

Project Summary Report

Improving Community Response against Malaria in Kaduna State

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Christian Aid Nigeria

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List of Acronyms

ACT	Artemisinin- based Combination Therapy
ANC	Ante Natal Care
BOA	Bank of Agriculture
CDC	Community Development Committee
CHA	Community Health Agents DRF
DRF	Drug Revolving Fund
FGD	Focus Group Discussion
ICRAM	Improving Community Response Against Malaria
IPT	Intermittent Preventive Treatment
LGA	Local Government Area
LLIN	Long Lasting Insecticidal Net
PHC	Primary Health Centre
RBM	Roll Back Malaria
RDT	Rapid Diagnostic Test
SDP	Service Delivery Point
SDSS	Sustainable Drug Supply System
VSLA	Village Savings and Loans Associations

Background

The Improving Community Response against Malaria (ICRAM⁺) was a two year project implemented in 10 communities spread across 5 wards (Kasuwan magani, Kallah, Kufana, Afogo and Idon) in Kajuru Local Government Area of Kaduna State. The project started in July, 2014 with the overall aim of supporting the efforts of the Kaduna State Government to reduce incidences of malaria in the State. Specifically, the project aimed to: deliver quality community health programming, increase the number of families protected from malaria through use of long lasting insecticidal nets, promote a 'net culture' among beneficiaries where nets are valued and used consistently, especially by vulnerable groups (pregnant women and children under the age of 5 years) and increase the number of people seeking effective malaria diagnosis (testing) and treat with Artemisinin-based combination therapy (ACT). The project was supported by JC Flowers Foundation and Christian Aid, in Partnership with Nazarene Rural Health Ministry and Archdiocesan Catholic Healthcare Initiative both in Kaduna.

In order to ensure sustainability of project gains and to encourage ownership by the community, project implementation was done through community structures. These structures are the Community Development Committees (CDC) which was made up of up to 15 community members for each community; each community also had four Community Health Agents (CHAs). The project adopted a two pronged approach where the CDC which is a group of people resident in the community represent the interest of other community members by ensuring that quality health services are readily available in the health facilities and is easily accessible to the community members. They act as spokespersons/intermediaries for the communities, and by working together as a team they present the views, observations and priority health development needs of the community to health facility staff and local government authorities. They do all these to find long lasting solutions to already identified health challenges or priorities in their communities. The CDCs also update their communities through feedback meetings on developments at the health facilities and progress made towards addressing community health needs. The CHAs on the other hand pay regular visits to households within their communities to inspect and reinforce net hanging culture, educate community members on malaria prevention and symptoms, and encourage families to seek testing and effective treatment at nearby health facilities. They also gather information and data on the outcome of the project on the benefitting families and help identify and flag community health priorities to CDCs for follow-on action.

The Community Development Committees (CDCs) and the Community Health Agents (CHAs) in the various communities are volunteers. They were nominated and selected by their communities following a specified criteria, their nomination was confirmed by their respective District Heads or traditional leaders.

Project Goal and Objectives

The goal of the ICRAM^{+K} project was to “**reduce the incidence of malaria in Kaduna state**”

The project had two broad Objectives which were:

- To increase by 60% the number of households protected by malaria nets and other malaria prevention methods in target communities/project sites in Kaduna state by end of 2016.
- To establish structures for community participation in demand and delivery of better healthcare services with women and girls involvement in formal and informal decision-making in 60% of 10 target communities by end of 2016.

The project had the following outcomes:

Outcome Indicator 1: Percentage of community members reporting access, use and benefits of malaria prevention methods.

Outcome Indicator 2: Number (and description) of marginalized partner-supported communities informing policies, plans and or budgets related to health services

Outcome Indicator 3: Percentage (and description) of community members supported by partners who report changes in health seeking behaviours.

Outcome Indicator 4: Percentage (and description) of service providers reporting availability of diagnosis and treatment options in Service Delivery Points.

Summary of Project Achievements

Outcome Indicator 1: Percentage of community members reporting access, use and benefits of malaria prevention methods.

Household ownership and use of nets

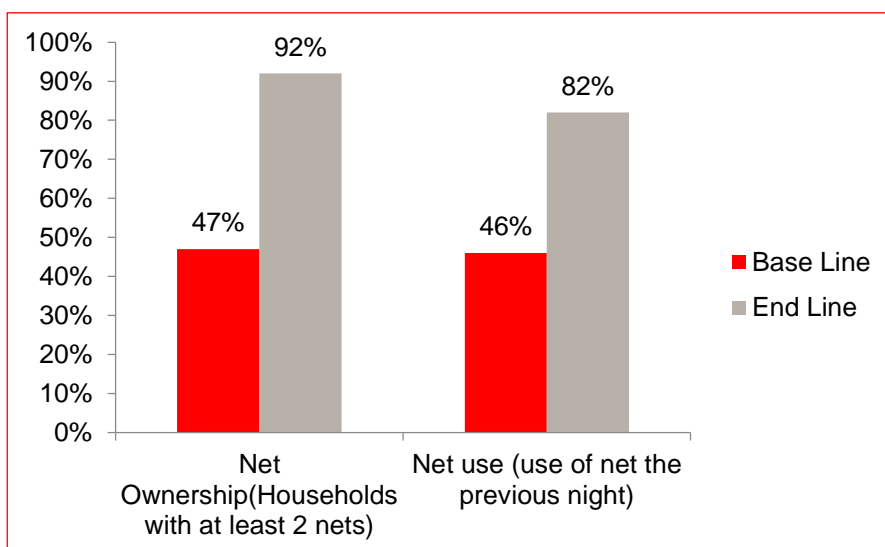
The ICRAM^{+K} project distributed 15,000 LLINs in the period of its implementation and was based on a strategy of gap filling. Which was implemented after the Global Fund supported state LLIN replacement campaign. The distribution was aimed at ensuring that all households in project communities had access to net for the protection of malaria. Also a lot of efforts and activities were implemented such as health education and promotion, monitoring and supervision by CDCs and CHAs which contributed to improve net ownership and usage thereby improving the overall net use culture. At the end of the project about 96% of households in the project communities had at least one net while 92.2% of households owned at least two nets. This is an improvement from the baseline where 51.5% of households owned at least one net and 46.9% households own at least two nets.

Below: In Idon Community, a woman and her baby sleep under a mosquito net provided by Christian Aid Nigeria



Another key achievement of the project was net use, the project improved use of net by target communities. The end of project evaluation showed that as high as 82% of households who own nets reported that someone in the household slept in the net the previous night which is much higher than baseline findings of 46%

Figure 1:1 Net ownership and use



A lot of these developments have been credited to the community structures; the CDCs and the CHAs especially. Some of the activities of the CHAs as reported by some of the community members are “they move to all places to making sure we use these nets” attested one of the women groups during the end line evaluation.

Community members share their stories;

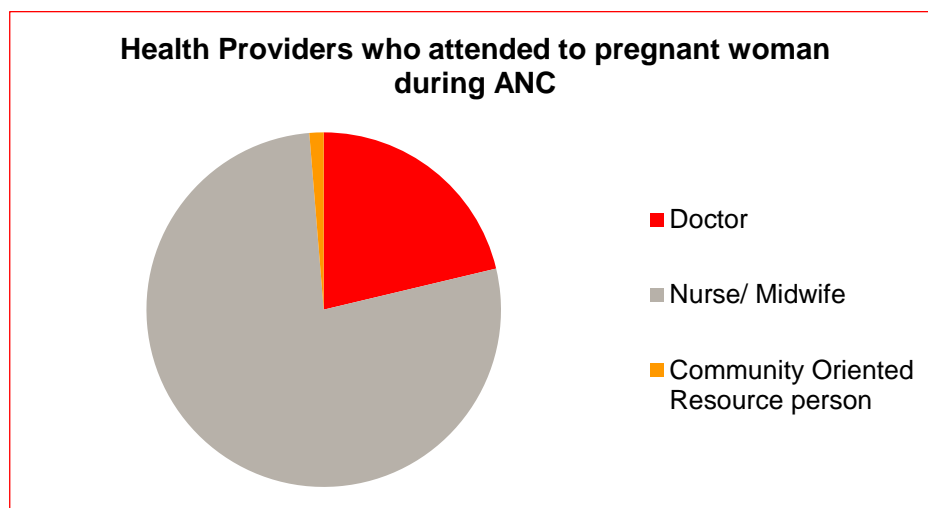
Hadiza Sani: *“Nets have helped us. When we were not using nets here our children were usually constantly very sick, but now it has reduced very well. My children used to be sick but with this net now, there is no sickness. They have theirs and I have mine.”*

Ante Natal Care (ANC) Attendance and Uptake of Intermittent Preventive Therapy (IPT)

The project through the health awareness and promotion by the CHAs contributed to the improvement of antenatal attendance of women of reproductive age (15-49) in target communities. Eighty nine percent (89%) of women of reproductive age attended ANC in their last pregnancy within the last two years, majority of them were attended to by a skilled provider, 21.3% were attended to by a Doctor, 77.5% by a Nurse/Midwife and 1.3% by a Community Resource Person. The ANC attendance as shown in the end line report is much higher than the base line findings which was 29.7% and reveals an improvement in antenatal attendance over the project period.

The findings further reveal that for the uptake of IPTp during pregnancy, about 56.1% of women who attended ANC in their last pregnancy recall that they were given SP/Fansidar as prevention for malaria over 50% of them received the treatment 3 times during their pregnancy which is in line with the national guideline on IPTp.

Figure 2:1 skilled providers who attended to pregnant women in community during last pregnancy



Deborah Yakubu (Woman – Kufana): *“When I was pregnant, I was given IPT (they will put 3 tablets in your palms and asked you to take all at once. I took twice and before the third, I had delivered. Women did not know much about ante-natal in the past, but now they know very well and attend too. They ask us to go for scan which helps during delivery.”*

Outcome Indicator 2: Number (and description) of marginalized partner-supported communities informing policies, plans &/or budgets related to health services

Formation of Community Structures CDCs

The Community Development Committees were set up across the entire project communities, each CDC had an average membership of 15 men and women (health facility staff were members of CDCs in some communities). The CDC members stand as representatives for the communities, and by working together as a team they present the views, observations and priority health development needs of the community to health facility staff and local government authorities. They do all these to find lasting solutions to already identified health challenges or priorities in their communities. The CDCs also update their communities through feedback meetings on developments at the health facilities and progress made towards addressing community health needs. The capacity of the CDCs was built on advocacy, stakeholder engagement and resource mobilisation, this contributed to building confidence and increasing awareness which resulted in some of the achievements recorded in their communities. The CDCs have successfully advocated on a number of pressing issues, ranging from posting of additional health facility staff to some Primary Health Centres, completion of abandoned health post at Makyalli (awaiting commissioning). Some of the identified priority health needs have been addressed by the LGA while commitments have been given on several others; Self-help initiatives like re-digging of well in Kallah, borehole repairs and construction of benches for the health facility have also been carried out.

There was also registration of all ten (10) CDCs into farmers' cooperative society with the Ministry of Agriculture and opening of group and individual accounts with Bank of Agriculture Kaduna. Four CDC groups (Kallah, Afogo, Makyalli and Idon) have completed the engagement process for Ginger farming under the Anchor borrow project coordinated by Kaduna Agricultural Development project in collaboration with Bank of Agriculture and Central Bank of Nigeria. One hectare of land have been mapped by the project and awaiting the commencement the Ginger farming in each of the four communities by April / May 2017. The remaining six CDC groups have also completed the process and waiting for the next cycle to apply for other farm produce like corn.

Below: CDC facilitating environmental sanitation in Afogo Community, Kajuru LGA, Kaduna



Some community members share their experience and opinions about the CDCs:

Sarah Maji – *“This work (CDC) is not for money but because they want their communities to be healthy, they are doing it. They tell you to clean gutters as dirty gutters they encourage mosquito growth. Some people used to see them as nuisance. Hence I feel that if you are a CDC if you don’t show patience, you can’t do the work. People are usually very nasty to them but they are usually very patient because of the overall interest of the village. If they see an unclean area they clean it themselves. They share themselves into two sections of the community, each group on each side of the main road, they tell us to help clean where you cook and so on”*

Outcome Indicator 3: Percentage (and description) of community members supported by partners who report changes in health seeking behaviours.

Health seeking behaviour

Community health agents were identified and trained to provide education on malaria and LLIN usage using a malaria education manual adapted from the 2015 revised National Malaria Elimination Advocacy Communication and Social Mobilization tools on Transmission, Prevention and Treatment of malaria.

. Health promotion activities by the CHAs resulted in increased awareness about malaria and adoption of safe preventive practices, increased net ownership and usage, increased voluntary testing and reduced presumptive treatment of malaria.

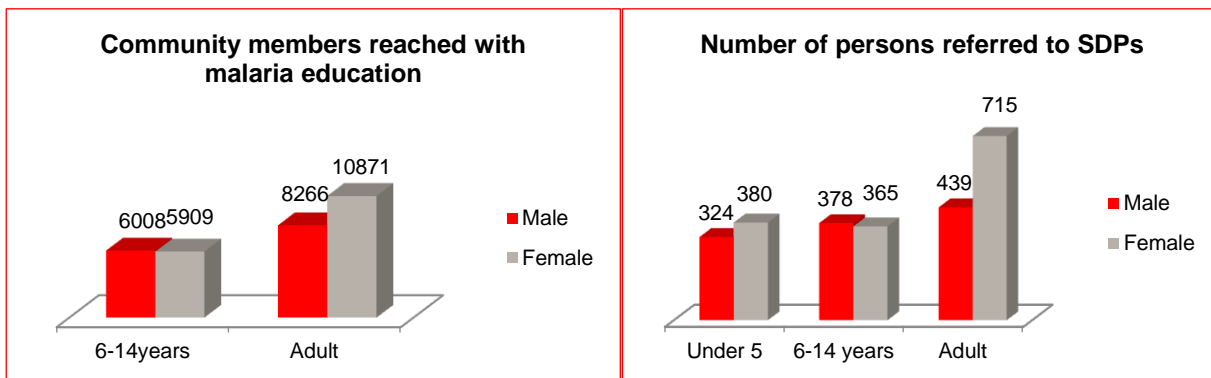
Specifically the project aimed to increase the number of households seeking effective malaria diagnosis and treatment at health facilities. The project achieved as high as 79% of households seeking treatment for fever at Government Health facilities (in most cases PHC). Project data

also show that most households (89.7%) seek treatment for fever within one day of onset of fever, which is an improvement from the baseline data of 47.8%.

Below: A community Health Agent using the malaria education manual



The ICRAM+K project reached a total number of 31,054 persons (14,274M; 16780F) with malaria education and 2,601 (1,141M; 1,460F) persons were referred to Service Delivery Points (SDPs) by the community health agents.



Prompt and effective treatment of malaria is one of the malaria prevention strategies. Findings from the end line evaluation show that the responses from the FGD groups attest to the efficacy of using ACTs for treatment. Some testimonies such as “*This medicine works*”, and as confessed in one of the groups, “*they have no smell, if taken it helps very well*”. “*We take this drug and get well quick*”. Knowledge on the uses of ACT versus other medication and the need for testing was described by the groups. Some of the testimonies from the project communities:

Community members share their experiences:

Kasimu: *“Why we didn’t want to be going to the hospital is that they will charge us much but if you use N50 or N20 you can buy drugs in the chemist. But when Nazarene organization came they encouraged us to go and be tested first to know what is wrong, so that you will not have typhoid and be given malaria drugs which will not work”*

Aminu Mohammed: *“They move from House to House to educate people on the importance of nets, ANC, going to hospital. To me they have bridged the gap between hospital and people’s homes. In the past the Government issued nets but there was no explanation as to their importance and how to use them. The CDCs have bridged that gap. There is one house in my area, their cooking room, well; gutter and toilet are in one place. So dirty! The CDCs asked them to clean the place and remove the dirt but they refused to do it. The CDCs came the next day and did it themselves. The place is so neat now and the owners of the house are very happy.”*

Bature maigada: *“Community agents (CHAs) have a calendar that has pictures that they use to educate us. For uneducated people the pictures can teach them. CHA and CDC have helped us very well.”*

Outcome Indicator 4: Percentage (and description) of service providers reporting availability of diagnosis and treatment options in Service Delivery Points.

ICRAM⁺^K has trained eight officers in charge of health facilities and fourteen Patent Medicine Vendors from the project communities using the 2015 revised national guidelines on diagnosis and treatment of malaria.

Tracking availability of commodities, diagnosis and treatment options was a key step taken on the project to ensure that community members receive quality health services as at when required, and formed a basis for reporting stock out of commodities. Within the period of implementation, one of the project partners, ACHI DACA tracked and reported monthly stock of malaria commodities in all seven (7) facilities across 10 communities in five wards during LGA and State RBM meeting.

Below: Quality Service Committee Meeting with CDC, Partner staff and Local Government Staff at the Kajuru LGA Headquarters



Several advocacy visits were conducted to the State Roll Back Malaria Manager where issues of stock were presented. This resulted in availability of Malaria commodities such as ACT, RDT, LLIN, and intermittent Prevention Treatment for pregnant women in all health facilities. The Sustainable Drug Supply System (SDSS) through the Drug Revolving Funds (DRF) available at all facilities also aided the availability of Malaria commodities. The DRF was used to purchase high quality drugs from the central store and sold at cheaper rates to community members.

Significant changes have been recorded across the ten (10) project communities as a result of project interventions. These changes are evident in the improvement of health workers attitude towards patients, increase in access and utilization of health services especially malaria prevention and treatment options by community members. Others are posting of health workers to health facilities by the LGA and State to improve human resource for service provision, availability of malaria diagnosis and treatment options, the buy-in and commitment of duty bearers and LGA stakeholders in addressing health development needs, and community self-help initiatives.

Sustainability of Project Gains

The project was implemented through community structures made up of 15 community development committee (CDC) members and 4 community health agents (CHAs) in each of the 10 project communities. The Community Health Agents were largely responsible for bringing about the required changes in behaviour, knowledge and attitude on transmission, prevention and treatment of malaria while the Community Development Committees led on advocacy to the Local Government for provision of healthcare services. The gains of working with these structures in the community are intended to go beyond the period of project implementation. Some of the gains include:

Registration of all ten (10) CDCs into farmers' cooperative society with Ministry of Agriculture and opening of group and individual accounts with Bank of Agriculture Kaduna under the Anchor borrow project coordinated by Kaduna Agricultural Development project in collaboration with Bank of Agriculture and Central Bank of Nigeria for farm produce farming

Village Savings and Loans Associations (VSLA) were piloted in some supported communities.

To support the livelihoods of these volunteers and improve their income generation, the project was designed to operate an **'alternative reward system'**, whereby a small contribution was made towards an income-generating activity for each CDC member and CHA committed to the project for up to one year. The system empowered CDCs and CHAs, both men and women economically to contribute to sustainable and resilient livelihoods for them and improve the overall health outcomes of the community members through their continued support long after the project ends.

Recommendations and Conclusion

To sustain the achievements made on the ICRAM^{+K} project, the following need to be taken into consideration:

- Sustain community and stakeholders engagement strategies
- Scale up of the project to other communities or LGAs
- Ensure continuous community mobilisation and participation
- Sustain networking and collaboration with LGA and State government for resource mobilization and funding
- Work with faith/religious leaders as change agents to carry forward project gains.

End notes