaria control interventions including research, design, production, dissemination, monitoring and evaluation To contribute to and support the establishment of a network linking all stakeholders in advocacy and BCC for malaria To identify best practices in malaria control and prevention and provide technical advice on updating and dissemination of appropriate messages and best practice level To collaborate with health training institutions on life-skills curriculum development for students and teachers (KICD, KIE) Report regularly to MICC	Head, Health Promotion Unit	NMCP	NMCP Health Promotion Unit Ministry of Education Ministry of Information, Communications and Technology Community Health Unit Reproductive and Maternal Health Unit Neonatal, Child and Adolescent Health Unit KeNAAM Kenya Red Cross PS Kenya Public Relations Officer (MOH) PMI/USAID, DFID, UNICEF, WHO, AMREF, World Vision, Malaria No More, Clinton Health Access Initiative, PIMA, PATH, MSH Private sector KEMRI

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