

NetsforLife® Program Final Evaluation Report

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ACRONYMS

| | |
|-----------------|--|
| LLIN | Long Lasting Insecticide Net |
| ITN | Insecticide Treated Bed Net |
| MCA s | Malaria Control Agents |
| NGO s | Non-Governmental Organizations |
| IPT | Intermittent Preventive Treatment |
| IPTp | Intermittent Preventive Treatment in pregnancy |
| ZAC | Zambia Anglican Council |
| NHSP | National Health Strategic Plan |
| IPTP | Intermittent Preventive Therapy in Pregnancy |
| GDP | Growth Domestic Product |
| CRC | Convention on the Rights of Children |
| ICCM | Integrated Community Case Management |
| RDT s | Rapid Diagnostic Tests |
| FDG s | Focus Group Discussions |
| SP | Fansidar (Sulphadoxine Pyrimethamine) |
| WHO | World Health Organization |
| HIV/AIDS | Human Immuno –Virus/ Acquired Immuno-Deficiency Syndrome |
| IRS | Indoor Residual Spraying |

EXECUTIVE SUMMARY

NetsforLife® is a malaria prevention program under Episcopal Relief & Development which is the development wing of the Episcopal Church of the United States of America. The NetsforLife® program is a unique partnership that brings together corporations and foundations in the fight against malaria in 17 countries in sub-Saharan Africa. In Zambia, the program is managed by Zambia Anglican Council (ZAC). Zambia NetsforLife® program started in 2006 with the primary aim of contributing to a reduction in malaria related morbidity and mortality in the Country. The program has thus worked closely with the National Malaria Control Program, the Ministry of Health and other partners in Zambia in this direction.

BACKGROUND

The Zambian Anglican Council (ZAC) is the body which represents all five Dioceses, health institutions and training institutions for the Anglican Church of Zambia. ZAC implements integrated health and development programs at the field level in partnership with the local dioceses of the Anglican Church. The NetsforLife program focuses on malaria prevention in the five dioceses.

The NetsforLife® program in Zambia which focuses mainly on rural communities where malaria is high and access to health facilities is limited, aims at contributing to the reduction in malaria related morbidity and mortality in the Country. Since 2006 to date, ZAC has implemented the NetsforLife® program in some communities in a number of districts in the Country. The program has been in two Phases. The Phase I of the program started in 2006 and came to an end in September 2008. The Phase II started in October 2008; to date, the Zambia NetsforLife® program has distributed over 1,154,000 Long Lasting Insecticidal Nets (LLINs), trained over 3,800 Malaria Control Agents and reached over 3,041,000 people with malaria messages in its Phase II project.

The program develops community structures that help in changing the behavior and attitudes of the people with the objective of increasing knowledge and improving practices on malaria prevention.

Activities undertaken under the program include:

1. Community entry and (Assessment/baseline survey)
2. Sensitization/Education of community members on malaria and its prevention
3. Selection and training of community volunteers (referred to as Malaria Control Agents after they are trained)
4. Registration of beneficiaries and distribution of long lasting insecticide treated nets using the hang-up methodology in most communities
5. Follow up on net usage and door-to-door education of beneficiaries by trained Malaria Control Agents
6. Monitoring and annual Evaluation (by consultant or independent organization)
7. Quarterly and Annual Reporting to partners.

Presently, NetsforLife® has volunteers (known as Malaria Control Agents) in communities conducting follow up of LLINs to ensure consistent and correct usage and the proper care for the nets as well as educating/sensitizing beneficiaries on malaria. The program's strength in working with the community structures and working through the District Health structures has resulted in massive community participation thus reaching people at the grass root levels amongst others.

Goal of the NetsforLife® Project: To contribute to the reduction in malaria related morbidity and mortality

Specific objectives:

- To increase knowledge and improve practices on Malaria prevention and management
- To increase coverage of Long Lasting Insecticidal Nets (LLINs).

The evaluation of the NetsforLife Program is to check on the general performance of the programme; whether the objectives were achieved, if there are lessons to learn from the projects in terms of best practices.

The evaluation was carried out from 22nd May to 12th June 2013. This report summarizes the findings of the final evaluation. The evaluation mainly consisted of the qualitative and quantitative components. The basis of the quantitative portion, which is reported on here, was through a generic questionnaire which 600 respondents undertook randomly.

The qualitative component, which included focus group and key informant interviews, also provided some information on knowledge, attitudes, and practices in the selected communities as they relate NetsforLife Program.

Methodology

The evaluation was quantitative, descriptive exploratory and qualitative study, which explored the various practices as relates to the malaria program capturing their perceptions, knowledge, practice and experiences of various households, Malaria Control Agents and community members.

It was done in the month of May from the 22nd May to 12th June 2013. The evaluation was primarily quantitative focusing on structured interviews using a generic questionnaire, focus group discussions (FGD) but also included secondary data review on malaria prevalence.

The team was composed of six member's i.e. Consultant, Assistant and four data collectors. The quantitative data from the time the project commenced to the current period was collected from in Chibuluma/ Chibote, Kasenga, Kakwalesa, Mikumbila, Garden and Chilumba areas from the five Diocese where the project is undertaken. The evaluation team used a structured questionnaire to collect information from 100 heads of households in each catchment area on Malaria in terms of Social Demographic data, Knowledge levels/ Perceptions about Malaria, Malaria Prevention Behaviors/ Practices, Program Evaluation and Malaria Treatment Seeking behaviors.

Summary of Findings

Malaria Activities in general

Malaria activities and programs are being driven by the local Malaria Control Agents and the diocesan Supervisors in all the six areas and it is evident from the findings that NetsforLife program has had a very significant impact on both knowledge levels and practices in the community. It is important to also acknowledge that other stakeholders in some areas are complimenting the program such as some local clinics and other stakeholders. The use of the church and local communities in the implementation of the program have entrenched these malaria messages and made the part of their lifestyle. **As one Jessy Kanyinji, 70years old of Chibuluma put it “ The malaria messages we have learnt from the program have been very beneficial as they do not only assist me educate other members of the community but have helped me as I take care of my children, grandchildren and myself better.”**

Finding on the Outcome Indicators

LLIN Coverage

Proportion of Households with at least two LLINs

This indicator is critical because it highlights the basis of the Netsforlife project in that it looks at the availability of the ITNs to the most basic element of the community, the household. The proportion of households with ITNs though according to the findings being at 56% is even higher in that the indicator only captured those households with two ITNs and above but there

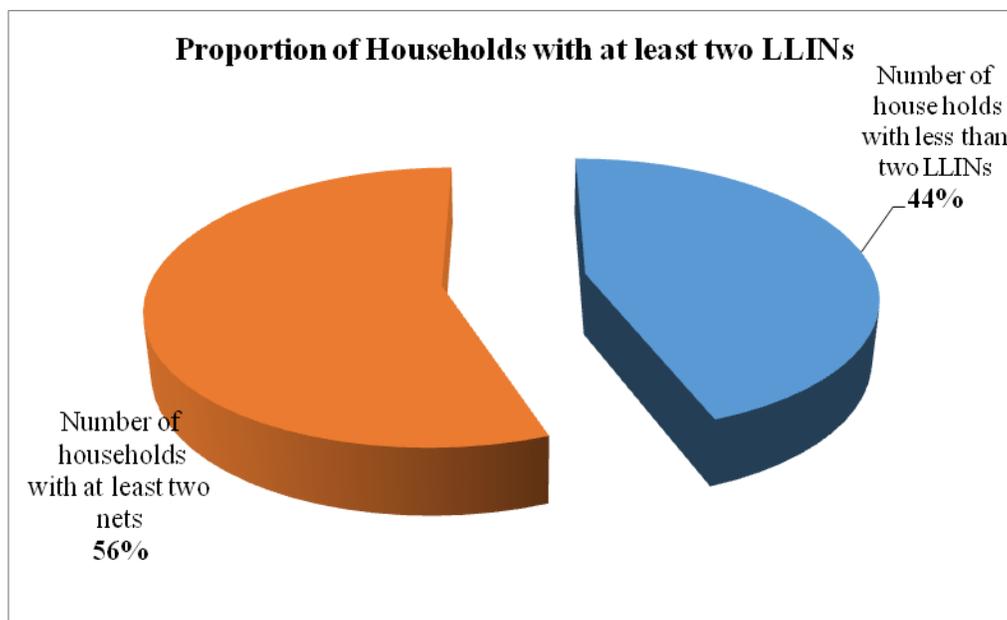
were more households with occupants only entitled to one ITN but whose number was not captured by the data base.

The coverage of this indicator also shows that the project coverage at 56% almost attained the WHO Abuja Declaration on Roll Back Malaria which indicates that at least 60% of those at risk of malaria, particularly children under five years of age and pregnant women, benefit from the most suitable combination of personal and community protective measures such as insecticide treated mosquito nets and other interventions which are accessible and affordable to prevent infection and suffering from the disease.

The program also contributed significantly towards the attainment of the Zambian National Health Strategic Plan (NHSP) 2011-2015 overall goal to provide cost-effective, quality and gender sensitive primary healthcare services to all as defined in the Basic HealthCare Package on malaria whose objective is reducing the incidence of malaria from 252/1000 in 2008 to 75/1000 in 2012 through Implementation of the malaria prevention and control interventions including IRS, ITN distribution, Intermittent Preventive Therapy in Pregnancy (IPTP,) and prompt and effective treatment.

According to the Zambian National Health Strategic Plan, these malaria control strategies have markedly reduced transmission and parasite prevalence in Lusaka and the surrounding areas to less than 1% (where Garden and environs). There were also areas where sustained malaria prevention and control had markedly reduced transmission and parasite prevalence was at or under 10% in young children at the peak of transmission (Central, Copperbelt, Northwestern, Southern, and Western Provinces). However, due to some lapses in malaria control, resurgence of infection and illness, and parasite prevalence in young children exceeded 20% at the peak of the transmission season in Eastern, Luapula, and Northern Provinces.

There is need therefore to sustain the gains that the Nation have achieved so far through these interventions including ITNs to ensure that the whole country has reduced parasite prevalence and consequently reduced malaria incidence.



The pie chart above indicates that the proportion of households with at least two LLITNs is 56%. The average number of people in a household from the findings is five per household. The number of nets per person might look less but this is adequate when you look at the bed spaces per household.

Proportion of households with a pregnant woman with at least two LLINs

Malaria in pregnancy has very severe consequences if not well managed. This indicator therefore highlights an important aspect of the NetsforLife program which had a deliberate policy to target vulnerable groups in the community to be provided with essential preventive key messages and LLITNs. The attainment of provision of LLINs to 57% proportion of households with pregnant women is commendable in that the program almost managed to attain the Abuja Declaration Malaria in pregnancy target of providing at least 60% of those at risk of malaria, particularly pregnant women, benefit from the most suitable combination of personal and community protective measures such as insecticide treated mosquito nets and other interventions which are accessible and affordable to prevent infection and suffering from the disease.

According to the Abuja Declaration on Malaria statistics, the disease and economic burden that malaria places on hundreds of millions of Africans and the barrier it constitutes to development and alleviation of poverty is massive,

Taking note that:

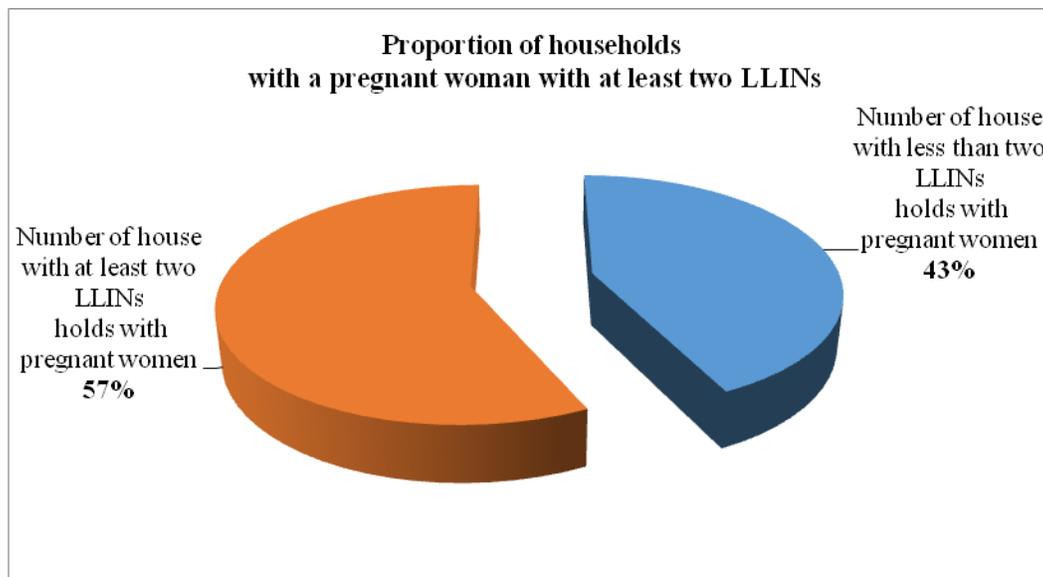
- Malaria accounts for about one million deaths annually in Africa,
- Nine out of ten cases of malaria worldwide occur in Africa south of the Sahara,
- Malaria costs Africa more than US\$12 billion annually, and can be controlled for a small fraction of that amount,

- Those who suffer most are some of the continent's most impoverished and that malaria keeps them poor,
- A poor family living in malaria affected areas may spend up to 25% or more of its annual income on prevention and treatment,
- Malaria has slowed economic growth in African countries by 1.3% per year. As a result of the compounded effect over 35 years, the GDP level for African countries is now up to 32% lower than it would have been in the absence of malaria,
- Malaria can re-emerge in the areas where it is under control,

Provision of LLITNs to 57% households with a pregnant woman therefore not only reduced the incidence of Malaria in these homes with pregnant women but also contributed significantly to mitigate some of the above negative factors that comes with the malaria ailment in a home, community and or country.

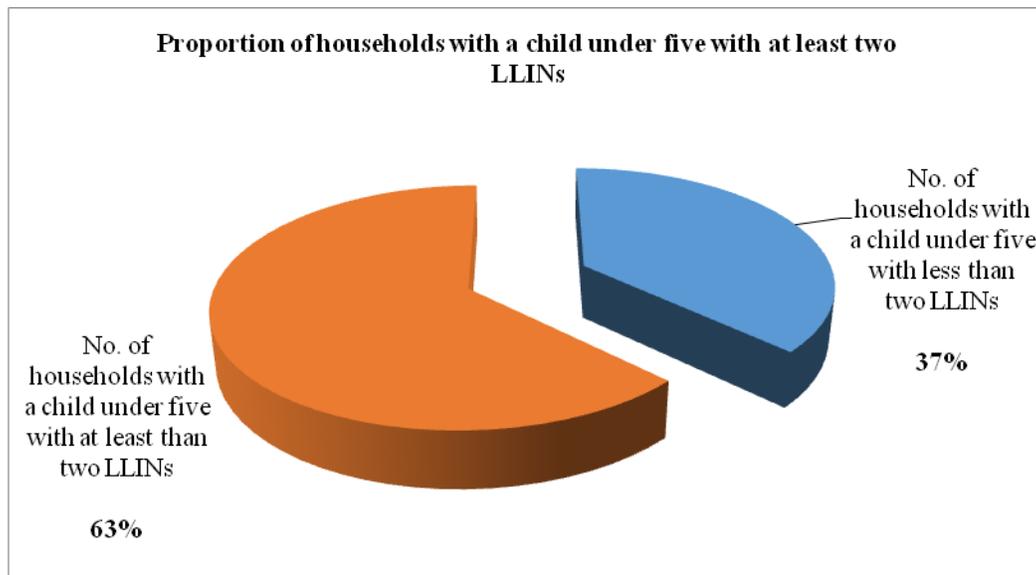
Malaria has many serious complications on the health of both the woman and the unborn child such as anemia, abortions, low birth weight baby, malnutrition and even death and the provision of the LLINs to the households reduced the occurrence of these complications more especially that the program implementation of interventions targeted the vulnerable communities.

During discussions our findings were that most households with pregnant women acknowledged the importance of the women to be provided with a LLIN for the prevention of malaria in pregnancy and the complications that comes with the disease.



The pie chart above also show that 57% of households with pregnant women had at least two nets and in our other findings, the vulnerable groups'i.e. pregnant women and under five children are given priority to sleep under LLINs.

Proportion of households with a child under five with at least two LLINs



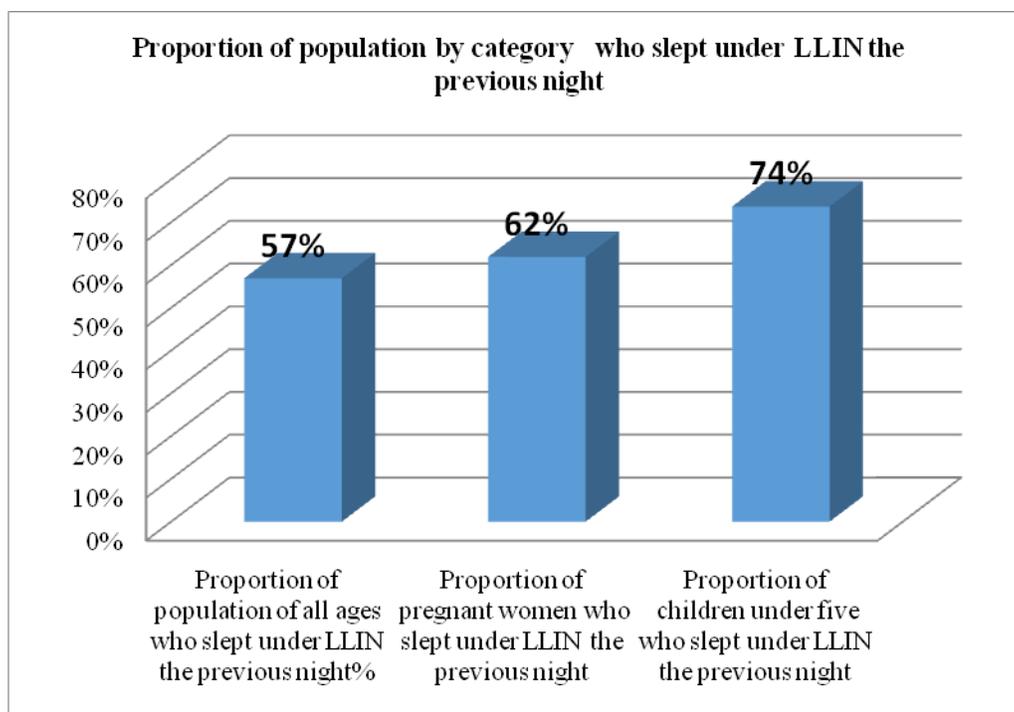
Similarly, the pie chart above also show that 63% of households with children under five had at least two nets and in our other findings, the vulnerable groups i.e children under five are given priority to sleep under LLINs

As can be seen from the above table, the under five children constituted the highest number of vulnerable members targeted by the NetsforLife Program. The attainment of 63% households with a child under-five with at least two LLINs was more than 60% target given by the Abuja Declaration on Malaria.

The attainment of more than 60% of those at risk of malaria, particularly children under five years of age to benefit from the most suitable combination of personal and community protective measures such as insecticide treated mosquito nets and other interventions which are accessible and affordable to prevent infection and suffering is a sure way of meeting the Convention on the Right of the Child (CRC) which recognizes the right of all children to good health and nutrition.

During Focus Group Discussions it was noted that in almost all the communities visited the respondents were very passionate in the provision of LLITNs to the under-five children in their households. Even when it was observed that the LLITNs were not adequate in the household, under-five children were given priority. This could be noted from the findings that only 57% households with pregnant women had at least two LLITNs compared to 63% attained by households with under-five children.

Proportion of population of all ages, pregnant women and under-five children who slept under LLINs the previous night



The graph above shows the proportion of population by category who slept under LLINs the previous night and it clearly shows and confirms our assertions that the two most vulnerable groups of people are given priority to sleep under LLINs with the highest proportion being that of under five children at 74%.

As could be seen from the above findings, the proportion of children under-five who slept under LLIN the previous night was 74% compared to 62% for the proportion of pregnant women who slept under LLIN the previous night and the proportion of population of all ages who slept under a LLIN the previous night which stood at 57%. During FGDs the respondents indicated that adults in general sometimes felt that they do not need to sleep under the LLIN. This was attributed to various factors such as beliefs, the status of the person when sleeping and the priority attached to child survival by most facilities.

Some of the factors mentioned which contributed to adults not sleeping under the LLIN which were mentioned during discussions were as follows:

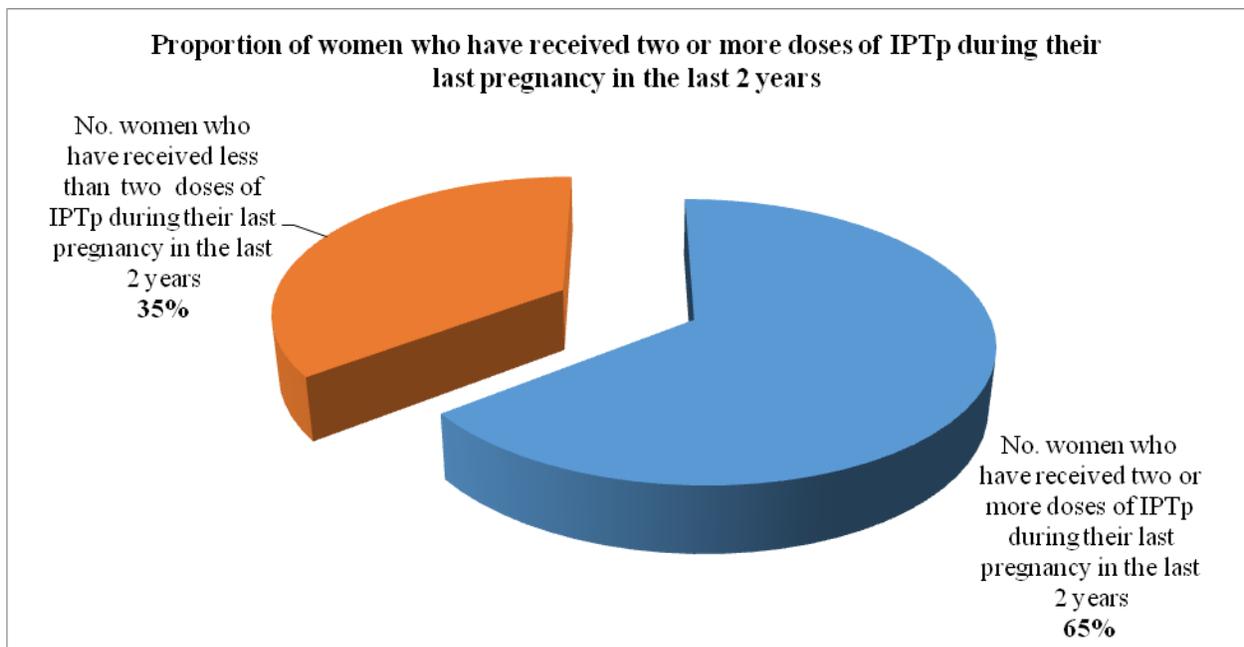
- Most adults felt that they had more resistance to malaria than the children and therefore prioritized the children in LLIN usage.
- Even in homes with inadequate LLIN but with both pregnant women and the under-five children, the respondents indicated that priority was given to the under-five children to sleep under the net.

- There were respondents that said they felt uncomfortable sleeping under the LLIN such as “feeling hot”, “feeling breathless” and “reacting to the chemicals”.
- Some respondents also indicated that if the adult takes some alcohol the previous night they are more likely to not to sleep under the LLIN.

Sensitization of the community is therefore important to ensure that these negative beliefs and practices do not continue to make the adults not to use the LLIN because they are also vulnerable to malaria in most cases especially those with HIV/AIDS and pregnant women.

IPT

Proportion of women who have received two or more doses of IPT during their last pregnancy in the last 2 years



The pie chart above shows that IPT uptake for two or more doses is quite high at 65% considering the constraints that pregnant women face in accessing these services due to long distances to reach health facilities in the project sites.

The table above shows that at least 65% number of women received two or more doses of IPT during their last pregnancy in the last 2 year. This coverage was even higher than the Abuja Declaration target of providing IPT to at least 60% of all pregnant women who are at risk of malaria, especially those in their first pregnancies, have access to chemoprophylaxis or presumptive intermittent treatment. The good coverage according to most respondents was due to the following factors.

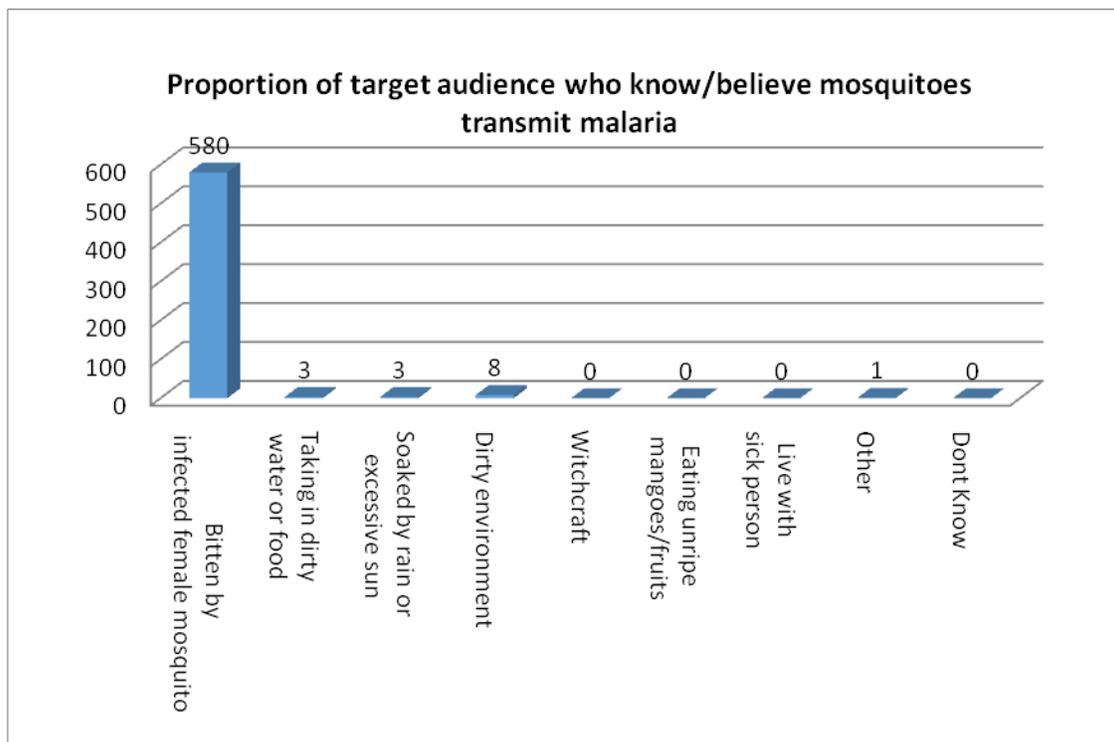
- Very active Malaria Control Agents (MCAs) at community under the NetsforLife program provided sensitization of the community on pregnant women attending Antenatal at the nearest health facilities and access to these basic but essential services available.

- The strong link that the program created between the local health facilities and the Malaria Control Agents under the NetsforLife.
- Good referral system of the pregnant women in various communities to the local health facilities that was put in place by the program.

The high coverage of this indicator was therefore a very strong proxy which highlighted the strong relationship that the program had with the other health providers of malaria interventions in the community where the program was being implemented. This was confirmed by the in-depth discussions findings that all the other health providers providing health interventions in these areas where the NetsforLife program was being implemented were aware of the presence of the program. The MCAs for the program were also not only working on Malaria interventions by the NetsforLife program but were involved in the programs under other stakeholders such as Indoor Residual Spraying (IRS), Integrated Community Case Management (iCCM) etc. As one chairperson of the MCAs in Chibuluma indicated “ *due to the fact that we are under the church, the community feels more comfortable to listen and discuss health issues with us compared to other health providers in the community doing the same work*”.

Knowledge

Proportion of target audience who know/believe mosquitoes transmit malaria

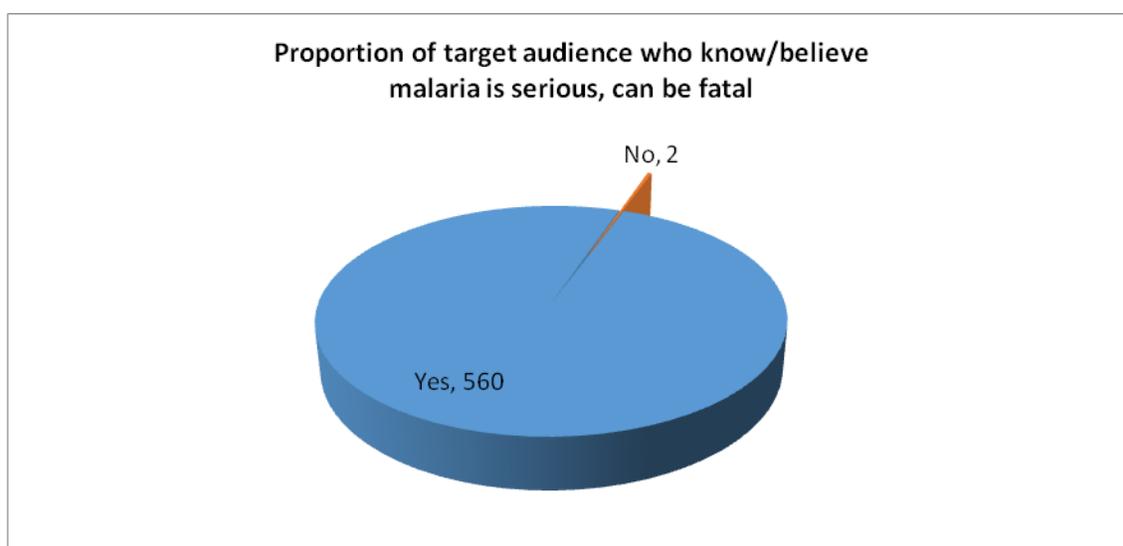


On the knowledge levels of the target audience, the findings show a remarkable number of people who know and believe that mosquitoes transmit malaria. This is a positive stride in malaria prevention and control.

As can be noted from the above table, 97% proportion of respondents talked to knew/believed that mosquitoes transmit malaria. This was a remarkable finding in that all the malaria interventions the program was implementing, the most important factor was to have a community that had the right knowledge. Knowledge empowers the community to adopt important lifesaving interventions in any program under implementation.

However another 1.7% proportion who believed that malaria was transmitted by taking in dirty water or food, being soaked by rainy water and other reasons highlights that there was need to continue to sensitize the community members despite the number being minimal.

Proportion of target audience who know/believe malaria is serious, can be fatal



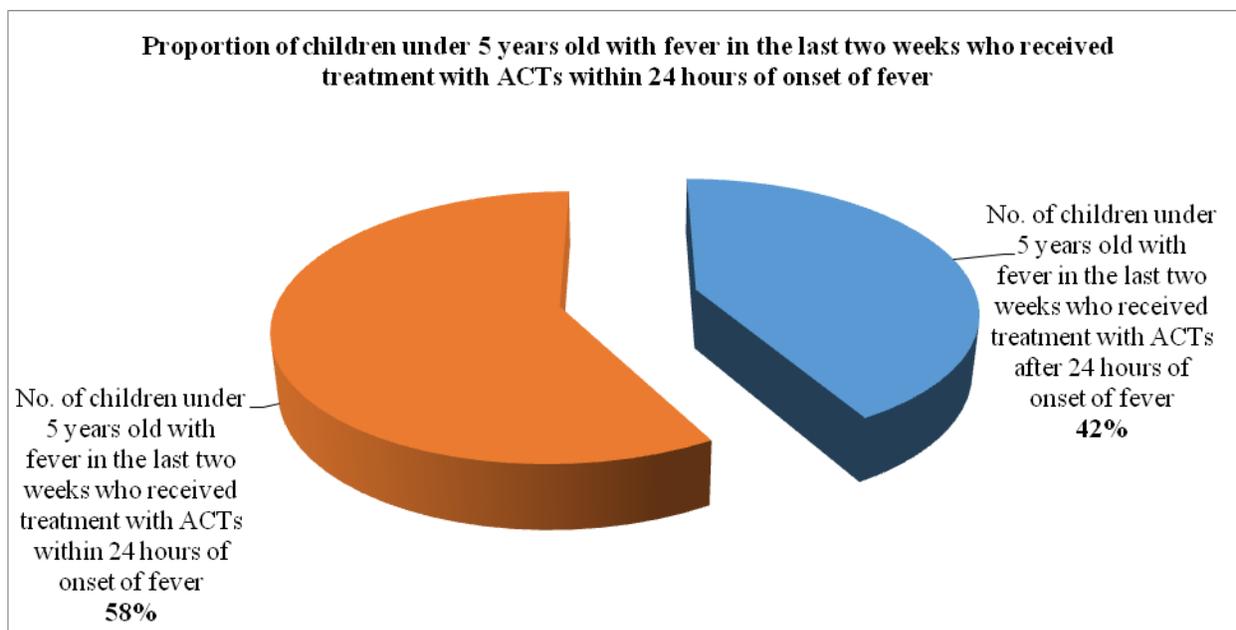
Similarly to the above findings, the at least 560 of the 600 respondents attested that malaria is serious and can be fatal.

As can be noted from the above table, the 560 respondents talked to indicated that they knew/believed that malaria was a serious disease which can be fatal. This was also a remarkable finding which could compel the members of the community to seek medical attention early when they feel the signs and symptoms of malaria. Knowledge empowers the community members to also avoid the many complications that malaria can cause if not managed early.

The factors that could make the community not to appreciate this fact could be genuine lack of information by community members or some may have felt that there were both preventive and treatment interventions for malaria which were readily available and therefore the disease need not be fatal

Practice

Proportion of children under 5 years old with fever in the last two weeks who received treatment with ACTs within 24 hours of onset of fever

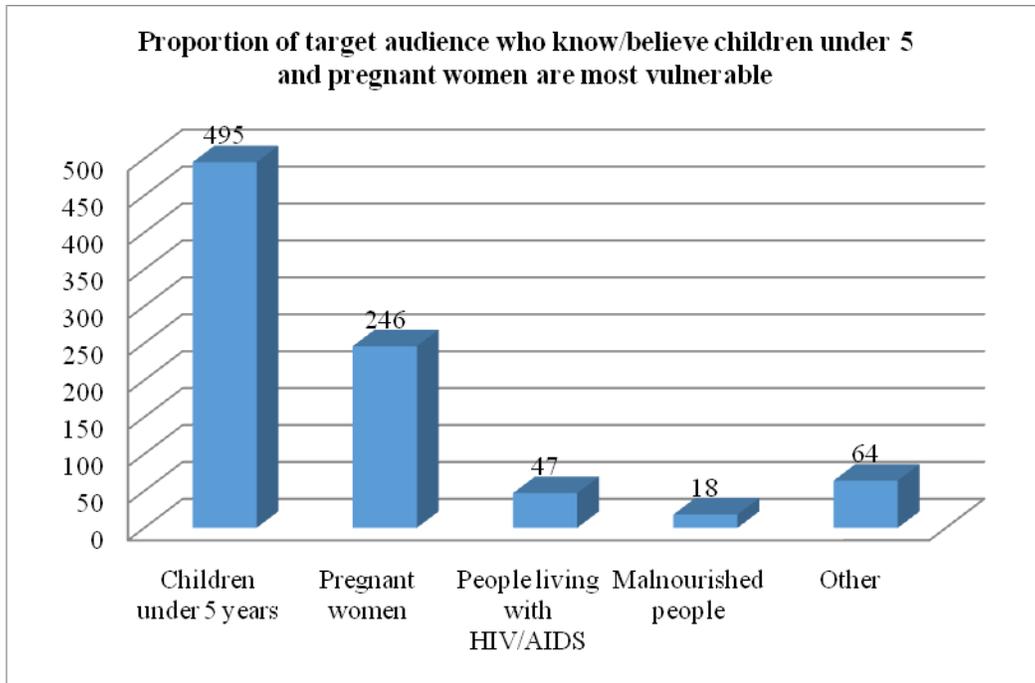


The pie chart above shows that a larger proportion of under five children received ACT treatment within the first 24 hours after the onset of fever. This shows that most respondents would take the children to a health facility early or at least know the correct management of malaria.

The table above shows that 58% of the respondents talked to made sure that children under-five years old with fever in the last two weeks received treatment with ACTs within 24 hours. This indicator is only 2% short of the target of the Abuja Declaration on Malaria which states that at least 60% of those suffering from malaria have prompt access to, and are able to correctly use, affordable and appropriate treatment within 24 hours of the onset of symptoms. Considering the long distances that most of the caregivers had to travel to the nearest health facilities/ providers and availability of RDTs and ACTs at these facilities, this was also a good achievement. What needs to be recognized as well is that the above factors were not among the mandate of the program to provide but only to encourage accessibility which was done. Availability of ACTs and provision of a health provider/ facility as near as possible to the community (within 12 Kilometers) was the responsibility of the Government.

What contributed to the delay in providing treatment were sometimes stock outs of ACTs and RDTs by the local facilities, long distances to the nearest facilities and in some cases giving wrong medication such as paracetamol only as treatment. One of the major findings of the study was that most caregivers were still giving analgesics only initially before they confirm that the child was indeed affected by malaria.

Proportion of target audience who know/believe children under 5 and pregnant women are most vulnerable

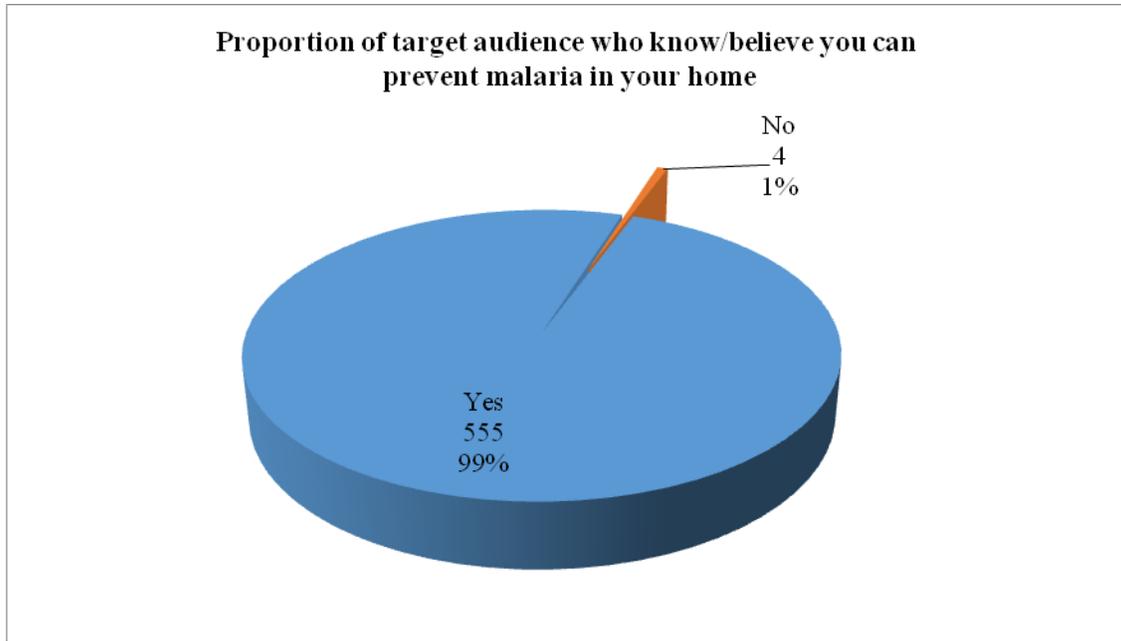


The graph above clearly shows that the respondents know who the most vulnerable groups are to malaria and this can be attributed to the intensive sensitization programs that were undertaken by the malaria control agents in the communities.

The findings shown by the table above highlights the perceptions of the respondents indicated earlier that the community feels that children under five years old were a priority vulnerable group followed by the pregnant women. This awareness is good in that morbidity and mortality due to malaria of the two groups could be reduced. The other respondents who talked about people living with HIV/AIDS and malnutrition were also right in their own way. In most of these responses the experiences that the respondent had gone through also had the bearing on the answer they deem to be the priority vulnerable group.

It should be noted however, that the 64 under other vulnerable groups, the respondents referred to the old people.

Proportion of target audience who know/believe you can prevent malaria in your home

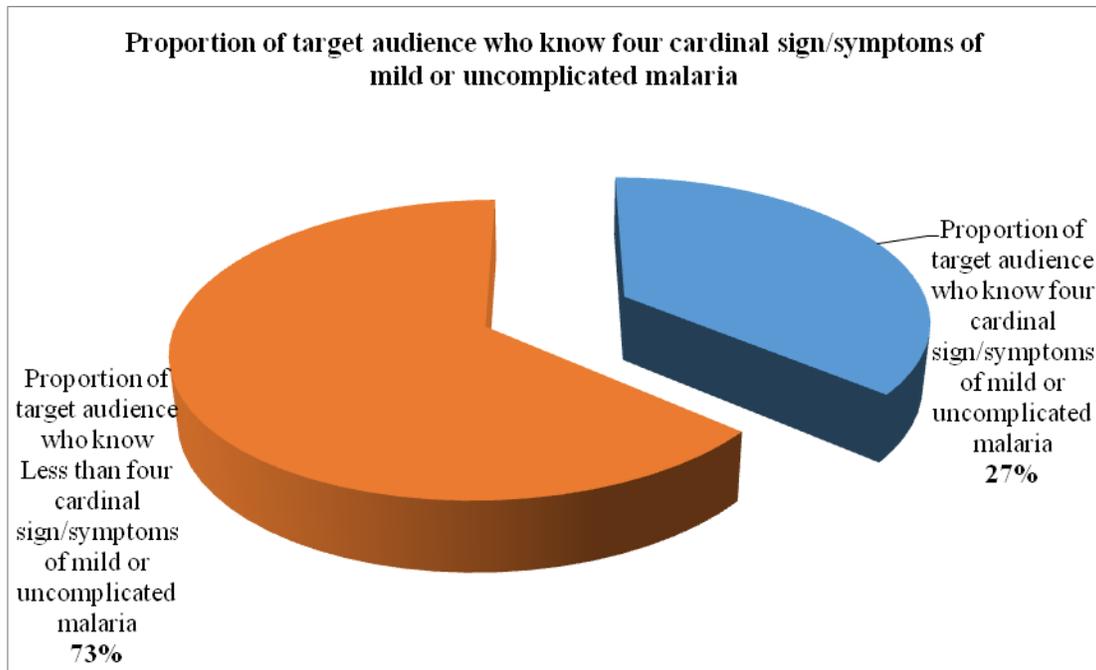


The chart above continues to show a positive trend in the knowledge and practice as regards to malaria prevention and control at household level. With these positive findings, sustainability on preventive measures should be maintained.

The proportion of target audience who know/believe they can prevent malaria their homes were 99%. This high level of awareness by respondents on prevention and control of malaria is also attributed to the facts already highlighted under proportion of target audience who know/believe mosquitoes transmit malaria.

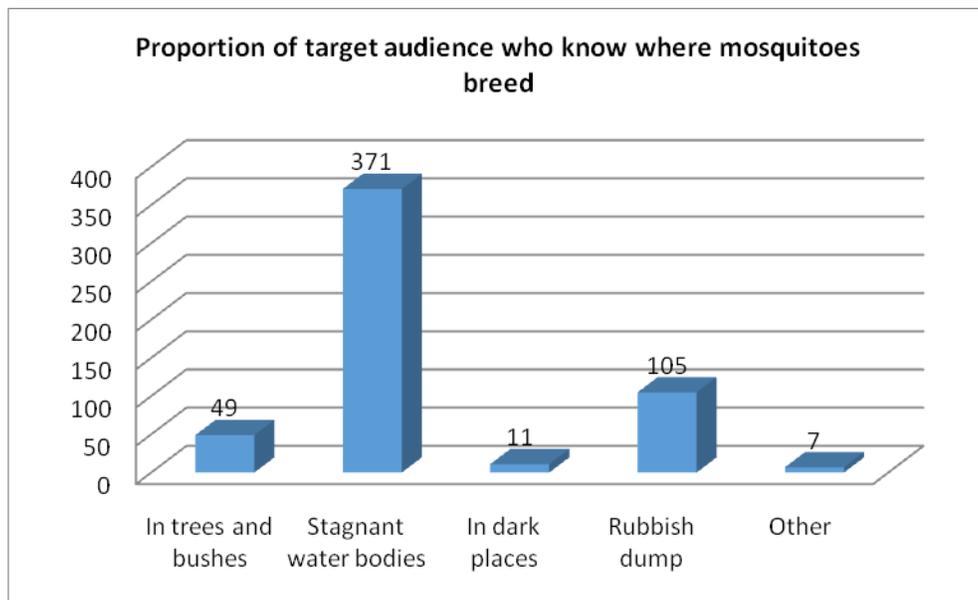
Proportion of target audience who know four cardinal sign/symptoms of mild or uncomplicated malaria

The table below shows that only 27% of the proportion of target respondents knew four cardinal signs/symptoms of mild or uncomplicated malaria. This was very low compared to 73% of those respondents that knew less than four cardinal signs/symptoms of mild or uncomplicated malaria. It is important however, to show that despite the seemingly low awareness on cardinal signs/symptoms of mild or uncomplicated malaria, almost all the respondents knew that fever is one of the critical sign/ symptom in malaria followed by joint pains.



On the contrary, the pie chart above show that only 27% knew the four cardinal signs/symptoms of mild or uncomplicated malaria. However, the findings show that fever and joint pains were the most known to be the major signs/ symptoms of malaria.

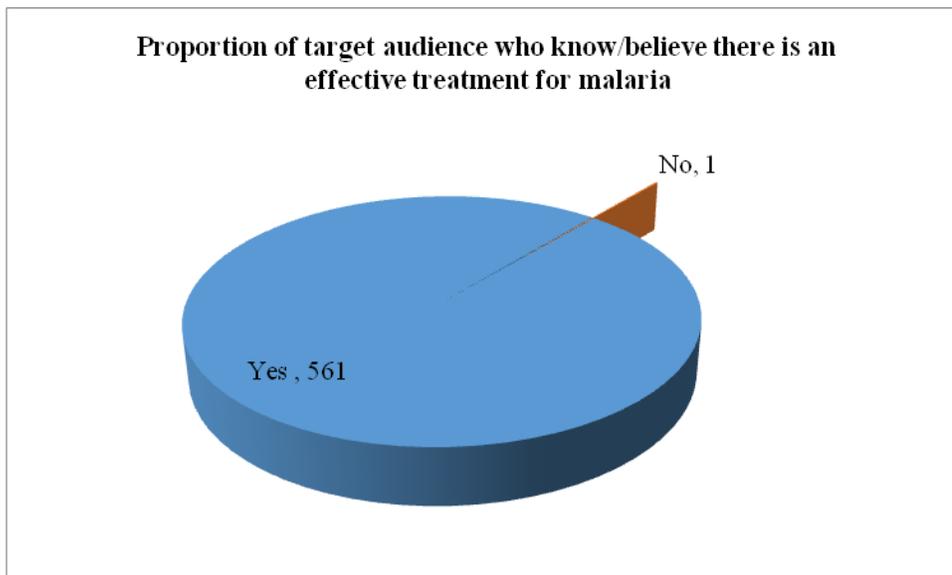
Proportion of target audience who know where mosquitoes breed



The graph above shows that knowledge on prevention and control of malaria is high as evidenced by the number of target audience who knew that mosquitoes breed in stagnant water bodies at 371

The graph showing the findings on the respondents on knowledge on malaria prevention and control of malaria is high as evidenced by the number who gave at least one factor that promoted mosquito breeding highest being stagnant water bodies. However there is need to sensitize the community further to enable them identify factors/ conditions that may contribute more to malaria prevention.

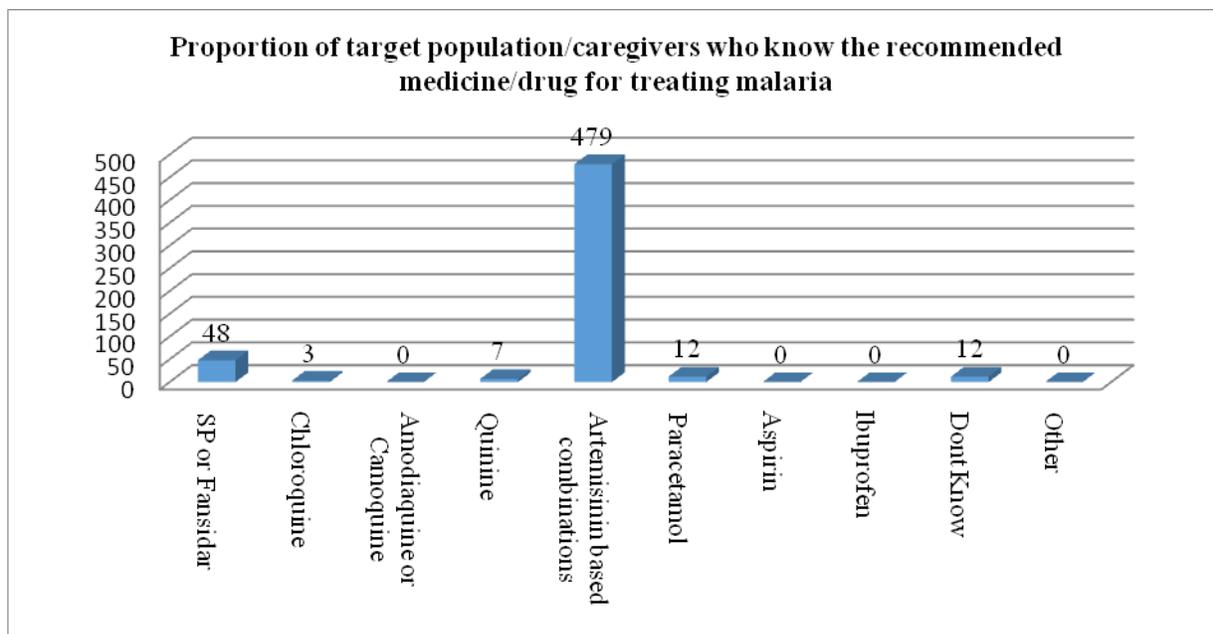
Proportion of target audience who know/believe there is an effective treatment for malaria



The proportion of target audience who know/believe that there is an effective treatment for malaria is also very high that this shows the receptivity of the malaria treatment seeking behaviors promoted under the under the Netsforlife program.

The proportion of target audience who know/believe there is an effective treatment for malaria 561 out of 600 respondents talked to. This shows the knowledge level of 93.5% among respondents which was a very high coverage. This high level of awareness by respondents on effective treatment for malaria is also attributed to the facts already highlighted under proportion of target audience who know/believe mosquitoes transmit malaria.

Proportion of target population/caregivers who know the recommended medicine/drug for treating malaria

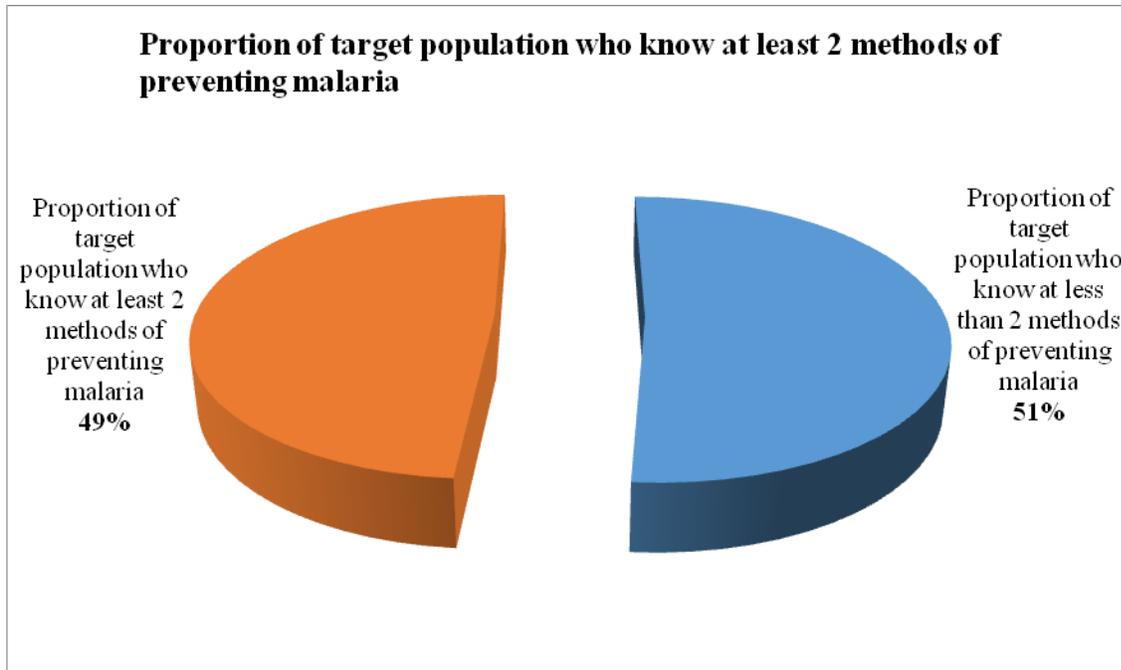


The graph above also clearly shows the high levels of knowledge on the recommended drug for treating malaria.

The table above shows that 479 respondents or proportion of target population/ caregivers knew the first line recommended medicine/drug for treating malaria which is Artemisinin based combinations. Although this is good there is still need to worry because 84 respondents still did not know the first line recommended medicine/ drug for treating malaria. These contribute significantly to effective management of the disease and consequently lead to complications and death.

As can be noted SP or Fansidar is the second drug/medicine at 48 which the respondents said could be used to treat malaria followed by paracetamol and those that did not know at 12 each respectively. This means there is still need to sensitize the community on the best drug to be used as the first line management of malaria.

Proportion of target population who know at least 2 methods of preventing malaria



Recommendations

The findings indicate that the malaria situation in the six communities is still a big concern especially for children and pregnant mothers. There are some children that still do not sleep under an LLIN despite the household having the nets. Some pregnant women on the other hand do not also sleep under the LLIN and take IPT three times according to national guidelines. Where the household has these nets there is still a concern in that some of the LLIN available were distributed more than 36 months ago and there was need to either check the effectiveness of the insecticide or be replaced all together with new nets.

The health providers at National, Diocesan and Community levels despite doing a good job so far needs some training and retraining to ensure that the key messages being disseminated were consistent with the national malaria guidelines.

1. **Interventions should seek to further improve the availability of the LLIN at household level.** The survey findings indicate that despite the LLINs being available to most households, some members of the households including the vulnerable such as children and pregnant women do not have access to the nets. This point to the need to improve access to and utilization of the LLIN at community level.

2. Improve utilization of available LLINs, IPT and Malaria management strategies.

- In some households despite the LLIN being available in adequate numbers, some of the members of the households do not still sleep under the nets. It is therefore important to strengthen the dissemination of malaria control messages and monitoring of the use of these nets right at community level.
- Some Pregnant women do not take IPT or if they do, they do not take the three required doses as per guidelines leaving them exposed to many malaria complications that may occur by not taking these lifesaving drugs. It is critical therefore to continue to provide the right messages to the community to encourage them to meet these standards. There is also need to strengthen the link between the Malaria Control Agents and the local health workers based at the local clinics. This can be done by strengthening involvement of local health workers during the training of these MCAs and monitoring.
- Some caregivers and pregnant women who were managed for fever/ malaria took as long as 72 hours to reach the local health facility for management. Some also made self-prescriptions and wrongly managed the fever/ malaria using Fansidar and Paracetamol/Aspirin. It is clear that these findings require further sensitization of the community to seek early treatment and get the right medication.

3 Specific interventions of capacity building are further required for the Malaria Control Agents.

- The findings of the evaluation show that the Malaria Control Agents are the highest source of information by the community on malaria. It would be important to ensure that the MCAs are provided with all the requisites to enable them to undertake their responsibilities effectively.

Conclusion

In conclusion, malaria remains the highest cause of disease and mortality in all the six areas where the evaluation was conducted. It is also very evident that the NetsforLife program has been a major provider of these lifesaving services in the community. The link therefore by the community, the Church and Government needs to be encouraged and if possible scaled up even to other areas which may not have had such programs. As shown by the above results the program has effectively achieved its main objectives of contributing to the reduction in Malaria related morbidity and mortality in the areas it is operating in through the provision of information and the lifesaving LLITNs.

However the LLITNs have not been available for the last 24 months for continued supply to households who may require replacement or new families that do not have the nets. Ministry of Community Development Mother and Child Health need to work hard in order to ensure all the logistics required for proper management of patients are available at all times.

References:

- Zambian National Health Strategic Plan
- WHO Abuja Declaration on Health

GENERIC QUESTIONNAIRE

FIX IMPLEMENTING PARTNER'S NAME

Questionnaire #

| | | |
|--------------------------------------|---|------------------------------|
| Province/County: | District: | Archdeaconry/Diocese: |
| Study Area/Community/Village: | Name of Household Head: | Interviewer's Name: |
| Date: | Status: Complete <input type="checkbox"/> In-complete <input type="checkbox"/> | Checked by: |

Directions: Please answer all questions by circling the number of your choice(s) or writing in the spaces provided where applicable

| No | QUESTIONS | CODING CATEGORY | CODE (For office use) |
|---|---|---|-----------------------|
| SECTION A : SOCIODEMOGRAPHIC DATA | | | |
| A1 | Age of Respondent (in complete years) | | <input type="text"/> |
| A2 | Sex of Respondent | 1 – MALE 2 – FEMALE | <input type="text"/> |
| A3 | Number of people in household | | <input type="text"/> |
| A4 | Number of children below five (5) years? | | <input type="text"/> |
| A5 | Number of pregnant women | | <input type="text"/> |
| SECTION B : KNOWLEDGE LEVELS AND PERCEPTIONS ABOUT MALARIA | | | |
| B1 | How is malaria transmitted? / How does one get malaria? | 1 – BITTEN BY INFECTED FEMALE MOSQUITO 2 – TAKING IN DIRTY WATER OR FOOD 3 – BEATEN BY RAIN OR EXCESSIVE SUN 4 – DIRTY ENVIRONMENT | <input type="text"/> |

| | | | |
|----|--|---|--|
| | | 5 – WITCHCRAFT 6 – EATING UNRIPE MANGOES/FRUITS 7 – LIVE WITH SICK PERSON 8 – OTHER; (<i>Pls. Specify</i>) _____ 9 - DON'T KNOW | |
| B2 | Please can you tell us four signs/symptoms of malaria? | 1 - FEVER/HIGH TEMPERATURE 2 – HEADACHE 3 - JOINT PAINS/GENERAL BODILY PAIN 4 – TIREDNESS 5 – VOMITING 6 - LACK OF APPETITE/ BITTER TASTE IN MOUTH 7 - DIARRHEA/ ABDOMINAL PAIN 8 – OTHER; (<i>Pls. Specify</i>) _____ 9 - DON'T KNOW (<i>Multiple Response allowed</i>) | <input type="text"/> <input type="text"/> <input type="text"/> |
| B3 | Where do malaria-transmitting mosquitoes breed? | 1 – IN TREES AND BUSHES 2 – STAGNANT WATER BODIES 3 – IN DARK PLACES 4 – RUBBISH DUMP AND OTHER DIRTY PLACES 5 – OTHER; (<i>Pls. Specify</i>) _____ 9 – DON'T KNOW | <input type="text"/> |
| B4 | Which group of people are most vulnerable to malaria | 1 – CHILDREN UNDER 5 YEARS 2 – PREGNANT WOMEN 3 – PEOPLE LIVING WITH HIV/AIDS 4 – MALNOURISHED PEOPLE 5 – OTHERS(<i>Pls. Specify</i>) _____ 9 – DON'T KNOW (<i>Multiple Response allowed</i>) | <input type="text"/> |
| B5 | Can malaria be fatal (kill)? | 1 – YES 2 – NO 9 – DON'T KNOW | <input type="text"/> |
| B6 | Can malaria be prevented at home? | 1 – YES 2 – NO 9 – DON'T KNOW | <input type="text"/> |
| B7 | What do you think can be done to prevent malaria? | 1 – DRAINING STAGNANT WATER 2 – CLEARING OVERGROWN BUSHES 3 – SLEEPING UNDER ITNS 4 – USING MOSQUITO COIL 5 – BURNING OF HERBS 6 – TAKING ANTIMALARIA DRUGS 7 – INDOOR RESIDUAL SPRAYING 8 – OTHER; (<i>Pls. Specify</i>) _____ 9 – DON'T KNOW (<i>Multiple responses allowed</i>) | <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> |
| B8 | Can malaria be cured if you use appropriate medicines? | 1 – YES 2 – NO 9 – DON'T KNOW | <input type="text"/> |
| B9 | What is the drug/medicine recommended for malaria | 1 – SP/FANSIDAR 2 – CHLOROQUINE 3 – AMODIAQUINE/CAMOQUINE | <input type="text"/> |

| | | | |
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| | treatment? | 4 – QUININE 5 – ARTEMISININ-BASED COMBINATIONS 6 – PARACETAMOL 7 – ASPIRIN 8 – IBUPROFEN 9 – DON'T KNOW 10 – OTHER | |
| SECTION C : MALARIA PREVENTION BEHAVIOURS AND PRACTICES | | | |
| C1 | Does your household have at least one mosquito net? [<i>If 2, skip to C6</i>] | 1 – YES 2 – NO 9 – DON'T KNOW | <input type="text"/> |
| C2 | Is there at least one Long Lasting Insecticidal Net (LLIN) in your household? | 1 – YES 2 – NO 9 – DON'T KNOW | <input type="text"/> |
| C3 | How many LLINs do your household have? | NUMBER OF NETS | <input type="text"/> |
| C4 | Where did you get your mosquito nets from? | 1 – NETSforLIFE 2 – GOVERNMENT/HOSPITAL/CLINIC 3 – MARKET/SHOP 4 – OTHER NGOs 5 – OTHER; (<i>Pls. Specify</i>) _____ (<i>Multiple responses allowed</i>) | <input type="text"/> |
| C5 | How many people in your household slept under a net the previous night? | NUMBER OF PEOPLE | <input type="text"/> |
| C6 | Do you have pregnant women in your household? [<i>If 2, skip to C10</i>] | 1 – YES 2 – NO | <input type="text"/> |
| C7 | How many pregnant women in your household slept under mosquito nets the previous night? | PREGNANT WOMEN | <input type="text"/> <input type="text"/> |
| C8 | In the last two years, have pregnant women in your household been receiving SP/Fansidar (Intermittent Preventive Treatment - IPT) | 1 – YES 2 – NO 9 – DON'T KNOW | <input type="text"/> |
| C9 | How many times did they take | | <input type="text"/> |

| | | | |
|---|---|---|----------------------|
| | SP/Fansidar (IPT) during pregnancy to prevent malaria? | NUMBER OF TIMES | |
| C10 | Do you have children below five years in your household? [<i>If 2, skip to C12</i>] | 1 – YES 2 – NO | <input type="text"/> |
| C11 | How many children below five years slept under a net the previous night? | CHILDREN BELOW 5 YEARS | <input type="text"/> |
| C12 | Apart from mosquito nets, what other preventive measure(s) do you do to prevent malaria in your household? | 1 – GET RID OF STAGNANT WATER 2 – USE MOSQUITO REPELLENT/SPRAYING 3 – IN-DOOR RESIDUAL SPRAYING 4 – SLASHING OF WEEDS 5 – CLEANING NEIGHBOURHOOD 6 – COVERING OF WATER CONTAINERS 7 – BURNING OF COILS, LEAVES, DUNGS,etc 8 – NOTHING 9 – OTHER; (<i>Pls. Specify</i>) _____ (<i>Multiple responses allowed</i>) | <input type="text"/> |
| SECTION D : PROGRAM EVALUATION | | | |
| D1 | For the past six months, do you remember receiving or hearing or seeing some education on malaria prevention/treatment? | 1 – YES 2 – NO 3 – DON'T REMEMBER | <input type="text"/> |
| D2 | If yes to C10, what was your source of information (where did you hear, see or receive the information)? | 1 – RADIO 2 – TELEVISION 3 – VOLUNTEERS/MCA's 4 – MOBILE VANS 5 – POSTERS 6 – COMMUNITY SENSITIZATION SESSIONS 7 – OTHER; (<i>Pls. Specify</i>) _____ (<i>Multiple responses allowed</i>) | <input type="text"/> |
| D3 | Have you heard of NetsforLife malaria prevention campaign? | 1 – YES 2 – NO | <input type="text"/> |
| D4 | Do you think that NetsforLife activities in your community have helped you to understand and prevent malaria better? | 1 – YES 2 – NO 3 – NOT MUCH 9 – DON'T KNOW | <input type="text"/> |
| SECTION E : MALARIA TREATMENT SEEKING BEHAVIOURS | | | |

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|----|--|---|----------------------|
| E1 | In the last two weeks, has a child under 5 years been ill with fever? [<i>If 2 or 9, skip to the end of the questionnaire</i>] | 1 – YES 2 – NO 9 – DON'T KNOW | <input type="text"/> |
| E2 | Was the child given medicine for fever or malaria during this illness? [<i>If 2, skip to E4</i>] | 1 – YES 2 – NO 9 – DON'T KNOW | <input type="text"/> |
| E3 | What drug/medicine did the child take? | 1 – SP/FANSIDAR 2 – CHLOROQUINE 3 – AMODIAQUINE/CAMOQUINE 4 – QUININE 5 – ARTEMISININ-BASED COMBINATIONS 6 – PARACETAMOL 7 – ASPIRIN 8 – IBUPROFEN 9 – DON'T KNOW 10 – OTHER | <input type="text"/> |
| E4 | How long did it take you to start medication after seeing the onset of fever? | 1 – LESS THAN 24 HOURS 2 – LESS THAN 48 HOURS 3 – LESS THAN 72 HOURS | <input type="text"/> |
| E5 | Was the child seen at a health facility during this illness? | 1 – YES 2 – NO 9 – DON'T KNOW | <input type="text"/> |

Thank you for your cooperation

