USAID
FROM THE AMERICAN PEOPLE

Ms. Carrie Foti
Catholic Medical Mission Board
10 West 17th Street
New York, NY 10011

September 30, 2009

Reference: Malaria Communities Program RFA: USAID M/OAA/GH-09-252

Subject: Cooperative Agreement No. GHS-A-00-09-00007-00

Dear Ms. Foti

Pursuant to the authority contained in the Foreign Assistance Act of 1961, as amended, the U.S. Agency for International Development (USAID) hereby awards to the Catholic Medical Mission Board (CMMB) hereinafter referred to as the "Recipient", the sum of $1,447,709 to provide support for a program in Zambia as described in the Schedule of this award and in Attachment B, entitled "Malaria Communities Program."

This Cooperative Agreement is effective and obligation is made as of the date of this letter and shall apply to expenditures made by the Recipient in furtherance of program objectives during the period beginning with the effective date September 30, 2009 and ending September 29, 2012. USAID will not be liable for reimbursing the Recipient for any costs in excess of the obligated amount.

This Cooperative Agreement is made to the Recipient on condition that the funds will be administered in accordance with the terms and conditions as set forth in Attachment A (the Schedule), Attachment B (the Program Description), Attachment C (Branding Strategy and Marking Plan), Attachment D (Standard Provisions), and Attachment E (Initial Environmental Examination), all of which have been agreed to by your organization.

Please sign the original and all enclosed copies of this letter to acknowledge your receipt of the Cooperative Agreement, and return the original and all but one copy to the Agreement Officer.

Sincerely,

Jamie Alissa Beck
Agreement Officer
USAID

Attachments:

A. Schedule
B. Program Description
C. Branding Strategy & Marking Plan
D. Standard Provisions
E. Initial Environmental Examination

ACKNOWLEDGED:

BY: _____
TITLE: _____
DATE: _____

Attachment B
PROGRAM DESCRIPTION

1. Program Strategy and Technically-Appropriate Interventions

The 2006-2010 Zambia Malaria Control Strategic Plan (ZMCSP) emphasizes a rapid scale up of integrated malaria preventive activities. The aim of the rapid scale up is to reach at least 80% coverage of core preventive activities in order to dramatically impact on the burden of disease due to malaria by 2010 that can contribute to economic growth. CMMB aims to integrate its BCC/demand generation community mobilization activities with the aforementioned partner's clinical and ITN distribution activities to ensure a fully-linked malaria control program in line with the MOH Strategic Plan. CMMB will also carry out training of CHWs and sensitizing households on how to identify danger signs in children under 5 and make prompt referrals to health facilities for treatment in the MCP project.

Goal: Prevent malaria-related mortality and morbidity in Luapula Province through a community-based facility-linked prevention and treatment program.

Objective 1. Increase % of children under-five and pregnant women who are appropriately utilizing an ITN from baseline percentages (TBD) to 85% by October 2012 in targeted communities.

Objective 2. Increase the % of pregnant women receiving 2 or more doses of IPTp according to national guidelines to 85% by Oct 2012.

Objective 3. Increase the % of children under-five suspected or diagnosed with malaria to receive timely treatment with ACT to 85% by Oct 2012.

Because of the intense work that will be involved in training and mobilizing communities, the implementation of our MCP will be done in phases using constituencies as geographical areas of implementation. Each district has 3 constituencies and there are 20 wards per each constituency. Through simple random sampling, we have selected one constituency from each targeted district (Pambashe in Kawambwa, Chifunabuli in Samfya and Chipili in Mwense) which will be activated in year one. In year two we shall add all the constituencies in all the 3 districts such that by end of 3 years all the districts will be implementing MCP.

The number of villages and households differ per each constituency and respective wards. Based on the 2000 census by the CSO[i] there are a total of 1,512 villages in the 3 targeted districts: 658 in Samfya, 415 in Kawambwa and 439 in Mwense. However the head counts by NHCs and DHMTs are often higher than the data provided by CSO. Our strategic direction is to group the villages into units of around ten villages to be placed under 2 mentors or trainers of CHW, and four CHW will be trained to mobilize and engage communities in the activities outlined below. CMMB strongly believe that this strategy will strongly influence ownership of the MCP from the onset.

District	Samfya	Kawambwa	Mwense
Villages	658	415	439
Clusters/Units	66	41	44
CHWs trained	264	164	176

Each village has approximately 93 households with about 5 members per household (per communication by the CMMB Zambia Office with the CHIs implementing MTA in the targeted districts). Therefore there are approximately a total of 151 units composed of 10 villages in the targeted districts in which CMMB will implement the MCP activities.

Due to the fact that the three districts have low uptake of malaria prevention and control activities, CMMB expects that the coverage of ITN, IPT, and ACT for under 5 will be markedly lower than the average for Luapula province. As part of CMMB's scientific and comprehensive approach to

ensure full coverage from baseline to the 85%+ for the objectives of the project, CMMB will carry out a cluster survey (10 sites in each district for a total of 30 sites) to determine the actual percentage covered and scale-up activities accordingly. Consequently, the exact numbers of beneficiaries are not known, but rather estimated, and the focus of the project remains to ensure full coverage of 85%+ for the aforementioned activities for the target populations in the three districts.

Activities to Realize Objective 1 through 3

The cornerstone of this MCP project is centered around community mobilization and dissemination of education to raise awareness as well as carrying out behavior change communication (BCC) activities with the local population to increase demand and uptake of malaria services. As mentioned in the Project Context, CMMB will provide linkages to MOH, CHAZ, and other collaborating entities for the distribution of ITNs, the provision of IPT at the clinics (during the ANC visit), and the treatment of children diagnosed with malaria as appropriate. However, the BCC materials and the community-based system of CHW support and awareness campaigns are what will drive the uptake of such existing services and create a culture of prevention and control of malaria in the Luapula province. CMMB's MCP initiative supports the national health priority of improving capacity of community-based infrastructure, especially community health workers (CHWs) by developing training in malaria, providing supportive supervision, and assessing their performance. CMMB will not hire or create another cadre of CHWs with the sole purpose of malaria control or working under this MCP program. On the contrary, CMMB will work with the MOH, CHAZ, and all local NGOs with CHW programs to unify their efforts on malaria control and integrate the MCP community component into their CHW programs. The output from this exercise will be development and availability of the following training manuals/protocols:

a) Training guidelines for training of mentors and trainers of CHW,
b) Training manuals for CHW;
c) Clinical guidelines for CHW on identifying danger signs and symptoms of malaria in children under 5 years and pregnant women;
d) Guidelines on management of malaria in children under 5 years and pregnant women at household level at community level;
e) Guidelines for re-treatment of ITNs by CHW
f) Guidelines for conducting BCC sessions on prevention of malaria to men women and children by community health workers;

Activities to Realize Objectives 1 and 2

a) Training of community mentors and community health workers (CHW)

The MCP will focus on improving capacity of community leaders and CHW in line with the MOH *Road Map for Accelerating the Attainment of the Millennium Development Goals Related to Maternal, Newborn and Child Health in Zambia: " Empowering and formalizing alternative human resources such as Community Based Agents, to improve access to health care delivery*[ii]**.** In meetings to prepare this proposal, the Luapula Provincial Health Office (PHO) expressed the view that Zambia's tradition of community volunteer involvement in health care has come under strain. The perception is that volunteers, first motivated by training opportunities, become increasingly de-motivated by a lack of supplies, transport difficulties, and the absence of incentives. In order to promote retention and motivation of CHW we shall institute a performance based community financing system in collaboration with the MCP Steering Committee (MCP-SC) that will be established (refer to section under management). This financing may include support to purchase bicycles, utility bags and protective clothing. The bicycles may be used as transport for other health related activities in addition to malaria MCP activities in order to contribute to overall health related outreach.

Using the training manuals developed under activity one, CMMB in collaboration with the 3 targeted DHMTs and associated CHI management teams will train community coordinators from NHCs and culturally revered community leaders, including chiefs, village headmen and tradition healers to train and mentor CHW in mobilizing communities, deliver BCC sessions and to facilitate distribution and retreatment of ITNs to villages and households. In the ongoing MTA program and prior experience in community mobilization programs, we have observed that if revered community

leaders are actively involved in the delivery of BCC sessions harmful social- cultural norms can be addressed effectively. Further, in rural areas men are more likely to listen to these community leaders, and because of the controlling power of men over women this can positively influence ownership and use of ITNs at household level. All available CHWs will be trained in addition to others who will be recommended by the mentors. In line with the strategic direction of organizing 10 villages into units supervised by 2 community mentors and 4 CHW to engage to conduct community mobilization and deliver MCP- BCC sessions, we shall train 70 community mentors and 140 CHW at 35 units during year one.

b) Community mobilization and participation

As noted above our MCP will build on the malaria prevention activities being executed by the existing NHCs, CHW and community based organizations working in these districts. Community mobilization will be essential to bringing preventive services to a broad community with a focus on the targeted population. As stated in the 2006- 2010 MCSP: "*The rapid scale-up of malaria control in Zambia will only prove successful if communities and individuals have confidence in and accept the prevention and treatment measures being implemented. Sustainability of these programs can be achieved through community empowerment*". Thus our proposed community mobilization and participation activities will focus on empowering people at both village and household levels. In our MCP community mobilization and participation the following activities will be emphasized:

i. Regular BCC sessions at villages to communities addressing the socio-economic and cultural beliefs that impede ownership and or results inappropriate use of ITNs at household level. This will involve interactive and iterative methodologies using tailored messages, developed as outlined, through a range of approaches to encourage sustained positive behaviors at individual and community levels. This will address the following:
   - The importance of children under 5 years to always sleep under an ITN. Some of the known myths in Luapula province that will be addressed regarding use of ITNs include: ITNs are not completely effective, that only white and blue colored ITNs may work, that the chemicals that are used in retreating ITNs can cause complications in children, and the attitude of misusing bed-nets for fishing at the expense of preventing malaria in children and pregnant women for immediate and temporary economic gain[iii];
   - The importance of pregnant mothers to always sleep under an ITN;
   - The benefits of prompt access to ACT for children under 5 years suspected of being ill due to malaria. Similarly, promotion of prompt treatment for pregnant women who are suspected to be suffering from malaria will also be emphasized;
   - The importance of taking at least two doses of IPT for pregnant women. This will be executed in concert with promoting early access to ANC services in order to ensure appropriate intake of IPT doses according to national guidelines;

   Activities for the MCP will also be integrated within the MTA project with the purpose of greater engagement and sensitization of men to prioritizing the use of ITNs to their children and wives (especially if pregnant) and to change the behavior from ignorance and apathy around malaria control to full engagement and ownership of their family's health and malaria-free future. This is because in rural Zambia men play a critical and influential attitude in the participation of health services by households, including prevention strategies and health seeking behaviors.

ii. Strengthening the referral system and treatment for children under 5 suspected/diagnosed with malaria. This will be accomplished by training community leaders and CHW in community clinical algorithms and protocols that will be developed as part of the activities under objective one. The protocols will help CHW identify and refer children under 5 years suspected to be suffering from malaria. As noted above CHW will be supported by the community leaders who will be trained as mentors or trainers to ensure follow up of children under 5 years in order to promote prompt (within 24 hours) access and adherence to ACT. CHW and their mentors will be providing regular messages and MCP- EBCC sessions in an integrated method as outlined in the next paragraph. Forms and registers will be developed as part of the M&E plan and will be used

to measure performance of the 2 way referral system that will be established with particular emphasis on referrals of under 5 children suspected or diagnosed with malaria.

The MCP- BCC sessions will be integrated to include messages on ownership and appropriate use of ITNs, IPTp, and recognition of danger signs due to malaria and promotion of prompt access to ACT for children under 5 years suspected and or diagnosed with malaria. Each unit of 10 villages will participate in a minimum of 2 of these sessions in addition to special campaign periods (such as child health campaigns) during the project life span. However, data collection and reporting on occurrence and outcome of pregnancies; number of children under 5 years treated for malaria; other relevant vital events regarding children under 5 years and pregnant women will done on a monthly basis. Based on quarterly analysis of this data we shall decide on additional MCP- BCC sessions to be allocated to a unit of 10 villages (refer to the section on M&E for a summary of critical indicators). In addition MCP BCC sessions will be conducted at health facilities once every two months during year one and quarterly during the last 2 years of the project's life span.

During all EBCC sessions at both health facility and village level, ITNs will be distributed as needed, re-treatment of bed nets will be done as well as random physical checks on households with children under 5 years and with pregnant women to determine household ownership and appropriate positioning of ITNs as part of monitoring and evaluation. All materials (ITNs and Insecticides for retreating bed nets), ACT and IPTp drugs will be provided by the health facilities under the ongoing regular static and outreach services support by MOH through NMCC and CHAZ. In addition, at all CHIs implementing the MTA program we shall integrate MCP- EBCC messages into all MTA EBCC activities. Based on our experience in implementing MTA and engaging communities in health programs we shall use a range of BCC methodologies that are participatory and iterative including role plays and focus group discussions in order to have a positive impact on behavioral change regarding malaria prevention and treatment.

Partnerships and collaboration with key stake-holders

CMMB will actively pursue collaboration with the MOH organs, community and non-governmental organizations active in each district that are involved in maternal and child health programs, HIV care and prevention services. CMMB shall collaborate closely with the local USAID Mission PMI team in a manner including but not limited to the following:

- The CHAZ and MOH through NMCC, the Luapula PHO and DHMTs will be part of the steering committee and will ensure that health centers and CHIs have adequate supplies: ITNs; ACT drugs; Long Lasting Re-treatment Chemicals (LLRC) such as K-O TAB 123® that are long lasting; and drugs for IPTp.
- CMMB shall work closely with the Luapula Foundation through their mobile VCT to ensure that men and women who test HIV positive have access to ITNs through appropriate confidential referral system that will also promote enrollment into HIV treatment and prevention services that are available at health centers and CHIs in the targeted districts. Luapula foundation will also be part of the MCP steering committee.
- The HCP will offer advice to the steering committee in designing and development or adaptation of existing I.E.C/BCC materials and strategies
- The USAID Mission PMI team will be sought as needed to provide technical support in all MCP activities that will also include monitoring and evaluation and dissemination of good practices to a large audience. CMMB shall also adhere to all the requirements of the USAD PMI local mission team as will be specified in cooperative agreement if we are awarded this grant.
- CMMB will also work closely with UNICEF during the special campaigns in promoting child health activities focused on malaria prevention in pregnant mothers and children under 5.

6. Performance Monitoring and Evaluation

The program M&E plan will include:

- Monitoring of malaria-related incidents per MoH facility records.
- Monitoring reports from community health workers
- Baseline, and final KAP surveys
- Integration of DHS 2007 and MIS 2008 markers like major causes of under-five mortality and malaria parasite prevalence.

KAP evaluations will identify the key behaviors to change by community, the main incentives/barriers to practicing these behaviors, and the factors determining ways audiences can be reached (language, literacy, community meetings, etc.). Indicators to be tracked in survey will include:

% change from baseline in knowledge of proper use of ITNs
% change from baseline in attitudes about "who" uses ITNs
% change in reported use of ITNs for pregnant women
% change in reported use of ITNs for children under-five
% community health workers correctly identify symptoms of malaria
% community health workers reported using ACT in past year

Indicators from Facility-based MoH Records:

% change in number of women accessing IPTp during ANC
% children under five with suspected malaria received ACT from CHW or facility-based provider

Indicators from CHW logs will include;

ITNs distributed by month
Pregnant women identified by household by month
children under-five identified by household by month
children under-five identified with symptoms of malaria by month.
community members given malaria-related health education (Talks, materials)

The data on malaria from the 2007 DHS and the 2006 MIS will be used as baseline before program implementation. Our continuous monitoring and evaluation will include monthly reports and quarterly analysis of data submitted by health facilities and CHW on activities to realize the objectives as outlined in the preceding section. We shall also be monitoring and evaluating performance of CHW and their mentors/trainers through qualitative measures such as completeness and timely submission of malaria community registers, quality delivery of MCP BCC sessions and comprehension by persons participating or exposed to these sessions. Below is a summary table of indicators that will be used to measure program effectiveness.