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#### EVALUATION OF THE MALARIA COMMUNITY CASE MANAGEMENT PROGRAM, OLD MUTARE, WARD 23, MUTASA DISTRICT, ZIMBABWE

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#### Abstract

The Malaria Community Case Management (MCCM) program serves to improve access to health services in hard to reach and underserved communities through the use of village health workers and school health coordinators. They mainly educate, test and treat. This was introduced in Zimbabwe after the Alma Ata declaration of 1978, which underscored the role of primary health care in achieving health for all. A descriptive cross sectional was used to do the evaluation in Old Mutare, Ward 23 Mutasa district in the eastern province of Manicaland in Zimbabwe. VHWs and some community members were interviewed about the MCCM. Key informants from the provincial office and health facilities were also interviewed. The MCCM programme in Old Mutare was implemented by trained VHWs (83.3% female) who had strong malaria knowledge and enabled high community awareness, improved prevention practices, and better health-seeking behaviour. Case management outcomes were most evident for uncomplicated malaria through effective assessment, RDT testing, treatment, referral, and reporting. However, MCCM utilization was constrained by insufficient functional VHW coverage across villages (57.1% of estimated need), VHW absenteeism, and stock-outs/limited availability of essential commodities and supplies. In addition, transient and hard-to-reach populations—especially artisanal miners—reduced service uptake and limited the programme's overall access and impact. Strengthening supply chains and supervision, scaling up VHW coverage near artisanal mining sites, and reintroducing school health coordination are therefore critical to sustain and optimize malaria control gains in Ward 23.

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**Introduction:-**

Achieving healthy communities is a forever present burden on our leaders but it requires effort from all sectors and the community members. After the Alma Ata declaration of 1978, the role of primary health care in public health was seen to be key in attaining health for all [1]. Primary health care's goal is to have health services accessible to the whole populace, and community-based health workers (CBHWs) are central to attaining this. History of CBHWs dates back to the 1800s and these cadres are the first line health care workers mainly in rural areas [2]. In Zimbabwe, the most common CBHWs are Village Health Workers (VHWs) and as the name suggests they are a bridge between health facilities and villagers in the rural areas. The main aim of the VHWs is to improve health related matters in their communities. This is done by giving health education and promotion, advising on prevention and control of diseases, diagnosis and treatment of some ailments, referral of patients to clinics and monitoring the community's health risks amongst other things. Malaria is one of the diseases the VHWs are trained to test and treat through the Malaria Community Case Management (MCCM) program introduced by the Ministry of Health and Child Care (MoHCC) in Zimbabwe. Malaria is a potentially life-threatening disease characterised by fever, headache and chills. It is caused by an infection with *Plasmodium* parasites transmitted by *Anopheles* mosquitoes. The VHWs are given malaria rapid diagnostic test kits, antimalarial drugs and other consumables. This means ideally in Zimbabwe's rural areas, it's expected to find most uncomplicated malaria cases being handled at VHW level.

The MCCM program has been seen to work well by providing early access to treatment which will be closer to patients and thus ameliorating numerous challenges sick members of the community would encounter whilst accessing health services. To ensure this program runs smoothly the VHWs are trained well by senior nurses in their districts and also receive refresher trainings almost biannually. This study serves to evaluate the MCCM program carried out by VHWs in Old Mutare, Mutasa District, Manicaland province so as to learn from the strengths of the program and also discover some weaknesses that will present avenues of improvement. The MCCM program was introduced by the MoHCC to improve access to health services in hard to reach and underserved communities. The program is meant to be carried out by VHWs and school health coordinators. VHWs have significantly expanded health service coverage to those living in malaria endemic areas. Malaria is a significant public health burden across the globe with approximately 263 million recorded cases that resulted in 597 000 deaths in 2023. Africa carries the bulk of this burden, accounting for 94% of this global case load. Zimbabwe recorded 636 000 cases during 2023 [3].

In Zimbabwe, the Village Health Workers were introduced in April 1981 to support primary health care and universal health coverage. VHWs have been given the mandate to test and treat malaria in rural areas. VHWs are considered to be key health care workers in hard to reach areas. A good health workforce is key to this delivery system. Globally, there has always been a shortage of health workers. Zimbabwe reportedly had 8 core health workers per 10,000 populations in 2015 against the WHO's recommended 23 per 10,000 populations [4]. Brain drain from migration of workers across all sectors especially health is often cited as the major contributory factor to the shortage [5]. It is estimated that by 2030 the health workforce needed will be 84 million with a shortfall of 18 million to achieve universal health coverage [6]. This study has focused on the role of VHWs in managing malaria cases in their communities. The MoHCC aims to have at least one VHW in each village and approximately 60% of villages are covered [7]. Each village is approximated to have around 100 households. In Zimbabwe, VHWs go through an initial eight-week training (theoretical and practical) followed by biannual refreshers or when need arises. They are supervised by the sister in charge at their nearest health facility to whom they submit weekly reports. VHWs work on a voluntary basis and are supposed to get a quarterly allowance of US\$ 42 but these are erratic [8].

Communities have seen increased access to healthcare and better health consciousness through VHWs [9-11]. The VHWs receive training to carry out testing and treating rapid diagnostic test (RDT) positive patients. Patients get quick accessible treatment and this also reduces the load of patients on health facilities in malaria prone areas [8] like Mutasa district in Manicaland. However, VHWs are not a panacea for underperforming health systems but they have a special niche that buttresses functional and supportive systems [12]. Since the inception of VHWs programs there has always been challenges like inadequate funding, training, supervision and evaluation; also lack of political commitment since some were ignorant to their importance and regarded them as second-class care givers and temporary [13]. This resulted in the outright failure of the programs in some countries. There has been no formal evaluation to measure the impact of VHWs' role in malaria management in Zimbabwe but their contribution to primary health care initiatives is clear. This study was carried out to evaluate the Malaria Community Case Management program in Old Mutare, Mutasa district, so as to get information on its effectiveness, strengths and possible areas that need assistance.

This evaluation aimed to evaluate the effectiveness of the MCCM program in Old Mutare, Mutasa district by establishing the reasons for low uptake of the program, assessing the recruitment criteria and training of VHWs. It will also assess the adequacy of inputs, identify the outcomes and assess community knowledge and utilization of the MCCM program. Malaria is a health burden in Zimbabwe which killed 317 people in 2023 [3]. MoHCC works to lessen this burden by efforts in prevention, control and treatment. Introduction of MCCM program was meant to bring malaria care closer to the people who mostly need it but if VHWs are seeing lesser patients, this means that sick individuals are travelling longer distances to access health care. This delays treatment, introduces consultation fees and may result in some cases progressing to severe malaria. This study hopes to uncover reasons behind patients opting to go to health facilities rather than their VHWs. An evaluation into the program will help identify strengths and weaknesses of the program and thus be able to learn from them. The findings will be used to come up with recommendations to improve the effectiveness of the MCCM program. This will benefit the health delivery system and the community at large.

### **Methodology:-**

This study was done in Old Mutare, Ward 23 Mutasa district in the eastern province of Manicaland in Zimbabwe. It is located about 30km north of Mutare City which is the province's capital city. According to ZimStat 2022 projected population estimates, Ward 23 has an estimated population of 8065 people across 2061 households with an average household size of four people and an estimate of 589 children under 5 years. The main economic activities in this area are agriculture, artisanal mining and vending. The area has two health facilities which are Premier clinic and Old Mutare Mission hospital. VHWs in the Old Mutare area were interviewed. Old Mutare Mission hospital catchment area has 10 villages so is expected to have at least 10 VHWs and Premier clinic has six villages so is expected to have at least six VHWs. The Provincial Nursing Officer (PNO), The Provincial Expanded Program on Immunization Officer (PEPIO), Nurses in Charge, Environmental Health Technicians (EHTs) and nurses at the health facilities were the key informants.

106 community members were interviewed about their knowledge and utilization of the MCCM. A descriptive cross sectional was used to do the evaluation. Interview administered questionnaires and focus group discussions will be held with the VHWs and Key Purposive sampling will be done for healthcare workers. Informant Interviews with the Nurses in Charge at the 2 facilities, a VHW trainer and the PNO. Some community members will be selected randomly for interviews to determine the community utilization of MCCM. Permission was sought from the Provincial Medical Director's office to carry out data collection. Verbal consent will be sought from all participants in the study after explaining the purpose of the study. Confidentiality will be maintained by not mentioning names of participants. Privacy and confidentiality were maintained throughout the study.

### **Results:-**

#### **Demographics of VHW in Old Mutare**

The MCCM program in Old Mutare was being run by VHWs only and there were no school health coordinators (SHCs) in the Old Mutare area. Premier clinic had five functional trained VHWs and Old Mutare hospital had seven. There were four villages noted to not be practising MCCM because they did not have trained VHWs. Old Mutare area had 12 trained VHWs who were functioning, with 5 at Premier clinic and 7 at Old Mutare Mission Hospital. Ten of these were female (83%). The age ranges were from 34 to 62 and 33.3% of them were in the 50-59 years' age range. They had all reached secondary education. Their time in service under the MCCM program ranged from 4 to 23 years.

#### **Recruitment criteria and training for MCCM**

The VHWs in Old Mutare who were undertaking the MCCM program had all been trained and it was clear that a VHW would not start work before being trained. There were four villages that had selected their candidates for VHW but they were not taking part in any MCCM activities until they were trained. The trained VHWs had been trained for between 2 to 4 weeks at a clinic in the district but for most it was at Sherukuru clinic. After training they were all attached at a clinic in their village for 1 to 3 weeks and had all received from 3 to 10 refresher courses. All the 12 VHWs met the selection criteria recommended by the MoHCC which are:

1. Chosen by the community
2. Resident of the village
3. Able to read and write
4. Aged 25 years and above

5. Interested/passion in health issues
6. Exemplary in issues of health and hygiene
7. Able to communicate/ strong communication skills
8. Respectable
9. Able to observe confidentiality
10. Committed to work on voluntary basis
11. Approachable person
12. Organized person
13. Mature individual

VHWs' malaria knowledge level was assessed based on the number of correct questions answered using a three-point Likert scale where 0-2 correct answers =poor knowledge, 3-5 =Fair and 6+=Good. Among 12 VHWs, malaria knowledge was high: all (100%) correctly knew what malaria is, its transmission, prevention/control, signs of uncomplicated malaria, how to calculate treatment regimens, risk factors, and how to use RDTs. Only slightly fewer knew VHW roles in MCCM (91.7%), when to refer (91.7%), and how to identify groups at risk (83.3%). Knowledge was lowest for severe malaria signs/symptoms (83.3%).

### Inputs for the MCCM program

The MCCM program requires the VHWs to be given resources by the health facilities closest to them to be able to carry out their work. Table1 below, is showing the resources they are supposed to have and whether they had them at the time of the evaluation.

**Table 1:-** Inputs of the MCCM program.

INPUT	IN STOCK	COMMENT
<b>Equipment and Supplies</b>		
RDT kits		
Thermometer	<input checked="" type="checkbox"/>	Some ran out of batteries
MUAC tape	<input checked="" type="checkbox"/>	
Salter scale	<input checked="" type="checkbox"/>	
Latex Gloves	<input checked="" type="checkbox"/>	
Cotton wool	× <input checked="" type="checkbox"/>	Even the health facilities were in short supply
Sharps box		
Plastic bin	× <input checked="" type="checkbox"/>	Usually improvise my using a box
Methylated spirit	×	Even the health facilities were in short supply
Plastic paper		
Sanitizer/ Disinfectant	<input checked="" type="checkbox"/>	
Plastic apron	<input checked="" type="checkbox"/>	
Torch	× <input checked="" type="checkbox"/>	A few had but had no batteries
Bicycle		Not functioning because they need repair
Communication gadgets and airtime	× <input checked="" type="checkbox"/>	
Raincoat/Work Shoes/Gumboots	×	Hard to travel during the rainy season which is the malaria peak season
VHW Uniforms		
<b>Medicines</b> <input checked="" type="checkbox"/>		
Coartmeter, all strengths	partly	Some VHW had 3x6 and others had 4x6 only. Even the facilities did not have all strengths. There was a 2-week period during malaria outbreak where they ran out and the health facilities also had short supply so couldn't share.
Rectal Artesunate	×	Not available even at the health facilities
Paracetamol or Aspirin	×	Not available even at the health facilities
<b>Stationery</b>		
Treatment schedule		
Pencils and paper	<input checked="" type="checkbox"/>	Supplying themselves
Day book	<input checked="" type="checkbox"/>	
Monthly report form	<input checked="" type="checkbox"/>	Not photocopied well, so some sections were not

INPUT	IN STOCK	COMMENT
		showing
Malaria health education materials		
MCCM Manual	<input checked="" type="checkbox"/>	
RDT/Malaria medicines register	<input checked="" type="checkbox"/>	
Referral slips	<input checked="" type="checkbox"/>	

The MCCM program was receiving ample support and supervision from the health facilities. Weekly checkups when the VHWs send their reports and monthly in person meetings. There are also refresher trainings done, with the most recent one having been done in 2024 where they were also given MCCM manuals.

### Outcomes of the MCCM program

The role of the MCCM program was evident in the Old Mutare area and the following were the outcomes of the program that the VHWs were undertaking:

Increased usage of malaria prevention and control methods such as spraying (indoor residual spraying), long-lasting insecticide-treated bed nets (LLINs), coils and repellents. Although Ward 23 (Old Mutare) did not reach the 95% national IRS target, the ward achieved an optimal IRS coverage of 90% which is above the WHO recommended 85% impact level. The VHWs have advised the shop owners to stock coils and repellents because these are some of the prevention preferred by some of the populace for example artisanal miners and vendors.

Increased awareness on malaria. The evaluation showed that the community had high awareness about malaria in general since it is a disease that has been upon them for long. All (n=106, 100%) community members interviewed knew that malaria was treatable, how malaria was transmitted, the signs and symptoms of uncomplicated malaria mainly fever, headache, weakness and chills. However, there was poor knowledge on the symptoms of severe malaria. All participants had good knowledge on prevention methods.

Increased uptake of environmental methods of preventing malaria like clearing grass from yards (n=65, 61%). The 39% remaining were mostly artisanal miners.

The VHWs were sufficiently knowledgeable on patient assessment to recognize signs and symptoms of malaria, testing and diagnosing symptomatic individuals with an RDT and treatment of those who test malaria positive with the right dosage regiment. Explaining to people how to take treatment correctly and the importance of completing the malaria treatment course

General health seeking behaviors in the community increased by encouraging people to seek treatment soon after developing a fever

Referring patients who do not improve or who worsen after starting treatment to the health facility and giving pre-referral treatment and referring patients who present with severe malaria

Recording and reporting all malaria cases in a complete, accurate, and timely manner

Maintaining stocks of their RDT kits and antimalarial drugs

The MCCM program had seen some myths that the community had about malaria being busted by the VHWs engaging people. Some of the myths were believing that eating raw food gives malaria, chilli peppers heal malaria and that IRS increases mosquitoes that enter the house.

### Community knowledge and utilization of the MCCM program

The study showed that the community has high awareness of the MCCM program with 83% (n=88) of community members questioned indicating they knew about the program and also where their VHW resided. Some of the community members even mentioned that when they feel malaria symptoms they go to the VHW but when they think it's not malaria that's when they would come straight to the clinic. The reasons for the high knowledge of the MCCM is because most of the VHWs were chosen by the community so they are aware of them and how they serve the community. The community also showed high awareness about malaria since it is a disease that has been upon

them for long. Knowledge on how malaria was transmitted was 98% and 100% of participants knew that malaria could be treated. All participants knew some of the signs and symptoms of uncomplicated malaria mainly fever, headache, weakness and chills. However, there was poor knowledge on the symptoms of severe malaria. All participants had good knowledge on prevention methods and residents were utilizing some of the methods like coils, repellents, IRS and ITNs. Community members were also taking part in clearing environmental factor which increased malaria risk like cutting grass and clearing stagnant water sources close to their homes. However, there was resistance to these environmental prevention methods from the artisanal miners because they felt like it would eat up their time.

#### **Reasons for low uptake of the MCCM program**

It was noted that out of the 16 villages in the catchment of Premier Clinic and Old Mutare Mission hospital, only 12 had functioning VHWs. The other four villages did not have trained cadres. The communities had selected some individuals but they were still awaiting training. People in these four communities were all reporting to the nearest health facility because they did not have VHWs. Though some villages had a VHW, that one VHW was not enough to cover the whole village. Grange A and Premier Central were reporting have populations of more than 800 people. Some VHWs were located too far from where most of the people were located, though being in the same village. This was made worse by the presence of artisanal miners who were scattered along the Mutare river in Premier Central but this was now further away from the VHW who was located where most of the original community members resided. The community had raised this problem with the community leaders but due to some political interference there were no changes made.

It was noted that the community members would sometimes resort to visiting the clinic because the VHW would be absent when they would visit their household. In some cases, the absence was very frequent due to VHW running other business that would take them away from their station like farming, dealing in gold and vending. This is expected because they also need to make a living since they have very low allowances of US\$42 a term from the MoHCC. Once the community especially the artisanal miners experienced this repeated absence they would prefer to go to the clinic which they know will always be open, and the word would go around. The artisanal miners will not want to lose any time away from their work stations because of fear of their peers stealing from them, so they will just head straight to the clinic. The community also showed high satisfaction with the malaria care they got from the health facilities because of prompt service and being attended to nicely, but since the VHW would be at their home they may delay attending to a patient while they finish doing something personal.

In one village, some artisanal miners shared that they do not go to the VHW for health care because the VHW segregates them because they do not deal gold with that VHW. Whenever they would go to seek healthcare, the VHW would tell them that she/he does not have any resources to test or treat them whilst they would be treating others. In some few cases, the villagers would not go to the VHW because of personal differences they had with them. Old Mutare area has many transient individuals like artisanal miners, boarding scholars and merchants. These individuals are not originally part of the community so will not be aware the MCCM program or even the location of the VHW. Artisanal mining had increased due to the gold rush that was exacerbated following closure of one big mining firm that had been operating in the area. Workers retrenched from the firm, local residents and migrants from other areas took over the mine dumps and ore. In the case of boarding scholars they visit their schools' health facilities.

During the time of this study, the Old Mutare area was experiencing a malaria outbreak. Due to the outbreak, there was a period of 2 weeks where resources were depleted and the VHWs ran out of antimalarial drugs. The VHW would have a test kit but if an individual tested positive they would then refer them to the health facility to get medication. This frustrated the community so once word goes around that the VHW doesn't have enough resources people will then just resort to going straight to the facility. Another reason for low numbers in MCCM, could be the VHWs not recording all the cases they receive leading to incomplete records. Some VHWs also report their data late to the facility which then messes with the longitudinal monitoring of malaria cases.

#### **Key informant findings**

Nine key informants were interviewed, comprising of PNO, PEPIO (who is also a trainer of VHWs), two Nurses in Charge, two EHTs and three nurses at the two facilities. Thematic analysis was used to comprehend their responses. The prevention methods being used by the community and were to be working were early treatment, health promotion, IRS, larviciding, coils, repellent lotions and environmental. The VHWs had asked shop owners in their

areas to always stock mosquito coils and repellents since they were the methods that had been noted to be used by most of the community.

The key informants had knowledge of some villages not having VHWs and had been continuously engaging community leaders to hold meetings to choose their VHWs. Though this was quite urgent especially because of the need to have malaria care close to the communities during the malaria season, key informants could only encourage the process to be done quickly. The community has a very good health seeking behavior but usually rush to clinic because of the reasons stated above.

Suggested improvements were to increase number of VHWs in some villages like Premier Central which has a special population of artisanal miners which are located far from the community VHW. Minimizing political interference in selection and also encourages the community to be guided by the criteria list. The MoHCC should try to take up suggestions on malaria control given by the community so as to instill a sense of ownership and also trust the MCCM program.

### **Discussion:-**

Although Old Mutare did not reach the 95% national IRS target, the ward achieved an optimal IRS coverage of 90% which is above the WHO recommended 85% impact level. However, with artisanal mining going on, the benefits of IRS are minimised as even local residents now spend most of their time engaging in early morning or late-night activities such as artisanal mining and vending. Artisanal mining involves lots of physical labour, thus with Old Mutare having a hot and humid climate, artisanal miners do not wear clothes that cover their whole body when engaging in early morning or late-night activities thus exposing them to mosquito bites. Most artisanal miners and vendors sleep in houses made of poles and plastic, tents and wooden cabins that have openings that allow entry of the malaria vector. The Artisanal mining and associated activities end up underestimating MCCM program effectiveness.

The study revealed that the community had good malaria knowledge levels and this was attributed to the community sensitisations and health education done partly by the VHWs. However, our findings were contrary to Kureya et al. [14] in Chipinge, where most cases had low levels of knowledge on malaria. This difference in our findings could be attributed the different livelihood means in these set ups. Despite the community having good knowledge on malaria transmission in Old Mutare the need for a livelihood continuously drives them to artisanal mining where they have prolonged exposure to the malaria vector. Some of the challenges faced by VHWs were high patient load especially because of the malaria outbreak, lack of adequate compensation, limited drugs and supplies which is similar to a study done by Banek et al, 2015. During the evaluation, the VHWs expressed that they felt demotivated due to limited support from the health system.

Some essential resources for the MCCM program were not available at the time of evaluation and there was also reports of even running out of Coartem at some instances. If the requisite input resources are not available, then the low uptake of the program will be due to lack of support from the district or MoHCC at large. Logistical issues such as stock-outs of essential medicines and diagnostic tools can severely limit the ability of CHWs to provide timely care (Wesangula et al., 2014). The IPT program in Sanyati District had inadequate inputs; not all processes were achieved and, most of the program outputs were not met as most clients who were eligible.

MCCM has been shown to significantly improve access to malaria diagnosis and treatment, particularly in rural areas where healthcare facilities are scarce. Studies indicate that training community health workers (CHWs) to diagnose and treat malaria can lead to timely interventions, reducing morbidity and mortality rates associated with the disease. For instance, a study conducted in Uganda demonstrated that the implementation of CCM led to a 30% reduction in malaria-related deaths among children under five years old [15]. Similarly, evaluations in Zimbabwe have reported increased access to artemisinin-based combination therapies (ACTs) through community health initiatives, which have been pivotal in managing malaria cases effectively [16].

According to ZimStat 2022 projected population estimates, Ward 23 has an estimated population of 8065 people across 2061 households with an average household size of four people and an estimate of 589 children under 5 years. If the intention is to have 1 VHW per 100 households that means Old Mutare should be having at least 21 VHWs but the evaluation showed that there were only 12 trained and functional VHWs which is just 57.1% of what is sufficient for the area. The lack of SHCs in the area also makes the situation worse. A study in Zambia, showed

that scaling up malaria service points through MCCM from 43 to 4503 in a 5-year period was associated with a 19% reduction in severe malaria admissions among children under five (incidence rate ratio [IRR] 0.81,  $p < 0.001$ ) and 23% reduction in malaria deaths among under-fives (IRR 0.77) [17]. These results support the continued investment in MCCM scale-up in similar settings, to improve access to malaria diagnosis and treatment.

Community engagement is a crucial component of successful CCM programs. Studies have shown that when communities are actively involved in malaria prevention and treatment efforts, the uptake of services improves significantly. For example, a study in Benin found that community mobilization efforts led to increased demand for malaria testing and treatment, resulting in higher treatment rates among children [18]. Health education initiatives that inform community members about the signs and symptoms of malaria, as well as the importance of seeking prompt treatment, are essential for enhancing the effectiveness of CCM [19]. Continuous monitoring and evaluation (M&E) are vital for assessing the impact of CCM programs and identifying areas for improvement. Effective M&E frameworks can help track health outcomes, service delivery, and community engagement levels. For instance, the implementation of a robust M&E system in Malawi allowed for real-time data collection, which informed program adjustments and improved service delivery [20]. Similarly, evaluations in Zimbabwe have emphasized the importance of data-driven decision-making to enhance the effectiveness of CCM interventions [16]. The evaluation of malaria community case management reveals a multifaceted approach to combating malaria in resource-limited settings. While MCCM has demonstrated effectiveness in improving access to care and reducing malaria-related morbidity and mortality, challenges such as stock outs of essential resources persist. Addressing these challenges through enhanced training, robust supply chains and active community involvement will be crucial for the sustainability and success of MCCM programs. Furthermore, implementing comprehensive monitoring and evaluation frameworks will ensure that these programs can adapt to changing epidemiological patterns and continue to meet the needs of the communities they serve.

### Conclusion:-

Malaria Community Case Management (MCCM) of malaria has emerged as a critical strategy in the fight against malaria, particularly in resource-limited settings. This evaluation discusses the effectiveness, challenges, and outcomes of the program. The MCCM program in Old Mutare is not performing well because of insufficient VHWs, malaria care resources and presence of the special population of artisanal miners. When it is assessed against the original residents of the area it is doing better, however, due to the rampant artisanal mining activities being done in the area there has been an influx of miners whom may downplay its effectiveness. In transient communities like Old Mutare with artisanal miners, boarding scholars and farmers the people are always changing so there is possibility that the community may not know the VHW so they don't make use of them. Another thing noted was that when one individual would have a bad experience at the VHW like absence the word would travel fast and people would be quick to resort to the health facilities.

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