National Malaria Behavioral Change Communication Strategy

National Malaria Control Program
Ministry of Health and Social Welfare
Republic of Liberia

SEPTEMBER 2005
Executive Summary

In 1998, the World Health Organization (WHO) launched the Roll Back Malaria (RBM) initiative to reduce malaria mortality by 50% through 2010. In support of the global RBM Initiative, African governments convened a consensus meeting in Abuja, Nigeria in 2000. As a signatory to the Abuja Declaration on Roll Back Malaria, Liberia is committed to its successful implementation at the highest political level.

Malaria is the leading cause of out-patient attendance in Liberia and accounts for 40% to 45% of all hospital visits. Malaria is also the leading cause of in-patient deaths.

The Ministry of Health and Social Welfare (MOHSW) proposed in 2003, the development of a national Behavior Change Communication (BCC) strategy to guide partners of the National Malaria Control Program in implementation of the communication and health promotion components of the Abuja Declaration, in a more structured manner.

The development of the Malaria BCC Strategy commenced in March 2004 at a consultative workshop of partners including MOHSW, national and international NGOs, and United Nations agencies. Following a series of review meetings, the BCC Strategy was finalized in September 2005.

The Malaria BCC Strategy outlines approaches for achievement of five principal objectives, namely:

- To improve early detection and prompt referral of malaria in children by primary caregivers,
- To increase coverage for intermittent preventive treatment (IPT) for pregnant women,
- To increase use of insecticide treated nets (ITNs) for under-fives and pregnant women,
- To train service providers (community health workers), and
- To advocate for support from policy-makers.

The primary target audience for the BCC Strategy includes pregnant women and parents of the under five-year old child in rural and peri-urban areas of Liberia. This group is typically low literate, of low socio-economic status and rely on local languages for communication.

Implementation of activities for achievement of the BCC objectives will be phased, with initial focus on increasing the use of ITNs by pregnant women and under-fives. This intervention is expected to be implemented for an initial period of one year. Thereafter, an evaluation will be conducted to determine retention or a change the focus to one of the other objectives.

The phased approach to implementation of the BCC Strategy with a focus on ITNs in no way implies the absolute exclusion of the remaining four and equally important communication objectives at any given time. Achievement of the other objectives will be concurrently pursued albeit to a lesser degree, a situation dictated by the availability of human, material and financial resources.

The work plan on page 29 outlines the schedule for implementation of the BCC Strategy. Even though some aspects of the plan have already been implemented, the official timeline for implementation of phase one activities is September 2005 to August 2006. Evaluation of that component is scheduled for October 2006. It is envisaged that funds will be made available timely to expedite implementation of activities as planned.
Acknowledgement

The Ministry of Health and Social Welfare extends profound thanks and appreciation to Africare for financial and technical support provided for the development of the Malaria BCC Strategy. Your support was indeed strategic to initiation of the process, a gesture for which we owe you a depth of gratitude.

We also acknowledge the invaluable contributions of other partners of the National Malaria Control Program including: national and international NGOs, government sectoral ministries, United Nations agencies and private individuals.

This acknowledgement would be incomplete without recognition of the Global Fund for HIV/AIDS, Tuberculosis and Malaria. The Global Fund has greatly assisted the NMCP to begin concretization of its vision. We entertain the hope that the Liberian people will in the near future, enjoy a life free of malaria.

We recognize the efforts of the NMCP staff, under whose technical leadership the Malaria BCC Strategy was developed.

Dr. Joel J. Jones
Program Manager
National Malaria Control Program
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<th>Description</th>
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<tr>
<td>ACT</td>
<td>Artemisinin-based Combination Therapy</td>
</tr>
<tr>
<td>BCC</td>
<td>Behavior Change Communication</td>
</tr>
<tr>
<td>CBO</td>
<td>Community Based Organization</td>
</tr>
<tr>
<td>CHT</td>
<td>County Health Team</td>
</tr>
<tr>
<td>CHW</td>
<td>Community Health Worker</td>
</tr>
<tr>
<td>DHS</td>
<td>Liberia Demography Health Survey</td>
</tr>
<tr>
<td>EPI</td>
<td>Expanded Program on Immunizations</td>
</tr>
<tr>
<td>IMCI</td>
<td>Integrated Management of Childhood Illnesses</td>
</tr>
<tr>
<td>IPC</td>
<td>Inter Personal Communication</td>
</tr>
<tr>
<td>IPT</td>
<td>Intermittent Preventive Treatment</td>
</tr>
<tr>
<td>ITNs</td>
<td>Insecticide Treated Nets</td>
</tr>
<tr>
<td>KAP</td>
<td>Knowledge, Attitude &amp; Practice</td>
</tr>
<tr>
<td>KPC</td>
<td>Knowledge, Practice &amp; Coverage</td>
</tr>
<tr>
<td>MCH</td>
<td>Maternal and Child Health</td>
</tr>
<tr>
<td>MENTOR</td>
<td>Malaria Emergency Network Technical Operational Response</td>
</tr>
<tr>
<td>MERLIN</td>
<td>Medical Emergency Relief International</td>
</tr>
<tr>
<td>MOH&amp;SW</td>
<td>Ministry of Health &amp; Social Welfare</td>
</tr>
<tr>
<td>NGO</td>
<td>Non-governmental organization</td>
</tr>
<tr>
<td>NMCP</td>
<td>National Malaria Control Program</td>
</tr>
<tr>
<td>OPD</td>
<td>Out-patient department</td>
</tr>
<tr>
<td>RBM</td>
<td>Roll Back Malaria</td>
</tr>
<tr>
<td>RDT</td>
<td>Rapid Diagnostic Test</td>
</tr>
<tr>
<td>SP</td>
<td>Sulphadoxine-pyrimethamine</td>
</tr>
<tr>
<td>TBA</td>
<td>Traditional Birth Attendant</td>
</tr>
<tr>
<td>TTM</td>
<td>Trained Traditional Midwife</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organization</td>
</tr>
</tbody>
</table>
I. Background

In 1998, the World Health Organization (WHO) launched the Roll Back Malaria (RBM) initiative to reduce malaria mortality by 50% by 2010. In support of the global RBM Initiative, African governments convened a consensus meeting in Abuja, Nigeria in 2000. As a signatory to the Abuja Declaration on Roll Back Malaria, Liberia is committed to its successful implementation at the highest political level.

Malaria is the leading cause of out-patient attendance in Liberia and accounts for 40% to 45% of all hospital visits. Malaria is also the leading cause of in-patient deaths.

Prior to the current acute health situation in Liberia resulting from 15 years of civil war, the nation’s child mortality rate reported as 235/1000 was among the worst in the world. Available data estimates child mortality rate for malaria at 41/1000, thereby accounting for 17.8% of all child mortality. Based on the indicators above and considering the population of the country, an estimated 120,000 children under the age of five years die each year in Liberia from all causes. The conservative calculation is that 21,300 children die annually in Liberia of malaria alone. This number is considered an under-estimation however, it is difficult to undertake a verification study at the moment, due to the complex emergency in Liberia.

Maternal mortality is also extremely high in Liberia; it is estimated at 780/100,000. There is little or no use of Intermittent Preventive Treatment (IPT) for malaria during pregnancy; risk of infection is high such that both mother and child may suffer complications and possible death due to the disease.

There is little or no organized involvement of the community in malaria control; there is need to not only raise community awareness of the dangers of the disease but perhaps more importantly, to build the required capacity in communities to prevent transmission of the disease, manage fevers, improve compliance with treatment regimen and refer severe cases for treatment.

Effective community involvement in malaria control requires training to sensitize, empower and mobilize community members in malaria control, thereby paving the way for their ownership of the program. Community involvement should be solicited for immediate and long term program development including planning, implementation, monitoring and evaluation. The involvement of community members in malaria control is recognized as being paramount to achievement of the targets of the Abuja Declaration on Roll Back Malaria.

The Liberia National Malaria Control Strategy for the period 2004-2008 has outlined the following objectives in the strategic response:

**General objective:** To reduce morbidity and mortality due to malaria by 50% by 2010.

**Specific objectives:**

---

1 National Malaria Strategic Plan
2 Desk Analysis WHO 2001
Case Management:
- To increase access to prompt and effective treatment at health facility, community and household levels.

Prevention:
- To increase the use of Intermittent Preventive Treatment (IPT) and Insecticide Treated Nets (ITNs) among pregnant women.
- To increase the use of ITNs among children under five years of age.
- To increase the use of a combination of personal and community protective measures among those at high risk of malaria.

Cross cutting issues:
- To increase awareness and knowledge of malaria control and prevention practices.

The Ministry of Health and Social Welfare (MOH&SW) proposed in 2003, the development of a National Behavior Change Communication (BCC) strategy to guide partners of the National Malaria Control Program implement the communication and health promotion components of the Abuja Declaration, in a more structured manner.

The Behavior Change Communication Strategy presents approaches that all organizations involved in malaria control and behavioral change programs shall adopt and adapt in a complementary and coordinated manner. A coordinated implementation of programs would among other benefits, ensure a more efficient use of limited resources.

The development of the Malaria BCC Strategy commenced in March 2004 at a consultative workshop of partners including the Ministry of Health and Social Welfare, national and international NGOs, and United Nations agencies. Following the workshop, the strategy was drafted and subsequently reviewed by the workshop participants and their respective organizations. A consensus meeting was held in June 2004 to obtain additional input into the document. The BCC Strategy was finalized in September 2005.

II. Problem Statement

Malaria is a major public health problem in Liberia. It is the leading cause of OPD attendance (40-45%) and is also the number one cause of in-patient deaths\textsuperscript{10}. Hospital records suggest that at least 17.8% of in-patient deaths are attributed to malaria. Although the socio-economic impact of malaria has not been assessed, the cost of treatment to families and the cost of lost days of work should be considerably high.

Resistance to chloroquine, Liberia’s first line drug for malaria treatment until 2003, was first noted in the country in 1988 and has since been rising. Recent studies in Harper, Maryland County revealed that P. falciparum resistance to chloroquine is 74% while that of sulphadoxine pyrimethamine (SP) which was the second line drug is 51%. In light of this high level of resistance and following consultations with WHO and other partners, the Government of Liberia revised the malaria drug policy to reflect Artemisinin-based Combination Therapy (ACT) as the first line drug for malaria treatment in Liberia.

The proper use of ITNs has been shown to reduce the incidence of malaria in populations which regularly use them. In the Republic of Liberia, ITNs use is not widespread. The
Government of Liberia strongly advocates for the use of long lasting Insecticide Treated Nets, particularly for pregnant women and children under five years.

Malaria has the potential to cause death within 48 hours of the onset of symptoms, especially for children under five years. A recent WHO study found that “... effective home-based care intervention can reduce childhood mortality by 20 –40%.” Therefore, effective malaria control relies heavily on early diagnosis and prompt treatment.

Various studies have demonstrated that the majority of childhood fevers are cared for at home, without consulting a health professional. Unfortunately, caregivers lack adequate knowledge of antimalaria medicines and home management, a situation that often leads to inappropriate treatment of fevers. Severe complications and deaths due to malaria often result from the inability of caregivers to recognize danger signs and symptoms, manage them appropriately and/or refer them promptly.

The Malaria BCC Strategy outlines approaches for the achievement of five basic objectives:

- To improve early detection and prompt referral of malaria in children by primary caregivers,
- To increase coverage for IPT for pregnant women,
- To increase use of ITNs by pregnant women and under-fives,
- To train service providers (community health workers), and
- To advocate for support from policy-makers.

III. Knowledge, Attitudes and Practices (KAP) Situation Analysis

Knowledge of Malaria
Knowledge on the transmission of malaria varies in different parts of the country. Table one presents data from four Knowledge, Attitude and Practice (KAP) studies on malaria transmission and mosquito breeding by three non-governmental organizations - MERLIN, World Vision, Africare - the Ministry of Health and WHO. The findings can be summarized as follows:

- Knowledge of malaria = 61%
- Knowledge of mosquito breeding site = 85%

Table 1: Knowledge of malaria in different parts of Liberia.

<table>
<thead>
<tr>
<th>Study (year)</th>
<th>Location</th>
<th>Malaria Transmission</th>
<th>Mosquito Breeding</th>
</tr>
</thead>
<tbody>
<tr>
<td>Merlin (1999)</td>
<td>Nimba</td>
<td>89%</td>
<td>74%</td>
</tr>
<tr>
<td>World Vision (2001)</td>
<td>Bomi &amp; Cape Mount</td>
<td>17%</td>
<td>90%</td>
</tr>
<tr>
<td>MOH &amp; SW/WHO (2001)</td>
<td>Monrovia</td>
<td>79%</td>
<td>90%</td>
</tr>
<tr>
<td>Africare (2003)</td>
<td>Monrovia</td>
<td>57%</td>
<td></td>
</tr>
</tbody>
</table>

Treatment Seeking Behavior
Table two presents results from five studies regarding what caregivers of children do when their children have a fever: Summary of findings:
The studies found that some respondents used more than one treatment-seeking behavior.

**Table 2. Treatment-seeking behaviors for suspected malaria.**

<table>
<thead>
<tr>
<th>Study</th>
<th>Location</th>
<th>Visit Health Facility</th>
<th>Pharmacy/Drug Store</th>
<th>Home</th>
<th>Traditional Sources</th>
</tr>
</thead>
<tbody>
<tr>
<td>Merlin</td>
<td>Nimba</td>
<td>67%</td>
<td>17%</td>
<td>17%</td>
<td>10%</td>
</tr>
<tr>
<td>World Vision</td>
<td>Bomi/Cape Mount</td>
<td>58%</td>
<td>3%</td>
<td>20%</td>
<td>5%</td>
</tr>
<tr>
<td>Africare 2000</td>
<td>Bong/Nimba</td>
<td>33%</td>
<td></td>
<td>17/28%</td>
<td></td>
</tr>
<tr>
<td>MOH &amp; SW/WHO</td>
<td>Monrovia</td>
<td>75%</td>
<td>7%</td>
<td>8%</td>
<td>3%</td>
</tr>
<tr>
<td>Africare 2003</td>
<td>Monrovia</td>
<td>65%</td>
<td>2%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Prevention: Mosquito Net Knowledge and Practice/Use**

Available data shows that knowledge of malaria prevention is low (less than 50%) throughout Liberia and also varies in different parts of the country (See table 3).

Knowledge about use of mosquito nets to prevent transmission of malaria is even lower (23%) than knowledge on malaria prevention (49%).

**Table 3. Knowledge of malaria prevention methods.**

<table>
<thead>
<tr>
<th>Study</th>
<th>Location</th>
<th>% Correct</th>
</tr>
</thead>
<tbody>
<tr>
<td>Merlin</td>
<td>Nimba</td>
<td>58%</td>
</tr>
<tr>
<td>World Vision</td>
<td>Bomi &amp; Cape Mount</td>
<td>41%</td>
</tr>
<tr>
<td>MOH&amp;SW/WHO</td>
<td>Monrovia</td>
<td>58% (one only) &lt;58% (more than one)</td>
</tr>
<tr>
<td>Africare 2003</td>
<td>Monrovia</td>
<td>20% (nets) 27% (EC)</td>
</tr>
</tbody>
</table>

A Ministry of Health and WHO study assessed knowledge and practice of prevention activities; the study found that knowledge of preventive methods did not always translate into the application or practice of the method. (See Table 4)

**Table 4. MOH&SW and WHO Knowledge, Practice and Coverage (KPC) survey on methods to prevent malaria.**

<table>
<thead>
<tr>
<th>Activity</th>
<th>Know (%)</th>
<th>Use (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nets</td>
<td>31</td>
<td>9</td>
</tr>
<tr>
<td>Coils</td>
<td>29</td>
<td>24</td>
</tr>
<tr>
<td>Spray</td>
<td>43</td>
<td>43</td>
</tr>
<tr>
<td>Environmental Control</td>
<td>44</td>
<td>37</td>
</tr>
</tbody>
</table>
Clearly, more people need to have knowledge about the relationship between mosquito net use and malaria prevention in order to meet the goals of over 50% utilization of nets by pregnant women.

The MOH&SW and WHO KPC study also assessed people’s use history and preferences for mosquito nets - the results of which are presented in Table 5. According to the study, 38% of the sample had owned nets in the past; the major reasons cited for not currently owning mosquito nets were their non-availability and high cost.

Table 5. Mosquito net use and preferences.

<table>
<thead>
<tr>
<th>Factor</th>
<th>Characteristic</th>
<th>Number</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mosquito Net Known</td>
<td>92</td>
<td>92</td>
<td></td>
</tr>
<tr>
<td>Not known</td>
<td>8</td>
<td>8</td>
<td></td>
</tr>
<tr>
<td>Used Mosquito net in past Yes</td>
<td>49</td>
<td>49</td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>51</td>
<td>51</td>
<td></td>
</tr>
<tr>
<td>Owned net in past Yes</td>
<td>38</td>
<td>38</td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>62</td>
<td>62</td>
<td></td>
</tr>
<tr>
<td>Why not own a net Not available</td>
<td>35</td>
<td>35</td>
<td></td>
</tr>
<tr>
<td>Too hot</td>
<td>1</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Too expensive</td>
<td>27</td>
<td>27</td>
<td></td>
</tr>
<tr>
<td>No Reason</td>
<td>37</td>
<td>37</td>
<td></td>
</tr>
<tr>
<td>Own net now Yes</td>
<td>9</td>
<td>9</td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>91</td>
<td>91</td>
<td></td>
</tr>
<tr>
<td>Why Like Net Prevent mosquito</td>
<td>80</td>
<td>80</td>
<td></td>
</tr>
<tr>
<td>Prevent Malaria</td>
<td>16</td>
<td>16</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>3</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Why Not Like net Too hot</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Too expensive</td>
<td>1</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**IPT Use & Knowledge**

The Africare 2000 KPC on IPT use during pregnancy in Bong and Nimba counties found that 85% of mothers took malaria prophylaxis as follows:

- Chloroquine: 77%
- Fansidar: 2%
- Quinine: 0.4%
- Can’t specify: 20%

**Ante-natal visitation**

The following information was taken from the 1999/2000 DHS:

**Service Utilization**

- Antenatal services sought for 90% of births
  - 27% by medical doctor
  - 58% by nurses and midwives
- Timing of first antenatal visit is late
- About 36% births take place in health facilities, and 63% take place at home.
• Less than 5% of births in last 3 years were delivered by a medical doctor; 47% delivered by nurse or midwife, 46% by TBA.

Desired practice:
• Pre-natal visitation early (within first trimester of pregnancy) and monthly until delivery.

Key barriers ante-natal visit:
• Knowledge of benefits lacking
• Long distance to health facility (HF), long time spent at HF and high cost of service
• Myths that ferrous/folic tablets and/or TT vaccine given to pregnant women during ante-natal visit is harmful to baby

Information sources: literacy and radio listening information
Liberia has low literacy rate; according to the 1999/2000 Demographic Health Survey (DHS) only 37% of Liberians are functionally literate. Female literacy is 24% while the literacy rate for males is 50% (twice as high as female literacy). Literacy levels are more than twice as high in urban areas (61%) as compared to rural areas (25%).

A Mercy Corps listenership study conducted in March 2003 in Margibi, Grand Bassa and rural Montserrado counties found Liberian (simple) English (41.3%) as the preferred language for radio broadcast followed by formal English (33.3%); local language broadcast was preferred by 25.2% of respondents.

IV. Strategic Approach

The national malaria communication strategy will use a multi-channel approach, with a combination of various communication channels mutually reinforcing each other. A multi-channel approach works best to build synergy among the various interventions to strengthen the overall campaign impact. The approach encompasses:

• Focus on four priority areas: infant and child care, prevention among pregnant women, improved service delivery provision and advocacy,
• A slogan and symbol to unify all Malaria BCC interventions,
• Community and county level communication activities to change social norms influencing care for the child’s health within the home and community, the use of ITNs for pregnant women and children under five and IPT for pregnant women,
• A national level media campaign to address and empower parents regarding home-based management of malaria, treatment adherence, use of ITNs and importance of IPT for pregnant women;
• Enhancement of Community Health Workers(CHW) ability to educate target audience through interpersonal communication and counseling skills training and provision of provider and client support materials;
• Advocacy and media initiatives that contribute to a more conducive environment for home-based management of malaria, IPT and ITN usage.
V. Goals

1. **Overall Goal:** To Reduce mortality and morbidity due to malaria in children under five years and pregnant women. (To increase public awareness of the dangers of malaria and the use of appropriate preventive measures by vulnerable groups)

2. **Infant and Child Care Goal:** To increase the rural and peri-urban mother’s ability to provide home-based care for children with malaria

3. **ITN Goal:** To increase the number of rural and peri-urban pregnant women and children under five years who sleep under ITNs.

4. **IPT Goal:** To increase the number of pregnant rural and peri-urban women who receive recommended IPT before full term.

5. **Improved Service Delivery for malaria management Goal:** To ensure service providers provide accurate and appropriate information and give prompt and effective treatment to pregnant women and children under five years with malaria, consistent with the messages of the RBM campaign.

6. **Improved Policy Environment Goal:** To ensure policy-makers provide political and financial support for IPT, ITNs, home-based care and service delivery of malaria.

**Objectives and Indicators**
The objectives were derived to give a method to monitor the progress and effectiveness of the strategies outlined. The behavioral objectives derived in the strategy development process and suggested indicators that can be used to measure progress towards the objectives have been outlined on page 29.

COMMUNICATION STRATEGIES

VI. Infant and Child Care Communication Strategy

**A. Situation Analysis**
High mortality and complications in under-fives from malaria are in part due to caretakers’ lack of knowledge of malaria prevention, non-recognition of danger signs of the disease and non-compliance with treatment regimen. Caretakers shall be trained and empowered to prevent and manage malaria in the home by recognizing signs and symptoms, prompt referrals, giving the recommended first-aid, adhering to prescribed treatment regimens, and using ITNs. The most relevant audience for improving early detection and referral of malaria is the primary caregiver, the parents. Home-based treatment with analgesics and/or antimalarial medicines is often the first action taken by
parents. In most instances, the dosage of the treatment is often inadequate and there is increasing resistance to locally available drugs, such as chloroquine.

As a result of high level of resistance to chloroquine, Liberia in 2003 reviewed its antimalarial medicine policy and recommended ACT as the new first line medicine. Caregivers are being trained to promptly refer their under-fives to the health facility, following the sponging/bathing of child with cold water and/or administration of an analgesic (i.e. paracetamol). Sponging with cold water will make the child more comfortable and reduce the chances of complications such as convulsion and shock. Parents shall therefore be given essential information about disease prevention, symptoms and danger signs, and case management to enable them adequately mount the appropriate response to malaria at the household level.

B. Audience

Primary Audience
Parents (esp. mothers), as the primary caregivers are the primary target audience for the malaria control BCC. The program will be implemented in the rural and peri-urban areas of Liberia and will have a special focus on women of child bearing age (14-49). They are typically low literate, of low socio-economic status, and rely on local languages.

Secondary Audience
The secondary target audiences are older siblings, grandparents, in-laws, other relatives, community leaders (religious, traditional, women’s group youth group, etc.) and all those who could influence decisions at the household level regarding health care.

C. Behavioral Objectives
1. By the end of 2006, increase the proportion of parents and other caregivers of under-fives who: a) know two or more signs of malaria; b) reduce their child’s temperature in the home with paracetamol and/or by sponging child down immediately at onset of fever;
2. By the end of 2006, increase the proportion of parents and other caregivers of under-fives, who correctly administer the full course of malaria treatment with recommended medicines.

D. Early Detection and Prompt Referral Recommendations
Caregivers should be able to do the following:
- Give child an analgesic (i.e. paracetamol),
- Sponge the child down (bathe child with cold water) to reduce the fever (body temperature), to make the child more comfortable and reduce the chances of convulsion and shock while on the way to a health facility,
- Take the child to a health facility immediately at the onset of fever
- Complete malaria treatment (within given time) even if child appears to have recovered before treatment is completed
- Take your child back to the health facility immediately if the fever does not go down in 2 days after starting treatment with anti-malaria medicines.
- Go immediately to the health facility if you or your child has any of the following danger signs:
  - is unusually sleepy or difficult to wake up
fits (convulsions)
- stiff neck
- has difficulty breathing
- vomiting everything
- fever that does not go away two days after starting medication.

E. Desired Action Response
1. Primary Audience: “I will recognize the symptoms of malaria, sponge, administer paracetamol and refer my child to a health care provider immediately.”
2. Secondary Audience: “I will encourage and support my relative/neighbor to know/learn/recognize the symptoms of malaria, apply first aid and refer patient to a health care provider.”

F. Key Barriers to early detection and prompt action
Lack of knowledge is among the key barriers; Accurate knowledge includes, but not limited to: recognition of symptoms and danger signs of malaria, awareness of the current recommended anti-malaria medicine and its availability only through trained health workers, awareness that malaria is a life-threatening disease and should be treated promptly as well as prevented through the use of ITNs and the fact that temporary relief of symptoms does not equal a cure from disease.

Existing attitude towards malaria also negatively affects appropriate treatment. Because malaria is endemic in Liberia, the disease is not consistently perceived as serious or life threatening. A harmful practice such as non-compliance with treatment also serves as a barrier to adequate treatment of malaria at the household level. Many Liberians use incomplete treatment regimen either because the child’s health appears to have improved and therefore see no need to continue with medication. Further, given the high level of poverty in Liberia and the high cost of anti-malarials coupled with the high frequency at which children under five catch malaria, parents often put aside some tablets for future use.

Various social norms within the community threaten prevention and adequate treatment at the household level.
- In several communities, convulsions are believed to be due to witchcraft (a dragon) therefore traditional, rather than clinical cures, are sought.
- Many people prefer and often ask for chloroquine injection in the belief that it rids the body of malaria more quickly than the tablet.
- The sequence for seeking health care often causes delays in prompt referral of the child to a health facility; mothers often need approval from the fathers or mother-in-laws, before taking child to the clinic.

There are also numerous economic barriers to improved home treatment and prevention. Although chloroquine is cheap, the recurrence of malaria and the cost of frequent purchases of antimalarial drugs quickly add up. There is also an economic burden of repeated episodes of malaria, costing families’ money, time, and lost work. As chloroquine is inappropriately administered and deemed ineffective, more and more Liberians search for alternative malaria medications thereby increasing the cost of treatment.
Physical barriers pose another threat; access to health facilities is a major problem for referral, especially in the rural areas. While there is high access to loose tablets and chloroquine syrup throughout Liberia, availability of the new combination therapy, ACT, has not yet reached all parts of the country. Until an effective network of health workers is established who can provide the recommended first-line treatment, access will continue to be denied to many people who need the service.

G. Tone
The communication strategy to educate parents on early detection and prompt referral of malaria cases will balance an empowerment message with a nurturing tone. The campaign will emphasize building parents’ confidence and strengthening capacity/competency in caring for their child’s health; it will promote that the child’s health is central to the family’s overall well-being.

H. Tactics/Communication Channels

<table>
<thead>
<tr>
<th>Strategy</th>
<th>Activities</th>
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</thead>
<tbody>
<tr>
<td>Community based – event</td>
<td>Music, Various competitions</td>
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<tr>
<td></td>
<td>Drama</td>
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<td>Games</td>
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<tr>
<td>Community based – ongoing</td>
<td>CHW networks (establishment and training)</td>
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<tr>
<td></td>
<td>Standard curriculum development for various groups</td>
</tr>
<tr>
<td></td>
<td>Activity sheets and information cards</td>
</tr>
<tr>
<td>Mass Media – Print Materials</td>
<td>National unifying logo</td>
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<td></td>
<td>Leaflets, Fact sheets</td>
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<td></td>
<td>Posters</td>
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<td>Stickers</td>
</tr>
<tr>
<td>Mass Media – Radio</td>
<td>Magazine program</td>
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<td></td>
<td>Spots (PSAs)</td>
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</table>

The lead component of the infant and child communication strategy is community-based interventions, both event-based and on-going activities. The community is a strategic partner to engage for the change of social norms related to prevention of malaria as well as early detection and referral by the target audience. There will be various community events presented through music, drama, cultural troupes and games to create awareness about the importance of home-based care. The community-based interventions will tap into the existing resources within the community, such as drama troupes and various community groups and organization/partners. The activities will be developed in an interactive and entertaining manner to elicit audience participation. County health authorities and other partner organizations involved in malaria or child health are encouraged to be a part of the activities and be available to address inquiries and issues arising from health promotion programs.

There will be on-going community and in-school activities to maintain the campaign’s presence in the community over the long term. As an integral part of reactivating the CHW system, a curriculum with supporting job aids will be developed for CHWs and local NGOs to use during community group activities. Community health workers will be
given activity sheets and malaria information cards to use during client or group education sessions. Community education will also occur through local NGOs, mother’s clubs, religious organizations, traditional leaders, and other gatherings at the community level. Activities at the county/community level will complement the national mass media campaign.

Radio spots, print materials, and various hand-outs to promote the desired behavior will be distributed by all relevant partners. The materials will address normative issues including compliance and seeking treatment promptly following recognition of symptoms. Due to the high illiteracy rate in Liberia, the messages will be disseminated via radio (when feasible) and in vernacular languages, to have the greatest reach.

The print media will be used during the campaign to disseminate information throughout the country. A logo and/or slogan will be developed to unify the various components of the malaria campaign. The logo will introduce a recognized symbol and slogan that will be included in all of the radio and print materials, placed in all service delivery points and communities as well as affixed to all approved ITNs for Liberia. Leaflets with information on basic home-based care and stickers with malaria information and reminders will be produced to provide accurate information to mothers on the home-based care of malaria. Appropriate educational materials will be developed to appeal to the various levels of literacy, including graphic designs and pictures. Posters showing symptoms of simple and severe malaria will be produced and distributed to communities, health facilities, and public places where parents (esp. women) frequently go or gather.

The electronic media provides an effective communication channel for reaching large audience of Liberian caregivers at any given time. Radio is a widely available and popular channel which people respect; community participation in radio programs has increased considerably in post-war Liberia. Radio activities will include a national weekly radio magazine show with various sessions including a drama, questions and answers, and discussion on various child health issues, including home-based care and prevention of malaria. Radio spots will be aired in local languages to empower women to manage and prevent malaria in the home and to stress the benefits of prompt referral and compliance with the treatment regimen. All campaign materials and the creative concepts will be pre-tested with relevant members of the target audience, prior to reproduction.

VII. Artemisinin-based Combination Therapy (ACT) Communication Strategy

A. Situation Analysis
Like most countries in Africa, chloroquine was Liberia’s first line drug for malaria treatment for a long time. Chloroquine resistance was however first noted in the country in 1988 and has since been rising. Published and unpublished works by Liberians and other partners report that chloroquine resistance ranged from 5% to 17% in 1993 in various parts of the country, and by 2001 it had risen to 74%. Fifty one percent resistance to sulphadoxine-pyrimethamine (SP) also known as Fansidar, which was the
second line drug, has also been documented. In light of this, and following consultations with WHO and other partners, the Government of Liberia revised the malaria drug policy to reflect Artemisinin-based Combination Therapy (ACT) as the new first line drug for treatment of malaria in Liberia.

Currently, the general public has little or no information about ACT. This has led to various misconceptions and rumors about the therapy and some are reluctant to take the medicine as recommended.

B. Audience
Primary: Pregnant women and mothers of children under five in peri-urban and rural Liberia.
Secondary: Community Health Workers, Husbands, fathers, boyfriends, in-laws, relatives and community/traditional leaders - those who influence household decisions regarding care and prevention of malaria.

C. Behavioral Objectives
To increase the proportion of pregnant women and children under five who take the full course of ACT as prescribed for every episode of malaria, by 10% by the end of 2006.

D. Desired Action Response
Primary: I understand the dangers of malaria during pregnancy to myself, my unborn baby and my child under-five. I will fully complete my treatment with ACT whenever I have malaria.
Secondary: I will encourage pregnant women and children under five to take a full course of ACT whenever they have malaria.

E. Key Barriers
- People are taking artesunate without amodiaquine because of their belief that the amodiaquine has severe side effects than the artesunate.
- People are rejecting treatment because of the large quantity of the single dose.
- Administration of the medicine was previously based on age instead of body weight, thus resulting in severe side effects in some instances.
- Refusal to take the medicine because of misconception that the medicine makes one feel worse before you get better, among others.
- Inadequate supply of the rapid diagnostic test (RDT) due to logistical bottle-necks.
- Little or no information about ACT to the general public before it was introduced.
- The high cost of ACT on the open market makes it difficult for some individuals to purchase the medicine.

F. Tone
The communication strategy to educate pregnant women and parents on compliance will balance an empowerment message with a nurturing tone. The campaign will emphasize building pregnant women and parents’ confidence and strengthening their capacity to comply and care for themselves and their children’s health.

G. Tactics/Communication Channels
### VII. Service Provider Communication Strategy

#### A. Situation Analysis

In spite of numerous barriers to seeking treatment from the health facility (particularly in the rural areas), problem analysis has shown that an average of 49% to 71% of caregivers in the rural and urban areas respectively, visit a health facility for malaria treatment.

Service provision for malaria basically occurs on two levels:
- the health facility by trained health workers
- within the community by community-based health workers and other interest groups (pharmacists, petty vendors, black-baggers and traditional herbalists).

With improvements in security conditions throughout the country, more and more health facilities are being rehabilitated and opened for service. The MOH&SW/NMCP and the NGO, MENTOR Initiative, are training professional health workers in the new malaria case management protocols, including ACT. All health facility teams undergo in-service training courses in preparation for the introduction of ACT, in compliance with the national policy. Other categories of health care providers (e.g. CHW, TTM) shall be subsequently trained and mobilized as key partners for the dissemination of health information about malaria prevention and control.

#### B. Audience

**Primary Audience**
1. Facility-based health workers who work primarily with children under five years of age
2. Community health workers: Community health workers are strategic members of the larger community of health care providers because they are often consulted by parents

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<tr>
<th>Strategy</th>
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<tbody>
<tr>
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<td>Music, Various competitions Drama Games</td>
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</tr>
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<td>Mass Media – Radio</td>
<td>Magazine program Spots (PSAs)</td>
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</tbody>
</table>
when their children have fever; they present a valuable opportunity and resource for communicating essential information about care, treatment, side-effects and prevention to caregivers.

MOH&SW recommends a phased approach in training of the primary audience, with the initial target being facility based health workers. The reason being, ACT is a new medicine that is being introduced and needs close monitoring initially, to ensure safety and compliance. Community health workers remain a key audience none-the-less, in providing prevention and treatment seeking information to their communities therefore their training is also mandatory.

Secondary Audience: Pregnant women and caregivers of children under five years of age.

C. Behavioral Objectives
1. By the end of 2006, increase by 10% the proportion of service providers who effectively counsel and give accurate information on early detection, prompt referral, home management and prevention of malaria to caregivers of children under five years.
2. By the end of 2006, increase by 10% the proportion of service providers who effectively counsel and give accurate information on intermittent preventive treatment and prevention of malaria to pregnant women.
3. By the end of 2006, increase by 10% the proportion of service providers who effectively educate caregivers on the importance of completing the full course of anti-malaria treatment.

D. Desired Action Response
1. Primary Audience: “I will provide simple and accurate information regarding prevention, early detection and referral of malaria in children under five years and pregnant women, to my clients.”
2. Secondary Audience: “I will demand accurate information and effective treatment and prevention of malaria from my health worker.”

E. Key Barriers
• Health service providers lack adequate information and training on the new combination therapy for malaria and best practices in the field of malaria management.
• Health workers do not routinely provide health education due to their heavy workload; they usually have limited or no time to adequately counsel clients on the importance of prevention of malaria in pregnant women, as well as home management and ITNs usage for children under five years of age.
• Service providers often lack appropriate interpersonal communication skills to ensure clients’ understanding of the benefits of prevention and treatment, and tools for counseling and health education.
• The lack of transportation such as vehicles/cars, motor bikes and bicycles to carry out outreach activities and supervision in hard to reach communities.
• Community health workers network is not fully functional
• Community health workers do not have access to current malaria prevention and treatment information; there is a general lack of support for CHW
• Low salary for health workers; they however remain committed to service delivery.
• The health care delivery system is generally poor in terms of equipment, efficacious drugs, infrastructure, transportation and salary.

F. Tone
The communication campaign will establish health service providers as a friendly, knowledgeable and dependable source of information on the prevention and treatment of malaria. The campaign will emphasize that strengthening their health education skills will enhance their position in the community and in the long run, reduce their workload because eventually, less people will be sick from malaria.

G. Tactics/Communication Channels

<table>
<thead>
<tr>
<th>Strategy</th>
<th>Activities</th>
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</thead>
<tbody>
<tr>
<td>Inter-personal Communication</td>
<td>IPC Training (in-service/refresher)</td>
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<tr>
<td></td>
<td>Branding friendly providers (button/logo)</td>
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<tr>
<td>Education Materials</td>
<td>Flip charts</td>
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<td>Posters</td>
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<td></td>
<td>Job Aids</td>
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<td>Bill board</td>
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<td></td>
<td>Fact sheets /Leaflets</td>
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<tr>
<td>Mass Media</td>
<td>Newspaper advertisement, Journal</td>
</tr>
<tr>
<td>Print</td>
<td>Newsletters</td>
</tr>
<tr>
<td>Electronic</td>
<td>Radio – drama</td>
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<td></td>
<td>Radio – spots, film show, Television, Internet</td>
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</tbody>
</table>
A multi-channel approach shall be used to provide essential information to health service providers such as:

- Properties/characteristics of the new combination therapy,
- Recommended methods for the prevention of malaria in pregnant women and children under five through the use of IPT and ITNs,
- The importance of providing simple and clear information as well as high quality services to the patient

To improve the quality of service, health workers will be trained in interpersonal communication. The training will among others, emphasize the importance of counseling patients and ensuring that they have a clear understanding of the correct use of the new antimalarial medicine. The health workers who attend the training will receive buttons with the campaign logo to identify them and facilitate their acceptance by the community.

Training activities shall be further supported through the development and provision of educational materials and job aids for health workers, to strengthen their capacity to provide accurate information to clients. The key job aid will be a flip chart covering all aspects of malaria prevention and treatment; the flip chart will be used with individuals or groups of clients. All health facilities will receive posters to display and job aids with dosage reminders to encourage the health worker comply with providing information to their clients. Reminder cards will be distributed to caregivers with guidelines for full treatment compliance and malaria prevention.

The mass media will be used extensively to increase public awareness of the role of the health service provider in malaria control in the community. A health worker character will be incorporated into radio/magazine/drama, to model and promote appropriate counseling and malaria medicine dispensing behavior. This will create awareness among mothers that the health service provider is knowledgeable about antimalarials and should therefore serve as a reliable source of health information and service delivery. Radio spots and television messages will also reinforce the information in dramas as well as those given at training sessions and in print materials.

**IX. Pregnant Women’s Communication Strategy - IPT**

**A. Situation Analysis**
In October 2003, the Ministry of Health and Social Welfare revised the national policy provision regarding the malaria chemo-prophylactic drug for Intermittent Preventive Treatment for pregnant women from chloroquine to Fansidar. Pregnant women are now given one dose of Fansidar during their second trimester and another dose during their third trimester. Prior to this policy revision, chloroquine was taken by pregnant women as a weekly prophylaxis.

Formative research has shown that about 85% of pregnant women in both rural and urban areas take some form of prophylaxis during pregnancy to prevent malaria.
According to the 1999/2000 DHS, pre-natal visit to the health facility is high. Mothers receive pre-natal care for 90% of births. The median time for the first pre-natal visit is four months after pregnancy with about 35% of pregnant women making their first visit in the fourth and fifth months. Over 11% had their first visit after the sixth month, a time period considered to be too late for full IPT benefits. Pre-natal visits are often made to mid-level health workers (registered nurse, certified midwife) and/or trained and untrained traditional midwives.

B. Audience
Primary: Pregnant women in peri-urban and rural Liberia. They are typically low literate, of low socio-economic status, and rely on local languages.
Secondary: Husbands, fathers, boyfriends, mother-in-laws, relatives, community/opinion leaders and those who influence decisions made at the household regarding care and prevention of malaria.

C. Behavioral Objectives
1. By the end of 2006, there will be 20% increase in the percentage of women of reproductive age (14-49) in peri-urban and rural areas who know the importance of taking IPT.
2. By the end of 2006, there will be a 12% increase in the percentage of pregnant women in peri-urban and rural areas who complete two doses of IPT – the requirement according to the national protocol.

D. Desired Action Response
Target Audience: “I will visit a trained health professional within the first three months of my pregnancy for pre-natal care and make sure to complete two doses of IPT – one each in the second and third trimesters - in order to protect myself and my unborn child from malaria.”
Secondary Audience: “I will encourage my wife/daughter/relative/neighbor to seek pre-natal care within the first three months of their pregnancy and to take IPT in the second and third trimesters in order to prevent malaria and ensure a healthy mother and baby.”

E. Key Barriers
The barriers to pregnant women taking IPT are similar to the barriers to treatment-seeking practices among caregivers:

- Pregnant women often lack knowledge of the benefits of IPT during pregnancy,
- Health worker not knowledgeable therefore they do not give IPT,
- Pregnant women in rural areas often have limited access to resources they need to complete IPT including funds needed to travel to a health facility/health worker or to purchase the drugs. Further there is poverty in the face of competing priorities therefore, if funds are available, they may not be used for IPT/malaria prophylaxis,
- Inadequate number of trained and easily accessible community health workers including TTMs who can provide information on IPT,
- Pre-natal care not always available; women are left to themselves to decide about care during pregnancy.
Further to the barriers above is the high use of traditional herbs to prevent malaria.

F. Tone
The tone for the campaign targeting pregnant women will be one of empowerment. Pregnant women can take the required minimum/simple but necessary steps to receive the best care possible for themselves and their unborn babies. The campaign will also focus on how the secondary audience can support pregnant women and why it is important to do so.

G. Tactics/Communication Channels

<table>
<thead>
<tr>
<th>Strategy</th>
<th>Activities</th>
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</thead>
<tbody>
<tr>
<td>Improve Quality of Service</td>
<td>IPC Training – facility based workers, CHW, TTM</td>
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<td></td>
<td>Fansidar access</td>
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<tr>
<td>Safe Motherhood Integration</td>
<td>Ensure message consistency with Safe Motherhood and IMCI promotion activities</td>
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<tr>
<td>Peer Education</td>
<td>Curriculum development</td>
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<td>Training of peer leaders</td>
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<td></td>
<td>CBO training, job aid development</td>
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<tr>
<td>Mass Media</td>
<td>Radio dramas</td>
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<td></td>
<td>Radio spots</td>
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<td></td>
<td>Community drama</td>
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<tr>
<td>Print Media</td>
<td>Posters</td>
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<td>Pamphlets</td>
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<tr>
<td>Use of IPC Channels</td>
<td>Health Talks in OPD and during outreach session for integrated service (RBM, EPI, MCH, IMCI)</td>
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Promotion of IPT among pregnant women shall be tailored to the availability of Fansidar, the prescribed chemoprophylaxis, at various levels of the health delivery system. The campaign should roll out concurrently with or shortly after training takes place in a given area. Training for health service providers shall include a module on provision of essential information on the benefits of IPT.

In order for pregnant women to have the one-on-one opportunities with trained health professionals necessary for education about IPT and obtain prenatal service, the BCC campaign shall collaborate with safe motherhood campaigns in promoting pre-natal visitations.

The target audience shall be reached through a combination of communication channels. Women’s CBOs are key opportunities for peer education. These organizations can take many forms including Mother Support Groups, farming co-operatives and susu clubs. Where such groups do not exist, efforts will be made to establish them. A module shall be developed for community health workers and TTM/TBAs to assist this cadre of health workers in conducting education sessions among women CBOs.

In addition to peer education, the mass media will be used to reach the target audience. Radio programs will be developed that include pregnant women as characters who will be confronted with the decision to take IPT. Also, radio and television spots will be produced and aired which encourage pre-natal visitation for malaria prevention in the
pregnant woman and the unborn child. The appropriate educational materials will be
developed to suit women who are marginally literate and disseminated through the print
media. The materials will include posters for display at health facilities, out-reach
service delivery points and other locations where rural women are known to frequently
gather such as local markets and churches.

Reaching the secondary audience is equally important in order for pregnant women to
gain the support and approval of family, friends and community/opinion leaders. It is
important to therefore create general awareness about IPT among these various
populations.

X. Insecticide Treated Nets Intervention - ITNs

A. Situation Analysis
Generally, there is high public knowledge that mosquitoes are the cause of malaria. Formative research has however shown that the public does not associate the mosquito
net with malaria prevention. The research also showed the use of ITNs among pregnant
women to be very low though, generally acceptable. Current national procurement and distribution mechanisms of ITNs are inadequate, therefore, most caregivers do not have easy access to them; it is however expected that availability of ITNs will increase through the Global Funds.

B. Audience
Primary: Pregnant women and mothers of children under five in peri-urban and rural
Liberia. 
Secondary: Husbands, fathers, boyfriends, in-laws, relatives and community/traditional
leaders - those who influence household decisions regarding care and prevention of
malaria.

C. Behavioral Objectives
By the end of 2006, at least 15% of pregnant women and children less than five years will
consistently sleep under a insecticide treated mosquito net.

D. Desired Action Response
Primary Audience: I understand the dangers of malaria during pregnancy to myself,
my unborn child and my child under five years of age and will take all actions to prevent
malaria including correctly and consistently sleeping under ITNs.”
Secondary Audience: “I will encourage my pregnant wife/relative/neighbor to sleep
under a treated mosquito net every night to prevent malaria.” ; “I will also encourage my
wife/relative/neighbor to ensure that her child under five sleeps under a treated mosquito
net every night, to prevent malaria.”

E. Key Barriers to the Use of ITNs
Barriers to the use of ITNs are similar to those encountered by care-givers of children
under five therefore, similar communication strategies will be used to reach both groups. The barriers include:
1. Lack of knowledge of the causes of malaria therefore lack of knowledge of
measures to prevent the disease.
2. Limited supply of the ITNs: mosquito nets are imported into the country by a few business partners and donor agencies.

3. High cost of ITNs: There is no standing government regulation regarding the sale price and distribution channel, therefore nets owners determine their own prices which are generally high for the average member of the target audience.

4. Non-existence of a decentralized health delivery system with a functional community health component through which ITN can be promoted and distributed.

5. Limited number of trained health workers and health facilities as well as adequate logistics for distribution and retreating of nets.

6. Non-acceptance of ITNs due to varying reasons including being too hot to sleep under and their use in some regions of the country to cover the dead.

7. The practice of discrimination against the primary target audience in family situations where there are less nets than those who need them; this situation would affect the use of the ITN even if it were available in the home.

F. Tone
The tone for the campaign targeting pregnant women and caregivers of children under five will be one of empowerment. Pregnant women and caregivers can take the few simple steps to receive the best care possible for themselves and their babies.

G. Strategies/Communication Channels
The same strategies and communication channels to be used to reach pregnant women for IPT will also be used for ITN intervention.

XI. Advocacy for Key Constituencies

A. Situation Analysis
Advocacy is an integral component to the malaria control communication strategy as public policy and social norms influence individual behavior. The advocacy component of the BCC Strategy aims to build a supportive environment for acceptance as well as improvement in access to antimalarial medicines, ITNs and quality of health service.

There are several policy issues that need further clarification and promotion. Examples are:

- the new antimalarial drug policy,
- government subsidized importation and distribution of ITNs,
- regulation regarding the sale price of ITNs including certain dispensations for low income families.

Government and community leaders have given little priority to home-based management of malaria in the past. Advocacy activities shall be undertaken in an effort to begin changing this political and social context. Although the RBM strategy has approval at the highest level of the government, there is need to gain the support of health care providers in both the public and private sectors, policy-makers (i.e. the legislators), and community leaders (traditional and religious) for the various approaches to be successfully implemented within the community. Advocacy will also stimulate discussions and debates on policy and program options for various approaches to malaria prevention/control and case management.
Access to the new anti-malaria therapy is another challenge needing resolution from policy-makers. Presently, government policies regarding the importation and sale/distribution of ACT are not clear; in the absence of their resolution, these issues will continue to threaten availability of service and restrict access to anti-malaria commodities.

The Government of Liberia presently depends on donor agencies for the supply of ACT and lacks control over the quantity of ACT and ITNs that is imported into the country at any given time. This situation greatly affects availability of supplies at various delivery points. Hopefully, with the coming in of the global funds, this situation will greatly improve.

B. Audience
There are two sets of priority audiences:
- Relevant government decision makers (Finance, Budget, the Legislature) will be targeted to gain political support for Malaria BCC Campaign.
- Health professionals (authorities of MOH/NMCP, professional health associations, midwives, traditional healers, private practitioners, etc.) including local NGOs and CBOs,

The donor community is also an important audience to be mobilized as partners in order to gain financial and logistical support for the Malaria Control Campaign.

C. Behavioral Objectives
1. To provide political and financial support for the malaria communication campaign,
2. To provide policy support for the various components of the Malaria control communication campaign in relation to medicines, ITNs and logistical support for service provision.

D. Tone
The numerous health issues and the complex emergency situation in Liberia have created competing demands for political and financial support for health and development programs. Malaria is the leading killer of children under five years of age and accounts for 54% of under-five mortality. This health indicator is unacceptable and should be considered a crisis which requires concerted efforts from all sectors for improvement.

The Malaria Control BCC Strategy shall build on existing positive community health practices and resources for the reduction of malaria mortality, rather than introducing new ones. Policy-makers shall be encouraged to support the communication strategy by prudently allocating resources based on priorities that have been derived from data-based monitoring of activities.

Policy-makers shall be sensitized to the direct relation between easy access to safe and efficacious antimalarial medicines and successful infant and child care of malaria.
E. Tactics/Communication Channel
Advocacy activities will basically use the interpersonal approaches. This will consist of many informal and formal meetings with policy-makers and partners to develop consensus on program strategies and policy directions. There will also be briefing packages produced for government officials, donor agencies, partner organizations and the news media. The news media will lead public dialogue and debates regarding infant and child care of malaria and provide further coverage on the need for easy access to efficacious antimalarials as well as provide wide publicity for program achievements.

XII. Research

The Malaria BCC campaign will make use of existing research findings for follow up operational research. Available sources of data include all studies referenced to in this document. Additionally, a number of focus group discussions on fever-reduction practices and the use of ITNs and IPT already exist as background information. A planned baseline study under the malaria component of the Global Fund project promises to provide reliable data to update critical communication indicators obtained earlier.

The impact of capacity building activities related to training will be measured primarily through pre and post-tests and responses to follow-up questionnaires that assess application of training content to their job. Additionally, the capacity building of CHWs program will be monitored and evaluated using exit interview from mystery clients following an antimalarial purchase or consultation for service and measuring the recall messages of CHW immediately following the training and six months from the training.

XIII. Coordination

To facilitate implementation of the project activities, a Malaria Communication Working Group will be formed. This technical group will include representatives from the Ministry of Health and Social Welfare and all organizations involved in the implementation of malaria communication activities. The communication technical group will be responsible for monitoring the implementation of program strategies including advocacy as well as program evaluation. The group will meet as needed to plan, review materials, provide input into the design of community activities, provide guidance with regards to advocacy activities and in general, facilitate decisions regarding the implementation of activities.

Coordination of activities at the county level will be done under the technical leadership of the County Health Team (CHT) headed by the County Health Officer (CHO). It is envisaged that the multi-sectoral/multi-disciplinary committee that coordinated planning and implementation of polio national immunization days (NIDs) will be used for RBM activities. BCC for malaria will be coordinated by the Community Health Department of the county.

In fostering community participation and ownership for RBM, health promotion activities at district and community levels should be coordinated by the local health and development committee. It is very important that BCC activities be implemented through
existing community structures and systems. This arrangement will require the forging/strengthening of alliances with programs such as EPI, IMCI and MCH.

Reports of BCC activities for RBM will be made through the existing MOH&SW reporting system established for the CHT and NGO partners.
XIV. Work Plan

A. Communication Strategy Development
1. Development of communication strategy for malaria
   March 2004
2. Revision of communication strategy for malaria
   June 2005
3. Identification of existing IEC materials on malaria
   August 2005
4. Formation of Malaria Communication Working Group
   Sept. 2005
5. Consensus Building Workshop
   Sept. 2005

B. Development of Communication Interventions
6. Advocacy package prepared
   Sept. 2005
7. Design workshop for radio magazine show
   Mar. 2004
8. Develop campaign logo,
   Jun. 2004
9. Message and material development workshop
   Aug. 2005
10. Develop RBM curriculum for community groups
    Jul. 2004
11. Development of radio magazine show
    Oct. 2005

C. Production of Communication Interventions
12. Pretest campaign logo, print, radio, and training materials
    Sept. 2005
13. Production of radio spots
    Sept. 2005
14. Production of print materials
    Oct. 2005
15. Training of service providers
    Dec 2005
16. Distribution of print materials and logo signs
    Nov. 2005

D. Launch of Communication Campaign
17. Campaign Launch Event
    Dec. 2005
18. Airing of radio spots at national level
    Oct. 2005
19. Airing of radio serial drama
    Nov. 2005
20. County/communities activities
    Dec. 2005
21. Local drama troupes in communities
    Dec. 2005

F. Monitoring and Evaluation
22. Development of Questionnaires
    Nov. 2005
23. Exit Interview
    Dec. 2005
24. Pre and Post Test
    Dec. 2005
25. Mystery Client
    Jan. 2006
26. Impact Evaluation
    Oct. 2006
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<th>Priority Area</th>
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| Infant and Child Care | 1. By the end of 2006, increase the proportion of mothers and primary caregivers of children under five who: a) know 2 or more signs of simple malaria; b) know malaria is transmitted only by mosquitoes c) believe visiting a community health worker or health facility is the best action to take when their child under five has malaria. 2. By the end of 2006, increase the proportion of Mothers and other Caregivers of children under 5 who: a) know 2 or more signs of malaria; b) reduce their children temperature in the home with paracetamol and/or by sponging within 24 hours of fever onset; c) treat fevers in their under-five year old children within 24 hours with the correct | Strategy Activities  
Community based – event  
*Music  
*Drama  
*Games  
Community based – ongoing  
*CHW networks  
*Standard curriculum for groups  
*Activity sheets and information cards  
Mass Media – Print Materials  
*National unifying logo  
*Leaflets  
*Posters  
*Stickers  
Mass Media - Radio  
*Magazine program  
*Spots (PSAs)  
Television  
Newspaper  
Internet  
1. # malaria radio and TV programs produced and aired  
2. # malaria radio and TV spots produced and aired  
3. # malaria information materials (posters, leaflets, brochures) produced and distributed.  
4. # CHW trained in malaria education sessions with standard curriculum  
4. # malaria education sessions given at health facilities and in communities  
5. # malaria entertainment-education community events.  
6. # or % of mothers and primary caregivers of children under five who have heard or seen messages about fever management in under-fives through: radio spots/programs, informational materials (posters, leaflets, brochures), during health education sessions (at clinic, directly by service provider, or in community education sessions) or prescriptions  
1. Percent (%) of mothers or primary caregivers of children under five who report practicing recommended home-based management (either sponging or administering paracetamol or both) within 24 hours of fever onset.  
2. Percent (%) of mothers or primary caregivers of children under five who can correctly state 2 or more signs of simple malaria in children under five.  
1. Percent (%) of mothers or primary caregivers of children under five who report seeking treatment from professional health worker for children under five with fever, within 24 hours of onset.  
3. Percent (%) of mothers or caregivers of children under 5, whose children under five were prescribed ACT, who report completing treatment regimen as recommended. | 1. Percent (%) of mothers or primary caregivers of children under five who report practicing recommended home-based management (either sponging or administering paracetamol or both) within 24 hours of fever onset.  
2. Percent (%) of mothers or primary caregivers of children under five who can correctly state 2 or more signs of simple malaria in children under five. |
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<td>first line recommended drugs and c)administer the full course of the first line recommended drugs to their children under 5, to whom it has been prescribed.</td>
<td>community events.</td>
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| Improved Service Delivery Provision | 1. By the end of 2006, increase 10% the proportion of service providers who effectively counsel and give accurate information to caregivers of children under 5 years on: a)early detection, b)prompt referral, c)home management, d) treatment adherence, and e) prevention of malaria. 2. By the end of 2006, increase by 10% the proportion of service providers who effectively counsel and give accurate information on intermittent preventive treatment and prevention of malaria to pregnant women. 3. By the end of 2006, increase by 10% the proportion of service providers who effectively counsel and give accurate information to caregivers of children under 5, to whom it has been prescribed. | Inter-personal  *Trainings  *Branding friendly providers (button/logo)  
Print & Education Materials  *Flip charts  *Posters  *Leaflets  *Job Aids  
Mass Media  *Radio – drama  *Radio - spots  
Mass Media - Radio  *Magazine program  *Spots (PSAs)  
Television  
1. # of professional health providers trained in inter-personal communication skills 2. # of community health workers trained in inter-personal communication skills 3. # flip charts produced and used by service providers 4. # radio spots / programs produced and aired 5. # print materials produced and distributed 6. # of Radio and TV Spots produced and aired | 1. Percent(%) of mothers or primary caregivers of children under 5, exiting facilities, who report receiving information regarding malaria detection, prompt referral, home management, treatment adherence and prevention of malaria for children, and who are able to correctly identify recommended practices in each of the 5 categories. 2. Percent(%) of pregnant women who report receiving information about IPT from a health professional. 3. Percent(%) of mothers or primary caregivers of children under five and pregnant women who report being exposed to provider aid/educational materials (flip chart). | 1. Percent(%) of mothers or primary caregivers of children under five who report practicing recommended home-based management (either sponging or administering paracetamol or both) within 24 hours of fever onset. 2. Percent(%) of mothers or primary caregivers of children under five who report seeking treatment from professional health worker for children under five with fever, within 24 hours of onset. 3. Percent(%) of mothers or caregivers of children under 5, whose children under five were prescribed ACT, who report completing treatment regimen as recommended. 4. Percent(%) of pregnant women receiving full course of IPT according to national protocols. 5. Percent(%) of mothers or primary caregivers of... |
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| **Pregnant Women – IPT** | 1. By the end of 2006, there will be a 20% increase in the percentage of women of reproductive age (14-49) in peri-urban and rural areas who know the importance of taking IPT.  
2. By the end of 2006, there will be a 12% increase in the percentage of pregnant women in peri-urban and rural areas who complete 2 doses of IPT according to national protocol. | Newspaper  
Internet  
*Training – facility based workers, CHW, TTM, etc.  
*Fansidar access  
Safe Motherhood Integration  
*Ensure message consistency with Safe Motherhood promotion activities  
Peer Education  
*Curriculum development  
*Training of peer leaders  
*Peer/CBO sessions  
Mass Media  
*Radio dramas- programs  
*Radio /TV program& spots  
*Community drama | 1. # malaria radio and TV spots and programs addressing IPT produced and aired  
2. # malaria information materials (posters, leaflets, brochures) addressing IPT produced and distributed.  
3. # women trained as peer educators  
4. # malaria education sessions given at health facilities and in communities addressing IPT.  
5. # malaria entertainment-education community events (drama or other) addressing IPT carried out.  
6. Proportion of women of reproductive age (14-49) who have heard or seen malaria education events (drama or other) addressing IPT. | 1. Proportion of women of reproductive age (15-49) who know the importance of taking IPT.  
2. Proportion of pregnant women seeking pre-natal services at clinic or health facility, or community health worker, where Fansidar is available. | children under five who report using an ITNS for their children under five.  
6. Percent(%) of pregnant women reporting using an ITNS. |
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<td><strong>Insecticide Treated Nets</strong></td>
<td>1. By the end of 2006, at least 50% of pregnant women and children under 5 years will consistently and correctly sleep under a treated mosquito net.</td>
<td>Print Media *Posters *Pamphlets</td>
<td>messages about IPT through: radio, informational materials, peers or health workers</td>
<td>1. Proportion of pregnant women who understand the importance of sleeping under an ITNS. 2. Proportion of mothers or caregivers of children under 5 who understand the importance of sleeping under an ITNS.</td>
<td>1. Percent(%) of pregnant women reporting using an ITNS. 2. Percent(%) of mothers or primary caregivers of children under five who report using an ITNS for their children under five.</td>
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<td><strong>Advocacy</strong></td>
<td>1. Increase political and financial support for the malaria communication campaign.</td>
<td><em>Strategy Activities</em> Community based – event *Music *Drama *Events</td>
<td>Community based – ongoing *CHW networks *Standard curriculum for groups *Activity sheets and information cards</td>
<td>Community based – ongoing *CHW networks *Standard curriculum for groups *Activity sheets and information cards</td>
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<td>2. To provide policy support for the various components of the malaria communication strategy in relation to medicines, ITNSs and logistical support for service provision</td>
<td>*Meetings with key persons Mass Media – print materials *Advocacy materials *Eletronic-Programs</td>
<td>produced and distributed. 3. # of media personnel trained in malaria advocacy 4. # of radio and TV programs produced and aired</td>
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References


5. Desk analysis, WHO 2001