Building Community Capacity to Control Malaria in Central Malawi

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Country: Malawi

Annual Report on Year Two

October 1, 2008 – September 30, 2009

A group of 30 new volunteers in malaria T-shirts after initial training in Ntchisi District–Nthawira congregation, along with some MCP staff and HSAs for the area

Christian Reformed World Relief Committee

In collaboration with:
Nkhoma Relief and Development

Point of Contact:
Alan Talens, Health Advisor
Christian Reformed World Relief Committee
2850 Kalamazoo Ave, SE
Grand Rapids, MI 49560
Tel: (616) 224-0740 x4148
Email: atalens@crwrc.org

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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
CSSA	Child Survival Sustainability Assessment
CRWRC	Christian Reformed World Relief Committee
DHMT	District Health Management Team
FBO	Faith-Based Organization
GOM	Government of Malawi
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
USAID	United States Agency for International Development

A. Main Accomplishments

The major activities planned for year two included:

- Recruitment and training of project staff and volunteers
- Establishment of volunteer groups for communities the project expanded into in year two,
- Advocacy related to creating an environment in which it is easier for people to practice the behaviors that are promoted,
- Development of messages on behavior change and distribution of IEC materials, and
- Continued collaboration with relevant stakeholders and other PMI partners in Malawi.

Christian Reformed World Relief Committee (CRWRC) and Nkhoma Relief and Development (NRD) achieved most of the plan, though some challenges surfaced in the process. The main activities and accomplishments are described below.

Project Management and Expansion

- The CRWRC Health Advisor from headquarters traveled to Malawi in December to conduct **a training workshop on the Sustainability Framework**. Project staff developed indicators for sustainability assessment and have been developing tools for measuring the sustainability of the program. NRD finalized the development of tools for measuring the sustainability of the program with the help of CRWRC Program Consultant (Phil Grabowski) during June. Project staff will start using the tools after finalizing the training design for staff. Supervisors followed this design as they trained Facilitators in their areas during July.

- **CRWRC hired and oriented a new Program Coordinator** to fill the vacancy created when the former Coordinator announced her resignation at the end of year one. This was a critical hurdle to clear before other major components of the work plan could be addressed. So CRWRC is very pleased to have found a highly qualified person for this important post: Chipiliro Kambombe. She has been very successful in managing this program since January.

- **Four new Supervisors were hired** in January for the year two expansion into additional working areas. The program has been introduced in the new districts of Kasungu, Ntchisi, Nkhotakota and a new area within Salima district. During February and March, the Supervisors attended District Executive Committee meetings where key stakeholders were gathered in order to introduce the MCP program within the new catchment areas (Ntchisi, Nkhotakota, Kasungu). The new Supervisors have been trained in the Behavior Change Strategy and Sustainability Framework. Four new motorbikes and a 4-wheel-drive vehicle were purchased to facilitate project implementation in the new areas.

- **Twenty new Facilitators were hired** in February for the four new working areas. Twenty bicycles were procured for the new Facilitators.

- In March, **the new Facilitators received training** in the Behavior Change Strategy, the Sustainability Framework, and Participatory Rural Appraisal. A refresher course was provided to year one Facilitators in June; it covered malaria and behavioral change, new

- **The Facilitators established volunteer groups** in the new areas of operation (Nkhotakota, Kasungu, Ntchisi and new area of Salima) during the months of April and May. A total of 80 groups, consisting of 15 Volunteers each, have been established. The cumulative number of volunteer groups established since year one is 174.

- The Program Coordinator participated in a "Finance for Non-Finance Managers" course at the Malawi Institute of Management in June in order to equip herself with accounting skills need to strengthen financial management of the project.

- CRWRC **hired a new project accountant**, Isaiah Mkandawire, who started in August. He is quite experienced and has brought in new ideas which will contribute greatly to the effective running of the program.

- **Training of new volunteers** for new areas started in July and was completed in August. A refresher course for year one volunteers took place in the month of August as well. Home visitation continued to take place on an ongoing basis (see statistics on beneficiaries reached in the table below).

Behavior Change Strategy

- In January, CRWRC and NRD worked together to analyze the results of focus group discussions for Behavior Change Strategy and Barrier Analysis for year one. This analysis informed final decisions about the **Behavior Change Strategy**.

- In May and June 2009, **baseline data was collected in the new areas** of Kasungu, Ntchisi, Nkhotakota and new parts of Salima. In July a Doer/Non-doer Questionnaire was used to collect information for analyzing the barriers to practicing the key behaviors promoted by this program. Findings indicate that though people have high knowledge of malaria being fatal, a lot of them feel apathetic about it and accept it is a traditional part of life. Thus they do not take effective measures to reduce its incidence. Only 15% of the interviewed households who owned nets had re-treated their nets within the past two years. More than half of the interviewed pregnant women who had ITNs do not sleep under them due to reasons like rash and feel of suffocation. Late care seeking behavior is prevalent in most areas. Kasungu district has the highest percentage of people who sought health assistance late after noticing signs and symptoms of malaria in their under five children. Most respondents in the area attributed this to long distance to the hospital. Finally, most pregnant women reported that they had not received two doses of SP due to late commencement of ANC clinics. Additional information is provided in section F of this report.

Advocacy

- During April and May, project staff **mapped the resources and facilities** in all the new working areas. This helped us to know where beneficiaries are constrained in performing the

desired behavior due to a lack of supporting facilities. The program has started **advocating for new facilities in under-served areas.** For example, in one area of Kasungu, the nearest facility on one side is 15 km away, while the nearest facility on the other side is 38 km away. The government-recommended maximum distance is 10 km. The District Health Officer agreed that this area is very much under-served within the whole district and encouraged us to advocate for the services. The program supervisor for the area presented the issue to the Member of Parliament of that area, who later met the District Health Officer on the issue. The Member of Parliament also wrote to other stakeholders who work within this area for assistance. The program will continue to follow up on this issue in year three. At the time of reporting, traditional leaders from the furthest area (38km from the health facility) had already mobilized some resources to start building a health post, which is currently at foundation level.

- Project staff also advocated for effective operation of some outreach clinics within the area. Previously people could only obtain ITNs or LLINs from the main Health Center and not through outreach clinics. **Now the outreach clinics have SP for pregnant women and LLINs for both pregnant mothers and children under five. In addition, the area now has Health Surveillance Assistants (HSAs) allocated by the District Health Office after a long time without any.** These HSAs will help to identify families from within the communities that need ITNs/LLINs and will be getting the nets for them from the main Health Center. These HSAs will undergo a ten-week training workshop. So far about 105 out of 500 HSAs from the district have been trained. CRWRC and NRD have advocated that the some of the HSAs from with the target communities be accommodated in the next group. The program is very grateful to DHO that at least now three of our four behaviors have been covered. The only remaining behavior is the late seeking behavior. The program is yet to find out ways of dealing with this challenge.

Coordination and Collaboration with PMI Partners

- During year two, coordination and collaboration with other PMI partners was an important part of our strategy. In May our project staff participated in the **review of the BCC strategy for National Malaria Control Program (NMCP)**, which was conducted by a consultant from C-Change (engaged by USAID). New messages were developed. CRWRC and NRD delayed the printing of brochures and T-shirts until NMCP messages were finalized at the end of the third quarter. Brochures and T-shirts were printed with BCC messages during June and July. T-shirts have been distributed to new volunteers while brochures have been distributed to both old and new volunteers.

- We planned to produce a comic book or drama scripts. Preliminary work is still in progress it will however extend to first quarter of year three, as we are working at the pace of **Population Services International (PSI)** personnel (PMI partner) who are helping the program with artwork.

Jonathan Zulu wearing a T-shirt for volunteers, printed with the message “Pregnant women sleep under ITNs/LLINs every night all year round”

- In May, our program site in Dowa was visited by the C-Change consultant. During the visit it was noted that most beneficiaries do not have nets. The health center is only supplied with 200 nets for three months, but the area has a population of 39,000. The issue was raised with PSI which distributes nets to health centers. **PSI asked us to create a list of all other communities within our catchment area which receive fewer nets compared to the population of the area.** PSI may consider increasing the numbers of nets distributed to these communities. Supervisors and Facilitators have since been asked to find out from all the health centers within their operating areas to come up with population figures compared with number of nets distributed to such centers. There were some delays in compiling data because many times our staff arrived at the facilities when the health personnel who were responsible for the distribution of nets were not in. But the report was completed in October 2009 and was sent to PSI.

- Some of our Facilitators and Volunteers reported that health centers in several districts were not open during some days, for various reasons. This prevented people from receiving treatment within first 24 hours of signs and symptoms of malaria. We reported the issue to NMCP, who talked with responsible District Health Offices. The issue has since been resolved. The clinics identified are now open when they should be.

- CRWRC and NRD participated in the **net re-dipping and hang up campaign organized by National Malaria Control Program**, which was successfully conducted in all areas of our operation. The program mainly took part in the sensitization campaign through our Facilitators and Volunteers. The programs' Volunteers also participated in the actual re-dipping exercise which was done June 22-26. Attendance in most of our working areas was high compared to the areas outside our catchment area due to the effective sensitization campaign done by our staff. At the time of reporting, NMCP was not finished collecting reports from the Districts, but we did see statistics from three of the districts. (This additional data is provided in section F of this report.) Some districts are still doing mop up net re-dipping campaigns which are expected to finish by end of this month.

Volunteers with some beneficiaries getting ready for a mop up net re-dipping exercise in Ntchisi District

- We recently received a report that, in some remote areas of Dowa, vendors are selling the anti-malarial drug LA. This is very dangerous for communities. Resistance can easily develop if people take LA without following the protocols. The facilitator for the area reported the issue to personnel from one of the Health Centres but recent reports indicate that people are still selling LA during market days. The issue has therefore been referred to NMCP by the program for their prompt action.

Program Monitoring and Evaluation

- CRWRC and NRD have just begun an initial evaluation of the effectiveness of the program for year one. Depending on performance of community groups, the program will expand to other new areas. About six new groups have been formed so far. The program will however need to do a thorough sustainability (community capacity) assessment for the old groups before it proceeds to forming more new groups. This will be done in the first quarter of year three.

A group of volunteers from Mtakataka area in Dedza District singing a malaria song during their monthly group meeting

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 2 Target: 264 Year 2 Actual: **174** Number of volunteers reaching other community members with information on malaria prevention and treatment Year 2 Target: 2,520 Year 2 Actual: **2,567** Number of households participating in the program Year 2 Target: 25,200 Year 2 Actual: **26,130**	Recruit and orient new Program Coordinator	Completed	New Program Coordinator was hired in the first quarter, started work in the second quarter (January)
		Recruit and orient four additional Supervisors	Completed	Four new Supervisors were hired in the second quarter-January. All new supervisors were trained in BCC and Sustainability framework by February 2009. They have started very well in their areas of operation and have generally managed to collaborate and network well with partners at district level
		Recruit 20 Malaria Program Facilitators	Completed	20 Facilitators were hired in February. There are now 42 facilitators. One Facilitator passed away in August. Another one resigned on medical grounds. Another resigned in September. They have all been replaced.
		CRWRC's Health Adviser travels to Malawi to provide training/consultation on the Sustainability Framework.	Completed	The Health Advisor conducted the Sustainability Framework training in Malawi in first quarter December. A total of 46 volunteers are yet to be replaced, however their beneficiary families are still active. There was supposed to be a total of 2,613 volunteers reaching out to 26,130 families
		Facilitators trained in community mobilizing, the BEHAVE Framework, and M&E	Mostly completed; more planned for year 3	All the new Facilitators were trained in BCC, PRA and sustainability in March. And in June, both the old and new Facilitators participated in a training workshop on Malaria (new drug regimen) and community mobilization. Training in M&E is to be done in the 1st quarter of year 3.
		New Supervisors and Facilitators are introduced to and build relationships with their local District Health Management Team (DHMT) and congregation ministers, Traditional Leaders and District Executive Committees	Achieved in all areas except District Executive Committee for Dedza.	There has been an overwhelming response and willingness to support the program in all areas that have been reached so far. DHMT, DEC and Area Development Committee teams of Ntchisi (which is one of the pilot districts for decentralization in Malawi) for an exceptional overwhelming response and willingness to support the program. If such willingness to support the program is maintained, it assures us of sustainability of the program even after the project ends. The assistant coordinator who is responsible for Lakeshore was instructed to complete these meetings by September 30. There is need to strengthen links for Dowa and Mchinji.

Project Objectives	Indicators & Current Measurements	Key Activities, as outlined in the year 2 work plan	Status of Activities & Outputs Achieved	Comments
		Scale up the program to 12 new congregational catchment areas for a total of 25 catchment areas covering 9 districts.	Completed	The program is currently active in all the 25 congregational catchment areas. We are in the process of identifying community groups and their beneficiaries that are performing very well with an idea of scaling up the program to other areas within the congregations
		Conduct focus group discussions to enhance understanding of BA results from year one. Develop behavior change strategies.	Completed	In January, results of focus group discussions were analyzed and used to inform the development of the Behavior Change Strategy. The results for Baseline survey have been informative of the current level of operation for the communities.
		Collect baseline data and conduct barrier analysis for year 2 areas	Completed	Data entry for barrier analysis is completed. We still need to analyze the results. Our plan is to use the barrier analysis to select appropriate behavior change strategies to implement in year 3.
		Each Facilitator establishes 4 community groups consisting of 15 volunteers each.	Completed, but ongoing work is needed to replace volunteers that have dropped out.	Each new facilitator has managed to recruit 4 groups of 15 volunteers. Eighty groups in total have been formed from the year 2 districts However, we experienced problems with retention of volunteers for year one. This year, a total of 281volunteers dropped out. The reasons range from marriages to low morale to need for incentives. We have managed to replace all of them except 46. A special training will be organized for new replacement volunteers. We plan to have volunteer exchange visit, award giving for a hard working group at the end of the year and at least bi-annual training to increase their morale apart from distribution of T-shirts on yearly basis.

Project Objectives	Indicators & Current Measurements	Key Activities, as outlined in the year 2 work plan	Status of Activities & Outputs Achieved	Comments
		Volunteers trained by Facilitators in community mobilization, malaria prevention and treatment interventions, BCC techniques, and M&E (twice per month meetings).	2,567 volunteers have so far received training.	Volunteers are equipped to reach out to the identified households with malaria messages. Activity will continue in year 3 as new volunteers replace those that have dropped out.
		Households with pregnant women and/or children under five identified and assigned to volunteers (10 per volunteer). Volunteers meet with each household twice per month.	26,130 households identified to be direct beneficiaries.	Volunteers reaching out to the beneficiaries with messages through community awareness campaigns where songs, dramas, poems, and/or dances are performed.
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 2 Target: 60% Year 2 Actual: **63%** Number of households participating in the program that own at least one ITN Year 2 Target: 15,120 Year 2 Actual: **16,473** Number of households participating in the program that have re-treated their ITN(s) Year 2 Target: 3,000 Year 2 Actual: **To be**	Identify distribution points for ITNs where they will reach the poorest of the poor and communicate these to the NMCP.	Completed	Some health centers were not taking ITNs to outreach clinics. (e.g. Dowa and Kasungu). We advocated with DHMTs on this issue. District officials have agreed to communicate with all health centers in their districts about the need to take ITNs to outreach clinics. Project personnel in those areas have since been invited to visit outreach areas to verify the availability of both SP and ITNs.
		Educate households about how to access free or subsidized LLINs through local distribution points.	Facilitators and volunteers have shared educational messages on how to access subsidized LLINs.	All the beneficiaries have this information. It's only in some areas where they have failed to get them from the points due to stock outs. The program has however collaborated and agreed with health personnel from some health centers that they should be informing the program's volunteers and or facilitators once the LLINs are available so that they can take the messages to the beneficiaries
		Mobilize communities to attend annual net re-treatment campaigns organized by the GOM.	Completed	We participated in net re-dipping campaign organized by NMCP, which was conducted in all our working areas. We mainly took part in the sensitization campaign through our facilitators and volunteers. Our volunteers also participated in the actual re-dipping exercise which was done June 22-26.

Project Objectives	Indicators & Current Measurements	Key Activities, as outlined in the year 2 work plan	Status of Activities & Outputs Achieved	Comments
	reported in next report. (Some districts like Lilongwe, Ntchisi are still completing the net re-dipping campaign. Actual figures will be available after the mop up exercise.)			Many people came for the campaign within our areas of operation due to the effective sensitization campaign done by our staff as compared to the areas outside our catchment area. See data in section F. Data was only available for three districts. The areas shaded in grey are our catchment areas.
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 2 Target: 50% Year 2 Actual: **47%** Proportion of children under five in targeted households who slept under an ITN the previous night Year 2 Target: 50% Year 2 Actual: **46.4%** Number of households participating in the program that received messages about proper net use Year 2 Target: 25,200 Year 2 Actual: **26,130**	Train 2,520 volunteers in BCC techniques for increasing the number of pregnant women and children under five sleeping under ITNs.	2,567 volunteers have been trained in BCC for increasing use of ITNs	The program has to emphasize the need to sleep under ITNs and reduce the perception that ITNs cause rash or suffocation for pregnant mothers as they percentage of net use continues to be low.
		Coordinate with PMI partners in country to access existing IEC materials or develop new ones. Volunteers will share IEC materials with beneficiaries, and Nkhoma Synod Health Dept. facilities will make them available to patients.	Brochures with BCC messages were printed in June and July. T-shirts with messages were distributed to Volunteers in July together with the brochures.	Printing of IEC materials was delayed because of the need to wait until the C-Change consultant hired by USAID completed the review of the NMCP behavior change strategy (May)
		Use of IEC and BCC to increase the correct and consistent year-round use of ITNs at the community level.	26,130 households receiving messages about proper net usage	The volunteers for the program came up with songs, dramas, and dances on correct and consistency use of ITNs all year round

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 2 Target: 60% Year 2 Actual: **not surveyed yet** Proportion of women in targeted households that cite IPTp as a necessary treatment during pregnancy Year 2 Target: 80% Year 2 Actual: **87%** Number of volunteers trained to counsel pregnant women to obtain treatment Year 1 Target: 2,520 Year 1 Actual: **2,567** Number of pregnant women participating in the program who received a second dose of IPTp Year 2 Target: 3,000 Year 2 Actual: **1,830**	Train 2,520 volunteers in IPTp promotion.	2,567 volunteers have been trained in basic IPTp promotion.	
		Coordinate with PMI partners in country to access existing IEC materials on IPTp or develop new ones. Volunteers will share IEC materials with beneficiaries, and Nkhoma Synod Health Dept. facilities will make them available to patients.	NMCP did not have enough IEC material, so we printed the same messages as a program and distributed the them to all volunteer groups	There is a need to continue emphasizing the importance of early ANC attendance to increase numbers of those who take second dose of SP. Most of the women attend ANC late, and therefore are only able to take the first dose.
		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).	2,900 pregnant women have received messages about IPTp and ANC care.	Volunteers received initial training about IPTp and its relation to ANC clinics in both years.

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. **Strategic Objective 5** (continued)	Proportion of children under five years old 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 2 Target: 50% Year 2 Actual: **not surveyed yet** Number of Facilitators trained on use of new first line drugs Year 2 Target: 42 Year 2 Actual: **42** Number of volunteers trained in the new drug policy Year 2 Target: 2,520 Year 2 Actual: **2,567** Number of households participating in the program that received information about the new drug policy. Year 2 Target: 25,200 Year 2 Actual: **25,670**	Link Facilitators to training on the proper use of the new first line drugs (provided by other PMI partner in Malawi).	Completed	In year one, basic training on the use of LA was conducted by Health officers of the District hospitals. DHMT member for Lilongwe who is also malaria coordinator for the district offered more in-depth training to all facilitators on the use of LA during their refresher training.
		Facilitators train volunteers on the Government of Malawi's new first line drug policy.	2,567 volunteers trained in the new drug policy	
		Coordinate with PMI partners in country to access existing IEC materials on malaria treatment or develop new ones. Volunteers will share IEC materials with beneficiaries, and Nkhoma Synod Health Dept. facilities will make them available to patients.	Printed and distributed IEC on Malaria and have printed training manual on both malaria and BCC and have since been distributed to volunteers in all areas	The material has been of great importance and has eased the work of our volunteers as are able to use visual aids and are able to read and understand the training manuals, thus ensuring that right messages are delivered to the beneficiaries.
		Use of IEC and BCC at the community level that is focused on the new drug policy and changing the behavior of care givers so that children receive prompt and effective treatment.	IEC and BCC materials currently in use by the community volunteers	

B. Factors Impeding Progress

Delays in work plan implementation early in year two were mainly caused by the gap created with the departure of the first Program Coordinator. This position needed to be filled before four new Supervisors and twenty new Facilitators could be hired and oriented. The extra time to recruit project staff contributed to the delay in the formation of volunteer community groups. Most of the activities planned for the first quarter were postponed, which delayed other activities that were scheduled for the second quarter. However, most of the planned activities for year were accomplished in the third and fourth quarter.

We have completed the expansion of the program into all the new working areas that were designated to start in year two. However, there was a delay in starting to implement activities in other districts due to postponement of District Executive Committee meetings by the District Assemblies in Nkhotakota and Ntchisi districts. These set things back a bit but did not prevent us from beginning implementation in all the year two areas.

We were supposed to have formed additional groups for our year one areas. This process has just started; we only managed to form six new community groups. We considered doing an aggressive push at the end of year two to roll out the program to all the working areas according to plan. For the communities and their leadership to be well mobilized and sensitized, we decided not to rush through it because of the importance of obtaining buy-in of local stakeholders and ensuring that the earlier community groups have grasped the concept very well and can sustain the program activities on their own. The decision to go slower was also related to our desire to identify high quality volunteers who are really committed to the program, so as to ensure low rates of volunteer turnover. The expansion to the new communities with the year one working areas will be completed in the first half of year three.

A special introductory briefing on the programs implemented by the MCP was given to some key stakeholders who were not familiar with what happened in the first year. The program was not fully introduced to all relevant stakeholders when it was rolled out at the end of year one, and as a result, we did encounter some resistance from key stakeholders in those working areas. We overcame this challenge by organizing special briefing meetings for such stakeholders to obtain their support. The experience has reinforced to us the importance of taking the time to secure local support for the program before recruiting volunteers and forming groups.

The biggest challenge we faced in year two of implementation was retaining volunteers and replacing those that dropped out. About 281 volunteers from year one dropped out of the program due to a variety of situations. Some married and moved out of the area. Others found employment or became busy with seasonal livelihood activities. Low morale was an issue for some who thought they would be getting some kind of pay (even though they were told at the beginning that it was an unpaid position). This has caused some extra expense, since we had to spend time recruiting new volunteers, organize training for them, and print new T-shirts for them. This is a major reason why more time and care will be taken to find volunteers that are the right fit for the program. Some of the volunteers recruited in the year one working areas were nominated by community leaders because they had been “volunteers” in other NGO programs in the past. But these individuals had been paid in those positions and expected the same from

MCP. As we recruit volunteers in the year two working areas or replacements for year one working areas, we will be looking for individuals with a personal passion for addressing the problem of malaria (e.g. people who have lost a family member to malaria). During year three we will work on volunteer management strategy that incorporates greater recognition and support for volunteers. We will also look at the volunteers' duties to make sure they are not being asked to handle a greater workload that can be managed by volunteers.

One Supervisor for Dowa district resigned in August. This has deterred progress of the program in the district, with some activities being postponed until the position is re-filled. The position has been advertised. Currently the Supervisor of Ntchisi district (the nearest district) is working hand in hand with one of the facilitators from within Dowa to ensure that progress is still made.

Three Facilitators from Mchinji have left (one quit, one resigned on medical grounds, and one died). This temporarily left a big gap which delayed the progress of the programs in the district. However, all of these facilitators have been replaced, and there are no current vacancies among the facilitator posts.

Salima and Mangochi districts have seven Facilitators each. Five of them reside long distances away from the project area where they work. Because of this, the Supervisors for Salima and Magochi are not able to effectively monitor the performance of their Facilitators. This has affected the quality of work done in a few catchment areas. To address this concern, one more Supervisor will be recruited to support and monitor the Facilitators that are in the remotest catchment areas.

A few of the delays in program implementation were related to the pace of activities of other PMI partners in country. For example:

- We planned to work together with the Health Surveillance Assistants (HSAs) on the net retreatment campaign, but there were delays in the NMCP receiving the insecticide necessary for doing the retreatment.
- Plans to collect data on program performance in year one working areas was postponed due to net re-dipping campaign, which required about three weeks in June.
- The delay in the production and distribution of pamphlets with behavior change messages was due in part to delays experienced by the designers (PSI).

There were also some factors outside our control (or that of other PMI partners) that affected the pace of implementation:

- A lot of beneficiaries and volunteers were busy in their fields during the second quarter, so there were fewer household visits as compared to other quarters.
- The third quarter spanned a political campaign period, so most of our volunteers as well as beneficiaries were busy attending rallies.

C. Technical Assistance

In 2008-09, CRWRC received some technical assistance on sampling strategy for the baseline survey. This came from MCHIP (formerly known as CSTS+). Support was provided by Karen Fogg, Jennifer Luna, and the head statistician at DHS.

CRWRC's Health Advisor, Will Story, provided TA for the sustainability framework by conducting a three-day training. MCHIP provided some feedback on the design of this workshop.

In year two, CRWRC and NRD also sought technical assistance from:

- St John of God College of Health Sciences Lecturer in Research and Statistics in defining variables and analyzing data for both Baseline and Barrier Analysis survey for year 2 working areas.
- PSI personnel for artwork to be used in brochures and for help in the creation of comics and drama scripts.
- The District Malaria Coordinator from the Ministry of Health (Member of Lilongwe DHMT) trained our Facilitators in the new drug policy.
- Staff from the Ministry of Gender and Community Development trained our Facilitators and Supervisors in community mobilization

D. Specific Information Requested

No specific information was requested.

E. PMI Team Collaboration In Country

The collaboration between the PMI team and our program has continued to be of increasing benefit throughout the year. PMI team members continue to meet once every month where partners update each other on what is happening in their organizations. This meeting has proved to be very fruitful as, apart from sharing what is happening in various organizations, PMI members also help to solve each others issues and challenges and even advise each other on where to access assistance on issues that require outside input. Some activities that the program did with other PMI partners are listed below:

- In May, the program participated in the review of the BCC strategy for National Malaria Control Program (NMCP) which was conducted by a consultant from C-Change (engaged by USAID). This took place at Mangochi for close to a week. It was during this meeting where new messages on malaria were developed.

- USAID personnel and C- Change consultant visited one of our project sites to appreciate our work in the area

- We received malaria training manuals from NMCP. All Supervisors have training manuals, and all Facilitators have case management booklets from NMCP which they are using to train volunteers.

- The program participated in the Malaria Research Findings Dissemination conference organized by Malaria Alert Center on 20th and 21st August.

- We consult with Concern Universal MCP on an on going basis regarding malaria related issues. We plan to hold a meeting with them in October to share ideas and discuss how we can help each other as we are doing taking the same messages on malaria BCC strategy to communities.

F. Other Relevant Information

Working closely with health facility personnel, traditional leaders and church leaders has proved to be a very effective way of reaching out to the communities with BCC massages. In areas where traditional leaders have understood the program very well, they are playing a major role in bringing about behavior change. For example, some traditional leaders charge any pregnant woman who goes to a TBA or any TBA who assists any pregnant women at their home rather than referring them to the health facility for ANC and delivery. Other traditional leaders have made it a rule that all pregnant women should be sleeping at their homes during funerals, rather than sleeping at the house where the funeral has occurred as it prevents them from sleeping under ITNs/ LLINs. Church leaders help in disseminating BCC messages as they allocate some time for our personnel and volunteers to talk about malaria in church gatherings while health personnel help to provide required services that will help in promotion of the program's four behaviours.

Below are the results for the baseline surveys and barrier analysis for year 1 and 2. The results for year two areas will be analyzed in November and used to inform the development of behavior change strategies for those districts that started operations in year two.

Key Baseline Data	Y1 Areas	Y2 Areas
Respondents	440	607
Have no nets	27.5%	9.6%
Of those with nets, % that obtained them in the past 12 months	72%	56.7%
Of those with nets, % whose children <5 slept under a net	63%	76%
Of those who had fever, % that sought help from health facility or trained personnel	84%	73.8
Of those who sought treatment, % who sought help within 24 hours of onset of fever	41% (started meds within 24 hrs)	8.8% (sought treatment)
Pregnant women who took SP to prevent malaria	65%	66.6%
Pregnant women who sleep under a net	49%	46%
Pregnant women who sleep under a net every night	35%	34%

Barrier Analysis Results Summary Table (statistically significant differences in bold):

	Net use by children <5	Net use during pregnancy	IPTp	Care seeking for children <5
Knowledge	High	High	**Higher in doers**	High
Perceived susceptibility	High	**Higher in doers**	**Higher in doers**	High
Perceived severity	High	High	**Higher in doers except lakeshore**	**Higher for doers on lakeshore**
Self efficacy (What makes it difficult? What makes it easier?)	Leaving the net hanging makes it easier to do every night	Leaving the net hanging makes it easier to do every night	Attending ANC at right time makes it easier	Closure of health facility during odd hours makes it difficult
	Funerals make net use difficult because of spending night outside	Funerals make net use difficult because of spending night outside	Knowledge of importance of malaria is more in doers than non doers	Not receiving appropriate drugs when health facilities have stock outs makes it difficult.
		Consistent use of nets even during the dry season is difficult	Thinking about the goal of having a healthy baby makes it easier	Underrating the danger when the child has a low fever.
Action efficacy	High	No data	No data	No data
Divine will	Not significant	Not significant	Non-doers said it is God's will to get malaria	Not significant
Social norms	Chiefs and peers in funerals- peers Abusive and drunk fathers	Chiefs and peers in funerals- peers Abusive and drunk husbands	Husband Peers Health Personnel	Grand parents, village elders often try to promote traditional healing instead of going to health facilities.
Cues for action	Hanging net	Hanging net	Advise from HSA, volunteers	High fever
Positive consequences	See list	Healthy baby, healthy pregnancy	Healthy baby Healthy pregnancy	Right treatment Development work
Negative consequences	Rash, heat, suffocation	Rash, heat, suffocation	Dizziness Weakness Heart palpitations	Some have had negative experiences with harsh health personnel.

Tchisi District Net Re-treatment Data

Health facilities shaded in grey are in the impact area of the CRWRC's Malaria Communities Program.

Health Facility	# nets registered	# nets treated	coverage %
Ntchisi boma	13103	11972	91.3
Malomo	**11610**	**11093**	**95.5**
Kamsonga	**7229**	**7229**	**100**
Khuwi	7309	6453	88.2
Chinguluwe	**5568**	**5909**	**106.1**
Nkhuzi	5250	4690	89.3
Nthondo	5418	4413	81.4
Mzandu	4076	3764	92.3
Kangolwa	3755	3307	97.9
Chinthebwe	3349	2795	83.4
Ndinda	1180	1025	86.8
TOTAL	**67847**	**62650**	**92.3**

Nkhotakota District Net Re-treatment Data

Health facilities shaded in grey are in the impact area of the CRWRC's Malaria Communities Program.

Health Facility	# nets registered	# nets treated	coverage %
DHO	28147	24528	91
Kapiri	6618	5800	88
Malowa	**6454**	**5638**	**87**
Msenjere	7212	5100	71
Bua	6315	5000	79
Mwansambo	**4928**	**4817**	**87**
Mpamantha	4588	4572	99
Ngala	5106	4454	87
Chididi	4385	4377	99
Benga	**4228**	**4119**	**97**
Nkhunga	5418	4000	74
Katimbira	5397	4000	74
Alinafe	**3301**	**3291**	**99**
St. Annes	3139	3100	99
Liwalazi	3720	3000	81
Matiki	9754	2852	29
Dwangwa	2994	2414	81
Kasitu	2833	2400	85
Mtosa	**2500**	**2149**	**86**
Cane Growers	1649	1400	85
Kaongozi	1534	1069	70
Lupachi	457	400	89
GRAND TOTAL	**120,677**	**98,480**	**82**

Salima District Net Re-treatment Data

Health facilities shaded in gray are in the impact area of the CRWRC's Malaria Communities Program.

Health Facility	# nets registered	# nets treated	coverage %
Khombedza	**19008**	**18896**	**99.4**
Salima DH	13489	14376	106.6
Maganga	7690	7098	92.3
Admarc	9408	7029	74.7
Mchoka	**4707**	**5049**	**107**
Chipoka	**4524**	**4671**	**103**
Kaphatenga	4676	4572	97.8
Thavite	**4305**	**3895**	**90.5**
Makioni	**3187**	**3586**	**112.5**
Lifuwu	3996	3451	86.4
Lifeline	**3201**	**2871**	**89.7**
Sengabay	2690	2824	105
Ngodzi	**2586**	**2654**	**103**
Chinguluwe	3505	2596	74
Mafco	2283	2434	106.6
Chitala	**2644**	**2074**	**78.4**
Chagunda	1551	1695	109.3
Parachute	595	665	111.8
Kindo/Katawa	885	632	71.4
GRAND TOTAL	**94927**	**91069**	**95.9**

G. Publications or Presentations

No publications or presentations at conferences have been done.

H. Stories

SUCCESS STORY: Healthy Baby Girl Born to the Bandas after Four Malaria/Anemia Suspected Miscarriages

Chikwilila village is an isolated village in Dedza district. Though the village is only 5 km from the Nakalazi health facility, the village has cultural beliefs and misconceptions about malaria and its related complications that prevent the people from accessing services from the health facility. People rely on elders to make decisions about where to access health services. Fever and symptoms of anemia are thought to be treatable with traditional medicine. Most rural people use the existing traditional birth attendants for antenatal care and maternity services and buy drugs from local vendors.

Tereza is one of the MCP volunteers working in this community. In one of her household visits she came across the Banda family. Upon chatting with them, they revealed that they did not have any children even though Lydia Banda had been pregnant four times. The family, just like most of the families within the village, had never sought health assistance from trained health personnel. They always relied on traditional birth attendants for help and bought drugs from

local shops whenever the wife was sick. Lydia described her history with pregnancies by saying, "I could feel general body weaknesses and joint pains just like malaria symptoms which preceded all the miscarriages".

Tereza frequented her visits to the Banda family to share with them behavior change messages related to preventing malaria. She encouraged Lydia to go for antenatal care (ANC) services and to receive the anti-malarial drug SP in order to protect herself from malaria. At 4 months into her next pregnancy, Lydia went to Nakalazi Health Centre where she received her first dose of SP and an insecticide treated net (ITN). During her examination, she was found to be anemic. As a result, she was referred to Mua Mission hospital where she received a blood transfusion. She received a second dose of SP at 7 months into her pregnancy.

"I guess that if I did not go to seek health assistance I could have ended up with another miscarriage. With the transfusion I became stronger and healthy till delivery" Lydia reported.

Tereza continued to visit Lydia and even escorted her to the hospital when she was due for delivery. Lydia delivered a health baby girl and named her Pemphero, which means Prayer. The parents acknowledged that their prayer had been answered after such a long time of misfortune.

When project staff visited them, the family thanked the program through Tereza for what had happened to them. Lydia expressed her gratitude to Tereza and the entire program staff for the messages she received which helped her to deliver the baby. She credits Tereza and her advice for enabling her to finally deliver a healthy baby.

Baby Pemphero sleeping in her mum's lap

Her husband Gelevazio added, "The net that she was given at the hospital prevented her from getting any more malaria attacks. We sleep with baby Pemphero in that net every night, for we have seen its benefit."

When asked what advice she would give to other women who do not know the importance of accessing antenatal care, Lydia said she would encourage them to access antenatal care as soon as they know that they are pregnant so that they can receive an ITN, which will protect them from mosquito bites and hence from malaria. Also, she advises that they should receive SP at both 4th and 7th months to protect themselves from malaria which with frequent attacks can cause anemia which affects the unborn babies.

The husband encouraged all who might be undergoing similar circumstances to rush to the hospital. And those who undermine people from seeking hospital assistance should instead

encourage others to access the care they need. In his own words he said “it is not good to go to TBAs as they are not professionals, rather go to the hospital for ANC and delivery as the personnel are able to detect your problems early hence able to help you in good time”.

The mother of Lydia, Grace Asowa who was with the family at the time of the interview said that she was very grateful to Tereza that though the family comes from an isolated area from the rest of the villages, she was still able to follow them. She therefore encouraged all volunteers as well as the entire program to continue with the good work as they had seen its fruits. She acknowledged that innocent souls are suffering and dying from malaria due to ignorance. She concluded by saying that they will take the news to their family friends.

The traditional leader for the area who failed to attend the meeting due to some engagements sent a word of appreciation to the program for the work that it is doing through its volunteers, and promised to support the activities of the program. Project personnel plan to visit the traditional leaders for the area for a general discussion on malaria and on their role as traditional leaders in promoting the four behaviours the program is promoting.

From left: Mrs Tereza Kankhwala and her son (Volunteer for the family), Tazima Chandilanga (Supervisor for the District), Gelevazio Banda (father of Pemphero), Lydia Banda and her child Pemphero, Grace Asowa (grandmother of the child), Chipiliro Kambombe (Malaria Communities Program Coordinator)

SUCCESS STORY: Addressing Health Centre Staff Shortages that Hindered Promotion of Care Seeking Behaviors

Project staff and volunteers in Nkhotakota District have had difficulty promoting the four behaviors of this Malaria Communities Program. The major reason is the lack of trained health personnel at the Mtosa Health Centre who can provide services that we are encouraging people to access. When the program was starting, the health facility was only able to get staff on relief. They could only stay for a few weeks or months before going back to their original work place. In the month of April and May the facility did not have any medical assistant or a nurse to help patients. Most patients were going to Thavite health centre, which is a facility in the next district of Salima and is about 27 km from Mphala village (which is served by Mtosa Health Centre). Because of this, people stopped seeking medical help. Pregnant mothers went back to receiving antenatal care and maternity services from TBAs.

One of the TBAs, Catherine Mazoni, openly said " I continued providing services despite having been advised by the government to stop, because pregnant women were still coming to me as they had no where to go since there were no staff at the hospital."

The supervisor for the district then went to meet the District Health Management Team (DHMT) members to inform them of the problem and request more staff for the health facility. As a result of the visit of the supervisor and frequent reminders from her, the DHMT responded to the request very fast. In August the clinic received one medical assistant and two nurses.

The new person in charge of the hospital, Nyembezi Jere, indicated that the hospital has indeed faced acute shortage of staff in the past, but she was confident that they will be better able to serve the communities.

Under-five clinic in operation at Mtoso Health Center

When asked to comment on the coming of the new staff, the chairperson for our program volunteers, Mr Chisale, said that the volunteers are very pleased with the development. He stated that he goes to the Health Center frequently just to check on the quality of services rendered to the community under his catchment area, and he is satisfied with the work. Communities are now being reached with messages that they should go to the health centre to access malaria treatment, ANC services and ITNs**.** The hosptail is now receiving a lot of patients and clients now that the message has gotten out that the hospital is operational again.