RAPIDS/World Vision/Against Malaria Foundation

Net Distribution

ZAMBIA

Phase 2

February-March 2010

Introduction

Reaching HIV/AIDS Affected People with Integrated Development and Support (RAPIDS) is a consortium of six Non-Governmental Organizations (NGO's), World Vision (lead agency) Africare, CARE, Catholic Relief Services (CRS), Expanded Church Response (ECR), and The Salvation Army (TSA) in Zambia. The five year program is funded through an investment by the U.S. Government under the President's Emergency Plan for HIV/AIDS (PEPFAR). The overall goal of RAPIDS is to improve the quality of life of Zambians affected by HIV and AIDS. RAPIDS achieves this goal by applying a household model focused on vulnerable populations. This model utilizes caregivers at the rural village level to provide health services to the household level. RAPIDS' 19,839 community based caregivers provide ongoing support to 258,812 orphans and vulnerable children, 65,790 people living with HIV/AIDS, and 98,467 youth reaching 52 districts in of all of Zambia's nine provinces.

In 2007, RAPIDS partnered with the Global Business Coalition on HIV/AIDS, Tuberculosis and Malaria (GBC) to assemble a private public partnership with the Office of the U.S. Global AIDS Coordinator (OGAC), The President's Malaria Initiative (PMI), Vestergaard-Frandsen, and a number of corporate partners to secure and distribute nearly 500,000 LLINs to the most vulnerable HIV and AIDS affected households in Zambia. This partnership addressed the critical linkages between malaria and HIV/AIDS. This targeted distribution of nets complimented the Ministry of Health's National Malaria Control Centers ITN distribution.

In 2009 RAPIDS, in conjunction with World Vision US (WVUS), wrote a proposal to the Against Malaria Foundation (AMF) to provide an additional 301,000 LLINs into Zambia in order to fill in the gaps in coverage left from the 2007 distribution.

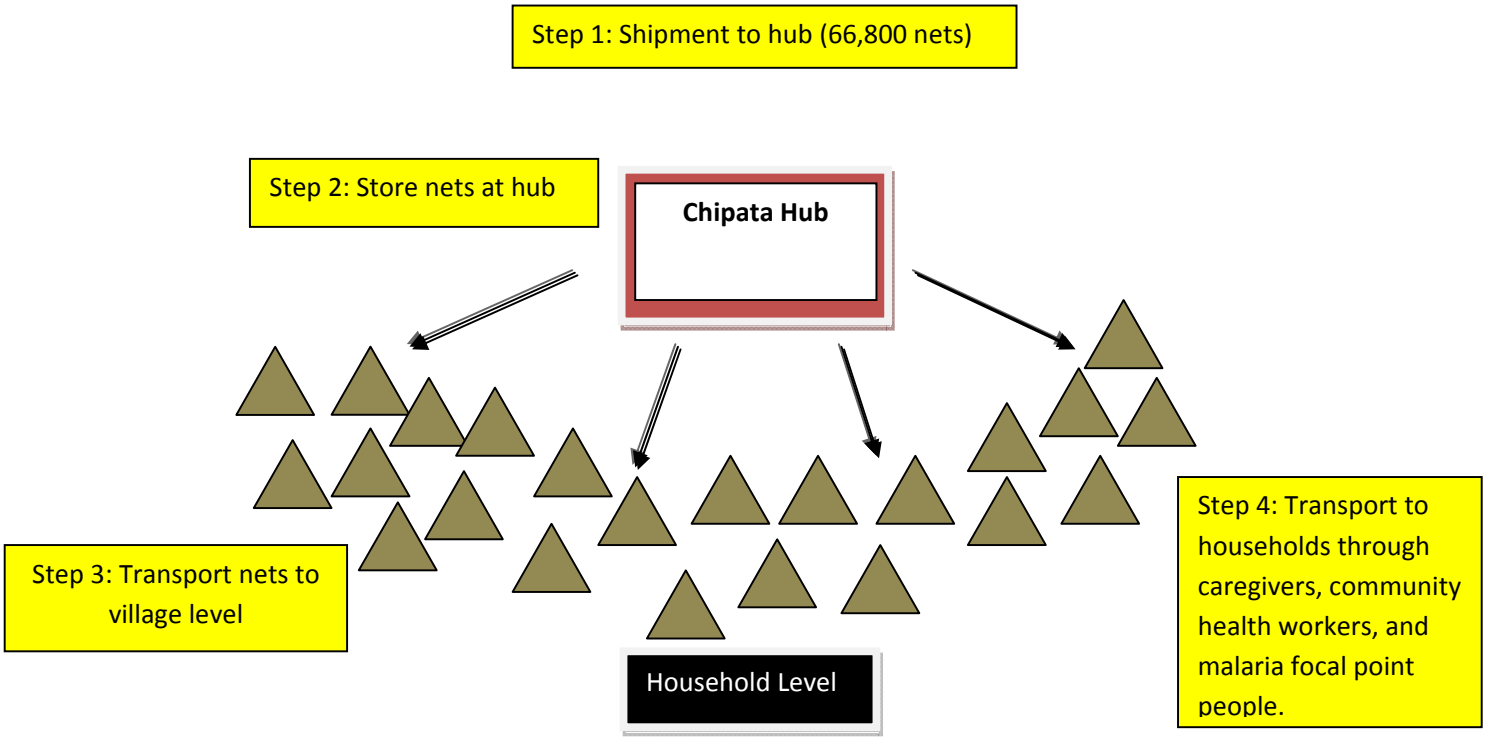
The first phase of this distribution began with 133,400 PermaNet 3.0 LLINs being delivered in 3 provinces in Zambia (Northern: Mbala and Kasama districts, Southern: Monze, Choma, Sinazongwe, and Mazabuka districts, and Eastern: Nyimba, Petauke and Katete districts) by RAPIDS in partnership with WVUS and Against Malaria Foundation. These districts received LLINs in a 2007 distribution, but the National Malaria Control Program (NMCP) and district staff identified gaps in LLIN coverage. RAPIDS, with WVUS, aimed to fill these gaps in order to achieve universal coverage (3 LLINs per household) within those communities where RAPIDS' partners have a presence. The areas included in the distribution were chosen in consultation with the NMCP. The selection was based on the level of vulnerability of the community, the malaria prevalence rate, and the number of LLINs needed within the districts where World Vision Zambia (WVZ) and RAPIDS are actively working.

The second phase (Phase II) of this distribution took place throughout February and March 2010, bringing another 167,000 PermaNet 3.0 nets into Zambia. These nets were again delivered in the same 3 provinces in Zambia (Northern: Mpika district, Southern: Kalomo district, and Eastern: Chipata district) by RAPIDS, in partnership with WVUS and Against Malaria Foundation. The nets were delivered in other districts within these same provinces that demonstrated an acute need for mosquito nets and had been identified by the NMCP.

Distribution Logistics

The illustration below shows how the nets were distributed to the households post receipt from the port, through the hub (the district selected as being central for easy distribution of nets in the province, which also cuts down on distribution costs for the program instead of the nets being transported to the capital Lusaka and then sent out to the provinces) to the household.

Distribution Logistics Scheme



Nets were delivered at two different ports and then transported over land by trucks to the hubs. In phase II, RAPIDS/WVUS decreased the number of districts involved in the distribution in order to try to completely cover those districts. Thus, the three hubs (Kalomo, Chipata and Mpika) identified where the nets were stored, were also the same districts in which the distributions took place.

Since many of RAPIDS' partners were in the process of closing down their district operations at the time of this distribution, the number of partners involved was limited. In phase II, WVZ and CARE International partnered to conduct the distributions in Kalomo and Chipata districts, while WVZ took the lead in Mpika district. Having limited partners involved in the distribution actually gave the partners the opportunity to work more closely with the District Health Management Team in order to obtain the necessary data. Prior to the start of the distribution partners at the district level, in coordination with their caregivers and district health staff, were required to fill out beneficiary lists for each of the villages receiving nets. These lists stated the beneficiary's name, number of people in their household, and

number of nets they were to receive on the day of distribution. Caregivers went door to door in each village receiving nets in order to make sure each village involved in the distribution was covered. Since there were villages included in certain sections that were not covered by caregivers, the caregivers worked closely with the community health workers, malaria focal point people, area development committee members, clinic staff and headmen in order to confirm no one was missed.

When filling out the beneficiary lists, in order to reach the goal of 'complete LLIN coverage in these areas' and fill in the gaps from the 2007 distribution, district partners and caregivers identified whether households had one, two, or three nets existing in their household prior to distribution. Then depending on the number of functional nets the household was currently possessed, caregivers assigned each beneficiary one, two, or three nets in order to ensure the household was fully protected.

Collection of these completed sheets decreased the amount of time it took to distribute the nets on the distribution days, beneficiaries simply arrived, signed for their net and took them home. If a beneficiary could not sign, ink pads were also available so the beneficiary could sign with his or her thumb print instead.

The District Health Management Team (DHMT) was instrumental in helping the partners make sure they were targeting each village in a given section of the district. The DHMT was also able to identify which sections had recently been covered with mosquito nets distributions facilitated by the District Health Office. This information sharing enabled the partners to cover the areas within the district that had gaps in coverage.

The table below indicates where nets were sent, first by district and then by partner at the district level.

Hub/District	Number of Nets	Partner	Number of LLINs Needed by Partner	Zone Name	Number of Households per Village	Number of Nets per Village
Kalomo	66,800	WVZ	19,253	Munkolo Zone	393	865
				Simwami Zone	244	664
				Zimba Zone	569	1293
				Mayoba Zone	310	676
				Muzya Zone	601	1384
				Chuundwe Zone	487	1051
				Chilesha Zone	499	1093
				Choonga Zone	729	1566
				Mukwela Zone	596	1188
				Namwianga Zone	459	1051
				Sipatunyana Zone	3269	6419
				Naluja Zone	876	2003
		CARE	44,204	Dimbwe Zone	1355	3190
				Masempela Zone	3433	7827
				Kanchele Zone	3990	11461

				Luyaba Zone	2072	5566
				Siamafumba Zone	2060	5311
				Simwatachela Zone	3521	7493
				Simalundu Zone	1502	3356
		WVZ & CARE	3,343	Mapatizya Zone	1888	3343
Chipata	66,800	WVZ	29,971	Chankhanga Zone	3934	8451
				Chibvungula Zone	1942	4077
				Chiwoko Zone	764	1788
				Mwangazi Zone	2214	4855
				Mshawa Zone	1412	3108
				Kwenje Zone	2350	5353
				Chingazi Zone	1004	2339
		CARE	36,829	Chipangali Zone	1100	2022
				Kapara Zone	2444	4974
				Mkanda Zone	1699	2306
				Vizenge Zone	459	1372
				Chinunda Zone	961	2364
				Rukuzye Zone	1746	3056
				Mafuta Zone	703	1030
				Kasenga Zone	1506	2718
				Chiparamba Zone	2022	3052
				Mnukwa Zone	714	870
				Makwe Zone	1033	1235
				Tamanda Zone	1946	4506
				Madziatuba Zone	1692	3440
				Mushawa Zone	2168	3884
Mpika	33,400	WVZ	33,400	Kopa Zone	4912	10,523
				Mpika Zone	10,026	22,877

After the nets were delivered to the hub/districts, the distributions started in Kalomo in Southern province and then moved on to Chipata in Eastern province. The Mpika distribution in Northern province overlapped with both the Kalomo and Chipata distributions. Teams were present in each province in order to help with the distributions. All distributions ran for two weeks, from February 4th to March 13.

Modes of Distribution

Nets were distributed to beneficiaries in one of three ways:

- Delivery from hubs to the village level. Caregivers and beneficiaries would gather in a common meeting point within the village so that when the team came with nets, the beneficiaries were ready to receive them.

- Delivery to clinics or schools. Nets were dropped at Rural Health Centers or schools that were within close proximity of a few villages. Beneficiaries then gathered at this common meeting point where caregivers gathered to lead mass distributions.

- Delivery by caregivers or community health workers to beneficiaries. In some cases caregivers or community health workers collected nets for beneficiaries that were too sick, too old, or unable to attend the distribution, and delivered the nets to the beneficiary's home.

Each distribution began with a health presentation by district health staff or caregivers that highlighted the signs and symptoms of malaria, prevention methods, proper treatment, malaria prevalence in the community and proper net usage including a net demonstration. In many cases local drama teams helped to illustrate these points with sketches and songs. In addition, discussions on improper net usage were discussed and caregivers and community members agreed to hold each other responsible for appropriate use of the net.

Successes

- Caregivers were extremely efficient at organizing communities, dividing up supplies, translating educational information to communities, and mobilizing individuals. Their dedication to the project and their communities made the distribution a success.

- Involvement by the District Health Office provided the partners with valuable information about the areas with the district that had already received nets. This greatly increased the partner's efficiency and allowed them to completely cover the remaining gaps within the district.

- Including other village level staff such as malaria focal point people, community health workers, environmental health technicians, clinic staff, area development committee workers, neighborhood health committee members and headmen helped decrease the work load of the caregivers and gave them additional information about the needs of each village. This allowed caregivers to certify they were reaching everyone.

- District partners conducted planning meetings with other partners prior to the distribution in order to share communication and develop a logistics plan.

- Providing a health talk which highlighted effects of malaria and malaria rates in the area was very powerful. In addition, in many locations a drama followed which showed proper net-

hanging techniques and proper net usage. This engaged the audience, raised questions and addressed issues of accountability.

- Working through the district and the local health centers was very helpful as community members became more aware of the epidemic and nets that were not picked up by caregivers could be left at the health center for later pick up.

Challenges

- Rains created many problems for the distributions. In many cases villages could not be reached on the assigned day for distribution because of flooding. Bridges and roads to certain villages were wiped out due to rain. Vehicles became stuck trying to deliver nets or attend distributions. Beneficiaries were sometimes unable or unwilling to attend distributions when the rains were too heavy. While this was mediated as best as possible, it may have lead to decreased net coverage.

- Trucks were delayed in two of the districts. In Kalomo, the truck arrived a few days late and in Mpika it arrived a week late. This created problems given that the distribution was already being conducted on a strict time schedule. Moreover, in certain areas it meant that enough time had elapsed and the rains became heavier in those areas.

- Large spread out districts. Providing additional funding for staff and logistics to travel to the most remote locations would be helpful for future distributions.

- In one area the goals of the distribution were not properly communicated by the district to the village level. This meant that on the day of distribution the caregivers and clinic staff were unable to do the distribution. Information had to be re-gathered and a new distribution day set.

- There are always going to be some extraneous reasons for why beneficiaries don't come to receive their nets. It is important to foresee and avoid these as much as possible. Exampleas are groups or individuals who refuse to participate, those who forget the date or time of the distribution, community events such as funerals that arise suddenly and conflict with the day of the distribution, seasonal occupational requirements, etc.

Lessons Learned

- The distributions need to be planned around seasons and farming schedules as much as possible as these considerations strongly affect attendance.

- During the distributions the following activities were implemented and highly successful: 1) Have beneficiaries arrive approximately 1 hour before the distributions begin and have caregivers engage them in song and dance, 2) Arrange for the clinic nurse or MOH staff to give the health talk and make it applicable to the local context (discuss prevalence of malaria, etc), 3) Ask community members to present a drama depicting proper and improper net usage and appropriate hanging techniques, 4) After the drama encourage community members to ask

questions and make comments on the messages from the talk and the drama, and 5) Lastly, break up into caregiver groups and show each group where their caregiver will be meeting. It is important to have enough people available to carry the nets to the caregiver locations and then let the caregivers immediately distribute to their groups. This will ensure the appropriate persons are receiving nets and save time.

Conclusions

The net distribution highlighted the advantages of how an integrated effort makes interventions such as the net distribution a success. Creating additional partnerships during phase II greatly increased the efficiency of the distributions. Working more closely with District Health Management Teams and including other village based health workers provided partners and caregivers the tools to obtain complete coverage. The support of international partners like Against Malaria Foundation and WVUS, partners and organizations in Lusaka, partners across the districts, caregivers, households and beneficiaries were vital to ensuring the success of the distributions. Future distributions should expand upon this integrated approach by increasing time and resources available pre-distribution so that district and village level staff are all included and educated on the data collection methods. This dedication to the initial collection of data will better inform future programs and increase the level of participation of interested parties. The continuation of building public/private partnerships is also important to such programs, as they allow work to be done that otherwise would be too expensive for one organization to take on alone.