Building Community Capacity to Control Malaria in Central Malawi

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Country: Malawi

Annual Report on Year One

October 1, 2007 – September 30, 2008

Community drama about ITN usage in Dowa district

Christian Reformed World Relief Committee

In collaboration with:
Nkhoma Relief and Development

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TABLE OF CONTENTS

List of Acronyms and Abbreviations

ACT	Artemisinin-based Combination Therapy
ANC	Antenatal Clinic
BCC	Behavior Change Communication
CBO	Community-Based Organization
CCAP	Church of Central Africa, Presbyterian
CDC	Centers for Disease Control
C-IMCI	Community-based Integrated Management of Childhood Illness
CSSA	Child Survival Sustainability Assessment
CRWRC	Christian Reformed World Relief Committee
DHMT	District Health Management Team
FBO	Faith-Based Organization
GOM	Government of Malawi
HSA	Health Surveillance Assistants
IEC	Information, Education, Communication
IPT(p)	Intermittent Preventive Treatment (during pregnancy)
ITN	Insecticide Treated Net
LA	Lumefantrine Artemether
LLIN	Long Lasting Insecticidal Net
MCP	Malaria Communities Program
MOH	Ministry of Health
NGO	Non-Governmental Organization
NMCP	National Malaria Control Program
NRD	Nkhoma Relief and Development
PMI	President's Malaria Initiative
PSI	Population Services International
SP	Sulfadoxine-pyrimethamine
USAID	United States Agency for International Development

A. Main Accomplishments

CRWRC has accomplished a number of activities according to its work plan during this first year. The main accomplishment is that the CRWRC project has managed to bridge the gap between the clinical/hospital-based interventions and the local Malawian at the village level. The Project works with people in remote, hard to reach areas reaching them with relevant information and behavior change interventions.

There has been a series of trainings for CRWRC staff and program volunteers. The staffs were trained using the Designing for Behavior Change curriculum which was then reiterated to the Program Facilitators at their level in Chichewa, the vernacular language. The Program volunteers have been trained in basic issues of malaria, including how it is caused, how to prevent it, and the new treatment regimen of Lumefantrine Artemether (LA). Volunteers were trained on intermittent preventative treatment in pregnancy (IPTp), consistent use of insecticide treated nets (ITNs) and net re-dipping.

Below are some of the Project activities for the year in detail.

- Hiring of all designated staff members for the Malaria Project has been completed. The Project hired a Program Coordinator and Assistant Coordinator in December 2007. Program Supervisors were hired in February 2008, and they commenced their work immediately with their first activity being the Designing for Behavior Change workshop. An advertisement was run in local churches for Program Facilitators, who were successfully hired between March and April 2008.

- Supervisors and Facilitators were introduced to church ministers and elders in congregations in the operating areas in order to facilitate good cooperation and participation. This was done in March and April 2008. Local church ministers were emphasized as a priority during staff orientation, because they are strategically the Project's entry point for service.

- The program was then introduced to all operational districts through the District Health Management Teams in the six districts where CRWRC and NRD planned to implement the program in year one: Lilongwe, Dowa, Mchinji, Mangochi, Salima and Dedza.

- Recruitment of program volunteers has successfully been completed in all districts. The program recruited 1,320 volunteers in the communities. There has been a slight turnover on the number of volunteers due to effects of transfers and finding paid jobs in some instances. The current number of volunteers available on the ground is 1,290.

- Training on Designing for Behavior Change (DBC) was conducted with Supervisors, Coordinators, NRD general staff, and other PMI partners. During this training, a pilot barrier analysis survey was completed in one community for one behavior. Program Coordinators and Supervisors replicated the DBC training for Program Facilitators. At these DBC trainings, the newly hired Supervisors and Facilitators were also given general orientation to the program.

- A barrier analysis survey was conducted for all the four behaviors of our project in all five districts of operation. This barrier analysis was conducted on the four behaviors that are being promoted by the project, namely:
  1. Increasing the proportion of under-five children sleeping under ITNs;
  2. Increasing the proportion of pregnant women sleeping under ITNs;
  3. Early treatment seeking behavior for children under five years of age with fever; and
  4. Increasing the proportion of pregnant women taking the second dosage of sulfadoxine-pyrimethamine (SP) for IPT.

The results showed that there is high knowledge of perceived danger of malaria by both the care takers of under-five children and pregnant women. However, this knowledge is not translated into positive behavior practices. Most pregnant women do not access the second dose of SP because visits to the antenatal clinic are usually commenced very late in the second trimester; thus only one dose is usually received before delivery.

Karen Fogg of CSTS+ visited the program in August 2008

Project Objectives	Indicators & Current Measurements	Key Activities	Status of Activities & Outputs Achieved	Comments
Strategic Objective 1: Strengthen and sustain community capacity for malaria prevention and treatment interventions.	Number of community groups formed Year 1 Target: 88 Year 1 Actual: 88 Number of volunteers reaching other community members with information on malaria prevention and treatment Year 1 Target: 1,320 Year 1 Actual: 1,290 Number of households participating in the program Year 1 Target: 13,200 Year 1 Actual: 4,584	Recruit 22 Malaria Program Facilitators.	22 Facilitators recruited.	
		Train 22 Facilitators in community mobilizing, the DBC Framework, and M&E.	22 Facilitators trained.	All facilitators were trained in DBC framework in May 2008
		Conduct barrier analysis and analyze results to develop behavior change strategies.	4 surveys conducted (one on each behavior to be promoted).	Results of the barrier analysis survey show that there is high knowledge of malaria as a killer and dangerous disease, but translation of knowledge into practice is very low.
		Each Facilitator establishes 4 community groups consisting of 15 volunteers each for a total of 88 community groups and 1,320 volunteers.	88 community groups formed. 1,320 volunteers recruited and 1,290 retained as active volunteers (some left for paid jobs). More will be recruited in the next few months.	Each community facilitator has managed to recruit groups of 15 volunteers except for the Mangochi groups where one area has groups of 10 each because of the sparse population. Another area with more population has 20 each to compensate. 88 groups of volunteers have been formed.
		Facilitators train the 1,320 volunteers in community mobilization, malaria prevention and treatment interventions, BCC techniques, and M&E (through meetings twice per month).	1,290 volunteers have been trained in basic malaria issues including use of ITNs, IPT, and the new drug regimen of LA.	
		Households with pregnant women and/or children under five are identified and assigned to volunteers (10 per volunteer). Volunteers meet with each household twice per month.	4,584 households identified to be direct beneficiaries.	In Lilongwe 449 households have been identified. Along the lakeshore (Salima, Dedza and Mangochi) 4,135 households have been identified. At the date of compiling this data 1,234 of the households identi-fied had pregnant women. The other 3,350 are households with under-five children.

Project Objectives	Indicators & Current Measurements	Key Activities	Status of Activities & Outputs Achieved	Comments
Strategic Objective 2: Increase the proportion of households with a pregnant women or children under five that own at least one ITN.	Proportion of targeted households with a pregnant woman or children under five with at least one ITN Year 1 Target: 50% Year 1 Actual: Not surveyed Number of households participating in the program that own at least one ITN Year 1 Target: 6,600 Year 1 Actual: Not surveyed Number of households participating in the program that have re-treated their ITN(s) Year 1 Target: 0 Year 1 Actual: Not surveyed	Identify distribution points for ITNs where they will reach the poorest of the poor and communicate these to the NMCP.	NMCP has just finished an ITN campaign of distributing free ITNs to the poorest. However, its impact has not yet been assessed.	Poorest households are rated by traditional authorities.
		Educate households about how to access free or subsidized LLINs through local distribution points.	Still pending. Will commence soon after volunteer training has been finalized.	
		Mobilize communities to attend annual net re-treatment campaigns organized by the GOM.		No outputs from this activity were expected until year 2.
Strategic Objective 3: Increase the proportion of children under five and pregnant women who sleep under an ITN every night.	Proportion of pregnant women in targeted households who slept under an ITN the previous night Year 1 Target: 30% Year 1 Actual: Not surveyed Proportion of children under five in targeted households who slept under an ITN the previous night Year 1 Target: 30% Year 1 Actual: Not surveyed Number of households participating in the program that received messages about proper net use Year 1 Target: 6,600 Year 1 Actual: Not surveyed	Train 1,320 volunteers in BCC techniques for increasing the number of pregnant women and children under five sleeping under ITNs.	1,290 volunteers trained in BCC for increasing use of ITNs	Information dissemination still pending year 2.
		Use of IEC and BCC to increase the correct and consistent year-round use of ITNs at the community level.		The selection of IEC materials for this behavior is being finalized based on the results of the Barrier Analysis survey.

Project Objectives	Indicators & Current Measurements	Key Activities	Status of Activities & Outputs Achieved	Comments
Strategic Objective 4: Increase the proportion of pregnant women receiving two or more doses of SP for IPTp during their pregnancies.	Proportion of women in targeted households who received two or more doses of IPTp during their last pregnancy in the last two years Year 1 Target: 60% Year 1 Actual: Not surveyed Proportion of women in targeted households that cite IPTp as a necessary treatment during pregnancy Year 1 Target: 80% Year 1 Actual: Not surveyed Number of volunteers trained to counsel pregnant women to obtain treatment Year 1 Target: 1,320 Year 1 Actual: 1,290 Number of pregnant women participating in the program who received a second dose of IPTp Year 1 Target: 1,742 Year 1 Actual: Not surveyed	Train 1,320 volunteers in IPTp promotion.	1,290 volunteers were trained in basic IPTp promotion.	More training will be provided in year two to give more information and strategies for promoting IPTp
		Coordinate with CDC to access IEC materials on IPTp for volunteers to share with beneficiaries and for Nkhoma Synod Health Department facilities to make available to patients.	Coordination is happening with PMI partners and NMCP for IEC materials on IPTp.	
		Volunteers promote behavior change among pregnant women to increase earlier ANC attendance and to increase their understanding of the importance of IPTp (which is provided free at ANC clinics).	Volunteers received initial training about IPTp and its relation to ANC clinics	
Strategic Objective 5: Increase the proportion of children under five with suspected malaria receiving treatment with an antimalarial drug within 24 hours of onset of symptoms.	Proportion of children under five years old in targeted households with fever in the last two weeks who received treatment with an anti-malarial within 24 hours of onset of fever Year 1 Target: 40% Year 1 Actual: Not surveyed	Link 22 Facilitators to training on the proper use of the new first line drugs (provided by other PMI partner in Malawi).	Basic training on the use of LA was conducted by Health officers of the District hospitals. There are plans that the District Health Management Team (DHMT) will be asked to train the facilitators more in depth on the use of LA.	

Project Objectives	Indicators & Current Measurements	Key Activities	Status of Activities & Outputs Achieved	Comments
Strategic Objective 5 (continued)	Number of Facilitators trained on use of new first line drugs Year 1 Target: 22 Year 1 Actual: 0 Number of volunteers trained in the new drug policy Year 1 Target: 1,320 Year 1 Actual: 0 Number of households participating in the program that received information about the new drug policy. Year 1 Target: 6,600 Year 1 Actual: 0	Facilitators train volunteers on the Government of Malawi's new first line drug policy.	Awaits the training by DHMT for facilitators and other project staff	
		Use of IEC and BCC at the community level that is focused on the new drug policy and changing the behavior of care givers so that children receive prompt and effective treatment.	The selection of IEC materials for this behavior is being finalized based on the results of the Barrier Analysis survey.	

B. Factors Impeding Progress

The main limiting factor for the whole project has been time. It was expected that things would move fast and that by June 2008 training of volunteers would be completed. However, activities took longer than expected, such as the data collection for barrier analysis, which took two months (June and July 2008). Initially it was planned that the barrier analysis would take place in May, May was used to train facilitators.

Another limiting factor was that the volunteers requested to be the first trained in what they would be teaching the communities. This changed the whole implementation plan, since initially the volunteers were to be trained on the job by Facilitators every week for a short session. This required us to develop training materials for a workshop aimed at volunteers. These materials have been developed in conjunction with the NMCP and BASICS. This training will be finalized before the end of October 2008. For this reason only a few households have been identified for the activities.

Another challenge was accessing information, education and communication (IEC) materials. This challenge has been rectified by the USAID Mission office. Our program can access the available IEC materials from the Health Education Unit of NMCP and from PSI Malawi.

The next step in our behavior change communication (BCC) strategy is selecting the IEC materials that can help participants overcome barriers to the promoted behaviors, which were identified through the Barrier Analysis surveys. These materials will then have to be produced in some format that can be distributed in the communities. Materials will be reviewed and approved by NMCP before distribution.

Community level IEC materials are relatively new for NMCP and PSI in Malawi. During our Partners meeting on 25th September 2008, a subcommittee was formed composing of PSI Malawi, NMCP and BASICS to look into preparation of a workshop on formulating more IEC materials for the community level that will be pretested and approved before use by partners.

The other problems that were talked about during the previous quarterly reports were already rectified. These included:

- There were delays in procuring some of the motor cycles for the Program Supervisors and processing them through the Malawi Revenue Authority. But this is finished now, and all the equipment and supplies for the program have been acquired as planned.

- All community Program Facilitators have been connected to church ministers and their District Health Management Teams.

- There are road network problems in some target communities because of the heavy rainfall this year in January, which caused some bridges to be destroyed. The poor rural road network remains a challenge, however most bridges that were destroyed have been repaired.

- The MCP Program Coordinator has transitioned into using one of the former CRWRC offices in Lilongwe. There are just two people in the office (the coordinator and accountant). The rest of the staff are based in the communities and the assistant coordinator is based in the small town, Salima where he is renting an office. Nkhoma Relief and Development is our sub-grantee but their offices are more than 60km away from Lilongwe and not in the direction of any of the communities where we are implementing this project.

C. Technical Assistance

CRWRC has interacted with the Child Survival Technical Support Project (CSTS+) for feedback about its monitoring systems for this project. The CRWRC Malawi staff and CRWRC's Health Adviser in the headquarters office worked together to develop the monitoring system. Ideas were then shared by CSTS+ about how to improve the system so that information is collected efficiently.

CRWRC received technical assistance for the Designing for Behavior Change workshop from Bonnie Kittle, an independent consultant with over 30 years of experience in training design and facilitation. She trained the MCP project staff on how to design and monitor a behavior change program. This workshop also included a training of trainers for the Program Coordinator, Assistant Program Coordinator and the Program Supervisors which focused on how to conduct a Barrier Analysis and how to use the results to develop behavior change activities.

The project also sought some technical assistance during analysis of the barrier surveys. The issue was mainly due to lack of time on the part of the Coordinator to complete data entry and analysis of the data. A social scientist from the Centre for Social Research at the University of Malawi, Chancellor College was asked to do the analysis for the Project.

D. Specific Information Requested

CRWRC was asked to clarify about how volunteers are selected and about how beneficiary households are targeted.

The selection of volunteers was the primarily responsibility of village headmen who appointed people who have passion for malaria and a heart of giving to become volunteers in their specific clans. These volunteers then identified ten households in their nearby area with pregnant women or children under five years of age needing education and behavior change about malaria prevention and treatment.

The identification of the households is still in progress. There are a total of 4,584 households of beneficiaries that have been identified so far. These identified households have a total of 1,234 pregnant women that might transit to under-five shortly. The other 3,350 are households with under-five children.

CRWRC was also asked to clarify about the Barrier Analysis Survey.

The barrier analysis survey was conducted in June and July 2008. The survey has revealed that there is great knowledge of perceived threat and illness of malaria but low practice in taking action and doing something about it. Related to this is the need for men to encourage their female partners to change their behavior towards preventing and treating malaria.

The barrier analysis also confirmed other studies that most pregnant women start their antenatal clinics rather too late in the second trimester. This has led to low uptake of the second dose of SP for IPTp. While some pregnant women start their antenatal clinics and receive their first dose of SP early enough, they usually only return to the clinic for delivery, thereby missing their second dose. In other words, it isn't simply the behavior of beginning antenatal care too late that needs to change, it is also the inconsistency in visits to antenatal clinics.

NRD has since printed T-shirts for volunteers in one area. These T-shirts carry messages that address male involvement as well as taking at least two doses of SP during pregnancy. More IEC materials will be distributed to the volunteers emphasizing how to overcome the particular barriers identified for each behavior. The analysis is still being finalized and some questions that have come up will be followed up in the field through focus group discussions.

E. PMI Team Collaboration In Country

The collaboration between the PMI Team and our program has been of increasing benefit throughout the year. PMI Team members meet the last Thursday of each month to discuss the progress made and to address issues faced by the organizations. These meetings also give an opportunity to partners to collaborate better and fill necessary gaps in their work according to the strategy and goals of both the NMCP and PMI. Some of the activities that our program has done together with the PMI Team follows:

- First, our MCP program was introduced to the National Malaria Coordination Program through the PMI Mission office by Ms. Kate Wolf. The introductions were made in February when the Program Consultant and Program Coordinator met the Deputy Program Manager of NMCP. During the same visit, the MCP program had an opportunity to explain about our working strategies, which districts we work in and we received authority to meet the DHMTs of operating districts.
- May 2008 was the month when the USAID mission office recruited a Malaria Logistics specialist, who is the point of contact when we are dealing with the PMI Team head office at USAID.
- In June and July 2008, some of the MCP Program Facilitators had an opportunity to be trained by BASICS (the PMI partners which is sub-granting to the Malawi Red-Cross Society) in Dowa. This training was for Health Surveillance Assistants (HSAs) in Dowa who are working in BCC focused on malaria in areas other than those operated by our MCP program.

- In August 2008, there was a workshop by BASICS (a partner of PMI) in Liwonde, where all the partner members were invited to participate. NRD and all the other NGOs working on malaria met for three days and discussed ways to collaborate and work together better towards one goal. Our MCP Coordinator was on the planning committee for this meeting.
- In August 2008, the PMI Team received a visitor from the US: Ms. Karen Fogg of CSTS+. She visited one of our MCP sites in Dowa. This showed good collaboration between our MCP program and the PMI Team of USAID Malawi.
- In September 2008, the PMI Team assisted our program staff to access IEC materials from the producing sources like PSI Malawi and the NMCP, as well as Health Education Units. Preparations are underway on a workshop that will invite all the local partners to give input on what kind of IEC materials they need for their projects and in what format they should be presented i.e. pamphlets, fliers, billboards etc. There is a technical interim committee working on the logistics and the way forward for the workshop. This working committee is comprised of representatives from PSI, the USAID Mission, BASICS, and NMCP.
- In October 2008, there was a visit by the global coordinator of PMI, Mr. Admiral Timothy Ziemer who also visited another one of our MCP program sites in rural Lilongwe.

F. Work Plan Matrix

Objective / Activity	Outputs Year 1	PMI Targets to which outputs will contribute	National Indicators Supported by	Timeline	Key Sub-partners	Location (districts)
***Strategic Objective 1*: Strengthen and sustain community capacity for malaria prevention and treatment interventions.**						
Activity: Recruit and orient new Program Coordinator to replace Mrs. Mdala, whose resignation becomes effective mid-November.	New Program Coordinator recruited and oriented	All of these outputs must be achieved in order to accomplish the activities listed under Strategic Objectives 2-5. Therefore, these outputs contribute to all the PMI Targets listed below.	All of these outputs must be achieved in order to accomplish the activities listed under Strategic Objectives 2-5. Therefore, these outputs contribute to all the NMCP indicators listed below.	November - December	CRWRC and NRD	Dowa, Lilongwe, Mchinji, Salima, Dedza, Mangochi, Nkhotakota, Ntchisi, Kasungu
Activity: Recruit and orient 4 additional Supervisors.	4 additional Supervisors hired and oriented			November - December	NRD	
Activity: Recruit Malaria Program Facilitators	20 Malaria Program Facilitators recruited			December	NRD	
Activity: CRWRC's Health Adviser travels to Malawi to provide training and consultation on the Child Survival Sustainability Assessment (CSSA) Framework	Project staff (Coordinator, Assistant Coord and Supervisors), along with other NRD staff, trained in the CSSA Framework			December	CRWRC and NRD	
Activity: Facilitators trained in the community mobilizing, the BEHAVE Framework, and M&E	20 Facilitators trained			January	NRD	
Activity: New Supervisors and Facilitators are introduced to and build relationships with their local District Health Management Team (DHMT) and congregation ministers	Relationships established and communication opened with DHMT and ministers in all target communities			January	NRD, DHMT, and congregational ministers	
Activity: Scale up the program to 12 new congregational catchment areas.	Program active in a total of 25 congregational catchment areas covering 9 districts.			January - September	NRD	
Activity: Conduct barrier analysis in new communities. Conduct focus group discussions to enhance understanding of BA results from year one. Develop behavior change strategies.	Barrier analysis completed and behavior change strategy finalized			November (focus groups to follow up on BA conducted in year one); February - April (new geographic areas added in year two)	NRD	
Activity: Each Facilitator establishes 4 community groups consisting of 15 volunteers each.	80 new community groups formed. 1,230 new volunteers recruited.			March - May	NRD	

Objective / Activity	Outputs Year 1	PMI Targets to which outputs will contribute	National Indicators Supported by	Timeline	Key Sub-partners	Location (districts)
Activity: Volunteers trained by Facilitators in community mobilization, malaria prevention and treatment interventions, BCC techniques, and M&E. (twice per month meetings)	1,230 new volunteers trained; 1,290 ongoing volunteers trained			October through September	NRD	
Activity: Households with pregnant women and/or children under five identified and assigned to volunteers (10 per volunteer). Volunteers meet with each household twice per month	25,200 households identified to be direct beneficiaries			October for the first group and March for the second group	NRD	
***Strategic Objective 2*: Increase the proportion of households with a pregnant woman or children under five that own at least one ITN.**						
Activity: Identify distribution points for ITNs where they will reach the poorest of the poor and communicate these to the NMCP.	Distribution points for ITNs identified and communicated to NMCP	More than 90% of households with a pregnant women and/or children under five will own at least on ITN.	% of the poorest of the poor owning ITNs.	Whenever government distribution campaigns may occur	NRD, NMCP, DHMT, and local health facilities	Dowa, Lilongwe, Mchinji, Salima, Dedza, Mangochi, Nkhotakota, Ntchisi, Kasungu
Activity: Educating households about how to access free or subsidized LLINs through local distribution points	15,120 households in the program own at least one ITN		% of households owning ITNs.	October - September	NRD	
Activity: Mobilize communities to attend annual net re-treatment campaigns organized by the GOM	10 community re-treatment campaign events		% of nets re-treated.	November	NRD, NMCP, and DHMT	
***Strategic Objective 3*: Increase the proportion of children under five and pregnant women who sleep under an ITN every night.**						
Activity: Train volunteers in BCC techniques for increasing the number of pregnant women and children under five sleeping under ITNs.	2,520 volunteers trained in BCC techniques to increase net usage	85% of children under five and pregnant women will have slept under an ITN the previous night.	% of community committees trained.	October - September	NRD	Dowa, Lilongwe, Mchinji, Salima, Dedza, Mangochi, Nkhotakota, Ntchisi, Kasungu
Activity: Coordinate with PMI partners in country to access existing IEC materials on ITN use or develop new ones. Volunteers will share IEC materials with beneficiaries, and Nkhoma Synod Health Department facilities will make them availalble to patients.	IEC materials on IPTp obtained		% of pregnant women and children under five sleeping under ITNs.	October - September	NRD and possibly PSI, NMCP, CDC and/or HEU.	
Activity: IEC and BCC to increase the correct and consistent year-round use of ITNs at the community level.	25,200 households receiving messages about proper net usage		% of pregnant women and children under five sleeping under ITNs.	October - September	NRD	

Objective / Activity	Outputs Year 1	PMI Targets to which outputs will contribute	National Indicators Supported by	Timeline	Key Sub-partners	Location (districts)
***Strategic Objective 4*: Increase the proportion of pregnant women receiving two or more doses of SP for IPT during their pregnancies.**						
Activity: Train volunteers in IPTp promotion	2,520 volunteers trained in IPTp promotion	85% of women who have completed a pregnancy in the last two years will have received two or more doses of IPTp during that pregnancy.	Number of IPT community	October - September	NRD	Dowa, Lilongwe, Mchinji, Salima, Dedza, Mangochi, Nkhotakota, Ntchisi, Kasungu
Activity: Coordinate with PMI partners in country to access existing IEC materials on IPTp or develop new ones. Volunteers will share IEC materials with beneficiaries, and Nkhoma Synod Health Department facilities will make them availalble to patients.	IEC materials on IPTp obtained		% of pregnant women taking second dose of SP.	February and June	NRD and possibly PSI, NMCP, CDC and/or HEU.	
Activity: Volunteers promote behavior change among pregnant women to increase earlier ANC attendance and to increase their understanding of the importance of IPTp (which is provided free at ANC clinics).	85% of women in targeted households that cite IPTp as a necessary treatment during pregnancy.		% of pregnant women taking second dose of SP.	October - September	NRD, Nkhoma Synod Health Dept., and District Health Office	
***Strategic Objective 5*: Increase the proportion of children under five with suspected malaria receiving treatment with an antimalarial drug within**						
Activity: Link Facilitators to training on the proper use of the new first-line drugs.	42 Facilitators trained on use of new first line drugs.	85% of children under five with suspected malaria will have received treatment with an antimalarial drug in accordance with national malaria treatment policies within 24 hours of onset of their symptoms.	% of health workers or HSAs trained.	October - September (whenever training is offered)	NRD and DHMTs with local health facilities	Dowa, Lilongwe, Mchinji, Salima, Dedza, Mangochi, Nkhotakota, Ntchisi, Kasungu
Activity: Facilitators train volunteers on the GOM's new first line drug policy	2,520 volunteers trained in the new drug policy		% of health workers or HSAs trained.	October - September	NRD	
Activity: Coordinate with PMI partners in country to access existing IEC materials on malara treatment or develop new ones. Volunteers will share IEC materials with beneficiaries, and Nkhoma Synod Health Department facilities will make them availalble to patients.	IEC materials on IPTp obtained		Proportion of communities with IEC materials on family and community practices.	February and June	NRD and possibly PSI, NMCP, CDC and/or HEU.	
Activity: IEC and BCC at the community level that is focused on the new drug policy and changing the behavior of caregivers so that children receive prompt and effective treatment	25,200 households receive information about the new drug policy		Proportion of communities with IEC materials on family and community	October - September	NRD	

G. PMI Annual Report Information

1. Insecticide-Treated Bednets	Number (MCP contribution only except where noted)	Comments	Data Source
Total number of ITNs procured	**N/A**	MCP does not have a component of procurement.	
Total number of ITNs distributed	**N/A**		
Please indicate the number of ITNs distributed through:			
(a) campaigns	(a) N/A		
(b) antenatal clinics or child health clinics	(b) N/A		
(c) private/commercial sector	(c) N/A		
(d) other distribution channels (specify)	(d) N/A		
Number of nets retreated with insecticide	0	Planned for year two (2008-09)	
If IEC activities have been carried for ITNs, please provide more information below. Describe any community sensitization/ mobilization meetings held, radio/TV spots aired, brochures/pamphlets/posters created, drama/theatre shows held. Community sensitization about the importance of using an ITN and re-treating bed nets with insecticide commenced already in the communities through dramas, dances and choirs. The coordinator, together with the field staff, teach the volunteers important messages and ask them to produce songs, dramas, poems and dances that reinforce these important messages. After scrutinizing their activities the messages are corrected and these dances, dramas, poems and songs are performed in the communities for the beneficiaries to learn from.			

2. Malaria in Pregnancy	Number (MCP contribution only except where noted)	Comments	Data Source
Number of health workers trained in IPTp	N/A		
Number of SP tablets procured	N/A		
Number of SP tablets distributed to health facilities	N/A	*If available, please also provide the number of SP tablets that were distributed to patients.*	
If any IEC activities have been carried out for IPTp, please provide more information below. Describe any community sensitization/ mobilization meetings held, radio/TV spots aired, brochures/pamphlets/posters created, drama/theatre shows held. Community sensitization on the importance of IPTp has commenced in the communities through dramas, dances and choirs. The coordinator, together with the field staff, teach the volunteers important messages and ask them to produce songs, dramas, poems and dances that reinforce these important messages. After scrutinizing their activities the messages are corrected and these dances, dramas, poems and songs are performed in the communities for the beneficiaries to learn from.			

3. Case Management	Number (MCP contribution only except where noted)	Comments	Data Source
Number of health workers trained in ACT use	NA		
Number of ACT treatments procured	N/A		

Number of ACT treatments distributed	N/A	*If available, please also provide the number of ACT treatments that were distributed to patients.*	
Please indicate the number of ACT treatments distributed through:			
(a) health facilities	(a) N/A		
(b) community health workers (HBMF, CCM)	(b) N/A		
(c) private/commercial sector	(c) N/A		
Number of health workers trained in malaria diagnostic techniques (RDTs or microscopy)	N/A		
Number of RDTs procured	N/A		
Number of RDTs distributed to health facilities	N/A	*If available, please also provide the number of RDTs that were actually used.*	

If any IEC activities have been carried out for ACTs/RDTs, please provide more information below. Describe any community sensitization/ mobilization meetings held, radio/TV spots aired, brochures/pamphlets/posters created, drama/theatre shows held.

Community sensitization about the importance of quickly accessing effective treatment for malaria, especially for children under five, has commenced in the communities through dramas, dances and choirs. The coordinator, together with the field staff, teach the volunteers important messages and ask them to produce songs, dramas, poems and dances that reinforce these important messages. After scrutinizing their activities the messages are corrected and these dances, dramas, poems and songs are performed in the communities for the beneficiaries to learn from.

Has your MCP-funded project played a role in logistics, supply chain management, and/or pharmaceutical management related to ACTs? Please describe. Include any effects that the your project has had on the logistics etc of ACTs procured by other donors as well.
N/A

4. Additional information

(a) For any of the above focus areas, has your project helped *facilitate* the implementation of malaria activities by other major partners such as the MoH, Global Fund, UNICEF, WHO, etc ? Please list instances where MCP-funded activities resulted in synergies with other partners. Highlight examples that show how your project has complemented the work of other partners, resulting in greater impact, less duplication, more collaboration, etc

No.

(c) Have any new policies related to malaria been initiated since your project began in your target location? Please list these below. (Examples of any new policies or changes to policies include (but are not limited to): distribution of free nets, distribution of free drugs, adoption of ACTs/IPTp, support and adoption of community treatment (HBMF), new drug treatment policies and guidelines, new RDT policies and guidelines, new IVM policy or strategy, new NMCP strategy, adoption of IRS and/or agreement to spray households indoors, lifting of any taxes/fees imposed on malaria commodities, changes in government allocations or human resources)

No changes have been documented currently.

6. Photos, Stories, and Quotes: Please include at least 2 success stories that illustrate PMI activities in your country. For photos, please include a photo credit and a brief caption. High-resolution photos are preferred. Please also send any quotes about PMI that are specific to your country. These can be quotes from MOH officials, other partners, community health workers, health facility workers, beneficiaries, etc.

See attached documents

H. Other Relevant Information

One important aspect of CRWRC's Malaria Communities Program is that it uses both the church structure as well as cultural and traditional aspects of the community to facilitate behavior change at the household and community levels. This has greatly assisted in bridging the gap between the routine curative clinical services and the community beneficiary in the village**.**

I. Publications or Presentations

No publications or presentations at conferences have been done.