

**Field Action Report**

## KILUSAN LIGTAS MALARIA: Advancing Social Mobilization towards Sustainable Malaria Control in the Province of Palawan, the Philippines

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**Abstract:** As malaria continues to be a public health problem in the Philippines, its control is now the responsibility of the Local Government Unit (LGU). In this set-up, social mobilization is believed to be the key strategy in effective and sustainable implementation of malaria prevention and control activities. Palawan has always been the most malarious province in the country. Despite untiring malaria control efforts and huge funds spent to curb this malady for which Palawan has become known, this province remains the largest contributor of malaria cases and deaths. Thus, Kilusan Ligtas Malaria (KLM: meaning Movement Against Malaria) has focused on social mobilization in the implementation of malaria prevention and control. Microscopic confirmation of malaria is done by trained village microscopists, while health education-promotion activities, advocacy and linkage building are carried out by trained village community organizers. The noticeable outcomes are the increase in malaria case finding as reflected in the total number of malaria smears done, the increase in microscopic confirmation of malaria, and the decline in clinical diagnoses. Other outcomes include policy development and implementation in the form of executive orders and community ordinances to support the village microscopists and community organizers. Now, the biggest challenge of KLM is maintaining the momentum and sustaining gains.

**Key Words:** social mobilization, malaria control, sustainability, the Philippines

### BACKGROUND

Social mobilization continues to be a strategy employed by health program implementers for malaria control in the Philippines. It is the process of generating and sustaining the active and coordinated participation of all sectors at various levels to facilitate and accelerate the improvement of the situation of children, women and other vulnerable groups [1].

With the devolution of health services under the 1991 Local Government Code [2], the LGU is mandated to provide direct health care services particularly at the primary and secondary level. In this situation, a strategy that is believed to be the key in the effective and sustainable implementation of health programs is social mobilization. The country's Department of Health has embodied this strategy in its national malaria control policy as a vehicle towards sustainability.

In the country's National Objectives for Health for

2005 to 2010, one of the focused thrusts is the mobilization of local governments and community resources for malaria case detection and management, and for surveillance in the malaria-free areas [3]. The significance of social mobilization as a strategy is recognizable in several local malaria control efforts with positive results [4]. Among these experiences, the social mobilization efforts in the province of Palawan through the KLM are rich and worthy of mention.

### THE PROBLEM, ITS MAGNITUDE, AND A CALL FOR ACTION

In the Philippines, malaria remains the most persistent mosquito-borne infection, ranking 8<sup>th</sup> in the leading causes of morbidity [5]. The disease is present in varying prevalence in 63 out of the total 79 provinces.

The province of Palawan consistently tops the country's list of malaria endemic provinces. The province consists of 1,780 islands and islets and is the second largest province covering 3.93% of the total land area of the coun-

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try. It is tagged as the Philippines' last frontier because of its rich forest and marine life. Eighteen out of the 23 legislated municipalities and the City of Puerto Princesa are considered malarious. As a Category A province where the Annual Parasite Index (API) has not fallen below 10/1,000 cases in the last five years and the number of cases exceeds 1,000 annually for the last 5 years, the disease has consistently been among the top 5 causes of morbidity and top 10 causes of mortality.

Table 1 reflects the cases and deaths within the 5-year period of 1995 to 1999. In 1997 and 1998, the number of deaths due to malaria reached beyond 100 individuals at 173 and 103 respectively, the highest number within the time period. In 1999, cases from Palawan contributed 26% to the national malaria burden [6].

Following the implementation of the malaria control

Table 1: Number of cases and deaths due to malaria from 1995 to 1999, Palawan, the Philippines

Year	Suspected cases*	Confirmed cases**	Total cases	Deaths
1995	23,948	7,258	31,206	38
1996	20,263	7,704	27,967	85
1997	38,115	5,386	43,501	173
1998	32,629	4,841	37,470	103
1999	43,842	9,609	53,451	95

\* Diagnosed through signs and symptoms, no slide confirmation

\*\*Diagnosed through microscopy

Source: Department of Health and Provincial Health Office records and annual reports, 1996-2000

component of the Asian Development Bank's Second Palawan Integrated Area Development Plan Project from 1990 to 1997 [7, 8], the observable high deaths towards the end of 1997 and in 1998 was cause for apprehension. This prompted the Provincial Government to seek additional assistance for the control of the disease.

With the end of the Second Palawan Integrated Area Development Plan Project, assistance in malaria control was received from the Japan International Cooperation Agency (JICA), and the JICA-sponsored endeavor Women's Health and Safe Motherhood Project began and was ongoing in 1997. This was implemented by the Department of Health Regional Office [9] and provided a major source of drugs, mosquito nets and insecticides for the province [10].

Considering these commodities, the Provincial Government spearheaded a proposal for the implementation of a province-wide community-based malaria control project that would focus on community mobilization to maximize utilization of the resources and support provided by JICA. The project KLM was proposed to complement the malaria control efforts by enhancing case detection through the training of village microscopists and improving household utilization of the control services through the establishment of village community organizers and working groups, and extensive health promotion.

In 1999, the KLM was formally established by the Provincial Government in partnership with the Pilipinas Shell Foundation, Inc., the Shell Philippines Exploration

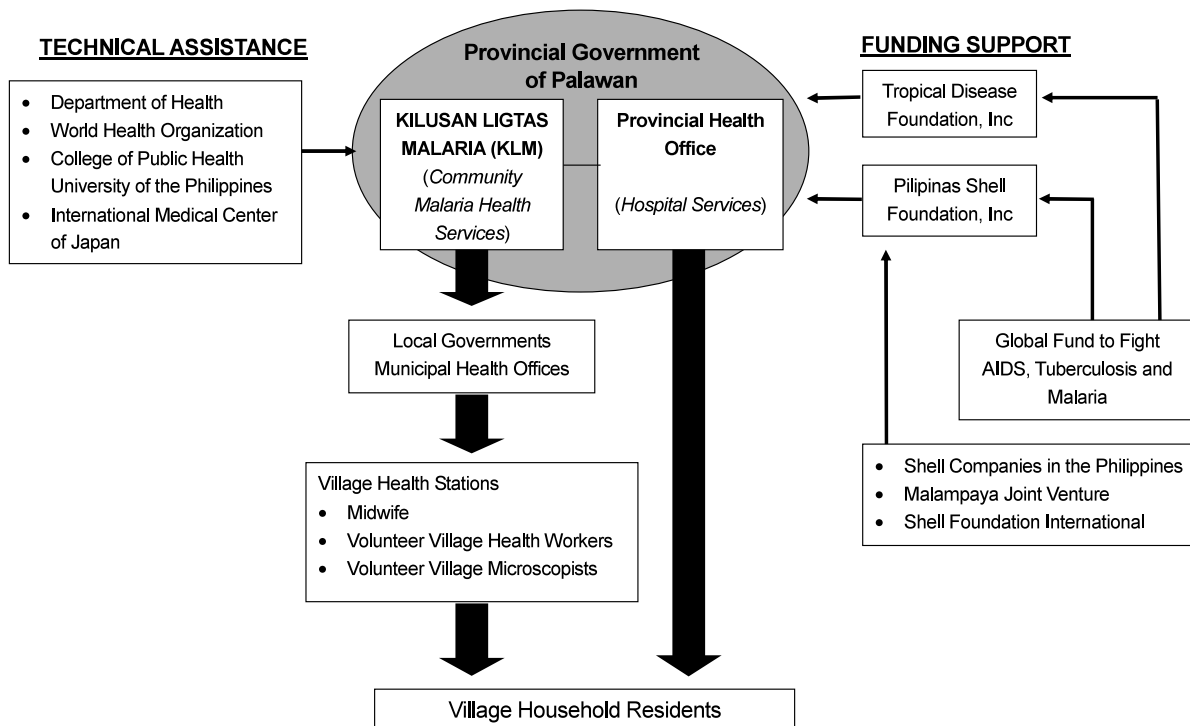


Fig. 1 Service delivery system

BV, and the Malampaya Joint Venture Partners for its 2-year duration. The KLM forms a major part of Shell's corporate social responsibility thrusts even to this day. Running on its 7<sup>th</sup> year, KLM funding remains a matrix of provincial government and external fund source - the Pilipinas Shell Foundation, Inc., the Malampaya Joint Venture Partners and the Global Fund to Fight AIDS, Tuberculosis and Malaria [11] (Fig. 1).

### KLM'S SOCIAL MOBILIZATION FOCUS (1999-2003)

In the absence of available trained microscopists, the diagnosis of malaria relied solely on clinical signs and symptoms. Due to the high prevalence of malaria, fever was sufficient to make a presumptive diagnosis and to institute treatment. Confirmatory diagnosis through microscopy was usually limited to places with established health facilities, such as Rural Health Units, hospitals, or private clinics. Thus, both health program implementers and the communities thought of training village microscopists to address the problem.

From the start in mid-1999 when KLM discussed the implementation plans with the Department of Health, Provincial Health Office, and Municipal Health Offices. Local government officials from both municipal and village levels were briefed by KLM-hired community organizers. These discussions and briefings ensured the smooth selection of trainees and the commitment of the local government and partner implementers.

A provincial training team was established with the assistance of the University of the Philippines College of Public Health and the first training was done in August 2001. In December 2002, 344 village microscopists (one for each endemic village excluding 76 non-endemic villages) completed training and were provided with microscopes and initial reagents and supplies. By 2003, these village microscopists were conducting the microscopic diagnosis of malaria. Today, approximately 80% of them remain and continue to provide microscopy services in their communities.

KLM developed other volunteers like the village community organizers to assist in the health education-promotion activities in schools, community and special group gatherings. These activities focused on information about prevention and control and the promotion of diagnosis through the trained village microscopists. Malaria Awareness Day or day of festivities was integral to the awareness raising initiatives. Working groups for malaria were also established in each village where the meetings served as avenues for short term planning and direction setting.

Advocacy and Linkage Building (ALB) was a main-

stay among the KLM hired community organizers. This focus sought to ensure that partners remain enlightened and supportive of the control activities being espoused. Primary targets were the local government leaders who were encouraged to continue support to their village microscopists and to the malaria control program.

### OUTCOMES

The introduction of the village microscopists into the mainstream malaria control program in Palawan and the health education-promotion activities have generated significant observable outcomes. Despite the passive case detection system, an increase in case detection is reflected by the increase in the number of smears gathered in 2002, 2003 and 2004 as compared to that collected in 2000 and 2001 when village microscopists were not yet dispatched to their communities. This heightened case detection has likewise resulted to the confirmation of more than 22,000 malaria cases in 2004 (Fig. 2). Furthermore, a decline in the number of clinically diagnosed malaria cases was observed along with the increase in cases being confirmed.

On the economic side, in 2003, it is estimated that total of about 20.2 M PhP (476,190 USD at 42 PhP = 1 USD) representing transportation expenses to the nearest Rural Health Unit or microscopy station was saved because of the

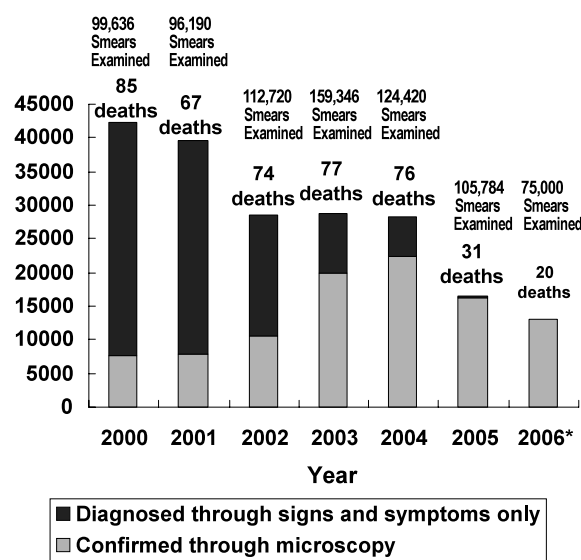


Fig. 2 Malaria Cases in Palawan, the Philippines, from 2000 to 2006

\*Partial data, from approximately 90% of expected reports.

Source: 1. Malaria Control Service, Region IV Extension Office  
2. Provincial Health Office  
3. KLM, Provincial Government of Palawan

Table 2. Goal, accomplishments and programs of KILUSAN LIGTAS MALARIA, 2006

<b>Goal</b>	Establish a malaria-free Palawan by 2020 through the implementation of proven, effective and innovative malaria control strategies
<b>Accomplishments for 2006</b>	
<i>Early Case Detection and Treatment</i>	• Proficiency courses and upgrading of microscopes for 116 village microscopists
<i>Vector Control</i>	• Provision of drugs for more than 10,000 patients
<i>Social Mobilization</i>	• Distribution of 58,313 conventional mosquito nets
	• Treatment of 19443 Mosquito nets
	• 28 Malaria Awareness Day celebrations facilitated
	• 5 radio plug versions aired over 5 months
	• 631 Malaria Sessions in the villages facilitated
	• 121 School Information Dissemination sessions facilitated
<i>Program Administration and Management</i>	• 2 Basic Malaria Management Course sessions for Rural Health Units conducted
	• Microscopy Quality Assurance Orientation to Validators
	• Epidemic Management Training facilitated
<b>Program Effect and Impact 2006</b>	
<i>Morbidity and Mortality</i>	• 73,189 individuals smeared
	• 13,084 confirmed malaria cases and 20 deaths
	• 20% lower morbidity compared to figures last year of the same time period
<i>Beneficiaries</i>	• Total of 105497 individuals received services or participated in activities
	• Approximately 38886 individuals being protected by treated nets
<i>Sustainability</i>	• Approximately 10 M PhP provided by LGU in support of malaria control activities (7.5 M from Province and 2.5 M from villages and municipalities)

proximity of the village microscopists [12].

Similarly, ongoing ALB has yielded a total of 20.07 M PhP from the village, municipal and provincial governments as support for malaria control activities from 2000 to 2003. The majority of this support was in the form of financial incentives to the village microscopists and village community organizers who received an average of 500 PhP (12 USD) per month. Another important outcome is the initiation and institution of policies in support of the program by the LGUs. In 2002, an executive order from the governor was released declaring October as malaria awareness month for the province and enjoining everyone to observe and participate in its practice. In 2004, a provincial ordinance was released recognizing the valuable contributions of the village microscopists and encouraging all mayors to continue supporting them and their operations in the communities.

### CHALLENGES

Although there have been positive outcomes, challenges still remain. Convincing the various stakeholders to place their trust in the village microscopists was a primary goal. The establishment of a validation system helped not only the stakeholders, but also the microscopist in maintaining their self confidence. Proficiency refresher courses were later conducted in 2005.

Generating financial support for the malaria control activities from local governments and partners required con-

stant follow-up and representation. The malaria control activities likewise compete for a share from a pot of minimal finances. Vigilant ALB enabled continued commitment to the cause.

The greatest challenge is maintaining momentum and sustaining the gains (Table 2). With the malaria control program linked in the ever-evolving local political structures and systems, change is expected. The LGUs may lose interest and funding support may be discontinued or reduced. The current approach is to maximize the support from external partners. Although public health, especially malaria control services, is considered the duty of government, the current financial realities they face bound them to refocus. In such instances, private sector funding becomes an option worth considering. Hence, it is an effective strategy to engage the private and non-government sector whenever opportunities arise. Promotion of local policy to earmark funds for malaria control is also an option but will definitely entail longer and more complex processes.

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