Development Project Management Plus Deliverable

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DPMI Module: Two, Strategic Partnerships and Social Entrepreneurship

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[*This report contextualizes the attached strategic partnership matrix. First, the report explains the problem that necessitated a partnership between Population Services International and Peace Corps. Second, the report describes this partnership's evolution. Finally, the report evaluates the attached strategic partnership matrix and connects lessons learned to development project management themes.*]

Situation Analysis

In Malawi, malaria is the leading cause of morbidity and mortality for children under five-years-of age and pregnant women.[1] Malaria is the most common cause of outpatient visits, hospitalization, and death. In 2007, for example, 34 percent of the population was affected by malaria.[2] Malaria decreases the socioeconomic status of families through loss of work, school absenteeism, and expenditures on treatment. Many Malawians, however, have rampant apathy and fatalism towards this parasitic disease. Most people self-medicate and seek care at health facilities as a last resort.

In recent years, Malawi's Ministry of Health, in association with multilateral and bilateral donors and non-governmental organizations, has used the following interventions to prevent and treat malaria: Intermittent Preventive Treatment (IPT) of pregnant women, Long Lasting Insecticide Treated Nets (LLINs), and Indoor Residual Spraying (IRS). LLIN use is the most common and effective malaria prevention intervention. Recently, only pregnant women and children under-five years of age received LLINs. This distribution strategy gave the most vulnerable groups priority over scarce medical commodities.

The old distribution strategy, however, did not reach all under-five children and pregnant women. My host institution, Namandanje Health Center, like most health centers, only distributed insecticide treated nets to pregnant women attending static antenatal clinics and children finishing their immunization regimens. However, the five percent of the area's pregnant women who miss all antenatal clinic visits and the children who fail to get all their vaccinations did not receive nets.[3]

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[1] Malaria Communication Strategy for Malawi 2009-2011, Ministry of Health, Government of Malawi, November 2009.

[2] Malaria Strategic Plan 2005-2010, Ministry of Health, Government of Malawi, November 2005

[3] Namandanje Health Center's Maternity Ward In-Charge estimates that five percent of pregnant women never visit antenatal clinic

Many households, moreover, do not have pregnant women or under five-children, yet have people with low immunity to malaria such as the elderly and people living with HIV. These vulnerable populations fell through the cracks of the old distribution system. Of the 5,022 households located within Namandanje Health Center's catchment area only 3,264 had at least one LLIN.[4] Insufficient LLIN coverage, then, was the main cause of the 2,734 malaria cases Namandanje Health Center treated in 2010.[5] Almost two thousand of these cases were in children under five-years of age, while nearly 800 were in people over five-years of age.[6]

Partnership Formation Process

The latter situation is antithetical to the World Health Organization's recommendation of universal access to insecticide treated nets. Fortunately, however, Malawi aims to adhere to the WHO's recommendation. The Ministry of Health has pledged to have 90 percent of households sleeping under long-lasting insecticide treated nets by 2015. Using multiple federal agencies, the United States President's Malaria Initiative is helping Malawi achieve this goal. In late July of 2010, for example, the Centers for Disease Control and Prevention's Malaria Coordinator asked Peace Corps—Malawi to ramp-up its malaria prevention activities.

Peace Corps—Malawi's Director therefore established a Malaria Task Force to increase the organization's role in malaria prevention and treatment. The task force first recommendation was to pick low hanging fruit and allow Peace Corps volunteers (PCVs) to distribute LLINs donated by the Against Malaria Foundation. As one of the five volunteers on this task force, I helped Peace Corps—Malawi build a partnership with the main distributor and of these LLINs, Population Services International—Malawi.

The Malaria Task Force began courting PSI—Malawi in September 2010. At the first meeting, PSI—Malawi showed task force members its warehouse that stores over 500,000 LLINs and its fleet of vehicles that distribute the nets to rural health centers. This tour demonstrated two things: first, that PSI—Malawi had an established supply chain system; and second, that PSI—Malawi was experienced in meeting logistical challenges.

Task force members likewise demonstrated competency of malaria issues at the grass-roots level by discussing the following behaviors limiting proper use of insecticide treated nets. These behaviors include: inconsistent net use; low priority for net procurement; inappropriate use of free nets, for example, fishermen using LLINs as fishing nets; and the belief that sleeping under a LLIN causes impotence. These discussions helped establish parameters around which to conduct the new distribution campaign. After the tour, PSI—Malawi's director meet with the task force to clarify critical programmatic issues. This meeting helped determine targeted populations, supply chain, net security, monitoring of net usage, and impact assessment.

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[4] According to PSI—Malawi, 65 percent of Malawian households use ITNs. Sixty-five percent of 5,022 households is 3,264.

[5] Namandanje Health Center's Out-Patient Department Registry, January to December 2009

[6] Ibid.

Tool Evaluation

Although the initial meeting with PSI—Malawi did not cement all details, it confirmed that PSI—Malawi would deliver LLINs to PCVs who designed innovative malaria prevention interventions. These interventions first had to reach households not currently served by traditional insecticide treated net distribution channels; and second had to cover pregnant women and under five-children where possible. My proposal to Peace Corps—Malawi for Namandanje Health Center's malaria campaign used a strategic partnership matrix to communicate how an intervention would satisfy these two seemingly conflicting goals.[7]

The Malaria Task Force used my proposal to standardize a request form for Peace Corps volunteers designing malaria interventions. Upon selecting the winning volunteer interventions, Peace Corps gave PSI—Malawi the names and contact information of volunteers needing LLINs. PSI—Malawi then delivered nets to volunteers. Peace Corps volunteers were responsible for securing nets and implementing, assessing, and reporting on the proposed malaria prevention intervention.

The said strategic partnership matrix has several strengths. First, the matrix's list of activities—which paired set tasks for each member of the partnership—provided a clear sequence of events during implementation. Second, by illuminating the intervention's distinctive features—producing lessons learned, reaching last mile households, and reducing soft coercion—the matrix highlighted the factors that gave life to the partnership. Third, by mapping out the alliance's strategy—which included empowering local actors to take charge of net distribution, verifying net usage, and fostering accountability for allocation of scare resources—the matrix enabled the partnership to clarify its sustaining elements.

The partnership matrix did have three weaknesses, however. First, the matrix did not include an exact timeline for each activity. This oversight enabled Peace Corps—Malawi to have loose deadlines for selecting innovative malaria interventions. This oversight also allowed PSI—Malawi to distribute LLINs during the rainy season, which was later than most PCVs expected to receive the nets.

Second, this matrix diverges from Development Project Management Institute Module Two's strategic partnership matrix template and categorizes partners. Strategic partners were those involved with in the original organizational courting; boundary partners, on the other hand, were those working with the strategic partners to deliver services. It is unclear whether this distinction diminishes the contributions of "boundary" partners. Village health volunteers, for example, put in more hours on this project than any other actor, but the matrix considers them a "boundary" partner. Third, the matrix does not serve as a stand alone document for project implementation. Volunteers had to provide clear indicators and monitoring frameworks to meet the project needs.

Though the strategic partnership matrix's three main weaknesses limited it from serving as an effective implementation tool, its main strengths helped Peace Crops—Malawi and Population Services International—Malawi to outline the partnership's responsibilities, sustaining elements, and life force. My creating and using the matrix in Malawi, moreover, proved to me that the matrix is an effective communication tool for strengthening partnerships.

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[7] See Appendix One for the detailed Strategic Partnership Matrix

Appendix One: Strategic Partnership Matrix

<table>
<tr><td rowspan="2">Actors</td><td colspan="12">Strategic Partners: Peace Corps—Malawi (Peace Corps Volunteers, PVCs) and Population Services International—Malawi (PSI Drivers)</td></tr>
<tr><td colspan="12">Boundary Partners: Machinga District Environmental Health Office (Health Surveillance Assistants, HSAs, and Village Health Volunteers, VHVs) and T/A Liwonde Area Chiefs</td></tr>
<tr><td rowspan="2">Activity Domain</td><td colspan="3">Households Identified</td><td colspan="3">LLINs Secured</td><td colspan="3">H/Hs collect LLINs</td><td colspan="3">LLIN Use Tracked</td></tr>
<tr><td colspan="3">o VHVs and chiefs identify H/Hs needing LLINs;
o HSAs and PCV confirm list through random visits.</td><td colspan="3">o PSI Driver delivers LLINs to health center;
o PCV inventories and monitors LLIN supply.</td><td colspan="3">o Listed H/Hs collect LLINs at NHC by village;
o VHVs and chiefs verify recipients;
o HSAs demonstrate proper LLIN use;
o VHVs assist H/Hs with LLIN setup.</td><td colspan="3">o PCV and HSAs corroborate LLIN use through random spot checks;
o VHVs report H/Hs not using LLINs to village head;
o PCV implements new project in village with highest LLIN use.</td></tr>
<tr><td rowspan="2">Process Factors</td><td colspan="4">Volunteerism</td><td colspan="4">Verification</td><td colspan="4">Accountability</td></tr>
<tr><td colspan="4">o Creates an enabling environment for local actors to improve their communities.</td><td colspan="4">o Confirms status of vulnerable households and avoids duplication;
o Physically corroborates LLIN use through spot checks.</td><td colspan="4">o Group village competition fosters accountability: group village with highest LLIN use receives future development project.</td></tr>
<tr><td rowspan="2">Value Adding Mechanism</td><td colspan="4">Reduces Soft Coercion</td><td colspan="4">Reaches “Last-Mile” Households</td><td colspan="4">Produces Lessons Learned</td></tr>
<tr><td colspan="4">o Volunteers and HSAs do not receive allowances or other material incentives in exchange for participation</td><td colspan="4">o Reaches households not targeted by the current LLIN distribution system.</td><td colspan="4">o Researches nets life span and what happens as they wear out; thus may inform policies on net disposal.</td></tr>
<tr><td>Impact on Service Delivery</td><td colspan="12">This project enables PSI—Malawi and Peace Corps—Malawi to reach 1,600 “last-mile” households under-served by the current LLIN distribution system.</td></tr>
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