PIRCOM PROJECT LEARNING BRIEF

Communities Free of Malaria in Mozambique

April 2020

MALARIA PROJECT LEARNING SUMMARY

SUMMARY

The Interfaith Program to Combat Malaria (PIRCOM) received funding from GlaxoSmithKline (GSK) and Comic Relief in 2017 to implement a malaria prevention project for 36 months. The project is implemented in Bilene and Chokwe districts in Gaza province and Homoine and Morrumbene districts in Inhambane province.

The objective of this project learning brief is to identify the lessons learned from the project implementation to strengthen PIRCOM's programming in future.

Methodology: This brief was compiled from a document review of project reports and interviews with project staff and community workers during a site visit to the project in Bilene and Chokwe districts carried out in the last quarter of the project. Also, a workshop focusing on reflecting on the project monitoring system was conducted and lessons learned from this workshop are included in this brief. All information was collected prior to the end of project evaluation. This brief is not a project evaluation, but rather a compilation of the lessons learned, reflections and recommendations for PIRCOM to strengthen future programs.

BACKGROUND

PIRCOM's signature intervention is the incorporation of faith leaders in their approach to behaviour change communication messaging. Faith leaders are important community figures and are well respected and therefore provide a different platform to disseminate health messages.

PIRCOM is implementing their project in two districts in Gaza and Inhambane Provinces. These areas are characterised by high mobility and migration, with a large percentage of adult males working in South African mines.

The unique profile of these communities necessitates specialised interventions. For example, working in the mines is a very high-risk profession and therefore the risk threshold of these workers and their families is much different to that of the general population. It is therefore more difficult to conduct behaviour change with community members that have a different perceived risk of malaria than the general population.

Gender norms are also more starkly apparent in communities with high mobility. Often the male head of the household is the one who decides when their wife or children can go to the health facility. Given the transient nature of the work, it can take time to get this authorisation if the head of the household is not present.

PROJECT OBJECTIVES

OBJECTIVE 1

Improved malaria prevention and treatment knowledge among faith leaders, community leaders, local health committees and local health volunteers from 2017 to 2019.

OBJECTIVE 2

Improved use of effective malaria prevention and treatment methods in targeted communities.

OBJECTIVE 3

Strengthened health system in data management of malaria cases.

LESSONS LEARNED

1

PROJECT MONITORING ACTIONS

PIRCOM Monitoring and Evaluation (M&E) staff participated in a workshop to review the project monitoring challenges and learn new skills to address these challenges (Page 5).

2

PROJECT IMPLEMENTATION

PIRCOM identified aspects of their project implementation that worked well, in addition lessons learned to improve their interventions for future projects. These points all relate to key learning questions (Page 7).

PROJECT ACTIVITIES

INTERPERSONAL COMMUNICATION

» Including messages from faith leaders during sermons;

» Home visits from community health volunteers;

» Community dialogues and women's groups;

» Women and men focus group meetings;

» Radio spots.

DATA QUALITY IMPROVEMENT (IN INHAMBANE PROVINCE)

» Provided health facilities with equipment such as computers to input data on the electronic data collection system;

» Conducted trainings of technicians and held supervision meetings to discuss data quality.

LESSONS LEARNED ABOUT PROJECT MONITORING ACTIONS

PROJECT MONITORING LESSON LEARNED #1: DO NOT TRY TO MEASURE OUTCOME DATA DURING ROUTINE MONITORING.

PIRCOM tried to measure outcome and implementation data, which resulted in a high volume of data for routine monitoring activities such as home visits. For example, on the home visit monitoring form, they asked if the household had a mosquito net and the number of nets they have. This was asked at every household at every visit. This indicator is not likely to change much during the 3 year project and having a mosquito net is neither a project indicator nor a project activity. This outcome level data would be better left for the baseline and end of project evaluations and it would reduce the amount of information collected at each home visit.

PROJECT MONITORING LESSON LEARNED #2: NEED MORE SPECIFIC PLANS FOR PROJECT INTERVENTIONS IN ORDER TO MONITOR THEM WELL.

For example, the social and behaviour change communication (SBCC) messages at religious services were not well defined.

The faith leaders were trained on several topics related to malaria knowledge, prevention and treatment.

They were then encouraged to share these messages in group dialogues or during religious services. However, there was no defined way to give the messages - the leaders could choose when and in what format (group vs. religious service) to give the message. There was also not a defined period that the leader should complete all the messages. It was therefore difficult to know how well the leaders were working because there were no clear standards.

PROJECT MONITORING LESSON LEARNED #3: NEED MORE STAFF AT THE DISTRICT LEVEL TO PROVIDE SUPERVISION TO COMMUNITY VOLUNTEERS AND FAITH LEADERS.

There were only three PIRCOM staff per province. Supervision sessions with community volunteers and faith leaders are vital to capturing qualitative data such as success stories. If there are not enough staff to meet regularly with volunteers this information is lost.

LESSONS LEARNED ABOUT PROJECT MONITORING ACTIONS

PROJECT MONITORING LESSON LEARNED #4: NEED TO MORE CLEARLY DEFINE WHAT SHOULD BE MONITORED FOR EACH INTERVENTION.

This clarity comes from a detailed Monitoring and Evaluation Learning Plan. Typically, indicators are derived from project outputs. However, in the PIRCOM Monitoring and Evaluation Learning Plan, there were few outputs and they consisted primarily of outcomes and activities.

PROJECT MONITORING LESSON LEARNED #5: THERE IS A LOT OF WORK THAT PIRCOM DOES THAT IS NOT MEASURED IN THE MONITORING AND EVALUATION LEARNING PLAN.

As the saying goes, if it is not measured, it didn't happen! Two of PIRCOM's strengths in this project were the capacity building they provided to faith and community leaders and the contextualistion of the SBCC messages to reach the specific needs of the communities. Neither of these are reflected in the project Monitoring and Evaluation Learning Plan.

CONCLUSIONS

The PIRCOM Monitoring and Evaluation (M&E) staff participated in a workshop to review the project

monitoring challenges and learn new skills to address these challenges. In short, PIRCOM staff were encouraged to more specifically define their interventions, be clear about what they want to measure, focus on measuring the quality of the interventions and how well they are being implemented according to the project plan and make specific log frames that include outcomes, outputs and activities.

PIRCOM was encouraged to increase the number of staff to provide more supervision which will increase the quality of the interventions as well as capture qualitative project data.

Finally, they were encouraged to include all the work they are doing in the project log frame.

LESSONS LEARNED: PROJECT IMPLEMENTATION

LESSON LEARNED #1

How will community mobilisation help to increase malaria prevention and demand for timely malaria testing and treatment?

» The use of many forms of communication was successful. For example, beneficiaries heard messages from community health workers (CHW), faith leaders, community leaders and on the radio.

» In the future, PIRCOM could engage with adolescents and children. In this project, only women of reproductive age and adults were the focus since these are the identified priority groups for malaria prevention in Mozambique.

LESSON LEARNED #2

What impact will the activities conducted to improve data quality at health facilities have on overall data quality and improved surveillance of malaria cases in affected communities?

» One of the most helpful strategies for improving data quality was encouraging the focal points to enter data at the end of each day.

» This helped clarify any doubts and helped the workload become manageable. Quarterly supervision meetings and assistance with computers and training greatly facilitated the online reporting at the health facilities.

» PIRCOM also reflected on their own data collection and felt that in the future they would have more sophisticated methods to collect project monitoring data. In addition, they will conduct a midterm monitoring assessment and not only rely only on the end of project evaluation to collect impact level data.

LESSON LEARNED #3

How will training of community and religious leaders, local health committee members, and volunteers enhance malaria behaviour change communication and improve prevention and treatment of malaria?

» PIRCOM found that including the religious leaders brought a different and important authority figure into the malaria intervention. Religious leaders also had a wide reach with their messages.

» While the messages from various leaders and health workers was positive overall, they experienced a decrease in participation after multiple actors called for meetings with the community. In the future, PIRCOM could organise their group sessions and have a series of sessions for each group to encourage participation and organise the topics and facilitators of the sessions.

» In the future, PIRCOM wants to include traditional healers in their malaria prevention messages, as they are influential leaders in the health system.

LESSON LEARNED #4

How do the meetings organised by women's groups contribute to greater adherence to early initiation of prenatal consultations and malaria prevention in pregnancy?

» It is essential to empower women to be able to make decisions about their health. Many women have to seek approval from their husband before going to the health centre or taking their child, which can cause delays.

SUCCESSES

1) Use of mosquito nets in fields:

There is a river running through Chokwe District and many women cross the river to farm. They are gone most of the day and take their children with them. PIRCOM worked with the local communities to identify a problem with small children staying in areas with high mosquito populations. Women constructed posts to hang mosquito nets, so their children could be protected while their mothers cultivate the fields.

2) Individualised programming:

PIRCOM worked with each community to understand what the main challenges were and how to address them. In some areas the biggest concern was that people were bitten by mosquitos when they were outside their houses, so the emphasis on mosquito nets was not helping them. PIRCOM community health activists then taught the community members about local plants that are natural repellents.

CHALLENGES

Some people are resistant to change behaviour

It is difficult to do behaviour change with a household without the permission of the husband or at least an older family member (such as the mother-in-law). This is changing slowly.

High demand for malaria prevention activities

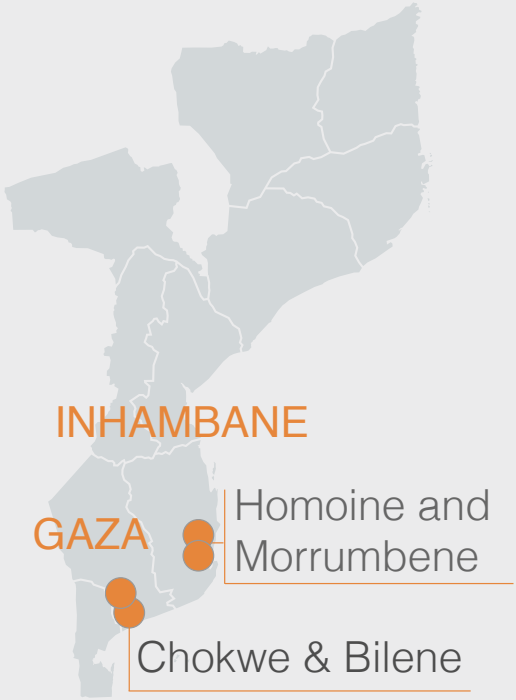
Community activists often felt that they could not cover the whole area they were assigned or were requested by community members to go to other areas because people wanted to hear their messages.

Gender norms are very strong

While many community members benefited from the prevention messages, there were some who were very resistant and have not changed their behaviour.

PLANTS WITH NATURAL MOSQUITO REPELLENT

Pictures 1 and 2: Local plants with natural mosquito repellent properties



Districts where this project was active.

This learning brief was compiled by an independent consultant from September- December 2019 during the last quarter of the project, but before the End of Project Evaluation was conducted. Information was gathered through interviews with project staff, a site visit and interviews with project community health volunteers and faith leaders and secondary data analysis.