Government of Malawi

Malaria Communication Strategy for Malawi

2009 – 2014

Ministry of Health
National Malaria Control Programme
Community Health Sciences Unit
P/Bag 65,
Lilongwe

November 2009

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Foreword

Malaria is a major public health problem in Malawi. It is the leading cause of morbidity and mortality in children under five years of age and pregnant women. It is the most common cause of outpatient visits, hospitalization and death. Malaria is also a developmental problem as it has a serious socioeconomic impact on families and the nation, through loss of work, school absenteeism and high levels of expenditures on treatment.

The government of Malawi through the Ministry of Health and its partners are committed to controlling malaria in the country. As part of malaria control strategies, the Ministry has developed several guiding malaria documents one of which is the Malaria Communication Strategy for Malawi for 2009 to 2015. Using the strategy as a guide, behaviour change communication will lead to improved community uptake of malaria control interventions.

The main malaria behaviours that need to be adopted and maintained by individuals, families and communities, include, among others, Malaria Case Management, Intermittent Preventive Treatment (IPT) of pregnant women with SP and malaria prevention with special emphasis on Insecticide Treated Nets/ Long Lasting Insecticide Treated Nets (ITNs / LLINs) and Indoor Residual Spraying (IRS).

I am hopeful that concerted efforts to implement this malaria communication strategy with support of global, regional and national partners will enable Malawi to significantly reduce the health and socioeconomic burden of malaria.

Hon. Prof. Moses Chirambo, MP
Minister of Health

Acknowledgements

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We greatly appreciate the contributions of the participants in the two communication strategy development meetings that took place in April and May of 2009. A complete list of these participants can be found in Annex C of this document. We would also like to specifically thank the core writing team of Mr. John Zoya, National Malaria Control Programme (NMCP); Mr. Daniel Maseko, Health Education Unit; Mr. Charles Yuma, Populations Services International; Mr. Chancy Mauluka, BASICS Project, Management Sciences for Health; Ms. Carol Larivee, Communication for Change (C-Change) Program, Academy for Educational Development; and Mr. Joshua Volle, C-Change Program, Academy for Educational Development.

In addition, we are also thankful to the key reviewers of this document for their important contributions: Ms. Katherine Wolf, USAID; Mr. John Justino, PSI; Mr. Rudi Thetard, BASICS; and the final review by Ms. Doreen Ali, Head NMCP.

Finally, in advance, we would like to thank all of the organizations and individuals who will work hand in hand with the National Malaria Control Programme over the next five years to empower Malawians to take charge of malaria in our families and in our communities.

C.V. Kang'ombe
Secretary for Health
Ministry of Health

Acronyms

ADC	Area Development Committee
AEDO	Agriculture Extension Development Officer
ADP	Agricultural Development Division
ANC	Antenatal Clinic
BCC	Behavior Change Communication
CDA	Community Development Assistants
CDC	Centers for Disease Control and Prevention
CBO	Community Based Organization
CHAM	Christian Health Association of Malawi
CPAR	Canadian Physicians for Aid and Relief
CRWRC	Christian Reformed World Relief Committee
DHB	District Health Budget
DHMT	District Health Management Team
DHO	District Health Officer
DHP	District Health Plan
DHS	Demographic and Health Survey
EHP	Essential Health Care Package
GoM	Government of Malawi
GVH	Group Village Heads
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
HRC	Health Research Committee
HSAs	Health Surveillance Assistants
IEC	Information, Education and Communication
IRS	Indoor Residual Spraying
ITMs	Insecticide-Treated Materials
ITNs	Insecticide-Treated Nets
IMCI	Integrated Management of Childhood Illness
IPTp	Intermittent Preventive Treatment for Malaria in Pregnancy
KAP	Knowledge, Attitude and Practice
LA	Artemether-Lumefantrine
LLIN	Long Lasting Insecticide Nets
MDHS	Malawi Demographic and Health Survey
MOH	Ministry of Health
MOHP	Ministry of Health and Population
NGO	Non-Governmental Organization
NMCC	National Malaria Control Committee
NMCP	National Malaria Control Programme
NRCM	National Research Council of Malawi
NSMP	National Safe Motherhood Programme
PLWA	People Living with HIV and AIDS
PMPB	Pharmacy, Medicines and Poisons Board
RBM	Roll Back Malaria
SBCC	Social and Behavior Change Communication
SP	Sulfadoxine-Pyrimethamine
SWA	Social Welfare Assistants
TBA	Traditional Birth Attendant

TRaC	Tracking Results Continuously
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
VDC	Village Development Committee
WB	World Bank
WHO	World Health Organization

Executive Summary

The National Malaria Control Programme is embarking on a new era in communication for malaria which calls for a comprehensive communication strategy that will:

- **Empower communities**, families, and individuals to take charge of malaria control.
- **Create a demand** for information and services on malaria prevention and control.
- **Stimulate community dialogue, discussion, and action** on malaria control.
- **Increase depth of knowledge** about malaria prevention and treatment.
- **Increase coverage** of social and behavior change communication (SBCC) to all communities in Malawi.

The evidence shows that it is not enough to provide information on malaria to communities and expect a change in malaria indicators. It is necessary to overcome the basic apathy and fatalism associated with living with malaria as well as many related traditional beliefs and practices.

Grounded in the Social Ecology Model of Communication and Behavior, a national branded communication campaign utilizing mass media, advocacy and social mobilization will be developed. The campaign will aim to empower communities and families to take charge of malaria. Malaria-prepared communities be marketed through the mass media and link to a branded campaign. Media will be used to magnify successes from the community level to the nation as whole and spur a competition for positive malaria behaviors resulting in reduction of malaria episodes and improved case management. Advocacy strategies will be employed to bring malaria action into the national spotlight and bring in new national structures and partners to join the movement to take charge of malaria.

Underlying the strategy will be systematic capacity building on social and behavior change communication for malaria. A participatory monitoring and evaluation plan will ensure the strategy is updated and renewed to reflect new information and needs in the community. Finally, for this strategy to be a success, it will take the coordinated and concerted effort of many partners and sectors. A coordination plan will be put in place, building on existing structures to ensure the success of this initiative.

1. Introduction

Malaria is having a major impact on the economic development of Malawi, with 28% of household incomes spent on treating and dealing with the outcomes of malaria (GOM Malaria Strategy Plan 2005 -- 2010.) While providing malaria information to communities contributes to changed behavior, there is a need for a comprehensive social and behavior change communication strategy to spearhead a concerted effort to control malaria in Malawi.

The National Malaria Policy states that *"information, education and communication (IEC) improves recognition of malaria by individuals and child carers. IEC encourages people to seeking prompt care and take preventive measures. IEC also promotes participation by individuals, families and communities in planning. It enhances resource mobilization and actions to control malaria. The 2000 MDHS suggested that health education messages must be designed for a large number of individuals and heads of households who have little or no formal education and limited access to mass media. Health education messages must explore a variety of means to effectively communicate to the public."*

To achieve this goal, a National Malaria Communication Strategy has been developed to provide a framework for all organizations working on combating malaria in Malawi. A coordinated effort is essential to ensure deeply engrained behaviors related to malaria are changed.

The National Malaria Control Programme joined forces with key stakeholders working on malaria in Malawi in a participatory process and developed a draft communication strategy in 2005. This document builds on that initiative and reflects changes in the new drug policy and the introduction of indoor residual spraying. This strategy is based on a series of consultations with key individuals and organizations working on malaria in Malawi from January through May 2009. During these meetings, a review took place on the draft strategy and participants presented and consolidated various research findings covering net usage, care seeking behavior, and IPTp. In Annex A, a complete list of research studies and resource documents can be found.

The assumption underlying this strategy is that the service delivery, policy, management, logistics, and supply interventions that are necessary complements to any successful communication strategy will be put in place. Recognizing the crucial importance of these issues, the managers of this communication program must closely coordinate with their service delivery counterparts. Advocacy-related communication will be crucial to ensure that the necessary services are in place. Communication programs should be synchronized with services; for example, when LA is fully available and health workers trained in a certain district, appropriate communication interventions should accompany or follow closely behind to sensitize the community.

2. Background

2.1 Epidemiology

Malaria is the leading cause of morbidity and mortality, particularly in children under five years of age and pregnant women. In 2007, it affected 34% of Malawi's population. It is the most common cause of outpatient visits, hospitalization and death. (GOM Malaria Strategic Plan 2005 – 2010).

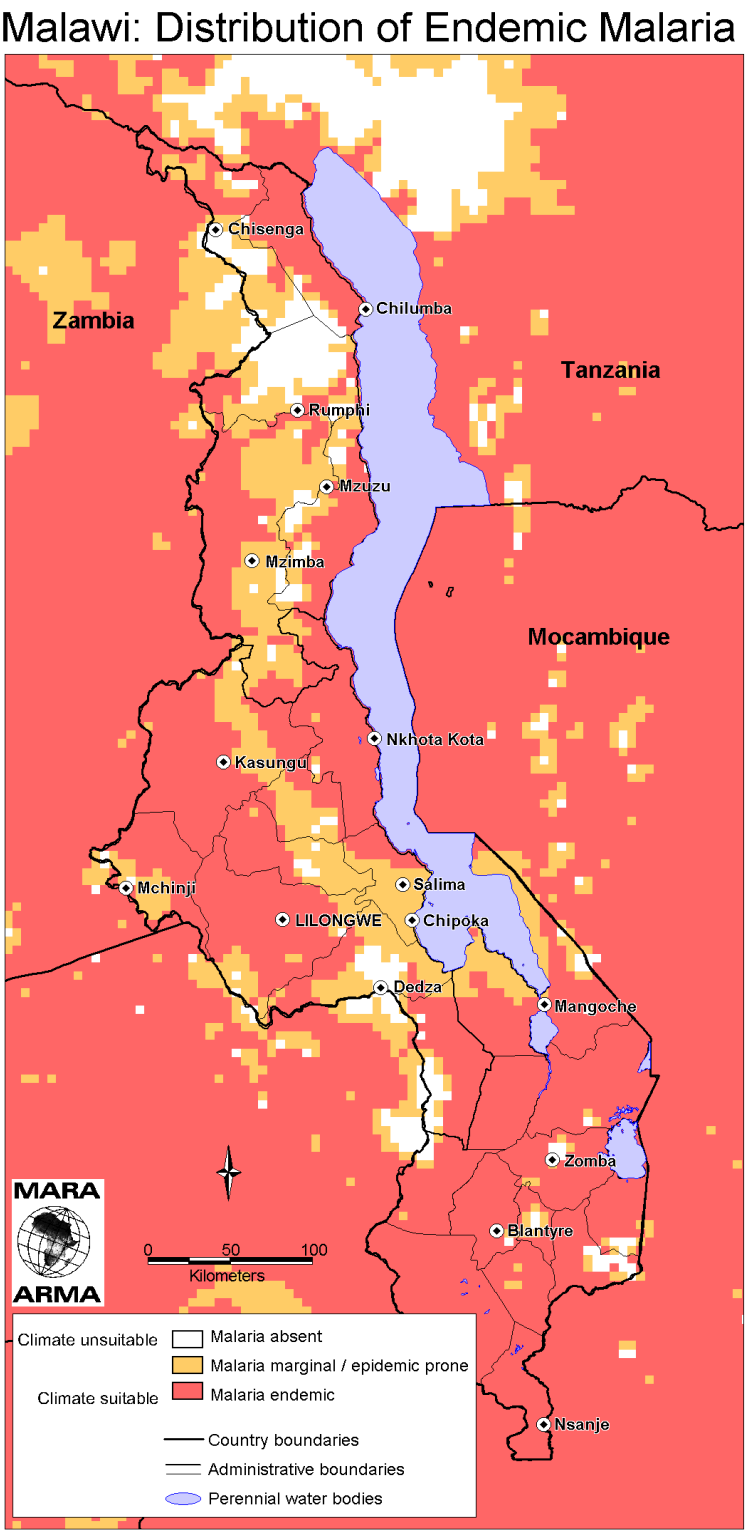
Malaria is also a development problem as it has a serious socioeconomic impact on families and the nation through loss of work, school absenteeism, and high levels of expenditure on malaria treatment, especially by poor households. It presents with any of the following signs and symptoms: fever, generalized body pains, vomiting and diarrhea, headache, joint pains, convulsions, unconsciousness, and anemia.

Malaria and anemia (usually attributed to malaria infection) are estimated to be responsible for about 40% of all under-five hospitalizations and 30% of all hospital deaths in under-five children. *Plasmodium falciparum* is by far the most common species, accounting for 98% of the infections, and is responsible for severe disease and most deaths. Other species, including *P. malariae* and *P. ovale*, account for up to 2% of cases. *P. vivax* is very rare.

Female anopheles mosquitoes transmit malaria from one infected person to another. The most common malaria vectors in Malawi are *Anopheles gambiae*, *A. funestus* and *A. arabiensis*. It is estimated that there are between 30 and 50 infective bites per person per year. These contribute to an estimated 6 million episodes of malaria per year in the general population.

Malaria transmission in Malawi is principally determined by climatic factors – rainfall, humidity, and temperature. In terms of endemicity, Malawi can best be described as a stable transmission malaria country. Figure 1 on the following page illustrates the endemicity distribution of malaria in Malawi.

Approximately 85% of the population of Malawi consists of traditional rural farmers with limited access to mass media and electronic forms of communication.



This map is a product of the MARA/ARMA collaboration (http://www.mara.org.za). July 2001, Medical Research Council, PO Box 17120, Congella, 4013, Durban, South Africa
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Swiss Tropical Institute, Multilateral Initiative on Malaria (MIM) / Special Programme for Research & Training in Tropical Diseases (TDR), Roll Back Malaria (RBM).
Malaria distribution model: Craig, M.H. et al. 1999. Parasitology Today 15: 105-111.
Topographical data: African Data Sampler, WRI, http://www.igc.org/wri/sdis/maps/ads/ads_idx.htm.

Figure: Map of Malawi and relative malaria transmission intensity and endemicity distribution

2.2 Key Malaria Intervention Strategies

There are four major interventions to combat malaria in Malawi:

- ***Intermittent Preventive Treatment (IPTp) for all pregnant women*.** The Ministry of Health currently recommends that at least two doses of sulfadoxine-pyrimethamine (SP) be provided one month apart to pregnant women during the second and third trimester as a way of preventing malaria. This intervention forms an integral part of a comprehensive antenatal care (ANC) package.

- ***Long Lasting Insecticide Nets (LLIN)*.** In line with the current WHO recommendations of universal access to insecticide treated nets, the Government of Malawi (GoM) shall embark on universal distribution of treated nets in order to obtain maximum coverage of all people by 2015. Re-treatment of existing ITNs will continue until universal coverage of LLINs is completed. It is especially important that all pregnant women and children under five sleep under a long lasting insecticide treated net every night, all year round.

- ***Case Management and Care for Fever within 24 Hours with LA*.** Malawi changed its first line malaria treatment policy from use of SP to Artemisinin based combination therapy (Artemether-Lumefantrine) in 2007 in line with the current WHO recommendations. This treatment is currently health facility based and is recommended to be administered within 24 hours of onset of fever. However, plans are underway to scale up to community distribution channels through village health clinics.

- ***Indoor Residual Spraying (IRS)*.** IRS implementation still remains a challenge for Malawi despite successful results from pilot areas due to limited capacity in procurement. However, Malawi is planning to scale up IRS implementation to high transmission districts.

2.3 National Targets for Malaria from NMCP

The objectives of the national malaria policy are that by 2015:

- At least 90% of children under five years of age and pregnant women have access to effective malaria treatment within 24 hours of the onset of symptoms
- At least 90% of households sleep under LLINs which are accessible and affordable
- At least 90% of all pregnant women receive Intermittent Preventive Treatment for malaria in pregnancy
- At least 90% of the districts experiencing increased seasonal malaria have capacity to detect and respond effectively
- Generate evidence for decision making in malaria program operations on an ongoing basis
- Scale up IRS implementation from one to seven highly endemic districts.

3. Behavior Change Goals

To achieve the national goals, the following malaria behaviors need to be adopted and maintained by individuals, families, and communities. Social and behavior change communication interventions play an important role in contributing to these goals.

3.1 Case Management

- Seek care at health facility within 24 hours of onset of fever
- Complete drug course as per prescription
- Take LA for first line treatment for malaria
- Policymakers have complete knowledge of new drug policy

3.2 IPT

- All pregnant women take at least two doses of SP on the 4th and 7th month of pregnancy or one month apart within second and third trimester
- All pregnant women attend ANC at least four times during the pregnancy

3.3 ITN/LLIN

- All households should have one net for every two people
- All members of the household sleep under an ITN/LLIN every night, all year round
- Pregnant women and children under five sleep under an ITN/LLIN every night, all year round
- People sleep under an ITN/LLIN even if their house has been sprayed

3.4 IRS

- Families and communities do not wash, smear, or plaster the walls of their house after house is sprayed with insecticides
- Families remain out of their houses for the recommended time following spraying
- IRS is safe and effective.
- People sleep under an ITN or LLIN even if their house has been sprayed

4. The Evidence

4.1 Behavioral Challenges and Determinants

A number of studies have been undertaken in the past two years that outline some of the major behavioral determinants of malaria behaviors (see Annex A for a complete list). These range from the PSI TRaC study on net usage to the KAP Baseline Survey Report of the Pholombe Malaria Project that examined care seeking practices and treatment of childhood fevers. The data from these studies have informed the development of this strategy. In addition to access issues (for drugs and nets), there are myths and misconceptions, cultural issues, and negative health worker attitudes that impact the uptake of positive malaria-related

behaviors. It is clear that malaria is not perceived as a major threat and that fatalism and a lack of self efficacy are major challenges.

Many communities have different myths and misconceptions about malaria and treatment of malaria. These are specific by community. Some examples include:

- Malaria is caused by witchcraft
- Sleeping under a net and IRS makes you impotent
- Misconceptions about side effects of SP contributes to late uptake of the IPTp

Other challenges emanate from fears and perceptions of malaria and services provided, such as:

- SP may cause abortion in pregnancy
- Once the fever and symptoms of malaria cease, one is fine and it is no longer necessary to continue taking the medication.
- When you do not see or hear the mosquitoes, you do not need to use the ITNs

Apart from cultural challenges, there are behavioral challenges emanating from inadequate knowledge:

- There is poor knowledge on dose regarding the new LA regimen
- Some mothers do not know the frequency of taking SP during pregnancy while others do not know the importance

IRS is a new intervention in Malawi. As it unfolds, efforts will be made to address any behavioral issues that could negatively impact the spraying intervention. From the behavior challenges found, the following were some of the conclusions about the behavioral determinants:

- **Perceived availability of nets and drugs.** People who feel that nets and drugs are not available do not use nets and do not seek appropriate treatment respectively.
- **Self- Efficacy.** The more people feel confident in their ability to protect their families, the more they are willing and able to practice prevention.
- **Traditional disease.** Malaria is part of life in Malawi and is seen as normal and natural.
- **Risk perception.** There is a low perception of malaria as a life threatening disease.
- **Beliefs relating to malaria.** People's capacity to adopt and sustain a new behavior is influenced by their beliefs.

4.2 Potential Research Areas

Two areas emerge for further study:

- Qualitative study to better understand how threat perception changes as people use or do not use nets/have or do not have easy access to treatment services.

- Operations research to understand the effective life of the polyester and polyethylene nets distributed and what happens to these nets as they wear out. This could support the development of a strategy/policy which addresses net disposal/re-use at a national level.

5. Target Populations

5.1 Primary Target Populations

- ***Care Givers of Children Under Five***

Care givers of children under five are usually mothers or grandmothers, responsible for the health and wellbeing of themselves and their children. They are steeped in traditional culture and myths and need to seek permission to bring a sick child to the clinic.

Current Behaviors

- Self medicate with local drugs or drugs found in local shops, e.g. pain killers or anitmalarials to which the malaria parasite is resistant
- Seek care at the health facilities as a last resort
- Do not attend early ANC
- Fail to adhere to treatment regimen
- Inconsistent use of nets

Perceived and Real Challenges

- Do not perceive malaria as a major issue
- Have closer links to TBAs and traditional healers than the health system
- Drugs are not available at the local shops
- Administering LA entails carefully following dosage recommendations
- Nets are not always available
- Health worker attitudes
- Distance to and operating hours of the health facility
- Scorching and rashes from insecticides

Potential Perceived Key Benefits

- Having a healthy and strong child
- Having energy to take care of their family if not dealing with the impact of malaria
- Having more money to take care of their families
- Will sleep peacefully without the annoyance of mosquitoes and other insects

Opinion Leaders

- TBAs
- Older women in the community
- Village leaders
- Religious leaders

- ***Adult Men***

Current Behaviors

- Self-medicate with local drugs or drugs found in local shops
- Seek care at the health facilities as a last resort
- Low treatment compliance
- Do not place a priority on procuring nets for their families
- Do not support their wives in ANC attendance
- Inappropriate use of nets (example of fishermen using nets for fishing nets)

Perceived and Real Challenges

- Do not perceive malaria as a major issue
- Are not involved in issues linked to the health of their wives and children
- Often receive information about heath issues from their wives – they do not attend all of the various community education sessions
- Drugs are not available at the local shops and must be obtained at the health facility
- Do not have complete drug compliance under the new drug policy
- Nets are not always available
- Scorching and rashes from insecticides
- Various cultural beliefs such as attitude and beliefs related to sexual potency and net usage
- Distance to the health center

Potential Perceived Key Benefits

- Having a healthy and happy family
- Having energy to take care of their family
- Having more money to take care of their families
- Will sleep peacefully without the annoyance of mosquitoes and other insects

Opinion Leaders

- Village leaders
- Religious leaders
- Traditional authorities

- ***Pregnant Women***

Current Behaviors

- Only attend ANC near the end of their pregnancy and only take one dose of IPT
- Do not always sleep under a net/LLIN
- Seek support from TBAs
- Use of traditional medicines as alternative treatment of malaria

Perceived and Real Challenges

- Fear of being tested for HIV
- Culturally inappropriate to share the knowledge of pregnancy in the early months
- Negative attitudes of health workers
- Distance to the health center
- Fear and belief that SP causes serious side effects to a pregnant woman i.e. dizziness, heart palpitations, miscarriages etc.
- Feeling/belief that malaria signs and symptoms are a normal process of pregnancy
- Scorching, unpleasant odor, rashes, and/or suffocation from nets

Potential Key Benefits

- Prevents delivery complications
- Delivering a healthy child
- No miscarriage

Opinion Leaders

- TBAs
- Older women in the community
- Village leaders
- Religious leaders
- Traditional leaders

In addition, PLWA need to be specifically targeted as they are more vulnerable to severe malaria. There is also a potential risk of taking SP and cotrimoxizole concurrently.

5.2 Secondary Target Populations

Key opinion leaders influence the decisions and behaviors of the primary target populations. These groups will be targeted to support the challenge of taking charge of malaria in their communities:

- ***Traditional healers*** are often the first line of call for fever in the community. They need to be enlisted to work with the programme to refer community members for appropriate treatment.

- ***Traditional Birth Attendants*** are often the first persons contacted when a women is pregnant in the community. It will be important to work with the TBAs for appropriate referrals to the ANC.

- ***Village leaders*** can set the tone for a malaria “take charge” programme in their communities and need to be empowered to urge community members to action in their fight against malaria.

- ***Shop keepers*** are often a first or second point of call for treatment options. They also need to be enlisted to refer to the appropriate health facilities.

- ***Health workers*** are critical front line workers for malaria. Work needs to be done to foster closer ties between the health worker and the communities to overcome the perception of health worker attitudes.

- ***Religious leaders*** play an important role in the communities, providing counseling and spiritual advice. They can be leaders in malaria programming.

- ***Traditional authorities*** are respected by all members of the community and should be the central figures in mobilizing communities to take charge of malaria.

- ***Political leaders*** need to raise the level of discussion on malaria at the national, district, and local levels to show how important the Government of Malawi is taking the issue of controlling malaria.

6. Behavior Change Communication Goals

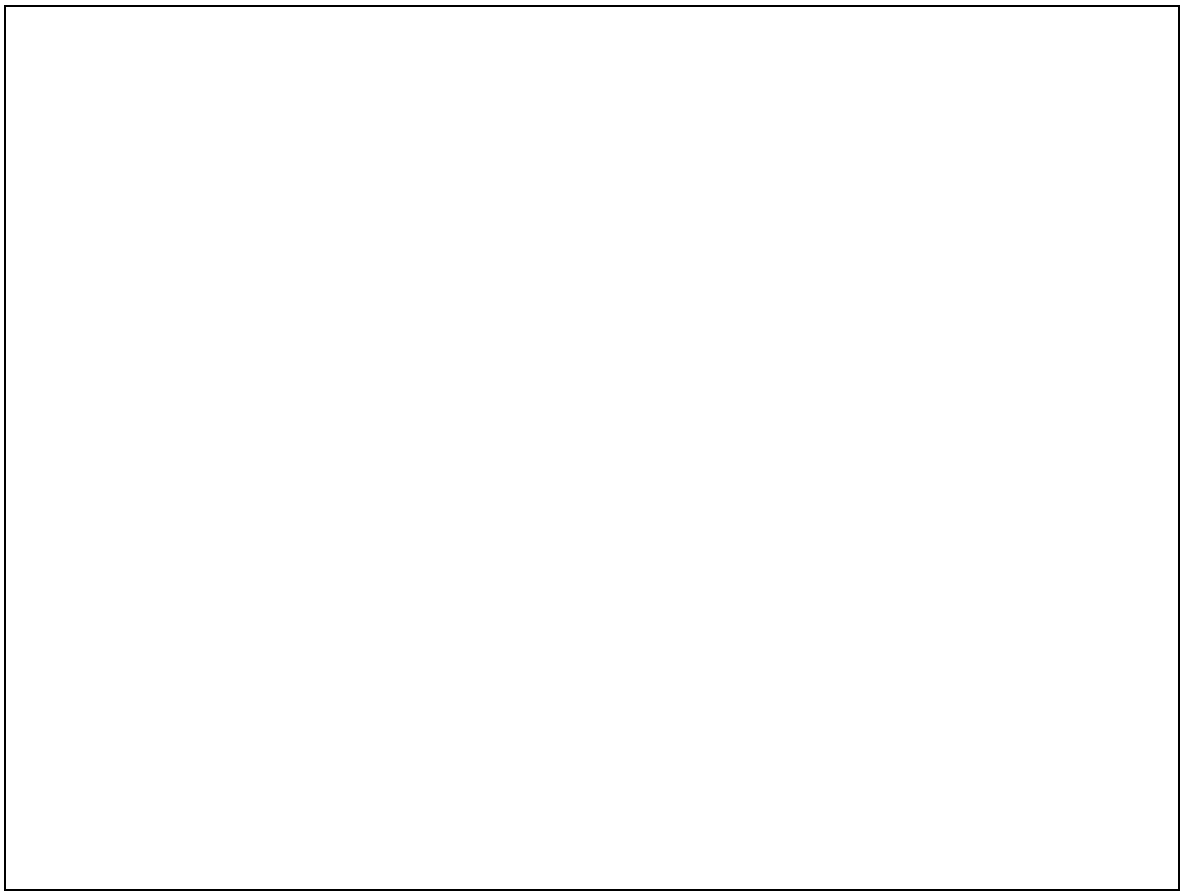
The overriding BCC goal is to raise the issue of malaria as a critical issue in Malawi. There is a sense of apathy around malaria, with the feeling that it is a traditional part of life. The communication for malaria needs to:

- **Empower communities**, families and individuals to take charge of malaria
- **Create a demand** for information and services on malaria control
- **Stimulate community dialogue, discussion and action** on malaria control
- **Increase depth of knowledge** about malaria prevention and treatment
- **Increase coverage** of social and behavior change communication to all communities in Malawi

7. Approach and Key Messages

The NMCP is being guided by the social ecological model of communication and behavior change with the premise that individuals function within culturally determined social networks and communities. To make an impact on malaria, communication interventions need to take place on all levels and:

- Integrate top-down and bottom-up approaches
- Combine media and interpersonal communication
- Have community empowerment as a goal



This ecological approach suggests the need for a comprehensive SBCC programme to target individual behaviors, engage with the community, and help address underlying society factors that impede the uptake of malaria prevention and control behaviors. Two other theories guide this strategic approach. The *Health Belief Model* is formed on the basis of expected benefits, barriers, and ability to act against the perceived risks and severity of the health threat. Changing the sense of perceived risk and ability to act is very important to impact malaria in Malawi. In addition, the *Diffusion of Innovations* theory provides insight on how to work with communities to introduce new innovations (new technologies, drugs, and norms) and magnify those who change their behaviors first (early adopters) to the communities at large.

The NMCP calls for a branded comprehensive communication campaign utilizing all channels of communication. The overall theme will need to focus on empowering communities to take charge of malaria while providing them with critical prevention and treatment information.

7.1 Branded Approach

There will need to be a campaign name, logo, and slogan developed (using a creative brief to guide agencies in the development) as well as rigorous pretesting.

Perceptions	Emotional Pulse Points	Theme Concept
Malaria is seen as a traditional/normal disease, part of life Low perception of malaria as a life threatening condition Low self efficacy to take action against malaria	Respect and hierarchy of Malawian society Need to be seen as smart about malaria to be respected	Malaria is no longer a traditional disease, we can take charge of it. A smart man (community) doesn't let malaria in, a foolish man lets money and energy drain from his family…

To find the most effective trigger to get the attention and action of a malaria weary society, it may be necessary to conduct some additional rapid formative research into the issue of risk perception and how to utilize the core Malawian concepts of respect and hierarchy. The branded campaign is a critical element of the strategy. Until Malawians take malaria seriously and see the sense and importance of conserving their health, energy, and financial resources, specific messages on net use and treatment will be ineffective.

7.2 Message Creation

The following information necessary for message creation will be framed around the overall concept of the campaign. Draft messages are illustrative; a creative team will work with this information to develop effective communication messages that fit within the overall theme of the campaign.

Care Givers of Children Under Five
Case Management ▪ Fever is a major sign of malaria. Take your child to the clinic within 24 hours (one day) ▪ Malaria is dangerous for children under five! If treatment is delayed, the child may faint or die. Show your love by taking the child to the clinic before the end of 24 hours/one day from the onset of fever ▪ Make sure that your sick child has taken LA according to the doctor's prescription ▪ Community leaders (including family opinion leaders), encourage the woman to go to the clinic within 24 hours from the onset of fever – even without your consent! ▪ Community leaders, it is your responsibility to address fears and perceptions on malaria through discussions with your people
ITN ▪ Parents! Make sure your child sleeps in an ITN every night, all year round, to prevent malaria

Adult Men
Case Management ▪ Seek prompt treatment to avoid malaria complications ▪ Doctors, encourage your patients to complete malaria treatment ▪ One course=one person! To ensure your full recovery, do not share
ITN ▪ Let's sleep under LLINs all year round to avoid mosquito bites ▪ ITNs are available when you need one; sleep under an ITN to avoid being bitten by malaria mosquitoes
IRS ▪ Spray your house even if you sleep under an ITN to avoid being bitten by malaria mosquitoes
IPT/SP ▪ Men, encourage your spouses to take SP during pregnancy ▪ Men, encourage your spouses to start ANC early ▪ Men, escort your spouses to ANC

Pregnant Women
Case Management ▪ Pregnant woman! Seek treatment from the nearest clinic before the end of 24 hours (one day) from the onset of fever ▪ Pregnant women, take full compliance of anti-malarial treatment when prescribed at the clinic
ITN ▪ Pregnant women are more vulnerable to malaria and should sleep under an ITN/LLIN while pregnant every night, all year round, to prevent malaria
IRS ▪ Sprayed houses kill mosquitoes and protect you and your unborn baby from malaria
IPT/SP ▪ Pregnant women, avoid miscarriage by taking two doses of SP during pregnancy ▪ Husbands, show your love by encouraging your wife to attend ANC to receive two doses of SP during pregnancy ▪ Pregnant woman! You can still take SP on an empty stomach

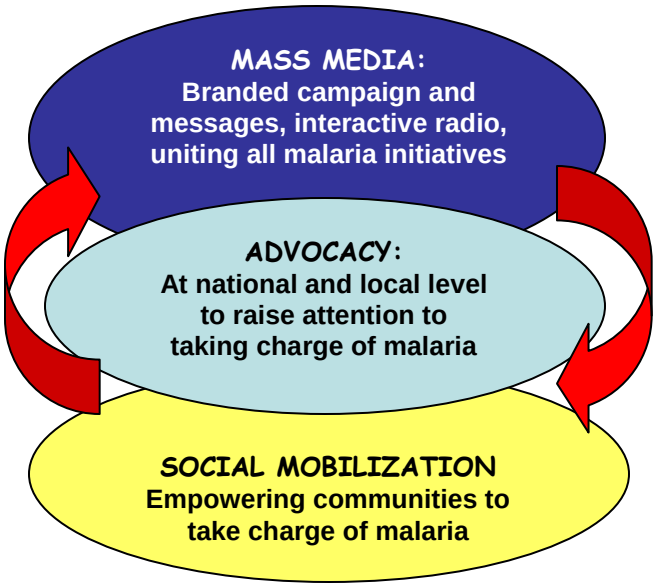
Once finalized, the key campaign messages will be the starting point for discussion and action at the community level, supported by opinion leaders and policy makers.

8. Communication and Social Mobilization Interventions

A combination of mass media, advocacy, and social mobilization will be utilized to reach the goals of this strategy. Only a concerted, coordinated effort will have the desired impact.

8.1 Mass Media

A branded national malaria mass media campaign will be developed with the main focus of breaking through the fatalism and apathy around malaria and empowering communities and families to take charge of malaria. The campaign will segment and target the key primary audiences and ensure accurate and understandable malaria information is available for a low literate audience. The campaign will be the umbrella for messaging that all other interventions will follow. It will be developed to phase in new messages during the course of five years to keep the momentum going as well as keep alert to new issues and needs in the community.



As the majority of target populations live in rural areas, the use of mass media will be strategic. The following is an illustrative list of media to be used. Actual details will be finalized as the national campaign is developed.

Channels of Communication	Activity	Advantage
Broadcasting: Radio Television at national or community level	• Branded radio spots • Interactive radio programmes • Call in shows • Mobile video	▪ Wide coverage in a short time ▪ Use of local language ▪ It depicts behavior rather than describing ▪ Offers a 2-way interaction, especially in call in programs
Print media	Series of low literate print materials for use in communities: ▪ Poster ▪ Brochures ▪ Flip charts ▪ Inserts ▪ Picture codes	▪ Wide coverage ▪ Use of local language ▪ Covers issues thoroughly ▪ Audience able to internalize the message
Information Technology	Texting	▪ It updates and disseminates information very rapidly ▪ Can be interactive and user directed ▪ Can combine picture and text

In each year, there will be three waves of mass media. Print materials will be produced at a large scale to cover the country and support the social mobilization

interventions. A systematic process of concept development and pretesting will be followed to ensure materials and messages have the desired effect.

Every year, based on the monitoring and evaluation findings, the messages and media will be reviewed and updated as necessary.

8.2 Social Mobilization

Mobilizing communities to take charge of malaria is a central focus of the communication strategy. Only when communities are empowered and make malaria prevention a norm will the physical and economic impact of malaria be overcome.

To accomplish this, a number of activities can take place at the community level. Central to the programme and marketed through the national mass media campaign is the development of ***malaria-prepared communities***. Malaria-prepared communities:

- Know the data on malaria in their communities
- Actively monitor the situation by tracking progress against a standard criteria check list
- Organize community programmes and events to educate and discuss the issue of malaria in their communities
- Work with community members to see that nets are procured, hung, and used, and that women get to ANC in time for two doses of SP
- Support clinic visits within 24 hours of onset of fever

A ***malaria-prepared community tool kit*** will be developed to provide suggestions and tools for empowering families and communities. The tool kit will contain instructions on how to undertake various activities, picture codes, and other BCC materials from the national campaign.

- **Tapping into Community Systems**

To initiate this process of developing malaria prepared communities, it will be necessary to tap into the administrative, technical, and traditional systems that support communities.

- **Review of Communication Modules *vis a vis* Malaria.** The communication training modules for the DHMT, HSAs, and volunteers will be reviewed to gauge the strength of their relevance with malaria challenges. This will ensure that implementing agents are better able to challenge the cultural barriers that demand interpersonal and group dynamic communication skills.

- **Orientation of District Assembly Stakeholders.** For the mainstreaming agenda to be fruitful, different government departments and other sectors at the district level will be oriented on the strategy. During orientation, the

stakeholders will be expected to work out the way forward for their participation in the implementation of the strategy.

- **Training of Community Leaders.** Community leaders will be oriented on malaria themes and their expected roles during the implementation of the strategy. Leaders will develop plans of action to implement in their areas. These activities will include development of a community based monitoring of malaria prevention and control activities, i.e. tracking down indicators of success.

- **Training of HSAs.** Health Surveillance Assistants will be orientated on the priority issues in the malaria strategy and commit to develop plans of how they are going to disseminate the messages and supervise volunteers during the implementation of the strategy.

- **Training of 'Volunteers.'** Volunteers will be representative leaders from existing groups. Training will be done at the Group Village Head (GVH) level and include representatives from the following groups:
  - Village Health Committees
  - CBOs
  - VDCs and ADCs
  - Water Point/Borehole Committees
  - Agriculture Committees
  - Teachers
  - Church Leaders
  - Other Volunteers

  These trainers will later orient others from their respective groups and be responsible for motivating their groups or followers to adopt positive behaviors in the prevention and control of malaria. Volunteers will be equipped with interpersonal communication skills that enable them to break through cultural barriers using interpersonal dialogue. They will also be trained on how to track indicators of impact through a simplified monitoring tool so that there is a community based system of monitoring feeding into the reports of HSAs and the district. The expected immediate results from these trainings will be that volunteers can conduct household visits, public talks and lead/facilitate community based initiatives.

- **Potential Activities**

  - **Household Visits.** These will be conducted by HSAs and volunteers in the villages. Small group discussions and person-to-person conversations will be conducted to stimulate dialogue. During these visits, HSAs and volunteers will use visual aids like flip charts, modules, and picture codes.

- **Village Meetings.** Community leaders, HSAs, and volunteers will conduct meetings to disseminate malaria messages and respond to community-specific queries on knowledge and attitudes surrounding malaria.

- **Health Discussions.** Apart from the facility based heath discussions, similar activities will be made targeting ordinary villagers in their local settings like churches, water points, and market places.

- **Community Interactive Radio.** Community discussions on malaria will be recorded into a radio programme for broadcast. Radio listening groups could be formed to listen to how different communities have tackled making their villages malaria free.

- **Open Days.** Open days will be organized where the trained community, drama groups, volunteers, and the community as a whole will have a chance to disseminate and showcase malaria messages and interventions. Activities during open days will include traditional dances, health education band performances, testimonies, and video shows.

- **Training of Theatre for Development Clubs.** Clubs will be trained in participatory drama techniques and conduct performances by village to stimulate dialogue and address barriers of behavior change surrounding issues of case management, ITN use, IPTp, etc.

- **School Health Programs.** Trained HSAs and volunteers (including teachers) will hold health talks at schools to address issues of malaria. The Malaria Coordinator and IEC officer will support these activities.

- **Community Incentives.** To motivate role models and volunteers, there will be a need to provide incentives for key volunteers and give recognition to successful volunteers and communities.

- **Monitoring and Evaluation.** There will be participatory monitoring of malaria interventions across the national, district and community levels.

8.3 Advocacy

To take charge of malaria at all levels, advocacy is an important intervention. It entails a continuous and adaptive process of gathering, organizing, and formulating information into arguments that can convince policy makers to priorities that issue. An advocacy plan will be developed to support the malaria programme; advocacy efforts will aim to:

- Place malaria on both the political and developmental agenda
- Foster political will and increase financial and other resource allocation
- Gain support for and ensure visibility of the malaria campaign
- Raise malaria prominence on political and community agendas
- Lobby for malaria funding and policy commitments

- Ensure transparency and accountability in malaria programme governance

The advocacy plan will target:

- Policy makers such as politicians and top government officials such as the Parliamentary Health Committee and ministries Local Government and Finance.
- Traditional authorities – including Group Village Heads, Village Heads and community leaders
- International donors (bilateral and multilateral)
- Partners – civil society organizations, faith based organizations, NGOs, and CBOs
- District Assembly

Activities will include the following:

- Parliamentary caucuses/debates
- Press conferences, summits, and/or symposia
- Organization of night of nets campaigns
- TV/radio talk shows
- Celebrity ambassadors
- Formation of networks and coalitions
- Writing or sending communiqués to local/national legislators
- Meetings with decision makers (governments, traditional authorities, civil society organizations e.g. Malawi Health Equity Network, etc.)

8.4 Mainstreaming

Malaria messages and interventions in other program areas and sectors will be mainstreamed to reach rural communities in Malawi at scale with malaria communication, enable easy mobilization of resources, and allow cost effectiveness in the implementation of malaria control/prevention and other government programs. Mainstreaming will be done in public and private sectors at national, district, and community levels.

- **Within the Health Sector**

Mainstreaming within the health sector will ensure that programs under the Ministry of Health, Christian Health Association of Malawi, and private health facilities are integrated where possible. Programs on various other topics will include malaria messages and interventions while being implemented; for instance sensitization on sanitation can incorporate malaria messages.

At the district level (e.g. under DHO jurisdiction), the integrated approach will be indicated in the District Implementation Plan to ensure that the mainstreaming vision is translated into a tangible commitment.

- **District Assembly/Executive Level**

Different programs under the district assembly will integrate malaria messages and interventions; for instance, the Agriculture Extension Development Officers (AEDO) can incorporate messages on malaria during village sensitization meetings on agricultural production. In the following table are examples of how the different programs may interface with malaria interventions in terms of reciprocal benefit.

Examples of the Interface of Programs and Benefits for Integration
▪ **Agriculture:** A sick man cannot produce bumper harvest. These will increase outreach as AEDOs are almost everywhere in the rural communities.
▪ **Education:** A sick pupil or teacher cannot go to school. Primary school advisors and teachers can help disseminate the information both to parents in meeting and pupils in school. Pupils will extend messages informally to their parents
▪ **Home Affairs:** Could coordinate in monitoring net abuse and the selling of drugs on the market, etc..
▪ **Forestry:** Sick people cannot participate in aforestation programs. FA will extend the outreach through their clubs and other village meetings.
▪ **Social Welfare and Community Development:** Community Development Assistants (CDA) and Social Welfare Assistants (SWA) can help disseminate the information to communities during social welfare and development endeavors

- **Private Sector**

For companies and parastatals, the entry message will be that sick people decrease production. Among other interventions, these bodies will integrate malaria messages and interventions through:

- Message dissemination during meetings, conferences, etc.
- Development of malaria friendly policies e.g. buying/subsidizing nets for employees and indoor spraying
- Use of social obligation/other funds to reach other vulnerable communities

- **Community Level**

Malaria mainstreaming will involve leaders of different groups/institutions in the community so that they extend messages and intervention to others of their group. The groups will include, among others:

- Health committees
- CBOs
- Village Development Committees and Area Development Committees
- Water Point/Borehole committees
- Agriculture committees
- Teachers
- Church leaders
- Other volunteers

9. Partners and Coverage

The National Malaria Control Programme has a number of partners working throughout the country. The NMCP will work to fill the gaps in coverage through the identification of new partners and mainstreaming into existing programming and structures in the communities. The goal will be complete coverage of malaria communication in Malawi by 2014.

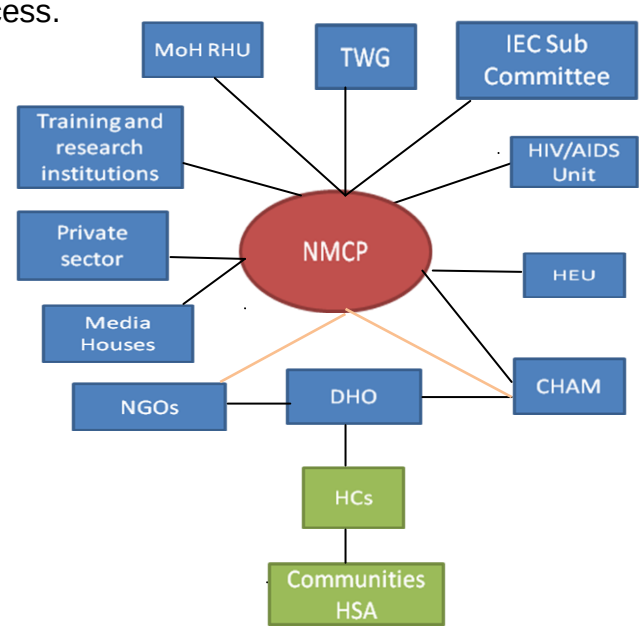
10. Capacity Building

There is a need to build the capacity in social and behavior change for malaria in Malawi to ensure a sustainable and effective programme over time. Towards that end, a capacity building strategy will be developed in concert with the Health Education Unit to ensure malaria programme managers at the national and district level have the basics to manage and coordinate malaria communication activities. This strategy will be inclusive of NGOs and front line health workers. Specific activities will include:

- Conduct organization assessments of social and behavior change competencies of key institutions and organizations
- Development of a core curriculum (adapted from existing sources) for use in the programme in Malawi
- Training of programme managers on an overview of social and behavior change communication for malaria – including top staff of the NMCP
- Training of IEC officers in the districts on SBCC for malaria
- Integration of SBCC modules into on-going in-service training for front line health workers
- Specific training of major NGOs and CBOs working to impact community level malaria

11. Coordination Mechanisms

Coordination of BCC activities is critical to the success of the strategy. To maximize effectiveness, the following partners have been proposed to spearhead the coordination process.



The goal of coordination is to enhance harmonization of different stakeholder agendas on IEC in malaria prevention and control and ensure standardization of malaria message development and delivery. All partners in the coordination cycle have a crucial role to play. Each partner's role has been outlined as follows:

National Malaria Control Programme

- Organize and coordinate quarterly meetings
- Source funding for IEC development
- Facilitate development and review of IEC strategy on malaria prevention and control
- Monitor and evaluate message development and delivery
- Plan IEC intervention

Health Education Unit (HEU)

- Spearhead the development of IEC materials
- Review effectiveness of malaria IEC materials
- Plan and conduct IEC interventions
- Capacity building of IEC officers and other stakeholders in different aspects of IEC delivery

BCC/IEC Sub Committee

- Develop and review IEC materials and strategies for malaria management and control
- Scrutinize and approve proposed IEC interventions on malaria

NGOs/DHO/CHAM/District Assembly

- Plan IEC malaria interventions
- Implement IEC interventions on malaria prevention and control
- Monitor and review IEC interventions
- Mainstream and integrate malaria interventions into different programs

Media Houses

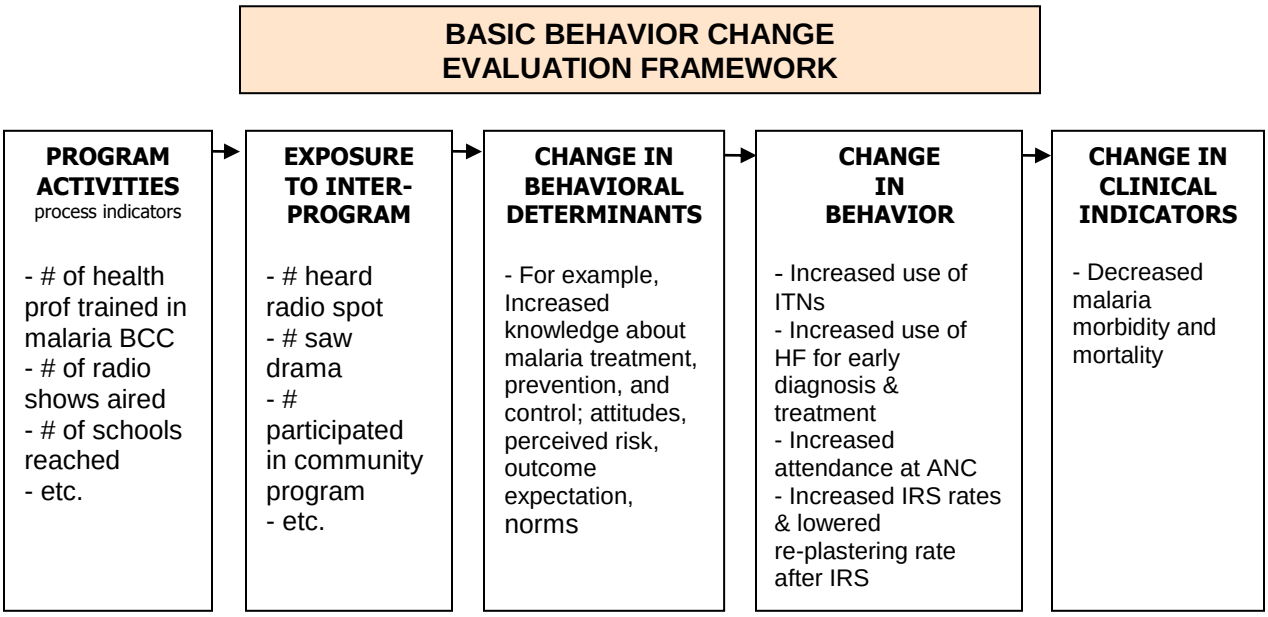
- Enhance positive attitude on malaria information
- Initiate sourcing and disseminate correct malaria information
- Enhance transparency and accountability in malaria IEC programming
- Produce investigative stories on malaria control

To ensure coordination takes place, it will be necessary to have a fulltime dedicated staff person responsible.

12. Monitoring and Evaluation

A detailed monitoring and evaluation plan will be developed to ensure the communication is having the desired effect. A Basic Behavior Change Evaluation Framework will guide the M&E efforts. The framework proposes that program activities lead to a change in behavioral determinants such as knowledge,

perceived risk, outcome expectation, intermediate behaviors, and skill; and that those changes lead to greater frequency of the target behaviors. By including indicators for each element in the model, we can show where there has been impact along the path to behavior change.



To ensure ownership and responsibility of malaria programming at the community level, a participatory plan will be developed. Communities will be empowered to track their own malaria indicators utilizing the heath indicators register that already exists in communities.

12.1 Mass Media and Social Mobilization

Illustrative indicators include the following.

IEC/BCC Process Indicators
• Number of malaria workers trained in malaria IEC/BCC activities • Number of tool kits developed and distributed • Number of community leaders oriented • Number of IEC/BCC materials produced • Number of IEC/BCC materials distributed • Number of radio shows aired • Number of radio listening groups held • Number of communities reached by malaria IEC/BCC • Number of drama groups trained in malaria scripts • Number of drama groups performing malaria plays in the community • Number of communities participating in the take charge of malaria programme • Number of household visits made • Number of village meetings held • Number of health talks conducted • Number of health talks in schools
Exposure Indicators
• % of the target group who heard any radio spots on ITNs, IRS, care seeking • % of the target group who heard radio spots on malaria treatment • % of the target group shown how to hang the net • % of targeted population who were reached by community activities, by type of community activity • % of targeted villages that participated in IRS Q&A sessions • % of targeted population receiving a Malaria Prepared Community Tool Kit

Intermediate Outcomes / Determinants
• % of target group who know who the most important users of ITNs should be • % of target group who can explain/demonstrate how to hang an ITN properly • % of target group who believe that ITNs are safe for children under 5 and/or pregnant women • % who believe that nets must be used nightly • % who believe it important to seek treatment from a qualified provider w/in 24 hours • % who intend to acquire an ITN in next X time. • % who intend to get first-line anti-malarial with 24 hours the next time their child has fever • % of those who received treatment who intend to complete protocol • % of target group who can recognize signs & symptoms of febrile illness in children under 5 • % of target group who know what medicine to give their child with a fever • % of target group who know for how many days a child with a fever should receive his/her medications • % of target group who know where to access the recommended anti-malarial • % with correct knowledge of malaria diagnosis, treatment, prevention, and control
Behavioral Change Indicators
• % of households with a pregnant woman and/or child <5 owning at least one ITN • % of households with one net for every two people • % of children <5 who slept under an ITN the previous night • % of pregnant women who slept under an ITN the previous night • % of households where ALL members slept under a ITN or LLIN the previous night • % of pregnant women and children <5 who slept in a house that is protected by IRS • % of nets owned that were used the previous night • % of parents of children under 5 with fever who sought treatment from qualified health personnel within 24 hours of onset of fever • % of parents of children under 5 who started their child on a drug course and completed it as prescribed • % of adults seeking care at health facility within 24 hours of onset • % of individuals with fever accessing malaria diagnostic and treatment services • % of adults who started a drug course and completed it as prescribed • % of pregnant women who received IPTp and followed treatment protocol • % of pregnant women attending ANC at least four times during the pregnancy • % of populations taking LA and not SP for first treatment for malaria, by target population • % structures sprayed in targeted areas • % of sprayed houses where members continue to sleep under a ITN or LLIN
Clinical/Health Impact Indicators
• decrease in morbidity (uncomplicated and severe) • decrease in mortality

12.2 Advocacy

For advocacy, the following illustrative indicators will be utilized. These will be adjusted based on the final advocacy plan.

Process Indicators
• Number of debates conducted • Number of conferences and summits conducted • Number of malaria ambassadors identified • Number of communiqués sent to local legislators • Number of communication training modules for the DHMT, HSAs, and volunteers reviewed for strength and relevance to malaria • Number of meetings organized with decision makers (District Assembly Stakeholders, Community Leaders, Health Survey Assistants) • Number of volunteer trainings conducted
Exposure Indicators
• Number of MPs that participate in debates • Number of participants attending the conferences and symposia • Number of decision makers participating in orientation meetings, by type of decision maker • Number of community volunteers trained
Intermediate Outcomes
• Number of public statements on malaria by top politicians • Number of malaria ambassadors active
Impact Indicators
• # of national policies that follow WHO recommendations • % of national health budget dedicated to malaria prevention and treatment • # of NMCP or malaria-dedicated staff members

12.3 Mainstreaming

The focus on the mainstreaming activities is on the rural communities in order to enable easy mobilization of resources and allow cost effectiveness in the implementation of malaria control/prevention and other government programs.

Process Indicators
• Number of harmonization meetings with programs run by the health sector • Number of harmonization meetings with District Assembly
Exposure Indicators
• Number of health sector program members attending harmonization meetings • Number of District Assembly members attending harmonization meetings
Intermediate Outcomes
• Number of health sector programs including messages on malaria • Number of programs under the district assembly with integrated malaria messages and interventions

12.4 Capacity Building

Process Indicators
• Core curriculum developed/adapted (benchmark) • Number of managers trained on the overview of social and behavior change communication for malaria (including staff of the National Malaria Control Programme) • Number of trainings for district level IEC officers on social and behavior change communication for malaria • Number of in-service trainings for front line health workers including social and behavior change communication for malaria • Number of trainings for NGOs and CBOs working to impact community level malaria
Exposure Indicators
• Number of people attending trainings on social and behavior change communication for malaria, by population (managers, IEC officers, front line health workers, NGOs, CBOs)
Intermediate Outcomes
• Increased knowledge of social and behavior change communication design • Increased knowledge of social and behavior change communication implementation • Increased knowledge of social and behavior change communication monitoring

12.5 Methodology

The monitoring of this activity will take place through the routine data collection systems of NMCP partners. This system will be set up once the final data collection points are established and will be carried out throughout the life of the project.

This data will focus on 'how much' of each activity partners are carrying out and will allow the NMCP to monitor progress towards achieving the stated goals. The kinds of indicators to be captured in this routine data collection system include all of the process indicators listed above as well as some of the exposure indicators. The exposure indicators included would be those that keep track of and monitor how many members of the target population are attending meetings, involved in home visits, participating in trainings, participate in conferences, meetings, orientations and debates, etc.

NMCP staff will also work to monitor any changes that take place in the public arena. NMCP will monitor, through partners, print and broadcast material for accurate malaria messages. In addition, NMCP staff will be monitoring government representatives making public announcements, giving speeches,

and setting policies to gather additional evidence that the atmosphere is changing and is becoming more supportive of malaria prevention and treatment.

The evaluation for this activity can be conducted through a population based survey and an assessment of partner skills.

The **population based survey** will focus on the knowledge, intentions and behaviors of the target populations and will measure the indicators outlined above. To do this, it will be necessary to design a sample that is nationally representative and can be disaggregated by gender and rural vs. urban sites. The survey will need to be conducted at the outset of the program to capture a good baseline of these indicators and then conduct it again each year during the life of the programme. Where possible, this survey will be integrated into ongoing surveys of the GOM and/or partner organizations.

To measure the capacity of partners in NGOs, CBOs, and in the District Assemblies the NMCP will carry out an **SBCC skills assessment** using internationally available standard tools with follow up assessments to measure agencies perceptions of their skills in designing, implementing, and monitoring their communication activities. This assessment can be carried out at baseline and then again each year during the life of the strategy to measure increases in capacity to do SBCC campaign.

13. Timeline for Key Bench Mark Activities

Activity	*2010*				*2011*				*2012*				*2013*				*2014*			
	1	**2**	**3**	**4**	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**
Mass Media																				
Campaign Developed (2009)																				
Campaign Implemented	xx		xx		xx		xx		xx		xx		xx		xx		xx		xx	
Messages Reviewed					xx				xx				xx				xx			
Social Mobilization																				
Community Tool Kit Developed (2009)																				
Community Leaders Trained	xx																			
Implementation of Activities		xx	xx	xx	xx	xx	xx	xx	xx	xx	xx	xx	xx	xx	xx	xx	xx	xx	xx	xx
Advocacy																				
Ambassadors Identified	xx																			
Advocacy Activities			xx		xx		xx		xx		xx		xx		xx		xx		xx	
Coordination																				
Coordination Meetings	xx	xx	xx	xx	xx	xx	xx	xx	xx	xx	xx	xx	xx	xx	xx	xx	xx	xx	xx	xx
Review Meetings	xx				xx				xx				xx				xx			
M&E																				
Collection of Monitoring Data	xx	xx	xx	xx	xx	xx	xx	xx	xx	xx	xx	xx	xx	xx	xx	xx	xx	xx	xx	xx
Evaluation Studies	xx									xx							xx			

Annex A: List of Resource Documents

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Rosenstock IM, Strecher VJ, Becker MH. The health belief model and HIV risk behavior change. In DiClemente RJ (ed) Preventing AIDS: Theories and Methods of Behavioral Interventions. New York, NY: Plenum Press; 1994.

Annex B: List of Partner Organizations

Government of Malawi
Agricultural Development Division
Ministry of Health
Ministry of Education
Health Education Unit
National Malaria Control Program
Ministry of Agriculture
Malawi Broadcasting Corporation

Civil Society, Non-Governmental and Faith Based Organizations
Canadian Physicians for Aid and Relief
Christian Health Association of Malawi
Christian Reformed World Relief Committee
Concern Universal
Malawi Red Cross
Management Sciences for Health
Population Services International
Project Hope
Zodiac Radio

Multilateral and Bilateral Donors
Centers for Disease Control and Prevention
Japanese International Cooperation Agency
United Nations Development Programme
United Nations Children's Fund
United States Agency for International Development
World Bank
World Health Organization

Annex C: List of Participants in Communication Strategy Development Meetings

NAME	Organization / Designation
1. Doreen Ali	Ag. Malaria Control Program Manager, NMCP
2. John A. Chiphwanya	Malaria Entomologist, NMCP
3. Joe Kumadzulo	Malaria Grants Manager, NMCP
4. Carol Larivee	Senior Communication Specialist, Communication for Change Program, AED
5. John Zoya	Malaria Control Officer, NMCP
6. Charles Yuma	Senior Program Manager, PSI
7. Themba Phiri	Phalombe Communities Project, Concern Universal
8. Chipiliro Kambombe	Malaria Communities Program Coordinator, CRWRC
9. Owen Lupeska	Project Officer, Zodiac Radio
10. Monica M'manga	Assistant Controller of Program, MBC
11. Phillip Klemens Kapulula	Lecturer in Sociology, U. of Malawi
12. Hector D. Kamkwamba	PHEO, Health Education Unit
13. Danel Maseko	SHEO, Health Education Unit
14.Tobias A.P. Kunkumbira	Health Education Officer, Health Education Unit
15. Gloria Kunyenga	Program Manager, Red Cross
16.Chimwemwe Chamangwana	Project Hope
17. Arnold Mndalira	Health Education Officer
18. Ella Chamanga	Health Education Officer
19. John Sande	Program Officer (Malaria), NMCP
20. Johnes Moyenda	Malaria Officer, NMCP
21. Chancy Mauluka	BCC Officer, BASICS, MSH
22.Gloria Kunyenga	Malawi Red Cross