Federal Democratic Republic of Ethiopia
Ministry of Health

Advocacy, Communication and Social Mobilization Guide for Malaria Elimination in Ethiopia

February 2017
Addis Ababa

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Foreword

The Federal Ministry of Health is pleased to have this National Advocacy, Communication and Social Mobilization (ACSM) Guide for Malaria Elimination in Ethiopia. The development of this guide through a series of joint consultative process with the involvement of both experts in malaria control, social and behavioural change communication and health promotion from partners is commendable.

Considering the global malaria elimination initiative and encouraged by the achievements of malaria control the country has made, the Ministry has adopted the goal of malaria elimination by 2030. This target can be achieved when the affected population actively take part and adopt the recommended practices and behaviours. Effective ACSM interventions help play significant role to reach out target audiences and achieve expected changes at different levels.

The design of this guide which is based on the lessons and challenges of previous malaria control efforts, taking into consideration of malaria elimination targets, identification of key domain of influences and priority needs of malaria elimination phases, The Ministry would strongly testify that this guide will be of great help for all implementers at all levels.

The Ministry congratulates the Malaria Elimination Technical Working Group (TWG) and ACSM working group for developing and finalizing this document with their expertise inputs. Moreover, the Ministry would like to urge all concerned stakeholders to provide due attention and resources to support the use and implementation of the guide.

The Ministry will continue to provide the necessary support to improve in this regard and remains committed to follow up and create enabling environment.

List of Abbreviations

ACD	Active Case Detection
ACSM	Advocacy, Communication and Social Mobilisation
ACT	Artemisinin-based Combination Therapy
ARRA	Administration for Refugees and Returns Affairs
BCC	Behaviour Change Communication
CSO	Civil Society Organization
EDHS	Ethiopia Demographic and Health Survey
EM	Environmental Management
FMOH	Federal Ministry of Health
HDA	Health Development Army
HEP	Health Extension Program
HEW	Health Extension Worker
FBO	Faith Based Organization
HH	Household
HSTP	Health Sector Transformation Plan
ICT	Information Communication Technology
IEC	Information, Education and Communication
IOM	International Office for Migration
IPC	Interpersonal Communication
IRS	Indoor Residual Spraying
LLIN	Long Lasting Insecticidal Net
NGO	Non- Governmental Organization
NMIS	National Malaria Indicator Survey
SBCC	Social and Behaviour Change Communication
SMS	Short Message System
ToR	Terms of Reference
TWG	Technical Working Group
VHC	Village Health Committee
WHO	World Health Organization

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1. Introduction

The government of Ethiopia has successfully implemented malaria prevention and control interventions. These have led to reduction of malaria morbidity and mortality. The frequency and magnitude of malaria epidemics have also substantially decreased. The achievements made so far have prompted the country to move towards nationwide malaria elimination by 2030. The success depended on the adoption of desired behaviours by people most affected by malaria, participation of partners in support of the elimination and commitment of political leaders at all levels to create enabling environment in terms of policy support and resource allocation.

Advocacy, communication and social mobilization (ACSM) play key role in raising awareness, brining behaviour change, and engaging communities, fostering partnership and soliciting for commitment at all levels in the government structure.

To effectively support the implementation of malaria elimination initiative and help achieve its objectives; this guide has been developed through consultative process with the involvement of partners under the leadership of the FMoH. Attempts to capitalize on previous experiences in health communication were made to identify problem behaviours, gaps and issues. The approach used to socio ecological model to understand the domains of message delivery in addressing factors responsible for the adoption of recommended behaviour and creation of enabling environment at the level of individual, community, decision makers. Intensive consultation was made to create an in-depth understanding of the needs of the malaria elimination paths; namely optimization, pre-elimination, elimination and prevent re-introduction.

This leads to setting of objectives and strategies targeting specific groups of population with corresponding key messages and appropriate channel of communications. The guide includes implementation plan, monitoring and evaluation, and annexes.

2. National Communication Context

2.1 Communication Infrastructure

Mass media remains one of the major sources of health information in the country. According to Ethiopia Demographic and Health Survey (EDHS), the proportion of women between 15 and 49 who listen to the radio has increased from 16 per cent in 2005 to 22 per cent in 2011, while the proportion among men 15-59 has increased from 31 per cent to 38 per cent. Education, entertainment, and information to the public is disseminated through electronic media (TV and Radio), and electronic media (TV and Radio).

The Information Communication Technology (ICT) Policy which aims to contribute for the socio-economic transformation targets to health service as one of its strategic focus to improve the effectiveness of the national health policy and strategy through public dissemination of health information using the internet. The expansion of mobile coverage, internet and social media present huge potentials to reach to intended target audiences through short message system (SMS) messaging and creating access for malaria elimination messages and information.

2.2 Health communication context

Malaria control has been one of the programs highlighted in the national health sector plans. The fact that the newly designed flagship Health Sector Transformation Program (HSTP 2016-2020), puts great emphasis for "the promotion of good health practices at individual, family and community levels" as its first strategic objective referring to and the provision of comprehensive health service delivery including preventive, curative, rehabilitative and emergency health services.

Previous malaria control strategic plans had paid due emphasis to the importance of information, education and communication/behaviour change communication (IEC/BCC) in raising the awareness and knowledge of people to promote informed decisions and participation in malaria prevention, treatment, and control. Over the

past years, immense efforts in the development of promotional materials, mass media, interpersonal communication, sensitization messages and community mobilization have been undertaken at various levels. Lessons documented from these experiences will continue to inform and improve malaria elimination ACSM activities. The 2016/17-2019/20 National Health Communication Strategy did also highlight malaria control as part of the targeted diseases for prevention.

2.3 Health Extension Program/ Health Development Army

One of the innovative initiatives by the FMoH is the health extension program (HEP) which is designed to bring health services closer to communities. Malaria control has benefited from the HEP. The HEP created unprecedented opportunities for communities to have access to basic health services through health extension workers deployed at health post in community level. This opportunity with support from health development army (HDA) will continue to play in mobilizing individuals, families and communities through community conversations and social mobilizations.

2.4 Information, Education and Communication/ Social and Behaviour Change Communication

Information, education and communication materials for behaviour change communication such as brochures, posters, and booklets targeting different segments of the population had been developed and disseminated throughout the nation in different major languages. Various forms of strategies are employed in reaching communities and creating access to IEC materials.

2.5 Interpersonal Communication Networks

It is important to identify existing information sharing networks of people use to disseminate information and take advantage of those networks. In day to day life, families, residents in neighborhoods, employees in work places, etc. exchange information through words of mouth (interpersonal communication networks). It is therefore important to identify appropriate information networks, places and time people choose to do so.

2.6 Social and Community Networks

Social and community networks including community based organizations can be used as a means to exchange information and create social pressures to influence behavior change, set norms and provide support to community members in coping with crisis situations. Community based organizations such as youth and women associations, farmers' union, etc., could be used as mechanisms of delivery to reach out people and mobilize for participation. Understanding of community and social networks such as "Edirs" for example, which are proved to be effective in some of health programs need to be identified and engaged for this initiative.

2.7 Religious institutions

Religious institutions play a pivotal role in promoting key health behaviors at their respective churches or mosques by informing their fellows. It is therefore important to engage them as change agents to influence individual behavior change in the use of long lasting insecticidal nets (LLINs), seeking early treatment and avoidance of re-plastering of households after spray. It is important to identify or map and make use of engaging these organizations.

3. Target Groups: High risk groups of population

Over 60% of the country is malarious, malaria transmission is unstable and herd immunity of the population to malaria is low. Thus, all or parts of the population remain at risk of malaria; pregnant women and children under five are exposed for higher risk.

Migrant workers who travel to low lands in search for economic opportunities in large scale farming, mining and constructions projects across the country are at high risk and pose serious challenges for the malaria elimination.

Refugees from all corners coming to Ethiopia, for example; South Sudan and Somalia are also targets for malaria elimination interventions.

4. Behavioural problems, gaps and issues

Cultural diversity compounded with disparities in the level of knowledge, access and use of anti-malaria interventions hamper progress for successful implementation of interventions and attainment of national elimination goals and objectives.

It is therefore imperative to understand problem behaviours, health communication gaps and issues of the anti-malaria interventions.

Individual and household level

- Despite progress in increase of knowledge and use of anti-malaria interventions made to date, the level of knowledge towards appropriate use of anti-malaria interventions including use of services, nets, medicines, etc. is still low and long way to reach towards elimination. This has been hampered partly due to the low health literacy level of population which prevents understanding and uptake of malaria prevention and control interventions.
- The situation pertaining to use of LLINs compared to its coverage is low. This situation is further compounded by incorrect and inconsistent use of LLINs by individuals.
- In terms of case management, early treatment seeking for children who had fever from health facility or provider is as low as 24.2 %[1]. Adherence to complete treatment is equally low.
- IRS intervention has in the past been grossly affected by poor acceptance and has led to a decline in coverage. Community practices of re-plastering of walls after IRS and refusal to accept spraying their house pose challenges to meet or achieve IRS targets.

Community level

- Some of the community issues and current gaps hindering the uptake of malaria elimination interventions include low and incorrect utilization of LLINs, abuse of LLNIs, poor health seeking behaviour, poor adherence to treatment, poor acceptance of IRS, and re-plastering of walls after IRS.
- These situations relate to the low level/ insufficient commitment to mobilize and engage the communities in malaria control. Involvement of communities to dialogue on social values and norms related to re-plastering of walls for example during holidays require enhancing relationship to win their commitment and get attention if community support and acceptance of malaria elimination is to be successful. There have been reports of misuse of anti-malaria interventions at community level.
- Inadequate participation of communities in environmental management activities also has been one of the challenges encountered in the past.

Socio and environmental level

- Challenges and gaps in terms of policy implementation do exist at all levels. Despite the fact that Government has put in place policy instruments and legal frameworks, low prioritization of social-environmental issues at program development level.

[1] 2011Ethiopia National Malaria Indicator Survey

- The growing development projects such as dam construction, water–based development projects have increased the threat of malaria transmission through the creation of dumps and expansion of farms, uncontrolled irrigation schemes, breeding sites, deforestation, poor management of surface water, etc.

In general, knowledge gaps, factors that discourage families from adopting recommended behaviours in different cultures need to be identified. In relation to the community attitudes specific to IRS, environmental management, and use of LLINs, issues or gaps that discourage them from adopting norms and own anti-malaria interventions to a level that would expedite malaria elimination need to be studied. Likewise, the level of commitment adequate enough to produce the required enabling environment is also an area to be looked further.

5. General Objectives

To assist in strengthening engagement and participation of individuals, families, communities and leaders in taking full responsibility and bringing meaningful behavioural change in malaria elimination in Ethiopia by 2030.

Specific objectives:

1. By 2020, 100% of individuals, families, communities in targeted districts will have adopted and practiced the recommended/ desired behaviours on malaria elimination;
2. By 2030, 100% of high risk populations - travellers, traders, seasonal migrants, refugees, etc. will have exhibited appropriate health seeking behaviours for malaria elimination;
3. By 2025, all communities will have set norms to effectively implement/ use malaria elimination interventions (appropriate norms to own malaria elimination
4. By 2025, 100% of communities in targeted districts will have acquired appropriate skills to identify malaria cases/suspected cases and engage/participate in active community based surveillance;
5. By 2025, the Government at all levels will have delivered the needed policy and financial support to achieve the goal of malaria elimination and beyond;
6. By 2020 100% of targeted districts will have used data and evidence to track the progress and improve malaria elimination ACSM interventions;
7. By 2020, 100% implementers at all levels will have established institutional coordination and partnership mechanism to improve implementation of Malaria Elimination ACSM.

6. Conceptual framework of ACSM

Ethiopia aims to eliminate malaria nationwide by 2030[2]. This goal will be achieved in three major objectives; reduction of malaria case incidence to zero, reduction of malaria mortality rate to zero level by 2030 and prevention of re-establishment of malaria.

ACSM plays a great role in supporting and contributing to the achievements of the stated goal and objectives through increased:

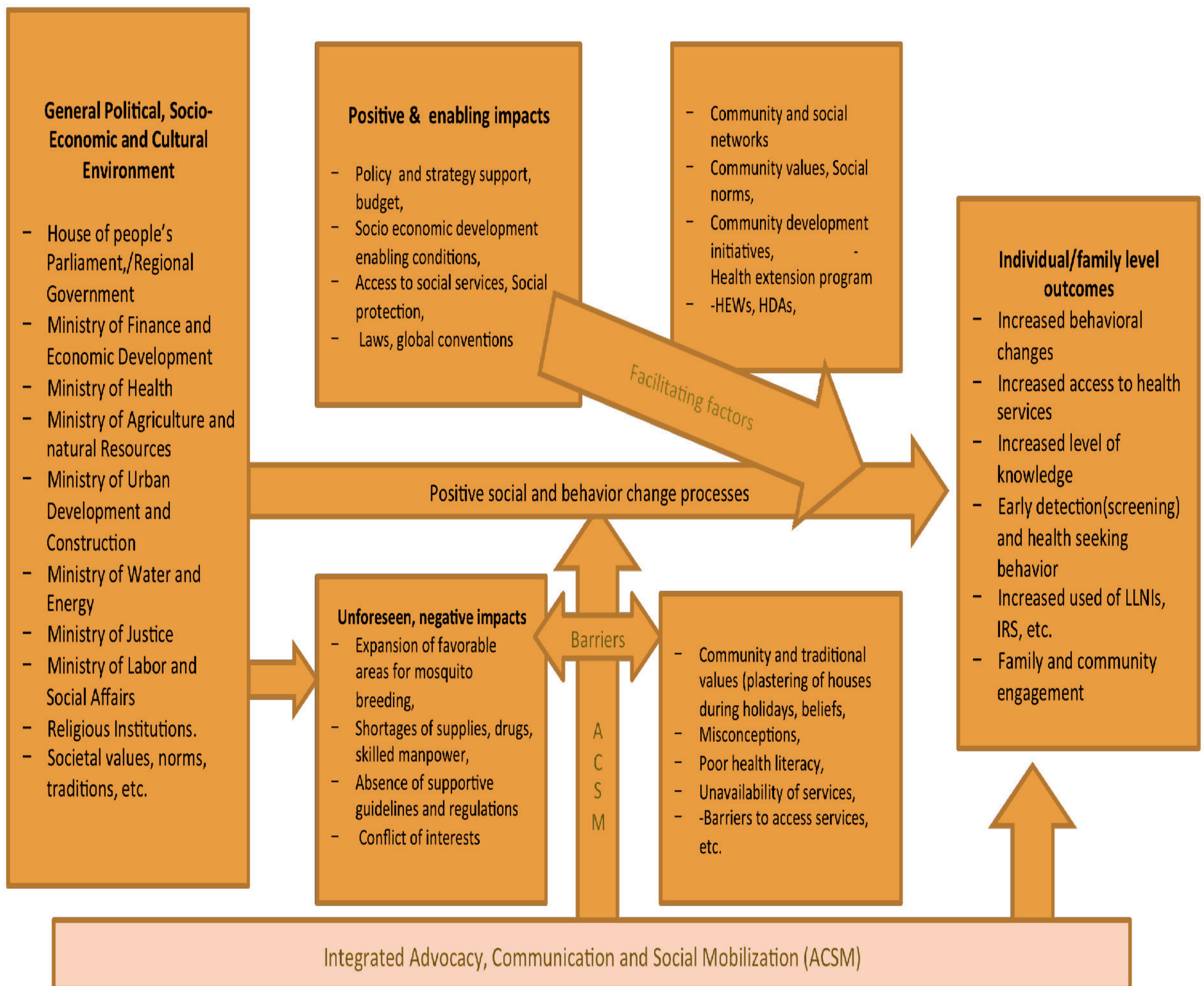
- Uptake of appropriate use of LLINs and coverage of IRS
- Access to screening, treatment and compliance
- Level of community participation and engagement to control environmental factors for malaria spread,
- Access to services, and
- Level of commitment for resource mobilization and enabling support by decision makers and community leaders

Conceptual framework

The conceptual framework presented in figure 1 is used to design effective ACSM interventions. The essence of ACSM lies on the basis of the levels of social determinants in the general socioeconomic and cultural conditions, social and community networks and individuals and family level.

[2] National malaria elimination guidelines, 2016, FMoH

Figure1: Conceptual framework of advocacy, communication and social mobilization



7. ACSM strategic framework

The malaria elimination guidelines emphasizes that interventions initiated at optimization level shall not be withdrawn, rather momentum of efforts will be sustained with variation in the intensity of some of the interventions either they may be reduced or increased along the path.

The geographic coverage and targeting on the basis of high transmission areas by foci, hotspots, cluster of households, local cases and imported cases in each phase will also be considered to combine effective ACSM interventions to intensify for better huge impact.

Phase 1: Optimization

At individual level, the strategic approach is to ensure for high level awareness of malaria elimination interventions, adoption of recommended behaviours, skills in identification of malaria signs and taking actions to tackle barriers to adoption of interventions.

At household level, high emphasis will be given for correct use of LLINs (100% utilization), continuous access to early diagnosis and treatment, to some degree in taking actions to control larval source management, seeking IRS and maintenance behaviour.

At community level, efforts will be maximized to promote and encourage establishment of community norms, fostering resilient community engagement, identification and dispelling of misconceptions. These could be achieved through mobilizing resources and engaging community leaders, influential groups, district level health authorities, health professionals and media. *Interpersonal, community and social networks* need to be identified and used as a source of malaria elimination interventions information, facilitate dissemination and motivate behaviour change by tackling individual-level barriers and influencing existing social and cultural norms that expose to malaria. In addition to health extension workers and the health development armies, peers, model households, health care providers, social capitals such as "Edirs", traditional and religious social networks could play a great role in this regard.

At organizational level, the intent of activities is to promote and facilitate by influencing adoption of policies and work place regulations to initiate malaria elimination interventions including establishment of information and treatment centres, development projects where employees are working in malarious areas. Measures will also be taken to reorient local health offices and facilities to collaborate and support development organizations.

At public policy level (decision-makers) level, the focus will be on the creation of an enabling environment through continuous advocacy and securing high level political commitment at regional and national levels to ensure availability and accessibility of malaria elimination commodities and required resources. In addition, interpretation and implementation of existing guidelines and strategies issued to create an enabling environment will be given due consideration in order to sustain adoption and practice of recommended behavior, raise local resources and broaden public awareness.

Phase 2: Pre-elimination phase

At individual level, the focus will be on sustaining adopted behaviours and strengthening interventions initiated at optimization level.

At household level, the emphasis will be on participation of family members in active case detection (meaning that they will be able to identify symptoms and signs and seek treatment), targeted vector control (correct use of LLINs, improve acceptance of IRS/discouraging re-plastering of walls after IRS, and involvement of individuals in environmental management activities). In addition, households will be involved in foci identification.

At community level, efforts need to be strengthened to maintain community norms, community

engagement to continuously identify and dispel rumours and misconceptions. ***Interpersonal, community and social networks*** need to play rallying information sharing of local success stories achieved in active case detection, targeted vector control, and identification of foci and hotspots. Local leaders, health extension workers and the health development armies are expected to lift up motivation and participation of networks (social, traditional and religious) as well as others who actively could strengthen community engagement and ownership of interventions.

At organizational level, implementation of activities will continue to keep up the momentum of policy and strategy implementation, identify hindrances to facilitate and sustain individual behaviour change as well as communities' engagement in working with development projects and sectoral offices.

At public policy or decision-makers' level, focus will be on strengthening of enabling environments created through addressing underlying bottlenecks hindering progress and taking corrective actions to strengthen interventions. Continuous policy dialogue at regional and national level will be organized to call for actions for greater investment to enhance accessibility of malaria elimination interventions to the unreached groups of people (foci). These may include infrastructural investment, health system strengthening including building the capacity of community health volunteers for example.

Phase 3: Elimination

At individual level, the focus will be on family members and patients to raise awareness on referral and screening, early treatment seeking behaviour and advice on treatment compliance.

At household level, family members will be encouraged to get involved in active case-based surveillance, screening of people in surrounding villages/households, seeking and complying with the treatment. In addition, communities will be encouraged to sustain foci identification and reporting of returnees of sick individuals (internal and external population movements).

At community level, it is important to keep the momentum and resilience of communities' involvement in following up of Test, Treat & Track (T3) activities, and continue in identification of foci and hotspots, referral and screening. The *role of social, traditional and interpersonal networks* will be highly important to actively search and take community actions for control of larva source and manage environmental factors.

At the organizational, the intent of activities at this level is to make sure that identified community based organizations are continuing their role and that appropriate support for availing and creating access to preventive and treatment services are provided. Support regarding access to information sources to sustain behaviour change, and avail preventive vector control interventions, overseeing the effectiveness of work place policies and regulations to ensure that malaria elimination interventions are going on.

At public policy or decision-makers, on top of previous efforts, emphasis will continue on strengthening of cross - border joint initiatives specifically related to information sharing, synchronization of activities, and creation of enabling environment through coordination mechanisms. In addition, actions to create enabling environment for resource and community mobilization to improve access to unreached (foci) will be given due emphasis.

Phase 4: Prevention of re-introduction of infection

In this step, emphasis will be given at decision making level to advocate for government authorities to put in place guidelines, ensure installation of equipment and placement of health staff to ensure screening at entry points. In addition, active and community-based surveillance shall be strengthened.

Table 1: ACSM strategic framework for malaria elimination

Specific Objectives	Strategies	Target Audience	Key Messages[1]	Channels[2]
1. By 2020, 100% of individuals, families, communities in targeted districts will have adopted and practiced the recommended/ desired behaviours on malaria elimination	• IPC through HEWs/HDAs on net use, health seeking behaviour, IRS acceptance, larval source management • Health talks on correct & consistent net use, health seeking behaviour, IRS acceptance using school clubs • Community mobilization (mass media, Community conversation, educational entertainment, promotional materials) • Use community champions • Re packaging of key malaria elimination messages	**Primary** • All people (high risk groups, night shift workers, development project workers, etc.) living in high transmission areas (foci, hotspots, cluster of households) • Imported cases (travellers/ tourists traders, migrants,) • Model households and communities • Secondary • Influential leaders • Religious leaders • Community leaders • Head of households • HEWS and HDAs • Tertiary • Political leaders • Media		• Face-to-face at all appropriate places (work place, market, households, health facilities, etc.) • Family health cards • Group meetings including traditional ceremonies • Mobile van • Radio • School mini media • Television • Leaflets, magazines, newspapers • Billboards/Posters/DVDs • MoH Hotline • Film • Information pack for community champions • Social media (Facebook, Twitter, What's App, SMSs) • School health clubs • Organize platforms such as World Malaria Day and as necessary in certain localities
2. By 2030, 100% of high risk populations travellers, traders, migrants, refugees etc.) will have exhibited appropriate health seeking behaviours for malaria elimination.	Review of registers for migrants by HEWs at checkpoints to identify individuals from high risk areas • Identify risk groups, promote voluntary testing among and link to services • Engage relevant industries (hospitality, transport sector, agriculture, dev projects) to provide personal protection • Build capacity of relevant industries (hospitality, transport sector, agriculture, development projects) on malaria elimination	**Primary** • High transmission areas (All people living in high transmission areas) • Imported cases (travellers/ tourists traders, migrants, refugees) • Secondary • Community leaders • Head of households • UNHCR/IOM/ARRA coordinators • Security personnel • HEWs/HDAs • Tertiary • Political leaders • Media		Face-to-face(IPC) through HEWs/ VHCs/HDAs Community Radio Road shows with entertainment Posters/billboards Training Community-Field Guide/Toolkits for malaria elimination

[3] *Specific key messages will be worked out based on identified gaps

[4] Tool kits will be developed to help users to adopt and practically support its implementation.

Specific Objectives	Strategies	Target Audience	Key Messages[1]	Channels[2]
3. By 2025, all communities will have set norms to effectively implement/ use malaria elimination interventions (appropriate norms to own malaria elimination (empowerment, engagement)	• Identification of existing community norms for malaria elimination • Situational assessment of behavioural barriers and facilitating factors for malaria elimination • Use of existing community structures (traditional, religious, civic) for the promotion and adaptation of new norms	**Primary** • All people living in high transmission areas(Hotspots), • Imported cases (travellers/ tourists traders, migrants,) • Influential leaders • Community leaders • Model households and communities • HEWs • HDAs • Model households and communities • Secondary • Administrators/Political leaders • Media		• Written norms/bylaws • Community structures • Community meetings • Focus Group discussions • Tool kits • Community radio • Coordinate to make use of platforms such as Global Refugee Days
4. By 2025, 100% of communities in targeted districts will have acquired appropriate skills to identify malaria cases/suspected cases and engage/ participate in active community based surveillance.	• Community conversations to build skills of community members to identify malaria cases • Build capacity of HEWs/HDAs to identify malaria cases	• High transmission areas (All people living in high transmission areas) • HEWs • HDAs • Caregivers • Hotspot/cluster of households/local cases (All individuals) • Imported cases (travellers/ tourists traders, migrants, visitors) • Secondary • Community leaders • Teachers • Tertiary • Administrators/Political leaders • Influential leaders • Model households and communitieS		• Face-to-face • Community meetings • Focus Group discussions • Tool kits • Community radio • Training
5. By 2025, the Government at all levels will have delivered the needed policy and financial support to achieve the goal of malaria elimination and beyond.	• Advocacy for the political leaders to support malaria elimination agenda • Advocacy for generating domestic resources • Designation of malaria ambassadors at all levels • Involve national and regional celebrities	**Primary** • Leaders at national levels and in high transmission areas • Partners • Religious leaders • Community leaders • Secondary • Media		• Advocacy Workshops/ visits • Political gatherings • Face-to-face • Advocacy Factsheets • Information pack for celebrities • Organize platforms and make use of WMD to advocate

Specific Objectives	Strategies	Target Audience	Key Messages[1]	Channels[2]
6. By 2020, 100% of targeted districts will have used data and evidence to track the progress and improve malaria elimination ACSM interventions.	• Build local capacity to generate evidences through Behavioural Surveys/ Operational Research • Revision and adaptation of -ACSM, M & E tools for use by HEWs/HDAs • Updating situational assessment • Conduct routine behavioural surveys for malaria elimination	**Primary** • Program Managers at all levels • Partners (Academic institutions, CSOs, Government Research Institutes etc.) -HEWs • HDAs		• Training • Research proposal • Collaborate with higher education institutes • Familiarize Monitoring and Evaluation Tools, reporting formats • Review meetings • M & E reports including researches • Job aids/Toolkits • Other platforms
7. By 2020, 100% implementers at all level will have established institutional coordination and partnership mechanism to improve implementation of Malaria Elimination ACSM	• Strengthen cross border collaboration • Strengthen interregional (within) collaboration • Strengthen partnerships at all levels	**Primary** • Political leaders at all levels • Program Managers at all levels • Partners • HEWs • HDAs		• Coordination meetings • ToR • ASMC work plans • Workshops • Other platforms • Periodic Review meetings

**Specific key messages will be worked out based on identified gaps*

8. Malaria elimination phases and priority ACSM areas

The matrix below presents the key areas of ASMC focus in relation to the unique characteristics of the malaria elimination phases.

Table 2: ASMC domain of influence by malaria elimination phases

Domains of influence	Optimization	Pre-elimination	Elimination	Prevention of reintroduction
Individual level	High level awareness on existing malaria interventions High level of malaria health literacy on elimination Development of skills on VC interventions Identification of signs & symptoms (uncomplicated and complicated) Addressing barriers for access to diagnostic and treatment Health-seeking behaviors	Sustaining optimization interventions Active participation (in identification and management of foci) Tailored messaging targeting specific areas/clusters Tailored messages House to house education	• Sustaining pre-elimination interventions • Inform family members and patients on ACD • Awareness on signs & symptoms and reporting individuals moving from other areas (encourage them to seek treatment) • Tailored messages • House to house education	Sustaining elimination interventions
Families (Household, Interpersonal)	• High level awareness and utilization of all malaria interventions • Effective treatment without interruption in all health facilities (compliance) • Implementing effective BCC • Strengthen existing surveillance system (ACD & Community-based surveillance) • Targeted VC (Improve IRS acceptance & discourage re-plastering of walls after IRS)	• Sustaining optimization interventions • ACD to guide cases and foci identification (requires support of the individual & community) • Tailored messages • House to house education	Sustaining pre-elimination interventions Case-based surveillance at HH level Tailored messages House to house education	Sustaining elimination interventions
Community	• High level awareness and utilization of all malaria interventions • Active engagement in information sharing, identification and dispelling of rumors and misconceptions. • Establishment of community norms, • Engagement in household and environmental management,	• Sustaining optimization interventions • ACD to guide cases and foci identification (requires support of the community) • Targeted IRS and Larval Source Management • House to house and engagement of core SMB team • Recognition for model households	• Sustaining pre-elimination interventions • Case-based and foci identification and investigation (community level • Follow –up on the 3Ts • House to house and engagement of core SMB team • House to house and engagement of core SMB team • Recognition for model households	• Sustaining elimination interventions • Cross-border (all borders) • Ownership of interventions. • Maintain community norms, community

Domains of influence	Optimization	Pre-elimination	Elimination	Prevention of reintroduction
Organizational	• Ensuring high level political commitment • Enabling environment (human resource and infrastructure) • Influence adoption of policies and work place regulations • Establishing information and treatment centres • Reorienting local health offices and facilities	• Keeping up the momentum of policy and strategy implementation, • Identifying hindrances to facilitate and sustain individual and community level outcomes	• Sustaining support for availing and creating access to preventive and treatment services • Ensuring accesses to information sources are sustainable for behavior change, • Ensuring that preventive vector control interventions are available and accessible	• Building on and sustaining achievements
Decision makers (policy level)	• Advocate for universal & effective coverage and utilization (including private sector)	• Sustaining optimization interventions • Advocate for targeting of interventions • Increase domestic financing • Health system strengthening (training, CM, Capacity Building)	• Sustaining pre-elimination interventions • Information sharing • Cross border initiatives (international) • Policy formulation for cross border initiatives	• Sustaining elimination interventions

9. ACSM implementation plan

Table 3: ACSM implementation plan for malaria elimination

	Objectives/Activity (ies)	Target Districts/ Popns	Level of Implementation	Responsible Party (ies)	Implementation Timeline			
					2016	2020	2025	2030
A	Objective 1: By 2020, 100% of individuals, families, and communities in targeted districts will have adopted and practiced the recommended/desired behaviours on malaria elimination.	All (545 Districts)	All					
	Act 1: Conduct mapping of communication/ IEC materials, update or develop for use at various levels/groups(family health, LLINs, IRS, SM, CM)		National/ Regional	NMCP				
	Act: 2. Disseminate and distribute malaria elimination materials		/ Regional	NMCP				
	Act 3: Conduct IPC (house-to-house) visits to promote and build practices for malaria elimination interventions		HHs	HEW/HDAs				
	Act 4: Conduct community conversations on malaria elimination through the existing community based structures (HDAs) 4.1 Update community conversation guide		Community	HEW/HDAs				
	Act 5: Conduct house-to house (IPC) in hotspots and foci		HHs	HEW/HDAs				
	Act 6: conduct of peer education in schools and integrate with school health clubs activities		Schools in Kebeles	School Heads/ Club Heads				
	Act 7: Conduct community mobilization workshops on key malaria elimination (ACSM) messages for community leaders		Kebele	HEW/HDAs				
	Act 8: Integrate malaria elimination into IRT to improve knowledge and skills of HEWs		Federal	NMCP, HE, PHD				
	Act : Revise and update FHC to incorporate malaria elimination		Federal	NMCP, HEP and PHD				
	Act 10: Develop training materials and peer education guide for use by school and community		National/Regional	NMCP, MoE				

	Objectives/Activity (ies)	Target Districts/ Popns	Level of Implementation	Responsible Party (ies)	Implementation Timeline			
					2016	2020	2025	2030
B	Objective 2: By 2030, 100% of high risk populations - travellers, traders, migrants, refugees etc.) will have exhibited appropriate health seeking behaviours for malaria elimination							
	Act 1: Map development projects in malaria endemic areas and encourage migrants workers to test at exit/entry points from/to malarious areas	Commercial farms/ residential villages	Devt project areas	MoH, Ministry of Federal Affairs, Investment Office, MoLSA, Ministry of Mines				
	Act 2: Encourage refugees to test on arrival through targeted malaria elimination messages in collaboration with IOM,UNHCR , HDAs, HEWs	All Entry/exit points	Refugee Camps	UNHCR, ARRA, IOM				
	Act 3 : Promote for establishment test and treatment facilities	All Entry/exit points and development project sites	Refugee Camps, Devt project areas	MoH, Ministry of Federal Affairs, Investment Office, MoLSA, Ministry of Mines				
	Act 4 : Promote voluntary testing for malaria using appropriate channels (billboards, posters)	All Entry/exit points and development project sites	Refugee Camps, Devt project areas	>>				
	Act 5: Encourage migrant workers and refugees to seek malaria protective interventions	All Entry/exit points and Devt project sites	Refugee Camps, Devt project areas	UNHCR MoH, Ministry of Federal Affairs, Investment Office, MoLSA, Ministry of Mines				
	Act 6: Develop orientation package on malaria elimination (ACSM) for institutions handling migrants, refugees & devt projects	Refugee camps and Devt project sites	Federal, Regional and sites at local levels	MoH, Ministry of Federal Affairs, Investment Office, MoLSA, Ministry of Mines				
	Act 7: Conduct orientation on malaria elimination (ACSM) for institutions handling migrants, refugees & devt projects (transport sector, agriculture, dev projects)	Devt project sites	Federal, Regional and sites at local levels	MoH, Ministry of Federal Affairs, Investment Office, MoLSA, Ministry of Mines				
C	Objective 3: By 2025, all communities are empowered and engaged to set appropriate norms to effectively implement and use malaria elimination interventions							

	Objectives/Activity (ies)	Target Districts/ Popns	Level of Implementation	Responsible Party (ies)	Implementation Timeline			
					2016	2020	2025	2030
	Act 1: HEWs and HDAs conduct community discussions (CC, FGD) to identify/determine behavioural barriers and facilitating factors for malaria elimination and establish appropriate community norms	All target districts	Community	ACSM Experts, HEWs, HDAs, Community leaders, Adm/ traditional leaders				
	Act 2: HEWs/HDAs reinforce implementation of norms	All target districts	Community	HEWs, HDAs, Community leaders, Adm/ traditional leaders				
	Act 3: Support community networks to promote and sustain environmental management, community based detection, referral and facilitate treatment	All target districts	Community networks/HEWs	ACSM experts, HEWs, HDAs, Community leaders, Adm/ traditional leaders				
D	Objective 4: By 2025, 100% of communities in targeted districts will have acquired appropriate skills to identify malaria cases/ suspected cases and engage/participate in active community based surveillance.							
	Act 1: Engage communities in the follow up of index cases, test families and neighbours to search for cases (Asymptomatic or gametocytes carriers)	HHs around IC	Community	HEWs, HDAs, Community leaders, Adm/ traditional leaders				
	Act 2: Empower families and communities to recognise malaria signs and symptoms, seek treatment and facilitate screening of neighbourhood	HHs around IC	Community	HEWs, HDAs, Community leaders, Adm/ traditional leaders				
	Act 3: Engage communities in information sharing including identification of breeding sites, reporting and follow up malaria elimination actions	HHs around IC	Community	HEWs, HDAs, Community leaders, Adm/ traditional leaders				
	Act 4: Develop materials on malaria elimination community surveillance (toolkits)	Target Districts/Popns	National	NMCP, HEP PHD				
	Act 5: Engage communities in planning and implementation to support targeted Mass Drug Administration (tMDA)	Target Districts/Popns	Community	District Health Office, Community Leaders, HEWs, PHCU				
E	Objective 5: By 2025, the Government at all levels will have delivered the needed policy and financial support to achieve the goal of malaria elimination and beyond.							
	Act 1: Advocate the Social Affairs Standing Committee in the National Parliament in support of malaria elimination	Federal	Federal	NMCP				

	Objectives/Activity (ies)	Target Districts/ Popns	Level of Implementation	Responsible Party (ies)	Implementation Timeline			
					2016	2020	2025	2030
	Act 2: Cascade orientation on malaria elimination to regions and other levels and audiences	Region, Zone, District, Kebele	Region, Zone, District, Kebele	MCPs				
	Act 3: Organise advocacy forums on malaria elimination at all levels	Targeted Districts	Region, Zone, District, Kebele	NMCPs, ACSM FPs				
	Act 4: Develop advocacy pack/factsheet for decision-makers at all levels	Targeted Districts	Region, Zone, District, Kebele	NMCPs, ACSM FPs				
	Act 5: Identify national and regional celebrities to promote and advocate for malaria elimination	National & Regional	National & Regional	NMCPs, RMCPs				
F	Objective 6: By 2020, 100% of targeted districts will have used data and evidence to track the progress and improve malaria elimination ACSM interventions.							
	Act 1: Set Malaria elimination M & E indicators	National	Region, Zone, District, Kebele	NMCPs				
	Act 2: Develop Malaria elimination M & E tools	National	Region, Zone, District, Kebele	NMCPs				
	Act 3: Train staff in OR, M & E at all levels	National	Region, Zone, District, Kebele	NMCPs, RMCPs				
	Act 4: Conduct Annual Review meetings and field visits	Targeted Districts	Region, Zone, District, Kebele	NMCPs, RMCPs, MCPs				
	Act 5: Strengthen partnerships with research-based institutions (EPHI) at all levels and with regional universities	National	National & Regional	NMCPs, RMCPs				
	Act 6: Carry out OR and disseminate findings	National & Regional	National & Regional	NMCPs, RMCPs, MCPs, Research Institutions				
G	Objective 7: By 2020, 100% implementers at all level will have established institutional coordination and partnership mechanism to improve implementation of Malaria Elimination ACSM							
	Act 1: Strengthen cross border collaboration	National/ Regional	National/Regional	NMCPs, RMCPs, MCPs, Foreign Affairs				
	Act 2: Strengthen partnerships at all levels	National, Regional	National/Regional	NMCPs, Regional ACSM FPs				

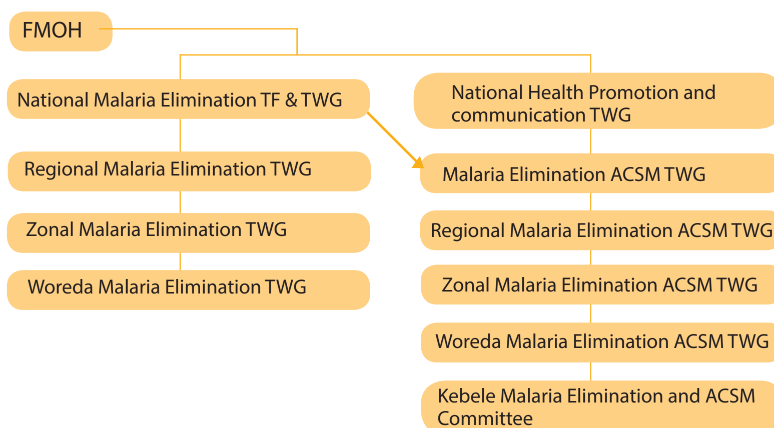
10. Institutional framework for ACSM in malaria elimination

Effective utilization of this operational guide at all levels (from central to kebeles) requires a strong institutional arrangement for coordination and fostering partnership needed for its implementation. Experience have shown similar initiatives that have remained in vain due to absence of a mechanism in place necessary for guiding, overseeing, reviewing and updating from achievements and challenges along the line of implementation.

The management, monitoring and evaluation aspect of ACSM activities at Community, Kebele, Woreda, Zone, Region and Central levels needs to have a system to exchange information, assess progress and take timely measures. To this end, a malaria elimination ACSM TWG has to be formed with the support of National Malaria Control and Elimination Program and the Health Extension Program and Primary Health Care Directorate (PHD).

The coordination structure for malaria elimination ACSM will have double accountability; both for the National Malaria Elimination TWG and for the National Health Promotion and Communication TWG. The same pattern of structure is recommended at all levels, except at kebele level, where the HEWs, HDAs and other players from community based organizations, social and community networks, etc. will form one and the same coordination mechanism for malaria elimination.

Figure 2: ACSM Coordination Structure



10.1 Roles and responsibilities of key players

National level

- Develop ToRs for the National Taskforce and TWG for malaria elimination
- Establish TWG for national ACSM and provide support to regions to establish regional TWGs
- Coordinate the national level to malaria elimination ACSM
- Plan, organize and monitor
- Mobilize resources for malaria elimination activities
- Organize Advocacy forums
- Launch malaria elimination program
- Identify celebrities
- Guide/share identification criteria with the regions
- Support RHBs in forming regional taskforces
- Develop inventory of all malaria materials and messages
- Harmonize malaria promotional messages
- Develop guidelines for messages and messages on malaria elimination
- Strengthen media relations, provide and harmonize malaria elimination messages
- Engage mobile service providers to circulate SMSs on malaria elimination

Regional level

- Develop ToRs for the Regional TWG for malaria elimination
- Establish TWG for regional ACSM and provide support to districts
- Coordinate the regional level malaria elimination ACSM
- Plan, organize and monitor ACSM
- Mobilize resources for malaria elimination activities
- Organize Advocacy forums at regional level
- Launch malaria elimination program
- Identify celebrities
- Hold review and regular meetings
- Design capacity building and training programs
- Provide technical support
- Strengthen media relations, provide and harmonize malaria elimination messages

Zonal level

- Establish TWG for zonal ACSM and provide support to districts
- Coordinate malaria elimination ACSM
- Plan and organize ACSM activities
- Supervise and monitor ACSM activities
- Mobilize resources for malaria elimination activities
- Report to regional level
- Cascade trainings to the lower levels
- Strengthen media relations, provide and harmonize malaria elimination messages

District level

- Provide technical support to HEWs and HDAs
- Avail promotional materials
- Skills trainings
- Support supervision
- Establish TWG for zonal ACSM and provide support to districts
- Coordinate malaria elimination ACSM
- Plan and organize ACSM activities
- Mobilize resources for malaria elimination activities
- Report to zonal level
- Cascade trainings to the lower levels

Community level

- Identify community champions
- Form\integrate Malaria Elimination into existing ACSM committee
- Organize awareness creation events
- Use existing forums to raise awareness on Malaria Elimination
- Mobilize communities for malaria elimination interventions
- Make use of town criers, house to house, traditional networks for ACSM information sharing to promote malaria elimination agenda
-

11. Monitoring and evaluation

Greater attention will be paid to M&E to understand how effectively and efficiently this strategy is contributing to the success of malaria elimination. Monitoring and evaluation of ACSM will provide guidance for ACSM to measure the progress of implementation of this strategy and evaluate its successes, as well as support tracking if targeted strategies and messages are conveyed through appropriate channels to the right audiences.

Table 4: Monitoring and evaluation framework

	Individuals	*Households*	*Community*	*Society*
	• Awareness • Malaria health literacy on elimination • Development of skills on bed net use • Identification of danger signs • Addressing barriers for access to treatment	• Universal & effective coverage Vs utilization • Vector Control • Effective treatment without interruption in all health facilities (compliance) • Ensuring continuous diagnosis and treatment (provision of malaria commodities including the private sector • Implementing effective BCC • Strengthen existing surveillance system (ACD & Community-based surveillance)	• Universal & effective coverage Vs utilization • Ensure political commitment and community engagement • Enabling environment (human resource and infrastructure)	Universal & effective coverage Vs utilisation
Pre – elimination	• Awareness of danger signs and health-seeking behaviour • Awareness on correct use of VC interventions (LLINs, IRS, EM) • Active participation	• ACD to guide cases and foci identification (requires support of the individual & community) • Targeted VC	• ACD to guide cases and foci identification (requires support of the community) • Targeted VC	• Increase domestic financing • Health system strengthening (training, CM, Capacity Building)
Elimination	• Inform family members and patient • Advise on treatment and compliance • Awareness on signs & symptoms and reporting individuals moving from other areas (encourage them to seek treatment)	• Case-based surveillance at HH level	• Case-based and foci identification and investigation (community level • Follow –up on the 3Ts • Cross-border (internal borders)	• Information sharing • Cross border initiatives (international) • Policy formulation for cross border initiatives
Prevent re-infection		⇩	⇩	⇩

Capacity building of health professionals at all levels and at different capacities, HEW supervisors and HEWs on M&E remains imperative to continuously and consistently improve the effectiveness of ACSM for malaria elimination. Indicators related to ACSM for malaria elimination should be identified in line with HMIS. In addition, identified indicators should be collect and analysed continuously.

Table 5: ACSM M&E plan in malaria elimination

Specific Objectives	Outcome	Indicators	Frequency of Data Collection	Means of Verification	Responsible body
1. By 2020, 100% of individuals, families, communities in targeted districts will have adopted and practiced the recommended/ desired behaviours on malaria elimination.	• Sprayed houses are not re-plastered • Correct and consistent use of LLINs • Seeking treatment within 24 hours within onset of fever is achieved • Complete compliance/ adherence to full course of treatment • All breeding sites (swamps, ponds, etc.) close to households are managed	% of sprayed houses not re-plastered % of HHs who consistently and correctly used LLINs % of cases who sought care within 24 hours % of cases who completed full course of treatment Number of breeding sites close to households managed	Monthly Monthly Weekly Weekly Weekly	Monthly Visit Reports Monthly Visit Reports Quarterly review meeting Patient Registry Books Home Visit Reports Blister Pack Breeding Site Visit Reports	HEWs, HDAs HEW HDAs WoHO HEWs Supervisors HDAs HDAs HEWs
2. By 2030, 100% of high risk populations - travellers, traders, migrants, refugees etc. will have exhibited appropriate health seeking behaviours for malaria elimination.	• High risk groups recognized signs and symptoms of malaria • High risk groups sought/adopt routine screening services for malaria at exit and after arrival • High risk groups sought treatment within 24 hours within onset of fever is achieved • High risk groups completed compliance/adherence to full course of treatment	% of individuals who recognize signs and symptoms of malaria % of individuals who sought/adopt screening services % of individuals who sought care within 24 hours % of cases who completed full course of treatment	Annually (Harvest time) Annually (After Harvest) Weekly Weekly	Survey Reports Patient Registry Books Patient Registry Books Surveys Refugee registry book	NMCP (To work/ partner with IOM) Farm Camps/ HEWs/HDAs Farm Camps HEWs/WoHO Farm Camps/ HEWs/HDAs Refugee camp/ ARRA/UNHCR
3. By 2025, all communities will have set norms to effectively implement/ use malaria elimination interventions (appropriate norms to own malaria elimination (empowerment, engagement)	• Community members trained on malaria sign and recognition of malaria. • Communities who set and practiced norms for malaria elimination	Number of communities trained on malaria symptom and sign Number of communities who have set norms for malaria elimination Number of communities who have implemented the set norms	Bi-annually	Site visit reports Community norms Interviews	HDAs /HEWs Community/ Kebele leaders
4. By 2025, 100% of communities in targeted districts will have acquired appropriate skills to identify malaria cases/suspected cases and engage/ participate in active community based surveillance.	• Community members able to recognize signs and symptoms of malaria • Community members referred, notified, involved in investigation and MDA	Number of community members in targeted districts who recognize signs and symptoms of malaria Number of community members who referred, notified and investigated malaria cases	Annually Every five years Monthly	Training reports Surveys Reports	RHBs/WoHO, HEWs HDAs

Specific Objectives	Outcome	Indicators	Frequency of Data Collection	Means of Verification	Responsible body
5. By 2025, the Government at all levels will have delivered the needed policy and financial support to achieve the goal of malaria elimination and beyond.	• Guidelines, policies, directives for malaria elimination in place • Increased budget allocation for malaria elimination • Increased number and experts to implement malaria elimination interventions • Health facilities equipped with health information system/ICT for surveillance • Health facilities with laboratory diagnostic equipment	Policy guidelines, directives on malaria elimination issued Proportion of budget allocated at all levels for malaria elimination Number of experts recruited and trained to implement malaria elimination Number of facilities equipped with health information system/ ICT for malaria elimination Number of health facilities with laboratory diagnostic equipment for malaria elimination	Every five years Annually Annually Annually Annually	Policy Docs, Guidelines, Directives Approved Budgets Approved HR Structure Health Facility Reports Health Facility Reports	FMoH NMCP Regional Regional Government Federal Government Districts Regional Government Federal Government Districts Regional Government Federal Government Districts Regional Government Federal Government Districts
6. By 2020, 100% of targeted districts will have used data and evidence to track the progress and improve malaria elimination ACSM interventions.	Corrective measures taken to improve ACSM based on M and E data and evidence	Number of districts using ACSM Monitoring data to track progress Number of districts using evidence generated from Operational Research to improve ACSM interventions	Monthly/ Quarterly/ Annually Quarterly/ Annually	Monitoring Reports Review meeting reports Reports	DHO HEWs HDAs DHO HEWs HDAs
7. By 2020, 100% implementers at all level will have established institutional coordination and partnership mechanism to improve implementation of Malaria Elimination ACSM	Coordination mechanisms for malaria elimination strengthened/established Joint planning, implementation, monitoring and resource mobilization	Number of coordination mechanisms established at levels Number of joint activities implemented	Quarterly Quarterly	Meetings/ Reports Meetings/ Activity Reports	FMoH, RHB, DHO, HEWs, HDAs FMoH, RHB, DHO, HEWs, HDAs

12. Annexes

Annex 1: Toolkit

This toolkit is prepared to provide a step by step guidance, introduce principles and present real stories or examples on how to plan culture and local context and carry out effective and integrated advocacy, communication and social mobilization, messaging and pre testing of materials.

1.1 Advocacy

For the sake of malaria elimination, the process of advocacy planning and implementation should consider, in addition to the issue identified, the kind of expected support that can be gained from different administrative levels and capacity or mandate of partners or organizations:

- Decision makers at national (public policy) and regional levels where the purpose of the advocacy aims to gain financial, policy related support including directives needed for creation of enabling environment for the strengthening of malaria elimination.
- At zonal and woreda levels where the purpose of advocacy focuses on gaining budget support to support specific activity implementation and ensuring that issues and capacity gaps (HR, facilities, supplies, etc.) on the ground get higher level attention.
- At the level of sectoral organizations, civil societies, NGOs, private organizations technical and financial support in strengthening of malaria elimination interventions and provision of access to malaria elimination interventions (LLNIs, IRS, test and treatment, information, protective materials, etc.) are important.
- Gaining full involvement and support of opinion, community, religious and influential figures to mobilize and get communities engagement and ownership of malaria interventions is the major purpose of advocacy at community level.

The other approach is to identify issues or bottlenecks that are so important to address, without which success of malaria elimination activities is impossible.

The following steps guide to organize advocacy plan at all levels.

Step one: Conduct situation analysis

- Gather and analyse evidences to determine the challenges, gaps or issues that need to be addressed through advocacy. The use of sources of information depends on the level of the advocacy plan. Generally, situational assessment reports generated from researches (qualitative, quantitative, FGD, IDI. etc.) can be used to identify data related to malaria elimination, and determine who is effected? How is the community affected?
- Understand government policy that relate to malaria elimination interventions (assess and follow the gov't guideline, strategic plans or gov't international commitment to malaria elimination)
- Identify and analyse key officials, Individuals, groups, institutions and media that have the power to make the change happen in relation malaria elimination at every level- national, regional and district.
- Identify key partners (NGOs, FBOs, institutions, organisations) who has a stake in the issues and who can support that conduct similar work in the geographic area of the advocacy effort.

Step two: Identify and prioritize issues

- Based on the malaria problems identified in the situation analysis, you need to identify and prioritize issues.
- Issues needs advocacy at national/ regional level are:

- Resource mobilization advocacy using evidence on the burden of malaria (health, social and economic impact) and economic cost of malaria elimination for growth and development, etc.;
- Enabling environment policy related support to address sectoral impact on malaria spread and the high risk population Directives and guidelines to strengthen cross border travellers screening and treatment, information sharing mechanism at the entry point;
- Interregional migration testing at points of entry / exit.

Step three: Develop advocacy strategy

Formulate advocacy goal and objectives

- Clearly put the goal and objectives advocacy plan that helps us to achieve what we want from the decision makers/political leaders.
- Formulate SMART objectives of the campaign (Specific, Measurable, Achievable, Realistic and Time- bound)
- This will help to measure whether they are achieved or not.

Identify target audience

- Distinguish primary target audience (institutions, individuals within them who have authority to make the policy decision) and secondary target audiences (politicians, media, development agency, NGOs) who can influence the decision.

Select advocacy approach

- Select the best advocacy strategy whether its dialogue or negotiations with the policy makers can influence the target audience, how media can be supportive of the advocacy.

Identify the key messages to be communicated.

- Develop your message based on the advocacy approach you follow. If the approach is public, make sure that your message are likely to mobilize the broadest support, gain attention by the media, the message is persuasive with the primary audience.

Step four: Developing/Framing the Plan

Prepare plan of action

- Once the goal, objective and strategic approach prepared, you need to map out systematic plan of actions to be undertaken to achieve the expected result. This includes time table and outcome indicators.

Budgeting and identifying the resource

- Advocacy plan requires substantial amount of money and likely to influence the advocacy work to be undertaken.

Step five: Implementation

- Getting the message across
- Make sure that the message carries specifically call to action as a good communication is a centre piece of effective advocacy. It needs to be clear and should explain what needs to be proposed. The message needs to be reinforced through the influence of secondary audience.

Table 6: Advocacy planning Template

Level	Issue/Challenge/ Gap	Advocacy Strategy: Goal/ Objective/Target Group	Message/Plan/Timeframe –when to implement the advocacy plan
National			
Regional			
Zonal			
Woreda			
Community based organizations, civil societies, NGOs, etc.			
Community			

1.2 Social mobilization

The planning for effective social mobilization rests on the responsibility of FMOH, RHBs and Health Offices at all levels and requires the following steps:

1. Mapping of stakeholders; whose interest to get involved and capacity to contribute are high; stakeholders who have interest but less capacity and others who have capacity but unaware of the program at all.

- Stakeholders at national, regional, zonal and woreda level include NGOs, Donors, and sector ministries, research institutions with mission to eliminate malaria and have interest to contribute for its elimination.
- At kebele level, in addition to the above list of stakeholders, community based organizations, social and community networks, religious and faith based organizations would involve in social mobilization.

2. In agreement of stakeholders identified, form coalition or social mobilization task force. The task force needs to have terms of reference, the purpose, and scope of activities, roles and responsibilities to guide its activities. In addition it pays attention for sustainability, accountability, and enhances community ownership of malaria program.
3. The coalition or task force will be tasked to coordinate, mobilize and raise awareness of

Malaria elimination through communication channels effective enough to reach the people.

- These include group and community meetings, school activities; traditional media group performances, road shows, home visits, etc. Print (Leaflets, posters, etc.) and audio-visual (spots, documentaries, etc.) and other communication aids in local language /dialects are often used to create awareness to activate social mobilization activities.

Table 7: Malaria elimination social mobilization activities

<table>
<tr><th></th><th>Stakeholders</th><th>Activities</th><th>Outcomes</th></tr>
<tr><td>National level</td><td>• Federal Ministry of Health (MOH); Line ministries (Education, Agri, Water, Energy, Land, etc.); NGOs
• Media institutions</td><td>• Establish a multidisciplinary committee
• Plan and implement communication and social mobilization
• Develop a national social mobilization plan
• Develop strategies for reaching special groups
• Develop and disseminate IEC messages and materials
• Coordinate and supervised social mobilization activities nationwide.</td><td rowspan="4">• Alliance formation
• Organizational
• Motivation
• Multi-sectoral collaboration
• Institutional agreements</td></tr>
<tr><td>Regional / Zonal level</td><td>• Regional Health Bureau/ zonal Department
• Line departments (Education, Information, Gender, Community Development, Local Government, etc.)
• Partners.</td><td>• Plan social mobilization activities
• train woreda level social mobilization teams
• coordinate social mobilization activities
• facilitate formation of lower-level social mobilization structures
• supervise woreda level social mobilization activities
• mobilized local resources
• identified and recruited partners
• designed strategies to reach special groups</td></tr>
<tr><td>Woreda level</td><td>• Woreda Health office
• Line offices (Education, Information, Gender, Community Development, Woreda Administrative)
• NGOs
• Local religious leaders and other partners.</td><td>• Plan social mobilization activities
• train HEWs and HDAs
• coordinate social mobilization activities
• facilitate formation of kebele level social mobilization structures
• supervise kebele level social mobilization activities
• mobilized local resources
• identified and recruited Stakeholders
• designed strategies to reach special groups</td></tr>
<tr><td>Kebele level/ community</td><td>• Kebele chairperson
• PHCU Head
• HEWs Supervisors
• HEWs
• Kebele Health Committee head</td><td>• Get training in social mobilization
• train HDAs
• plan mobilization activities
• conduct social mobilization activities
• Assist identification of sites and work with on during malaria elimination
• Identified and mobilized local resources, carried out sensitization in schools and coordinated, supervised and evaluated social mobilization activities in the kebele.</td></tr>
</table>

1.3 Community engagement

Depending on the prevailing way of working and common understanding what a community constitute, HEWs with the support of, and under the leadership of local leaders, need to initiate or revitalize community empowerment though community conversations in order to enhance their capacity and increase their engagement. It is necessary for implementers at grass root level to agree on basic characteristics and define what constitutes a community. This will help for effective planning and bringing together community members with shared vision.

Building capacity of communities

To get communities fully engaged and help them achieve all malaria elimination interventions, firstly they need to be adequately be informed and their capacity to assess their situation, analyze and take action.

Tips for HEWs for planning community capacity building activities

1. HEWs need to have good knowledge the malaria situation in their locality, the magnitude of malaria, how many people affected, conditions favorable for mosquito breeding, level of use of malaria interventions (LLNIs coverage, IRS coverage, access to treatment, movement of people coming in and out of their locality, level of communities understanding and engagement, etc.
2. With local administrative leaders need to meet and discuss on the need to mobilize and empower communities for effective engagement. If necessary, HEWs have to invite heath workers or their supervisor from nearby health center or woreda health office or from partners for this and subsequent meetings
3. Together with the local leadership, identify from community leaders, religious leaders and other influential leaders a core group for coordination
4. Map community based organizations, civil societies, etc. and identify those with the needed expertise and interest who could strengthen community empowerment and engagement.
5. Identify community champions based on criteria for example who have very good record of achieving best in using LLINs, IRS, environmental management and with less risk of getting malaria in his/her family.
6. Organize community groups to go through community conversation sessions on malaria elimination and importance of community engagement. Series of sessions need to be planned with focus on participatory skills building to assess malaria situation, analyze community level factors and take community action. (Practical exercises in but not limited how to do transect walk, community mapping, force fluid analysis, ranking techniques, etc.)
7. Facilitate lessons and experience sharing of best performing households (model) with others
8. Address myths and misconceptions and adopt strategies to help community members to have better understanding of malaria eliminations and related issues.

Benchmarks for effective community engagement

Community engagement in malaria elimination is measured with the level of outcome and participation and in decision making carry out activities to achieve the outcomes at lead to malaria elimination.

Table 8: Benchmarks for community engagement

Outcome	Activities
High level of awareness and full understanding of ME	• Recognizing malaria as a community health • Appreciate and analyze magnitude of the problem and underlying factors in the community • Set vision for ML, objectives expected community level changes as a result of ML ACSM, why community engagement)
Adopted Household practices and desired behaviors	100% constituent use of LLNIs, IRS, larva source management, seeking health care within 24hrs of signs/symptoms, information sharing pertaining to screening need and report
Active social and community networks	• Continuous mobilization and participation to sustain community engagement and progress • Mobilize local resources including knowledgeable individuals • Review and reflection (what went well, what not, what should be improved, etc.)

1.4 Peer education

Children, teenagers and the young in school in particular have unique learning opportunities and capabilities in many ways that can help them adopt lifetime knowledge and skills. In addition, these groups do interact with one another such as with their friends in and out of schools, families and in their communities to share information in matters related to their life and as such learn from each other.

It is therefore important to target these young groups both in and out of schools, through peer education and supporting them in getting organized in clubs, engage them for malaria elimination.

Peer education for malaria elimination aims to reach out all students in and out of schools with information and knowledge of malaria prevention and familiarize them with recommended household practices and behavior.

To assist schools start peer education, HEWs needs to be equipped with the techniques of peer education, map schools and youth groups in the community and coordinate with stakeholders to o plan process.

How to organize peer education:

1.4.1 Mobilize stakeholders

Identify relevant stakeholders (such as government officials, civil-sector leadership, health professionals, education leaders, and youth groups) and call for meeting to introduce the purpose of the peer education targeting students and out of school youth groups, the role they can play in malaria elimination and the need for collaborative partnership to make the initiative a success.

Tips

- Begin with a small group of committed stakeholders and plan to expand the process to be inclusive and inviting.
- Provide a brief and concrete description of the goals and objectives of the peer education for malaria elimination
- Use evidence-based data to advocate for the relevance and effectiveness of peer education
- Agree on the launch of peer education in schools

1.4.2. Set up coordinating team in schools

The role of school management is decisive to provide the necessary support and establish a coordinating team composed of focal person (teachers) who will be tasked to coordinate activities, a few students and members of school of community.

The coordinating team need to be clear with the objectives of the peer education and agree to identify important steps and measures to organize it in the school. The HEW can play a role in providing further information with the team members and next steps to undertake.

1.4.3. Determine peer educator's roles

- Orient candidates about malaria elimination, key practices to prevent malaria and clarify expected
- Train candidates with peer education techniques, attributes of good peer educator and clarify their roles as peer educator for malaria elimination
- Build their communication and facilitation skills and through role plays demonstrate how to communicate and influence individual and group behavior Highlight the importance of empathizing and understanding emotions, thoughts, feelings, languages of peers to better influence behaviors.
- Inspire and encourage peers to encourage their peers and family members to adopt health-seeking behaviors

1.4.4. Identify peer educators

Selection criteria:

Peer educators need to exhibit some skills to serve as peer educators. It is therefore essential to use the criteria below to identify students with the following skills and experience.

- Active students with good socialization and interactive ability
- Very good communication skills
- Experience of participation in school health clubs, mini media, drama, etc.
- Interest and motivation-

1.4.5. Provide Training

To able peer educators perform and play the role they are assumed to play and deliver expected outputs, it necessitates to design orientation or training focusing on malaria elimination, peer education skills and approaches is critical before they are tasked them for activities.

1.4.6. Set General and specific objectives

Having clear objectives will make the work of peer educators simple and guide focus areas determine effective activities.

Tips

- Assist peer educators in setting objectives and refining further with support from partners
- Discuss objectives and how they can be achieved; if there are no feasible ways to reach objectives, revise them to be more realistic.

1.4.7. Identify target audiences (participants)

- Assist each peer educator to identify and target its participants – each one is expected to get introduced and establish relationship with identified target groups of students.
- Clarify why is peer education for malaria elimination is being organized;
- Agree on:
  - Where the peer education will be held – **Venue?**
  - When the peer education will be held – **Time?**
  - How the peer education will be held - **Methodology?**

1.4.8. Identify needs of the target audience.

Further needs of the target audience in relation to malaria elimination can be identified through focus groups, and informal means, etc.

Tips

- Select an assessment approach that is affordable and feasible yet still provides useful information and guidance for planning.
- Use available data on the target audience when possible (e.g., Census and survey data; Ministry of Health service statistics; and Knowledge, Attitudes, and Behavior) to provide a broader context for your planning.

1.4.9. Develop work-plan

A work-plan (objectives, strategies, activities, partnership, budget, and timetable) is developed. It includes training plans, materials/tools acquisition or development, community/parent involvement, and a monitoring and evaluation (M & E) plan.

Tips

- Develop an operational plan detailing sequenced responsibilities and timelines.
- Identify barriers to implementation and ways to reduce their effects

1.4.10. Identify available resources and try to fill gaps.

Plan for resources needed to deliver activities as available, obtainable, or as existing gaps.

Tips

- Identify existing resources for each action of the work-plan.
- Be sure to consider the contribution of partners and community organizations willing to donate or exchange services.

1.4.11. Establish feedback mechanisms (M&E)

Put in place a practical ways for the target audiences and stakeholders to share views about the activities and make suggestions for improvement.

Tips

- Make suggestion boxes available to peer educators and their

1.4.12. Develop peer educators' capacity further

The coordinating team needs to consider the following methods to develop capacity of peer educators. This requires continuous assessment of their performance gaps and challenges.

- Probation - It is advisable to have the peer educators work on probation for 2-3 months on so that they can receive further refresher training in the basic skills required for their work.
- Counseling- Continuous sessions of counseling will help to improve communication patterns, family and interpersonal relations, self-confidence and self-respect.
- Training- Is very effective for skill development and education. It increases motivation and self-respect.
- One-to-one education- Personal and individual education are of prime importance in equipping the peer educators with information. Exposure visits - These are highly useful for refreshing and developing relationships, motivation, cohesion, "we feelings" and pride in one's work.
- Social contacts - Peer educators make many social contacts when they are involved in the advocacy process. This increases their motivation and commitment.
- Participation - Participation in the planning and evaluation of their work leads to better understanding and improves skills for implementation.

1.5 Message development

1.5.1 Key message designing and developing for malaria elimination

The success of ACSM depends on the type of message and the effectiveness of the mode of delivery to intended audiences. What matters next is also whether receiver of messages draws the right content of the meanings as it is intended based on her/his own background and needs.

Therefore, in order to develop an effective Malaria Elimination related message, the following points should be considered seriously:

- Attractiveness! to get the attention of the target audience
- Easy understanding with clarity – it should be short and simple for and clarity
- Culture specific and localized - to enable audience's identification with the message
- Endure interest
- Beneficial; it must appeal to get targeted audiences tempted to practice it
- Desired action for behavior change in audience's self interest

Appropriate messages designing require good understanding of the malaria elimination issue, the socio-psychographic profile of the target audiences affected, and the issues related to Malaria elimination by professionals in the field. Creativity in message design by those who engaged adds qualities required to improve understandability and attractiveness.

1.5.2 How to design key messages

It is important to identify key messages to guide the development of the actual messages to be communicated. Essential themes of key messages that should be included for all communication channels should undergo a validation process with expertise in the field. It is not only the facts and information but to identify as program responsible what we want target audience to do. Consideration thus should be given how messages inform how to overcome the barriers and lead to desired changes.

1.5.3 Key messaging

Table 9: Key message templates

Ask	Key messaging
What is the desired change?	Malaria cases should seek early diagnosis and completes treatment. For children, parents or family members assist them to do so.
What are the barriers?	Lack of information where, how to access measures Poor knowledge about inadequate knowledge of signs and symptoms
What are the communication objectives?	Create knowledge among target audiences about malaria, what causes it, signs and symptoms, where to seek treatment
What do the key promise and support statement say?	"Malaria can be treated with no further consequences if one get identified s/s, go or assist the person to get treatment at health facility "Nearby health facilities are fully equipped with treatment and skilled health workers"
What are the important themes?	Early detection, treatment adherence and completion
What are the most important points or information?	Early seeking of treatment, prevents further consequences including deaths

1.5.4 Pre-testing messages and design

The messages and materials should be tested on the following parameters:

- Accuracy
- Completeness
- Relevance
- Appropriateness in format, style, and readability level

The message should convey the exact statement or precise point you want to communicate. The following are an example of pre-test questions.

1. What is the main idea of the brochure, radio spot, or other type of material at hand?
2. Is this material for people like you or for other people?
3. Is there anything about the material or product that might confuse, offend, or embarrass some

   people? What in particular?
4. Is there anything in the material that you really like? Which part? Why?
5. Is there anything in the material that you do not like? Which part? Why?
6. Is the information/scenario/story believable? Why or why not?
7. Do you think the material is attractive or appealing? Why or why not?
8. What do you think can be done to make the material better?
9. Do you think this material will help people? How?

Annex 2: Key messages by target groups

For individuals/families/communities- on SO1

- Malaria is a disease spread by the bite of female Anopheles mosquito from an infected person to a healthy person
- All people in malarious areas are at risk of getting malaria. Children under 5 and pregnant women are most vulnerable
- Although malaria transmission can occur in the year round, you can prevent malaria at home and neighbourhoods.
- Use LLINs correctly and consistently; Don't misuse LLINs
- Keep your environment clear and avoid mosquito breeding sites. Malaria mosquitoes breed in uncovered water stored in anything at home or around the village
- IRS helps to avoid mosquitos from resting; re-plastering walls creates favourable conditions for mosquitos
- Know malaria signs and symptoms; take a person with malaria signs and symptoms to health facilities immediately within 24 hrs
- Comply to complete treatment
- Inform health workers if any returnee as a migrant worker or resident in malarious area comes home
- Inform health workers anyone who seeks malaria treatment and for further investigation of families upon return
- Participate in community activities called for vector control
- Provide families, friends and communities with correct information and help dispel misconceptions
- Prevent of mosquito bites between dusk and dawn is the first line of defence against malaria.
- Some groups of travellers, especially young children, pregnant women and individuals with a weakened immune system, are at particular risk of developing serious illness if they become infected with malaria.
- In pregnant women, malaria increases the risk of maternal death, miscarriage, stillbirth and low birth weight, as well as the associated risk of neonatal death.
- For high risk group of populations - on SO2
- Malaria is a disease spread by the bite of female Anopheles Mosquito from an infected person to a healthy person
- Know malaria signs and symptoms
- Be aware that you may have malaria and therefore, inform health workers in places you

are going to get testing and treatment services

- Use LLINs correctly and consistently; Don't use LLINs for unintended purpose
- Participate in community activities called for vector control
- Comply to complete treatment

For Community level - on SO3

Communities:

- Malaria is a diseased spread by the bite of female Anopheles Mosquito an infected person to healthy person
- All people in malarious areas are at risk of getting malaria. Children under 5 and pregnant women are most vulnerable
- Malaria transmission can occur in the year round; you can prevent malaria at home and neighbourhoods.
- Know that LLINs and IRS/ vector control are effective and recommended means of malaria prevention and control
- Participate in tracing new comers from malarious areas, encourage for testing, comply to complete treatment
- Participate in community level vector control activities

Community leaders:

- Mobilize participation of communities for information sharing about malaria breeding sites, use of interventions and access to treatments
- Reactivate community information platforms to discuss on progress made, challenges and ownership of interventions
- Designate community champions who will promote and mobilize communities' support and involvement in environmental management, advocate for norms to control correct use of LLNIs, and avoid re-plastering walls
- Support malaria elimination campaigns to create acceptability
- Set norms to improve use of LLNIs and IRS as well as environmental management

HEWs/HDAs:

- Know malaria signs and symptoms and key elimination interventions
- Work with health workers on key ASMC activities
- Coordinate to avail promotional materials and ensure access to ME key messages
- Work with community leaders to launch malaria elimination
- Mobilize participation of communities in ME activities
- Facilitate information sharing to strengthen community based surveillance for further action to get individuals tested and treated
- Make sure that RDT and malaria drugs are not stock out in your HP.
- Organise ITN hang-up campaign by mobilising school clubs
- Support school based malaria interventions by establishing anti malaria clubs
- Integrate malaria promotion in house to house messaging package

Decision Makers:

- Know key ME phases and interventions
- Know that vector control using LLINs and IRS/, case management and environmental interventions are key to effectively eliminate malaria and their support is critical for the success of the elimination
- Serve as advocates for ME in their respective constituencies
- Allocate funds for procurement and distribution of ME commodities and supplies
- Create enabling environment for engagement of stakeholders to improve partnerships
- Provide policy and directive support
- Create enabling environment (skilled human resources, promotional materials, communication infrastructure and air time)
- Launch ME to make ME visible and promote for increased acceptance

Annex 3: Effective messages

Table 10: Characteristics of effective messages

Key Characteristics of a Good Message	Guidance and Tips	Checklist for Developing effective Messages
Commands attention	The message should catch attention and generate interest among the audience.	The message stands out to your audience. The message is credible.
Clarity	Clear messages Avoid technical jargons that confuse or put the audience in confusion.	Make the message simple and direct. Focus should be to tell audience on what to know and do It provides the strongest points at the beginning of the message
Focus on benefit	Highlight the health and social benefit to gain upon adoption of the desirable behavior. (How do I directly benefit by changing to the suggested behavior?).	The message clearly states what the audience gets in return for taking an action. Design message conveying the benefits outweigh the barriers.
Consistent	Convey consistent and accurate information based on facts and figures of contemporary scientific findings	Key messages are used appropriately and ensure consistency and support for all of the program's materials.
Caters to the head and the heart.	Depending on the topic, messages should have the desired tone to have the desired impact on the target audience. For example, the tone may be reassuring, alarming, challenging, or straightforward	The message uses an appropriate tone for the audience. The appeal is appropriate as laid out in the creative brief.
Creates trust/credibility	Use credible source, based on the audience research	The information comes from a credible source for example FMoH
Calls to action	Malaria related messages should have a sense of urgency and deliver a call to action.	Clear call to action stating what the audience should base on the key messages The call to action is realistic.

Annex 4: Definitions

Advocacy:- is defined as "*a continuous and adaptive process of gathering, organizing and formulating information into arguments to be communicated through various interpersonal and media channels, with a view to raising resources or gaining political and social leadership acceptance and commitment, thereby preparing a society for acceptance of the program.*"[5]

The definition highlights to prepare an evidence based advocacy on the basis of well thought out plan using very convincing data and information related to the issue facing malaria elimination in every level at community, district, zone, region and national to gain support.

Communication: Communication aims to improve knowledge, attitude and practices through identifying, analysing and segmenting audiences on key health behaviours to encourage families and communities to seek care and treatment. Communication can spread knowledge and influence values and social norms on the risk of malaria transmission and benefits of effective methods of prevention and treatment. It can influence household members to adopt and sustain the culture of sleeping under LLINS every night giving priority to pregnant women and children under 5. It also makes possible to learn from the behaviour of others.

Design of key messages and with appropriate communication channels are important to inform targeted audiences what to do with the desired behaviours.

Social mobilization: social mobilization is defined as "...the process of bringing together all feasible inter-sectoral social partners and allies to identify needs and raise awareness of and demand for a particular development objectives. It involves enlisting the participation of such actors as institutions, groups, networks and communities in identifying, raising, mapping human and material resources thereby increasing strengthening self-reliance and sustainability of achievements made"[6 7].

The purpose of social mobilization can be achieved through awareness creation; use of community based approaches to reach and expand access of vector control interventions and enhance service delivery through community-based approaches.

Community engagement: is the process of working collaboratively with and through communities to address issues affecting their well-being.[8] This definition highlights the values and importance of the potential communities' capacity in dealing with their own issues if they are assisted with community capacity enhancement support. It also indicates to consider communities as partners rather than recipients. For malaria elimination, it is important to build on existing capacities for integration of malaria elimination and look for success stories. The way of working and approaches that the local leadership, HEP/ health extension workers, NGOs, Civil societies and community based organizations have achieved to engage communities need to be considered as potential experience.

[5] Communication handbook for Polio Eradication and Routine EPI, WHO,UNICEF, USAID, BASICS

[6] Ibid

[7] COMMUNITY ENGAGEMENT IN TUBERCULOSIS, WHO(http://www.who.int/tb/publications/community_engagement_factsheet_hg.pdf)

[8] Community involvement in tuberculosis care and prevention Towards partnerships for health, WHO