Original proposal received below.
Request: 20,000 LLINs (originally 50,000)
Approved: 10,000 LLINs

Against Malaria Foundation

LLIN Distribution Proposal Form

AMF use only. Date received by AMF: Date of decision:

A. Summary

# of LLINs	Country	Location	When	By Whom
20,000	Malawi	Zomba	September 2010 - October 2011	Save the Children

B. Further Information

INSTRUCTIONS PLEASE ADD INFORMATION IN THE BLUE BOXES. THE SPACE SHOWN IS A GUIDE ONLY. BOXES WILL EXPAND AS YOU TYPE TO FILL 3, 4 OR MORE PAGES AS APPROPRIATE. PLEASE ENSURE YOU PROVIDE ANSWERS TO THE SPECIFIC QUESTIONS ASKED. **PLEASE EMAIL RESPONSES TO ROB MATHER AT RMATHER@AGAINSTMALARIA.COM THANK YOU.**

Date proposal sent to AMF: **April 16, 2010**

1. Please describe the specific locations & villages to receive nets and the number to each? Please provide longitude/latitude information.
Important note: If the distribution is approved, approval will be for the nets o be distribution to these specific locations. Location changes will only be considered, and may be refused, if due to exceptional/unforeseen circumstances.

The proposed ITN distribution is planned in Chikowi Traditional Authority (TA), Zomba district of Malawi. The area has 54 primary schools, where Save the Children is implementing basic education and Early Childhood Development (ECD) interventions and will soon be beginning school health and nutrition interventions. The proposed ITN distribution is planned in 50 selected schools from this area. Shown below are the schools where the proposed ITN distribution is planned.

No	Name/location of School	Zone	Number of children	Number of ITNs[1]
1	Chikomwe	Chikomwe	200	400
2	Kayeramadzi	Chikomwe	200	400
3	Nakamba	Chikomwe	200	400
4	Mulinga	Chikomwe	200	400
5	Nantchengwa	Chikomwe	200	400
6	Chimbeta	Chikomwe	200	400
7	Kasimu	Chikomwe	200	400
8	Sakalawe	Chikomwe	200	400
9	Machereni	Chimwalira	200	400
10	Utwe	Chimwalira	200	400
11	Sambaalendo	Chimwalira	200	400
12	Bishop Mackenzie	Chimwalira	200	400
13	Mtimawoyera	Chimwalira	200	400
14	St. Pius	Chimwalira	200	400

[1] Please note that the exact number of nets to be distributed per school will be determined only after the final sampling is completed for the study and the list of children is prepared. The number of additional children to receive ITNs will also need to be determined through consultations with head teachers of the schools.

15	Chimwalira	Chimwalira	200	400
16	Malonje	Chimwalira	200	400
17	Sabola	Chimwalira	200	400
18	Jenala	Chimwalira	200	400
19	Nachiswe	Chimwalira	200	400
20	Mathuwa	Chimwalira	200	400
21	Nanjiri	Chimwalira	200	400
22	Ntangatanga	Namatapa	200	400
23	Namatapa	Namatapa	200	400
24	Namakwena	Namatapa	200	400
25	Nakholopa	Namatapa	200	400
26	Sunuzi	Namatapa	200	400
27	Namakungwa	Namatapa	200	400
28	Chanda	Namatapa	200	400
29	St. Martins	St. Martins	200	400
30	Taibu	St. Martins	200	400
31	Nathupi	St. Martins	200	400
32	Khuluvi	St. Martins	200	400
33	Mpanda	St. Martins	200	400
34	Thangala	St. Martins	200	400
35	Nazitimbe	St. Martins	200	400
36	Mateketa	St. Martins	200	400
37	Namalombe	St. Martins	200	400
38	Mchenga	St. Martins	200	400
39	Namiyala	St. Martins	200	400
40	Muluma	St. Martins	200	400
41	Ulumba	Chikala	200	400
42	Chimbeta	Chikomwe	200	400
43	Nalikukuta	Namiwawa	200	400
44	Namilambe	Namiwawa	200	400
45	Nanjiwa	Namiwawa	200	400
46	Thabwani	Namiwawa	200	400
47	Gologota	St. Anthony	200	400
48	Likhubula	St. Anthony	200	400
49	Makoka	St. Anthony	200	400
50	Thondwe	St. Anthony	200	400
Total			**12,000**	**20,000**

During the first phase of distribution during September-October 2010, the target is to distribute 5,000 ITNs to 2,500 children from 25 schools. An equal number of ITNs will be distributed to another 2,500 children from the remaining 25 schools during September – October 2011. The exact schedule of distribution and the number of children per school in will be determined only after consultations with all concerned parties.

The GPS coordinates for Chikowi is shown below:

Latitude:	-15.41667
Longitude:	35.3
Latitude (DMS):	15° 25' 0 S
Longitude (DMS):	35° 17' 60 E

2. Is this an urban or rural area and how many people live in this specific area?

The project site is Chikowi Traditional Authority (TA) in Zomba district, located in the Southern part of Malawi, South of Lake Malawi. The sub-Traditional Authorities are, Mbiza, Ntholowa and Ngwelero. The region is mainly rural with very poor road network and access to essential services. Zomba district has a rural population of 583,167 (Census 2008).

Chikowi TA area is has a population of 153,785 with 660 villages. The area encompasses 7 education zones and 54 schools with a total enrolment of 46,016 of which 23,186 Boys and 22,830 Girls. School attendance in the area is erratic as seen from the average daily attendance which is 66% for boys and 72% for girls (District Education Office).

3. Is this a high risk malaria area for this country? If yes, why do you designate it as high?

Malaria is endemic in all parts of the country, with seasonal peaks between December and April. Over 85 percent of malaria infections in Malawi are due to *P. falciparum.* According to the DHO's information, Zomba is a high malaria risk area and Chikowi reports high number of malaria cases through its five health facilities**.**

4. Baseline malaria case information. How many reported cases of malaria and malaria deaths were there in the specific area in the most recent period available? We are looking for data from health clinics in the area. Month by month information is strongly preferred. We are NOT looking for regional/national level information. Please cite sources. Baseline malaria case information forms the basis of comparison post-distribution.

The area has six health facilities namely: Ngwelero Health Centre (govt), Nasawa Health Centre (govt), Magomelo Health Centre (CHAM), Lambulira Health Centre (govt) Mayaka Health Centre (CHAM) and Thondwe (Govt).

During the 18 months period of July 2008-December 2009, there were a total of 86,828 cases of malaria from the project catchment area that includes six health facilities, including 38,380 cases among children under five years of age. In the entire district of Zomba, a total of 140,200 malaria cases were reported during the six-months period of July 2009-December 2009, including 28,205 cases from the six health facilities within Chikowi TA. A total of 400 in-patient deaths were reported from the districts during the same reporting period. Please refer to the attached worksheet for health facility-wise and month-wise details of malaria cases.

Malaria Data Zomba Malawi April 15.xls

5. Is this distribution of nets 'blanket coverage' of an area/village or to a select/vulnerable group? If the latter, please describe this group.

The distribution of ITNs will be targeted at school children registered in grades 1-5 in the 50 schools identified for this project. While malaria represents one of the main health problems afflicting Malawian children, bed net use in Malawi is still low. Only 31% of children under five sleep under a bed net, which is likely to be even lower for school-age children. International agencies have recognized that schools can and should play a role in malaria prevention (PCD *et al,* 2009)[2]

The proposed distribution is part of a research to "evaluate the effectiveness of distributing and promoting LLINs through schools in reducing prevalence of *Plasmodium falciparum* infection and anaemia and improving school attention among school children". The evidence base for policy development and programme implementation for school-based malaria control remains inadequate. This research will investigate the health and education benefits of distributing and promoting ITNs through schools and yield important information for both heath and educational policy makers and programme managers as they plan malaria control in school. The study will be conducted by Save the Children, in collaboration with the District Health and Education Office in Zomba, KEMRI Wellcome Trust and the London School of Hygiene and Tropical Medicine

The programme will be implemented in 50 schools and will be phased in over two years. The 50 schools will be randomly divided into two groups, the first 25 schools will receive

[2] Partnership for Child Development, London School of Hygiene and Tropical Medicine, Kenya Medical Research Institute- Wellcome Trust Research Programme, The World Bank (2009). Malaria Control in Schools: A toolkit on effective education sector responses to malaria in Africa.

LLINs in September-October 2010 and the second group will receive them in September-October 2011.

The children will be enrolled for the study based on the following selection criteria:

a. Pupil enrolled at participating schools in grades 1-5
b. Provision of informed consent from parent or guardian
c. Provision of assent by student

LLINs will be distributed to all children participating in the study. Each participating child will receive two LLINs free of costs, one for him/herself and another for his/her younger sibling. In consultation with the school head teachers, siblings from the same family will be identified to ensure that if there are two children from the same household both do not receive nets. This is to ensure that an excess number of nets are not provided to the same households.

6. What is the existing level of ITN use in this area? Are there existing bednet distribution programmes in this area?

Since November 2002, the Government of Malawi introduced a subsidy on mosquito nets and developed ITN guidelines to standardize and facilitate the distribution of mosquito nets in Malawi. The Government and development partners supply mosquito nets and insecticide treatment kits for distribution at subsidized costs to communities through three main distribution channels: health facilities, community organizations, and the private sector. Despite huge improvement in net ownership and use observed since 2000 (DHS, 2000), the 2006 MICS[3] shows that only 51% of households in Malawi have at least one net and 31% of children under five slept under a net the preceding night. In Zomba district only 45% households have at least one ITN and only 26% of children 0-5 years slept under an ITN last night (MICS2006).
Millennium project has so far distributed 4,000 nets have been distributed in adjacent areas of Chikowi, and 4,600 nets in Thodwe area which is close to Chikowi. Anglican Diocese of the upper shire also distributed 1,000 nets to their members in part of Nasawa area. These, however, do not overlap with our proposed intervention areas.

7. Why was the area/villages chosen for bednet distribution and who made this decision? Please provide the name, position, organisation contact information of the person/s making the decision.

In Zomba district, Chikowi TA area has one of the highest prevalence of malaria. Save the Children is implementing school health and nutrition interventions in this area which makes it feasible to integrate the LLIN distribution within the on going program activities in the area without requiring additional resources. This decision was made in by Prince Kasinja, Sponsorship Operations Manager, Save the Children in Malawi in consultation with the research team for this study and district health management team.

8. Have you consulted with the country's National Malaria Control Programme about this distribution and what was their response? Please provide the name, position and contact details of the person/s with whom you have liaised.

The proposed plan was discussed with Ms. Doreen Ali, National Malaria Control Program Manager, Cell +265-888-374-043, Email: alidoreen@yahoo.com
We were advised to ensure good coordination with the malaria control activities within the district through the health facilities to avoid overlaps.

9. Please give the name and contact information for the (government) head of the district health management team for the/each area. Please ensure you include contact information.

Dr. Chanizya,Mwalanbiya, District Medical Officer, Zomba District Hosptal, Zomba, Email: chanizya@yahoo.com

10. Please confirm the nets will be distributed free-to-recipients, a requirement for us to fund nets.

We confirm that the nets will be distributed free-to-recipients

[3] National Statistics Office, UNICEF Malawi (2006). Monitoring the situation of women and children: Malawi Multi-Indicator Cluster Survey Preliminary Report.

11. Please describe any pre-distribution activity, in particular how the size of the target group and number of nets required will be ascertained?

The District Health Management Team of the district will be actively involved to facilitate the coordination between district education and health offices. The district health office and the members of the district health management team responsible for malaria control activities in the district will be involved in the planning of the distribution.

Selected schools will be visited one month prior to the baseline survey date to have the purpose of the survey explained to the head teacher and school committee, and informed parental consent will be sought from the parents/guardians of children. A series of questions will be asked of the parent or guardian of each randomly selected participating child including: education, basic household assets indicators and use of mosquito nets. An information sheet and consent form will be given to all children and parents/guardians and 100 children (50 girls and 50 boys) will be then randomly selected from each school to participate in the study.

The list of additional children to receive LLINs will be prepared with the support of head teachers. This is to avoid selection of multiple children from the same households. The final list of all the selected children and the number of nets each was to receive will be prepared and a copy shared with the school.

Baseline health and education surveys will be conducted in July 2010 and follow-up health and education surveys will be conducted in July 2011.

12. Please describe how the bednets will be distributed and by whom. Please give detail. Please indicate over what time period (typically, the number of days or weeks) the distribution will occur.

Distribution timeframe will be identified after consultation with the head-teachers of each school and tentative dates for distribution in each school will be agreed on. The
Distribution dates would range from September 1, 2010 to October 31, 2010 for the first phase schools and September 1, 2011 to October 31, 2011 in second phase schools. A final distribution schedule will be arrived at after consultative deliberations with all the parties involved.
The Community Liaison Assistants, Basic Education Facilitators, Early Childhood Development (ECD) Facilitators who are currently involved in school health and nutrition and ECD activities that are implemented by Save the Children in the same areas will be primarily responsible for managing the LLIN distribution. The members of the Parent Teacher Associations (PTA) will also be involved to organize and support the net distribution sessions.

13. Please describe the malaria education component of the distribution. Please give detail.

A pupil booklet and teachers guide on the effective use of LLINs by schoolchildren and their families, developed and evaluated by Population Services International in Kenya will be adapted to the Malawian context and teachers trained to use it with their class. Save the Children will also use the Community Action Cycle, a proven community mobilization approach developed by Save the Children and other partners to mobilize the community to increase bed net use generally.

Each distribution session will be complemented with sensitization of parents/guardians on the following key areas:
• *Use and maintenance of LLINs:* process of proper nets hanging, how to maintain it, process of how to wash and dry them and etc.
• *Malaria prevention:* importance of sleeping under treated nets, environment sanitation, waste management, proper drainage system, protective clothing to prevent mosquito bite
• *Early Signs of malaria:* fever, vomiting, headache, loss of appetite.
• *Early treatment seeking:* Immediate referral to the nearest health facility or to a trained IMCI service provider in the nearest location

Demonstration of net hang up will be done in some selected houses close to the schools to

reinforce the messages given and also show the community how to customize net hanging in their kind of housing structures.

Health staff from the nearest health facility and/or Health Surveillance Assistants (HSA) will be involved to provide health education messages to the parents/guardians during the distribution sessions.

14. Please confirm: a) you will conduct immediate post-distribution follow-up to assess the level of usage (hang-up %) of the nets; b) this take place within four weeks of the distribution; c) you will provide us with the findings.

We confirm that we will conduct an immediate post-distribution follow-up to assess the usage within four weeks of the distribution and the findings will be shared with AMF.

15. Please confirm you will send a Post-Distribution Summary when the distribution is complete.**

We confirm to send AMF a post-distribution summary

16. Please confirm you will send us, post-distribution, at least 60 digital photos per sub-location*, taken at the distribution/s, to be added to our website as we report on the distribution to donors.**

We confirm that we will send AMF, post-distribution at least 60 digital photos per sub-location taken at the distribution to be added to AMF's website

17. Please confirm you will provide at least 20 minutes video footage from each sub-location. It does not need to be 'broadcast' quality and can be taken with a handheld digital video camera.**

We confirm that we will provide at least 20 minutes video footage from each sub-location

18. Please confirm: you will carry out longer-term Post-Distribution Surveys (PDss)** to assess the level of usage (hang-up %), correct usage and condition of the nets; b) this will take place 6, 18, 30 and 42 months after the distribution of the nets; c) you will provide us with the findings.

We confirm that we will carry out longer-term Post-Distribution Surveys to assess the level of usage, correct usage and condition of the nets and that we will share the findings with AMF.

19. Please provide your name, role and organisation and full contact information.

Prince Kasinja, Sponsorship Operations Manager, Save the Children in Malawi, Private Bag 254, Blantyre – Malawi. Phone: +265 1 847 831 (Office) +265 8 888 463 50 (Mobile) Email: pkasinja@savechildren.org

*Sub-locations are mutually agreed and are typically a portion of the total distribution ie A 20,000 net distribution, for photo and video reporting purposes, might be divided into 5 sub-locations.
**Information on the provision of photos, video, Post-distribution Report and Post-Distribution surveys is included in the attached document.

Ends— **THANK YOU!**

Original proposal received below.
Request: 18,881 LLINs
Approved: 4,500 LLINs

Against Malaria Foundation

LLIN Distribution Proposal Form

AMF use only:
Date received by AMF:
Date of decision:

A. Summary

# of LLINs	Country	Location	When	By Whom
18,811	Malawi	Malosa in Zomba District, Machinga District in areas of Likwenu and Chamba	July – December 09	MACOBO in collaboration with Population Services International

B. Further Information

INSTRUCTIONS
PLEASE ADD INFORMATION IN THE BLUE BOXES. THE SPACE SHOWN IS A GUIDE ONLY. BOXES WILL EXPAND AS YOU TYPE TO FILL 3, 4 OR MORE PAGES AS APPROPRIATE. PLEASE ENSURE YOU PROVIDE ANSWERS TO THE SPECIFIC QUESTIONS ASKED. WE DO NOT EXPECT LENGTHY ANSWERS. PLEASE EMAIL RESPONSES TO ROB MATHER AT RMATHER@BTINTERNET.COM THANK YOU.

Date proposal sent to AMF:

24. July 2009

1. Please describe the specific locations & villages to receive nets and the number to each? Please provide longitude/latitude information. 35.5 E 15.5 S
Important note: If the distribution is approved, approval will be for the nets o be distribution to these specific locations. Location changes will only be considered, and may be refused, if due to exceptional/unforeseen circumstances.

We are hoping to distribute the free nets to the listed villages once supplies available in Zomba District, and are; Disi 241 nets, Chitenjere1030nets,Malunga 640nets, Ndaje391nets, Nsuwira 385nets, Machemba 873nets, Mtambo 455nets, Chipire 205nets, Jauma 231nets, in Machinga will cover the following villages, Mkanda 1484 nets, Misewe 1245nets ,Maulidi 710 nets, Mgwira 865nets, Msoma 672nets, Mawiriga 1097nets, Chitimba 535nets, Mpango 970nets ,Kawamba 488 nets, Nkalawire 1898nets, Mang'anda 335 , Chowe 743 nets, Kalanje 1548 nets, Msusa 871 nets and Mbuliro 899 nets

2. Is this an urban or rural area and how many people live in this specific area?

All rural area consisting population of 18,811 people**,** which has 186 villages**.**

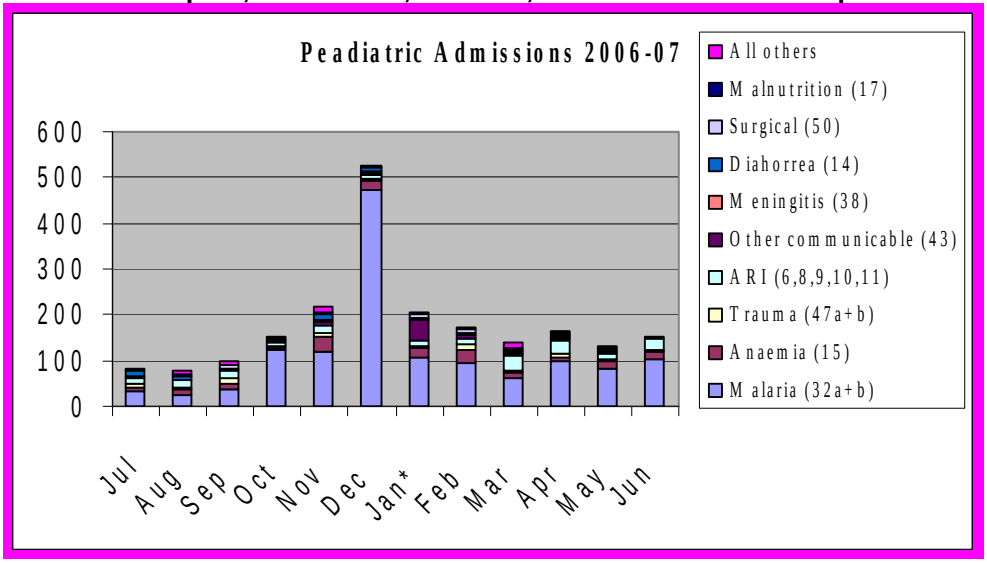
3. Is this a high risk malaria area for this country? If yes, why do you designate it as high?

Yes, areas are proximity to big rivers, swampy and are close to basin lake chilwa which has no outlet as compared to other lakes in Malawi and very close to broad forest of malosa plateau. *Malaria falciparum – cerebral complications and high mortality rate.*

4. Baseline malaria case information. How many reported cases of malaria and malaria deaths were there in this specific area in the most recent period available? We are looking for data from health clinics in the area. Month by month information is strongly preferred. We are NOT looking for regional level/national level information. Please cite your source. Baseline malaria case information forms the basis of comparison post-distribution.

Local Mission hospital report malaria > 50% diagnosis of paediatric admissions [of 2,366 admissions, 1,364] & 50% of mortality causes in children [72 of 142]

St Luke's Hospital, PO Box 21 , Chilema, Nr Zomba. Annual Report



5. Is this distribution of nets 'blanket coverage' of an area/village or to a select/vulnerable group? If the latter, please describe this group.

No this is not blanket coverage, but will be distributed in an area through selection of villages of very poor people and will be divided in zones with the approval of primary health care of each district.

6. What is the existing level of ITN use in this area? Are there existing bednet distribution programmes in this area?

Level if ITN use is very low in all the areas visited, and still not any bed nets distribution programmes except only pregnant women who received at St Luke's under five clinics.

7. Why was the area/villages chosen for bednet distribution and who made this decision? Please provide the name, position, organisation contact information of the person/s making the decision.

We are a community-based organisation of long standing in the area and have experience of working with volunteers in all the above-named villages.
Hazwell Phiri,
Home Based Care coordinator,
MACOBO,
Post Box 71,
Chilema- Malosa
265 9 297 327
macobo@sdnp.org.mw
due to high cases of continuous Malaria among poor women, Men and children and majority can not afford to purchase the mosquito nets due to high price, we decided to support them because the government can not manage to give out bed nets to such poor people because its expensive, so to avoid disturbing of development we've decided to give the poorer so that will contribute to their development**.**

8. Have you consulted with the National Malaria Programme in your country about this distribution and what was their response? Please provide the name, position and contact details of the person/s with whom you have liaised.

Consultation has been made to Public primary health officer, for St Luke's Hospital who has welcome the idea and has encouraged us to work hand in hands with his office for the project who will brief the zone malaria programmes office about the progress of the project.
His name is Symon Langisi, Clinical Officer,St Luke's Hospital, Box 21, Chilema- Malosa, Zomba.
Contact phones 265 995 602 026 / 265 888 323 587
email: symonlangisi @yahoo.co.uk or stluke's@sdnp.org.mw

9. Please give the name and contact information for the (government) head of the district health management team for the/each area. Please ensure you include contact information.

District Health Officer, Machinga District Evance Chisiano, Machinga District Health Office, Office, Private bag 24, Machinga. Contact line; 265 999 915 465	DHO	Zomba Central Hospital. Mr. William Mlotha, Zomba District Health Private bag 18, Zomba.

10. Please confirm the nets will be distributed free-to-recipients, a requirement for us to fund nets.

Yes. The areas, we are working majority are disadvantaged people who can not buy so with the statistics we get they are sleeping without nets due to poverty.

11. Please describe any pre-distribution activity, in particular how the size of the target group and number of nets required will be ascertained?

The pre-distribution will take 2month because the exercise needs proper good observations the required positive recipients and time frame for our staff who will take the effort of distribution as for Machinga will be exactly 4 weeks with bed nets of 14, 360

12. Please describe how the bednets will be distributed and by whom. Please give detail. Please indicate over what time period (typically, the number of days or weeks) the distribution will occur.

The bed nets will be distributed through the management of MACOBO in combination with health surveillances working in all locations identified as primary beneficiaries of the project in supervision with Home based care coordinator.
The distribution will only done on its special programme as a pilot project to eradicate malaria at village level, information education component will be integrated in this programme as to show how to take care of them, right drugs to treat bed nets and best place to dehydrated them when applied anti mosquito drugs, with this will help to reduce the high number of malaria pandemic.

13. Please describe the malaria education component of the distribution. Please give detail.

MACOBO will train all beneficiaries using the drama group as well as demonstration of how to drop a net in chemicals which can kills mosquitoes and other flying insects for a period of 10 months each, in that way will build the knowledge and awareness of the transmission, treatment and prevention of malaria in these communities, the program will be taking place immediately at every distribution centers, photos of the exercise will be shoot and send to concerned stakeholders.

14. Please confirm: a) you will conduct immediate post-distribution follow-up to assess the level of usage (hang-up %) of the nets; b) this take place within four weeks of the distribution; c) you will provide us with the findings.

The exercise will be done through community volunteers and government health assistants allocated in all the areas identified, secondly every village will be checked with the level of

malaria through their health passbook in this way it is a time to examine true figures of malaria per week in a month.

15. Please confirm you will send a Post-Distribution Summary when the distribution is complete.**

Post- distribution summary will be send to you after every distribution is done through email and your postal addresses.

16. Please confirm you will send us, post-distribution, at least 40 digital photos per sub-location, taken at the distribution/s, to be added to our website as we report on the distribution to donors.*

Digital photos per each program will be sending to you as evidence that the activity took place and we will work also with representatives from Malaria management office as our witness in the country that we've distributed to right beneficiaries.

17. Please confirm you will provide at least 5 minutes video footage from each sub-location. It does not need to be 'broadcast' quality and can be taken with a handheld digital video camera.*

MACOBO will provide 5mins video footage highlighting the packing, offloading and speeches made by influential leaders at the site of distribution, then few one by one recipients and their comments.

18. Please confirm: you will carry out longer-term Post-Distribution Reviews (PDRs)** to assess the level of usage (hang-up %), correct usage and condition of the nets; b) this will take place 6, 18, 30 and 42 months after the distribution of the nets; c) you will provide us with the findings.

MACOBO will take this project as to prioritizing the use of the mosquito nets by the physically defenseless. All the findings will be delivered to all stakeholders in every 3 months as to assess the level of the progress of the project.

18. Please provide your name, role and organisation and full contact information.

Henry Chikakuda, Organization chairman, MACOBO, Post Box 71, Chilema - Malosa Zomba, Malawi Tel/Fax: 265 1 539 369, 265 888 327 259 / 265 995 228 655
email; macobo@sdnp.org.mw

*Sub-locations are mutually agreed and are typically a portion of the total distribution ie A 20,000 net distribution, for photo and video reporting purposes, might be divided into 5 sub-locations.
**Information on the provision of photos, video, Post-distribution Summary and Post-Distribution Reviews is included in the attached document.

*Information on the provision of photos, video and a Post-distribution Summary is included in the attached document.

Ends— **THANK YOU!**

Original proposal received below.
Request: 20,000 LLINs
Approved: 10,000 LLINs

Against Malaria Foundation

LLIN Distribution Proposal Form

AMF use only:
Date received by AMF:
Date of decision:

A. Summary

# of LLINs	Country	Location	When	By Whom
20,000	India	Orissa	Jan/Feb 2010	S.O.V.A
e.g. 20,000	e.g. Namibia	e.g. Caprivi…	e.g. Apr-May2010	e.g. Red Cross

20th July 2009

18°49′N 82°43′E / 18.82, 82.72

SUMMARY

Area Name	Pop	# of HH	Nets (2/HH)	Day
Sunki	3,194	699	1,398	1-7
Ralegeda	3,280	698	1,396	8-13
Sargiguda	2,365	450	900	1-3
Batasana	7,100	1,501	3,002	4-13
Koraput NAC	2,775	685	1,370	14-17
Badekeranga	6,245	1,528	3,056	18-23

Lankaput & Suku	**10,406**	**2,823**	**5,646**	**24-33**	
Kundra	**7,902**	**1,080**	**2,120**	**34-39**	
Lima	**4,934**	**1,241**	**2,482**	**39-43**	
	48,201	**10,705**	**21,370**		

DETAIL

Area Name	Village Name	Pop	# of HH	Nets (2/HH)	Day	PP/HH	PP/NET
Sunki	Goudaguda.	117	30	60	1	3.9	2.0
	Totabalasa.	104	19	38	1	5.5	2.7
	Ippabalasa	124	25	50	1	5.0	2.5
	Sunki.	1,021	209	418	2,3	4.9	2.4
	Panasmanguda.	157	22	44	4	7.1	3.6
	Andarangi.	148	27	54	4	5.5	2.7
	Nimalpadu.	165	38	76	4	4.3	2.2
	Mungarugumi.	61	13	26	4	4.7	2.3
	Jamuguda.	106	16	32	5	6.6	3.3
	Sankupadu.	168	40	80	5	4.2	2.1
	Gadigudibalasa.	60	19	38	5	3.2	1.6
	Alasi.	66	13	26	5	5.1	2.5
	Metabalasa.	75	12	24	5	6.3	3.1
	Patalaudi.	62	14	28	6	4.4	2.2
	Ittabalasa.	89	22	44	6	4.0	2.0
	Gangapani.	105	21	42	6	5.0	2.5
	Laudi.	228	77	154	6	3.0	1.5
	Olagaon.	115	26	52	7	4.4	2.2
	Gurujiguda.	114	26	52	7	4.4	2.2
	Rengalpadu.	109	30	60	7	3.6	1.8
	Subtotal	**3,194**	**699**	**1,398**			
Ralegeda	Rallegada.	460	72	144	8	6.4	3.2
	Kartalaba.	123	29	58	8	4.2	2.1
	Ittabalasa.	89	19	38	9	4.7	2.3
	Budepadu.	62	13	26	9	4.8	2.4
	Badapadu.	167	38	76	9	4.4	2.2
	Bandhulupadu.	94	18	36	9	5.2	2.6
	Kumbhapadu.	63	12	24	9	5.3	2.6
	Metabera	163	33	66	10	4.9	2.5
	Sidipadu.	139	28	56	10	5.0	2.5
	B.Lamatapadu.	94	23	46	10	4.1	2.0
	Puthapadu.	276	76	152	10	3.6	1.8
	Mirialupadu.	265	65	130	11	4.1	2.0
	Jodimadili.	230	51	102	11	4.5	2.3
	Tangini.	145	31	62	11	4.7	2.3
	Rajuguda.	183	39	78	12	4.7	2.3
	Kurelupadu	226	48	96	12	4.7	2.4
	Jamuguda.	77	19	38	12	4.1	2.0
	Pilika Bitra.	59	12	24	13	4.9	2.5

	Bitra.	196	37	74	13	5.3	2.6
	Telarai.	169	35	70	13	4.8	2.4
	Subtotal	**3,280**	**698**	**1,396**			
Sargiguda	Andiramunda	600	90	180	1	6.7	3.3
	Sargiguda	240	55	110	1	4.4	2.2
	Pokhnaguda	403	100	200	2	4.0	2.0
	Birahandi	173	32	64	2	5.4	2.7
	Pathanguda	455	90	180	3	5.1	2.5
	Miriguda	494	83	166	3	6.0	3.0
	Subtotal	**2,365**	**450**	**900**			
Batasana	Lal Munda	292	79	158	4	3.7	1.8
	Khatlaguda	433	75	150	4	5.8	2.9
	Potraguda	773	167	334	5	4.6	2.3
	Batasana	999	210	420	6,7	4.8	2.4
	colony no 4	794	141	282	8	5.6	2.8
	Sitiliguda	779	142	284	9	5.5	2.7
	Colony no 5	437	73	146	10	6.0	3.0
	Camp no 4 B	257	60	120	10	4.3	2.1
	Camp no 6	178	44	88	10	4.0	2.0
	Camp no 7	701	182	364	11	3.9	1.9
	Kasomguda	631	118	236	11	5.3	2.7
	A.Ghatarla	826	210	420	12,13	3.9	2.0
	Subtotal	**7,100**	**1,501**	**3,002**			
Koraput NAC	Champaguda	422	101	202	14	4.2	2.1
	Goudaguda	238	69	138	15	3.4	1.7
	Relikumbha	510	137	274	16	3.7	1.9
	Rangabali kumbha	1,172	263	526	16	4.5	2.2
	Mendhaguda	288	78	156	17	3.7	1.8
	Landiguda	145	37	74	17	3.9	2.0
	Subtotal	**2,775**	**685**	**1,370**			
Badekeranga	Thanacolony	368	80	160	18	4.6	2.3
	Damsite	277	67	134	18	4.1	2.1
	Nuakerenga	178	47	94	18	3.8	1.9
	Salmanguda	350	109	218	18	3.2	1.6
	Dhauda-Padar	472	148	296	19	3.2	1.6
	Gangei-padar	880	170	340	19	5.2	2.6
	Puruna-puki	321	69	138	20	4.7	2.3
	Balipadar-Guda	163	30	60	20	5.4	2.7
	Nua-puki	244	61	122	20	4.0	2.0
	Putkernga.	246	47	94	21	5.2	2.6
	Lauriguda	163	25	50	21	6.5	3.3
	Kendubeda	491	88	176	21	5.6	2.8
	Taramajiguda.	216	35	70	21	6.2	3.1
	Devighat.	988	247	494	22	4.0	2.0
	Chakarliguda.	241	69	138	22	3.5	1.7

	Bogeipadar	597	186	372	23	3.2	1.6
	Residencial School Girls	50	50	100	23	1.0	0.5
	Subtotal	**6,245**	**1,528**	**3,056**			
Lankaput & Suku	Chappar	393	103	206	24	3.8	1.9
	Umuri	584	163	326	24	3.6	1.8
	Residencial School Chakarliguda	50	50	100	23	1.0	0.5
	Machhara	992	248	496	25	4.0	2.0
	Khaparaput	94	22	44	26	4.3	2.1
	Khagadhara	61	20	40	26	3.1	1.5
	Sukuriguda	224	60	120	26	3.7	1.9
	Khilaput	132	34	68	26	3.9	1.9
	Padeiguda	303	83	166	27	3.7	1.8
	Parajapandi	366	95	190	27	3.9	1.9
	Panasput	245	57	114	27	4.3	2.1
	Narjiput	230	58	116	27	4.0	2.0
	Girlaguda	122	30	60	27	4.1	2.0
	Simla	335	96	192	27	3.5	1.7
	Kechhla	332	95	190	28	3.5	1.7
	Lankaput	342	84	168	28	4.1	2.0
	Gulelput	229	59	118	28	3.9	1.9
	Paidaput	207	49	98	28	4.2	2.1
	Kolab	243	86	172	28	2.8	1.4
	Dumuriguda	129	39	78	28	3.3	1.7
	Masiput	141	46	92	29	3.1	1.5
	Sirisi	220	65	130	29	3.4	1.7
	Chandalmundar	184	46	92	29	4.0	2.0
	Pitai	552	138	276	29	4.0	2.0
	Ghatmundar	232	58	116	30	4.0	2.0
	Kalchur	244	61	122	30	4.0	2.0
	Bhoiguda	204	51	102	30	4.0	2.0
	Parajamundar	612	168	336	31	3.6	1.8
	Kadamguda	108	28	56	31	3.9	1.9
	Hingeiput	222	59	118	31	3.8	1.9
	Hatasuku	586	192	384	32	3.1	1.5
	Lanjisuku	348	93	186	32	3.7	1.9
	Malikudubi	116	31	62	32	3.7	1.9
	Hariamunda	712	178	356	33	4.0	2.0
	Padachenda	312	78	156	33	4.0	2.0
	Subtotal	**10,406**	**2,823**	**5,646**			
Kundra	Majurgula	105	22	44	34	4.8	2.4
	Bonuguda	174	44	88	34	4.0	2.0
	Bhadraguda	68	15	30	34	4.5	2.3
	Heruguda	161	33	66	34	4.9	2.4
	Heruguda colony	96	27	54	34	3.6	1.8
	chendia jhiligao	175	34	68	35	5.1	2.6
	jhiligao	227	52	104	35	4.4	2.2
	mundiguda	81	19	38	35	4.3	2.1

	Kaudiaguda	110	33	66	35	3.3	1.7
	raikundra	187	51	102	35	3.7	1.8
	Bausia guda	181	42	44	36	4.3	4.1
	Kudum padar	3,392	78	156	36	**43.5**	**21.7**
	chatriguda	98	20	40	36	4.9	2.5
	Bhajiguda	60	12	24	36	5.0	2.5
	jeeraguda	393	70	140	36	5.6	2.8
	kenduguda	407	94	188	37	4.3	2.2
	sardhapur-1	168	36	72	37	4.7	2.3
	sardhapur-2	202	52	104	37	3.9	1.9
	makdiguda	157	41	82	37	3.8	1.9
	katnikund	259	60	120	38	4.3	2.2
	kaliaguda	152	26	52	38	5.8	2.9
	tabhapadar	259	44	88	38	5.9	2.9
	pakhnaguda	150	47	94	38	3.2	1.6
	Ghandgaguda	435	87	174	39	5.0	2.5
	padampur	205	41	82	39	5.0	2.5
	Subtotal	**7,902**	**1,080**	**2,120**			
Lima	Bandia guda	155	31	62	39	5.0	2.5
	kusum guda	481	134	268	40	3.6	1.8
	chandrapadia guda	61	11	22	40	5.5	2.8
	Behera guda colony	97	20	40	40	4.9	2.4
	Beheraguda	119	26	52	40	4.6	2.3
	Tentulipar	99	25	50	40	4.0	2.0
	Chanchara guda	91	25	50	40	3.6	1.8
	Santali guda	134	33	66	40	4.1	2.0
	Pradhani guda	185	51	102	40	3.6	1.8
	Ghatgundal	341	80	160	41	4.3	2.1
	Khutuguda	116	26	52	41	4.5	2.2
	Manji guda	67	17	34	41	3.9	2.0
	salap padar	117	26	52	41	4.5	2.3
	Badtalia guda	132	33	66	41	4.0	2.0
	Agram guda	81	22	44	41	3.7	1.8
	Pandkimari	260	61	122	41	4.3	2.1
	Gundal	298	82	164	42	3.6	1.8
	Pandripani	339	80	160	42	4.2	2.1
	Katri guda	61	18	36	42	3.4	1.7
	Barma guda	107	31	62	42	3.5	1.7
	Ada munda	41	11	22	42	3.7	1.9
	Hatguda	117	33	66	42	3.5	1.8
	Khalapi guda	288	64	128	43	4.5	2.3
	Jhalaguda	110	32	64	43	3.4	1.7
	Jhadiguda	81	32	64	43	2.5	1.3
	Kumbarguda	333	81	162	43	4.1	2.1
	Pukiaguda	332	76	152	43	4.4	2.2
	Gunthaguda	291	80	160	43	3.6	1.8
	Subtotal	**4,934**	**1,241**	**2,482**			

Grand Total	**48,201**	**10,705**	**21,370**

2. Is this an urban or rural area and how many people live in this specific area?

Rural

3. Is this a high risk malaria area for this country? If yes, why do you designate it as high?

High Risk.

Provisional data for the year 2006 (provisional) reveals the largest numbers of cases in the country were reported by Orissa, followed by Jharkhand, West Bengal, Assam, Chhattisgarh, Rajasthan, Gujarat & Uttar Pradesh and the largest numbers of deaths were reported by Assam followed by Orissa, West Bengal, Arunachal Pradesh, Meghalaya, Maharashtra, Mizoram, Gujarat & Karnataka.

Statistics stated by Dr John Oommen, during an interview on film in Feb 2009. Dr Jonny is a clinical and community health and malaria specialist in Orissa.
'Orissa has 3% of the population of India, 30% of the malaria cases, and 95% of those are falciparum' Dr Jonny is contactable 0091 674 3201850 and jcoommmen AT gmail.com
www.mrcindia.org/MRC_profile/epidemiology/true_incidence.

www.mrcindia.org/rourkela
Malaria is a major public health problem in Orissa state, which contribute highest number of malaria cases (22 %), 43% of total P. falciparum cases and about 50% of all reported deaths due to malaria in the country although it constitute only 4% of the total population of India. Tribal areas of the state such as Sundargarh district are the most seriously affected regions of the state where malaria exists in meso- to hyper endemic form. *P. falciparum* is the major cause of malaria and accounts for 80-90% malaria cases in the tribal areas of the state, which have distinct ecological features such as hilly terrain, forest fringe and forested area or foothill ecosystems where all the malariogenic factors operate at their maximum efficiency. Malaria is clearly one of the major health problem in this region and is responsible for significant morbidity and mortality.

Report from 2002 [PDF] HEALTH STATUS OF PRIMITIVE TRIBES OF ORISSA - 2:37am File Format: PDF/Adobe Acrobat - View
1 Regional Medical Research Centre, Indian Council of Medical Research, Chandrasekharpur, Bhubaneswar 751 023, India 2SCB Medical College and Hospital, Cuttack 753 007, India

Orissa, an eastern Indian state with 3.47% of the country's population, contributes 23% of the malaria cases, 40% of *Plasmodium falciparum* cases and 50% of malaria attributed deaths in the country. 2. Retrospectiveanalysis3 of the epidemiological data of Orissa reveals that there is a steady rise in the number of malaria-attributed deaths from 131 in 1995 to 465 in 2002.

4. Baseline malaria case information. How many reported cases of malaria and malaria deaths were there in this specific area in the most recent period available? We are looking for data from health clinics in the area. Month by month information is strongly preferred. We are NOT looking for regional level/national level information. Please cite your source. Baseline malaria case information forms the basis of comparison post-distribution.

National Vector bourne disease Control Programme data.
Malaria cases in Orissa 2008. 359,619. Recorded deaths – 218
'Report by Orissadiary correspondent; Bhubaneswar: Feb 18th 2009.
Study reveals Orissa has earned the dubious distinction of topping the list of cerebral malaria affliction standing at 44 per cent against the all-India figure of 725,502 cases per annum. The study reveals that Orissa not only soars the vulnerability scale but also posts itself in the pinnacle of fatality rate of plasmodium falcifarum.

5. Is this distribution of nets 'blanket coverage' of an area/village or to a select/vulnerable group? If the latter, please describe this group.

Blanket coverage.

6. What is the existing level of ITN use in this area? Are there existing bednet distribution programmes in this area?

I have worked in the area for 5 years and have seen very little evidence of bed net distribution. Where in a few villages nets have been distributed, they are not LLIN's.

7. Why was the area/villages chosen for bednet distribution and who made this decision? Please provide the name, position, organisation contact information of the person/s making the decision.

The area was chosen by Anne Heslop – contact 07956 549099. I have a small charity in Koraput, and have always known that the area was endemic but it wasn't until recently I became aware of the magnitude and repercussions of the rapidly changing epidemic and current statistics.

Specific villages were chosen by Sanjit Patnayak (secretary of SOVA)
SOVA (South Orissa Voluntary Action),Rangabali Kumbha Road,Koraput-764020,Orissa,India.Tel:06852-250194(F),250590,Mobile:91-9437077718
Email:sovakpt@gmail.com,website:www.sovakoraput.org

8. Have you consulted with the National Malaria Control Programme in your country about this distribution and what was their response? Please provide the name, position and contact details of the person/s with whom you have liaised.

I have discussed this proposal with Dr R.K Guru and Dr N Chowdrey in Koraput Orissa, who are the Central District Medical Officers specializing in Malaria in the region. I have also discussed this with Dr Jonni from the Christian Missionary Hospital in Bissam Cuttack, Rayagada, who is a malaria expert. Their response was to encourage the distribution.

The NMCP representative is Dr RK Guru.

9. Please give the name and contact information for the (government) head of the district health management team for the/each area. Please ensure you include contact information.

The contacts are Dr RK Guru and Dr N Chowdrey. They are both available at the CDMO in Koraput Orissa. Dr RK Guru's mobile no is 0091 9437 119061.

10. Please confirm the nets will be distributed free-to-recipients, a requirement for us to fund nets.

I confirm the nets will be free to recipients.

11. Please describe any pre-distribution activity, in particular how the size of the target group and number of nets required will be ascertained?

I intend to spend time in Koraput and Rayagda in October/Nov this year to plan and organize the distributions, and to begin the malaria (Re) education programme. We will run the preliminary malaria education meetings in conjunction with existing HIV/AID's conferences. The target group is so large that 20,000 nets is just a place to start. SOVA has been working with the target villages for 12 years and has the

statistics of all the villages. Most villages are between 50 -100 households so I have calculated that with 2 nets per household we will be able to 'blanket cover' approx 120 villages.

12. Please describe how the bednets will be distributed and by whom. Please give detail. Please indicate over what time period (typically, the number of days or weeks) the distribution will occur.

The 'bednets' will be distributed by SOVA, and aided by Anne Heslop. We will be enlisting the help of established women's groups and local volunteers. I believe it will take approx two months to complete the distribution. For 2 weeks of that month we will be assisted by Quinton Fivelman, and 2 medical students. It will be a focused effort and will begin with information/education. In previous meetings with villagers, I have found that despite NGO's attempts to educate using street plays, and leaflets most tribal's are still confused about the way malaria is contracted. The practice of treating 'any fever' with chloroquine also has to be re-thought, so re education is necessary.

About SOVA
SOUTH ORISSA VOLUNTARY ACTION, KORAPUT, ORISSA

SOVA were the first NGO to set up a charity in this area working with remote marginanlised tribal communities.

Number of full and part time staff: 57 Volunteers: 73

'We are non-profit, non-political, secular organization* working in Koraput, one of the poorest districts in India. Our team of committed development professionals works hands-on with over 225 tribal villages encouraging men, women and children to participate in their own holistic development. Our participatory process motivates the most marginalized people in society to work together in addressing issues that affect their lives. *We provide the training, information and resources; they make the difference.*

We work in five key areas – health, education, governance, livelihood and disaster relief – with a special emphasis on empowering women and children. Some of our varied projects include HIV/AIDS awareness through peer educators, reproductive health training to village midwives, alternative education for tribal children, additional income sources for farmers and advocacy tools for local self governing bodies, to name a few.
By partnering with local and national NGOs as well as government agencies, our combined efforts form a much bigger picture for eliminating poverty in India. As a lead NGO in South Orissa, we build the capacity of local NGOs and community-based organizations so they can work to their full potential.The grassroots community organizations and programs we develop and support provide tribals a platform to make informed decisions, stand up for their rights and help each other thrive. We measure success not by our own actions, but by those adopted and carried forward by the tribals themselves.

Square kilometers villages are spread over: Approx 960 Sq Km

13. Please describe the malaria education component of the distribution. Please give detail.

We intend to educate firstly by establishing that the recipients understand the way that malaria is transmitted. We will also explain that there are different types of malaria and that the most dangerous type, is now the most common, and is largely resistant to chlorequinn. Rapid diagnostic kits (SB Malaria Diagnostic Kit; Orchid Malaria Diagnostic Kit) are available and we will ensure that these are supplied to local health workers, and explain why it is necessary to diagnose the illness before treatment. We will show them how to se the mosquito nets, and also explain that to

eradicate malaria from the specific village/block it is vitally important that nets are used by the entire village every night, and we will encourage them to work together as a village to ensure that people comply with this. We will also remind them of the breeding requirements for the mosquito to thrive.

14. Please confirm: a) you will conduct immediate post-distribution follow-up to assess the level of usage (hang-up %) of the nets; b) this take place within four weeks of the distribution; c) you will provide us with the findings.

I confirm usage will be monitored, and that we will provide a report of the findings.

15. Please confirm you will send a Post-Distribution Summary when the distribution is complete.**

I confirm the above.

16. Please confirm you will send us, post-distribution, at least 40 digital photos per sub-location*, taken at the distribution/s, to be added to our website as we report on the distribution to donors.**

I confirm the above.

17. Please confirm you will provide at least 5 minutes video footage from each sub-location. It does not need to be 'broadcast' quality and can be taken with a handheld digital video camera.**

I confirm the above.

18. Please confirm: you will carry out longer-term Post-Distribution Reviews (PDRs)** to assess the level of usage (hang-up %), correct usage and condition of the nets; b) this will take place 6, 18, 30 and 42 months after the distribution of the nets; c) you will provide us with the findings.

I confirm the above.

19. Please provide your name, role and organisation and full contact information.

Anne Heslop. Anne Heslop Photography/Goats and Hopes for Orissa.
32a Arundel Sq, Islington, N7 8AS
0207 609 6339 and 07956 549099

*Sub-locations are mutually agreed and are typically a portion of the total distribution ie A 20,000 net distribution, for photo and video reporting purposes, might be divided into 5 sub-locations.
**Information on the provision of photos, video, Post-distribution Summary and Post-Distribution Reviews is included in the attached document.

Ends— **THANK YOU!**

Original proposal received below.
Request: 301,000 LLINs
Approved: 40,000 LLINs

SCHEDULE A - PROGRAMME DOCUMENT

Against Malaria Foundation

LLIN Distribution Proposal Form
A. Summary # of LLINs Country Location When By Whom

World Vision (WV) plans to distribute 301,000 LLINs in 17 districts reaching 3 Provinces (Northern, Southern and Eastern) in Zambia beginning in June 2009. These districts received LLINs in a 2007 distribution, but the NMCP and districts have identified gaps in LLIN coverage. WV aims to fill these gaps to achieve universal coverage (3 LLINs per household) within those communities where WV (or RAPIDS) has a presence. A community-based approach will be employed using volunteers to distribute the LLINs, demonstrate net hang-up, provide malaria education, and distribute written IEC/BCC material.

B. Further Information

1. Please describe the specific locations & villages to receive nets and the number to each? Please provide longitude/latitude information.
Important note: If the distribution is approved, approval will be for the nets to be distribution to these specific locations. Location changes will only be considered, and may be refused, if due to exceptional/unforeseen circumstances.

World Vision-RAPIDS supported communities in the districts below will be targeted for this LLIN distribution.

No.	District	Latitude/ Longitude	World Vision ADP Name	Partner	Total # LLINs needed/district	Estimated Population
1	Choma	16 48'S/26 59'E	Hamaundu, Moyo	WVZ	5,201	20,490
2	Kalomo	17 00'S/26 30'E	Kalomo, Siachitema, Twachiyanda	Africare WVZ CARE TSA	20,015	84,752
3	Monze	16 17'S/27 29'E	Choongo	Africare TSA WVZ	3,703	65,431
4	Kazungula	17 46'S/25 16'E		CARE CRS	8,388	27,306
5	Sinazongwe	17 15'S/27 28'E	Sinazongwe	WVZ	5,134	16,091
6	Livingstone	17 49'S/26 49'E		CARE TSA	6,297	61,973
7	Mazabuka (including Chikankata)	15 52'S/27 44'E	Magoye	TSA Africare WVZ TSA	9,773	40,644
8	Lundazi	12 20'S/33 07'E		WVZ	28,878	94,733
9	Chipata	13 38'S/32 28'E	Makungwa	Africare	49,183	147,016

				WVZ CARE TSA		
10	Petauke	14 14'S/31 20'E	Nyamphande	Africare WVZ CARE TSA	38,532	94,352
11	Katete	14 03'S/32 05'E	Katete	CARE WVZ	30,399	75,700
12	Nyimba	14 33'S/30 5'E	Nyimba	TSA WVZ	12,702	21,128
13	Kasama	10 16'S/31 09'E	Mwamba	WVZ	11,575	51,279
14	Luwingu	10 16'S/29 54'E	Buyantanshi	WVZ	11,575	16,152
15	Mpika	11 51'S/31 25'E	Mpika	WVZ	28,241	58,478
16	Mbala	08 46'S/31 24'E	Mbala	WVZ	24,102	149,634
17	Nakonde	09 19'S/32 46'E	Nakonde	WVZ	7,482	15,027
Total					**301,180**	**1,040,184**

2. Is this an urban or rural area and how many people live in this specific area?

These areas are mostly rural but also include some peri-urban area. The estimated total area population is 1,040,184.

3. Is this a high risk malaria area for this country? If yes, why do you designate it as high?

Yes. All nine provinces of Zambia are endemic for malaria with 90-100% of the population at risk. Although the number of malaria cases reported in Zambia declined in 2007, malaria still accounts for 45% of outpatient visits, 45% of hospital admissions, 47% of overall disease burden among pregnant women, and 50% of disease burden among children under-five years of age. The 2008 Malaria Indicator Survey (MIS) did show progress in parasitemia levels in children under five:

	% of UF with malaria parasites	
Province	MIS 06	MIS 08
Southern	8.6	7.9
Eastern	22.8	9.3
Northern	35.7	12.0

4. How many reported cases of malaria and malaria deaths were there in this area in 2005 or 2006? If you do not have statistics please make a qualitative comment.

No.	District	Malaria Incidence 2006
1	Choma	445
2	Kalomo	270
3	Monze	407
4	Kazungula	345
5	Sinazongwe	464

No.	District	Malaria Incidence 2006
10	Petauke	532
11	Katete	506
12	Nyimba	665
13	Kasama	436
14	Luwingu	428

6	Livingstone	359
7	Mazabuka	412
8	Lundazi	455
9	Chipata	437

15	Mpika	329
16	Mbala	337
17	Nakonde	229

Approximately 4.3 million clinically diagnosed cases of malaria were reported through the HMIS in 2007, this represents over a 10% decline from 2006. This figure overestimates the number of true malaria cases at the health facility level due to lack of diagnostic confirmation; it also underestimates the cases at the community level which go unreported.

5. Is this distribution of nets 'blanket coverage' of an area/village or to a select/vulnerable group? If the latter, please describe this group.

The distribution plans to fill a gap from the previous LLIN distribution in 2007 so that universal coverage is achieved in these areas.

6. What is the existing level of ITN use in this area? Are there existing bed net distribution programmes in this area?

During August of 2007 the National Malaria Control Centre conducted a mass distribution of LLINs in the three proposed provinces. At the time the objective was to reach 80% coverage, with a minimum of three nets per household. There continues to be LLIN distributions through ANC to pregnant women throughout Zambia. Again, this distribution is meant to fill identified gaps that remain.

Indicator	Proportion of households with at least one ITN		Proportion of children under 5 years old who slept under an ITN the previous night		Proportion of pregnant women who slept under an ITN the previous night	
	MIS 06	MIS 08	MIS 06	MIS 08	MIS 06	MIS 08
Province						
Southern	54	70	33	32	41	26
Eastern	45	75	29	57	38	46
Northern	33	89	18	64	21	65
Zambia	44	62	23	41	24	43

7. Why was the area/villages chosen for bed net distribution and who made this decision? Please provide the name, position and organisation of the person/s making the decision.

The areas have been chosen in consultation with the National Malaria Control Program. The selection was based on the level of vulnerability of the community and the number of LLINs needed within the districts where WV and RAPIDS are actively working.

The decision to target communities within the districts listed was made by Dr. Elizabeth Chizema Kawesha, Deputy Director, Public Health & Research – National Malaria Control Centre, Zambian Ministry of Health in collaboration with Dr. Mark Maire, Sector Specialist Infectious Diseases – Health Team, Resource Development and Management - for World Vision US.

8. Have you consulted with the National Malaria Programme in your country about this distribution and what was their response? Please provide the name, position and contact details of the person/s with whom you have liaised.

Yes. The National Malaria Control Program was consulted. World Vision-RAPIDS is a partner with Zambia's NMCP and aims to complement and supplement all national malaria prevention efforts. In line with this objective, World Vision-RAPIDS has collaborated with Dr. Elizabeth Chizema Kawesha throughout the development of this proposal.

National Malaria Control Program contact:

Dr. Elizabeth Chizema Kawesha, Deputy Director, PH & Research – Malaria
Cecilia Katebe, ITN Specialist

Zambia National Malaria Control Centre
P.O. Box 32509, Lusaka
Telephone: 260-1-282455
Telefax: 260-01- 282427

9. Please describe any pre-distribution activity, in particular how the size of the target group and number of nets required will be ascertained?

Prior to distribution World Vision/RAPIDS will work closely with Zambia's National Malaria Control Program to resolve the number of households to be reached in each community. Additionally, World Vision/RAPIDS partners within the identified districts will collaborate with the District Health Management Teams to determine how many nets each household will receive. Data available from the Rural Health Centres and District Health Management Teams will be used wherever available to verify that the nets are distributed effectively.
In addition, RAPIDS volunteer caregivers in the identified districts will be notified of the activity and RAPIDS will work with the District Health Management Teams to arrange the dates and time period of the distribution.

10. Please describe how the bed nets will be distributed, by whom, whether distribution will be a focussed effort or part of a combined programme and if there will be an information/education component to the distribution? Please indicate over what time period (typically, the number of days or weeks) the distribution will occur.

The nets will be distributed by WV/RAPIDS volunteer caregivers during community-based meetings. These meetings will be held over the span of one or two weeks, depending on community need. Prior to these meetings the caregivers will work with other Neighbourhood Health Committee (NHC) volunteers in the community to notify household heads of the distribution activity. During these meetings the caregivers, who have already been educated about malaria and prevention messages, will share their knowledge with net beneficiaries. Topics to be covered will include: how to hang and care for the net, when to use the net and why, the cause of malaria, ways of preventing malaria, and what to do when one is sick with malaria. After demonstrating how to hang the net, the caregivers will distribute the nets to the households along with a brochure that reviews the information given in local language.

11. What post-distribution follow-up is planned to assess the level of usage (hang-up percentage) of the nets? How long after the distribution will this assessment take place? Will you provide us with the findings? What will you be able to do subsequently to increase net hang-up if relevant?

WV/RAPIDS caregivers will work with the NHC to follow up with net beneficiaries by conducting home visits. During this activity the caregivers and NHC Committee volunteers will inquire about net usage and ask to see whether the net is hanging. If the net is not hanging, the caregivers and NHC members will seek to find out why the net is not in use and educate the household accordingly. This assessment will be ongoing and will begin within one month of the distribution. This activity will aim to promote and encourage net usage within the community, however because it will be done by community volunteers the findings will not be recorded.
If funding is available, World Vision/RAPIDS will to conduct a survey 12 months after the distribution to determine net usage by beneficiary households. In areas where net use is found to be low, World Vision/RAPIDS will seek to find out the reason and respond with appropriate Behaviour Change Communication strategies.

12. Please give the name and contact information for the (government) head of the district health management team for the/each area. Please ensure you include contact information.

NAME	POSITION	PHONE	MOBILE PHONE NU
Eunice Masi	DACA - Chipata District	-221157	0977-123920
Frederick Njamba	DACA - Katete District		0977-764860
Christa Nyirenda	DACA - Lundazi District	-480570	0955-
Martin Chishimba	DACA - Petauke District		0955-595135
Bywell Simpoysa	DACA - Kasama District	-222256	0977-456065
Rodrick Kabunda	DACA - Luwingu District		0977-893572
William Sikazwe	DACA - Mbala District	-450585	0977-650592
Daniel Nkondwa	DACA - Mpika District	0966-804063	
Nathan Kabwe	DACA - Nakonde District	-566965	0977-236441
Clement Moonga	DACA - Choma District	-220952	0977-883182
Jethro Muchindu	DACA - Kalomo District	-321150	
Catherine Chibala	DACA - Kazungula District		0977-320766/0966
Julius Chilongoshi	DACA - Livingstone District	45.9994162	0977-683590
Kenani Ndhlovu	DACA - Mazabuka District		0977-963666
Davie Moono	DACA - Monze	-250610	
Geofrey Kalaluka	DACA - Monze District	-250610	979257819
Lester Nambale	DACA - Sinazongwe District	26.99978882	0977-876660

13. Please confirm the nets will be distributed free-to-recipients, a requirement for us to fund nets.

The LLINs will be free.

14. Please confirm you will send us, post-distribution, at least 40 digital photos per sub-location, taken at the distribution/s, to be added to our website as we report on the distribution to donors.*

We will send digital photos. We will need to define sub-location.

15. Please confirm you will provide at least 5 minutes video footage from each sub-location. It does not need to be 'broadcast' quality and can be taken with a handheld digital video camera.*

We can provide video, but again need to define sub-location.

16. Please confirm you will send a Post-Distribution Summary when the distribution is complete.*

We will provide a post-distribution report upon completion of the distribution.

17. Please provide your name, role and organisation and full contact information.

Dr. Mark J Maire, Sector Specialist Infectious Disease
World Vision US

Phone 202.572.6445 | Fax 202.572.6480 | mmaire@worldvision.org
300 I "Eye" St. NE | Washington DC 20002 USA

*Information on the provision of photos, video and a Post-distribution Summary is included in the attached document.

Ends— **THANK YOU!**

Original proposal received below.
Request: 16,600 LLINs
Approved: 12,750 LLINs

Against Malaria Foundation

LLIN Distribution Proposal Form

AMF use only:
Date received by AMF:
Date of decision:

A. Summary

# of LLINs	Country	Location	When	By Whom
16,600	**Senegal**	**Region of Kedougou**	**May-Sept 09**	**Netlife and U.S. Peace Corps, District Sanitaire de Kedougou**
e.g. 3,000	e.g. Namibia	e.g. Caprivi	e.g. Apr-May06	e.g. Red Cross

B. Further Information

INSTRUCTIONS
PLEASE ADD INFORMATION IN THE BLUE BOXES. THE SPACE SHOWN IS A GUIDE ONLY. BOXES WILL EXPAND AS YOU TYPE TO FILL 3, 4 OR MORE PAGES AS APPROPRIATE. PLEASE ENSURE YOU PROVIDE ANSWERS TO THE SPECIFIC QUESTIONS ASKED. WE DO NOT EXPECT LENGTHY ANSWERS. PLEASE EMAIL RESPONSES TO ROB MATHER AT RMATHER@BTINTERNET.COM THANK YOU.

1. Please describe the specific locations & villages to receive nets and the number to each? Please provide longitude/latitude information.
Important note: If the distribution is approved, approval will be for the nets o be distribution to these specific locations. Location changes will only be considered, and may be refused, if due to exceptional/unforeseen circumstances.

See attached sheet Appendix 2

2. Is this an urban or rural area and how many people live in this specific area?

Rural – 40706

3. Is this a high risk malaria area for this country? If yes, why do you designate it as high?

Yes. High risk due to high malaria prevelence (Appendix 1) and lack of access to quality health care

4. How many reported cases of malaria and malaria deaths were there in this area in 2007 or 2008? Please cite your source. If you do not have statistics please make a qualitative comment.

In a comparable area, 30-50 people test positive for P. falciparum per month at the height of rainy season. The estimate amount of malaria related deaths in this area is 100 per year.

5. Is this distribution of nets 'blanket coverage' of an area/village or to a select/vulnerable group? If the latter, please describe this group.

Blanket coverage

6. What is the existing level of ITN use in this area? Are there existing bednet distribution programmes in this area?

In most of these villages, a handful of people may have nets. The condition of these nets varies. The Senegalese Government's PNLP (National Program for the Fight Against Malaria) plan, with the support of the President's Malaria Initiative, is planning to distribute nets to all children between 6 and 59 months of age in Senegal, coinciding with the Ministry of Health's Vitamin A distribution program in 2009. The Netlife / Peace Corps distribution would complete the blanket coverage of this population.

7. Why was the area/villages chosen for bednet distribution and who made this decision? Please provide the name, position, organisation contact information of the person/s making the decision.

The Department of Saraya was chosen because:
-It has one of the highest malaria prevalence rates in Senegal.
-Peace Corps Volunteers in the region are highly organized and closely collaborating with local health officials.
-The effort will add value and be closely coordinated with the Government of Senegal plan to distribute nets nationwide to children between 6 and 59 months of age.
-It is a manageable first phase of achieving 100% Kedougou region-wide coverage by 2010.
All villages in the Department of Saraya will be covered. This strategy was developed by the local health officials in consultation with Peace Corps Volunteers in the area. Contact: Chris Hedrick, Peace Corps Senegal Country Director - chedrick@sn.peacecorps.gov - +221 77 637 4704. Others participating in the strategy development include: Debbie Gueye, USAID Malaria Coordinator, dgueye@usaid.gov, **+221 33 869 6193. Dr. Yousouffa Ndiaye, Medecin Chef, District Sanitaire de Saraya, +221 77 637 0453. Dr. Doudou Sene, Regional Chef de Medecin, 77 639 0607**

More broadly, the region of Kedougou was chosen because it is at very high risk and has very high prevalence of malaria. Kedougou is the southeastern region in Senegal, bordering both Mali and Guinea. It is the most distant corner of Senegal from governmental and economic services. This Netlife / Peace Corps distribution also focuses on education around malaria prevention and treatment with these audiences. This area, with its new mining and migrant worker population, was chosen so we can also promote AIDS/HIV awareness during these educational sessions.

8. Have you consulted with the National Malaria Programme in your country about this distribution and what was their response? Please provide the name, position and contact details of the person/s with whom you have liaised.

We have consulted with the district and regional level health officials associated with the National Malaria program and with the US Government officials coordinating the President's Malaria Initiative. They are all supportive and working to ensure smooth collaboration. Contacts include: Debbie Gueye, USAID Malaria Coordinator, dgueye@usaid.gov, +221 33 869 6193. Dr. Yousouffa Ndiaye, Medecin Chef, District Sanitaire de Saraya, +221 77 637 0453. Dr. Doudou Sene, Regional Chef de Medecin, 77 639 0607

9. Please describe any pre-distribution activity, in particular how the size of the target group and number of nets required will be ascertained?

The Poste de Sante data is accurate enough in aggregate to place an order for LLINs to cover the Region of Kedougou. Based on approximately 130,000 people, and previous PC experience with LLIN distribution and the ratio of people to beds in the area, an estimated 75,000 LLINs would be needed to provide universal coverage. However, we have recently been informed of the Senegalese Government's PNLP (National Program for the Fight Against Malaria) plan, with the support of the President's Malaria Initiative, to distribute nets to all children between 6 and 59

months of age in Senegal, coinciding with the Ministry of Health's Vitamin A distribution program in 2009. If we take into account that 17% of the population is under the age of five, 62,250 nets would be needed in order to cover the remainder of the population.
Of the 62,250 nets required, 16,600 would be necessary in 2009 and 45,650 would be needed in 2010, for the planned 2 year campaign to provide universal coverage.

10. Please describe how the bednets will be distributed, by whom, whether distribution will be a focussed effort or part of a combined programme and if there will be an information/education component to the distribution? Please indicate over what time period (typically, the number of days or weeks) the distribution will occur.

Peace Corps will partner with shipping logistics experts in the US embassy Dakar to facilitate the unloading of the nets at the port and transfer to a local shipping company to transport them the 700km to Kedougou.
Once the LLINs have reached Kedougou, PCVs will work with the local Postes de Sante to create a comprehensive accurate census. Trainings will be done with local (Health Education Agents) HEAs, including extensive role-playing, site visits, and question and answer sessions in local languages. Based on the results of the census, the nets will be divided by village and prepared for transport.
From Kedougou, local governmental vehicles (sous-prefet, prefet, district sanitaire, Communautes Rurales), aided by support pledged by the local gold mining companies will transport the LLINs to selected Drop-off Points (DoP) in each zone. DoPs will be the largest, and/or most centrally located 3 or 4 villages in the catchment zone of each Poste de Sante.
LLINs left at each DoP will be divided by village, and HEAs will coordinate transport by bicycle of LLINs from the DoP to individual villages where they will be stored in the health hut, if available, or with the Village Chief until the day of the distribution.
During the distribution period, a distribution team consisting of language appropriate PCVs will be installed at the Poste de Sante, which will be used as a base of operations for all distribution activities in their catchment zone. The PCVs will sleep and take meals at the Poste and the Poste de Sante personnel will provide basic household services.
All distributions will be performed by bicycle. PCVs will bike (up to 60km per day) to villages where they will distribute the nets already brought in bulk to the village with the help the local HEAs to the population. To avoid the commercialization of the nets in the local market and assure their use, all LLINs will be removed from their packaging, and the name of the village, date, and net owners name will be written directly on the net in permanent marker.
Concurrent with the physical distribution of nets, the distribution team will perform trainings on proper usage of LLINs – time of day, season, washing instructions, etc. Trainings will also be provided on proper diagnosis of malaria and how to access Senegalese government-provided treatment. To make these trainings as memorable as possible, the distribution teams will perform skits using costumes and masks.

11. What post-distribution follow-up is planned to assess the level of usage (hang-up percentage) of the nets? How long after the distribution will this assessment take place? Will you provide us with the findings? What will you be able to do subsequently to increase net hang-up if relevant?

Follow up of the distributions will be done by local Peace Corps volunteer, local community health agents and area health post personnel. These assessments will be made at durations that coincide with other village visits. Since these village visits consist of the regular vaccination tours, they will occur at 2 to 3 month intervals. The main goal of these follow-ups is to make sure beds are hung up over beds and being used. If this is not occurring as desired, we will continue to educate the population about the benefits of proper bed net use.

12. Please give the name and contact information for the (government) head of the district health management team for the/each area. Please ensure you include contact information.

Dr. Yousouffa Ndiaye, Medecin Chef, District Sanitaire de Saraya, +221 77 637 0453.
Dr. Doudou Sene, Regional Chef de Medecin, 77 639 0607

In Saraya - Dr. Youssoupha N'Diaye
221-77-637-04-53
youlebou@gmail.com

In Kedougou - Regional Chef du Medecin, Dr. Doudou Sene
221-77-639-06-07
drdocsene@yahoo.fr

13. Please confirm the nets will be distributed free-to-recipients, a requirement for us to fund nets.

Nets will be free to recipients

14. Please confirm you will send us, post-distribution, at least 40 digital photos per sub-location, taken at the distribution/s, to be added to our website as we report on the distribution to donors.*

There will absolutely be 40 or more digital photos taken and submitted from each sub-location

15. Please confirm you will provide at least 5 minutes video footage from each sub-location. It does not need to be 'broadcast' quality and can be taken with a handheld digital video camera.*

5 minutes of video footage from each sub-location will be provided

16. Please confirm you will send a Post-Distribution Summary when the distribution is complete.*

A post-distribution summary will be submitted upon completion

17. Please provide your name, role and organisation and full contact information.

Andrew Sherman – Co President of Netlife
375 Cromwell Dr.
Rochester, NY 14610
USA
asherman@netlifeafrica.org
585.752.2799

*Information on the provision of photos, video and a Post-distribution Summary is included in the attached document.

Ends— **THANK YOU!**