



Timor-Leste

# Social and Behaviour Change Communication Strategy for Prevention of Re-establishment of Malaria Transmission in Timor-Leste







# **Social and Behaviour Change Communication Strategy for Prevention of Re-establishment of Malaria Transmission in Timor-Leste**





## Message from the Hon'ble Minister of Health



**dr. Odete Maria Freitas Belo, MPH**  
Minister of Health  
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Dili

The National Strategic Plan for the Prevention of Re-establishment of Malaria 2021-2025 was developed to address the prevention of re-establishment of malaria transmission through specific interventions integrated into strategic approaches. In keeping with the NSP, the Ministry of Health (MoH) is committed to contributing to the overall goal of improving the health status of citizens by providing quality health care to them. This has been achieved by establishing and developing a cost-effective and needs-based health system that specifically addresses the health issues and problems of women, children, and other vulnerable groups, particularly the poor, in a participatory way.

Behaviour Change Communication (BCC) and community mobilization are integral parts of the NSP 2021-2025, providing cross-cutting support to different interventions for the prevention of the re-establishment of malaria transmission. The BCC strategy 2015-2020 has been providing overall guidance for malaria control and elimination. Communication materials targeting different audiences and segments of the community were developed and disseminated through a combination of channels.

The external review mission of the National Malaria Program (NMP) in 2020 made recommendations related to IEC, advocacy, and community participation. It recommended developing a new communication strategy in consultation with relevant partners and stakeholders. This strategy document was developed by the NMP in consultation with relevant departments of the MoH, stakeholders, and partners, with technical support from WHO and funding support from the Global Fund, in alignment with NSP 2021-2025. Relevant guidance available from WHO, RBM Partnership, the Global Fund, USAID, and other partners, as well as other relevant sources, were referred to.

WHO has provided and continues to provide technical assistance to the MoH for the overall prevention of re-establishment of malaria transmission. This includes, but is not limited to, the strengthening of malaria surveillance and response. It is envisaged that this Social and Behaviour Change Communication (SBCC) strategy will facilitate an understanding of the prevention of re-establishment contexts and environments in which desired behavior change is expected and to be maintained at individual/community/societal levels.

I recommend that all stakeholders, partners, and program implementers use the "Social and Behaviour Change Communication Strategy for the Prevention of Re-establishment of Malaria Transmission in Timor-Leste" as a reference for designing effective SBCC strategies in Timor-Leste.



**dr. Odete Maria Freitas Belo, MPH**  
Minister of Health



## Message from WHO Representative



**Dr. Arvind Mathur**

WHO Representative to Timor-Leste  
World Health Organization  
Dili

The National Strategic Plan for Prevention of Re-establishment of Malaria 2021–2025 has been developed based on Timor-Leste's experience in malaria elimination and prevention. The plan focuses on effective implementation of surveillance and response, early diagnosis, and complete treatment for imported malaria cases, as well as targeted vector control with emphasis on vulnerability and receptivity for appropriate actions.

In 2021, the WHO Malaria Elimination Audit Tool (MEAT) was used to evaluate the programme's implementation, with recommendations categorised by critical elements and milestones. One of the recommendations was to develop a communication strategy for the prevention of re-establishment of malaria transmission.

Recognising the integral role of behaviour change communication (BCC), community participation, and advocacy in the prevention of re-establishment phase, the NSP 2021–2025 prioritises the development of a social and behaviour change communication (SBCC) strategy. This strategy draws on relevant theories, evidence, and context-specific activities/campaigns to promote, improve, and sustain malaria-related behaviours related to prevention, case management, surveillance, and response interventions.

The SBCC strategy will complement the NSP 2021–2025, with the goal of promoting and maintaining responsive behaviour towards malaria prevention. The strategy is envisioned as a living document that will be revisited and updated in line with the current malaria/country context and malaria elimination certification process.

I recommend all stakeholders, partners, and programme implementers to refer to the "Social and Behaviour Change Communication Strategy for Prevention of Re-establishment of Malaria Transmission in Timor-Leste" in designing an effective SBCC strategy for the country.

A blue ink signature of Dr. Arvind Mathur is written over the official seal of the World Health Organization for Timor-Leste. The seal is circular with the WHO logo in the center and the text 'WORLD HEALTH ORGANIZATION' and 'TIMOR-LESTE' around the perimeter.

**Dr. Arvind Mathur**  
WHO Representative



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## Abbreviations and Acronyms

ABER	annual blood examination rate
ACADA	assessment, communication analysis, design, action
ACD	active case detection
ACT	artemisinin based combination therapy
AL	artemether lumefantrine
ANC	antenatal care
APCD	activated passive case detection
APLMA	Asia Pacific Leaders Malaria Alliance
APMEN	Asia Pacific Malaria Elimination Network
APMO	administrative post/sub-district malaria officer
ARM	advocacy for resource mobilisation
AV	audio-visual
BCC	behaviour change communication
BSP	basic services package
CBO	community based organization
CCP	center for communication programs
CDC	communicable disease control
CHC	community health centre
COMBI	communication for behavioural impact
DHIS	district health information software
DOT	directly observed treatment
DRTL	Democratic Republic of Timor-Leste
EDPT	early diagnosis and prompt treatment
FB	facebook
FBO	faith based organization
G6PD	glucose-6-phosphate dehydrogenase
GF	The Global Fund
HIV	human immunodeficiency virus
HMIS	health management information system
HP	health post
HR	human resources
HRH	human resources for health
iDES	integrated drug evaluation surveillance
IDP	internally displaced persons
IEC	information, education and communication
INGO	international national government organization
IPC	inter-personal communication
IRS	indoor residual spraying
KABP	knowledge, attitude, belief, practice
KAP	knowledge, attitude, practice
LLIN	long-lasting insecticide-treated net
LSM	larval source management
M&E	monitoring and evaluation
MEAT	malaria elimination audit tool
MBS	mass blood survey
MHMT	municipality health management team
MMO	municipality malaria officer
MoH	ministry of health
MPHO	municipality public health officer



NGO	nongovernment organization
NHSSP	national health sector strategic plan
NIH	national institutes of health
NMP	national malaria programme
NSP	national strategic plan
OPD	outpatient department
PACD	proactive case detection
PCD	passive case detection
<i>P. falciparum</i>	<i>plasmodium falciparum</i>
PHC	primary health care
<i>P. malariae</i>	<i>plasmodium malariae</i>
<i>P. ovale</i>	<i>plasmodium ovale</i>
POE	point of entry
PSF	Promotor Saude Familiar (community health worker)
<i>P. vivax</i>	<i>plasmodium vivax</i>
QC	quality control
RACD	reactive case detection
RDT	rapid diagnostic test
RMNCAH	reproductive, material, newborn, child and adolescent health
SBCC	social and behaviour change communication
SDG	sustainable development goal
SEARO	South-East Asia Regional Office
SEM	socio-ecological model
SISCa	Servisu Integradu Saude Komunitaria (integrated community health services)
SMART	specific, measurable, appropriate, realistic, time bound
SMS	short messaging service
SnF	Saude na Familia (Health in the family)
TTU	Timor Tengah Utara
TWG	technical working group
UNICEF	United Nations International Children's Emergency Fund
USAID	United States Agency for International Development
VBD	vector-borne disease
VBDC	vector-borne disease control
WMD	world malaria day

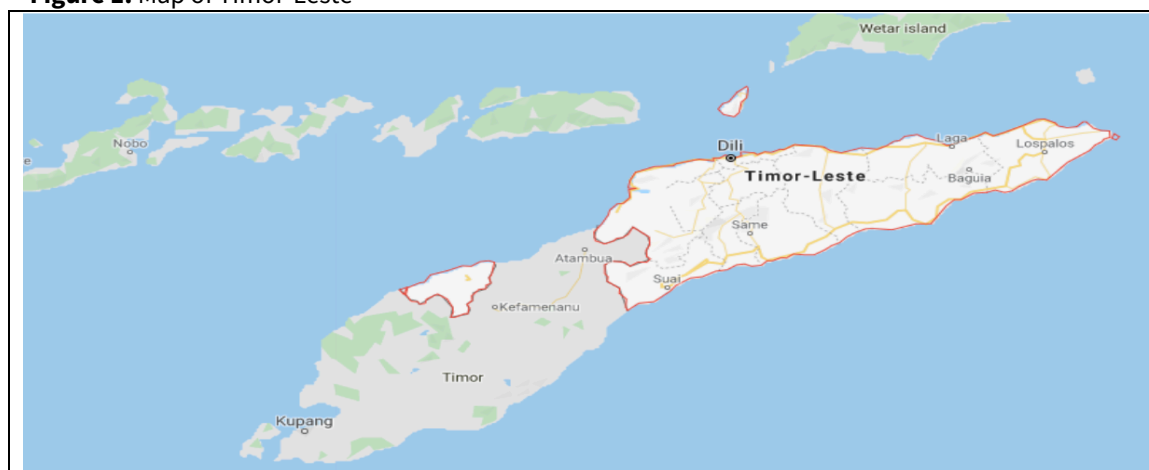
## 1. Background and introduction

### 1.1 Country profile

The Republica Democratica de Timor-Leste (Democratic Republic of Timor-Leste and referred as Timor-Leste) occupies primarily the eastern half of the island of Timor, with West Timor being part of the Republic of Indonesia. The country includes the nearby islands of Atauro and Jaco, and also Oecusse, an exclave in Indonesian West Timor (Fig. 1). The island topography consists of 80% mountains and coastal plains that are narrow swamp. There are no major highland valleys or permanent rivers. The maximum east–west length is 364 km and the maximum north–south length is 149 km.<sup>1</sup>

Timor-Leste is divided into municipalities (formerly called districts), which includes Dili, the capital of the country. Dili is the largest city and the main port. The second-largest city is the eastern town of Baucau. Each municipality is divided into sub-municipalities (formerly called sub-districts), and each sub-municipality is divided into sucos (village); each suco comprises a few aldeias (hamlets). In total, there are 13 municipalities, 65 sub-municipalities, 442 sucos and 2225 aldeias.<sup>2</sup> The municipalities and sub-municipalities bordering East and West Timor are given in Table 1.

**Figure 1.** Map of Timor-Leste



Source: NSP 2021–2025, National Malaria Programme, CDC, MoH, Timor-Leste.

**Table 1.** East and West Timor bordering municipalities/districts and sub-municipalities

East Timor bordering municipalities	East Timor bordering sub municipalities	West Timor bordering districts
Covalima	Tiliomar	Malaka
	Fatumean	Malaka
	Fatulilik	Malaka
Bobonaro	Bobonaro	Belu
Oecusse	Nitibe	Kupang
	Panche Macasar	Timor Tengah Utara (TTU)
	Passabe	Timor Tengah Utara (TTU)
	Oesilo	Timor Tengah Utara (TTU)

Source: NSP 2021–2025, National Malaria Programme, CDC, MoH, Timor-Leste.

<sup>1</sup> General Directorate of Statistics, 2017.

<sup>2</sup> Ibid.

Total population was 1,183,643 in 2015 comprising 50.8% males and 39% of the population being under 15 years with national median age of 19 years). Seventy percent of the population lived in rural areas and the rest in urban areas. The average household size was 5.8 persons. The literacy rate was 84% with rates being similar in males and females. The unemployment rate was 47% with the rate being higher in females (56% vs 39%). 50% of households had access to improved sanitation facilities. In 2019, the population was estimated to be 1,271,694. Majority of the population is engaged in subsistence farming. In 2014, 42% of the population was living in poverty. The economy is dependent on government spending and, to a lesser extent, assistance from international donors.

Tetun is the most common language in the country and is the first official national language. Portuguese, spoken by a few people, is the other official language. English and Indonesian are working languages. There are other languages spoken by the indigenous population across the country.

The country's climate can be classified into wet and dry seasons. However, variations exist between the north coast, south coast and the eastern district of Lautem. In general, the dry season lasts from May to November, with average temperatures varying between 20 and 30 °C. The north coast receives virtually no rain, whereas the cooler central mountains and the south coast get an occasional shower during this period. The “build-up” to the rainy season brings oppressive humidity around October to November, and occasional showers and temperature increases to 29–35 °C. With the arrival of the rains from December until April, flooding occurs in many parts of the country and travel becomes difficult. All these climatic and environmental conditions are favourable for perennial malaria transmission.

## **1.2 Overview of the health system**

Health care is enshrined as a fundamental right of a citizen in the Constitution of Timor-Leste. Hence, the state is obliged to protect and promote that right through the establishment of a national health system that is universal, general, free-of-charge wherever possible, and managed through a decentralized participatory structure. While acknowledging that health problems and their determinants are not solely within the boundaries of the health sector and its responsibility, the Ministry of Health (MoH) envisions a broad definition of health to ensure *"Healthy East Timorese People in a Healthy Timor-Leste"*.

In consistent with the vision statement, the MoH is to strive to ensure the availability, accessibility and affordability of health services to all East Timorese people, to regulate the health sector and to promote community and stakeholder participation, as well as other sectors. The MoH is expected to contribute to the overall goal of improving the health status of the citizens by providing quality health care to them by establishing and developing a cost-effective and needs-based health system, which will specially address the health issues and problems of women, children and other vulnerable groups, particularly the poor, in a participatory way.

The National Health Sector Strategic Plan 2011–2030 (NHSSP) adopts a "client centred" approach considering both the supply and demand sides of health care. It emphasizes social values in equity, cultural awareness, professionalism, integrity and ethics, right to best possible health care and accountability. These goals are then translated into a set of policy objectives linked to government priorities for the health sector. They are: 1) to strengthen the stewardship role of the MoH in the development of a strong integrated national health system; 2) to ensure access to and provision of quality primary health care (PHC) services and hospital care services; 3) to meet human resources needs; 4) to invest sufficiently and appropriately in health infrastructure; and 5) to strengthen health administration and management services.

The MoH comprises five directorates for community health services; planning and finance; administration, logistics and procurement; hospital and referral services; and for human resources. The National Malaria Programme (NMP) is under the Department of Communicable Disease Control (CDC), which is under the

Directorate of Community Health Services (DCHS). The curative institutions are under the Directorate of Hospital and Referral Services.

Medical care is provided by six hospitals (Five Regional Hospitals (RHs) and one National Hospital, 70 community health centres (CHCs) and 309 active health posts in the public sector; in addition there are 31 active private sector providers, most of whom are located in Dili and registered with the NMP. The government plans to have 442 HPs in the country, one each for each suco. PHC services are provided through the district health service structure, with CHCs, HPs and mobile clinics servicing geographically defined populations within a framework of the basic services package (BSP), while incorporating SISCa (Servisu Integradu Saude Komunitaria - Integrated Community Health Services). The essential services package is currently being revised to cater to the needs of the MoH. Management authority and responsibility have been devolved to the district health teams.

The nearest facility based services to the community are delivered through a network of HPs staffed by a team of one clinician, one nurse and one midwife. The team is able to deliver a minimum package of curative and preventive/promotive care. At sub-municipality level, CHCs have a wider range of staff, and provide a higher level of services than the HPs. They provide mobile clinic services and technical and managerial support to HPs. Some CHCs have inpatient facilities.

Municipality CHCs provide inpatient and outpatient services, with a staff component of 10–14 including a physician (the “Municipality Medical Officer”). Where there is no HP available in remote communities, CHCs provide basic mobile clinic services on a regular basis using a motorbike on a twice-per-week basis.

The community based activities consist of SISCa in villages; mobile services are conducted at other sites, e.g., schools, markets, community structures, and “mop up” services are regularly conducted according to programmatic needs. SISCa clinics serve populations of 1000–2000 and provide a combination of services ranging from antenatal care, maternal and child health care, immunization, health promotion and prevention, and diagnosis and treatment of common conditions.

As part of PHC services, a national family health programme (“Programa Nacional Saúde na Família”) was initiated in 2015. In this programme, domiciliary visits are made by teams comprising a doctor and health staff stationed at HPs with the aim of identifying health problems in families and prioritizing them. Details of households and family members including their health status are obtained. Persons with health conditions and illnesses that require further treatment and/or follow up are identified. These persons are referred for appropriate care. Data are entered into a national database.

On the basis of the estimated number of health care workers in government facilities and in private sector facilities, the MoH in the past had estimated that private clinics may be handling up to a quarter of basic health service delivery. There is greater use of private facilities among the non-poor than the poor. There are also about 32 faith-based clinics across the country.

The main feature of the health sector is the decentralization of health service delivery through devolution of key management responsibilities and resources to district health and personalized or autonomous health services. The municipality health system takes on a more implementation role of national policies, while gradually taking charge through the municipality health management teams (MHMT) in developing their own plans, supervising, coordinating, and monitoring and evaluating all activities at the district level, which reflects specified local needs. The main focus is on integrated community health care services in the form of BSP, which articulates a service delivery structure that begins in the local community and works its way to the national level for specialized services. The CHCs are service delivery units under the municipality health system, and are responsible for BSP implementation.

While sector strategic plans and delivery packages exist, implementation is a major challenge due to several factors: critical shortage of human resources for health (HRH), inadequate funding, and redundancy or limited impact/interest for policy, nearly a third of the people still living more than 5 km from the nearest health facility; weak referral system and stock-out of medicines. A system for supervision, monitoring and evaluation (M&E) exists, but it is yet to be optimal. Insufficient funds, late release of funds for supervision, and inadequate transport arrangements affect the frequency of supervision, which in turn impacts negatively on quality of services rendered.

Among the more serious problems are high infant mortality rates and under-five mortality rates caused by infectious diseases. Maternal and child malnutrition is a major problem. There is a high incidence of preventable communicable diseases such as tuberculosis, childhood respiratory infections, diarrhoeal diseases and a rising incidence of noncommunicable diseases. Malaria was a major problem in the country and was ranked second in the list of top 10 priority diseases 10 years ago. However, remarkably, the last indigenous malaria case was reported in June 2017.

### **1.3 Overview of the national malaria programme**

The National Malaria Control Programme was established in 2003 under the Communicable Disease Control Division. Currently, the national malaria programme (NMP) has the overall responsibility for malaria prevention of re-establishment in the country. Specifically, it is responsible for the formulation of technical and operational norms and procedures, planning, overall implementation of programme activities, coordination, monitoring, and ensuring adequate resources for the implementation of malaria prevention of re-establishment activities. There is a central management unit of the NMP at the national level within the National Directorate of Disease Control, comprising a programme manager under whom all activities are carried out. Under the programme manager at national level there are regional malaria officers, M&E officer, data entry officer, vector control officers, administrative officer and an entomology team consisting of entomology assistants and insect collector. Officers responsible for malaria vector control and entomology coordinate with the department of environmental health to carry out vector control activities based on epidemiological findings. Quality control technicians responsible for quality assurance of malaria microscopy and rapid diagnostic tests (RDTs) are attached to the national health laboratory (NHL) in Dili. In addition to staff, the NMP engages 36 volunteers in the border municipalities of Oecusse, Bobonaro and Covalima, where they assist to track migrants, remind residents to use long-lasting insecticide-treated net (LLINs) and also detect and treat infections.

The municipality health teams are responsible for planning, coordination of health service delivery, management of logistics, and M&E. They work in consultation and in coordination with the regional malaria officers at the national level. The NMP functions through municipality, administrative post/sub-district and health facility levels.

The functions related to communicable diseases control, including malaria, at the municipality level are planning, implementation, supervision, and M&E. These functions are carried out by the 13 municipality public health officers (MPHO) appointed at the 12-municipality level and Special Region Enclave Oecusse Administration. The municipality malaria officer (MMO), appointed as the focal point for malaria prevention of re-establishment at the municipality level, overlooks all malaria-related activities at the municipality level and is responsible for planning, implementation and supervision, monitoring of prevention of re-establishment activities in coordination with MPHO. Administrative post/sub-district malaria officers (APMO) are attached to the CHCs and they are responsible for malaria prevention of re-establishment activities at the administrative post/sub district level. The APMO compiles and sends data to the MMO monthly. The MMO collects, compiles and forwards all malaria-related data from all CHCs in the municipality to the health management information system (HMIS) and NMP. Real time web-based surveillance using DHIS2 was started in 2019, and all the malaria data collected by MMOs are added to the database.

The municipality laboratory analyst/technician (Level 2: External Competency Assessment) attached to each municipality is responsible for planning, M&E, and implementation of malaria diagnostic services, including microscopy and use of RDTs. The municipality technician is also responsible for training staff in the municipality in microscopy and the use of RDTs, quality control (QC) of malaria microscopy and RDTs, sending the samples of blood smears and RDTs for QC at the national lab, ensuring supplies of laboratory consumables at CHCs and HPs within the municipality, and supervising health facilities including hospitals and laboratories within the district.

At the administrative post/sub-district and HP levels, the staff is responsible for case detection and management of malaria patients using directly observed treatment (DOT). These responsibilities are primarily undertaken by the CHC at the administrative post level and staff at HP level. The time devoted to malaria prevention of re-establishment is dependent on the exigencies of the service at CHC. The CHC staff record patients' data in the registration book and send the monthly malaria data and anti-malarial drug usage to the MMO and the HMIS. They also collect data from HPs designated under each CHC; and a monthly malaria report is compiled. The HP staff carry out diagnosis and DOT of malaria patients. RDT kits are used in the HPs, where there is no malaria microscopy. In addition, the NMP has trained community volunteers at the high-risk administrative post/sub-district level in each of the high-risk municipalities specially at the West and East Timor border area municipalities; some of the volunteers were drawn from the cadre of community volunteers of the general health services to identify and diagnose malaria suspected cases. These volunteers are used to diagnose malaria patients using RDT and carry out DOTS for the confirmed patients under the guidance of respective APMO, who live far away from the health facilities. Volunteers educate the community on prevention of re-establishment, vector control and take part in distribution of LLINs coordinated by the CHCs and municipality health services. At border area municipality level with active and potential foci, temporary spraying teams have been recruited funded by the Global Fund grant to carry out indoor residual spraying (IRS). From the relevant municipalities, all records are sent to the MPH (Environmental health)/MMO.

WHO has provided and continues to provide technical assistance to the MoH for overall malaria prevention of re-establishment of malaria transmission. This includes, but is not limited to, strengthening of malaria surveillance and response including integrated drug evaluation surveillance (iDES), outbreak preparedness and response to any upsurges in vector-borne disease (VBD) transmission in the general population, entomological surveillance; and development of treatment guidelines, continued quality-assured malaria diagnosis and treatment at HPs, CHCs, hospitals; and cross-border collaboration. The NMP also coordinates with other departments within the MoH as well as other ministries for malaria prevention of re-establishment, besides the Global Fund, APLMA-APMEN (Asia Pacific Leaders Malaria Alliance-Asia Pacific Malaria Elimination Network), Rotarians Against Malaria (Australia), and select others.

Notably, with malaria elimination and roll out of the prevention of re-establishment phase in the country, the above-mentioned structures and functions will transition and evolve towards integration of malaria and other programmes. This would be made possible by bringing in/merging separate units responsible for other VBDs, namely, dengue control, lymphatic filariasis elimination under one umbrella of integrated vector-borne disease control division under the aegis of the MoH funded mostly by the national government.

#### **1.4 Malaria situation**

Malaria situation in the country has changed over the last 15 years. The incidence of malaria decreased from 223 002 cases in 2006, and the last indigenous case of malaria was reported in June 2017. In 2018 and 2019, eight and nine cases of imported malaria were reported, respectively. However, in 2020, a focal outbreak was noted with 14 indigenous cases. Deaths due to malaria have been ranging between 10 and



58 each year during the period 2006–2010. In 2012, only five deaths were reported and in 2014, one malaria associated death was reported. There has been no malaria death since 2015. Timor-Leste has moved from the malaria elimination phase to the prevention of re-establishment of malaria phase. Through the national strategic plan 2021–2025 (refer to section 1.5), the country proposes to prevent re-establishment of malaria and obtain ‘malaria-free’ certification from WHO building a sustainable programme integrated with the national health services.

The success is due to political commitment, universal access to malaria diagnosis using quality-assured RDT and microscopy, effective treatment using artemisinin-based combination therapy (ACT), and prevention measures including LLINs or IRS and combining larval source management (LSM), where feasible; improved epidemiological and entomological surveillance and response. The core interventions were supported by critical cross-cutting elements, behaviour change communication (BCC), positioning dedicated malaria staff with regular capacity-building, and availability of funding from the Global Fund, technical support WHO, as well as other partners/donors.

Malaria cases continue to be reported in the country among travellers, either nationals who return from travel to other countries, mainly neighbouring Indonesia, or foreign nationals who are infected abroad and travel to the country. Timor-Leste shares a porous land border with West Timor, Indonesia, which is endemic for malaria, and therefore transmission occurs just on the other side of the country’s border. Besides, one municipality Oecusse is surrounded by West Timor, except its ocean border. There is extensive travel of people to and from Timor-Leste to West Timor and to surrounding islands, which are also endemic for malaria. Such travel is associated with family ties and labour and business-related activities. Most imported cases have been detected in Dili (the capital) and Oecusse municipalities, among Timorese nationals who had travelled to Indonesia for various purposes. In addition to these, cases have been reported among the fisherfolk going to nearby Indonesian islands. Other at-risk groups include students, farmers, travellers, migrant workers and residents in border areas. Pregnant women and children under five are also considered at-risk population.

All malaria infections among the foreigners were among Indonesian nationals, who had come to the country for various reasons, including business and as migrant labour.

The ecology and climate in the country continues to provide ideal conditions for the creation of breeding sites for the malaria vector mosquitoes, thus maintaining a high malaria receptivity. This combined with importation of malaria cases expose the population to malaria outbreaks, if surveillance and response systems are not performing optimally. Continuous movement of people between areas of transmission and across borders maintains the potential for focal epidemics even in areas, which are considered to be at low risk for malaria. Additional factors such as population growth, poverty, and yet to be optimal primary health care interventions may contribute to the abrupt reappearance of malaria.

In the past, there was perennial transmission with the incidence peaking from January to March every year corresponding to the monsoon. Even during elimination and in the prevention of re-introduction/re-establishment phase, the most number of imported cases are detected in January and February of each year. This is because some families who have relatives in the neighbouring West Timor in Indonesia spend Christmas with their families in West Timor and return to Timor-Leste after a few days, with some having acquired malaria during the high transmission season in West Timor.

In the past, *P. falciparum* was the predominant species among malaria infections. There were also a number of mixed infections. With the reduction in the number of reported cases, there is no clear cut trend in the parasite species *P. falciparum*, *P. vivax* and mixed infections are reported. As point of care, reliable testing for glucose-6-phosphate dehydrogenase (G6PD) deficiency is not available in the country, and the NMP administers weekly doses of primaquine over 8 weeks under DOTS for *P. vivax* infection since 2016.

For *P. falciparum* infections, the stat dose of primaquine was started at the same time. *P. ovale* and *P. malariae* have not been diagnosed in Timor-Leste.

### **1.5 National strategic plan for prevention of re-establishment of malaria 2021–2025**

The National Strategic Plan (NSP) for Prevention of Re-establishment of Malaria 2021–2025 was developed to address prevention of re-establishment of malaria transmission through specific interventions integrated into strategic approaches. Evidence-based strategies that have been proven to work well and advocated by international agencies such as WHO and incorporated into the sustainable development goals (SDGs) are adhered to wherever possible.

#### **Vision:**

A “malaria-free” Timor-Leste to enable the people of DRTL to achieve their maximum potential.

#### **Mission:**

Plan and implement a comprehensive programme to prevent re-establishment of malaria in Timor-Leste.

#### **Goal:**

To remain free of indigenous malaria.

#### **Objectives:**

- To prevent re-establishment of malaria transmission in Timor-Leste
- To maintain zero mortality due to locally acquired malaria
- To achieve WHO malaria-free certification.

#### **Guiding principles:**

- Building country ownership and leadership, and fostering partnerships between the national malaria programme and communities, other sectors (agriculture, finance, education, defence, etc.), implementing partners including nongovernmental organizations and faith-based organizations, UN agencies, developmental partners, and technical agencies to forge the elimination phase through a multi-sectoral approach
- Efforts towards prevention of re-establishment of malaria through combinations of interventions responding to local needs and adapted to country specifications
- Intensified malaria case-based surveillance and case and foci investigation are required to prevent re-establishment of malaria
- Universal access to malaria diagnosis and treatment
- Universal access to malaria prevention in vulnerable populations
- Having systems that provide real-time information that will enable early response when cases are detected
- Equity in access to services for the most vulnerable and hard-to-reach populations.

#### **Strategies:**

##### **Objective 1:**

- Provide universal access to malaria diagnostic and treatment services free of charge
- Detect all infections early and to treat all patients with quality assured antimalarials based on national treatment guidelines to ensure radical cure and prevention of secondary transmission
- Ensure all suspected cases are tested for malaria (microscopy or RDT)
- Notification of all positive infections within 24 hours
- Investigate all cases and foci within 2 days of notification

- Protect vulnerable populations
- Respond quickly to prevent indigenous transmission of malaria (including distribution of LLINs and/or IRS, larviciding and environmental manipulation and management if needed)
- Quality assurance of malaria diagnostic services
- Re-orient public and private health sector staff towards prevention of re-establishment of malaria
- Re-orient national malaria programme towards prevention of re-establishment of malaria.

**Objective 2:**

- Ensure availability of antimalarial medicines at all diagnostic and treatment facilities including injectable medicines at all hospitals and treatment centres with in-ward facilities
- Ensure availability of adequate intensive care facilities in all referral hospitals and in the National Hospital.

**Objective 3:**

- Correct deficiencies highlighted in the external review of the programme in February 2020
- Apply for 'malaria-free' certification in 2021/2022.

**Key interventions:**

- Focused, intensified surveillance and vigilance
- Case management
- Malaria prevention.

**Supporting elements:**

- Expanding research and innovation for improved delivery of services
- Strengthening the enabling environment.

The strategic approaches and key interventions of the NSP 2021–2025 have been developed considering Timor-Leste's experience accumulated over the past years in malaria elimination and prevention as well as the guiding principles of WHO Global Technical Strategy for Malaria 2016–2030 and WHO South-East Asia Regional Office (SEARO) Regional Action Plan Toward Malaria-Free South-East Asia Region.

The strategic approaches and interventions under NSP 2021–2025 are directed towards effective implementation of surveillance and response, early diagnosis and complete treatment for imported malaria cases, targeted vector control with emphasis on the degree of vulnerability and receptivity for appropriate actions. A key focus is on sustainability of the NMP by integration with other VBDC programmes. The overarching cross-cutting areas include: a) quality assurance; b) cross-border collaboration; c) information, education, communication, advocacy and community participation; d) robust health sector workforce; e) enacting and enforcing legislation; f) restructuring of the NMP; f) M&E; and g) research.

**Prioritization**

On the basis of the updated epidemiological stratification of potential malaria transmission in the country, priority is given to areas bordering West Timor that includes border areas of Bobonaro and Covalima municipalities and Oecusse municipality, which is exclave by West Timor. In West Timor, the malaria incidence is about 2–10 per 1000 population and the area is in the control phase. There is a relatively porous border and undocumented travel across the border frequently takes place. High-risk groups and

mobile populations across the border need to be identified and protected. In addition, farmers engaged in

	Stratum 1: High risk of transmission	Stratum 2: Moderate risk of transmission	Stratum 3: Low risk of transmission	Stratum 4: Very low risk of transmission
Receptivity	Yes			Minimal
Vulnerability	Extensive migration of workers, students and fisherfolk and their families from malaria endemic areas of Indonesia	Moderate migration of workers, fisherfolk and their families from malaria endemic areas of Indonesia. Refugees	No or little migration from risk areas	Very little migration
	Border with Indonesia or extensive coastal contact	No border with West Timor		
	Slash and burn cultivation in the border areas and fisherfolk visiting nearby Indonesian islands	Slash and burn cultivation	Less slash and burn cultivation	
Municipalities/areas in the stratum	Oecusse municipality, Atauro island and border sub districts/admin. posts (Bobonaro, Covalima)	Bobonaro, Covalima beyond border sub municipalities, mainland Dili Municipality, sub-districts/admin. posts of Ermera, Manufahi and Viqueque municipalities where cases were reported	Ainaro, Baucau, Liquisa and Manatuto municipalities, sub districts/admin. posts of Ermera. Manufahi and Viqueque where cases were not reported, Aileu and Lautem districts' lowland areas	Aileu and Lautem municipalities' highland areas

slash and burn agricultural practices, especially in the border areas, and migrant fisherfolk are also vulnerable to malaria.

### Programme phasing

Timor-Leste has entered the prevention of re-establishment of malaria phase. Therefore, a new definition for a suspected malaria case has been derived. The epidemiological stratification of potential malaria transmission has been updated on the basis of vulnerability and receptivity,. While universal access to malaria diagnosis and treatment will be ensured, universal access to malaria prevention will be targeted to vulnerable population, and routine IRS will be gradually phased out depending on epidemiological and entomological findings and malaria situation in West Timor. Entomological surveillance will focus on spot surveys to map receptivity in the country that will provide evidence for updating epidemiological stratification of risk areas. The NMP will be restructured in a phased manner ensuring that efforts towards the prevention of re-establishment of malaria in the country are not compromised.

### Epidemiological stratification

The country has updated epidemiological stratification of malaria risk (Table 2).

**Table 2.** Epidemiological stratification

**Source:** NSP 2021–2025, National Malaria Programme, CDC, MoH, Timor-Leste.

The country has updated definition of a suspected malaria case for different strata:

In stratum 1:

- All persons with acute febrile illness.

In other strata, persons with acute febrile illness with one or more of the following features:

- No obvious alternative cause of fever
- History of traveling to malaria endemic areas within 1 year (<http://www.who.int/malaria>)
- Known history of malaria within 3 years
- History of blood or blood products transfusion within 3 months
- Patients with hepatomegaly and/or splenomegaly
- Any individual presenting with clinical features of severe malaria (according to the National Malaria Treatment Guidelines).

During prevention of re-establishment phase, all suspected malaria cases have to be tested for malaria using RDTs. In institutions with microscopy facilities, all suspected cases should be tested using both RDTs and microscopy. Further, it is important to note the surveillance activities in different strata (Table 3).

**Table 3.** Surveillance activities in different strata

Activity	Stratum 1	Stratum 2	Stratum 3	Stratum 4	Where
Passive case detection	Activated passive case detection (all fever cases = suspected malaria)	Passive case detection based on the narrower case definition of suspected malaria case. Occurrence of a case may trigger temporary, local activated passive case detection			Public, private, faith based, armed forces and police clinics and laboratories, SISCa and other mobile clinics
Proactive case detection	Migrant workers, fisherfolk, farmers practising slash and burn agriculture in border areas, security and police officers, students	Yes, if risk groups present			In workplaces or communities of migrant workers, fisherfolk, camps and hostels
Reactive case detection	Contact tracing and mass blood survey (MBS) in a 1.5 km area around the residence of confirmed case. Three times at 14-day intervals and once per year for 3 years				Community, workplace, camps, hostels
Case and foci investigation and response	Yes				
Case and foci classification	Yes				

**Source:** NSP 2021–2025, National Malaria Programme, CDC, MoH, Timor-Leste.

## 2. Communication landscape

As social and behaviour change communication (SBCC) stems from evidence base or situation analysis, the first step to design the strategy is to understand the overall communication landscape.

BCC and community mobilization are integral parts of the current NSP 2021–2025, providing cross-cutting support to different interventions for prevention of re-establishment of malaria transmission. The BCC strategy 2015–2020 has been providing overall guidance so far for malaria control and malaria elimination. IEC/BCC materials targeting different audiences have been developed and disseminated through channel-mix, for example, orientation/sensitization/trainings of malaria service providers and health staff and

(PSF-Promotor Saude Familiar), interpersonal communication (IPC) with patients and household members, use of “edutainment” – education through entertainment during SISCa, informal group discussions with community leaders and education sessions on malaria in schools. Flip charts in local language are used during SISCa and community sessions. There are short documentary films that has been developed on malaria diagnosis, treatment, vector control and prevention for the community and for the migratory workers. PSF and SISCa are both best practices for health promotion and community mobilization during house visits and outreach activities, particularly in hard-to-reach areas. In addition, advocacy at various levels is carried out. The NMP coordinates its IEC/BCC activities with the department of health promotion and with the ministry of education for its school-based malaria education activities. Advocacy at the community level is done through sessions with local chiefs, who are recognized leaders of the organizational and administrative structure in sucos and aldeias.

The communication strategy of the programme was developed as an integral part of the NSP of Malaria Control for 2015–2020. Communication materials targeting different audiences and segments of the community were developed and disseminated through a combination of channels. Judging from the remarkable impact, the programme has, in collaboration with the health service delivery network and its partner HealthNet (in Oecusse), implemented a well-targeted and effective communication strategy, resulting in high LLIN coverage (< 90% in target areas) and utilization (< 85%) including by pregnant women (89%) and children under five (89%); as well as good health-seeking behaviour with 75% of children having been brought to a health care facility or seen by a health worker within 48 hours upon onset of symptoms and > 90% within three days of onset of fever; high level of retention and recall among women who were interviewed about malaria symptoms and means of prevention. Advocacy activities have been successful in obtaining support from the leaders of the sucos and aldeias. Advocacy activity and messages were focused on obtaining support for the on-going malaria control services and activities and not towards seeking greater political commitment for sustainability. There were some challenges and gaps, which needed improvement.

The external review mission of the NMP in 2020 made some recommendations related to IEC, advocacy and community participation as follows:

- Develop a new communication strategy in consultation with relevant partners and stakeholders; priority behaviours should include the following:
  - Maintain awareness among local leaders, health care service providers and community members about malaria prevention and control;
  - Sustain high level of LLIN ownership and use among the target populations;
  - Immediate consultation of patients with fever and travel history to endemic areas or previous history of malaria;
  - Increase political commitment and ownership by the local administrative/health leaders of malaria programme.
- Include in the communication strategy an advocacy plan to enhance partnerships with local authorities and private sectors to mobilize additional resources, especially in areas with development projects, e.g., Oecusse.
- Messages and modes of delivery need to be revised in accordance with the targeted special groups, e.g., well-designed information leaflets or brochures for distribution to special risk groups or in areas where there is limited opportunity for interpersonal communication, e.g., border posts, harbours, construction/development project sites, etc., informing the target when and where to seek consultation, how to prevent getting malaria in the areas where they are going; materials should be available in Tetun, English and Indonesian.



- Revitalize coordination with the health promotion department and existing collaboration with the department of education and explore the possibility of expanding the malaria health education sessions into vector control and environmental hygiene in the curricula of middle school.
- Provide regular updates and IEC materials for the health care service providers and use them to maintain patient's awareness regarding malaria, its prevention and control.
- Strengthen and maintain the social mobilization skills of health promotion staff of CHC, malaria staff, and other partners involved in IEC activities, especially in border areas, Oecusse and Atauro, e.g., delivery of malaria and other relevant health messages in the community during SISCa and mobile clinic activities.

In 2021, WHO Malaria Elimination Audit Tool (MEAT) was administered with scoring for programme implementation and recommendations categorized by critical elements and milestones. One of the recommendations include the development of communication strategy for prevention of re-establishment of malaria.

In 2022, a rapid needs assessment was carried out that included desk review of country profile, existing strategy, guidelines, and programme review reports. In addition, the rapid assessment methodology included the following:

- Interactions with: Communicable Disease Control-CDC (MoH), national malaria programme (national and selected municipalities), Departments of Health Promotion, Environmental Health of the Ministry of Health, Government of Timor-Leste
- Interactions with the technical partner WHO
- Stakeholder consultation
- Visit to border areas of Bobonaro district and interactions with local Port Health Staff, Security Force.

This rapid assessment at the beginning of SBCC strategic design noted the following salient particulars:

- As malaria is not detected in most areas in the country, there is urgent need to maintain awareness among risk groups as well as community at large, with special emphasis in municipalities bordering Indonesia.
- Advocacy for and coordination with political leaders, decision-makers, community leaders, municipalities, corporate and non-health sectors are variable. Robust advocacy starting at the highest political level to sub-district and community level is priority.
- Partner and donor advocacy needs emphasis.
- Communication messages and channel-mix will need to be tailored to the context/risk groups.
- Communication will need to target primary, secondary and tertiary audiences for appropriate behaviour.
- All points of entry in border areas need to display banners/glow signs, stickers, etc. mentioning about "entry to malaria-free Timor-Leste" and the need for travellers to report fever for early diagnosis (within 24 hours of onset of fever) and prompt and complete treatment, and appropriate response.
- Equitable services, especially for the risk groups, need to be stressed.
- Coordination with other health departments (e.g., health promotion, environmental health, reproductive, maternal, new-born, child and adolescent health (RMNCAH)) needs to be reinforced.
- Coordination with non-health ministries/departments, e.g., education, needs to be revived for incorporating messages on malaria (and other VBDs) in school curricula

targeting children as change agents. Teachers will need to be oriented for disseminating information to children/others.

- Early diagnosis and prompt, complete treatment need to be continued priorities.
- Daily and correct use of LLIN need to be emphasized, where those are distributed.
- Acceptance of IRS and LSM need to be promoted, where targeted.
- Empowered participation is variable. Involvement of communities is needed in planning, implementation, as well as monitoring.
- All community leaders, as well as community level care providers and health facilities need to be sensitized regularly on early and correct diagnosis, case management, treatment compliance, prevention measures (PSF, Saude na Familia, HP, CHC, hospital).
- Qualified practitioners in private sector need to be trained on national treatment protocol.
- Over the counter medication, treatment from drug stores, traditional birth attendants, faith healers, and informal private sector need to be discouraged.
- Knowledge and awareness are essential and should be maintained, and persistent emphasis should be on getting people to act based on what they know within their contexts.
- While information dissemination and awareness on prevention, diagnosis and treatment are extremely desirable and enhanced over the years, evidence-based and context-specific SBCC activities/campaigns towards maintaining responsive behaviour need to be prioritized.
- Specific campaigns for risk and vulnerable groups need to be optimized.
- Communication strategy for prevention of re-establishment of malaria is needed.
- IEC/BCC tools, materials need to be tailored to address language barriers and rights/gender/socio-cultural inequities.
- Monitoring of BCC, advocacy and community mobilization efforts is not yet optimal and needs to be improved.
- Impact of BCC, advocacy and community mobilization needs to be evaluated periodically to redesign campaigns/activities for achieving behavioural objectives and overall programme goals.
- As integrated VBD control programme is rolled out, harmonized communication approaches need to be considered as appropriate. Potentials for integrated/harmonized activities and campaigns with other relevant programme need to be explored, especially in view of resource efficiencies.

Drawing on the above, salient enabling factors for SBCC include the following:

- High-level commitments for malaria elimination and pursuit of WHO certification of malaria-free Timor-Leste.
- The NSP for prevention of re-establishment of malaria transmission 2021–2025 is in place and recognizes BCC, community participation and advocacy as integral supporting elements in prevention of re-establishment phase.
- Community awareness on malaria, prevention and treatment measures have progressively enhanced although needs to be persistently reinforced and maintained.
- Capacities of service providers have been continually strengthened, though needs to be sustained, especially in view of a few/nil malaria cases.
- Partnership coordination between departments and sectors has improved, though needs to be optimized.

### 3. Social and Behaviour Change Communication (SBCC)

In public health and overall development domain, multifarious activities often emphasize on information dissemination towards enhanced knowledge and awareness, and encouraging individuals, families and communities to act. While the need for updates and optimal knowledge and awareness remains critical, especially when new technologies/tools/strategic approaches are rolled out, the bigger challenge is to encourage people to “act” based on what they know. Further, people do not change their behaviour all of a sudden and stay the “changed” way from that moment. Instead, people’s behaviour gradually moves through subtle stages of change: from becoming aware to becoming informed, then becoming convinced, followed by the decision to act, then the actual taking of relevant action the first time, then repeating the same, and finally maintaining that action continuously (Table 4).

**Table 4.** Behaviour adoption

First, we Then, we become And later	<b>H</b> ear about the new behaviour <b>I</b> nformed about it <b>C</b> onvinced that it is worthwhile
In time, We make the And later we take We next await and if all is well, we	<b>D</b> ecision to do something about our conviction <b>A</b> ction on the new behaviour <b>R</b> e-confirmation that our action was good <b>M</b> aintain the behaviour!

Source: Parks W. and Lloyd L.<sup>3</sup>

The "Stages of Change (Transtheoretical) Mode" indicate that as a person attempts to change a behaviour, he or she moves through five stages: precontemplation, contemplation, preparation, action, and maintenance (Table 5). People at different points along this continuum have different informational needs, and benefit from interventions designed for their stage. The model’s basic premise is that behaviour change is a process, not an event.<sup>4</sup>

**Table 5.** Stages of change model

Stage	Definition	Potential change strategies
Precontemplation	Has no intention of taking action within the next 6 months	Increase awareness of need for change; personalize information about risks and benefits
Contemplation	Intends to take action in the next 6 months	Motivate; encourage making specific plans
Preparation	Intends to take action within the next 30 days and has taken some behavioural steps in this direction	Assist with developing and implementing concrete action plans; help set gradual goals
Action	Has changed behaviour for less than 6 months	Assist with feedback, problem solving, social support, and reinforcement
Maintenance	Has changed behaviour for more than 6 months	Assist with coping, reminders, finding alternatives, avoiding slips/relapses (as applicable)

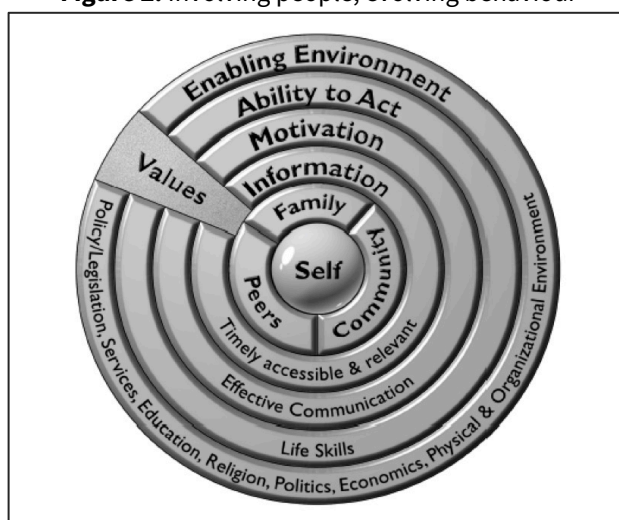
<sup>3</sup> Parks W., Lloyd L. Planning social mobilization and communication for dengue fever prevention and control: a step-by-step guide. WHO, Geneva 2004 (WHO/CDS/WMC/2004.2 and TDR/STR/SEB/DEN/04.1).

<sup>4</sup> Theory at a glance. a guide for health promotion practice (2nd edition). National Cancer Institute. NIH Publication No. 05-3896. 2005.

**Source:** Prochaska JO, DiClemente CC. Stages and processes of self-change of smoking: Toward an integrative model of change. *J Consult Clin Psychol.* 1983; 51(3): 390–395 (accessed from: Theory at a glance. a guide for health promotion practice (2nd edition). National Cancer Institute. NIH Publication No. 05-3896. 2005).

Changing people's behaviour is a highly complex activity, with goals/objectives often remaining elusive in spite of the best efforts. Many campaigns succeed in raising awareness about a particular issue, while failing, at the same time, to bring about the sustained behaviour change. Once motivated with information and awareness about a new practice, people need to learn and master new skills to enable them to apply it. At the same time their environment needs to evolve in such a way that they are encouraged to practise their new skills and knowledge. Campaigns must aim to reach beyond the individuals to include the people, who influence the individuals and their behaviour. Underpinning these personal and communal decisions are the values that lie at the core of the community and remain reference points to filter new information, learn new skills, discard old practices and beliefs, evolve the environment, and decide upon action. This integrated approach towards involving people in evolving behaviour is summarized in Fig. 2.<sup>5</sup>

**Figure 2.** Involving people, evolving behaviour



Source: McKee et al., 2000.

Communication for development and social change, development communication, communication for behaviour and social change, and communication for behavioural impact are defined as research-based, consultative process of addressing knowledge, attitudes, and practices. They are done through identifying, analysing and segmenting audiences and participants in programmes, and by providing them with relevant information and motivation through well-defined strategies using an appropriate mix of interpersonal, group and mass media channels, including participatory methods (McKee et al., 2002). Apart from individual/family/community behaviour change, an “enabling” environment, i.e., one that supports new or appropriate behaviours – perhaps by providing improved services, better housing/infrastructure construction techniques or superior policies and more effective legislation – is also imperative.<sup>6</sup>

Many approaches, conceptual frameworks of behaviour and behaviour change exist. Most of them focus on logical progress from assessment/analysis, strategic design, development and testing, implementation/action, and M&E, and back to planning for continuity with relevant intermediate steps. The WHO Communication for Behavioural Impact (COMBI) is an approach that refers to “...the task of mobilizing all societal and personal influences on an individual and family to (ensure) prompt individual and family action.”<sup>7</sup> COMBI focuses on, and is informed by, behavioural outcomes that are made explicit,

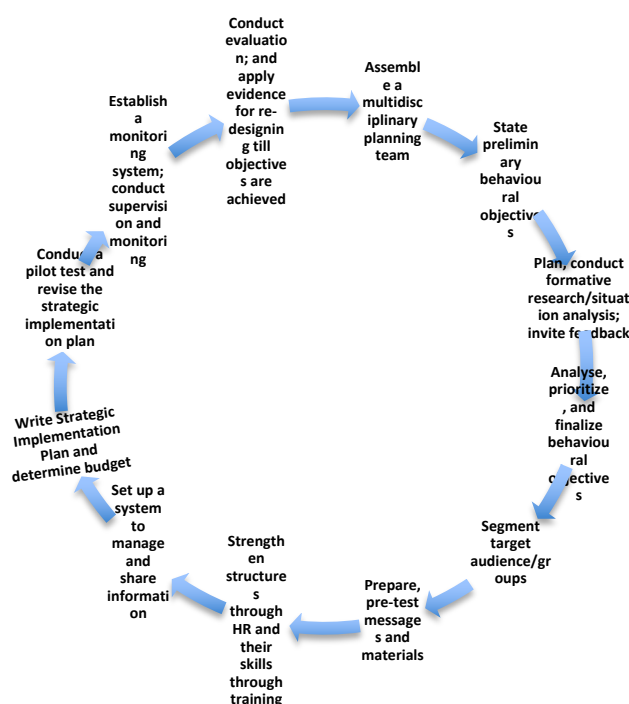
<sup>5</sup> Socio-ecological model for change. Neill McKee, Erma Manoncourt, Chin Saik Yoon, Rachel Carnegie. ed. 2000. Involving people, evolving behaviour. Co-published by Southbound, Penang and UNICEF, New York .

<sup>6</sup> Halstead S. Successes and failures in dengue control—global experience. *Dengue Bull.* 2000; 24.

<sup>7</sup> World Health Organization. 2004. Mobilizing for action: communication-for-behavioural-impact (COMBI).

while health education and promotion may be dedicated to behavioural outcomes stated implicitly (Fig. 3).<sup>8</sup> Its premise is that while knowledge of effective tools and technologies, availability of services, etc. need to be introduced or reinforced, that alone is not enough, since knowing what to do is in reality different from doing or adopting appropriate activities without the necessary motivation and an enabling environment. In other words, an informed and educated individual is not necessarily a behaviourally responsive one. COMBI's process blends strategically a variety of communication interventions intended to engage individuals and families in considering recommended healthy behaviours and to encourage the adoption and maintenance of those behaviours.<sup>9</sup> It entails purposive and tailor-made strategic communication solutions intended to engage a specific target audience to translate information into responsive action and integrate it with advocacy and social mobilization initiatives to create an enabling environment. It is also imperative to use participatory methods to include people in designing and implementation, and evaluation can be a productive way to start understanding the motivational gaps and barriers<sup>10</sup> and ensuring sustainability, which are integral to COMBI planning and implementation as well.

**Figure 3.** Communication model – COMBI



Source: Parks, Will, Lloyd, Linda & UNDP/World Bank/WHO Special Programme for Research and Training in Tropical Diseases. (2004). Planning social mobilization and communication for dengue fever prevention and control: a step-by-step guide/ Will Parks and Linda Lloyd. World Health Organization. <https://apps.who.int/iris/handle/10665/42832>

It is important to note that IEC programmes have been providing knowledge to enable individuals, families, and communities to play active roles in achieving, protecting and sustaining their own health. IEC can range from didactic one-way communication to entertaining methods. It can utilize a wide range of

<sup>8</sup> <http://www.k4health.org/sites/default/files/COMBI.pdf>

<sup>9</sup> [http://www.cominit.com/pdf/Combi4-pager\\_Nov\\_14.pdf](http://www.cominit.com/pdf/Combi4-pager_Nov_14.pdf)

<sup>10</sup> *ibid.*

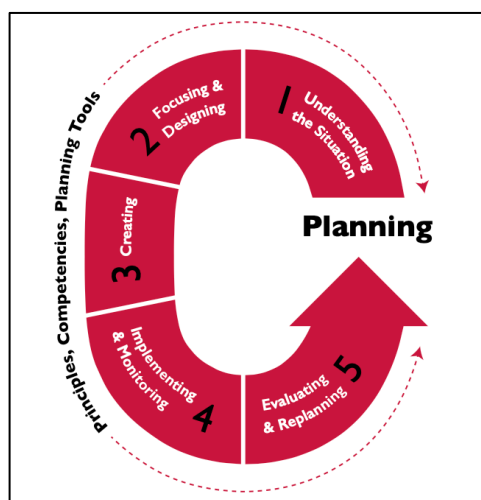
<sup>10</sup> A classification derived by a literature review by Mefalopulos (2003) includes (1) passive participation, when stakeholders attend meetings to be informed; (2) participation by consultation, when stakeholders are consulted but the decision-making rests in the hands of the experts; (3) functional participation, when stakeholders are allowed to have some input, although not necessarily from the beginning of the process and not in equal partnership; and (4) empowered participation, when relevant stakeholders take part throughout the whole cycle of the development initiative and have an equal influence on the decision-making process. Cited from: Mefalopulos, P. Development Communication Source Book: Broadening the boundaries of communication. 2008. World Bank. <http://siteresources.worldbank.org/EXTDEVCOMMENG/Resources/DevelopmentCommSourcebook.pdf>

media channels and materials. Fundamentally, the IEC approach assumes that people will follow health advice when they are provided with the "right" information.<sup>11</sup>

BCC intends to foster necessary actions in the home, community, health facility or society that improve health outcomes by promoting healthy lifestyles or preventing and limiting the impact of health problems using an appropriate mix of interpersonal, group and mass media channels. Maintaining social marketing focus, effective communication strategies rely on formative research with beneficiaries to understand the context, the issue from their perspective, and factors that influence improved practices.<sup>12</sup> In other words, BCC has a focus on individual/family/community and even care providers' behaviours to be changed, aligned with approaches; and has employed wider range of interventions beyond knowledge transfer as well as for greater dialogue and ownership. It has allowed for translation of information into responsive action drawing from behaviour/barrier/need analysis within an enabling environment resulting in desired behavioural outcomes and impact. BCC has been emphasizing analysis of behaviours and their determinants (or underlying causes) as the basis for strategies, approaches, and messaging.

In recent times, more emphasis is being given on paradigm shift from BCC to SBCC by many health/disease control/disease elimination programmes/development sector. SBCC is a research-based, consultative process that uses communication to promote and facilitate behaviour change and support the requisite social change for the purpose of improving health outcomes. It works at one or more levels: the behaviour or action of an individual, collective actions taken by groups, social and cultural structures, and the enabling environment.

SBCC approach is advanced by the USAID-funded C-Change Project, which created "C-Modules – A Learning Package for Social and Behavior Change Communication", to change individual behaviours and social norms. SBCC uses a systematic planning process that is evidence-based and grounded in social and behavioural theory (Fig. 4). The process starts with understanding the problem through a situation and target audience analysis followed by selecting and defining target audience(s) and desired behaviours; designing the SBCC strategy and interventions; creating messages, materials, and dissemination plan; implementing and monitoring; and evaluating and replanning for improved outcomes and sustainability.<sup>13</sup>



**Figure 4.** SBCC using planned process

Source: <https://www.usaidrdw.org/resources/tools/sbcc-guidebook> (Figure adapted from C-Modules: A Learning Package for Social and Behavior Change Communication <https://www.fhi360.org/resource/c-modules-learning-package-social-and-behavior-change-communication>)

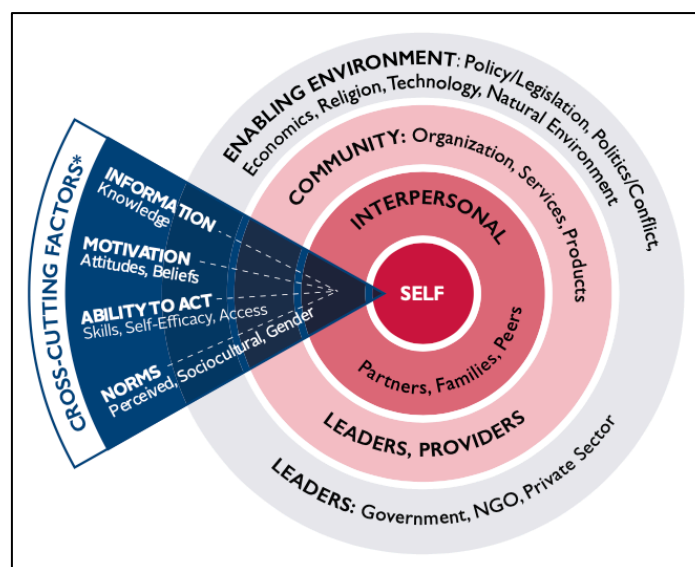
<sup>11</sup> <https://www.comminit.com/polio/content/defining-social-and-behavior-change-communication-sbcc-and-other-essential-health-commun>

<sup>12</sup> Ibid.

<sup>13</sup> <https://www.usaidrdw.org/resources/tools/sbcc-guidebook>



SBCC applies a socio-ecological model (SEM) that recognizes the relationship between people and their environment to identify “tipping points” to change individual behaviours and social norms (Fig. 5). With the self at the centre, the levels and analysis of influence for tipping for change include: interpersonal (partners, families, peers) and community levels (organization, services, products, leaders and providers). An enabling environment is crucial (policy/legislation, politics/conflict, economics, religion, technology, natural environment, leaders of government, NGOs and private sector), besides cross-cutting factors (determinants of behaviours) applicable at all levels of analysis and influence. These cross-cutting factors motivate behaviours of all “actors” within each level and include knowledge, perceptions, attitudes, beliefs, skills, social norms and gender roles, among others.<sup>14</sup> The SEM draws on synthesis of theories and approaches that helps in situation analysis and strategy development.<sup>15</sup>



**Figure 5.** SBCC using socio-ecological model

Source: <https://www.usaidrdw.org//resources/tools/sbcc-guidebook> (Figure adapted from C-Modules: A Learning Package for Social and Behavior Change Communication.  
<https://www.fhi360.org/resource/c-modules-learning-package-social-and-behavior-change-communication>)

The addition of an “S” to BCC intends to signify that individuals and their immediate social relationships are dependent on the larger structural and environmental systems: gender, power, culture, community, organisation, political and economic environments. SBCC explicitly encompasses social change perspectives that foster processes of community dialogue and action. Its core elements include: communication using channels and themes that fit an intended audience’s needs and preferences; behaviour change through efforts to make specific health actions easier, feasible, and closer to an ideal that will protect or improve health outcomes; and social change to achieve shifts in the definition of an issue, people’s participation and engagement, policies, and gender norms and relations. SBCC can achieve change as a separate intervention, but usually it is part of a comprehensive change strategy that includes multiple interventions, including communication.<sup>16</sup>

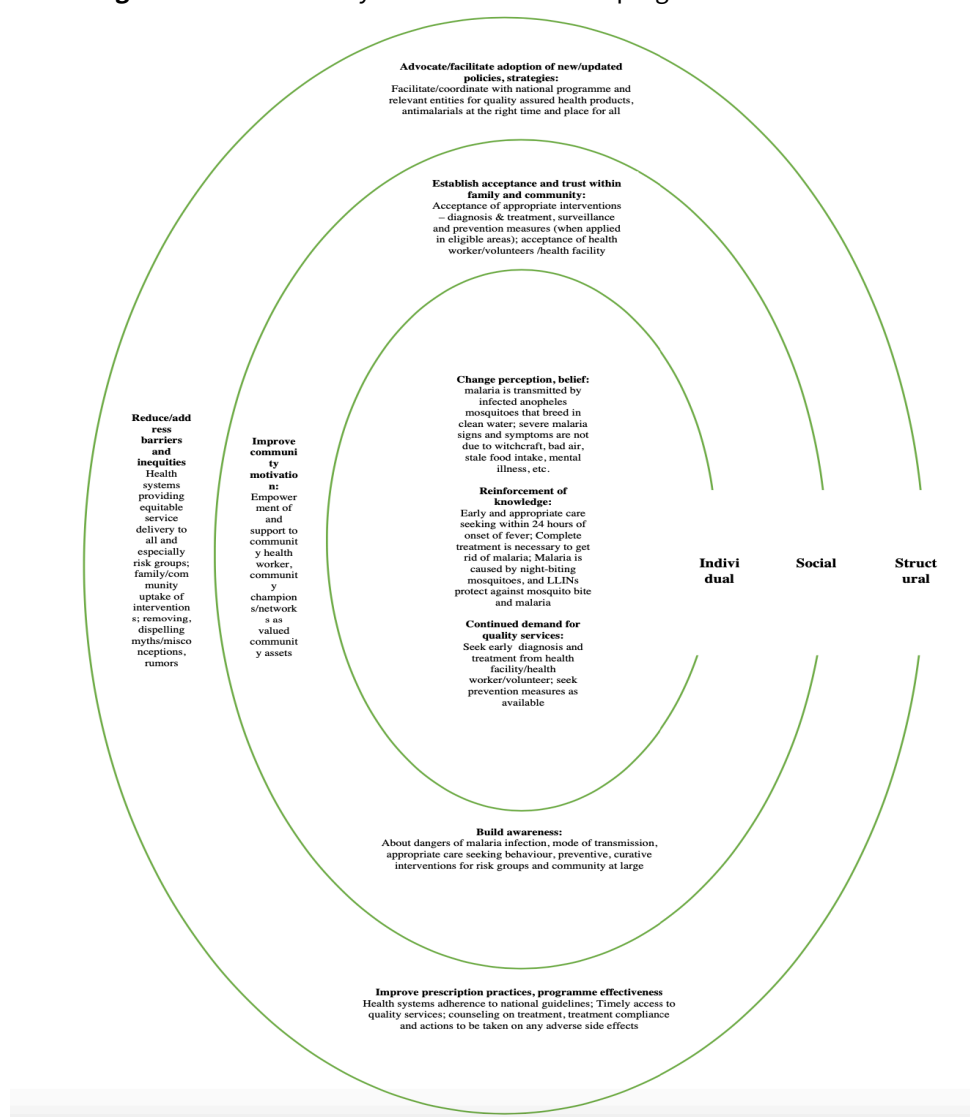
<sup>14</sup> <https://www.usaidrdw.org//resources/tools/sbcc-guidebook>

<sup>15</sup> C-Modules: a learning package for social and behavior change communication (SBCC). practitioner’s handbook. communication for change (C-Change) Project managed by FHI 360 and supported by USAID. Version 3. 2012

<sup>16</sup> <https://www.cominit.com/polio/content/defining-social-and-behavior-change-communication-sbcc-and-other-essential-health-commun>

Social and behaviour change discipline uses deep understanding of human and societal behaviour to design evidence-based interventions in order to increase the adoption of healthy behaviours by individuals and influence the gender and social norms that underpin those behaviours. It uses a range of approaches including communication-based approaches (e.g., mass and social media, community-level programming, and interpersonal communication) and non-communication-based approaches informed by behavioural economics and human-centred design to affect change. Research consistently shows evidence-based social and behaviour change programmes can increase knowledge, shift attitudes and norms and produce changes in a wide variety of behaviours. They have proven effective in several health areas, such as increasing the uptake of family planning methods, condom use for HIV prevention, and care-seeking for malaria.<sup>17</sup> Among others, a malaria SBCC literature review provided evidence and trends on which SBCC strategic approaches, interventions and channels were most likely to lead to change in malaria prevention and treatment behaviours, though more work was needed to ensure that best practices were documented and used consistently.<sup>18</sup>

**Figure 6.** Illustrative ways SBCC contributes to programme effectiveness



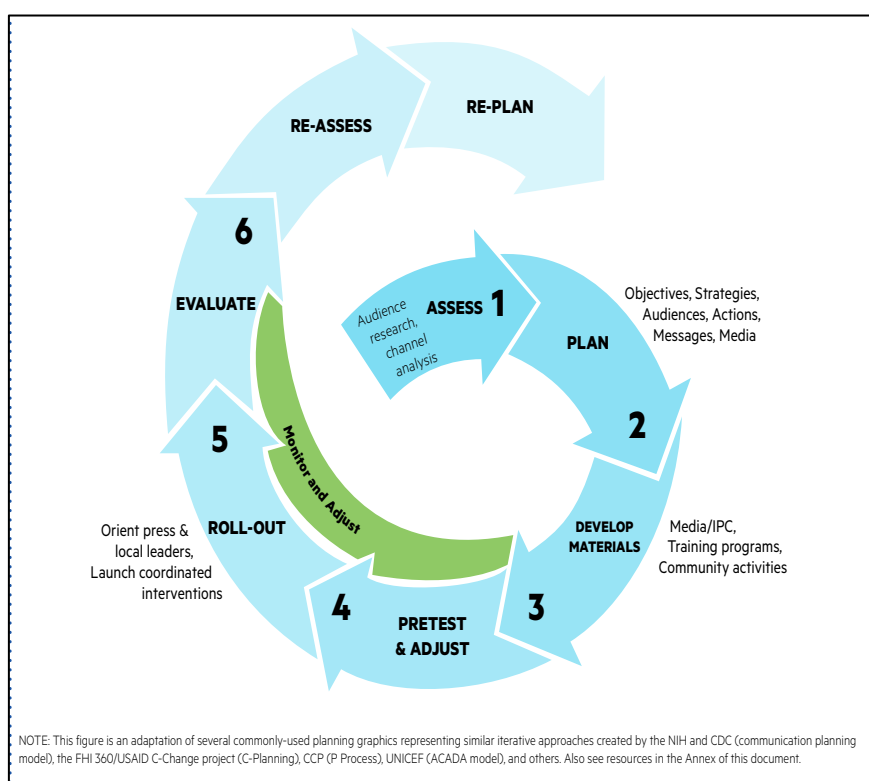
**Source:** The RBM Partnership to End Malaria (2018). The strategic framework for malaria social and behavior change communication 2018–2030. <https://d1u4sg1s9ptc4z.cloudfront.net/uploads/2021/03/framework-for-malaria-social-and-behavior-change-communication-2018-2030-english-2.pdf>

<sup>17</sup> <https://behaviorchangeimpact.org/>

<sup>18</sup> The Health Communication Capacity Collaborative (HC3). (2017). *Malaria SBCC evidence literature review*. Baltimore, Maryland: Johns Hopkins Center for Communication Programs.

The RBM Partnership to End Malaria (RBM Partnership) explains that SBCC is an evidence-based and theory-informed systematic process of identifying, analysing, and segmenting target audiences. There are a number of ways SBCC can contribute to malaria elimination programmes at different times and to varying degrees (Fig. 6). These contributions can be seen as underlying changes in critical groups that are planned to ultimately improve specific prevention and treatment behaviours. These outcomes in turn have an impact on malaria morbidity and mortality. Behaviour maintenance, rather than one-time trial or intermittent practice by all priority groups, is the overarching goal, so that perceptions of “what others are doing” and “what is the right thing to do” eventually become powerful motivators in themselves. Effective SBCC strategies contribute to these shifts in social norms.<sup>19</sup>

**Figure 7. SBCC planning process**



**Source:** The RBM Partnership to End Malaria (2018). The strategic framework for malaria social and behavior change communication 2018–2030. <https://d1u4sg1s9ptc4z.cloudfront.net/uploads/2021/03/framework-for-malaria-social-and-behavior-change-communication-2018-2030-english-2.pdf>

As mentioned earlier, the SBCC is evidence-based process building on target audience research to understand the target audience’s beliefs, preferences, constraints, motivations and current behaviours; pretest concepts and materials; monitor processes after programme launch and throughout the programme; and evaluate impact and analyse the reasons strategies have succeeded or failed using qualitative and quantitative methods—such as focus group discussions (FGDs) and knowledge, attitude and practice surveys, respectively. The process is as “iterative” because adjustments are made throughout the stages of the programme.

A “summative evaluation” measures behavioural outcomes against baseline indicators (when possible) and also serves as the basis for revising strategies and launching a subsequent programme stage.<sup>20</sup> Fig. 7

<sup>19</sup> <https://endmalaria.org/sites/default/files/RBM%20SBCC%20Framework%202018-2030%20English.pdf>

<sup>20</sup> The RBM Partnership to End Malaria (2018). The Strategic Framework for Malaria Social and Behavior Change Communication 2018–2030.

presents the systematic and iterative SBCC planning process adapted from several commonly used planning graphics created by the NIH and CDC (communication group model), the FHI 360/USAID C-Change project (C-Planning), CCP (P Process), UNICEF (ACADA model), and others.<sup>21</sup>

#### **4. Social and behaviour change communication strategy 2021–2025**

The NSP 2021–2025 recognizes BCC, community participation and advocacy as integral supporting elements in prevention of re-establishment phase. Accordingly, a SBCC strategy is deemed important. The strategy draws on relevant theories, evidence, understanding the need for context-specific activities/campaigns towards maintaining responsive behaviour as well as available guidance/resources. Prime focus is to employ a blend of advocacy, communication and social mobilization approaches guiding the planning, implementation and M&E of multifaceted activities that are coordinated within the programme and MoH as well as across partners. SBCC strategy will facilitate understanding the prevention of re-establishment contexts and environments in which desired behaviour change is expected and to be maintained at individual/community/societal levels. It will emphasize on identifying and deconstructing the myths and misconceptions (if any) and provide complete and correct information. Relevant information is used for target audience through appropriate local- and context-specific mix of inter-personal, group, mid-media and mass media channels, including participatory methods and creating/sustaining an enabling environment for the purpose.

The NMP has been, and is, responsible for planning, implementation and M&E of BCC activities so far, with major external funding from the Global Fund. From 2023 onwards, funding for NMP in Timor-Leste will transition from the Global Fund. Domestic resources will be invested to support the end game in terms of maintaining zero indigenous/local transmission and zero mortality throughout the country and maintaining the same status in the current prevention of re-establishment phase as well as apply and receive WHO certification.

Furthermore, the country is aiming at fulfilling the country commitments for achievement of SDGs and malaria elimination. Towards that end, and on account of above-mentioned transitioning from external to domestic financing, integration of malaria services with other VBD control programmes such as Dengue Control Programme and Lymphatic Filariasis Elimination Programme under the overall aegis of the MoH is envisaged. The prevention of re-establishment of malaria transmission phase is to be implemented in coordination with relevant departments/units and service delivery will be integrated under the overall general health system.

This strategy document is developed by the NMP in consultation with relevant departments of MoH, and stakeholders and partners and with technical support by WHO and funding support by the Global Fund in alignment with NSP 2021–2025. Relevant guidance available from WHO, RBM Partnership, the Global Fund, USAID, other partners, as well as other relevant sources were referred to.

At this juncture, while this strategy is primarily focused on supporting prevention of re-establishment of malaria transmission phase aligned with NSP 2021–2025, harmonization and integration of SBCC activities with other VBD programmes is envisaged as an integrated VBD control strategy to be developed and rolled out. An operational guideline drawing on this strategy as well as updated programme strategy guideline are envisaged.

##### **4.1 Purpose**

The SBCC strategy will complement the NSP 2021–2025 to promote, improve and sustain malaria desired behaviours related to prevention, case management, surveillance and response interventions through prevention of re-establishment phase. The strategy hinges on the SBCC outcomes expected among target

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<sup>21</sup> <https://endmalaria.org/sites/default/files/RBM%20SBCC%20Framework%202018-2030%20English.pdf>

audience and stakeholder/partner/donor.

The SBCC strategy will remain a living document. It will be revisited and updated as an integrated VBD control strategy is rolled out and/or when the current NSP 2021–2025 is updated/re-aligned because of any change in malaria/country contexts and/or malaria elimination certification process.

## **4.2 Guiding principles**

- Branding of malaria-free Timor-Leste as a regional, global example
- SBCC will be evidence-based drawing on understanding situation, needs of individuals, families, communities, and care providers; motivations and influences
- SBCC will be theory-based adapted to the local context regarding how change occurs
- SBCC objectives will align with NSP 2021–2025 objectives; and emphasize systematic planning and implementation
- SBCC will focus on correct information, responsive behaviour by risk groups, communities and simultaneously improve service delivery by care providers
- SBCC will synergize quality advocacy, BCC, community mobilization for reinforcing/maintaining knowledge and awareness, responsive behaviour, ownership, and strengthening an enabling environment through identifying/sensitizing advocates/change agents
- SBCC will be repetitive, intense and persistent using context-specific channel-mix, especially prioritizing areas fraught with receptivity and vulnerability, and targeting risk groups to be supported by necessary and tailored interventions for prevention of re-establishment
- SBCC will focus on desired coverage aligned with target audience segmentation based on epidemiological, demographic details as well as socio-economic, behavioural information and analysis of vulnerabilities, barriers and inequities; and also refer to the systematic attempt to influence behaviour/attitudes, or practices and environmental factors related to that behaviour, which indirectly or directly influence prevention of re-establishment through messages, dialogue, and persuasion
- SBCC will develop and strengthen capacities (trained leadership and staff within the NMP/MoH) on how to plan/implement evidence-informed advocacy, communication, and community mobilization
- SBCC will prioritize participatory approaches to foster ownership, self-monitoring and ensure sustainable end results; and will stress on coordination and harmonization of efforts by stakeholders/partners/donors
- SBCC will give due consideration to the lessons from COVID-19 pandemic as well as other relevant disease/health programmes
- SBCC will emphasize strengthened M&E, and use of indicators related particularly to outcomes/impacts
- SBCC documentation of lessons learned and best practices, i.e., what worked and what did not, will be imperative to inform planners and decision-makers
- SBCC will use mutually reinforcing activities and materials and be cost-effective; and ensure designing and dissemination of a comprehensive package with consistency and quality control as essential elements
- SBCC will need support in terms of availability of and accessibility to quality assured products/medicines and service delivery as pre-requisites; and consolidate commitments by necessary resource mobilisation/allocation.

## **4.3 Goal and objectives**

The overall goal and objectives of this strategy are same as in the NSP 2021–2025. However, the strategy is intended specifically to support the attainment of following objectives to support case management,

prevention and surveillance, and as well as increased country commitments and partnerships for strengthening of an enabling environment

**Goal:** Malaria-free Timor-Leste with no indigenous malaria.

Accordingly, the SBCC objectives to be pursued are:

- Through 2025, 95% of targeted population maintain awareness about malaria, signs, symptoms, mode of transmission, prevention, diagnosis and treatment, service delivery points
- Through 2025, 100% of public sector and others (security forces), CBOs, and 95% of targeted private sector remain oriented on case management according to national guidelines
- Through 2025, 100% of suspected malaria patients at all points of entry, public sector health facility/care provider (PSF/HP/CHC/Hospital, as applicable) or listed CBO and the private sector site receive a parasitological test (microscopy or RDT)
- Through 2025, 100% of suspected malaria patients report immediately (within 24 hours of onset of fever) to a public sector health facility/care provider (PSF/HP/CHC/Hospital, as applicable) or listed CBO and the private sector site, who are oriented on national guidelines
- Through 2025, 100% of confirmed malaria cases receive effective treatment according to national guidelines within 24 hours of confirmation of diagnosis
- Through 2025, 100% of confirmed malaria cases complete treatment according to national guidelines
- Through 2025, 95% population in target areas, especially risk groups, continue to recognize LLIN as effective personal protection tool and sleep under LLIN (in areas when LLINs are distributed)
- Through 2025, 95% households in target areas accepting IRS (in areas when IRS is conducted)
- Through 2025, 100% of villages in the target areas eliminating identified vector-breeding places
- Through 2025, 95% households/villages practice cleanliness
- Through 2025, political commitment is sustained and sufficient and sustained resources (domestic/external) are mobilized for prevention of re-establishment phase
- Through 2025, multi-sector partnerships and collaborations continue to be pursued
- Through 2025, media support and foster malaria-free Timor-Leste and prevention of re-establishment of malaria transmission
- Through 2025, 90% of community leaders supporting programme interventions in targeted areas.

The rationale for selection of behavioural objectives remains SMART (Specific, Measurable, Appropriate, Realistic, Time bound):

Specific – Who or what is the focus; what change(s) are intended

Measurable – Specified quantum--% change expected

Appropriate – Based on target needs and aimed at specific benefits

Realistic – Can be reasonably achieved

Time bound – Specific time period to realize behaviour objectives.

Expected outcomes:

- Optimized maintenance of awareness of symptoms of malaria, signs, mode of transmission, prevention, diagnosis and treatment and service delivery points among target audience

- Optimized health seeking behaviour for early diagnosis (within 24 hours of onset of fever) and prompt, complete treatment supported by equitable access to quality-assured diagnosis and treatment according to national guidelines
- Capacitated and motivated health systems – public sector and others (security forces), CBOs, private sector – providing quality service delivery according to national guidelines
- Optimized treatment compliance by malaria cases according to national guidelines
- Optimized access to and utilization of effective personal protection tools, i.e., LLINs in targeted areas, especially by risk groups
- Optimized participation by families, individuals at the time of focal responses
- Harmonized partnerships and collaborations with special emphasis on standardized services, resources mobilization and their efficient utilisation
- Strengthened enabling environment for sustaining prevention of re-establishment phase involving elected representatives, administrators, community leaders, partners, donors and various stakeholders.

#### 4.4 Target audience segmentation

Target audience segmentation, i.e., to whom the messages will be targeted, is a critical element of communication strategy. Target audience will include the following population groups:

- Migrant population groups (migrant worker/labour, students/teachers and their families, especially from malaria-endemic areas of Indonesia)
- Family/individual (including those constituting high-risk groups like pregnant women and children under five years)
- Slash and burn cultivators, their families, and community in the border areas
- Fisherfolk, their families, and community visiting nearby Indonesian islands
- Community leaders and public networks
- Health workforce, especially at border health posts, any other public sector health facilities/PSF/SnF
- Security workforce
- Pregnant women
- Blood donors
- NGOs/FBOs/private sector
- Political representatives
- Media
- Administration
- Partner/Donor
- Internally displaced persons (IDP), refugees.

The target audience is often disaggregated as primary, secondary, and tertiary categories, though such categorization is sometimes inter-changeable. An outline of target audience segmentation is presented in Table 6.

**Table 6.** Outline of target audience segmentation

Audience	Description
Primary audience:1	<p>In stratum 1, with high risk of transmission: in Oecusse municipality, Atauro island and border sub districts/administrative posts (Bobonaro, Covalima) with extensive migration (border with Indonesia or extensive coastal contact). SBCC will need to continue in this stratum for individual, families, and community at large in areas with receptivity and vulnerability to whom communication is targeted and among whom responsive behaviour is expected and with special emphasis on following population groups:</p> <ul style="list-style-type: none"> <li>• Migrant workers and their families</li> <li>• Students/teachers and their families from Timor-Leste and Indonesia</li> </ul>

Audience	Description
	<ul style="list-style-type: none"> <li>• Slash and burn cultivators, their families</li> <li>• Individual/family/community in border areas</li> <li>• Fisherfolk, their families, visiting nearby Indonesian islands</li> <li>• Pregnant women</li> <li>• Blood donors</li> <li>• Internally displaced persons/refugees</li> <li>• Community leaders</li> <li>• Health workforce</li> <li>• Security workforce.</li> </ul> <p>[The level of malaria risk for each of these groups is dependent on a number of location-specific factors, including degree of receptivity, vulnerability, accessibility to and strength of health system services besides socio-economic factors, and accordingly prioritization may be needed]. [Same groups may constitute secondary audience depending on the target behaviour, messages].</p>
Primary audience: 2	<p>In stratum 2, with moderate risk of transmission (and no border with West Timor): Bobonaro, Covalima beyond border sub municipalities, mainland Dili municipality, sub districts/administrative post of Ermera, Manufahi and Viqueque Municipalities where cases were reported with moderate migration.</p> <p>In this stratum too, special emphasis will be on population groups in areas with receptivity and moderate vulnerability to whom communication is targeted and among whom responsive behaviour is expected, such as:</p> <ul style="list-style-type: none"> <li>• Migrant workers and their families</li> <li>• Students/teachers and their families from Timor-Leste and Indonesia</li> <li>• Slash and burn cultivators, their families</li> <li>• Individual/family/community in border areas</li> <li>• Fisherfolk, their families, visiting nearby Indonesian islands</li> <li>• Pregnant women</li> <li>• Blood donors</li> <li>• Internally displaced persons/refugees</li> <li>• Community leaders</li> <li>• Health workforce</li> <li>• Security workforce</li> </ul> <p>[The level of malaria risk for each of these groups is dependent on a number of location-specific factors, including degree of receptivity, vulnerability, accessibility to and strength of health system services besides socio-economic factors, and accordingly prioritization may be needed]. [Same groups may constitute secondary audience depending on the target behaviour, messages].</p>
Primary audience: 3	<p>In stratum 3 with low risk of migration and with no or little migration from risk areas (and no border with West Timor): Ainaro, Baucau, Liquisa and Manatuto municipalities, sub districts/administrative post of Ermera, Manufahi and Viqueque where cases were not reported, Aileu and Lautem districts lowland areas.</p> <p>In view of receptivity, communication will need to be targeted for community at large and health workforce, among whom responsive behaviour is expected to be maintained.</p>
Primary audience: 4	<p>In stratum 4 with very low risk of transmission and minimal receptivity and with no border with West Timor, viz., Aileu and Lautem municipalities highland areas, SBCC activities will also be continued for community at large and health workforce, among whom responsive behaviour is expected to be maintained.</p>
Secondary audience	<p>People who directly relate to the primary audience through frequent contact and who may either influence or impede behaviour change among the primary audience. SBCC will target these people directly for expected changes in the primary audience.</p> <ul style="list-style-type: none"> <li>• Leaders/influencers at national, district, village levels (including village heads/chief, community leaders, religious leaders, NGOs, FBOs, support groups)</li> <li>• Private sector health care service providers (formal, informal including pharmacies)</li> </ul>



<b>Audience</b>	<b>Description</b>
	and other sellers of drugs, traditional healers, birth attendants. [Same groups may constitute the primary/tertiary audience depending on the target behaviour, messages].
Tertiary audience	People, groups, individuals, institutions, who may either influence or impede behaviour change in a community or area, by permitting/sanctioning or restraining an intervention. Socio-political, legal environment, decision-making processes, policy and guidelines, resource allocation, technical support, etc. are greatly influenced by them. <ul style="list-style-type: none"> <li>• Politicians, administrators, other leaders</li> <li>• Other health/disease control programmes, institutions</li> <li>• Other government institutions/department (non-health)</li> <li>• Media</li> <li>• Development partners/donors</li> </ul> [Same groups may constitute the primary/secondary audience depending on the target behaviour, messages].

The target audience in different categories is also disaggregated by demographic/socio-cultural/economic profiles to tailor campaigns/activities. For example, demographic characteristics generally include age, gender, marital status, education, occupation, income, and geographic location.

#### 4.5 SBCC strategic design

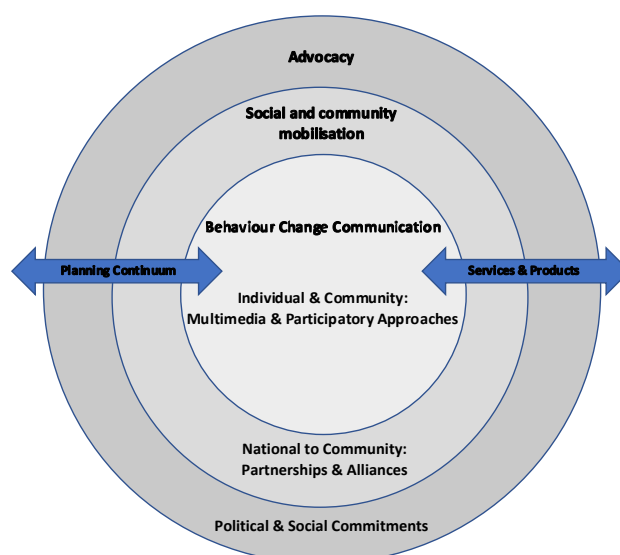
SBCC uses three strategies: BCC to change knowledge, attitudes, beliefs, and practices of consumers (target audience) and change social norms; social and community mobilization to change behaviours and social norms, and generate wider participation, coalition-building, and local ownership among groups, associations, and networks that are influential among consumers; and advocacy to generate active support, resources, and political-social commitment that create an enabling environment for lasting desired behaviour change.<sup>22</sup>

Drawing on the evidence, reviews, assessments, and various theories/models/frameworks and guidance, target audience segmentation, the SBCC strategic design for prevention of re-establishment phase in Timor-Leste will focus on multiple approaches that will be applied tailored to context and needs (Figure 8):

- Advocacy for appropriate target audiences for seeking support for designing/changing policy, strategy, regulation: political, administrators/policy makers, media, multi-stakeholder advocates/champions, nongovernment and private sector
- BCC for reaching and engaging appropriate target audiences through communication channel-mix
- Social and community mobilization for engaging with appropriate target audiences and multiple stakeholders and seeking participation: SISCa, community consultations, involvement of community groups, networks/change agents/professional or civic associations after orientation; community-based and community-led planning, implementation and monitoring.

**Figure 8. SBCC strategies**

<sup>22</sup> <https://www.usaidrdw.org/resources/tools/sbcc-guidebook> (Figure adapted from C-Modules: A Learning Package for Social and Behavior Change Communication, <https://www.fhi360.org/resource/c-modules-learning-package-social-and-behavior-change-communication>).



Source: Adapted from McKee, N. Social mobilisation and social marketing in developing communities, lessons for communicators [accessed from: C-Modules: A Learning Package for Social and Behavior Change Communication (SBCC). Practitioner's Handbook. Communication for Change (C-Change) Project managed by FHI 360 and supported by USAID. Version 3. 2012]]

The strategic design also draws on the "Pathways to a Health Competent Society model, which is based on the understanding that an individual who is highly health competent acts appropriately and consistently to improve or maintain health across multiple health areas that are personally relevant to him or her."<sup>23</sup> Fig. 9 presents the adapted version of the model guiding the overall SBCC strategic design to support prevention of re-establishment phase. The model is grounded on the underlying conditions like context (socio-cultural, economic, and political), disease/health situation, resources (human, financial, etc.). Drawing on the underlying enabling or constraining conditions, communication interventions are used to influence behaviours. Communication occurs within various domains viz., the environment, service delivery systems and among individuals/families/communities. These domains exert influence on the initial outcomes and subsequently desired behaviour outcomes that ultimately contribute to impact. The impact is the overall goal of achieving and sustaining malaria-free Timor-Leste and maintaining prevention of re-establishment phase.

**Figure 9.** SBCC strategic design

<sup>23</sup> Research Brief — Pathways to Health Competence for Sustainable Health Improvement. Health Communication Partnership. CCP. 2007.



motivating them to be advocates/champions towards social/organizational changes necessary for particular goal or programme. Priorities are defined, appropriate policies/legislation are framed, programmes are planned, sufficient resources are allocated and directions are provided thereby facilitating availability of and accessibility to resources and appropriate policy/legislative changes. The major areas include networking, coalition-building/alliances, briefing media, political/administrative engagement, and neutralizing opposition. One or a combination of approaches are recommended: networking, dialoguing, lobbying, mobilization, appealing, and persisting.

Timor-Leste has gone beyond elimination and is now in the prevention of re-establishment phase. It is committed to obtain ‘malaria-free’ certification by WHO. This requires that the government provides stewardship to sustained activities of the prevention of re-establishment of malaria transmission. Good leadership in, and management of, the malaria programme is essential to ensure prevention of re-establishment of malaria given the competing priorities the country faces straddled with limited resources. Programme implementation will need to be managed with rigour and flexibility, supported by robust monitoring and quality control. The programme will need to be responsive to the evolving needs of the prevention of re-establishment phase. An enabling environment for the smooth functioning and cordial/coordinated working relations with all stakeholders of the prevention of re-establishment programme will be imperative.

### **Activities:**

Advocacy activities will reinforce commitment for malaria-free Timor-Leste and prevention of re-establishment. The various activities under national, municipality and community levels are detailed below:

### **National level:**

- The NMP already has a strong national identity, especially in demonstrating success and leading a malaria-free Timor-Leste. However, advocacy activities will continue to further improve visibility/standing of NMP as a champion marching ahead towards prevention of re-establishment.
- A high-level national, multi-sector Task Force on Prevention of Re-establishment of Malaria will be established directly under the auspices of the Honourable Prime Minister for sustained political commitment, resources, inter-sectoral collaboration, including cross-border/international (regional and global) collaboration. Accordingly, the terms of reference will be developed. The membership will include all relevant departments of MoH (Departments of health promotion, environmental health, etc.), representatives of the concerned ministries (e.g., ministry of parliamentary affairs and social communication, ministry of finance, ministry of economic affairs, ministry of defence, ministry of foreign affairs and cooperation, ministry of education, youth and sports, ministry of tourism, trade and industry, ministry of social solidarity and inclusion, ministry of public works, ministry of agriculture and fisheries, ministry of transport and communications), besides the armed forces and border police, the economic development zones, representatives from civil society, research and academic institutions and the private sector. The Task Force will meet every year and review prevention of re-establishment phase. In addition to deliberation on roles and responsibilities of multi-sector stakeholders, an action plan with a specific time framework will be discussed (for all strata).
- Every year, 25th April, marked as World Malaria Day, is significant as it is observed as a campaign for advocacy at different levels, as well as for creating mass awareness and rallying multi-sectoral response to fight against malaria. It is also a day to share, discuss the present/current situation and plan for the future, highlighting the need for continued communication for collective action as well as investment for prevention of re-establishment. Therefore, series of events at the national, municipality, and village levels will

be conducted in a campaign mode ensuring maximum participation and visibility as per plan specifying the level of implementation, target audience, activity planned, person responsible, necessary budget and desired output/outcome. The community networks will support in mobilizing the masses, for various events like marathon, rallies, street plays, musical shows, quiz competition, banner displays, road shows, sports competitions, group discussions, sessions on malaria, and mass signature campaigns, etc. Through various events, signature campaign and pledge to “Keep Timor-Leste Malaria-Free”, will be fostered. Likewise, World Mosquito Day (20th August) campaign will be planned possibly in an integrated manner with other mosquito-borne disease programmes. The NMP, as a reinforced identity, will host advocacy events like national symposium, workshop, conference, other activities on World Malaria Day or World Mosquito Day or any other designated days with the participation of the honourable prime minister, minister for health and other ministers. The participants will include planners and decision-makers, technical partner, donor agencies, civil society, private sector and media. A press meet/briefing will be held and press releases will cover the entire country. At this platform, the achievement of malaria-free Timor-Leste as well as the importance of prevention of re-establishment will be reinforced towards improvement in the quality of life of the people, especially the poor, marginalized and vulnerable groups (for all strata).

- Advocacy for and with health care personnel will focus on the definition of a suspected malaria case and the need for considering malaria in the differential diagnosis of fever patients, especially with a travel history to a malaria-endemic country. Regular updates will be given to health care providers via regular training/orientation programmes to counsel/follow up fever cases in their coverage area. PSFs, volunteers are critical to the NMP at the grassroots. In addition to their training/orientation periodically, their performance will be complimented and recognized. They will be provided with identification signboards and badges with slogan of ‘malaria-free Timor-Leste’, among other logistics (for all strata).
- Advocacy targeting donors, partners, civil society, and private sector will be pursued for collaborations, resource support/resource sharing. With collaborations, sense of ownership will be strengthened across several entities. Meetings, workshops will be held periodically and advocacy products (reports, etc.) will be disseminated (for all strata).
- Advocacy targeting travel agents, hospitality sector, and industries/corporate sector will be conducted, besides construction/development project sectors. Group advocacy sessions will be conducted requesting to inform travellers regarding testing for malaria when arriving from endemic areas as well as about the risk of acquiring malaria when they visit malaria-endemic countries. Advocacy materials for travellers will be shared with travel agents (for stratum 1).
- Media advocacy will be pursued to reinforce the criticality of keeping Timor-Leste malaria-free for country’s development. Press briefing, releases, media workshops, etc. will be planned (for all strata).
- The roles and responsibilities of different sectors will be described in SBCC operational guidelines. For example, roles and responsibilities will include the following: the private sector and NGOs - malaria case management/referral and surveillance; the security forces - surveillance and referral; and the departments of health promotion and education - collaboration for promoting malaria messages in schools through curriculum and various programmes; among others. Coordination with the health promotion department and existing collaboration with the department of education will be revitalized. Malaria health education sessions will be expanded into vector control and environmental hygiene curriculum of the middle school (for all strata).
- Advocacy materials/products like reports and brochures will be prepared and disseminated. Efforts will be made to transition from any ‘malaria as low priority’ and/or ‘business as usual’ scenarios to ones with persistent attention to prevention of re-establishment. A strong investment case for sustaining malaria-free Timor-Leste through the prevention of re-establishment phase will be developed besides programme reports. The NSP 2021–2025 will

be updated into a business plan with financial gap analysis and appropriate costing to facilitate national as well as local level advocacy, planning and implementation (for all strata).

### **Municipality level:**

- Multistakeholder task forces will be constituted at municipality level. The task force or any such existing body will incorporate prevention of re-establishment of malaria transmission in their regular meeting agenda. An action plan with roles and responsibilities will be drawn in the SBCC operational guidelines, as mentioned earlier. In addition, advocacy workshop/meeting will be held under the overall guidance of the NMP. The participants will include task force members, civil society, private sector, schools, and selected chiefs from suco/aldeia. In addition, local media will be invited. The workshop will be convened on World Malaria Day or a designated day in consensus with the stakeholders (preferably prior to the transmission season). Display and distribution of appropriate materials (reports, brochures) will be emphasized (for all strata).

### **Community level:**

- The community leaders/networks will be engaged through advocacy activities. Community influencers/networks/groups will be involved for support and ownership of malaria-free Timor-Leste and for helping in dissemination of prevention of re-establishment to a wide spectrum of the community especially the risk groups (for all strata)
- Advocacy meeting will be held at suco/aldeia level under the chairpersonship of the respective chief (even existing platform for monthly meeting or SISCa may be utilized for the purpose) on World Malaria Day (WMD), other days of relevance. The convener would be the PSF under the overall guidance of CHC/municipality staff. The participants will include members, community, religious leaders, school teachers, CSOs (FBOs, CBOs, Self-Help Groups), and community volunteers. At least 50% women representation will be ensured. The agenda will be the same as mentioned above for the municipality level, though discussion on local solutions to issues in the form of action plan will be encouraged. Cleanliness campaign/larval source management will be planned, besides distribution of communication materials (brochure, sticker and poster). Such advocacy activities will render a voice to even the most marginalized and vulnerable sections at community level and inculcate a sense of ownership of prevention of re-establishment in their area (for all strata).

An indicative advocacy action plan to reinforce high-level commitments, stakeholder ownership, enhance partnerships and collaboration, especially with local authorities and other sectors including the private sector is presented in Table 7. This is not exhaustive and will be revisited from time to time, drawing on needs and resources.

**Table 7.** Advocacy action plan

<b>What (key messages)</b>	<b>Who (target audience)</b>	<b>When (timeline, frequency)</b>	<b>Where (place)</b>	<b>Why</b>	<b>How (medium, implementing entity)</b>
Key achievements and progress of prevention of re-	National Parliament (president, prime minister, other ministers like	During Parliament sessions, WMD (as sessions are	During Parliament sessions	Sustained and sufficient priority and commensurate resources for	Report by Minister of Health (to be supported by CDC/NMP

What (key messages)	Who (target audience)	When (timeline, frequency)	Where (place)	Why	How (medium, implementing entity)
establishment, disease status and measures taken by MoH; and malaria-free Timor-Leste for development	finance minister)	scheduled and WMD, National Health Day is convened every year)		prevention of re-establishment of malaria and malaria-free Timor-Leste for country's socio-economic development, which in turn will benefit all citizens and establish Timor-Leste as a success story; cross-border collaborations, appropriate laws/regulations, as needed	for report)
Key achievements and progress of prevention of re-establishment, disease status and measures taken by MoH; and importance of malaria-free Timor-Leste for development	Senior managers at MoH: Minister, vice-minister, council of directors	Meetings with minister, vice-minister, council of directors (when scheduled), WMD, National Health Day (as convened every year)	During meetings at offices/id identified venues	Sustained and sufficient support, resources for prevention of re-establishment of malaria and malaria-free Timor-Leste for country's socio-economic development, which in turn will benefit all citizens and establish Timor-Leste as a success story; cross-border collaborations, appropriate laws/regulations, as needed	Report by CDC/NMP
Key achievements and progress of prevention of re-establishment, importance of malaria-free Timor-Leste for	Municipality officers, sub district malaria officers, CHC managers, HP staff (including those at POE), PSF	Review, planning and coordination meetings (or when scheduled), WMD, National	During meetings at offices/id identified venues	Screening of people crossing border, early diagnosis and prompt, complete treatment, quality service delivery, especially at PoE, border areas, and	Report, AVs, brochures, banners, standees, stickers, messages through digital/social media, by

What (key messages)	Who (target audience)	When (timeline, frequency)	Where (place)	Why	How (medium, implementing entity)
country's development		Health Day (as convened every year)		dissemination of messages. Furthermore, priorities will be mobilizing community support for case investigation and response; raising awareness of the community regarding the potential for spreading of malaria in the area, preventive measures to be taken, to get tested for malaria if a person develops fever and the importance of taking the full course of treatment, if infected with the malaria parasite; involving community and leaders in malaria vector-breeding places and engaging community participation for environmental manipulation and management, if necessary. If an introduced or an indigenous case is reported, health authorities of the area will be immediately notified through municipalities and other central-level	NMP



What (key messages)	Who (target audience)	When (timeline, frequency)	Where (place)	Why	How (medium, implementing entity)
				authorities; and all public and private medical practitioners and health care institutions in the area will be alerted to the malaria case reported and advised to carry out activated passive case detection (APCD). Furthermore, importance and benefits of malaria-free Timor-Leste for country's socio-economic development, which in turn will benefit all	
Key achievements and progress of prevention of re-establishment, importance of malaria-free Timor-Leste for country's development	Relevant departments within MoH; non-health ministries/departments (Departments of MoH, departments of health promotion, environmental health, maternal and child health, etc.), representatives of the concerned ministries (e.g., ministry of parliamentary affairs and social communication, ministry of finance, ministry of economic affairs, ministry of	Review, planning and coordination meetings (or when scheduled), WMD, National Health Day (as convened every year)	During coordination/Task force meetings at offices/identified venues; important days like WMD	Importance and benefits of malaria-free Timor-Leste for country's socio-economic development, which in turn will benefit all; message dissemination through own channels for early diagnosis and prompt, complete treatment, prevention measures, appropriate laws/regulations, as needed, cross-border collaboration	Report, AVs, brochures, standees, stickers, messages through digital/social media, orientation sessions by NMP

What (key messages)	Who (target audience)	When (timeline, frequency)	Where (place)	Why	How (medium, implementing entity)
	defence, ministry of foreign affairs and cooperation, ministry of education, youth and sports, ministry of tourism, trade and industry, ministry of social solidarity and inclusion, ministry of public works, ministry of agriculture and fisheries, ministry of transport and communications)				
Key achievements and progress of prevention of re-establishment, disease status; and importance of malaria-free Timor-Leste for development	Community leaders/networks	Quarterly meetings (or when scheduled), WMD, National Health Day (as convened every year)	At Suco	Importance and benefits of malaria-free Timor-Leste for country's socio-economic development, which in turn will benefit all; sustained need for early diagnosis and prompt, complete treatment, adoption of personal protection measures like LLINs, etc. Furthermore, priorities will be mobilizing community support for case investigation and response; involving community and leaders on malaria vector-breeding places and	Report, AVs, brochures, banners, stickers, TV/radio programme, messages through digital/social media, road shows, SISCAs, orientation sessions by NMP

What (key messages)	Who (target audience)	When (timeline, frequency)	Where (place)	Why	How (medium, implementing entity)
				engaging community participation for environmental manipulation and management, if necessary	
Key achievements and progress of prevention of re-establishment, need for resources to support prevention of re-establishment; and importance of malaria-free Timor-Leste for development	The Global Fund	Before the Global Fund board meeting, dissemination of country allocations	Electronic/virtual	Critical funding support for specific interventions, like capacity-building at municipality level, LLINs, SBCC and advocacy, research, support sustaining malaria-free Timor-Leste for country's socio-economic development, which in turn will benefit all	Report and concept note by NMP
Key achievements and progress of prevention of re-establishment, need for resources to support prevention of re-establishment; and importance of malaria-free Timor-Leste for development	WHO	As needed	Respective offices/identified meeting venue	Critical technical assistance for capacity-building, assessments, guidelines/strategy, stratification, programme review, etc., and support for sustaining malaria-free Timor-Leste for country's socio-economic development, which in turn will benefit all	Report and concept note by NMP
Key achievements and progress of prevention of re-establishment, need for resources to support	Other donors/partners/platforms (APLMA-APMEN, RBM Partnership to End Malaria, multilateral and bilateral agencies, international	As needed	Respective offices/identified meeting venue	Support for capacity-building, other critical elements, including HR; support sustaining malaria-free Timor-Leste for country's socio-	Report, AVs, brochures, concept note, messages through digital/social media by NMP

What (key messages)	Who (target audience)	When (timeline, frequency)	Where (place)	Why	How (medium, implementing entity)
prevention of re-establishment; and importance of malaria-free Timor-Leste for development	research/academic institutions, etc.)			economic development, which in turn will benefit all	
Key achievements and progress of prevention of re-establishment, need for resources to support prevention of re-establishment; and importance of malaria-free Timor-Leste for development	Private sector/corporate sector	As needed	Respective offices/identified meeting venue	Support for capacity-building, other critical financial and non-financial (e.g., provision of diagnostic kits and drugs, training) elements, including HR; introduce/scale up workplace programmes; compliance with laws/regulations related to malaria and sharing of information (as applicable); support sustaining malaria-free Timor-Leste for country's socio-economic development, which in turn will benefit all	Report, AVs, brochures, standees, concept note, messages through digital/social media by NMP
Key achievements and progress of prevention of re-establishment, need for sustaining prevention of re-establishment; and importance of malaria-free Timor-Leste for	Indonesia	Quarterly/as needed	On both sides of international border through PoE	Support for sustaining malaria-free Timor-Leste as well as contribute to malaria elimination journey in Indonesia for socio-economic development in both countries, which in turn will benefit all; screening of	Report, BCC materials, information sharing through digital/social media as per consensus by NMP

What (key messages)	Who (target audience)	When (timeline, frequency)	Where (place)	Why	How (medium, implementing entity)
development				migrants, travellers, other risk groups, sharing of information regarding cases, providing treatment free of cost, promoting personal protection, dissemination of messages	
Key achievements and progress of prevention of re-establishment, need for resources to support prevention of re-establishment; and importance of malaria-free Timor-Leste for development	INGOs, national NGOs/CSOs, FBOs	As needed	Respective offices/identified meeting venue	Support for disseminating messages/materials for sustaining malaria-free Timor-Leste for country's socio-economic development, which in turn will benefit all. Furthermore, assistance will be sought (as appropriate) for community-level advocacy, BCC, and social community mobilisation	Report, BCC materials, orientation sessions, messages through digital/social media by NMP
Key achievements and progress of prevention of re-establishment, need for resources to support prevention of re-establishment; and importance of malaria-free Timor-Leste for	Media	As needed; WMD, National Health Day (as convened every year)	At identified venues	Support for sustaining malaria-free Timor-Leste for country's socio-economic development, which in turn will benefit all. Furthermore, when an imported case is detected, assistance of the media will be sought to inform the public of	Press release, press briefing, orientation sessions, messages through digital/social media by NMP

What (key messages)	Who (target audience)	When (timeline, frequency)	Where (place)	Why	How (medium, implementing entity)
development				potential onward transmission of infection	
Key achievements and progress of prevention of re-establishment, need for resources to support prevention of re-establishment; and importance of malaria-free Timor-Leste for development	Professional associations/bodies; research academic institutions	As needed; WMD, National Health Day (as convened every year)	At identified venues	Support for sustaining malaria-free Timor-Leste for country's socio-economic development, which in turn will benefit all; foster reporting of malaria cases through their networks and adherence to the national guidelines; support and participate in evaluation/research/surveys, etc.	Report, AVs, brochures, banners, standees, orientation sessions, messages through digital/social media by NMP

#### 4.5.2 Behaviour change communication

Communication is the process in which a **Message** from a **Source** is sent via a **Channel** to a **Receiver** with a certain **Effect** intended with opportunities for **Feedback**, all taking place in a particular **Setting** (MS.CREFS) [Table 8].<sup>24</sup>

**Table 8.** MS.CREFS: Components and considerations

Components	Important considerations
Message	Ensure that the language is clear and easily understandable. Not too technical. Giving too many messages confuses the audience, and therefore, prime focus is on 2–3 main central messages on the needs and benefits of prevention of re-establishment of malaria transmission
Source	Using a credible and locally-relevant source to deliver the message. For example, messages from the health workforce, local/community leaders. Even school-going children should be targeted to act as champions strategically since child/teenager will be more likely to persuade other children/teenagers to take action rather than a figure seen as authoritarian. Appearances make a difference in how the source is perceived
Channel	Identifying the most appropriate channel is important, either using the mass media through radio, television and newspaper and/or interpersonal channels such as door-to-door visits, group meetings, etc. The right channel must be used for the right target audience and generally the most effective is a selective mix of

<sup>24</sup> Parks W. and Lloyd L. Planning social mobilization and communication for dengue fever prevention and control: A step-by-step guide. WHO, Geneva 2004 (WHO/CDS/WMC/2004.2 and TDR/STR/SEB/DEN/04.1).

	channels
Receiver	The receiver filters and interprets the world through the cultural lens with which they view the world. An understanding of this world is crucial to effective communication. Therefore, how the need to explain correctly to take care of mosquito breeding to a migrant may be different from how one will deal with schoolchildren/women
Effect	This is the end result of communication. The effect is the behavioural focus through improving knowledge, skills and providing prompts/triggers that could have an impact on ultimate behavioural outcomes
Feedback	It is important to ensure that communication interventions are appropriate, effective and engage the receiver to provide feedback. Feedback/evaluation allows for such assurance and fine-tuning
Setting	This can facilitate or hinder communication. If the timing is wrong, or the setting/context is inappropriate, challenging, etc., all these factors affect how messages are heard and interpreted. Locations, such as points of entry in border areas, community setting, health centres, marketplaces and schools provide their unique features that can affect the dynamics of communication and must be considered in the planning of communication actions.

Source: Parks W. and Lloyd L. 2004.<sup>25</sup>

### Activities:

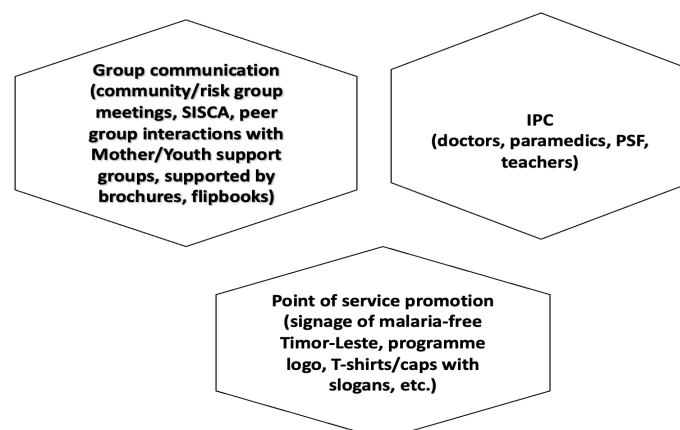
- Communication will be carried out through an umbrella campaign; localized campaign; and routine activities. Continuity will be ensured, which is critical for recall. Communication will foster positive messages/stories in front of target audiences and counter negative ones. Higher weights will be assigned before and during transmission season and to stratum 1.
- Risk groups (primary audiences) will be targeted relatively more persistently. BCC will be aligned with socio-economic strata and tailored messages and channels will be used. Success stories, best practices will be publicized. Communication materials will be prepared together with the department of health promotion and other concerned departments, relevant partners subsequent to pre-test.
- Communication planning will provide clarity regarding the five Ws: 1) What: the specific behaviour/action aimed at; 2) Who: the target - caretaker/care provider/policy-maker; 3) When: the time frame; 4) Where: the site; and 5) Why: the overall purpose. In addition, “how” or the approach/mode for communication (for all strata).
- A detailed media plan will complement the communication planning focusing on reaching the target audiences (estimated number or proportion of the target audience who will be exposed to the campaign within a time frame), frequency (number of times the target audience will be exposed to the message/materials within the time frame), types of messages to be disseminated through particular channel), and time frame (duration of media implementation). The media plan will be developed by the NMP in coordination with the department of health promotion, technical partner, relevant others (e.g., nongovernment entities, community) preferably with support from media agency having experience in designing/printing of communication materials and messaging across various media platforms and implementation (for all strata).
- A steady flow of information through different messages will be provided on priority behaviour (Early diagnosis and prompt treatment - EDPT, prevention, mobilizing community support for case investigation and response; involving community on

<sup>25</sup> Parks W. , Lloyd L. Planning social mobilization and communication for dengue fever prevention and control: A step-by-step guide. WHO, Geneva 2004 (WHO/CDS/WMC/2004.2 and TDR/STR/SEB/DEN/04.1).

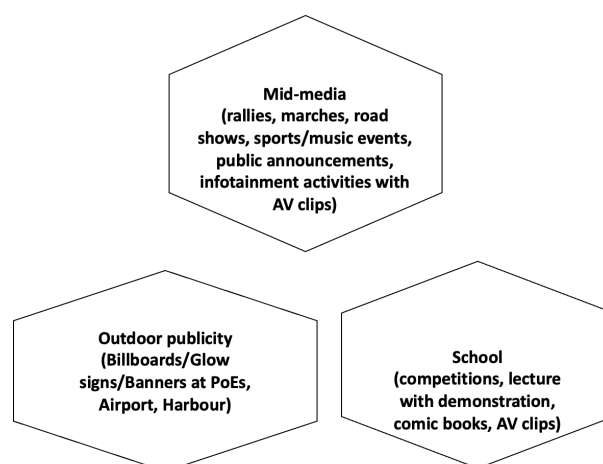
identifying malaria vector-breeding places and engaging them for manipulation and management of mosquito-breeding sources, as appropriate) through locale- and context-specific channel-mix targeted to the right audiences and using the right tools at right times (Fig. 10, 11 and 12). For desired impact, these approaches/channels are best applied in combination not exclusively, using content to reinforce messages through multiple media. Important considerations will include, but not limited to, desired reach (national/municipality/peripheral levels) and available resources. Reach of and access to various media, media habits, preferences of target audiences (preferred watching/listening time, programmes, channels) and perception about a particular media; and costs related to development/replication/distribution of materials, AV production and airing, etc. will be taken into account.

- Interpersonal communication (IPC) [one-on-one], group communication, point of service promotion (PSF, SnF, HP,, SISCa, health facilities) (for all strata);
- mass media - broadcast media (TV, radio), print media (newspaper, magazine), social media (Facebook, Instagram, YouTube, other available/popular ones), digital media (mobile ads, SMS), outdoor publicity (billboards, posters, standees, etc. at bus shelter/health desk at land, sea, air ports/marketplaces, other relevant sites/modes) (for all strata); and;
- mid-media (traditional song-dance/plays), school programmes, among others (for all strata).

**Figure 10.** Communication through IPC, group activities

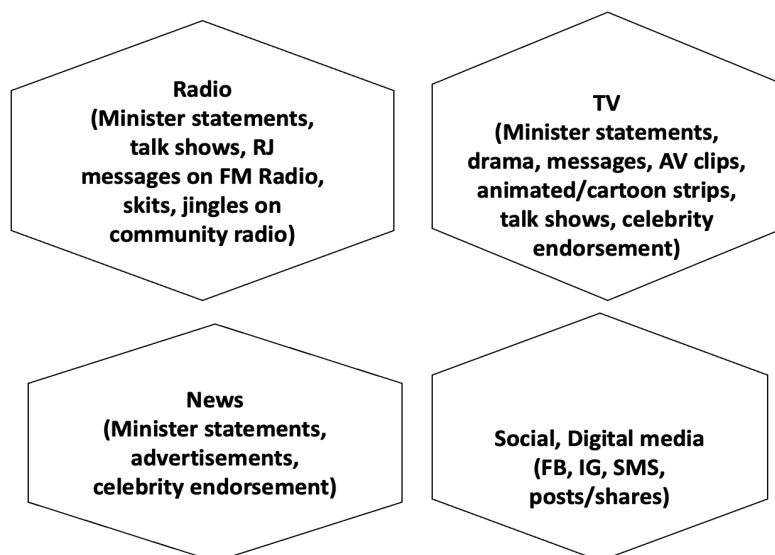


**Figure 11.** Communication through mid-media, outdoor publicity



**Figure 12.** Communication through mass media





- Appropriate communication materials (leaflets, stickers, brochures, flip books, flash cards, OPD registration forms, official stationery, calendars, mailers, gate folders and wall charts/information scroll) will be developed (with information about malaria, its signs and symptoms, mode of transmission, available facilities, importance of early diagnosis and complete treatment, importance of vector-control measures including benefit of using LLINs, managing mosquito breeding sites, etc.). While most communication materials will be printed in Tetun, those to be displayed/distributed at ports of entry will be printed in Tetun, English and Indonesian. Messages, materials for advocacy kits for policy- and decision-makers will be designed and disseminated in the official language and English (for all strata).
- Communication materials (leaflets, stickers, brochure, flip books, flash cards, OPD registration forms, official stationery, calendars, and wall charts/information scroll) for health care service providers will also be developed to support IPC through them to maintain patient's awareness, other SBCC activities (advocacy, mid-media activities, etc.) as well as to display at health facility/ports, and other places. While the materials will always focus on fostering support for sustaining malaria-free Timor-Leste for country's socio-economic development, which in turn will benefit all; messages related to interventions will be tailored to the needs and not crowded within a single material. Besides, more emphasis will be on pictures, illustrations especially for local level (for all strata).
- Creative components will emphasize communication objectives to be pursued (desired behaviour change being targeted); target audience (to whom the materials are intended); barriers as well as benefits and call to action to be addressed through right messaging and avoiding crowding of several messages within a single material; and tailoring to socio-cultural values, norms, literacy levels, and language considerations. Besides pre-tests, stakeholder consultations, community meetings, etc. will be post-launch forum for feedback.
- IPC during house-to-house visit (or patient visit to care provider) is effective and will continue by PSF, SnF to enhance appropriate use of LLINs, EDPT, as many people need reinforcement of messages or demonstration regarding correct hanging of nets, treatment, etc. It works best when there is one-on-one contact between the health worker and the person whose behaviour is to be changed to adopt new knowledge, life skills and practices to ensure the welfare of their families and children. One-on-one contact facilitates comprehension of new concepts and demonstration of new practices. Over a period of time, if done consistently, this method can result in adoption of new practices

on a sustainable basis. IPC materials will include: Flip book, fact sheets with a list of frequently asked questions and answers; how-to booklets and talking points for discussions with patient/family at facilities or homes (for stratum 1 and others, as needed).

- Mid-media activities through traditional song/dance/drama, etc. will be planned. Information through entertainment or education through entertainment is a powerful medium. The music/dance performances (often using the traditional/folk media) with messages will be created for risk groups and community at large. On account of reach, credibility, and ability to adapt performances to the standardized messages as well as costs, this medium will continue. The focus and venue will be selected with care, keeping in mind the socio-cultural milieu of the target audience. Scripts of the plays/shows will be sensitive to community, should be in local language, religious and socio-cultural values, norms; groups/troupes/individuals that are known to the audience will be engaged; orientation of the performers will be necessary to sensitize them on the messages/their delivery, especially to weave the messages into compelling and entertaining scripts. Interactions will be held between the target audience and performers. The performer will elicit feedback from the audience to involve them and also gauge their level of interest and retain attention. Sometimes dummy performers may be placed in the audience and at the appropriate moment, he/she may be included in the play/song. Since the show will be at the level (e.g., suco/aldeia), where the performers are familiar with the setup, credible message dissemination is expected. The audience is expected to trust the performers to the extent that they are willing to take their advice on the interventions being promoted. Successful performances are those whose scripts are flexible and open to spot improvisations to suit local context (for stratum 1).
- Child-to-child/child-to-family communication for dissemination of messages has proven impact in fostering knowledge and awareness and responsive behaviour among peer groups and family. School-based initiatives being critical in creating change agents in the short- to long-term, various programmes will be planned in coordination with relevant department within and outside MoH and others. The initiative will also include: orientation for principal, teachers, and messages dissemination during morning assembly. In addition, competitions (Poster/painting/projects/essay/slogans/drama on keeping Timor-Leste malaria-free); and classroom sessions. From time to time and on important days, processions/rallies by schoolchildren will be organized displaying BCC materials (placards) (for stratum 1 and others, as needed).
- Outdoor publicity through hoardings, glow signs, blimps, branding on wheels (bus, taxi, private car), etc. drawing on needs assessment, resource availability will be considered. Brochures, fact sheets with appropriate messages will be distributed to risk groups or in areas where there is limited opportunity for IPC, e.g., ports, harbours, construction/development project sites, etc., informing the target audience when and where to seek care, how to prevent getting malaria in the areas where they are staying/going. Outdoor publicity through hoardings, glow signs, blimps, etc. will be placed (for stratum 1 and others, as needed).
- Dependent on the available resources and the programme communication needs, assessment of reach (estimated viewership, readership, foot fall/traffic), mass media will be used to reach out to vast target audience within a short time frame. Music and dance, AV spots, jingles, skits, interactive programmes (phone-in programmes/talk shows), quiz programmes, documentaries will be designed to be aired on TV and radio. News and fact sheets urging all to access timely diagnosis in case of fever and complete, if found malaria positive (after travel), taking personal protection measures and removing mosquito-breeding sources, etc. and through such actions, keeping Timor-Leste malaria-free.
- Social media, digital media [SMS, WhatsApp, Facebook (FB), Instagram, YouTube, Twitter/Tik Tok] will be considered for message dissemination and even track treatment

compliance, EDPT, availability of services for travellers, etc. especially in view of penetration of mobile technology to even at suco level, where target audiences will include both care seekers (risk groups, community at large) and care providers (especially PSF, volunteers, at peripheral level) (for all strata).

- Mega events, like sports, music show, and road show will be planned with display of communication materials (banner, poster, signage, etc.), distribution of BCC kit (caps, T-shirts, stickers, etc.) on advocacy events like WMD, World Mosquito Day and relevant others (e.g., on the day when Timor-Leste receives malaria elimination certificate from WHO). During this event, municipality/CHC/HP/suco/aldeia and/or entities may be selected for recognition, who are able to demonstrate innovation, best practice for prevention of re-establishment (for all strata).
- The website of the MoH will include appropriate messaging especially on the achievement of malaria-free Timor-Leste and criticality of sustaining prevention of re-establishment for supporting donor, partner, stakeholder advocacy activities. Fact sheet with key malaria information will be included besides NSP 2021–2025, relevant technical articles (for all strata).

An indicative BCC action plan to reinforce knowledge, awareness and facilitate sustained responsive behaviour is presented in Table 9. This is not exhaustive and will be revisited from time to time, drawing on needs, resources. Each BCC activity will be carefully selected for specific programme priority intervention (problem statement), related communication objective(s) for target audience, creative content (messages, illustrations/pictorials), channels and type of materials.

**Table 9.** BCC action plan

What (key activities)	Who (target audience)	When (timeline, frequency)	Where (place)	Why	How (medium, implementing entity)
IPC	Risk groups; patients (fever cases; imported malaria cases; other patients, their families)	During care seeking, house visits	At home/health facility	Disseminate correct and complete information on prevention, early diagnosis and complete treatment; importance of cooperating when fever screening and other interventions are being carried out; reinforce service delivery availability from PSF/HP, other public sector health facilities; foster criticality of sustaining malaria-free Timor-Leste for country's socio-economic development, which in turn will benefit all	One-on-one communication by doctor, paramedic, PSF, volunteer, SnF, HP, other health facility
SISCa (Group communication) [at least 20 people to be targeted with representation from community]	Risk groups; patients (fever cases; imported malaria cases; other	As per plan; any WMD, other	Community level venue (meeting place, church)	Disseminate correct and complete information on prevention, early diagnosis and complete treatment; importance of cooperating when fever screening and other interventions are being carried out; reinforce service delivery availability from PSF/HP, other public sector health facilities; foster criticality of sustaining	BCC messages and resources to be disseminated by PSF, HP, CHC (doctors, paramedics can join) coordinated with municipality, NMP in coordination with the department of health promotion

What (key activities)	Who (target audience)	When (timeline, frequency)	Where (place)	Why	How (medium, implementing entity)
leaders, support groups, women]	patient s), community at large			malaria-free Timor-Leste for country's development, which in turn will benefit all	
School programmes (competitions, seminars, etc.)	School children and school teachers, their families, communities	As per plan (and not during exams, vacations)	School	Disseminate correct and complete information on prevention, early diagnosis and complete treatment; importance of cooperating when fever screening and other interventions are being carried out; reinforce service delivery availability from PSF/HP, other public sector health facilities; foster criticality of sustaining malaria-free Timor-Leste for country's socio-economic development, which in turn will benefit all	BCC messages and resources to be disseminated by PSF, CHC, municipality, NMP in coordination with the department of health promotion, ministry of education
Infotainment/entertainment [at least 20 people to be targeted with representation from community leaders, support groups, women]	Risk groups, community at large	As per plan (One day in a suco in a year during socio-cultural, religious gatherings, festivals, preferably alternating with SISCa and/or any other community consultations) ; WMD	Local market/community meeting points	Disseminate correct and complete information on prevention, early diagnosis and complete treatment; importance of cooperating when fever screening and other interventions are being carried out; reinforce service delivery availability from PSF/HP, other public sector health facilities; foster criticality of sustaining malaria-free Timor-Leste for country's socio-economic development, which in turn will benefit all	Professional troupe/singer with pre-developed script with entertainment angle; use BCC resources (flip book, poster, leaflets, banner, flyer, sticker, AV capsule); ensure participation of at least 20 people in each meeting with representation from support groups, etc., organized by NMP and relevant others
Outdoor publicity (hoarding/billboard, glow signs, branding on bus, taxi, others)	Risk groups, community at large	As per plan	National /municipality level with special focus on ports(land, sea, air)	Foster criticality of sustaining malaria-free Timor-Leste for country's socio-economic development, which in turn will benefit all; and disseminate correct and complete information on prevention, early diagnosis and complete treatment; importance of cooperating when fever screening and other interventions are being carried out; reinforce service delivery availability from PSF/HP, other public sector health facilities	By NMP in coordination with relevant government departments, ministries, private agency
Mega event	Risk groups,	WMD; other relevant days	National /municip	Foster criticality of sustaining malaria-free Timor-Leste for	By NMP in coordination with

What (key activities)	Who (target audience)	When (timeline, frequency)	Where (place)	Why	How (medium, implementing entity)
	community at large, audiences targeted for advocacy		ality level	country's socio-economic development, which in turn will benefit all; and disseminate correct and complete information on prevention, early diagnosis and complete treatment; importance of cooperating when fever screening and other interventions are being carried out; reinforce service delivery availability from PSF/HP, other public sector health facilities	relevant government departments, ministries, private agency
Radio/TV, print	Risk groups, community at large, audiences targeted for advocacy	As per media plan with intensification during monsoon season	Nationwide	Foster criticality of sustaining malaria-free Timor-Leste for country's socio-economic development, which in turn will benefit all; and disseminate correct and complete information on prevention, early diagnosis and complete treatment; importance of cooperating when fever screening and other interventions are being carried out; reinforce service delivery availability from PSF/HP, other public sector health facilities	By NMP in coordination with relevant government departments, ministries, private agency
Social, digital media	Risk groups, community at large, audiences targeted for advocacy	As per media plan throughout the year with intensification during monsoon season	Nationwide	Foster criticality of sustaining malaria-free Timor-Leste for country's socio-economic development, which in turn will benefit all; and disseminate correct and complete information on prevention, early diagnosis and complete treatment; importance of cooperating when fever screening and other interventions are being carried out; reinforce service delivery availability from PSF/HP, other public sector health facilities	By NMP in coordination with relevant government departments, ministries

#### 4.5.3 Social and community mobilization

One of the critical elements in prevention of re-establishment phase will include, but not limited to, engaging communities in planning, implementation and monitoring of interventions. Community involvement and ownership will be important drivers of sustaining the success story of malaria-free Timor-Leste and various possibilities will be explored to promote community mobilization and participation. It is important that individuals, families, and community share the vision and mission of NSP 2021–2025. Those

affected by malaria directly or indirectly will be engaged as active participant/stakeholder in prevention of re-establishment phase with special emphasis in stratum 1, for identifying priorities and influencing local-level programming approaches. Malaria being almost absent (except very few imported cases in specific areas), it will require perseverance in the community engagement process. Community dialogue and collective action will be integral to the process, when options for actions/solutions will be prepared. Social and community mobilisation will ensure continued priority regarding rights-based approach and address any exclusions, marginalization related to access to diagnosis and treatment, and preventive interventions.

Social and community mobilization will start with catalyst/stimulus that may be external or internal to the community. Internal catalyst/stimulus include malaria illness/death of an individual or upsurge in an area and external catalysts include motivation/actions by change agents (health care service providers/volunteers, chiefs, community networks, NGOs, FBOs, CBOs, school children/teachers, women's groups, youth groups, religious leaders, policy-makers/administrators, etc.), and information dissemination/campaigns (messages designed to promote individual behaviour or collective action). It is important to seek and sustain support from multisector stakeholders (who will also act as catalysts/change agents) and elicit their commitment for effective and sustained responses. The catalyst starts discussion and identifies, involves affected individuals, families as well as community, other stakeholders to discuss the problem and explore solutions. This includes clarification of perceptions, misconceptions, and myths. A key element of community mobilization is involvement of individuals who are most disadvantaged in the community, since those sections are often the worst affected. Inequities in access to quality health care and available interventions may still be challenges among them. Often the marginalized sections may be indifferent and may also ignore seeking appropriate care because of out of pocket expenditure or may resort to alternate options from traditional/informal private sector. Attitudinal and value changes will be promoted for informed decisions and responsive behaviour at individual, family and community levels through various community engagement activities.

**Activities:**

- Community leaders/community networks/affected individuals and their families/risk groups will be involved as catalysts for community dialogue and collective action towards immediate reporting in case of fever and adoption of appropriate interventions within their family, peer groups, and community to keep their areas malaria-free. Furthermore, priorities will be mobilizing community support for case investigation and response; raising awareness of the community regarding the potential for spread of malaria in the area, preventive measures to be taken, to get tested for malaria if a person develops fever and the importance of taking the full course of treatment if infected with the malaria parasite; involving community and leaders on malaria vector-breeding places and engaging community participation for environmental manipulation and management, if necessary.
- Community/community networks/platforms will stimulate increased and sustained demand for quality services. Existing community networks and forum for other disease programme may be leveraged, as appropriate. Community may be asked to prepare a community report card to rate its experience regarding accessibility of services (for stratum 1 and other strata, as needed).
- Knowledge and awareness of community, families, individuals regarding source and transmission risk reduction, diagnosis and treatment, and availability of services at different levels will continue to be reinforced with time-bound action plan. A channel-mix, viz. group discussions, community consultations, etc. will initiate community dialogue and collective action to generate mutual understanding, trust, confidence, enthusiasm and motivation. Participatory community consultations/meetings will be held at suco levels (from where imported cases have been reported) and focus on sensitization/understanding of community perspectives, their participation for adoption

of responsive behaviour (regarding EDPT, completion of treatment, personal protection, and environmental management). Script or slides and/or AV capsules will be used in addition to flipbooks, leaflets, and brochures to assist sessions (for stratum 1 and other strata, as needed).

- Community representatives will be included in task forces at different levels (for all strata).
- SISCa, the flagship programme through the department of health promotion will be a platform for group communication towards strengthening community outreach and knowledge, behaviour for integrated health promotion and community mobilization towards social and community mobilisation. Appropriate AV materials will include song/drama with messages relevant for prevention of re-establishment. SISCa offers large audiences in a short span of time, who are open and more receptive to information as they are in a health-seeking and/or leisure mode. In addition to continuation of early diagnosis and complete treatment, distribution of LLINs or insecticide impregnation of ITNs, source reduction may be organized (for stratum 1 and others, as needed).

An indicative social and community mobilization action plan to reinforce knowledge, attitude, belief, and facilitate sustained responsive behaviour is presented in Table 10. These activities aid social and community mobilisation, while being communication channels as well (as mentioned above). This is not exhaustive and will be revisited from time to time, drawing on needs and resources.

**Table 10.** Social and community mobilisation action plan

What (key activities)	Who (target audience)	When (timeline, frequency)	Where (place)	Why	How (medium, implementing entity)
IPC	Risk groups; patients (fever cases; imported malaria cases; other patients, their families)	During care seeking, house visits	At home/health facility	Foster criticality of sustaining malaria-free Timor-Leste for country's socio-economic development, which in turn will benefit all; contribute to maintaining correct and complete information on prevention, early diagnosis and complete treatment, service delivery availability from PSF/HP, other public sector health facilities; and importance of cooperating when fever screening and adoption of other interventions are being carried out	One-on-one communication by doctor, paramedic, PSF, volunteer, SnF, HP, other health facility
SISCa [at least 20 people to be targeted with representation from community leaders, support groups, women]	Risk groups; patients (fever cases; imported malaria cases; other patients),	As performance plan; WMD, any other	Community-level venue (meeting place, church)	Foster criticality of sustaining malaria-free Timor-Leste for country's socio-economic development, which in turn will benefit all and promote "malaria-free suco – health suco" concept; contribute to maintaining correct and complete information on prevention, early diagnosis and complete treatment, service delivery availability from PSF/HP, other public sector	BCC messages and resources to be disseminated by PSF, HP, and CHC (doctors and paramedics can join) coordinated with municipality, NMP in coordination with the department of health promotion

What (key activities)	Who (target audience)	When (timeline, frequency)	Where (place)	Why	How (medium, implementing entity)
	community at large			health facilities; and importance of cooperating when fever screening and adoption of other interventions are being carried out; optimizing community demand and utilization of services and supplies for EDPT, prevention	
Other BCC activities mentioned in the previous section also aid social and community mobilization.					

## 4.6 Messages

SBCC messages will be simple and distinctive for clear understanding and application. Instead of giving information only, messages will focus on behaviour change among the target audience as well as advocacy and community mobilization. Messages draw from technical policy/guidelines, evidence, and importantly from an understanding of the communities, contexts and environment.

Consultations/brainstorming led by the NMP will be periodically conducted to revisit message content for the target audience in a given context. Research/knowledge, attitude, practice (KAP) studies will need to be considered periodically to inform any revision/reinforcement. If resources are available and as feasible, a creative team (i.e., any communication/media agency) may be commissioned to support overall content creation for advocacy, communication, and social and community mobilization related products selecting right messages for right audience for the right purpose; under the overall guidance and inputs by NMP and concerned departments and experts.

While designing campaigns/activities as well as materials:

- Messages will draw on knowledge about target audiences (based on evidence) and focus on SBCC priorities to achieve the SBCC objectives
- Messages will capture the attention of target audiences; appeal to their hearts and minds (may range from positive, humorous, and sensitive to serious, fear-based, etc.). A mix of logic-based and emotion-based messages will be used
- Messages will be relevant and relate to real life situation and emphasize call to action
- Messages will be tailored to the context with considerations for religious, socio-cultural values, norms, and will be rights- and gender-sensitive (drawing on community, rights and gender assessments, reviews including application of the equity assessment tool – "Malaria Matchbox")
- Messages will focus on benefits, barriers, motivators and facilitate in solving conflicts.

### Message focus:

The messages will need to focus on identified as key needs, gaps, and barriers (Table 11).

**Table 11.** Messages relevant for programme interventions

Interventions	Message focus: Needs/gaps/barriers
Case management	<ul style="list-style-type: none"> <li>• Continuing universal access to malaria diagnosis and treatment services free of charge as per national guidelines</li> <li>• Ensuring all fever cases are tested for malaria (fever case = suspected malaria) within 24 hours of onset of fever</li> </ul>



	<ul style="list-style-type: none"> <li>• Maintaining awareness of signs and symptoms of malaria; recognizing signs and symptoms early</li> <li>• Ensuring early treatment-seeking behaviour by patients at appropriate health facility/HP/PSF</li> <li>• Emphasizing importance of appropriate and complete treatment, i.e., compliance with the full course of treatment</li> </ul>
Prevention	<ul style="list-style-type: none"> <li>• Protecting at-risk populations in stratum 1 with LLINs and ensuring their regular and correct use</li> <li>• Promoting correct, and regular use of LLINs</li> <li>• Responding quickly when an imported case is detected in receptive areas with coverage by IRS, larviciding and environmental manipulation and management, as appropriate</li> <li>• Emphasizing acceptance of IRS</li> <li>• Encouraging support for LSM, where applicable and where vector-breeding sites are "few, fixed and findable"</li> </ul>
Focused intensified surveillance and vigilance	<ul style="list-style-type: none"> <li>• Continuing dissemination/promotion of the criticality of testing all fever as suspected malaria</li> <li>• Continuing dissemination/promotion of the criticality of detection of all infections early and treatment of all patients with quality assured antimalarials based on national guidelines to ensure radical cure and prevention of secondary transmission</li> <li>• Continuing dissemination/promotion of the criticality of notification of confirmed case within 24 hours of detection by public and private sectors (to the MMO and NMP)</li> <li>• Allowing health workforce for contact tracing and MBS around the residence of a confirmed case</li> <li>• Allowing health workforce to test all at-risk population groups in receptive areas during proactive case detection (PACD)/activated passive case detection (APCD)/reactive case detection (RACD) when conducted</li> <li>• Cooperating during case and focus investigations and response by public sector health authorities.</li> </ul>

#### 4.6.1 SBCC priorities, target audience, key messages, channels/approaches

The section provides an overview of SBCC objectives, target audience, key messages, channels/approaches, and implementing entities related to the NSP 2021–2025 interventions and targets.

#### NSP 2021–2025 intervention: Case management - Universal access to malaria diagnosis and treatment

##### NSP 2021–2025 targets:

- 100% of persons have access to malaria diagnosis and treatment
- 100% of suspected malaria patients receive a parasite-based diagnosis
- 100% of confirmed malaria patients receive effective treatment based on national treatment guidelines within 24 hours of confirmation of diagnosis.

According to the NSP 2021–2025, achieving universal access to malaria diagnosis and treatment will involve three channels of service delivery: the public sector, CBOs and the private sector. During the prevention of re-establishment phase, private sector and CBO providers will be required to test and treat patients according to the National Malaria Treatment Guidelines, and will be required to notify all positive cases to the local health authorities within 24 hours of diagnosis. Malaria is a notifiable disease. Universal early diagnostic testing of all suspected cases as per revised definition, based on blood examination by RDTs or microscopy, will be made available at all health care institutions in the public sector, the private sector and outlets of CBOs. RDTs will be available in all primary care settings, including outreach services, in all existing HPs (as currently practiced) and malaria volunteers (PSF). Microscopy facilities will be available at all hospitals, CHCs and at municipality levels.

Treatment for *falciparum* and non-*falciparum* malaria will be based on national treatment guidelines, and in line with WHO guidelines. The ACTs (artemether/lumefantrine) is the recommended first-line antimalarial drug for the treatment of uncomplicated *vivax* and *falciparum* malaria except in the first trimester of pregnancy. A single dose of primaquine 0.25 mg per kg body weight is given to *falciparum* patients as a stat dose to eliminate gametocytes that may transmit the disease. This does not require prior testing for G6PD and has been recommended as safe by WHO. Due to unavailability of point of care testing facilities for G6PD and based on the recommendations of the external review, the 8-week primaquine regime will be given to *vivax* patients at weekly intervals under DOT, and to be continued for confirmed malaria patients.

## **NSP 2021–2025 intervention: Focused intensified surveillance and vigilance**

### **NSP 2021–2025 targets (relevant for SBCC):**

- 100% of suspected malaria patients receive a parasite-based diagnosis
- 100% of cases are notified within 24 hours
- In 100% of cases investigated, reactive case detection (RACD) and entomological surveillance will be completed by 7 days and response (IRS, LLINs and other vector control methods) initiated within 10 days, if necessary.

### **Programme and SBCC priorities in alignment with SBCC objectives:**

**Priorities – case management:** Sustained political commitment and sufficient resource availability to maintain malaria services for prevention of re-establishment of malaria transmission; recognition of signs and symptoms and early care-seeking behaviour by individual, family, community, and prompt, correct and complete treatment by malaria positive cases; equitable access by vulnerable groups, especially mobile and migrant population groups and other at risk groups; appropriate case management according to national guidelines by public/nongovernment and private sectors; case notification by all sectors.

**Priorities – focused intensified surveillance and vigilance:** For case detection, universal access to malaria diagnosis and treatment will be ensured. RDTs will be made available at all health care institutions including the private and NGO sectors (includes faith-based organizations) and malaria volunteers. Microscopy facilities will be available at all hospitals, selected CHCs and at district levels. Types of parasitological surveillance is under:

- **Passive case detection (PCD):** In stratum 1, APCD, where all fever cases have to be tested for malaria, is to be carried out in all health care institutions and where ambulatory health care services are provided. APCD will also be performed in areas of both strata in which an introduced or indigenous case is reported and where there is an active. In all other strata, facilities for PCD should be available and should be carried out using RDTs and microscopy where available.
- **Proactive case detection (PACD):** PACD is useful in special population groups that are considered vulnerable to the importation of malaria cases. It will focus on identified risk groups using RDT. It will be carried out in all identified high-risk groups such as migrant populations including workers, business people, fisherfolk, security and police officers, and students in all strata. In stratum 1, PACD among permanent residents of villages may be continued if cases are detected by this method in 2020. In all other strata, PACD will not be carried out among permanent residents of villages.
- **Reactive case detection (RACD):** RACD is the active detection of malaria infections once a case or a cluster of cases are reported. It comprises: 1) tracing of contacts of confirmed cases who shared the same exposure as the case; and 2) detecting cases in the neighbourhood of the residence of a reported case through MBS. The MBS will be repeated

thrice in a 1.5 km radius area in the neighbourhood of the reported case 14 days apart. An awareness programme on the symptoms of malaria, methods of prevention and the importance of testing for malaria, if someone develops fever, will be carried out during RACD.

- Case investigation: Case investigation will be carried out whenever a confirmed malaria case is detected. It involves detailed patient information and travel history, possible contacts and medical history to assess response interventions as well as review of past malaria cases from the area. Information generated from a case investigation allows the classification of a case by origin of infection. In prevention of re-establishment phase, case investigation is important to determine whether the patient has contracted the disease overseas or locally. Case investigation also assesses factors that may lead to onward transmission.
- Focus investigation: A malaria focus is defined as a locality situated in a formerly receptive malarious area with the continuous or intermittent epidemiological and ecological factors necessary for malaria transmission. A focus investigation will be carried out whenever a case is detected from a focus. It will be carried out regularly until the focus is cleared. A locally acquired case indicates that local transmission has occurred. Focus investigation and response measures including parasitological surveillance - RACD to screen the population within 1.5 km radius of each case, contact tracing, and carrying out ACD through MBS three times 14 days apart will be carried out in a 1.5 km radius of the residence of the reported case; treating all cases according to national treatment guidelines; screening of all fever cases reporting to health care institutions in the area (APCD); entomological surveillance to guide response and vector control; and supplementary vector control measures, if required. Any additional cases of malaria that are detected during RACD within the focus will undergo a full and separate case investigation process. Following activities will be included as response to prevent onward transmission of infection: a) mobilizing community support for case investigation and response; b) raising awareness of the community regarding the potential for spread of malaria in the area, preventive measures to be taken, to get tested for malaria if a person develops fever and the importance of taking the full course of treatment if infected with the malaria parasite; c) raising awareness of the community and leaders on malaria vector-breeding places and engaging community participation for environmental manipulation and management, if necessary. If an introduced or an indigenous case is reported, health authorities of the area will be immediately notified through municipalities and other central-level authorities. Further, all public and private medical practitioners and health care institutions in the area will be alerted to the malaria case reported and advised to carry out APCD. The assistance of the media will be sought to inform the public of potential onward transmission of infection.

**Message focus: Case management and focused, intensified surveillance and vigilance**

- Equitable access to malaria diagnosis and treatment services free of charge according to national guidelines
- Each fever case is tested for malaria (fever case = suspected malaria) within 24 hours of onset of fever
- Each malaria case is treated according to national guidelines within 24 hours of confirmation of diagnosis
- Sustained awareness of signs and symptoms of malaria; recognizing signs and symptoms of severe malaria
- Getting tested for malaria if someone has fever within a 1.5 km area around the residence and completing prescribed treatment according to national guidelines
- Allowing health workforce by individual, family, community for contact tracing and MBS within

a 1.5 km area around the RACD

- Allowing health workforce by individual, family, community to test all at-risk population groups in receptive areas in strata 1 and 2 during APCD when scheduled
- Cooperating during case and focus investigations and response by health authorities
- Early treatment-seeking behaviour by patients from appropriate health facility/provider
- Importance of complete treatment, i.e., compliance with the full course of treatment
- Ensuring resource mobilization from domestic/external sources
- Multi-sector and multi-stakeholder partnership and collaboration, especially involvement of community leaders, municipality leaders, and elected representatives
- Ensuring involvement of community leaders, municipality officials, elected representatives, donors, and partners in various campaigns/observance of WMD, and other events on sustaining malaria-free Timor-Leste
- Ensuring media attention and involvement of celebrities, etc. to promote malaria-free Timor-Leste.

**Target audience:**

**Primary audience 1:**

- Mobile and migrant populations (migrant workers and their families; slash and burn cultivators, their families)
- Students/teachers and their families from Timor-Leste and Indonesia
- Individual/family/community in border areas
- Fisherfolk and their families visiting nearby Indonesian islands
- Pregnant women
- Blood donors
- Internally displaced persons/refugees
- Community leaders
- Health workforce (public sector, NGOs/FBOs/private sector)
- Security workforce.

**Primary audience 2, 3:**

- Community at large
- Health workforce (public sector, NGOs/FBOs/private sector).

**Key messages:**

- Recognize signs and symptoms of malaria – fever
- Malaria, if not diagnosed and treated early, correctly and completely, can lead to complications and can even be fatal
- Visit/seek care from public sector health facilities/PSF/SnF/port health desk/listed CBO or private sector within 24 hours of onset of fever. Do not wait
- Take the right treatment, in the right dose for all medicines, for the right number of days. Do not stop treatment, even if you are feeling better
- Listen to advice of public sector health facilities/PSF/SnF regarding case detection results, correct and complete treatment
- Take full dose of ACT artemether-lumefantrine (AL) and full dose of primaquine
- Do not take any antimalarials on empty stomach
- Understand how to take the medicines and discuss side-effects; the first dose should be taken in front of care provider

- Seek information and know about correct malaria treatment. Do not take antimalarials from private sector clinics/practitioners, if correct malaria treatment is not followed. It will be harmful/fatal
- Do not accept treatment from any informal private provider [drug store/traditional or faith healers (dayan/matandok)]. It will be harmful/fatal
- Recognize signs of severity/failure to respond to treatment; seek help from public sector health facilities promptly
- Inform (care seeker)/ask (care provider) about previous treatments (to identify treatment failures) and symptom history
- Inform public sector health facilities/PSF/SnF immediately if you come across any neighbour/any community member having fever
- Immediately rush to the public sector health facility/PSF/SnF, if pregnant women have fever. Ensure prompt diagnosis and treatment. Treatment will not harm the mother or the baby. Ensure early and required antenatal care (ANC) attendance
- Get tested for malaria if your family member/your neighbour/your fellow worker are/is having fever and you live within a 1.5 km area around their residence and complete prescribed treatment according to national guidelines, if found positive
- Allow health workforce by individual, family, community when contact tracing and MBS is carried out within a 1.5 km area around the residence of a confirmed case
- Allow health workforce by individual, family, community to test all at-risk population groups in receptive areas when scheduled
- Cooperate during case and focus investigations and response by health authorities
- Timor-Leste is malaria-free country. Report fever or any other symptoms to port health desk before/after crossing border and follow advice of staff. Keep Timor-Leste malaria-free always
- Malaria-free Timor-Leste is a progressive step towards country's socio-economic development.

### **Key channels:**

IPC (by care providers), community meeting, info-/edutainment (including AV), mass media (radio, TV, newspaper), mega event supported by brochure, banner, sticker, flip-book, poster; billboard/hoarding/glow signs; digital media (social media, health apps, etc.), World Malaria Day, World Mosquito Day.

### **Target audience:**

### **Secondary audience:**

- Private health care service providers
- Pharmacies and other sellers of drugs, other informal health care service providers
- Traditional healers and birth attendants.

### **Key messages:**

- Timor-Leste is malaria-free country. Report fever or any other symptoms to port health desk before/after crossing border and follow advice of staff. Keep Timor-Leste malaria-free always
- Sustaining malaria-free Timor-Leste is a progressive step towards country's socio-economic development
- Inform public sector health facilities/PSF/SnF immediately, if you come across any neighbour/any community member having fever
- Immediately rush to the public sector health facility/PSF/SnF, if pregnant women have fever.

Ensure prompt diagnosis and treatment. Treatment will not harm the mother or the baby.  
Ensure early and required ANC attendance

- Recognize signs of severity/failure to respond to treatment; seek help from public sector health facilities promptly
- Ask (care provider) about previous treatments (to identify treatment failures) and symptom history
- Ensure quality assured diagnosis and treatment within 24 hours of onset of fever. Be informed about how to explain the treatment and possible side-effects. Ensure first dose is taken in front of you
- Ensure right treatment, in the right dose for all medicines, for the right number of days according to national guidelines. Follow up malaria cases for treatment compliance
- Ensure timely referral, if symptoms of severe malaria.

### **Key channels:**

Advocacy workshop/meeting; dissemination/orientation sessions on technical/study/evaluation reports; mass media, mega events supported by brochure, sticker; digital media (social media, health apps, etc.); World Malaria Day, World Mosquito Day (use other relevant days); thematic presentations, simple technical briefs on diagnosis and treatment of malaria as well as criticality of prevention of re-establishment of malaria transmission.

### **Target audience:**

#### **Secondary (other than those mentioned above) and tertiary audiences:**

- Leaders/influencers at national, district and village levels (including village heads/chief, community leaders, religious leaders, NGOs, FBOs, and support groups)
- Politicians, administrators, and other leaders
- Media
- Other health/disease control programmes, and institutions
- Other government institutions/department (non-health)
- Development partners/donors.

### **Key messages:**

- Timor-Leste is malaria-free country. Report fever or any other symptoms to Port Health Desk before/after crossing border and follow advice of staff. Keep Timor-Leste malaria-free always
- Sustaining malaria-free Timor-Leste is a progressive step towards country's socio-economic development
- Sustain support for EDPT, health system capacity strengthening/readiness, as costed under NSP 2021–2025 to prevent re-establishment of malaria transmission. Sustained and sufficient resources are must
- Support establishing screening at points of entry – land, sea, and air
- Recognize signs and symptoms of malaria – fever
- Malaria, if not diagnosed and treated early, correctly and completely, can lead to complications and can even be fatal
- Visit/seek care from public sector health facilities/PSF/SnF/Port Health Desk/listed CBO or private sector within 24 hours of onset of fever. Do not wait
- Take the right treatment, in the right dose for all medicines, for the right number of days. Do not stop treatment, even if you are feeling better
- Listen to advice of public sector health facilities/PSF/SnF regarding case detection results,

- correct and complete treatment
- Ensure quality assured diagnosis and treatment within 24 hours of onset of fever. Be informed about how to explain the treatment and possible side-effects. Ensure first dose is taken in front of you.

### **Key channels:**

Advocacy workshop/meeting; dissemination/orientation sessions on technical/study/evaluation reports; mass media, mega events supported by brochure, sticker; digital media (social media, health apps, etc.), World Malaria Day, World Mosquito Day (use other relevant days); thematic presentations, simple technical briefs/ on diagnosis and treatment of malaria as well as criticality of prevention of re-establishment of malaria transmission.

### **NSP 2021–2025 intervention:**

**Prevention: Universal access to prevention in stratum 1 and in potential foci. Vector control measures in other strata where cases are reported (response to case investigation).**

### **Programme and SBCC priorities in alignment with SBCC objectives:**

**Priorities:** Universal coverage by LLIN in stratum 1 and risk groups (including mobile and migrant populations, students, pregnant women, health and security forces) and in potential foci; correct and consistent LLIN use by beneficiaries; vector control measures (larval source management) will be confined to areas around where cases are reported. IRS will be applied in focus until focus status becomes “cleared” and in potential focus, and as response to case investigation (imported case) depending on receptivity of the area.

#### **Message focus:**

- Ensuring equitable access to LLINs by population in stratum 1 and risk groups in target areas
- Ensuring regular and correct use of LLINs in target areas
- Ensuring IRS when an imported case is detected in receptive areas
- Ensuring acceptance of IRS in target areas
- Ensuring larval source management in target areas and involvement of and acceptance by local communities/risk groups
- Promoting clean environment in households and village
- Ensuring resource mobilization from domestic/external sources
- Ensuring involvement of community leaders, municipality officials, elected representatives, donors, partners in various campaigns/observance of World Malaria Day, and other events on sustaining malaria-free Timor-Leste
- Ensuring media attention and involvement of celebrities, etc. to promote malaria-free Timor-Leste.

### **Target audience:**

#### **Primary audience 1 (in stratum 1):**

- Mobile and migrant populations (migrant workers and their families; slash and burn cultivators and their families)
- Students/teachers and their families from Timor-Leste and Indonesia
- Individual/family/community
- Fisherfolk and their families visiting nearby Indonesian islands

- Pregnant women
- Blood donors
- Internally displaced persons/refugees
- Community leaders
- Health workforce (public sector, NGOs/FBOs/private sector)
- Security workforce.

### **Key messages:**

#### **LLINs:**

- Malaria is serious, can be fatal
- LLINs are effective tools that last for 2–3 years, if used correctly and daily
- Only mosquitoes cause malaria. Malaria is spread from person to person only by infected mosquito bites
- Mosquitoes that bite at night cause malaria. That is why, LLIN is an effective tool to prevent malaria when used correctly and consistently
- You can prevent malaria in your home and village. You/your family will not get sick from malaria and save your expenses
- Sleep under LLINs every night. Tuck properly so that there is no gap for mosquitoes to enter. If any hole is noted during the life of LLIN, mend properly
- LLIN creates a barrier between you and your family members and the mosquitoes. The insecticide in LLIN kills/repels mosquitoes and other insects
- LLIN is safe for all including young children and pregnant women. Direct skin contact with the insecticide on a wet net may cause a tingling sensation, but this is not harmful
- LLIN ensures good sleep, free from buzzing, biting mosquitoes and other insects
- Acquire/own LLINs from PSF/Health Post, when mass distribution is scheduled in your area
- Hang LLINs correctly and at sundown every day. Take proper care of LLINs. Wash every two months
- If you go to forest/your family member goes to forest and stay and sleep there, it is important to carry LLIN and sleep under it to prevent mosquito bite and getting malaria. Use available support arrangements to hang LLINs
- If one sleeps in open means outside the room, use LLIN by hanging with available support arrangements
- Do not use LLIN to catch fish. It is harmful for fishes
- Recycle old LLIN (more than 3 years) by making ropes, screening doors/windows, etc.

#### **IRS:**

- Mosquitos are the only vectors that transmit malaria, spray your homes to reduce the number of mosquitos. By doing so you are helping to reduce the number of malaria cases
- IRS is effective, so allow team to spray inside every room, as required. It is not harmful. By doing so you are helping to reduce the proliferation of mosquitos
- Do not paint/plaster immediately after IRS.

#### **Larval source management (LSM):**

- Mosquitoes breed in water
- Mosquitos increase the risk of malaria in your family. Destroy all mosquito-breeding sites regularly
- Mosquito-breeding sites (potholes/pits, abandoned old tires, empty containers, unused articles) increase the risk of malaria. Mosquitos use them as nests. Fill potholes/pits empty/destroy abandoned old tires, empty containers, unused article and stop breeding of mosquitoes



- Take care/remove all temporary water collections
- Remove/destroy all water collections, as feasible
- Larval source management effective when mosquito breeding places are identified
- Larvivorous fish (e.g., gambusia, puntius, etc.) should be released in identified permanent water bodies, where feasible and applicable.

#### **Key channels:**

IPC (by care providers), community meeting, info-/edutainment (including AV), mass media (radio, TV, newspaper), mega event supported by brochure, banner, sticker, flip-book, poster; billboard/hoarding/glow signs; digital media (social media, health apps, etc.), World Malaria Day, World Mosquito Day (use other relevant days); "clean household/family or clean village" competitions.

***Primary audiences in strata 2 and 3 will be targeted with prevention/vector control messages only when those areas report malaria case and such interventions are applied.***

#### **Target audience:**

##### **Secondary audience (in stratum 1 only):**

- Private health care service providers
- Pharmacies and other sellers of drugs, other informal health care service providers
- Traditional healers and birth attendants.

#### **Key messages:**

##### **LLINs:**

- Malaria is serious; it can be fatal
- LLINs are effective tools that last for 2–3 years, if used correctly and daily
- Only mosquitoes cause malaria. Malaria is spread from person to person only by infected mosquito bites
- Mosquitoes that bite at night cause malaria. That is why, LLIN is an effective tool to prevent malaria when used correctly and consistently. LLINs protect you from mosquito bites and malaria
- Acquire/own LLINs from PSF/Health Post, when mass distribution is scheduled in your area
- Hang LLINs correctly and at sundown every day. Take proper care of LLINs. Wash every two months
- If patient/family member goes to forest and stay and sleep there, it is important to carry LLIN and sleep under it to prevent mosquito bite and getting malaria
- If one sleeps in open, i.e., outside the room, use LLIN by hanging with available support arrangements
- Do not use LLIN to catch fish. It is harmful for fishes
- Recycle old LLIN (more than 3 years) by making ropes, screening doors/windows, etc.

##### **IRS:**

- IRS is effective, so allow team to spray inside every room, as required
- IRS is not harmful.

##### **Larval source management (LSM):**

- Mosquitoes breed in water
- Take care/remove all temporary water collections
- Remove/destroy all water collections, as feasible

- Larval source management effective when mosquito-breeding places are identified
- Larvivorous fish (e.g., gambusia, puntius, etc.) should be released in identified permanent water bodies, where feasible and applicable.

#### **Key channels:**

Advocacy workshop/meeting; dissemination/orientation sessions on technical/study/evaluation reports; mass media, mega events supported by brochure, sticker; digital media (social media, health apps, etc.), World Malaria Day, World Mosquito Day (other relevant days); "clean household/family or clean village" competitions with stakeholder participation; thematic presentations, simple technical briefs on prevention of malaria and criticality of prevention of re-establishment in Timor-Leste.

#### **Target audience:**

#### **Secondary (other than those mentioned above) and tertiary audience:**

- Leaders/influencers at national, district and village levels (including village heads/chief, community leaders, religious leaders, NGOs, FBOs, and support groups)
- Politicians, administrators, and other leaders
- Media
- Other health/disease control programmes, institutions
- Other government institutions/department (non-health)
- Development partners/donors.

#### **Key messages:**

#### **LLINs, IRS, LSM:**

- Sustain support for universal access to prevention interventions as costed under NSP 2021–2025 to prevent re-establishment of malaria transmission. Sustained and sufficient resources are must
- Support provision for LLINs in stratum 1 and additional for at-risk groups
- LLINs are cost-effective relative to fogging
- Support provision of IRS, where targeted
- By ensuring and supporting LLINs/IRS/LSM (as applicable), you are protecting the communities, and at-risk groups from malaria
- Support and observe World Malaria Day and other relevant days with involvement of all sectors and stakeholders.

#### **Key channels:**

Advocacy workshop/meeting; dissemination/orientation sessions on technical/study/evaluation reports; mass media, mega events supported by brochure, sticker; digital media (social media, health apps, etc.), World Malaria Day, World Mosquito Day; "clean household/family or clean village" competitions with stakeholder participation.

### **4.7 Implementation framework**

The SBCC strategy will be implemented under the overall leadership of the NMP in close coordination with the department of health promotion. Inter-department integration/convergence of activities, as appropriate, as well as stakeholder and partner coordination and collaboration will be the key elements.

The NMP focal point for SBCC will be responsible for coordinating finalization of annual implementation/operational plan, media plan, appropriate messages and materials. The focal point will also coordinate and oversee trainings, implementation, monitoring, evaluation/research across the municipalities with respective teams and relevant stakeholders. The plan will emphasize on: what (key activity); and who (target audience), when (timeline, frequency), where (place), why (need/cost-benefit, etc.) and how (medium, implementing entity). The indicative activity plans for advocacy, BCC, social and community mobilisation presented in earlier section will provide the overall guidance and direction.

An annual implementation/operational plan with detailed activities, target audiences and areas of coverage and responsible entities and timelines will be prepared every year turning strategies into an actionable mode. The plan will be a budgeting, management and monitoring instrument, and will remain dynamic so as to keep options for revision/updating as activities begin and/or in the event of any change in context/NSP 2021–2025. The NMP will work with the municipalities and relevant departments (Department of health promotion, others) and consult stakeholders and partners (WHO and others) for finalising the annual implementation/operational plan in participatory and inclusive manner. An indicative outline of implementation/operational plan is presented in Table 12.

**Table 12.** Outline of implementation/operational plan

Process	Responsible entity	Timing
Consensus-building and dissemination meeting/workshop of stakeholders, partners and donors following rapid assessment of situation/needs of SBCC strategy and its implementation, M&E	NMP in coordination with WHO	At the beginning of/during strategy development
Key message development to address desired behaviour of target audiences. Pre-testing through stakeholder consultations. Need to prioritise - which messages first, which next, etc. [May commission professional agency]	NMP; Department of health promotion, other relevant departments in coordination with WHO and with support from media agency (after consensus-building and resource allocation)	During strategy development; and then revisit during development of content and finalization of advocacy/communication materials; and then after periodic review/assessment through strategy period
Development/customization of training plan, curriculum	NMP in coordination with WHO	During strategy development; and then at the time of strategy implementation periodically as per needs through strategy period
Building/strengthening of capacities of health cadres and community volunteers to implement strategy with special emphasis on effective delivery of the key messages	NMP	At the beginning of strategy implementation; and then periodically per need assessment (refresher training)
Dissemination of strategy document; and finalizing operational plan, media plan together with stakeholders. Identify lead within NMP and stakeholder organizations. Allocate resources (funding/manpower, etc.) [funding from external agencies, private sector will be explored]	NMP; selected stakeholders (as appropriate)	At the beginning of strategy implementation. High intensity just before and during malaria season and reasonable spacing throughout the year. Special programmes for occasions (e.g., World Malaria Day, other relevant days, etc.)
Designing and dissemination of SBCC resources (advocacy notes, flip book, leaflet,	NMP in coordination with Department of health	After finalizing strategy and at the beginning of strategy

Process	Responsible entity	Timing
brochure, AV capsule, story board for TV/radio programmes, etc.), press briefs, etc. [may commission professional agency]. [Ensure use of appropriate language and illustrations for different target audiences; as well as sufficient copies/time slots to reach the target audiences, etc.].	promotion, WHO	implementation
Ensuring availability of necessary health products, antimalarials at service delivery points as well as targeted areas; and funding	NMP; Municipality	At the beginning of strategy implementation
Rolling out implementation plan/media plan	NMP in coordination with Department of Health Promotion; Municipality	Through the NSP 2021–2025 period
Monitoring and supervision – identification of indicators and data/feedback flow mechanisms, timelines; collation of data for recording and reporting, analysis, and feedback. Harmonization across other VBD programmes as well as any relevant implementation by stakeholders (compatible data collection tools and reporting formats)	NMP, Municipality	Through the strategy period. NMCP, Department of health promotion, and health facility staff to supervise and monitor as well as participate as possible in community level activities (for quality control and coordination).
Evaluation, research - Drawing on results, revisit messages, channels, implementation plan, to sustain behaviour objectives through prevention of re-establishment phase	NMP in coordination with WHO	Mid-term, end term of strategy period

The SBCC implementation/operational plan will be aligned with annual work plan of the NMP and dependent on the resource allocation. Yearly calendar with frequency of SBCC activities at all levels (national, municipality, and peripheral levels) will be articulated; and will guide the NMP and various partners/stakeholders to strategically plan, coordinate and ensure appropriate spacing and avoid duplication of efforts. An indicative calendar of activities is given in Table 13.

**Table 13.** Indicative calendar of activities

Level	Place	Jan–March	April–June	July–Sept	Oct–Dec
Suco/Aldeia (all in stratum 1; selected ones in other strata)	A	<ul style="list-style-type: none"> <li>• SISCa – 3</li> <li>• Community meeting – 1</li> <li>• IPC – 100 households by PSF/HP/SnF</li> </ul>	<ul style="list-style-type: none"> <li>• SISCa – 3</li> <li>• Community meeting – 1</li> <li>• IPC – 100 households by PSF/HP/SnF</li> <li>• School programmes – 5</li> <li>• Infotainment on WMD – 1</li> </ul>	<ul style="list-style-type: none"> <li>• SISCa – 3</li> <li>• Community meeting – 1</li> <li>• IPC – 100 households by PSF/HP/SnF</li> <li>• School programmes – 5</li> </ul>	<ul style="list-style-type: none"> <li>• SISCa – 3</li> <li>• Community meeting – 1</li> <li>• IPC – 100 households by PSF/HP/SnF</li> </ul>
Municipality (all strata)	HQs; or at selected venues	Advocacy meeting with stakeholders	Mass media – TV, radio programmes; use of print, social and digital media; mega event on WMD	Advocacy meeting with stakeholders; use of print, social and digital media	Mass media – TV, radio programmes; use of social and digital media
National	Entire country	Advocacy meetings – high level; and with stakeholders,	Advocacy meetings with stakeholders, partners, donors;	Advocacy meetings with stakeholders, partners, donors;	Mass media – TV, radio programmes; advertisement/messa

		partners, donors; mass media – TV, radio programmes; advertisement/message dissemination in newspaper (print media); posts/messages on social and digital media	intensified mass media – TV, radio programmes; advertisement/message dissemination in newspaper (print media); posts/messages on social and digital media; mega event (road show/music festival, etc.) on WMD	intensified mass media – TV, radio programmes; advertisement/message dissemination in newspaper (print media); posts/messages on social and digital media	ge dissemination in newspaper (print media); posts/messages on social and digital media
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**Budgeting considerations:** The implementation/operational plan will include the estimated budget for various activities as indicated below. The given list is not exhaustive and will be tailored to the type of SBCC activity, site/level and extent of implementation.

- Stakeholder consultations for finalising implementation/operational plan and calendar, messages, materials and channels
- Designing, pre-testing and finalising creative portfolio; commissioning agency and/or experts
- Printing and distribution of materials; purchase of air time
- Advocacy meetings; press briefings; honoraria
- TWG meetings; transportation/refreshment /accommodation costs, per diem/honoraria, miscellaneous
- Mega event; sites/spaces/venues, and equipment
- Performance incentives for performers/artists/troupes
- Transportation/refreshment/accommodation costs, per diem
- Training-related costs (venue, materials, equipment, transportation/refreshment/accommodation costs, per diem/honoraria, miscellaneous)
- Monitoring and supervision related costs including printing and distribution of forms, recording/reporting and on site visit costs
- Evaluation, research, and survey costs
- Fee/remuneration of health cadres/volunteers, and relevant others
- Communication costs
- Administrative and overhead costs
- Miscellaneous activities.

#### 4.8 Structures and capacity strengthening

The NMP will lead planning, implementation, coordination and M&E of SBCC activities. Officers/staff will be identified for the purpose under the overall direction of the programme manager. As an integrated vector-borne disease control (VBDC) programme is being envisaged, structures as well as roles and responsibilities will be revisited. Similarly, officers at municipality and sub-district levels will be identified for the SBCC component.

A broad-based SBCC TWG comprising relevant departments, partners, and stakeholders will be considered to provide technical guidance on planning and coordination and oversee strategy implementation under the overall stewardship of the NMP/CDC. Constituted with clear terms of reference, the TWG will comprise experts from the field of public health, medical entomology, social sciences, communication and

advertising and representatives from WHO and various partner and donor agencies, civil society, and other relevant stakeholders. It will meet annually for review of progress and recommend if any revision in strategy, plans, and materials is needed. The TWG will emphasize on SBCC priorities for development of materials and reproduction of successful ones. All stakeholders will be encouraged to share SBCC materials in draft and final stage with the TWG for consensus and standardized advocacy and message dissemination.

A SBCC resource centre will be set up for designing, development, and dissemination within the NMP in close coordination with the department of health promotion. As any integration of all VBD programmes is launched, this resource centre will be considered to provide overarching support. The resource centre will be equipped with at a minimum: office automation products (desktop and laptop with necessary software, LCD projection panel, colour video monitors, TV, back projection screen, overhead projection facilities; high speed copiers, and scanning, binding and laminating facilities; AV facilities, amplifiers, music system, wireless public address system, photo camera, digital camera/video camera and portable exhibitions sets/frames, panels, flexi-boards, etc). It will serve as resource bank to support municipality and peripheral levels (CHC/HP/Suco/Aldeia).

The implementation of BCC strategy will require strengthening of capacity and skills at all levels in line with NSP 2021–2025. All concerned will receive training in SBCC, planning and implementation, M&E. The NMP training plan will include dedicated module on SBCC for staff, and volunteers, and key elements of the SBCC strategy will be shared. In addition, on job training, mentoring and coaching will be provided by the national level team during supervision and monitoring visits and during review and planning meetings, as appropriate. Social and community mobilization skills of health cadres/volunteers and change agents will also be strengthened.

Training plan will include objective(s), session content, materials, estimated budget, list of trainees and trainers, scheduled date and venue.

**Training title:** Training on “Social and Behaviour Change Communication (SBCC) for supporting prevention of re-establishment phase in Timor-Leste”

**Objectives:** To increase understanding of SBCC, its purpose, principles, and strategic design towards strengthening planning, implementation, management, and M&E of SBCC.

By the end of training, the trainees will be able to:

- learn about the SBCC concept and how it differs from IEC/BCC
- describe the different levels of the socio-ecological model
- describe key steps of planning
- describe SBCC strategy objectives, guiding principles, strategic design for prevention of re-establishment of malaria transmission in Timor-Leste
- describe target audiences
- describe message for various programme interventions
- know and describe the activities in terms of what, who, when, where, why and how
- describe M&E of SBCC.

**Number of trainees per batch:** 30

[One group of trainees will comprise national and municipality-level health cadres, SnF; and second group of trainees will comprise HP, PSF, volunteers. Training of the second group will use simpler, easy to understand language and will focus more on planning, implementation of community-level advocacy, IPC, group communication, mid-media activities].

**Duration of the training:** 2 days

**Venue:** At national level

Indicative session content is presented in Table 14.

**Table 14.** Training on SBCC for health cadres

Time	Sessions	Resource persons/Facilitators/Participants
<b>Day 1:</b>		
30 minutes	Registration	All participants
<b>Inaugural session</b>		
10 minutes	Welcome and objectives of training	Facilitators (National Malaria Programme - NMP)
10 minutes	Self-introduction	All participants
20 minutes	Remarks by dignitaries	CDC/MoH, partner organization/expert
5 minutes	Vote of thanks	NMP
<b>Technical sessions</b>		
15 minutes	Housekeeping/logistics announcements Tea/Coffee	NMP
30 minutes	Pre-test	Trainees/facilitators
30 minutes	- Malaria situation in Timor-Leste and overview of NSP 2021–2025 - Q&A	NMP/CDC All participants
30 minutes	- Understanding communication landscape and situation regarding barriers and inequities, motivators, socio-cultural contexts, norms from various assessments - Q&A	NMP/CDC/resource person/expert All trainees
30 minutes	- SBCC concept and theories, models - Q&A	Resource person/expert All trainees
60 minutes	Lunch	
60 minutes	- SBCC strategy - overview, target audience segments, strategic design (advocacy, BCC, social and community mobilisation), SBCC priorities and related message focus and channel-mix, reach of various channels - Q&A	Resource person/expert All trainees
60 minutes	- Group work introduction: Identification of causes and effects/challenges and solutions of issue(s) through ‘problem tree’ analysis and then shift to identification of means to reach/achieve the ends through ‘objective tree’ analysis - Presentation and discussion	Resource person/expert, facilitators All trainees (groups)
10 minutes	Day 1 closure following distribution of handouts with key messages and channel-mix for programme interventions; key SBCC strategic approaches and indicative activities	
<b>Day 2:</b>		
<b>Technical sessions (contd.)</b>		
15 minutes	Summary of Day 1 and feedback from selected trainees	Selected trainees
15 minutes	Audio-visual, short documentary films on journey of Timor-Leste from malaria control to malaria elimination to prevention of re-establishment phase	NMP
60 minutes	- Messages and channel-mix, materials for programme	Resource person/expert,

Time	Sessions	Resource persons/Facilitators/Participants
	interventions; key SBCC strategic approaches and indicative activities - Q&A	facilitators  All trainees
60 minutes	- Group work introduction: Implementation/operational plan for calendar year (what, who, when, where, why and how)  - Presentation and discussion	Resource person/expert, facilitators  All trainees (groups)
60 minutes	Lunch	
60 minutes	- Role plays related to IPC, group communication	Resource person/expert, facilitators, all trainees
60 minutes	- M&E of SBCC (describing M&E, key considerations before data collection, reporting and use, data quality aspects, indicator description, supervisory checklist) - Selection of key indicators and Q&A	Resource person/Expert  All trainees
<b>Closing session</b>		
30 minutes	Post-test	All trainees
15 minutes	Trainee feedback	All trainees
15 minutes	Declaration of post-test results and recognition of best scores/pre-to post-test improvement scores	
15 minutes	Closing remarks by dignitaries	CDC/MoH, partner organization/expert

Training sessions will include:

- Ice breakers and energizers between sessions
- Sharing of handouts related to technical sessions; and information regarding relevant toolkits and resources [examples, SBCC implementation kits, The RBM advocacy for resource mobilisation (ARM) for malaria guidelines, The RBM malaria social and behaviour change communication indicator reference guidelines, CCP monitoring and evaluation for social and behaviour change communication tailored to malaria case management interventions, CCP evidence-based malaria SBCC: From theory to programme evaluation, CCP M&E for malaria evidence database:<sup>26</sup> C-Modules: A learning package for social and behavior change communication (SBCC). Practitioner's handbook<sup>27</sup> ; and resources from <https://thecompassforsbc.org/how-to-guides>].

Training materials:

- Training registration form
- Pre-test, post-test forms
- Training feedback form
- Observer checklist (to be identified from CDC, MoH or from stakeholders/partners)
- Chart paper and markers, sticky notes
- Participant handouts (SBCC strategy, resource materials)
- Hard copies of PowerPoint presentation

<sup>26</sup> Source: The RBM Partnership to End Malaria (2018). The Strategic Framework for Malaria Social and Behavior Change Communication 2018-2030.

<sup>27</sup> C-Modules: A Learning Package for Social and Behavior Change Communication (SBCC). Practitioner's Handbook Communication for Change (C-Change) Project managed by FHI 360 and supported by USAID. Version 3. 2012



- LCD projector and other equipment.

The effectiveness of trainings will be assessed through pre-test, post-test and trainee feedback (Table 15). Later, the same will be gauged through performance reviews; application of acquired knowledge and skills in the workplace; and outputs and outcomes. The information sources and timelines are mentioned below:

**Table 15.** Particulars to assess effectiveness of SBCC training

Particulars	Timeline
Completed pre-test form	At start of training
Completed post-test form	At end of training
Completed feedback form including trainer rating	At end of training
Completed observer checklist on conduct of training, venue	At end of training

## 4.9 Monitoring and evaluation

Monitoring is a regular, systematic process of measuring performance against set targets and benchmarks in a programme, while it is ongoing. Evaluation periodically assesses current versus desired performance standards and seeks to analyse whether the needs are met as envisaged and any gap, bottleneck to improve further performance in similar or different contexts. In other words, the knowledge of “what works” and “what does not” will provide support for continuing and improving effective interventions and discontinuing and reallocating resources regarding others.

M&E of SBCC will be an integral component of national M&E Plan towards:

- ensuring SBCC activities are on track and providing opportunities for mid-course corrections;
- demonstrating that messages, channel/approach/medium reached and served its purpose – achievement of behaviour outcomes; and
- obtaining guidance for programme decisions.

A logical framework aligned with the national performance framework will include the key elements, inputs->process->outputs/coverage->outcomes->impact. Appropriate SBCC indicators will be embedded within the NSP 2021–2025 related national M&E plan. The indicators will be devised as standardized measures of performance and results. These will verify whether activities are being/ have been implemented as planned within specific timelines; ensure transparency and accountability; detect any shortfall and/or constraint; provide valid and timely feedback to the decision-maker(s), key stakeholders for informed planning and strategizing; as well as document and disseminate empirical evidence on ‘lessons learned’, thereby improving effectiveness of programme.

An indicative list of indicators is presented below drawing on NSP 2021–2025 and RBM Malaria Indicator Reference Guide.<sup>28</sup> Besides core malaria indicators, the list includes those referring to behaviour outcomes in terms of practice of healthy malaria behaviours, communication outcomes in terms of knowledge and attitudes towards malaria behaviours, products and services; and programme output/coverage in terms of population reached with SBCC activities and number of activities conducted. The NMP will select indicators to be included in national M&E plan subsequent to deliberations within SBCC TWG.

Impact indicators:

<sup>28</sup> The RBM Partnership to End Malaria (2018). The strategic framework for malaria social and behavior change communication 2018-2030; and RBM Partnership to End Malaria. 2017. Malaria Social and Behavior Change Communication Indicator Reference Guide: Second Edition. Venier, Switzerland: RBM.

- In-patient malaria deaths per year: rate per 100 000 persons per year<sup>29</sup>
- Confirmed malaria cases (microscopy and/or RDT)<sup>30</sup>
- Number of active foci of malaria (Zero active foci will indicate no re-introduction of malaria and that prevention of re-establishment efforts is effective).<sup>31</sup>

#### Outcome indicators:

- Proportion of population that slept under an insecticide-treated net the previous night (Disaggregation: males and females, at-risk group)
- Proportion of households with at least one LLIN for every 2 people
- Annual blood examination rate (ABER): per 100 population per year (Disaggregation: males and females, at-risk group)<sup>32</sup>
- Proportion of population who can recall signs and symptoms of malaria, mode of malaria transmission, and diagnosis, treatment and prevention measures, and availability of services free of charge (Disaggregation: males and females, at-risk group)
- Proportion of people with a favourable attitude towards product, practice, and service
- Proportion of people who perceive they are at-risk of malaria
- Proportion of people who feel that consequences of malaria are serious
- Proportion of people who believe that the recommended practice or product will reduce their risk
- Proportion of suspected malaria cases that receive a parasitological test at public sector health facilities/PSF/Port Health Desk (Disaggregation: males and females, at-risk group)
- Proportion of at-risk group members who accessed services from public sector health facilities/PSF within 24 hours of onset of fever (Disaggregation: males and females, at-risk group)
- Proportion of confirmed malaria cases that received first-line antimalarial treatment at public sector health facilities within 24 hours of case detection (Disaggregation: males and females, at-risk group)
- Proportion of care providers who carried out test of all cases of fever and reported to designated authority (public/NGO/FBO/private provider) according to national guidelines
- Proportion of care seekers who sought test for malaria within 24 hours of onset of fever from designated provider (public/NGO/FBO/private provider).

#### Coverage/output indicators:

<sup>29</sup> Overall programme goal is to maintain zero number of deaths due to malaria in the country. Zero malaria confirmed mortality rate will indicate that malaria prevention of re-establishment efforts is effective, including continued access to early diagnosis and treatment and /or effective treatment for severe malaria and preventive interventions.

<sup>30</sup> Zero indigenous malaria case will indicate that malaria prevention of re-establishment efforts is effective, including continued access to early diagnosis and treatment and /or effective treatment for severe malaria and preventive interventions.

<sup>31</sup> [Malaria re-introduction is the occurrence of introduced cases (cases of the first-generation local transmission that are epidemiologically linked to a confirmed imported case) in a country or area where the disease had previously been eliminated]; and [Re-establishment of malaria transmission is renewed presence of a measurable incidence of locally acquired malaria infection due to repeated cycles of mosquito-borne infections in an area in which transmission had been interrupted (*Note: A minimum indication of possible re-establishment of transmission would be the occurrence of three or more indigenous malaria cases of the same species per year in the same focus, for three consecutive years*)].

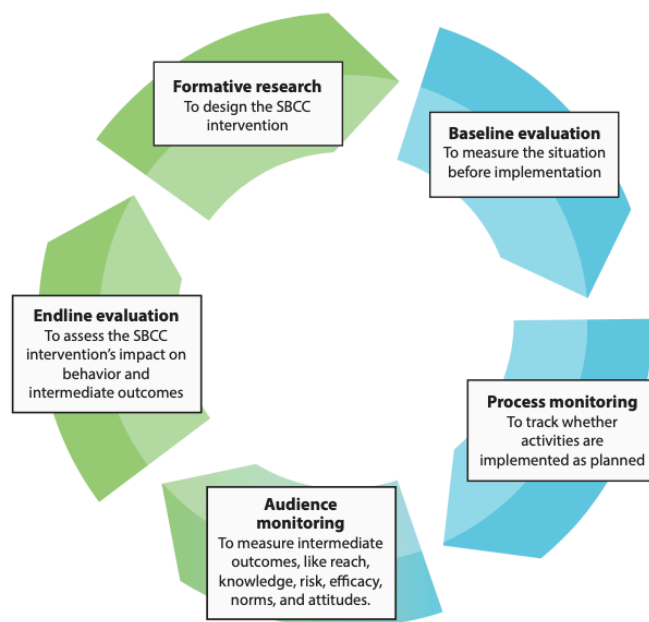
<sup>32</sup> [This will measure the level of diagnostic surveillance activity by means of ABER. As an indication of adequacy of case detection, in areas of high receptivity and/or vulnerability, this indicator will provide measure of application of rational parasitological testing for malaria]. [Higher testing rate (< 6%) is recommended in the Strata 1 (border sub districts in the border municipalities namely Oecusse, Bobonaro and Covalima) where receptivity and vulnerability is high. ABER < 3% is recommended for other strata except Strata 1]. [Special measures may be required to ensure coverage of mobile populations, temporary workers, illegal immigrant/refuge groups and others, whose allocation to an administrative unit is uncertain and who may not habitually use established stationary health facilities and services]

- Proportion of malaria cases, which were followed up on treatment by public health care service providers and received messages through IPC
- Proportion of households/families in targeted areas benefitted from preventive measures against malaria (LLINs, IRS, etc.)
- Proportion of houses that have been sprayed in targeted areas
- Number of people who recall hearing or seeing any malaria message in the last 6 months
- Number of care providers trained on SBCC and received SBCC resource materials
- Number of people educated on prevention of re-establishment of malaria transmission and related SBCC needs (Disaggregation: males and females, at-risk group)
- Number of targeted at-risk group who received SBCC materials
- Number of targeted schools, which conducted SBCC activities as defined in work plan
- Number of community meetings/SISCa held with the presence of community chief/stakeholders to reinforce malaria messages and promote malaria-free Timor-Leste
- Number of SBCC activity (radio/TV programme, community/school programme/others) conducted in targeted areas
- Number of mobile phone users who received messages through SMS/FB/others in targeted areas
- Number of villages covered/population reached by SBCC activity (radio/TV programme, community/school programme/others) in targeted areas
- Number of people reached, by type of activity (e.g., number of individuals/families who received messages through IPC by care provider)
- Number of villages that organized cleanliness days/number of villages identified as clean villages
- Number of advertisements
- Number of supervision visits carried out by central/municipality level officials covering SBCC component
- Number of advocacy sessions organized for community leaders, municipality officials/elected representatives, and media
- Number of community/at-risk group discussions organized with community leaders/municipality officials/elected representatives
- Number of community leaders/municipality officials/elected representatives who supported organization of community-level activities
- Number of partners/donors who are providing resource/any other support for sustaining malaria-free Timor-Leste
- Number of private sector companies/industries, which have written work place policy for protection of their employees and families against malaria
- Number of private sector companies/industries, which have invested in the prevention of re-establishment phase
- Number of NGOs/FBOs engaged with NMP for sustaining malaria-free Timor-Leste.

For each indicator, definition, rationale, data source, frequency of data collection and reporting, and means of verification will be part of the national M&E plan. Major data source will be SBCC and other programme reporting formats, activity registers for coverage/output and impact indicators, as appropriate. For outcome indicators, surveys will be considered.

Selection of indicators will be guided by different M&E stages through 2025 (Fig. 13).

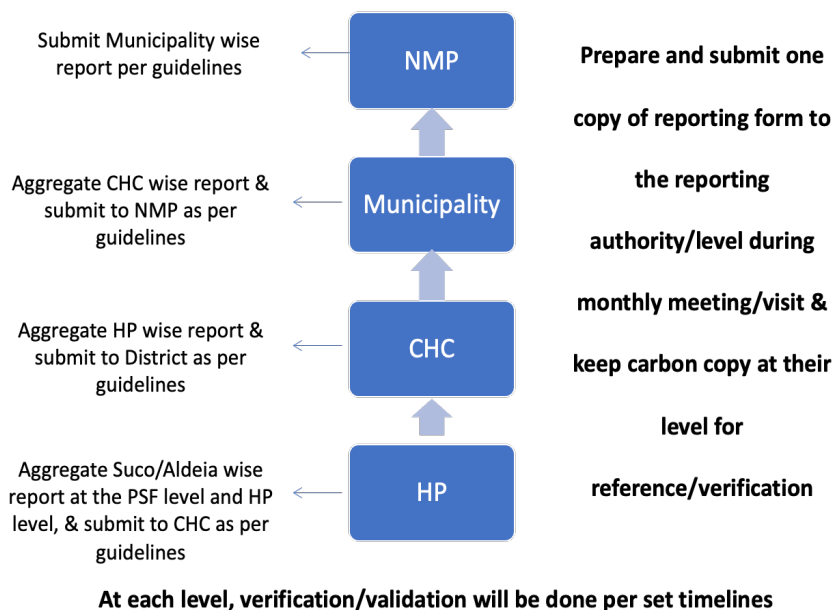
**Figure 13.** M&E needs during the life of a programme



Source: RBM Partnership to End Malaria. 2017. Malaria social and behavior change communication indicator reference guide. 2nd Edition. Venier, Switzerland: RBM.

The reporting system/data flow is presented in Fig. 14.

**Figure 14.** Recording/reporting and data flow across levels



The NMP will lead the M&E. The focal point and concerned staff will be responsible for routine reporting as well as evaluation, surveys, etc. to generate pertinent data. Standardized data collection tools and reporting formats will be used to capture data related to various SBCC activities together with supporting documents, as appropriate (e.g., attendance sheet for participants in community meetings endorsed by village head/chief, etc.). The national management information system (MIS) will be used to upload such data for periodic reporting, analyses, and feedback. Maintaining data quality will be crucial in terms of reliability, accuracy, timeliness, completeness and integrity. Overall programme data quality assurance system will be followed to validate the quality of data, and thereby provide information on possible need for improvement, if any.

## **Monitoring and supervision**

Regular supervision by the NMP and municipality will assess inputs, outputs and coverage, stakeholder involvement as detailed under:

- target area/population covered; number, method, timing of activities
- noticeability, comprehension, recall; quality and effectiveness of campaign/routine activities
- constraints, if any, and suggested way forward
- resource audits (adequacy/inadequacy of resource/personnel, performance of staff)
- training/re-orientation activities conducted for different levels.

A checklist will be used including, but not limited to the following elements:

- Check quality of activity; recording and reporting
- Check if key messages were delivered properly
- Carry out home visits to individuals/families who participated in the events to check if they recall the key messages (e.g., signs and symptoms of malaria, if diagnosed with malaria what will be done, etc.)
- Meet key stakeholders/community members to see if they know about availability of services with the PSF/HP, Port Health and the conduct of activities by them as well as whether community is assured about the first port of call, informed referrals, etc.
- Check if other players are following set guidelines, messages and appropriate channels.

The supervisor will attempt to address issues identified during visits or as early as possible and provide feedback to the supervisee.

Review and planning meetings at national/municipality levels: SBCC activities will be reviewed in monthly/quarterly/annual review as an integral component of overall programme review and planning meetings. During these meetings, implementation progress and coordination, capacity-building needs, and M&E will be discussed.

## **Evaluation and research**

The main objective of evaluation will be to assess the effect of implementation of communication strategy on target behaviours through measurement of:

- Changes in the baseline findings on knowledge, attitude, beliefs and skills
- Changes in behaviour of beneficiary or health care service seeker
- Changes in behaviour of health care service providers, and other stakeholders
- Changes in morbidity and mortality.

Baseline evaluation will be attempted entailing knowledge, attitude, belief and practice (KABP) and barrier analysis, emotion/logic-based motivation and driver analysis (target audience research going beyond demographics especially in terms of segmentation, internal and external barriers, conflicts surrounding behaviours; their need/want/desires; cost vs value of a behaviour; convenience to access to service/health product to maintain/adopt desired behaviour to be sustained in prevention of re-establishment phase, leveraging motivators; among others. The barrier/motivator analysis will help in understanding barriers and what drives people to adopt a desired behaviour/action, and those currently practicing desired behaviours to continue to adopt a desired behaviour/action. Such evidence will provide insight designing/fine tuning specifics of advocacy, communication, social and community mobilisation efforts,

messages, materials and channels. The efforts will be coordinated with technical partners like WHO. Dissemination of findings/results will support further planning, implementation.

Mid-term and end-term evaluations of SBCC as part of overall programme evaluation will be done at certain intervals, e.g., mid-term, and end of the NSP duration. Specific questionnaire will be used for the purpose and findings will update understanding on knowledge, attitudes, beliefs, values, social and cultural norms, aspirations, interests, lifestyle as well as practices (regarding use of interventions, sleeping patterns, media habits) relative to baselines. This will also facilitate understanding of target audience and drivers or motivating factors and barriers, inequities for behaviour change. The socio-economic frame of reference of at-risk groups and the most effective communication medium/channel for desired outcomes will be crucial. Furthermore, progress and/or challenges related to integrated messaging and activities for malaria and other relevant disease control programmes, when rolled out. Evaluation is usually done through a combination of survey, key informant interviews, FGDs, desk review of policies, strategy, guidelines, reports, etc. to obtain insight into how to make programmes more relevant and influential to the target audience and suitability of a channel/material.

A research agenda will be periodically updated in line with the research agenda for the NSP 2021–2025 to provide evidence for strategy changes and necessary improvements in implementation framework, etc. Both quantitative and qualitative research will be performed through method-mix.

All of the above will be part of the re-planning and strategizing for the next package of activities and campaigns.



**World Health  
Organization**

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Timor-Leste

**Social and Behaviour Change Communication Strategy for Prevention  
of Re-establishment of Malaria Transmission in Timor-Leste**

**Ministry of Health  
Democratic Republic of Timor-Leste**