



Malaria Control In Nigeria

A Strategy

For

Behaviour Change Communication

2004 - 2005

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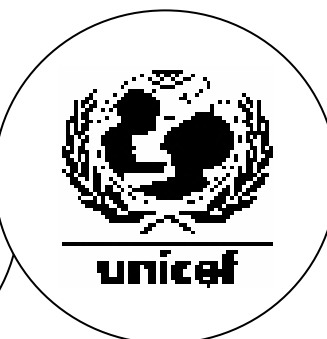


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Foreword

Malaria is a major cause of morbidity and mortality in Nigeria. It is endemic throughout the country with more than 90% of the total population at risk of stable endemic malaria. At least 50% of the population suffers from at least one episode of malaria each year. However, children aged less than 5 years and pregnant women are among the highest at risk of infection. It has been documented that malaria, a parasitic disease which is easily preventable, treatable and curable had remained one of the major public health problems in Nigeria. The obstacles to the success of malaria control and prevention interventions are both behavioural and non-behavioural. The behavioural factors relate to cultural practices, which promote mosquito breeding and mosquitoes' access to the people as well as the failure of at risk populations to use technologies proven to be effective for the treatment, control and prevention of malaria promptly and appropriately. The main non-behavioural factors include geographical or ecological peculiarities, the availability of mosquitoes and the presence of plasmodia. There is enough empirical evidence that communication plays a vital role in changing knowledge, creating positive attitudes and improving practice of positive health behaviour.

All arms of the government (from National to LGA), African Heads of States and Governments, the donor community, CBOs/NGOs, professional bodies have been involved in several initiatives aimed at mitigating the impact of malaria. This is demonstrated among others by the adoption of a National Malaria Control Policy and the development of a "A Strategic Plan for Rolling Back Malaria in Nigeria: 2001-2005," by the Federal Government of Nigeria and international summit on RBM, attended by leaders from endemic African countries held in Abuja in April 2000 during when specific targets for achievement by 2005, popularly called the 'Abuja Targets', were set. Availability and access to treatment and supplies have also improved over the years.

The REAPING Mission to Nigeria, facilitated by the Global RBM Secretariat, Geneva, in October 2003 has identified and recommended the development of a comprehensive Behaviour Change Communication (BCC) strategy that would achieve consistent, integrated and appropriate BCC interventions across all main RBM technical strategies and all participating partner agencies. This document, BCC strategy addressed priority activities for Malaria in Pregnancy (MIP)/Intermittent Preventive Treatment (IPT), Insecticide Treated Nets (ITNs) and Case Management (CM) using best practices among others advocacy, social mobilisation and behavioural change communication (program communication), preventive measures and access to treatment. There is the need for grassroots mobilisation and co-ordinated campaigns to appreciate the concept of IPT as well as the use of Sulphadoxine -Pyrimethamine during pregnancy. For Case Management, the major gaps identified included limited awareness of Pre-packed Drugs (PPD) and lack of promotional activities. The essential actions needed to reach the intended audiences included mass media campaign, Patent Medicine Vendors' (PMV) training, Community Based Organizations (CBOs) mobilisation and advocacy for the use of PPD. The lack of an umbrella communication strategy had handicapped awareness and demand creation for ITNs while a low level of advocacy has resulted in little commitment at state and LGA levels.

A participatory approach was used in the development of the strategy document and efforts were made to make the process as inclusive as possible of all the key stakeholders in RBM activities in order to get their endorsement and guide co-ordination of activities.

The document will serve as guide for Governments (at all levels) and all their partners, the public and private sector, and national and international agencies and donors in their programs towards getting and helping Nigerians adopt healthy behaviour. It is hoped that this document will be useful to all stakeholders (present & future) in planning, designing, implementing, and evaluating behaviour change interventions in malaria programming.

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The development of this document used a participatory approach and efforts were made to make the process as inclusive as possible of all the key stakeholders in RBM activities within and outside Nigeria. The process led by the RBM Secretariat/NMCP staff of the Federal Ministry of Health, involved core development partners (WHO, UNICEF, BASICS II (USAID), HCP (JHU/CCP, USAID), Futures Group UK (DfID), NetMark (USAID), PREMA EU, Policy Project (USAID), and SFH/PSI), relevant divisions/units of FMOH (HEB, RH and IMCI), States MOH and MOI and NGOs. We would not fail to mention that the document was developed at the instance of the recommendations of the REAPING Mission of 2003 facilitated by RBM Global Secretariat in Geneva.

I wish to express my appreciation to the following individuals and institutions who contributed in no small measure to the success of this very important strategy document:

The United States Agency for International Development (USAID), World Health Organization (WHO) and Department for International Development (DfID) who funded some of the meetings crucial to the development of this document and WHO that funded the printing of the final document.

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In addition, appreciations so many BCC and technical experts of FMOH, donor and international agencies, states Ministries of Health and Information for making themselves available and contributing during the preparation of this strategy.

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List of Acronyms

ACPR	Adequate Clinical and Parasitological Response
ACT	Artemisinin -based Combination Therapy
ANC	Antenatal Care
ARCH	Applied Research for Child Health
BASICS	Basic Support for Institutionalising Child Survival
BCC	Behaviour Change Communication
CAPA	Catchment Area Planning and Action
CBO	Community Based Organization
CDDs	Community Directed Distributors
CHP	Community Health Promoters
CM	Case Management
CQ	Chloroquine
CSO	Civil Society Organization
DfID	Department for International Development (UK)
DOT	Directly Observed Treatment
DTET	Drug Therapeutic Efficacy Testing
EU	European Union
FBO	Faith Based Organization
FCT	Federal Capital Territory
FMOH	Federal Ministry of Health
GFATM	Global Fund for AIDS, TB and Malaria
HCP	Health Communication Partnership
HED	Health Education Division (FMOH)
IMCI	Integrated Management of Childhood Illness
IMPAC	ITN Massive Promotion and Awareness Campaign
IPT	Intermittent Preventive Treatment
ITN(s)	Insecticide Treated Net(s)
JHU/CCP	The Johns Hopkins University Centre for Communications Programs
LBW	Low Birth Weight
LGA	Local Government Area
MCH	Maternal and Child Health
MIP	Malaria in Pregnancy
NAFDAC	National Agency for Foods and Drugs Administration and Control
NDHS	Nigeria Demographic and Health Survey
NMCP	National Malaria Control Programme (FMOH)
NGO	Non Governmental Organization
NNF	New Nigeria Foundation
NPHCDA	National Primary Health Care Development Agency
PHC	Primary Health Care
PMV/D	Patent Medicine Vendor or Dealer
PPD	Pre-packaged Drugs
PREMA	Pregnancy Malaria Anaemia Network
PSI	Population Services International
RBM	Roll Back Malaria

REAPING	RBM Essential Actions Progress Investments and Gaps
RH	Reproductive Health
SFH	Society for Family Health (Nigerian PSI affiliate)
SMOH	State Ministry of Health
SP	Sulfadoxine-Pyramethamine
TBAs	Traditional Birth Attendants
TCF	Tulsi Chanrai Foundation
TDR	Research & Training in Tropical Diseases
UK	United Kingdom
UNDP	United Nations Development Program
UNICEF	United Nations Children's Fund
US	United States
USAID	United States Agency for International Development
VHWs	Village Health Workers
WHO	World Health Organization

Executive Summary

In October 2003, an assessment of Nigeria's Roll Back Malaria (RBM) implementation identified the need for a comprehensive behaviour change communication (BCC) strategy that would achieve consistent, integrated, and appropriate BCC interventions across the main RBM priority strategies. Through a participatory approach, RBM partners met in December 2003 to develop the RBM situation analysis report which served as the background paper for the BCC strategy. In January 2004, 25 participants representing 12 RBM partner agencies met to produce the first draft of the RBM BCC strategy. Moreover, two regional workshops were held on May 13-14 and June 22 – 23, 2004 for stakeholders (mainly States' Malaria Program Managers and Health Educators) from the Southern and Northern States and FCT Abuja respectively for regional input and contributions.

This document describes the BCC strategy for RBM in Nigeria and addresses the three priority problem areas: Case Management (CM), Intermittent Preventive Treatment (IPT), and Insecticide Treated Nets (ITNs).

Goal: The goal of the RBM BCC strategy is to attain a coordinated national response for BCC programming addressing malaria prevention, control, and treatment that ensures coherent, uniform, and evidence-based interventions from all stakeholders.

Priority Problem Areas: This strategy focuses on three priority problem areas:

- Case management of malaria in children under five years old (CM)
- Malaria in pregnancy (MIP)
- Insecticide Treated Nets (ITNs)

For each of these problem areas, the BCC strategy outlines recommended practices, priority audiences, communication objectives, key promise, support points, and priority messages.

1. Introduction

This document results from an assessment of Nigeria's Roll Back Malaria implementation held in October 2003. The assessment identified the need for a comprehensive behaviour change communication (BCC) strategy that would achieve consistent, integrated and appropriate BCC interventions across all main RBM technical strategies and all participating partner agencies. The first section of this document provides background on the strategy development process and the nature and extent of the malaria problem in Nigeria. The second section outlines specific communication considerations for malaria in pregnancy (MIP), appropriate case management (CM) and promotion of insecticide-treated nets (ITNs). The third and final section draws conclusions from the process and recommended next steps.

The Roll Back Malaria (RBM) Board Secretariat commissioned a mission review to visit Nigeria from October 20-24, 2003 to assess the current status of the RBM programs in Nigeria. The Roll Back Malaria Essential Actions Progress Investments Gaps (REAPING) identified gaps, agreed on the support package needed to reach the Abuja targets in 2005, and assessed the critical actions needed at the country level to achieve the Abuja Targets.

The Mission reviewed the communication needs of each of the key components of RBM: Malaria in Pregnancy (MIP)/Intermittent Preventive Treatment (IPT), Case Management (CM), and Insecticide Treated Nets (ITN). The need for grassroots mobilisation and co-ordinated campaigns to appreciate the concept of IPT as well as the use of Sulphadoxine -Pyrimethamine during pregnancy was identified. For Case Management, the major gaps identified included limited awareness of Pre-packed Drugs (PPD) and lack of promotional activities. The essential actions needed to reach the intended audiences included mass media campaign, Patent Medicine Vendors' (PMV) training, Community Based Organizations (CBOs) mobilisation and advocacy for the use of PPD. The lack of an umbrella communication strategy had handicapped awareness and demand creation for ITN while a low level of advocacy has resulted in little commitment at state and LGA levels.

To bridge the gap, the REAPING Mission recommended the development of a RBM Communication Strategy. The communication strategy would address priority activities for Intermittent Preventive Treatment (IPT), Insecticide Treated Nets (ITNs) and Case Management (CM) using best practices. The strategies to be used will include advocacy, social mobilisation and behavioural change communication (program communication), preventive measures and access to treatment.

There is enough empirical evidence to show that communication plays a vital role in changing knowledge, creating positive attitudes and improving practice of positive health behaviour. It was decided that the followings activities would be implemented:

- Develop a comprehensive communication strategy to support essential actions for the achievement of Abuja targets taking cognisance of regional and state differences and prioritisation of communication approaches;
- Identify a range of implementing partners and build public/private partnership in health communication;

- Develop local capacity to manage/oversee and co-ordinate implementation of the communication strategy.

The FMOH NMCP or RBM staff guided the BCC strategy development process. Johns Hopkins University/Health Communication Partnership (JHU/HCP) provided technical assistance to the RBM Secretariat in the facilitation of the process under the auspices of the Health Communication Program of USAID.

1.1 Process Used in the Development of the RBM Communication Strategy

A participatory approach was used in the development of the strategy document and efforts were made to make the process as inclusive as possible of all the key stakeholders in RBM activities in order to get their endorsement and guide co-ordination of activities. From 4-5 December, 2003, a small group of RBM partners; led by the RBM Secretariat and including JHU/HCP, Futures Group, WHO and BASICS met in Minna, Niger state to develop the RBM Situation Analysis report. The objectives of the workshop were to:

- Discuss available research and information on malaria in Nigeria.
- Highlight target audiences and major problems/issues to address in the RBM strategy.
- Discuss and share information on different health promotion materials in Nigeria.
- Summarize and draft key points regarding the agreed gaps on health promotion messages.

The report of the situation analysis workshop provided the background paper for the development of the strategy.

From 12 - 17 January 2004, twenty five (25) participants representing 12 RBM partner agencies met to produce the first draft of the Roll Back Malaria (RBM) Communication Strategy that will guide the FMOH and all its Partners as well as other stakeholders in the design, development, implementation, monitoring and evaluation of effective communication interventions for all major audiences for malaria prevention, control, care, and treatment. Specifically, the objectives of the 6-day workshop were to:

- Gain insight into the communication activities of RBM partners.
- Revise any existing documents, plans and frameworks.
- Improve partnership through the joint development of a communication strategy.
- Produce a joint draft communication strategy.
- Prepare a plan for follow-up activities for the finalization of the draft document.

The first day of the workshop was used to compile and document all the communication work being done by all identifiable RBM partners in Nigeria. At the end of the workshop, documented summary of the activities of RBM Partners nationwide was developed as well as a draft of the Communication Strategy for RBM.

Workshop participants included both government and donor representatives. FMOH participants were drawn from NMCP, HEB, RH and IMCI units and programs. Core donor members included WHO, UNICEF, BASICS II (USAID), HCP (JHU/CCP, USAID), Futures Group UK (DfID), NetMark (USAID), PREMA EU, Policy Project (USAID), and SFH/PSI. The two local

NGOs that presented briefings were the New Nigeria Foundation (NNF), which provided community based RBM interventions with support from Exxon-Mobil and the Tulsii Chanrai Foundation (TCF) which collaborated with the National PHC Development Agency in providing community based primary health care services including malaria treatment and prevention. Representatives from Africare who would be receiving funds for malaria programming in the South-South Zone from Shell were unable to attend. Lastly, two regional workshops were held on May 13-14 and June 22 – 23, 2004 for stakeholders (mainly States' Malaria Program Managers and Health Educators) from the Southern and Northern States and FCT Abuja respectively for regional input and contributions.

1.2 Situation Analysis

Malaria is a parasitic disease which is easily preventable (BASICS 2001), treatable and curable (FMOH 2000). Yet it remains one of the major public health problems in Nigeria (Okop 2003, FMOH 2001). The malaria situation in the country is deteriorating despite numerous interventions that have been instituted so far. The obstacles to the success of these interventions are socio-cultural, economic and political in nature (FMOH 2001).

Malaria is caused primarily by plasmodia of various types – *Plasmodium ovale*, *Plasmodium malariae*, *Plasmodium vivax* and *Plasmodium falciparum*. Of these four species of plasmodium, *Plasmodium falciparum* causes the most severe malaria illness and death throughout the world (WHO 1998). *Plasmodium falciparum* is known to be the most devastating in Nigeria. The transmission of the parasite is facilitated through the bite of the female anopheles mosquitoes.

The prevalence of malaria in Nigeria is due to both behavioural and non-behavioural factors. The behavioural factors relate to some cultural practices, which promote mosquito breeding and mosquitoes' access to the people as well as the failure of at risk populations to use technologies proven to be effective for the treatment, control and prevention of malaria promptly and appropriately. The main non-behavioural factors include geographical or ecological peculiarities, the availability of mosquitoes and the presence of plasmodia. A thorough understanding of both behavioural and non-behavioural factors is crucial for the design of appropriate interventions for tackling malaria in Nigeria.

1.2.1 Malaria situation in Nigeria

Malaria is a major cause of morbidity and mortality in Nigeria (FMOH 2001). It is endemic throughout the country with more than 90% of the total population at risk of stable endemic malaria (NetMark 2001). At least 50% of the population suffers from at least one episode of malaria each year (FMOH 2001). The disease is the commonest cause of outpatient attendance across all age groups (FMOH 2001).

Some categories of people are, however, at highest risk of infection. These include children aged less than 5 years, pregnant women, visitors from non-malarious regions and those with sickle cell anaemia. It has been reported that the disease accounts for 20 – 30% of under-five mortality and that in highly malarious areas of the country the death toll could be as high as 50% (WHO 2000). The Federal Ministry of Health has noted that malaria leads to 25% of infant mortality and 30% of childhood mortality (FMOH 2001).

The result of the most comprehensive study of the malaria situation in Nigeria conducted across the six geographical zones in Nigeria had revealed much about the public health importance of malaria (FMOH 2000). The study confirmed the fact that malaria is a major cause of morbidity and mortality especially among vulnerable groups including women and children aged less than 5 years (FMOH 2001). The incidence of malaria among the under fives across the six geographical zones during the study were as follow: South-South - 32.7%, Southwest - 36.6%, Southeast - 30.7%, North-Central - 58.8%, Northeast - 55.3% and Northwest - 33.6%.

It was also found that malaria co-exists with some other prevailing health problems. Furthermore, it was found that malaria accounted for 11% of maternal deaths in the study areas. Malaria also accounted for 63% of the diseases reported in healthcare facilities across the six geographical zones. The prevalence of malaria among pregnant women was 48% (FMOH 2000; FMOH 2001).

1.2.2 Illness during pregnancy

The National Survey (FMOH 2000) has shown that doctors classified 48.2% of the ailments experienced by pregnant women as malaria. About 22.3% had malaria in combination with other illnesses. The prevalence of clear cases of malaria in pregnancy across the geo-political zones were reported as follow: South-South - 44%, South-West - 46%, South-East - 31%, North-Central - 56.4%, North-East - 64.5% and North-West - 46.6%. The total prevalence was found to be 48.2%. The prevalence figures would have been higher if pregnant women who had malaria in combination with other health problems were added.

1.2.3 Burden of Malaria

Malaria constitutes a major economic burden on endemic communities in Africa including Nigeria. For instance, it reportedly cost sub-Saharan countries, including Nigeria, more than US\$ 2 billion in 1997 (WHO 1998). Malaria is implicated in the reduction of human work capacity and productivity (GFFHR 2000). Consequently it adversely affects the socio-economic development of the nation (FMOH 2001, GFFHR 2000). The disease thus constitutes a great burden on the already depressed Nigerian economy (NetMark 2001a). The high rate of absenteeism among school children in Nigeria is attributed in part to malaria (Gbadegesin 2001; GFFHR 2000). Malaria causes great misery to sufferers, and adversely affects the social and psychological well being of individuals, families and the nation at large.

1.2.4 Health seeking/illness behaviours in malaria involving under-fives

The National survey conducted by the Federal Ministry of Health (FMOH 2000) showed that home management of malaria in children aged less than 5 years was very common in both communities with or without health care facilities. Home management tops the list of the first actions taken during illness in under-fives. It was also found that under-five caregivers visit a variety of sources such as patent medicine vendors, traditional healers, health centres, hospitals, private clinics, drug hawkers and diviners to obtain medications.

This finding, corroborated by another study carried out in southwestern Nigeria, has confirmed that home management of childhood malaria is very common (Adeniyi *et al.* 2002). The study

revealed that a total of 16.6% of childhood malaria cases were referred to hospitals because of persistence of symptoms. It was interesting to note that 7 out of 10 people patronized patent medicine vendors. Adeniyi and his colleagues, however, found that 85% of caregivers did not buy drugs from hawkers because of their lack of confidence in them.

Caregivers currently use a variety of drugs for the management of childhood malaria. Many of the drugs used were found to be inappropriate and are often used inappropriately and inadequately.

1.2.5 Illness behaviours/treatment seeking behaviours among pregnant women

Formal health facilities such as hospitals, clinics and health centres were the most common places used for the management of malaria in pregnancy (FMOH 2000). Many of the health workers who attended to these sick pregnant women included nurses/mid-wives (40.4%) and doctors (24.8%).

Home management of malaria was also found to be common among pregnant women across the six geo-political zones. For instance, 28 – 29% of pregnant women received treatment at home. Few pregnant women however, patronized patent medicine vendors (PMVs) and traditional healers.

1.2.6 Preventive health behaviours

The malaria preventive health behaviours among pregnant women have been found to be generally poor across the six geo-political zones. Daraprim was found to be the most commonly used chemo prophylactic with a national rate of use of 39%. Other drugs reportedly used included chloroquine but Sulphadoxine - Pyrimethamine was mentioned by very few respondents (FMOH 2000).

Other salient findings from the national malaria situation survey relating to preventive health behaviour in malaria included the fact that bed-net use among pregnant women was found to be generally low across geo political zones as only 10% of the respondents claimed to use bed nets.

The survey also revealed that the preventive measures reportedly adopted by some respondents included the use of the following: Window/door nets - 32.6%, Insecticides aerosol - 33.8%, Repellants -22.7% and Herbs - 23.0%

One study has shown that bed net use is generally poor in Nigeria among all categories of people. It was observed that only 12% of households in Nigeria reported owning mosquito nets (NetMark 2001). Brieger *et al.* (1996) also observed in a study conducted in Nsukka, Anambra State that altogether 22% of the survey respondents reported that bed nets had been used before by a member of their household. In some isolated cases, people are willing to pay for bed nets. Willingness to pay for bed nets and insecticides for treating them was found to be high in four communities in eastern Nigeria (Onwujekwe *et al.* 2000). Onwujekwe *et al.* 2000 noted that about 30% of their respondents were willing to pay for bed nets and actually redeemed their pledges (Onwujekwe *et al.* 2001).

The recently published Nigeria Demographic and Health Survey (NDHS, 2003) revealed that 12% of all households own at least a net (any type) while only 2% own at least one ITN. The

result also showed that ownership of nets (any type) is significantly higher among the rural dwellers than those living in urban areas. There is also a wide variation of net ownership across the six geo-political zones with more nets being available among the households in the North (except North East) than the South.

1.2.7 Drug Therapeutic Efficacy Test (DTET)

A major intervention for malaria control proposed by Roll Back Malaria is the provision of effective, affordable, acceptable and available anti-malaria drugs to enhance prompt and appropriate treatment of malaria episodes within 24 hours of onset of illness (FMOH 2002). However, emergence of a fast-spreading parasite resistance to the common anti-malaria drugs has been recorded. This calls for the continual evaluation of the efficacy of these drugs in order to inform decisions on malaria treatment policy issues.

In Nigeria, Chloroquine has remained the first line drug for the treatment of malaria while Sulphadoxine-Pyrimethamine is the second line or an alternative when circumstances make the use of Chloroquine inappropriate or impossible. Sulphadoxine-Pyrimethamine has also been adopted as the drug of choice for intermittent preventive treatment of malaria in pregnant women

The Federal Ministry of Health, with support from the World Health Organization, conducted the DTET, an anti-malaria drug therapeutic efficacy test in six sites covering the six geo-political zones of the country, in 2002 using approved WHO protocols. The study was conducted to update the National Anti-malaria Drug Policy and to determine the current efficacy of the first-line (CQ) and second line (SP) drugs for the treatment of uncomplicated malaria in the country.

The results indicate that adequate clinical and parasitological response (ACPR) for chloroquine was less than 75% in South East, South South, South West, North Central and North East while it is greater than 75% only in the North West. In case of SP, ACPR is less than 75% in South East, South South and North East and more than 75% in South West, North Central and North West. In view of the findings, RBM partners (Case Management sub-committee) headed by the FMOH are exploring the possibility of changing the current malaria drug policy to address the issue of resistance both in the short and long-term basis. This scenario poses another challenge for communicators.

1.3 National Responses to the Control and Prevention of Malaria

Nigeria has been involved in several initiatives aimed at mitigating the impact of malaria for decades. In 1997, Nigeria adopted a National Malaria Control Policy in response to the government's growing concern about the increasing burden of disease and death due to malaria. The National Health Policy identifies malaria control as a priority health programme. Even the current national health policy singled out malaria control and prevention as a priority issue.

Malaria control and prevention in Nigeria was given more prominence following the launching of Roll Back Malaria (RBM) in 1998. RBM is a global movement geared towards bringing about a significant reduction of the malaria burden with special focus on the high transmission areas of Africa (Goodman C; Coleman, P and Mills A 2000). The movement arose out of the growing political commitment to combat the disease by both affected countries and the donor community. Specifically, RBM has the goal of halving the world's malaria burden by 2010.

The RBM movement galvanized African leaders into action through constituting themselves into an African coalition to address the malaria problem. Subsequently, an international summit on RBM, attended by leaders from endemic African countries, was held in Abuja in April 2000. At the summit, African leaders expressed their commitment to combat the scourge in their various countries and to support and create the enabling environment that will make the success of RBM a reality. The Nigerian leadership constituted the arrowhead of the summit. The summit was a revolutionary move because it was the first time that the issue of malaria control and prevention attracted the attention and commitment of political leaders at the highest level on the African continent.

The African Heads of States' Summit on RBM spelt out specific targets for achievement by 2005 that are now popularly called the 'Abuja Targets' which are:

- To reduce malaria mortality and morbidity by 50%
- At least 60% of the population will have prompt access to appropriate and affordable treatment within 24-hours of symptom onset
- At least 60% of pregnant women and children under age five will use treated bed nets
- At least 60% of all pregnant women will have access to chemoprophylaxis or to intermittent presumptive treatment (IPT).

Immediately after the summit, Nigeria swung into action by setting up the national malaria control committee with four sub-committees under the auspices of the Department of Public Health, Federal Ministry of Health, to coordinate the control and prevention efforts. With a firm administrative framework in place, several stakeholder meetings were held involving partners from the Federal and State governments as well as from the national and international non-governmental organizations, donors agencies and the organized private sector.

A major milestone in the malaria control and prevention initiative within the context of the RBM in Nigeria was the conduct of the national malaria situational analysis study in 2000. The study cuts across the six geo-political zones in the country and yielded invaluable baseline information for planning. FMOH produced "A Strategic Plan for Rolling Back Malaria in Nigeria: 2001-2005" and conducted series of consensus-building meetings at national and zonal levels. National and community-level actions to roll back malaria are backed by a range of partnerships involving several stakeholders: governments, private sector, International and donor agencies, NGOs and the media. The Roll Back Malaria partnership is part of a broad societal action for health and human development.

There are still constraints towards the achievement of RBM objectives and these include lack of political will and commitment (at State and LGAs levels most especially), poor perception of the magnitude of the malaria burden, and poor treatment seeking behaviours of the individuals and communities. The development of resistance to drugs and insecticide by parasites and vectors has also compounded the control efforts.

Currently, there is no umbrella communication strategy for raising the level of awareness and creating demand for ITN and other malaria prevention and control technologies. Also, there is a low level of advocacy for the implementation of the RBM scheme at the State and LGA levels. The design and development of a behavioural change communication (BCC) strategy is a logical step for addressing this problem. The strategy will spell out effective ways of using interpersonal communication, community mobilization, media and other social change strategies to facilitate the adoption of the principles and practices related to the RBM initiative.

2. Strategic Considerations

2.1 Malaria in Pregnancy (MIP) BCC Strategy

According to the African Regional Office of WHO, in areas of high and moderate (stable) malaria transmission, malaria infections in pregnant women contribute to development of severe anaemia in the mother, resulting in an increased risk of maternal mortality. The impact on the infant's health results from maternal infection mainly during the second half of pregnancy. Malaria infection of the placenta and malaria-caused maternal anaemia contribute to low birth weight (LBW), which results in higher infant mortality and in impaired child development.

WHO recommends a three-pronged approach for MIP: 1) use of intermittent preventive treatment (IPT), 2) insecticide-treated nets (ITN), and 3) case management of malaria illness to reduce the burden of malaria infection among all pregnant women. In the majority of settings of stable malaria transmission in Africa, more than 70% of pregnant women attend antenatal clinic (ANC) at least once during their pregnancy, making a clinic-based prevention approach feasible. Only 61% of pregnant women in Nigeria attended any ANC according to the 2003 NDHS.

2.1.1 MIP Objectives

The Abuja Targets for 2005 contain goals related to the prevention of malaria in pregnancy and are the basis of the behavioural objectives related to Malaria in Pregnancy. These objectives are listed below along with sub-objectives required to achieve the main objective.

1. 60% of pregnant women will use insecticide treated nets.
 - 80% of women of reproductive age will state the benefits of sleeping under an ITN.
 - 80% of women of reproductive age will list the steps for correct ITN use.
 - 80% of women of reproductive age will describe where one can obtain an ITN.
2. 60% of pregnant women will use IPT at least twice between 4-8 months of gestation.
 - 80% of pregnant women will attend ANC and demand IPT
 - 80% of women of reproductive age will state dangers of malaria in pregnancy.
 - 80% of women of reproductive age will list the benefits of IPT.
 - 80% of women of reproductive age will mention where to get IPT and who should use it.
3. 60% of pregnant women will access appropriate treatment during episodes of malaria.
 - 80% of women of reproductive age will describe signs and symptoms that should prompt them to seek treatment for malaria.
 - 80% of women of reproductive age will describe the correct medicines and dosages for treating malaria.

- 80% of women of reproductive age will mention where correct and safe medicines for treating malaria can be obtained.

Objectives One and Three overlap with the two other main RBM technical interventions, ITN promotion and case management. These objectives also form the basis for essential and simple BCC messages. The challenge is to develop locally appropriate strategies to promote these messages and achieve the desired changes in health behaviour.

2.1.2 Background and Context

Unlike CM and ITNs, MIP is embedded in another public health service – antenatal care (ANC). That being the case, a two-layered communication strategy is needed. The first layer promotes the behaviours of ANC utilization, while the second encourages the woman utilizing ANC to request and subsequently use IPT and ITNs. This embedded nature of IPT positions it as an ANC service, not as a malaria control service. Therefore, BCC strategy must first analyse the factors that influence ANC utilization.

The enabling environment for MIP in Nigeria at present has started to witness some improvements. A national stakeholders consensus meeting to formulate MIP guidelines and policy for the country has been held and a draft document has been produced. One active stakeholder is the Reproductive Health Unit of FMOH, which has its own published Reproductive Health Program Policy and Guidelines. The RH Unit is crucial because of its purview over ANC services. At present these RH guidelines do not spell out MIP activities, and thus the participation of the RH Unit in the MIP guideline development should help achieve an integrated MIP policy.

The enabling environment also includes the local government level. The existence of national programs and guidelines does not guarantee that MIP will actually be offered by LGA Health Departments. Under the federal system, each LGA is responsible for determining and purchasing its own essential drugs. Therefore, both programmatic and political decisions are needed in each of the 774 LGAs to purchase SP or IPT drug for IPT and ITNs for pregnant women.

A consortium of USAID implementing partners (IPs), BASICS II, JHU/HCP and NetMark, has been conducting community-based education for pregnant women about the need for MIP in 20 local governments in Lagos, Kano and Abia States. The community coalitions that are part of this effort have been formed around local government health facilities that offer ANC, but the steps needed to ensure adequate MIP commodities (SP or IPT drug and ITNs) are not part of the project. One of the IPs functioning in these states promotes only commercial marketing of quality ITNs. Another donor, DfID through the Futures Group, is starting an ITN social marketing program in one of the three states. In other words, all efforts are geared towards awareness creation but falls short of providing ITNs or SP or IPT drug through established ANC.

PREMA-EU with WHO support has been undertaking an operations research project on MIP in three LGAs of Oyo State. Oyo was intentionally chosen because of its high ANC registration levels. The project is determining the feasibility of delivering, monitoring and sustaining MIP through LGA MCH clinics. Donations of SP have been supplemented with LGA purchased supplies in large part because of training and advocacy efforts by SMOH Malaria and RH staff in the three LGAs. The FMOH IMPAC program has started to provide seed or starter

stocks of ITNs but most SMOH and LGAs are yet to come on board to buy and distribute their own ITNs as their expected commitment to IMPAC. The key lesson of the PREMA project is that with active advocacy from SMOH and research staff, LGAs can see the political and health benefits of providing IPT for their women.

2.1.3 Audience Segmentation

Before proceeding further, it is necessary to define the focal population for BCC on MIP obviously as pregnant women. That said, one must look further to determine who actually currently uses ANC and who does not, and among the former, who uses ANC in a timely and appropriate manner. This leads to the issue of audience segmentation, and clearly there are three categories of users: 1) pregnant women who are not using ANC for their current pregnancy, 2) pregnant women who register late and/or attend few sessions, and 3) pregnant women who register on or before their second trimester and attend regularly enough to benefit from the full range of services and commodities offered including IPT, ITNs and actual case management during malarial illnesses. Although ANC registration ranges over 60% nationally, pregnant women who register on or before their second trimester and attend regularly may in fact represent only 30-40% of the population of pregnant women. Pregnant women who register late and/or attend few sessions are quite common. In the southwest and southeast where ANC registration exceeds 90%, half of the women do not attend for the first time until at least their seventh month of pregnancy. Further segmentation could be based on the following: parity, geo-political and educational levels.

Concerning parity, there are again three groups: (1) Women who are pregnant for the first time comprise the first group, and within this there may be two subgroups, those who are relatively young (e.g. adolescents, students) and those who are young adults. There may be some overlap between these two groups and both geographical and educational categorizations. Some pregnant adolescents in some communities do not register, or register very late because they are embarrassed and want to keep their pregnancies away from public attention as long as possible; (2) Women who are multiparous are another group, who feeling confident in their ability to cope with the accustomed pregnancy experience, do not perceive a need to attend ANC, even though their high parity in actuality is a risk factor; and (3) In between are women who have been pregnant at least once. They may attend because of factors ranging from desiring a safe pregnancy to enjoying the camaraderie of ANC gatherings with other women.

The various Demographic and Health Surveys completed in Nigeria over the years have documented that ANC registration attendance is generally higher in the southern zones of the country and among women with higher education. Low ANC utilization in the northern states needs to be viewed in a larger context of low utilization of orthodox health and social services. This region also displays the lowest child immunization rates. There are cultural, political and religious factors that render orthodox services suspect in the eyes of many people in the region. In these areas, orthodox medicines and products do compete favourably with indigenous medicines, but they are purchased through the informal private sector - the patent medicine shops.

In summary, there appear to be three main audiences among pregnant women.

- **Women who do not attend ANC at all:** Non-attendance of ANC varies by geopolitical zone with the highest in NW and the lowest in SS. This category of audience is mostly found in Northwest, Northeast, North Central and South South. The barriers to non-use of the facilities also vary across the regions based on their socio cultural, religious and economic characteristics. While poor availability and accessibility and general distrust may contribute to lack of use of facilities in the North, poor accessibility due to riverine terrain and conflict may contribute to non use of ANC in SS. These differences need to be considered in developing appropriate and realistic messages.
- **Women who Attend ANC:** The second group would comprise women who are already attending ANC in a timely manner and demand the services as a right. These women need to understand that MIP is a health right to be expected within ANC. This category is mostly found among pregnant women in the South (SW, SE and SS).
- **Women who Register Late:** The third group is made up those who register too late to benefit from two doses of IPT. They need to be convinced of the benefits of early registration. They are mostly found among women in Southwest, Southeast, South South and North Central.

In all cases, advocacy must address the need for an enabling environment where women can be guaranteed quality MIP services whenever they make such request.

In addition to the primary audiences of pregnant women, there are secondary audiences who influence women's behaviour. These include – Husbands, Mothers-in-Law, Traditional Birth Attendants (TBAs), Peers, CBOs (especially some FBOs that offer ANC and delivery services), and LGA leaders (chairmen, supervisory councillors for health, LGA medical officers for health) who make decisions about stocking and buying drugs and nets for MIP.

2.1.4 BCC Message Inventory

As mentioned in 2.1.2, there are already two specific efforts to promote MIP in four states reaching 23 LGAs. The attached chart outlines the BCC efforts and messages developed and used to date. The printed messages are generic and do not address audience segmentation. In general they are embodied in channels and tools that support interpersonal and small group communication. Mass media promotion of MIP was not in evidence. Examples of pregnancy-specific messages are outlined below.

- *Prevent malaria During Pregnancy. Malaria is Bad for Your Health and the Health of Your Unborn Child. Take a first dose of SP or IPT drug after you feel the baby move. Take a second dose of SP at least one month later. Visit the health centre and ask the health worker about your first and second doses of SP. A pregnant woman should not take SP or IPT drug before she feels her baby move. (USAID: BASICS II, HCP, SFH)*
- *Prevent malaria During Pregnancy. Malaria is Bad for Your Health and the Health of Your Unborn Child. Sleep under an insecticide treated net. (BASICS II, HCP, SFH)*
- *Malaria accounts for 2 out of every 10 deaths during pregnancy in Nigeria. Kill a mosquito today. Use Insecticide Treated Net (ITN). (DfID: Futures Group)*

These messages address two of the three components of MIP, but do not suggest that pregnant women seek prompt and appropriate treatment if they actually have malaria. While the counselling card used in the Catchment Area Planning and Action (CAPA) communities suggests that the Community Health Promoter (CHP) tells the mother to seek IPT at a health centre, it does not specifically encourage the mother to attend ANC. There is a need to also make messages generic in terms of recommended treatment as there are many brands of SP or IPT drug. Additional messages are needed and should be adapted to the cultural context of the three main audience segments. Examples are listed, but need to be enhanced and pre-tested in local environments.

- *Attend antenatal care when pregnant in order to get the best malaria prevention and treatment services.*
- *Register for ANC soon after you feel the baby move in order to get full protection from malaria.*
- *If you feel the symptoms of malaria, seek treatment from a reliable health provider before the day runs out.*
- *Encourage your local government leaders to provide malaria drugs and ITNs for pregnant women at local clinics.*

2.1.5 Future Directions

At the same time that the RBM BCC strategy was being developed, Stakeholders were meeting to develop Malaria in Pregnancy Guidelines for the country. It will be necessary for the two processes to inform each other. MIP is being developed as an important component of safe motherhood. Progress therefore, requires close collaboration between those developing BCC for RBM and BCC that promotes ANC and reproductive health services in general.

As mentioned, most of the BCC efforts to date have used interpersonal and group channels such as clinic based health talks and outreach counselling sessions by community health workers. Recommendations for strategies, channels and processes follow:

1. As will be the case for all three RBM technical interventions, there will be a need for strengthening each partner's comparative advantage in BCC as well as ensuring collaboration and coordination among partners to guarantee consistency and accuracy in message development. Unlike CM and ITN interventions, MIP lacks a strong coordinating focus. Current partners work in scattered communities in only a few states. Now that national MIP guidelines are being developed it is necessary to identify lead partners for national, mass media intervention planning as well as leadership in refining, standardizing and spreading community based MIP communication.
2. A specific gap identified is the need to develop and use mass media channels for MIP. Collaboration with ITN partners including UNICEF, NetMark and Futures Group, is needed to ensure that MIP messages appear on ITN billboards. Partners must also develop radio and television tools including public announcement spots, radio drama and talk show formats.
3. Mid-level communication through large CSOs including FBOs is needed to reach a large number of women, especially in areas with low or late ANC attendance. Religious

instructions are particularly valuable in promoting ANC attendance and subsequent demand for MIP services. CSOs are valuable for reaching husbands and other secondary audiences. CSOs can serve as effective advocates with LGA leaders to include MIP services among their essential programs.

4. Close collaboration is needed between NMCP and the RH Unit within the FMOH in developing standard training and advocacy materials for promoting MIP with SMOH and LGA health staff, thus ensuring that MIP is implemented within the context of a viable ANC service.
5. MIP in areas of low ANC utilization is a particular challenge and SMOH has to provide the lead, guidance and oversight functions. Appropriately trained and supervised outreach workers including Village Health Workers (VHWs) and TBAs may be needed to communicate about and thus promote directly observed IPT. This is a crucial role where FMOH standards for BCC and service quality need to be developed and promoted.
6. There is a need to take the interpersonal communication tools and messages to scale. Also, collaboration is needed among partners that developed the counselling cards and procedures in order to standardize the messages. These partners in turn need to involve NGOs that have community outreach (e.g. New Nigeria Foundation, Tulsi Chanrai Foundation) as well as private hospitals and clinics and train their staff to use the cards, materials and BCC procedures. For example, in states where the CAPA program worked, effort should be made to take the counselling process to other LGAs and NGOs with SMOH involvement.
7. Mechanisms need to be put in place to ensure continued use and production of MIP counselling and communication materials. USAID is committed to continuing CAPA-like activities in its new five-year plan and would thus be in a good position to coordinate the setting and maintaining of BCC standards in MIP education, communication, counselling and training at the community and LGA level.

2.1.6 MIP Message Inventory (current through January 2004)

Partner	Message	Channel	Comment
USAID: BASICS II, SFH, JHU/CCP's HCP	<ul style="list-style-type: none"> Prevent malaria During Pregnancy Malaria is Bad for Your Health and the Health of Your Unborn Child Malaria can cause death to both the mother and the unborn child 	<ul style="list-style-type: none"> Counselling Card provided to Community Health Representatives in 20 LGAs 	<p>Based on community outreach through local CBOs with links to LGA health clinics, though drugs and nets not guaranteed at clinics.</p> <p>Note that reference to a brand name of an antimalarial drug may be inappropriate.</p>
	<ul style="list-style-type: none"> Take a first dose of SP or IPT drug after you feel the baby move Take a second dose of SP or IPT drug at least one month later Visit the health centre and ask the health worker about your first and second doses of SP or IPT drug A pregnant woman should not take SP or IPT drug before she feels her baby move. 		
	<ul style="list-style-type: none"> Sleep under an insecticide treated net Not specifically scripted, but general messages to LGA leaders to provide essential medicines, supplies and services 		
PREMA-EU, Oyo State MOH, WHO	<ul style="list-style-type: none"> <i>Samples of messages:</i> Pregnant women are more prone to getting malaria Malaria in pregnancy causes anaemia IPT prevents consequences of malaria IPT should be taken after quickening & then again in the 3rd trimester 	<ul style="list-style-type: none"> Nurse-Midwife Training Sessions Health Talks to Mothers at Clinic 	<p>No materials developed.</p> <p>Messages are technical and many.</p>
	<ul style="list-style-type: none"> SP or IPT drug for IPT is part of your LGA's essential drug list 		
Futures Group (DfID)	<ul style="list-style-type: none"> Malaria accounts for 2 out of every 10 deaths during pregnancy in Nigeria. Kill a mosquito today Use Insecticide Treated Net (ITN) 	<ul style="list-style-type: none"> Calendar 	<p>Overall, MIP is not a conspicuous feature of BCC materials and tools.</p>
	<ul style="list-style-type: none"> A dead Mosquito can't give you malaria. Treat your net with insecticide 	<ul style="list-style-type: none"> Poster, Handbill Souvenirs like Exercise Book, T-shirt, Nylon Shopping Bag 	
	<ul style="list-style-type: none"> For best malaria protection Treat your net every 6 months 	<ul style="list-style-type: none"> Sticker Shop Dangler 	
Policy Project (USAID)	<ul style="list-style-type: none"> Malaria is a devastating disease which impacts on <ul style="list-style-type: none"> Infant and child mortality Maternal mortality 	<ul style="list-style-type: none"> Policy briefs Press kits/press conferences PowerPoint presentations Fact sheets/Brochures/flyers Conferences /Workshops 	<p>Effective techniques have been developed and adapted from HIV/AIDS and Population Policy projects</p>

2.1.7 Communication Outline - Malaria in Pregnancy

Audiences

Primary Audience 1: – Women who do not attend ANC at all

Audience Analysis – Currently have low ANC utilization and low utilization of modern health and social services. Cultural, political, and religious factors contribute to a general suspicion of modern health services. Messages for this audience should focus on the importance of ANC to receive important information and services, including information on malaria prevention and treatment. IPT is not well known. Very few are aware of the dangers of MIP, know the importance of sleeping under ITNs and know that that they should sleep consistently under ITNs when pregnant. These women are most commonly found in Northeast, Northwest, Northcentral and South South. Socio-cultural, religious and economic characteristics of these regions need to be considered in developing appropriate and realistic messages and communication interventions.

Primary Audience 2: - Pregnant women who regularly attend ANC.

Audience Analysis – These women understand the importance of registering early at ANC and attend ANC at least four times during pregnancy but may not know the importance of preventing and treating malaria in pregnancy. IPT is not well known. Very few are aware of the dangers of MIP, know the importance of sleeping under ITNs and know that that they should sleep consistently under ITNs when pregnant. They need to understand that IPT is a health right to be expected within ANC. This category of audience is commonly found in the South (SW, SE and SS).

Primary Audience 3: – Pregnant women who register for ANC too late to benefit from two doses of IPT.

Audience Analysis - These women (which may include multiparous women, adolescents and students with unwanted pregnancies) need to be convinced of the benefits of early ANC registration. Few are aware of MIP, and IPT is not well known. Very few know the importance of sleeping under ITNs and know that that they should sleep consistently under ITNs when pregnant. Pregnant women in the South (SW, SE and SS) and Northcentral most commonly fall into this category. Socio-cultural, religious characteristics of these regions need to be considered in developing appropriate and realistic messages.

Secondary Audiences – Husbands, Mothers-in-law, sisters and brothers-in-law and friends.

Change Agents – Health workers, TBAs, PMVs, VHWs, policy makers/political leaders especially at the LGAs, CBOs, FBOs, Traditional and Religious leaders, teachers (including those in Islamic/Mission schools in the North) and the media.

Recommended Practices

ANC - Pregnant women should register early and attend ANC at least four times during pregnancy in order to receive information on prevention and treatment of malaria in pregnancy.

IPT – Pregnant women should take SP or IPT drug as a Directly Observed Treatment (DOT) at least twice during pregnancy, once during the 2nd trimester (16-27 weeks or after quickening) and monthly after this but not after 36 weeks of gestation.

ITN - Pregnant women should sleep under mosquito nets, which are treated with approved insecticides and retreated every six months.

Case management – Pregnant women should seek immediate treatment of fever from a health facility during pregnancy whether they had taken SP or IPT drug as an IPT or not.

Secondary Audience and Change Agents: Health workers should administer IPT and recommend the use of ITNs during pregnancy. Political/policy makers should provide enabling and conducive environment for MIP prevention and case management through availability of affordable and accessible SPs or IPT drugs and ITNs. Media should disseminate relevant and appropriate information on IPT to pregnant women.

Communication Objectives

Primary Audiences

Increase the proportion of pregnant women who:

- 1) state the importance of regular ANC attendance;
- 2) attend ANC early enough in pregnancy to receive at least two doses of IPT;
- 3) mention the dangers of malaria in pregnancy and the importance of seeking prompt treatment of fevers;
- 4) state that ITNs effectively prevent malaria and use them throughout their pregnancies.

Secondary Audiences

Increase the proportion of:

- 1) Health workers who describe procedures correctly for IPT and who administer SP or IPT drug following IPT policy guidelines;
- 2) Husbands, CSO/FBO leaders and other secondary audience members who encourage pregnant women to start attending ANC early and regularly; and
- 3) Media practitioners who publish and/or broadcast relevant information on IPT regularly.

Key Promise

If you recognize and treat fevers promptly and correctly, sleep constantly at night under an ITN, and attend ANC early enough to take IPT twice during pregnancy, you are more likely to be healthy, have a safe delivery, and a healthy baby.

Support Points

- ANC provides women with information and services that benefit their health and the health of their babies.
- When women are pregnant, they are more likely to become sick with malaria.
- Malaria is particularly dangerous during pregnancy. It can cause stillbirths, miscarriages, anaemia, small and weak babies.
- Fevers during pregnancy are usually caused by malaria and need immediate treatment at a health facility. At the health facility, they will give the woman medicine that will not harm her or her baby.
- Health facilities have trained and friendly health workers that will attend to the pregnant mothers promptly.

2.1.8 Messages

ITN Use

- Malaria is spread from person to person by infected mosquito bites.
- You cannot get malaria from oily foods or from too much sun.
- The mosquitoes that cause malaria usually bite people at night, when they are sleeping. The best way to prevent malaria is to sleep under an ITN.
- It is particularly important for pregnant women to sleep under ITNs because they are more likely to get malaria and their bodies are less able to fight it.
- ITNs are mosquito nets that have been dipped in approved insecticides. Mosquito nets are twice as effective in preventing malaria when they have been dipped in approved insecticides.
- To be most effective, ITNs should be dipped in approved insecticides at least twice a year.
- ITNs prevent mosquito bites in two ways. They act as a barrier between the pregnant woman and the mosquitoes. The insecticides also kill or repel mosquitoes.
- ITNs are safe to use. The insecticides are not harmful to pregnant women or their babies.
- Testimonies from women who slept under ITNs during pregnancy, had no malaria during pregnancy and gave birth to healthy babies.
- ITNs give a good night's sleep, free from buzzing and biting mosquitoes and other insects. ITNs also reduce the number of mosquitoes and other insects in the room so others are more likely to sleep well too.
- Mosquito nets and insecticides are available from ANC clinics, markets, CBOs, NGOs, and chemists.
- Pregnant women should mend their mosquito nets promptly when they are torn to ensure effectiveness.
- Policy makers should make IPT and ITNs available, accessible and affordable

IPT as part of ANC

- Most adults have malaria parasites in their bodies but do not feel sick. This is especially dangerous during pregnancy. Even though the woman feels well, the parasites hide in the placenta, and can harm the baby. This can lead to anaemia, miscarriage, stillbirth, or a small, weak baby.
- To prevent these problems, women should take SP or IPT drug at least twice during pregnancy at the health facility– once during the 2nd trimester (16-27 weeks or after they feel their babies move) and monthly thereafter up until 36 weeks.
- IPT is provided as part of ANC services. Pregnant women should begin attending ANC during the first three months of pregnancy, where they will receive counselling and information about how to prevent malaria and other problems during pregnancy.
- Pregnant women should register at antenatal clinics early in their pregnancies and attend antenatal care a minimum of four times during each pregnancy. This enables them to receive the two recommended doses of IPT and other essential services during pregnancy.
- IPT is safe. It will not harm either the woman or her baby.
- Attend ANC and preserve your life and that of your unborn baby.

- Pregnant women should receive their first IPT at a health facility after they feel the babies move (quickening) at a health facility.
- Pregnant women who registered late in ANC during the 3rd trimester can still take 2 doses of IPT provided a month interval is observed and it is no later than 36 weeks of gestation.
- A pregnant woman should take SP or IPT drug at the health facility in the presence of a health worker. If the health facility does not have SP or IPT drug in stock and the woman buys SP at a drug store, she should return to the health facility and take the SP or IPT drug in the presence of a health worker.
- IPT replaces 'Sunday-Sunday' medicine. Do not use paludrine and SP or IPT drug together.

Case Management

- Fevers during pregnancy are usually caused by malaria.
- All fevers during pregnancy should be treated immediately at a health facility.
- Treatment for fever given at the health facility will not harm the mother or the baby.

2.1.9 Summary of Proposed BCC Strategy for MIP

Problem	Audiences	Communication Objectives	Communication Approaches	Possible Implementing Partners
Malaria in Pregnancy (MIP)	<p>Primary Audience 1: – Women who do not attend ANC at all</p> <p>Primary Audience 2: - Pregnant women who regularly attend ANC.</p> <p>Primary Audience 3: – Pregnant women who register for ANC too late to benefit from two doses of IPT.</p>	<p>Increase the proportion of pregnant women who:</p> <ol style="list-style-type: none"> 1) state the importance of regular ANC attendance; 2) attend ANC early enough in pregnancy to receive two doses of IPT; 3) mention the dangers of malaria in pregnancy and the importance of seeking prompt treatment of fevers; 4) state that ITNs effectively prevent malaria and use them throughout their pregnancies. 	<p><u>Community Channels:</u> Health talks, community mobilization</p> <p><u>Interpersonal:</u> Nurse/Midwife training workshops, health talks to mothers at clinics</p> <p><u>Mass Media:</u> Billboards, radio spots, counselling cards, posters, booklets, drama on radio and TV</p>	WHO, PREMA-EU, Oyo State MOH, USAID Implementing Partners UNICEF, FMOH, DfID, JHU/CCP, and World Bank
	<p>Secondary Audiences: Husbands, Mothers-in-law, sisters and brothers-in-law and friends</p> <p>Change Agents: Health workers, TBAs, PMVs, VHWs, policy makers/political leaders CBOs, FBOs Traditional and Religious leaders, teachers and the media</p>	<p>Increase the proportion of:</p> <ol style="list-style-type: none"> 1) Health workers who describe IPT procedures correctly and who administer SP or IPT drug following MIP policy guidelines; 2) Husbands, CSO/FBO leaders and other secondary audience members who encourage pregnant women to start attending ANC early and regularly and 3) Media practitioners who publish and/or broadcast relevant information on IPT regularly. 	<p><u>Community Channels:</u> Health talks, community mobilization</p> <p><u>Interpersonal:</u> Nurse/Midwife training workshops, health talks to mothers at clinics</p> <p><u>Mass Media:</u> Billboards, radio spots, counselling cards, posters, booklets</p>	WHO, PREMA-EU, Oyo State MOH, USAID Implementing Partners