Zimbabwe Ministry of Health and Child Care
National Malaria Control Programme

Malaria Communication Strategy

2016–2020

USAID FROM THE AMERICAN PEOPLE
CDC
U.S. President's Malaria Initiative

ZAPIM
Zimbabwe Assistance Program in Malaria

HEALTH COMMUNICATION CAPACITY COLLABORATIVE

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Acronyms

ACT	Artemisinin-based Combination Therapy
AIM	Action and Investment to defeat Malaria
ANC	Antenatal Care
API	Annual Parasite Incidence
CCP	Johns Hopkins Center for Communication Programs
CHW	Community Health Worker
CMC	Community Malaria Committees
DHE	District Health Executive
E8	Elimination 8
EPI	Expanded Program on Immunization
GTS	Global Technical Strategy for Malaria
HMIS	Health Management Information System
IEC	Information, Education and Communication
IPTp	Intermittent Preventive Treatment in Pregnancy
IRS	Indoor Residual Spraying
ITN	Insecticide Treated Net
KAP	Knowledge, Attitudes and Practices
LLIN	Long Lasting Insecticide Net
MCHIP	Maternal and Child Health Integrated Program
MCS	Malaria Communication Strategy
MICS	Multiple Indicator Cluster Survey
MiP	Malaria in Pregnancy
MIS	Malaria Indicator Survey
MOHCC	Ministry of Health and Child Care
MP	Member of Parliament
MPR	Malaria Programme Review
NGO	Non-governmental Organisation
NMCP	National Malaria Control Programme
NMSP	National Malaria Strategic Plan
RBM	Roll Back Malaria
PHE	Provincial Health Executive
PMI	President's Malaria Initiative
PSI	Population Services International
SBCC	Social and Behaviour Change Communication
TMT	Top Management Team
TRaC	Tracking Results Continuously
TWG	Technical Working Group
SP	Sulphadoxine-pyrimethamine
VHW	Village Health Worker
WHO	World Health Organization
WHT	Ward Health Team
ZAPIM	Zimbabwe Assistance Programme in Malaria
ZDF	Zimbabwe Defence Force
ZDHS	Zimbabwe Demographic Health Survey
ZINATHA	Zimbabwe National Traditional Healers Association

Foreword

Zimbabwe's Malaria Communication Strategy (MCS) has been developed to support the National Malaria Strategic Plan (NMSP), which in turn serves to accomplish goals of the National Health Strategy for the same period, 2016-2020. A participatory consultative process was conducted to review a wide range of documents including the 2016 Malaria Indicator Survey (MIS), Malaria Programme Review (MPR), Zimbabwe Demographic Health Survey (ZDHS), Multiple Indicator Cluster Survey (MICS), Tracking Results Continuously (TRaC) Survey, previous qualitative and quantitative surveys and programme reports to review past and current social and behaviour change communication (SBCC) progress in malaria. Several key findings include: high rates of indoor residual spraying (IRS) acceptance and an increasing rate of care seeking behaviour for fever. Findings also include low uptake and utilisation of long-lasting insecticide treated nets (LLINs), low malaria risk perception, low prompt care seeking among caregivers of children under five, and low uptake of intermittent preventive treatment for pregnant women (intermittent preventive treatment in pregnancy – IPTp). Changes in malaria epidemiology necessitated re-stratifying the country into five distinct transmission zones which are: free/sporadic; low and short seasonal; moderate and seasonal; high and seasonal; and high and perennial. Participants present for this consultation recognised the need to tailor different SBCC approaches for these transmission zones. This MCS describes changes in communication objectives between control areas (high and moderate transmission) and pre-elimination areas (low and unstable transmission).

The goal of the NMSP 2016-2020 is to reduce malaria incidence to 5/1000 and malaria deaths by at least 90 percent by 2020 compared to the 2015 baseline. The MCS will help accomplish this by focusing on NMSP Objective 5: "To increase utilisation of all malaria interventions to at least 85 percent by 2020." The vision of the MCS is "to have a malaria free Zimbabwe through empowered communities who have the knowledge and skills to protect themselves from malaria." The need to increase demand, uptake and utilisation of malaria interventions has therefore become this document's overarching priority. To achieve this, a more scientific and evidence-driven approach to malaria communication programming is needed. Formative research to understand social determinants of behaviour will be conducted to complement available information from routine data collection. This more complete understanding of behaviour determinants will enable the National Malaria Control Programme (NMCP), together with its partners, to engage communities and mobilise them to utilise appropriate malaria prevention and control interventions, which will in turn enable them to live healthier and more productive lives.

The MCS provides a framework for malaria SBCC implementers at all levels in planning, developing, implementing, monitoring and evaluating malaria communication programmes. Consistent with best practices outlined in the NMCP SBCC Implementation Guidelines, it uses a five-step planning process, and describes multiple reinforcing channels to influence prioritised behaviours. These behaviours will be tracked and programme progress evaluated using globally recognised indicators. The MCS is based on the premise that behaviour change is not merely a product of knowledge or the availability of information but is dependent on such factors as availability of resources, prevailing sociocultural norms and perception of individual and community priorities.

It is my hope that this communication strategy will be used by all implementing partners in malaria prevention, control and elimination to ensure that community participation becomes an integral component of the malaria communication programme in Zimbabwe.

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SECRETARY FOR HEALTH AND CHILD CARE ZIMBABWE

Acknowledgements

The development of the MCS marks a milestone in the efforts by the Ministry of Health and Child Care (MOHCC), through the NMCP, to ensure that SBCC for malaria is done in a more coordinated and systematic manner. This MCS builds on effective communication for malaria programming and develops strategies for SBCC at different levels to change behaviour and achieve a malaria free Zimbabwe.

The MOHCC wishes to thank all individuals, stakeholders and organisations that have contributed to the development and finalization of this strategy. Special gratitude is extended to the leadership of the NMCP under the Director; MOHCC personnel at the national, provincial and district level; other government departments; funding and implementing partners including, but not limited to, the President's Malaria Initiative (PMI), the World Health Organization (WHO), Zimbabwe Assistance Program in Malaria (ZAPIM), Population Services International (PSI), Plan International, Clinton Health Access Initiative (CHAI), Abt Associates Africa In-door Residual Spraying (AIRS) and the United States Agency for International Development Maternal and Child Health Integrated Program (USAID/MCHIP). We recognise the technical assistance of our consultants from the Johns Hopkins Center for Communication Programs (CCP) in the development and finalisation of this strategy. The support and commitment shown in the development of this document will go a long way towards the realization and implementation of the MCS.

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Background

In the last eight years, since Zimbabwe's first MCS, the burden of malaria has been reduced from an incidence of 94/1000 in 2008 to 29/1000 in 2015. Comparisons of multiple household surveys have found households in Zimbabwe accept IRS spraying at high rates, contributing to coverage that exceeds World Health Organization (WHO) recommendations. While prompt care seeking for fever remains low, it has increased in recent years. More can be done to improve the rates of IPTp uptake, as it appears pregnant women are not receiving the recommended doses. While LLIN ownership in Zimbabwe is increasing, more needs to be done to understand the levels of use throughout the year.

The current NMSP goal is to reduce malaria incidence to 5/1000, with the ultimate goal of reducing malaria deaths to near zero in 2020. Close collaboration with neighbouring Elimination 8 (E8) countries will ensure gains made are sustained.

Zimbabwe has five malaria transmission zones. The districts in the low transmission zones are gradually moving towards malaria pre-elimination and ultimately malaria elimination. As Zimbabwe's communities in the low transmission zones make this transition, evolving perceptions about the risk of malaria must be monitored closely. Just as the Roll Back Malaria (RBM) Action and Investment to defeat Malaria (AIM) and the WHO's Global Technical Strategy (GTS) documents stress the importance of entomological and human surveillance in achieving malaria elimination, tracking behaviours will also be essential. This MCS has added a new communication plan to track and address behaviours across the transmission spectrum.

This MCS moves beyond focus on individual behaviour change and acknowledges that individuals are part of families, families are surrounded by a community and communities function in an interconnected web of government and health structures. This MCS includes objectives and targets intended to achieve and measure individual, social and structural change.

Introduction

NMSP 2016 -2020 Mission: To provide, promote and advocate for: quality health services; equity in health; cost effective and efficient malaria interventions; transparency, accountability, ownership and partnership in the NMCP.

NMSP Goal: By 2020, reduce malaria incidence to 5/1000 and malaria deaths by at least 90 percent compared to 2015 levels.

MCS Vision Statement: To have a malaria free Zimbabwe through empowered communities who have the knowledge and skills to protect themselves from malaria.

MCS Goal: (NMSP Objective 5) Increase the utilisation of all malaria interventions to at least 85 percent by 2020.

Malaria Overview: In 2014, malaria ranked fifth among Zimbabwe's causes of morbidity and was the tenth highest cause of mortality. The 2015 Health Management Information System (HMIS) data pointed to a decline in malaria incidence from 94/1000 in 2008 to 29/1000 in 2015. Only Mbire, Mutoko and Nyanga districts were reported to have an incidence of above 200/1000. Some districts in Matabeleland North, Matabeleland South, Mashonaland West and the Midlands have achieved pre-elimination status, recording incidence figures of less than 5/1000 cases. Zimbabwe's simultaneous implementation of integrated vector control, case management, SBCC, epidemic preparedness and response and surveillance monitoring, evaluation and operational research have doubtlessly contributed to these reductions in malaria burden.

MCS (2016-2020) Behaviour Priority Objectives

- Increase the proportion of the population sleeping under LLINs to 85 percent by 2020.
- Maintain the proportion of households who accept to have their houses sprayed above 90 percent by 2020.
- Increase the proportion of women who have knowledge about the importance of IPTp during pregnancy to 85 percent by 2020.
- Increase the proportion of the population who utilise malaria prevention and control interventions to 85 percent by 2020.

Guiding Principles of MCS 2016-2020

1. **Evidenced -based information gathering and dissemination:** Systematic inquiry and use of resulting data on the determinants of behaviour is the basis for health communication interventions. In order to develop strategies that result in behaviour change, the knowledge levels, beliefs, cultural values and structures of the target groups need to be identified. Formative research and rapid assessments will also assist in the segmentation of the target groups and development of specific and key messages.

2. **Epidemiological evidence:** The use of available epidemiological data will greatly assist SBCC efforts by ensuring malaria is defined in terms of place, time and the population at risk.

3. **Multi-sectoral collaboration:** In order for the malaria prevention and control program to be successful, joint efforts are needed among all sectors, from the community to the national level. Collaboration and coordination of key partners and stakeholders will be crucial in mobilising financial and human resources.

4. **Community ownership, empowerment, initiative, involvement and participation:** Zimbabwean communities should be convinced that they remain at risk of contracting malaria all year round. Their ownership and participation in malaria control and prevention activities will make malaria elimination possible. Community participation will ensure that the approaches developed to address barriers to their health in their unique context are sustainable and effective.

5. **Use of multiple, reinforcing channels:** Use of multiple channels to reach target audiences has proved to be very effective in SBCC. Due to the stratified nature of malaria in the country this is an important component of this strategy. Some of the communication channels this strategy highlights include interpersonal communication, community mobilisation and mass media.

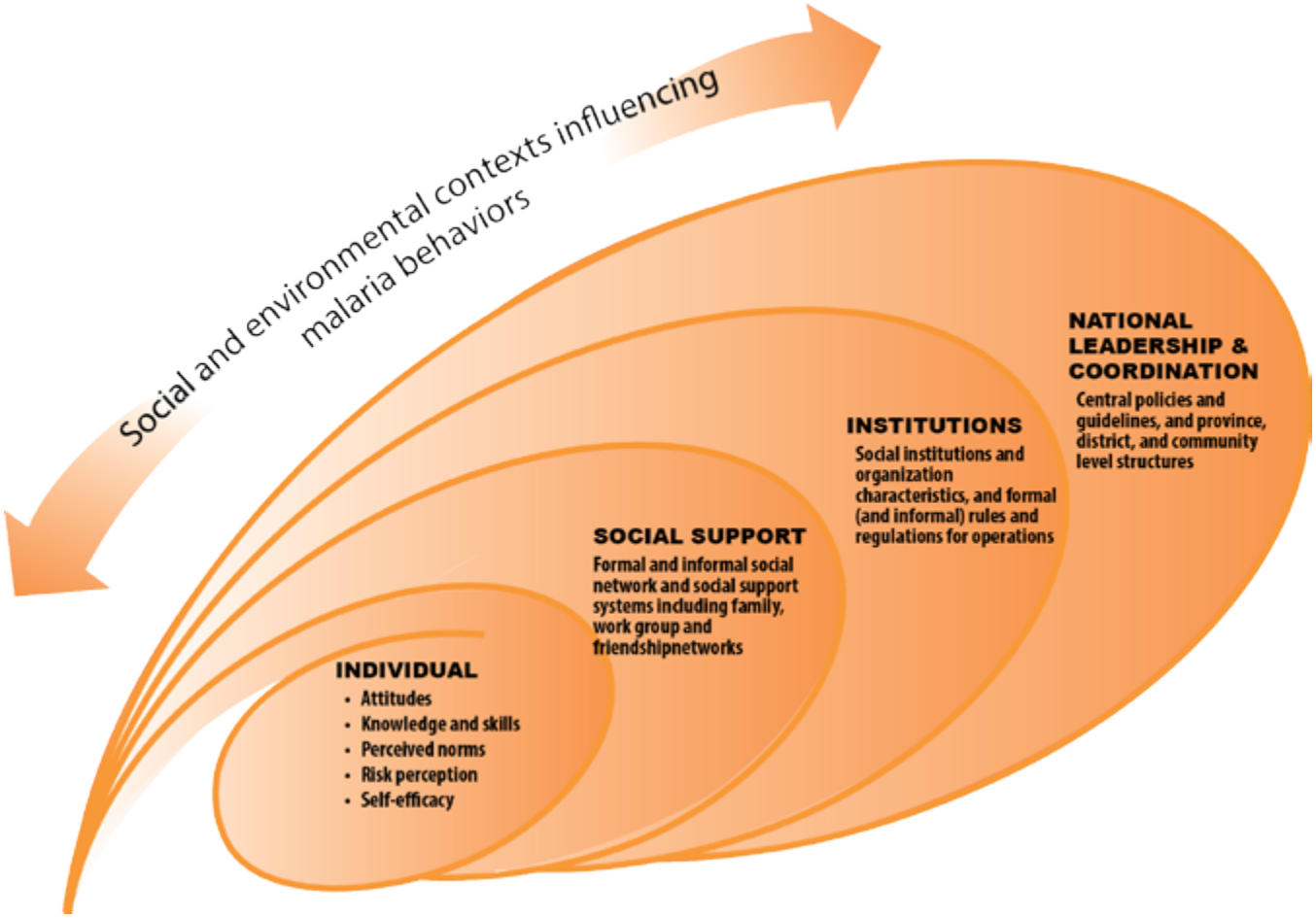


Figure 1: Socioecological model

Conceptual Framework: The MCS is guided by theory-based models of behaviour change. The socio-ecological model (Figure 1 above) highlights how behaviour influences (and is influenced by) individual, social and structural factors. Based on the Ecological Systems Theory, the socio-ecological model is the basis for decisions to focus on advocacy as an important part of this strategy.

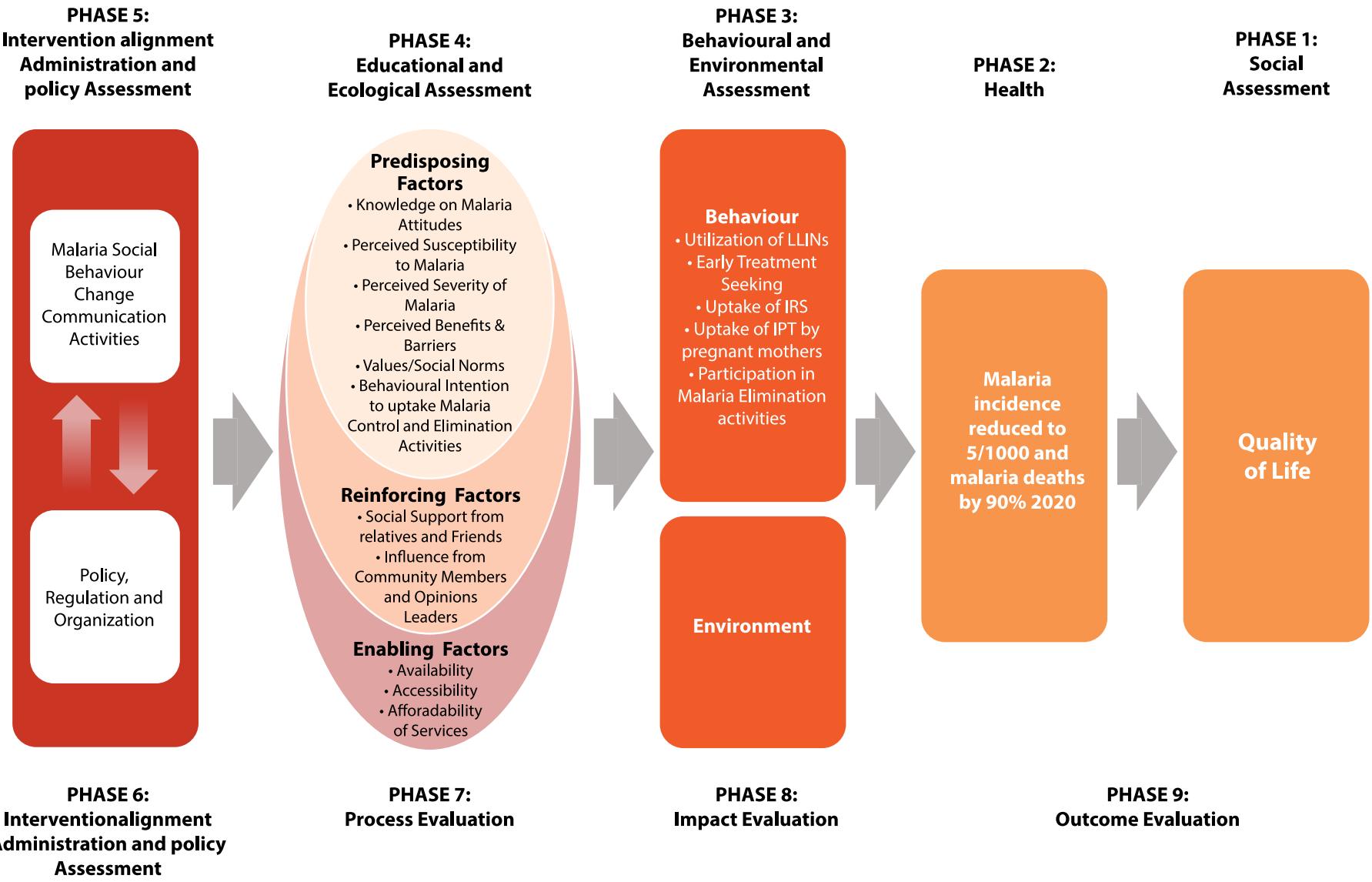
Green and Kreuter's **PRECEDE-PROCEED** planning framework (see Figure 2 on page 10) provides a roadmap for the design of SBCC programmes.

The Precede-Proceed Model is evidence based. Data derived from the MIS, HMIS, ZDHS and MICS was used to come up with epidemiological, behavioural, predisposing, reinforcing and enabling factors.

Thus, the SBCC interventions in this MCS are focused on addressing problems highlighted in nationally representative household survey data.

Global Guidance and Trends: The MCS is designed, first and foremost, to support national priorities laid out in the recently finalised NMSP. This is evident in the prioritisation of NMSP behaviours in this strategy. Recently released global strategies have emphasised the need to stratify malaria burden by analysing past data, and determine risk based on human, parasite, vector and environmental factors. This MCS is aligned to this approach and focuses on the use of data to stratify the implementation of SBCC activities according to malaria burden. Focus on surveillance, cross border collaboration and special populations are aligned with recent global recommendations as well.

Precede-Proceed Model



Strategic Communication for Malaria Control and Prevention

Strategy 1: Advocacy

NMSP Priority: Provide effective leadership and an enabling environment for optimal programme management and coordination at all levels by 2020.

Situation Analysis: Progress towards malaria elimination increases the importance of advocacy for malaria resources and community participation at all levels. This MCS will influence decisions within political and economic systems, institutions and communities for malaria prevention and control strategies. Over the next four years, advocacy efforts will be directed at the government to increase domestic funding for malaria as well as raise the profile of malaria in the country. Efforts will also be directed at political and community leaders to provide quality support at all levels for malaria elimination.

Domestic Funding: The vast majority of malaria funding comes from external partners (98 percent). Domestic appropriation for malaria decreased from 0.34 percent ($1.2 million in 2012) to 0.12 percent ($500,000) in 2015. Moreover, a significant portion of domestic funds are disbursed late, making it a challenge to utilise them in time for activities scheduled during the high transmission season.

Constituent Engagement: Out of the 25 members of parliament (MPs) consulted in June 2016 (who are on the Parliamentary Portfolio Committee on Health and Child Care), only four claimed to having contributed to malaria efforts in any way. Three had discussed malaria with constituents while one provided transport and food to IRS spray operators.

During the 2016 consultation with MPs, all legislators agreed that it was unacceptable that more than 95 percent of the malaria budget comes from donors. They pledged to advocate for increasing the budget in the coming financial year. MPs also pledged to mobilise resources within their constituencies to support malaria prevention and control strategies. These pledges need to be kept at the top of the mind of parliamentarians.

Recent advocacy efforts focused on producing advocacy packages to raise awareness on the dangers of malaria. Promotional materials, including folders and t-shirts with the message "Fighting malaria is my responsibility," have been distributed among senators and parliamentarians. Press conferences have also been held but media engagement to date has been limited. Future efforts might include making use of Zimbabwe broadcast channels that operate out of Harare, Bulawayo and Gweru. The desired behaviour among media outlets is to put malaria on their agenda and encourage use of existing interventions.

MCS Behavior Objective: Increase the number of legislators who actively advocate for increased domestic financial support for malaria by 2020.	**Priority Audience:** Legislators, business community and community and political leaders
	Secondary Audience: Ministry of Health and Child Care (MOHCC) Top Management Team (TMT), Provincial Health Executives (PHE), traditional and religious leaders, friends and family members of leaders and members of the media
	Communication Objective: Increase the number of legislators who believe it is the responsibility of the Zimbabwean government to ensure malaria programmes are adequately funded by 2020.
	Key Benefit: If legislators advocate for increased domestic support for malaria, then illness and death from malaria will decrease among their constituents and their popularity among voters will increase.
	Supporting Point: Increased popularity among voters increases the likelihood of re-election; decreased illness and death from malaria can lead to improved productivity in the constituency and improved economic and business conditions.
	Channel/Activities: Meetings and press conferences

MCS Behavior Objective: Increase the number of leaders who include malaria issues in their constituency agenda.	**Priority Audience:** Leaders at all levels
	Secondary Audience: Opinion leaders, partners and religious leaders
	Communication Objective: Increase the number of Zimbabwean leaders and legislators who feel that malaria is important enough to include in their constituency agenda by 2020.
	Key Benefit: Increased popularity among voters increases the likelihood of being nominated for re-election; decreased illness and death from malaria can lead to improved productivity in the constituency and improved economic and business conditions.
	Supporting Point: If leaders include malaria issues in their constituency agenda, then illness and death from malaria may decrease among their constituents and their popularity among voters may increase.
	Channels/Activities: Meetings and community dialogues

MCS Behavior Objective: Increase the number of leaders who participate actively in malaria interventions by 2020.	**Priority Audience:** Legislators, business leaders (small and medium enterprise association) and traditional and religious leaders
	Secondary Audience: Peers, family members, MOHCC TMT, PHEs and district health executives (DHEs)
	Communication Objective 1: Increase the number of leaders who feel that active participation in malaria interventions will address the malaria burden in their area by 2020.
	Communication Objective 2: Increase the number of leaders who feel that active participation in malaria intervention will maintain the low transmission status in their area by 2020.
	Key Benefit: Increased popularity among voters increases the likelihood of re-election; decreased illness and death from malaria can lead to improved productivity in the constituency and improved economic and business conditions.
	Supporting Point: If leaders include malaria issues in their constituency agenda, then illness and death from malaria may decrease among their constituents and their popularity among voters may increase.
	Channels/Activities: Meetings and launch of interventions
Implementation Considerations	Utilise existing advocacy forums like the provincial and district development committees and E8 ministerial meetings.

Strategy 2: Vector Control

NMSP Priority: Increase the utilisation of all malaria interventions to at least 85 percent by 2020.

National IRS Policy: IRS will be targeted at all eligible rooms and populations living in targeted areas and wards. Currently, 45 districts meet the criterion (high burden areas with an annual parasite incidence [API] of >5/1000 population) and receive IRS. During malaria epidemics, IRS will be used in targeted areas as part of epidemic response and in malaria elimination (API <1). IRS will be used, if applicable, in response to each confirmed active foci. IRS will be implemented as a separate intervention from LLINs except in cases where LLINs seem to fail to provide adequate incidence control. In this instance IRS will be deployed using a different class of insecticide than that used on treated nets.

Situation Analysis: Since the late 1940s, IRS has been the mainstay for vector control covering all areas of malaria transmission. The programme has been funded by the government and partners, achieving high acceptance levels and coverage. This success can be partially attributed to campaigns mobilising target communities prior to spraying season. According to the MPR in 2016, 92 percent of the targeted rooms were sprayed in 2012 and the coverage rose to 95 percent in 2015. The improvements in both the proportion of rooms sprayed and population protected in the targeted areas was evidence of a high IRS acceptance rate by targeted communities. The proportion of households who had their houses sprayed in the last 12 months increased from 49 percent (MIS 2012) to 62 percent (MIS 2016).

Despite the generally high IRS acceptance rate reported, malaria burden along the border areas (particularly with Mozambique) remain very high, calling for intensified cross-border SBCC interventions and formal research to determine the cause of high incidence to inform appropriate vector control interventions.

MCS Behavior Objective: Maintain IRS acceptance in targeted populations above 85 percent for the period 2016 to 2020.	**Priority Audience:** Head of household
	Secondary Audience: Village heads, chiefs, health workers, VHWs, school health master, religious leaders, community malaria committees (CMCs), councillors and landlords
	Communication Objective: Ensure that at least 95% of the targeted population feel IRS is a safe and effective intervention for the period 2016 to 2020.
	Key Benefit: If heads of household feel that IRS is a safe and effective intervention, IRS will be accepted and mosquito vector density will decrease.
	Supporting Point: Lower vector densities are associated with lower rates of malaria infection and more peaceful sleep; decreased illness and death in the community increases socio-economic productivity (e.g., not missing school or work) and decreases direct medical costs.
	Channels/Activities: Door-to-door sensitisation for the refusals and locked households, community meetings, print media, radio, TV, health alerts through mobile phones, campaigns, road shows and wall and commuter omnibus branding
Implementation Considerations	**IRS Chemical Rotation:** SBCC activities may need to inform communities about the type of chemical that will be administered.
	Policy Shifts: Communities should be informed about the reasons for new policy shifts on where IRS is provided. Areas that once received both IRS and LLINs may see a shift to use of one or the other.

National LLIN Policy and Strategies: The distribution of LLINs in Zimbabwe is guided by the Insecticide Treated Net (ITN) Policy of 2006 and the Zimbabwe LLIN distribution of 2013-2016 guidelines. LLIN use in Zimbabwe forms the second prioritised vector control intervention. However, LLINs and IRS will be implemented as separate interventions without overlapping except in special circumstances (e.g., if there is an increase in malaria incidence where LLINs are deployed, IRS may be considered using a different class of insecticide; populations living in mixed dwelling units; sprayable and non-sprayable rooms/structures; or in emergency situations).

Zimbabwe implements LLIN distributions targeting one net per sleeping space in areas targeted for control, consolidation and elimination. Free LLINs are distributed through mass campaigns while routine distribution has been piloted in two provinces (Mash Central and Mash West) to ensure universal access and coverage for all targeted at risk populations. LLIN distribution strategies in Zimbabwe consisted of the following: mass LLINs distribution which started in 2010 targeting one net per sleeping space and continuous LLINs distribution which started in 2014 using four channels, including the Expanded Program on Immunization (EPI) (targeting children at measles vaccination visit at nine months of age); antenatal care (ANC) clinics (targeting pregnant women at their first ANC visit); schools (targeting children in third and sixth grade); and community-based distribution using vouchers given by village health workers which are redeemed at health facilities or from health workers at outreach points. Universal coverage was achieved in all the areas targeted for LLINs mass distribution. The effective LLINs distributed in the communities targeted during the 2013-2015 period totalled 4,233,962 (MPR, 2016).

Situation Analysis: The proportion of households owning at least one LLIN increased from 46 percent (MIS 2012) to 58 percent (MIS 2016). Although LLIN ownership was suboptimal (58 percent – MIS 2016), it should be noted that the net attrition rate for Zimbabwe was in line with the WHO recommendation (eight percent loss in Year 1, 20 percent in Year 2 and 50 percent in Year 3). Zimbabwe conducted its last mass campaign in 2013 and the 2016 MIS was done prior to the planned mass distribution, which was done in September 2016, hence the low net access levels. The proportion of children under five who slept under an LLIN the night before the survey decreased from 50 percent (MIS 2012) to 33 percent (MIS 2016), while the proportion of women aged 15-49 who slept under an LLIN the night before the survey also decreased from 49 percent to 36 percent. According to the MIS 2016, the proportion of pregnant women who slept under an LLIN the night before the survey was 24 percent. It remains to be seen if a culture of net use has been established in target areas. It is important to note that the 2012 LLIN ownership and use proportions were calculated for only targeted LLIN districts, while the 2016 figures were calculated for all moderate and high transmission districts, including districts that did not conduct LLIN distributions. As a result, these temporal comparisons should be interpreted with caution, as the 2016 figures underestimate the coverage and use in LLIN target districts.

MCS Behavior Objective: Increase the proportion of individuals who use LLINs correctly and consistently throughout the year to 85% by 2020.	**Priority Audience:** All LLIN targeted household members
	Secondary Audience: Heads of households, village heads, chiefs, health workers, VHWs, school health master, religious leaders, community malaria committees and landlords
	Communication Objective: Ensure that at least 85% of the targeted population feel at risk of malaria throughout the year by 2020.
	Key Benefit: If all LLIN target household members perceive themselves to be at risk of contracting malaria, then they may be more likely to consistently use LLINs and avoid malaria infection.
	Supporting Point: Healthy household members are better able to engage in socioeconomic activities (not missing work or school), have decreased medical costs and greater peace of mind.
	Channels/Activities: School health dramas and clubs, radio, TV, health alerts through mobile phones, community sensitisation meetings, net hang up campaigns, commemorations, wall and commuter omnibus branding, road shows and community dialogue meetings
Low-transmission Areas	**Communication Objective:** Maintain the proportion of pregnant women in target districts who understand that using LLINS throughout the year protects them against malaria transmission by 85% 2020.

MCS Behavior Objective: Increase the proportion of women of childbearing age in target districts who sleep under an LLIN the previous night from 24% baseline levels to 85% by 2020.	**Priority Audience:** Women of childbearing age
	Secondary Audience: Partner/spouse, household members, health workers, community-based health workers and religious leaders
	Communication Objective: Increase the proportion of women of a childbearing age in target districts who perceive themselves protected from malaria if they sleep under an LLIN every night throughout the year to 85% by 2020.
	Key Benefit: If women of childbearing age consistently and correctly sleep under an LLIN, then they and the foetus will be protected from the effects of malaria infection.
	Supporting Points: Healthy pregnant women are able to productively engage in socio-economic activities and reduce direct medical costs. Pregnant women with LLINs may feel more empowered as they have a way to protect themselves and their babies.
	Channels/Activities: Interpersonal communication, health alerts through SMS, focus group discussions, information education and communication materials, campaigns, drama, health clubs and community radio
Low-transmission Areas	**Communication Objective 1:** Increase the proportion of women of childbearing age in target districts who understand that malaria can still be locally transmitted or imported from other areas to 85% by 2020. **Communication Objective 2:** Increase the proportion of women of childbearing age in target districts who believe that sleeping under an LLIN is the most effective method of preventing malaria to 85% by 2020.

MCS Behavior Objective: Increase the proportion children under five in target districts who sleep under a mosquito the night before the survey from 33% baseline levels to 85% by 2020.	**Priority Audience:** Caregivers
	Secondary Audience: Partner, household members and religious leaders
	Communication Objective: Increase the proportion of caregivers in target districts who perceive themselves and children under five protected from malaria if they sleep under an LLIN every night throughout the year to 85% by 2020.
	Key Benefit: If caregivers perceive themselves and children under five as protected when they sleep under an LLIN, then they will be more likely to ensure that children under five consistently and correctly sleep under an LLIN.
	Supporting Point: Correct and consistent use of LLINs by children under five reduces illness and death from malaria, as well as direct medical costs, and caregivers of healthy children are able to productively engage in socioeconomic activities.
	Channels/Activities: Interpersonal communication, health alerts through electronic devices, FGDs, campaigns, drama, health clubs, community radio and information, education and communication (IEC) materials
Low-transmission Areas	**Communication Objective:** Maintain the proportion of caregivers in target districts who understand that malaria can still be locally transmitted or imported from other areas by 85% 2020.
Implementation Considerations	**Policy Shifts:** Communities may need to be informed about the reasons for new policy shifts on where IRS is provided. Areas that once received both IRS and LLINs may see a shift to use of one or the other.
	Net Preferences: SBCC efforts will inform communities that they will be receiving rectangular nets. Emphasise the benefit of choice. If asked, explain how to transform the net to conical form.

Strategy 3: Case Management

NMSP Priority: Increase utilisation of all malaria interventions to at least 85 percent by 2020.

National Guidelines for Management of Malaria in Zimbabwe (2015): First-line treatment for uncomplicated malaria is the artemisinin-based combination therapy (ACT) called artemether-lumefantrine. The second-line treatment for uncomplicated malaria is artesunate-amodiaquine. Oral quinine will continue to be given as a second-line alternative especially for the patients to whom ACTs are contraindicated. At the community level, pre-referral artesunate suppositories will be used for severe malaria. In elimination areas a treatment of low-dose Primaquine will be introduced. Severe malaria cases are treated with parenteral artesunate until they are able to take oral medication, of which the recommended first-line/second-line full course or regimen is administered.

Situation Analysis: (Community and Health Worker Case Management) The proportion of mothers and caregivers who seek advice or treatment for fever has increased since the 2008. While MICS 2014 (47 percent), DHS 2015 (50 percent), and MIS 2016 (64 percent) surveys are carried out with different methodologies and during different seasons, making comparison problematic, all three show a modest but significant improvement in treatment seeking behaviour. Improvements in this critical behaviour may be partially attributed to an improving, enabling environment with many access points to health systems. Community health workers (CHWs) have been trained in community case management on an on-going basis since 2012.

More needs to be done to raise awareness on the importance of prompt care seeking, as MIS 2016 data found only six percent of respondents had been exposed to messaging about seeking care. Only 36 percent of respondents identified fever as a main symptom of malaria. Among mothers who did seek care at health facilities, almost a third responded that they would discontinue ACT once their children's symptoms subsided, indicating the need to better explain the importance of completing doses as instructed.

The current levels of care seeking are likely due to a mix of awareness, social, cognitive and religious influences. The cost of time and transportation are likely deterrents to visits to health facilities in Zimbabwe. Perceived risk and severity are issues commonly cited in other countries and may be true among some communities in Zimbabwe. However, there is no evidence to support any one of these possible behavioural determinants. Future research on social factors, attitudes and perceived consequences would help prioritise which factors to address and prioritise. Reluctance to seek treatment at health facilities among Apostolic congregants does appear in MIS results, indicating this is an important target group to engage.

MCS Behavior Objective: Increase the proportion of adult men and women and children of all ages who seek care from a health worker or health facility within 48 hours to 85% by 2020.	**Priority Audience:** Adult men and women, and children of all ages
	Secondary Audience: Head of household, village head, CHWs, church leaders and faith and traditional healers
	Communication Objective: Increase the proportion of adult men and women and children of all ages who feel malaria is severe enough to warrant immediate action by 2020.
	Key Benefit: If care is sought within 48 hours, then duration and severity of illness would be lessened and productivity (e.g., work, school, farming, business) would be increased.
	Supporting Point: Decreased duration and severity of illness leads to improved health and well-being; increased school attendance improves school performance; decreased absenteeism from work increases economic benefits to the individual, family and community; and increased time for farming creates opportunity for enhanced food production.
	Channels/Activities: Interpersonal communication from a CHW, community meetings and appropriate life events
Low-transmission Areas	**Communication Objective:** Increase the proportion of adult men and women, and children of all ages who, upon feeling symptoms of malaria, seek care immediately by 2020.

MCS Behavior Objective: Increase the proportion of caregivers of children under five who seek care from a health worker or health facility within 48 hours to 85% by 2020.	**Priority Audience:** Caregivers of children under five years old
	Secondary Audience: Head of household, village head, CHWs, church leaders and faith and traditional healers
	Communication Objective: Increase the proportion of caregivers who perceive fever to be dangerous enough that they do not wait before seeking care from 64% baseline levels to 85% by 2020.
	Key Benefit: If I seek care for my child under five within 48 hours (children under age five are at higher risk of severe disease and death), then my child will have a higher likelihood of survival and will thrive and properly develop.
	Supporting Points: A healthy child requires less care and allows more time for the caregiver to do other work. A sick child increases the stress for the caregiver and family and can result in increased costs for care.
	Channels/Activities: Interpersonal communication from a CHW, community meetings and appropriate life events
Low-transmission Areas	**Communication Objective 1:** Increase the proportion of caregivers of children under five who believe malaria can be spread in their community by 2018 and beyond. **Communication Objectives 2:** Increase the proportion of caregivers who perceive their child is at risk of contracting malaria when they have a fever by 2018 and beyond.

MCS Behavior Objective: Increase the proportion of caregivers who state they will give the complete dose of ACT as prescribed from 27% baseline levels to 85% by 2020.	**Priority Audience:** Caregivers of children under five
	Secondary Audience: Service providers, CHWs, spouse/partner, nuclear family members and peers
	Communication Objective: Increase the proportion of caregivers of children under five who state that giving their child the full regimen of ACT is a priority in their household from 27% baseline levels to 60% by 2020.
	Key Benefit: If my child completes a full course of ACTs, then the child is more likely to fully recover.
	Supporting Point: A healthy child requires less care and allows more time for caregiver to do other work. A sick child increases the stress for the caregiver and family and can result in increased costs for care.
	Channels/Activities: Vaccine campaign outreach events, health facility education sessions, print materials demonstrating full dose and community education sessions with health workers
Low-transmission Areas	**Communication Objective 1:** Increase the proportion of caregivers of children under five who understand why ACT and primaquine treatments are necessary by 2020. **Communication Objectives 2:** Increase the proportion of caregivers of children under five who believe that taking primaquine to clear parasites is necessary by 2020.
Implementation Considerations	**Policy Shifts**: Communities should be aware of changes in treatment such as the use of rectal artesunate for pre-referral treatment, ASAQ as second-line management of uncomplicated malaria and primaquine administration in pre-elimination areas. While trademark names are not important, general information on why previously recognised treatment has changed may maintain acceptance and compliance in communities. Health workers should probe for any prior medications taken before referral (such as traditional medicines).

Malaria in Pregnancy Policy: IPTp is only recommended for pregnant women residing in districts with moderate to high malaria transmission. Sulphadoxine-pyrimethamine (SP) is given as early as possible in the second trimester. SP is not administered to women receiving cotrimaxazole prophylaxis. SP should be given at least four weeks apart, with as many doses as possible up through delivery.

Situation Analysis: (Malaria in Pregnancy) ANC services are available under one roof in Zimbabwe public healthcare institutions. According to DHS 2015, first ANC booking was 93 percent with 76 percent attending four or more visits. Only 39 percent attended ANC in the first trimester, reducing potential opportunities to be educated about the importance of SP and the number of doses they could receive.

The IPTp intervention was delivered in 30 target districts from 2008-2015, achieving a coverage of 35.3 percent in 2012, which increased to 37 percent by 2016 (MIS). In 2015, Zimbabwe adopted WHO recommendations for three or more directly observed doses of IPTp at intervals of one month apart beginning as early as possible in the second trimester.

High ANC rates have not resulted in equally high increases of IPTp uptake. Suboptimal IPTp uptake in Zimbabwe may be explained by a number of issues outlined in a 2016 MPR. Delayed delivery of medicines through Zimbabwe's Informed Push System led to sporadic supply at the national level and stock-outs throughout target districts. The MPR also pointed out that the high prevalence of HIV in Zimbabwe masks IPTp coverage, as records of pregnant women taking cotrimoxazole prophylaxis (who are not eligible for IPTp) are not captured. The MPR also recommended stronger links between the NMCP and the Family Health department to improve delivery of IPTp.

At the community level a pattern of late booking limited the total number of IPTp doses many women were able to receive. Low IPTp uptake may also be partially explained by low exposure to information about malaria in pregnancy (MiP). Less than one percent (MIS 2016) of those surveyed recall hearing or seeing a message about taking tablets to prevent MiP. Just two percent of pregnant women asked responded that taking antimalarial medicine is a good method of preventing MiP. A desk review to confirm lessons learned about delays in ANC booking might clarify how best to encourage earlier ANC attendance.

MCS Behavior Objectives: 1. Increase the proportion of pregnant women who book at ANC early in their first trimester to 85% by 2020. 2. Increase the proportion of pregnant women who receive three or more doses of IPTp from 27% baseline levels to 85% by 2020.	**Priority Audience**: Pregnant women
	Secondary Audience: Spouse/partner, service providers, elders, mothers-in-law, aunts and peers
	Communication Objective 1: Increase the proportion of pregnant women who are aware of the benefits of booking ANC early to 85% by 2020. **Communication Objectives 2:** Increase the proportion of pregnant women who believe IPTp is an effective method of preventing MiP to 85% by 2020.
	Key Benefit: If I am aware of IPTp and its effectiveness, then I am more likely to take a complete course of IPTp (at least three doses) and have a healthier pregnancy and child.
	Supporting Points: A healthier pregnancy reduces direct medical costs and allows me to be more productive during pregnancy. A healthy child requires less care and allows more time for caregiver to do other work. A sick child increases the stress for the caregiver and family, and can result in increased costs for care.
	Channels/Activities: ANC appointments, community meetings, SMS, Care Group male and female champions and community support groups
Low-transmission Areas	**Communication Objective 1:** Increase the proportion of women of childbearing age in target districts who understand that malaria can still be locally transmitted or imported from other areas to 85% by 2020. **Communication Objective 2:** Increase the proportion of women of childbearing age in target districts who believe that sleeping under an LLIN is the most effective method of preventing malaria to 85% by 2020 (LLIN use will be the only means of prevention in areas that no longer recommend IPTp).

Traditional and Faith Healers Policy: Effective collaboration between the practitioners of conventional health care and traditional medicine is crucial to maximise timely, appropriate and effective management of illnesses. The MOHCC recognises traditional medicine as common practice and sanctions registered practitioners. This enactment regulates the operations of traditional healers in conformity with the provisions of the MOHCC mandate. In a bid to regularise their practice the MOHCC set up a traditional medicine department with a directorate. Recognised traditional healers have been sensitised to recognise the signs and symptoms of malaria and to refer all malaria cases early for treatment.

Situation Analysis: Pre- and post-tests conducted at traditional and faith healers' trainings in 2016 showed that healers had high levels of knowledge on the causes of malaria and signs and symptoms. However, there is also anecdotal evidence of misconceptions of malaria signs and symptoms. For example, some traditional medicine practitioners define malaria as "n'yongo" (gastritis) and there are various traditional medicines and faith healing rituals for the condition. Performance of these rituals – which often includes the induction of vomiting – leads to delays in seeking care at the health facility. Another potential cause of delay occurs when traditional healers keep the client for two days to monitor a suspected gastritis condition, waiting for it to resolve, at which point they begin to suspect that it is malaria and refer the client to the hospital.

MCS Behavior Objective: Increase the number of traditional and faith healers who refer individuals with symptoms of malaria by 2020.	**Priority Audience:** Traditional and faith healers
	Secondary Audience: Service providers, community leaders, the Zimbabwe National Traditional Healers Association, Traditional Medical Practitioners Council and the Union for the Development of Apostolic Churches in Zimbabwe Africa
	Communication Objective: Increase the proportion of traditional and faith healers who know the signs and symptoms of malaria by 2020.
	Key Benefit: If I, as a traditional or faith healer, know the signs and symptoms of malaria and promptly refer, then I will reduce disease and death from malaria in my community, and increase my reputation and standing as a practitioner.
	Supporting Point: The healer is recognised as knowledgeable and trustworthy by the community. Prompt treatment of malaria cases saves lives. Collaborating with the conventional medical community increases the profile and provides recognition for traditional and faith healers.
	Channels/Activities: Sensitisation meetings, IEC materials and community dialogues

Strategy 4: Surveillance

NMSP Priority: To strengthen surveillance, monitoring, evaluation and operational research for evidence-based programming in all malaria interventions for the period 2016-2020.

Situation Analysis: In Zimbabwe's 47 malarious districts, 20 are classified as pre-elimination districts. Efforts to achieve pre-elimination and elimination require new vector control, case management, and surveillance strategies. These new strategies require enhanced evidence-based SBCC to raise community awareness, increase community acceptance and improve community participation in their own health and well-being. To achieve this, communities need frequent, correct information and a shift in community and social norms where malaria is tolerated as an inevitable malady. This therefore requires SBCC activities that convey correct information about the new status quo (i.e., a shift from control to pre-elimination or elimination) in their localities. The following considerations should be made in pre-elimination districts:

- Advocacy among communities and their leaders on the new malaria continuum/situation that now prevails in their locality

- Awareness building about the severity of rare cases of malaria in areas where acquired immunity is declining
- Awareness building on the need to comply with service providers who may recommend testing and treatment even for those not sick/symptomatic
- Encouragement of community participation in activities like larval source management
- Promoting appreciation for and compliance with individual malaria case follow up by health workers
- Awareness building about potentially rapid changes in IRS or LLIN implementation

Special considerations for low-transmission settings are described throughout the strategy. Behaviours unique to pre-elimination districts include community participation in community-based surveillance and vector control activities.

MCS Behavior Objective: Increase the proportion of communities that are actively participating in community-based surveillance activities up to 50% by 2020.	**Priority Audience:** Heads of households and caregivers
	Secondary Audience: Community leaders (village heads, councillors and religious leaders)
	Communication Objective1: Increase the proportion of community members who understand the different malaria intervention efforts required for different malaria transmission zones by 2020. **Communication Objective 2:** Increase the proportion of community members who know that regardless of the low risk malaria incidence the community is still at risk by 2020. **Communication Objective 3:** Increase the proportion of community members who know that it is possible to be infected with malaria without signs and symptoms by 2020. **Communication Objectives 4:** Increase the proportion of community members who know the protocol and process of reactive case detection by 2020. **Communication Objective 5:** Increase proportion of community members who accept reactive case detection.
	Key Benefit: If, as a head of household or caregiver, I understand the malaria interventions, malaria risks and the public health process for case detection and reaction, then I will be more likely to comply and participate and I, my family and community will have less disease and death from malaria.
	Supporting Point: In a healthy community, there is more time to focus on education, social and economic activities.
	Channels/Activities: Interpersonal communication (including community meetings, one-on-one meetings with leadership and religious gatherings), community radio and mobile phone-based technology

MCS Behavior Objective: Increase proportion of communities that participate in community-based vector control activities, such as larval source management by 2020.	**Priority Audience:** Heads of households and community leaders
	Secondary Audience: Environmental Health Technicians and CHWs
	Communication Objective 1: Increase the proportion of heads of households and community leaders that understand the importance of community-based vector control by 2020. **Communication Objective 2:** Increase the proportion of heads of households and community leaders that understand the process and steps involved in community-based vector control by 2020.
	Key Benefit: If I, as a head of household or community leader, understand the importance of and processes for community-based vector control, then I will be more likely to accept and comply, and my community will have less malaria vector mosquitoes and less disease and death due to malaria.
	Supporting Points: In a community with less malaria vector mosquitoes, there is less malaria. And, in a community with less malaria, more time can be focused on education, social and economic activities.
	Channels/Activities: Interpersonal communication (including community meetings, one-on-one meetings with leadership and religious gatherings), radio, mobile phone-based technology, IEC materials and branding
Implementation Considerations	Surveillance has been driven by health workers. Communities will need to take ownership and actively participate in community-based surveillance of malaria cases, and work to maintain positive attitudes about prompt treatment seeking behaviour for fever.

Strategy 5: Cross-border Initiatives

NMSP Priority: Increase utilisation of all malaria interventions to at least 85 percent by 2020.

Situational Analysis: In Zimbabwe, malaria epidemiology has significantly changed over the past decade, characterised by a general reduction of malaria burden in the southern and central areas of the country and a heavy malaria burden remaining along the eastern and northern border districts. Zimbabwe's malaria burden is especially high along the Zimbabwe-Mozambique border, where about 64 percent of cases in 2015 were reported (Zimbabwe District Health Information System, Version 2).

Cross-border social and economic complexities pose a challenge in prevention and control of malaria but also present an opportunity for more coordinated SBCC initiatives. According to a cross-border survey conducted by MCHIP in 2015 in five of the border districts of Manicaland, 35% of cases reported on the Zimbabwe side in the districts surveyed came from travellers from Mozambique. Cross-border movements were noted to be motivated primarily by the desire to see friends and relatives and secondarily to engage in international trade. Cross-border travellers perceive malaria as a major cause of illness affecting them after travel, although there was no deliberate effort to use personal protection. About 65 percent of traders and travellers reported no use of personal protection measures when travelling to malarious areas in Mozambique. Despite ownership of LLINs by travellers living along the border areas (on both sides), none reported net use when sleeping outdoors during their travel. Upon falling ill, most of the communities living in Mozambique along the border opted to obtain health care services from Zimbabwe. In the MCHIP study, 69 percent of the interviewees from Mozambique sought health care from the Zimbabwe side of the border. This information presents an opportunity to reach out to these groups and develop SBCC materials with appropriate language(s) which can be understood by people living in border communities (e.g., Shangani and Portuguese).

Formal governmental cross-border initiatives have been initiated between Zimbabwe and Zambia (ZamZim Initiative), and between Zimbabwe, Mozambique and South Africa (MOZIZA Initiative), however, limited harmonisation of malaria prevention activities have occurred in practice. There are no active cross-border SBCC activities being coordinated by Zimbabwe and its border countries. The E8 Global Fund to Fight AIDS, Tuberculosis

and Malaria grant supports Southern African countries committed to eliminating malaria in the region – Mozambique, Zimbabwe, South Africa, Botswana, Zambia, Swaziland, Angola and Namibia – creating a potential formal platform for improved SBCC coordination and collaboration.

MCS Behavior Objective: Increase the proportion of traders and travelers surveyed who perceive themselves at risk of contracting malaria by 2020.	**Priority Audience:** Cross border traders, travellers and security officers
	Secondary Audience: Cross-border associations, health promotion officers, border service providers, immigration officers, peers and senior Zimbabwe Defence Force (ZDF) officers
	Communication Objective: Increase the proportion of cross-border traders/travellers who perceive themselves to be at risk of contracting malaria by 2020.
	Key Benefit: If these priority audiences perceive themselves to be at risk of contracting malaria, then they may be more likely to engage in prevention activities and avoid malaria infection.
	Supporting Points: Healthy cross-border travellers are better able to engage in socioeconomic activities. Healthy security officers are better able to perform critical duties.
	Channels/Activities: Fliers, posters, community sensitisation meetings, video clips, community dialogues, "welcome" malaria warning SMS and intercountry advocacy meetings
Low-transmission Areas	**Communication Objective:** Increase the proportion of traders and travellers who perceive malaria as a disease without borders and seek treatment early by 2020.
	Channels/Activities: Engage communities living along the border areas to strengthen malaria awareness and generate mechanisms for cooperating in malaria control work at every level: national, provincial, district and local levels. Develop and harmonise cross-border malaria elimination communication strategies, planning and implementation, and participate in various networks for elimination including E8.
Implementation Considerations	Where memorandums of understanding exist with neighbouring country districts in border regions, SBCC activities should be coordinated.

Strategy 6: Special Populations

NMSP Priority: To protect at least 85 percent of the population at risk of malaria with appropriate malaria prevention interventions for the period 2016-2020.

Situation Analysis: The unique circumstances, environment and economic activities of some populations in Zimbabwe put them at increased risk of contracting malaria and make exposing them to SBCC challenging. These special populations include groups such as artisanal miners, fresh produce/market/garden farmers, cross-border traders, fishermen, communities in border regions, church groups (who camp outdoors for church conferences for up to two weeks in some cases), sex workers and long-distance truck drivers. This list may not be exhaustive as geographical reconnaissance of the special populations has not been done. Many of these groups work outdoors during Anopheles mosquito biting times. Traders and cross-border communities move to and from areas of different malaria endemicity (internal and cross border) and may experience limited access to health services. Farmers and artisanal miner activities often create vector breeding sites (e.g., fields with puddles of water or stagnant water created due to gold panning) which increase their risk of contracting malaria. These populations are not able to use the conventional preventive tools – LLINs and IRS – to prevent malaria. No deliberate efforts have been made to date to target these special populations with SBCC activities to encourage preventive interventions. These special populations may be mobilised to use personal or spatial repellents and any other recommended intervention that protects them from human-vector contacts.

MCS Behavior Objectives: 1. Increase the number of special populations who protect themselves against mosquito bites by 2020. 2. Increase the number of special populations who actively seek information on malaria prevention options by 2020.	**Priority Audience:** All special populations
	Secondary Audience: Health workers, VHWs, the families and friends of special groups', church leaders and traders association leadership
	Communication Objective 1: Increase the number of special groups who perceive they are at high risk of malaria by 2020. **Communication Objective 2:** Increase the number of special groups who take personal precautions to prevent mosquito bites by 2020. **Communication Objective 3:** Increase the number of special groups who believe that using repellents will protect them from malaria by 2020.
	Key Benefit: If these priority audiences perceive themselves to be at risk of contracting malaria, then they may be more likely to engage in prevention activities and avoid malaria infection.
	Supporting Point: Healthy members of special groups are better able to engage in socioeconomic activities.
	Channels/Activities: Meetings, brochures and short videos
Implementation Considerations	Healthier workers should be aware that these groups, outside the mainstream, exist and make sure to try and find/address them.

Strategy 7: Branding

National Malaria Brand: A brand is a set of marketing and communication methods that seeks to create a lasting impression in the minds of clients. A strong brand is well-recognised and memorable. The NMCP will develop and use such a brand so that all activities, from 2016 to 2020, across partners have a consistent identity associated with trustworthiness and positive outcomes. This brand will elevate the visibility and ownership of the national response.

A national brand for malaria should develop a nationwide identification with, and a sense of collective ownership over, the fight against malaria. It should communicate the idea that malaria elimination is a worthwhile goal and that everyone should do their part. Government officials, funding and implementing partners, non-governmental organisations (NGOs), the mass media, community media and the health system, including health providers and traditional and religious leaders, should all use the same brand in order to reach high exposure in communities and families. The brand will connect individuals, families, communities and partners at all levels in the fight against malaria.

Creation of a National Brand: The key components include a brand's identity, communication (such as logos, payoff line, slogan and acknowledgements) and policies on how to use the brand. To create a national brand, the Zimbabwe SBCC Technical Working Group (TWG) will:

- Review or collect data on motivating factors for the population's adoption of the key malaria behaviours in this strategy. Zimbabwe is on the verge of eliminating malaria and there is a need to see if this idea captures the attention of and sparks motivation and engagement among the population and stakeholders.
- Form a taskforce within the SBCC TWG to lead the development of the brand. The taskforce will develop a series of creative briefs (for different channels) describing the brand's identity, key behaviours and messages, materials to be developed and motivational considerations.
- Engage an advertising agency to be responsible for using the guidance provided in creative briefs to create various versions of the brand.
- Develop brand communication materials such as logos, payoff lines and slogans in local languages, and pre-test them among the target audiences, including communities and stakeholders such as NGOs and government departments.

- Formally introduce the final brand to stakeholders at all levels so they understand which brand to use, when, why and how.
- Update this national communication strategy with the final branding materials, including (as appropriate) logo, payoff line, radio and TV acknowledgement, graphic or colour theme and jingle.

Use of the Brand:

- The SBCC TWG should review all branded materials before they are finalised and released to the public
- All approved materials should use the new national malaria brand
- The malaria brand should only be used on communication, products, services and materials that follow national policies, standards, strategies and guidelines
- The malaria brand can be co-branded with other agencies or companies
- Only agencies or companies with credible ethical values will be allowed to use the malaria brand
- The brand can only be used in situations where the SBCC TWG can retain full review and approval rights on all elements. This restriction narrows partnership possibilities but also reduces the risk of inconsistencies in malaria branding
- The branding materials must be placed in a prominent place in audio, print and visual materials
- Recall of the brand should be assessed in national surveys – this is a good way to measure the extent to which malaria SBCC activities have reached the population

Implementation Plan

Planning Process: The Zimbabwe NMCP conducted a five-day workshop from January 16-20, 2017, to develop the new five-year National MCS for Zimbabwe. Participants included representatives of the MOHCC, WHO, President's Malaria Initiative (PMI), United States Agency for International Development (USAID), and implementing partners Population Services International (PSI), Abt Associates/ZAPIM project, Abt Associates African Indoor Residual Spraying (AIRS) Project, and the Maternal and Child Survival Project (MCSP). The workshop was facilitated by the Health Communication Capacity Collaborative (HC3) project which is implemented by the Johns Hopkins Centre for Communication Programs (CCP).

The new national malaria communication strategy supports the recently developed National Malaria Strategic Plan (2016-2020). The Government of Zimbabwe (GOZ) continues to make significant strides in curtailing malaria incidence, and the country is poised to strengthen pre-elimination efforts as it moves toward the goal of eradicating malaria throughout the country. Vector control, including IRS and use of LLINs, along with case management and preventing MiP, constitute Zimbabwe's core priority malaria prevention and control interventions.

The January 2017 stakeholder workshop used a participatory approach to gain insights and strategy recommendations from a variety of perspectives across organizations and geographic regions. Several provincial-level participants contributed important context and experience to inform the communication strategy design. Once the first draft of the strategy has been completed, all stakeholders will be asked to review and comment. This validation process will help ensure the strategy is accurate and that stakeholders feel ownership as they move towards implementation.

Workshop participants identified key behaviours to prioritize across the primary intervention areas – vector control, MiP and case management. In addition, the stakeholders developed a new set of behaviours and objectives related to pre-elimination, cross-border issues and key populations.

Implementation Plan: This implementation plan provides a road map for all malaria actors in Zimbabwe to ensure that roles, responsibilities, activities, timelines and budgets are clear, synergistic and efficient, thereby ensuring a smooth implementation of all malaria interventions. Gaps in programming are described to highlight unmet needs. This implementation plan is a living document; partners should regularly update this resource as needs, funding, activity timelines and geographic focus change over time.

Systems Overview:

1. **National level:** The NMCP Director coordinates all the malaria activities. The SBCC Officer is in-charge of all SBCC activities. All malaria partners are accountable to the NMCP. The national-level NMCP is responsible for formulation of policies and guidelines and resource mobilization.

   The SBCC subcommittee – which is made up of representatives from all the provinces, implementing partners, uniformed forces, WHO and NMCP – advises NMCP on SBCC technical issues, reviews SBCC plans and upcoming events, approves the promotional materials that are produced at the national level, plans national events (such as the Southern African Development Community and World malaria day) and approves SBCC materials before finalization and printing. The subcommittee meets quarterly. The national-level authorities will be responsible for the following activities:

   - Launch of the MSC 2016-2020
   - Orientation of provincial staff and distribution of the MSC to provinces and partners
   - Initiation of malaria advocacy activities, including facilitating commemoration of international days, strengthening of partnerships and resource mobilization
   - Collaboration with other partners in malaria prevention and control to develop health learning materials, media products and utilize multimedia channels to disseminate of malaria information
   - Support research, monitoring, evaluation and use of findings

2. **Provincial level:** The provincial level provides technical support and coordinates the planning and implementation of programmes, distributes resources to the district, ensures national policies and guidelines are followed and monitors and evaluates programmes. The overall coordination and reporting of all SBCC activities in each province is done by the provincial health promotion officer (PHPO) who consolidates the district reports into one provincial report and submits this report to national-level NMCP quarterly through their provincial malaria SBCC focal person. The provincial level will be responsible for the following activities:

    - Drafting the MiProvide guidance in the implementation of communication activities and strengthening of existing multi-sectoral provincial partnerships on malaria
    - Provide guidance in the formation/ strengthening of malaria committees
    - Build capacity in SBCC among health care providers
    - Supervise and support implementation of the MCS by districts
    - Facilitate the conducting of research by districts
    - Establish a platform to facilitate planning and review of malaria SBCC activities

3. **District level:** The district level coordinates health care in the entire district and supports and supervises the implementation of all programmes. Most of the SBCC activities are implemented at the district level and are coordinated by the district health promotion officer with support from the DHE. The district level will be responsible for the following activities:

    - Promoting the key behaviours for each of the four core interventions
    - Strengthening collaboration with local authorities and partners
    - Developing and utilizing multi-media channels for dissemination of malaria information
    - Monitoring and evaluation of MCS activities
    - Strengthening research on determinants of behaviours

4. **Health facility level:** The rural health facility level provides primary health care services. Other responsibilities include supporting the community structures and coordinating the ward health team (WHT), and monitoring and supporting activities of the village health workers. The reporting follows the same structure – from the rural health facility level through to national level. The health facility level will be responsible for implementing the activities:

    - Promoting priority behaviours for each of the four core interventions
    - Orienting CHWs and WHTs
    - Monitoring the activities of WHTs and CHWs
    - Liaising with local leadership during implementation of the activities

5. **Community/ward level:** The community/ward level will be responsible for participating in the planning and implementation of malaria core interventions. Local leaders will mobilise and sensitise community members to support the malaria activities at the community level. Supervision and monitoring of the programme will be conducted by the local WHT and local councillors.

6. **Village level:** This is the level we find the community members. The VHWs also stays in villages. All the activities are implemented at this level.

Malaria SBCC Activity Mapping

Population Services International (PSI)

- Print media (brochures, flyers, posters and flip charts), outdoor media (billboards, commuter omnibuses, walls paintings) and mass media (video filming and radio spots)
- Interpersonal communication (house-to-house visits)
- Community mobilization (net hang up campaigns, roadshows, community sensitization meetings, school health clubs and school competitions)
- Training VHWs and school health coordinators on SBCC
- Communication guides for all interventions
- TRaC surveys measuring and monitoring SBCC activities
- Malaria commemorations

Plan International

- Community mobilization (school health clubs, community sensitization meetings, schools competition and net hang up campaigns)

ZAPIM

- Community mobilization (net hang up campaigns and community sensitization meetings)
- Print media (brochures and posters)
- Malaria commemoration

MCHIP

- Malaria commemorations
- Community mobilization (community sensitization meetings)

United Methodist Church

- Community mobilization (community sensitization meetings on repellents)

Implementation Plan Timeline

Strategy	Activity	Responsibility	Partners	2017	2018	2019	2020
Solicit leaders to provide influence and political support for the utilisation of malaria interventions	Conduct advocacy meetings for leaders at national, provincial, district and ward levels (IRS, LLINs, treatment guidelines and elimination)	NMCP	All partners	X	X	X	X
	Placement of press statements	NMCP	All partners	X	X	X	X
	Create media briefs on LLINs and IRS at national and provincial levels	NMCP	All partners	X	X	X	X
	Identify and utilise malaria champions/ ambassadors	NMCP	All partners	X	X	X	X
	Develop advocacy packages for key populations and elimination areas	NMCP	All partners	X	X	X	X
	Identify and utilise malaria champions/ ambassadors	NMCP	All partners	X	X	X	X
Engage networks of people to raise awareness on malaria	Review and update existing SBCC strategy in line with the NMSP	NMCP	All partners	X			
Implement formative research to understand the social determinants of behaviour, and use it to inform SBCC approaches and messages	Conduct, document and disseminate national-level knowledge, attitudes and practices (KAP) study	NMCP	All partners	X	X	X	X
	Create other SBCC operational research priorities for 2017-2020	NMCP	All partners	X	X	X	X
	Conduct other SBCC research activities, as prioritised	NMCP	All partners	X	X	X	X
Reinforce and improve KAP for positive malaria behaviours	Hold community sensitisation meetings for IRS, pre-elimination and case management	NMCP	All partners	X	X	X	X
	Conduct community dialogues to identify and address barriers to uptake and utilisation of malaria interventions	NMCP	All partners	X	X	X	X
	Develop behaviour change communication materials in multiple languages	NMCP	All partners	X	X	X	X
	Brand strategically located static and mobile surfaces (e.g., walls, commuter-omni buses, billboards) with malaria messages in different languages	NMCP	All partners	X	X	X	X
	Capacitate CMCs to mobilise the community to accept and use square LLINs	NMCP, PHEs and DHEs	All partners	X	X	X	X

Strategy	Activity	Responsibility	Partners	2017	2018	2019	2020
Reinforce and improve KAP for positive malaria behaviours	Train school health coordinators and support child-to-child malaria communication	NMCP, PHEs and DHEs	All partners	X	X	X	X
	Train/orient health facility and community-based health workers on SBCC processes	NMCP, PHEs and DHEs	All partners	X	X	X	X
	Use social media (e.g., Facebook, Twitter, Whatsapp and SMS) to disseminate malaria messages		All partners	X	X	X	X
	Develop and broadcast LLINs, IRS and case management radio and TV spots	NMCP	All partners	X	X	X	X
	Develop malaria internet-based repository	NMCP	All partners	X			
Engage special populations and groups to take positive actions to prevent malaria	Conduct malaria special population campaigns and commemorations	NMCP, PHEs and DHEs	All partners	X			

Outstanding Issues:

- Need increased support for research, monitoring and evaluation, and the use of findings
- Inadequate funding and competing activities
- Communication approaches were not evaluated due to lack of targets and SBCC evaluation plan in the previous strategy approaches
- Limited involvement of other sector ministries (e.g., education) and private sector (e.g., LLIN manufacturing companies)
- Limited documentation on best practices and lessons learned of most of the implemented activities
- Lack of repository and knowledge management system for SBCC materials, documents and research

Monitoring, Evaluation and Quality Assurance: SBCC activities will be monitored by the production of activity reports to assess whether a planned activity has been carried out. Changes in knowledge, attitudes, beliefs and behaviour will be monitored by the results from population-based surveys (e.g., TRaC Surveys, MIS, MICS, KAPS and DHS). Activity reports will be submitted upon completing an SBCC activity, and quarterly reports will highlight the activities carried out during each quarter. The annual SBCC report will be derived from the quarterly reports of that year, and will act as a benchmark against planned SBCC activities for that year.

Monitoring and Evaluation

Monitoring and Evaluation: LLINs

Behavior Objectives	Indicator and Definition	Rationale	Data Source	Baseline	Target	Next Steps
Increase the correct and consistent use of LLINs to 85% by 2020.	**Indicator**: Use to access ratio **Interpretation**: Of the population with access to a net, what percentage of them are using it? **Numerator**: Percentage of the population who slept under a net the previous night **Denominator**: Percentage of the population with access to a net **Numerator**: Number of rooms receiving IRS in the spraying season **Resources:** • RBM Monitoring and Evaluation Reference Group Household Survey Indicators for Malaria Control, 2013 • VectorWorks ITN Use to Access Report, 2017	The SBCC programme seeks to increase use among people who have access to a net. If there are not enough nets in the household, then it will not be possible for all household members to use a net. **Note 1:** This is a BEHAVIOURAL indicator – see NMSP for indicators on OWNERSHIP of and ACCESS to LLINs **Note 2:** This can be interpreted as a ratio or a percentage.	MIS and ZDHS MIS is conducted in the rainy season while ZDHS is conducted in the dry season. Compare the net use to access ratio in the rainy and dry seasons.	0.23 (Dry season, 2015 ZDHS) 0.76 (Rainy season, 2014 MICS)	0.80 during both dry and rainy season	Incorporate key SBCC indicators like this one from the MCS into the NMSP. Make sure indicators are clearly understood among SBCC TWG members and differentiate between vector control indicators and SBCC indicators.

Monitoring and Evaluation: LLINs (Continued)

Communication Objectives	Indicator and Definition	Rationale	Data Source	Baseline	Target	Next Steps
Ensure that at least 85% of the targeted population feel at risk of malaria from 2016 to 2020, throughout the year.	**Indicator**: Proportion of people who perceive they are at risk of malaria (susceptible)* (star [*] signifies priority **Numerator**: Number of respondents who perceive they are at high risk of malaria (defined as having a mean score greater than zero on the relevant Likert scale question) **Denominator**: Number of respondents surveyed **Resource:** RBM Malaria SBCC Indicator Reference Guide **Indicator:** Proportion of people who feel that consequences of malaria are serious (perceived severity) **Numerator:** Number of respondents who perceive the consequences of malaria are serious (people with a mean score of >0) **Denominator:** Number of respondents surveyed	People who do not believe they are risk will not use LLINs. "Risk perception" is composed of two things: (1) whether they think they will get malaria, and (2) whether they think malaria will have severe effects on them or their family. **Resource:** Douglas (1985) defines risk as the likelihood of a specific event occurring multiplied by the magnitude of consequences associated with that event.	Household or community survey		85% (Higher targets are desired for communication objectives because they affect behavioral results.)	Suggest adding the following questions from the RBM SBCC indicator guide to the next household/ community survey: • During the rainy season, I worry almost every day that someone in my family will get malaria (susceptibility). • People in this community only get malaria during rainy season (susceptibility). • My children are so healthy that they would be able to recover from a case of malaria (severity). • I do not worry about malaria because it can be easily treated (severity). • Nearly every year, someone in this community gets a serious case of malaria (severity). • I cannot remember the last time someone I know became dangerously sick with malaria (severity).

Monitoring and Evaluation: IRS

Behavior Objectives	Indicator and Definition	Rationale	Data Source	Baseline	Target	Next Steps
Maintain IRS acceptance in targeted populations above 95% for the period 2016 to 2020.	**Indicator:** Proportion of households sprayed with IRS within the last 12 months **Numerator:** Number of households that report their houses having received IRS for prevention of malaria in the last 12 months preceding the survey **Denominator:** Number of households surveyed **Alternate Indicator:** Proportion of rooms sprayed during the spraying seasons **Numerator:** Number of rooms receiving IRS during the spraying season **Denominator:** Number of rooms targeted to receive IRS during the spraying season	The decision by the population to have their houses sprayed is an indicator of their acceptance that the intervention is important for them and is dependent on the the impact of SBCC	MIS Program reports	62.4% (MIS 2016)	0.80 0.80 (During both dry and rainy season) 95%	This indicator needs to be calculated considering that the population receiving IRS will always be less than 50%.
Communication Objectives	**Indicator and Definition**	**Rationale**	**Data Source**	**Baseline**	**Target**	**Next Steps**
Ensure that at least 95% of the targeted population feel IRS is a safe and effective intervention for the period 2016 to 2020.	**Indicator:** Proportion of the target population surveyed who believe that the IRS will reduce their personal risk of malaria **Numerator:** Number of respondents who believe IRS will reduce their risk of malaria **Denominator:** Number of respondents surveyed	Within the Stages of Change Continuum (FHI, 2004), before behaviour change can occur, people must first be knowledgeable about the change that needs to happen and believe they will personally benefit from adopting the behaviour.	MIS		95% of the surveyed pulation	Suggest adding these questions from the RBM SBCC indicator guide to the next household/ community survey: • I have noticed fewer mosquitoes around since our homes were sprayed with IRS. • The liquid used to spray the walls is often too diluted to kill many mosquitoes. • Re-plastering the walls of a house after they have been sprayed will make the spray less effective at killing mosquitoes.

Monitoring and Evaluation: Case Management

Behavior Objectives	Indicator and Definition	Rationale	Data Source	Baseline	Target	Next Steps
Increase the proportion of caregivers of children under five who seek care from health facilities.	**Indicator**: Proportion of children under five years old with fever in the last two weeks for whom advice or treatment was sought from a health worker **Numerator**: Number of children under five years old who had a fever in the previous two weeks for whom advice or treatment was sought **Denominator**: Number of children under five years old who had a fever in the previous two weeks	This indicator captures national-level care-seeking behaviour for the treatment of malaria among children under five years old. Although this is detecting care-seeking behaviour for caretakers of under-fives it can be taken as a proxy for the general understanding of the population of fever as a potential predictor of malaria.	MIS and DHS	64.9% Total 58.9% Health facility (public or private) (MIS 2016)	85%	This indicator needs to be calculated considering that the population receiving IRS will always be less than 50%.
Communication Objectives	**Indicator and Definition**	**Rationale**	**Data Source**	**Baseline**	**Target**	**Next Steps**
Increase the proportion of caregivers who perceive fever to be dangerous enough they do not wait before seeking care from 64% in 2016 (MIS) to 85% by 2020.	**Indicator**: Proportion of the target population surveyed who believe that fever (malaria) is a condition requiring attention by a health worker. This indicator measures self confidence in taking action when a child is suspected to have malaria. **Numerator**: Number of respondents who believe a fever (malaria) is a condition requiring attention by a health worker **Denominator**: Number of respondents surveyed	Key behaviour change theories and models recognize the importance of perceived self-efficacy in the adoption and sustained practice of a behaviour. Bandura (2004) notes that belief in personal efficacy play a central role in personal change; he asserts that self-efficacy is the foundation of human motivation and action.	MIS	64% (MIS 2016)	85%	Suggest adding these questions from the RBM SBCC indicator guide to the next household/ community survey: *I am going to ask you about a series of actions you could take, and I would like you to tell me how confident you are that you could actually do that action successfully. For each action, please tell me if you think you definitely could, probably could, probably could not or definitely could not do each action successfully* • Find money to take the child to the clinic when malaria is suspected • Find someone I trust to tell me whether my child has malaria • Get the appropriate treatment for my child when s/he has malaria • Make sure my child takes the full dose of medicine that s/he is prescribed • Find resources to travel with my child to the clinic within 24 hours when he/she is very sick

Monitoring and Evaluation: Malaria in Pregnancy

Behavior Objectives	Indicator and Definition	Rationale	Data Source	Baseline	Target	Next Steps
Increase the proportion of pregnant women who book an ANC appointment early in their first trimester to 85% by 2020.	**Indicator**: Proportion of pregnant women who book an ANC appointment in their first trimester **Numerator**: Number of pregnant women who book an ANC appointment in their first trimester **Denominator**: Number of the women who book an ANC appointment	The SBCC program seeks to increase the number of women who book ANC early which enables them to receive the maximum recommended doses of SP over the course of their pregnancy.	MIS and DHS	39% (MIS 2016)	85%	Close collaboration with the department of Family and Child Health is needed to track this indicator.
Communication Objectives	**Indicator and Definition**	**Rationale**	**Data Source**	**Baseline**	**Target**	**Next Steps**
Increase the proportion of pregnant women who are aware of the benefits of booking ANC in their first trimester to 85% by 2020.	**Indicator**: Proportion of the target population surveyed who are aware of the benefits of booking ANC in their first trimester **Numerator**: Number of pregnant women who book ANC in their first trimester **Denominator**: Number of pregnant women who book an ANC appointment	Knowledge is a prerequisite for intention to act.	KAP study		85%	

Monitoring and Evaluation: Malaria in Pregnancy (Continued)

Behavior Objectives	Indicator & Definition	Rationale	Data Source	Baseline	Target	Next Steps
Increase the proportion of pregnant women who receive two or more doses of IPTp from 27% baseline levels to 85% by 2020.	**Indicator**: Proportion of pregnant women who receive two or more doses of IPTp **Numerator**: Total number of pregnant women who received two or more doses of IPTp **Denominator**: Total number of pregnant women who book ANC	This behavioural indicator is dependent on the time the woman books ANC as well as the availability of SP.	MIS and DHS	27% (MIS 2016)	85%	Close collaboration with the department of Family and Child Health is needed to track this indicator.
Communication Objectives	**Indicator & Definition**	**Rationale**	**Data Source**	**Baseline**	**Target**	**Next Steps**
Increase the proportion of pregnant women who believe IPTp is an effective method of preventing MiP from 2% baseline levels to 85% by 2020.	**Indicator:** Proportion of the target population surveyed who state taking antimalarial medicine during pregnancy as an effective means of avoiding malaria infection **Numerator:** Number of pregnant women surveyed who state antimalarial medicine taken during pregnancy is an effective means of avoiding malaria infection **Denominator:** Number of pregnant women surveyed	Response-efficacy is an important behavioral determinant when promoting commodities.	KAP study	2% (MIS 2016)	85%	

Monitoring and Evaluation: Surveillance

Behavior Objectives	Indicator and Definition	Rationale	Data Source	Baseline	Target	Next Steps
Increase the proportion of communities actively participating in community-based surveillance activities when malaria case(s) are identified up to 50%.	**Indicator**: Proportion of communities actively participating in community-based surveillance activities when malaria case(s) are identified **Numerator**: Number of communities actively participating in community-based surveillance activities when malaria case(s) are identified **Denominator**: Number of communities in the target area (elimination setting)	In order to pick up cases of malaria and hence prevent secondary cases of malaria evolving, it is important for communities to maintain a high rate of suspicion of malaria and be ready to advise the health service of any suspected malaria case for possible investigations.	Program reports		80%	Communities are generally organized around the health centre and will to be able to follow up on this indicator. It is important that health centre committees are activated.
Communication Objectives	**Indicator & Definition**	**Rationale**	**Data Source**	**Baseline**	**Target**	**Next Steps**
Increase the proportion of the population that believes participating in community-based surveillance activities can reduce the number of people with malaria in their community.	**Indicator**: Proportion of the population that believes participating in community-based surveillance activities can reduce the number of people with malaria in their community **Numerator**: Number of individuals who believe that participating in community-based surveillance activities can reduce the number of people with malaria in their community **Denominator**: Number of people in the surveyed area	When a community believes malaria only comes from an infected person, community members are more likely to take action when they suspect someone may be infected in order to prevent the infection coming to them or their household.	Household survey		85%	Develop a questionnaire to capture this perception. This questionnaire needs to be included in the next household survey.

Appendix 1: Consultative Meeting Participants

Dr Joseph Mberikunashe	Director	NMCP
Fortunate Manjoro	SBCC Officer	NMCP
Wilson Chauke	Vector Control Officer	NMCP
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Busisani Dube	Assistant M&E Officer	NMCP
Israel Tinashe Kaduku	Public Health Officer	NMCP
Nomsa Lindiwe Ndhlela	Public Health Officer	NMCP
Marica Nyaera	Accountant	MOHCC/HQ
Yeukai Tarambwa	District Health Promotion Officer	Matebeleland South
Thobekani Moyo	Community Health Nurse	Matebeleland South
Alexio Tafirenyika	Malaria Programme	Ministry of Defence
Byron Chapoterera	Health Promotion Officer	Mashonaland Central
George Machacha	Provincial Health Promotion	Mashonaland East
Kasima N Nhemachena	Provincial Health Promotion	Masvingo
Agnes Mugumbate	Provincial Health Promotion	Manicaland
Rosa Conway Nyasulu	Community Health Nurse	Manicaland
Cynthia Ncube	Provincial Health Promotion	Matebeleland North
Talent Moyo	Provincial Health Promotion	Midlands
George Kambondo	Provincial Health Promotion	Mashonaland West
Vitalis Kwashira	Environmental Health Officer	Midlands
Nyaradza Nemaware	Environmental Health Officer	Mashonaland Central
Anderson Chimusoro (Dr)	Country Team Advisor	WHO
Jasper Pasipamire	Malaria Program Officer	WHO
Christie Billingsley	Malaria Advisor	PMI
Regis Magauzi	Malaria Advisor	PMI
Peter Troell	Malaria Advisor	PMI
JB Rwakimare	Technical Director	ZAPIM
Cecilia Mhiti	SBCC Specialist	ZAPIM
Norman Mugwati	SBCC CM	ZAPIM
Tarisai Katiyo	Provincial Coordinator	Abt Associates
Joy Chikwena	Malaria Programme Manager	PSI
Vimbayi Machiwana	National Malaria Coordinator	PLAN
Munashe Madinga	Programme Manager	CHAI
Robert Munhenga	Focal Person	E8
Patience Panganai	Health Promotion Officer	MCHIP
Allison DiVincenzo	Communications Advisor	USAID
Andrew Tompsett	Malaria Advisor	PMI
Angela Acosta	Monitoring and Evaluation	VectorWorks
Mike Toso	Malaria Programme Officer	CCP
Gael O' Sullivan	SBCC Technical Lead	Abt Associates

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