



MALARIA COMMUNITIES PROGRAM

Building Community Capacity in Malaria Control

INTRODUCTION

Building community capacity is foundational to both prevention and treatment of malaria, from creating demand for nets to increasing trust between health workers and community volunteers. A recent study in Zambia showed enhanced community capacity can lead to community action with significant effects on some health behaviors, including children's net use.¹ Health worker shortages and tight government budgets have made community volunteers, specifically community health workers (CHWs), even more critical to the success of malaria control efforts in reaching the poorest and most remote communities. Interventions implemented without community partnership risk being culturally insensitive and contextually inappropriate, and may ultimately fail to achieve reductions in malaria morbidity and mortality. Building community capacity by engaging community health workers, community leaders, village health committees, and other community structures is an essential step to effective malaria control and the means to achieving sustainable impact. Several Malaria Communities Program (MCP) partners supported by the President's Malaria Initiative (PMI) have successfully strengthened community capacity for prevention and control of malaria.

The Malaria Communities Program

The Malaria Communities Program (MCP) was launched on December 14, 2006. Through 20 awards to 18 partners in 12 countries, the President's Malaria Initiative (PMI) has supported efforts of communities and nongovernmental organizations (NGOs) to combat malaria at the local level.

The MCP has increased local and indigenous capacity to undertake community-based malaria prevention and treatment activities; built local ownership of malaria control for the long term in partnership with communities and National Malaria Control Programs (NMCPs); and extended coverage of PMI and NMCP interventions to reach a larger beneficiary population.

METHODS AND DATA

This case study examines different models of community outreach and engagement implemented by five MCP partners: the Christian Reformed World Relief Committee (CRWRC)² Malawi, HealthPartners Uganda, Catholic Medical Mission Board (CMMB) Zambia, Aga Khan Foundation (AKF) Mozambique in partnership with Progresso, and Lutheran World Relief (LWR) Mali. MCHIP collected multiple forms of data from these five partners using qualitative methods, including individual interviews with key project personnel and review of key documents. MCHIP then compared data across projects to better understand the overall contributions made by MCP. Some partners conducted surveys, and this report includes relevant quantitative data. Data are limited by a lack of standardized reporting on this topic. Future studies about the relationship between community capacity and malaria control could utilize frameworks described in relevant literature for planning and reporting results.

¹ Underwood C et al. 2013 Community capacity as means to improved health practices and an end in itself: Evidence from a multi-stage study. *Intl Quarterly of Community Health Education* 33(2): 105–127.

² Now called World Renew.

KEY FINDINGS

The major sub-theme emerging from the data was effective utilization of community volunteers as a way to build community capacity and sustain project results. Each partner's strategy to engage and retain volunteers included these key attributes: selection of volunteers, motivation/retention of volunteers, ensuring sustainability of the volunteer program, and addressing challenges.

Building community capacity can be described as the means by which communities and individuals enhance their skills, abilities, resources, and commitments to identify challenges and solutions in their communities, and nurture their unique talents and leadership. In this process, individuals and groups increase their abilities to impact the health and vitality of their communities. MCP partners trained, empowered, and equipped volunteers with skills and tools to promote key messages about malaria prevention and treatment. MCP partnerships with National Malaria Control Programs (NMCPs) and community members have strengthened local ownership by facilitating community-driven processes for volunteer selection and supervision. Trained volunteers have helped increase community demand for nets and fostered trust between health workers and community volunteers, creating a foundation for communities to control malaria. Charts 1 and 2 show positive trends in selected MCP project areas in net ownership and use, which may result from strengthened community capacity, as seen in the Zambia study.³

Chart 1. Percentage of households in selected MCP project areas with at least one insecticide-treated net (ITN)

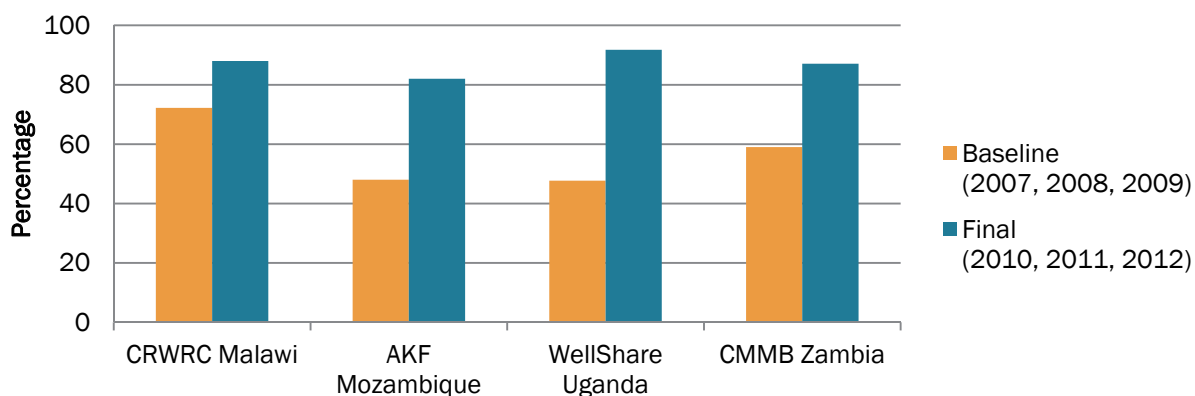
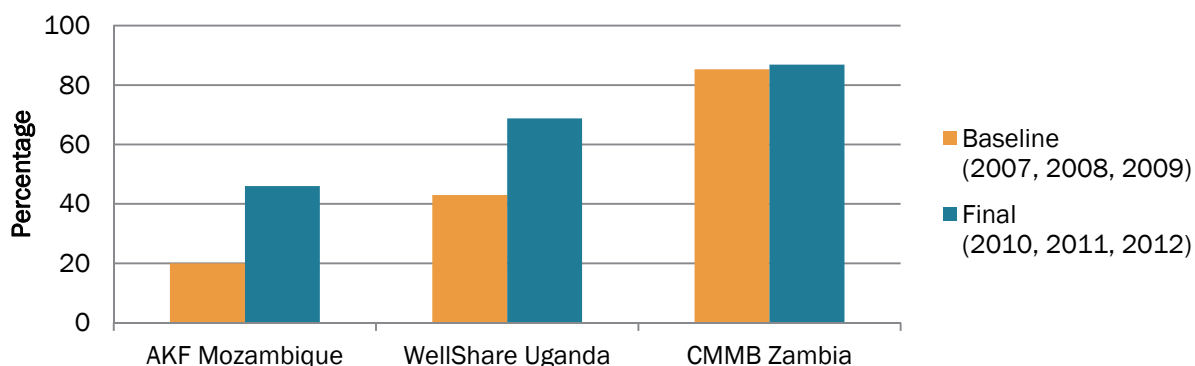


Chart 2. Percentage of children under 5 in selected MCP project areas who slept under an ITN the previous night



³ Underwood C et al. 2013 Community capacity as means to improved health practices and an end in itself: Evidence from a multi-stage study. *Intl Quarterly of Community Health Education* 33(2): 105–127.

Selecting Volunteers

MCP partners laid the groundwork for community ownership by ensuring that the volunteers gained the respect of their communities. In the five MCP projects, communities were instrumental in selecting volunteers, although the particulars of the selection process varied among projects (see Table 1 for the various types of community health volunteers supported by MCP partners). In Uganda, Mozambique, and Mali, volunteers or volunteer roles and criteria followed national guidelines, so MCP projects enhanced existing structures. In Zambia and Malawi, MCP partners contributed to defining volunteer roles and selection criteria, and recruited new volunteers with community participation. When community members announced the selection criteria publicly at village meetings, then nominated and subsequently elected new volunteers, they took greater ownership of the volunteers' role.

Table 1. Community health workers/Volunteers trained by MCP partners

Partner	Project Area Population	Cadre	Number Trained
CRWRC Malawi	1,576,292	Care Group Volunteers	5,017
LWR Mali	478,813	<i>Relais</i>	786
AKF Mozambique	396,301	<i>Agentes Polivalentes Elementares de Saúde (APEs)</i> <i>Activistas</i>	96 431
HealthPartners Uganda	731,392	Village Health Teams (VHTs)	1,745
WellShare International Uganda	871,318	Community-Based Distributors (CMD)	1,026
CMMB Zambia	69,300 (beneficiaries)*	Community Volunteers	275

*CMMB reported the total beneficiary population of mothers/caregivers and children under five.

Motivating and Retaining Volunteers

MCP partners needed to consider how much time a volunteer could give, how many people or households one volunteer could serve adequately, what incentives to offer, and what expectations the volunteers could realistically fulfill. They also considered whether local community resources could assist in generating additional incentives and support for volunteers. Table 2 highlights the different types of incentives these MCP projects used, including money, equipment (bicycles, T-shirts, etc.), continued trainings, supervision (or mentoring), and leadership opportunities. All MCP partners interviewed mentioned that training provided by the Ministry of Health (MOH) greatly motivated the volunteers, which built their confidence and helped earn respect from their communities.

MCP partners used creative methods to motivate and retain volunteers. Following the Care Group methodology, CRWRC Malawi's volunteers were responsible for visiting just 10 households (identified as a manageable target) each month in their catchment area. To help volunteers recoup economic losses from time spent on volunteer duties, HealthPartners Uganda linked Village Health Team (VHT) members to Village Savings and Loan activities.

MCP partners implemented a variety of supervision systems, including conducting joint supervision visits with MOH staff and holding monthly meetings with volunteers. Supervisory visits were tremendously motivating to volunteers, providing opportunities to recognize their efforts and reinforce their credibility in communities. Monthly or quarterly meetings encouraged a cohesive spirit of teamwork and motivated volunteers to continue their work.

Their leadership role motivated many of the volunteers. In Zambia, CMMB embedded supervision in traditional community structures by facilitating traditional leaders' supervision of CHWs, which helped to increase local ownership and ensured accountability of volunteers to their communities. In Uganda, WellShare International staff commented on the significance of

training for community health volunteers, saying, “Volunteers are treated like technical staff on the project, which motivated them and built their capacity.”

Table 2. MCP project approaches to motivating and retaining community volunteers

Project	Community Cadres	Role	Incentives	Link to Formal Health System
CRWRC Malawi	Care Group Volunteers	Selected groups of volunteers, each volunteer responsible for 10 households. Conduct household visit to provide malaria education.	T-shirts, soap, and lunch allowance	Health Surveillance Assistants (government-supported cadre of community health workers) were paired with community facilitators to supervise Care Group volunteers.
	Community Facilitator	Oversaw Care Groups; provide bi-monthly supervision visits.		
	Supervisor	Oversaw 4-5 facilitators.		
LWR Mali	<i>Relais</i> (community health volunteers)	Provided malaria education to community health solidarity funds and mobilized community members.	Payment to conduct target identification surveys; T-shirts on World Malaria Day	Identified vulnerable members for distribution of nets, who were linked with the MOH's CHW cadre (<i>agents de santé communautaire</i> [ASC]).
AKF Mozambique	<i>Activistas</i>	Communicated messages on prevention, conducted house-to-house visits to share information about malaria, verified correct use of bed nets, sensitized the community about indoor residual spraying, and held public meetings or discussions about malaria.	Bicycles, pens, notebooks, flip charts, T-shirts, and hats	<i>Activistas</i> engaged with CHCs, bringing forward issues that needed to be addressed in the community regarding malaria and also other health issues. CHCs are a revival of former government-sanctioned community health management committees, and were involved directly in supervising and organizing the work of the <i>APEs</i> and <i>activistas</i> .
	CHWs (<i>Agentes polyvalentes elementares</i> or <i>APEs</i>)	Provided diagnosis and treatment of malaria in the community.		
	Community Health Committees (CHCs)	Supervised <i>APEs</i> and <i>activistas</i> .		
HealthPartners Uganda	VHTs	Conducted household visits and community education sessions. Each VHT is responsible for 25 households.	T-shirts, badges, bags, job aids, and BCC materials Subsidized VHT premiums if they became UHC members	VHTs support the health delivery structure at community level and serve as a Health Centre I. VHT members work voluntarily and provide data to the District Health Office on their activities by filling out the registers and submitting reports.
WellShare Uganda	VHTs Civil Society Organizations (CSOs)	Conducted household visits and community education sessions. Each VHT is responsible for 25 households.	T-shirts, badges, bags, job aids, and BCC materials	VHTs support the health delivery structure at community level and serve as a Health Centre I. VHT members work voluntarily and provide data to the District Health Office on their activities by filling out the registers and submitting reports. VHT members were matched with CSOs based on needs, activities, and skill set to share malaria messages.

Project	Community Cadres	Role	Incentives	Link to Formal Health System
CMMB Zambia	Community Health Workers (CHWs)	Conducted BCC activities in communities.	Lunch allowances, gumboots, and bicycles	Supervised by facility health workers.
	Traditional Leaders Neighborhood Health Committees	Supervised and facilitated activities. Held monthly community meetings to discuss health issues.		Jointly, with facility workers, supervised 4 CHWs. Developed joint action plans with facilities based on community concerns, including determination of CHW responsibilities.

Ensuring Sustainability through Ownership and Leadership

Two important topics emerged for ensuring sustainability of project outcomes: ownership and leadership. One aim of building community capacity is creating a sense of ownership. Community health volunteers can facilitate community input to and ownership of health services.

AKF Mozambique found that the Community Health Committees (CHC) system linked communities with health facilities by increasing access to care and resources for vulnerable community members. LWR Mali mobilized communities to address financial barriers to care by establishing agreements with local health facilities through insurance schemes. The VHTs supported by HealthPartners Uganda worked closely with the District Health Office and were supervised by health facility workers, as were the Care Group volunteers supported by CRWRC Malawi.

A Malawi Red Cross volunteer, speaking of CRWRC’s approach, noted that knowledge “contributes to the communities’ capacity in the sense that the households are able to share the information on their own, and they are more knowledgeable and discuss on their own, even when the volunteer is not there. The households can share with one another. This strategy is very sustainable.” The Progresso Program Director for the AKF/Progresso Mozambique project said: “We want them to own a different attitude towards malaria and [understand] that they have a contribution to make to their own health—in this sense the project was very useful and successful. We have tried to build the community’s sense of ownership for the activities we are promoting at the community level.”

MCP-supported volunteers adopted leadership roles in their communities. As integral community members, volunteers conveyed key malaria messages to their communities, who were more receptive of messages provided by their own leaders than those from external health workers. The PMI Advisor in Zambia, referring to CMMB’s project, emphasized the leadership role of the volunteers: “It’s a combination of the messages and being respected in the communities People have internalized messages into their daily life; having CHWs and traditional leaders in community with the knowledge, and considered experts, will continue the value of the program over time.”

Addressing Challenges

Programs working with volunteers should consider the challenges noted here and in related literature and create strategies for overcoming them while they are planning their activities. There are many challenges to building community capacity, especially related to community expectations when an external organization is involved. External resources run the risk of creating dependence. According to a District Health Management Team member from Malawi, “Volunteers expect a lot of things from the project; they normally think there is a lot of money attached to the project, so it requires some time to explain to them that this project is trying to increase their capacity to manage their own problems. These volunteers are also responsible for doing other activities for their domestic lives, so time spent visiting households is lost economic

activity [for them] and balancing this is a challenge.” Although they did not report attrition data, one step that some MCP partners took to maintain a full volunteer roster was to conduct trainings of new volunteers on a regular basis in order to replace dropouts. MCP partners also found that they retained the hardest workers because they were natural, committed leaders who cared about their communities.

Another challenge was the singular program focus. MCP projects found that communities looked for other messages from volunteers related to different health subjects. The Program Director from Progresso, in Mozambique, explained: “This project had a very narrow focus on malaria. We found that this is not very useful in the community. At the community level there should be more integrated programming that can meet the various needs of the households.” Future programs can leverage the platforms created by MCP partners through strengthened volunteer cadres to address other health problems.

KEY MESSAGES

Robert Newman, Director of the World Health Organization’s Global Malaria Program, recently spoke of what must happen in current malaria control programs: “What will really move malaria control forward between now and 2015 is going to be the work by the unsung heroes at the community level and in district health facilities. That’s where the battle will be won or lost.” MCP experiences in building community capacity for malaria control should inform future efforts to improve household behaviors and strengthen relationships between communities and health facilities. The following key messages were derived from this case study:

- **Messages delivered by volunteers were well-received.** MCP partners reported that working through community volunteers was key to their achievements because volunteers could deliver context-specific malaria messages frequently. Charts 1 and 2 present positive results that support this finding.
- **Volunteers linked communities and health facilities.** Close collaboration helped to integrate the community and facility health systems through standardized behavioral messages, services adjusted to need and context, and empowered community members. Community participation in volunteer selection contributed to a sense of ownership of the process and product (health messages).
- **Motivating volunteers required innovation and community involvement.** MCP partners worked within specific contexts to create systems to support volunteers. Community selection of volunteers fostered their accountability to their own community rather than to the NGO or project. Leadership in their communities is an incentive for many volunteers.

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