



Implementing seasonal malaria chemoprevention in an urban setting

Lessons learnt from Burkina Faso

Key learning

- Informing an urban population of the benefits of seasonal malaria chemoprevention requires the use of additional communication channels, such as radio stations and social media platforms.
- Urban lifestyles and the complexity of urban contexts necessitate the recruitment and training of a higher number of community distributors compared to rural settings, as door-to-door delivery of seasonal malaria chemoprevention is slower in the city.
- Recruiting community distributors who are familiar with and trusted by the communities they serve is more challenging in urban areas, yet it is key to securing caregivers' approval to administer drugs, maintaining distributors' motivation and ensuring distributors do not miss households.

Background

In the Sahel, seasonal malaria chemoprevention (SMC) is a highly effective intervention for preventing malaria infection during the rainy season — the peak transmission period — among those most at risk: children under five.

SMC is primarily delivered door-to-door by community distributors, who work in pairs to administer four monthly therapeutic courses of antimalarial drugs sulfadoxine-pyrimethamine and amodiaquine (SP+AQ) to eligible children. Distributors are volunteers, but receive a *per diem* for every day they work on the campaign.

The World Health Organization (WHO) recognises SMC as a safe, cost-effective and feasible intervention that can prevent up to 75 percent of all malaria episodes in under-fives when used alongside other interventions, such as indoor residual spraying and insecticide-treated nets.^[1] WHO estimates that SMC saves the life of one in every 1,000 children treated.^[2]

Malaria Consortium has been a leading implementer of SMC since 2013, starting with an implementation pilot in Nigeria. We then led the rapid scale-up of SMC through the ACCESS-SMC project in 2015–2017, reaching seven million children in Burkina Faso, Chad, Guinea, Mali, Niger, Nigeria and The Gambia.^[3] Since 2018, Malaria Consortium has continued to implement SMC in Burkina Faso, Chad and Nigeria. In 2019, we reached six million children, 1.3 million of whom were in Burkina Faso.^[4]

Activities

In Burkina Faso, Malaria Consortium's SMC programme works with government and implementing partners to plan SMC campaigns, select and train community distributors, facilitate supervision, increase community engagement, procure and distribute SP+AQ, and provide technical advice on SMC implementation at regional and national levels. In 2019, our SMC programme took place in both rural and urban settings, as part of the country's policy of achieving nationwide coverage with SMC distributed in all 70 districts. Burkina Faso's capital, Ouagadougou, was also covered for the first time.

Lessons learnt

During implementation, socio-economic differences between urban and rural settings, and rapid urbanisation in Ouagadougou impacted campaign delivery more significantly than anticipated, necessitating strategic adaptations. Below are some of the key lessons learnt.

- Delivering SMC via a door-to-door approach was slow. Not only were many children found to be in the care of paid staff who lacked the authority to consent to SMC on their behalf, but they were also more dispersed; urban households tended to have fewer children and were more isolated socially than their rural counterparts meaning that children had to be treated one by

one rather than collectively. This difference in lifestyle required frequent repeat visits to the same urban households to reach every eligible child and the recruitment of additional community distributors. We also set up fixed treatment sites in health centres and markets in Ouagadougou to provide an alternative way for people to access SMC. However, these sites were underused as people were unaware of their existence or did not have time to visit.

- The use of town criers to communicate key information about the campaigns — including the benefits of and where and when to receive SMC — was less effective as urban families rely less on word of mouth information sharing than rural communities. Communication plans were, therefore, modified to include radio broadcasts, social media, banners and posters ahead of the second campaign. To mitigate caregivers' negative feedback about the campaign on social media due to consent issues, the Ministry of Health enhanced its communications, including through media interviews, to explain better the importance of consent.
- Due to Ouagadougou's rapid urbanisation, population estimates were inaccurate and the number of children eligible for treatment was underestimated. This was despite data from recent (June 2019) long lasting insecticidal net and vitamin A distributions having been used during campaign planning. Ahead of the second monthly treatment cycle, we therefore recruited additional community distributors and increased the stock of drugs.
- Densely populated cities like Ouagadougou — with large catchment areas — require a high number of community distributors. This was not sufficiently planned for when allocating trainers and supervisors. With training conducted only a few days in advance of the start of the campaign, heads of health facilities did not have enough time to train such high numbers of distributors in combination with their usual activities. As a result, training sessions included up to 100 community distributors, and were shorter and less interactive than intended. This may have negatively impacted distributors' performance, although more quality evaluations are required to fully assess this.
- Community distributors in Ouagadougou were often less familiar with the neighbourhoods they served than their peers in rural settings. Simply being from the neighbourhood did not mean they knew the details of each household composition. This increased the risk of them missing certain households, losing motivation and dropping out. Caregivers in Ouagadougou were also less likely to know the community distributor personally and were, therefore, less trusting and accepting of the intervention, sometimes refusing entry to community distributors. In addition, less communal knowledge about families led to safeguarding concerns.



Town crier spreading information about SMC, Burkina Faso

Recommendations

Based on our experience administering SMC in Ouagadougou, we recommend that implementers in urban areas:

- recruit more community distributors as the ratio of distributors to target population needs to be higher in urban areas, and adapt distribution approaches to local contexts, including assessing the feasibility of setting up fixed distribution sites and evaluating where these are more likely to be used
- adopt clearer and more targeted campaign messaging, and budget for radio, television and social media costs to ensure that distribution dates are known well in advance, parents authorise paid caregivers to consent to treatment and caregivers are aware of the locations of fixed sites
- formalise the process of gaining informed consent to ensure it can be properly obtained
- explore alternative approaches when estimating target populations and mapping individual neighbourhoods — including spatial intelligence tools based on satellite imagery — to ensure that uneven population growth across the city is considered in campaign planning and the recruitment of distributors
- increase flexibility around drug procurement and stock management in areas where population changes are known to occur rapidly and often informally
- keep the number of trainees per training session low and share training schedules with supervisors and distributors several months in advance
- hold training sessions a few days prior to the start of SMC implementation — so the knowledge is retained — and on different dates in different districts to allow for more sessions to be supervised and supported by heads of health facilities
- include a vetting process when recruiting community distributors to guarantee that each pair consists of at least one community member with adequate knowledge of the households in the area
- maintain community distributors' motivation — and reduce the risk of drop-outs or poor adherence to guidelines — by ensuring adequate training, supervision and prompt payment of *per diems*.

References

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Cover image: Children in Burkina Faso benefitting from SMC

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