

**Summary from the Technical Workshop on Cross-Border
IEC/Behaviour Change Communication Strategies to Contain
Artemisinin Resistant Malaria**

In the context of

**Bill & Melinda Gates supported project: “A Strategy for the
Containment of Artemisinin resistant Malaria Parasites in
Southeast Asia”**



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Background and Introduction

There is evidence for the emergence of artemisinin resistance along the Cambodia-Thailand border area. In recognition of this worrying situation as a global emergency, the World Health Organization (WHO) and partners have begun to take steps to confirm and characterize artemisinin resistance, to define optimal strategies and support the preparation of plans of action in Cambodia and Thailand, and to contain the spread of artemisinin tolerant parasites. This initiative is funded by the Bill and Melinda Gates Foundation (BMGF) and initially runs for a period of two years, 2009 – 2010.

It is acknowledged that containment of resistance will require a joint, harmonized cross-border strategy, particularly with regards to Behaviour Change Communication which is one of the objectives of the containment strategy and is key towards the success of this project. As the containment of artemisinin resistance is a regional and global public health concern, it will be beneficial to share experiences and lessons learned from various governmental and non-governmental organizations, local authorities, and other countries. The Malaria Consortium (MC), one of the partners in this WHO-led strategy to contain artemisinin resistant parasites along the Thai-Cambodian border, will organize a series of technical meetings in 2009 to support the monitoring and evaluation of the Project.

The overall objective of this workshop is to harmonize the cross-border BCC/IEC strategies to contain artemisinin resistant malaria in the 7 border provinces of Thailand and 10 provinces of Cambodia.

Specific objectives of the workshop

- To exchange information about current IEC/Behavior Change Communication strategies and activities of national programmes in the context of the Containment Project;
- To harmonize cross-border IEC/Behavior Change Communication strategies and key messages for target populations;
- To foster and share innovative IEC/Behavior Change Communication strategies, activities, and materials for targeted populations;
- To ensure adequate M&E of IEC/Behavior Change Communication strategies are in place and properly monitored and evaluated.

The agenda and list of participants are included as annexes 1 and 2, respectively.

The presentations were distributed to participants and are available on CD ROM by request.

Opening Remarks and Welcome

Dr. Ly Tung, Deputy Director, Provincial Health Department, Siem Reap Province

Dr. Duong Socheat, CNM and Ms. Saowanit Vijaykadga, BVBD

Dr Ly Teung, Deputy Director of the Province Health Department of Siem Reap Province, welcomed all the participants. The Government of Cambodia has made great efforts to fight malaria in rural areas focusing on those who live in the borders and in the mountainous area. This shows our commitment to malaria control. This workshop will develop new strategies and raise awareness to get effective treatment and prevention for this disease especially in the border areas.

Dr Socheat also welcomed the participants. He said that we are here to discuss an IEC/BCC strategy which is an important task in the containment project to fight artemisinin resistant parasites. We have been working with Thailand for a long time. On this particular project we have been working for nearly a year. We have had some delays but we need to ensure that containment of artemisinin resistant malaria is a success and doesn't spread to other areas in Cambodia. Funded by the Bill and Melinda Gates Foundation, we are all working very hard towards this.

In the next 3 days we will have discussions to identify key issues needed to implement BCC/IEC to ensure that the people on the border are aware of the national programmes' efforts. We only have 2 years in which to do a lot of work and we have to ensure that we need to fight the spread of the disease. Given the scope of this project are we going to be successful? The short 2 years makes this only a pilot project and we will conduct a final evaluation to identify more issues to help us to deal with this project more successfully. If we don't contain these parasites then all malaria work will be useless. As 2 years is short, I would like us to consider and think together to make sure that this disease does not spread further. If there is no more project money then our work on the borders will not be worthwhile and I appeal to donors to provide further support to contain resistant malaria.

Ms Vijaykadga said that on the Thai side it is important to set up meetings between Thailand and Cambodia and also Thailand and Myanmar. It is important to meet together in official capacity and also include China, Lao PDR, Vietnam and Myanmar.

Now we have this special project between Thai and Cambodia and it is terrific that we have the opportunity to work together. It is important for all the people in both countries to understand the work and everyone who is conducting the work also has the opportunity to benefit from this support. We need to foresee what the next job is and also to help the people. We would like to thank the donors.

Containment Project Overview

Dr. Najibullah Habib, Containment Project Manager, WHO

Goal of the Containment Project

The Containment of Artemisinin resistant *Plasmodium falciparum* parasites by removing selection pressure and reducing and ultimately eliminating Falciparum malaria.

Main points

Dr Habib said that Objective 2 of this workshop is extremely important and required if we are to have an impact. All the objectives of the Containment Project are pertinent to IEC/BCC. Dr Habib reminded the participants of the key objectives of the Containment Project:

1. To eliminate resistant parasites by detecting all malaria cases in target areas and ensuring effective treatment and gametocyte clearance
2. To decrease drug pressure for selection of artemisinin resistant malaria parasites
3. To prevent transmission of resistant parasites by mosquito control and personal protection
4. To limit the spread of resistant parasites by mobile/migrant populations
5. To support containment/elimination of resistant parasites through behaviour change communication, community mobilization and advocacy
6. To undertake basic and operational research to fill knowledge gaps and ensure evidence-based strategies
7. To provide effective management and coordination for rapid and high quality implementation



The Containment Project is taking place in Zone 1 (8 administrative districts (ADs) in five operational districts (ODs) in four provinces in Cambodia and 3 districts in two provinces in Thailand) where there is evidence already of artemisinin resistant *Plasmodium falciparum*

and Zone 2 (7 provinces in Thailand and 10 provinces in Cambodia) where there is no evidence yet, but the risk is high due to their proximity to Zone 1.

The project is a collaborative effort of agencies with the range of key skills and capacity to mount the necessary response led by the WHO at global, inter-regional, regional, and country level. Managed by both WHO SEARO (Thailand) and WPRO (Cambodia), the project management team is based in Cambodia but with strong liaison with the Bureau of Vector Borne Disease (BVBD) in Thailand and Center for Malariology, Parasitology, and Entomology (CNM) in Cambodia. The project has several partners including the Malaria Consortium for overall monitoring and evaluation (M&E) and technical input, Institute Pasteur Cambodia (IPC), Mahidol-Oxford Research Unit (MORU), and the Center of Excellence for Biomedical and Public Health Informatics (BIOPHICS). Furthermore, there are two national (Thailand and Cambodia) and one international task force committees to provide technical advice and oversight for the project.

The strategy for the containment of artemisinin tolerant malaria parasites is a 2 year bi-country project working with many partners. We are now fully staffed and need to move on to something concrete. Dr Habib stressed that we need to help national programmes and strengthen their capacity.

Objectives of the Meeting

Dr David Sintasath, Regional Epidemiologist, Malaria Consortium

This is the third of four meetings to be organized by the Malaria Consortium. In the first meeting in February, Monitoring and & Evaluation indicators were developed and in the second meeting in June, a strategic framework to access mobile and migrant populations was outlined.

The main aim of the workshop is to develop a cross-border strategy for BCC and IEC in order to deliver effective prevention and treatment of malaria and to stop the spread of resistant parasites outside the area of the containment project. To this end, it is anticipated that a basis for a clear plan of action will be developed from this workshop.

Both countries have strong IEC/BCC units and they are moving forward with their activities. However, a shared BCC/ IEC strategy to contain the spread of artemisinin resistant malaria parasites between the two countries is critical to the Containment Strategy, as conflicting messages will hinder the efforts of the project.

Dr Sintasath outlined Malaria Consortium's responsibilities in the containment project.

- Monitoring and Evaluation: Malaria Consortium have developed an indicators framework and will be working with country programmes to conduct household, drug outlet, and facility surveys in zones 1 and 2
- Technical advisory support as members of national and international task forces
- Human Resource support: Malaria Consortium has completed recruitment for key staff including epidemiologist, data manager, field officer and communications specialist.

- Operational research support including the qualitative assessment of Mass Screening And Treatment (MSAT) and situational analysis on migrant and mobile populations
- Dissemination of information including organization and facilitation of media trips and reports

Objective 5 of project- BCC/IEC is the main focus of this workshop but also keep in mind that it is important in all the other containment objectives. Below is the list of indicators that we are working towards for this objective.

- Proportion of household respondents in Z1 aware of key messages increased to 50% by end 09 and >90% by end 2010
- Proportion of cross-border mobile/migrant populations aware of key messages at least 30% by end of 2009 and at least 50% by end of 2010
- In Cambodia, a) % of recognized private drug sellers who are aware of new treatment policy in Zone 1 and b) % of recognized private drug sellers aware of appropriate malaria diagnosis and treatment in Zones 1 and 2: at least 50% by end of 2009 and >80% by 2010
- In Thailand, % of private companies where "malaria corners" are functioning
- % of respondents in zones 1 and 2 who are aware of new treatment policy and appropriate malaria diagnosis and treatment
- % of provincial and district government meetings held each year against what is planned for advocacy and progress of containment operations
- Number of media reports each year promoting containment operations and advocacy, locally and internationally

Objectives of workshop:

- To exchange information about current IEC/Behaviour Change Communication strategies and activities of national programmes in the context of the Containment Project;
- To harmonize cross-border IEC/Behaviour Change Communication strategies and key messages for target populations;
- To foster and share innovative IEC/Behaviour Change Communication strategies, activities, and materials for targeted populations;
- To ensure adequate M&E of IEC/Behaviour Change Communication strategies are in place and properly monitored and evaluated.

In closing, Dr Sintasath said we need to exchange information not only between national programmes but also from NGOs and partners and this is an opportunity to learn from each other. He stressed that as this is a special project we need special tools and we should be creative and come up with a unique workable and practical strategy for BCC/IEC and to keep

this in mind as we develop strategies and tools and also how we are going to evaluate and monitor those strategies and tools.

Overview of BCC/IEC strategies

Mr. Muhammad Shafique, Communications Specialist, Malaria Consortium

Mr Shafique presented us with the history of the development of health education, IEC and BCC followed by examples of BCC “what works” in the context of Myanmar.

Main points

First Mr Shafique clarified the key concepts of health education, IEC and BCC.

- Health education increases awareness and influences the attitudes and knowledge relating to improvement of health and was developed as early as 1792. It was used extensively in the 1980s on sexual health, HIV /AIDs, vaccination and anti smoking campaigns
- Information Education Communication (IEC) was developed in the early 1990’s to complement the missing components of health education. IEC is a process of working with individuals and communities to develop communication materials/tools to promote positive behaviors which are appropriate to their settings.
- Behaviour Change Communication (BCC) is an interactive process of working with individuals and communities to 1) develop communication strategies to promote positive behaviours AND 2) create a supportive environment to enable them to adopt and sustain positive behaviours.
- BCC should be supported by appropriate theoretical models, using appropriate tools for the right target audience. BCC models can be individual, interpersonal and community-based. The best method is to use a combination of models to develop a strong BCC strategy.
- Formative research is the essence of any BCC Strategy Development. Identify existing behaviours, determinants of behaviours to target those behaviours, barriers, and target audiences, key stakeholders who have influence who can help to develop strategy and potential tools and channels of communication. Use desk research to understand what has already been done and conduct formative research using in-depth interviews and focus group discussion to fill the knowledge gap.

Major aspects of BCC

1. Health Education

Health education can be further divided into 3 components:

- 1.1. Interpersonal communication: It is a very effective component of health education in which we provide information to communities in person and clarify their questions on the spot. We trained CHWs, one per village in Myanmar. They were trained both on malaria control as well as on interpersonal communication skills to ensure the effectiveness of their interaction with the communities. This was a very effective approach as it allowed clarifications during communication.

1.2. Folk media: It is very effective communication media as it has its roots in the culture and traditions of the community. We used street theatre, a popular form of folk media in Myanmar to provide the health education with entertainment.

1.3. Mass Media: It is very important, however, we need to ensure that whether it is suitable for the communities we are working in. It is used to reinforce key messages and validate and authenticate messages given at the grass root level by the village volunteers.

2. Community Mobilization: Community mobilization is very important in health programme as it develops ownership and empowers communities to play an active role in the programme. In Myanmar, we involved the communities throughout the project cycle and built their capacity in health education and communication to create an enabling environment at the community level.

3. Advocacy: Advocacy should be undertaken at all levels to get the support of key leaders/decision makers for the programme. We organized advocacy events at the community level in which community members, leaders, and families shared their success stories. It reinforces key messages through success stories, acknowledges volunteers and motivates them to work for longer.

At the end Mr. Shafique shared the key lessons learned from the Myanmar programme.

Lessons learned

- Involve community/volunteers in BCC strategy, increase involvement of target audience in designing of messages and materials, use consistent messages across materials and methods to reinforce messages, use a mix of channels for better impact i.e. IPC, folk media and mass media.
- Communication flow: He stressed that repetition is very important in BCC. If people hear the same message from different channels, they will retain the message which will lead to behaviour change. Therefore it is essential that messages are consistent, harmonized and linked with all materials and communication channels.
- Challenges- on how we approach the community and how we use appropriate tools. There will be barriers but we need to think innovatively, outside the box, and we will definitely succeed.

Discussion

At the end of his presentation, he responded to the following questions of the participants:

- How can the people reach the IEC material? First, distribute the material to the village volunteers in a monthly meeting and then trained them on how to use the flipcharts, brochures and other IEC materials. The materials should be distributed during or after an activity such as health education session. Distributing material with out any background information is not very effective.
- Which of the 3 approaches IPC, Folk Media and Mass Media are the most effective? Each approach has its own importance and effectiveness. Interpersonal Communication provides us with the luxury of personal interaction with the communities to provide them

health related information. We can clarify their questions/queries at the spot. Folk Media is very effective because it is imbedded in the culture of the communities. Whenever you develop BCC strategies based on the culture, they are more acceptable and owned by the communities. Folk media helps us to reinforce messages through theatre and songs.

- Mass Media (Radio, TV) has its own importance. Mass Media can reach to thousands of people in a short period of time. It is also used to validate and authenticate the messages given by the volunteers through Interpersonal Communication. The combination of all three media is very effective and help people to internalize the messages.
 - Has there been assessment on how long it takes to change the behaviour, costs and also coverage? Behaviour Change Communication takes time. However, it also depends on us that how we designed the BCC strategy and how we approach the community. If we develop culturally sensitive approaches, involve communities through the programme design and use all channels in an appropriate way, we can definitely show impact even in a short time frame. We have conducted a KPC survey in 2006 in Myanmar to establish the benchmark for our BCC interventions and programme will conduct the end line in this year to measure the impact of our BCC interventions.
 - Sustainability of our approaches is important during the implementation. We need to make sure we build capacity of the community volunteers and health systems so programme is sustainable. There is a need to invest in volunteers and also make the approach cultural appropriate.
 - The main differences in IEC and BCC are that BCC is creating an enabling environment in the community to create a positive change. Changing behaviours is very challenging. By just providing information we cannot change the behaviour. We need to create an enabling environment at the household, community, and health facility level to facilitate communities to change their behaviours.
- In the 2 years we need to make sure we know what we need to measure- behaviour change, knowledge change, and attitudinal change.

BCC/IEC strategies, progress & challenges in Cambodia

Dr Boukheng Thavrin, Chief of Health Education, CNM

Dr Thavrin gave us an overview of the progress on IEC/BCC in Cambodia. She came up with the following updates regarding the BCC activities in Cambodia.

Main Points

- The BCC Working Group meeting was held on 12-13 March 2009 to review current Malaria BCC strategy. The working group identified gaps, clarified roles of BCC in the Containment Project and provided suggestions for improvements revising the BCC strategy to address containment issues.
- CNM has developed the BCC strategy to address containment issues during March-May, 2009. The BCC strategy has been launched since June 2009.
- She emphasised that the communities of the affected areas have to play a key role in the success of the containment project. Containment requires changing of old behaviours that are conducive to spread of resistance (e.g., purchasing of inappropriate/fake drugs).

- BCC needs to be built up on previous work. We can refine and improve BCC activities based on previous experiences of different partners.

Behavioural Factors contributing to Artemisinin Resistance and Possible BCC Interventions	
Behavioural factors	Possible interventions
<p><i>Mobile populations and migrants</i> People travelling from within Cambodia and as far away as Myanmar, mainly to mine for gems or collect forest products.</p>	<p>i. <u>Carrying out a situational analysis</u>: to understand and map the behaviour ii. Developing and scaling up <u>cross border BCC/IEC tools</u> to provide consistent direction to end-users iii. <u>Inform incoming and outgoing mobile/migrant populations</u> about malaria risk, prevention and diagnosis and treatment.</p>
<p><i>Artemisinin monotherapy</i> Most (70–80%) people with fever seek treatment from the unregulated private sector, where artemisinin monotherapies are widely available and used.</p>	<p>Develop and disseminate IEC materials that include information on the dangers of monotherapy and also emphasise that they are legally banned</p>
<p><i>Sub-therapeutic levels of artemisinins</i> These contribute to selection pressure and continued infectiousness.</p>	<p>Develop and disseminate IEC materials that contain an appeal to comply with treatment regimens</p>
<p><i>Substandard and counterfeit drugs</i> The widespread availability of counterfeit artesunate is well documented. These sophisticated products often contain no or very little artesunate.</p>	<p>Develop and disseminate IEC materials that warn people about the potential dangerous consequences</p>

Dr. Thavrin mentioned four phases of an effective BCC strategy; 1) develop and adapt messages 2) select appropriate communication channels 3) implement the messages through different channels for health education and promotion and 4) monitor and evaluate the project to see the impact that if there is any improvement in the BCC indicators or whether the project has influenced the behaviour changes in the community.

The BCC working group has identified key containment messages, target audiences, and media. This will be followed by the IEC materials development based on the need of target audiences. She explained that key BCC activities include, workshops, situational analysis and develop and pre-test IEC/BCC materials.

Dr. Thavrin pointed out that the BCC strategy will focus on the following key themes:

- Rational drug use
- Mass screening and treatment
- Mobile/migrant populations
- Personal protection measures and prevention

- Focal indoor residual spraying (IRS)
- Active case detection

The programme will use the following BCC tools and communication channels to deliver the messages to the communities:

- A document on BCC strategy for containment
- News bulletin for private sectors
- Mass media including TV and radio
- Mobile video units
- Standardized packages of job aids for village health workers (VHWs)
- Standardized packages of job aids for private sector providers
- Interpersonal communications through community volunteers
- National Malaria Day/Week celebrations
- Patients and family health education at public health facilities

She shared the key responsibilities of Malaria BCC working group. She said that the working group is a platform for information sharing among stakeholders, advice on approaches and content, identification and documentation of best practices, and ensuring coordination among partners.

Dr. Thavrin threw light on the role of partner organizations which is as follows:

- Provide/share technical expertise
- Share experiences working with specific target population
- Resource sharing advantages video production equipment
- Coordinate and conduct joint implementation with other organizations working on malaria prevention and control at the grassroots level.

She emphasized the close coordination and collaboration among NGOs and government and said that national governments cannot play the entire role. Other partner organizations need to support and work closely with national and provincial government for better impact.

While mentioning the highlights of BCC, she stated that a comprehensive BCC strategy has been developed in March 2009. The BCC materials with key containment messages have been developed, pre-tested, and are under the procurement process. She also stressed the importance of M&E and said that surveys and situational analyses will be conducted to establish the benchmark for BCC. Formative and operational researches will be conducted among migrants. Monitoring and supervision will be done on a regular basis to ensure the quality of implementation. Dr Thavrin showed the IEC materials (i.e posters, banners, billboards) developed for migrant and mobile populations. She informed the participants that 3 key messages on 3 different billboards will be displayed for migrant and mobile populations on border checkpoints and common social/crowded places.

At the end she gave some suggestions on how to improve BCC interventions:

- Create demand for only those items/drugs/LLIN which are already available and accessible in the community. Commence health education campaigns/sessions only when the flow of supplies of drugs/LLIN is confirmed. Practical demonstrations of how to use LLINs is the must at the time of LLINs distribution to the community.
- Locate/identify mobile and migrant populations using snowball and respondent driven sampling and cluster tracing techniques. Use Mobile Malaria Workers (MMWs) to track them from bus station , taxi stands and border checkpoints
- Overcome language barriers by translating IEC materials in Thai and other ethnic minority languages for better understanding of the community
- Counter deliberate misinformation on drugs by using village leaders, monks and other key influential persons as entry points to the community. Develop posters with pictures of fake drugs and display at the bus stop and market places to educate people not to use fake drugs.
- Persuade/mobilize traders and drug sellers to change their practices through interpersonal communication such as workshop and orientation programmes
- Inform people about new interventions by making announcements through public address systems, and mobile malaria workers

Discussion

A question was raised regarding how one can coordinate with government to gets its support regarding logistics and human resources to implement the programme. Dr Thavrin responded that this is a question for programme management. All we can do is to show the results to the governments and then they will endorse our activities (e.g. National Malaria Day campaigns).

In Cambodia, prevention is a problem for many diseases. There has been an increase in knowledge but the behavioural changes are very slow. We have used many communication channels including interpersonal communication through Village Health Workers (VHWs), and mass media. The problem is that our VHWs have not received any training; hence some cannot properly answer questions raised by the communities. We need to properly train on interpersonal communication and how to facilitate the group discussions. We have developed a questionnaire for volunteers to make sure that they are also changing their own behaviour. We also have developed a monitoring checklist to monitor the activities of VHWs. We use this checklist with the community members to know whether the VHWs have been conducting their activities in the village or not.

When we develop the IEC materials, we should display it at appropriate and visible locations for effectiveness of the materials. Dr. Thavrin emphasised that the person involved in developing IEC materials and products should have a sound background and good understanding of BCC. He/she should have a good knowledge of adult learning theories and diffusion theories so that he could plan a culturally appropriate BCC strategy based on the need of target audience for malaria control programmes.

BCC/IEC strategies, progress & challenges in Thailand

Ms Rungrawee Tipmontree, Public Health Technical Officer, BVBD

Ms Rungrawee gave an overview of the BCC Strategy in Thailand and the progress that has been made so far.

Main points

Ms Rungrawee mentioned that Thailand's BCC strategy emphasizes on 4 key areas:

1. Comply with new anti-malaria drug Malarone
2. Regular use of LLIN
3. Use of LLIHNs during overnight stay in the farm or forest
4. Early seeking behaviour for malaria diagnosis and treatment

Target groups which can be classified as Thai and Non-Thai target groups for the BCC intervention have been identified:

- Thai target audience includes permanent residences, mobile population, forest workers, border rangers (i.e., army, marine)
- Non-Thai target audience includes daily workers (short term – 7 days or less and longer term workers – more than 7 days)

She updated the participants about the plans and progress of IEC/BCC in Thailand:

- Conducted a workshop in June 2009
- Developed key messages and designed IEC/BCC materials
- Pre-test prototypes I and refine it based on the pre-test results in August 2009
- Pre-test prototypes II and refine it based on the pre-test results in September 2009
- Produce, distribute and display/install BCC materials, cut-outs in October 2009

Ms. Rungrawee mentioned that a pre-test of prototypes 1 was conducted with the communities and prototype II was developed based on their feedback. She said that IEC materials developed on behaviours regarding regular use of LLINs, LLIHNs and early seeking for malaria diagnosis and treatment will also be translated into the Khmer language. She explained that BCC materials will be distributed to the target populations. Posters and cut-outs will be displayed at factories, border check points, army check points, health centres, and malaria units.

At the end of her presentation she raised some issues/questions regarding the BCC in Thailand:

- IEC/BCC materials should be more appropriate for the migrant and mobile populations
- The BCC program needs supportive environments (i.e. coverage of services provided, LLINs, LLIHNs)
- Will the BCC programme change behaviours of the target population?

Discussion

We have received complaints from Cambodian people that even those people who travel to Thailand for tourism are asked for a blood test for malaria at Thailand border check point. Ms. Rungrawee clarified that not all people who cross the border need to be tested. We need to test only those who come for work. She emphasised that we also need to check history of malaria and fever before testing the blood.

She mentioned that the IEC materials have been translated in both Thai and Khmer languages to benefit the mobile and migrant population of both countries. It would be good if the Khmer migrant workers could get some health education at their workplaces in Thailand; however, being daily labourers they usually do not have time for health education activities. She shared the IEC materials produced for Lao PDR and Myanmar languages using budget from the Global Fund. However, she said that we need to find out how to deal with this group in the Containment Project.

She appreciated and said that this is the first time there have been efforts for harmonizing the BCC activities, IEC materials in both languages which is already a big achievement in the project. She mentioned that Malarone is being used for the first time in Zone 1. It is a very expensive drug which costs around 60-70 USD per treatment. Most of the people who use the drug are non-Thai people. There is concern why those people are treated with such expensive drug who are working even less than 7 days in the country. We need to ensure that they are under directly observed treatment to avoid any misuse of the drug. We need to make sure that our BCC/IEC materials are addressing these questions. There is a follow-up schedule up to 42 days but how to address those who are staying only for a short time will also be a challenge that needs to be addressed.

Ms. Rungrawee stated that some of the IEC material has been produced and focused on people crossing borders legally. What should be the strategy to reach to the illegal migrants who have a very strong network? To reach the illegal migrants we need to work with **both formal and informal** networks.

At the end she said we need to explain to the people why the malaria treatments in both zones and both sides of the border are different. If the messages are not clear and conflicting, this may lead to the confusion which can be more detrimental to the containment efforts.

University Research Corporation

Ms Khorn Linna, IEC/BCC Specialist, URC

Ms. Linna gave us a comprehensive overview of University Research Corporation's (URC) IEC and BCC activities in Cambodia. The programme is called Malaria Control Cambodia (MCC) and is funded by USAID. URC also works in areas covered by the Containment Project.

Main Points

Ms. Linna mentioned that the BCC component of their programme has 2 main objectives:

1. To increase awareness among migrant and mobile population and local community members about malaria transmission and prevention through mass media, small media and community outreach and mobilization and advocacy in target provinces of MCC projects (BTB, BMC, Pailin and OMC)
2. To enhance the capacity of government health staff and community health network (VHVs and VMWs) on BCC

She then explained the major BCC Strategies of MCC:

- Develop and or adapt IEC materials (mass and printed media together to achieve the best result)
- Build capacity of the health staff and community volunteers in communication skills, malaria control and prevention, novel and attractive methodologies to educate/disseminate malaria messages to the target audience, appropriate use of IEC materials using participatory approaches to ensure the audience interaction
- Conduct video shows to promote screening and treatment and increase malaria knowledge. Video show is an effective channel to reach the audience
- Integrate malaria BCC activities with community based antenatal care (ANC), child health activities. Primary school children are a key group to spread messages to peers, family, and community
- Monitor and evaluate BCC activities and materials

While mentioning the achievement of the project, she said that 17 malaria billboards have been printed and installed at social and crowded places in the target malaria endemic areas. They have developed and printed 950 sets of educational flipcharts for village health workers. They have conducted Training of Trainers (TOT) of 122 health staff who will conduct further trickle down training of village health volunteers (VHVs). She highlighted that MCC has successfully used mass media as well in their BCC campaign. MCC provided financial support to local radio and TV channels for broadcasting educational spots for 5 months in 2008 and 3 months in 2009. She said that in 2009 they only used radio as TV was not accessible for the target audience. She gave an example of a call- in radio programme-entitled “I am worried about my health.” There is a short role play followed by a number for listeners to call in to. The radio call-in show has been a successful strategy.

Ms Linn also shared some programme challenges and lessons learned with the participants, including:

- ✓ Coordination: Coordination among partners is needed to standardize IEC/BCC materials for general population and high risk groups such as migration and cross border populations
- ✓ Outreach difficulties: Difficulty in providing health education to the communities in the malaria endemic remote areas along Thai-Cambodian border

At the end she shared the future plans that MCC will develop which includes a BCC strategy for mobile and migrant populations at Thai/Cambodian border. They will also develop BCC activities for Public Private Partnership (PPP).

Discussion

A comment was raised regarding the costs for TV and radio spots and who will subsidize these costs? Ms Linna responded that the cost is \$100/month per province for TV and the call in show. The radio show was good because it encouraged participation of many people such as women, men, young and old. This is a very effective strategy and appeals to the target groups. MCC conducted HH surveys to determine the target group and listening time and based on that information they fixed the show time between 5 and 6 pm.

Population Services International

Mr. Mak Sarath, Malaria Project Manager, PSI

Mr. Mak Sarath gave an overview of PSI's BCC strategy. PSI has developed an IEC/BCC strategy for the private sector. He said that PSI is an NGO that covers social marketing in Cambodia. PSI has been established in Cambodia since 1993 and working on different programmes including malaria and covers 17 out of 24 provinces including the Containment Project area.

Main Points

- ✓ PSI's goal is to support the government and CNM to leverage the private sector to increase access to services for malaria diagnosis, prevention and treatment.
- ✓ The main objectives of the project include 1) ensuring appropriate products are accessible through private sector and 2) improving provider and consumer behaviours regarding malaria prevention and treatment. He mentioned about the social marketing of malaria products and emphasised that we need to have the products available at the community before creating the demand for them.
- ✓ PSI's delivery channels include sales representatives, united health networks, medical representatives and mobile video unit. The outlets include drug stores, cabinet pharmacies, village shops and market stall depending on the product.
- ✓ Communication messages have been created and adapted based on the target audience. The messages have been communicated via different media for providers and communities.
- ✓ The key messages include the following:

Diagnosis and treatment

- Get the test first campaign
- How to correctly use Malachek
- Why taking pre-packaged ACTs, (not a cocktail/monotherapies/fake drugs) is so important
- Completion of the entire dose is critical
- Message for both providers and consumers

Prevention

- Why using nets in forest is crucial?
- What are the benefits of treated nets vs conventional nets?
- How to take care of LLINs?
- Where to get LLINs?

He highlighted that PSI provides multi-level training to service providers covering qualified, semi-qualified and non-qualified providers and trains around 800 service providers every year. Medical detailing provides one-on-one education to the providers every month. Each provider is contacted 10 times a year to improve correct use of products, increase the reach to underserved rural health providers, obtain first hand information, and ensure products are readily available to providers. PSI also conducts training of future service providers such as nursing students. The nursing students receive training during their 3rd year of the nursing course.

While mentioning the communication strategy Mak Sarath said that major communication channels for target population are mass media, mobile video units and IEC/BCC materials:

- ✓ Mass media includes TV and radio spots. The spots are pre-tested with communities before use. The mass media disseminate messages for both providers and consumers/communities.
- ✓ Mobile video units are used in high risk areas
- ✓ IEC/BCC develops promotional and point of sale materials. IEC materials includes leaflets, posters and banners.

PSI's communication messages are informed by focus behavioural studies that allow PSI to segment populations and track behavioural changes over time. The main communication challenges include difficulties of mobile video units, MDP teams, and sales teams to reach the targeted villages during rainy season and very high demand for some products with low supply available because of procurement lead time and funding constraints. Mr. Mak Sarath concluded with the future plans of the PSI project that include scale up mass media campaigns, revise all PSU training curriculum/job ads/radio/TV to reflect the national treatment guideline, introduce new RDT combo test, support new ACT and new bundling strategy, and continue to base all PSI communications on sound research.

Discussion

The discussion was around not enough IEC for substandard drugs and monotherapies. There is a need to focus IEC on this issue as low quality drugs penetrate the market and will be sold. However, IEC materials can be completed only after WHO endorses the drug. We need to wait until the message is clear. Even though we do have to wait what we can do is to be clear with the message not to use monotherapies (as most of these fake drugs are monotherapies) and cocktail drugs. This message is still not coming across. He informed the participants that PSI has conducted an assessment on behaviour change for 'test first then treatment' and is currently analysing this result.

Partners for Development

Mr. Ya Saroeun, Malaria Programme Team Leader, PFD

Mr. Ya Saroeun gave an overview of the Partners for Development (PFD) project. PFD has been working in several provinces including the Containment Project area and receive funding from Global Fund and USAID/URC.

Main Points

- ✓ PFD has been implementing 3 main approaches in the programme which are:
 1. Child-to child methodologies
 2. School-based malaria interventions
 3. Community-based malaria interventions
- ✓ The main objective is to increase awareness of malaria transmission and prevention and to seek early diagnosis and treatment among target populations.
- ✓ The programme interventions include training school teachers on malaria and also to have malaria main streamed in school programmes. Child-to-child role play has also been developed and used. Mr. Ya Saroen shared with the participants that malaria networks, Lucky Draws during health education sessions, quiz shows after audience watching video and health education by VHWs are some of the successful strategies of the programme.

Discussion

As several of the activities with community members are conducted at night times, this might be an easy opportunity for the spread of malaria. Is there any prevention method to avoid mosquito bites during such meetings?

Mr. Ya Saroeun responded that activities are conducted in the evening because the community members are only available in the evening. The activities are conducted far from the forest area. Also PFD staff or VMWs inform the community members to wear long sleeve shirts during the meeting. PFD uses repellent during the meeting as well.

Health Unlimited

Mr Sam Ossophea, Malaria Coordinator, HU

Mr Sam Ossophea represented Health Unlimited (HU) in the meeting. Health Unlimited is funded by Global Fund Round 2, 4, 6, and 7.

Main Points

Mr. Sam mentioned that BCC/IEC material is developed in collaboration with the National Malaria Programme. One of main strategy of HU is to build capacity of public health staff and community volunteers which is being done in the following way:

- Conduct Training of Trainers (ToT): ToT on how to use the malaria BCC and IEC materials to Public Health Staff (PHDs and HCs) and teachers.

- Community based training: The trainers then provide trickle down training to different group of community volunteers for example local authorities, community school teachers, model school pupils, VHWs, community youth association, private drug outlets, traditional healers, and indigenous clan leaders.
- Training of beneficiaries: The trained community volunteers then provide training to target beneficiaries (e.g. villagers, mobile populations, students, and pregnant women)

Mr Ossophea highlighted the major BCC/IEC activities of the programme and said that HU has different types of training from commune counsellors to teachers. The materials are distributed to them and in turn are distributed in the communities. During supervision visits they found that the community workers like to use flipcharts and leaflets to conduct the health education at the community level. He also said that they are providing training on drama to the students. He said they select 10 students - 5 girls and 5 boys (adolescents) - and train them on drama techniques. He highlighted the role of mass media in the programme and said that HU has developed radio spots which are broadcasted through radio FM every month which covers almost 90% of population in the province. For those who don't have radio, we provide them loudspeakers and cassettes with messages (spots) to play for the community.

Mr Ossophea shared the key lessons learned:

- Materials linked with quiz attract more participants
- Mobile video shows attract more participants in a rural community
- Drama is an effective health education method for communities
- Use of skill assessment checklist to upgrade malaria knowledge and facilitation skills of VHWs can be very successful strategies
- VHWs like flipcharts with calendars which help them to plan the health education sessions
- Use of cartoons and children in the radio spots as their voices promote more interest in the BCC messages
- Use of school health model teams is an effective method in providing health education in classes and communities
- Support of local authorities to the VHWs in health education activities ensure more community participation /attendance during the health education sessions

BBC World Service Trust

Mr Charles Hamilton, Head of Project, BBC World Service Trust

Mr Charles Hamilton gave us an overview of the BBC World Service Trust's activities in Cambodia. He mentioned that the BBC World Service Trust has been using communications for development, mainly in TV and radio formats. The BBC World Service Trust has been working in Cambodia since 2003 primarily on HIV/AIDS and maternal and child health (MCH). Since 2006, it has been working on malaria with CNM (GFR6) and has done similar work in Myanmar. He showed some of the TV spots and part of a drama developed for malaria during his presentation.

Main Points

- Mr. Charles Hamilton mentioned that main objective of the project is to raise awareness using the mass media on malaria prevention and early detection and treatment.
- Their media campaign includes 4 TV and 4 Radio spots and one drama. Single message spots are more cost-effective because it reaches wider audiences. They have also produced a 30 minutes drama on malaria. The BBC Trust always tries to be innovative and our approach is more subtle.
- Use of humour in spots makes the message more interesting for the audience. We use subtle messages to trigger a cognitive change. He said that they pre-test all media messages with target audiences to make it appropriate for the communities. Their Knowledge, Attitude, Practices and Behaviours (KAPB) surveys show that knowledge is high but behaviour changes are very low in the communities.
- TV and media access in Cambodia is on the increase. Ownership of mobile phones is on the increase. Radio listeners are also increasing. Experience has shown that any media strategy must be TV led. TV5 has a larger rural audience and wider reach. The BBC Trust maps media with their surveys. However, TV is not an effective strategy for niche communities in zone 1 (e.g. forest community as they don't have a high ownership and access to radio and TV). They should be targeted by interpersonal communications through community volunteers.

Mr. Charles shared the key BBC Messages of their project:

1. Prevention: Use of LLINs
2. Treatment: Symptoms, health seeking behaviours (shorter formats used)
3. Completing course of medicine and adherence to drugs (longer formats used)

At the end of his presentation, he shared the lessons learned with the participants:

- Mass media works better with retention and volume or frequency of spots is very important.
- Audiences that are exposed to more than one output have better recall and better positive indicators.
- Use branding to be clear.
- People connect with drama emotionally. The drama shows people doing good or bad behaviours and also shows the consequences of those behaviours. People learn from what happens to those people due to their good or bad behaviours.

Discussion

We have observed that although we have not seen much funding for BCC in R2 and R4, many partners have since received funding and are working very actively in IEC/BCC. Despite this, activities in the community are still not deeply penetrated. We only reach those areas where we find it accessible. Those far reaching areas we have only reached 10-15% of mobile populations. Real interventions do not reach target populations - especially mobile. There is a need for more funding for VHV and MVHTs.

If we want to achieve our goal by 2015, I would like all development partners and donors to put a focus on the community. Also, empowering local authorities will reduce the burden on the government.

Group Work (Day 1) Development of Key Shared Messages

The participants were assigned to the following 4 working groups pertaining to BCC and IEC:

1. Diagnosis and Treatment
2. Prevention
3. Private Sector
4. Migrants and Mobile Populations

The first task of the groups was to address objectives 2 and 3 of the meeting.

Objectives 2 and 3: To harmonize cross-border IEC/Behaviour Change Communication strategies and key messages for target populations and to share innovative strategies, activities, and tools

Both Thailand and Cambodia had already done a lot of work and have developed key messages for their programmes. The task of the group work involves 1) identifying and harmonizing/refining key messages for target populations to ensure that the messages were not conflicting. 2) ensuring the messages were appropriate for both the Cambodian and Thai contexts, and can be easily translated 3) identifying the cross- border activities required for each message and the target populations to be addressed, 4) identifying innovative tools and communication channels to carry out the activities. The outputs from the groups are compiled into Table 1.

It is important to note that the definition of the private sector is different between Cambodia and Thailand. In Thailand, there appears to be relatively little private sector involvement on the eastern border that provides diagnosis and treatment services for malaria. The government partners with private sector employers aim to create “malaria corners” with health education materials. In Cambodia, the private sector refers to a variety of private sector drug outlets and clinics that provide diagnosis and treatment to patients. Therefore, the key messages for the private sector are mostly applicable to Cambodia.

GROUP WORK DAY 1 – Comments, questions, and discussions

Group 1: Diagnosis and Treatment - Key messages:

1. If you suspect to have malaria seek diagnosis and treatment quickly at a hospital, health centre, health post or VMW/MMW
2. Complete full 3 days of treatment to cure your malaria.
3. Carry a treatment history card

Treatment card. There was a healthy discussion among the participants on the use of treatment card developed by Thailand. Is the treatment card going to be used on the Khmer side as well? If yes, then it needs to be discussed with our committee first. The participants said that in Cambodia they would also like to develop a similar card for the patient so that the authorities should know that this patient is under treatment for malaria. We may call it malaria patient card. The participants suggested that it would be good to have the Thai card translated in English so that the Cambodia could get an idea to develop a card with similar information. The card is developed for follow-up of the patients therefore very important to be used on both sides. One participant suggested that the card should be developed as soon as possible so that it can be implemented at the end of the month.

Malarone. The next discussion point was malarone as the first line drug. Thai patients will get malarone (atavaquone proguanil) for treatment. This is the first time malarone is being used as a first line drug. The adherence to the 3 day treatment is very important.

It was also proposed to exclude mobile and migrant population from malarone treatment due to the difficulties of ensuring proper 3-day adherence. As in Thailand they will properly follow-up every patient. However, in the Cambodian side it would be very difficult to trace those mobile workers (malaria patients) for the follow-up. One participant clarified that follow up of malarone for three days is only linked to Mass Screening and Treatment (MSAT). It is not for routine treatment in zones 1 and 2.

Follow-up. Participants from group 4, (mobile and migrant populations) pointed out that a lot of migrants crossing the border to work in Thailand. There are 3 districts where malarone is used. What will happen if they move before completing the treatment or follow-up? The decision needs to be made on what to do in that situation. The critical question is ensuring 3 days of DOTs. In Thailand 80-90% follow-up is being done with the patients. However, there is no follow-up in Cambodia. Thai colleagues understand that VMWs are using RDTs at the community level. The VMWs may help on the follow-up issue as well.

The participants said that the target audiences are very large and diverse. We need to think of the segmentation of migrant groups (e.g. long and short term migrant to properly follow-up or reach to them). We need to actively involve the health providers and private drug sellers in the BCC strategy.

A participant shared experience and said that if someone contract malaria from zone 1 or 2, after he/she receives the treatment, they coordinate with URC to follow-up the patient on 7, 14, 21 and 28 day. The follow-up is to know if they have any symptoms on D7. They conduct blood smear and send to Pasteur Institute. In the future, they need to expand this work to Village Malaria Workers so that they could coordinate further with the regional hospital.

Group 2: Prevention – Key messages:

1. Sleep inside impregnated LLITN net to prevent malaria. Both sides agree to mention where to get LLLITN free.

2. If you stay in farmhouse or go to forest, sleep in hammock net. Alaredy developed the material on Thai side. Target population of the message is farm, forest and migrant workers. The material is translated in both Thai and Khmer languages for Zone 1 and 2 at the border
3. Whenever you leave village and go to malaria area please carry and sleep in a hammock treated net. The material is developed in Cambodia and will be used in both languages at the border

Harmonizing formats. There was a long discussion on using the similar messages, pictures, formats, fonts, and colours schemes on the IEC materials for both sides. However, it was agreed that pictures can be different according to the different setting and context. Some messages will also be different on both sides based on the different interventions. It was more or less agreed that same formats, colours, fonts and materials (as much as possible) should be used in both languages on both sides to create an impression of the same programme. One participant said “We need to connect with the culture but people need to be aware that it is from the same programme.”

Language. Should all of our BCC/IEC material be prepared in both Thai and Khmer languages? It was agreed that both languages should be used at the border for the better understanding of mobile and migrant populations of both sides. However, in the other areas, languages of the country should be used to develop the IEC materials. It was also discussed that the messages should be more comprehensive so that the audience could comprehend the message properly (e.g., we need to provide complete information on how to use bed nets).

Materials and tools. On the question of using various materials, it was discussed that we need to be very careful in using IEC materials and tools. The materials should be linked with the activity. If we develop too many materials, we may lose the interest of the community. It was also recommended that we do not use posters and billboards as a stand alone activity. There should be supportive interpersonal communication activities to help the audience understand the messages given on the posters and billboards. Billboard and poster serve as a reminder or a cue for action. Cambodia will use the interpersonal communication strategy through volunteers in zone 1 and 2.

Group 3: Private Sector – Key messages:

1. Always test patients with fever prior to treatment (Zone 1)
2. Go to receive diagnosis and treatment from a recognized private sector provider (Zone 2)
3. Refer children U<5, pregnant women and people with severe malaria to nearest public health facility (Zone 2)
4. Good providers refer all confirmed or suspected malaria patients to public health facilities to receive appropriate treatment and follow up (Zone 1)
5. Only prescribe government recommended drugs (Zone 2)
6. Take malaria medication correctly as prescribed by your service provider and you will be cured

7. When prescribing malaria treatments inform the patient how to take the medicine properly
8. It is illegal to sell artesunate monotherapies to treat malaria
9. Do not use or buy medicine from unknown source. It could be fake medicine

It was discussed that these key messages are more relevant to Cambodia since there is limited private sector involvement in Thailand. In Cambodia, the private sector is very active and provides diagnosis and treatment and can refer to a variety of outlets. In Zone 1, the private sector is encouraged to refer all cases of malaria to public health facilities where patients can get appropriate treatment.

Certification. The participants discussed the possibilities of developing a logo to be displayed at the trained service providers' clinic so that the community can identify where proper treatment and medicines are available. Some participants were skeptical about the adherence of private providers to the recommended treatment. They questioned whether workshops, training and follow-ups will change their behaviours to stop the use of monotherapies. They suggested that if they don't follow the new drug policy they should be punished by the law. The participants emphasized that the private sector should stop selling monotherapies and counterfeit drugs. We need to conduct regular meetings with law enforcement agencies to get rid of monotherapies from outlets. The participants suggested that private sector should also be involved in prevention.

Group 4: Mobile and Migrant Populations – Key messages

1. *Malaria is an illness with fever caused by mosquitoes*
2. *Sleep under ITN/LLIN/LLIHN*
CAM: Whenever you migrate from your village/town – Please use insecticide treated net to prevent malaria
THAI: Sleeping under insecticide treated nets – Protect yourself from malaria
3. *If you have a fever, you may have malaria – Seek early consultation from your nearest health facilities*
CAM: If you suspect having malaria, please consult Village Malaria Worker or Health facilities.
THAI: If you get sick from malaria – Take Malarone – Get well soon

Malaria corners. The participants discussed the malaria corners in detail. Malaria corners will be set up in selected factories and private companies at border areas in Thailand. The malaria corners will display the IEC materials, posters, and banners to educate the mobile and migrant workers/population on malaria. Some participants raised concerns that malaria corners will display only printed IEC materials which are not very appropriate for mobile population as they may be illiterate and cannot read and write. They suggested that we need to consider some other verbal (interpersonal communication) ways of getting the message across.

Brokers. We can involve the brokers/in charge of migrant workers on the Thai side for health education. A broker is legally allowed to keep 20 migrant/farm workers. He/she

takes care of their employees' health, food, residence and work permit extension. A broker can be a good communication channel to access migrant workers at Thai side.

Billboards. There was a long discussion on how and where to install the billboard. How many messages should be displayed on one billboard? If we use only one message per billboard, then can we place two billboards together to display two different messages? Participants agreed that if there are 2 different messages, we can use two different billboards installed in the same direction. We can also use two messages on one billboard as well. The group stressed on the selection of the appropriate location for the billboard. It should be installed in a way that commands attention of the mobile and migrant populations.

Monitoring and Evaluation of IEC/BCC activities

Mr. Muhammad Shafique, Communications Specialist, Malaria Consortium

Mr Shafique gave an overview of Monitoring and Evaluation to set the scene for the working groups to develop an M&E framework for their suggested activities from Day 1.

Main Points

- Monitoring - corrects, reorientates and redesigns delivery systems
- Evaluation - gives the impact of a programme

Monitoring	Evaluation
<p>Answers these questions:</p> <ul style="list-style-type: none"> • What is happening to the delivery system/training? • Why is it happening? (flaws/gaps) • What are the interim effects? (in the target audience, in health workers) • How can it be fixed, corrected, redesigned? 	<p>Answers these questions?</p> <ul style="list-style-type: none"> • What happens as a result of the intervention? • What behaviour change took place? • What proportion of the target audience adopted the new behaviour? • What was the health impact on the target audience?
<p>Purposes:</p> <ul style="list-style-type: none"> • To correct, reorientate, or redesign delivery systems. • To readjust communication strategy and messages. 	<p>Purposes:</p> <ul style="list-style-type: none"> • To determine the level of behavior adoption • To determine program impact on health status
<p>Implementation:</p> <ul style="list-style-type: none"> • Monitoring begins as soon as possible when a BCC strategy is implemented and continues through the intervention. • Data are collected periodically, and frequently, at preset intervals or when the occasion permits it. • Monitoring is customarily done by the same people implementing the BCC 	<p>Implementation:</p> <ul style="list-style-type: none"> • Data are generally collected at different points that permit a comparison; for example: <ul style="list-style-type: none"> - Before the BCC strategy begins to establish a baseline - After a longer period (frequently more than a year or two) to make the post intervention comparison • Data collection is planned to allow

<p>activities.</p> <ul style="list-style-type: none"> Data are analyzed as needed and used immediately for program correction. 	<p>sufficient time for intervention impact to take place.</p> <ul style="list-style-type: none"> Research is most often conducted by internal researchers not directly involved in the BCC activities Data are analyzed and used at a central level after program completion.
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What to monitor:

1. Logistics- distribution of print materials, mass media, broadcasts, health education talks, distribution of supplies
2. Interim effects- knowledge and effects. We monitor the interim effects through exit interviews, site visits, and individual interviews
3. Knowledge - for example how many pregnant mothers recall health education talks or radio messages regarding malaria
4. Reaction - Is there any evidence that audience is reacting negatively to the messages or behaviour promoted
5. Target behaviour monitoring - look at changes of behaviour in your target audience - these findings about behaviour changes can help you change or adapt your strategy

How to monitor:

Mr. Shafique mentioned the following ways to monitor the BCC activities:

- Regular audits of materials at distribution points
- Listening to broadcasts
- Regular field trips to distribution points to check on availability of products or supplies
- Observations at service delivery points or training sessions using monitoring guides
- Focus group discussions to investigate the impact of promotional messages and to detect possible confusion

He mentioned that regular monitoring can help us to take timely decisions to improve the implementation. Monitoring of BCC activities informs us:

- Are the IEC materials i.e. posters, billboards, banners etc. displayed at proper common and social places to benefit the communities
- Do we need to change strategy of the training sessions to make it more relevant and effective
- Are the channels for health education and advocacy effective and appropriate to the communities?

Group Work (Day 2) Development of a M&E Framework for BCC/IEC

The second task of the groups was to address objective 4 and to develop a monitoring and evaluation framework.

Objective 4: To ensure M&E of IEC/Behaviour Change Communication activities are in place and properly monitored and evaluated

Each of the activities and actions identified in the previous exercise were developed further in a detailed action plan, which included 1) prioritising the activities for each country 2) setting indicators and targets for these actions, 3) setting means of verification 4) defining who would be responsible for these actions and a time line for the actions to be achieved and 5) assumptions that would need to be made to complete the activities. The outputs from the group are compiled into Table 2.

GROUP WORK DAY 2 – Comments, questions, and discussions

Group 1: Diagnosis and Treatment

The participants discussed that the billboard will be an effective strategy to disseminate the messages on treatment and diagnosis. They asserted that billboards with key messages on treatment and diagnosis should be installed at common gathering places of zone 1 and 2, such as bus and taxi stands. It was decided that billboards should be installed in a way that it attract the attention of all the mobile and migrant population.

The participants talked about the evaluation of the IEC/BCC methods and tools. They mentioned that the project will need to measure the proportion of people who understand the key messages and where did they get the messages through respondent surveys.

One participant asked the question that whether the project scope allow us to evaluate the effectiveness of each individual tool or we will evaluate all tools together. It may not be possible to evaluate the effectiveness of individual communication tools. There is a baseline survey planned to have an idea of the target audience and their existing behaviours. This information regarding knowledge, attitude and behaviours will serve as baseline. After developing and implementing the IEC/BCC based on the survey, it was suggested to conduct the qualitative assessment after 3-6 months to demonstrate how our IEC/BCC strategies and tools are working in the communities. A question was raised regarding how to determine that how many people have seen or read the billboards? It was suggested that it is difficult to capture the number of people reading or benefiting from the billboards. We should use simple questions to collect this information on where did they saw and understood the messages.

Group 2: Prevention

The prevention group came up with 3 major activities; 1) develop, print and distribute IEC materials 2) produce and disseminate spots on mass media 3) conduct health education campaigns on malaria day and malaria week.

The main discussion was on the type of material that should be developed and printed on both sides. Responding to one of the indicators of group 2, participants suggested that we need to be more specific on the indicators and instead of saying % of behaviour change in target population, we should clearly indicate the target audience i.e. mobile or migrant, or community. The participants also highlighted that this project is about behaviour change so the group 2 should have more behaviour indicators in their M&E plans. It was suggested that we should conduct some joint BCC activities at checkpoints during world malaria day.

Group 3: Private Providers

Quality assurance. Group 3 suggested the concept of minimum standards of the private providers. Some private providers are not very qualified and government want to get rid of them. By minimum standards, we want to highlight that there should be a minimum qualification/standard of the private providers to ensure their quality of services. They also talked about a *private sector working group* and the *counterfeit eradication committee*. The participants realized the need to involve the private sector actively in our programme. Before doing any activity we should consult local authorities but we do not properly involve the private sector in our project activities.

Sustainability. The participants also discussed sustainability of this project. They said that when phasing out we should again involve the local authorities and properly hand over the projects to communities or other partners so that the things could continue. For example, PSI has just finished one of their project, but the local authority have never been involved in the phasing out so we can't continue the work and take the things forward. This is something we need to discuss with CNM.

The participants deliberated that as the private sector is growing bigger and bigger, we need to reconsider how to deal with this sector properly. We also need active participation of law enforcement agencies to get rid of the counterfeit and fake drugs from the private sector. The private sector can support local authorities and we must focus on the activities of private providers and the pharmaceutical manager at the local level.

Referral. With regard to referral of the patients, we usually refer patient from the private sector to the public health system. If we just measure the number of referrals, it is not enough. We need to know how many people who are referred actually arrive at the health facility.

The participants said that what we are discussing about the private sector is our idea but what the private sector actually does is a different matter. We need to think over it seriously about what incentives are available for the private sector to mobilize them to comply with the new drugs policy.

Group 4: Mobile and Migrant Populations

It was suggested that we should share costs of other projects and grants i.e. GFR6 and RCC to contribute to some of the activities of this project. We should develop and design evidence based strategies in the project. We gathered through all the discussions that we

will produce posters, banners, billboard and leaflets for BCC activities. We also agreed that we will use the posters, billboard and leaflets at the border. We also discussed that we will use IEC material in both languages at the border. Malaria Consortium organised this meeting to ensure a harmonized IEC/BCC strategy in the programme to avoid conflicting messages.

At the end, one participant shared his experiences of working near the border. He mentioned that the problem we found was that the Cambodian authorities don't allow people to go and get malaria diagnosis and treatment from Thailand. The communities still find out the ways to get the treatment from Thailand. They lie to the authorities that they want to go to the market; actually they go for the malaria test and treatment. We need to share health information to all who cross the border. We need to inform all groups including the army and the provinces besides the mobile and migrants workers.

Summary and Recommendations

Ms. Michelle Thompson, Epidemiologist, Malaria Consortium

Summary

- ✚ Much work in BCC/IEC has already been done by both National Programmes – strategies, key messages, and tools developed. The main outcome of this workshop is to harmonize these cross-border strategies and key messages.
- ✚ NGOs and other partners are active with BCC/IEC activities, yet there are opportunities for synergies and collaboration.
- ✚ Participants worked in key topic areas (diagnosis and treatment, prevention, private sector, and mobile and migrant populations) to develop harmonized, cross-border key messages and strategies.
- ✚ The importance of monitoring and evaluation of BCC/IEC activities was stressed.

Harmonization of Key Messages

Diagnosis and Treatment

1. *If you suspect you have malaria, seek diagnosis and treatment quickly at a public health facility*
 - CAM: If you suspect you have malaria, seek diagnosis and treatment quickly at a hospital, health center (HC), health post (HP) or VMW/MMW.
 - THA: If you suspect you have malaria (fever or headache), seek FREE diagnosis and treatment quickly at a Malaria Clinic (MC) or Malaria Post (MP).

2. *Complete full 3-day course of treatment to cure your malaria.*

- CAM: Complete the full 3 days of treatment to cure your malaria and stop drug resistance.
- THA: Complete the full 3 days of treatment to cure your malaria. You will have 9 follow-up visits (during and post treatment) from malaria staff to ensure full recovery

3. *Carry your malaria treatment card.*

- CAM: *[Need further discussion about a malaria patient card]*
- THA: Carry your treatment card.

Prevention

1. *Sleep inside an impregnated LLIN net to prevent malaria*

- CAM/THA: Both agree need to mention where to get LLIN free
- THA: *If you stay in farmhouse or go to forest sleep in hammock net (LLIHN) to prevent malaria.*
- CAM: Whenever you leave village and go to malaria area please carry and sleep in hammock treated net

Sub-messages (For Thailand):

1. Beware of malaria! Have to sleep in LLITN
2. You should re-treat your bednets. It is free of charge.

Private Sector (relevant for Cambodia only)

1. *Always test patients with fever prior to treatment (Z1/Z2)*
2. *Go to receive diagnosis and treatment from a recognized private sector provider (Z2)*
3. *Refer children U<5, pregnant women, and people with severe malaria to nearest public health facility (Z2)*
4. *Good providers refer all confirmed or suspected malaria patients to public health facilities to receive appropriate treatment and follow-up (Z1)*
5. *Only prescribe government recommended malaria drugs (Z2)*
6. *Take malaria medication correctly as prescribed by your service provider and you will be cured (consumer). When prescribing malaria treatment, inform the patient how to take the medicine properly (provider).*
7. *It is illegal to sell artesunate monotherapies to treat malaria.*

Mobile and Migrant Populations

1. *Malaria is an illness with fever caused by mosquitoes*
2. *Sleep under ITN/LLIN/LLIHN*

- CAM: Whenever you migrate from your village/town – Please use insecticide treated net to prevent malaria
 - THAI: Sleeping under insecticide treated nets – Protect yourself from malaria
3. If you have a fever, you may have malaria – Seek early consultation from your nearest health facilities
- CAM: If you suspect having malaria, please consult Village Malaria Worker or Health facilities.
 - THAI: If you get sick from malaria – Take Malarone – Get well soon

Recommendations

- ✚ In developing IEC/BCC materials, countries should consider using similar formats, fonts, logos, etc (as much as possible) – but the meaning of key messages should be harmonized. It is important to make sure that messages are not conflicting and easy to understand in both languages.
- ✚ Tools and channels developed should consider how to reach non-literate populations. Mobile and migrant populations may require other channels beyond printed materials and billboards (e.g., interpersonal communication strategies, speaker announcements, and role plays).
- ✚ Use of both languages for BCC/IEC tools and channels at border areas is important for cross-border collaboration and harmonization. The border crossing areas are important opportunities to reach migrants and mobile populations. Key messages should be clear and targeted for these populations.
- ✚ Engaging the private sector is an important component of our strategy beyond diagnosis and treatment (e.g., surveillance, mobile phone companies, etc). The private sector, particularly in Cambodia, is an important component of the containment strategy. There is a need to engage these private sector groups (drug outlets, vendors, farm owners, etc) as a majority of diagnosis and treatment are through the private sector.
- ✚ National programmes should plan for joint Malaria Day campaigns. A cross-border Malaria Day campaign will help to strengthen the collaborative harmonization of activities and strategies between the two countries.

Closing Remarks

Dr Charles Delacollette, MMP Coordinator, WHO

From the Mekong perspective on IEC/BCC, there have been a lot of efforts that have taken place in both countries and we need to acknowledge that it is not new. What has been missing in the discussions during the workshop is truly development of innovative tools in IEC/BCC and this is a missed opportunity. Currently there is money available from BMGF

and GF to develop innovative tools and make strategic alliances in IEC/BCC especially with partners that have developed specialized skills. These specialists have not been used enough and we are currently using the same list of instruments and tools that have been used for the last 30 years. Partnerships should be a little bit better between all the partners.

There are many good recommendations from this meeting. However, the main challenge will be making sure that the public sector e.g. VMWs etc are in place and functional. If the public health system is not delivering the drugs, if the private sector is not engaged then you can't expect people to believe in the messages they are being given. In Thailand, the system is working. In Cambodia, at the moment there is money (GFR6, RCC, BMGF) for the next 2 years and possible for 5 years to get things done.

We have to acknowledge the differences between what the 2 countries are doing but more importantly we should think if what they are doing is right so we can discover best practices. This information is particularly useful and provincial people need to keep up the dialogue and share best practices.

It is important to start the surveillance process. It is very important that people who are receiving very expensive drugs that these drugs are well used by the people are receiving them. Also, you have migrants who are not captured and also asymptomatic carriers. We need to make sure these groups are also using malaria services.

We need new tools to be able to target illiterate people. The networks for unregistered migrant and mobile population are not used enough. They all have their own networks and we need to understand and be able to mobilize these unregistered networks. This is an international project supported by the international community. If there are any political issues then these should be on the agenda of the next International task force meeting in November rather than during technical discussions. We must strive to maintain the dialogue between the two countries and to create a collaborative team, and a properly harmonized BCC/IEC strategy will help us in that endeavor.

Dr Charles Delacollette thanked the organizers of this meeting and all the participants for attending this workshop. He was especially encouraged by the dialogue and partnership between the IEC/BCC units of Thailand and Cambodia – at both national and provincial levels. However, he cautioned that more work is needed.

The meeting was officially closed by Dr. Charles Delacollette.

Appendix 1: Agenda of the Workshop

Technical Workshop on Cross-Border IEC/Behavior Change Communication Strategies to Contain Artemisinin Resistant Malaria

A project funded by the Bill and Melinda Gates Foundation

Apsara Angkor Hotel
Siem Reap, Cambodia
19 – 21 August 2009

Objectives:

- To exchange information about current IEC/Behavior Change Communication strategies and activities of national programmes in the context of the Containment Project;
 - To harmonize cross-border IEC/Behavior Change Communication strategies and key messages for target populations;
 - To foster and share innovative IEC/Behavior Change Communication strategies, activities, and materials for targeted populations;
 - To ensure adequate M&E of IEC/Behavior Change Communication strategies are in place and properly monitored and evaluated.
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Wednesday 19 August 2009

08:30 – 09:00	Registration	
09:00 – 09:30	Opening remarks and welcome	Dr. Duong Socheat, CNM Ms. Saowanit Vijaykadga, BVBD
09:30 – 09:45	Introduction of participants	
09:45 – 10:00	Containment Project Overview	Dr. Najibullah Habib, WHO
10:00 – 10:15	Objectives of the meeting	Dr. David Sintasath, MC
10:15 – 10:45	GROUP PHOTO & TEA BREAK	

Objective 1: To exchange information about current IEC/Behavior Change Communication strategies and activities

10:45 – 11:15	Overview of IEC/BCC strategies	Mr. Muhammad Shafique, MC
11:15 – 12:00	BCC/IEC strategies, progress & challenges in Cambodia	Dr. Boukheng Thavrin, CNM
12:00 – 12:45	BCC/IEC strategies, progress & challenges in Thailand	Dr. Rungrawee Tipmontree, BVBD

12:45 – 13:00	Discussion	
13:00 – 14:00	LUNCH	
14:00 – 14:45	University Research Corporation	Dr. Kheang Soy Ty and Khorn Linna, URC
14:45 – 15:15	Population Services International	Mr. Mak Sarath, PSI
15:15 – 15:30	Partners for Development	Mr. Ya Saroeun, PFD
15:30 – 16:00	TEA BREAK	
16:00 – 16:30	Health Unlimited	Ms. Bree Waters, HU
16:30 – 17:00	BBC World Trust	Mr. Keo Sophearith, BBC
18:00 – 19:00	WELCOME RECEPTION	

Thursday 20 August 2009

Objectives 2 and 3: To harmonize cross-border IEC/Behavior Change Communication strategies and key messages for target populations and to share innovative strategies, activities, and tools

08:30 – 09:00	Introduction to Group Work	Dr. Mallika Kaviratne, MC
09:00 – 12:30	Group Work: Refining and harmonizing <u>Key Messages</u> , <u>Strategies</u> , and <u>Tools</u>	
	1. Diagnosis and Treatment	
	2. Prevention	
	3. Private Sector	
	4. Migrants and Mobile Populations	
12:30 – 13:30	LUNCH BREAK	
13:30 – 15:30	Group 1 & 2 Presentations & Discussion	Dr. Boukheng Thavrin, CNM
15:30 – 16:00	TEA BREAK	
16:00 – 18:00	Group 3 & 4 Presentations & Discussion	Dr. Rungrawee Tipmontree, BVBD

Friday 21 August 2009

Objective 4: To ensure M&E of IEC/Behavior Change Communication activities are in place and properly monitored and evaluated

08:30 – 08:45	M&E of IEC/BCC activities	Mr. Muhammad Shafique, MC
08:45 – 09:00	Introduction to Group Work	Mr. Steve Mellor, MC
09:00 – 12:00	Group Work: M&E Framework for BCC/IEC activities <ul style="list-style-type: none">- Key Messages and Activities- Indicators and Targets- Means of Verification- Responsibility and timeframe- Assumptions	
12:00 – 13:00	LUNCH	
13:00 – 15:30	Group Presentations & Discussion	Group Rapporteurs
15:30 – 16:00	TEA BREAK	
16:00 – 16:30	Summary and Recommendations	Ms. Michelle Thompson, MC
16:30 – 16:45	Closing Remarks	Dr Charles Delacollette, WHO

