Building Community Capacity to Control Malaria in Central Malawi
(GHN-A-00-07-0008-00)

Country: Malawi

Annual Report on Year Three

October 1, 2009 – September 30, 2010

A group of beneficiaries with their volunteers from Thumba area in Kasungu with nets obtained from NMCP

Christian Reformed World Relief Committee

In collaboration with:
Nkhoma Relief and Development

Point of Contact:
Stephanie Sackett, Associate Director - Grants
Christian Reformed World Relief Committee
2850 Kalamazoo Ave, SE, Grand Rapids, MI 49560
Tel: (616) 224-0740 x4156
Email: ssackett@crwrc.org

Submitted on October 29, 2010

TABLE OF CONTENTS

	List of Acronyms and Abbreviations	2
A.	Main Accomplishments	3
	Table of key activities and indicators for each objective	9
B.	Factors Impeding Progress	15
C.	Program Changes	16
D.	Monitoring and Evaluation Activities	17
E.	Technical Assistance	18
F.	Specific Information Requested	19
G.	PMI Team Collaboration In Country	19
H.	Other Relevant Information	20
I.	Publications or Presentations	20
J.	Stories	20

List of Acronyms and Abbreviations

ACT	Artemisinin-based Combination Therapy
ANC	Antenatal Clinic
BCC	Behavior Change Communication
CBO	Community-Based Organization
CCAP	Church of Central Africa, Presbyterian
CDC	Centers for Disease Control
C-IMCI	Community-based Integrated Management of Childhood Illness
CRWRC	Christian Reformed World Relief Committee
DHMT	District Health Management Team
DHO	District Health Office
FBO	Faith-Based Organization
GOM	Government of Malawi
HH	Households
HSA	Health Surveillance Assistants
IEC	Information, Education, Communication
IPTp	Intermittent Preventive Treatment (during pregnancy)
ITN	Insecticide Treated Net
LA	Lumefantrine Artemether
LLIN	Long Lasting Insecticidal Net
MCP	Malaria Communities Program
MOH	Ministry of Health
NGO	Non-Governmental Organization
NMCP	National Malaria Control Program
NRD	Nkhoma Relief and Development
PMI	President's Malaria Initiative
PSI	Population Services International
SP	Sulfadoxine-pyrimethamine
U5s	Under 5 (Children)
USAID	United States Agency for International Development

A. MAIN ACCOMPLISHMENTS

Background

Christian Reformed World Relief Committee (CRWRC) is implementing Malaria Communities Program (MCP) in the central region of Malawi and Mangochi. The objective of this five-year program is to reduce malaria associated morbidity and mortality among children under five and pregnant women through building and sustaining community capacity.

The behaviors promoted by this program include:

- Ownership and correct, consistent, year-round usage of insecticide treated bed nets by pregnant women and children under 5.
- Pregnant women going for antenatal care (ANC) in their first trimester and receiving two doses of SP during pregnancy for malaria prevention.
- Caregivers seeking treatment immediately for children under five suspected of malaria, so that treatment with an anti-malaria drug can be given within 24 hours of onset of symptoms

This report outlines the major activities and achievements of this program during the 2009-10 program year, which was the third year of implementation.

The main accomplishments highlighted in this report include those identified through the mid-term evaluation of the program, which took place during July and August 2010. As part of the mid-term evaluation, regular monitoring data was reviewed and a small survey of the 25 catchment areas (in nine districts) using Lot Quality Assurance Sampling (LQAS) methodology was conducted. The same questions asked at baseline were asked again in this survey.

Household use of insecticide treated nets

The behaviors of ITN ownership and usage are where the program is noticing the most obvious improvements in the indicators. Net ownership has increased noticeably in the past two years, with 92% of households (who are enrolled in our program) owning at least one net, this is a positive development as the program in has managed to exceed the target of PMI which is 90% within its catchment areas. More than half (54%) of the households surveyed at mid-term now own two or more nets. Many people interviewed who do not currently have nets expressed a desire to obtain one. This shows that more people have appropriate knowledge about malaria prevention and are practicing the behaviors promoted by the program volunteers.

There has been a noticeable increase in the number of children being put under nets to sleep at night. When surveyed at mid-term, 87% of respondents said that a child slept under the net the previous night. This statistic corresponds to what people in the communities told us. Many said that at 6:00 p.m. when the sun sets and the mosquitoes come out, they put their babies down to sleep in the house under the net.

Indicator	Baseline Value	Midterm Value	EOP Target
Households that have a net	(n=439) 72.2%	(n=170) **91.1%**	90%
Households with at least two ITNs	(n=439) 27.1%	(n=168) **50.6%**	--
Who in the household slept under a bed net last night? No one Child	(n=439) 54.2% 45.8%	(n=170) **20.6%** **79.4%**	85% of under 5 children
Percentage of women surveyed that slept under an ITN all of the time when they were pregnant?	(n=439) 34.9%	(n=170) **63.5%**	85%

There has been a significant increase in the number of pregnant women sleeping under a net (more than 25% increase from baseline). This may have a lot to do with the fact that pregnant women are the one group in Malawi targeted by the health system to receive free nets if they attend ANC. But the women interviewed by our evaluation team indicated that the messages they received from the program volunteers were an important factor in deciding to use the net. The volunteers verified that nets have been hung in the homes and give assistance to households in correctly hanging their nets. The program saw this as one area that needs to be intensified in the coming year to meet the PMI target.

Treatment of Malaria in Children Under Five

The midterm survey data indicates that more caregivers are obtaining anti-malarial drugs to treat fever for under-five children and that more children are receiving treatment within 24 hours of the onset of symptoms. It was clear from interviews with beneficiaries that they know very well the symptoms of malaria. They rush the child to the health center immediately when they note symptoms of malaria. During focus group discussions in the communities and interviews with the health facility staff serving our target areas, we heard from nearly everyone (including health center staff) that the cases of malaria are fewer than they were a couple of years ago. An inspection of some health facility records also showed a decline in cases from previous years. And there were indications that the number of severe cases seems to have declined.

Indicator	Baseline Value	Midterm Value	EOP Target
Percentage of children with fever that were given an anti-malarial drug for treatment	(n=190) 41.1%	(n=70) **62.9%**	85%
Percentage of children with fever that received a drug for treatment (not necessarily an anti-malarial) on the same or next day after the fever started	(n=190) 36.8%	(n=70) **62.9%**	85%

Preventive Treatment for Pregnant Women

As the data below illustrates, about 88% of pregnant women were already accessing preventive treatment for malaria (SP) prior to the start of the program. Since the program began, it appears there may have been a modest increase in the number of women receiving two doses (from 68.8% at baseline to 73.7% at mid-term). In interviews, people told the evaluation team that women used to wait until the fifth, sixth or seventh month of pregnancy to go for ANC. (They didn't want to reveal they were pregnant early because of superstition.) But now more women are starting ANC in their first trimester.

Indicator	Baseline Value	Midterm Value	EOP Target
Percentage of women that took SP during pregnancy	(n=439) 88.6%	(n=170) 88.8%	--
Percentage of women that had 2 doses of SP during pregnancy	(n=439) 65.1%	(n=170) 72.9%	85%

Community Mobilization

By September 30, 2010, a cumulative total of **267 groups of volunteers** had been formed and a total of **4,012 volunteers** had been recruited. This represents 80% achievement of the life-of-project targets.

This past year the number of volunteers that dropped out was significantly less than the year before (90 this year vs. 235 the year before). And most of the drop-outs this year are due to volunteers joining other professions, getting married, or moving out of the area, rather than low morale (which was the case the previous year).

Most volunteers are visiting the households assigned to them twice per month. The interviews conducted during the mid-term evaluation verified that these visits are being done regularly and that they are effective in educating people and helping them to adopt the desired behaviors. We heard stories of households receiving visits on days when a child in the house was sick and being encouraged to seek immediate treatment for the child. The beneficiaries expressed a lot of appreciation for the visits, and several people in the communities who are not enrolled as beneficiaries said they wished they could receive these visits from the MCP volunteers too. Beneficiaries frequently bring their neighbors in to hear the messages from the Volunteers.

Drama performed by group of volunteers at Mchinji- Mchemani

In addition to the house-to-house visits, program volunteers organized and conducted **369 community awareness campaigns** during year three (against an annual plan of 324) in order to reach even more people in the communities. The campaigns at community level use dramas, songs, and health talks to communicate the messages related to net ownership, proper net usage, early care seeking for children with malaria symptoms, and early attendance at ANC for preventive treatment for pregnant women. The campaigns attracted many people from the community who enjoy the dramas. These events have increased awareness and knowledge in the community on malaria prevention and treatment. This has resulted in communities having increased demand for ITNs/LLINs, ANC services (IPTp), and treatment services. Those in attendance at these community awareness campaigns included 267 chiefs. We estimate that more than 50,000 community members heard malaria messages through these events. In addition, the volunteers and Facilitators gave 299 health talks to 6,797 pregnant women and 19,871 caretakers during outreach clinics for under fives and ANC.

Training

All 42 Facilitators were trained in building and assessing community capacity, facilitation skills, leadership skills, monitoring and evaluation, Introduction to Theatre for Development, interpersonal skills and communication. Refresher training for volunteers that started in year one and year two was done in the months of May and June 2010.

One of the volunteers from Thumba Kasungu receiving a certificate after completion of training. Left to right: Mr Kanyambita from Kasungu DHO, Reverend Chidzulo from Thumba congregation, Chipiliro Kambombe (MCP Coordinator)

Exchange Visits

Volunteer groups do exchange visits where one group which is doing well visits another group that needs encouragement, as a way of encouraging one another and sharing experiences. This acts as a motivation for the group that is doing well as are able to visit other places and also acts as a motivator even for the group that needs encouragement as they also want to be a group that one day can visit their friends. During these exchange visits, groups share experiences they have had organizing their programs, record keeping

Part of volunteer groups from Kamanzi and Mpando- Lilongwe areas sharing experiences during an exchange visit

Advocacy – LLIN Distribution Points

Five new LLIN distribution points were identified in Nkhotakota, where 96 communities are benefiting from them. These are Kangamowa, Chimkango, Chitsulo, Masewe and Takumana. These points were identified by the program facilitators and HSAs working in the area after looking at the distance that is there between the village and the hospital. The program Supervisor and the HSA supervisor then went to verify. Then the District Malaria Coordinator and the District ITN coordinator were informed, and they referred the matter to the appropriate health centers. The health center personnel worked hand in hand with the program staff to mobilize and open the distribution points. The establishment of these points has helped in reaching out to beneficiaries who were not able to access ANC, under-five services and nets due to distance to the nearest health center.

Project staff advocated for effective operation of some outreach clinics within the catchment area. It has been noted that apart from Kasungu (where the project first identified that most outreach clinics do not take place and that where they take place they don't distribute nets), other districts too mainly only distribute ITNs or LLINs at the main health center and not through outreach clinics.

MCP program staff talked with responsible District Health Offices (DHOs), health centers and the National Malaria Control Program (NMCP). Most outreach clinics are now distributing LLINs at under-five outreach clincs, but they are still not available at ANC outreach clinics. The program will continue to advocate for this.

Following a distribution of nets obtained through NMCP, volunteers from Thumba area in Kasungu demonstrate for beneficiaries how to hang a net.

The program also talked with NMCP regarding Thumba, which is an area in Kasungu that is about 39 km away from nearest health center. MCP program staff told NMCP that Thumba should be considered for distribution of LLINs at their outreach clinic. The beneficiaries in this area were very much willing to adopt new behaviors being taught to them but were failing to do so due to long distance to the nearest health facility. The program is very grateful to NMCP as ot facilitated the distribution of 300 nets to the beneficiaries in the month of September.

Sustainability

One successful approach used by project staff is to approach community leaders such as Village Heads, Group Village Heads, and religious leaders before starting to work in a new area. This helps to gain their support. As a result, the community leaders give the volunteers opportunities to share malaria messages at community gatherings and church events. The village headmen tell people in the community that they should listen to the volunteers and heed their advice (especially if the volunteer encounters resistance), and they themselves also give messages about using nets, getting SP while pregnant, and seeking treatment early for children.

Volunteers were approved by community leaders. This has given the community leaders a feeling of ownership in the program. When there are drop-outs, the village leaders are involved in approving replacements. They receive reports from the volunteers on their activities and provide some accountability for the work of the volunteers in the community.

The program ensures sustainability by also appointing some of the village leaders as role models in recognition of their active participation and commitment to the program. Each community has at least one or two role models. These role models talk on behalf of the program on behaviors that need to be followed. Some have already put in place a by-law that community members are

free to take ITNs to funerals (the social barriers around practicing these behaviors are best addressed through the influence of the chiefs).

This program has been successful in building resident community capacity for malaria prevention and treatment. Knowledge about malaria will continue to reside in the community after the program concludes in 2012. Most volunteer groups interviewed during the mid-term evaluation said they will continue their malaria education activities and continue to meet as a group even after the program ends.

Sustainability is enhanced by the strong links that have been formed between volunteers and local structures such as the HSAs, the village chiefs, the local church, the Village Development Committees, and the Village Health Committees. Even after the project concludes, it is likely that HSAs will continue to provide some level of supportive supervision and advice to the volunteer groups.

IEC

During the reporting period, the program produced over 1,800 t-shirts with malaria messages on the four behaviors and distributed them to volunteer and other relevant stakeholders who are active on the program, including some chiefs. The program also produced 7,500 posters with malaria messages which were distributed to health facilities and to volunteers.

PSI and BASICS provided us with messages and designs for IEC materials for malaria prevention and control. This is in line with USAID's recommendation to PMI partners to use already available messages from NMCP on IEC materials to ensure consistency in messages disseminated to the public on malaria prevention.

Some posters produced by the program, hanging at a health facility in Mchinji

Project Objectives	Indicators & Current Measurements	Key Activities, as outlined in the year 2 work plan	Status of Activities & Outputs Achieved	Comments
Strategic Objective 1: Strengthen and sustain community capacity for malaria prevention and treatment interventions.	Number of community groups formed Year 3 Target: 336 Year 3 Actual: **267** Number of volunteers reaching other community members with information on malaria prevention and treatment Year 3 Target: 5,040 Year 3 Actual: **4,012** Number of households participating in the program Year 3 Target: 50,400 Year 3 Actual: **40,120**	Focus group discussions to enhance understanding of Y2 barrier analysis	Completed	84 FDGs were done for the new districts: Kasungu, Ntchisi, Nkhotakota and part of Salima
		CRWRC's Associate Director for Grants visits the Malawi field office to orient new staff person	Completed November 2009	A visit was made to the USAID Mission during this trip, where introductions were made to Pius Nakoma.
		Supervisors and Facilitators conduct focus group discussions on malaria best practices with DHMT, Traditional Authorities, and pastors.	Done as planned, but will continue in the next year	114 FGDS were held at community level with some DHMT, traditional and religious leaders present in all the districts. General discussions on program progress were held with DHMTs in 6 districts. Two DHMTs have not yet been met due to their tight schedules. The program resolved to meet whoever will be available from these DHMTs
		Facilitators form 168 new community groups, bringing the cumulative total to 336.	93 new groups were formed bringing a cumulative total of 267.	Implementation delays occurred at the end of year one when the MCP Coordinator resigned. As a result, some volunteers groups were formed later than planned. And it is necessary to make sure that that groups have achieved a high enough level of capacity to sustain their activities before the Facilitators leave them to work on forming groups in new areas.
		Facilitators recruit 2,520 new volunteers, bringing the cumulative total to 5,040.	1,125 new volunteers were recruited for a cumulative total of 4,012	This past year the number of volunteers that dropped out was significantly less than the year before (90 this year vs. 235 the year before). Most of the drop-outs are due to volunteers joining other professions, getting married, or moving out of the area, rather than low morale.
		5,040 volunteers trained	A cumulative total of 2,887 volunteers have completed their training.	Come volunteers were recruited toward the very end of year three and were not trained before September 30. That is why there are fewer volunteers trained than recruited.

Project Objectives	Indicators & Current Measurements	Key Activities, as outlined in the year 2 work plan	Status of Activities & Outputs Achieved	Comments
		Assess the sustain-ability of 168 volunteer groups using capacity indicators	Completed	168 groups were assessed and deemed ready to operate independently, so the Facilitators will be freed up to begin 168 new groups in other areas.
		Facilitators monitor the performance of volunteer groups by attending their meetings twice per month and doing supervisory follow-up to households	1,008 monthly meetings took place in the fiscal year. Supervision is done regularly and is ongoing	
		Develop volunteer management and retention strategy	Completed	Volunteer groups will be assisted in staring small income generating activities so there can be some income to support the groups' activities. This is hoped to achieve sustainability of the groups after completion of the project
		Supervisors hold monthly district meetings with Facilitators	A total of 96 monthly meetings took place	Reviews are done on the impact of the program at district level, reports are given and submitted, facilitators are trained in specific topics
		Supervisors conduct quarterly trainings for the 42 Facilitators	Done once a year where all the facilitators in a district come together and are trained together by their Supervisor.	Done once because of budget constraints. However, informal trainings occur when they attend district meetings on monthly basis.
		Mid-term evaluation of the program conducted by CRWRC headquarters staff	Completed August 2010	21 communities were visited to find out how the program is progressing in all the 9 districts of operation. The mid-term evaluation report is submitted as an addendum to this annual report.

Project Objectives	Indicators & Current Measurements	Key Activities, as outlined in the year 2 work plan	Status of Activities & Outputs Achieved	Comments
Strategic Objective 2: Increase the proportion of households with a pregnant women or children under five that own at least one ITN.	Proportion of targeted households with a pregnant woman or children under five with at least one ITN Year 3 Target: 70% Year 3 Actual: **91.1%** Number of households participating in the program that own at least one ITN Year 3 Target: 38,500 Year 3 Actual: **36,790** Number of households participating in the program that have re-treated their ITN(s) Year 3 Target: -- Year 3 Actual: **15,441**	Identify distribution points for ITNs/LLINs where they will reach the very poor and where supplies are too low and communicate this information to PSI and NMCP	Identified five more distribution points this year from Nkhotakota district, bringing the total to 53 since program's inception	In some areas like Kasungu discussions are still on with the DHO
		Volunteers educate households about how to access free or subsidized LLINs locally	Continues to happen on an ongoing basis	Interviews conducted during the mid-term evaluation verified that there is a high level of knowledge in the community about how to access LLINs.
		Mobilize communities to participate in annual net re-treatment campaigns organized by the GOM	15,441 MCP beneficiaries participated in the campaign last year	Most households have long lasting insecticidal nets, which do not require re-treatment.
		Volunteers conduct community awareness campaigns that use songs, dramas, and health talks to promote net ownership and correct net usage	369 community awareness campaigns conducted in Y3	This exceeded the target of 324 campaigns which were planned for the year

Project Objectives	Indicators & Current Measurements	Key Activities, as outlined in the year 2 work plan	Status of Activities & Outputs Achieved	Comments
Strategic Objective 3: Increase the proportion of children under five and pregnant women who sleep under an ITN every night.	Proportion of pregnant women in targeted households who slept under an ITN the previous night Year 3 Target: 55% Year 3 Actual: **63.5%**[1] Proportion of children under five in targeted households who slept under an ITN the previous night Year 3 Target: 55% Year 3 Actual: **79.4%**[2] Number of households participating in the program that received messages about proper net use Year 3 Target: 50,400 Year 3 Actual: **40,120**	5,040 volunteers trained in BCC techniques for increasing the number of pregnant women and children under five sleeping under ITNs	So far 2,887 of the 4,012 volunteers recruited have been formally trained on BCC.	The remaining 1,125 have been informally trained on BCC and are able to convey messages to their households, but will undergo a formal training in October with the rest of the newly formed groups.
		Coordinate with PMI partners in country to access IEC materials on ITN use. Volunteers share the IEC materials with beneficiaries	7,500 posters and 1,800 t-shirts were produced and distributed to volunteers. 42 malaria booklets from the MOH Health Education Unit were distributed to the Facilitators.	There is still shortage of IEC materials, as the communities to be reached are vast. PSI helped in development of posters featuring the four behaviors that the program is promoting the program.
		50,400 households receive messages about proper net usage	40,120 households have been receiving messages	There are more volunteer groups yet to be established, which is why the full number of households is not being reached yet.

[1] Out of 170 households interviewed at midterm, 108 (63.5%) said the woman slept under the ITN all the time during her last pregnancy.
[2] Out of 170 households surveyed, 135 said that at least one child had slept under a net in the home the previous night. The way the question was asked does not allow us to see if all the U5 children in the household were under a net. We only know that 79.4% of households are putting at least some of their children under the net to sleep.

Project Objectives	Indicators & Current Measurements	Key Activities, as outlined in the year 2 work plan	Status of Activities & Outputs Achieved	Comments
Strategic Objective 4: Increase the proportion of pregnant women receiving two or more doses of SP for IPTp during their pregnancies.	Proportion of women in targeted households who received two or more doses of IPTp during their last pregnancy in the last two years Year 3 Target: 70% Year 3 Actual: **72.9%** Proportion of women in targeted households that cite IPTp as a necessary treatment during pregnancy Year 3 Target: 85% Year 3 Actual: **100%** Number of volunteers trained to counsel pregnant women to obtain treatment Year 3 Target: 5,040 Year 3 Actual: **2,887** Number of pregnant women participating in the program who received two doses of IPTp Year 3 Target: 5,000 Year 3 Actual: **10,788**	Train 5,040 volunteers in IPTp promotion	2,887 formally trained, 1,125 informally trained	Formal training for 1,125 plus other new volunteers will be done mid October
		Coordinate with PMI partners in country to access IEC materials on IPTp. Volunteers share the IEC materials with beneficiaries.	2,500 posters with IPTp messages produced and distributed to all volunteer groups and health facilities	
		Volunteers promote behavior change among pregnant women to increase earlier ANC attendance and to increase their understanding of the importance of IPTp (which is provided free at ANC clinics)	This is happening as planned and will continue	10,788 include all women that received 2 doses of SP after being taught by the program. This is cumulative over the last three years. Informal trainings on IPTp were provided for the 1,125 volunteers that were newly recruited.

Project Objectives	Indicators & Current Measurements	Key Activities, as outlined in the year 2 work plan	Status of Activities & Outputs Achieved	Comments
Strategic Objective 5: Increase the proportion of children under five with suspected malaria receiving treatment with an antimalarial drug within 24 hours of onset of symptoms.	Proportion of U5 children in targeted households with fever in the last two weeks who received treatment with an anti-malarial within 24 hours of onset of fever Year 3 Target: 65% Year 3 Actual: **62.9%**[3] Number of Facilitators trained on use of new first line drugs Year 3 Target: 42 Year 3 Actual: **42** Number of volunteers trained in the new drug policy Year 3 Target: 5,040 Year 3 Actual: **2,887** Number of households participating in the program that received information about the new drug policy. Year 3 Target: 50,400 Year 3 Actual: **40,120**	Link 42 Facilitators to training on the new first-line drug	All 42 facilitators were trained November 2009	The Lilongwe Malaria Coordinator from Lilongwe District Health Office trained all facilitators in new drug policy in November 2009
		Facilitators train and offer refreshers to 5,040 volunteers on the new first line drug	Trained 2,887	All old volunteers were formally trained in new drug policy. New ones were only informally trained but will have formal training in October 2010 (the first quarter of year four).
		Coordinate with PMI partners in country to access IEC materials on malaria treatment. Volunteers share IEC materials with beneficiaries.	2,500 posters with care seeking messages printed and distributed to volunteers and health facilities	Could not print more posters due to budget constraints.
		Identify and report availability (stock outs) of new ACT medicines in remote areas of program operation	Reports were made to PMI and DHOs.	During the months of April and May, all the health centers that the program assessed that are within the program catchments area had adequate supplies of LA. However, in June and July several areas reported stock outs.
		Volunteers use IEC and BCC to inform households about the new drug policy and to change the behavior of caregivers so that children receive prompt and effective treatment	Volunteers use posters when doing HH visits, when giving health talks at the hospital and during community campaigns	The IEC materials were not enough as there was an outcry by other healthy facilities. But we could not produce more than due to budget constraints.
		Volunteers conduct community awareness campaigns on early care seeking/treatment	Done	

[3] Of the 170 households surveyed, 70 said they had a child that had been sick with malaria in the past two weeks. Of those 70, 44 had been treated for the fever within 24 hours. But the way the question was framed in the survey it is not certain how many of them were treated with an anti-malarial drug.

B. Factors that Impeded Progress

Community Mobilization

We wanted to have all 5,040 volunteers recruited by the end of year three but fell a bit short of this goal. There are still 1,028 volunteers to recruit and 69 community groups to form. The reason that the community mobilizations targets for year three have not been met is that the MCP staff want to make sure that the groups formed earlier in the program have good capacity before the Facilitators re-direct their attention to the formation of new groups. The program was designed in a way that each Facilitator should establish four community groups with 15 volunteers in each group. Then after these began to function well and developed the capacity to manage their activities with less support from the Facilitator, up to four new groups would be formed. The MCP management staff intend to complete the formation of all of the groups by the end of the first quarter of year four.

Treatment of Malaria in Children Under Five

Caregivers say that they are rushing sick children to the health center immediately when symptoms begin. But frequently they encounter challenges getting to the health centers, which for most people are 10-40 km away. Most people have to walk on foot carrying the child, and when they arrive at the health center, it is not uncommon to queue for a long time to receive medical attention or to be turned away because the health center is out of drugs or because there is not enough time for the clinician to see all the patients. There are frequent stock-outs of LA, the first line drug. In spite of these challenges, the caregivers seem determined to access anti-malarial drugs for their children when they are ill. And during the mid-term evaluation, many who were interviewed expressed a desire for the HSAs or community health workers in the area to be equipped with some kits for dispersing treatment out in the villages.

Village clinics are operated by HSAs in some areas and are supposed to have supplies of LA. But often village clinics experience stock-outs of LA, and then caretakers must take children to visit the health center, which is very far away. This was reported to NMCP, and they said that the problem was that the drugs for HSAs were passing through the district hospitals and health centers and were being used there first to address stock-outs before reaching the HSAs. NMCP representatives said that they are working to address this concern so that village clinic drugs go straight to the HSAs, ensuring availability of anti-malarial drugs at the village clinic level.

Because of the critical need to have a health facility nearby, three communities within our catchment areas (Nkhotakota, Salima and Kasungu) have built health posts on their own (self-help), where ANC and under-five outreach clinics are held. The program only provided plastic sheets for roofing. Now pregnant women and caretakers of the under-fives are attending these clinics closer to them. These buildings provide privacy when outreach clinics are conducted.

Ownership of ITNs/LLINs

Many beneficiaries reported shortages of free nets for pregnant women at the health center. If they are not available when a woman comes for her first ANC appointment, she might receive one if she comes to the health center to deliver her baby. But it is still possible that she may not receive one at all, if they are stocked out when she delivers. (Stock-outs of nets appear to be common. There appears to be a flat number that a health center can receive in a consignment,

regardless of the population size served by the health center. This was presented to NMCP, and they said they would look into the matter to ensure that nets are distributed according to population.)

Only pregnant women who go for ANC or delivery at the health center can access a free net. People say they cannot afford to buy nets, so within a household there may be several children (some of them under five) who are not sleeping under a net because there is only enough for the pregnant mother and youngest child to be covered. Due to the culture of handouts, people want to access free nets, but are reluctant to pay the 800 Kwacha cost to buy a net. People say they would buy subsidized nets if they were available. CRWRC and NRD will work on messages to encourage families to purchase nets so that all the children in the household can be covered.

Stock outs of LA and ITNs

Most health centers do not distribute nets during ANC outreach clinics, and because of that pregnant women who live far from the health facility are not receiving nets. Likewise there has been an experience of stock outs of LA in some of the facilities especially in the months of July to September 2010. (It was reported at one of the PMI meetings that the whole country will experience some stock-outs of LA due to some logistical problems from central medical stores.) This discourages community people from seeking health services. The advocacy activities described in the Accomplishments section will continue.

Fuel Scarcity

During the months of November – December 2009 and September 2010, there were critical fuel shortages in the country. This affected the work of Supervisors, who are expected to monitor the work of facilitators and volunteers in different parts of the district and attend meetings organized by the Facilitators and other partners. Program staff dealt with fuel shortages by combining trips with DHO staff in order to reach out to more areas which could not otherwise be visited.

Inadequate IEC materials

The program being a BCC program relies more on messages and one more effective method of disseminating these messages is through posters. It has been a challenge for the program to source and produce IEC materials due to budget constraints. Program staff discussed this issue with the Ministry of Health – Health Education Unit to increase the number of IEC materials related to malaria that are available. It was noted that there are more IEC materials for other diseases like cholera, diarrhea, and HIV/AIDS than for malaria.

C. Program Changes

No significant changes to the program strategy or objectives were recommended as a result of the mid-term evaluation that was completed in August.

D. Monitoring and Evaluation Activities

Facilitators meet with volunteers two times per month. The second meeting of the month is the time to gather reports on the households that are being visited by the volunteers. Each month the Facilitators provide a report to the District Supervisor on all the beneficiaries and volunteers in their working areas. On a quarterly basis, the Supervisor brings the Facilitators together at the district level for a meeting to discuss accomplishments and challenges. On a quarterly basis, the Supervisors also meet with the DHMTs and other district authorities to share information about the program

Performance Visits

During the past year, 114 performance visits were made by the district Supervisors and/or the MCP Coordinators. Visits were done in collaboration with other stakeholders in the catchment area. The purpose of these visits was to allow project staff to assess the performance of individual volunteers by visiting beneficiary households. These assessment visits have been very helpful as the program staff, together with stakeholders, were able to assess the level of understanding of malaria issues by beneficiaries and to evaluate progress. It has become apparent that household visits done by volunteers have helped beneficiaries to become more aware of malaria, its causes, management and prevention as evidenced by correct answers that were being given by beneficiaries during the performance assessment visits. It was also encouraging to note that most beneficiaries take their children to hospital within 24 hours of onset of symptoms of malaria, though others fail due to long distances.

Stakeholders involved in these performance visits included: chiefs, local NGO staff, church leaders, HSAs, DHMT members, and chairmen of different village committees. Stakeholders present were able to address problems that beneficiaries face. For example, hospital personnel were able to respond to issues such as delays in receiving treatment at the hospital. Chiefs were able to respond to community suggestions to form new by- laws that will help protect pregnant women and under five children from getting malaria. These visits also helped to strengthen the relationship amongst stakeholders as all the local stakeholders are involved in the exercise.

Mid-Term Evaluation

A midterm evaluation of the Malaria Communities Program took place August 2-10, 2010. Some of the information used during the evaluation process was provided by the project's monitoring system. Other information was gathered through interviews and focus group discussions. The questions explored in the evaluation included the following:

- Is there satisfactory progress in project implementation?
- Is the project achieving its objectives?
- Are the interventions sufficient to reach the desired outcomes?
- What barriers exist to achieving the objectives?
- What follow-up actions might improve the project?

The evaluation process also looked at the following features of the program:

- Project management
- Adherence to Malaria Program policies of the Government of Malawi

A participatory and collaborative method was used, which involved CRWRC and NRD, along with other key stakeholders such as a the National Malaria Control Program (NMCP), Ministry of Health-Health Education Unit, other President's Malaria Initiative partners (Concern Universal and MSH-BASICS), district level health officials and personnel, and the community members involved in the program. The evaluation team assessed the progress achieved to date, along with the barriers encountered and formulated recommendations for next steps.

Prior to assembling the evaluation team on the field for the qualitative assessment, the MCP project staff collected regular monitoring data and conducted a small survey of the 25 catchment areas (in nine districts) using Lot Quality Assurance Sampling (LQAS) methodology. The same questions asked at baseline were asked again in this survey.

The evaluation team split into three sub-teams for four days of field work. A diverse mix of communities was visited in all nine target districts, including areas in the uplands and those along the lakeshore. A total of 21 communities were visited. Focus group discussions were conducted separately with three different groups in the community: 1) community leaders (village head men and religious leaders), 2) program beneficiaries, and 3) MCP volunteers. After the field work, the evaluation team reconvened to report the key findings from the field visits. A deeper analysis and discussion of the information gathered was done to formulate recommendations and some key action steps.

The stakeholder meeting at the end of the evaluation included program staff, partners, MOH personnel, a USAID Mission representative (Pius Nakoma), some traditional leaders, volunteers and beneficiaries. Data obtained from the field visits and interviews were presented. Participants asked questions of the evaluation team and offered their feedback and suggestions on the action steps that would be most important for the last two years of the project.

E. Technical Assistance

TA Needs for 2010-11

Program staff would like to receive consultation from an expert that could help to review the project M&E system (including tools and forms that staff are currently using) and build the capacity of project staff in M&E. We would also like assistance in modifying the survey questionnaire that was used at baseline and mid-term so that when we do the final survey in year five the data helps us to answer the questions about whether life-of-project targets were achieved.

TA Received in 2009-10

The MCP Coordinator and Assistant Coordinator participated in a week-long training organized by USAID, which took place in Kenya at the end of October 2009. The training covered BCC as well as PDME and was very useful in helping staff to prepare for the mid-term evaluation that also took place in year three. The Coordinator and Assistant Coordinator trained the eight Supervisors on what they had learned during January 2010.

The two Coordinators and eight Supervisors were provided with training on LQAS sampling methodology during July 2010 in preparation for the mid-term evaluation. CRWRC's Health Advisor in the US headquarters office—Alan Talens—provided some consultation on LQAS and helped to design the structure of the survey. But then an outside consultant was contracted to provide the training to project staff in Malawi on LQAS methods and to assist with some data analysis after the survey data was collected.

F. Specific Information

No specific information was requested during the work plan consultation for this project or from the review of previous reports.

G. PMI Team Collaboration in country

- Collaboration between CRWRC and the PMI team has been very good. MCP project staff attended almost all the PMI meetings that were scheduled in the past year.
- Some program staff had a chance to visit Concern Universal (the other MCP grantee in Malawi) in the month of April 2010 to learn about their project and share ideas for BCC.
- Representatives from BASICS, Concern Universal and NMCP participated in the mid-term evaluation of our project during August.
- Program volunteers continued to help in the "Mop Up" net re-dipping campaigns which were conducted by NMCP through DHOs. By June 2010, volunteers mobilized 15,541 beneficiaries to re-dip their ITNs.
- Program volunteers also mobilized people to participate in measles Child Health Week and campaigns organized by MOH in the months of April and June, respectively.
- Project staff talked with NMCP about the unavailability of nets during outreach clinics in other hard to reach areas and got a positive response. Three hundred LLINs have been distributed to the beneficiaries as a result. NMCP promised to distribute more in due course.
- Project staff participated in the stakeholders meeting organized by USAID in May and in the review meeting organized by NMCP in June.
- The program continues to work with all local government decentralized structures such as District Executive Committee (DEC), Area Development Committee (ADC), Village Development Committee members (VDCs), and other stakeholders like Village Health Committees, Health Centers and District Health Management Teams by briefing them on malaria issues in specific catchment areas, offering suggestions for how to resolve them, and facilitating meetings where stakeholders are involved in reviewing progress of the program.

H. Other Relevant Aspects of the Program

For more information on the program, please read the mid-term evaluation report that was submitted along with this annual report.

I. Publications

No project team members have published any papers or made any presentations on the project at any major conferences or events since the last annual report.

J. Stories

First Person Story

Rose Watson is a 35-year old mother who lives in the area of Senior Group Head Village Thandaza in Nkhotakota District. Benga Health Center is about 14 kms away from her village and has been providing outreach clinics in her area for under-five children.

She has been pregnant three times. Her first child died in 2008 when he was six months old. During her first two conceptions she utilized traditional medicine through traditional healers and traditional birth attendants (TBAs). Rose says she used to believe that traditional medicines from the TBAs cleanse you when your husband goes out with other women so that you do not have problems during delivery. Her first delivery was attended by a TBA. The care she received from the TBA included a physical beating. "The TBA thought I was delaying the delivery," Rose reported.

After delivery, the child was not taken to any under-five outreach clinics and did not receive any immunizations or conventional health services. Rose shared the beliefs widely held in the community that injections (immunizations) make children legs swollen. "These beliefs and misconceptions led me to strongly trust the traditional help (traditional leaders and TBAs)," said Rose. Because Rose had not heard any of the health talks that are normally given at the under-five clinics, she did not know what to do when her six-month-old son later developed jaundice (yellowing of eyes. Rose consulted a traditional healer and was told that her relatives had bewitched her son. The healer told her, "The first person to meet you back at home is the one that has bewitched your son." This brought unnecessary tension with her relatives in the village, as they suspected that one of her own relatives bewitched the son. The child died a few hours later after taking the medicine that Rose was given by the traditional healer.

Later she went to the same TBA to deliver her twin sons, because she was forced to do so by her community. She had problems giving birth to the twins, and she acknowledges that it was by chance that these kids were able to grow up.

Rose Watson with her kids at home

By the time of her third pregnancy, the Malaria Communities Program had started its activities in the area that included her village. The community groups

identified her as one of their beneficiary households to benefit from their monthly visits. The volunteer who visits her, Yesani Mbiya, has taught her many things related to preventing malaria during pregnancy, protecting under-five children from malaria, the symptoms of malaria, and the importance of accessing health services from the health center and nearby outreach clinics.

Rose Watson says that she has learned many things through this program and believes had it been the program came earlier she wouldn't have lost her first son. She now clearly understands the symptoms of malaria and the importance of early health seeking behaviors. She says that even though her twin sons were not delivered at the health center, she ensures that they receive proper care from the health center and through under-five clinic within her village. She attended the antenatal clinic at the health centre and received two doses of SP and other pregnancy related care from Benga Health Center. During her fourth month of pregnancy, she received an insecticide treated net (ITN). She received a second ITN at the delivery. Having received two nets, the whole family of five is able to sleep under an ITN every night, and they are all benefitting from the protection from malaria that the nets provide.

Rose Watson now has great trust in the Malaria Communities Program and the local health facility. She has much more knowledge in malaria, and she uses it to teach others. She even helps the Health Surveillance Assistants (HSAs) who conducts under-five clinic in her village in teaching her neighbors. "I do this because the program has taught me much that I need to give back to others, who are living blindly." Rose is now a model to women in her community.

Case Study: Addressing the problem of distance from health facilities in two communities

Community #1: Kangamowa

Senior Group Village Kangamowa in Nkhotakota District is more than 22 kms from the nearest health facility, which is Alinafe Catholic Community Hospital, a Christian Health Association of Malawi facility. Since the village has a small population, it does not have its own Government health center. No outreach clinics occur within the village. To access health services, people have to travel all the way to Alinafe Hospital. This means spending money for transport as well as treatment at the facility (since it is not a government facility). A lot of people are discouraged by the long distance to the health facility, so they seek help from the nearest traditional healers and traditional birth attendants (TBAs) for treatment and delivery.

The Malaria Communities Program (MCP) entered the community with Behavior Change Communication related to malaria in 2008. The major challenge was that there were gaps that existed between knowledge about proper care seeking and the availability of necessary services that would make the behavior possible to practice. Pregnant women were failing to access preventive treatment for malaria and antenatal care (ANC) due to the long distances to surrounding health facilities. The pregnant women could not get SP, bed nets, and other pregnancy related care.

Kangamowa outreach clinic

After being informed about various aspects of malaria and health, the communities realized the absence of some critical services. They started requesting relevant service providers to start providing services such as outreach clinics.

The MCP staff encouraged the village heads to mobilize the groups to mould bricks and build a structure that could be used as an outreach clinic. Through the community, the program staff also approached Alinafe Hospital to find out if they could provide staff on a monthly basis to conduct outreach clinics in the area. The Malaria Communities Program provided a plastic sheet so that the roof would not leak.

Currently under-five clinics and ANC clinics are being conduct at the newly constructed structure once a month. During these clinics, the program volunteers give health talks on malaria to both pregnant women and caretakers of children under five. They also help the Health Surveillance Assistants (HSAs) in weighing under-five children. Children receive immunizations and are screened. At the ANC outreach clinics, pregnant women receive SP, insecticide treated nets, and other health services.

Community members are happy that apart from increasing their knowledge on malaria, they are now able to practice the behaviors. They thank MCP for the support and for helping them to link with Alinafe Hospital. The MCP volunteers are happier because the messages they share with households are being complemented with the availability of bed nets, SP and other services.

Senior HSA Mr Mkomba from Alinafe Hospital reports that the facility has witnessed an increase in number of maternity cases, which he believes is a result of the health talks, given by the MCP volunteers at the outreach clinics, which encourage mothers to seek health services. Since the construction of the clinic in November there have not been any cases of roadway delivery, as people are seeking services in time.

A 30-year-old pregnant woman, Mrs Kanyezi, said that her husband has no bicycle to take her to the community hospital for antenatal clinic. And so the establishment of an ANC outreach clinic has helped her to receive her first dose of SP and a bed net.

Community #2: Thumba

Thumba is an isolated, rural area in Kasungu District with a population of 18,741. It is 39 kms from the nearest health facility.

Before MCP started in Thumba in 2009, people in the area sought health services from the TBAs and traditional healers because they did not know the importance of utilizing the health services and because of the long distance to the health facilities

After the program volunteers started promoting early care seeking, sleeping under ITNs and accessing two doses of IPTp, the people were ready to practice the behaviors. But the distance from the health facility remained a significant barrier. When program staff recently made a visit to the area, they were told stories about two households that tried to access urgent care at the health facility for people who were sick. One paid K7,500 ($49) and the other K15,000 ($99) to

hire transportation to take the sick person to Wimbe Health Center. This is something that a local farmer can not easily afford, even after selling his yearly produce.

Most ANC outreach clinics in the area were not operational at the time that the Malaria Communities Program was being introduced in Thumba. Pregnant women could not access the free ITNs and had a difficult time receiving two doses of SP to prevent malaria. When the program started it approached the District Health Officer (DHO) on the matter. The DHO promised to send staff to do the monthly ANC outreach clinic. The villagers mobilized themselves and built a shelter. The program contributed a plastic sheet for roofing.

The DHO said that the district would ensure that clinics take place. The Malaria Communities Program offered to contribute fuel during times when the district was experiencing shortages to ensure that the outreach clinics take place every month. The DHO also gave priority in training and posting some HSAs for Thumba area, and now village clinics have started operating. The introduction of ANC outreach clinics and village clinics have made it possible for pregnant mothers to receive two doses of SP and for children under five to receive rapid malaria treatment.

Unfortunately, even though the outreach clinic shelter was built, no nets were being distributed during outreach clinics. Program staff again approached the Wimbe Health Facility personnel and the District Health Management Team (DHMT) members (primarily the ITN coordinator, Malaria Coordinator and DHO) to highlight this concern. In addition, program staff also started approaching other partners to help address some of the problem of unavailability of nets.

One of the beneficiaries in Thumba showing her net

One of the partners the program staff approached was NMCP, which promised to send a consignment of nets through Wimbe Health Center. NMCP sent 300 nets to program beneficiaries in August 2010. These nets were delivered to the Wimbe Health Center and given to the HSAs from Thumba area. These HSAs distributed the 300 nets to our MCP program beneficiaries in the presence of the program staff and a representative from DHO.

All the pregnant women and care takers who received the nets expressed their joy and gratitude to the program for sourcing the nets for them. Most of them indicated that they have never slept under a net as they could not get them from the hospital or even from local shops. One beneficiary who has a child under five, Catherine Mussa, said, “I am very grateful to MCP. Before this program came, as a family, we did not know much about malaria and were not even taking any measures to prevent it. But with the coming of the program volunteer to visit me up to three times a month, now I am very conversant of the disease and all the behaviors that we need to follow to prevent ourselves from getting malaria.”

She indicated that the major barrier preventing her and her children from sleeping under an ITN every night was the unavailability of nets in Thumba. She thanked the program and Ministry of Health for the net distribution exercise and also for teaching them how to hang their nets.

Some beneficiaries showing their nets after receiving them

Just like the beneficiaries, the Village leaders also expressed their gratitude to the program and Ministry of Health for the nets. The senior Group Village Head said, "These nets will go a long way in preventing malaria cases in this village." He thanked the program for starting its operations in the area and said that he is able to see change happening. He added that "there were some NGOs before who also distributed some nets in some areas of this community, but the problem was that they did not first of all teach the people before giving the nets as such almost all the nets were misused. But I thank this program because it first started with teaching the people so that they can have knowledge. With this knowledge on malaria no one can misuse them but put them to their appropriate use"

The Thumba MCP volunteers were all smiles when the nets were handed out. It had been hard for them to encourage people to sleep under nets when there were no nets to be had anywhere nearby.

MCP staff chatting with one of the beneficiaries after she received a net

The program would very much like to thank NMCP for the contribution it has made in helping beneficiaries who come from hard to reach area to access nets.

The program will conduct a post-distribution monitoring and evaluation exercise to assess the impact that this distribution will contribute towards malaria reduction.