HEALTH COMMUNICATION CAPACITY COLLABORATIVE

MALAWI QUALITY MEDICINES CAMPAIGN PLANNING WORKSHOP

November 16-17, 2016
Cross Roads Hotel, Lilongwe, Malawi
Workshop Report

USAID FROM THE AMERICAN PEOPLE

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ACKNOWLEDGEMENTS

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ACRONYMS

ACT	Artemisinin-based Combination Therapy
AL or "LA"	Artemether-lumefantrine
CHAM	Christian Health Association of Malawi
CMST	Central Medical Stores Trust
DHS	Demographic and Health Surveys Program
DTI	Drug Theft Investigation Unit
FHI360	Family Health International 360
GFATM	Global Fund for AIDS, Tuberculosis and Malaria
GHSC	Global Health Supply Chain
HAC	Health Advisory Committee
HC3	Health Communication Capacity Collaborative
HC4L	Health Communication 4 Life
HES	Health Education Services
HSA	Health Surveillance Assistant
MAD	"Make a Difference"
MAS	Mobile Authentication System
MCS	Malaria Communication Strategy
MIS	Malaria Indicators Survey
MOH	Ministry of Health
NMCP	National Malaria Control Program
OIG	Office of Inspector General
PMI	U.S. President's Malaria Initiative
PMPB	Pharmacy, Medicines and Poisons Board
PPMV	Patent and Proprietary Medicine Vendor
PSI	Population Services International
PSM	Procurement and Supply Management Project
RDT	Rapid Diagnostic Test
SBCC	Social and Behavior Change Communication
SSDI-Communication	Support for Service Delivery Integration – Communication
SSFFC	Substandard, Spurious, Falsified, Falsely-labeled and Counterfeit
USAID	United States Agency for International Development
WHO	World Health Organization

BACKGROUND AND INTRODUCTION

The continued availability and use of substandard, spurious, falsified, falsely-labeled and counterfeit (SSFFC) medicines impedes global efforts to eradicate malaria, as such medicines result in treatment failure, death and a distrust of the health system. According to the World Health Organization (WHO), 10 to 30 percent of all medicines in developing countries are substandard or falsified (Mackey & Liang, 2013). Antimalarial medicines constitute the bulk of SSFFC medicines, contributing 52.5 percent and 92.6 percent of all substandard and counterfeit medicines respectively (Hajjou et al, 2015). In fact, it is estimated that SSFFC contributed to 122,350 deaths in children under five years old among 39 sub-Saharan African countries (Renschler et al., 2015).

In general, poor quality medicine tends to fall into three categories (Kaur et al., 2015):

- **Substandard**: Medicine that does not contain enough active ingredient due to unintentional errors caused in manufacturing.
- **Falsified**: Medicine that does not contain enough or any active ingredient due to intentional fraudulent manufacturing. May carry false representation of their source or identity.
- **Degraded**: Medicine that does not contain enough active ingredient due to poor conditions during storage, handling, or transportation (light, heat, humidity, etc.). Stolen or diverted medicine is at great risk of becoming degraded.

While the desk review and landscaping assessment done by the Health Communication Capacity Collaborative (HC3) found that both substandard and falsified medicines are present in Malawi, the national SSFFC malaria medicine problem primarily revolves around widespread prevalence of medicine theft, particularly medicine removed from the public sector and brought into the private and illegal sectors – both within Malawi and across its borders. Malaria medicine diversion is particularly concerning because it increases the risk for degraded medicine, and subsequent treatment failure and resistance.

Although the Government of Malawi, donors (e.g., the United States Agency for International Development/USAID and the Global Fund for AIDS, Tuberculosis and Malaria/GFATM) and implementing partners have set in place a number of activities to strengthen the supply chain, few activities have been aimed at improving consumer awareness and reporting. Communication efforts to encourage rational drug use, to discourage the use of stolen medicines and encourage the public to report theft have not been implemented at scale or evaluated. Consequently, existing resources, like the national "Make a Difference" (MAD) Malaria/TIPS Hotline, are not well known. In addition, no public communication has been done to improve awareness of the "Government of Malawi" markings on artemisinin-based combination therapy (ACT) packaging.

In response to this situation, the National Malaria Control Program (NMCP), with HC3 support, organized a two-day workshop of stakeholders on November 16 and 17, 2016, to plan a social and behavior change communication (SBCC) campaign aimed at protecting the public from diverted and degraded malaria medicine. The campaign plan resulting from this workshop will be implemented by the Malawi NMCP and the Pharmacy Medicine and Poisons Board (PMPB) in partnership with USAID/U.S. President's Malaria Initiative (PMI) SBCC partner Health Communication 4 Life (HC4L), supporting the National Malaria Communication Strategy components dealing with malaria medicine diversion. This report documents that campaign planning workshop.

WORKSHOP GOAL AND OBJECTIVES

The overall goal of the two-day workshop was to develop a campaign plan to help protect the public from poor quality malaria medicine in Malawi. This workshop was designed to meet the following objectives:

Objective 1

- To review the malaria medicine situation in Malawi

Objective 2

- To assist the NMCP, PMPB and malaria stakeholders to design a campaign promoting the use of good quality medicines for treatment of malaria

WORKSHOP OUTPUTS/OUTCOMES

Participation

The workshop was well attended by 26 participants who represented an array of key stakeholders, including representatives from the following organizations (see Appendix A for complete list):

1. NMCP
2. Support for Service Delivery Integration – Communication (SSDI-Communication)
3. PMI (USAID)
4. SSDI Systems
5. Population Services International (PSI)
6. PMPB
7. Ministry of Health (MOH) Health Education Services (HES)
8. GFATM
9. SSDI Services
10. Galaxy Media
11. Malawi Broadcasting Corporation
12. Global Health Supply Chain – Procurement and Supply Management (GHSC-PSM) Project
13. Family Health International (FHI) 360
14. Malaria Care
15. MOH Drug Theft Investigation Unit (DTI)
16. Zodiack Broadcasting Station
17. Pharmaceutical Society of Malawi

WORKSHOP DAY ONE – JUNE 16, 2015

Opening and Welcome

Shadreck Mulenga (NMCP) opened the workshop with a prayer and welcoming words on behalf of the Malawian government. He highlighted the progress Malawi has made to combat malaria, as well as the threat poor quality malaria medicines pose to this progress. Following his remarks, Chancy Mauluka (SSDI-Communication) provided an overview of the workshop.

Malaria Case Management Strategy

The first presentation came from **Taonga Mafuleka (NMCP HES)**, who walked the participants through the Malaria Communication Strategy (MCS) component of the National Health Communication Strategy (2015-2020). According to his presentation, the related behaviors promoted by the MCS include prompt healthcare seeking from health facilities within 24 hours after the onset of fever, sustained public awareness of the correct malaria treatment, testing before treating for malaria and reinforced collective ownership of health commodities at public health facilities by community members (e.g., encouraging community members to report suspected cases of pilferage through safe and confidential channels). The NMCP and malaria SBCC implementing partners use a variety of channels to reach these goals, including health workers, community volunteers, community mobilizers and mass media (both print and electronic). They also host advocacy meetings, community dialogues and health facility talks. Mr. Mafuleka also highlighted the importance of consumer behavior, showing that while the Malaria Indicators Survey (MIS) found that 58 percent of respondents sought treatment from health facilities, the remaining 42 percent may be self-diagnosing and treating from the private sector – two behaviors that increase the risk of purchasing SSFFC malaria medicines.

Dubalou Moyo (NMCP) then introduced the national case management guidelines, which state that suspected malaria cases (fever plus one additional sign or symptom) should be tested, and only those clients with positive test results should be prescribed malaria medicine. He explained that the first-line treatment changed from monotherapies to lumefantrine-artemether (AL or "LA") in 2007, although other ACT options are available in Malawi. Microscopy is also used to monitor the type of malaria present in the country. Participants asked several clarifying questions after this presentation. For example, Mr. Mafuleka questioned whether the country had enough rapid diagnostic tests (RDTs) to handle the demand generated by the HES communication campaign. Mr. Moyo added that campaigns need to educate clients so they are satisfied and understand why they are not provided medicine because they test negative for malaria. He also explained that the private sector can offer RDTs and quality ACTs, but can also look for lesser quality products than required by the public sector.

HC3: Promoting Quality Malaria Medicines through SBCC Initiative

After tea break, **Cheryl Lettenmaier (HC3)** introduced HC3's Promoting Quality Malaria Medicines through SBCC initiative and Implementation Kit (I-Kit) (https://sbccimplementationkits.org/quality-malaria-medicines). She provided an overview of poor quality medicine, going over the prevalence of SSFFC antimalarial medicines and the three categories they tend to fall into: **substandard** (genuine products that do not meet qualifications), **falsified** (deliberately mislabeled with respect to identity, content or source) and **degraded** (drugs that have deteriorated after production). The HC3 project, she explained, aims to improve the capacity of program managers and key stakeholders to develop and implement state-of-the-art SBCC programs that address malaria medicine quality issues and promote the use of good quality medicines. Her team has created an I-Kit which provides guidance on this process, and highlights the key factors to consider when developing tailored SBCC activities.

To ensure the I-Kit was based on evidence and best practices, HC3 conducted a desk review about SBCC used to combat poor quality medicines, held a global stakeholder meeting to discuss country-based activities and broader initiatives and partnered with the National Malaria Elimination Program (NMEP) and National Agency for Food and Drug Administration and Control (NAFDAC) in Nigeria to develop and implement its Good Quality Malaria Medicines Campaign. This campaign ran in Akwa Ibom State, Nigeria, from May to September 2016 and involved trainings, stickers, posters, fact books, advocacy sheets and TV and radio spots to reach malaria medicine consumers, patent and proprietary medicine vendors (PPMVs), journalists and decision makers. Ms. Lettenmaier explained that the campaign promoted several key case management messages (e.g., visit the health facility within 24 hours of fever for a malaria test; if positive for malaria, treat with ACTs; obtain ACTs only from health facilities, pharmacists or licensed PPMVs; check medicine packets for registration number, expiration date and mobile authentication system/MAS scratch pad; and report poor quality medicine to the regulatory authority). Exposure to the campaign was high (77.6 percent) and 72 percent of survey respondents indicated they would do something differently the next time they needed antimalarial medicine, most notably using the MAS scratchpad on the medicine packet. The lessons learned from this campaign, as well as the desk review and key informant interviews, have been shared and informed the content of the I-Kit.

Ms. Lettenmaier explained that HC3 has been asked to provide technical assistance to the NMCP to develop a campaign around its malaria medicine situation, which is affected by the diversion of ACTs from the public sector to the private sector. Experts believe the poor storage conditions of diverted medicine (e.g., exposure to excessive heat, moisture, etc.) negatively influences medicine quality. A 2015 medicine quality study found that 88.4 percent of samples failed quality tests. However, some debated during the question and answer period about how much this study represents the current antimalarial medicine environment, as results are not broken down by samples from legal and illegal sectors.

Malaria Medicines Quality in Malawi: Understanding the Issues

DTI Unit: The Issue of ACT Leakage from the Public Sector

Austin Kumenda (MOH's DTI Unit) shared his unit's work addressing the national issue of medicine pilferage from public sources to private or illegal vendors. According to his presentation, many of the people stealing medicine are repeat offenders, who work at health facilities or within the supply chain,

and are part of a larger system of criminals. Border districts are at higher risk for poor quality medicine. Several factors contribute to medicine theft, including the poor quality of data, limited accountability, inadequate staffing levels, the connected nature of health facility networks (where everyone knows each other and most of the power rests with one person) and weak legal ramifications that do not deter criminal acts by health personnel. Mr. Kumenda's team and partners investigate medicine theft through border checks and audits, although there has not been an audit for quite some time. He also emphasized the need to increase accountability and reporting, saying, "the responsibility rests with the community – because most of our information is coming from the community." He suggested recognizing the role that Health Advisory Committees (HACs) and accountability clubs could play in this fight and developing programing to capitalize on their work. While the issue of medicine pilferage is a new topic in the global community, during the question and answer session participants pushed the group to move beyond awareness. A media representative also used this session to advocate for the role of the media.

NMCP: ACT Procurement and Distribution Systems – Government Hospitals and Health Centers, Private Sector Pharmacies/Clinics and Village Clinics

Flora Kalimba (NMCP) explained that the main goal of the supply chain is to get good quality ACTs and RDTs to health personnel and clients. Several managing partners work with the MOH, such as the GFATM and PMI (Financing and Coordination/Procurement), Central Medical Stores Trust (CMST) (Procurement/Warehousing and Distribution) and individual health facilities. The Logistic Management Information System (LMIS) database captures and reports data from the various stages of the supply chain – from quantification (forecasting) to procurement to storage and distribution. The NMCP submits its distribution requests at the end of each month, and 15-30 days later GHSC, Bollore and CMST deliver the medicine. According to Ms. Kalimba, poor documentation, stock imbalances and incomplete LA registers are the key challenges the supply chain faces.

PMPB: What Is Being Done to Regulate the Quality of Malaria Medicines in Malawi?

Wilfred Mathiya (PMPB) spoke about the history and current challenges of the PBMB. Before the PMPB was established in 1988, no effective medicine regulation existed in Malawi. At this time, quality medicines could not be assured, and street markets and self-medication was very common. While Mr. Mathiya argued that the situation has improved, he also said many people are still buying and dispensing medicines that are not appropriate for their needs.

The PMPB works in three key areas: (1) quality assurance of medicine (at quality control labs), (2) pharmacovigilance and (3) medicine inspection (through post-marketing surveillance and port of entry inspections). PMPB uses visual and physical assessments to ensure medicine quality. It also checks that all medicines are registered and in line with the standards set forth by treatment guidelines for major diseases in Malawi, good manufacturing practice reports, WHO prequalification policies or requirements of another authority (for example, the U.S. Food and Drug Administration). According to Mr. Mathiya, PMPB faces several barriers to fulfilling their mandate, including unqualified persons handling medicines (such as street vendors and market sellers) and weak border control. Additionally, lack of funds and inadequate supplies (e.g., minilabs, distance between medicine sites, etc.) create challenges, as does medicine shortages that encourage health workers to use expired medicine.

Pharmaceutical Society of Malawi: Malaria Medicines Prescribing and Dispensing Practices in the Private Sector

Enock Foster (Pharmaceutical Association) explained that LA is the first-line treatment for uncomplicated malaria. It is available in government hospitals, retail pharmacies and private clinics. LA can only be prescribed by doctors, medical assistants, nurses and clinical officers, and should only be given after the client has tested positive for malaria. Licensed wholesalers are the only recommended private sources for LA. According to Mr. Foster, approximately 95 percent of people have access to LA – leaving at least 5 percent of the population vulnerable to self-medication. He recommended LA remain the first-line medicine, and that the PMPB increase their efforts to monitor LA in drug stores and border crossings to reduce the presence of poor quality medicine. During the presentation, Mr. Foster said LA is a prescription-only medicine. However, during the question and answer period, participants explained that guidance had changed and consumers can now get LA without a prescription.

NMCP: Malaria Medicines Prescribing and Dispensing Practices in the Public Sector

Dubulao Moyo (NMCP) stated that good dispensing practices ensure "the correct medicine is delivered to the right person, in the right dosage, form and quantity with clear instructions, and in an appropriate package that maintains the potency of the medicine." He explained that only healthcare workers who have attended malaria case management service pre-training/training and HSAs who have attended integrated community case management training/operate a village clinic are allowed to prescribe LA. If the patient has signs of severe malaria, they should receive pre-referral treatment and a referral (if being treated at the community level), pre-referral treatment and a test (if at the health center level) and a test and treatment if positive. Those clients who test positive should receive LA or artesunate-amodiaquine (if treatment failure occurs). If the client does not test positive for malaria and does not have signs of severe malaria, the provider should assess for other causes of fever. Providers are supposed to counsel clients on the reason they are receiving the medicine, the proper dose and duration, and the steps to take if symptoms worsen. Case management statistics show some progress, with 67.5 percent of suspected malaria cases in the country getting tested, 92.5 percent of confirmed cases receiving LA. However, there is still room for improvement.

HC3: Review of Consumer/Client Care and Treatment-Seeking Practices Research

Cori Fordham (HC3) presented the various trends and barriers that are known about care and treatment-seeking practices in Malawi, especially prompt care-seeking within 24 hours of symptoms, testing before treating with quality ACT/LA and taking the full dose of medicine for confirmed malaria. She explained that most of the available data is for caretakers of children under five, but the data also provides insights into practices among the population at large. Based on the data available, most caretakers (between 65 and 75 percent according to the Demographic and Health Surveys/DHS and Malaria Indicators Survey/MIS) sought medical assistance for children with fever, with the majority going to a government facility. However, only 32 to 41 percent of children taken for treatment were tested (DHS and MIS).

One researcher who studied the Chikhwawa district found that treatment seeking occurred in three phases: (1) the "assessment period phase" when people may wait or try home treatments until the cause of fever is determined; (2) the "outside home phase" when people seek either biomedical care or traditional medicine based on their understanding of modern science and whether their first treatment source resulted in a recovery; and (3) the "evaluation of treatment response phase" when they may return to their treatment source, or switch between the public and private sources depending on

finances, accessibility and decision-making authority (Ewing et al., 2015). The percentage of people who first seek treatment from formal care sources decreases as children get older (Chibwana et al., 2009). Research shows the majority of Malawians seek treatment at public sources/government facilities (47.8 percent public sources, 6.5 percent CHAM, 5.3 percent private sources and 7.3 percent drug shops), and those who first went to a health center seeking treatment were significantly more likely to go to a public source (71.5 percent compared to 47.8 percent). Data gaps as well as key informant interviews show that financial constraints, limited health knowledge and concerns around poor quality medicine are barriers to people procuring quality medicine. Self-medication with quality medicine, as well as old medicine or medicine bought from hawkers, also negatively contributes to this problem.

What Is Being Done to Engage the Public about this Issue?

HC3: MAD Campaign

Chancy Mauluka (SSDI-Communication) described SSDI-Communication's partnership with USAID's Office of Inspector General (OIG) to create a campaign aimed at encouraging the public to report cases of pilferage to the MAD Malaria Hotline (a GFATM and OIG-supported hotline where callers can report theft of malaria medicine and commodities). The campaign also motivates culprits to stop buying and selling pilfered medicines or facilitating pilferage. The primary audience was culprits and whistle blowers, the secondary audience was politicians and law enforcers. After creating a communication brief, the team developed a poster and newspaper ads promoting the MAD Malaria Hotline. They also produced radio spots and programs featuring discussions and real stories about the situation, the causes and effects of pilferage, as well as the roles and responsibilities of the community and the benefits of changing behaviors. This project resulted in increased reports of culprits being arrested. However, the impact was limited as it was short term and not integrated into larger malaria communication efforts.

PMPB: PMPB Public Awareness Campaigns

Wilford Mathiya (PMPB) spoke about Malawi's public education campaigns to engage people around issues of medicine quality. In recent years, the PMPB has worked with Deloitte on a hotline that receives tips about suspicious cases and illegal activity (90 percent of tips have been led to successful arrests). They have also developed and pretested community awareness materials, radio and television messages and educated community leaders about the sources of quality medicines and the dangers of buying from illegal markets. In addition, the PMPB conducted press briefings on the topics of pilferage and quality medicine and held newsworthy events when it burned confiscated shipments of substandard medicines. However, implementing public awareness activities has come with challenges. Outdated laws support weak punishment for people caught stealing medicines, especially when they are caught and tried in their own communities. Lack of donor support and inadequate funds also limits the impact of the PMPB, which would like to continue working with communities and police, support hospitals in buying good quality medicines, test medicine quality more frequently and audit sources of illegal medicine when cases are identified.

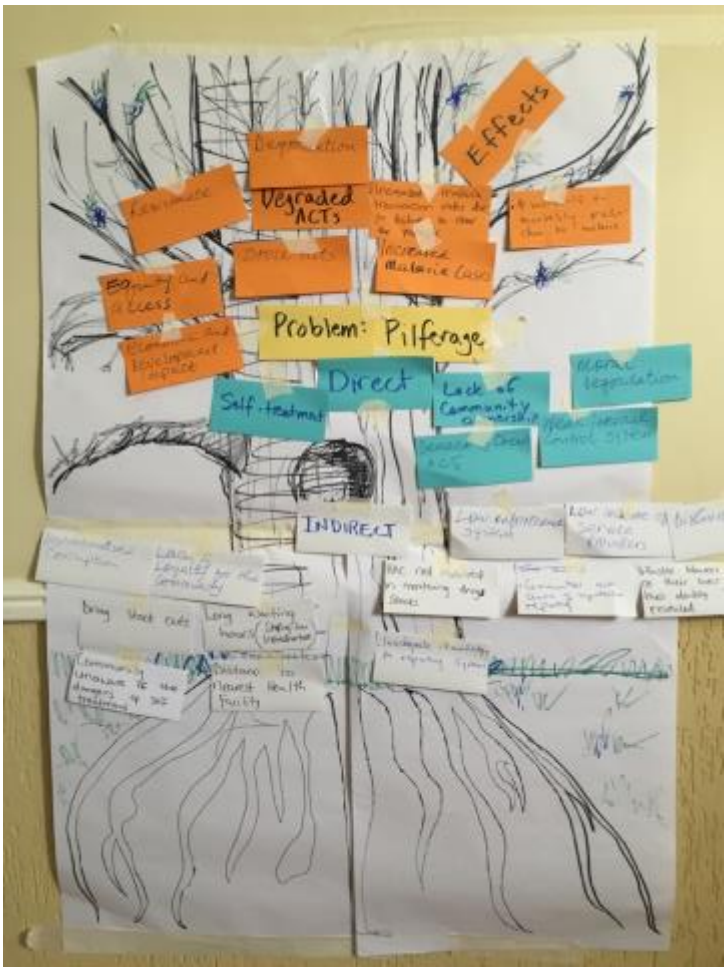
Problem Statement

After hearing all of the presentations, the participants worked in groups to identify the main problem the campaign should focus on. Since there was no consensus at first, this activity continued into the next day so the first day could end promptly at 5pm.

WORKSHOP DAY TWO – JUNE 17, 2015

Opening and Welcome

The second day started with a recap of the previous day by **Taonga Mafuleka (HES)**. Maintaining the small groups formed the previous day, participants continued to discuss the main problem. This time, all groups were in agreement that malaria medicine pilferage was the main problem to be addressed by the campaign. Participants then reconvened into small groups to identify the direct and indirect causes and the effects of malaria medicine theft. The final analysis is represented in the problem tree below.



Audience Identification

Participants divided into groups of three, and **Cori Fordham (HC3)** walked them through identifying and prioritizing the three most important audiences based on their understanding of the problem. Participants were advised to think of audiences who:

- are most affected by the problem or could do the most to influence it (primary audience); and
- influence the primary audience (secondary audiences).

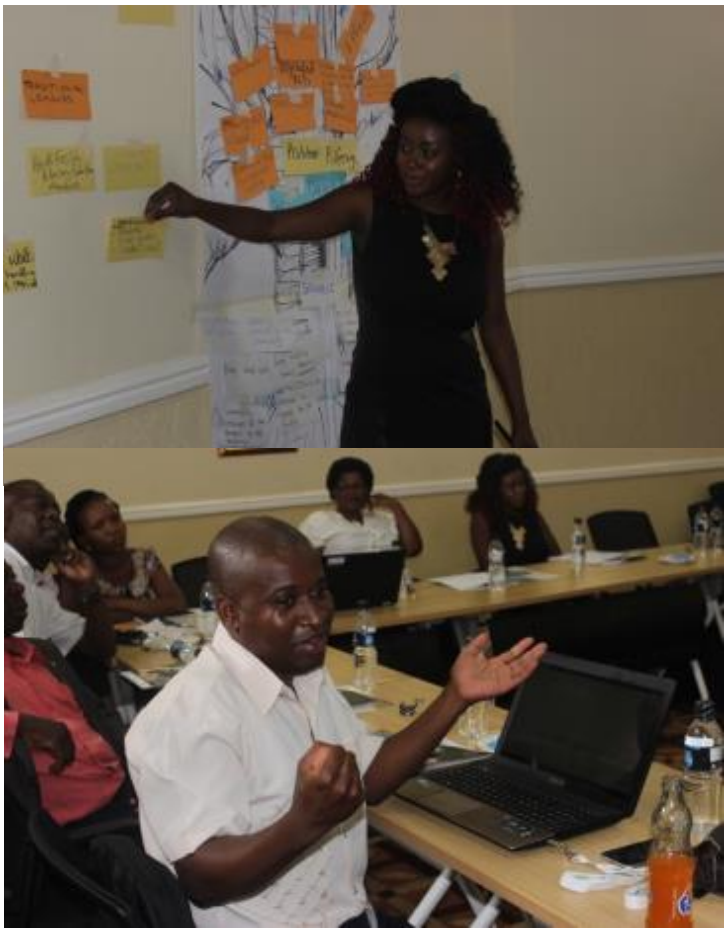
Working independently, the three groups came up with two primary audiences:

- **Primary Audience 1:** malaria clients/consumers who buy anti-malarial medicines
- **Primary Audience 2:** health providers who treat patients with fever and malaria

The group had a larger discussion about whether the secondary audience should be traditional leaders, the health facility advisory committee or key community members. After much discussion, it was decided the team developing the communication brief for the secondary audience would decide which of the three audience segments to focus on.

Audience Analysis and Communication Briefs

Once participants were clear on the problem at hand and the audiences that should be included in the program, it was time to increase understanding of the identified audiences and develop communication briefs for them. Cheryl Lettenmaier (HC3) led this process for the rest of the day.



Participants were then divided into three small groups and asked to develop a communication brief for their assigned audience. Each group was given a worksheet to complete (see **Appendix C**). Participants worked at this task both before and after the lunch break, and then presented their briefs to the larger group. The teams did not have time to revise their briefs after feedback, but the HC3 team took note of comments and incorporated them into the Communication Briefs in **Appendix D**.

Afterward, meeting participants briefly brainstormed ways to strengthen the campaign plan's reach and impact by partnering with other organizations and integrating messages about medicine pilferage with existing work. The following organizations were recommended:

- MOH/NMCP
- DTI Unit
- PMPB
- HC4L
- MAD Malaria/TIPS Hotline
- UNICEF (social accountability campaign)
- Malawi Health Equity Network (works with HACs)
- Local Government Access Project
- Onse Project (Community Mobilization)
- Options UK
- Health and Rights Education Program
- Health Journalist Associations

The workshop came to an end at 5:00 PM after participants agreed on the following immediate next steps:

1. HC3 will complete and share the Malawi Quality Malaria Medicines landscape document, based on the literature scan, key informant interviews and information provided during this meeting.
2. HC3 will share the presentations from the meeting, as well as the meeting report with NMCP, PMI and the participants.
3. HC3 will review and complete the communication briefs for each of the three audience segments, integrating feedback provided during the presentations. The briefs will be shared with a smaller group of volunteers for initial review by participants identified during this meeting and will then be sent for a final review by HES, NMCP, SBCC Working Group and HC4L. See **Appendix E** for Review Teams.

APPENDIX A: PARTICIPANT LIST

	ORGANIZATION	PARTICIPANT
1	NMCP	Richard Chola
2	NMCP	Shadreck Mulenga
3	SSDI-Communication	Chancy Mauluka
4	PMI(USAID)	Edson Dembo
5	ABT Associates/SSDI Systems	Husdon Nkunika
6	PSI	Ricky Nyaleye
7	PSI	Zach Mangochi
8	Pharmacy, Medicines & Poisons Board	Wilford Mathiya
9	Pharmaceutical Association	Enock Foster
10	Health Education Services	Taonga Mafuleka
11	MOH-NMCP (GFATM)	John Zoya
12	JHPIEGO/SSDI Services	Dan Wendo
13	Galaxy Media	Benson Nkhoma Somba
14	MOH-HES	Tobias Kunkumbira
15	Malawi Broadcasting Corporation	Monica Mmanga
16	GHSC-PSM	Elias Mwalabu
17	USAID	Rumbani Ligowe
18	FHI360	Innocent Kommwa
19	FHI360	Robert Chizimba
20	Malaria Care	McPherson Gondwe
21	GFATM	Sule Abah
22	NMCP	Akuzike Banda
23	MOH-DTI UNIT/AUDIT	Austin Kumwenda
24	ZODIACK	Sheila Chimphamba-Lupenga
25	MOH-NMCP	Flora Kalimba
26	MOH-NMCP	Humphrey Tung'ande

APPENDIX B: AGENDA

Tuesday and Wednesday, 16 and 17 November, 2016
Crossroads Hotel, Lilongwe, Malawi

Day 1

Time	Topic	Person Responsible
		AM Moderator: Chancy
08:30 – 09:00	Registration	
09:00 – 09:15	Opening/Welcome/Introductions	*NMCP*
9:15 – 9:30	Purpose of the workshop and overview of the agenda	*SSDI-Communication*
9:30 – 10:00	Malaria communication strategy	*HES*
10:00 – 10:30		*NMCP*

	Case Management Strategy	
10:30 – 11:00	Tea Break	
11:00 – 11:30	HC3 Substandard and Falsified Malaria Medicines Activity	HC3
11:30 – 13:15	Malaria Medicines Quality in Malawi: Understanding the issues	
	• ACT procurement and distribution systems—government hospitals and health centers, private sector pharmacies/clinics, and village clinics	*NMCP* *PMPB* *Pharmaceutical Association*
	• What is being done to regulate the quality of malaria medicines in Malawi	*NMCP*
	• Malaria medicines prescribing and dispensing practices in the private sector	*Drug Theft Investigation Unit*
	• Malaria medicines prescribing and dispensing practices in the public sector	*HC3*
	• The issue of ACT leakage from the public sector	
	• Consumer/client treatment seeking practices	
	Discussion/Q&A	
13:15 – 14:15	LUNCH BREAK	*PM Moderator: Taonga Mafuleka, HES*
14:15 – 15:00	What is being done to engage the public in this issue?	
	• MAD Campaign	*SSDI-Communication*
	• PMPB public awareness campaign	*PMPB*
	Discussion/Q&A	
15:00 – 17:00:	Plenary exercise: Defining the problem	*HC3*
17:00	**Adjourn**	

Day 2

Time	Topic	Person Responsible
08:30 – 09:00	Review previous day and Day 2 agenda	*HES*
09:00 – 09:30	Introduction to communication process and briefs	*HC3*
09:30 – 10:30	Exercise: Identifying Priority Audiences	*HC3*
10:30 – 11:00	Tea break	
11:00 – 12:00	Small group exercise: Defining desired practices, actual practices, barriers and facilitators, and communication objectives for each priority audience	*HC3*
12:00 – 13:00	Plenary presentations and feedback	*HES*
13:00 – 14:00	LUNCH BREAK	
14:00 – 15:00	Small group exercise: Benefit statement, support points, message content, channels and activities	*HC3*
15:00 – 16:00	Plenary presentations by small groups and feedback	*NMCP*
16:00 – 16:30	Opportunities for integration with existing programs	*HC3*
16:30 – 17:00	Next steps	*HC3*
17:00	Closing remarks and Adjourn	*NMCP*

Purpose of Meeting:

1) Review what is known about Malaria medicines quality in Malawi
2) Design communication briefs for priority audiences to help address the issue of Malaria medicines quality in Malawi

APPENDIX C: AUDIENCE ANALYSIS AND COMMUNICATION BRIEFS WORKSHEETS

Worksheet 1: Audience Analysis

Audience:

Desired Behavior/Practice:

Current Behavior/Practice:

Key Constraint:

Communication Objective:

Worksheet 2: Communication Briefs

Audience:

Key Benefit Statement:

Support Points:

Message Content:

Communication channels and activities:

APPENDIX D: COMMUNICATION BRIEFS, BY AUDIENCE SEGMENT

COMMUNICATION BRIEF
PRIMARY AUDIENCE 1: CONSUMERS

Audience Description: This audience includes all consumers of malaria medicine in Malawi, including caretakers of children with fever (male and female), people who test positive (or negative) for malaria and people who get their medicine from the formal public and private sectors with prescriptions, as well as those who buy from vendors or hawkers. The focus will be on men and women aged 15 and older, and populations of lower socio-economic status, living in both rural and urban areas.

Desired Behavior: Members of this audience should only obtain malaria medicine from licensed medical facilities, pharmacies, drug stores or community clinics. They should report any suspected stolen medicines to health facility advisory committees and/or law enforcement, and participate or initiate community efforts aimed at monitoring public sector medicines and preventing theft.

Current Behavior: Many consumers use good quality medicine obtained through the formal regulated sector, but many others get medicine that is likely poor quality from private shops, markets or hawkers. They are unlikely to report poor quality or suspicious malaria medicines because they do not understand or fear the consequences of medicine theft, or because they do not want to go against the status quo. They may not know where or how to report suspected stolen or poor quality medicine, or may not feel they have a responsibility or ability to change things. They may not see how their buying practices influence the medicine market as a whole.

A culture of silence exists among this audience which prevents them from reporting pilferage. Some fear reprisals and lack faith in the law enforcement and correctional system. Many do not know where to report or whom to report to. Others benefit in some way from the status quo.

Obstacles/Constraints to Adopting the Desired Behavior:

- A culture of silence. Most people do not want to disturb the peace, and often the people who are involved in theft are relatives or friends.
- Institutionalized corruption covers its tracks, making it difficult to find evidence or prosecute. This creates an attitude of fatalism among the audience.
- A low risk perception around poor quality medicines and theft. The audience does not see how the problem affects them.
- The audience does not feel that public health facilities and the medicines they provide belong to them. They do not feel any responsibility for public sector medicines and medical supplies.
- Desire for inexpensive medicine in the face of stockouts, as well as the temptation to avoid travel and long wait times at hospitals that may be stocked out.
- Perceived or actual economic benefits from the status quo.
- Unaware that stolen medicines are likely to be degraded or substandard, and therefore less likely to treat malaria effectively.
- Lack awareness concerning where to report suspicious or stolen malaria medicines.

Communication Objectives: As a result of our SBCC intervention, consumers of malaria medicines will:

- Know that antimalarial medicines available in public health facilities are procured using public funds, are of good quality and are effective for malaria treatment.
- Treat malaria using ACTs obtained from government or CHAM facilities or community clinics, or purchased from licensed pharmacists or drug stores.
- Feel they have a responsibility to contribute to the prevention of pilferage of antimalarial medicines by supporting the formal market and reporting suspected medicine theft.
- Participate in community initiatives aimed at preventing and ending pilferage of antimalarial medicines.

Key Benefit Statement: Accessing antimalarial medicines from licensed sources and avoiding/reporting sources of suspected stolen medicines will improve the availability of good quality malaria medicines at low cost, ultimately protecting your health and the health of your family.

Supporting Points:

- Not all fevers are malaria. Get tested for malaria at a government or CHAM health facility or community clinic, and only take malaria medicine if you test positive.
- Good quality malaria medicine is available in Malawi through licensed pharmacies, drug stores, government and CHAM health facilities and community clinics.
- Malaria medicines provided by the government are only for prescription by government health facilities and community clinics, and are provided free of charge. If you find them anywhere else, they have been stolen.
- Stolen medicines sold in markets or by hawkers or shops are usually not stored correctly and lose their potency. They may not work to treat malaria effectively.
- Malaria medicine provided through the government belongs to the people of Malawi. It is meant to be provided free of charge. When malaria medicine is stolen, this results in stockouts and means you will need to travel to other health facilities or purchase malaria medicine from a licensed pharmacy or drug shop, when you should have gotten free treatment.
- You can help ensure good quality malaria medicines are available in your health facilities by reporting suspected stolen medicine to your health advisory committee or through the toll-free MAD Malaria/TIPS Hotline.
- Use case studies to show individuals and communities that have taken no action, leading to adverse results, and others that have acted together to stop medicine theft and had positive results:
    - Demonstrations
    - Personal testimonies
- Calls to action by influential people.

Message Content/Tone: Factual and empowering.

Media/Communication Channels:

- Mass media: radio (national and community) spots, reporting, drama series and talk shows
- Mass media: television talk shows, reporting and spots
- Print: Add messages to the Family Health Booklet; job aids for use during community meetings
- Mobile text message reminders
- Community dialogue meetings
- School health education programs

COMMUNICATION BRIEF

PRIMARY AUDIENCE 2: HEALTH PROVIDERS

Audience Description: This audience includes facility-based health workers, including doctors, nurses, lab technicians, pharmacists and health surveillance assistants (HSAs). While these providers work in a range of settings, most work in rural. They have at least a secondary school education and receive approximately $50 per month salary.

Desired Behavior: Members of this audience should safeguard commodities (including malaria medicines) from theft, misuse or damage; manage commodities in an accountable manner; and confront and report colleagues who steal or misuse medicines and commodities. They should also educate clients about the dangers of self-medication with medicines from hawkers and vendors.

Current Behavior: While many health workers are honest, some steal and sell antimalarial medicines to other channels, like hawkers or private hospitals. Even those who are not involved in theft do not report or denounce malpractice/pilferage, contributing to a culture of silence. Many are not accountable, may not follow treatment guidelines or keep up-to-date and accurate records.

Additionally, some have an unfriendly attitude toward clients, which influences the way people view the quality of their health care and their willingness to overcome barriers to utilize government health services. Most do not educate clients about how to protect themselves from poor quality malaria medicines and the benefits of using good quality medicines.

Key Obstacles/Constraints to Adopting the Desired Behavior:

- Some health workers are dishonest or have poor ethics. They feel they have rights that are not being fulfilled through the system, and do not feel a duty to protect commodities or supplies.
- If they are not involved in theft, they do not see any point in denouncing those who are, asking, "What good will it do if I report/denounce?"
- Cost of living is high, and health workers' salaries are low.
- Punishments for medicine theft are too weak to deter offenders or to encourage others to denounce them.
- Supply and demand imbalances between the regions lead to an over stock of medicines in one region while there is a shortage and market for them in others.

Communication Objective: As a result of our SBCC intervention, public-sector health workers will feel responsible to take action to prevent and stop (report/denounce) the pilferage of malaria medicines.

Key Benefit Statement: Stopping, preventing, reporting and denouncing the pilferage of malaria medicines will give you the satisfaction of having enough medicine to treat clients effectively, improving the health of the community. Rather than the shame of being implicated in medicine theft, you will be recognized and appreciated by the community you serve.

Supporting Points:

- Pilferage of malaria medicines leads to the death of innocent people from treatment failure. Stolen medicines are usually not stored appropriately and degrade. This substandard medicine may not effectively treat malaria.
- Health workers are heroes by virtue of their profession – they serve and save lives. Be noble by preventing and stopping pilferage.
- Protecting stocks of malaria medicines from theft will prevent stockouts. Facilities with adequate malaria medicine stocks are better able to serve their communities, which improves their reputations and makes it easier for health workers to do their job.
- Those who are not involved in diverting medicine avoid jail, as well as the public shame and loss of respect that comes with being seen as a corrupt health worker.
- There are confidential ways to report suspected stolen medicine. As health workers are closest to the situation, they can make a big impact by denouncing and reporting diversion.
- Share testimonies and stories of health workers who are involved in malaria medicine theft and are caught, as well as testimonies and stories of health workers whose identity is protected and who benefit from denouncing and reporting other health workers involved in theft.

Message Content/Tone: Factual and empowering.

Media Communication/Channels:

- Mass media: radio program and spots (national and community)
- Mass media: television programs and spots
- Drama (graphic and realistic)
- Print: posters and stickers
- Meetings with health workers

COMMUNICATION BRIEF

SECONDARY AUDIENCE: TRADITIONAL AND COMMUNITY LEADERS

Audience Description: This audience includes leaders, both male and female, living primarily in rural areas. This audience varies depending on the community, but includes the people who are influential and respected in their communities (e.g., elders, faith-based leaders, etc.). Some of their community members are using good quality medicine from the formal regulated sector, but others may buy medicine from open markets or hawkers. They may also buy medicine without first getting tested for malaria, or take partial doses of medicine they have been saving from previous prescriptions.

Desired Behavior: This audience should encourage their subjects/constituents to visit health facilities for testing and treatment of fevers, discourage self-medication for malaria and mobilize their communities to be vigilant in monitoring and safeguarding medicines at both community and facility levels.

Current Behavior: They currently provide guidance about the well-being of the community, but may not see malaria medicine pilferage and reporting as a priority or something they can influence. By not speaking up about stolen medicine use and reporting, they contribute to the culture of silence.

Key Obstacles/Constraints to Adopting the Desired Behavior: While these leaders may know about the health/wellness issues in their community, as well as issues of corruption, they may not know how to report suspected medicine theft, or understand how malaria medicine theft negatively impacts the health of their followers. Some leaders accept bribes and most want to please political leaders who may be involved in medicine theft.

Communication Objectives: As a result of our communication, traditional and community leaders will:

- Know antimalarial medicines available in public health facilities are procured using public funds, and that when medicines are diverted the community's ability to effectively treat malaria is undermined.
- Feel responsible for mobilizing their communities to provide checks and balances and report medicine pilferage.

Key Benefit Statement: Promoting a culture of accountability, as well as stopping, reporting and denouncing instances of medicines pilferage, improves the availability of quality malaria medicines in your community, resulting in more effective treatment of malaria, and therefore healthier lives. Leaders who speak out are respected and recognized.

Supporting Points:

- Encourage community members to treat confirmed malaria with medicine from licensed pharmacies, health facilities and drug stores, and to report any suspected stolen malaria medicines.
- Spearhead local community efforts aimed at breaking the culture of silence by monitoring medicines supplied to government health facilities, and reporting theft to health facility advisory committees, national hotlines or law enforcement. Promote accountability and develop reporting mechanisms that make sense within their community.
- Formulate/endorse by-laws that restrain subjects and/or health workers from medicine theft.

- Pilferage weakens the effectiveness of malaria medicine – you cannot guarantee stolen malaria medicine has enough of the active ingredient needed to treat malaria.
- Malaria medicines are purchased for government health facilities with public funds and they belong to the people of Malawi, so communities need to protect them from pilferage.
- Holding community members accountable by reporting pilferage and developing other mechanisms for checks and balances are ways to protect communities from the effects of malaria medicine pilferage.
- By not addressing the subject, and sometimes actively contributing by taking bribes, leaders put themselves and their family members at risk for serious health problems, and are personally contributing to creating and sustaining a culture of silence and a market for diversion.
- If caught accepting bribes or contributing to the problem, leaders will be seen as immoral and lose respect in their community.
- Describe how to report suspected stolen medicines using the MAD Malaria/TIPS Hotline.
- Share examples of community practices that successfully protect malaria medicine from pilferage.
- Demonstrate the advantages to leaders and communities of actively protecting malaria medicine supplies and use at their health facilities.

Message Content/Tone: Factual and empowering.

Media/Communication Channels:

- Mass media: radio (national and community)
- Print: leaflets/flyers, job aids and illustrated stories for use during meetings
- Meetings with Area Development Committees
- Community advocacy meetings
- Orientations for leaders

APPENDIX E: REVIEW GROUPS

Landscape Review Team:
The landscape will be send to all participants, but will be specifically reviewed by:

- Shadreck Mulenga
- Richard Chola
- Taonga Mafuleka
- Chancy Mauluka
- Wilford Mathiya
- Innocent Kommwa
- Edson Dembo
- John Zoya

Campaign Plan Review Team:
The campaign plan will be send to all workshop participants in the first round, but then will be specifically reviewed by:

1. SBCC Working Group and HC4L
2. SBCC Working and HC4L
3. Innocent Kommwa, Shadreck Mulenga and Taonga Mafuluka
4. Final approval by the Director of Preventative Medicine

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