

Essential Malaria Actions: Ethiopia

December 2012

Malaria Situation in Ethiopia

Despite the low parasite prevalence, malaria is the leading communicable disease in Ethiopia. Overall, according to the Federal Ministry of Health (FMOH), in 2009/2010 malaria accounted for up to 12% of outpatient consultations and 10% of health facility admissions. About 75% of the country is malaria-endemic (defined as areas <2,000 m), with about 68% (i.e., 54 million) of the country's total population living in areas at risk of malaria. The FMOH estimates that there are 5–10 million clinical malaria cases each year, half of which are caused by *P. falciparum* and *P. vivax*; approximately 70,000 people are estimated to die of malaria each year.

The 2007 Malaria Indicator Survey (MIS) showed that 68% of households in areas at risk of malaria had at least one long-lasting insecticide-treated bed net (LLIN). Among the most vulnerable groups—pregnant women and children under 5 (U5) who owned a net—LLIN usage was 66% and 60%, respectively. In addition, of those reporting a child U5 with a fever within the last two weeks, 15.4% sought medical attention.

Using the results of this survey the Ethiopian FMOH and donor organizations like the President's Malaria Initiative (PMI) have placed renewed emphasis on stakeholders' scale-up of interventions at all levels: service delivery, diagnosis and treatment accessibility, surveillance for epidemic outbreaks, social and behavior change communication (SBCC), policy, and management.

National Health Policy of Ethiopia

The National Malaria Prevention and Control Strategic Plan 2011–2015 is part of the more comprehensive Health Sector Development Plan (HSDP) IV (2011–2015) of the Government of Ethiopia. The goals, with respect to malaria control, in the HSDP IV are:

- By 2015, achieve malaria elimination within specific geographical areas with historically low malaria transmission.
- By 2015, achieve zero deaths due to malaria in the remaining areas with malaria transmission.



C-Change's Taye Dosane meeting with a family from South West Shoa in Oromia Region using Essential Malaria Actions to engage them in a discussion on the actions necessary to prevent and treat malaria.

The specific associated objectives as indicated in the same document are:

- 100% of suspected malaria cases are diagnosed using rapid diagnostic tests (RDTs) and/or microscopy within 24 hours onset of fever;
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- 100% of positive malaria diagnoses are treated according to national guidelines;
- 100% of households in malarious areas own, on average, two LLINs;
- at least 80% of people at risk of malaria use LLINs;
- indoor residual spraying (IRS) coverage is increased and maintained to 90% of households in IRS-targeted areas;
- 100% of health posts in malarious kebeles provide the full malaria prevention and treatment package, including outreach services;
- a high-quality, broad-based malaria infection detection, investigation and response surveillance system achieved to further reduce malaria transmission.

The strategic plan, which gives top priority to community empowerment and social mobilization, recognizes the critical role of SBCC in maximizing the efficacy and impact of all malaria prevention and control interventions.

The C-Change Program

In September 2008, USAID/Ethiopia awarded an Associate Award to C-Change to implement a range of activities supported by PMI.

The aim of PMI is to reduce malaria morbidity and mortality by 70% by 2015 through scaling up coverage of proven malaria prevention and control interventions, including LLINs, IRS in households, and improved case management. C-Change was tasked with providing state-

of-the-art and evidence-based technical and program support to the FMOH, the Oromia Regional Health Bureau (ORHB) and other in-country malaria stakeholders to maximize access to, use of, and adherence to all main malaria prevention and control interventions.

C-Change's goal in Ethiopia is to integrate mass media, interpersonal communication, and community engagement to help empower Ethiopian families to take preventive and treatment-seeking actions related to malaria and antenatal care/maternal, newborn, and child health, so that families' health status is improved. Using formative research and pretesting materials, C-Change created a number of easy-to-use, front-line teaching tools and short skills-based trainings that can be owned and managed by woreda (i.e., district) and kebele (i.e., municipality) level teams.

In addition, C-Change sought to strengthen the capacity of regional, woreda, and kebele structures to create sustainable SBCC interventions that resonate with target populations and at risk groups. These interventions contributed to:

- establishing and sustaining socio-cultural norms for the use of LLINs, including increased demand for LLINs, increased LLIN ownership, and their correct and consistent use, especially among the most vulnerable groups (i.e., U5 children and pregnant women);
- increasing community awareness about the effectiveness of IRS and facilitating reduced re-plastering of household walls post-spraying;
- Improving malaria diagnosis and treatment-seeking behavior (e.g., with regards to timeliness and appropriateness);
- Increasing community knowledge regarding malaria diagnosis, treatment, prevention, and control;
- Increasing the capacity and involvement of local NGOs in malaria prevention and control.

Addressing Behavioral Barriers with Action

C-Change’s communication activities in Ethiopia used an SBCC approach aimed at addressing barriers via an integrated strategy of advocacy, social/community mobilization, and behavior change communication. C-Change used multi-channel, multi-level communication interventions to maximize outcomes and geographic and target population reach, while strengthening SBCC capacity of local partners. All C-Change Ethiopia’s SBCC work is based on a Model Community approach (See Figure 1).

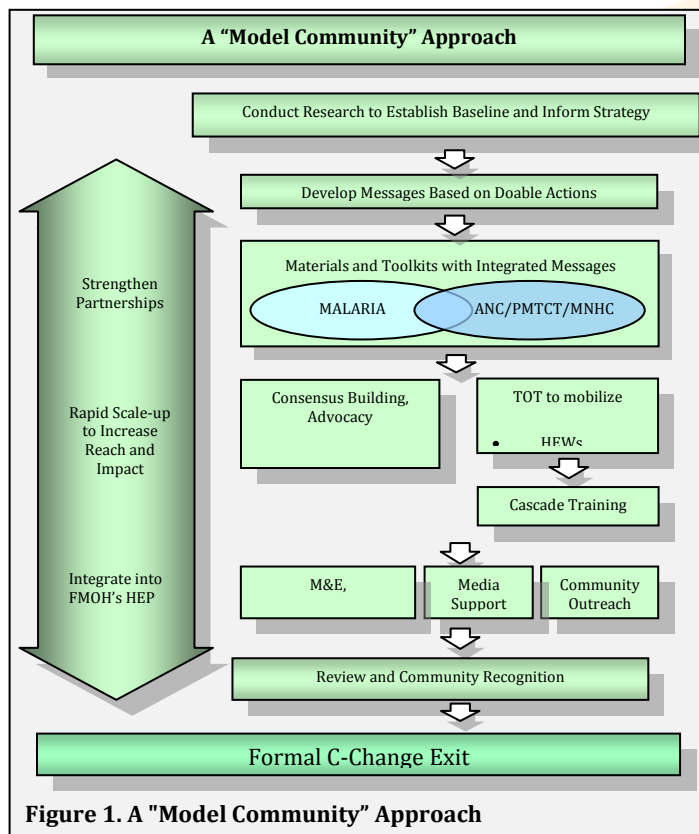


Figure 1. A "Model Community" Approach

The Model Communities campaign seeks to encourage households to adopt and regularly practice the desired malaria control and prevention actions and create demand for LLINs and early treatment-seeking behavior. The campaign is based on the understanding that a significant percentage of community members are already engaged in or regularly practice the desired health-seeking behavior within the targeted community.

Central to C-Change’s Model Community framework is identifying and targeting some of the key behavioral barriers. According to the baseline survey conducted in 2008, C-Change identified a number of barriers and norms related to malaria prevention and control.

These barriers include:

- lack of knowledge and risk perception or perception of the severity of the disease, misconceptions, and ineffective practices regarding malaria prevention, diagnosis, and treatment at the community level;
- absence of a socio-cultural norm to use LLINs;
- low acceptance of IRS by at-risk communities and high post-application wall re-plastering rates;
- delay in seeking diagnosis and treatment upon the onset of fever;
- lack of adherence to malaria treatment.

Subsequently, the C-Change Ethiopia project is designed to overcome these barriers by

- addressing the social norms and attitudes linked to malaria and increasing self-efficacy for positive malaria actions;
- designing interventions that embrace an integrated approach using three strategic approaches (i.e., advocacy, social/community mobilization, and behavioral change) for maximum impact;
- effecting household behavior change by influencing communal social norms through use of a Model Community approach.

From the identification of the barriers and norms, C-Change developed six cross-cutting communication strategies.

Strategy 1: Use research to inform and guide problem analysis, strategy development, and programmatic design.

Strategy 2: Actively engage the community by leveraging existing structures and community such as Health Extension Workers (HEWs) and volunteer Community Health Workers (vCHWs); volunteers to mobilize communities for action to control malaria.

Strategy 3: Reinforce interpersonal communication interventions via the application of mass media interventions to promote essential actions to families.

Strategy 4: Strengthen capacity in SBCC by providing training and mentorship at all levels of the ORHB and other Regional Health Bureaus (RHBs) structure, emphasizing practical communication applications and establishment of a mentoring relationship at all levels.

Strategy 5: Strengthen partnership and the linkages among stakeholders, e.g., health centers, HEWs, vCHWs, local organizations, schools, and individual families, to build a cohesive, comprehensive effort to boost malaria control efforts.

Strategy 6: Ensure the sustainability of prevention and control activities after project completion through the application of capacity building interventions at the local, regional and federal levels.

C-Change translated the strategies into a multi-faceted approach focused on:

1. developing simplified and clearly articulated EMAs that seeks to motivate the targeted audiences to adopt and implement them;
2. using the Champion Community model as its strategic framework(see figure 2) to encourage communities to actively engage in prevention and control activities;
3. building consensus and obtaining buy-in from stakeholders ranging from government officials

4. and community leaders to partners as the entry point for most activities.

Creating the Essential Malaria Actions

While stakeholders in Ethiopia were scaling-up biomedical interventions, there were relatively few active coordinating mechanisms and almost no overarching communication guidelines. Cognizant of this, the National Malaria Control Support Team (NMCST) recommended that a Malaria Communication Taskforce be established to undertake the responsibility of establishing a coordinating mechanism.

In October, 2008, C-Change Ethiopia organized a macro-planning workshop to streamline the process and maximize the impact of malaria communication activities

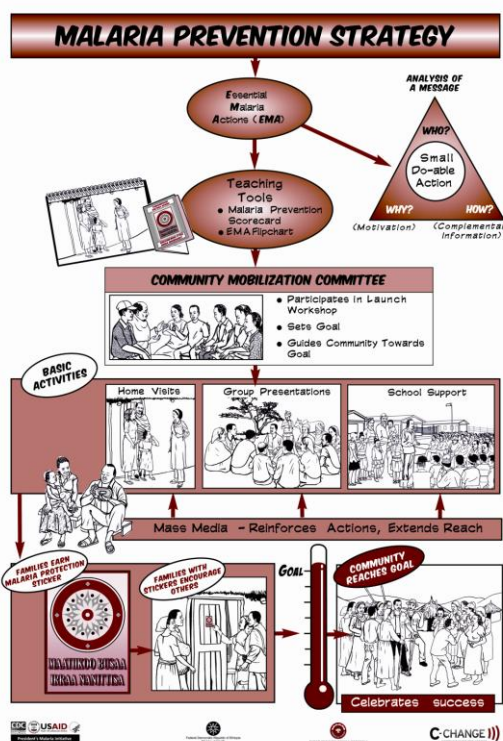


Figure 2. C-Change Ethiopia Malaria Prevention Strategy

across the malaria control effort. Workshop participants included members of the NMCP and key

PMI-funded partners working in malaria prevention and control across Ethiopia. The workshop sought to develop a common approach to SBCC interventions and cross-partner coordination. In addition, the participants articulated the need for a common and harmonized set of messaging aimed at the highly endemic regions. Following the workshop, C-Change assisted with the establishment of a National Communication Taskforce. The taskforce is chaired by the FMOH and works closely with the ORHB and other regional health bureaus.

In February 2009, during the Message Harmonization Workshop, taskforce members identified priority malaria health actions at the family and community level. Twenty priority actions were identified based on the current malaria situation and findings of various studies with those 20 being further reduced to 8 essential malaria actions that were considered crucial behaviors and adoptable at the individual level.

Following the workshop, eight EMA, with draft illustrations were pre-tested in different areas of the country. Findings were analyzed and presented to the Malaria Communication Taskforce, during an EMA Finalization Workshop, in April 2009. During the workshop, participants reviewed messages and illustrations. The input and comments from team members on the EMA illustrations and messages were further improved and pre-tested and published in the EMA Tool.

Integration of the EMAs into the Model Community Campaign

The goal of the EMA tool is to help health systems and organizations working in malaria to standardize action-oriented communication efforts. For its part, C-Change integrated the EMA as the central tenet of its Model Communities campaign.

The Model Communities campaign, with the EMAs articulating the desired action, seeks to engage the targeted population at both the family and community levels by

The Eight EMAs

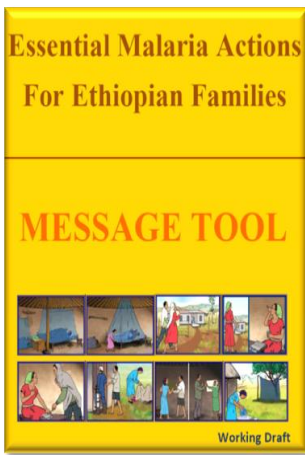
- All family members should sleep under insecticide-treated bed nets (ITNs) or long lasting insecticide-treated bed nets (LLINs) every night.*
- Give priority to pregnant women and children under five to sleep under LLINs.*
- Whenever a family member has a fever, take the person to the nearest health facility immediately.*
- Take all (full course) of the anti-malaria drugs prescribed to you by health personnel.*
- Do not interrupt or share your anti-malaria drugs, prescribed to you by health personnel.*
- Cooperate with sprayers during indoor residual spraying (IRS) period.*
- Do not re-plaster your homes after spraying is complete.*
- Wash your LLIN with "regular" soap and hang (or lay to dry) in the shade.*

utilizing as local experts and/or champions those community members who have already adopted the desired behavior; it is they (not an external expert or spokesperson) who are called upon to share and promote their successful practices with other community members.

During the roll out of the campaign, C-Change and CARE identified and trained a select group of community champions, HEWs and vCHWs to promote the EMAs in the community. As an incentive, families that can recall the EMAs and demonstrate that have adopted the actions (i.e., bed net hung) are certified as practicing the EMAs and receive community-wide recognition at community events and a Model Family sticker is applied to their door (see figure 3).



The health facility keeps track of the progress of the community on a chart at the local health facility. When a predetermined number of households have achieved the Model Family status, the community is recognized as a Champion Community. In addition to the community-level engagement, radio programs reinforcing the EMAs and successful communities are conducted concurrently with the on-the-ground campaign to reinforce the EMAs and promote



malaria prevention and treatment-seeking behavior across the broadcast area.

Accomplishments

Launched in 2009 the Champion Communities campaign initially targeted four zones and total of 21,442 households (107,210 people). Each of these households achieved Model Family status and their communities were awarded Champion Community recognition as they had acquired basic knowledge of the EMAs and the behaviors and could recall four of the eight doable actions. Since the launch, C-Change has reached four woredas representing 517 kebeles and 434,954 families in the C-Change target areas. Over 209,563 families display a Champion Community sticker or a Malaria Protection Sticker.

At the time of this writing, C-Change had not yet completed its endline survey. Once completed, an addendum to this case study will be updated with a report on the comparative survey.

Success Factors and Lessons Learned

Integration into Existing Systems: Community Centered Action. Families live within communities. The focus of the C-Change approach is to create an enabling environment for the essential malaria actions.

Multiple, Reinforcing Channels. The simple essential malaria messages can be found at all levels, individual through house-to-house visits, at the community level and schools through events and school-based programming and at the airwaves of local and regional radio. The messages are simple, clear, and easy to understand.

Simple Tools. Training tools and guides are simple and easy to follow. Guides are used to carry out Training of Trainers at the zonal level and to cascade down to the woreda and kebele levels.


Coordination with all Partners. This ensures scale, saturation, and sustainability.

C-Change works with and supports multiple partners in designing SBCC materials, including providing technical support in mass media and training. For example, C-Change assisted RTI to develop additional messages and materials aimed at overcoming key barriers identified in IRS programming. In addition, C-Change provided IFHP with over 60,000 SBCC materials to support their community programs.

Exit Strategy. C-Change designed the project with a clear capacity building plan to ensure the continuation of the program. Lot Quality Assurance Surveys will be carried out in most intervention areas to determine effectiveness of the project. Findings will determine whether C-Change should exit from that area or continue reinforcing interventions.

Addendum

Since their creation in 2009, the EMA model has been replicated in Kenya (2012) and the Democratic Republic of the Congo (DRC) (2011). Both countries undertook a similar process of engagement and consultation but each developed a set of EMAs that were tailored to their particular situation. In Kenya, for example, the process led to the creation of the EMAs as an extension of the National Malaria Communication Strategy while DRC used the EMA's as part of its 3 plus 1 community-based SBCC intervention in four provinces of DRC. Some specific actions were modified to reflect the current malaria control priorities. For example, one of Ethiopia's EMAs emphasis is on acceptance of IRS application and the prevention of re-plastering after application whereas DRC's emphasized bednet usage and repair as opposed to prevention of re-plastering. Regardless of their specific list of essential actions, the EMA's seek to translate malaria-transmission knowledge into a do-able action that can be performed by households and individuals.



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