



# MALAWIAN CASE STUDY

Promoting Quality Malaria Medicines through SBCC

September 2017



U.S. President's Malaria Initiative





*A pharmacist examines available medicines in Malawi. © 2013 SC4CCM/JSI, Courtesy of Photoshare.*

## INTRODUCTION

The continued availability and use of substandard, spurious, falsely-labeled, falsified and counterfeit (SSFFC) medicines impedes global efforts to control and eradicate malaria, as such medicines do not include enough active ingredient to treat the disease. Not only do SSFFC antimalarials result in treatment failure and death, but they also waste health resources, create distrust in the health care system and contribute to growing levels of artemisinin resistance. Antimalarial medicines constitute the bulk of SSFFC medicines—53 percent of all substandard and 93 percent of all falsified medicines (Hajjou, et al., 2015). It is estimated that SSFFC antimalarials were associated with 122,350 deaths in children under five years old among 39 sub-Saharan African countries (Renschler, et al., 2015).

Poor quality medicine tends to fall into three categories (Kaur, et al., 2016):

- **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; it may carry false reputation of its source or identity.
- **Degraded:** Medicine that does not contain enough active ingredient due to poor conditions, such as storage environments, handling or transportation (light, heat, humidity, etc.), weakening the original quantity. Stolen or diverted medicine is at risk of becoming degraded.

In response, the Health Communication Capacity Collaborative (HC3) partnered with the U.S. President's Malaria Initiative to create a global initiative focused on using social and behavior change communication (SBCC) to address the dangers posed by SSFFC antimalarial medicines and promote positive behaviors that will protect the public. As part of this initiative, HC3 developed an online **Promoting Quality Malaria Medicines through SBCC Implementation Kit** (I-Kit) to provide guidance to local stakeholders and program managers who are interested in designing and implementing targeted SBCC campaigns to respond to their specific SSFFC malaria medicine issue.

When this initiative began in 2015, HC3 conducted a literature review to learn how global and national programs had used SBCC to combat SSFFC malaria medicines. The review found very few examples of evidence-based, strategically produced and evaluated SBCC activities upon which to base guidance. To fill this gap, HC3 designed, implemented and evaluated an SBCC campaign targeting malaria medicine consumers, informal medicine vendors and key decision-makers in Akwa Ibom State, Nigeria. It incorporated learnings from this experience into the I-Kit.

Next, HC3 wanted to test the relevance and adaptability of its guidance in a different country, whose medicine situation differed from Nigeria's. HC3 decided to partner with national representatives in Malawi to respond to their quality medicine issue.

### **BACKGROUND: HC3's WORK IN MALAWI**

Over the past five years, Malawi has identified several issues with the quality and availability of malaria medicine in the country and has been actively working to address them through a number of system strengthening activities. However, little has been done to raise consumer awareness. In 2016, PMI Malawi invited HC3 to assist the Ministry of Health (MOH) in developing a communication campaign plan to promote positive attitudes and practices, and reduce consumers' risk. HC3 saw this as an opportunity to test the flexibility and adaptability of the processes and tools that were developed for Akwa Ibom and shared in the I-Kit, as the context in Malawi is quite different than that in Nigeria. Although all three kinds of poor quality medicines can be found in both countries, Nigeria's poor quality antimalarial issue is centered on substandard medicine, and Malawi's primary issue, by contrast, is degraded medicine, due to diversion.

This case study documents HC3's process and lessons learned from its work in Malawi. HC3 followed the strategic **SBCC P Process™** to design the campaign plan. The P Process entails five steps that guide communicators through a participatory, research and theory-based approach for carrying out impactful SBCC programs:

- **Step 1:** Inquire
- **Step 2:** Design the Strategy
- **Step 3:** Create and Test
- **Step 4:** Mobilize and Monitor
- **Step 5:** Evaluate and Evolve

Unlike the demonstration project in Akwa Ibom, Nigeria (See [Akwa Ibom Case Study](#) for more information), HC3 did not have a field office nor ongoing malaria SBCC activities in Malawi. As such, its involvement was limited to providing technical assistance for the campaign plan. It was decided that the new SBCC implementing partner, Health Communication for Development (HC4D), would adopt the plan once its baseline data was collected and activities had begun.

For this project, HC3 conducted the following activities::

1. Desk Review
2. Landscaping Exercise
3. Campaign Planning Stakeholder Meeting
4. Campaign Plan Development

At the time of this project, there was a transition between SBCC implementing partners, which created challenges to moving forward with the strategy. To overcome these challenges, all relevant stakeholders were involved in the campaign planning process, including: Support for Service Delivery Integration-Communication/Johns Hopkins Center for Communication Programs Malawi (incumbent), HC4D (new implementing partner), the National Malaria Control Program (NMCP, government agency) and PMI Malawi (donor). PMI Malawi has also been working with the Make a Difference (MAD) Malaria campaign.

## INQUIRE: UNDERSTANDING THE MALARIA MEDICINE SITUATION

In order to gain a better understanding of the malaria medicine environment in Malawi, HC3 created a situation analysis document based on the results of two activities: 1) a desk review of available literature, and 2) a two-week, in-country landscaping exercise. An extensive summary of these findings can be found below, as well as in the [Situation Analysis of Antimalarial Medicine in Malawi](#).

Originally, the desk review was meant as formative research to understand the malaria medicine situation in Malawi, and the in-person landscaping exercise was meant to confirm the findings of the review and fill in the knowledge gaps. This approach was based on HC3's experience in Nigeria, where there was plenty of literature on the topic of SSFFC medicines. However, due to the sensitive nature of medicine theft and the limited amount of publicly available literature, HC3 had to rely on in-person conversations for much of the information and materials. Given this challenge, the situation analysis document was an iterative one that was updated as key informants provided information or recommended additional resources.

For the desk review, the HC3 team searched online databases to find peer-reviewed and gray literature (malaria operational plans, program reports and evaluations, SBCC materials, etc.). Relevant personnel or organizations that appeared in the literature were then flagged for an in-person interview. The current national SBCC implementing partner also made recommendations and helped to schedule interviews. The HC3 team asked each of the key informants for program documents and recommendations for additional contacts both before and during the interview. (See [Situation Analysis](#) for the list of organizations interviewed for this project.)

When conducting key informant interviews, the HC3 team used the sample questions and general guidance found in the I-Kit, especially the ["Conduct a Situation Analysis and Identify Potential Partnerships"](#) and ["Learn about the Media Landscape"](#) sections. Key informant interviews began with broad questions, such as, "Where do people in Malawi get their antimalarials?" or "Tell me about how hospitals get their medicine?" Based on their answers and area of expertise, the team would then ask more focused questions. A point was made to build rapport before bringing up the topic of medicine theft, given the sensitive and illicit nature of the topic. At the end of every interview, HC3 would ask for suggestions about how to improve antimalarial medicine diversion. HC3 drafted summaries of the interviews into an internal trip report highlighting key insights and recommendations.

During both the desk review and in-person interviews, HC3 paid close attention to information about the quality of malaria medicine available in Malawi; the scope and source of diversion; consumer attitudes and behaviors; and successes and challenges within the supply chain, regulatory, medicine dispensing and criminal justice systems. The team also noted any areas of opportunity for SBCC programs, including potential partners, audiences and calls to action (e.g., ways for consumers to identify or report poor quality or stolen medicine, systems for health workers to prevent leakage from within, etc.).

Both the desk review and key informant interviews yielded four valuable insights that were incorporated into what would eventually become the Promoting Quality Malaria Medicines Campaign Plan.

### **1. Many consumers are getting their medicine from low-risk regulated sources, but poor quality malaria medicine remains a problem**

Most people in Malawi get treated for malaria in government health facilities, where artemether/lumefantrine (or LA) is free of charge and considered to be of good quality. However, it is common for people to self-treat from the informal, unregulated market. In addition, many people also do not finish the full dose of medicine, saving doses for another time or person.

Since there are no LA manufacturers in Malawi, the majority of medicine is donated and imported. There are pharmacies and drug shops, but these are mostly used by people who live in urban environments and have disposable incomes. Only licensed pharmacists and health workers may legally sell LA.

## **2. Malaria medicine in Malawi is prone to quality issues due to theft from the public sector to the private sector**

Although Malawi has identified some cases of substandard and falsified medicine, the most pressing issue affecting medicine quality is drug pilferage – in particular, the diversion of medicines meant for the public sector to the informal and private sector (e.g., private hospitals, public markets, privately owned pharmacies, small shops or outside of the country). This theft not only weakens the supply chain, but also the effectiveness of the medicine, as the conditions under which diverted medicine is stored (heat, humidity, dampness, etc.) put it at risk for deterioration. Malawi has put several controls in place to assess the quality of antimalarials in its supply chain, many of which are run by the Pharmacy, Medicines and Poisons Board (PMPB). However, the PMPB has limited funding, staff and equipment and, at the time, had not been able to conduct border inspections in the previous six months.

## **3. Despite strong political will, progress is challenged by the internal nature of the crime**

In 2014, the Malawian government, with support from its development partners, stepped up efforts to address medicine diversion in the country. The government launched several initiatives to strengthen the supply chain, as well as a hotline to report suspect medicine. It began labeling malaria medicine boxes as “Government of Malawi” to identify batches. It also formed a Drug Theft Investigation Unit to investigate theft from the individual to global levels. In addition, the current version of the [Malaria Communication Strategy](#), includes messages about medicine theft. USAID, PMI and the Global Fund to Fight AIDS, Tuberculosis and Malaria have also been working on this issue for several years now.

## **4. Neither social norms nor potential legal ramifications deter theft**

There are several domestic and international issues that influence the presence of theft. The government of Malawi has paid the most attention to strengthening the public sector, leaving the private sector largely unregulated. The country’s borders are not tightly controlled, putting residents of the surrounding districts at a higher risk for buying poor quality medicines. Additionally, weak laws and law enforcement are not strong enough to deter theft, even after a person is caught.

Social norms around the issue are also a barrier to progress, as petty corruption is normalized by every day acts like officials asking for free samples of medicine during health facility visits. Key informants felt that drug theft was seen as something everyone was doing or something that didn’t hurt anyone. They also felt that health workers who steal medicine may rationalize their actions as a “perk” or something that justified the means. It was suggested that community members do not report theft because of ignorance, a lack of ownership and a pervasive culture of silence. However, despite these barriers, key informants mentioned wanting to find ways of improving community and social accountability about reporting theft.

## **DESIGNING A CAMPAIGN PLAN**

### ***Campaign Planning Stakeholder Workshop***

After drafting a situation analysis, HC3 supported the NMCP in organizing a two-day campaign planning workshop on November 16 and 17, 2016. The meeting was designed to review and confirm the malaria medicine situation in Malawi and guide malaria stakeholders in designing a campaign plan that protected the public from the risks caused by diverted medicine and promoted the use of good quality malaria medicine.

The workshop was attended by 26 participants who represented an array of key stakeholders, including representatives from the following organizations, many of which had been interviewed during the in-country landscaping exercise (See the [Meeting Report](#) for a complete list):

1. NMCP
2. Support for Service Delivery Integration – Communication
3. PMI (USAID)
4. SSDI Systems
5. Population Services International

6. PMPB
7. MOH Health Education Services
8. Global Fund
9. SSDI Services
10. Galaxy Media
11. Malawi Broadcasting Corporation
12. Global Health Supply Chain – Procurement and Supply Management Project
13. Family Health International 360
14. Malaria Care
15. MOH Drug Theft Investigation Unit
16. Zodiack Broadcasting Station
17. Pharmaceutical Society of Malawi

During the workshop, participants sought to provide everyone with a similar understanding of the malaria medicine situation in Malawi. Participants were given the opportunity to ask questions or comment after each presentation. This format was designed so that national stakeholders were painting the picture, rather than HC3. This approach was especially important given the political nature of this topic.

The two-day workshop was organized into three sections: 1) Understanding and analyzing the malaria medicine situation; 2) Identifying and analyzing priority audiences; and 3) Developing communication plans for each audience. The HC3 team used the **“Step 2: Design a Communication Strategy and Build Partnerships”** section of the I-Kit to create the agenda for the workshop. It used the sample design workshop agenda from Nigeria and the How-to Guide on conducting a stakeholder workshop to determine the agenda for the meeting.

### **1. Understanding and Analyzing the Malaria Medicine Situation**

NMCP invited key informants to make presentations on various aspects of the situation. Participants presented on:

- National Malaria Communication Strategy
- National Malaria Case Management Strategy
- ACT procurement and distribution systems (government hospitals and health centers, private sector pharmacies/clinics and village clinics)
- Medicine quality assurance and regulation in Malawi
- Prescribing and dispensing practices in the public and private sectors
- Leakage from the public sector
- Consumer and client treatment-seeking practices
- Public engagement and awareness activities

After the presentations, HC3 used the guidance from the I-Kit to lead small groups through creating a problem tree, an exercise that helps to identify the core problem, direct and indirect causes, and effects. A report on the root cause analysis can be found in the **Meeting Report**.

**Problem Statement: Medicine is being diverted from the regulated public sector into the private sector, putting it at risk for quality issues.**

## 2. Identifying and analyzing priority audiences

Once the groups were in agreement, they worked together with stakeholders to identify the campaign's target audiences, based on those populations that were most affected by the problem or could do the most to influence it (i.e., primary audiences), as well as those who could influence the primary audiences (i.e., secondary audience). The stakeholders identified two primary audiences and one secondary audience for their plan.

- **Primary Audience 1:** Malaria clients/consumers who buy anti-malarial medicines
- **Primary Audience 2:** Health providers who treat patients with fever and malaria
- **Secondary Audience 1:** Traditional and community leaders

Drawing on the situation analysis presented during the meeting, participants worked in small teams to describe each audience and define the practices/behaviors they should adopt to reduce the presence and risk of SSFFC malaria medicines. Factors that constrain or support adoption of those practices were also identified.

## 3. Developing communication objectives for each audience

Based on the analyses, participants agreed on specific objectives for communication with each audience, supporting arguments and messages, and suggested communication channels. The meeting ended with each group presenting its assessment and proposed SBCC approach. Participants also generated a list of potential partners and agreed on next steps and a timeline.

Following the stakeholder meeting, HC3 updated the situation analysis and drafted the workshop report. These materials were shared with participants in order to synthesize and reinforce the information presented at the stakeholder meeting. All participants, especially those who volunteered to be a part of the review team, were given the opportunity to comment.

## CAMPAIGN PLANNING DOCUMENT DEVELOPMENT

HC3 reviewed the three audience assessments and created a comprehensive campaign plan. The campaign plan was sent to the MOH and USAID/PMI for them to disseminate for further review. The plan will be adapted after C4H's baseline data are analyzed and their scope of work is finalized.

Much like the communication strategy that was developed to promote quality malaria medicine in Akwa Ibom, Nigeria, the [campaign plan](#) for Malawi was designed to raise awareness about the dangers of poor quality malaria medicines/availability of good quality medicines and promote rational drug use. It also capitalized on existing mechanisms, such as the MAD Malaria Campaign/TIPS Hotline.

However, the Malawian campaign plan also sought to inspire audiences to view medicine diversion as something greater than petty theft and encourage them to break the culture of silence. It was designed to motivate consumers to report stolen medicine, as well as participate in community efforts aimed at monitoring public-sector medicines and preventing theft. After hearing campaign messages, health providers would feel that they have a role to play in protecting their community by preventing, reporting and denouncing pilferage. Traditional leaders would also know that diversion weakens their community's ability to effectively treat malaria and would take action to improve accountability.

## LESSONS LEARNED AND CONSIDERATIONS

Walking through this process in Malawi revealed five lessons:

- **Remember pilferage is political.** Because this topic was very sensitive, with varying understandings about the scope and cause of the problem, it was useful to have external consultants conduct the situation analysis to provide an objective viewpoint. Findings of the situational analysis should be presented in consultation with the national stakeholders, to help confirm or correct assumptions.

- **Meet your various audiences where they are.** During the in-country landscaping exercise, the team visited a health facility and spoke with community members, which they had not done for the Akwa Ibom demonstration project. Talking directly to the communities affected by this issue, and receiving a guided tour of a facility helped the team better understand the impact and consequences of medicine theft, and some of the underlying reasons for it.
- **The campaign process should be highly participatory.** As external consultants, HC3 conducted the situation analysis and facilitated the campaign planning stakeholder meeting based on its experiences in Nigeria. The team also worked with the NMCP, who invited stakeholders to present the background information about the malaria medicines quality issue in Malawi. As such, the campaign plan was largely designed by national stakeholders who intimately understood the culture and systems in which the problem was taking place. Even when HC3 presented its situation analysis, the emphasis was placed on having local stakeholders validate their findings, rather than dictating the results in a top-down manner.
- **Local tools can be adaptable.** HC3 referred to the guidance provided in the I-Kit and the lessons learned from the Akwa Ibom campaign design process. Despite the differences between the Nigerian and Malawian medicine situations, the team found the tools and experiences very useful. The guidance provided in the I-Kit was relevant and adaptable, and could be used in a number of settings.
- **Funding determines outcomes.** Unfortunately, funding to implement the campaign plan was not immediately available. So, although the campaign plan is final, it has not yet been implemented.

**The materials and results of the Malawi Campaign Plan development process have been invaluable in informing and verifying the I-Kit on Promoting Quality Malaria Medicines, as well as in building the evidence base for SBCC's ability to address this topic.**



This publication was made possible by the support of the American People through the United States Agency for International Development (USAID). The Health Communication Capacity Collaborative (HC3) – based at the Johns Hopkins Center for Communication Programs (CCP) – is supported by USAID's Office of Population and Reproductive Health, Bureau for Global Health, under Cooperative Agreement #AID-OAA-A-12-00058. Unless otherwise noted, all photos are courtesy of Photoshare.

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