World Swim For Malaria Foundation

LLIN Distribution Programme – Detailed Information

Summary

# of LLINS	Country	Location	When	By whom
3,700	**Kenya**	**Gai and Itivanzou**	**Nov-Dec06**	**AMREF and Akamba Aid Fund**

Further Information

1. Please describe the specific location & villages that will receive nets and the number to each?

We will target two neighbouring sub-locations in the Kyuso division of Mwingi district, Eastern province: 2900 nets for Gai sub-location (Kyuso location) and 800 nets for Itivanzou sub-location (Kamuwongo location).

2. Is this an urban or rural area and how many people live in this specific area?

This is a rural area, and most of the inhabitants are poor. 2006 census records show Gai sub-location to have a total population of 6485 over an area of 118km^2, and Itivanzou 1732 over 30km^2. Assuming 18% of the population are under 5 and a further 4% are pregnant women, the total 'high risk' population is 1807. Assuming an average of 4.5 members per household, there are 1826 households.

3. Is this a high risk malaria area for this country? If yes, why do you designate it as high?

Yes. Mwingi district is classified by the Kenya Malaria Information Service as being Arid, therefore Epidemic Prone. Transmission rates are reported by local clinicians to be very high during the long and short rains of November and April, and moderate in-between.

4. How many *reported* cases of malaria and malaria deaths were there in this area in 2005? If you do not have statistics please make a qualitative comment.

Gai clinic, the only health facility in Gai sub-location, treated 1894 confirmed malaria cases in 2005. Katakani clinic, the only facility in Itivanzou sub-location, treated 1175 that same year. Many more infected individuals will not have sought treatment. Death rates are not available as they are recorded at a district level only, but qualitatively judged to be high by nurses at both clinics.

5. Is this distribution of nets 'blanket coverage' of an area/village or to a select/vulnerable group? If the latter, please describe this group.

We will favour blanket coverage to maximise the impact of the LLINs, as the community-wide effect of reducing the local mosquito population, thus protecting non-net users as well, only applies in cases of dense LLIN coverage. This method is modelled on the practices employed and recommended by entomologists at the London School of Hygiene and Tropical Medicine distributing nets in Tanzania.

6. What is the existing level of ITN use in this area? Are there existing bednet distribution programmes in this area?

Focus group discussions and small group polls revealed current levels of ITN use to be very low. 2003 census figures suggest around 5% coverage for pregnant women and children under 5.

Nets are sold through Gai clinic and Population Services International for 50 KSH each to children under 5 and pregnant women, through MCH and ANC appointments. Katakani clinic has recently been approved PSI Distributor status but is awaiting training.

However, many at risk individuals cannot afford either the cost of the required ANC or MCH appointment to qualify for a net, or they cannot afford the 50 KSH. There are also other vulnerable groups – elderly, HIV positive (local prevalence estimated from Voluntary Counselling and Testing to be 36%) and orphans – who do not qualify for PSI nets.

Nets are not available in local shops. A recent free distribution of 200 LLINs by Akamba Aid Fund (AAF) revealed high demand for more. There are no other ITN distribution schemes. PSI are aware of our proposal and approve of it.

7. Why was the area/villages chosen for bednet distribution and who made this decision?

Akamba Aid Fund are a small charity targeting poor families in Gai and Itivanzou sub-locations. The two clinics there – in Gai and Katakani villages – have good relations with AAF and are willing to help with the distribution. The Trustees of AAF chose Gai and Itivanzou and, acting on the advice of Professor Greenwood, approached AMREF for support and advice during distribution for our two local employees, and help in logistics of net transport.

8. Have you consulted with the National Malaria Programme in your country about this distribution and what was their response?

Dr Willis Akhwale, Head of the Division of Malaria Control, Kenya, states that the proposed distribution is most welcome, and that he is happy to endorse it. He has requested blanket coverage, but if this is not possible, targeting of children and pregnant women.

9. Please describe any pre-distribution activity, in particular how the size of the target group and number of nets required will be ascertained?

AMREF and AAF staff will work with sub-chiefs, community group leaders and clinic staff to draw up a list of every household within Gai and Itivanzou sub-locations. Assuming an average of 4.5 members per household, and an average of 2 individuals sleeping under each net, a figure of 2 nets per household has been agreed upon. To allow for discrepancies, we have rounded up from estimates of 1441 and 384 households respectively for Gai and Itivanzou to 1450 and 400, thus requiring 2900 plus 800 equals 3,700 nets.

10. Please describe how the bednets will be distributed, by whom, between which dates, whether distribution will be a focussed effort or part of a combined programme and if there will be an information/education component to the distribution?

Each household head will receive a note informing them of the number of nets allocated to their household. They can exchange this note for nets held at Gai or Katakani clinic over a specified few days. As household representatives gather at the clinics to collect their nets, education sessions will take place, led by AAF employees and clinic staff.

11. What post-distribution follow-up is planned to assess the level of usage of these nets?

AAF staff will carry out unscheduled home visits to randomly selected households in the months following distribution and record their findings. These visits will also be an opportunity for further education, problem solving, and assessment of the impact of ITN use on health, on an individual and community level.