Federal Ministry of Health
National Malaria Control Programme

Advocacy, Communication and Social Mobilization Strategic Framework and Implementation Plan

June 2010

ROLL BACK MALARIA

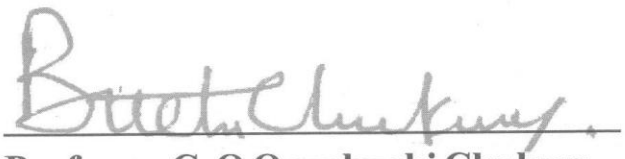
FOREWORD

Malaria has had a devastating impact on the people of Nigeria. The Federal Government of Nigeria (FGN) and its partners are taking important steps in addressing malaria prevention and control. The National Malaria Strategic Plan 2009-2013 (NMSP) sets bold targets for achieving the Scale up for Impact (SUFI) and the Universal Coverage targets, set in Abuja in 2008. The current environment is favourable to achieving the ambitious targets, as we have increased political will, increased support, and more public and private sector stakeholders, improve technical capacity of implementation staff, more funding and development partners' support. Advocacy, Communication and Social mobilization (ACSM) which is the focus of this ACSM strategic framework and implantation plan provides the foundation for achieving these targets

There have been a series of ACSM strategies in Nigeria. This is the most recent and most far-reaching. This document is designed to ensure that the ACSM effort is more coordinated, harmonized and integrated across organizations, as well as throughout the levels of government (from federal to state to local government authority (LGA).

The previous effort in ACSM is appreciated and has set the standard for strategic communication interventions in Nigeria. However, we need to rise to a new level of leadership and quality in the ACSM effort.

I am pleased that this document would add value to the good work that the Federal Ministry of Health (FMOH) and its Roll Back Malaria (RBM) partners are doing to promote malaria control through ACSM. I commend it effective implementation to all partners



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We appreciate the efforts of NMCP staff and the SuNMaP team for their overall leadership, technical and managerial support. We also appreciate the World Bank for the key role it played in supporting this strategy development process. We take this moment to express our thanks to all involved.

Members of the ACSM/NMCP TWG contributed tremendously by coordinating, planning and participating in a series of meetings for the development of this strategy document. We particularly appreciate the Chairman and Secretary of the subcommittee. We take this moment to express our thanks to all involved.

We are also grateful to the representatives of various partners and stakeholders for their commitment and active participation during the development of the strategy document.

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LIST OF ACRONYMS

ACOMIN	Association of Civil Societies on Malaria and Infant Nutrition
ACSM	Advocacy, Communication and Social Mobilisation
ACT	Artemisinin- based Combination Therapy
ADR	Adverse Drug Reaction
ANC	Ante-Natal Care
ARFH	Association for Reproductive and Family Health
BCC	Behaviour Change Communication
CBO	Community-Based Organisation
CDC	U.S. Centers for Disease Control and Prevention
CHAN	Churches Health Association of Nigeria
CM	Case Management
CMD	Chief Medical Director
CRM	Customer Relationship Management
CSO	Civil Society Organisation
CST	Country Support Team
DFID	UK Department for International Development
FANC	Focused Ante-Natal Care
FAQs	Frequently Asked Questions
FHI	Family Health International
FHU	Family Health Unit
FMOH	Federal Ministry of Health
FMOIC	Federal Ministry of Information and Communication
FOMWAN	Federation of Muslim Women Association of Nigeria
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
GFFHR	Global Forum For Health Research
HERFON	Health Reform Foundation Nigeria
HIV	Human Immuno-deficiency Virus
HMM	Home Management of Malaria
HPU	Health Promotion Unit
IHVN	Institute of Human Virology, Nigeria
IPC	Inter-Personal Communication
IPT	Intermittent Preventive Treatment
IRS	Indoor Residual Spraying
ITN	Insecticide Treated Bednet
IVM	Integrated Vector Management
JHPIEGO	Johns Hopkins Program for International Education in Gynaecology and Obstetrics (but now known just as “JHPIEGO”)
JSI	John Snow, Inc.
LGA	Local Government Areas/Authorities
LCCN	LLIN Campaign Coordinating Network
LLIN	Long-Lasting Insecticide-treated Nets
M&E	Monitoring and Evaluation
MDGs	Millennium Development Goals
MERG	RBM Monitoring and Evaluation Reference Group
MFLG	Ministry for Local Government
MIP	Malaria in Pregnancy
MIS	Management Information System
NACA	National Agency for the Control of AIDS

NAFDAC	National Agency for Food and Drug Administration and Control
NGO	Non-Governmental Organisation
NIFAA	Nigerian Inter-Faith Action Association
NMCP	National Malaria Control Programme
NMSP	National Malaria Strategic Plan
PATHS2	Partnership for Transforming Health Systems 2
PMI	US President's Malaria Initiative
PMV	Patent Medicine Vendor
PPP	Public Private Partnerships
PPT	PowerPoint
PR	Public Relations
PSA	Public Service Announcement
PSM	Procurement and Supply Management
RBM	Roll-Back Malaria
RDT	Rapid Diagnostic Testing
RMC	Role Model Care-givers
RMS	Research and Marketing Services, Ltd
SC	Sub-Committee
SFH	Society for Family Health
SM	Social Mobilisation
SMOH	State Ministry of Health
SP	Service Provider
SP	Sulphadoxine-Pyrimethamine
SUFI	Scale-Up For Impact
SuNMaP	Support to the National Malaria Programme (DFID-funded)
TF	Task Force
TWG	Technical Working Group
UA	Universal Access
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	United Stated Agency for International Development
V/O	Voice Over
WB	World Bank
WHO	World Health Organisation
YGC	Yakubu Gowon Center

Introduction

Malaria is a major public health problem in Nigeria. The Federal Government of Nigeria has recognised the problem and has been addressing it for years, through primary health care. In 1997, a renewed focus on malaria was initiated, with the first National Malaria Control Policy.

In 2009, the Ministry of Health developed a 5-year National Strategic Plan for Prevention and Control of Malaria (NMSP). The vision is for a malaria-free Nigeria, with ambitious targets for this five year period, including the national scale up LLIN coverage, prompt diagnosis and treatment of malaria, and prevention of malaria in pregnancy.

One of the critical elements needed to achieve malaria scale up is the changing of behavioural and social norms with regard to sleeping under long-lasting insecticide treated nets (LLINs), early and correct diagnosis and treatment of malaria, especially in the most vulnerable parts of society, children under five and pregnant women, and early attention to pregnant women, with a focus on preventing and treating malaria.

This strategic framework and implementation plan is intended to guide malaria partners in the implementation of advocacy, communication (BCC) and social mobilisation (ACSM) interventions designed to support the national malaria control efforts. The term strategic communication is used to encompass all efforts related to ACSM. This strategic communication plan should ensure message harmonization and message integration, as well as help partners prioritize effective communication interventions- focusing on the right message, to the right audience at the right time.

The strategic framework is followed by an implementation plan and a framework for monitoring and evaluation. These are intended to minimize duplication and enhance synergy. With all of our partners working together, with a common direction and a shared vision, we can all play our part to make Nigeria malaria-free.

Situation Analysis

Demographic, Social and Epidemiological overview

According to the 2006 census, Nigeria had a population of 140 million people and is by far the most populous country in Africa with a high population growth rate, currently estimated at 3.2%. Malaria is a major cause of morbidity and mortality in Nigeria (Nigeria Demographic and Health Survey 2008).

Malaria is caused primarily by plasmodia of various types – *Plasmodium ovale, Plasmodium malaria, Plasmodium vivax* and *Plasmodium falciparum*. Of these four species of plasmodium, *Plasmodium falciparum* causes the most severe malaria illness and death throughout the world. As of 2006 it accounted for 91% of all 247 million human malarial infections (98% in Africa).[1] *Plasmodium falciparum* is known to be the most devastating in Nigeria. The transmission of the parasite is facilitated through the bite of the female anopheles mosquito.

[1] "World Malaria Report 2008". World Health Organisation. 2008. pp. 10. http://apps.who.int/malaria/wmr2008/malaria2008.pdf. Retrieved 2009-08-17

Malaria is endemic throughout the country with more than 90% of the total population at risk of stable endemic malaria (NetMark 2001). The Sahel regions and the high mountain area of the plateau experience slightly lower rates of transmission. At least 50% of the population suffer from at least one episode of malaria each year (FMOH and NMCP, 2009). Malaria currently accounts for nearly 110 million clinically diagnosed cases per year. An estimated 300,000 children die of malaria each year, and 11% of maternal related mortality is related to malaria in pregnant women. The Federal Ministry of Health has noted that malaria leads to 25% of infant mortality and 30% of childhood mortality (FMOH and NMCP, 2009). Malaria is the most common cause of outpatient attendance across all age groups (FMOH and NMCP, 2009). Though preventable, malaria remains one of the major public health problems in Nigeria. While everyone is at risk, some categories of people are, however, at the highest risk of infection. These include children aged less than 5 years, pregnant women, visitors from non-malarious regions, people living with HIV, and those with sickle cell anaemia.

Malaria constitutes a major economic burden on endemic communities in Africa including Nigeria. In Nigeria, about 132 billion Naira is lost to malaria annually in the form of treatment costs, prevention, loss of work time, etc. (FMOH and NMCP, 2009). Consequently, this reduction of human work capacity and productivity adversely affects the socio-economic development of the nation (FMOH 2001, GFFHR 2000). For example, the high rate of absenteeism among school children in Nigeria is attributed in part to malaria (Gbadegesin 2001; GFFHR 2000).

National Response to the Control and Prevention of Malaria

In 1997, Nigeria adopted its first National Malaria Control Policy that identified malaria control as a priority health programme. Prior to that, malaria was integrated into primary health care.

- **The RBM partnership**

Nigeria's Roll Back Malaria (RBM) programme was launched in 1998 as part of a global movement for enlisting broad-based participation in scaling up malaria control efforts. RBM is geared towards bringing about a significant reduction of the malaria burden with special focus on the high transmission areas of Africa (Goodman C; Coleman, P and Mills A 2000). Specifically, RBM has the goal of halving the world's malaria burden by 2010 with further reductions over subsequent years to achieve an overall reduction of 80% in 2030.

The Nigerian leadership constituted the arrowhead at an international RBM summit held in Abuja in 2000. African leaders expressed their commitment to combat the scourge in their various countries and to support and create the enabling environment that will make the success of RBM a reality.

- **National Malaria Control Programme**

In Nigeria, the control of malaria is a primary responsibility of the Federal Ministry of Health, and is implemented by the FMOH/ National Malarial Control Programme (NMCP). The National Malaria Control Programme is responsible for coordinating the national response through policy formation, setting standards and monitoring quality assurance, resource mobilisation, capacity development and technical support,

epidemic control, coordination of research, and monitoring and evaluation. NMCP supports the coordination structures between the Federal and state levels. Service delivery to communities and households is achieved through the state and LGA levels.

- **National Malaria Strategic Plan**

A national malaria situational analysis study was conducted in 2000. Following a series of consensus-building meetings at national and zonal levels, the FMOH produced "A Strategic Plan for Rolling Back Malaria in Nigeria: 2001-2005". This strategy was updated for the period of 2006-2009. A current version exists for 2009 – 2013 and states specific targets to be achieved and sustained. (FMOH and NMCP, 2009).

The long-term vision is a malaria free Nigeria. The goal of the malaria control programme is: To reduce by 50% malaria related morbidity and mortality in Nigeria by 2010 and minimize the socio-economic impact of the disease. Specifically, the overall objectives for the period 2009 – 2013 are:

- To nationally scale up for impact (SUFI) a package of interventions which include appropriate measures to promote positive behaviour change, prevention and treatment of malaria
- To sustain and consolidate these efforts in the context of a strengthened health system and create the basis for the future elimination of malaria in the country

The core interventions for malaria control during the next five years will be as follows:

- Prevention of malaria transmission through Integrated Vector Management (IVM) strategy (Universal access and use of Long-lasting Insecticide Nets (LLINs), selective use of Indoor Residual Spraying (IRS) and reducing breeding sites)

- Prompt diagnosis and adequate treatment of clinical cases at all levels and in all sectors of health care (scale up of diagnostic testing (rapid and microscopy), early recognition and appropriate treatment).

- Prevention and treatment of malaria in pregnancy (integrated vector management, early recognition and treatment and Intermittent preventive treatment (IPT), all embedded within Focused Ante-Natal Care (FANC).

The obstacles to the success of these interventions are socio-cultural, economic and political in nature (FMOH 2001). They include lack of political will and commitment, poor perception of the magnitude of the malaria burden, and poor treatment seeking behaviours of the individuals and communities. The development of resistance to drugs and insecticide by parasites and vectors has also compounded the control efforts.

Partners have made concerted efforts to improve the quality and impact of malaria control efforts and have all agreed to Scale Up all malaria interventions For Impact.

While previous efforts have yielded some result, more still needs to be done to be able to scale up for impact.

Development and state of prior BCC strategies for malaria

There is empirical evidence to show that communication plays a vital role in changing knowledge, creating positive attitudes and improving practice of positive health behaviour. The first communication strategy for malaria was developed in 2004. It was revised in 2008 to incorporate changes in the malaria policy. This current strategy is intended to go beyond individual behaviour change to include advocacy and social mobilisation in an effort to make malaria control interventions more effective and sustainable. Advocacy will raise the profile of malaria control, make information more accessible, and create ownership at the highest levels, and social mobilisation will engage communities directly in malaria control, and will create ownership of malaria interventions at the most local levels.

Overview of this new National Malaria Advocacy, Communication and Social Mobilisation (ACSM) Strategic Framework and Implementation Plan (SFIP)

This new strategy will provide an overall framework under which all malaria advocacy, communication and social mobilisation efforts will fit. These include the following;

- Enhancing the image of Nigeria's efforts against malaria including the branding of malaria control efforts in Nigeria and re-vamping the current NMCP website. Advocacy and media communication will be used to raise the profile of malaria control for further action to be taken by authorities, partners and other key stakeholders
- Public and Private Sector Partnerships to foster active collaboration between NMCP and relevant civil society and private sector organizations
- Social Mobilisation for active involvement of target groups and associations to address the needs in relation to malaria control efforts
- Behavioural Change Communication to provide guidance about the individual and collective behaviours to bring about effective malaria prevention and case management
- Implementation plan to guide ACSM activities in support of malaria control
- Monitoring and Evaluation mechanisms to monitor ACSM interventions and measure their impact

Behavioural overview

Priorities set out in the current NMSP include to;

- reduce malaria related mortality
- reduce malaria parasite prevalence in children under five
- increase ownership and use of long-lasting insecticidal nets (LLINs)
- introduce and scale-up indoor residual spraying (IRS)
- increase the use of diagnostic tests for fever patients
- improve appropriate and timely treatment of malaria, and
- increase coverage of intermittent preventive treatment (IPT) of malaria during pregnancy.

There are four domains of strategic communication: advocacy, services or systems, community and individual. By focusing strategic communication efforts on the behaviours of people in each of these domains, we are able to bring about initial outcomes, behavioural outcomes and sustainable health outcomes. These domains of

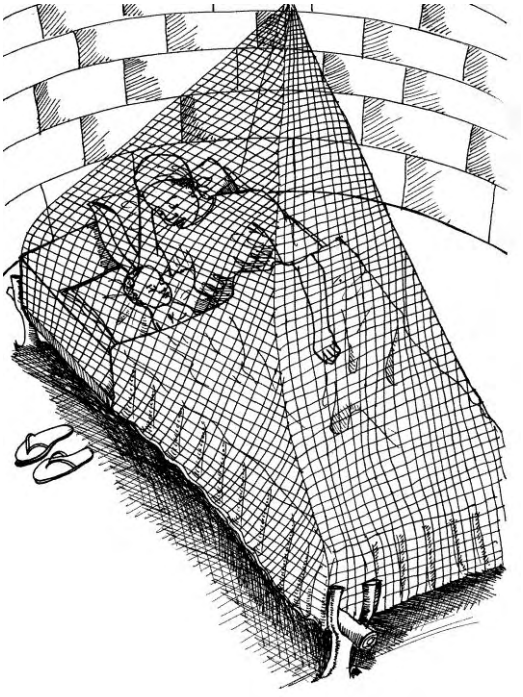
strategic communication guide us on the pathways to malaria prevention and control in Nigeria.

The key **advocacy** behaviours for ensuring a supportive policy environment associated with malaria include:

* Multi-sectoral partnerships
* Public opinion
* Institutional performance
* Resource access
* Media support
* Visibility / sharing successes

The key **service or systems** level behaviours associated with malaria include:

* Improved quality of services
* Appropriate MIP care
* Correct diagnosis
* Adherence
* Client satisfaction



The key **community** level behaviours associated with malaria include:

* Improved vector control
* Working with communities for improved participation in community-oriented interventions
* Leaders advocating
* Resource allocation

The key **individual** behaviours associated with malaria include:

- Prevention of malaria transmission through Integrated Vector Management (IVM) strategy
    - Acceptance and acquisition of LLINs, learning how to hang them up and sleeping under the LLINs every night
    - Accepting IRS and supporting its implementation, in selected sites

- Prompt diagnosis and adequate treatment of clinical cases at all levels and in all sectors of health care.
    - Good care seeking behaviour; early detection (including diagnostic testing) and treatment at facility and community level, including appropriate referral
    - Caregivers providing prompt malaria treatment for children under five with fever

- Prevention and treatment of malaria in pregnancy.
    - Attending FANC four times during pregnancy
    - IPT using SP during pregnancy

- Pregnant women to sleep under the LLINs at night
- Early diagnosis and treatment of malaria in pregnant women

While current efforts have recorded progress with some of the behaviours, some still remain low. Communication can play a great role in improving the adoption of these behaviours.

SWOT Analysis

This SWOT analysis looks at the "big picture" of malaria control in Nigeria, which sets the stage for the ACSM approaches.

Strength	**Weakness**
• Existing Malaria control programme • Viable Partnership • Injection of funds from the Federal Government of Nigeria (FGN) and partners • Policy support • ACSM coordination • Viable community systems to support Home Management of Malaria	• Poor data gathering and poor use of statistics • Duplication of efforts • Weak coordination with states and LGAs • Low visibility of the malaria work • Poorly defined partner roles • Inconsistent political will and commitment in states and LGAs
Opportunities	**Threats**
• Malaria still a major killer • Strong political support • Renewed interest in malaria control • New partner, new commitment • Private sector participation • Civil society and community involvement • Pervasive media networks • Multi-sectoral involvement	• Competing donor and national interest • Frequent changes in policy direction • Frequent staff re-deployment • Donor fatigue/over engagement fatigue • Inadequate cooperation from other tiers of government • Weak capacity of health workers • Stakeholders undervalue ACSM interventions • Major risk groups (children under five and pregnant women) are not the main drivers of policy

Conceptual Framework for the Strategy

Communication for Development

This malaria communication strategy is couched in the principle of communication for development. Communication for development is an articulation of the roles of each of the following in obtaining the desired results:

- ✓ **advocacy** for leadership and direction
- ✓ **social mobilisation** with a focus on positive change of social norms
- ✓ **behaviour change communication**

These three approaches combined form communication for development, intended to bring about social change. Communication for development is not just sending a message, or providing information, but it is the theory-based practice of interactions designed, based on research, to bring about and sustain the desired change.

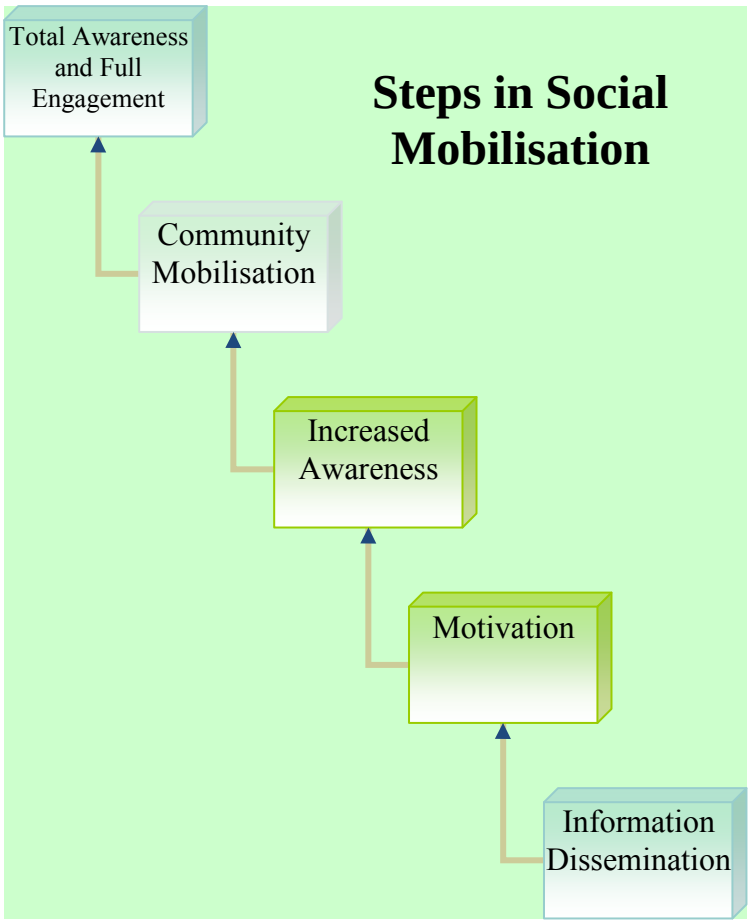
Communication Theory

The root of the word communication is commune or to make common- it is the bringing of people together to find shared or common understanding, which can lead to collective action. Advocacy relies on communication strategies to achieve its goals. Social mobilisation, too, relies on communication strategies to ensure community engagement. Similarly, changing individual and household behaviour relies on communication. ***Strategic communication*** **is a process carried out with the active participation of stakeholders and beneficiaries that addresses a long-term vision and affects the causes of as well as the barriers to behaviour change.[2] Therefore, ACSM is embraced in the term strategic communication.**

Public policy **advocacy** is the effort to influence public policy through various forms of persuasive communication. Public policy includes statements, policies, or prevailing practices set by those in authority to guide or control institutional, community, and sometimes individual behaviour. Advocacy is the deliberate process of influencing those who make policy decisions. Advocacy involves delivering messages that are intended to influence the actions of policy makers. (See Annex 3 for a description of the A-Frame for Advocacy)

[2] Payne-Merritt, A, and Rimon, J. Johns Hopkins Bloomberg School of Public Health Center for Communication Programs, 2003.

Social mobilisation is the process of motivating community members to be engaged in changing community and social norms. Social change is a complex process. The first step is information dissemination. Disseminating a common message to the general public can influence the factors that work behind it. The second step is motivation- as the information disseminated in step one motivates people to become more engaged in addressing the community issue (in this case, malaria). As people are more engaged, their awareness of the issue and the response is increased and the community as a whole begins to mobilize itself. The pinnacle of the process is total awareness and full engagement of the community. Examples of social mobilisation approaches include:



* Outreach schemes using community members as distributors of information for message dissemination. These are most successful when proper materials and training are given to the individuals best placed in the community to take on roles as educators.
* Small groups of committed individuals within the community, who plan and execute a project.
* Using volunteers in the community, sustaining the interest of volunteers and ensuring that relevant and achievable goals are set.

Behaviour Change Communication (BCC) is considered as a set of interventions intended to bring about individual changes in behaviour. BCC has its origins from and draws on numerous models and theories. These models and theories explain why people do what they do and how to influence changes in those behaviours. They provide the theoretical basis for how an intervention can affect the determinants of behaviour and cause a desired change.

See Annex 4 for an overview of ACSM theory.

When strategic communication interventions are designed on the basis of theory they are more easily evaluated and more likely to succeed. However, it is important to stress that there needs to be message harmonization across all strategic communication interventions and that all partners must adhere to this as one of the guiding principles of this strategy.

The Communication Pathways Model for Social and Behavioural Change is a model of strategic communication for development, in that it draws from a variety of advocacy, social mobilisation and BCC theories and is structured around three distinct but complementary domains of communication[3]. This model recognises that social and individual behaviour change will not happen as a result of one intervention alone or focusing on one level of society, but rather through social, individual, and structural change coming together to produce a supportive society. Thus, strengthening community capacity, changing social norms, and improving specific health behaviours requires attention at three levels of society: 1) creating enabling environments; 2) improving service support; 3) mobilizing communities and engaging individuals. This conceptual framework charts the continuum of social change among these three levels to illustrate how communication interventions lead to initial outcomes, subsequent behavioural outcomes, and finally sustained health outcomes.

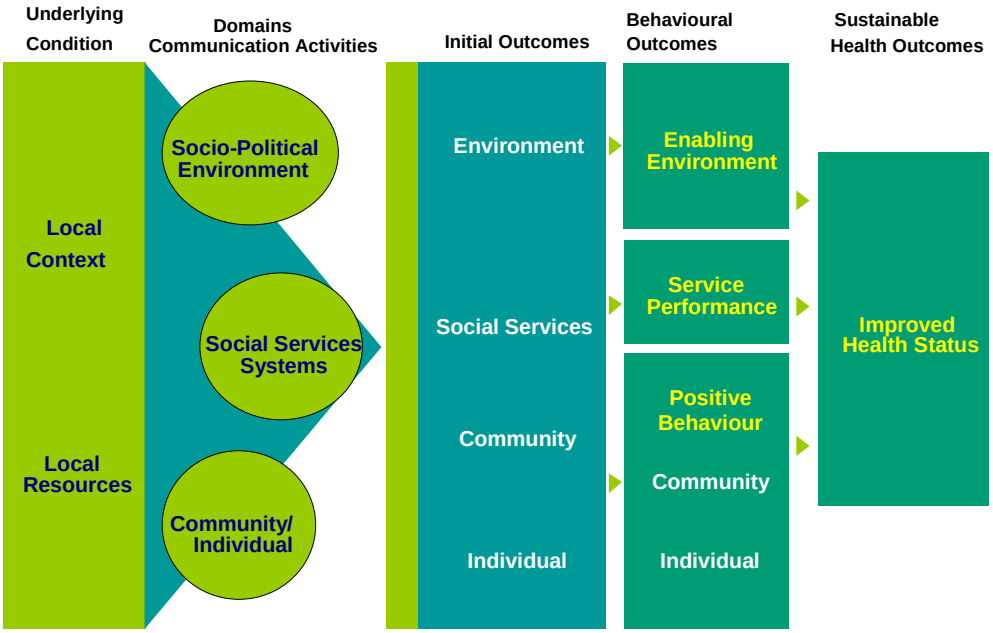
Health behaviour is affected by the larger socio-political environment. Research has shown that sustained healthy practices are more likely to happen when the following 4 elements are in place:

- **An enabling socio-political environment** — where policy decision-makers and leaders are engaged and speaking out publicly, providing resources to support healthy practices, and the with the media fully involved and committed to support the cause,
- **Efficient social systems** — where services and products are available, all health providers promote healthy behaviours,
- **Communities in action** — where the healthy behaviours are the norm, support groups exist and are open to all, and community members fully own the dialogue and actions looking for solutions to the health problem, and
- **Individuals and households** that have the skills, motivation, knowledge, attitudes, and resources to maintain their own health.

This communication strategy outlines the key, synergistic role in each of the domains to accomplish major health outcomes at the social level, as noted below. The pathways model below and the version developed specifically for malaria control in Nigeria describe the relationship between the domains of communication and the elements required to have successful and sustainable positive chances in health outcomes. For Nigeria there is a unique set of underlying conditions, which influence the domain of strategic communication. With strategic interventions in advocacy, systems development, social mobilization and BCC for individuals and households, the inputs and processes will lead to expected outcomes and impact. By following the pathways model, as illustrated below, we are guided toward appropriate message development and programme implementation designed for impact.

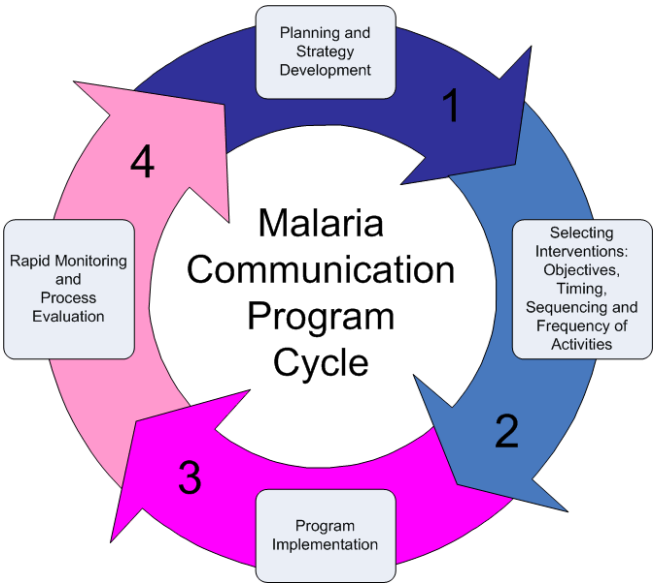
[3] Payne-Merritt, A, Johns Hopkins Bloomberg School of Public Health Center for Communication Programs, 2004.

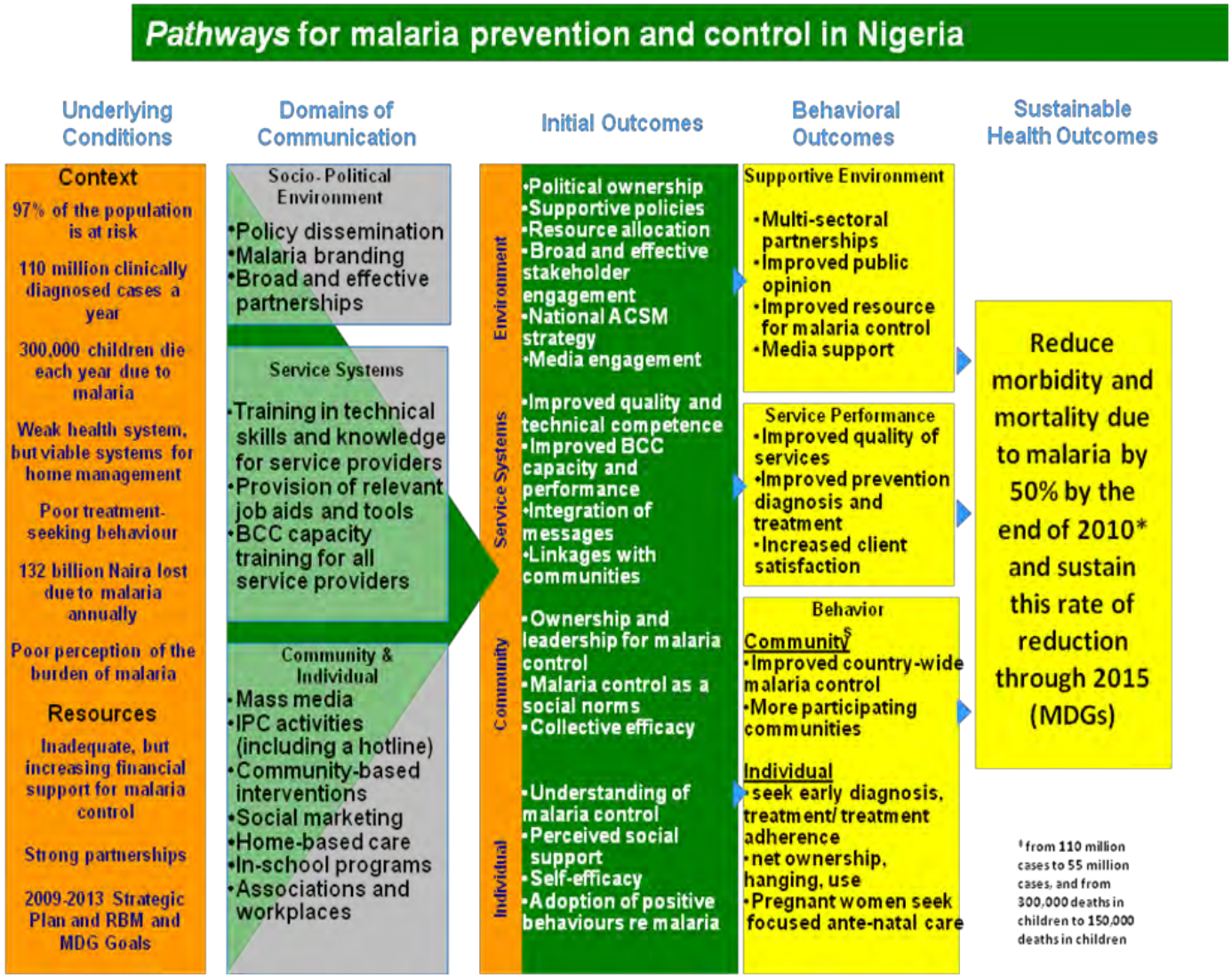
Figure 1: Communication Pathways for Social And Behavioural Changes



The Planning Process

Communication is a process. For any communication intervention to be effective, it must follow a process of planning and strategy development (based on the analysis of the evidence), selecting interventions (including the objectives, timing, sequence and frequency of activities), implementation (development and pre-testing of materials, training), and monitoring and evaluation, leading to re-planning. Throughout these steps, the audience must be engaged in the process. The image to the right illustrates the planning process (as developed by the U.S. President's Malaria Initiative (PMI)). For a more detailed description, see Annex 5.




Pathways for malaria prevention and control in Nigeria
Underlying Conditions
Domains of Communication
Initial Outcomes
Behavioral Outcomes
Sustainable Health Outcomes
Context
97% of the population is at risk
110 million clinically diagnosed cases a year
300,000 children die each year due to malaria
Weak health system, but viable systems for home management
Poor treatment-seeking behaviour
132 billion Naira lost due to malaria annually
Poor perception of the burden of malaria
Resources
Inadequate, but increasing financial support for malaria control
Strong partnerships
2009-2013 Strategic Plan and RBM and MDG Goals
Socio-Political Environment
•Policy dissemination
•Malaria branding
•Broad and effective partnerships
Service Systems
•Training in technical skills and knowledge for service providers
•Provision of relevant job aids and tools
•BCC capacity training for all service providers
Community & Individual
•Mass media
•IPC activities (including a hotline)
•Community-based interventions
•Social marketing
•Home-based care
•In-school programs
•Associations and workplaces
Environment
•Political ownership
•Supportive policies
•Resource allocation
•Broad and effective stakeholder engagement
•National ACSM strategy
•Media engagement
Service Systems
•Improved quality and technical competence
•Improved BCC capacity and performance
•Integration of messages
•Linkages with communities
Community
•Ownership and leadership for malaria control
•Malaria control as a social norms
•Collective efficacy
Individual
•Understanding of malaria control
•Perceived social support
•Self-efficacy
•Adoption of positive behaviours re malaria
Supportive Environment
•Multi-sectoral partnerships
•Improved public opinion
•Improved resource for malaria control
•Media support
Service Performance
•Improved quality of services
•Improved prevention diagnosis and treatment
•Increased client satisfaction
Behavior
Community§
•Improved country-wide malaria control
•More participating communities
Individual
•seek early diagnosis, treatment/ treatment adherence
•net ownership, hanging, use
•Pregnant women seek focused ante-natal care
Reduce morbidity and mortality due to malaria by 50% by the end of 2010* and sustain this rate of reduction through 2015 (MDGs)
§ from 110 million cases to 55 million cases, and from 300,000 deaths in children to 150,000 deaths in children

Guiding Principles

The guiding principles of this communication strategic framework and implementation plan, to which all partners should abide include:

1. **National ownership and leadership**- all partners agree to follow the direction set out by the Federal Ministry of Health (FMOH), giving support and guidance to the State and local governments. The government appreciates the assistance and advice from development partners, and encourages them to achieve **consensus** and ensure **a coordinated response**.

2. **Public-private partnerships** shall be embraced. They extend the reach and increase the effectiveness of malaria control interventions.

3. **Malaria branding**- malaria implementing partners agree to a unified "branding of malaria". This branding of malaria will facilitate ownership of malaria control efforts, as well as increasing the visibility of the malaria control interventions.

4. **Message harmonization**- to ensure that all partners are sharing the same voice. Message harmonization will ensure that the intended audience is not confused by conflicting messages, and will provide for increased message reinforcement.

5. The **community** is the core of malaria control. While children under 5 and pregnant women are the most vulnerable, malaria affects all Nigerians. Therefore, the involvement of patients, family members, communities, service providers, media, policy makers, and political leaders is critical in all stages of design, implementation and evaluation of malaria interventions.

6. Malaria communication and other malaria interventions shall be **integrated** into all health initiatives, with proper planning. For example, routine immunization and routine antenatal care are opportunities for malaria interventions. Similarly, special events and campaigns create opportunities for integration of malaria messages.

7. Use **data/evidence for decision-making** and program design. There is data available to initiate the design of communication interventions, however, more research could be conducted, including operations research. There should be a focus on formative research in communication intervention design. Furthermore, it is important to monitor and evaluate interventions and to use the information to guide on-going program development.

8. **Gender** should be mainstreamed into the design of interventions at all levels. In the case of malaria control, gender is focused on enhancing access to information and services for women and girls.

Branding strategy for malaria control efforts

Overview:
A brand is the sum total of consumer perceptions formed over time as a result of many and varied consumer contacts with the brand.
A logo is a vital part of branding. There is a global Roll Back Malaria logo which has been accepted as a representation of all partner efforts in malaria control.
The focus of this segment of the strategic framework and implementation plan is to present the national branding of malaria control efforts [malaria, for short]. By branding malaria, we are able to elevate the nation's response by promoting visibility, ownership, partnership and engagement.

A malaria-free Nigeria
The expectation for malaria control in Nigeria is easily captured in the following positioning statement: **a malaria-free Nigeria. This summarises the vision and promise of malaria control efforts in the country.**

No visual expression captures this positioning statement better than the globally recognised '**no mosquito'** symbol[4] within a **green-white-green Nigerian map**. This logo concept clearly illustrates the vision for a malaria-free Nigeria and articulates the brand promise.

To support the positioning statement and the malaria logo, is an action oriented pay offline which serves to activate the positioning statement across all communication channels. Thus, the malaria [control effort] pay-off line is as follows: **a malaria-free Nigeria … play your part.**

Malaria Brand Communication Ownership:
The malaria brand is owned by all partners implementing malaria control efforts in Nigeria under the leadership of the National Malaria Control Programme. Every communication [print, electronic or online], emanating from this partnership must recognize this alliance through the placement of partner logos.

The logo and payoff line should be applied correctly and consistently on all communication materials. It should only be used on communication, products, services and materials that follow national policies, standards, strategies and guidelines.

Print:
While the malaria logo, being the main message, will prominently feature, preferably at the top right [or middle] of the material, the Coat of Arms and the RBM logos will sit prominently at the bottom left and bottom right respectively, while any other partner[s] directly responsible for the particular malaria control communication effort [in terms of funding, for instance] will have their logo[s]

[4] The "no mosquito" symbol is used to represent no malaria-carrying female anopheles mosquitoes. Even when malaria is eliminated in Nigeria, there will still be mosquitoes in Nigeria

placed in the material in a less distracting proportion.

The Coat of Arms will represent government effort at all levels [Federal, State and Local Government] and should be used where Government efforts and contributions need to be acknowledged. It also represents efforts of the Federal and State Ministries of Health including their relevant malaria control programme counterparts. Usually, this is done by writing appropriate text under the coat of Coat of Arms. For example, Ogun State Ministry of Health/Federal Ministry of Health.

The RBM logo represents the efforts of all RBM partners and should be used where these efforts need to be recognized.

Radio
After the malaria message, the Voice over Artiste will always say: "This message is brought to you with support from the Government of Nigeria and Roll Back Malaria Partners, with funding from …" [as clarified under Print above].

This will be followed by the payoff line: "**A malaria-free Nigeria … play your part**" which will be accompanied by a Sonic Brand Trigger.

TV
Television has its own dynamic capabilities to balance message ownership. After the main message for instance, the malaria logo may freeze on the screen for a few seconds then the Coat of Arms and the RBM logo may either line up prominently below it or come after it. The funding partner[s] logo[s] will also find a place here. TV is an interactive medium and there is no end to its dynamism in terms of balancing ownership.

All of the above shall be national branding guidelines.

State Government malaria campaigns
Every State Government in Nigeria is a part of the RBM partnership and malaria campaigns in States must follow the national branding guidelines above.
Where the malaria control effort is independently funded by the State, the Coat of Arms may be replaced with the State Government logo, while the application of every other guideline remains.

Private sector malaria campaigns
Malaria control is everyone's responsibility. The impact of the scourge on productivity and profitability levels is especially not lost on the Private Sector of the economy. Therefore, with a renewed call-to-action like **"… play your part"**, it is expected that the sector will be even more galvanised to actively support the campaign.

Interested Corporate Nigerian organisations must however be made to comply by the following criteria:

- First, the malaria brand will co-brand with only private sector companies that have unquestionable ethical values.
- Second, the malaria brand will co-brand only in situations where we can retain full review and approval rights on all elements of communications. This probably

narrows partnership possibilities, but it also reduces the risk of inconsistencies in malaria branding.

- Third, the malaria logo with payoff line must be placed at a prominent place in the layout.
- If the malaria logo is resized, it must be done proportionally to the original.
- The logo must be printed preferably in the colour version.
- If, however, printed in only one colour, the black and white version must be used.

Malaria Brand Manual

The purpose of a Brand Manual is to give a brand a uniform corporate identity across all communication channels in order to achieve greater visibility and more powerful marketing possibilities.

A brand manual stipulating necessary guidelines, graphic identity standards including house fonts [typography and font family], graphic elements, pantones of colours, logo usage in various colour and reverse modes, sizes and variations, is available at the NMCP Secretariat and downloadable at the NMCP website.

Overview of the ACSM Strategic Framework

This communication plan incorporates the advocacy, communication and social mobilisation approaches to controlling malaria. It is based on the premise that everyone is at risk of malaria infection. It is designed to encourage leaders, health workers, community members, and individuals to take specific minimal doable actions to prevent and or treat malaria in themselves and in others; and it specifies how they are to be done, and the benefits of taking those actions. The plan is based on the theory that behaviour change is a process that begins with sending and receiving the relevant messages; followed by recalling them, believing them, intending to act on them, acting and advocating/recommending them to others. It also recognises that change is influenced by actions that are taken in various domains, namely: in the socio-political environment, the health system, and in the community/individual. These actions eventually lead to the enabling environments, improved social services and behavioural changes that then result in improvements in health status.

The plan's proposed interventions are adaptable to cultural requirements at the state and local government levels. They are also anchored on the following principles to facilitate ownership and sustainability, namely:

- Universal access to the relevant interventions in vector management, case management and malaria in pregnancy
- Ensuring equity through a community based approach and focus on hard to reach communities.
- Access to all malaria interventions should be treated as public health good, and
- Nationwide coverage of interventions, given consideration to local context

Below is the broad objective of the communication plan followed by the specific objectives and the anticipated results of implementing the plan.

Broad Objective

The broad objective is the same as the goal of the National Malaria Control Programme (NMCP), which is: **To reduce by 50% malaria related morbidity and mortality in Nigeria by 2010 and minimize the socio-economic impact of the disease.** The attainment of this objective will be facilitated by rapidly scaling-up for national impact the package of communication and service delivery interventions to promote positive behaviour change, prevention and treatment of malaria. Advocacy, communication and social mobilisation must also be directed at strengthening the health system to sustain the interventions till malaria is eliminated from Nigeria. This will lead to the achievement of the long-term vision of "a **malaria-free Nigeria."**

Specific Objectives[5]

The following objectives are central to achieving universal access to malaria prevention, diagnosis, treatment and control interventions.

[5] The behavioural and communication objectives have been largely derived from the objectives agreed to in the 2006 African Union Summit on Malaria.

1. Integrated Vector Management Integrated Vector Management (IVM) Objectives (Long Lasting Insecticide Treated Nets (LLIN) , Indoor Residual Spraying (IRS) and environmental management) The communication plan for integrated vector management seeks to reduce vector-borne disease morbidity and mortality, through the prevention, reduction and/or disruption of disease transmission, via the utilization of multiple control measures in a compatible manner. The focus of the IVM programme is on scale up of access and use of LLINs. Additionally, there is a strategic focus on IRS in selected sites. Specific results include:

a) At least 80% of households with two or more LLINs by 2010 and sustained at this level until 2013.
b) At least 80% of children less than 5 years of age sleep under LLIN by 2010 and sustain coverage until 2013
c) To introduce and scale up IRS to 80% household coverage in selected areas by 2010 and 20% by 2013 as a complementary strategy to LLIN and ensuring at least 85% of targeted structures are sprayed in adequate quality.

Code	Behavioural Objective	Code	Communication Objectives
BO 1	80% of mothers of children under 5 years (or caregivers) will ensure that their children under 5 years of age sleep under LLINs every night.	CO 1	90% of mothers of children under 5 years (or caregivers) will state correctly the role mosquitoes play in the transmission of malaria
BO 2	80% of pregnant women will sleep under LLINs every night.	CO 2	90% of pregnant women will state correctly the role mosquitoes play in the transmission of malaria.
BO 3	80% of children under-5 years will sleep under LLINs every night.	CO 3	90% of mothers/caregivers of children under 5 years will describe the dangers that malaria poses to young children.
BO 4	90% of mothers of children under 5 years (or caregivers) will obtain or purchase LLINs in their community.	CO 4	90% of pregnant women will describe the dangers that malaria poses to pregnant women.
BO 5	90% of pregnant women will obtain or purchase LLINs in their community	CO 5	85% of household members, in selected sites, are aware of the benefits of IRS.
BO 6	90% of mothers of children under 5 years (or caregivers) will hang and use LLINs correctly so that they and their children will be protected.	CO 6	85% of household members, in selected sites, understand the procedure involved in the exercise.
BO 7	90% of pregnant women will hang and use LLINs correctly so that they and their children will be protected.	CO 7	85% of household members, in selected sites, are knowledgeable on the safety of insecticides when used appropriately.
BO 8	85% of heads of households, in selected sites, accept and participate in the spraying process.	CO 8	85% of household members, in selected sites, state that IRS is an effective way of protecting households and communities from malaria.

2. Case Management The communication framework for case management seeks to increase the proportion of mothers or Role Model Caregivers who: tell the symptoms of, and treat fevers in children less than five years within 24 hours with the appropriate Artemisinin-based Combination Therapy (ACT), seek accurate diagnosis for malaria, recognise and report adverse drug reactions (ADRs) to healthcare providers; and can recognise and mention at least two danger signs of malaria that require immediate treatment at the health facility. It also seeks to increase the proportion of the secondary audiences, such as husbands and heads of households, who facilitate early recognition, diagnoses and appropriate treatment of all forms of malaria in line with the National Policy on Malaria Diagnosis and Treatment, and report ADRs to NAFDAC and make referrals to health facilities in cases of severe malaria. Specific results are:

a) Reduction of malaria parasite prevalence in children less than 5 years of age by 50% by the year 2013 compared to baseline of 38% in 2007.
b) At least 80% of malaria patients receive appropriate and timely treatment according to national treatment guidelines by 2013.
c) At least 80% of fever cases in children under 5 will receive appropriate and timely treatment according to the home management of malaria guidelines by 2013.
d) At least 80% of fever patients 5 years of age and above will receive a diagnostic test for malaria from a health facility by 2013.

Code	Behavioural Objective	Code	Communication Objectives
BO 1	80% of children under the age of 5 will be given appropriate anti-malarial treatment within 24 hours of onset of symptoms of malaria, following the guidelines of home management of malaria.	CO 1	90% of family members will recognise and describe the symptoms of malaria in young children and state the need to seek treatment within 24 hours.
BO 2	80% of Patent Medicine Vendors will sell age specific colour-coded and pre-packaged anti-malarial drugs to care givers whose children have malaria	CO 2	85% of caregivers will have access to appropriate and affordable treatment within their communities, through the Role Model Caregivers.
BO 3	80% of caregivers of children 5 years of age and above with fever will seek correct diagnosis using RDTs or microscopy	CO 3	90% of caregivers will mention appropriate anti-malarial medicines, state the correct dose for each, and the importance of completing the full course of treatment.

3. Malaria in Pregnancy The communication plan also aims to increase the proportion of pregnant women who can state the importance of regular FANC attendance and attend FANC early enough in pregnancy to receive at least two doses of the IPT (three doses in special circumstances). By the end of the life of this communication plan, more pregnant women should also know and mention the danger signs in pregnancy, the importance of seeking prompt treatment once those symptoms are noticed, know that LLINs effectively prevent malaria and use them throughout their pregnancies. The objectives are also targeted at increasing the proportion of the secondary audience (namely: policy-makers and implementers, health workers, husbands and other family members, and the media, etc) who are guided by MIP policy guidelines in correctly administering IPTs, who encourage pregnant women to start attending FANC early and regularly; and who publish or broadcast relevant information regularly on the prevention and treatment of MIP regularly. Additional results include:

a) All (100%) pregnant women attending FANC receive at least two doses of IPT by 2013 (three doses in special cases).
b) At least 80% of pregnant women sleep under an LLIN by 2010.
c) At least 80% of pregnant women with fever will seek diagnosis and treatment according to the Malaria in Pregnancy Guidelines by 2013.

Code	Behavioural Objective	Code	Communication Objectives
BO 1	80% of pregnant women will use Long Lasting Insecticidal Nets (LLINs).	CO 1	90% of pregnant women will state the benefits of sleeping under an LLIN.
		CO 2	90% of pregnant women will list the steps for correct LLIN use.
		CO 3	90% of pregnant women will describe where one can obtain an LLIN.
BO 2	At least, 80% of pregnant women attending FANC will use IPT at least twice (three times in special cases) after quickening (one month apart) usually from 4 months of gestation	CO 4	85% of pregnant women attending FANC will demand IPT
		CO 5	90% of pregnant women will state dangers of malaria in pregnancy.
		CO 6	90% of pregnant women will list the benefits of IPT.
		CO 7	90% of pregnant women will mention where to get IPT and who should use it.
BO 3	80% of pregnant women will access appropriate diagnosis and treatment during episodes of malaria.	CO 8	90% of pregnant women will describe signs and symptoms that should prompt them to seek treatment for malaria.
		CO 9	90% of pregnant will describe the correct medicines and dosages for treating malaria.
		CO 10	90% of pregnant women will mention where correct diagnosis and safe medicines for treating malaria can be obtained

Message Template

To achieve these results, it is necessary for all partners to communicate in the same voice, using a harmonized set of messages. Below are the core messages related to the above objectives:

	Overview	**IVM**	**Case Management**	**MIP**
Beliefs to promote:	1. Female anopheles mosquitoes spread malaria 2. Malaria is serious, can be fatal 3. Children under 5 and pregnant women are most vulnerable 4. Malaria transmission can occur year-round 5. You can prevent malaria in your home	1. Female anopheles mosquitoes that bite at night are the only cause of malaria 2. LLINs must be used nightly 3. IRS is an effective means of malaria prevention and control 4. Insecticides used in IRS are safe 5. LLINs are an effective means of malaria prevention and control 6. LLINs are safe for the general population and specifically children under 5 and/or pregnant women 7. Malaria mosquitoes breed in uncovered clean stagnant water only. Getting rid of those breeding sites is the only effective environmental management strategy	1. There is effective treatment for malaria. 2. It's important to treat fever in children under 5 within 24 hours 3. It is important for all people to seek early diagnosis and treatment for fever	1. Malaria is harmful to the pregnant woman and the unborn child 2. That LLINS can prevent malaria in pregnant women 3. Malaria in pregnancy can be prevented through IPT and it is safe for pregnant women to take it. 4. Malaria in pregnancy can be treated and the medicine is safe for pregnant women to take
Actions to promote to		1. Obtain LLIN (through free distribution, or purchase,	1. Treat children under 5, within 24 hours of onset	1. Go to FANC as early as possible or at least

individuals/ households:		if you need another) 2. Hang your LLINs properly 3. Maintain and wash your LLIN properly, 4. Sleep under an LLIN every night 5. Prepare buildings for IRS and allow sprayers inside structures, in selected sites 6. Participate in community action for vector control 7. Encourage fellow community members to access and use LLINs	of fever 2. For adults and children 5 years of age and above, seek correct diagnosis of malaria prior to taking malaria treatment 3. Take the complete dose of anti-malarial treatment correctly 4. Encourage fellow caregivers of children under 5 to seek early diagnosis and treatment of fever through HMM or facility-based approaches	before 4 months pregnant 2. Return to FANC as scheduled 3. Receive IPT at least twice (three times in special cases), the first time after quickening and the second time a month after the first dose. Take the IPT (SP) in the health centre under DOT 4. Obtain and use your LLIN properly during and after the pregnancy 5. When pregnant women feel fever, they should seek appropriate diagnosis (through microscopy or RDTs) and treatment 6. Encourage fellow pregnant women to follow MIP actions
Myths and mis-conceptions to address:	1. "Malaria is normal and not dangerous." 2. "My child or I get malaria from	a. "LLINs cause rashes and other allergies."[6] b. "It is too hot to sleep under an LLIN." c. "LLINs are difficult to	1. "I can tell when my child has malaria just by looking." 2. "When I feel better I can stop taking the	1. "It is normal to have fever after delivery and you are expected to endure it." 2. "I don't want to tell

[6] It is true that LLINs have been known to cause rashes and allergies but they are not serious and soon pass. Some of these reactions have been known to occur when instructions on correct use of an LLIN have not been followed. See the Frequently Asked Questions in Annex 6 for more information.

	walking in the sun, stress or things other than mosquitoes."	hang properly." d. "LLINs make good fishing nets, sponges, cover cloths for sleeping."[7] e. "IRS is not safe." f. "IRS increases the number of insects in the house." g. "It is difficult to prepare the house for IRS." h. "IRS stains the walls."	malaria medicine."	anyone about my pregnancy status because it brings bad luck." 3. "I shouldn't take medicines while I am pregnant"

[7] See Annex 6 for correct information regarding many myths and misconceptions about LLINs

Details of ACSM Strategic Framework

To have the greatest impact and the most cost-effective communication interventions, program planners should carefully segment and define the intended audience. This definition will include a description of the audience, including demographic, sociological and psychographic characteristics. The audience should be as narrowly defined as possible. There will be a bigger impact with a more narrowly focused and well executed communication intervention, than with one intended to reach "a general audience". Therefore, the following table outlines the key "Do-able Actions" to be taken by each audience by intervention area. It should be viewed as illustrative and formative and operations research should refine these details.

	Integrated Vector Management	**Case Management**	**Malaria in Pregnancy**
Policy Makers/ Legislators	* Know that LLINs and IRS/ vector control are effective and recommended means of malaria prevention and control *Subsidise costs of media reporting and programming on malaria * Serve as Malaria Ambassadors at the highest level of policy and participate in public events **LLIN** * Provide funds for, and procure, distribute adequate supplies of LLIN at designated/ branded popular facilities in every community nationwide * Support partnerships for coordinated and harmonized LLIN strategy * Provide legislative support to relevant LLIN policy and strategy * Create enabling environment of local manufacture of LLINs **IRS** *Support and promote IRS as a malaria prevention strategy * Support, promote and fund coordinated IRS campaign to create acceptability and use in selected communities	* Know that there is effective treatment for malaria when diagnosed early, especially in children under 5 * Plan for and ensure health service providers are updated and properly trained in case management using ACTs **Diagnosis (RDT and microscopy)** * Support use of evidence-based practices for case management * Support the establishment of a quality control system for malaria service delivery * Support and fund procurement and distribution of microscopes and RDT equipment for all health centres * Make laws that ensure that malaria diagnosis and treatment is accessible and affordable **ACT** *Support and promote the use of ACT as the government approved treatment for malaria * Subsidize the cost of ACTs *Support and promote the home management of malaria (HMM) for	*Understand the dangers of malaria during pregnancy * Know that there is effective treatment for malaria when diagnosed early, especially in pregnant women *Support the scale up and improvement of FANC services * Support provision of free FANC to pregnant women in every community **IPT** *Support and fund regular provision of Sulphadoxine Pyrimethamine (SPs) for IPT in all maternity wards/ health centers *set policy on the provision of safe drinking water in health facilities **Diagnosis (RDT and microscopy)** *Provide microscopes and RDT equipment to all health facilities *Support quality assurance and use of RDTs and microscopy **LLIN** *Provide and fund mechanism for regular resupply and restocking of FANC facilities with LLINs in every

	* Make policies that ensure that IRS is safe and is done properly **<u>Environmental Management</u>** * Review, update and operationalise policy for vector control *Review, update and operationalize the Environmental Sanitation Policy *Document larvicide pilot study, disseminate and develop policy to follow	childhood fevers	community
Media	* Provide continual media coverage to sustain support for enabling policy, legislative and corporate environment for effective LLIN strategy * Highlight creative community initiatives that successfully ensure total coverage of all malaria control interventions, including the use of LLINs, integrated vector control, IRS where applicable. * Provide media support to initiatives that empower communities and individuals to know their right to prevent malaria and hold their state and local governments accountable for funding and implementing all government approved and funded malaria control interventions in their communities; and publicise their complaints. *Report malaria prevention stories using human interest angle	*Publicize current diagnosis and treatment guidelines * Highlight creative community initiatives that successfully implement HMM, RDT/microscopy interventions. * Provide media support to initiatives that empower communities and individuals to know their right to malaria care * Empower individuals and communities to hold their state and local governments accountable for funding and implementing all government approved and funded malaria diagnosis and treatment interventions in their communities; and get feedback. *Report malaria diagnosis and treatment stories using a human interest angle, emphasizing on the correct malaria diagnosis and treatment behaviours.	* Provide media support to initiatives that empower communities and pregnant women to know their right to FANC and hold their state and local governments accountable for funding and implementing all government approved and funded FANC and malaria in pregnancy interventions in their communities; and publicise their complaints. *Report malaria in pregnancy stories using a human interest angle, emphasising on the correct MIP behaviours.
Health Provider/ Patent Medicine Vendors (PMV)/ Community	* Know that LLINs and IRS/ vector control are effective and recommended means of malaria prevention and control **<u>LLIN</u>** * Counsel clients on the use of LLINs as an effective means of malaria prevention and control	* Know that there is safe and effective treatment for malaria when diagnosed early, especially in children under 5 **<u>Diagnosis</u> (RDT and microscopy)** * At facility level, test everyone with fever for malaria, where possible * Ask about previous treatments (to	* Know that there is effective treatment for malaria when diagnosed early, especially in pregnant women **<u>IPT</u>** *Encourage early and consistent FANC attendance; give appointments for next visit

Health Worker (including RMCs)/ Private Sector Partners	* Promote LLINs at every opportunity (FANC visits, Child visits, etc) * Give information on why/how/when to use LLIN, including demonstrating how to hang LLINs and the economic benefits * Provide information on when to get free LLINs and where to buy them **IRS [only in selected sites]** * Counsel clients about the use of IRS as a safe and effective means of malaria vector control * Correct the misconceptions about IRS and other forms of IVM **Sprayers:** * Carry out effective, quality operations * Wear protective equipment (ensure women sprayers are not pregnant, potentially exposing the foetus and avoid using chronically ill people as sprayers) * Carry an ID card to identify you as a sprayer	identify treatment failures) and ask about symptom history **ACT** * Prescribe/dispense the right ACT in the right doses * Explain clearly how to take medication, discuss the side effects and emphasize the need to complete the full course of treatment * Recognise signs of severe malaria and treat or refer * Counsel clients with misconceptions about how to recognise the onset of malaria and when to stop treatment * Strengthen mechanism to address adverse drug reactions (ADR) to ACTs at community and facility levels	*Counsel pregnant women on the benefits of IPT *Provide IPT to pregnant women at least twice (three times in special cases) * Strengthen mechanism to address adverse drug reactions (ADR) to SP at community and facility levels **Diagnosis (RDT and microscopy)** *Test all pregnant women for malaria at ANC booking, and on presentation of signs and symptoms related to malaria **LLIN** *Provide pregnant women with LLINs according to the guidelines *Encourage correct maintenance and use of LLINs * Ask and counsel pregnant women and spouses about correct hanging, use and maintenance of LLINs
Community Gatekeepers/ local organizations (i.e. Community Development Associations)/ CBOs	* Know that LLINs and IRS/ vector control are effective and recommended means of malaria prevention and control **LLIN** *Promote LLINs at every opportunity (community meetings, special events, etc) *Demonstrate maintenance, use, hanging, etc. *Monitor net usage by door to door campaigns **IRS [only in selected sites]** *Mobilize community to plan and implement periodic community-wide IRS to control the malaria vector * Conduct enlightenment campaigns to	* Know that there is effective treatment for malaria when diagnosed early, especially in children under 5 * Identify and mobilize Role Model Care-givers (RMCs) * Use community meetings and special events to correct all misconceptions about fever and malaria and disseminate appropriate messages **Diagnosis (RDT and microscopy)** * Sensitize the population for home based management of malaria for children under 5 for early diagnosis and treatment. * Sensitize the population for good facility-based care seeking behaviour for	*Know that pregnant women need to attend FANC in order to receive intermittent preventive treatment for malaria * Know that there is effective treatment for malaria when diagnosed early, especially in pregnant women *Mobilise and support the provision of FANC services and consumables **IPT** *Encourage early and consistent FANC visits **Diagnosis (RDT and microscopy)** * Sensitize the population on the importance of pregnant women going

	correct all misconceptions about IRS and other IVM strategies	anyone with fever. **<u>ACT</u>** * Sensitize community about ACT as government approved treatment for malaria	for early diagnosis and treatment of malaria. *Mobilize community to acquire the RDT equipment for your health facility, and use it **<u>LLIN</u>** *Encourage pregnant women to start attending FANC early and to obtain LLINs as provided for in the LLIN policy * Encourage the correct use of LLINs by pregnant women
Individuals/ Families/ Heads of households	* Know that LLINs and IRS/ vector control are effective and recommended means of malaria prevention and control * Know that everyone benefits when everyone uses LLINs *Encourage your friends and neighbors to prevent malaria effectively **<u>LLIN</u>** * Request for, and obtain a net card (where relevant); collect your two free LLINs * Buy additional LLINs if you need more for your household * Wash and maintain LLINs correctly * Hang and use LLINs correctly and consistently * Ensure every member of your household sleeps under an LLIN every night * Ask a health provider to clarify all your fears about the use of LLIN and other IVM interventions **<u>IRS</u> [only in selected sites]** * Prepare house before spraying * Allow sprayers inside home, request for sprayer ID card	* Know that there is effective treatment for malaria when diagnosed early, especially in children under 5 *Encourage your friends and neighbors to seek early diagnosis and treatment for malaria in children under 5 **<u>Diagnosis</u> (RDT and microscopy)** * Recognise fever as a symptom of malaria and the high risk that malaria poses for children under 5 * Seek diagnosis and treatment for children under 5 within 24 hours of on-set of fever **<u>ACT</u>** * Acquire and give the right ACT, in the right dose, for the right number of days * Recognise signs of severity/complications/ failure to respond to treatment and seek help promptly * Know the signs of Adverse Drug Reactions (ADRs) and report all ADRs to your health worker immediately	*Know that pregnant women need to attend FANC in order to receive intermittent preventive treatment for malaria * Know that there is effective treatment for malaria when diagnosed early, especially in pregnant women * Encourage your pregnant friends and neighbors to seek early FANC and to follow correct MIP practices **<u>IPT</u>** *Attend FANC in first trimester and return regularly *demand IPT twice during pregnancy (three times in special cases) **<u>Diagnosis</u> (RDT and microscopy)** * Recognise fever as a symptom of malaria and the high risk that malaria poses for pregnant women * Seek early diagnosis and treatment of fever in pregnant women **<u>LLIN</u>** * Obtain, hang and sleep under an LLIN

	* Don’t wash walls after spraying		* If you need a new net, buy one

Activities by Government and Partners to support audiences to achieve do-able actions

In order to achieve the anticipated results, the key messages and do-able actions must be communicated to the intended audiences and the audiences need to be supported to implement their do-able actions. Below is a list of activities that will facilitate the implementation of the do-able actions to bring about the desired behaviours and actions.

Policy Makers/Legislators/ Public Private Partners

- Prepare advocacy kits with relevant information and present to Policy Makers, Legislators, the Media and Community Gatekeepers and Relevant Private Sector Players during planned advocacy events
- Use global and national malaria and related health events to organize sensitization and mobilisation events targeting the policy and legislative environment and key players, with branded promotional materials and media coverage
- Use the multimedia, including social media to reach political and business leaders to place action on malaria on the front burner of public discourse
- Facilitate public-private sectors dialogue to make possible private sector support for relevant malaria control policies and investment in local manufacture of some of the drugs and commodities

Media

- Conduct periodic press trips to selected facilities and communities in all geopolitical areas to highlight best practices in malaria control, success stories and problematic interventions
- Set up malaria media network
- Support health reporters' creative initiatives in reporting malaria issues in Nigeria, including the establishment of weekly malaria columns and news magazines
- Partner with credible private sector players in malaria control interventions to encourage credibility and adherence to all policy and legislative initiatives on malaria control
- Conduct media advocacy as and when necessary to ensure that bottlenecks that develop in the malaria control process are dislodged
- Co-opt media executives and renowned health beat reporters/correspondents as permanent members of the ACSM
- Develop/train and deploy local/traditional media and theatre groups as vehicles for publicising information about malaria control, including commemorative events and days to rural communities
- Develop and deploy a periodic multi-media campaign that includes press trips, radio magazine series, radio and TV instructional series, jingles, billboards and community radio, etc to place and retain malaria control events on the front burner

Health Provider/ PMV/ Community Health Worker/ Private Sector Health Company

* Train community health workers and community volunteers on effective BCC and Community Mobilisation on malaria to deliver interventions through IPC
* Train health workers to engage the community in vector control
* Provide every health worker and provider with all the job aids they need to guide them in counselling clients on IVM, including LLINs, IRS where applicable, and Environmental Management. Train and retrain them on the use of the job aids
* Conduct periodic community-related provider efficiency to ensure community owns and assists the health facility to meet its health promotion, and malaria control, prevention and treatment needs
* Put in place an effective drugs and materials procurement services and management structure to prevent stock outs
* Provide every health worker and provider with all the job aids they need to guide them in counselling clients on, and administering case management intervention including: RDT/microscopy, ACT. Train and retrain them on the use of the job aids
* Train and re-train health providers and health workers on updated malaria control approaches, including refresher courses on message harmonization on integrated vector control, hanging and usage, case management, malaria in pregnancy, myths and misconceptions to address, and beliefs and actions to promote
* Integrate malaria issues into other healthcare services in the health facility
* Provide every health worker and provider with all the job aids they need to guide them in counselling clients on and administering Malaria in Pregnancy intervention including: IPT, LLIN and RDT/microscopy. Train and retrain them on the use of the job aids
* Facilitate school visits by health workers to conduct health talks with teachers focused on malaria signs and symptoms in school children and how to make refer them with their parents to the nearest health facility for care
* Facilitate public-private-community sectors dialogue to make possible private sector support and subsidy/ (reduced cost) for relevant malaria control interventions and investment in local manufacture of some of the drugs and commodities

Community Gatekeepers/ local organizations (i.e. Community Development Associations)/ CBOs

- Distribute malaria materials within the community
- Train opinions leaders (local leaders, religious leaders, teachers, civil servants, business people) on effective malaria BCC
- Conduct periodic community-related provider efficiency assessments to ensure community owns and assists the health facility to meet its health promotion, and malaria control, prevention and treatment needs
- Conduct periodic sensitization meetings for opinion leaders at community, ward and village levels involving CBOs, community development associations as well as local government authority officials to hear and address their concerns and pass relevant messages on malaria control
- Develop talking points on malaria control for religious and opinion leaders to include in their sermons and speeches, especially on festive occasions when several members of the community return home
- Facilitate the establishment of a community-run malaria control drugs, LLIN and sprays and RDT procurement, use and distribution system, supported through communal contributions

Individuals/ Families/ Heads of households

- Facilitate mass community outreach or health educations sessions at village/ community events to provide information and messages on LLINs, case management, malaria in pregnancy, IRS and vector control, including occasional shows of community theatre and video shows produced specially for such events in the local language
- Promote quarterly household visits by community health workers (CHW) for LLIN promotion and net hanging
- Promote quarterly household visits by CHW to sensitize relevant locations on IRS
- Promote quarterly household visits by CHW to counsel families on good care seeking behaviour
- Promote quarterly household visits by CHW to counsel couples of reproductive age about the necessity and frequency of FANC for pregnant women
- Engage and train village griots and local theatre groups to develop and tell stories that enlighten individuals and families about malaria and how it is got, and encourage them to protect themselves and their environment from malaria and its vector
- Provide print material on LLINs, case management, malaria in pregnancy, IRS and vector control for household distribution
- Billboards and mobile cinema (MVU) or road shows to promote LLINs, good care seeking behaviour and FANC where possible
- Promotion of LLINs and good care seeking behaviour through anti-malaria clubs in schools, for children with younger siblings
- Create listeners' clubs to listen to the Distance Learning Program on radio to hear messages on malaria

Implementation Plan

Effective implementation of the ACSM strategy will depend on the active engagement of relevant structures as available, with each tier of government and partners performing their roles and responsibilities effectively. Also the design of the plan envisages certain conditions and assumption as precursors and catalysts for effective implementation of the strategy.

Structures
The implementation structures at the national level include the FMOH and the relevant departments/ divisions including the ACSM Section of the NMCP, the Health Promotion and the Family Health Divisions of FMOH, and relevant departments of the Federal Ministry of Information. Others are media organisations, NGOs, CBOs and FBOs. At the State and LGA levels, similar organs of government are responsible for the planning and implementation of ACSM activities. BCC should be incorporated into all NMCP activities including diagnosis case management and preventive activities. Each of these structures collaborates with and are supported by the international development partners including UNICEF, SFH, World Bank, USAID and DFID

Assumptions/ Conditions Precedent
Nigeria will witness a steady but appreciable decline in Malaria burden, as government at all levels and partners continue to plan and collaborate to scale up programmes for universal coverage and impact. However, the level of success achieved in effective application of the ACSM strategic will depend on effective management of certain on socio- economic, political and environmental factors including:

- Ongoing support by government and development partners of the waves of state LLIN campaigns.
- Stable political environment with supportive governance mechanism, which facilitates efficient health systems, backed by efficient allocation and utilisation of human and material resources.
- Availability of good quality Malaria control products (LLIN, ACT, SPs) for routine distribution at service delivery points and at commercial retail outlets, at affordable price
- Effective planning, coordination and harmonisation of activities of Role Back Malaria Partners for integration of funds and for avoidance of duplication of efforts.
- Compliance with National Policy on Malaria at all levels and at public and private health facilities

Roles and Responsibilities of Partners
The role and responsibilities of government at all levels and the partners in the effective application of the ACSM framework are as follows:

FMOH / NMCP/ACSM Unit: in collaboration with the relevant divisions in the Ministry and with development partners shall: (i) set up and serve as secretariat of the TWG/ACSM subcommittee, which has roles for planning, development/ review of work plans (ii) provide technical assistance to states and LGAs (training, research, development of prototype Communication support materials) (iii) Participate in all technical working groups for planning, implementation monitoring and evaluation of Malaria control activities at the national level. (iv) Liaise and support the Media for

effective mass media advocacy and programmes for Malaria control at the national level

ACSM Unit at State Level: Shall perform roles similar to the national ACSM Unit at the state level. Specifically, the state ACSM units has responsibility for (i) adapting the national ACSM strategies and plan for Malaria control for the state (ii) provide technical assistance and support the LGAs (planning, implementation, training and development of prototype communication support materials) (iii) Liaise with development partners and donors and NGOs in planning, implementation and evaluation of state ACSM activities

LGA/ACSM Units shall perform roles similar to the state ACSM Unit at the state level. In addition, the LGA units shall **(i)** liaise with State/ACSM (Health Promotion Units), NGOs and other partners for effective planning, implementation and evaluation of ACSM activities (ii) conduct routine ACSM activities at the LGA & community level

ACSM- IMPLEMENTATION CHART

The implementation chart is a tabular expression of the activities to be performed by partners to support audiences to achieve do-able actions, as listed above under the detailed ACSM strategic framework. The activities are grouped under the following headings: i) socio-political level, which targets policy makers, legislators and private sectors (ii) the media (iii) systems level, which targets heath care providers (iv) community level (v) individual/ household level (vi) corporate communication and (vii) coordination. The column for activities is matched with other columns for implementation: approaches, timeline, partners, budget as estimated and source of fund. The indicators by level of intervention are listed in Annex 8.

	Activities	**Approaches**	**Q1**	**Q2**	**Q3**	**Q4**	**Q5**	**Q6**	**Implementing Partners**	**Budget**	**Source of Funding**
1	**SOCIO-POLITICAL LEVEL (Policy Maker & Leaders)**										
1.1	Identify key players, advocacy needs and key issues on malaria control	• Advocacy Meetings	X						NMCP, NIFAA, ACOMIN, WB, HERFON, other Int. Dev Partners	N1.3M	NMCP, WB, GFATM, SFH, UNICEF, USAID, YGC.
1.2	Develop/Adapt, produce and use Advocacy Kits (including kits for CBOs and NGOs) on LLINs, Malaria control Intervention	• Workshop • Review Meeting • Use of Print and Electronic formats	X	X					NMCP, NIFAA, ACOMIN, HERFON, WB, Int. Dev Partners	N4.5M	NMCP, WB, GFATM, SFH, UNICEF, USAID, YGC
1.3	Conduct Advocacy events targeted at executives and Legislature and community leaders on Malaria control	• Advocacy event- (seminar, round table, and symposium) • National Malaria Conference • Advocacy materials			X	X	X	X	NMCP, NIFAA, ACOMIN, HERFON, WB and other Int. Dev Partners	N5.0M	NMCP, WB, GFATM, UNICEF, USAID, YGC. SFH, SuNMaP

		(Fact sheet, Policy Documents and Briefs)									
1.4	Conduct Mass Media Advocacy targeted at Policy makers and Legislature in Support of Malaria Control	Media Forum, Feature Articles, News Analysis, Documentary, Editorials			X	X	X	X	NMCP, NIFAA, ACOMIN, WB, HERFON, other Int. Dev Partners	N7.5M	NMCP, WB, GFATM, SFH, UNICEF, USAID, YGC.
1.5	Promote access to correct information (Web site, hotline, List serve)	Produce Fliers, Set hotline bookmarks			X	X	X	X	NMCP, NIFAA, ACOMIN, WB, HERFON, other Int. Dev Partners	N6.5M	WB, SFH
1.6	Organise Fund Raising events in support of LLIN	Fund Raising	X	X	X	X	X	X	NMCP, NIFAA, ACOMIN, WB, HERFON, other Int. Dev Partners	N2.0M	NMCP, WB, GFATM, SFH, UNICEF, USAID, YGC
1.7	Facilitate public-private sectors dialogue in support of investment in local manufacture of some of the ACTs	• Policy Dialogue • Interactive Forum		X		X		X	NMCP, NIFAA, ACOMIN, WB, HERFON, other Int. Dev Partners	N3.5M	NMCP, WB, GFATM, UNICEF, USAID, YGC, SFH, SuNMaP
2.	MASS MEDIA										
2.1	Co-opt media executives and renowned health beat reporters/correspondents as permanent	Identify experienced health reporter from major media house. • Formally induct into ACSM committee.	X						NMCP, WB, UNICEF, WHO, USAID	N8.0M	NMCP, WB, GFATM, UNICEF, YGC, SFH, USAID, AFRH

	members of the ACSM	Encourage production/ publishing of regular reports on activities									
2.2	Develop/train and deploy local/traditional media practitioners to publicise information about malaria control,	• Select , train and support local/traditional media practitioners for effective coverage and reporting on Malaria	X	X					NMCP, NIFAA, WB, ACOMIN, HERFON WB and other Int. Dev Partners,	N9.5M	NMCP, WB, GFATM, UNICEF, USAID, YGC. SFH
2.3	Develop and deploy a periodic multi-media campaign etc to place and retain malaria control events on the front burner	• Press trips, radio magazine series, radio/ TV instructional series, jingles, billboards, community radio,			X	X	X	X	NMCP, NIFAA, SFH, ACOMIN, WB, HERFON, and other Dev Partners	N10.5M	NMCP, WB, GFATM, UNICEF, USAID, YGC. SFH
2.4	Use appropriate Mass media programmes and formats to inform and educate Communities, individuals and households on ACTs & RDTs	• Radio & TV Spots, Magazine , Drama, Discussion Programme, Newspaper features, Cartoons, Documentary,			X	X	X	X	NMCP, NIFAA, WB, ACOMIN, HERFON and other Dev Partners	N12.0M	NMCP, WB, GFATM, UNICEF, USAID, YGC. SFH
2.5	Utilise opportunistic interface with the media for updates on Malaria control activities	• Quarterly Media Forum, Press Briefing	X	X	X	X	X	X	NMCP, NIFAA, WB, ACOMIN, HERFON, and other Int. Dev Partners	N6.5M	NMCP, WB, GFATM, UNICEF, USAID, YGC. SFH
2.6	Establish and support a Network forum for	Inauguration Meeting, Quarterly Meeting,	X	X	X	X	X	X	NMCP, NIFAA,	N11.5M	NMCP, WB, GFATM,

	Journalists on Malaria	• Training on Effective reporting on Malaria							ACOMIN, WB, HERFON, and other Int. Dev Partners		UNICEF, USAID, YGC. SFH
3	**SYSTEMS LEVEL (Service providers)**										
3.1	Develop/adapt and produce BCC materials/ Job Aids and Tools Kits for service providers, PMVs, RMCs , CBOs and NGOs) on Malaria Control	• Workshop , • Review Meeting • Materials produced, • Distribution Plan	X	X					NMCP, WB, NIFAA, UNICEF, WHO, SuNMaP	N7.8M	NMCP, WB, GFATM, UNICEF, USAID, YGC, SFH
3.2	Training for service providers, PMVs and RMCs - on IPC, Community Mobilisation, Use of BCC materials /Job Aids/tools kits	Workshop, Motivational leaflets, Job Aids on malaria control		X	X				NMCP, WB, NIFAA, WB UNICEF, WHO, Int. Dev Partners, SuNMaP	N9.0M	NMCP, WB, GFATM, UNICEF, USAID, YGC, SFH, SuNMaP
3.3	Support for effective logistic system and coordination to ensure availability of commodities for routine distribution	Adequate commodities with relevant BCC, materials, regular health talks & community outreaches			X	X	X	X	NMCP, WB, NIFAA, WB UNICEF, WHO, SuNMaP	N4.5M	NMCP, WB, GFATM, UNICEF, USAID, YGC, SFH, SuNMaP
3.4	Set up regular community level for a, to respond to quality issues relating to malaria	Regular meetings of community members with health facility staff to for quality service delivery			X	X	X	X	NMCP, WB, NIFAA, WB UNICEF, WHO, SuNMaP	N6M	NMCP, WB, GFATM, UNICEF, YGC, SFH, SuNMaP
3.5	Organised School health services focusing	School visits by service providers,							NMCP, WB, and other	N7.5M	NMCP, WB, GFATM,

	on Malaria Control (Health Talks, Orientation on case Management, and referral)	Health Talks, Referral services							UNICEF, WHO, USAID		UNICEF, YGC, SFH, USAID
4	**COMMUNITY LEVEL**										
4.1	Develop, produce and distribute BCC materials (including Talking Points for Community leaders) individual and households on Malaria control	Workshop, Print and Electronic BCC Packages (Leaflet, Posters, Jingles, Spots) produced, Distribution Plan	X	X					NMCP, WHO, UNICEF, CHAN, USAID, NIFAA, FOMWAN, WB, AFRH, ACOMIN	N8.5M	NMCP, WB, GFATM, UNICEF, YGC, AFRH, USAID
4.2	Develop appropriate mass media programmes and formats to inform and educate individuals and households on malaria control	Radio & TV Spots, Magazine , Drama, Discussion Programme, Newspaper features, Cartoons, Documentary,			X	X	X	X	NMCP, CHAN, UNICEF, WHO, USAID, NIFAA, FOMWAN, WB, ACOMIN, AFRH	N12.5M	NMCP, WB, GFATM, UNICEF, YGC, SFH, USAID, AFRH
4.3	Use community approaches to inform and educate communities Community leaders CBOs and NGOs , on malaria control	Community Dialogue, Road shows, rallies, Community Drama, Town Announcers, House to House Visits, Distribution of BCC materials			X	X	X	X	NMCP, WB, UNICEF, WHO, USAID, FOMWAN, CHAN, NIFAA, ACOMIN, AFRH	N9.0M	NMCP, WB, GFATM, UNICEF, YGC, SFH, USAID, AFRH
4.4	Develop and Maintain community level	CBOs and NGOs to set up revolving		X	X	X	X	X	NMCP, CHAN,	N4.0M	NMCP, WB, GFATM,

	mechanisms for procurement and management of Malaria commodities	schemes for drugs and other malaria commodities							UNICEF, WHO, USAID, NIFAA, FOMWAN, WB, ACOMIN, AFRH		UNICEF, YGC, SFH, USAID, AFRH
4.5	Train opinions leaders (local leaders, religious leaders, teachers, civil servants, business people) on effective malaria BCC	Orientation Meetings, Community level Workshops		X	X	X	X	X	NMCP, CHAN, UNICEF, WHO, USAID, NIFAA, FOMWAN, WB, ACOMIN, AFRH	N10.0M	NMCP, WB, GFATM, UNICEF, YGC, SFH, USAID, AFRH
4.6	Set up community groups, led by the identified Malaria Champions (MCs), to resolve any negative information around malaria that can lead to a crisis if not addressed promptly	Identify MCs Orientation for orient MCs to correct myths, misconceptions about malaria		X	X	X	X	X	NMCP, CHAN, UNICEF, WHO, USAID, NIFAA, FOMWAN, WB, ACOMIN, AFRH	N6.5M	NMCP, WB, GF/TAM, UNICEF, YGC, SFH, USAID, AFRH
4.7	Develop talking points on malaria control for community leaders (religious, traditional, opinion)	Talking points used at Sermons, during Speeches, especially at festive periods		X	X	X	X	X	NMCP, CHAN, UNICEF, WHO, USAID, NIFAA, FOMWAN, WB, ACOMIN,	N9.0M	NMCP, WB, GFATM, UNICEF, YGC, SFH, USAID, AFRH

									AFRH		
5	**INDIVIDUALS AND HOUSEHOLD LEVELS**										
5.1	Create for a to motivate individuals to adopt and maintain desirable behaviour for malaria	Annual Essays & other Competition & awards to LLIN champions (Families/Students. Use international and national commemorative events			X			X	NMCP, WB, UNICEF, WHO, USAID, FOMWAN, CHAN, NIFAA, ACOMIN, AFRH	N5.8M	NMCP, WB, GFATM, UNICEF, YGC, SFH, USAID, AFRH
5.2	Develop adapt produce and BCC materials on Malaria	Workshops, review meeting	X	X					NMCP, WB, UNICEF, WHO, USAID, FOMWAN, CHAN, NIFAA, ACOMIN, AFRH	N12.0M	NMCP, WB, GF/TAM, UNICEF, YGC, SFH, USAID, AFRH
5.3	Create mechanism for individuals and households to be well informed and tale appropriate actions about Malaria control.	Create Malaria radio and TV Listeners clubs, school clubs, Bill Boards, and local theatre groups. Use village griots		X	X	X	X	X	NMCP, UNICEF, WHO, USAID, FOMWAN, WB, CHAN, NIFAA, ACOMIN, AFRH	N7.5M	NMCP, WB, GFATM, UNICEF, YGC, SFH, USAID, AFRH
54	Support individual and household for active engagement in community services for malaria control malaria	Utilisation of Community health worker, RMCs and IRS sprayers		X	X	X	X	X	NMCP, UNICEF, WHO, USAID, FOMWAN, WB,	N5.5M	NMCP, WB, GFATM, UNICEF, YGC, SFH, USAID, AFRH

	control								CHAN, NIFAA, ACOMIN, AFRH		
6	**CORPORATE COMMUNICATION**										
6.1	Publicize information about NMCP among Staff of FMOH, other Min, Dept, & Agencies, the media and donor agencies.	Symposium, Seminar, Leaflet on NMCP web site and its benefits, Fact Sheets, Policy Briefs	X	X	X	X	X	X	NMCP, NIFAA, ACOMIN, HERFON, WB, Int. Dev Partners,	N8.5M	NMCP, WB, GFATM, UNICEF, USAID, SFH
6.2	Develop branding for Malaria with appropriate identity	Branding materials, design and production of Brand Manual, Media and Event Launch of the Malaria Brand, plus other communication materials	X	X	X	X	X	X	NMCP, WB UNICEF, USAID, and other Int. Dev Partners,	N40.0M	NMCP, WB, GFATM, UNICEF, USAID, SFH
6.3	Develop manual for Branding Strategy.	Consultancy	X	X					NMCP, USAID, WB, UNICEF, Int. Dev Partners	N25.0M	NMCP, USAID GFATM, SFH, UNICEF, WB
6.4	Revamp and maintain NMCP site to meet International standards	Consultancy, Use of Quarterly report of NMCP & partners, Appropriate IT tools	X	X	X	X	X	X	NMCP, WB UNICEF, USAID, and other Int. Dev Partners,	N80.0M	NMCP, WB, GFATM, UNICEF, USAID,SFH
6.5	Produce Packages (Newsletter, Documentaries) for updates, document and share the successes	Quarterly Report of Partners, other relevant reports. The Newsletter and Distribution plan	X	X	X	X	X	X	NMCP, USAID UNICEF, WB, other private sector partners,	N24.0M	NMCP, WB, GFATM, UNICEF, USAID, YGC, SFH

	stories of NMCP/ Partners and distribute as appropriate								Int. Dev Partners		
7	**COORDINATION**										
7.1	Organised regular forum for planning, coordination and harmonisation of ACSM activities	Monthly Meeting of ACSM committee, Other coordination Meetings as appropriate	X	X	X	X	X	X	NMCP, WB UNICEF, USAID, and other Int. Dev Partners	N3.6M	NMCP, WB, GFATM, SFH, UNICEF, USAID, YGC
7.2	Collaboration with other units to organize commemorative events (World Malaria Day) for coordination and harmonization	Planning Meeting, BCC materials, Community events, Advocacy events				X	X		NMCP, USAID UNICEF, WB, other private sector partners, Int. Dev Partners	N25.0M	NMCP, WB, GFATM, UNICEF, USAID, SFH
7.3	Dissemination ACSM Strategy, findings of surveys and other research, Policy documents, and other materials	Dissemination Meetings, Distribution Plan, User -friendly format of reports	X	X	X	X	X	X	NMCP, USAID, UNICEF, WB, other private sector partners, Int. Dev Partners	N12.0M	NMCP, WB, GF/TA GFATM, UNICEF, USAID, SFH

Coordination Structure

All malaria control activities are undertaken under the leadership of the Federal Ministry of Health, through the National Malaria Control Programme. Generally, the NMCP coordinates all malaria control interventions in Nigeria through six technical units namely ACSM, IVM, Case Management, M&E, Procurement and Supply Management (PSM) and Program Management. The NMCP is guided by the National Malaria Strategic Plan. All partners involved in malaria control form the country Roll Back Malaria Partnership. The Nigerian RBM partnership has great strength and NMCP's ability to coordinate partner efforts remains vital. Coordination will guarantee harmonization of partners' activities, maximum synergy of efforts and optimal cost-effectiveness and sustainability.

National Malaria Strategic Plan 2009-2013 provides the platform for coordination of malaria ACSM activities. It builds on the previous plans, making the necessary changes based on the situation analysis and changes in current thinking. Recognizing that each implementing partner may have their own guidelines regarding implementation, accountability and reporting, there is only **one strategic plan** to which all partners contribute, **one coordination mechanism** to ensure maximum synergy and avoidance of duplication, and **one M&E plan** to measure progress and assess impact (**the three ones**). The coordination of ACSM activities resides under the auspices of the ACSM unit of the NMCP. The ACSM Unit is supported by RBM partners.

Coordination at State Levels

Coordination of malaria communication activities at the states should be clearly defined. Using the ongoing LLIN campaigns as a case study, each state set up the State equivalent of the Federal LLIN Campaign Coordinating Network (LCCN). The state LCCN and partners worked closely to ensure the smooth and successful delivery of the nets. A comprehensive stakeholder analysis is used to identify all key partners, including non-governmental organizations (NGOs), private sector, civil society including FBOs and all others involved in malaria ACSM activities in the states.

The State Malaria Control Programme (SMCP) should provide leadership at the state level and build on the existing mechanism to set up a viable ACSM coordination structure at the state level to localize the national strategy in furtherance of coordination efforts

As part of moves to assist with harmonization of ACSM activities, the NMCP with the support of partners undertook a detailed partner mapping of all ACSM activities. This document details partners involved in ACSM activities, location (Federal and State levels), areas of intervention, and some costs attached. The mapping presents a snapshot that allows for better planning and synergy of efforts, which are prerequisites for coordination. Details are in Annex 7.

FMOH
Programme Mgmt Unit
ACSM Unit
Partners
NMCP
M&E Unit
Case Mgmt Unit
IVM Unit
P&S Mgmt Unit
SMOH/ Relevant Agency
Programme Mgmt Officer
ACSM Officer
Partners
SMCP
M&E Officer
Case Mgmt Officer
IVM Officer
P&S Mgmt Officer
RBM Focal Person
Partners
LGA PHC Department
Mobilisation Officer
DSNO
Others

Research, Monitoring and Evaluation

Strategic communication should be evidence based and also results oriented. Research, monitoring and evaluation are critical to the design and implementation of any successful ACSM activity.

Formative research is the basis for developing effective strategies for influencing behavior change. It helps researchers identify and understand the characteristics - interests, behaviors and needs - of target populations that influence their decisions and actions. Formative research is a crucial first step which is integral in developing programs as well as improving existing and ongoing programs.

Having set the behavioural outcomes, outputs and their corresponding indicators as well as the behaviour change strategies for how to achieve them, it is imperative to find out whether we have achieved the results or not, at the end of the programme or project. ***Monitoring*** and ***evaluation*** (M&E) are two different but complementary activities. The overall goal of M & E is to measure program effectiveness. In addition to measuring program effectiveness at national levels, it may focus on activities at state or even the lower levels.

During implementation of the interventions, activities need to be monitored to see if they are on the right track and mid-course corrections can be made, if necessary. Monitoring is a continuous process of collecting input, processes and output indicators, whereas evaluation is a systematic review of the impact of those processes on the health outcomes of the target population. Evaluation enables programme designers, implementers and funders to determine the degree of success of the intervention to guide future planning and decision-making.

Monitoring and evaluation are essential to objectively establish progress towards the achievements of the objectives of this communication strategy and in tracking the performance of the ACSM component of the National Malaria Control efforts.

"Indicators" are to show the status or position to be reached/achieved at the particular level of outcome, output or activity.

- Communication **process** indicators measure inputs and activities
- Communication **output** indicators measure consequences of inputs and activities
- Communication **outcome** indicators measure long-term impact/result of the inputs and activities

The key aspects of the M&E framework include:

- Monitoring of the implementation of the activities as they happen through process and output indicators

- Assessing the outcomes and the contribution of ACSM activities to the overall goal of the National Malaria Control Programme "To reduce by 50% malaria related morbidity and mortality in Nigeria by 2010 and minimize the socio-economic impact of the disease"

Formal evaluation is necessary to determine and document the impact of a set of interventions. While it is difficult to attribute specific interventions to outcomes or impact, it is important to study those relationships to focus on the most effective set of interventions.

M&E will be implemented within the framework of the three ones which have been defined under the coordination section.. All work regarding monitoring and evaluation of malaria control and subsequently ACSM activities in Nigeria will be based on this single M&E plan that will be guiding all partners. Implementing partners are responsible for the implementation of this M&E plan – coordinated by ACSM/NMCP.

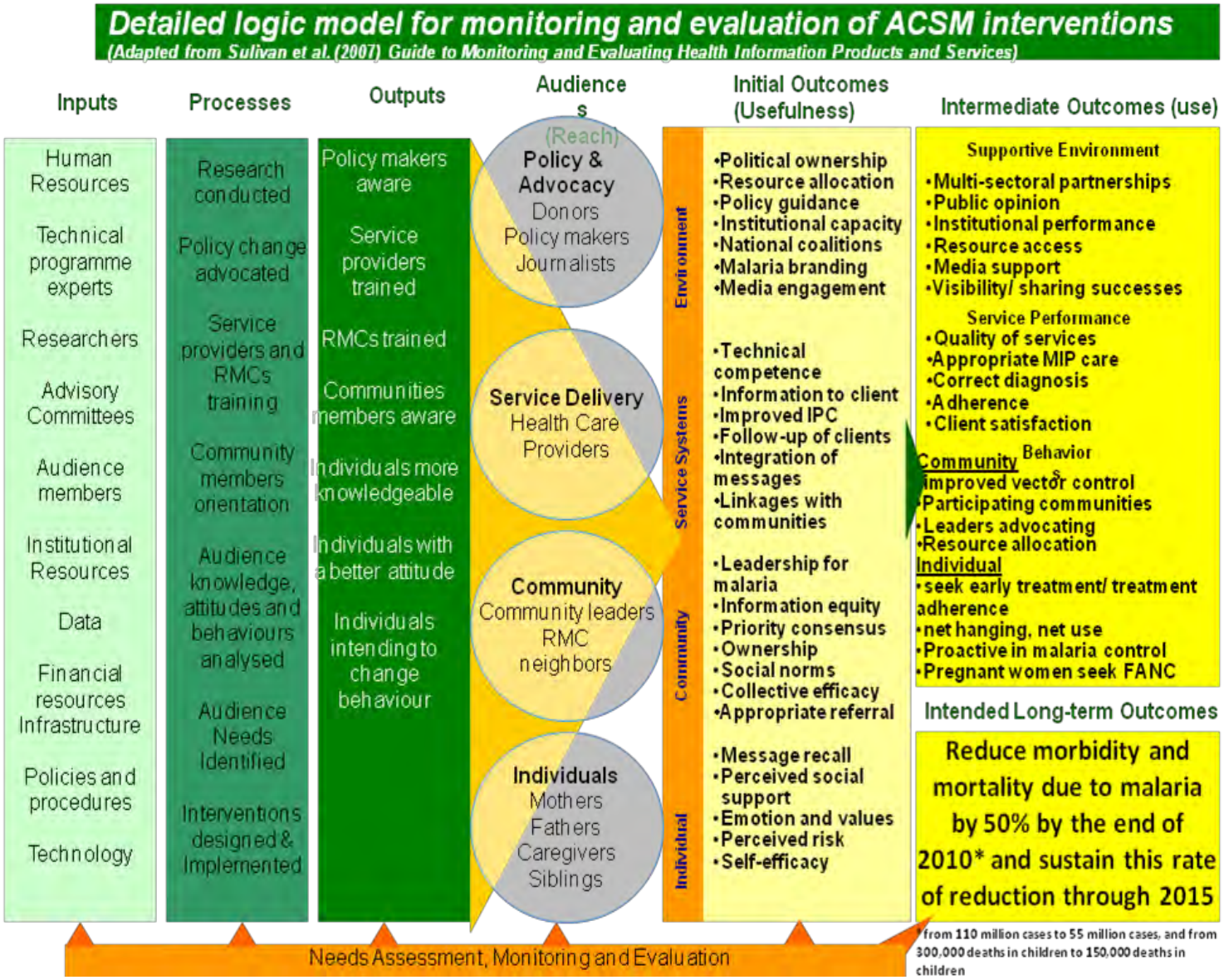
At present, there are numerous monitoring and evaluation activities in the area of health in general and malaria, specifically. The monitoring and evaluation of communication for malaria is built on the existing structures and systems. The following logic model ties into the Pathways model and illustrates the connection between the theoretically planned interventions and the desired sustainable health impact. Using this logic model, it is clear that we need indicators to measure each step on the path. These indicators are detailed in Annex 8. They are groups according to domain of communication, rather than by process, output, outcome and impact, but each fills a role in monitoring or evaluating the implementation of ACSM in Nigeria.

These indicators rely heavily on existing data collection, with some special studies to enhance the richness of the data. The following are regularly collected data sets:

- Nigeria Demographic and Health Survey, the gold standard of data collection and analysis. The NDHS has been conducted in 1998, 2003, 2008.
- Omnibus Survey, twice yearly study, on-going data collection, since 1980- In 2008, questions about mosquito nets where included and early in 2010 SuNMaP included a section on malaria, and hopes to repeat this every 6 months. Multi-Indicator Cluster Survey, conducted by the National Bureau of Statistics and UNICEF, every 3 years
- A Malaria Indicators Survey is being planned for, and is expected to be conducted every 2 years
- FMOH HMIS routine data collection

Documentation and Lessons Learned/Knowledge Management

Finally, documentation of data collected, operations research and best practices is a crucial component of strategic communication. It provides a simple and realistic mechanism to ensure the sharing of relevant information. It is imperative that key information, lessons learned and tacit knowledge gained in the process of implementing this communication strategy are recorded and shared in a systematic way with partner organizations so that their value is not lost.


Detailed logic model for monitoring and evaluation of ACSM interventions
(Adapted from Sulivan et al. (2007) Guide to Monitoring and Evaluating Health Information Products and Services)
Inputs
Processes
Outputs
Audiences (Reach)
Initial Outcomes (Usefulness)
Intermediate Outcomes (use)
Human Resources
Technical programme experts
Researchers
Advisory Committees
Audience members
Institutional Resources
Data
Financial resources Infrastructure
Policies and procedures
Technology
Research conducted
Policy change advocated
Service providers and RMCs training
Community members orientation
Audience knowledge, attitudes and behaviours analysed
Audience Needs Identified
Interventions designed & Implemented
Policy makers aware
Service providers trained
RMCs trained
Communities members aware
Individuals more knowledgeable
Individuals with a better attitude
Individuals intending to change behaviour
Policy & Advocacy
Donors
Policy makers
Journalists
Service Delivery
Health Care Providers
Community
Community leaders
RMC
neighbors
Individuals
Mothers
Fathers
Caregivers
Siblings
Environment
Service Systems
Community
Individual
•Political ownership
•Resource allocation
•Policy guidance
•Institutional capacity
•National coalitions
•Malaria branding
•Media engagement
•Technical competence
•Information to client
•Improved IPC
•Follow-up of clients
•Integration of messages
•Linkages with communities
•Leadership for malaria
•Information equity
•Priority consensus
•Ownership
•Social norms
•Collective efficacy
•Appropriate referral
•Message recall
•Perceived social support
•Emotion and values
•Perceived risk
•Self-efficacy
Supportive Environment
•Multi-sectoral partnerships
•Public opinion
•Institutional performance
•Resource access
•Media support
•Visibility/ sharing successes
Service Performance
•Quality of services
•Appropriate MIP care
•Correct diagnosis
•Adherence
•Client satisfaction
Community Behaviors
•Improved vector control
•Participating communities
•Leaders advocating
•Resource allocation
Individual
•seek early treatment/ treatment adherence
•net hanging, net use
•Proactive in malaria control
•Pregnant women seek FANC
Intended Long-term Outcomes
Reduce morbidity and mortality due to malaria by 50% by the end of 2010* and sustain this rate of reduction through 2015
Needs Assessment, Monitoring and Evaluation
* from 110 million cases to 55 million cases, and from 300,000 deaths in children to 150,000 deaths in children

Annex 1- Contact List

NAME	ORGANISATION	TITLE/POSITION
NMCP		
Dr Folake Ademola Majekodunmi	NMCP	Former National Coordinator
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Abegunde Ope	NMCP	Project Manager
Glory Opusunju	NMCP	Programme Mgt Branch
Abel Ajeigbe	NMCP	IT Specialist
Niyi Ojuolape	NMCP	Communication
Kunle Adeniyi	NACA/NMCP	Communication
Comfort Ubah	NMCP	NMCP/C.Mgt Branch
Nneka Ndubisi	NMCP	NMCP/IVM Branch
Oluwadayo Ogundeji	NMCP	ACSM /Branch
Abegunde Ope	NMCP	Project Manager
Esther Clement Gumba	NMCP	ACSM Branch
Nneka Ndubisi	NMCP	Prg. Officer
Emmanuel Ekpor	NMCP	ACSM
Emmanuel U.O. Obi	NMCP	M&E
FMOH/Health Promotion		
Mrs. L.U. Eleazu	FMOH/HP	AD/HE
FMOIC		
Adeline Ojogwu	FMIC	DD Crib
Aminu Sadiq	FMIC	Corper
Kolajo Ehime Modupe	FMIC	AD /Accreditation
Partners		
Caroline Vanderick	SuNMaP	Programme Director
Dr. Maxwell Kolawole	SuNMaP	Deputy Prog. Director
Dr. Ebenezer Baba	SuNMaP	Public Health Specialist
Ugbebor Ogheneovo	SuNMaP	Commercial Sector Analyst
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Babafunke Fagbemi	CCPN	Executive Director

Dinesh Nair	World Bank	
Dr Wole Odutolu	World Bank	Public Health Specialist
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Dr Olaokun Soyinka	WHO	HPO
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Omorebokhae Onomoase David	CHAN	Director/ Advocacy & MIS
Obasi Ogbonnaya	CCPN	Consultant
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Elizabeth Serlemitsos	JHU/CCP	Lead Consultant
Babafunke Fagbemi	CCPN	Executive Director
John Dada	SuNMaP	Communications Specialist

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Annex 3: A Frame for Advocacy[8]

Analysis is the first step to effective advocacy, just as it is the first step to any effective action. Activities or advocacy efforts designed to have an impact on public policy start with accurate information and in-depth understanding of the problem, the people involved, the policies, the implementation or non-implementation of those policies, the organizations, and the channels of access to influential people and decision-makers. The stronger the foundation of knowledge on these elements, the more persuasive the advocacy can be.

Key questions are:

1. What are the problems?
2. What are the existing policies that cause or relate to these problems and how are they implemented?
3. How would changes in policy help resolve the problems?
4. What type of policy change is needed (legislation, proclamation, regulation, legal decision, committee action, institutional practice, or other)?
5. What are the financial implications of the proposed policy change?
6. Who are the stakeholders associated with the desired policy change?
7. Who are the advocates and supporters?
8. Who are the opponents?
9. Who are the decision-makers?
10. Who are the undecided or swing voters?
11. How are changes in policies made at different levels?
12. Who and what influences the key decision-makers?
13. Whom do they believe?
14. Who are their influential constituents and co-workers?
15. What arguments are they most likely to respond to?
16. What are their priorities—rational, emotional, personal?
17. What is the communication structure related to policy-making?
18. What are the channels that reach policy-makers?
19. What is a credible message for policy-makers?

Strategy: Every advocacy effort needs a strategy. The strategy phase builds upon the analysis phase to direct, plan, and focus on specific goals and to position the advocacy effort with clear paths to achieve those goals and objectives. The strategy phase includes the following steps:

1. Establish a working group to develop a strategy and plan activities.
2. Identify your primary and secondary audiences (pro, undecided, and your competition).

[8] **Source: Johns Hopkins Center for Communication Programs**

3. Develop your SMART objectives (specific, measurable, appropriate, realistic and time bound).
4. Position your issue to offer key decision-makers a unique and compelling benefit.
5. Follow a model for policy change that suits the situation and advocacy objectives.
6. Identify your resources and plan to build coalitions and mobilize support. Seek out and work with appropriate partners, coalition advocates, spokespeople, and the media. Identify your competition.
7. Plan the activities that are the most appropriate for your intended audience.
8. Refine positions to achieve a broader consensus. Minimize the opposition or find areas of common interest as often as possible.
9. Prepare an implementation plan and a budget.
10. Plan for and combine multiple channels of communication, including personal contacts, community media, mass media (print, radio, TV), and new information technologies such as E-mail and the Internet.
11. Develop indicators to monitor the process and evaluate the impact.
12. Give the proposed policies or policy change an appealing name, easily understood and designed to mobilize support.

Mobilisation: Coalition-building strengthens advocacy. Events, activities, messages, and materials must be designed with your objectives, audiences, partnerships, and resources clearly in mind. They should have maximum positive impact on the policy-makers and maximum participation by all coalition members, while minimizing responses from the opposition. Steps in mobilisation include:

1. Develop an action plan describing the situation, intended audience, the audience impacted by change, advocacy objectives, key activities and timelines, and indicators to evaluate each activity.
    - Encourage all coalition partners to participate actively.
    - Plan events incorporating credible spokespersons from different partner organizations.
    - Develop schedule and sequence of activities for maximum positive impact.
2. Delegate responsibilities clearly to coalition members to implement and monitor specific events and activities.
3. Network with enlarge coalitions and to keep them together.
4. Organize training and practice in advocacy.
5. Identify, verify, and incorporate key facts and data to support your position. Compile data/documentation which supports your position and which shows importance of taking action.
6. Link your position to the interests of policy makers.
7. Present information in a brief, dramatic, and memorable fashion.
8. Incorporate human interest and anecdotes into your messages.
9. Specify desired actions clearly.
10. Emphasize urgency and priority of recommended action.
11. Plan for and organize news media coverage to publicize appropriate events, present new data, and credit key players.
12. Rally visible grassroots support.

Action: Keeping all partners together and persisting in making the case are both essential in carrying out advocacy. Repeating the message and using the credible materials developed over and over helps to keep attention and concern on the issue. Actions for advocacy includes:

1. Monitor and respond rapidly to other views and opposition moves. Be flexible.
2. Carry out planned activities continuously and on schedule.
3. Establish a means to keep all coalition members informed of activities and the results.
4. Develop and maintain media support with personal contacts, press releases, press conferences, and professional assistance.
5. Do not fear controversy and try to turn it to your own advantage.
6. Avoid any illegal or unethical activities.
7. Hold policy-makers accountable for commitments.
8. Keep a record of successes and failures.
9. Monitor public opinion and publicize positive changes.
10. Acknowledge and credit the role of policy-makers and coalition partners.

Evaluation: Advocacy efforts must be evaluated as carefully as any other communication campaign. Since advocacy often provides partial results, an advocacy team needs to measure regularly and objectively what has been accomplished and what more remains to be done. Process evaluation may be more important and more difficult than impact evaluation. Keys to evaluating advocacy efforts:

1. Establish and measure intermediate and process indicators.
2. Evaluate specific events and activities.
3. Document changes based on initial SMART objectives.
4. Compare final results with indicators to measure change.
5. Identify key factors contributing to policy changes.
6. Document unintended changes.
7. Share results. Publicize successes in a clear and understandable manner to stakeholders.

Continuity: Advocacy, like other communication interventions, is an ongoing process rather than a single policy or piece of legislation. Planning for continuity includes articulating long-term goals, keeping functional coalitions together, and keeping data and arguments in tune with changing situations. Steps to plan for continuity include:

1. Evaluate resulting situations.
2. If desired policy changes occur, monitor implementation.
3. If desired policy changes do not occur, review previous strategy and action, revise, repeat advocacy process or identify other actions to be taken.
4. Develop plans to sustain/reinforce change.
5. Persevere.

Annex 4- Overview of Behaviour Change Theory

Health Belief Model- (Hochbaum, Rosenstock and Kegels, 1950s) is a model which focuses on the attitudes and beliefs of individuals to help predict or explain health behaviours. Individual behaviour can be predicted based on the perception that there is a negative health condition, that the individual is at risk for that negative health condition, that the condition can be avoided, the individual also believes that there is an action that can be taken to avoid the negative health condition, and that the individual believes that s/he can successfully take that action. Based on the perceived susceptibility, perceived severity, perceived benefits and perceived barriers, one can determine the "readiness to act". These perceptions can be addressed through communication enhancing the "readiness to act" and stimulating behaviour change.

Threat-Efficacy Model- (Witte, 1992) is a parallel processing model providing an explanation for the KAP-gap. This model, building on the Health Belief Model, describes the process of people being exposed to a threat, assessing their level of susceptibility to the threat and its perceived severity. When someone perceives that a threat is high, he or she then assesses his or her own ability to address the threat. If the individual feels that s/he know of an effective strategy to deal with the threat and s/he is confident that s/he is able to implement this strategy, then the person is said to have high perceived efficacy and s/he will initiate a danger control response to minimize the threat. If the individual perceives a low self efficacy to address the threat, s/he will initiate a "fear control response" which will not address the threat itself, but rather will deny or ignore the threat. When the model is used effectively to bring about behaviour change, the BCC program will be designed to manage fear, as well as to provide hope or the vision of an opportunity. The model was developed on the basis of a message coming in as a perceived threat, followed by an assessment of perceived self-efficacy to deal with the threat, concluding with a balancing of the threat and efficacy. When communication effectively provides both the threat as well as the efficacy, the individual will identify a danger control response and adopt the new behaviour.

Cognitive Theories

1. Theory of Reasoned Action (Fishbein and Ajzen, 1975)/ Theory of Planned Behaviour states that change will only happen when a person intends to change. Intent comes from a positive attitude toward the change and a perception that there is a positive perceived social norm around the behaviour and self efficacy.

2. Social Learning Theory (Bandura, 1977) focuses on the adoption of a behaviour that has been modeled by a compelling person (real or fictitious). By modeling the behaviour, the recipient will increase his/her self-efficacy to perform the behaviour.

Social Process Theories postulate that social influence relies on people's perceptions of the attitudes and behaviours of those in their social networks. In particular, their perceptions that many people in their network act a certain way (descriptive norms) and that the people in their network expect them to act that way as well (injunctive norms). Norms become the expectation that one acts a certain way combined with the belief that

there will be social sanctions if one doesn't. Descriptive norms are the expectation of how to act. Injunctive norms are the expectation of the sanctions. It has been theorized that injunctive norms mediate the effects of descriptive norms on behaviour. (Rimal 2009)

Emotional Response Theories posit that emotional reactions precede the effects of knowledge and attitude. In other words, a highly emotional message will be more likely to influence behaviour, than a message with low emotional content.

Mass Media Theories include the Cultivation Theory (Gerbner, 1973) which states that repeated, intense exposure to messages portraying new behaviours will lead to a perception that these new behaviours are the norm. It becomes a "social legitimization" of the new behaviour which influences the existing behaviour.

Stage/Step Theories:
1. Diffusion of Innovation (Ryan and Gross, 1943) shows how a new idea or practice is communicated over time. The focus is on the factors that influence people's thoughts, actions and the process of adopting a new idea or behaviour, emphasizing on the role of interpersonal networks in the diffusion of new ideas (eg. getting people talking about the behaviour, especially "hidden behaviours" such as those related to sex.) Furthermore, diffusion of innovation must be viewed in the context of the characteristics of the innovation (is it complicated, culturally acceptable, affordable, available?).

2. Input/Output Persuasion Model (McGuire, 1969) emphasizes the hierarchy of communication effects and how different aspects, such as message design, source, channel and audience characteristics influence a change in behaviour.

3. Stages of Change (Prochaska, DiClemente and Norcross, 1992) uses a psychological approach to monitor changes in knowledge, attitude and behaviour, viewing it as a spiraling or step process from pre-contemplative, contemplative, preparatory, action, maintenance, and ultimately advocacy to others, of the new behaviour.

Ideation Conceptual Model- (Kincaid, Figueroa, Storey and Underwood, 2001) provides an explanation as to how and why new ways of thinking and the sharing of those new ways of thinking happens through social interaction within communities. This model provides an exhaustive list of the psychosocial determinants of behaviour, many of which happen in the context of the community, and suggests that when these determinants are found together they have an additive effect. Thus the more psychosocial determinants addressed in any communication intervention, the stronger the effects of the intervention should be. It is a shift from macro-level structural explanations to micro-level influences on decision-making. Ideation is embedded in the Pathways Model.

Annex 5: Malaria Communication Planning Cycle

Step One: Planning and Strategy Development

Communication strategies and activities should be designed to encourage specific target audiences to take a certain action and specify why and how. Many communication theories focus on progressive change. This includes receiving messages, recalling them, believing them, intending to act on them, and acting.

Rapid Assessment

The first step to designing and implementing a communication/social mobilization strategy is to understand the current behaviors of the target audiences and their motivations. Start with a needs assessment that includes a review of the existing policies, plans, and activities for malaria control. The assessment results and information - especially any community mobilization and demand creation gaps and/or opportunities addressing cultural change, ownership and participation - should serve as the starting point for developing a communication strategy and activities.

Most of the rapid assessment and formative research should take place in the initial planning stages of communication activities. The rapid assessment will allow implementing teams to compile and ***assess*** current knowledge, beliefs, practices, opinions, and other behavioral determinants.

Formative research can have enormous impact on how communication activities are designed. Before gathering any new information, collect and review whatever information already exists using data sources that can include:[5]

- Household survey results, including Demographic and Health Surveys (DHS)
- Health facility data
- MOH/NMCP, health education unit policies, guidelines, training materials
- Program review reports (focused program review, comprehensive review or desk review)
- Country program profile
- KAP (knowledge-attitude-practice) survey results (constitutes literature search-both published and gray)
- Qualitative research or ethnographic study reports about what people know, believe, and do concerning malaria/fever, including what they call different types of fever, what they believe causes them, and how they treat them
- Other donors/partners implementing malaria activities, including bilaterals
- Interviewing researchers who have conducted studies on these topics.

It is important to understand the program's target audiences, specifically: who they are, what they believe and what they do and do not do.

Formative Assessment

Once the rapid assessment has been completed and analyzed, gaps can be identified. To get the missing information, limited formative assessments should be conducted, and

should not constitute a lengthy process. This formative research can be quantitative and/or qualitative. As a rule, quantitative methods (such as surveys on knowledge, attitudes and behaviors using questionnaires—the "what") are more focused on precise measurement of pre-determined questions and qualitative methods (e.g., focus groups, in-depth interviews, participant observation—the "why") are more exploratory and focused on an understanding of complex realities and processes.

The findings from any new formative assessments, combined with those from the rapid assessment, should be used to develop the communication strategy that will describe interventions and define the objectives, timing, sequencing, and frequency of activities.

Step Two: Selecting Interventions: Objectives, Timing, Sequencing, and Frequency of Activities

After gathering and analyzing the information from a Rapid Assessment, the next logical step in the process is to determine what types of activities are needed to achieve the goals and priorities, in light of the information collected.

Through the annual planning process, revisit successes and challenges in communications activity implementation in each intervention in order to modify these approaches as disease patterns shift and different communications activities and messages are warranted.

To strategically determine what activities to undertake, use the data collected from the rapid (formative) implementation review to answer the following questions:

1. Who are the priority and supporting groups that need to act?
2. What are the desired behaviors/actions for these populations to achieve the goals?
3. Which factors would enable these key behaviors/actions? Which barriers need to be reduced?
4. What are the recommended activities to build on these factors/overcome these barriers?

Step Three: Program Implementation

Most materials and media for the general public should be developed AFTER the appropriate policies have been implemented, the products are commonly available, key messages have been determined, and health staff has been trained.

As media and materials are based on key messages and target audiences, it is important to plan how and when to phase in new messages and materials. Communication activities for the general public about malaria message platform appear for a specified time (e.g. quarterly) before a different message or activity begins. This strategic schedule maximizes the impact of focused messages on target audiences. Messaging should be more intensive just before and during the malaria season, or prior to specific events like spraying rounds or distributions of nets.

When creating an overall timeline of activities, it is important to have realistic expectations. Consider which preparatory activities need to be addressed first – followed

by a subsequent sequence of activities – and estimate how long each activity will take. With regard to developing materials, for example, consider the cycle of creating draft materials-pretesting materials-revising materials-pretesting- (revising) dissemination/ outreach. Adequate time should be allotted for each step in the cycle; this depends on who is working on each step and their schedule and availability. It's best to plan for at least two rounds of pretesting. Keep in mind that delays happen. Think about occurrences or conditions that have created delays in the past, and factor those in during the timeline development process. Some factors might include conflicting schedules and unavailability of key personnel, delays with producing/printing materials, holidays or other observances, unexpected illnesses among key personnel, and political transitions or civil society unrest.

Materials/media planning and dissemination
Planning materials/media to be developed is facilitated by crafting a creative brief that allows implementers to review and agree upon key aspects of products and activities. The creative brief is also useful to help the team decide what elements any communication activity should include and should bear in mind the "seven c's of strategic communication":

1. Command attention
2. Cater to the head and to the heart
3. Communicate a benefit
4. Create trust
5. Consistency counts
6. Clarify the message
7. Call to Action

When communication implementation plans are developed, it is important to consider how to distribute materials that are developed.

Step Four: Monitoring and Evaluation
Monitoring of strategic communication activities should focus on program implementation and process and output indicators. Although one does not expect to evaluate each communication intervention individually, there is an interest in evaluating BCC/IEC to demonstrate outcomes and highlight lessons learned to inform BCC/IEC policy and programs. This type of evaluation should be based on outcome indicators.

Strategic communication outcome indicators should all have a behavioral component. For instance, the proportion of children aged less than five years who slept under an insecticide-treated net the night before a survey is equally dependent on household ownership and use behavior. Progress toward these outcomes is measured in surveys, such as DHS and MIS, every few years. Repeated measurement of these outcomes may suggest the success (or failure) of communications activities, while not being able to tease out their specific contribution.

Monitoring: Monitoring is most often based on process and output indicators to track program activities. Strategic communication activities should be monitored

to show what activities have been done. Monitoring helps to assess whether program activities are on track, how close they are to meeting the projected timeline and budget, and whether staff members perform their roles correctly. Even before communication activities are launched, create monitoring mechanisms to receive feedback on the interventions and to identify any problems early so that they can be addressed quickly. This type of information should be collected and reviewed regularly to make program adjustments and to assure that the incoming data are reliable, complete, and timely.

Program implementers will need to keep track of their program input, records of how their programs are implemented, what types of activities are conducted, when, where, and by whom. By and large, this type of monitoring allows managers to describe the process of strategy, materials, and activity development and implementation, including methodology and when the steps happened.

Evaluation: The outcome and impact evaluation of malaria control efforts will not specifically evaluate BCC/IEC; however, behavior change is a necessary step to achieving success. Given the need for behavior change to support malaria prevention and treatment, the fact that BCC/IEC success is likely to be context-specific, and the lack of a set of BCC/IEC interventions with demonstrated success in the field, BCC/IEC should be evaluated in its own right. Implementers can evaluate the success of communication activities by tracking progress toward outcome indicators in program areas. Changes in outcome indicators should be interpreted alongside output indicators for communications interventions as reported through routine monitoring of communications activities in the same areas.

Annex 6: Frequently Asked Questions to promote and sustain LLIN use

S/no	General Information	Questions	Answers
1	**Correct net use**	**How do I use my nets correctly?**	**You can use your net correctly by:** • Airing the nets under the shade and (not under the **SUN**) for 24 hrs • Hanging over your sleeping area • Lying under the net • Tucking in all sides and sleep • Rolling it up in the morning
2	**Care of the net**	**How do I care for my net?**	**You can care for your net when you:** • Wash with mild soap when dirty • Wash not more than 5 times in a year • Spread under the shade to dry after washing • Mend when torn • Replace after 4 years or 20 washes
S/no	**Concern/issue**	**Questions**	**Answers**
3	**Irritation and rashes**	**Can anything happen if I do not use my net correctly?**	**Yes. To avoid any discomfort make sure you follow these instructions:** • Air the nets under the shade and (not under the **SUN**) for 24 hrs before use to prevent transient itching and rashes • Avoid body contact until you have aired the net under the shade for 24 hours • Do not use the net as cover cloth or wrapper/blanket • If you experience any form of skin and eye reaction such as itching, rashes, redness of the skin and eyes, be assured that the reactions are temporary and will clear after a short time • When nets are used correctly according to instructions (air for 24 hrs under the shade before use), there should be no itching and rashes • Sleeping under the net protects you from mosquito bites that spread malaria • Sleeping under the net ensures sound and undisturbed sleep
4	**Heat**	**It feels hot when I sleep under the net. What do I do?**	**To reduce this discomfort, do the following:** • Keep your windows open for fresh air to reduce heat (use within local context) • The feeling of discomfort will reduce as

			you continue to use the net
5	**The mosquitoes pass through the holes on the nets**	**Can mosquitoes pass through the holes on my LLIN?**	No. The mosquitoes cannot pass through the openings/holes on the LLIN. Openings in the nets are for proper ventilation • Use the net; it kills mosquitoes. • Tuck in the nets properly when you sleep • Mend your nets when torn • Replace after 4 years or 20 washes
6	**Nets not working as insecticides fade with time and use** **Odour is unpleasant and harmful**	**How long will I use the net?** **When do I replace my net?** **My net has an unpleasant smell. What do I do?**	LLINs kill mosquitoes for up to 4 years • When dirty wash with mild soap • Spread under the shade to dry after washing • Wash not more than 5 times in a year • Mend when torn • Replace after 4 years or 20 washes Odour A few people experience this smell as unpleasant. This smell is from the insecticide used to treat the net. The Odour of the insecticide on the net will not affect you. • Ensure that you air the nets under the shade for 24 hrs before use. • The odour will stop after few days of use • Better to tolerate the odour which disappears in few days than have malaria • Keep your windows open for fresh air to reduce the odour (use within local context)
7	**Where the nets can be used**	**Where can I use my net?**	Hang the net over any sleeping area; mat, bed, mattress, floor, field or open space. Sleep under it to prevent malaria
8	**Malaria transmission period and net use**	**Are nets needed all year round?**	Yes. Malaria transmission is all year round Sleep under the net every night. • Anybody can get malaria. LLINs are available in hospitals, pharmacies, chemists and markets, and they are affordable.
9	**Where to get nets**	**Where can I get a net?**	• LLINs are available in hospitals, pharmacies, PMVs, chemists and markets, and they are affordable. • If the free nets are not enough for your household buy more • Pregnant women attending FANC and children under 5 completing immunization will receive free nets from the Government health facilities

			• Nets are affordable. Protect yourself from mosquito bites, save hospital cost. • Costs of Nets are cheaper than the costs of treating malaria, buy one today.
10	**Hanging**	**How do I hang my net?**	• Most nets come with hanging kits and instructions on how to hang • However if you do not have any of these you can hang your nets with any readily available material such as bamboo/sticks, ropes (rafia), old wrapper/cloths and nails • Step-by-step Tips (use with demonstration) 1. Air for 24 hours in shade 2. Identify and nail the points to hang net 3. Tie one end of a rope to the corners of the net 4. Tie the other end of the rope to the nail 5. When not in use, gather the lower ends and fold up the net above the bed 6. When sleeping under the net, make sure the edges are well tucked-in • It is easier/cheaper to hang the net than to treat malaria • It is easier to hang the net than to treat malaria • Protect your family from mosquito bites hang and use your nets • You can easily learn how to hang up your net • You gain health and save money when you hang and use your net. *Different scenarios and different sleeping areas , Indoor, outdoor, Use of readily available materials, and emphasis on benefits to overcome laziness in hanging*

Annex 7: Partner Mapping

ROLL BACK MALARIA PARTNERS PROFILE 2010

S/N	FEDERAL/ STATE	ADVOCACY, COMMUNICATION AND SOCIAL MOBILIZATION						
		POLICY, PLANNING & COORDINATION	GENERAL ADVOCACY & COOPERATE COMMUNICATION	COMMUNICATION ON MIP	COMMUNICATION ON CASE MGT	COMMUNICATION ON LLIN CAMPAIGN	COMMUNICATION ON ROUTINE LLIN DISTRIBUTION	HEALTH EDUCATION INCLUDING IBBC
	Federal	3,10, 12, 19	3, 12	3, 12	3, 12	3, 12	3, 12	3, 12
1	Abia	12	12	12	12	12	12	12
2	Adamawa	12, 19, 20	12	12	12	12,19, 20	12, 19, 20	12
3	Akwa Ibom	6	9	9	9	9	9	9
4	Anambra	3, 6	3	3	3	3	3	3
5	Bayelsa	6	9, 10	9, 10	9, 10	9	9, 10	9, 10
6	Bauchi	6	9	9	9	9	9	9
7	Benue	6, 12	12	12	12	12	12	12
8	Borno	6, 12	12	12	12	12	12	12
9	Cross River	6, 12	10, 12	10, 12	10, 12		10, 12	10, 12
10	Delta	6, 12	10, 12	10, 12	10, 12		10, 12	10, 12
11	Ebonyi	6, 12	10, 12	10, 12	10, 12	12	10, 12	10, 12
12	Edo	6, 12	12	12	12	12	12	12
13	Ekiti	6, 8	8, 10	8, 10	8, 10	8	8, 10	8, 10
14	Enugu	6, 7	7, 10	7, 10	7, 10	7	7, 10	7, 10
15	FCT	6, 12	10, 12	10, 12	10, 12	12	10, 12	10, 12
16	Gombe	6, 9	9	9	9	9	9	9
17	Imo	6, 12	12	12	12	12	12	12
18	Jigawa	6, 8	8, 10	8, 10	8, 10	8	8, 10	8, 10
19	Kaduna	6, 7, 19, 20	7, 10	7, 10	7, 10	7, 19, 20	7, 10, 19, 20	7, 10
20	Kano	3, 6, 8	8	3, 8	3, 8	3, 8	3, 8	3, 8
21	Katsina	3, 6, 9	9	3, 9	3, 9	3, 9	3, 9	3, 9
22	Kebbi	6, 9, 12,19, 20	9, 12	9, 12	9, 12	9, 12,19, 20	9, 12,19, 20	9, 12
23	Kogi	6, 12	12	12	12	12	12	12

S/N	FEDERAL/ STATE	ADVOCACY, COMMUNICATION AND SOCIAL MOBILIZATION						
		POLICY, PLANNING & COORDINATION	GENERAL ADVOCACY & COOPERATE COMMUNICATION	COMMUNICATION ON MIP	COMMUNICATION ON CASE MGT	COMMUNICATION ON LLIN CAMPAIGN	COMMUNICATION ON ROUTINE LLIN DISTRIBUTION	HEALTH EDUCATION INCLUDING IBBC
24	Kwara	6	10	10	10		10	10
25	Lagos	3, 6, 8	8, 10	3, 8	3, 8	3, 8	3, 8	3, 8
26	Nassarawa	6, 8	8	8	8	8	8	8
27	Niger	6, 7	7	3, 7	3, 7	3, 7	3, 7	3, 7
28	Ogun	3, 6, 7	7	3, 7	3, 7	3, 7	3, 7	3, 7
29	Ondo	6, 12	12	12	12		12	12
30	Osun	6, 12	12	12	12		12	12
31	Oyo	6, 12	10, 12	10, 12	10, 12		10, 12	10, 12
32	Plateau	6, 12	10, 12	10, 12	10, 12	12	10, 12	10, 12
33	Rivers	6	10	10	10			10
34	Sokoto	6, 7, 12, 19, 20	7, 10, 12	7, 10, 12	7, 10, 12	7, 10, 12, 19, 20	7, 10, 12, 19, 20	7, 10, 12
35	Taraba	6, 8	8, 10	8, 10	8, 10	8	8, 10	8, 10
36	Yobe	6, 12	10,12	10, 12	10, 12	12	10, 12	10, 12
37	Zamfara	6, 12	10, 12	10, 12	10, 12	12	10, 12	10, 12

S/NO	PARTNERS
1	Clinton Foundation
2	DFID
3	DFID/SuNMaP
4	FMOH
5	GF
6	GF/NMCP
7	GF/NMCP/ARFH
8	GF/NMCP/FHI
9	GF/NMCP/IHVN
10	GF/SFH
11	GF/SFH/ACOMIN
12	GF/YGC
13	GF/YGC/CMD
14	GF/YGC/JSI
15	JAICA
16	JPHIEGO
17	MDG OFFICE
18	SMOH
19	UNICEF
20	UNITAID
21	USAID
22	USAID/Deliver
23	WB
24	WB/Booster
25	WHO

Annex 8: Indicators

Sociopolitical level

	Indicator	Definition	Indicator (measurement)	Possible Source	Frequency of Reporting
S 1	Resource allocation	Are resources sufficient to achieve the objectives of the national malaria strategy?	% of health budget dedicated to malaria at all levels	FMoH and SMoH	Annually
			Number of policies put in place to respond to global technical guidance on malaria	NMCP annual report	Annually
			Number of advocacy events held	Project reports	Quarterly
S 2	Partnerships	Are the partners doing the programs they committed to doing according to plan?	Existence of NMCP's ACSM strategic framework and implementation plan, updated every 18 months.	NMCP annual report	Annually
			Number of partners working within the guidelines of the ACSM strategic framework and implementation plan • Number of networks/partnerships involved • Number of community groups taking action on malaria	Partner mapping	Annually
			Proportion of partners' work plans harmonized with ACSM implementation plan	Partner work plans	Annually
S 3	Coordination	Are the coordination meetings	Number of coordination meetings held in adherence to schedule or	Minutes and reports of meetings	Monthly (according to meeting

		happening as scheduled?	plan Client satisfaction survey on the website	 Special survey report	schedule) Annually
		Are NMCP units and partners regularly submitting updates to the NMCP website?	Proportion of partners that provide update regularly on the website	Webmasters report	Quarterly
		Are partners adhering to the set of harmonized messages	Number of reports of materials produced not using the harmonized messages	Ad hoc reports	Biannually
S 4	Media support	Has the media been providing accurate and frequent coverage of the malaria situation in Nigeria?	Number of articles/ features (print) or programmes on electronic media on malaria Number of media orientation workshops conducted Media network for malaria established	Independent study Project reports Project reports	Annually Quarterly Quarterly

Health Systems level

	Indicator	Definition	Indicator (measurement)	Possible Source	Frequency of Reporting
HS 1	Facility-based health worker skills	IVM: education about LLINs and providing LLINs	No. LLINs distributed	LLIN campaign reports/ facility records	Annually
			% of health care workers who can describe the step of LLIN care and use	Facility records/ HMIS	Annually
		Case man-agement	% of health workers that can diagnose and manage and refer malaria cases effectively	Facility records/ HMIS	Annually
		MIP: educating about LLINs and IPT	% of pregnant women who visited FANC facilities and were given LLINS	Facility records/ HMIS	Annually
		Providing LLINs to pregnant women Providing IPT	% of health providers that can list the components of focused FANC and include MIP	Facility records/ HMIS	Annually
		Case man-agement for pregnant women	% of pregnant women who visited FANC facilities and were tested for malaria.	Facility records/ HMIS	Annually
HS 2	Role Model Care-givers	Health education on malaria prevention and treatment	Rates of use of RMCs at community levels by community members	Supervisors reports	Quarterly
			Number of people trained as RMCs	SMOH reports of training	Quarterly
		Dispense ACTs to	% of RMC who know when to dispense ACTs to		

		caregivers of children with fever	children under 5		
HS 3	Patent Medicine Vendors		% of PMVs who have referral records that show referral of pregnant women to FANC	Facility reports/ HMIS	Annually

Community level (using a Likert scale)

	Indicator	Definition	Possible Source	Frequency of Reporting
C 1	Feel that local leaders support malaria prevention in the community	Do the members of the community perceive that their local leaders support community initiatives for malaria prevention	NDHS Omnibus Survey MIS MICS	Every 5 years Every 6 months Every 2 years Every 3 years
C 2	Feel like your neighbors think malaria control is important	Do the members of the community perceive that their neighbors support community initiatives for malaria prevention	NDHS Omnibus Survey MIS MICS	Every 5 years Every 6 months Every 2 years Every 3 years
C 3	Feel like malaria is an important problem in your community	Degree to which respondents feel that malaria is an important problem for the community	NDHS Omnibus Survey MIS MICS	Every 5 years Every 6 months Every 2 years Every 3 years
C 4	Feel like your community can do something to prevent malaria, as a community	Degree to which respondents feel that they can do something about malaria, as a community	NDHS Omnibus Survey MIS MICS	Every 5 years Every 6 months Every 2 years Every 3 years
C 5	Feel the routine systems are working efficiently as a source of LLINs	Degree to which respondents have confidence in the routine systems for supply of LLINs for pregnant women that attend FANC	NDHS Omnibus Survey MIS MICS	Every 5 years Every 6 months Every 2 years Every 3 years
C 6	Percent of communities that have a community volunteer trained in HMM and supplied with ACTs	Number of communities with a RMC trained in HMM and supplied with ACTs /total number of communities	Activity/ Project reports	Quarterly/ Annually

C 7	Percent of communities that have a community volunteer equipped to do RDT	Number of communities with a RMC equipped to do RDT/total number of communities	Activity/ Project reports	Quarterly/ Annually
C 8	Community has conducted LLIN campaigns	Number of targeted communities that have conducted LLIN campaigns	Activity/ Project reports	Quarterly/ Annually
C 9	Have participated in LLIN campaign activities	Percent of households within targeted communities that participate in LLIN campaign activities	Activity/ Project reports	Quarterly/ Annually

IVM Indicators for individual level

Knowledge Indicators to be collected				
#	Indicator	Definition	Possible Source	Frequency of Reporting
K1	Knowledge of the means of tranmission of malaria	% of people surveyed	Omnibus Survey	Bi-annually
K2	Knowledge of the ways to prevent malaria	% of people surveyed	Omnibus Survey	Bi-annually
K3	Support from the husband to use an LLIN	% of people surveyed	Omnibus Survey	Bi-annually
Message Exposure Indicators to be collected				
#	Indicator	Definition	Possible Source	Frequency of Reporting
M1	Heard messages about LLINs	% of people surveyed	Omnibus Survey	Bi-annually
M2	Heard messages about the importance of children under five sleeping under an LLIN	% of people surveyed	Omnibus Survey	Bi-annually
Behavioural Indicators to be collected				
#	Indicator	Definition	Possible Source	Frequency of Reporting
B1	Proportion of households with at least one LLIN	Number of households that own at least one LLIN/Number of households surveyed	DHS survey MIS survey	Every five years Every two years
B2	Proportion of households with a child under 5 with at least one LLIN	Number of households with child under 5 that own at least one LLIN/Number of households surveyed	DHS survey MIS survey	Every five years Every two years
B3	Proportion of the population of all ages who slept under an LLIN the previous night	Number of household residents and visitors who slept under an LLIN the previous night/Total number of residents and visitors who slept in the surveyed households the previous night	DHS survey MIS survey	Every five years Every two years
B4	Proportion of children under 5 who slept under an LLIN the previous night	Number of children under five who slept under an LLIN the	DHS survey MIS	Every five years Every two

		previous night/Total number of children under five who slept in the surveyed households the previous night	survey	years

Case Management Indicators for individual level

Knowledge Indicators to be collected				
#	Indicator	Definition	Possible Source	Frequency of Reporting
K1	Knowledge of the symptoms of malaria	% of people surveyed	Omnibus Survey	Bi-annually
K2	Knowledge of the importance of seeking diagnosis and treatment of fever in children under five within the first 24 hours of the onset of fever	% of people surveyed	Omnibus Survey	Bi-annually
K3	Knowledge of where to go for diagnosis and treatment of fever in children under five (community HMM/ facility)	% of people surveyed	Omnibus Survey	Bi-annually
Message Exposure Indicators to be collected				
#	Indicator	Definition	Possible Source	Frequency of Reporting
M1	Heard messages about the importance of early diagnosis and treatment of children under five with fever	% of people surveyed	Omnibus Survey	Bi-annually
M2	Heard messages about the importance of completing all malaria treatment	% of people surveyed	Omnibus Survey	Bi-annually
Behavioural Indicators to be collected				
#	Indicator	Definition	Possible Source	Frequency of Reporting
B1	Proportion of children under five with fever in the last two weeks who received treatment with ACTs within 24 hours of the onset of fever from RMC or through HMM	Number of children under five who had a fever in the two weeks prior to the survey who received ACTs for treatment within 24 hours of the onset	DHS survey MIS survey	Every five years Every two years

		of fever/ Total number of children under five who had a fever reported in the two weeks prior to the survey		
B2	Proportion of children under five with fever in the last two weeks who received ACTs within 24 hours of the onset of fever from a health facility	Number of children under five who had a fever in the two weeks prior to the survey who received any anti-malarial medicine for treatment within 24 hours of the onset of fever/ Total number of children under five who had a fever reported in the two weeks prior to the survey	DHS survey MIS survey	Every five years Every two years
B3	Proportion of children under five with fever in the last two weeks and within 24 hours of the onset of fever, used an RDT	Number of children under five who had a fever in the two weeks prior to the survey who had a finger or heel stick within 24 hours of the onset of fever and an RDT was used to test for malaria/ Total number of children under five who had a fever reported in the two weeks prior to the survey	DHS survey MIS survey	Every five years Every two years
B3	Proportion of children under five with fever in the last two weeks and within 24 hours of the onset of fever, used a microscope to test for malaria	Number of children under five who had a fever in the two weeks prior to the survey who had a finger or heel stick within 24 hours of the onset of fever and a microscope was used to test for malaria/ Total number of	DHS survey MIS survey	Every five years Every two years

		children under five who had a fever reported in the two weeks prior to the survey		

Malaria in Pregnancy Indicators for individual level

Knowledge Indicators to be collected				
#	Indicator	Definition	Possible Source	Frequency of Reporting
K1	Knowledge of the risk of malaria in pregnancy	% of people surveyed	Omnibus Survey	Bi-annually
K2	Understanding of the importance of early FANC attendance for pregnant women, within the first four months of pregnancy	% of people surveyed	Omnibus Survey	Bi-annually
K3	Understanding the importance of pregnant women sleeping under an LLIN	% of people surveyed	Omnibus Survey	Bi-annually
K4	Understanding the importance of IPT for pregnant at least twice (three times in special cases)	% of people surveyed	Omnibus Survey	Bi-annually
K5	Understanding the importance of early detection and treatment of pregnant women with fever	% of people surveyed	Omnibus Survey	Bi-annually
Message Exposure Indicators to be collected				
#	Indicator	Definition	Possible Source	Frequency of Reporting
M1	Heard messages about the importance of pregnant women sleeping under an LLIN	% of people surveyed	Omnibus Survey	Bi-annually
M2	Heard messages about the importance of early FANC for pregnant women, before four months	% of people surveyed	Omnibus Survey	Bi-annually
M3	Heard about the importance of pregnant women taking IPT	% of people surveyed	Omnibus Survey	Bi-annually
M7	Heard messages about the importance of early diagnosis and treatment of pregnant women with fever	% of people surveyed	Omnibus Survey	Bi-annually
Behavioural Indicators to be collected				
#	Indicator	Definition	Possible Source	Frequency of Reporting
B1	Proportion of households	Number of households	DHS	Every five

	with a pregnant woman with at least one LLIN	with a pregnant woman that own at least one LLIN/Number of households surveyed	survey MIS survey	years Every two years
B2	Proportion of pregnant women who slept under an LLIN the previous night	Number of pregnant women who slept under an LLIN the previous night/Total number of pregnant women who slept in the surveyed households the previous night	DHS survey MIS survey	Every five years Every two years
B3	Proportion of pregnant women who presented themselves for FANC within the first 4 months of the pregnancy	Number of pregnant women, more than 4 months pregnant, who had presented themselves for FANC within the first 4 months of pregnancy/ Total number of women more than 4 months pregnant	DHS survey MIS survey HMIS service statistics	Every five years Every two years Quarterly
B4	Proportion of pregnant women counseled on malaria in pregnancy during FANC	Number of pregnant women, who attended FANC who were counseled on malaria in pregnancy/ Total number of pregnant women who attended FANC	DHS survey MIS survey	Every five years Every two years
B5	Proportion of pregnant women administered IPT once during FANC	Number of pregnant women, who attended FANC who were administered IPT once/ Total number of pregnant women who attended FANC	DHS survey MIS survey	Every five years Every two years
B5	Proportion of pregnant women administered IPT twice during FANC	Number of pregnant women, who attended FANC who were administered IPT twice/ Total number of pregnant women who attended FANC	DHS survey MIS survey	Every five years Every two years