LLIN DISTRIBUTION REPORT

Balaka District, Malawi

October 2012 to December 2013

Carried out by Concern Universal with Balaka District Council

LLINs and distribution funded by the Against Malaria Foundation (AMF)

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Note: 12Mar14- AMF is still checking the consistency of some of the numbers reported here as several numbers do not match those in prior reporting. Once resolved, a final version of this report, corrected as necessary, will replace this version. As these potential errors are believed to be minor and will not detract from the overall report, we are publishing this version now to avoid delay in making this report available.

Background

Malaria is the leading cause of mortality and morbidity in Malawi responsible for about 40% of all hospitalizations of children under five years and 34% of all outpatient visits across all ages. *Plasmodium falciparum* is the most common species accounting for 98% of infections and almost all of the reported cases of severe disease and death. In Malawi, malaria transmission occurs all year round although it increases during the rainy season (late November to mid March). It is estimated that Malawians receive 30 to 50 infective bites per year.

The Malawi government through the Directorate of preventive health services, in the ministry of Health established the National Malaria Control Programme (NMCP) with the objective of reducing the level of malaria related morbidity and mortality from the 2004 figures by 75% by 2015. To achieve these goals the NMCP laid down malaria preventive and control interventions amongst which are included health promotion, distribution and usage of Long Lasting Insecticide Treated Nets (LLIN), intermittent presumptive treatment for malaria in pregnancy and residual spraying as primary preventive interventions.

In 2011-2012 the government of Malawi with assistance from the Global Fund and other partners implemented the universal coverage national campaign in which over 5.5 million LLIN were distributed for free to the households all over the country. However, though 123,627 nets were distributed in Balaka District, this covered only 64% of the sleeping spaces.

It is against this background that Concern Universal Malawi in conjunction with Balaka District Council conducted a second universal LLIN distribution in the district as part of the National Malaria Control Program's universal net distribution supplementary effort. Therefore CU received 160,000 LLIN from Against Malaria Foundation (AMF) to conduct the distribution in Balaka District and cover the remaining sleeping spaces.

Pre-distribution activities

The programme commenced in January 2013 with the planning of a number of pre-distribution activities such as community sensitizations, project staff orientations and trainings, beneficiary registration exercises, data entry and beneficiary registration verification campaigns which were carried out before the distribution started in September 2013.

Balaka District Health Office has 16 health facilities out of which 14 are classified as Health Centers and 2 as Health Posts. While Chimatilo and Dziwe Health Posts report to Balaka District Hospital and Kwitanda Health Center respectively. These 2 Health Posts as well as Mwima Health Center are manned by Health Surveillance Assistants (HSAs) hence they do not carry out malaria diagnosis. Out of the 16 Health Facilities 5 belong to Christian Health Association of Malawi (CHAM).

Orientation

The project team carried out an orientation process whereby stakeholders were sensitized on the project's objectives and how we expected to achieve them. The target groups were the District

Executive Committee (DEC) members, the local leaders, the District Health Management Team, the District Environmental Health Team and the Health Surveillance Assistants (HSA).

The orientation process was divided in two categories.

The first consisted of briefing and sensitization meetings targeted at the District Executive Committee members, local leaders and the District Health Management Team so that they were aware of what was to take place in their respective areas of jurisdiction.

The second comprised detailed briefing and training sessions for the HSAs aiming to build their capacities and urge for their commitment stressing the importance of their role in the process. It was during the HSAs orientation that the data collection forms were introduced and explained how the registration data was going to be collected. A total of 275 HSAs and their supervisors in the district were oriented on how to extract the relevant data required by the project.

Community Sensitizations

The project team conducted community sensitizations to all 905 villages through the decentralized structures of the 7 Area Development Committees (ADCs) of Kalembo, Amidu, Kachenga, Sawali, Msamala, Nkaya and Chanthunya and it's Village Development Committees (VDCs) so as to sensitize the community and its leaders of the impeding net distribution project, on the procedures that were to be followed, to identify the beneficiaries and the objective of the net distribution initiative and what the project aimed to achieve. This was done to alert the community and allow the initiative to be carried out in the most accountable manner and inform the beneficiaries that the nets, donated by AMF, were going to be distributed free-to-beneficiary.

Beneficiary Registration

The previously trained 275 HSAs carried out the household registration in all villages using a standard beneficiary form that captured: (Annex 1).

Health Centre: This identifies the name of the Health Center under which the village of the beneficiary resides.

GVH Name: This identifies the group village head under which the village of the beneficiary belongs.

Village Name: This identifies the village in which the beneficiary resides.

T/A: This identifies the Traditional Authority Area in which the village of the beneficiary registered belongs.

HSAs Name: This identifies the Health Surveillance Assistant who collected the data.

Name of Household: This identifies the head of the household.

Total number of people in the household: The total number of people living in the identified household.

Number of beneficiaries under five and over five: This captures the segmentation of the people living in the household as either under 5 or over 5 years old.

Total number of usable LLIN in the household: This identifies the presence or the absence of the LLIN in the identified household. The HSAs were oriented on how to identify a usable LLIN. Thus if the household already had a net the data collector was advised to physically inspect the net(s) in order to qualify it usable or not usable (to be a useable it had to be an LLIN and be classed as in 'Very good' condition, defined as having two or fewer holes of less than 2cm in diameter).

Number of Sleeping Spaces in the household: This column was used to identify the number of sleeping spaces that the household had. The sleeping spaces are the actual places in the household that are laid when the occupants are sleeping. This tool is the major determinant in household net requirement allocation since the objective of the initiative is to cover the unprotected sleeping spaces.

Nets required: This is the number of nets required to cover all sleeping spaces in the household. For each individual household it reflects the difference between the number of sleeping spaces in the household and the total number of usable LLIN in the household. This difference can't be looked at from a group of households' perspective since it can be influenced by the fact that some households had more usable nets than required (more nets than sleeping spaces). CU staff at the office completed this field.

The village beneficiary registration exercise was carried out over a period of 5 days following the HSA training. To promote transparency and accuracy in the registration process, a village headman, a member of the Village Development Committee (VDC) and a volunteer member of the village health committee accompanied the HSAs. The village headman had the role to assure that all beneficiaries in the village were dully registered during the exercise as well ratify the information provided by the household owners.

Data entry

The registration forms were then submitted to the project team for data entry into the database. Data entry for all the forms from the 905 villages took about a month and followed by the printout of the registration books.

Table 1: Number of households and nets required after the initial registration.

Health Facility	Number of Households	Number of Nets Required
Balaka Health Center	17,090	21,387
Chiyendausiku	3,336	6,128
Kalembo	6,194	11,722
Kankao	6,357	11,165
Kwitanda	6,036	8,538
Mbera	10,986	20,202
Mwima	6,069	10,478
Namanolo	7,247	14,226
Nandumbo	4,274	7,937
Phalula	5,517	9,420
Phimbi	5,859	9,507
Ulongwe	3,572	5,146
Utale 1	3,516	6,061
Utale 2	3,928	7,404
Total	**89,981**	**149,321**

Beneficiaries/household data verification

The project team with the assistance of the health personnel and the local leaders conducted the beneficiary household data verification exercise in all the 905 villages which were divided into 91 clusters of two or more villages based their closeness. In order to ascertain that all the households were dully registered during the house registration exercise and confirm that all of those who were registered had been entered into the net project database as well as eliminate duplicated registrations, every household in the printout was roll-called. During this verification process, the project staff crosschecked the particulars in the printed register with what was written in the manual register they submitted to the office by the HSAs.

Verification of the long lasting insecticide treated nets registers was done at village level where everyone was present. The community was eagerly listening as team members were calling out the name of the household, the number of people in the house hold, number of LLIN in that household, number of sleeping spaces in the household in question and finally the number of nets the household was going to receive. Upon completing name calling out, those villagers who did not hear their names being called were registered so that they could be included in the database. One HSA was assigned to cross check the call out from the printout roll with the raw data and, where the printout differed with the raw data this was noted and later sent back to the data center for data updating. The community also played an important role during the verification in that whenever a name was called that did not exist in their village, they advised the team members to delete such a beneficiary from the list, which was done after consultation with the village head. The other strength of the roll calling during the verification was that whenever the data that the beneficiary gave on registration was different with what the communities' perception of the household, the community could raise the issue and the beneficiary could be taken to task to justify. Whenever the community disagreed with the justification, they were advising and recommending the verification team members on the total number of the nets the household should get. This improved transparency of the net distribution process.

After the household verifications, the registers with editions were referred back to the data entry team so that they could include the corrections and alterations made and observed during the verifications.

Figure 1: Verification exercise at one of the cluster under Ulongwe Health Center

Table 2: Changes in the number of required nets after the verifications.

Health Facility	Nets Required	Nets Required After Verification	Change in Nets Required	% Change
Balaka D. Hospital	21,387	28,731	7,344	34.3
Chiyendausiku	6,128	6,128	0	0
Kalembo	11,722	12,116	394	3.4
Kankao	11,165	11,165	0	0
Kwitanda	8,538	8,323	-215	-2.5
Mbera	20,202	21,264	1,062	5.3
Mwima	10,478	10,752	274	2.6
Namanolo	14,226	14,226	0	0
Nandumbo	7,937	7,937	0	0
Phalula	9,420	9,420	0	0
Phimbi	9,507	9,507	0	0
Ulongwe	5,146	5,146	0	0
Utale 1	6,061	6,686	625	10.3
Utale 2	7,404	7,404	0	0
Total	**149,321**	**158,805**	**9,484**	**6.4**

After the verifications the number of nets required suffered some changes with the highest variations registered in Balaka HC and Utale 1 HC, with 34.3% and 10.3% respectively. Skipping of beneficiaries during the registration process as well as duplication of registration data where the causes of the discrepancy identified during the verification process, which enabled us to do the necessary corrections before printing the registers in preparation for the distribution process.

Distribution

Concern Universal staff in collaboration with Balaka District Assembly Health Sector staff conducted the LLIN distribution. The distribution plan was arranged based on the draft used during the verification process to assess the progress and monitor the resource allocation.

Aiming to test the distribution plan and identify necessary corrective actions regarding distribution methodologies, logistical resource allocations a pilot distribution exercise was carried out in one of the clusters under Kalembo Health (Mtelera cluster, covering Mtelera, Mtambalika, Masambuka, Chitseko and Matiya villages), with a planned number of 1,379 Nets to be allocated.

During the pilot distribution the following lessons were learned and adjustments made to the initial plan.

1. Considering the distance between the warehouse and the distribution sites as well as the road conditions it was realized that ferrying the nets straight from the warehouse to the clusters on the distribution day would disrupt activities. Therefore, it was decided to transfer the nets to the respective Health Centers the day before the distribution and from there to the distribution site early morning before the start of the distribution.
2. The number of distribution staff members deployed at each distribution site was adjusted depending on both the number of nets to be distributed and the number of villages located at the site.
3. The HSAs were assigned to inform the respective village heads and village development committee members to announce the distribution dates to their respect villages in order to avoid the absence of the beneficiaries.

4. Back-up plans were drafted in order to reallocate vehicles for net transport in case of the unexpected unavailability of the District Health Office lorry assigned to the net distribution operations.

Figure 2: Distribution team vehicles that were used to carry nets from the warehouse to health centers.

The main distributions commenced in the month of October after addressing the logistical challenges that were encountered during the pilot distribution.

On the distribution day the community gathered and the distribution team, with the assistance of the health personnel, conducted a Health Talk which included a demonstration on how to effectively hang the nets, at what appropriate time the net should be hung and how to take care of the nets in order increase their lifespan.

Figure 3: Vehicles arriving with the nets at a distribution point at one of the cluster under Ulongwe HC.

Figure 4: The project team demonstrated how to hang the nets during the Health Talk.

Upon completion of the Health Talk the beneficiaries were roll called and lined on village-by-village basis. The nets were then unpacked from the plastic wrappers and the initials of the receiving household head written on each of the labels to discourage the community from selling the nets.

The distributions were made in the presence of the HSAs, the respective village headman, the member of the Village Development Committee (VDC) and a Volunteer Member of the Village Health Committee. This was done to make the process as transparent as possible and to avoid cases of mistaken/false identities. Whenever a third person claimed to be sent on behalf of the beneficiary the nets were only handed over with the approval of the village chief and the VDC member and the identity of the person collecting the net was documented in both registers. During the distributions, two registers were printed for each village and the team had to verify that both registers had been signed or thumb printed by the receiving household member.

Upon completing the distribution, the village chief, the HSA and the distribution officer had to sign both registers before one register was surrendered to the village head for the villages' record keeping while the distribution officer kept the other register.

Figure 5: Beneficiaries queuing to receive the nets on a distribution day at Mterela cluster Ulongwe.

The 'week 1' distributions

The first week distributions comprised of the distributions that were done during the pilot distribution (1,369) nets in the five villages of Kalembo and the main distributions in the first week. During the period covered all villages under Nandumbo and Ulongwe Health Facilities (28 and 26 villages respectively). A total of 30,191 nets were distributed the first week representing 19% of the total number of nets to be distributed.

Table 3:

Health Centre	Number of Villages	Villages distributed	Number of households	Population	Number of sleeping spaces	Usable LLIN in place	Nets required	Net distributed	Gap
Kalembo	42	24	5,118	20,400	12,715	2,997	9,630	9,278	352
Ulongwe	26	26	3,575	15,492	8,965	3,816	5,150	5,115	35
Nandumbo	28	28	4,277	18,348	11,182	3,334	7,947	7,510	437
Mwima	59	47	4,913	18,162	11,892	3,226	8,672	8,288	384
Total	**155**	**125**	**17,883**	**72,402**	**44,754**	**13,373**	**31,399**	**30,191**	**1,208**

'Week 2' Distributions

During the second week of the distributions, the project team in collaboration with the district assembly conducted the distributions in the villages under Mwima, Namanolo, Phalula and part of Phimbi Health Centers. During this week the distribution plan was changed due to village wrangles in Chatama village that kept us from proceeding with the distributions, which were postponed to a later date. In Phimbi only 36 of the 40 villages were covered with the remaining 4

re-scheduled. During the week a total of 27,825 nets were distributed bringing the total number of nets distributed to date up to 58,016, representing 36% of the total nets required. There was a high turnover of nets under Namanolo HC due to the 889 nets that were not distributed to Chatama village.

Table 4:

Health Centre	Number Of Villages	Villages Distributed	Number of Households	Population	Number Of Sleeping Spaces	Usable LLIN in Place	Nets Required	Net Distributed	Gap
Mwima	59	11	1,163	4,870	2,728	907	1,822	1,815	7
Namanolo	31	31	7,324	34,504	21,549	6,653	14,392	12,808	1,584
Phalula	64	64	5,524	24,048	14,429	4,981	9,434	9,097	337
Phimbi	81	40	2,730	10,958	6,425	2,067	4,353	4,105	248
Total	**235**	**146**	**16,741**	**74,380**	**45,131**	**14,608**	**30,001**	**27,825**	**2,176**

‘Week 3’ Distributions

During the third week of the distributions the team covered Phimbi, which included the 4 villages that were left in the previous weeks’ distributions. However Ntaja village did not receive the nets as it was reallocated to a cluster physically closer to facilitate the beneficiaries. Distributions for Utale 1 and Utale 2 were concluded as planned. In Kwitanda we covered 25 of the 66 villages. The total number of nets distributed during the week was 32,314 hence by the end of the third week of distributions a total of 90,330 nets were handed over, representing 56% of the total distributions.

Table 5:

Health Centre	Total Villages	Villages Distributed	Number of Households	Population	Number of Sleeping Spaces	Usable LLIN In Place	Nets Required	Net Distributed	Gap
Phimbi	81	40	3,382	14,102	7,863	2,483	5,396	5,127	269
Utale 1	32	32	3,518	14,669	8,653	2,750	6,065	6,020	45
Kankao	84	83	6,358	26,683	15,179	4,032	11,167	10,966	201
Utale 2	39	39	3,930	17,218	9,934	2,636	7,408	7,320	88
Kwitanda	66	25	1,812	7,691	4,856	2,201	2,923	2,881	42
Total	**302**	**219**	**19,000**	**80,363**	**46,485**	**14,102**	**32,959**	**32,314**	**645**

‘Week 4’ Distributions

During this week the team concluded the distribution for the remaining 41 villages under Kwitanda HC, and also finalized the 39 villages under Chiyendausiku HC. We also conducted distributions in the remaining villages under Kalembo HC. These villages were left when we were distributing Kalembo in the first week, as the access would be easier through Mbera. However two villages weren’t concluded and would be covered during the mop-up. During the fourth week a total of 39,246 nets were distributed thereby raising the total number of distributed nets to 129,576, representing 81.6% of the total distribution.

Table 6:

Health Centre	Number of Villages	Villages distributed	Number of households	Population	Number of sleeping spaces	Usable LLIN in place	Nets required	Net distributed	Gap
Kwitanda	66	41	4,234	18,630	10,461	5,615	5,628	5,480	148
Chiyendausiku	39	39	3,337	13,897	8,208	2,099	6,131	6,070	70
Mbera	183	166	10,384	46,252	26,249	7,145	19,092	19,033	59
Kalembo	40	16	1,083	4,746	2,698	699	2,104	2,083	21
Balaka D.H.	104	37	5,037	21,387	12,092	5,234	6,617	6,580	37
Total	**432**	**299**	**24,075**	**104,912**	**59,708**	**20,792**	**39,572**	**39,246**	**335**

‘Week 5’ Distributions

During the fifth week the team covered 67 villages under Balaka Health Center, however some villages refused to receive the nets due to inconsistencies between the number of nets they were expecting to receive and the announced number to be distributed. Upon scrutinizing the issues raised by the beneficiaries it was discovered that some households were missing in the register due to a printing error. Some villages were also missing in the database despite having been checked during the verification process. Hence 24 more villages were added in the database increasing the number of villages clustered under Balaka to 128. This database error also affected some villages under Mbera, Kalembo and Mwima, however, upon rectifying the error the villages were scheduled for distribution during mop-up. During ‘week 5’ 11,700 nets were distributed totaling 141,276 nets distributed in the District since the beginning of the exercise, representing 89% of the total coverage.

Table 7:

Health Centre	Total Number of Villages	Villages distributed	Number of households	Population	Number of sleeping spaces	Usable LLIN in place	Nets required	Net distributed	Gap
Balaka	104	67	11,893	53,105	32,032	16,560	14,285	11,700	2,585
Total	**104**	**104**	**16,930**	**74,492**	**44,124**	**21,794**	**20,902**	**11,700**	**0**

‘Week 6’ Distributions (Pre Mop-up)

During this week we covered 5 villages under 4 Health Centers, including the two villages under Kalembo that had been skipped due to the database error, while in the remaining villages we targeted the households that were absent during the initial distribution.
Upon distribution of this week’s 1,045 nets the total number of nets handed out is 142,321.

Table 8:

Health Centre	Number of Villages	Number of households	Population	Number of sleeping spaces	Usable LLIN in place	Nets required	Net distributed	Gap
Balaka D.H.	1	506	2,399	1,455	641	590	590	0
Kalembo	2	163	801	443	77	366	366	0
Phalula	1	105	487	289	85	204	36	0
Kankao	1	40	143	90	38	53	53	0
Total	**5**	**814**	**3,830**	**2,277**	**841**	**1,213**	**1,045**	**0**

Mop-Up Distributions

Since during the initially planned distributions days some beneficiaries, for different reasons, did not show up to receive the entitled nets a ‘mop-up’ exercise was conducted in order to cover all the households spread through different villages where a significant number of nets remained undelivered.

The villages initially skipped due to database errors were also taken into account and covered during the mop-up distributions along with the villages that were reallocated to a different cluster in order to be closer to the beneficiaries, keeping them from travelling long distances to receive the nets.

Table 9: Summary of mop-up distributions

Health Center	Villages	Distribution
Balaka	34	7,458
Kalembo	1	35
Kankao	1	126
Kwitanda	2	64
Mbera	21	2,045
Mwima	1	274
Namanolo	2	917
Phalula	1	224
Phimbi	1	225
Utale 1	5	541
Total	**69**	**11,909**

During the mop-up exercise, distributions were conducted in 69 villages from 10 Health Centers.

In Balaka a total of 7,458 nets were distributed to 34 villages including to the 24 that had been initially skipped in the database.

Regarding Kankao HC, 126 nets were distributed in Zandeya village, which hadn’t turn up during the main distributions.
Of the 158,805 nets that were projected for distribution in Balaka District, 154,230 nets were distributed representing 97% of the projected numbers. The 3% difference was justified by death occurrences within the households in question, as well as reallocation of beneficiaries to different households, villages or districts (due to marriage, professional reason, boarding school attendance, etc) during the time-lapse between the registration and distributions.

Table 10: Final distribution data by Health Center

Health Center	Total Number of Villages	Number of Villages Distributed	Number of Households	Population	Number of Sleeping Spaces	Usable LLIN in Place	Nets Required	Nets Distributed	Gap
Balaka HC	128	128	19,233	85,222	50,614	21,352	28,731	26,328	-2,403
Chiyendausiku	39	39	3,336	13,890	8,205	2,099	6,128	6,070	-58
Kalembo	42	42	6,368	25,972	15,868	3,769	12,116	11,762	-354
Kankao	84	84	6,357	26,680	15,177	4,032	11,165	11,145	-20
Kwitanda	66	66	5,902	25,735	15,013	7,670	8,323	8,425	102
Mbera	183	183	11,556	51,130	29,081	7,805	21,264	21,078	-186
Mwima	59	59	6,199	23,603	14,929	4,185	10,752	10,377	-375
Namanolo	31	31	7,247	34,153	21,344	6,616	14,226	13,725	-501
Nandumbo	28	28	4,274	18,338	11,174	3,332	7,937	7,510	-427
Phalula	64	64	5,517	23,996	14,399	4,965	9,420	9,357	-63
Phimbi	81	81	5,859	24,039	13,761	4,265	9,507	9,457	-50
Ulongwe	26	26	3,572	15,483	8,958	3,813	5,146	5,115	-31
Utale 1	35	35	3,808	15,836	9,397	2,885	6,686	6,561	-125
Utale 2	39	39	3,928	17,211	9,929	2,635	7,404	7,320	-84
Total	**905**	**905**	**93,156**	**401,288**	**237,849**	**79,423**	**158,805**	**154,230**	**-4,575**

Table 11: Final distribution data per week/Health Center

		Nets Distributed							
		Week 1	Week 2	Week 3	Week 4	Week 5	Week 6	Mop-up	Total
1	Balaka HC	0	0	0	6,580	11,700	590	7,458	**26,328**
2	Chiyendausiku	0	0	0	6,070	0	0	0	**6,070**
3	Kalembo	9,278	0	0	2,083	0	366	35	**11,762**
4	Kankao	0	0	10,966	0	0	53	126	**11,145**
5	Kwitanda	0	0	2,881	5,480	0	0	64	**8,425**
6	Mbera	0	0	0	19,033	0	0	2,045	**21,078**
7	Mwima	8,288	1,815	0	0	0	0	274	**10,377**
8	Namanolo	0	12,808	0	0	0	0	917	**13,725**
9	Nandumbo	7,510	0	0	0	0	0	0	**7,510**
10	Phalula	0	9,097	0	0	0	36	224	**9,357**
11	Phimbi	0	4,105	5,127	0	0	0	225	**9,457**
12	Ulongwe	5,115	0	0	0	0	0	0	**5,115**
13	Utale 1	0	0	6,020	0	0	0	541	**6,561**
14	Utale 2	0	0	7,320	0	0	0	0	**7,320**
	Total P/ Week	**30,191**	**27,825**	**32,314**	**39,246**	**11,700**	**1,045**	**11,909**	
	Grand Weekly Total								**154,230**
	Grand Total								**154,230**

Challenges and lessons learned

Registration

The HSAs complained about the one week period for beneficiary registration that was assigned for the exercise since there was no uniformity in the number of allocated villages per HSA. This was reflected in the accuracy of the data collected by the HSA, as some were rushing to complete the assignment within the given time, resulting in a higher number of errors either through duplication or completely missing some beneficiaries.

Chieftaincy wrangles also influenced the registration process as some beneficiaries who challenged the legitimacy of the leader were skipped during the initial registration. The majority of the cases were identified during the verification, as the local leaders could not influence the verification staff, and the necessary data corrections were made.

Verification

During the verifications, the community members played an important role by pointing out the beneficiaries skipped during the roll call as well as indicating the beneficiaries called out that no longer resided in the village.

The other strength of the roll calling during the verification was that whenever the data collected during registration was different from what the communities perceived, the issues was raised and the beneficiary could be taken to task to justify. Whenever the community disagreed with the justification, they were advising and recommending the verification team members on the total number of the nets the household should get. This improved transparency of the net distribution process.

Cluster allocations

In the future, allocation of villages to clusters should be verified during the collection of the registration forms from the HSAs in order to assure that villages are allocated to the closest cluster (or with easiest access). This will keep HSAs from grouping the villages according to their personal convenience instead of the beneficiaries' and prevent the latter from requesting cluster changes during the verification.

It was perceived that villages without a permanent HSA were allocated to clusters according to the HSAs preference in order to keep them from travelling to remoter villages during both the verifications and distributions.

Data entry

The planned timeframe for data entry was considered short by the data clerks whom ended up making errors while trying to work at a faster pace. This led to delays due to time spent rectifying the errors detected during the verification process.

These errors affected the normal delivery of our services and contributed to some initial suspicion from the communities when confronted with incomplete or incorrect verification lists.

Distribution

During the distribution the major challenges had to do with logistics. The insufficient number of vehicles available for the exercise caused delays, with the same vehicle being used both for nets and staff transport.

Reporting

The above-mentioned challenges, in particular the issues related with data entry, influenced the timely report writing, as the figures obtained from the database didn't always match the registers.

Recommendations

In order to prevent the recurrence of data errors a dedicated data official should be assigned to manage all project data. With multiple data entry clerks splitting tasks, the lack of a dedicated and specialized data official/supervisor created challenges, making it difficult to timely trace the errors made during data entry and printing. The data officer should be in charge of managing the database, crosscheck it with the raw data and make required information available in a timely manner at the Project Manager’s request.