Government of Malawi

Malawi Overarching Communication Strategy for Accelerated Child Survival and Development using an Integrated Management of Childhood Illness Approach 2007 – 2011

Foreword

Experts believe the Millennium Development Goal (MDG) on reducing child mortality (MDG4) is the litmus test for the achievement of all of the MDGs. If we miss this target, we may well miss the others. But if we hit this target, the ripples will be felt across Malawi in poverty reduction, educational success, productivity, economic growth and, above all, lives saved. Although Malawi is on track to achieve MDG4 thanks to recent advances in disease management and water access among other interventions, there is still a lot to be done. One in every eight children born in Malawi does not live beyond five years of age. High levels of malnutrition, poor maternal health, neonatal illnesses, pneumonia, diarrhoea, malaria and HIV/AIDS continue to threaten child survival.

We know that many of these causes of infant, child and maternal disease and death can be prevented by achieving universal coverage of the 15 High Impact Interventions identified by the Government of Malawi. These include: breastfeeding, complementary feeding, antenatal care and clean delivery, insecticide-treated bed nets, water and sanitation, child protection, early learning and stimulation, HIV/AIDS and paediatric antiretroviral therapy, oral rehydration therapy, anti-malarial treatment, vitamin A, antibiotics, de-worming, immunisation, intermittent presumptive treatment. Of these 15 high impact interventions, the success of almost half (47%) are based on communication alone, while another forty per cent (40%) require a combination of communication and logistics to be successful. An effective communication strategy, therefore, is of critical importance to the successful promotion of Accelerated Child Survival and Development (ACSD) in Malawi.

The 2007–2011 Overarching Communication Strategy for ACSD is a first attempt in Malawi and probably in Southern Africa to bring together and harmonize the vertical communication strategies of all sectors affecting child survival. Specifically, it articulates an integrated framework for communication of the 15 high impact interventions from nine different ministries. The branding strategy is unique in that it is both integrated and sector-specific thus helping to ensure a smooth transition from the existing communication approaches to the new strategy. Emphasis is placed on strengthening communication mechanisms and structures to ensure timely and efficient implementation. In line with Malawi's Decentralisation Policy, district communication teams will lead development and execution of communication plan. Communication support at national level will focus on designing national initiatives and facilitating their implementation by strengthening necessary mechanisms, capacity and tools.

This strategy is the result of a comprehensive planning exercise revolving around two national consultations. The first national consultation brought together all national-level stakeholders including representatives from the Ministry of Health, Ministry of Irrigation and Water Development, Ministry of Information and Civic Education, Ministry of Women and Child Development, Ministry of Education, Science and Technology, Ministry of Local Government and Rural Development, and the National Aids Commission as well as UN agencies, donors and NGOs. Building upon the results of this first consultative process, a second consultation was held with key stakeholders from selected districts in Malawi. The resulting strategy is a tribute to the high level of support and collaboration given by participating ministries, districts, donors, UN agencies and NGOs, not to mention the communities across Malawi, whose participation in this strategy is vital. We would therefore like to extend our thanks to all those who contributed to the pioneering of this communication strategy.

Executive Summary

Malawi's Overarching Communication Strategy for Accelerated Child Survival and Development (ACSD) has been developed in line with Malawi's ACSD policy and plan, to support the acceleration of child survival and development in the country. The document describes a five-year strategy from 2007–2011 for ACSD and outlines a three-year plan of action 2008–2010. It is a living document that will be reviewed and updated periodically in consultation with key stakeholders.

The communication strategy's framework has been designed to enable existing communication activities and new communication activities to co-exist. New integrated communication initiatives will be introduced in a phased manner to compliment existing communication techniques. The current communication approaches that support vertical programmes will continue to run until they can be phased out and replaced with the integrated communication initiatives. This approach will ensure a smooth transition from the existing communication approaches to the new communication strategy.

The new strategy incorporates several cross-cutting communication approaches. Firstly, a human rights perspective will be applied to ensure that there is adequate flow and exchange of information between participant groups, including vulnerable groups, thus enabling them to exercise their right to participate in decisions that affect their children's health, survival and development. Secondly, a branding strategy has been developed to allow for easy identification and recall of messages being communicated to the participant groups. Thirdly, multiple and sustained community engagement points will be used to influence behaviour change through a holistic approach that engages with participant groups at as many points as possible. Lastly, the strategy is based on evidence regarding what type of communication activities should be directed to which participant groups. This will help increase the effectiveness of the message to persuade participant groups to change behaviour.

The communication strategy will take into account particular guiding principles. One of the guiding principles is that the development of communication initiatives will be based on past evidence and that evidence will be used to steer focus to families and households by developing specific messages that target their needs as opposed to developing generic messages. Another guiding principle is that communication should focus on behaviour change rather than mere information giving, and on collective action rather than individual action. In addition to these principles, the focus of the communication strategy will be on moving from dialogue to interaction and from sensitisation to empowerment. Finally, the guiding principles also stipulate the use of multiple and sustained channels of communication and the development and coordination of partners and key players in implementing the strategy.

In line with global priorities, ACSD communication will focus on communicating high impact interventions that are proven to accelerate child survival and development regarding maternal health, newborn health, and child health. Within these areas, priority high impact interventions to be scaled up at district level during the first year of implementation have been identified using a consultative process. Based on the district priorities, national priorities for the first year of implementation have also been identified. Communication on other high impact interventions will be introduced successively and scaled up in subsequent years. Priority high impact interventions for scaling up communication for the first year of implementation in Malawi include: exclusive breastfeeding; complementary feeding; antenatal care and clean delivery; insecticide-treated bed nets; and water and sanitation. Additional high impact interventions to be scaled up in the second year include: child protection; early learning and stimulation; HIV/AIDS and paediatric anti-retroviral therapy (ART); oral re-hydration therapy; and anti-malarial treatment. High impact interventions to be scaled up in the third year include: vitamin A; immunisation; intermittent presumptive treatment for malaria during pregnancy; de-worming; and antibiotics for sepsis, pneumonia and dysentery.

The Malawi Overarching Communication Strategy for ACSD will have four main strategies of engaging different stakeholders. The first will employ intensive advocacy with policy makers to rally resources

behind ACSD communication. The second strategy will rely on community engagement and networking by developing relationships within communities and with the private sector, the media and other relevant organisations. The third strategy will directly engage families using various branded messages and face-to-face communication. The fourth strategy will enhance communication and interpersonal skills of field staff to ensure they have the right skills to deliver messages to the communities with whom they work.

To ensure that the implementation of the strategy is effective, a combination of monitoring and evaluation methods will be employed. Firstly, formative research will provide the basis to adjust messages to better suit participant groups. Secondly, impact tracking will provide a continuous assessment mechanism to determine whether the ACSD communication strategy is meeting its objectives. Lastly, summative research will provide a summary of the overall impact of the ACSD communication strategy once it has been implemented in full.

Contents

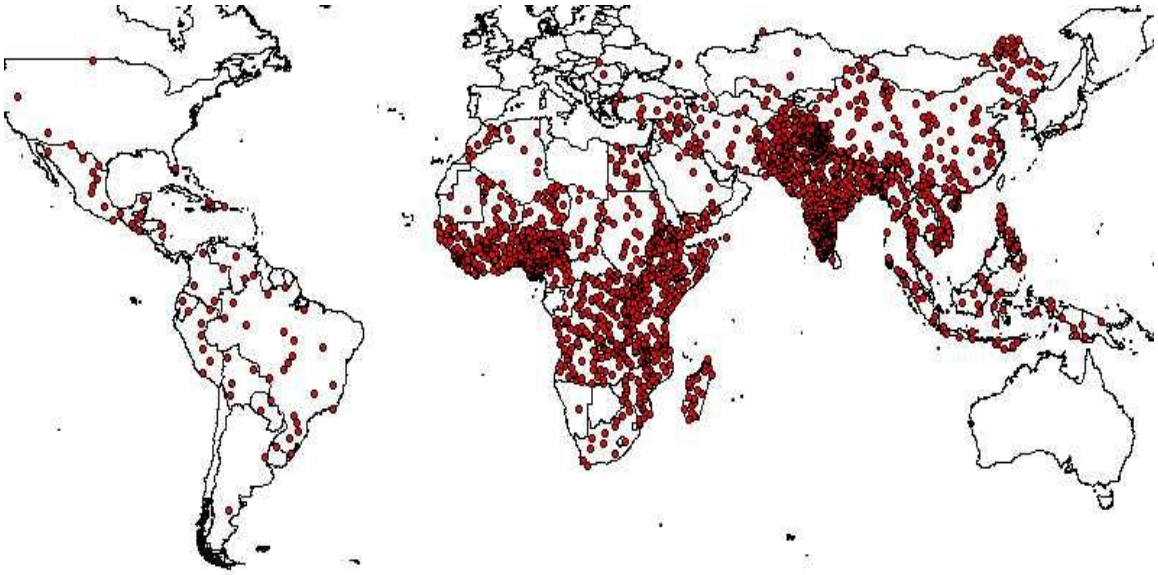
1. Introduction

Lessons learned and summative findings reveal that most health delivery systems in Sub Saharan Africa, particularly in Malawi, are faced with renewed challenges. These include: decreasing allocations; poor service; inadequate supplies; and a variety of communication problems. Within this latter category, findings have identified three main areas of concern: communication breakdowns between different vertical health programmes; shaky relationships between healthcare providers and community members; and above all, lack of engagement of local leaders in community health. These factors have led to a new thinking on how to accelerate child survival and development and the need for an overarching communication strategy to facilitate the social change necessary to prevent children from suffering due to common illnesses.

The Malawi Five Year Overarching Communication Strategy for ACSD provides strategic direction and interventions in three key areas. First, it articulates a **long-term strategic plan** to lead communication interventions with clear vision and direction, including a three-year activity plan outlining contributions and responsibilities. Second, the **communication strategy is based on human rights perspective**. Third, it will focus on facilitating social change through a process of community **engagement in the area of community health**.

2. The Challenge

Each year nearly 11 million children under the age of five die around the world. The vast majority (98 per cent) of these deaths occur in the world's poorest countries in sub-Saharan Africa and Asia. Neonatal disorders, diarrhoea, acute respiratory infections (ARI), malaria, measles, other fevers and malnutrition are the main determinants of child and maternal diseases and deaths. Malnutrition is associated with 54 per cent of all child deaths. Young people are also vulnerable to HIV/AIDS due to high-risk behaviour, sharing of needles, migration and a low level of education.



Global distribution of U5MR, each dot represents 5000 deaths.

Malawi has an estimated population of 10.3 million[1] and an annual growth rate of 2.0. Seventeen per cent of Malawi's population is under five years of age. The average household size is 5.7 persons per household, with an estimated 1.9 million households countrywide. The literacy rates in urban and rural areas are 45 per cent and 23 per cent respectively. Malawi has an agro-based economy with 60 per cent of the population living below the poverty line. The country's gross domestic product (GDP) per capita is estimated at US$200.

According to the Malawi Demographic and Health Survey (MDHS) 2004, maternal mortality is 984 out of 100,000 and infant mortality is 76 per 1000 live births, while the under-five mortality is at 133 per 1000 live births. This means that about one in every eight children born in Malawi dies before reaching their fifth birthday. One of the major causes of death among children under five is the high burden of disease such as malaria, diarrhoea, pneumonia, anaemia and malnutrition. The situation is exacerbated by the HIV/AIDS pandemic. Some of the factors leading to this high burden of disease include: poor quality of health care services (due to poor health worker skills in disease management, lack of resources and equipment, and low institutional capacity); and poor childcare practices in the household and community (due to lack of resources, knowledge and skills for childcare).

Many Malawians do not have access to sanitary latrines. Poor sanitation is a major cause of diarrhoea that kills uncounted children every year in Malawi. Deteriorating water quality, both bacterial and chemical, is a major threat to the life of millions. Both household and community hygienic conditions are far from satisfactory. Lack of appropriate and timely knowledge about health issues is another basic factor of poor health in Malawi.

Many of these causes of infant, child and maternal diseases and deaths can be prevented. Recent studies have shown that over 63 per cent of child deaths could be prevented by achieving universal coverage of high impact interventions.

3. Accelerated Child Survival and Development in Malawi

The Five-Year ACSD Strategic Plan spells out how the Government of Malawi will scale up high impact interventions to more children and mothers in all areas and villages in Malawi more quickly, more equitably, and more sustainably than before. Increased impact is a function of several factors including: coverage of the target population, programme effectiveness, efficiency, sustainability and equity. The following diagram shows the broad categories of programmes and respective fifteen high impact interventions:

4. ACSD Strategic Results from 2007 to 2011

The strategic results expected form the interventions and approaches outlined in this strategy are as follows:

1. All children suffering from common illnesses managed holistically at out-patient and in-patient health facilities and at home.
2. All health facilities have at least two Integrated Management of Childhood Illness (IMCI) trained health service providers; are supplied with all essential drugs and supplies; and have adequate transportation and communication systems for effective management of common childhood illnesses.
3. Eighty per cent of households practice all the key care practices of IMCI.
4. All IMCI partner support efforts scaled up to achieve and maintain universal coverage of a standardised minimum package of IMCI interventions through a managed partnership.

[1] Census 1998

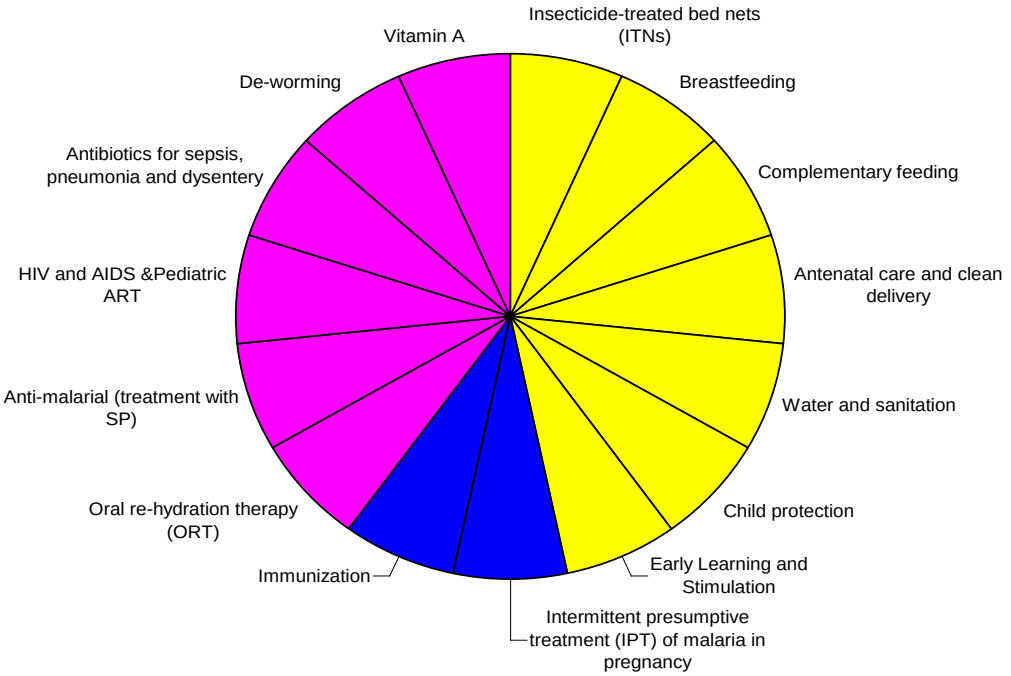
5. Specific ACSD Results by Year

- Essential newborn care and paediatric HIV/AIDS care incorporated into the IMCI in-service and pre-service training curricula of health workers, with clear link to nutrition and maternal health by June 2007.
- Number of health workers who have undergone five-day in-service IMCI training increased from 2,179 to 3,000 by end of June 2007.
- Number of clinical and nursing pre-service training institutions provided support to offer IMCI training increased from 5 to 20 by June 2007.
- Essential drugs available in all 542 public health facilities, with no stocks-outs of tracer drugs longer than two weeks in a year by June 2008.
- Adequate transportation and communication systems established and maintained in all 542 public health facilities by June 2010.
- Forty-five (45) members each from district and city assemblies and district and city/town executive committees, or a total of 1,260 members, oriented and mobilised to provide leadership for ACSD in all districts by June 2008.
- Twenty-eight (28) joint district and city/town IMCI technical working groups and 8,400 extension workers (300 per district) trained in the IMCI approach for ACSD by June 2008.
- Thirty (30) community leaders from each of 161 traditional authorities (4,830 in total) and 1,610 community leaders at group village and village level sensitised and mobilised for village action planning and implementation for ACSD in all districts by June 2008.
- All goods and services needed for ACSD by district specified, quantified, forecasted, ordered, distributed and monitored every year.
- Existing community structures in all districts, including area development committees (ADC), village development committees (VDC), village health committees (VHC), child protection committees, water committees, etc, empowered to mobilise households for ACSD and to monitor provision of goods and services related to each high impact intervention by June 2008.
- Extension workers, community leaders and community members organise and implement maternal, newborn and child high impact interventions: (a) at home (family/household); (b) during home visits by health surveillance assistants (HSAs) and other extension workers; (c) during village clinics and at community-based childcare centres (CBCCs); (d) through outreach/mobile health services; and (e) through mass campaigns (e.g., child health days, SADC malaria week) and other sectoral delivery strategies (e.g., school health, child protection committees) in all districts by June 2008.
- Community members in all villages/townships/wards in all districts, cities and towns sensitised and mobilised to access and utilise facility-based high impact maternal, newborn and child interventions by June 2010.

6. Why Communication?

As shown in the diagram below, almost half (47%) of all high impact interventions are based on communication alone, while another forty per cent (40%) require a combination of communication and logistics to be successful. An effective communication strategy, therefore, is of the utmost importance.

HII split by those requiring communication only, communication and logistics and logistics only



Communication only 1	**Yellow – 47%**
Communication and logistics	**Pink – 40%**
Logistics only	**Blue – 13%**

The following sections will provide a brief review of the theoretical underpinnings of this Overarching Strategy, based on current global evidence. Many of the ideas and issues expressed here have been most recently articulated in the document *Strategic Communication: For Behaviour and Social Change in South Asia.*[2] This will be followed by a discussion of how these concepts relate to the current child survival situation in Malawi and how they can be specifically applied in that context.

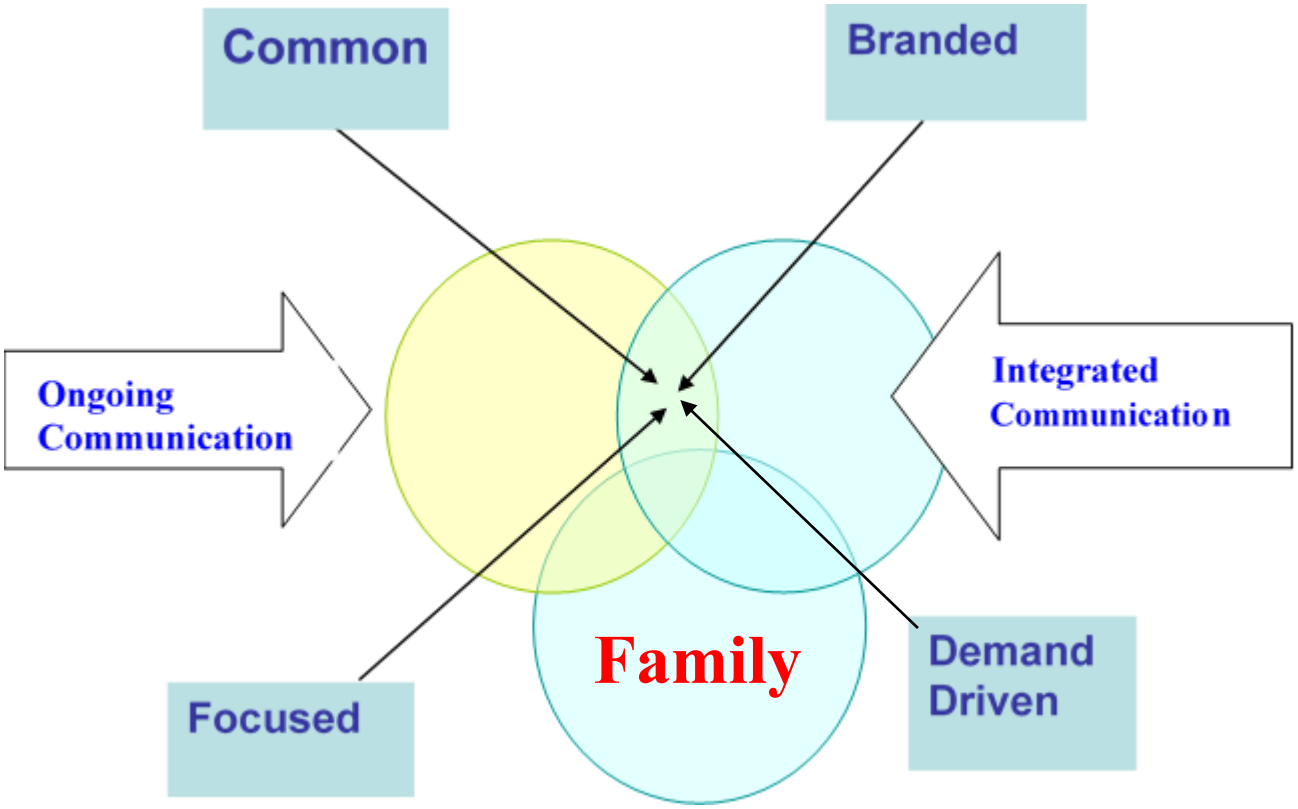
7. ACSD Overarching Communication Framework

Programmatic interventions are already established to ensure the provision of quality service(s) to prevent disease and disability. However, innovative and extensive communication inputs are also needed within the programmatic framework for specifically defined development or behaviour changes within specific participant groups.[3] Respective health and other programmes already have some good communication components. Yet they all are being run vertically. What these vertical communication efforts lack is mutually reinforcing synergies that build upon and coordinate the strengths in each vertical programme or intervention. In order to ensure synergies and systemic communication support to 15 high impact interventions, development of, and adherence to, an overarching ACSD Communication Framework is critical.

[2] UNICEF Regional Office for South Asia. February 2005.

[3] The term 'participant group' will be used instead of the more conventional 'target audience' or 'target group.' Audience implies a passivity that should NOT be encouraged. The behavioural communication process is not about aiming and shooting things at people. These are activities in which all stakeholders, including communities, NGOs, the Government of Malawi, and UNICEF, must participate together. Active participation should be encouraged instead.

What is proposed in this ACSD Overarching Communication Framework is a two-pronged strategy to reinforce the synergies of the vertical programmes at the point where they intersect. The framework of this two-pronged, over-arching communication strategy is shown in the diagram below.



The first strategy is to continue to fine tune the **ongoing communication** interventions that are sector/programme specific. Existing interventions will be redesigned to ensure more systemic on-going communication with linkages to communication activities by the relevant vertical programmes including immunisation, nutrition, maternal care and water and environmental sanitation.

Within this framework, however, **integrated communication** must also be added. Here, direct and exclusive communication support will be planned and executed. This will revolve mainly around institutionalised face-to-face interactions and persuasion by six key community communicators such as HSAs, traditional healers, school leaders, traditional leaders, representatives from faith-based organisations and the postal system. The periodic support of local media and special events will be provided to initiate/boost awareness raising efforts.

Thus, the main strategy is a combination of interpersonal communication components, including face-to-face activities and group activities with support from local leaders such as religious leaders and teachers and change agents such as HSAs and traditional healers.

As shown in the diagram above, family is where all communication efforts come together as the family receives the benefits of the four vertical approaches of communication, i.e. common, branded, focused and demand-driven.

8. Cross Cutting Communication Approaches

8.1 Communication from a human rights perspective

Communication takes place every day, every hour and at every occasion. Every day people make decisions; explore ways for surviving and coping; discuss norms and standards to apply in their families and communities; absorb and apply new information and experiences; and affirm themselves. This **flow and exchange** continuum of communication reflects existing power relationships and can therefore either support or constrain people's choices. Viewed from a human rights perspective, communication is explicitly recognised as both a right and a means to claiming other human rights.

The conventional approach to communication does not build on existing community knowledge and experiences to address issues across a variety of sectors. Instead, the conventional approach concentrates on the process of message and materials development by experts and promotes knowledge and solutions from the experts without taking into account local wisdom.

Many rights holders, especially women, children, poor, sick, vulnerable and disadvantaged community members, are left out altogether, unable to participate or effectively communicate in decision making because of their socio-economic status and prevailing taboos. They are dominated by circumstances and many can not get their voices heard.

Communication from a human rights perspective seeks to empower communities to take control of their own behaviour change by increasing community capacity to take action through dialogue and mutual understanding of issues and potential solutions. It aims to give a voice to voiceless right holders so they can express themselves and be heard in modes that are indigenous and authentic to them. It also seeks to encourage duty bearers to listen to the opinions of all right holders especially the marginalised and disempowered, so that all view points can be considered and included in decision making. The ability of rights holders to collectively articulate a vision for their own development and to realise their right to participate in its fulfilment is an essential aspect of communication from a human rights perspective.

In the Overarching Communication Strategy for ACSD, several strategic approaches and interventions have been proposed to ensure connectivity and participation both within communities and between community members and outside communicators such as health professionals, policy makers and resource providers.

8.2 Branding and Positive Image of Child Survival and Development

Through commercial marketing approaches, an integrated ACSD identity and brand will be introduced. This will help to make available uniform ACSD symbols and messages for activities at all levels. Usage of a new brand will ensure better recall and motivation and will help differentiate new concepts from other on-going campaigns. In the branding process, positive and happy images of child survival and development will be used to bring a happy and refreshing perspective to the effort of saving children's lives.

8.3 Consistency

Consistency in messages, interventions and media presence will make the communication easier to understand and will help seek required actions. Therefore, a long-term and consistent, branded presence will be ensured on all fronts.

8.4 Multiple and Sustained Community Engagement Points

Following the multi channel reach approach, multiple and sustained community engagement points will be developed to engage every important and credible source of motivation to facilitate social change around child survival and development. A list of ongoing and new community reach sources, designed to initiate and sustain community engagement, is provided below:

- *Facts for Life clubs* to be established in each school involving 40 students and 1 teacher per school;
- *Best Household of Month*, a regular competition to reach out to mothers to be run by designated health facilities;
- *Child Survival Ambassador*, a credible elder for each village to be selected to impart health tips during cultural events;
- *Care Groups* of 20 mothers to conduct periodic visits, under the supervision of HSAs, to 10-15 families with children under five or pregnant women;
- *Community Day*, several events designed to engage community;
- *Flag Village*, a periodic event to motivate people around better health;
- *Holy Bible Says*, churches and pastors to help raise awareness;
- *Holy Quran Says*, mosques and imams to help raise awareness;
- HSA, child protection workers (CPW) and other extension workers empowered to facilitate social change;
- *Community Corner*, a prominent place in each village to be set up as community corner to display community announcement and messages;
- *Community Viewing*, a special gathering to arrange rural cinema;
- *Community Radio*, programmes designed to ensure that communities are reached, heard and engaged; and
- A variety of communication material to help supplement face-to-face activities.

9. ACSD Communication Guiding Principles

In the design of the Overarching Communication Strategy for ACSD, the following set of guiding principles has been established to ensure that appropriate communication processes are followed:

9.1 Evidence

Each communication plan will be based on evidence and data. Planned formative research will direct communication interventions, especially usage of materials and messages by communication channels.

9.2 Focus on Households and Community

Communication activities should focus on specific messages for households rather than just using generic messages for individuals. This will help ensure wider focus from individual level to household and community levels.

9.3 Focus on Behaviour Change, not Merely Information Giving

Although increasing knowledge is one of the goals of the ACSD communication strategy, knowledge alone is not enough. All communication interventions should therefore focus on encouraging positive and healthy behaviour change rather than just giving information.

9.4 Behaviour Emphasis on Collective Action

As an overarching intervention, the ACSD strategy must widen its focus from emphasis on individual behaviour to collective action. Similarly the knowledge acquisition process must be widened from top-down selling mode to a community-based, participatory, problem-solving approach and learning mode.

9.5 Focus on Dialogue and Interaction

To achieve collective action, it is important to shift focus from messages and products to regular dialogue and interaction.

9.6 Moving from Sensitisation to Empowerment

Communication and orientation will aim mainly to empower households and communities. A two-way process between the service providers and the communities must be in place to ensure that feedback is received from the community and that communities are prepared through ongoing engagement at every level of implementation.

9.7 Use of Multiple Communication Channels

No single channel of communication will be sufficient to ensure that ACSD information is disseminated widely. A balance must be struck between local media, community and facility level channels. Each should be complementary to the others and mutually reinforcing in their messages.

9.8 Partnership and Coordination of all Players is Key

All implementing partners must work in a coordinated fashion with the district ACSD sub-committee on communication. Communication goals and objectives of all those working to expand child survival and development should be guided by this document and its messages.

10. The Diffusion of Innovations Model

Diffusion Theory helps in the design of communication strategies by focusing on:

1. Data that identifies which groups are already practicing recommended behaviours and which groups have not yet adopted the practices;
2. General types of communication strategies that should be considered; and
3. Specific communication activities, channels and media that should be considered and tested.

The Diffusion of Innovations Model helps shed light on how new ideas, products, and social practices are spread within a community, or from one community to another

A new idea or innovation typically moves slowly through a societal group as it is first introduced. Some groups are slower to accept new things than others. Then, as the number of individuals trying the innovation (the adopters) increases, the diffusion of the new idea moves at a faster rate. One way to look at the adoption process would be to see the adopter groups as a bell-shaped curve – in order to visualise the approximate percentage of people in each group.

10.1 Diffusion Theory and the ACSD Communication Framework

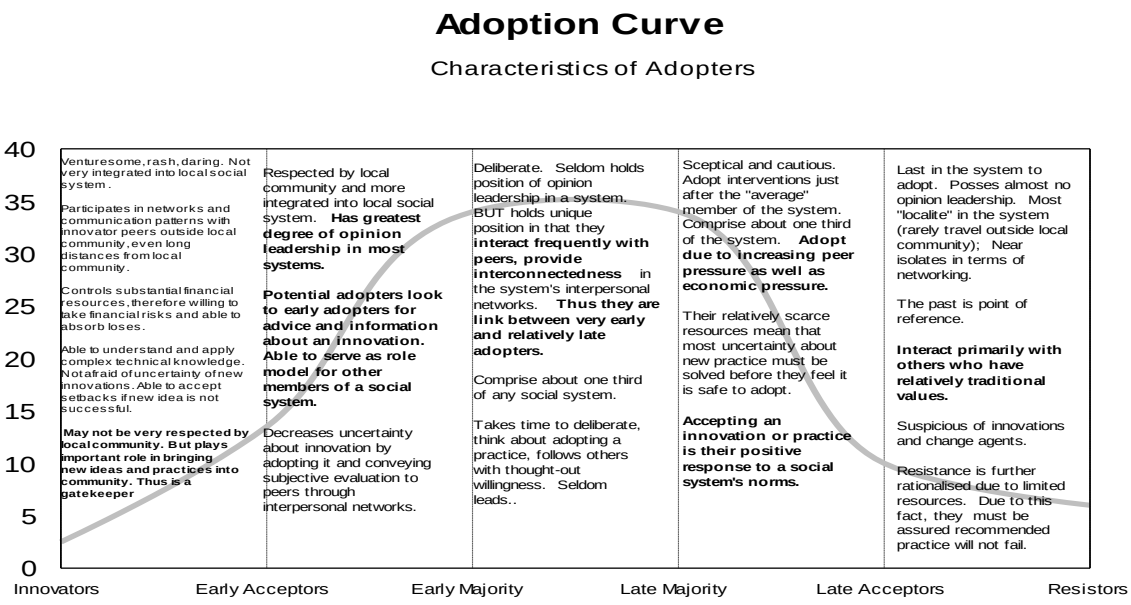
The first advantage in using *Diffusion Theory* is that by knowing which groups have not adopted the new practices and behaviours, we can focus more precisely on:

- the characteristics of the groups still to be addressed; and therefore,
- the strategies that will best reach these groups; and therefore,
- the activities, media and other channels that will be most efficient in reaching these groups.

A second advantage of this approach is that it will save time, money and other resources.

In the previous section, it was mentioned that each of the adopter groups shared certain general characteristics. These can be summarised as follows:[4]

[4] Rogers, (2003) Op. Cit... For a deeper understanding of the summary text contained in the two graphs presented here, please see a fuller explanation in Appendix 2.



These characteristics, also found in appendix one, include very brief information about (a) communication behaviour, i.e., with whom they speak and how they obtain information; (b) social status; (c) economic status; and (d) psychological orientation to society. This will help in the design of communication inputs that are sympathetic to each of the groups' needs.

10.2 Application in the Malawian Context

In order to apply this model in the Malawian context, the need for baseline data becomes essential. Once the percentage of people practicing any of the given interventions is known, it becomes much simpler to plan for communication interventions. Appendix two provides a tool for analysing which baseline data is available according to the behaviours that will be suggested further on in the Framework.

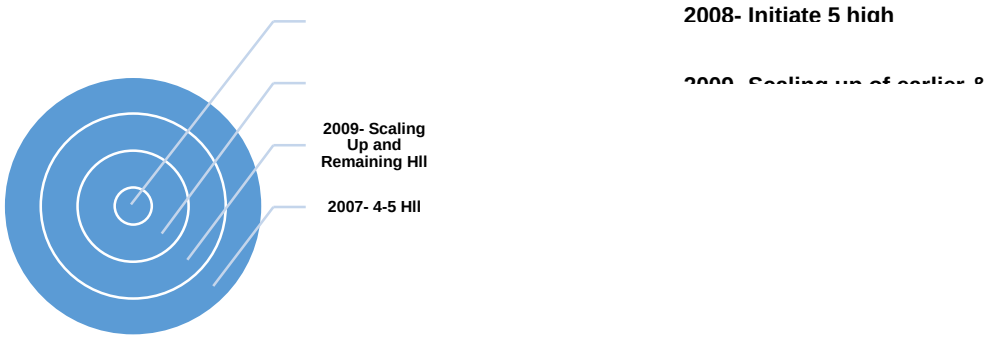
11. Communication Focus

The main areas of focus for the communication strategy are as follows:

1. **Maternal health** – care for pregnant women and promotion of breastfeeding.
2. **Child health** – better nutrition, care during illnesses, psycho-social stimulation, routine immunisation, vitamin A, protection from diarrhoea and malaria, use of iodised salt.
3. **Newborn health –** care for newborns, feeding and protection from diseases.
4. **Community health** – role and contribution of communities through social sanitation.
5. **Nutrition** - optimal breastfeeding, complementary feeding with breastfeeding, etc.

12. Communication Priorities

The first year of the Communication Strategy is dedicated to conceptualisation and design of the new integrated approach and consensus building among key stakeholders. In 2008, communication support will be provided to five high impact interventions (HIIs) that have been identified and prioritised by the selected districts. In 2009, these same interventions will be scaled up while a new set of five high impact interventions are jointly selected with relevant district representatives for communications support. In 2010, efforts will be made to scale up communication efforts for the 10 earlier high impact interventions while at the same time initiating communication support for a new set of five high impact interventions. The last year will focus exclusively on scaling up communication activities for all 15 ongoing interventions.



Recommended phasing of HII areas to be scaled up by year

The following is the proposed phasing based on district priorities and whether logistical support will be required before communication can be implemented.

Year 2008	Year 2009	Year 2010
Breastfeeding	Child protection	Vitamin A
Complementary feeding	Early learning and stimulation	Antibiotics
Antenatal care and clean delivery	HIV and AIDS and paediatric ART	De-worming
ITNs	ORT	Immunisation
Water and sanitation	Anti-malarial treatment	IPT

13. Branding ACSD

Branding is a key component of commercial marketing and consumer industries. It brings a combination of images and value that help the target audience to make appropriate choices and judgements about a product, organisation or service. To make ACSD a reality, it is important to brand the communication for ACSD high impact interventions. The main objective of combining branding and development communication approaches for ACSD is to establish an identity for an integrated approach. Strategic usage of symbols, designs and motivation will ensure better recall and will help highlight the linkages

and differences among high impact interventions and between these interventions and other ongoing campaigns. Consistency in messages and media presence will make the message easier to understand and will help bring about desired actions. A set of new brands and sub-brands will be introduced to facilitate positive and happy recall and feelings among households and communities.

13.1 ACSD Brand Strategy

The ACSD brand strategy will be developed on two positioning platforms. The master brand positioning represents the integrated nature of ACSD communication. The second platform will involve four brand and several sub-brand positioning platforms related to newborn babies, maternal health, child health and community health and social sanitation. The positioning of each of these brands will have a unique identity represented by a communication idea that runs through all campaigns relating to a brand, but is also linked to the integrated ACSD brand positioning.

The positioning platforms have been developed to reflect the central nature that child survival and development play in enriching the lives of families and communities. This is the reasoning behind using the word **'life'** in all the positioning statements. The enjoyment of life encompasses care, hope, joy and good health. Each of these aspects of life is reflected in the relevant ACSD area since they represent a universal understanding of a good life.

13.2 ACSD Brand Positioning and Communication Strategy

The ACSD integrated brand will be positioned on the platform**,** 'A Good Life - ACSD'. The integrated brand positioning of ACSD is designed to reflect the desired benefits that communities can expect if they change behaviour and adopt the 17 key care practices. The key message that the integrated ACSD brand will communicate is the satisfaction and limitless opportunities that families and communities adopting key care practices will be able to access by maintaining good health.

13.2.1 ACSD Communication Idea

Due to the multi-faceted and integrated nature of the overall ACSD brand, and the various different participant groups within the community, the ACSD branding and communication strategy will adopt a 'community as family' approach. The key message underlying the ACSD communication idea will be that it takes more than the nuclear family to raise a child and have a healthy family in Malawi. The communication idea suggested for the ACSD integrated brand, therefore, is 'my community, my family'. In addition to communicating the fact that the community is one's family, the communication will also encourage collective responsibility for the community at large. Lastly, the communication idea will reflect the pride that communities feel when its individual members do well, thus emphasising 'the good life' model. The three aspects to the communication idea are: 1) extended family; 2) collective responsibility; and 3) shared success and joy.

Using this communication idea, messages can be adapted to target the different target groups as follows:

National and district leaders:	'A good life for my nation, my family'.
Traditional leaders:	'A good life for my village, my family'.
Religious leaders:	'A good life my church/mosque, my family'.
Community and family members:	'A good life my community, my family'.

The ACSD brand and logo will reflect all the colours of the four positioning platforms as follows: **Pink for maternal health; green for newborn health; orange for child health; and blue for community health and social sanitation.**

13.2.2 Newborn Brand Positioning

The 'newborn' brand will be positioned on the platform, 'A happy start to life'. The positioning of the 'newborn' brand will reflect the importance of taking care of newborn babies in order for them to grow and succeed in life. It will also reflect the fact that a community's future depends on the survival of newborn babies.

Newborn Communication Idea

Following the ACSD integrated brand positioning and communication idea, the newborn communication idea will centre on family care of newborn babies for the future survival of the family. The communication idea proposed, therefore, is 'a happy start'. This communication message will reflect the collective responsibility of the community at large to take care of newborn babies. It will also reflect the relationship between taking care of newborn babies and future happiness of families and communities. The supporting communication idea is:

Mothers, fathers and other family members: 'A happy start to life for our family'.

The colour that will be used for communication on newborns is green. Green represents newness, everlasting properties, and hope. It is associated with the cycle of life and with babies being born.

13.2.3 Maternal Health Brand Positioning

The Maternal Health brand will be positioned on the platform, 'Life smiles again'. This positioning reflects the hopeful state mothers, families and communities are in when expecting the arrival of a baby.

Maternal Health Communication Idea

The communication idea will centre on hope, expectancy and love. The messages will concentrate on raising the profile of mothers by communicating the importance of keeping mothers happy and healthy during and after the expectancy period. The communication idea proposed for the Maternal Health Brand is 'Life smiles again on us'.

Mothers, fathers and other family members: 'Life smiles again on our family'.

The colour that will be used for maternal health is pink. Pink represents love, happiness and delicateness, and is associated with the emotions that expectant mothers feel.

13.2.4 Child Health Brand Positioning

The child health brand will be positioned on the platform, 'Children are life'. This positioning is based on the recognition that parents live for their children's happiness. It reflects the fact that children are at the core of the families' existence.

Child Health Communication Idea

Children are a source of joy for adults. They represent all the things that adults can no longer do now that they are older because they do not have the time or energy. The communication idea proposed is designed to bring adults back to a time when they were children. The message will encourage adults to relive their childhood through their children. The children will be viewed as the lifeline that links adults to their own childhood in the community. Children, therefore, must be taken care of and kept healthy so that they can play this crucial role in society. The communication idea proposed is therefore: 'Life's joy'. This communication idea will be used to develop communication materials that deliver key messages related to child health in order to achieve the communication objectives.

Family members: 'Children are life, our family's joy'.

The colour that will be used for child health is orange. Orange represents enthusiasm, creativity and joyfulness, all of which are associated with young children.

13.2.5 Community Health and Social Sanitation Brand Positioning

The community health and social sanitation brand will be positioned on the platform, 'A good life for me'. The positioning reflects the link between sanitation and a good life.

Community Health and Social Sanitation Communication Idea

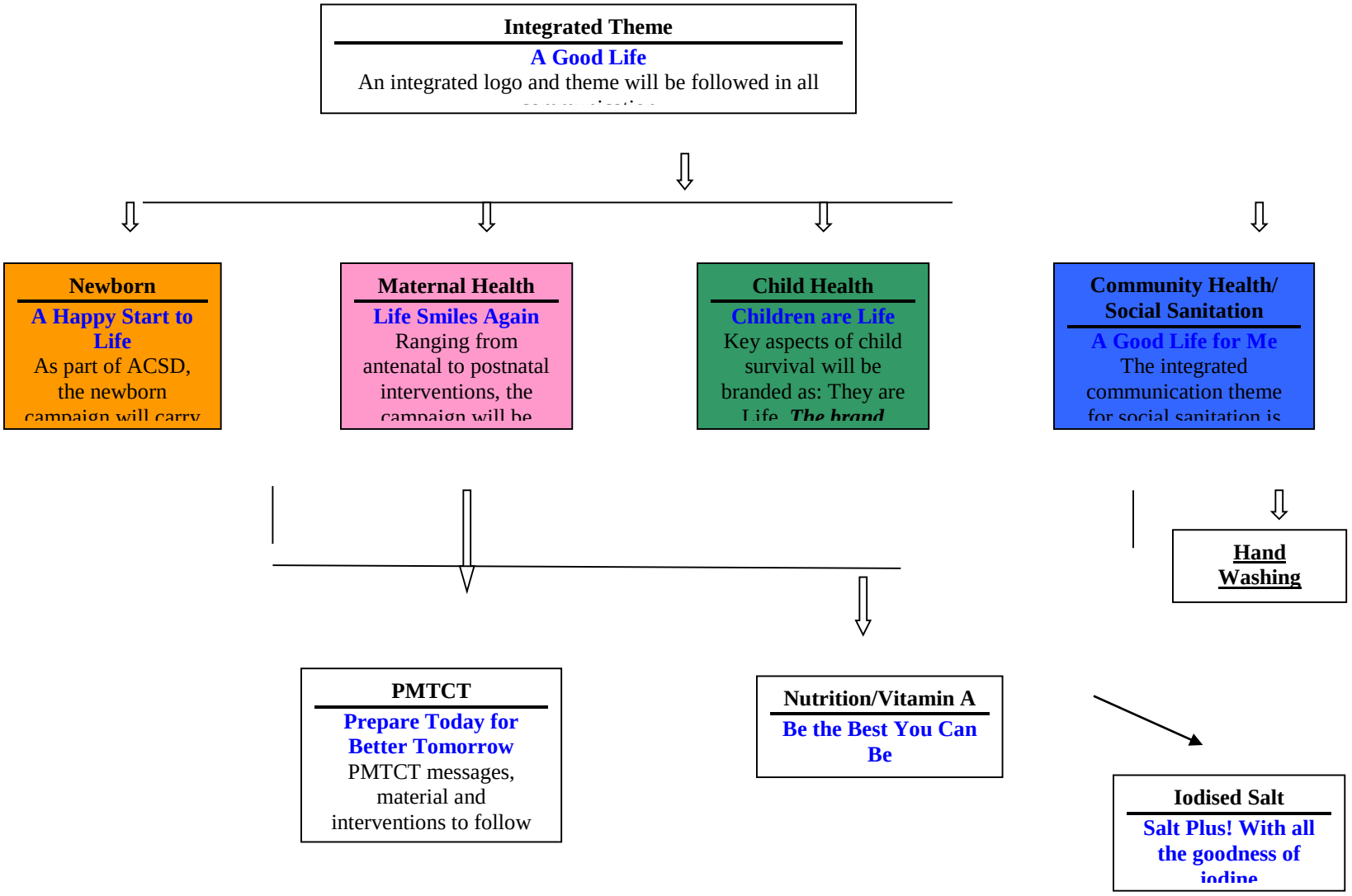
The communication idea proposed for social sanitation is one that focuses on bringing family members together and bringing community members together. The message will be that if families and communities adopt certain practices related to sanitation they will have a good life as individuals. The message will stress that it will only be possible if everyone around the community responds. The communication idea proposed is 'a healthy life for all, a good life for me'. The two groups will have these messages:

Family members: 'A healthy family, a good life for me'
Community members: 'A healthy community, a good life for me'

The colour that will represent community health and social sanitation is blue. Blue represents water, cleanliness and calmness, which are associated with leading a healthy and problem-free life.

The ACSD integrated brand plan and communication ideas have been summarised in the diagrams on next page.

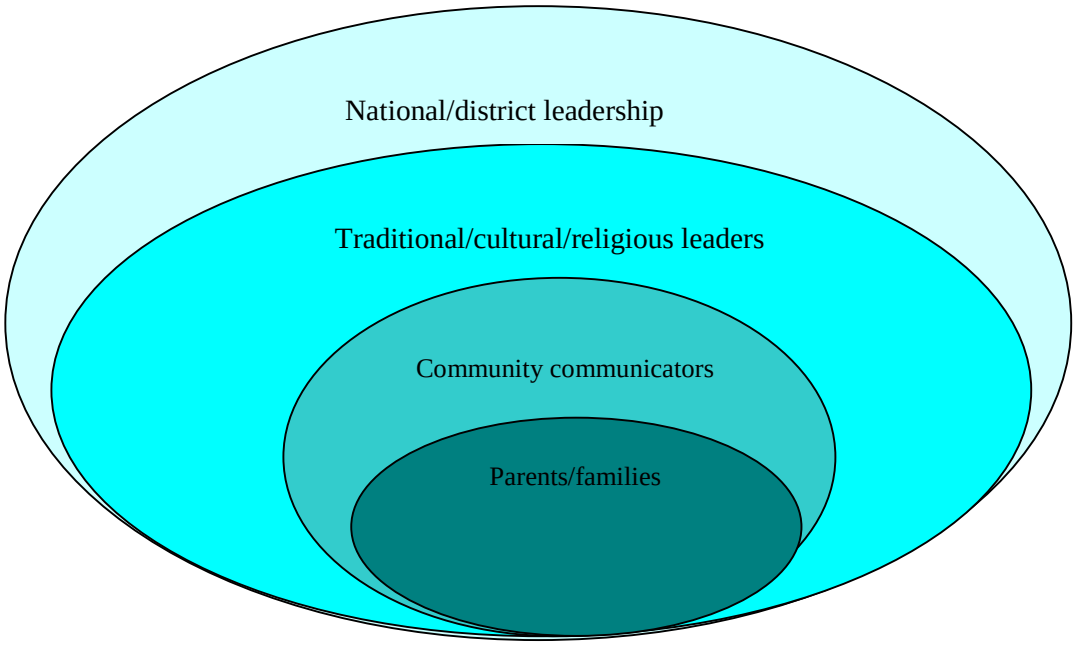
ACSD Brand Plan



14. Priority Participant Groups

The participants of this Overarching Strategy are summarised as follows:

- Parents/families
- Community communicators
- Traditional/cultural/religious leaders
- National/district leadership



While it will be necessary to develop behaviour within families, they do not exist in a vacuum. Families are part of communities. Thus community concerns become a major consideration in discussing the health of people within families. The challenge is to find and involve those communicators within communities who can help to introduce activities and follow them up. It is also necessary to address leadership at all levels. Consequently, there is a need for outcome-oriented, behaviour-based advocacy to explain the roles of leadership within the context of family health.

15. Communication Objectives

By the end of 2011, the strategy proposes to achieve the following objectives among participating low-income groups living in rural and urban slum areas in ACSD target districts:

- Increase the percentage from x[5] % to y[6] % of breastfeeding mothers of children less than 6 months who can list three benefits of exclusive breastfeeding (EBF).

[7] Percentages for values of 'x' will reflect baseline data.

- Increase the percentage from x % to y % of breastfeeding mothers of children less than 6 months exclusively breastfeeding.
- Increase the percentage from x % to y % of breastfeeding mothers who can list three benefits of complementary feeding of children over 6 months.
- Increase the percentage from x % to y % of breastfeeding mothers who provide nutritious complementary foods to children over 6 months.
- Increase the percentage from x % to y % of mothers demanding vitamin A supplementation from health service providers for their 6 to 59 months children.
- Increase the percentage from x % to y % of pregnant women demanding vitamin A supplementation.
- Increase the percentage from x % to y % of pregnant women sleeping under insecticide-treated mosquito nets (ITNs).
- Increase the percentage from x % to y % of under-five children sleeping under insecticide-treated mosquito nets.
- Increase the percentage from x % to y % of child-bearing age men and women utilising prevention of mother-to-child transmission (PMTCT) services.
- Increase the percentage from x % to y % of children undergoing routine immunisation in a timely manner before their first birthday.
- Improve understanding and actions at family level for care of children suffering from diarrhoea and acute respiratory infection (ARI).
- Improve understanding and actions at family level to prevent child abuse/neglect and to take appropriate actions whenever it occurs.
- Improve understanding and actions at family level to promote mental and social development by responding to children's needs for care and providing a stimulating home environment.
- Improve understanding and actions at family level to provide better care for and facilitate pregnant women's access to antenatal care and skilled birth attendants at the time of delivery.
- Improve understanding and actions at family level to ensure access, usage and maintenance of household latrine and hand washing on all critical occasions.
- Decrease number of diarrhoeal cases among children from x number to y number through the use of safe water, adequate sanitation and hand washing.
- Improve understanding and actions to ensure appropriate storage and usage of safe and clean drinking water.
- Obtain strategic and sustained community engagement in awareness raising efforts.
- Mobilise and facilitate traditional and religious leaders to lead social change processes in their respective constituencies.

16. Communication Outcomes

The expected outcomes of the communication strategy are that:

- Communities and community leadership are involved in, and supportive of, ACSD activities.
- Key parliamentarians and district leadership from focus districts are oriented and mobilised to provide leadership for ACSD in all districts.
- Leaders from Christian and Muslim communities are reached and mobilised to promote ACSD.

[6] Target percentages for 2011 for values of 'y' will be inserted after baseline data is known.

- Traditional chief and village heads have better understanding of, and are mobilised to support, ACSD.
- Households in all villages/townships/wards in focus districts, cities and towns are persuaded to access and utilise facility-based high impact maternal, newborn and child interventions.
- Reported incidence of diarrhoea among children under five has reduced (or reduced level of under-five morbidity related to diarrhoeal disease).
- Eighty per cent (80%) of households are aware of how and why high impact interventions are necessary for child survival and development.
- Visible political support for ACSD is evident at national and district levels.

17. ACSD Communication Strategies

17.1 Intensive Advocacy

Intensive advocacy will be done with national and district government to shape the policies, legislation, plans and resources in favour of interventions aiming to improve child survival and development.

17.2 Community Engagement and Networking

Special emphasis will be given to community engagement in different forms between different rights holders and duty bearers.

Existing and new **community communicator networks,** such as HSAs, VHCs, women's groups, mother's groups, community dialogue, church, mosque, media, traditional leaders, FFL clubs, and the postal system, will be involved and/or created through innovative communication approaches to communicate with communities, patients, parishioners, members, friends, families and neighbours.

Alliances will be developed with private sector, media partners and development journalists to support ACSD programme and communication objectives.

17.3 Communication with Families and Communities

Face-to-face communication will be concentrated mainly in selected areas/districts while other channels will cover all the districts. Face-to-face communication will be supplemented by low cost local channels, including drama, dance, gatherings, announcements, billboards, stone chalking and communication materials. Innovative incorporation of ACSD messages will be done through sustained community engagement.

Local branded campaigns will be designed and launched on selected high impact interventions according to local disease patterns, weather, on-going health campaigns, local priorities, timing and logistics considerations.

17.4 Capacity Building

Capacity building of field staff in interpersonal communication, motivational techniques, social mobilisation skills and persuasion processes from a human rights based perspective will be a priority.

18. Proposed Activities for Promoting Desired Actions

Participant Group	Desired actions	Barriers/obstacles to desired actions	Activities for promoting desired actions	Materials required
Key policy and decision makers at national level	Promote, support and mobilise funds for the implementation of the ACSD policy.	Inadequate coordination among vertical programmes within Ministry of Health (MoH) and limited coordination between the line ministries; Lack of timely, costed implementation plans; Inadequate awareness of the ACSD Policy among policy makers to promote the implementation of the ACSD policy; Failure to make key policy makers responsible for ACSD decisions.	Conduct quarterly coordination meetings between the programmes within MoH and between line ministries on ACSD; Advocate for integrated planning/implementation; Fundraising activities for ACSD (through public announcements, private sector mobilisation, etc.) Provide regular briefs/updates to policy makers on ACSD; All decisions approved by the relevant policy maker.	ACSD policy; Advocacy Kit; Costed strategic policy with the identification of funding gaps, using *marginal budgeting for bottlenecks;* Latest research findings and reports; Minutes of meetings where recommendations are made.
	Integrate the overarching communication component at all levels and stages of planning and execution for ACSD.	Inadequate guidelines for multi-sectoral integration of planning and execution.	Lobby for integration of comprehensive communication component in ACSD planning and execution process; Revision and updating of planning and implementation guidelines; Participation of key policy makers in Strategic Communication Planning for ACSD.	Revised guidelines for multi-sectoral integration of planning, and execution of ACSD; Latest research findings and reports; Approved overarching Communication Plan.

Participant Group	Desired actions	Barriers/obstacles to desired actions	Activities for promoting desired actions	Materials required
United Nations (UN) agencies, ministries, non-governmental organisations (NGOs), donors	Bi-monthly meetings of an interagency coordination committee (ICC) for ACSD with ministries, UN agencies, NGOs, donors.	Inadequate coordination between ministries, UN agencies, NGOs, and donors for implementation of high impact ACSD interventions; Culture of donor driven programmes.	Establish ICC for ACSD (including ministries, UN agencies, NGOs, donors) with subcommittee on communication; Develop a Terms of Reference (ToR) for ICC on ACSD.	ACSD Policy; Advocacy Kit; ToR of ICC for ACSD; Activity reports.
Key policy and decision makers at district level	Promote, ensure support and mobilise funds for implementation of the ACSD policy; Advocate for integrated implementation of activities towards the achievement of the MDGs.	Isolation of individual programs; Lack of support on ACSD from central to district level; Lack of knowledge of HIIs for achievement of MDGs; Lack of knowledge of results-based management.	National Roundtable for District Commissioner's Offices (DCOs) and other key district officials on ACSD; National-level field visits to districts to discuss, provide support, and exchange information; Conduct briefings on the HIIs, the achievement of MDGs, and principles of result-based management.	Activity Reports; Agenda; ACSD Policy; Advocacy Kit; Budget reports; Planning documents.
Members of Parliament	Political and district leadership takes part in supporting ACSD in respective districts and constituencies.	Lack of information about significance of ACSD; Lack of understanding of the role they can play in ACSD; Other competing priorities.	Arrange national-level meetings with Members of Parliament (MPs) from all districts to brief them about ACSD and the role they can play in it; Public debates.	Brief presentation on ACSD and suggested role of MPs; Advocacy Kit.
Religious leaders	Understand and promote ACSD related practices; Communicate benefits of ACSD to members of their congregation.	Lack of information about significance of ACSD; Lack of understanding of the role that ACSD can play; Other competing priorities.	Arrange special briefings, material and equipment to promote better understanding/clarity on roles and regular sharing of information.	Variety of material and equipment.

Participant Group	Desired actions	Barriers/obstacles to desired actions	Activities for promoting desired actions	Materials required
Traditional leaders	Promote behaviour change and support ACSD activities and ensure that communities play their role in adopting high impact practices.	Lack of understanding of the issues and respective roles of key stakeholders.	Special meetings; Special community events.	Information, Education and Communication (IEC) materials; theatre for development (TFD); radio and television programs; video shows; community radio listening clubs; briefing pack.
School population	Follow relevant key care practices and act as change agents within respective schools, communities, peer groups and families.	Many not reached or convinced; Lack of networking facilities and opportunities.	Set up special FFL Clubs and empower children through activities; Provide strategic opportunities to act as change agents and demonstrate appreciation for good work.	FFL material and local language versions.
Community communicators	Community members, especially young and credible people, volunteer time and energy to persuade families and neighbourhood on HIIs.	Lack of information about HII practices, their role and where the service is available.	Strategic involvement through Care Groups.	Identification and recognition material.
HSAs, field/extension workers	Field health workers have knowledge and skills to promote ACSD and provide care and counselling; Field Health Workers take lead to motivate families about ACSD.	Lack of knowledge, skills and supervisory support; Role in informing communities and families not recognised; Communities not approached or involved.	Refresher training/orientation of field health workers on interpersonal communication (IPC), a human rights approach to communication (HRAC) and motivation; Instructions issued for field health workers to ensure involvement in social mobilisation.	Revised IPC training package for field health workers; Instructions by District Health Office (DHO); Special material/film for field health workers.
Families and communities	Follow key care practices and obtain timely access to relevant services.	Lack of information about HII practices, where services are available, and the role they can play.	Door-to-door persuasion; special community events; regular and innovative mass media campaign; branded hoardings; IPC to raise awareness/remove misunderstanding.	Mass media campaigns; branded site paintings; messages on fixed site; inclusion in IPC training for field health workers.

19. Communication Implementation Process

To facilitate social change, communication processes and activities will be undertaken at different levels and will go through several stages. For effective implementation, better coordination and overall clarification, it is important to define roles at each level as well as the processes that need to be followed. Following are the key contributions expected at each administrative level with respect to reaching communities and families for motivation and action:

1. Communication support at national level will primarily focus on **designing** national initiatives and **facilitating** their implementation through development of necessary mechanisms, building capacity and providing necessary tools. The communication material will also be developed/produced centrally to ensure branding and uniformity of messages.

2. District communication teams will lead the **development and execution of the plan**. Following national initiatives, the district team will be responsible for directing district communication initiatives, raising and managing resources, building capacity, coordinating local media support to face-to-face interventions and monitoring progress.

3. At community level, **cross-sectoral entry** will be ensured from a cultural, traditional, religious and human rights perspective. Families and households will be persuaded through **creative and sustained multi-channel reach**.

20. 2008 – 2010 Activity Calendars

20.1 2008–2010 Activity Calendar for National Communication Process and Advocacy

Activity	Timeframe	Cost/Source (MK)			*Responsible* Lead
		2008	2009	2010	
In collaboration with stakeholders (including media), develop, finalise and disseminate Malawi Overarching Communication Plan for ACSD: • Arrange national consultation with all key stakeholders; • Finalise the strategic plan through final consultation.	May 07	MK2,000,000 UNICEF MK 2,000,000 UNICEF			MoH Health Education Unit (HEU) with support from UNICEF
Facilitate the drafting and finalisation of district specific Overarching Communication Plans, with key stakeholders: • Conduct final district specific consultation.	Aug 07	MK 2,000,000 UNICEF			HEU supported by UNICEF
Conduct national advocacy round-table on ACSD programme with Parliamentarian Committees on Health and HIV/AIDS: • Brief steering committee on ACSD; • Committee chairs disseminate info to Parliamentarians.	June 08	MK 100,000 UNICEF MK 3,500,000 UNICEF			HEU, IMCI Secretariat
Zonal dissemination with District Commissioners (DCs) and other key stakeholders for better understanding on support mechanism for ACSD: • Disseminate relevant documents prior to meeting.	May 08	MK 3,000,000 UNICEF	MK3,000,000 UNICEF	MK3,000,000 UNICEF	HEU supported by UNICEF
Conduct formative research on a national basis to guide communication implementation: • Develop protocol and ToRs for consultants, etc.	March/June 08	MK 5,600,000			HEU, IMCI Secretariat
Develop/integrate and implement training plan for field workers on IPC, social mobilisation skills etc: • Develop and update existing training manual; • Pilot training manual; • Training of Trainers etc.	Aug/Oct 2008	MK 9,000,000 UNICEF			HEU, IMCI Secretariat
Develop and implement collaboration plans with private sector organisations and media for joint programming and incorporation of key messages in their ongoing programmes: • Consultation meetings.	April/May 2008	MK 1,500,000 UNICEF	MK1,500,000 UNICEF	MK1,500,000 UNICEF	HEU, IMCI Secretariat
Sub Total		MK26,700,000 US$190,714	MK4,500,000 US$32,142	MK4,500,000 US$32,142	

20.2 2008–2010 Activity Calendar for National Social Mobilisation Plan

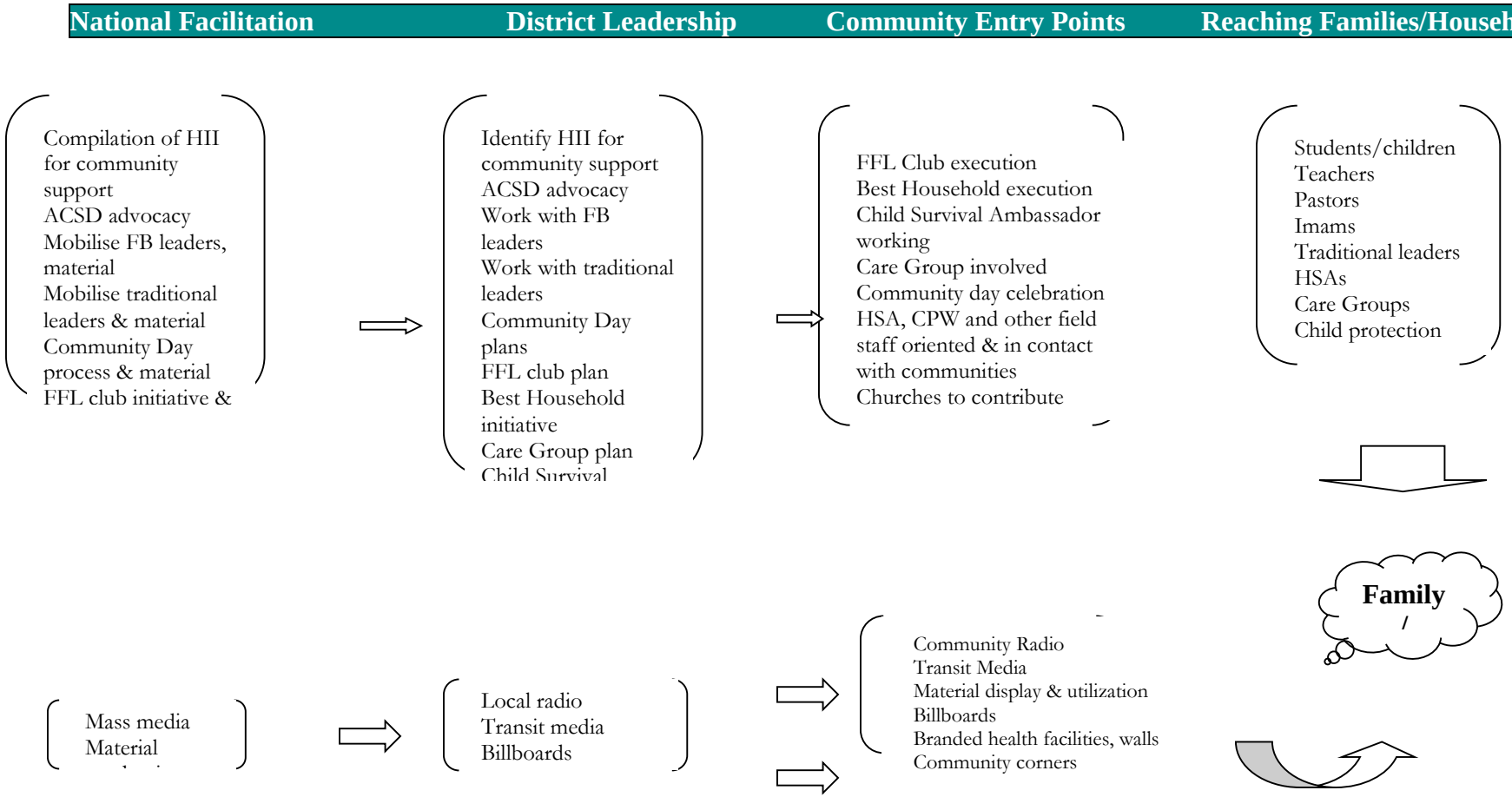
Activity	Time frame	Cost/Source (MK)			Lead Responsible
		2008	2009	2010	
Identify and designate a focal person in each community as *Child Survival Ambassador* to promote healthy life style: • Community meetings to identify Child Survival Ambassador; • Develop ToRs and incentives for Child Survival Ambassador	April/June 2008	MK2,000,000 MK200,000 UNICEF/ community	MK2,000,000 MK200,000 UNICEF/ community	MK2,000,000 MK200,000 UNICEF/ community	Districts, IMCI Secretariat
Provide national-level orientation for, and seek support from, key private practitioners from selected districts on ACSD programme: • Identify key private practitioners; • Develop and conduct orientation programme.	Oct 2008	MK 1,800,000			HEU, IMCI Secretariat
Invite key traditional leaders from selected districts to help in raising awareness on ACSD among communities: • Identify key traditional leaders (e.g., senior TA chiefs); • Ensure sensitisation on ACSD.	March 2008	MK 1,900,000			HEU, IMCI Secretariat
Invite key religious leaders (Christian and Muslim) from selected districts to help in raising awareness on ACSD among communities: • Conduct an inventory of religious leaders; • Ensure sensitisation on ACSD.	Dec 2007/ April 08 onwards	MK 1,900,000			HEU, IMCI Secretariat, MIA
Identify and involve community communicators from respective communities in Care Groups to lead communication process: • Learn from nutrition programme, and pilot after consensus	Ongoing	MK 1,500,000	MK1,500,000	MK1,500,000	HEU, IMCI Secretariat
Strategically involve, strengthen and sustain existing Community Communicator Networks (HSAs, home craft workers, environmental officers, VHCs, women's groups, and mother groups) to contribute to ACSD awareness: • Conduct an inventory of support groups; • Orient groups on ACSD communication strategies.	Ongoing	MK 1,000,000	MK1,000,000	MK1,000,000	Districts
Sub Total		MK10,300,000 US$ 73,571	MK4,700,000 US$33,571	MK4,700,000 US$33,571	

20.3 2008–2010 Activity Calendar National - Strategic Communication Plan

Activity	Timeframe	Cost/Source (MK)			Lead Responsible
		2008	2009	2010	
Design, plan and launch Facts for Life Club programme in selected schools based on key health messages and practices, materials and activities to empower girl and boy pupils. Process: • Review/explore linkages to school nutrition programme; • Draft, share with relevant colleagues, and finalise concept note; • Pilot in targeted districts.	March 2008 Dec 2010	MK 56,000,000	MK 56,000,000	MK 56,000,000	School and Nutrition Technical Working Group (TWG), HEU
Design, field test and print: 1. 5 ACSD Posters on HII agreed for 2008 2. 6 ACSD Posters on HII agreed for 2009 3. ACSD Badge 4. ACSD Brochure 5. ACSD Partners Brochure 6. Hoardings in selected 8 districts 7. Hospital Signs 8. Transit media 9. Advocacy kit including CD 10. Chitenjes with key messages 11. Inter health facilities competitions 12. FFL booklet adult version/child version 13. Best practices competition 14. Posters for training purposes 15. FFL flipcharts for schools 16. Reading materials Process: • Prepare and finalise material distribution list; • Arrange delivery at district level.	March 2008	MK 20,000,000	MK15,400,000	MK 10,000,000	HEU
Brief ad agencies on objectives and themes of electronic and print messages. Draft, produce and field test television/radio/newspaper messages/programmes on: 1) ACSD logo/message strip/music and printing/airing on 5 HIIs; 2) Branding and airing ACSD serial/series/talk show; 3) Printing/airing incentive-based messages involving celebrities. Process: • Partnership release of mixed media campaign; • Strengthen/establish community radios for social change; • Strengthen listening clubs.	Ongoing				HEU

Mark special health days/weeks as part of periodic campaigns: • Discussions with MoH and other agencies.	Ongoing	MK 5,000,000	MK 5,000,000	MK 5,000,000	HEU
Establish network/work with existing network of development journalists for special reports and articles in newspapers: • Create inventory of, and form partnership with, appropriate journalists and new networks.	Ongoing	MK 100,000	MK 100,000	MK 100,000	HEU
Design, pilot and sustain FFL school clubs in selected districts: • Develop FFL child/adult comics; • Link up with school health and nutrition committee.	April 08 Onwards			*Cost already included above*	HEU
Design and run innovative and strategic branded mass media campaign, preferably through partnership with private sector and media organisations: • Draft concept notes on area of programming/partnership and enter into partnerships.	March 08 Onwards	MK 20,000,000	MK 20,000,000	MK 20,000,000	HEU, IMCI
Engage communities, especially marginalised and voiceless groups, through village level dance/theatre/comedian groups on childcare and development discussions and actions: • Create long term partnership with dance/theatre/comedian groups for Community Day.	May 08 Onwards	MK 2,000,000	MK 2,000,000	MK 2,000,000	HEU, Districts
Design and launch a Letter to Community Initiative in partnership with Malawi Post Service: • Form partnership with Malawi Post Service; • Organise possible letter to community/picture competition.	March 2008	MK 6,000,000	MK 6,000,000	MK 6,000,000	HEU, UNICEF
Arrange periodic assessment to monitor impact of communication interventions on knowledge and practices: • Create dialogue with M&E to devise monitoring checklist	July 2008	MK 4,000,000	MK 4,000,000	MK 4,000,000	HEU, IMCI
Sub Total	MK358,100,000 US$2,557,857	MK57,000,000 US$407,143	MK52,500,000 US$375,000	MK47,100,000 US$ 336,429	
Grand Total		MK143,100,000 US$1,022,143	MK110,700,000 US$790,714	MK104,300,000 US$745,000	

21. ACSD Communication Flow Framework



1. Communication support at national level will primarily focus on **designing** national initiatives and **facilitating** their implementation through development of necessary mechanisms, capac material will be developed/produced centrally to ensure branding and uniformity of messages.
2. District communication teams will lead **development and execution of communication plan**. Following national initiatives, the district teams will be responsible for directing district cor managing resources, building capacity, coordinating local media support for face-to-face interventions and monitoring progress.
3. At community level, **cross sectoral entry** will be ensured from a cultural, traditional, religious and human rights perspective.
4. Families and households will be persuaded through **creative and sustained multi channel reach**.

22. ACSD Community Communication Packages and Delivery Mechanism

Community Communication Package	Reach	Responsible/Support
FFL Clubs in schools teacher with support from partner NGO	40 students and 1 teacher per school	School head
Best Household of Month competition run by responsible health facility	Majority of mothers in each community	Regular
Child Survival Ambassador village head/traditional chief	Population attending cultural events	Through
Care Group coordinate, mothers to participate	Households with children under fives	HSA to
Community Day to lead and NGO to assist	Population at community events	Village head
Holy Bible Says Pastor, MIAA and Communication Committee	Followers visiting Church	Church
Holy Quran Says Imam, MIAA and Communication Committee	Followers visiting Mosque	Mosque

23. Key Messages

23.1 Key Messages for Maternal Health

Group	Measurable behaviour – Knowledge/recall	Measurable behaviour – Behaviour/Practice
Pregnant women and spouse/partner	• Pregnant and lactating women should receive increased quantity and better quality food from the six food groups; • Every pregnant women should attend antenatal clinic (ANC) at least four times during pregnancy; • Every pregnant woman has a right to receive sulfadoxine-pyrimethamine (SP), tetanus toxoid (TT3), iron and vitamin A; • Every pregnant woman has right to skilled attendants during childbirth; • Every pregnant woman should go for an HIV test to know how to protect her unborn child; • Every HIV-positive pregnant woman should receive anti-retroviral drugs to prevent HIV transmission to unborn child; • Every mother should attend PNC within 7 days of childbirth.	• Pregnant/lactating women eat more and better food; • Pregnant women attend ANC at least four times; • Every pregnant woman receives SP, TT3, iron and vitamin A; • Every pregnant woman is attended by a skilled worker during childbirth; • Every pregnant woman goes for an HIV test to know how to protect her unborn child; • Every HIV positive pregnant woman receives anti-retroviral drugs to prevent transmission of HIV to her unborn child; • Every mother attends post-natal clinic (PNC) within 7 days of childbirth.
Family and community members	• Pregnant and lactating women should receive increased quantity and better quality food from the six food groups; • Family members should help to reduce workload of pregnant women so that they can get more rest; • Every pregnant woman should attend ANC at least four times during pregnancy; • Every pregnant woman has a right to receive SP, TT3, iron and vitamin A; • Every pregnant woman has right to skilled attendants during childbirth; • Family and community members should be prepared to transport pregnant women to the nearest health facility as soon as labour starts; • If labour continues for more than 12 hours, the pregnant woman should be taken to the nearest hospital where emergency operation facilities are available; • Every mother should attend PNC within 7 days of childbirth.	• Pregnant and lactating women eat more and better food; • Family members help pregnant women to get sufficient rest; • Every pregnant woman attends ANC at least four times during pregnancy; • Every pregnant woman receives SP, TT3, iron and vitamin A; • Every pregnant woman is attended by skilled birth attendant during childbirth; • Family and community members are prepared to transport pregnant women to the nearest health facility as soon as labour starts; • Preparedness of community and family for childbirth. Awareness/use of referral options; • Every mother attends PNC within 7 days of childbirth.

Skilled workers and especially family members	• Every pregnant woman should attend ANC at least four times during pregnancy; • Every pregnant woman has a right to receive SP, TT3, iron and vitamin A; • Every pregnant woman has right to skilled attendants during childbirth; • If labour continues for more than 12 hours, the pregnant woman should be taken to the nearest hospital where emergency operation facilities are available; • Every pregnant woman should go for an HIV test to know how to protect her unborn child; • Every HIV positive pregnant woman should receive anti-retroviral drugs to prevent transmission of HIV to her unborn child; • Every mother should attend PNC within 7 days of childbirth.	• Every pregnant woman attends ANC at least four times during pregnancy; • Every pregnant woman receives SP, TT3, iron and vitamin A; • Every pregnant woman is attended to by a skilled worker during childbirth; • Preparedness for process of childbirth and awareness of referral options; • Every pregnant woman goes for an HIV test to know how to protect her unborn child; • Every HIV positive pregnant woman receives anti-retroviral drugs to prevent transmission of HIV to her unborn child; • Every mother attends PNC within 7 days of childbirth.

23.2 Key Messages for Newborn Health

Group	Measurable behaviour – Knowledge/recall	Measurable behaviour – Behaviour/practice
Parents/care givers	• Every newborn child should be put on the breast within one hour of birth; • Within the first seven days of life every newborn baby should be checked for danger signs (i.e. failure to breastfeed, fast and difficult breathing, fever, red umbilical cord, hypothermia); • Breast milk is the best nutrition for the first six months of your child's life. Do not give any other food or drink – breastmilk is enough; • Breastfeeding helps prevent babies and young children from becoming susceptible to dangerous illnesses.	• Every newborn child put on the breast within one hour of birth; • Every newborn baby checked for danger signs within the first seven days of life; • Babies not given any other food or drink during first six months – breastmilk is best; • Mothers practising exclusive breastfeeding during the first six months.
Family and community members	• Every newborn child should be put on the breast within one hour of birth; • Within the first seven days of life every newborn baby should be checked for danger signs (i.e. failure to breastfeed, fast and difficult breathing, fever, red umbilical cord, hypothermia); • Breastmilk is the best nutrition for the first six months of the child's life. Do not give any other food or drink – breastmilk is enough; • Breastfeeding helps prevent babies and young children from becoming susceptible to dangerous illnesses.	• Every newborn child put on the breast within one hour of birth; • Every newborn baby checked for danger signs within the first seven days of life; • Babies not given any other food or drink during first six months – breastmilk is best; • Mothers practising exclusive breastfeeding during the first six months.
Food purchasers and food preparers	• Breastmilk is the best nutrition for the first six months of a child's life. Do not give any other food or drink – breastmilk is enough; • Breastfeeding helps prevent babies and young children from becoming susceptible to dangerous illnesses.	• Every newborn child put on the breast within one hour of birth; • Every newborn baby checked for danger signs within the first seven days of life.
Skilled workers	• Every newborn child should be put on the breast within one hour of birth; • Within the first seven days of life every newborn baby should be checked for danger signs (i.e. failure to breastfeed, fast and difficult breathing, fever, red umbilical cord, hypothermia); • Breastmilk is the best nutrition for the first six months of a child's life. Do not give any other food or drink – breastmilk is enough.	• Every newborn child put on the breast within one hour of birth; • Every newborn baby is checked for danger signs within the first seven days of life; • Babies not given any other food or drink during first six months – breastmilk is best; • Mothers practising exclusive breastfeeding during the first six months.

23.3 Key Messages for Child Health

Group	Measurable behaviour – Knowledge/recall	Measurable behaviour – Behaviour/practice
Parents/ caregivers	• Breastmilk is the best nutrition for the first six months of the life of your child. Do not give any other food or drink – breastmilk is enough; • From six months to two years children need quality food from the six food groups 5-6 times a day and breastfeeding should be continued up to two years; • Diarrhoea can be prevented through use of safe water, toilets and regular washing of hands with soap and water, especially after use of toilet and before touching food and feeding children; • Keep ORS at home and administer at first signs of diarrhoea, while continuing to breastfeed; • Buy and regularly use iodised salt. It is important for all family members and in children it prevents learning disabilities and delayed development; • The first three years of baby's life is the most important period for growth and learning. Children learn best when caregivers talk with them, give them affection and attention, and encourage them to play; • Immunisation protects children from seven diseases. Start immunisation of children as soon as they are born – during outreach, mobile clinic or at the nearest health facility; • All children under five years of age have a right to sleep under an insecticide-treated mosquito net every night, all year round; • Every child with suspected or confirmed HIV should receive cotrimoxazole preventive therapy from six weeks of age until the child has been tested and HIV infection ruled out; • All HIV positive children should receive cotrimoxazole therapy indefinitely; • All HIV-positive mothers should exclusively breastfeed their babies for six months only. After this the child should be exclusively fed on replacement foods; • Every member of the family and community who is aware of, recognises or witnesses child abuse and/or neglect must report to the nearest authority (police, child protection workers); • Every child aged 6 months to five years should receive a dose of de-worming drugs every six months; • All children with fever should be treated with the recommended anti-malarial.	• Exclusive breastfeeding for the first six months; • Breastfeeding continued from six months to two years, with quality complementary foods; • Consistent use of safe water, pit latrines/toilets and regular washing of hands with soap and water at critical times; • ORS kept at home and administered at first signs of diarrhoea; • Purchase and use of iodised salt; • Active family participation in development of child; • Vaccination of child from seven diseases within first year; • Children sleep under mosquito net all year round, every night; • HIV confirmed or suspected children receive cotrimoxazole until HIV ruled out; • Cotrimoxazole given to all HIV positive children indefinitely; • HIV positive mothers exclusively breastfeed their children for ONLY 6 months; • Child abuse promptly reported; • All children receive de-worming drugs every six months; • All children with fever receive anti-malaria treatment.

Group	Measurable behaviour – Knowledge/recall	Measurable behaviour – Behaviour/practice
Family and community members	• Breastmilk is the best nutrition for the first six months of a child's life. Do not give any other food or drink –breastmilk is enough; • From six months to two years children need quality food from the six food groups 5-6 times a day and breastfeeding should be continued up to two years; • Diarrhoea can be prevented through use of safe water, toilets and regular washing of hands with soap and water, especially after use of toilet and before touching food and feeding children; • Buy and regularly use iodised salt. It is important for all family members and in children it prevents learning disabilities and delayed development; • Provide children with adequate micronutrients (especially vitamin A, iodine and iron), either in their diet or through supplementation; • The first three years of baby's life is the most important period for growth and learning. Children learn best when family members give them affection and attention, talk with them and encourage them to play; • All children under five years of age have a right to sleep under an insecticide-treated mosquito net every night, all year round; • All HIV-positive mothers should exclusively breastfeed their babies for six months only. After this, the child should be exclusively fed on replacement foods; • Every member of the family and community who is aware of, recognises, or witnesses child abuse and/or neglect must report to the nearest authority (police, child protection workers); • All children with fever should be treated with the recommended anti-malarial; • Every child 6 months to 5 years should receive de-worming drugs every 6 months	• Exclusive breastfeeding for the first six months; • Breastfeeding continued from six months to two years, with quality complementary foods; • Consistent use of safe water, toilets and regular washing of hands with soap and water at critical times; • Purchase and use of iodised salt; • Children provided with adequate micronutrients; • Active family participation in development of child; • Children sleep under mosquito net all year round, every night; • HIV confirmed or suspected children receive cotrimoxazole until HIV ruled out; • Child abuse promptly reported; • All children with fever receive anti-malaria treatment; • All children receive de-worming drug every six months.
Food purchasers and food preparers	• Breastmilk is the best nutrition for the first six months of a child's life. Do not give any other food or drink – breastmilk is enough; • From six months to two years children need quality food from the six food groups 5-6 times a day and breastfeeding should be continued up to two years; • Diarrhoea can be prevented through use of safe water, toilets and regular washing of hands with soap and water, especially after use of toilet and before touching food and feeding children; • Provide children with adequate micronutrients (especially vitamin A, iodine and iron), either in their diet or through supplementation;	• Exclusive breastfeeding for the first six months; • Breastfeeding continued from 6 months to 2 years, with quality complementary foods; • Consistent use of safe water, toilets and regular washing of hands with soap and water at critical times; • Purchase and use of iodised salt;

Group	Measurable behaviour – Knowledge/recall	Measurable behaviour – Behaviour/practice
	• All HIV positive mothers should exclusively breastfeed their children for six months only. After this the child should be exclusively fed on replacement foods.	• HIV-positive mothers exclusively breastfeed babies 6 months ONLY.
Skilled workers	• Breastmilk is the best nutrition for the first six months of a child's life. Do not give any other food or drink – breastmilk is enough; • From six months to two years' children need quality food from the six food groups 5-6 times a day and breastfeeding should be continued up to two years; • Provide children with adequate micronutrients (especially vitamin A, iodine and iron), either in their diet or through supplementation; • Immunisation protects children from seven diseases. Start immunisation of children as soon as they are born – during outreach, mobile clinic or at the nearest health facility; • All children under five years of age have a right to sleep under an insecticide-treated mosquito net every night, all year round; • Every child with suspected or confirmed HIV should receive cotrimoxazole preventive therapy from six weeks of age until the child has been tested and HIV infection ruled out; • All HIV positive children should receive cotrimoxazole therapy indefinitely; • All HIV positive mothers should exclusively breastfeed their children for six months only. After this the child should be exclusively fed on replacement foods; • Every member of the family and community who is aware of, recognises, or witnesses' child abuse and/or neglect must report to the nearest authority (police, child protection workers); • Every child aged 6 months to five years should receive a dose of de-worming drugs every six months; • All children with fever should be treated with the recommended anti-malarial.	• Exclusive breastfeeding for the first six months; • Breastfeeding should be continued from six months to two years, with complementary quality foods; • Purchase and use of micronutrients; • Vaccination of child from seven diseases within one year; • Children sleep under mosquito net all year round, every night; • HIV confirmed or suspected children receive cotrimoxazole until HIV ruled out; • Cotrimoxazole given to all HIV positive children indefinitely; • HIV positive mothers exclusively breastfeed their children for ONLY 6 months; • Child abuse promptly reported; • All children receive de-worming drugs every six months; • All children with fever receive anti-malaria treatment.

23.4 Key Message for Community Health

Group	Knowledge/Recall	Behaviour/Practice
All community members	• Formation and engagement of community support groups in ante and postnatal care of mother and child; • Creation of community committees to help implement maternal, neonatal and child health (MNCH) interventions; • Participation of community in supporting key care practices; • Responsiveness of community regarding their roles and responsibilities as duty bearers; • Community readiness to mobilise resources in support of community-based interventions; • Community-based monitoring systems (community village feedback meetings).	• Community groups support antenatal and postnatal care of mother and child; • Community committees help implement MNCH interventions; • Community supports key care practices; • Community members responsible for their roles as duty bearers; • Community mobilisation of resources in support of community-based interventions; • Community-based monitoring systems (community village feedback meetings).
Leaders of community	• Formation and engagement of community support groups in ante and postnatal care of mother and child; • Creation of community committees to help implement MNCH interventions; • Participation of community in supporting key care practices; • Responsiveness of community regarding their roles and responsibilities as duty bearers; • Community readiness to mobilise resources in support of community-based interventions; • Community-based monitoring systems (community village feedback meetings).	• Community groups support antenatal and postnatal care of mother and child; • Community committees help implement MNCH interventions; • Community supports key care practices; • Community members responsible for their roles as duty bearers; • Community mobilisation of resources in support of community-based interventions; • Community-based monitoring systems (community village feedback meetings).
Community-based organisations (CBOs)	• Formation and engagement of community support groups in ante and postnatal care of mother and child; • Creation of community committees to help implement MNCH interventions; • Community readiness to mobilise resources in support of community-based interventions.	• Community groups support antenatal and postnatal care of mother and child; • Community committees implement MNCH interventions; • Community monitoring systems (community village feedback meetings).

23.5 Nutrition

23.5.1 Optimal Breastfeeding from 0 to < 6 months

1. Mother	**Give the first milk made especially for the newborn as it will protect your baby from illness.**
Supporting information	- This first milk (colostrum) will help to expel your baby's first dark stool; - Colostrum contains many important factors that protect your new baby from disease.
2. Mother	**Put your baby on the breast immediately after birth (within 30 minutes – even before the placenta is expelled) to stimulate your production of milk.**
Supporting information	- Immediate breastfeeding within 30 minutes of birth will help to expel the placenta and reduce post-partum bleeding; - Artificial feeds (such as sugar water, water, butter, etc.) are not necessary and may interfere with establishing good breastfeeding practices during the first days of the baby's life.
3. Mother	**Feed your baby only breastmilk for the first six months (not even giving water or any other fluid) so that your baby will grow healthy and strong.**
Supporting information	- Feeding the baby only breastmilk provides the best nourishment possible for baby and will protect her/him from diseases such as diarrhoea and respiratory infections; - Giving the baby water or other liquids may make your baby sick with diarrhoea; - If the baby takes water or other liquids, its appetite for breastmilk may decrease meaning it sucks less on the breast leading to poor growth; - Even during very hot weather, breastmilk will satisfy all your baby's thirst for liquids during the first six months.
4. Mother	**Breastfeed your baby on demand, at least 8-12 times day and night, to produce enough milk and provide your baby enough food to grow and be healthy.**
Supporting information	- Frequent breastfeeding helps the milk to flow and increases bonding between mother and child; - Ensure proper positioning and attachment of baby on breast so your baby gets adequate breastmilk and so as to avoid problems such as sore and cracked nipples; - Advise mothers with nipple and breast problems to seek immediate care from a health worker.
5. Mother	**Empty one breast before switching to the second, so that your baby gets the most nutritious hind milk that he/she needs to grow strong and healthy.**
Supporting information	- Foremilk quenches thirst because it is more watery; - Hind milk is richer and satisfies baby's hunger so that it will not cry as much.

6. Husband	**Ensure that your wife who is breastfeeding has two extra meals a day to maintain her health and the health of the baby.**
Supporting information	- To maintain their health, breastfeeding women need to eat a wide variety of foods, particularly animal products (meat, milk, eggs, etc), fruits and vegetables. - Ripe papaya, orange, carrot, pumpkin, mango and liver are especially good for the mother.
7. Mother	**During illness, increase the frequency of breastfeeding for your baby to recover faster.**
Supporting information	- Continue to breastfeed during diarrhoea, even increasing the frequency to replace the liquid lost; - Breastfeeding more during illness will help your baby to fight the sickness and not lose weight; - Breastfeeding also provides comfort to a sick baby; - Sick mothers can continue to breastfeed their baby.
8. Mother	**After each illness increase the frequency of breastfeeding for the baby to regain health and weight.**
Supporting information	- Each time a baby is sick, s/he will lose weight so it is important to breastfeed as often as possible; - Your breastmilk is the safest and most important food you can offer to help your baby to regain health and weight.
9. Mother	**Take vitamin A supplementation within 8 weeks of delivery for the baby's health and strength.**
Supporting information	- Ask a health worker for vitamin A supplementation after the birth; - Taking a vitamin A capsule will enrich the mother's breastmilk with important nutrients to keep the baby healthy and strong.
10.All family	**Sleep under an insecticide-treated net (INT), especially pregnant women and children, to prevent getting malaria.**
Supporting information	- Malaria causes anaemia which will make family members unwell and very tired. - Family members with fever need to be taken to a health facility for immediate treatment.
Additional nutrition message regarding vitamin D for infants 0 to 6 months	
Mother and father	**Expose your baby to sunlight for 20 to 30 minutes daily to ensure s/he grows well.**
Supporting information	- Exposure to sunshine will help ensure your baby has adequate vitamin D, which is important for bone growth and good health.

Note: it is recommended that women who

23.5.2 Complementary Feeding with Breastfeeding 6 to 24 Months

1. Mother and father	**Introduce a variety of complementary foods at six months (e.g., *likuni phala* or soft enriched porridge) 2-3 times a day so your baby can grow healthy and strong.**
Supporting information	- After 6 months, the child is growing faster and is more active, hence breastmilk alone is not adequate to meet the child's needs; - The child is physiologically mature to eat, digest and utilise other foods and fluids; - Porridge can be made from many different types of cereals and tubers (e.g. potatoes, *likuni phala* flour, maize/millet/sorghum flour, rice, and mashed sweet and Irish potatoes); - The consistency of the porridge should be thick enough to be fed by hand; - Thicken the porridge as the baby grows older, making sure that it is still able to easily swallow without choking; - Thin gruels made with water are not healthy for your baby as they do not provide enough of the nutrients it needs to grow strong and healthy; - When possible use milk instead of water to prepare the porridge; - Foods given to the child must be stored in hygienic conditions to avoid diarrhoea and illness. - Different types of complementary foods are found in different areas. Porridges that can be used to feed babies 6 to 12 months of age include: *Likuni phala* enriched with vegetable oil and sugar to which mashed fruit and vegetable can be added; porridge made from *mgaiwa*, millet, or sorghum flour or rice that is enriched with milk, egg, fish powder, meat, poultry and fruits and vegetables; groundnut, soya and pumpkin seed flour; or enriched yellow/Irish potatoes.
2. Mother	**Continue to breastfeed your child on demand, at least 8 times, day and night until two years and beyond to maintain its strength.**
Supporting information	- During the first and second year, breastmilk is still an important source of nutrients for your baby.
3. Mother and father	**Enrich your baby's porridge at each meal with a variety of foods from the six groups (such as avocado pear; butter; oil; milk; meat; eggs; fish; groundnut, soya or pumpkin seed flour; vegetables and fruits) for it to grow and get strong.**
Supporting information	- From 6 months onwards, feed your child different types of porridge enriched with a variety of foods from the six food groups in addition to breastmilk; - Try to feed different foods from the six food groups each time; - Mash or chop in small pieces and soften the enrichment foods so the baby can easily chew and swallow without choking; - Add foods rich in fat such as butter, oil and avocado pear every time; - Animal foods (meat, liver, fish, milk and eggs) are especially good for your baby and will keep it healthy and strong; - Fruits such as papaya, mangoes and vegetables such as *chisoso, bonongwe*, spinach, carrots and pumpkin are good sources of vitamin A while raw tomatoes, oranges, lemon, *masau*, watermelon are good sources of vitamin C. Vitamin C helps the body to use iron for more blood formation in the body. Vitamin A helps the body to fight infections and is used for good sight; - Dark green leaves (such as *chisoso, bonongwe*, sweet potato leaves, spinach and pumpkin leaves) and legumes contain important nutrients such as iron and will help your baby grow strong.

	- Types of enrichment foods from the six food groups that can be given with the porridge include: Fat foods: oil and butter, avocado pear Animal products: meat, fish, eggs, milk, poultry Legumes: beans, peas, groundnuts, soya flour, cow peas Fruits : Ripe papaya, mangoes, pumpkin, banana, oranges Vegetables: carrots, dark green leafy vegetables.
4. Mother and father	**From 6 to 12 months of age, feed the child 2 nutritious *snacks* between meals each day to ensure healthy growth.**
Supporting information	- Babies have small stomachs and can only eat small amounts at each meal so it is important to feed them frequently throughout the day for more total nutrients - By 8 months the baby can begin to eat snacks/finger foods such as pieces of ripe mango, papaya, avocado, banana, other fruits and vegetables, fresh and fried bread products, boiled potato, sweet potato, peanut butter, *chambiko*, yoghurt - Feed these nutritious snacks at least 1-2 times each day in between meals; - Foods given to the child must be stored in hygienic conditions to avoid diarrhoea and illness; - Fruits must be properly washed in clean safe water before giving to child.
5. Mother and father	**From 12 to 24 months of age, feed your child at least 3-4 times a day using a variety of family foods, along with 1-2 other nutritious snacks each day to ensure healthy growth.**
Supporting information	- It is very important that the family's meals are also enriched with a variety of foods from the six food groups; - Give the child different foods at each meal, feed 3-4 times a day; - Young children have small stomachs and can only eat small amounts at each meal so it is important to feed them frequently throughout the day; - Other solid foods and nutritious fluids can be given as many times as possible (at least 2 times) each day and can include ripe mango, papaya, avocado, banana, other fruits and vegetables, fresh and fried bread products, boiled potato, sweet potato, *chambiko* and yoghurt; - Foods given to the child must be stored in hygienic conditions to avoid diarrhoea and illness.
6. Mother and father	**As your baby grows older, feed more food at each meal in order to ensure that they are eating enough to maintain healthy growth.**
Supporting information	- As children grow, they need more food because they are growing and becoming more and more active; - Offer a variety of different foods from the six food groups remembering to encourage your child to eat more at each meal as they get older.

7. Mother	**Feed the child from an individual plate or bowl to make sure it eats all the food given at its own pace.**
Supporting information	- A child, 12–24 months is still young and eats slowly, hence it may not be able to compete with older siblings if eating from the same plate. In order to ensure that the child gets enough to eat, feed the child from its own plate.
8. Mother	**Be patient and actively encourage your baby to eat all its food in order to grow healthy.**

Supporting information	- At first the baby may need time to get used to eating foods other than breastmilk, so have patience and take enough time to feed it, even using play and singing or talking to help it eat. Make the time for eating special; - Forced feeding will discourage babies and young children from eating; - As they are too little to feed themselves, babies need to be fed directly to make sure they eat all the food given to them; - Even when older, young children should be supervised during mealtime to make sure they eat all the food put on their plate.
9. Mother, father, family	**During illness, increase the frequency of breastfeeding and offer additional food to your child to help her/him recover more quickly.**
Supporting information	- Fluid and food requirements are higher during illness; - Take time to patiently encourage your sick child to eat as her/his appetite may be decreased because of the illness; - It is easier for a sick child to eat small frequent meals, so feed the child foods s/he likes in small quantities throughout the day; - It is important to keep breastfeeding and feeding complementary foods to your child during illness to maintain her/his strength, to reduce the weight loss and to help fight the disease and recover quickly.
10. Mother, father and other family	**When your child has recovered from an illness, give her/him one additional meal of solid food each day during the two weeks that follow to help her/him recover quickly.**
Supporting information	- Children who have been sick need extra food and should be breastfed more frequently to regain the strength and weight lost during the illness. - Take enough time to actively encourage your child to eat this extra food as s/he still may not appear hungry due to the illness.
11. Mother, father and other family	**Feed your baby using a clean cup – never a bottle, as this may cause your baby to get diarrhoea.**
Supporting information	- Feed your child using a cup – it is easier to clean and cheaper to buy than a bottle. - Bottles are very difficult to keep clean and can give your baby diarrhoea.
12. Mother and all family members	**Wash your hands with soap and water before preparing food, before eating, and before feeding young children to avoid diarrhoea.**
Supporting information	- Touching food with unclean hands can cause diarrhoea; - Utensils for feeding the baby also have to be clean; - Use a cup to feed a baby/young child; never a bottle which can cause diarrhoea; - Food given to children must be stored in hygienic conditions to avoid diarrhoea and illness.
13. Mother and father	**When your baby is 6 months old, make sure s/he receives vitamin A supplementation every six months (two times per year) until the child is 59 months to make her/him strong and for good sight.**
Supporting information	- Ask a health worker to give vitamin A supplementation two times a year to your child between 6 to 59 months of age; - Vitamin A is important for your child's eyesight to prevent night blindness; - Vitamin A also helps your child fight illness;

	- Be sure to bring your child for vitamin A at the health clinic every six months or during child health vitamin A supplementation campaigns.
14.Mother, father and other family	**Feed your child vitamin A rich foods to help your child grow strong and healthy.**
Supporting information	- Pawpaw, mangos, pumpkin, carrots, *bononGwe, chisoso*, cassava leaves, spinach, yellow sweet potatoes, *masamba wolendera*, pumpkin/cassava/sweet potato/cow pea leaves and liver are all good sources of vitamin A and other nutrients. - Children should eat these foods as often as possible; - Give the child vitamin A rich-foods together with oil or fat-rich foods such as ground soya/pumpkin flour, vegetable oil, avocado pear to help the body use the vitamin A effectively; - Oil or fat rich foods help the body utilise vitamin A properly, hence always add fat or oil rich foods when cooking; - Eat fruits rich in vitamin A with a meal to help utilise the vitamin A in the body.
15.Mother and father	**When your child is two years old, s/he has to receive de-worming medicine every six months to maintain healthy growth.**
Supporting information	- Ask a health worker for de-worming medicine to be given two times a year to your child between the ages of 2 to 5 years; - Intestinal parasites cause young children to become anaemic which will make your child unwell and tired.
16.All family members	**Sleep under an insecticide-treated net (ITN), especially pregnant women and children, to prevent getting sick with malaria.**
Supporting information	- Malaria causes anaemia which will make your child or family members unwell and very tired. Children are at higher risk than adults of dying from malaria; - Take a child and other family members with fever to a health facility for immediate treatment.
17. Mother and father	**Ensure that all family food is cooked using iodised salt so that family members remain healthy, and for good mental development of the child.**
Supporting information	- Foods that we eat do not contain enough iodine. Therefore, always use iodised salt when cooking food for the child or family; - Pregnant women need to use iodised salt to ensure the health of their new baby.

23.5.3 Women's Nutrition

1. Women	**Consume a variety of quality foods from the six food groups to maintain your strength and avoid illness.**
Supporting information	▪ To maintain your health, eat a variety of foods from the 6 food groups such as meat, milk, eggs, fruits, vegetables, legumes, and avocado pear in addition to your staple food (nsima, rice, cassava, sweet potatoes); ▪ Eat foods rich in vitamin A, such as meat, yellow fruits, and vegetables, fish, *matemba and usipa*; ▪ Eat fruits rich in vitamin A such as pawpaw, mangoes, and pumpkin with a meal. Also eat vegetables rich in vitamin A such as carrots, green leafy vegetables with cooking oil or ground nut, soya, pumpkin seed flour.
2. Husband and other family	**Ensure that the pregnant woman has one additional meal every day to maintain her strength.**
Supporting information	- Pregnant women need to eat a variety of foods, particularly animal products (meat, milk, eggs, etc), plus fruits and vegetables; - Ripe papaya, mango, orange, carrot and pumpkin are especially good; - Pregnant women need to eat more food than usual NOT decrease their intake.
3. Pregnant women	**Take iron/folic tablets everyday for your good health and strength throughout your pregnancy.**
Supporting information	▪ A pregnant woman needs more foods for proper growth of the child and for herself to be strong and remain healthy; ▪ Taking iron/folic tablets everyday for at least six months during pregnancy will help to keep both the mother and child healthy; ▪ Eat iron rich foods such as liver, red meat, and green leafy vegetables; ▪ Eat vitamin C rich foods such as raw tomatoes, *masuku*, *masau*, *malambe* with a meal to help the body to use iron properly.
4. Husband and other family	**Make sure the pregnant woman gets iron/folate tablets to maintain her strength during the pregnancy.**
Supporting information	- Ask a health worker for iron/folate tablets to be given to your pregnant wife over a six month period; - Ask your wife to take her iron/folic tablets everyday for at least six months during the pregnancy; - Pregnant women have an increased need for iron; - Iron/folate tablets are important to prevent anaemia in pregnant women and will help to keep mother and the new baby healthy; - Liver is also a good food source of iron for pregnant women; - Liver, red meat, green leafy vegetables are also good sources of iron for pregnant women; - Encourage your wife to take vitamin C rich such as raw tomatoes, orange, *masuku, malambe* with a meal to help the body to use iron from plants; - Vitamin A is very important for the good health and strength of the baby; - Vitamin A helps to fight against infections and gives proper eye sight; - Make sure the breastfeeding woman receives vitamin A supplementation soon after the birth of the baby, before discharge from the hospital or within eight weeks the birth of the child; - If she delivers with the help of a traditional birth attendant (TBA) encourage her to go back to the health clinic for vitamin supplementation.

5. Breast-feeding mother	**Take a variety of foods from the six food groups with two extra meals in between to maintain your strength and the health of the baby.**
Supporting information	- To maintain their health, breastfeeding women need to eat a wide variety of foods, particularly, animal products (meat, milk, eggs, etc), fruits and vegetables. - Ripe papaya, mango, orange, carrot, and pumpkin are especially good for the mother.
6. Husband	**Ensure that your breastfeeding wife has two extra meals a day to maintain her health and the health of the baby.**
Supporting information	- To maintain their health, breastfeeding women need to eat a wide variety of foods, such as animal products (meat, milk, eggs, etc), fruits, vegetables, legumes, avocado pear; - Ripe papaya, mango, orange, carrot, and pumpkin are especially good for the mother.
7. Mother	**Take vitamin A supplementation within 8 weeks of delivery for the baby's health and strength.**
Supporting information	- Ask a health worker for vitamin A supplementation after the birth of the baby or before you are discharged from the hospital; - If you deliver with the help of a TBA, always go back to the health clinic to get Vitamin A supplementation before 8 weeks after the delivery of your child; - Taking a vitamin A capsule will enrich your breastmilk with important nutrients to keep the baby healthy and strong; - Vitamin A helps fight against infection and improves eye sight.
8.All family members	**Sleep under insecticide-treated net (INT), especially pregnant women and children, to prevent getting malaria.**
Supporting information	- Malaria causes anaemia, which will make members of your family unwell and very tired; - Family members with fever need to be taken to a health facility for immediate treatment.
9. Husband	**Make sure your pregnant wife gets de-worming pills once in the second or third trimester of pregnancy.**
Supporting information	- Ask a health worker for mebendazole (500 mg) to be given once to your pregnant wife in the second or third trimester of pregnancy; - Intestinal worms can cause anaemia which leads to tiredness and poor health.

23.6 Advocacy Messages

Several key global advocacy messages for ACSD are listed below:

1. 10.5 million children are denied their right to survival every year, dying before their fifth birthday. Most of these deaths are preventable. The gap between what we can do to save lives and what we are actually doing can – and must – be closed.

2. Governments are committed to achieving Millennium Development Goal (MDG) 4: a two-thirds reduction in child mortality by the year 2015. However, of the 60 priority countries (those with the highest proportion of annual under-five deaths), only seven have reduced the rate of under-five deaths since 1990 and are on track to meet MDG4, while 21 have made little progress and the remaining 14 countries have seen their under-five mortality rate increase.

3. As the Lancet Countdown Report shows, global coverage of the critical, low-cost interventions that work is unacceptably low. Urgent action is needed, particularly in Sub Saharan Africa.

4. Pneumonia is the number one killer of children under five, according to a new report from UNICEF/WHO. It accounts for almost 20 per cent of all under-five deaths worldwide, or 2 million children each year. That is more than AIDS, malaria and measles combined. Only 20 per cent of caregivers in developing countries know the danger signs that signal pneumonia and only half of suspected cases are taken to a doctor.

5. The world will not reach the 2015 goal unless it mobilises political will and resources for child survival. Achieving the goal will require multiple efforts on multiple fronts. Health systems must be strengthened, but countries need secure financing in order to do so. The necessary financing will not be secured unless child mortality is pushed further up the political and development agenda.

6. MDG4 is the litmus test for the achievement of all of the MDGs. If we miss this target, we may well miss the others. But if we hit this target, the ripples will be felt worldwide in poverty reduction, educational success, productivity, economic growth and, above all, lives saved.

7. MDG4 may be the most achievable of all MDGs. Seven countries: Bangladesh, Brazil, Egypt, Indonesia, Mexico, Nepal and the Philippines are already making strong progress and are on track to achieve the goal. These experiences should be highlighted and the lessons shared.

8. We need to address two additional challenges to the precarious gains made in child survival in many countries: the HIV/AIDS pandemic and the political and military epidemic of conflict. Of the 20 countries with the highest under five mortality rates, more than half are affected by these complex emergencies.

9. Child mortality is being rolled back in areas where proven interventions in child health are combined and taken to scale, such as immunisation and nutrition, clean water, proper sanitation, hygiene education, vitamin A supplements, improved neo-natal and newborn care. All effective, all low-cost, all live-savers.

10. Programmes for Accelerated Child Survival and Development in such countries as Ghana are showing dividends by strengthening health systems at local level. Preliminary results show that under-five mortality may have fallen by up to 25 per cent in areas where such programmes have been taken to scale. But elsewhere, coverage rates for essential child survival interventions are too low, and are inconsistent within countries.

11. We have the tools and we know what works. Going to scale with the interventions that work could have a dramatic impact on reducing child mortality if they were available to all mothers and children who need them. And there is cause for hope, with new technologies and low-cost medicine, new

financing mechanisms such as the International Finance Facility for Immunisation, and new approaches, such as integrated child survival programmes.

12. We believe that with renewed commitment from the international community and national governments, the 2015 goal can be reached. Though the overall numbers paint a bleak picture, there are countries that have made strong progress in reducing child mortality. Today, we have unprecedented opportunities to ramp up proven interventions, saving millions of young lives every year.

13. The Child Survival Symposium aims to kick off the development of a global 'road map' to reach MDG4 that is backed by resources and by a new determination to end the scourge of child mortality: a map of the strategies and the investments needed at the global, regional and national level.

14. It builds on commitment in the African region and the decision of the African Union to develop a road map to reach MDG4 in Africa, as well as the joint WHO/UNICEF Child Survival Strategy developed by the African Ministries of Health.

15. It builds on the growing momentum around child survival, including the Lancet Countdown meetings and the political commitment of Prime Ministers in Africa and of Prime Ministers Stoltenberg and Singh.

16. It aims to galvanise technical, programmatic and resource mobilisation to achieve MDG 4, by demonstrating the technical feasibility of achieving MDG 4 and encouraging donors to make specific commitments, particularly for African countries, and strengthening links to related partnerships or initiatives such as the Global Alliance for Vaccines and Immunization (GAVI), PEPFAR, PMI, IDPF, PMNCH. The work of GAVI shows how dramatic progress has been made on immunisation. The challenge now is to increase resources for other proven child health interventions and to close the significant gap between the resources currently available for child health and the estimated needs.

17. As a first step, the international community needs to mobilise financial resources to support the Strategic Framework for the achievement of MDG4 in Africa, where the financing gap is largest.

24. Monitoring, Coordination and Indicators

Regular and institutionalised monitoring of communication processes and impact for high impact interventions is an integral part of the ACSD Overarching Communication Plan. In addition to routine monitoring by programme and communication colleagues at different levels, third-party monitoring system will be evolved and applied. Selected institutions/partners from focus districts will be involved to periodically determine if the planned communication activities are being implemented according to the agreed plan.

In order to ensure effective coordination among all partners, national and district teams and between the national level and selected districts, a coordination mechanism has been chalked out. The first process activity at all levels is the formation of a Sub Committee for ACSD Communication. The terms of reference for the National Sub Committee for ACSD Communication are given in Annex 2. Regular interactions have been proposed for the communication committees and between programme and communication teams. Quarterly district progress reports in a pre-described format are part of the coordination. Similarly a bi-annual meeting to review and plan activities for the remaining part is another attempt to make sure that all relevant colleagues interact for better coordination.

The following indicators are based on initial thinking and recent experience of communication support to several high impact interventions:

A. Assessment of Communication Process

1. Number of districts that have finalised communication plan for ACSD.
2. Number of districts that have formed a sub-committee for ACSD communication.
3. Progress reports prepared, received and compiled.
4. Bi-annual meetings organised.
5. Communication materials drafted, designed, printed, distributed and utilised.
6. Planned activities undertaken at different levels for advocacy purposes and/or to mobilise partners and resources.
7. Communication committees meet at least once per month to implement the plan.

B. Assessment of Communication Activities

24.1 Formative research

Formative research is normally conducted to determine the existing practices influencing behaviour patterns. In the case of implementing ACSD communication activities, the information required relates to existing behaviour currently being implemented by communities around the 17 key care practices. This information provides the basis for adjusting messages that are better suited for the target/participant groups.

24.1.1 Literature review of existing practices

In the case of the 17 key care practices, the Malawi Demographic Health Survey (2004), the Multi Indicator Cluster Survey (MICS) and other surveys will provide information on the existing practices and will be used as a source of the information required on existing behaviour related to 17 key care practices. The information reviewed will be in two categories:

- Existing behaviour requiring re-enforcement; and
- Existing behaviour requiring change.

This will be done by reviewing the literature from the MDHS report and other survey reports to identify and categorise the existing practices into the two above-mentioned groups. Following this categorisation, specific communication objectives that can address the issues around the 17 key care practices will be developed.

24.1.2 Pre-testing of Communication Materials

In order to design and produce culturally appropriate communication materials, it will be necessary to pre-test communication materials to determine the following:

- The acceptability of the ACSD logos and designs;
- The logo/design that results in better recall and linkages between ACSD branded communication and key messages;
- The interpretation of messages developed and whether they correspond with the key messages being communicated; and
- The most effective communication channels for delivering ACSD communication.

This information will be gathered using focus group discussions of key participant groups.

24.2 Impact tracking surveys

Mechanisms for tracking the ACSD communication activities and the impact of the activities on behaviour change will be developed to determine effectiveness of ACSD communication campaigns. Periodic impact tracking surveys will be conducted in the ACSD districts to determine:

- Knowledge of ACSD communication activities by participant groups;
- Knowledge channels through which ACSD is being communicated;
- Preferred channels of communication by participant groups;
- Level of understanding of key messages being communicated;
- Level of behaviour change as a result of specific communication activities; and
- Level of behaviour change as a result of specific communication channels.

24.3 Summative research

Summative research is proposed at the end of the ACSD communication campaign period to assess the overall effectiveness of the implementing ACSD communication. This research should be combined with research on the overall effectiveness of the implementation of the ACSD policy.

Appendix 1: Diffusion of Innovator Adopter Groups

Adopter Group	Characteristics	Media and Channels which may be appropriate for various adopter groups
Innovators *(approx. 2.5% of a population)*	- **Venturesome, rash, daring, likes to take risks**. Not very integrated into local social system. Not connected to local peer networks. Participates in networks and communication patterns with innovator peers outside local community, even long distances, from local community. Thus 'cosmopolite.' - Controls substantial financial resources, therefore willing to take financial risks and able to absorb losses. - Able to understand and apply complex technical knowledge. Not afraid of uncertainty of new innovations. Able to accept setbacks if new idea is not successful. - May not be very respected by local community. **But plays important role in bringing new ideas and practices from elsewhere into local community**. Thus is a gatekeeper.	- Will **act on information** received **through the media** - although perhaps not the traditional media. - Will act on information received **through networks of peers from outside community**. Does not necessarily need role model verification of information. - Actively seeks out and is receptive to information about interventions, recommended behaviours and practices. Acts as gatekeeper: bringing new and/or recommended information, ideas and practices into a community.
Early Adopters *(approx. 13.5% of a population)*	- Respected by local community and integrated into local social system. Has **greatest degree of opinion leadership** in most systems. *Potential adopters* look to *early adopters* for advice and information about an innovation. **Able to serve as role model for other members of a social system.** - Decreases uncertainty about innovation by adopting it and conveying subjective evaluation to peers through interpersonal networks.	- Will **act on information** received **through the media** - including traditional media. Will act on information received **through networks of peer-educators from within the community (**local *innovators***)**. - Will accept new and/or recommended information, ideas and practices from *innovators* if **convinced the practice will 'work.'** Can be mobilised by change agents to introduce recommended practices into a community. - Can **act as model** for others (usually the *early majority*) because they know the *early adopter* is careful and judicious in adopting recommended practices.

Adopter Group	Characteristics	Communication Behaviour
Early Majority *(approx. 34% of a population)*	- Deliberate. Seldom hold positions of opinion leadership in a system. BUT hold unique position in that they **interact frequently with peers** and provide **interconnectedness** in the system's interpersonal networks. **Thus they are the link between very *early* and relatively *late adopters*.** They comprise about one third of any social system. - Take time to deliberate, think about adopting a practice, **follows others with well thought-out willingness,** but seldom leads.	- Will respond to information and behaviour models from peers. Therefore use of peer educators is recommended. Moreover, since the *early majority* is the link from *early acceptors* to *late majority*, asking this group to be the 'satisfied acceptors' to influence the *late majority* is also highly recommended. Use of mass and traditional **media to give supportive information and modelling of behaviours** is also recommended to reinforce the influence of the *early adopters*. - Allying with change agents and *early adopters* to **monitor continuation of practices** is recommended in order to **establish sustained behaviour**.
Late Majority *(approx. 34% of a population)*	- Sceptical and cautious. Adopt interventions just after the 'average' member of the system. Comprise one third of the system. Adopt due to increasing peer pressure as well as economic pressure. - Their relatively scarce resources mean that most uncertainty about new practices must be solved before they feel it is safe to adopt. - Accepting an innovation or practice is their positive response to a social system's norms.	- Allying with *early majority* as 'satisfied acceptors' is recommended. - Allying with mass and traditional media is recommended to establish the recommended practices and behaviours as part of social norms. Allying with local and national opinion leaders to reinforce the social acceptance of the recommended behaviour or practice is also recommended. - Strategy could emphasise economic importance and/or positive resource benefits of recommended practices.
Late Acceptors and Resistors *(approx. 10% and 6% of a population)*	- Last in the system to adopt. Possess almost no opinion leadership. Most un-travelled group in the system, nearly isolated in terms of networking. The past is main point of reference. Interact primarily with others who have relatively traditional values. - Suspicious of innovations and change agents. - Resistance is further rationalised due to limited resources. Due to this fact, they must be assured that recommended practice will not fail.	- Testimonials from both leaders and members of these two groups are very important to convince these groups of the positive benefits of recommended practices. This can be accomplished through the mass and traditional media. - Linking recommended practices to community traditions is essential. - Equally important are demonstrations that recommended practices are economically **beneficial** NOT harmful. - Much peer group education and individual counselling is required. Allying with 'satisfied acceptors' **from these groups** essential.

Appendix 2: Intervention and Behaviour Themes

Intervention and Behaviour Themes	**Baseline[7] Available?**	
	Yes	No
Breastfeeding, complementary feeding;		
Prevention of diarrhoeal diseases through use of safe water, toilets and hand washing;		
Care of children suffering from diarrhoea, ARI and malaria;		
Completion of routine immunisation schedule for children under 15 months in a timely manner;		
Better care and increased access by pregnant women to antenatal care and skilled birth attendants at the time of delivery;		
Children's consumption of protein;		
Fathers playing with children;		
Mothers, grandmothers, fathers, siblings constantly talking with child;		
Children playing with water, sand, dry/wet cloth;		
Language concept development: making comparisons, identifying similarities;		
Substitute behaviour for corporal punishments;		
Washing hands after using toilet, before preparing food, before eating and feeding children;		
Purchasing iodised salt, storing it in a cool dry places, and adding it to food only just before serving;		
Family members giving children affection and attention, talking to them and encouraging playing;		
Immunisation protecting children from seven diseases;		
Starting immunisation of children as soon as they are born, through local vaccinator or nearest fixed centre;		
Not giving any other food or drink – just breastmilk is enough;		
Giving children from 6–24 months a variety of other foods 5-6 times a day and continuing breastfeeding up to two years;		

[7] Multi Indicator Cluster Survey Report (2000); Baseline Survey in Lower, Central and Upper River Divisions (2003).

Annex 1: ACSD Brand Communication Material

No.	Type of material	Target audience	Total	Allocation per district	Responsible for delivery	Estimated Cost (MK)
1	ACSD maternal health poster	General public	10,000	1000	DHO	700,000
2	ACSD child health poster	General public	10,000	1000	DHO	700,000
3	ACSD newborn poster	General public	10,000	1000	DHO	700,000
4	ACSD social sanitation poster	General public	10,000	1000	DHO	700,000
5	ACSD generic poster	General public	10,000	1000	DHO	700,000
6	ACSD nutrition poster	General public	10,000	1000	DHO	700,000
7	Community day banners	Communities	100	10	DC	3,000,000
8	Best household of the month shields	Households	2000	200	DC	600,000
9	Facts for Life booklet (households)	Schools	20,000	2000	District Education Office (DEO)	5,000,000
10	Facts for Life booklet (Chichewa)	Health workers	20,000	2000	DEO	5,000,000
11	Facts for Life booklet (children)	Schools	20,000	2000	DEO	5,000,000
12	Care group branded t-shirts	Care groups	5000	500	DHO	3,000,000
13	Care group branded chitenjes	Care groups	10,000	1000	DHO	3,000,000
14	Post Office letter writing competition posters	Schools and public visiting Post Office	10,000	1000	MPC/ DEO	700,000
15	Child health information cards for child health days	General public visiting CHAM facilities	10,000	1000	CHAM	2,000,000
16	Safe motherhood information cards	Mothers and fathers visiting CHAM facilities	10,000	1000	CHAM	2,000,000
17	ACSD brochure	General public	10,000	1000	DC	1,000,000
18	ACSD badge	General public	20,000	2000	DC	1,000,000
19	Advocacy kit	Policy makers	5000	500	DC	500,000
20	ACSD sign boards/ paintings	General public	20	10	DC	1,000,000
21	ACSD vinyl sheets for vans in selected districts	General public	10	1	DC	1,000,000
22	Hoardings in selected districts	General public	10	1	DC	2,400,000
23	ACSD partners brochures	Community communicators	5000	500	DC	500,000
24	Flip charts on ACSD	Health Workers	5000	50	DHO	2,500,000
25	Information cards on ACSD	Health Workers	10,000	1000	DHO	2,000,000
Total estimated cost in Malawi Kwacha (MK)						**45,400,000**
Total estimated cost in US Dollars (US$)						**324,286**

Annex 2: ACSD Sub-Committee on Communication

Terms of Reference

A team of professional communication staff from ACSD participating Ministries and partner organisations, under the leadership of the Health Education Unit, will be responsible to plan, implement, coordinate and monitor the Overarching ACSD Communication Plan and report to the National ACSD Working Group. The main responsibilities of the ACSD sub-committee are to:

1. Hold monthly meetings to review the progress of implementation of the communication plan's activities.
2. Design and finalise the national plan in a participatory process with clear roles and contributions from each ministry/partner. After finalising, share the plan to the relevant authority for final go ahead.
3. Facilitate implementation of communication activities through different communication networks, partners and in close collaboration with relevant district and sub-district officials.
4. Develop, design, field test, produce and distribute the communication material as per plan.
5. Ensure regular interaction with all partners for effective implementation of the Plan of Action and report periodically on the progress achieved.
6. Raise and utilise resources for effective implementation and ensure expenditure according to the plan.
7. Support planning and implementation of district specific ACSD communication plans.
8. Plan and implement a monitoring system to assess usage and effectiveness of communication material and activities in light of programme planning, operational processes and coverage.

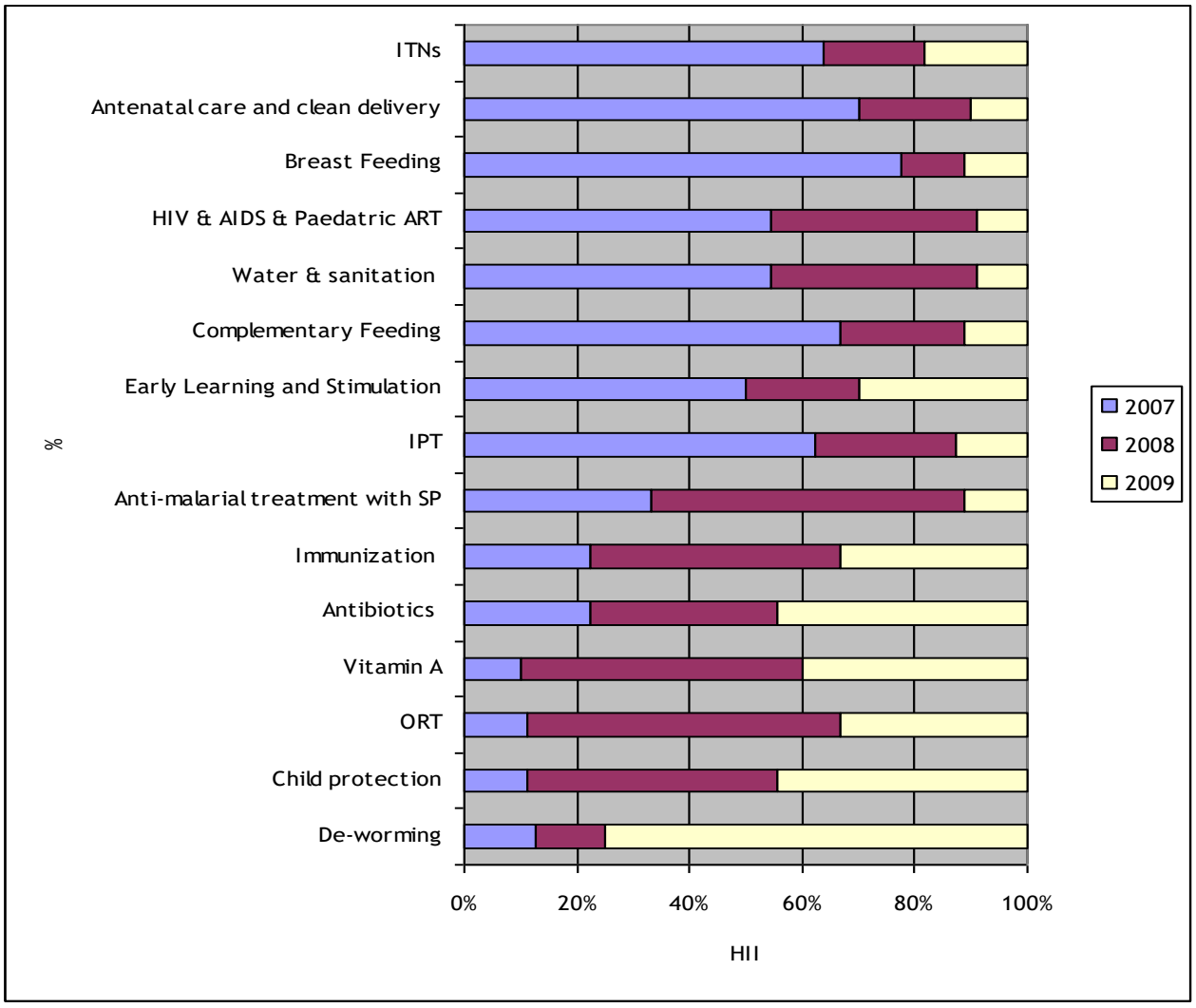
National Composition

1. Deputy Director Preventive Health Services **(Secretary)**
2. Senior Health Education Officer, ACSD
3. Programme Communication Officer, UNICEF
4. ACSD Communication Focal Point, Ministry of Information and Civic Education (MoICE)
5. ACSD Communication Focal Point, Ministry of Irrigation and Water Development (MoIWD)
6. ACSD Communication Focal Point, Ministry of Local Government and Rural Development (MoLGRD)
7. ACSD Communication Focal Point, Ministry of Women and Child Development (MoWCD)
8. ACSD Communication Focal Point, Malaria Programme, Ministry of Health (MoH)
9. ACSD Communication Focal Point, Ministry of Education, Science and Technology (MoEST)
10. IMCI Coordinator, MoH
11. Nutrition Unit Representative, Nutrition Unit, MoH
12. PMTCT Representative, HIV/AIDS Unit, MoH
13. Reproductive Health Unit Representative, MoH
14. Media/Communication Focal Point from WHO
15. Media/Communication Focal Point from UNFPA
16. Media/Communication Focal Point, Malawi Interfaith (MIAA)
17. Media/Communication Focal Point, National Aids Commission
18. Media/Communication Focal Point, WFP
19. Media/Communication Focal Point, CHAM

Annex 3: High Impact Intervention Priorities

Summary of District Priorities by Year

A summary of annual district priorities with respect to high impact interventions for communication is shown in the graph below:



Annex 4: Seventeen Key Care Practices in Malawi

1. Exclusive breastfeeding
2. Complementary feeding and sustained breastfeeding
3. Micronutrients
4. Mental and social development
5. Care of orphans and other vulnerable children
6. Hygiene and sanitation
7. Malaria prevention
8. Child abuse and neglect
9. HIV/AIDS prevention and care
10. Feeding and giving fluids during illness
11. Home health practices
12. Prevention of accidents and injuries
13. Immunisation
14. Health care seeking
15. Compliance treatment, follow up and referral
16. Care for pregnant women and lactating mothers
17. Men’s participation in childcare

Annex 5: Minimum Package of High Impact Interventions

High impact interventions	Operational definitions
For prevention	
1. Insecticide-treated bed nets (ITNs)	• Protecting all children under five years of age and pregnant women from malaria by ensuring that they regularly sleep under recommended insecticide-treated mosquito nets (ITNs); • Caregivers acquire insecticide-treated mosquito nets; • Caregivers re-treat the ITNs at least once a year.
2. Intermittent presumptive treatment (IPT) of malaria in pregnancy	• Administering at least two doses of recommended anti-malarial, one month apart, for the prevention of malaria during pregnancy, starting from the second trimester (after quickening).
3. Breastfeeding	• Breastfeed infants exclusively for six months, taking into account policies and recommendations on HIV and infant feeding; • Infants of less than 6 months of age who were exclusively breastfed in the last 24 hours.
4. Complementary feeding	• Starting at six months, feed children freshly prepared energy- and nutrient-rich complementary foods, while continuing to breastfeed up to two years or more; • Children aged 6-9 months receiving breastfeeding and appropriate complementary foods and children who are 24 months of age or under and are still being breastfed.
5. Immunisation	• Taking children as scheduled to complete a full course of immunisations, including anti-tuberculosis vaccine (BCG), diphtheria-pertussis-tetanus (DPT), oral poliomyelitis vaccine (OPV) and measles before one year; • Children aged 12-23 months vaccinated against measles before 12 months of age; • Children aged 12-23 months who are fully immunised against diphtheria, pertussis and tetanus before their 1st birthday.
6. Antenatal care and clean delivery	• Ensuring that every pregnant woman conducts the recommended four antenatal visits, receives recommended doses of tetanus toxoid (TT3) vaccination, and is fully supported by her family and community in seeking appropriate care, especially at the time of delivery and during the postpartum/lactation period; • Pregnant women receive institutional delivery or are assisted by skilled birth attendants. Use of simple and clean delivery kits (plastic sheet, thread to tie the umbilical cord, new razor blade to cut cord, umbilical cord cutting board, and soap to wash hands).
7. Vitamin A	• Providing children with adequate amounts of micronutrients (particularly vitamin A, iodine and iron), either in their diet or through supplementary sources; • Children aged 6-59 months who have received a high dose of vitamin A in the last 6 months.
8. Water and sanitation	• Disposing of all faeces safely, and washing your hands with soap after defecation, and before preparing meals and feeding children.

High impact interventions	Operational definitions
For treatment	
9. Oral re-hydration therapy (ORT)	• Continuing to feed and offer more fluids, including breastmilk, to children when they are sick; • Children under five with diarrhoea in the last 14 days given ORT; • Caregivers of sick children advised to give extra fluid and continue feeding.
10. Anti-malarial treatment (SP)	• Children who were reported to have had fever in the previous 2 weeks and were treated with locally recommended anti-malarial treatments; • Per cent of caregivers of children who know at least two of the following signs for seeking immediate medical care: child is not able to drink or breastfeed; child becomes sicker despite home care; child develops a fever (in malaria-risk areas or if child aged less than 2 months); child has fast or difficult breathing; child has blood in the stools; or child is drinking poorly; • Proportion of children prescribed oral anti-malarial, whose caregivers can correctly describe how to give the proper treatment.
11. HIV/AIDS and Paediatric ART	• Children with suspected or confirmed HIV infection. The clinical expression of HIV in children is highly variable. Some HIV positive children develop severe HIV-related signs and symptoms in the first year of life. Other HIV positive children may remain asymptomatic or mildly symptomatic; • Management of children with confirmed, suspected or possible HIV infection includes antiretroviral drug treatment and cotrimoxazole therapy; • ART is not a cure; the goal of ART is to prolong life by disabling the virus in the individual. Anti-retroviral (ARV) doses given to PMTCT babies and PMTCT mothers. Adherence to treatment is therefore important; • Cotrimoxazole preventive therapy is given to children with confirmed or suspected HIV infection or children who are HIV exposed to prevent pneumocystis carinii pneumoniae (PCP) and other opportunistic infections. • Cotrimoxazole preventive therapy should be given from 6 weeks of age until child has been tested and HIV infection ruled out. If an HIV exposed infant is confirmed HIV positive, cotrimoxazole therapy should be continued indefinitely.
12. Antibiotics for sepsis, pneumonia and dysentery;	• Access to the recommended antibiotics and administration by HSAs or authorised caregivers for newborns with sepsis, children with pneumonia or fast breathing and children with mucoid or blood-stained stools; • Recognise when sick children need treatment outside the home and take them for health care to the appropriate providers.
13. De-worming	• Children aged 6-59 months who have received a dose of anti-helminths drug (albendazole) in the last 6 months; • Pregnant women who have received dose of anti-helminths drug (albendazole).

High impact interventions	**Operational definitions**
For social and mental development	
14. Child protection	• Preventing child abuse/neglect and taking appropriate action whenever it occurs; • Four forms of child abuse and/or neglect: physical, sexual, emotional and neglect (denying a child food, cleanliness, education, prompt treatment, etc); • Proportion of caregivers who can identify the four forms of abuse and/or neglect and their related signs and symptoms; • Proportion of caregivers who have witnessed child abuse and/or neglect and have taken action to stop it.
15. Early Learning and Stimulation	• Promote mental and social development by responding to a child's needs for care, and through talking, playing and providing a stimulating environment; • Caregivers who promoted stimulation of the child through talking, playing, and other age appropriate physical and emotional interactions in the last three days.

Annex 6: List of Acronyms

ACSD	Accelerated Child Survival and Development
ADC	area development committee
AIDS	acquired immune deficiency syndrome
ANC	antenatal clinic
ARI	acute respiratory infection
ART	anti-retroviral therapy
ARV	anti-retroviral
BCG	anti-tuberculosis vaccine (bacille Calmette-Guerin)
CBCC	community based childcare centre
CBO	community based organisation
CHAM	Christian Health Association of Malawi
CPW	child protection worker
DC	District Commissioner
DCO	District Commissioner's Office
DEO	District Education Office
DHO	District Health Office
DPT	diphtheria-pertussis-tetanus
EBF	exclusive breastfeeding
FB	faith-based
FFL	Facts for Life
GAVI	Global Alliance for Vaccines and Immunizations
HII	high impact intervention
HIV	human immunodeficiency virus
HRAC	human rights approach to communication
HSA	health surveillance assistant
ICC	interagency coordination committee
IEC	information, education and communication
IMCI	Integrated Management of Childhood Illness
IPC	interpersonal communication
IPT	intermittent presumptive treatment
ITN	insecticide-treated mosquito net
M&E	monitoring and evaluation
MDGs	Millennium Development Goals
MDHS	Malawi Demographic and Health Survey
MIAA	Malawi Interfaith
MICS	Multi Indicator Cluster Survey
MK	Malawi Kwacha
MoEST	Ministry of Education, Science and Technology
MoH	Ministry of Health
MoICE	Ministry of Information and Civic Education
MoIWD	Ministry of Irrigation and Water Development
MoLGRD	Ministry of Local Government and Rural Development
MoWCD	Ministry of Women and Child Development
MNCH	maternal, neonatal and child health
MP	Member of Parliament
NGO	non-governmental organisation

OPV	Oral polio vaccine (OPV)
ORT	Oral rehydration therapy
PCP	Pneumocystis carinii pneumoniae
PMTCT	Prevention of mother-to-child transmission (of HIV)
PNC	Post-natal clinic
SADC	Southern Africa Development Community
SP	Sulfadoxine-pyrimethamine
TA	Traditional authority
TBA	Traditional birth attendant
TFD	Theatre for development
TOR	Terms of reference
TT3	Tetanus toxoid (TT3)
TWG	Technical working group
UN	United Nations
UNFPA	United Nations Population Fund
UNICEF	United Nation's Children Fund
VDC	Village development committee
VHC	Village health committee
WFP	World Food Program
WHO	World Health Organisation

Annex 7: Glossary of Terms

Advocacy	Advocacy consists of the organisation of information into arguments to be communicated through various interpersonal and media channels with a view to gaining acceptance and actions in support of the issue or programme from political and social leadership.
Branding	Branding is a combination of images and values that help the target audience to make appropriate choices and judgments about a product, organisation or service.
Capacity building	Capacity building refers to information, skills and motivation for relevant staff and volunteers on programme process, advocacy, social mobilisation and interpersonal communication skills.
Community	A community is an organised group of people who share a sense of belonging, beliefs, norms and leadership, and who usually interact within a defined geographical area. Some communities share common goals and interests, are mutually supportive and are distinguishable by what they do.
Program communication	Programme communication is the process of identifying, segmenting and targeting specific groups/audiences at family or community level with particular activities and messages using mass media and interpersonal channels, both traditional and non-traditional.
Social mobilisation	Social mobilisation is the process of bringing together all feasible and practical inter-sectoral social allies to raise people's awareness of, and demand for, a particular development programme to assist in the delivery of resources and services and to strengthen community participation for sustainability and self-reliance.