



17th June, 2015

Background

NetsforLife® an award-winning¹ malaria prevention program brings together corporations, foundations, nonprofits, and faith-based organizations, under the leadership of Episcopal Relief & Development. The organization empowers communities to implement strategies aimed at reducing the number of people being infected with malaria and to promote effective treatment if people do get ill, thus saving many lives – particularly children under five and pregnant women who are most susceptible to malaria.

NetsforLife® works through the Anglican Church structure in implementing countries to mobilize and train community volunteers who in turn educate communities on the causes and treatment of malaria. We distribute Long-Lasting Insecticidal Nets (LLINs) and help families hang the nets and use them correctly, and consistently monitors LLIN use with participating households.

Since 2006, *NetsforLife*® has accomplished the following in 17 sub-Saharan African countries:

Output Indicators	Achievements (2006 to 2014)
Children Under 5: Lives Saved	109,414
LLINs Distributed	21,922,378
Malaria Control Agents Trained	110,953
People Sensitized	41,726,540
Influenced net distribution policy in 5 countries	Angola, Ghana, Liberia, Sierra Leone, Zambia

1. Malaria Control Agents (MCAs) – selection, training, and activities

a. Criteria by which volunteers are selected

The program conducts consultative meetings with community leaders and members to identify and select community volunteers who are trained by the program as Malaria Control Agents (MCAs)

¹ *NetsforLife*® won the 2010 Global Business Council Award as the “Best Public Health Program Exhibiting Exemplary Public - Private Partnership”

for their respective communities. These MCAs assist in the implementation of program activities by carrying out Social & Behavior Change Communication (SBCC)/education, net distribution and monitoring of LLIN usage at the household level.

During community meetings organized by Project Officers, community members are guided by the program's criteria for volunteer selection to select community volunteers who can effectively work for the success of the program in their communities. The program uses gender sensitive lens and encourages females to be volunteers and does not consider the religious background, gender, marital status, race or sexual orientation in its selection of volunteers.

Criteria for selecting volunteers

- ❖ The proposed volunteer should be prepared to offer voluntary services to his/her community
- ❖ The person should be resident in the community and not likely to relocate in the next couple of years
- ❖ The person should be able to speak the predominant local language(s) very fluently
- ❖ Should be willing and able to educate the general population on health issues especially malaria
- ❖ Should be able to communicate easily/ Good interpersonal skills
- ❖ Should be of good character
 - a. Dynamism (ability to take initiative)
 - b. Good moral values, sociable, trustworthy
- ❖ Should be approachable and accepted by the community
- ❖ Should not be less than 18 years
- ❖ Should have at least basic education to be able to read and write

b. Training protocols (e.g. how many days, is there a final test, etc.)

Training of MCAs differ from country to country and training needs are determined by the caliber of volunteers to be trained, the type of distribution whether it is hang-up, replacement or a new community benefiting from an initial distribution or a refresher training.

Trainings are conducted to equip community volunteers with appropriate knowledge and skills to carry out household registration exercise, net distribution and hang-up, SBCC activities to promote the regular care and consistent use of the net, monitoring of households, data management, and reporting and community feedback.

In most countries, where nets are to be distributed in new communities, volunteer trainings are conducted for 3 days. Pre and post tests are included in training package to assess volunteers' understanding of the disease and other relevant topics. Training content are designed to suit the technical knowledge needed and the cadre of volunteers to be trained. In most instances, certificate of participation are provided to volunteers who successfully undergo such trainings. The provision of certificates incentivize these volunteers and authenticate their ability to provide such services to the community.

The program recognizes that continuous training are an essential prerequisite for an effective volunteer program and an important factor in retaining the motivation of workers, in light of the low levels of education of most volunteers. Periodic refresher training are organized to allow MCAs learn new skills, take on new challenges, and interact with peers, keeping the job interesting and promoting personal development. For major LLIN hang-up campaigns, cascaded trainings are organized for volunteers, supervisors and community leaders while on the other hand, refresher training are held for volunteers during net replacement campaigns. Net distribution trainings can last up to a week and are usually cascaded and are usually facilitated by program staff, Ministry of Health staff or consultants. A generic LLIN hang-up training manual can be found [here](#).

c. Remuneration for MCAs

MCAs provide voluntary services and are usually classed as unpaid. In most countries, incentives are implemented as part of a systematic program. These are often in-kind and in some cases, in-cash payments. Successful in-kind payments are planned and implemented by the community and the program to motivate volunteers. For instance, in some part of Ghana, beneficiary families in most communities have sometimes taken turns working for free on the farms of volunteers in recognition of their important contribution. During mass campaigns, volunteers are paid daily stipends considering how time consuming and demanding these campaigns are. The daily stipends are calculated based on amounts suggested by the countries' Ministry of Health.

Another type of in-kind payment are material items provided by our program. Such items are often, though not always, related to the volunteers' job functions. Successful in-kind payments provided by Episcopal Relief & Development have included bags to carry supplies, t-shirts, agriculture tools, raincoats, backpacks, food supplies for home improvement, educational materials, certificates, bicycles, etc. Some of the in-cash payments can be cited in Ghana where MCAs receive small stipends (approximately US \$5) from the program as tokens to motivate them and across most program areas, MCAs receive normal meeting transport refunds in order to attend review meetings and trainings. These incentives make volunteers feel appreciated. Our internal experience has shown that any kind of financial support or subsidy, despite its positive short-term impact, is problematic for long-term sustainability.



In some selected countries such as Uganda, volunteers have successfully formed savings and loan groups where members are given access to credit programs while some have gone into animal husbandry to sell proceeds and provide assistance to members in need. In other countries, these volunteers are given preferential treatments such as first-in-line treatment at health posts. For

instance, in Ghana and Zambia, MCAs with identity cards receive preferential treatments that allow them to be seen quickly at clinics as a form of recognition by the community.

Other types of incentives, often intangible, are critical to job satisfaction and fulfillment. These incentives include a good relationship with health/ project staff, personal growth and development opportunities, training, and peer support which are promoted by the program. Perhaps the most important nonmonetary incentive has been a good relationship with the community. *(Picture above: Volunteers showing off their incentives including t-shirts, bicycles, bags received in Ghana)*

d. Records of the households visited and number of people educated during visit

MCAs are expected to visit at least 20 beneficiary households a month. During the visit, MCAs educate families, check on the status of LLIN, whether they are still hanging and in use and reports back to the project officer in their monthly reports. The report covers data on the following:

- ✚ Number of household visited
- ✚ Number of children under 5, pregnant women and other occupants in the household
- ✚ Status and quantity of nets in households
- ✚ Position of LLINs (hanging or not)

Currently, the program has educated over 41 million people in sub-Saharan Africa. MCAs conduct monthly household visits for at least 18 months to ensure that families are using the nets and they are in good condition. Below are snapshots of monitoring data from selected districts in Ghana and Zambia. Detailed report for both countries can be read [here](#).

e. Any other information collected by or from MCAs

In some countries, MCAs gather/provide information and education on other diseases such as HIV, diarrhea, pneumonia to households when they visit.

District	# of under 5 in HH	# PW in HH	others	# of LLINs hung	LLINs still hanging	Found but not hanging	Good LLINs	Torn LLINs (mending)	Bad LLINs (replacement)	# of Adults sensitized	U 5 LLINs Usage	PW LLINs Usage	Others(LLINs usage	#HH Visited
Kaleo/Nadowli	126	18	208	156	139	17	144	5	7	246	102	15	187	41
Wa West	84	12	174	112	92	20	95	6	11	211	71	12	158	32
Total	210	30	382	268	231	37	239	11	18	457	173	27	345	83
EJURA														
SEKYEDUMASI	622	154	3,027	1,590	1,406	184	1,277	65	148	2,128	540	145	2,535	480
BOSOME FREHO	589	169	2,732	1,434	1,264	170	1,149	111	174	1,706	509	155	2,244	390
Total	1,211	323	5,759	3,024	2,670	354	2,426	176	322	3,834	1,049	300	4,779	870
Akuapem South	428	32	1449	984	928	42	560	12	398	420	362	25	920	360
Akuapem North	452	41	1564	998	942	39	642	7	319	456	387	28	1001	360
Total	880	73	3013	1982	1870	81	1202	19	717	876	749	53	1921	720
Builsa	478	81	1554	1251	1117	69	814	232	140	1718	561	79	1445	350
Bawku West	689	113	2703	1737	1274	384	1312	183	163	3148	642	121	2086	720
Talensi/Nabdam	850	235	2890	1926	1453	228	1457	145	79	2814	536	137	1365	690
Total	2017	429	5217	4914	3844	681	3583	560	382	7680	1739	337	4896	1760
Bibiani	455	139	2,732	1,299	1,038	201	790	144	305	2,227	395	135	1,517	540
Wiawso	413	111	2,367	1,172	958	53	705	160	145	1,857	396	89	1,316	540
Total	868	250	5,099	2,471	1,996	254	1,495	304	450	4,084	791	224	2,833	1,080
Karaga	153	46	245	115	76	34	73	28	14	88	70	23	103	102
Total	153	46	245	115	76	34	73	28	14	88	70	23	103	102
Grand total	5,339	1,105	19,470	12,659	10,611	1,407	8,945	1,070	1,889	16,931	4,501	941	14,774	4,513

Table 1.0 Ghana: Summary data of LLINs distributed and households visited for quarter 2, 2013.

Table 2.0 Zambia: Summary data of LLINs distributed and households visited for quarter 1, 2014.

District	Number of HHs visited	Number of people in HHs			No. of LLINs distributed	LLINs found hanging	LLINs found but not hanging	Condition of nets			Total number of adults sensitized	Net usage		
		PW	U5	Others				Good	Torn, needs mending	Bad, needs replacement		PW	U5	Others
Mansa	68	18	205	185	2400	204	14	200	4	Nil	203	18	205	133
Mwense	40	25	82	133	1200	140	5	145	0	Nil	158	25	82	133
Chipili	57	36	118	188	680	152	36	188	0	Nil	224	36	118	152
Kitwe	365	108	775	1284	3500	935	160	160	935	Nil	1392	108	624	935
Chongwe	78	41	136	291	500	234	0	234	9	Nil	105	21	36	48
Kafue	88	15	24	49	205	264	0	264	0	Nil	88	15	24	49
Chipata	45	31	94	145	900	89	46	126	9	Nil	176	31	94	99
Petauke	33	12	66	120	350	198	0	198	0	Nil	132	12	66	120
KapiriMposhi	62	21	121	230	500	153	33	146	7	Nil	292	21	121	216
TOTAL	836	307	1621	2625	10,235	2369	294	1661	964	0	2770	287	1370	1885

2. Baseline and post-distribution surveys (i.e. evaluation reports)

a. List of the 17 core indicators

NetsforLife® has 17 key indicators which are basic indicators for malaria prevention within our broad goal and specific objectives. The program's household survey indicators (outcome indicators) for malaria control were modified to reflect global standards and recent changes in the M&E world as a results of best practices and policy recommendations. The following indicators were adapted from WHO recommended Household Survey Indicators for Malaria Control handbook (June, 2013) which is also supported by CDC-USAID, PMI-USAID, Roll Back Malaria Partnership, UNICEF and MEASURE Evaluation. Partners are allowed to add-on other programmatic indicators that will help track changes as pertained to country specific strategy.

	Indicator	Definition	Frequency	Data Source
1.	Proportion of households with at least one ITN	Numerator: Number of households surveyed with at least one ITN Denominator: Total number of households surveyed	Yearly	Evaluation Report
2.	Proportion of households with at least one ITN for every two people	Numerator: Number of households with at least one ITN for every two people Denominator: Total number of households survey	Yearly	Evaluation Report
3	Proportion of population with access to an ITN within their household	Numerator: Total number of individuals who could sleep under an ITN if each ITN in the household is used by two people Denominator: Total number of individuals who spent the previous night in surveyed households	Yearly	Evaluation Report
4	Proportion of population that slept under an ITN the previous night	Numerator: Number of individuals who slept under an ITN the previous night Denominator: Total number of individuals who spent the previous night in surveyed households	Yearly	Evaluation Report
5	Proportion of children under five years who slept	Numerator: Number of children under five years who slept under an ITN the previous night	Yearly	Evaluation Report

	under an ITN the previous night	Denominator: Total number of children under five years old who spent the previous night in surveyed households		
6	Proportion of pregnant women who slept under an ITN the previous night	Numerator: Number of pregnant women who slept under an ITN the previous night Denominator: Total number of pregnant women within surveyed households	Yearly	Evaluation Report
7	Proportion of existing ITNs used the previous night	Numerator: Number of ITNs in surveyed households that were used by anyone the previous night Denominator: Total number of ITNs in surveyed households	Yearly	Evaluation Report
8	Households covered vector control: Proportion of households with at least one ITN and/or sprayed by IRS in the last 12 months	Numerator: Number of households that have at least one ITN and/or have been sprayed by IRS in the last 12 Months Denominator: Total number of households surveyed	Yearly	Evaluation Report
9	Universal coverage of vector control: Proportion of households with at least one ITN for every two people and/or sprayed by IRS within the last 12 months	Numerator: Number of households with at least one ITN for every two people and/or have been sprayed by IRS in the last 12 months Denominator: Total number of households surveyed	Yearly	Evaluation Report
10	Proportion of Women who Received Three or More Doses of Intermittent Preventive Treatment during ANC Visits during Their Last Pregnancy	Numerator: Number of women who received three or more doses of a recommended prophylactic antimalarial drug treatment, at least one of which was received during an ANC visit, to prevent malaria during their last pregnancy that led to a live birth within the last two years Denominator: Total number of women surveyed who delivered a live baby within the last two years	Yearly	Evaluation Report
11	Proportion of children under five years old with fever in the last two weeks	Numerator: Number of children under five years old with fever in the previous two weeks who had a finger/heel stick	Yearly	Evaluation Report

	who had a finger or heel stick	Denominator: Total number of children under five years old who had a fever in the previous two weeks		
12	Proportion of children under five years old with fever in the last two weeks for whom advice or treatment was sought	Numerator: Number of children under 5 years old who had a fever in the previous 2 weeks for whom advice or treatment was sought Denominator: Total number of children under 5 years old who had a fever in the previous 2 weeks	Yearly	Evaluation Report
13	Proportion receiving any Artemisinin Combination Therapy (ACT) (or other first-line treatment), among children under five years old with fever in the last two weeks who received any anti-malarial drug	Numerator: Number of children under 5 years old who had a fever in the previous 2 weeks who received first line treatment according to national policy Denominator: Total number of children under 5 years old who had a fever in the previous 2 weeks who received any anti-malarial drugs	Yearly	Evaluation Report
14	Parasite Prevalence: Proportion of children aged 6-59 months with malaria infection	Numerator: Number of children aged 6-59 months with malaria infection detected by rapid diagnostic test or microscopy Denominator: Total number of children aged 6-59 months tested for malaria parasites by rapid diagnostic test or microscopy	Yearly	Evaluation Report
Output Indicators – These are to be reported periodically in the quarterly report				
	1. Number of ITN Distributed	<ul style="list-style-type: none"> ▪ Number of new ITN distributed ▪ Number of ITN replaced 	Quarterly	Quarterly Report
	2. Number of people trained	<ul style="list-style-type: none"> ▪ Number of people trained as MCA (Retained after registration and distribution) ▪ Number of people trained with project funds to support HH registration, distribution and hang-up of ITNs 	Quarterly	Quarterly Report

	3. Number of Households visited	<ul style="list-style-type: none"> ▪ Proportion of households with at least one ITN ▪ Proportion of households with at least one ITN for every two people ▪ Number of ITNs needed for replacement ▪ Proportion of ITN in good condition ▪ Proportion of pregnant women who slept under ITN the previous night ▪ Proportion of children under five years who slept under ITN the previous night ▪ Number of people reached with malaria messages/education 	Quarterly	Quarterly Report

b. What are the names/affiliations of the organizations that implement the surveys?

Surveys undertaken in all operational countries are carried out by research institutions or qualified consultants. Below is a list of institutions and consultants that have conducted surveys for the organization:

Country	Name of Lead Consultant	Name of Institution
Angola	Paulo Manuel	Program Department, Diocese of Angola
Botswana	Dr. Tshepho Sethunya Mosime	University of Botswana
Burundi	Ir André BIZOZA	Independent Consultant
DR Congo	Paul Mansiangi	University of Kinshasa School of Public Health
Ghana	Dr. James Akazili	Navrongo Health Research Centre (NHRC)
Guinea	Moussa Sanoh	Independent Consultant
Kenya	Rose Okwako	Leadership and Development Initiative Consultants
Liberia	Jonathan Enders	Liberian National Consultancy Firm

Malawi	Charles Chimombo	Chimombo and Associates
Mozambique	Stephen Daniel John Mungone	EJ: Estevao Joao/Consultation & Services
Nigeria	Edem Edem	Christian AID, Nigeria
Sierra Leone	Robert Sam-Kpakra	Independent Consultant
Tanzania	Gao John Gao	MEA Foundation, Tanzania
Uganda	Dr Henry S. Katamba	Pretium Solutions Uganda Limited
Zambia	Mwanza Nebert	Independent Consultant
Zimbabwe	Inocent Kaba	Zimbabwe Christian Aid, Masvingo, Zimbabwe
United Kingdom	Albert Kilian	Tropical Health LLP

c. Methodologies of the baseline and post-distribution surveys

The collection and interpretation of data are a critical part of *NetsforLife*[®]'s approach in order to identify and solve problems, measure progress and advocate for policy change. A KAP (knowledge, attitude & practice) baseline survey, carried out by independent consultants, is conducted before the program begins in new settings. In addition to the quantitative baseline information, focus-group discussions are often conducted to investigate further why people do not sleep under a net or use other malaria practices, and to find local solutions to these issues, including new educational messages.

As a complement to monthly monitoring of net use, the program conducts follow-up surveys using the same questions and indicators 18 months after net distribution to track progress with LLIN usage, retention as well as knowledge about malaria and its prevention and control.

Information from monthly household visits also show the number of nets that a family owns and data on their usage. This evidence helped convince governments in five African countries to officially recognize *NetsforLife*[®]'s methods – that is, household distribution and hanging of nets, plus regular monitoring – as best practice.

Post distribution evaluations (final evaluations) are also carried out by independent consultants or reputable research institutions normally 18 months after net distribution for our implementing partners. Consultants are guided by a scope of work, *NetsforLife*[®] generic questionnaire which

addresses the *NetsforLife*® outcome indicators. In most cases, preferred sampling methodologies are discussed with the lead consultant. In each country, consultants put in specified measures in selecting and training field enumerators. Questionnaires are customized to local settings and are pre-tested. Ethical clearances are considered and respondents' consents are requested before interviews begin. Respondents are also assured of confidential clause for information provided. Consultants are made responsible to ensure data quality and integrity during data collection and entry. Draft reports from all countries are reviewed by partner program team as well as M&E team in Episcopal Relief & Development. The program's generic baseline questionnaire can be accessed [here](#).

The sampling methodology options preferred are either Lots Quality Assurance Sampling (LQAS) methodology or use of multi-stage cluster sampling with probability proportionate to size of the communities. Consultants are required to conduct a participatory evaluation providing for meaningful involvement of all partners, volunteers, program beneficiaries as well as relevant internal and external stakeholders wherever practical. They are also encouraged, most often, to include some qualitative assessment methods to gather more community information.

One cited evaluation includes a study by the University of Kinshasa in the Democratic Republic of Congo which evaluated the effectiveness of the *NetsforLife*® “hang-up” methodology versus the standard distribution method in two zones of comparable size. Net possession rates increased from 30% to 98.6% in the communities where the *NetsforLife*® methodology was used (compared to 88.6% in the other communities) and five months later 85.5% of homes still had their nets (compared to 68.5%). Increased involvement and community engagement gives the program an influence by creating a “net culture” where malaria prevention is valued and practiced widely. Full report of the evaluation can be read [here](#).

d. By what criteria are bed nets allocated and distributed (residency, sleeping spaces, family size, self-report vs. verification, etc.)?

Recent efforts promoting the use of LLIN have shifted emphasis from a focus on vulnerable populations to a broader objective of universal coverage, defined at the household level as the use

of LLINs by all household members regardless of age or gender. Most often, the ratio of at least one LLIN for every two household members is typically sufficient to achieve universal coverage in a population and has been used broadly in most of the distributions carried out in our program areas.

Prior to distribution of mosquito bed nets, trained enumerators are made to collect household census data which help in estimating the required number of bed nets needed in each household. A team of 8 to 10 enumerators are assigned a supervisor who periodically cross-check sampled household information.

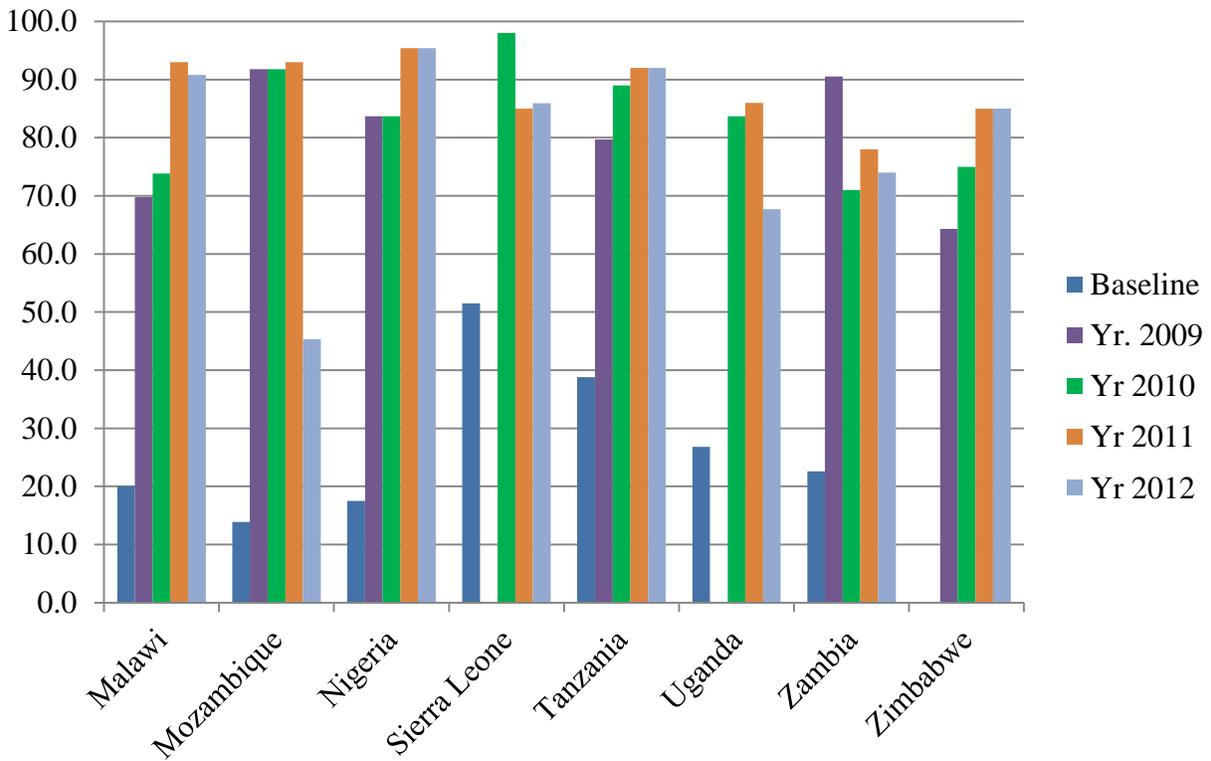
Using the registration data on the day of distribution, beneficiaries are asked to thumb print or endorse the number of nets they receive against the name of the household. For major hang-ups, volunteers visit the household and assist families to hang the nets. In Ghana, special stickers were designed to indicate the number of nets received by households. These stickers which are posted on the doors and other visible locations of the household are signed by supervisors who verified the number of nets received by the household. The entire community serves as watchdogs and witness the distribution. Pictures of distributions, trainings and beneficiaries can be viewed [here](#).

e. Detailed results from the surveys, especially:

- i. How many bed nets exist in the targeted communities before the distribution? Are they of good quality? (E.g. do they have holes?)**
- ii. Are the bed nets installed and used properly?**

Our 2013 [final evaluation report](#) which covers the Phase II of the program gives detailed summary of indicators that are tracked in all program areas. A highlight of the report shows that net ownership rose from an average baseline value of 8.42% to 85.3% in 2011. Democratic Republic of Congo recorded the highest coverage of 98.6% as at 2012. Proportion of pregnant women who slept under LLIN the previous night moved from a baseline value of 16.9% to 84.2% in 2011. LLIN usage for children under five also recorded a baseline figure of 15.6% and had an exponential increase to 89.4% in 2010.

Trend Analysis of proportion of children under five years who slept under LLINs the previous night



3. Distribution data

- a. **Confirmation that bed nets reach the intended recipients, such as lists with the # of nets distributed, photos/videos, or other documents.**

A total number of about 22 million nets have been distributed by the program to date. A breakdown of nets distribution per country is below:

Country	LLINs distributed
Angola	125,263
Botswana	64,450
Burundi	418,776
DRC	988,230
Ghana	6,758,057
Guinea	46,559
Kenya	181,114
Liberia	400,117
Malawi	774,034
Mozambique	520,305
Namibia	76,530
Nigeria	914,448
Sierra Leone	1,017,707
Tanzania	117,485
Uganda	7,507,100
Zambia	1,945,842
Zimbabwe	66,361
TOTAL	21,922,378

✚ Pictures of distributions, trainings and beneficiaries can be viewed [here](#).

✚ Links to videos

- ✚ Video on *NetsforLife*® methodology

<https://www.youtube.com/watch?v=zYCion8rzzs>

- ✚ Episcopal Relief & Development/ *NetsforLife*® was part of the unique partnership that distributed over 12 million mosquito nets in Ghana. Link to video:

https://www.youtube.com/watch?v=K4_Wcnxs7Sc&feature=youtu.be

- ✚ Some videos that highlight our work and achievements include:

<https://www.youtube.com/watch?v=U6IGIR1v1Ks>

- ✚ *NetsforLife*®: Instilling hope

https://www.youtube.com/watch?v=rqsfOI_Bo-E

- ✚ *NetsforLife*® Helps to Combat Malaria in Ghana

<https://www.youtube.com/watch?v=26acaSPPqZo>

- ✚ Fighting against Malaria April, 2010

<https://www.youtube.com/watch?v=UUiMygEiEIo>

4. Country-level staff monitoring

- Reports/changes resulting from country-level team visits
- Any other documents or data that country-level staff might collect

A major change that occurred in our program was the shift from point distribution to hang-up methodology. It was noted from previous reports and monitoring data that people had challenges mounting the nets and using them correctly. To increase usage, the program promoted the hang-up methodology in most countries. Five of these countries – Angola, Ghana, Liberia, Sierra Leone and Zambia – have adopted aspects of *NetsforLife*®’s methodology as part of their national nets distribution policy, and many more have solicited the program’s input in country-wide strategic planning.

Using its unique networks to access peri-urban, urban and remote communities that are typically unreachable by national health programs, *NetsforLife*® has developed and modeled successful technical distribution strategies. In addition, the program’s proven monitoring and evaluation methods are being widely implemented in order to ensure better overall results. Building on its successes, the program will continue to distribute nets and work in malaria-endemic African countries while collaborating with international agencies, national programs and local malaria stakeholders.

5. Budget documents

- a. **A projected budget for 2015 or 2016**
- b. **2-3 years of the most recently available records of actual organizational expenses (preferably broken down by country and/or program)**

A projected budget for 2015 and expenditure report for 2013-2014 can be retrieved [here](#). The organizational expenses are broken down by program.

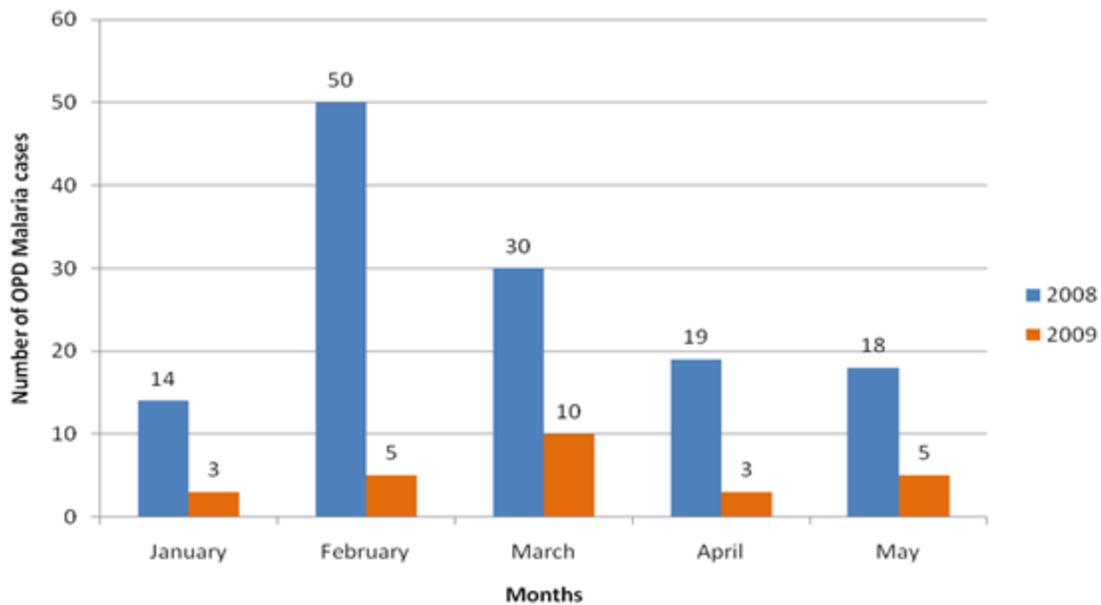
6. Other information

- a. *Malaria case rate and mortality rate data from target communities (Samuel mentioned having malaria case rate data for Zambia and Zimbabwe)*

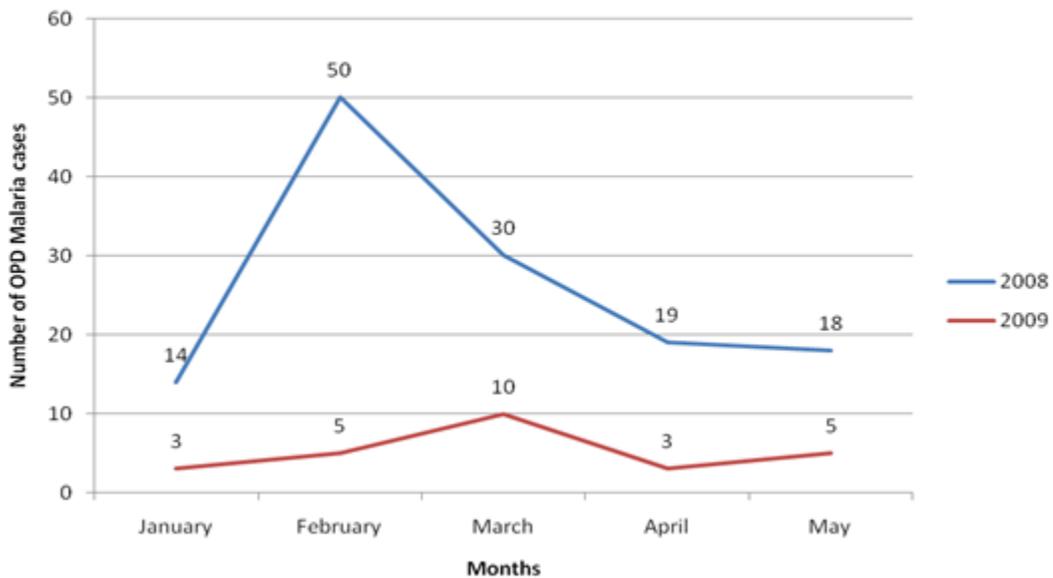
Reduction in OPD Malaria Cases in Zimbabwe

During a visit to Zimbabwe for field monitoring and capacity building, the program team had the opportunity to interact with officers in charge of the clinics that serve the localities. At one of the health centers, Chiwenga health centre, the nurse in charge, Mrs. Matimba, was full of praise for the *NetsforLife*® program as she had recorded less malaria cases (about 50% reduction) and attributed this to the success of the *NetsforLife*® program. At another health post, Rambanapasi clinic, the nurse in charge also indicated that malaria cases had drastically reduced and they only record about one or two cases of malaria per month. The team observed the registers at the two centers, comparing malaria reported cases for similar months in 2008 to 2009 and there was about 80% and 50% reduction in malaria reported cases in Rambanapasi and Chiwenga health centers as per the figures below.

OPD Malaria Cases in Rambanapasi Clinic, Zimbabwe in January - May, 2008/9



OPD Cases in Rambanapasi Clinic, Zimbabwe in January - March, 2008/9



b. Anything else you think would be helpful in helping us understand/verify *NetsforLife*®'s impact

✚ *NetsforLife*®'s active participation in the hang-up campaign in Ghana is acknowledge (on page 3) of a [process evaluation report](#) conducted by a principal investigator (PI), Dr. Steven Harvey from University Research Co., LLC for USAID and partners.

✚ **Beneficiary story from Zambia**

1. Church in holistic life-saving approach

Mrs Belinda Chsanga, a mother of five children from the Central Diocese in Zambia, has benefitted from LLINs from the *NetsforLife*® program in her community. She was visited by the Program Manager of the Central Diocese and some malaria agents to monitor the utilization of LLINs and also to distribute and hang nets at the new sleeping spaces that she has which were identified in the previous visit by the malaria agents. She expressed her profound gratitude to the Anglican Church/Episcopal church and by extension to all the donors of the *NetsforLife*® program and stated “Tukotota ichilonganino ca Anglican twalukumona kwati umulimo wa Church kushimikila bwaka pa sondo pano mwe mukotulangulukilako kumalwele Lesa amipale.” Which is literally translated as: “We are grateful to the Anglican Church; we thought that the Church’s duty is to preach the Word of God in the pulpit on Sundays but to our utmost surprise the Anglican Church has come to our aid in the prevention of diseases. God bless you”. She also added, ‘before receiving the LLINs I used to suffer from malaria a lot of times which used to make me fail to work in the fields and look after my children well. My children also used to suffer from malaria frequently and they used to miss school a lot. However since I received the mosquito nets, I have not suffered from malaria at all because I always sleep under the mosquito nets and my children are also enjoying very good health. Since then, they no longer miss school and this has improved their performance at school. I am very grateful to the Anglican Church for the work that is being done and I would like you to continue working as the work you are doing is saving a lot of lives”.